National Urban Health Mission

As per United Nations projections, if urbanization continues at present rate then 46% of India's population would be living in urban areas by 2030. While the National Rural Health Mission has primarily catered to rural areas, urban health issues need immediate attention, especially in the context of the urban poor. The NUHM was launched on 20th January, 2014 in all cities/towns with a population of more than 50,000 to tackle the problem of deteriorating urban health.

Extent of the Problem

- While the national infant mortality rate is 44 per thousand live births, it is higher at 54.6 per thousand live births amongst the urban poor.
- 67.5% institutional deliveries in urban areas, 44.4% amongst urban poor.
- 62.9% anemic in urban areas, 71.4% amongst urban poor.
- 32.8 % underweight children in urban areas, 46% amongst urban poor.

Objectives

The National Urban Health Mission aims to improve the health status of the urban population with a focus on the disadvantaged and poor population. The mission aims to provide equitable access to quality health care through a revamped public health system, partnerships (public-public & public-private) and community based mechanism. The expected outcomes of the program are:

- Reduced Infant Mortality Rate(IMR) in urban areas by 40% to 20 per 1000 population
- Reduce Maternal Mortality Rate (MMR) in urban areas by 50 % to 1 per 1000
- Achieve universal access to reproductive health including 100% institutional delivery
- Achieve Total Fertility Rate of 2.1
- Achieve all targets of Disease Control Programmes (such as National Iodine Deficiency Disorders Control Programme, National Vector Borne Disease Control Programme, Revised National TB Control Programme, etc.)

Framework for Implementation

National Level

- Mission Steering Group - is under the chairmanship of Minister, Health and Family Welfare. It provides policy direction to the mission and has the authority to approve financial norms of all components of the mission.
- Empowered Programme Committee - is under the Secretary, Health and Family Welfare. It has the flexibility to change financial norms approved by the mission steering group by 25%, with larger variations being approved by the mission steering group.
- National programme coordination committee - is headed by the Mission Director, an officer of the rank of Additional Secretary. It is responsible for the appraisal of State programme implementation plans.

State Level

- State health mission - is chaired by the Chief Minister and includes nominated public representatives such as the MPs and MLAs in the state. It deals with policy matters related with the health sector at the state level and insures inter-sectoral coordination.
- State health society - is chaired by the Chief Secretary and is the executive organ of the State health mission. It is responsible for the approval of the state health plan and implementation of the mission in the state.
- State program management support unit - provides technical assistance to the state health mission and society. It has experts and skilled professionals like management information system (MIS) specialists, consultants recruited from the open market.

City and Community Level

- States may either decide to constitute a separate City urban health mission and City urban health society or use the existing structure of the District health mission and District health society under the NRHM. The District health mission would be headed by the urban local body and would deal with policy related matters, whereas the District health society would be headed by the Municipal commissioner/District collector and would be the executive wing of the District health mission.
- Mahila Arogya Samiti - will act as a community group involved in awareness generation, community based monitoring and linkages with services comprising of 10-12 women and would function as a community group, preferably at the slum level.

The mission seeks to achieve its goals through interventions at different levels-

- **Urban Social Health Activist (USHA)** – Each slum/community will have on frontline community worker called USHA on the lines of ASHA under NRHM, for delivery of services at the doorstep. She will cover around 1000-2500 beneficiaries across 250-500 households. She should be a women resident of the slum, preferably in the age group of 25-45 years. She would be chosen through a community driven process involving urban local body counselors, self help groups, Anganwadi, etc. She would maintain interpersonal communication with beneficiary families and would serve as a link between the health facility (Urban Primary Health Centre) and the urban slum populations.

- **Auxiliary Nurse Midwife (ANM)** – 4-5 ANMs would be posted in each primary health center depending on the population. The ANM would be responsible for outreach sessions at the community level. The sessions will include check-ups, drug dispensing and counseling. Outreach sessions will be planned to focus special attention for reaching out to the vulnerable sections like slum population, rag pickers, sex workers, brick kiln workers, street children and rickshaw pullers.

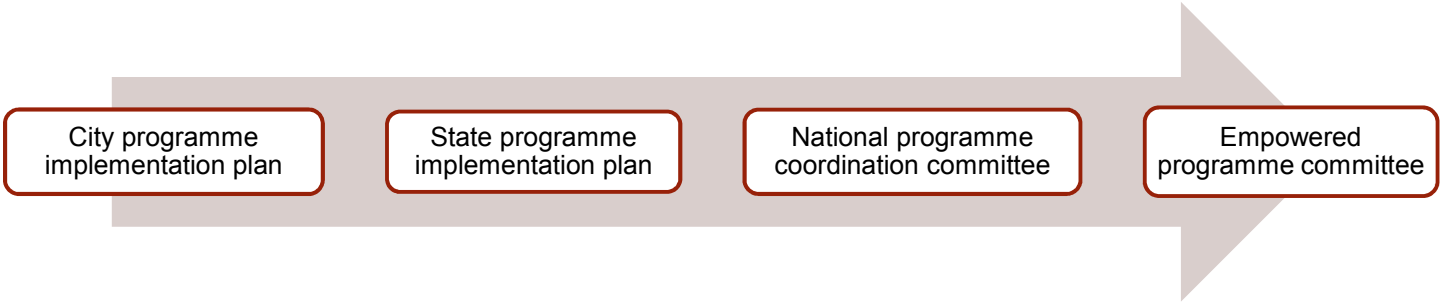
- **Urban Primary Health Centre (U-PHC) –** It may be located within a slum or near a slum within half a kilometer radius. At the U-PHC level, services provided will include Outpatient department (OPD) consultation, basic lab diagnosis, drug /contraceptive dispensing and distribution of health education material and counseling for all communicable and non communicable diseases. One U-PHC must be present for every 50,000 population.

- **Urban Community Health Centre (U-CHC) –** It may be set up as a satellite hospital for every 4-5 U-PHCs. It would provide in patient services (30-50 bedded facility) and would be set up in cities with more than 5 lakh population. One U-CHC must be present for every 2,50,000 population.

Funding Mechanism

The flow of funds has to root from community demand. As shows in diagram 2, City/District Health Society prepares the community program implementation plans (CPIP) and sends it through the ranks. The CPIPs would be consolidated at state level as **State Programme Implementation Plan (SPIP)**. Release of funds would depend on the SPIP which will have to be approved by Chairman of Empowered Programme Committee(Union Secretary of Health & Family Welfare) based on appraisal by National Programme Coordination Committee chaired by Mission Director (rank of Additional Secretary).

The Centre – State funding pattern will be **75:25** for all States except North Eastern States, including Sikkim, and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand for whom it will be **90:10**.



Strategies

To ensure efficient implementation of NUHM and achievement of its goals, it would be essential to incorporate innovative practices and strategies, in order to improve the provisions of the scheme.

- **Public Private Partnerships –** In view of the large number of private providers in urban areas, partnerships particularly with not for profit should be encouraged. Some of the NGOs working in the Health Sector are LEPRA Society, Uday Foundation, Smile Foundation, Udaan, etc. The NGOs may also support in undertaking situational analysis, identification and mapping of slums and Link Volunteers.

- **Community based groups** – Groups such as the Mahila Arogya Samiti can be responsible for health & hygiene behavior change promotion and community risk pooling mechanism. The urban poor incur high out-of-pocket expenditure often leading to indebtedness and poverty. To mitigate this risk, it is proposed to encourage Mahila Arogya Samitis to pool monetary resources and “save for a rainy day” thereby lowing financial risks of the community.

- **Convergence with other schemes –** Geographic Information System(GIS) based physical mapping of the slums being undertaken under Jawaharlal Nehru National Urban Renewal Mission **(JNNURM)** and the spatial representation of socio-economic profile of slums being undertaken under Rajiv Awas Yojana **(RAY)** can be useful in the development of City Level Plans under NUHM. Women groups mandated under Swarna Jayanti Shahri Rozgar Yojana **(SJSRY)** may be federated into Mahila Arogya Samitis.

- **Member of Parliament Local Area Development Scheme (MPLADS)** – All members of parliament (MPs), members of legislative assemblies (MLAs) and municipal councilors (MCs) receive area development fund which can be mobilized for creation of health facilities in underserved urban areas and procurement of equipment such as Mobile Medical Units and ambulances etc. This fund can be utilized to accomplish goals of the mission.

- **Corporate Social Responsibility (CSR)** – Around 2 percent of the total profit of all corporate sector companies is earmarked for social development under CSR. This fund can also be mobilized for health sector through efforts of Ministry of Health & Family Welfare and the State Government's Department of Public Enterprise (DPE) for public sector and Ministry of Corporate Affairs for the private sector. The Community Development Programme by Indian Oil Corporation Ltd. (IOCL), Mobile Health Outreach Programme by Gas Authority of India Ltd. (GAIL) and the Ranbaxy Community Healthcare Society are examples of such initiatives.