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KHPT's Position Paper on Urban Health

Spotlight on the Health and Well-Being for the Urban Vulnerable

Not So Long Ago…

On the 24th of March 2020, a nationwide lockdown (for a nation of 1.3 billion people) was declared in India in the face of the COVID-19 pandemic.[i] Although there were a relatively few confirmed cases in the country at that time, concerns of widespread transmission within India's densely populated areas led to the order. It stated, ***"a total ban is being imposed on people, from stepping out of their homes for a period of 21 days"***, and was operational with about four hours of notice. With exceptions made for the police, emergency, and essential services, the lockdown mandated a suspension of all transport services, and closing of government offices, and commercial and industrial establishments[ii]. Restrictions on economic activity meant that most urban poor and migrant workers were left without wages, rations, safe shelter or social protections.[iii,iv]

Photo credit : Rajesh Balouria via Pixabay, April 2020.

And thus, in the backdrop of one of the most globally devastating public health crisis in our collective memories, the earliest visible impact in India was the mass reverse exodus of the working poor from cities back to their villages of origin. Nearly **10.4 million migrant workers began walking on foot,** many with no means of transport to make their journeys, crossing several regional borders and traversing hundreds of kilometres towards their native homes. Many died along the way.[iv,v]

Even as a more devastating second wave of Covid-19 hurtled into 2021, a receding third wave followed in early 2022, further exposing the grim characteristics that make up the migrant poor identity - **uncertainty, informality, impermanence, insecurity, and societal indifference.**[vi] If the extremes and precarities of everyday survival faced by the urban poor - migrants, the homeless, informal workers, the disabled, street children, transgender and sex workers- were barely manageable prior, they were now aggravated in every conceivable way.[vii]

The pandemic setting described here is meant to serve as a more recent reminder of how urban vulnerabilities compound during crises. What this scene helps underscore, as an example, is that the urban fabric - woven with threads of migration, informality, and precarity - presents unique challenges for health equity and health systems resilience. As India rapidly urbanizes, the imperative to recognize urban health needs and priorities as significant and more urgent becomes undeniable. This, then, requires an understanding the evolution of urban health frameworks and guidelines in India.

Urban Health and its History in the Public Health Narrative

Historically, urban health priorities in India have been tangential to mainstream public health thinking. Concurrently, trends have shown that urban populations in India have grown consistently over the decades. India's urban population is projected to be ~675 million by 2035 and UN projections[viii] show that globally, urban dwellers will exceed rural populations by 2050, with over two-thirds (~68%) of all inhabitants occupying urban environments.[ix]

Post-independence, nearly 85% of India's population resided in rural areas. In this context, the nation's historical policy and budgetary emphasis on prioritizing rural healthcare and development were necessary and well-thought out,[x] based on the foundational 1946 Bhore Committee recommendations.[xi] India's first Five-Year Plan (1951-56) established differentiated health care for rural and urban settings, though, the focus on urban preventive and promotive health remained minimal until the first National Health Policy (1983).[xii] The 1992 Krishnan Committee recommendations and the 74th Constitutional Amendment Act (CAA)[1] empowered urban local self-governments, as units closest to the people in the governance structure, to provide services related to public health, sanitation, and vital statistics while emphasizing people's participation and convergence across services.[xiii] Then, the Ninth (1997-2002) and Tenth (2002-07) Five-Year Plans subsequently prioritized the urban poor by proposing Public Health Centres (PHCs) within 1-3 km of slums and consolidating all health services- including non-communicable diseases (NCDs) and maternal-child health through accessible PHC delivery points.[xiv,xv]

The Eleventh Five Year-Plan (2012-17) was the landmark in urban health efforts[xvi] - in 2013, the National Urban Health Mission (NUHM) was introduced in addition to the National Rural Health Mission, to foster a national, all-inclusive health coverage mission.[xvii] By 2017, the revised National Health Policy identified the need to focus on the primary health care needs of the urban poor and vulnerable - that included the ***"homeless, street children, rag-pickers, rickshaw pullers, construction workers, sex workers, temporary migrants."*** [xviii] The 2017 policy also stated that it would prioritize a focus on the 'convergence' of multiple determinants of health ***(air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress),*** developing public-private models of partnership to enhance healthcare access and delivery in urban settings, improving access to adequate (tiered) healthcare and referral services, along with inclusion of the healthcare needs of those residing in peri-urban areas.[xix]

Currently, the NUHM is being implemented in 35 states and union territories of India, in all cities and towns ***"with a population of 50,000 and above, district and State Headquarters with more than 30,000 population, and the seven metropolitan cities of India,"*** [xx] as per the 2011 census.[xxi] In fact, the Draft NUHM Framework of 2023 proposes that ***"all cities and towns classified as 'urban' per the Registrar General of India with a minimum population of 15,000 ought to be brought under the purview of the NUHM."*** [xxii] (The implications herein, along with a larger description of the hierarchical structure, functioning of the NUHM, and the need to conduct a formal evaluation of its implementation to help refine its work, will follow in subsequent briefs.)

Further embodied by the layered and heterogenous nature that is the urban, there was an urgent and immediate demand for ***"a comprehensive public health intervention with a package of 12 services."*** [xxiii] This has been mirrored in the Ayushman Bharat scheme that was instituted by the Government of India in 2018 and closely followed by Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) of 2021 to enhance institutional and health system readiness through comprehensive capacity building across all levels of care (primary, secondary, tertiary), ensuring robust preparedness for effective pandemic and disaster response both now and in the future.[xxiv]

PM-ABHIM envisages a more holistic approach to decentralised healthcare by creating Urban Health and Wellness Centres (HWCs) and poly-clinics equipped with diagnostic infrastructure at the urban PHCs.[xxv] The revised 2023 Framework of the NUHM reiterates the need for holistic healthcare services with ***"effective intersectoral convergent actions to address wider social determinants of health"*** – and enlists objectives to address urban health service delivery, integrated comprehensive primary healthcare services, appropriate referral mechanisms, improved surveillance of syndromic, environmental, vector-borne and chronic diseases, strengthening prevention and promotion of healthy lifestyles and behaviours, reducing out-of-pocket expenditure and strengthening community platforms and structures such as the Mahila Arogya Samitis (MAS) and Urban Health, Sanitation and Nutrition Committees (UHSNCs).[xxvi]

[1]Footnote: The legacy of British colonial administration lent to the establishment of early and strong municipal governance structures in the three Presidency towns - Madras, Bombay, and Calcutta - where mayor's courts were created in the early 1700s primarily to transfer financial responsibility for local administration. However, despite this historical foundation in select cities, and even with the legislative impetus that the 74th CAA provides, most urban local bodies today have little agency and freedom to conduct their operational duties as stated in the amendment.

Situating the Health and Well-Being for the Urban Vulnerable

So, what ails the urban poor today? What are their vulnerabilities, challenges, priorities?

Historically, urban experiences, in comparison to the rural health landscape, have been portrayed in grey literature as being more advantageous across multiple health indicators, at times based on presumptions related to the availability of better health care resources and access, ***and the presence of private medical infrastructure.***[xxvii,xxviii] The underlying nuances that tend to be glossed over in this context are related to the "heterogeneity" of what constitutes the urban experience, specifically among the poor - stark variations in socio-economic and education levels, access to health care, informality of residence and occupation, and environmental vulnerabilities that can be traced back to unplanned urbanization, consequential unchecked environmental degradation, and disparate health and social outcomes related to extreme weather events.[xxix]

Contemporary research identifies multiple determinants impacting the health of the vulnerable, particularly social and environmental health risks inherent to urban settings alongside the scarcity of the fundamental prerequisites to health and well-being - such as potable water access, ambient air quality, and adequate residential or sanitation infrastructure.[xxx] The urban health setting also highlights an emergence of a complex disease burden encompassing reproductive and paediatric health challenges, injuries, mental health and interpersonal violence, infectious diseases, and mounting non-communicable disease burden and emergent pathogenic threats.[xxxi,xxxii]

Well intentioned and multiple state and national-level recommendations, plans, and programs exist – however, public health facilities, health care planning, and delivery in urban settings remain unevenly distributed, with services that are fragmented and/or limited for primary healthcare, alongside overburdened secondary and tertiary care services, rendering significant implications for equity in service coverage for the urban poor.[xxxiii] As a recent analysis of health metrics using multiple data sources, including the National Sample Survey (NSS), National Family Health Survey (NFHS), Longitudinal Ageing Study in India (LASI), and government health statistics showed: ***the urban poor can exhibit health outcomes inferior to their non-poor urban and rural counterparts*** across various indicators including neonatal, infant, and under-5 mortality rates, disability, and tuberculosis.[xxxiv] According to the National Family Health Survey-5 (NFHS-5) (2019-2021), the under-five mortality rate amongst the poorest urban populations was 63.4 per 1000 live births, compared to 58.8 amongst the poorest rural populations. Similarly, the infant mortality rate amongst the poorest urban quintile was 53.1 deaths per 1000 live births, as compared to 47.7 in the rural poorest quintile. And the neonatal mortality rate of the poorest urban was 39.2 per 1000 live births, when compared to 33.5 in the rural poorest quintile.[xxxv]

Looking Ahead

The path forward for health equity requires **a bold reimagining** of how cities can serve their most vulnerable residents. As India's urban transition unfolds - driven by demographic shifts, rural-to-urban migration, evolving social structures, and rapidly increasing populations - the health challenges multiply: for example, respiratory illnesses from poor air quality and poor living conditions, climate-related heat stress and vector-borne diseases and overstrained sanitation. The solutions developed and scaled in India over the next three decades will influence urban health approaches across similar settings in Asia, Africa, and Latin America.

Could we envision vibrant informal settlements where community health collectives leverage hyperlocal data to demand evidence-based change for their neighbourhoods? A time when state and municipal governments embrace the true devolution of responsibilities as envisioned in the 74th CAA, and where climate-resilient health infrastructure, and capacitated and prepared public health systems provide affordable, responsive care in cities, at all tiered levels?

In this context, we highlight the more nuanced aspects that are along the trajectory of health for the urban vulnerable and their determinants of influence. They are broadly listed as follows:

- India's healthcare system operates within a constitutional framework of federalism that divides powers between Central and State governments, with decentralization-related legislation in place to further empower local institutions and communities to participate in healthcare governance, to enhance responsiveness, accountability, and equity in service delivery. This structure enables states with substantial authority to shape healthcare frameworks and manage resources tailored to local needs, and allows for decision-making power to flow to grassroots levels where contextual realities are best understood.
    - Despite these structural advantages, significant obstacles persist within the urban including fragmented and disempowered governance, unequal resource distribution across states and localities, shortages of healthcare professionals and frontline workers, and lacking infrastructure - challenges that continue to hinder equitable access to quality healthcare across India's diverse social landscape.
- The 74th Constitutional Amendment called for devolution of responsibilities and ownership to municipalities to be empowered as effective institutions of elected urban local self-government, stressing the importance of people's participation in governance. Among 18 different components mentioned therein, public health, slum improvement, WASH, and urban poverty alleviation are a few vital functions.[xxxvi]
    - Thirty-two years later, based on inconsistencies in the understanding and implementation

of the amendment, we remain behind from reaching the goal of effective devolution of power across all functions to municipalities empowering local self-governance in our cities.[xxxvii]

- Urban health reforms rest on the need for going beyond the siloed thinking and operations of institutional, administrative, and governance structures.[xxxviii] We require functional rural-urban transition bodies, financial and decision-making autonomy at the district and municipal levels, and convergence at the level of state-led departments of Health and Family Welfare, Housing and Urban Affairs, Public Works, Transportation, Education, Water and Sanitation, Women and Child Development, Urban Development authorities, and sector-based parastatals that often work on intersecting hyperlocal issues but have limited common platforms or opportunities to engage with each other.
    - Holistic and comprehensive health outcomes cannot be separated from housing security, livelihood stability, educational opportunities, legal recognition, and social protections and dignity.[xxxix]
- The lack of equitable and accessible primary healthcare services vis-à-vis overburdened secondary and tertiary care services, compounded by inadequate human resources and infrastructure can result in an increased reliance on private healthcare, with high out-of-pocket expenditures for many households without financial protections.[xl]
    - The total health spending in the country must be raised to 2.5% of the GDP, as recommended by the NHP, 2017 - to raise adequate resources for the sector and prioritise a resilient public health sector in urban areas.[xli]
    - Despite recent increases in overall health spending, its growth doesn't match the rising Indian economy. In the urban context, while the NUHM's budget has slowly gained traction over the years we have a long way to go -- from zero allocations[xlii] in 2021-2022[xliii] and 2022-2023[xliv] Union Budget, to funds now provided under a ***Flexible Pool for RCH and Health System Strengthening*** for the National Health Programme and NUHM (actuals at Rs. 24,851 crores in 2023-2024, revised estimate of Rs. 28,783 crores for 2024-2025, and a budgeted estimate of Rs. 30,010 crores for 2025-2026).[xlv]
    - Financial allocations under the 15th Finance Commission,[xlvi] with the involvement of urban local self-governments, can bolster decentralized planning and governance required to build urban public health infrastructure and delivery.[xlvii]
- For guidelines and recommendations to work, an alignment in multiple definitions of 'urban'[xlviii] across all levels of government is required.[xlix]
    - The definition of 'urban' in India was conclusively defined last in the 2011 Census - which was deemed as incomplete and fragmentary - leading to undercounting and ambiguity, even at that time.[l] Since then, the rate and scale of urbanization has compounded and a national census has not been held, yet[li] Therefore, different authorities at the levels of government e.g. the national missions, state governments or municipalities depict variations in their parameters of what constitutes as 'urban' in India, today.
    - Disparate definitions can lead to anomalies in earmarking boundaries, and miscounting population size and disease burden, especially for the jurisdiction of municipalities, limiting service delivery and monetary and human resource allocation.[lii] In addition, a systematic defining, tracking, and documentation of what ***vulnerability*** means in the urban is required, alongside the zonal classification and mapping of urban, peri-urban, and transitional areas. Local interests and the appeal (real and perceived) of keeping "rural" labels likely prevent many areas from being officially recognized and notified as urban - even when they clearly are.
- The horizontal expanse of rural life contrasts sharply with the vertical compressive growth and realities of urban existence. Unlike rural communities, where generational roots, strong social ties and networks, and shared caste, language, ethnicity, and/or religious identities can create a relatively homogeneous (and perhaps bucolic) social fabric, urban informal settlements are tapestries of a multitude of migration stories, diverse linguistic backgrounds and traditions, varied cultural practices, and distinct histories and survival strategies.[liii]
    - Deploying uniform interventions following a one-size-fits-all mentality has the potential to perpetuate the very marginalization social and health programs seek to address. Meaningful public health and social development programming might need a radical departure from top-down uniformity toward bottom-up, hyperlocal, community-centric understanding and responsiveness.
- Climate change related extreme weather events are occurring more frequently and severely, which increasingly undermine health outcomes and add a significant burden on an already strained urban health system. Extreme weather events often disrupt food security, prevailing water and air quality and sanitation systems - exacerbating heat strokes, vector-borne diseases and existing chronic disease outcomes.[liv]
    - Strengthening urban infrastructure such that it integrates climate adaptation and resilience is required. Existing public health systems must embrace emerging technologies to enhance data collection, collation, utilization

for surveillance, early warning, and response systems; civil society organizations and health systems must foster community participation in designing and delivering localized healthcare services, leveraging technological tools to ensure continuity of care and equitable access for all populations.

- Lastly, a thorough analysis of "Where is urban health in India at?" is hindered by a lack of data[lv] - what ought to be measured, the granularity and disaggregation of those measurements, and integration of data across sectors and topics (e.g. health, climate, urban planning, infrastructure). Contextual, integrated, and interoperable data are required to lend to a deep understanding of issues that underpin gaps in availing robust information to design hyperlocal social and health solutions.

Conclusion

Our Journey in the Urban

Since 2003, KHPT's early efforts, dedicated towards priority needs related to HIV prevention and care, laid a foundational understanding that the urban vulnerable - whether sex workers, transgender peoples, truck drivers, or migrants bonded into labour. We have come to understand deeply that an urban setting is not only where poverty exists tangibly, but also a context that can determine the severity of that poverty, its associated social and health inequalities, and its deep-rooted vulnerabilities. Our work in Tuberculosis (TB) interventions demonstrated the need for highly contextualised, inclusive and convergent aspects of the continuum of care that is required when targeting coverage and care for the urban vulnerable. In the last decade, KHPT's work in the urban has been exclusively focused on enhancing the access, demand and delivery of Comprehensive Primary Healthcare services to the urban poor and vulnerable in cities of Bengaluru and Mysuru. These interventions are situated at identified urban PHCs as advised by the government, to enhance intersectoral convergence between the Department of Health and Family Welfare, urban local bodies including the municipal authorities, and community structures and stakeholders.

KHPT aims to continue to learn, describe, and build evidence on:

- How actualising health and well-being of the urban vulnerable is one of the most acute, complex, contextual, and necessitated challenges of our time [e.g. in the context of mobility (rural to urban and intra-urban), shifting demographics, informal and gig economies];
- The significant data gaps in indicators and measurements of health and well-being in the urban context and what is required to address them; and
- What constitutes urban vulnerability - detailing its many tiers, dimensions, and ground-level disparities and realities -
- The various intersections of climate change and urban health bearing in mind the heterogeneous nature of urban communities with limited place-based identity and complex challenges in defining and addressing "community" in the urban.
- The community driven, agency building solutions, innovations and interventions that we must come together on, to build, collaborate on, and develop - an "ecosystem" towards this area of focus.

Our decades of experience have taught us that place matters. In this context, KHPT aims to catalyse systemic change in the urban health space by developing an ecosystem for centering community voices and priorities through its significant and foundational urban-specific experiences of coordinated knowledge building; key stakeholders and funders engagement; health systems, local governance, and community structures strengthening; guideline shaping; and sustainable program implementation in direct coordination with the government and decision-makers.

We envision the development of a public health and social development collective; a cohort of like-minded organizations coming together to create space for, develop, engage, and enhance:

- empowered municipalities with adequate financial and operational autonomy;
- communities armed with granular health data that reflects their lived realities, healthcare personnel and frontline workers fully invested in community and population level health outcomes and in integrating private services with public health systems;
- public health systems that understand intersectionalities related to climate, housing, transportation, education, livelihood support with health;
- committed and informed public and private funding towards health and social innovations;
- the application of cutting-edge technological thinking and tools to enable the development of health and social innovations and amplify their reach; and
- frameworks and guidelines developed and/or enhanced with regard to India's ever-expanding existing and future cities and urban settings.

We believe that, ultimately, success in the realm of urban health will be measured not just by increased investment - though essential - but also by a transformative appreciation of the urban complexity as a whole, and a community demand for, and ownership of hyperlocal health solutions.

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