

Need for Dedicated Focus on Urban Health within National Rural Health Mission

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Summary

National Rural Health Mission represents an important public health initiative to address essential health needs of the country's underserved population. For the mission to achieve its goals, urban population needs to be included in its scope. Urban poor population constitutes nearly a third of India's urban population and is growing at three times the national population growth rate. Health status and access of reproductive and child health services of slum dwellers is poor and comparable to the rural population. Public sector urban health delivery system, especially for poor, has so far been sporadic, far from adequate and limited in its reach. Other factors contributing to inadequate reach of services are illegality, social exclusion of slums, hidden slum pockets, weak social fabric, lacking coordination among various stakeholders and neglected political consciousness. Opportunities for impacting urban health are several. Efforts to improve the conditions of urban poor necessitate strengthening national policy and fiscal mandate, augmenting and strengthening the urban health delivery system, coordinating among multiple stakeholders, involving private sector, strengthening municipal functioning and building community capacities. National Rural Health Mission should be broadened to National Public Health Mission.

Key Words: Public Health, National Rural Health Mission, Urban Health, Urban poor

INTRODUCTION

Public Health Initiatives for more than India's 1 billion people are aimed at mitigating disease burden and improving health. These endeavors have been on for the past several decades. A few notable of these include Universal Immunization Programme, Child Survival and Safe Motherhood Program, Reproductive Child Health Program, and Integrated Child Development Scheme¹.

The National Rural Health Mission (NRHM) represents a renewal, convergence and heightening of attention to disease prevention, communicable disease control, health protection and promotion. NRHM approach reflects the growing realization among public health professionals that continued investment in clinical care brings diminishing returns² and that ailments and problems addressed so successfully by public health measures in several countries and among the better off segments of India's population still persist among a very large proportion of our population. The NRHM provides an opportunity for health administrators to a) provide need-based health care b) ensure reach of public health services to the underserved segments through vitalized health system c) enable socio-economically and educationally weak communities to take better care of their health and d) bring all pieces of the health and intricately linked sectors to function in a harmonized and complementary manner to optimize impact.

While public health indicators (Under 5 mortality, infant mortality) in India had improved measurably over the last few decades, a plateauing has been observed during the last 10 years (Figure 1).

Among several factors contributing to this plateau a notable issue is that the essential public health services have remained inaccessible (owing to physical distance, affordability or other reasons) for large segments of India's population in rural as well as in urban areas. For NRHM to achieve its goals, the growing urban population needs to be included in its scope.

This paper discusses issues pertaining to health conditions of the urban poor, present status of services, challenges and suggests options for NRHM to bridge the large gap.

URBANIZATION AND URBAN POVERTY

Urban growth has been exponential in India over the last few decades. While India's rural population has doubled from 1961-2001 the urban population has grown four fold². Out of the total population of 1027 million as on 1st March, 2001, 742 million lived in rural areas and 285 million in urban areas.

* Census of India defines urban areas as a) all areas with a municipality, corporation, cantonment board or notified area committee etc b) a place satisfying the following three criteria simultaneously: a minimum population of 5,000; at least 75 percent

The percentage decadal growth of population in rural and urban areas during the decade was 17.9 and 31.2 percent respectively³. Population projections by the United Nations indicate that by 2030, India's urban population will grow to 576 million and constitute 40 per cent of the total population⁴. In 2001, there were 35 cities with million plus population and 393 cities above 100,000 population. It is estimated that the number of million plus cities in India will grow to 51 by 2011 and 75 by 2021. In addition there would be 500 large cities with population above 100,000 by 2021³. The Indian demographic scenario represents a 2-3-4-5 syndrome: in the last decade, as India grew at an average annual growth rate of 2%, urban India grew at 3%, mega cities at 4% and slum populations rose by 5-6%⁵.

Estimates of poverty ratio in urban areas range from 67 million⁶ to 90 million⁷. However, these estimates do not reflect the true magnitude of urban poverty because of "un-accounted" for, unrecognized squatter settlements and other populations residing on pavements, construction sites, fringes etc. Large Urban slum and other urban poor populations have remained unreached by the public health services^{8,9,10}.

Urbanization of Poverty

Poverty is not merely a rural phenomenon. As a proportion of total poverty, the urban component has increased from 15% in the early 1970s to about 25% in the mid 1990s. In other words; one out of four poor persons of the country is now an urban resident.

Why is the urban poor population growing rapidly?

The rapid growth of slum population is contributed by: a) Migration into a city from villages and smaller towns owing to better employment opportunities, diminution of rural agricultural land and related livelihood opportunities; b) Natural increase in urban poor population which has a higher fertility rate than urban middle and upper class; c) Expansion of city boundaries to include peripheral rural areas, some of which get converted into slums as erstwhile rural land is colonized for housing purposes.

HEALTH STATUS OF THE URBAN POOR IN INDIA

Slum dwellers in cities suffer from adverse health conditions owing to insufficient services, low awareness, and poor environment. However, the rhetoric of urban bias in development and better

of male working population engaged in non agricultural pursuits and a density of population of at least 400 per sq. km. (1000 per sq. mile)

conditions in urban areas vis-à-vis rural areas has masked the real picture of urban poor. Millennium Development Goal 7 (Target 11) aims to significantly improve the lives of at least 100 million slum dwellers world wide by the year 2020¹¹. Even this very conservative target seems a tall order unless this large underserved section of population is adequately reached through public health services.

Child, infant and neonatal survival among urban poor is similar to rural population

Under-5, infant and neonatal mortality rates are considerably higher among urban poor as compared to urban averages¹² and almost as worse as their rural counterparts (Figure 3). This and other urban poor health data in this paper is based on re-analysis of NFHS 2 data by Standard of Living (SLI) Index, taking low SLI as representative of urban poor. One out of ten children born among the urban poor during the year is not likely to see their fifth birthday.

High Incidence of under-nutrition among urban poor children

More than half of India's urban poor children are underweight (Figure 4). In most States, under-nutrition among urban poor children is worse than in rural areas. Survival patterns among the urban poor, clearly point at the need for extra focus on this large segment of India's population.

Access to Reproductive and Child Health Services is low among Urban Poor

The reach of essential preventive health services to the urban poor and utilization of health services by these segments is abysmally low: a) about 60% of children are not completely immunized by 1 year of age; b) use of birth spacing methods is abjectly low at 4%; c) almost 6 out of 10 babies are delivered at home in the absence of a trained health worker. The meager access of MCH services among urban poor is obscured by urban averages.

Health Conditions and Access to Services is worse in EAG States*

The eight large and less developed EAG States of India constitute 32% of India's urban population and are home to 28 million urban poor².

* Empowered Action Group (EAG) is a administrative mechanism to facilitate the preparation of area-specific programmes, with special emphasis on the eight states which have lagged behind in containing population growth to manageable limits. GoI constituted the EAG States Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Jharkhand, Chhatisgarh and Uttaranchal. in the MoHFW w.e.f 20th March 2001.

In these less developed states under-5 mortality and Infant mortality among the urban poor is about 1.3 times and 1.6 times higher than their respective National figures¹⁰. Access to RCH services amongst urban poor is also worse than other states of the country¹⁰.

- Institutional deliveries, among urban poor in UP are 6.5 times lesser (13.1%) than in Tamil Nadu (85.6%).
- Similarly, complete immunization coverage among urban poor in UP is 29.7 percent compared to 74.4 in Tamil Nadu.

Poorer access to services has contributed largely to deprived health conditions of urban poor in these states.

GOVERNMENT EFFORTS FOR IMPROVING HEALTH OF URBAN POOR

Though Government efforts have been primarily rural centric, a few urban schemes have been implemented in the past. These include the Urban Family Welfare Scheme (1950), Urban Revamping Scheme (1984), Sterilization bed scheme (1964) and post partum centers (1966) in urban areas. However, the coverage of the schemes has been far from complete. The rapid growth in urban population has further eroded the coverage levels of these schemes. Recently, the World Bank funded India Population Projects (IPP- V and VIII) have attempted to provide health care services the urban poor. However, these schemes have been operational only in the mega cities like Delhi, Mumbai and Chennai.

WHY DO PRIMARY HEALTH SERVICES NOT REACH THE URBAN POOR?

Those with the greatest need for health care often have least access to it. Reach and effectiveness of maternal and child health services in urban slums are strained by several challenges. These can be classified into the four categories viz., Systemic Factors, Urban Poor Related Factors, Weak Coordination among and limited capacity of Stakeholders, and Inadequate Political and Civil Society Consciousness.

A. Systemic Factors

The existing Urban Health Delivery System is far from adequate to respond to needs of escalating urban poor population.

1. Lack of organized public sector infrastructure and services in urban areas: Despite accounting for one-fourth of the country's poor population, urban areas have less than 4%¹³ of Govt. Primary Health Care facilities. With a total urban population of 285 million, the available Urban Primary Health Infrastructure translates to one health facility (UFWC/HP) for about 1.5 lakh urban population. IPP-VIII and other programs

operational only in selected cities did not reach all urban poor even in these cities.

Large number of urban areas have been completely left out or poorly targeted. Health Posts were established in only 10 States of the country. 32% of health posts were established in Maharashtra while the scheme remained uninitiated in Bihar. Only about 1/10th of the sterilization beds are in EAG states¹². Staffing has also not increased in response to urban growth¹⁴.

2. Higher allocation for Bigger Cities: There is inequitable distribution of available resources for urban poor among different cities. While, medium-small cities have significant urban population most urban programs have focused on mega cities like Mumbai, Delhi, Kolkata, Chennai. These mega cities are preferred to other relatively smaller cities for financing since they have greater management and negotiation capacity that enables them to garner more resources¹⁵.

It is projected that many of the presently smaller cities will join the rank of million-plus cities in the next two decades¹⁶. Thus preparedness in the smaller cities is needed to meet this growing challenge.

3. Poor access and utilization despite proximity: Poor access despite proximity is a result of a) weak demand b) minimal outreach services c) very weak community-provider linkages d) timings that often do not suit the daily wage earning urban poor. Urban poor prefer home deliveries despite availability of government and private hospitals, because of concerns like, securer environment at home, nobody to take care of other siblings at home in event of hospitalization, perceived unfriendly treatment at Government hospitals, and expensive private health care facilities.

Poor access of services is also reflective of the family having to cope with imperative issues such the risk of eviction and struggle for access to basic services like water and sanitation, all these being compounded by low health awareness.

4. Lack of sensitization among the service providers: Sense of apathy towards slum dwellers, considered an 'unnecessary intrusion' into the city, exists among service providers. Health service providers are often rough in their behavior towards slum dwellers. This dissuades the latter from availing services.

5. Poor living environment that compounds the lack of health services: This rapid, unplanned urbanization and simultaneous growth of urban population in limited urban living spaces visibly impacts the quality of life of slum dwellers. Access to water supply and sanitation facilities among the urban poor is low. 61.7% of urban poor households

do not receive piped water supply and 65.9% do not have any toilet facility¹⁰.

When infrastructure and services are lacking, urban settlements are amongst the world's most life threatening environments. Child mortality and morbidity (diarrhea in particular) have been associated with poor water quantity and quality, lack of sanitation and poor hygiene practices¹⁷.

Location of slums in unhygienic surroundings accentuates health adversity. Slums located adjacent to large open drains have a greater incidence of diarrhea and other water-borne diseases¹⁸. Slums adjacent to waste disposal sites face hazards of polluted water and air. Pigs, vultures and other animals affect levels of hygiene maintainable in a slum thereby increasing the risk of spread of infection amongst children who come in close contact with the outside environment.

B. Urban Poor Related Factors

Issues pertaining to 'urban poor' populations also pose further challenges in urban health care.

1. Illegality of slums and Social Exclusion: Slums are almost always initially informal settlements with no land tenure rights. They are considered synonymous with pockets of dirty, diseased and gloomy people and wished to disappear to make way for a clean and posh neighborhood by their upper and middle class neighbors¹⁹. Governments often try to relocate and at some other times demolish entire slums to 'clean up the city' or for meeting legal obligations. The demolition drive that left 4.5 lakh people homeless was part of Vision 2020, the government's plan to make Mumbai a "world-class" city like Shanghai²⁰.

Planners and service providers often harbor the perspective that providing service to 'illegal slums' implies giving them legal sanctity. In Indore, immunization services scarcely reached non-notified slums while notified slums received benefits of repeated interventions⁸. Figure 6 shows that basic service availability in non-notified slums is half or lesser than in notified slums.

2. Large proportions of slums are invisible: Services usually do not reach hidden and missing pockets of urban poverty that are not part of official slum lists such as limestone and brick-kiln workers, construction site workers, workers of local industry (leather, jute, glass). Bound to a specific industry, they are usually on some private land, unseen by most²¹.

Owing to long delays in updating of official slum list in most cities, slums may remain unrecognized for years. As an example, in Agra city, as per the

list of Department of Urban Development Authority (DUDA), there were 215 slums with an estimated population of 3 lakh. An assessment of the underserved population, conducted in 2005 for planning Agra's Urban Health Project, identified 393 slums with a population of approximately 8 lakh²².

3. Weak social fabric, collective negotiation capacity: Issues like illegality, social exclusion, uncertainty of land tenure, threat of eviction, and being forced to live in a disabling environment result in a sense of resignation among slum dwellers about their surroundings and wellbeing with compromised motivation to invest in infrastructure.

Other factors like heterogeneity among slum dwellers due to in-migration from different areas, varied cultures, fewer extended family connections, and more women engaged in work leads to lesser willingness and fewer occasions to build urban slum community as a strong collective unit.

4. Temporary Migration and Floating Populations: Temporary migration to their native villages, especially of pregnant women for delivery results in missing out receiving services from either residence. Mother and baby do not receive services in the village due to distances, unavailability of previous record of services received and lack of awareness and negotiating capacity.

Health service delivery for floating population in urban areas is a challenge for urban health planners. Large cities and religious towns have substantial and regular inflow of floating population. Mumbai city officials estimate about 2-3 million floating population²³. City population of Haridwar, a religious town, is virtually overrun by pilgrims on special occasions in the year particularly the Magh Mela, Baisakhi, Kanwar Mela. Pilgrims run into tens of millions, once every 6 years during Kumbh / Ardh Kumbh²⁴.

C. Weak Coordination among and limited capacity of Stakeholders

1. Weak / absent coordination among public and private urban health stakeholders: There are multiple urban health stakeholders including Health and Family Welfare Department, ICDS, ULBs, DUDA, NGOs, CBOs, Donor Agencies, Professional Bodies (IMA, IAP), Formal and informal Private practitioners, Corporate sector, Charitable Organisations, Employee State Insurance and local resources such as schools. These stakeholders operate in isolation with little coordination. They can benefit greatly by sharing resources, information, and expertise and avoiding duplication of efforts.

2. *Weak municipal capacity in most states:* The capacity of ULBs except in larger metropolitan cities is observed to be weak. In most of the 73 rapidly urbanizing 2 lakh to 40 lakh size cities, Maternal and Child Health service delivery capacity of Municipal bodies is grossly inadequate. Most Municipal Bodies have insufficient health program management experience which is also responsible for the underutilization of funds available under various Central government schemes such as the National Slum Development Programme (NSDP).

D. Inadequate Political and Civil Society Consciousness

Major political forces appear to harbor a significant greater rural bias while thinking of poverty. This has resulted in most attention being paid to rural poverty while the poor in urban areas have been neglected or at best provided passing reference in government policies and programmes. An analysis of rural and urban ICDS coverage shows that one AWC to total population ratio in rural areas is 1:1260 (79%) and 1:6114 in urban areas (16%)²⁵. The civil society also views slums with indifference.

OPPORTUNITIES FOR IMPACTING URBAN HEALTH

Though the challenges in improving the health of the urban poor are many, there are several opportunities which can be leveraged to reach the objective of better health in urban slums. These include:

Growing Recognition of the problem and burgeoning interest: The Government has acknowledged non-availability as well as substantial under utilization of available primary health care facilities in urban areas along with an overcrowding at secondary and tertiary care centers²⁶. MCH services to urban poor have been recognized as important thrust area by the government under the National Population Policy-2000, National Health Policy-2002, Draft RCH II and the Tenth Five Year Plan. The MOHFW has constituted a "Task Force to advise the NRHM on "Strategies for Urban Health Care" which indicates the Government's commitment to improve health services for the urban poor.

Resources and Potential Partners Abound: City planners and programmers can collaborate with a range of public sector and private partners: Health Dept., NGOs, Private and Charitable hospitals, ULBs amongst other to have a greater impact on health services coverage in urban slums.

Urban Poor Geographically Approachable: Crowded living of slums and their proximity to the

already existing government and private health services makes larger number of people geographically accessible for outreach activities in lesser time unlike rural areas where population is more dispersed.

74th Constitutional Amendment, an Opportunity for City Governments: The 74th Constitutional Amendment which delegates powers and responsibilities to ULBs is a big opportunity to improve the conditions in disadvantaged urban settlements. Under the 12th Schedule of the 74th Amendment, health services are mandated as functions of ULBs. It is also in the political interest of elected representatives to utilize this opportunity and broaden the spectrum of their current activities to include health services to the urban poor. This will help better serve and nurture their constituencies.

Basic Health issues are those with which we are familiar: Technical health priorities of antenatal care, safe / clean deliveries, neonatal care, immunization, diarrhea and ARI are all issues that public health programmers are familiar with. Interventions for the above priorities e.g. diarrhea prevention and treatment or malnutrition prevention are well established.

Urban poor can be easily reached for communication activity: Exposure to mass media has been shown to have substantial effects on people's attitudes and behaviors in India, even after controlling for urban / rural residence^{27, 28}. Since availability and access of mass media is higher in urban areas, urban poor can be easily reached for communication activity and are more likely to embrace change.

WHAT CAN BE DONE?

This paper suggests approaches to improve health of the Urban Poor as we move forward on the agenda of progressing towards achieving aims of the National Rural Health Mission.

Strengthen National Policy, Fiscal Mandate and Vitalize Implementation: It will be crucial to ensure an equitable rural-urban distribution when allocating resources for policies and programs aimed at improving health of the population. Existing policies need to be improved to make them more urban poor friendly, practical and measurable. Broadening the scope and focus of the *National Rural Health Mission to unequivocally include the urban poor and re-designating it as the National Public Health Mission merits consideration.* Energetic policy implementation can be ensured through a) regular training of officers and b) increasing information about various schemes to urban poor. Civil Society uproar generated from time to time will add the very helpful social push. Measures for ensuring

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implementation of 74th constitutional amendment and strengthening ULBs are needed.

Strengthen and Augment Urban Health Delivery System: Once the NRHM focus is expanded to include health services to the urban poor, an operational plan for strengthening urban health services will have to be put in place. There is a clear need to a) develop, support and strengthen dedicated Public Sector Infrastructure for urban health services with special focus on preventive services for slum dwellers and b) establish Urban Health Authority at City and State levels within the institutional framework of NRHM with clear roles, responsibilities and accountability for result based indices of the urban-poor.

To improve reach and quality of health services there is a need to a) provide motivational training to health providers (ANMs, MOs, Supervisors) to be more sensitive towards the disadvantaged and to coordinate effectively with slum based Community Health Volunteers (along the line of the Accredited Social health activist proposed for rural areas in NRHM) and with slum level CBOs; b) develop a delivery system that is responsive to the needs of slum dwellers and facilitates them to avail services; c) regularize outreach services in slums; d) Provide health card to every urban child to ensure basic health services.

Go beyond Notified slums to find the Urban Poor: The urban health component of NRHM would need to define approach to developing city level urban health plans which are responsive to the urban context. Comprehensive planning is critical to ensure that un-listed and invisible urban poor clusters or slums (which are also the neediest) are reached. Official slum lists need be regularly updated. Public health service administrators need to be sensitized that legality / notification related issues do not come in the way of reaching out to a family or a cluster with basic health services as mandated in the Indian constitution. Since urban poor populations are highly mobile and diverse an in-built flexibility will enable urban health services ensure that such population are included.

Coordinate among Multiple Stakeholders: The NRHM has mandated convergence of different sectors for optimal utilization of available resources. This aspect of the NRHM assumes greater relevance in urban areas where presence of many stakeholders is a palpable opportunity. For enhancing reach to the urban poor it is important to utilize resources from different departments / sectors. For example regular coordination meetings between various stakeholders (Health Department, DUDA, Charitable organization, ICDS, Municipal Corporation, CBOs, Local representative and local resource) at ward level in Indore facilitated by a

non-governmental organization have resulted in improved health services to the low income populations²⁹. Health department could collaborate with other stakeholders (water and sanitation departments) and NGOs to provide basic environmental improvements and health services in slums. The inter-sectoral convergence approaches being developed for NRHM could be expanded and adapted to include urban specific sectors and stakeholders to improve health services for the urban poor.

Involve Private Sector: NRHM has clearly identified Public Private Partnerships as a key approach towards vitalizing implementation of health programs and mandated a significant role for NGOs³⁰. In urban areas, involving (private doctors, charitable facilities, NGOs, Corporate sector) for defined essential services including outreach services is a clear opportunity. Public Private Partnership (PPP) can be an important bridge strategy for meeting the public health challenge of quickly expanding services and reaching to the under-served. Slums uncovered by health services were covered by PPP in Andhra Pradesh, Bangalore and Guwhati³¹. PPP enables use of existing Public and Private infrastructure and capacities to expand services rather than invest time in building new infrastructure-saving costs and time.

Strengthen Municipal Functioning: To pursue the mandate enshrined in the 12th schedule of the 74th Constitutional Amendment, it is essential that municipalities are equipped adequately for urban health programming, generating resources at the local level, better financial management and effectively engaging with private sector partners.

Extra focus on EAG States: NRHM has identified certain high focus States where there is a greater need for improving health services. From within NRHM high focus states, the low performing EAG States³⁰, which are home to 43% of India's urban poor, present a special challenge of poorer health status and poor availability of services for urban disadvantaged. Program planning, implementation and monitoring capacity is far weaker than the better performing states. Municipal governance and program and fiscal capacity is also weaker than other states. These EAG States also present a special opportunity being a small number of administrative units which have the potential to vastly expand and improve urban health services with support and encouragement. Greater emphasis through capacity enhancement efforts, more frequent review and hand holding to these states will enable them reach out to a very large proportion of the country's urban poor. Pilot lead programs could be established in one or two cities in each of EAG States to serve as early learning

sites as an impetus to further urban health efforts and as an impetus to advance urban health efforts.

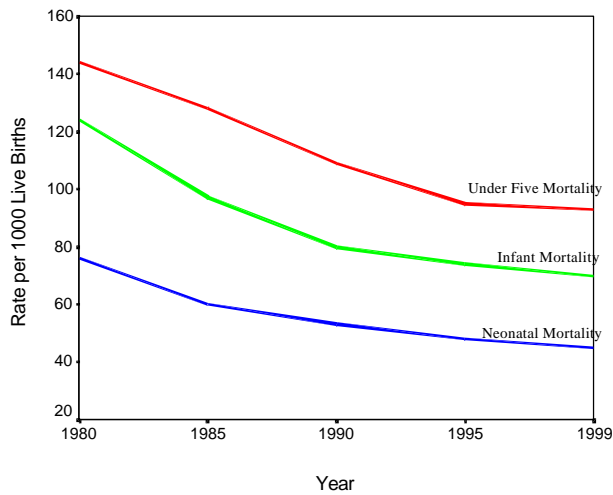
Build Capacity of Slum Communities for Improved Utilization of Services: The NRHM outlines the need to strengthen community level capacities to improve health of the communities and the need to measure outcomes at the community level. To address low uptake of services by urban poor it is vital to a) strengthen community-provider linkages through a trained cadre of slum based health volunteers similar to the ASHA proposed in NRHM, women health groups and other appropriate strategies b) build capacity of community groups to facilitate promotion of context relevant behaviors pertaining to maternal and child health. NGOs can play a crucial role by building capacity of slum communities and thus enhance utilization of public sector services³².

**“A stitch in time saves 9”
...we are talking of 90 million here.
Can we afford to wait?**

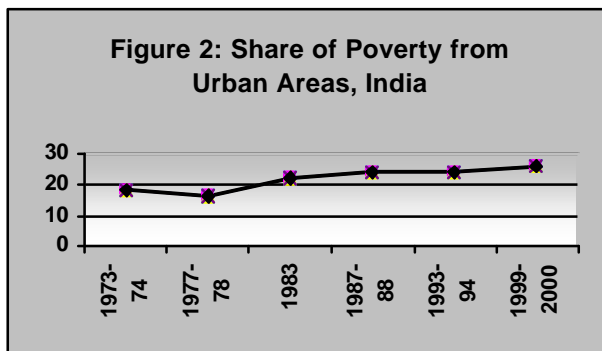
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Figure 1: Recent Trends in Mortality

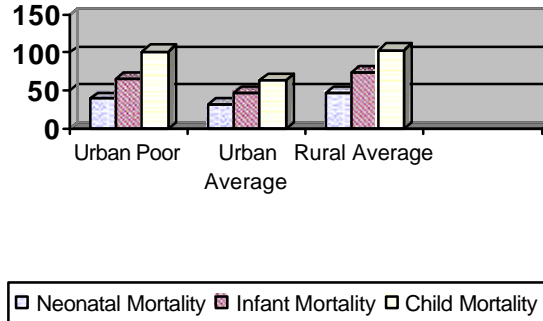


Source: SRS Bulletin (2002)



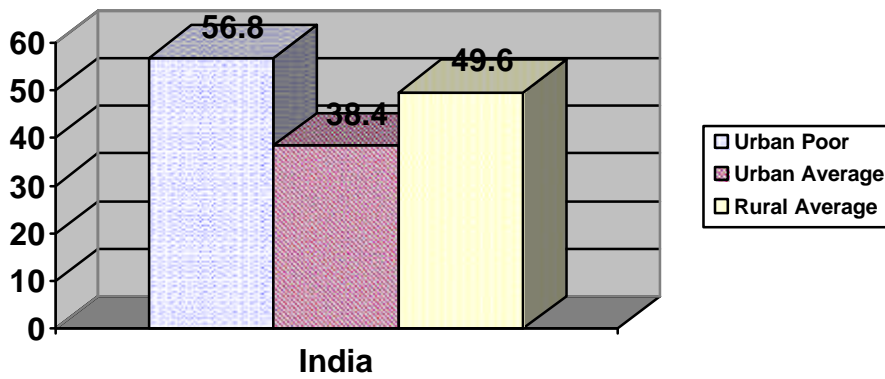
Source: Based on poverty figures stated in the ‘Report of the Steering Committee for the Tenth Five Year Plan’. GoI. Planning Commission (2001).

Figure 3: Neonatal, Infant and Child Mortality, India, 1998-99



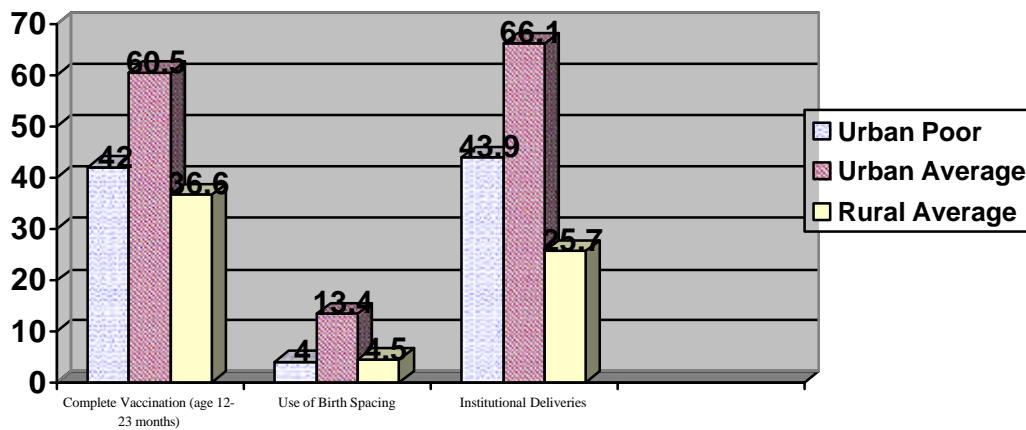
Source : Analysis of NFHS-2 data by Standard of Living Index

Figure 4 : Nutritional Status of Children, India, 1998-99



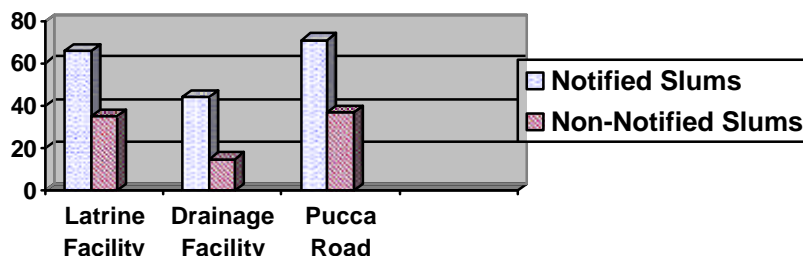
Source : Analysis of NFHS-2 data by Standard of Living Index

Figure 5 : Access of RCH Services, India, 1998-99



Source : Analysis of NFHS-2 data by Standard of Living Index

Figure 6: Availability of Basic Services in Notified vs Non-Notified Slums in India



Source: NSS 58th Round. 'Condition of Urban Slums, 2002', National Sample Survey Organisation, Ministry of Statistics and Programme Implementation, Government of India, December 2003

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