

# Government of West Bengal

## The Urban Health Strategy

### 2008



DEPARTMENT OF HEALTH & FAMILY WELFARE  
& DEPARTMENT OF MUNICIPAL AFFAIRS

**Background:**

The mission of the Government of West Bengal is “**To improve the health status of all the people of West Bengal, especially the poorest and those in greatest need**” as stated in the West Bengal Health Sector Strategy (2004-13).

According to the Census of India 2001, the urban population of the state stands at 22.4 million, which is 28% of its total population of 80.2 million. Historically, the percentage of urban population in the state has always been higher than the national average. The state ranks first in respect of the average population density in urban areas (approximately 6745 per Sq Km) and fourth in terms of absolute size of urban population amongst all Indian states.

West Bengal has experience of implementing successful urban health programmes in several parts of the state. However the state does not have a well structured and clearly articulated statewide urban health strategy. A multitude of health care providers exist with different jurisdictional areas and varying statutory responsibilities. This poses management and implementation problems and fragments efforts. Further, there is a lack of organized and coordinated primary health care services in urban areas. Hence a consistent and focused approach to urban health is imperative

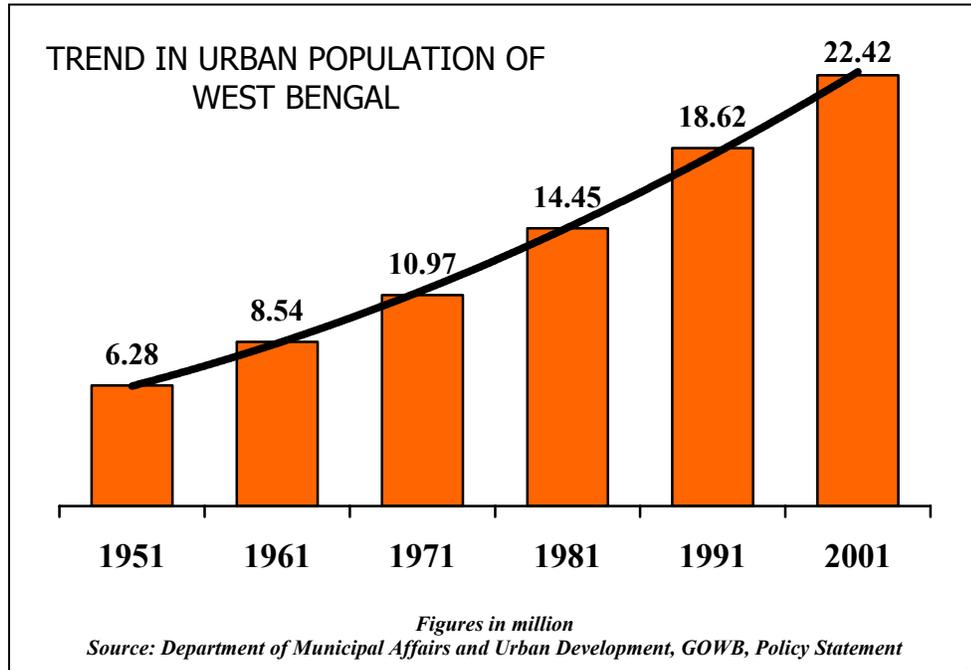
The Government is now committed to ensuring accessible, equitable and quality health care services to the urban population of the State. Towards this end the Department of Health & Family Welfare (DHFV) and Department of Municipal Affairs & Urban Development (DMA & UD) propose to contextualise the strategic framework within which the State shall seek to address the health concerns of the urban poor.

**Current Urban Health Scenario in West Bengal**

**Urbanization in West Bengal**

The urban population of West Bengal has had an upward spiral though the rate of increase has slowed down in recent years. This is partially due to the state policy on agricultural prosperity that has significantly checked the process of rural to urban migration.

The trend in urban population is depicted in the following table :



### Urban Units in West Bengal

The number of various urban units in West Bengal in 2001 is as follows :

Municipal Corporation	Municipalities
6	120

### Health Infrastructure in Urban West Bengal

The public health infrastructure of West Bengal is overstretched due to the huge population pressure on the state and because of the fact that a lot of curative services are also rendered through the public healthcare delivery system. 76% of all health institutes in the state are run by the government, compared to 40% in other parts of India (West Bengal Human Development Report 2004).

From the Mapping of Health Infrastructure in Urban Local Bodies in West Bengal (executed by West Bengal Municipal Association), it is found that the health infrastructure in the 126 municipalities is a collage with different

combinations of facilities available, ranging from abundance to paucity. There are towns with plentiful health facilities – government, private and community-based interventions. On the other hand, there are towns, which do not have a minimum health infrastructure.

Health infrastructure in the municipalities is divided in four categories viz.

1. Hospitals, health centres and sub-centres supported by the State Health Department.
2. Facilities owned by the other government departments,
3. Municipality controlled facilities and
4. Private sector facilities.

A major problem is inequitable distribution of health facilities in the different categories of municipalities, especially the facilities owned by the municipalities. 25% of the facilities are taken away by the 4% of the municipalities and 50% of the facilities are enjoyed by only 12% of them. Cold chain is another factor that requires to be looked into to ensure efficacy of vaccines. It was found that only 40% of the municipalities have control over their cold chain, for others they depend on the State Health Department. (West Bengal Municipal Association, 2005).

It was found that 42% of all facilities supported by the State Health Department and situated within municipal boundaries are part of the rural health system. Facilities owned by government organizations and other government departments, like jail hospitals and ESI hospitals, serve special groups of people and are hence inaccessible to the general population.

Private facilities are abundant in some municipalities and bridge the gap between demand and supply. These include private nursing homes, a large group of private practitioners, a few NGO initiatives and quacks. These available facilities are concentrated in bigger towns and small municipalities are dependent on rural infrastructure located in municipal areas. There are super specialists physicians practicing side by side with unqualified Rural Medical Practitioners (RMPs). No information flows from the private agencies to the government system. As a result services provided by them remain unaccounted for. In the absence of a stringent quality assurance system, the quality of health care in private sector is always under question.

## **Urban Health and Disease Burden**

Unfortunately, policymakers do not have enough information on the health conditions of the urban poor. Where there is data specific to the health of the urban populations, it often suffers from at least some weaknesses. First, health data is usually aggregated to provide an average of all urban residents - wealthy and poor - rather than disaggregated by income or a wealth. It thus masks the health conditions of the urban poor. Second, the urban poor are often overlooked altogether. The informal or often illegal status of low-income urban settlements contributes to the fact that public health authorities often do not have the means or the mandate to collect data on urban poor populations. Further, health data are usually based on household surveys. This means that most surveys do not count the homeless.

Communicable diseases are a major problem in urban populations in general and slum populations in particular. “High levels of overcrowding also make poor urban residents vulnerable to contracting communicable diseases such as tuberculosis, acute respiratory infections, and meningitis. Vaccine-preventable diseases such as measles spread more rapidly in overcrowded urban areas among nonimmunised populations. Inadequate provision for drainage can increase risk of malaria as its mosquito vector breeds in flooded areas and ditches; inadequate provision for sanitation often raises the risk of urban dengue and yellow fever because the vector breeds in latrines, soakaway pits, and septic tanks... High rates of HIV/AIDS are becoming an increasingly distressing fact of urban life in developing countries. ” (Lancet Millennium Project series, March 2005).

Recent years have seen a series of out break of vector borne diseases like Dengue, Malaria and water borne diseases like Hepatitis A and acute diarrhoeal diseases in various ULBs. There have been reported deaths besides acute ill health, burdening the already stretched health system. This reflects the inadequacy of the ULBs to prevent these situations and to respond effectively and rapidly to contain the outbreaks.

Recent SRS data available for the year 2006 shows an appreciable improvement in the birth rate in the urban areas down to 12.3 and an infant mortality rate of 29 per 1000 live births. However, it is assumed that these averages are a result of the improved status in the 41 Kolkata Municipal Area municipalities and 22 others (a total of 63 municipalities) which has had dedicated programme with external assistance since 1992. The 63 municipalities, which do not have any dedicated health programme, are also the ones, which have a distinct disadvantage in terms of geographical location (further away from Kolkata), very

poor health service facilities (Mapping Of Health Infrastructure In Urban Local Bodies, November 2005, West Bengal Municipal Association).

Disaggregated data for urban poor women's fertility, contraception usage and attended delivery data is not available currently however, the overall indicators for these outcomes is available for the state as a whole and several of the health indicators (notably MMR, NMR, IMR and TFR) for West Bengal are better than their national equivalents.

The following tables reveal the major health indicators for the state.

**A comparison of the birth rate and death rate of West Bengal**

Birth Rate			Death Rate		
Rural	Urban	Total	Rural	Urban	Total
20.7	12.3	18.4	6.2	6.3	6.2

Sample Registration System 2006

**Selected Health and Demographic Indicators for India and West Bengal**

Indicators	West Bengal			All India
	Rural	Urban	Combined	
Life expectancy at birth (years)(2000-04)(SRS)	63.0	69.4	64.4	63
Total Fertility Rate (SRS 2005)	2.4	1.4	2.1	2.9
Maternal Mortality Ratio (per 1,00,000 LB)(RGI Survey 2001-03)	-	-	194	301
Current use of contraception by any modern method (NFHS-3) 2005-06	49.9	49.9	49.9	48.5
Female literacy rate (2001 census)	53.2	75.7	59.6	53.7
Infant Mortality Rate (SRS 2006)	40.0	29.0	38.0	57
Neonatal mortality rate (per 1000 LB) SRS 2005	32	20	30	37
Child Mortality Rate (per 1000 LB) (1-5 years) NFHS-3	-	-	12.2	18.4
Child Vaccinations : complete 2002-04 (NFHS-3)	62.8	70.3	64.3	43.5
Perinatal Mortality Rate(SRS 2005)	34	21	31	37
Still Birth Rate (SRS 2005)	9	7	9	9

### **Strategic issues to be addressed in Urban Health**

- Lack of uniform urban health infrastructure and non-availability of primary health care in some urban areas.
- Non existence of appropriate screening and referral system. Secondary and tertiary care often remain underutilized on one hand and on the other, several secondary and tertiary care facilities are often overcrowded in terms of outpatient attendance and inpatient bed occupancy leading to poor quality of services.
- The limited presence of private service providers due to locational disadvantages of some municipalities.
- The limited organizational experience in the delivery of health care in 63 non Kolkata Municipal Area (KMA) municipalities.
- The lack of population based health status data and its implication for planning and benchmarking.
- Poor disease surveillance, absence of appropriate diagnostic services etc. often putting the public health system under strong criticism when the early warning signals for impending outbreaks are not recognized and outbreaks spread.

### **Experiences and Lessons learnt in Urban Health Care in West Bengal**

The State has the experience of various projects (CUDPIII, IPP-VIII, IPP-VIII (Extn.), CSIP RCH Sub Project and HHW's Scheme) covering 63 ULBs. In KMA areas, through the Kolkata Metropolitan Development Authority (KMDA), the Department of Health and Family Welfare (DHFV) has implemented four projects funded by external agencies. The projects are World Bank (WB) funded CUDP-III (1984 – 1992), DFID funded CSIP (1992-1998), WB funded IPP-VIII (1994-2002) and European Commission supported UHIP. Post IPP-VIII funding, DHFV also has the experience and learning from the maintenance phase, which continues till date.

An independent end line survey of IPP- VIII project showed a notable fertility decline among the slum population, marked improvement in maternal and

child health as evidenced by a decrease in infant mortality and increased utilization of the RCH services. The projects provided lessons both in implementation and organizational front.

**Institutional lessons:**

- a. Decentralization in administrative and financial matters can create both ownership and local political commitment at the Urban Local Body (ULB) level and lead to strengthened capacity and confidence in managing such programmes.
- b. Various community structures (ward committees) along with adequate leadership of the local bodies can work on combating exclusion, mobilizing resources and energy, and achieving effective implementation. The ward committees can help in creating awareness about the project besides providing their inputs in the micro planning for their ward and help facilitate the work of the Honorary Health Workers.
- c. Community participation can be encouraged through the ward/block committees in different stages of planning, implementation and monitoring of the programme in their respective wards/block.
- d. The deployment of female honorary health workers (HHW) approximately @ 1 per 1000 poor population can be effective in bringing about a major change in the health seeking behaviour and help achieve desired health outcomes.
- e. Use of private practitioners to complement primary clinical care and immunization services through the sub centres work reasonably well, wherever they are available.
- f. Flexibility in project design allows for accommodation of local needs and capacities.
- g. It is important to clarify the roles and responsibilities of the multiple organizations providing urban health services.
- h. It is needed to identify and recognize the marginalized populations like settlements along railway tracks, rag pickers, migrants in squatter colonies etc. to avoid being excluded from the benefits of such projects.

- i. A system of repeated and continued refresher trainings for HHW and regular feedback mechanisms are required to make effective use of lessons learned from the field.

### **Technical Lessons:**

- a. A formal referral chain with linkages to facilities providing higher-level care should be ensured since stand-alone facilities like maternity homes are difficult to sustain.
- b. There is need to include the larger urban population for preventive and public health intervention.
- c. Service package should include a mix of public health and primary level curative care in addition to emphasis on preventive and promotive care.
- d. There is need for population based health status data and it being factored in local planning.

The Urban Health Strategy outlines some broadly common objectives and operational strategies for all ULBs but it would be adequately adapted to the local needs, priorities and available resources depending on the commitment and capacities of the ULBs and other key stakeholders.

### **Goal:**

The goal of the Urban Health Strategy of the Government of West Bengal is:

**Improved health for all urban populations with special focus on poor, underserved and vulnerable population**

### **Objectives:**

- To decrease maternal, child and infant mortality by providing better and consistent quality services to families in urban areas with special focus on urban poor, underserved and vulnerable populations through enhanced demand and universal access to quality services.
- To reduce the prevalence of communicable diseases currently covered by the national health programmes and reduce the risk of epidemic outbreaks by reducing exposure to health risk factors.

- To improve the quality of basic health services by providing supervisory, managerial, technical and interpersonal skills to all levels of health functionaries.
- To generate awareness and enhance community mobilization through IEC/BCC to supplement and make the above interventions effective

### **Key strategies:**

- ❖ Universal coverage – the entire urban population including both APL and BPL to be covered, while keeping the focus on BPL.
- ❖ Strengthening service delivery through a uniform 3-tier service delivery model.
- ❖ Strengthening institutional arrangements and inter departmental convergence.
- ❖ Strengthening monitoring and evaluation.

### **Key Strategy 1: Universal Coverage**

The Urban Health Strategy proposes to target the entire urban population of West Bengal, while keeping the focus on the poor, the marginalized and the underserved.

### **Key Strategy 2: Strengthening service delivery through a uniform 3-tier service delivery model**

A multi pronged approach will be taken to strengthen service delivery through a plethora of measures:

- Institutionalizing the existing 3-tier primary health care model (Appendix-1) by
  - Strengthening community out reach through the Honorary Health Worker (HHW) and First Tier Supervisor (FTS) at the sub-center
  - Strengthening infrastructure – physical and human resource related (Including introduction of a new cadre of personnel called First Tier Supervisor (FTS) – Public Health to be based at ULBs).
- Community empowerment and involvement through a number of measures like recruitment of HHWS from the community, discussions and awareness generation on health and nutrition issues and determinants of health through existing community groups (CDS / SHG's etc), participation of these groups in ward committees and through them providing organizational inputs in planning and managing the programs

- Supporting and strengthening existing facilities in ULBs, where needed.
- Strengthening the public health role of the municipalities through establishing standardised outbreak control protocols, etc.
- Preparation of ULB specific action plan to reflect the operational strategies, and address the ULB specific determinants of health.
- Introducing newer models of service delivery where necessary like :
  - Public Private Partnerships (PPPs) with NGOs/private sector for training, data management etc
  - Mobile health care services in hard to reach areas etc
- Adopting and implementing appropriate Behaviour Change Communication (BCC) strategies to improve health communication – this will combine interactive group and interpersonal methods on the ground, mass media initiatives and advocacy with various stakeholders.

### **Key Strategy 3: Strengthening institutional arrangements and inter departmental convergence**

The institutional arrangements will take into account the multiplicity of agencies that will form part of the arrangement and will be planned to be conducive to:

- Strengthening stewardship role of DHFW through establishment of Urban health cell in DHFW
- Strengthening the capacity of Department of Municipal Affairs (DMA) through establishment of an Urban Health Cell with dedicated officials to oversee urban health and strengthening the implementation capacity of the State Urban Development Agency
- Formation of an inter-departmental coordination committee steered by the DHFW and MA & UD, with representation from other key stakeholders like Department of Public Health Engineering, Department of Women and Child Development (DWCD), School Education Department, Higher Education Department and Kolkata Municipal Corporation (refer Appendix-2 for chart on institutional arrangements for Urban Health)
- Formation of a health committee under the District Health and Family Welfare Samity, under the Chairmanship of the District Magistrate to liaise with the ULB level health and family welfare committees.
- Defining the roles and responsibilities of the departments, including patterns of fund flows.
- ULB and ward level health committees to coordinate multi departmental response including, but not limited to:
  - Water quality management, solid waste management, sanitation and hygiene, tracking of seasonal disease

outbreaks, compulsory reporting of all notifiable disease from all health facilities and undertaking vector control measures.

- To continue with the decentralisation of management and implementation of the program to the municipalities
- Improved capacity of human resources at all levels – community level, ULB level and at the level of State Urban Development Agency
- Referral linkages with the District and the Block facilities of the DHFW.

#### **Key Strategy 4: Strengthening Monitoring and Evaluation**

The UH strategy will enable establishment of the necessary institutional and financial requirements to have a well-functioning Monitoring and Evaluation (M&E) system ensuring measurement of performance and impact to become regular and hence able to continuously inform the planning process.

The M&E will work in the overall framework of the HMIS for the DHFW and MA & UD and will include, but not be limited to:

- Establishing routine monitoring systems and its implementation in consultation with both departments (Refer Appendix 3)
- Designing systems to record and capture early warning signals for impending outbreaks in order to improve epidemiological surveillance and disease prevention
- Periodic surveys to capture health status of the urban population

## **APPENDIX 1**

### **SERVICE DELIVERY MODEL**

#### **Service Delivery Model:**

The programme envisages implementation of a multi level service delivery model supporting a strong community outreach intervention. The service package will include apart from emphasis on preventive and promotive care a mix of public health and primary level curative care.

#### **The First Tier**

The objective of the community outreach is to move the health care from institutions to the doorstep with access of all beneficiary households to Honorary Health Workers (HHWs). The community level operational strategy will be to include both urban poor and the general population. For the Urban Poor an intensive approach including regular home visits and maintaining a Family Health Card will be initiated. A community outreach clinic providing basic preventive and promotive services will be provided close to their habitation. (refer to the 2<sup>nd</sup> tier – sub center)

The service delivery will be expanded to all municipal population through initiation of outreach services using female honorary health workers (HHWs) to be recruited from urban communities. This outreach will be organized with the Ward as the geographical unit. The Ward Councilor/ Ward Health sub committee would be providing support and oversight.

For the general population the approach would be to provide Public Health inputs through various educational and service strategies included under various National Health Programmes.

The number of HHWs per ULB will be determined by the number of urban poor in that ULB distributed one per 1000 such poor population or the number of wards whichever is more. The municipalities will allocate the HHWs according to the agglomeration of low socio economic population in a ward.

#### **The Second Tier**

This will be designated as Sub Centre and will cater to a population of 5000 urban poor from a cluster of wards, such that it provides a much better level of primary health care and introduce more flexibility in its timings. The sub centre will be

closer to the community and the municipality, aided by the GIS maps for optimum location.

A First Tier Supervisor (FTS) will be selected from amongst the HHWs after at least six months experience and an additional training input. One set of these FTS will be allocated responsibility at the sub centres and provide support to five HHWs in their outreach work and will manage the sub centre. First Time Supervisor (FTS) will be providing counseling plus basic primary care.

There will be another category called the FTS – Public Health who will be responsible for 20,000 general population in terms of the public health inputs. They will be part of the ULB team and work under the supervision of the Health Officer (HO) of the ULB.

The Sub Centre will be manned by a FTS and a Medical Officer (part time).

A structured Monitoring and supervision schedule will be in place and training of the FTS will include developing skills for appropriate supportive supervision work undertaken through monitoring and performance Indicators.

### **The Third Tier- Referral Facility**

The referral Facility the third tier of support will be a BPHC/Rural Hospital/Sub Divisional Hospital/ District hospital. Where these are not accessible or the municipalities have successfully implemented maternity home then these can be used as referral facilities.

In 15 ULB where no such DHFW secondary facility exists an Urban Health Centre under the management of the DHFW will be set up. This facility will serve as a daily OPD besides providing preventive interventions not available at the sub center.

### **Package of Services**

#### **First Tier : Community level Honorary Health Workers (HHWs)**

The HHW will provide the following services, at the minimum,

- Fortnightly visit to at least 200-300 households. Daily at least 15-20 houses are required to be visited. The family schedule to be updated in every visit noting births and deaths including entry of newborns, new comers and

deletion of those died or left permanently and whether the birth was under a safe hand or in a institute

- Enquiring about pregnancies and registering them. Enquiring about abortion and MTP and noting the same
- Focused counselling on antenatal care and providing them referral slips to visit the sub-centre.
- Enquiring about immunization status of mother and infants and children.

### **RCH**

- Identifying malnourished children, motivation and referral slips to sub-centre
- To distribute contraceptives
- Referral for institutional delivery/ emergency referral
- Motivating and taking the mother / pregnant women / children to the sub centre for immunization.
- Encouraging the pregnant mothers to visit the sub centre for ANC check up by the PTMO
- Information, education and communication: breast feeding, contraceptives, diet, ORS, personal hygiene, immunization, environment including general cleanliness, promoting institutional delivery and utilization of existing institutions, etc
- Encouraging mothers to go in for institutional delivery.
- To hold mothers meeting **RCH- Linked activities**
  
- Follow up of referrals
- To assist in outreach immunization activities
- To assist in immunisation campaign whenever undertaken: Pulse polio etc

### **Public Health – Direct**

- While Enquiring about any death in the family; ascertain whether the death is from any listed communicable diseases.
- Enquiring for occurrence of important identified communicable diseases in the house during the period from last visit till present and looking for any current illness in the family ; noting the same and advising accordingly.
- Preparation of HMIS report including recognition of early warning signals and information to higher level.
- Recognizing danger sign with relation to ARI, Diarrhoea etc. and advising on initiation of treatment and referral whenever needed
- Distribution of ORS and demonstrating preparation of ORS

- To motivate adolescent boys and girls/men and women through referral to appropriate treatment centres
- Liaison with community leaders
- Participating in the ward committee meeting

**Public health – Linked service**

- Support to National Health programs
- Support to outbreak investigation etc
- HHW will be accountable to ward committee/ councillor

**Second Tier: Sub Centre**

This will be designated as Sub Centre and will cater to a population of 5000 urban poor such that it provides a much better level of primary health care and introduce more flexibility in its timings. The Sub Centre will be manned by a FTS and ULB Health Officer/ a medical officer and will offer the following minimum services:

- Child health care services including immunization, distribution of IFA, Vitamin A, ORS packets etc.
- ANC services and counseling for institutional delivery.
- Promotion of Family Planning - oral pills, condom use, counseling for adoption of terminal methods.
- Primary treatment of common ailments

The specific services will be delivered through predetermined clinic days as follows:

1. ANC/PNC and Family Planning counseling clinic – two days in a month.
2. Immunization Clinic – Once a week.
3. General treatment clinic by Doctor – Once a week.
4. Growth Monitoring of U-5 children Clinic – Once a month.
5. Health Awareness Programme – Once in a fortnight.

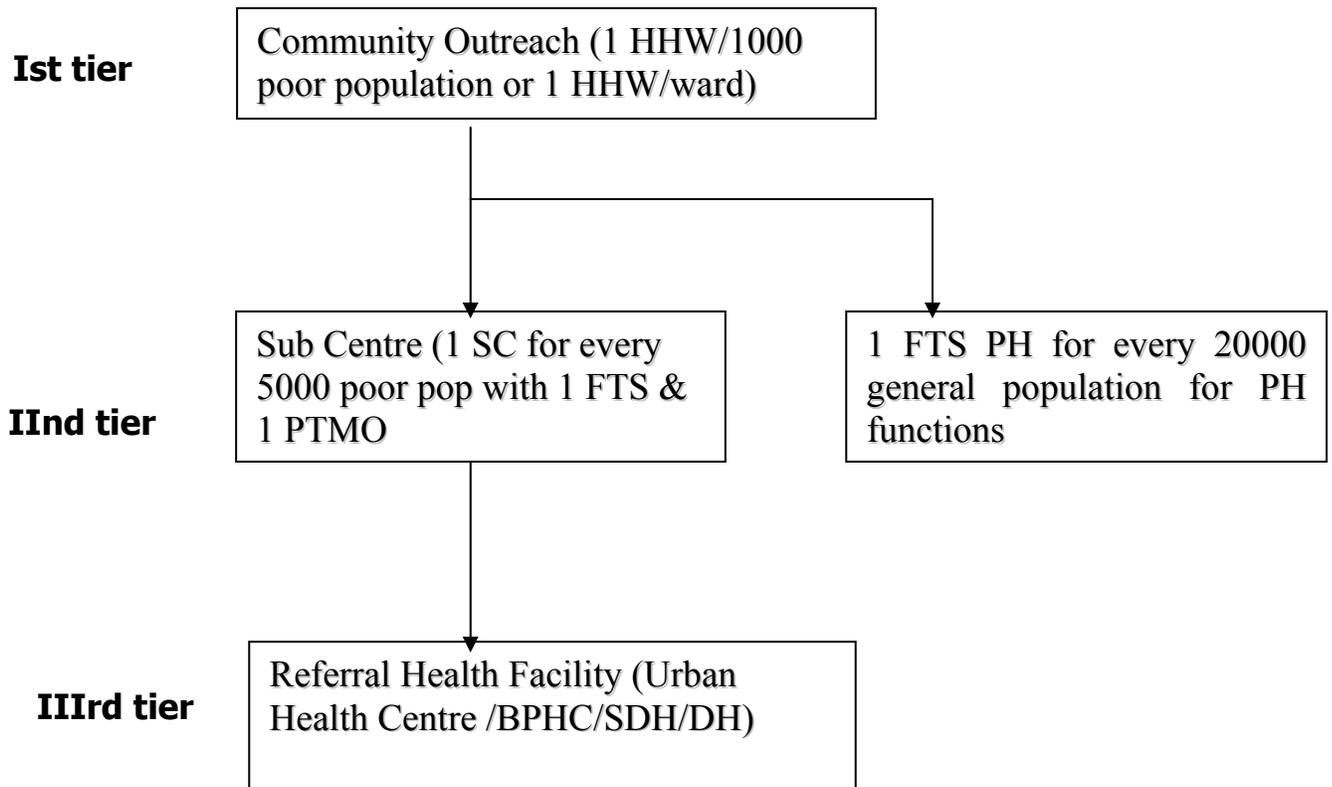
**The Third Tier- Referral Facility:**

The referral Facility the third tier of support will be a BPHC/Rural Hospital/Sub Divisional Hospital/ District hospital.

The facilities available will include a minimum of the following services:

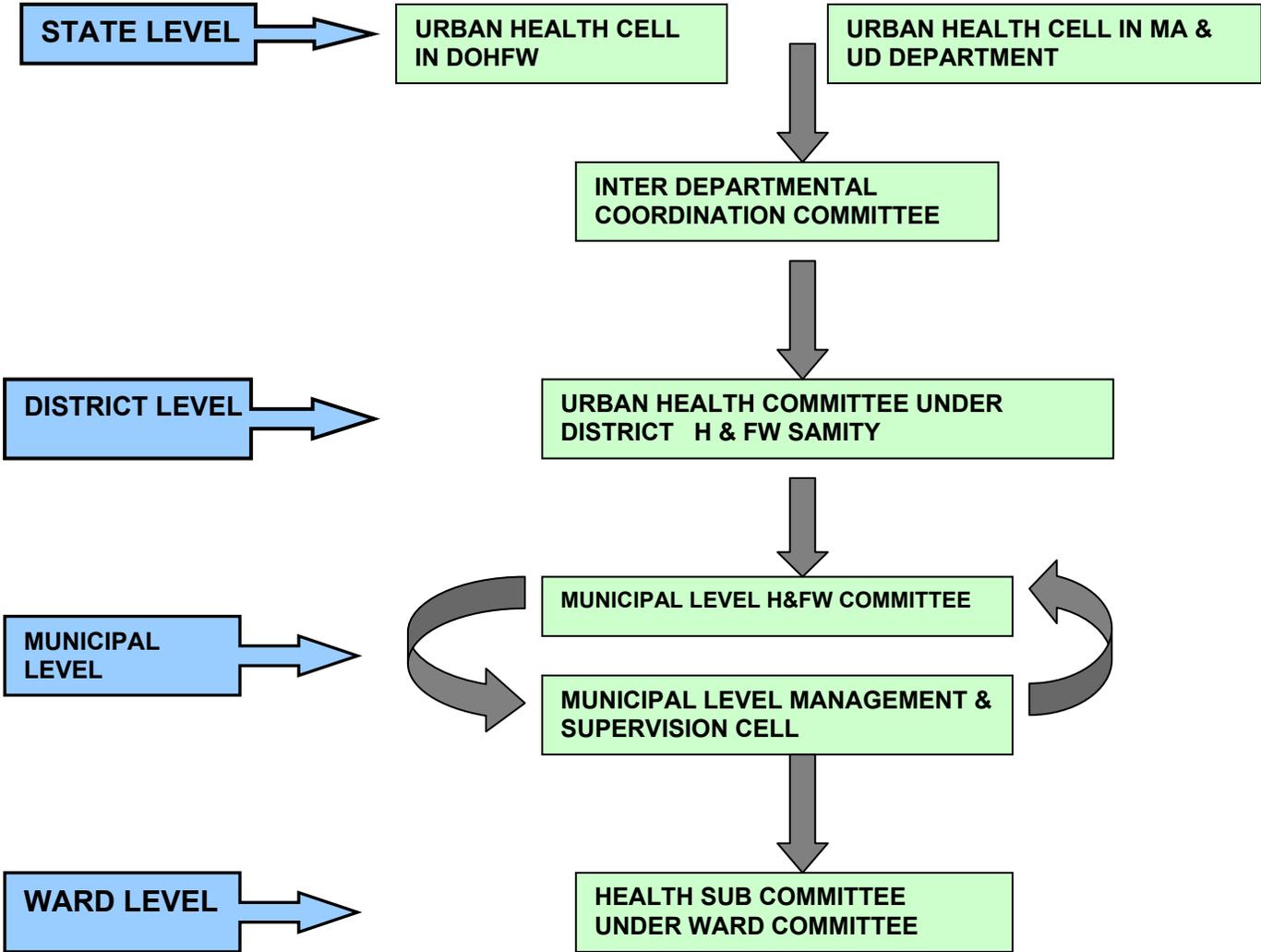
- Full range of Family Planning services including laparoscopic services.
- Institutional Delivery services
- Essential and Emergency Obstetric Care
- MTP services
- Child health referral services including essential and emergency newborn care.
- Basic medical and surgical services.
- Services under national disease control programmes

### **SERVICE DELIVERY MODEL**



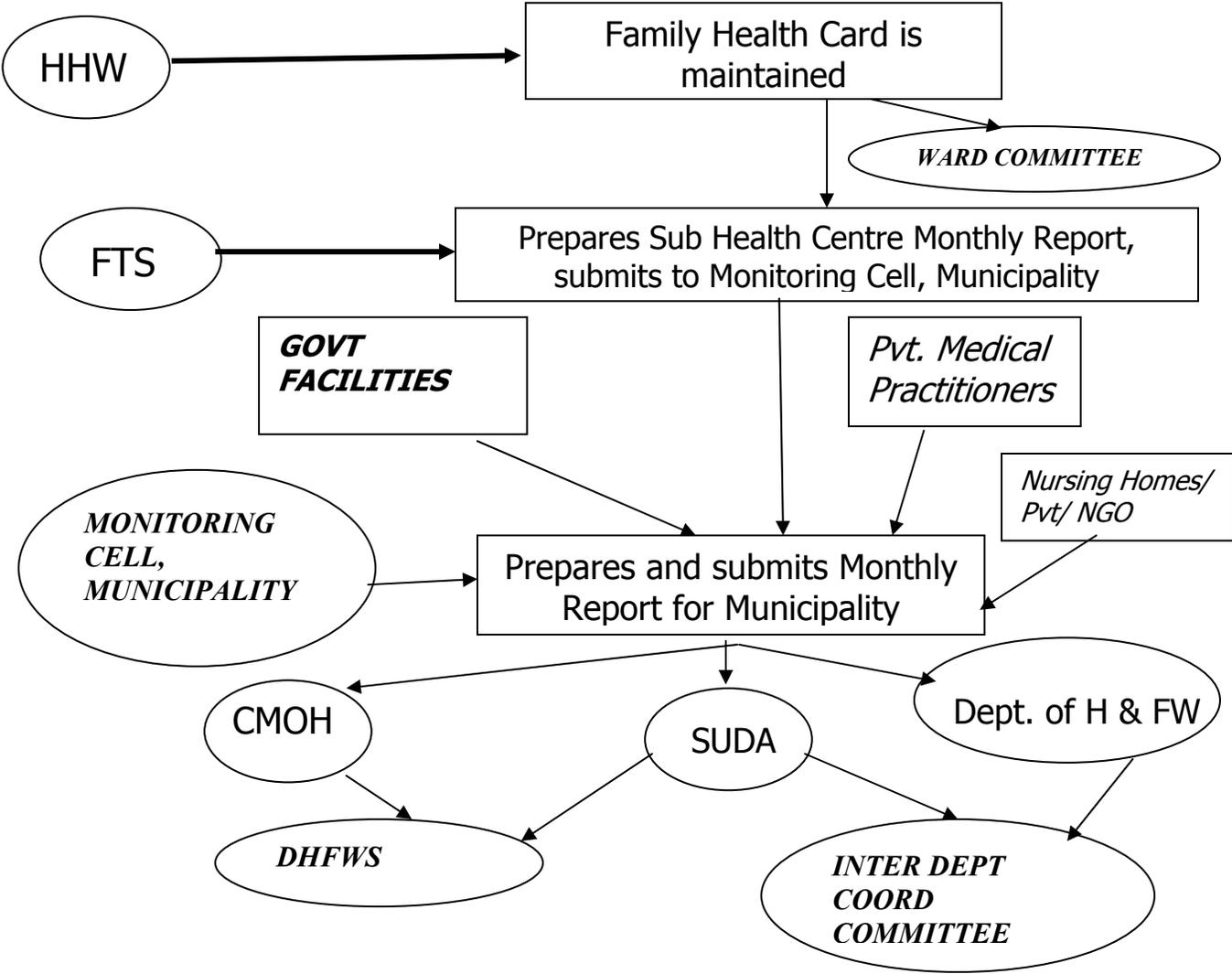
**APPENDIX 2**

**INSTITUTIONAL ARRANGEMENTS FOR URBAN HEALTH**



APPENDIX 3

**H M I S**



## **Roles and responsibilities of key agencies**

### **Department of Health and Family Welfare**

The DOHFW will play a lead role in steering policy, formulation of standards and norms, operational guidelines and, coordinating with department of municipal affairs.

An Urban health cell will be formed in the DHFW to manage activities related to the urban health. At the district level, a Urban Health committee under the District Health Samity will be formed and a nodal person at the district level responsible for urban health affairs will be identified.

### **Department of Municipal Affairs**

The Municipal Affairs Department will be responsible for implementation of the Program through the 126 municipalities. It will be responsible for the overall execution of the Program and will provide management support. It has identified the State Urban Development Agency (SUDA) to provide technical backstopping, capacity building and monitoring/supervision support to the implementation efforts.

The department of municipal affairs is entrusted with the responsibility of providing legal and administrative support to the urban local bodies of the state and to implement some of the urban development Programs through the ULBs. The key functions of the department are to facilitate as well as monitor municipal functions of Corporations and ULBs, to formulate acts and rules governing the ULBs, and to facilitate capacity building of ULBs.

### **SUDA : State Urban Development Agency**

**SUDA** was set up in 1991 with a view to ensuring proper implementation and monitoring of the centrally assisted Programs for generating employment opportunities and alleviation of poverty throughout the state. SUDA is a society registered under the West Bengal Societies Registration Act, 1961.

The main function of SUDA is to manage the programs through coordination with different agencies like MA & UD, ULBs, DHFW, provide technical assistance to ULBs, monitor and report on progress, mobilise resources, and act as a nodal agency for various Programs.

The technical agency (SUDA) of the Municipal affairs department will be the key agency to provide technical backstopping, capacity building and

monitoring/supervision support to the implementation efforts. More specifically it will provide support in the area of: (i) managing the partnerships with ULBs. (ii) Capacity building of ULBs. (iii) IEC /BCC activities. (iv) Administrative and HR functions. (v) Accounting, commercial and supply chain functions.

### **ULBs**

At the ULB level, technical support would be provided by the implementing agency, and staffing at ULB and outreach level would be optimized in order to achieve the program objectives efficiently and effectively.

The Urban Local Bodies would be the implementing organisations. They would be responsible for implementing the health programs including staff recruitment, placement, training, managing logistics, ensuring linkages with other arms of the ULB like conservancy, sanitation etc, procurement (where necessary), monitoring the placement and functioning of sub centres, submission of regular reports and expenditure statements to appropriate authorities and liaisoning with SUDA and DHFW where necessary.