Spatial Mapping by GIS to assess the need of Urban Health Policy in the deficient areas of Health Infrastructure

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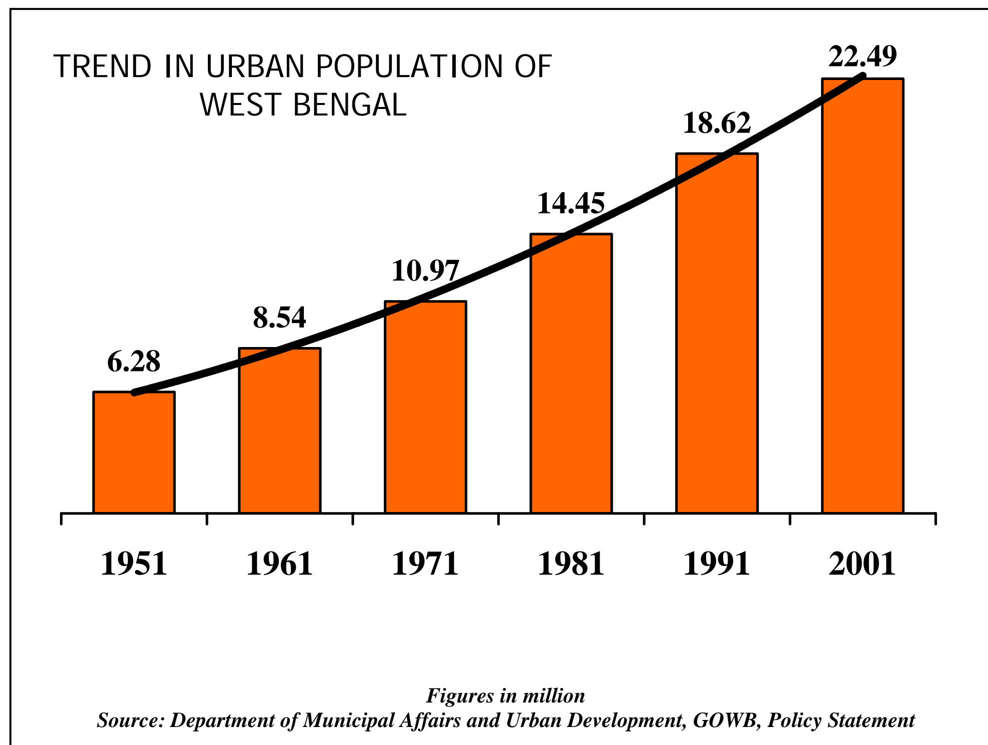
1. Introduction

Urban health assumes great importance due to increasing urbanisation in the country as a whole and the state of west Bengal in particular. Though agricultural prosperity in West Bengal has checked the rural to urban migration and slowed down the rate of urbanisation in recent years, yet a whopping 28% of its total population lives in urban areas. The state ranks fourth in respect of absolute size of the urban population amongst all Indian states. Average population density in urban areas of the state is highest in the country. In absence of adequate government health infrastructure in urban areas, urban health mostly depends on private facilities. Though there is abundance of private facilities in urban areas, their quality varies to a great extent. Detection of polio cases in urban areas (one in 2001, seven in 2002, five in 2003 and two in 2005) clearly indicates that there are deficiencies in urban health care services, particularly in respect of preventive and promotive health.



Figures in million
Source: Department of Municipal Affairs and Urban Development, GOWB, Policy Statement

Objectives

In view of the above, West Bengal Municipal Association a registered body with the Government since 1934, with the financial support of UNICEF and Technical support from Environment Cell KMDA, has implemented a project to map all existing health infrastructure in all municipal areas. The project aimed to prepare a database of all existing health infrastructure in municipalities followed by GIS mapping. Finally, to develop definite proposals for individual municipalities to be collated at regional and state level for submission to the Government. The first phase of the project concentrates on preparing the database and analysis of the same to identify both qualitative and quantitative gaps in the health scenario of urban West Bengal. Conserving spatial data collected in phase-I in a GIS format and ULB wise data analysis, coordination planning, gap identification and developing models was in the second phase of the project.

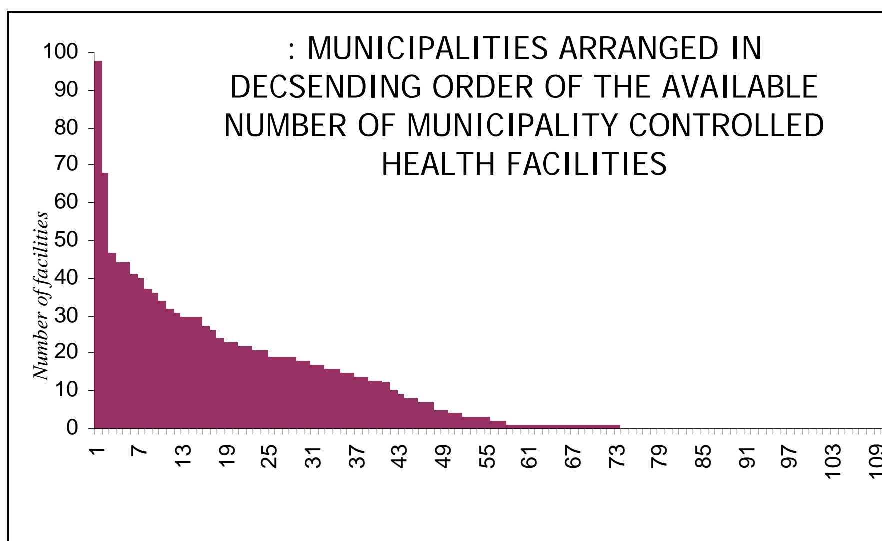
Coverage

The project intends to cover 124 of the 126 local bodies of the state and excludes Kolkata and Howrah municipal corporations which were dealt separately. The analytical report is based on the data of the 124 local bodies, which include four municipal corporations, 15 municipalities with more than 2 lakhs of population (Category-A), 9 municipalities with a population ranging between 1.5 and 2 lakhs (Category-B), 31 municipalities with a population ranging between 75,000 and 1,50,000 (Category-C), 45 municipalities with a population ranging between 25,000 and 75,000 (Category-D) and 16 municipalities with less than 25,000 population (Category-E)[1]. The analysis of health infrastructure of these municipalities portrays a perfect collage of different combinations ranging from abundance to paucity. There are towns with plenty of health facilities – government as well as private, together with community-based interventions reaching out to every corner of municipal area. On the other hand, there are towns, which do not even have an apology of a health infrastructure.

Findings

Health infrastructure existing in urban areas are divided in four categories – (i) hospitals, health centres and sub-centres supported by the State Health Department, (ii) facilities owned by the various other government departments, (iii) municipality controlled facilities and (iv) those belonging to the private sector. 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[2]. Though a segment of the municipal population accesses services from

these facilities, the local bodies are always under apprehension that sooner or later they are going to be withdrawn from the municipal areas. Health facilities



like jail hospitals, ESI hospitals etc. owned by a few government organisations and other government departments are meant for special groups of people and hence inaccessible to the mass in general. The only exceptions are the medical units of ICDS, which are present in very few municipalities like Kamarhati, Assansol. 50% of the municipalities have certain infrastructural advantages (meant for the poor) due to some community-based interventions presently being supported by the Municipal Affairs department of the Government of West Bengal and external agency like DFID[3]. Private facilities are abundant in some municipal areas and bridge the gap between demand and supply. These include private nursing homes, a large group of private practitioners and a few NGO initiatives. In the absence of a stringent quality assurance system, the quality of health care in private sector is always under question. Private sector health facilities are mostly run by part-time doctors and untrained nurses. The project could make a list of 13460[4] qualified (MBBS) private practitioners and more than 8,000[5] non-MBBS doctors including the homeopaths, unani and RMPs in 120 towns. Analysis shows that most of the available facilities are concentrated in bigger towns and small municipalities are dependent on rural infrastructure located in municipal areas.

There are approximately 25 hospital beds per 10,000 population in urban areas 53% of which belong to the State Health Department, 13% to other government

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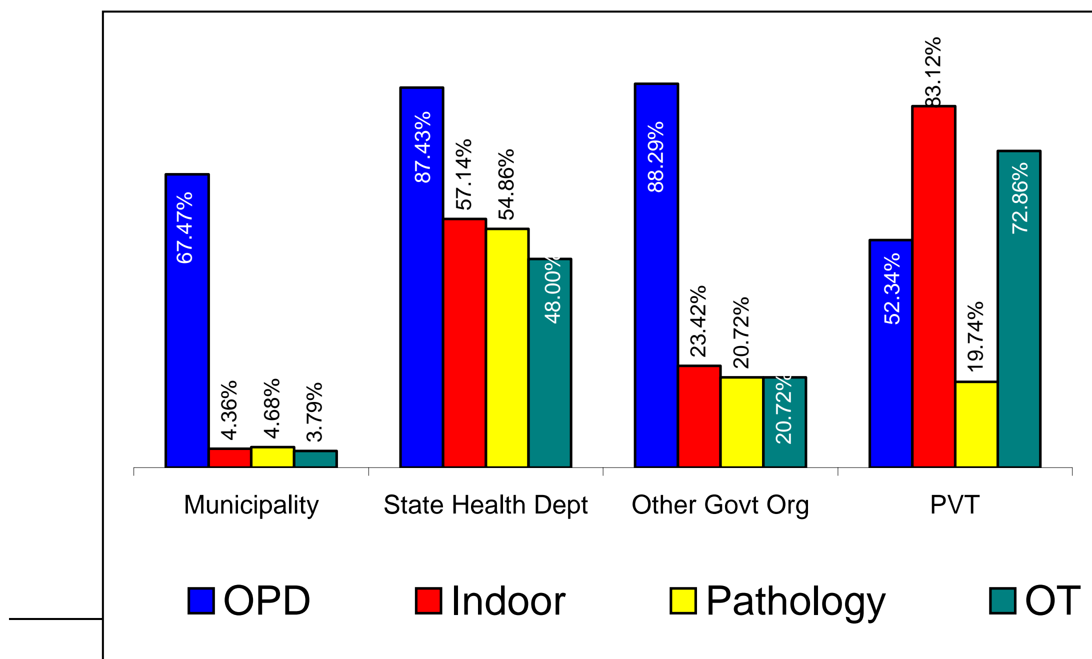
departments and 29% to the private sector[6]. Municipal facilities account for only 5% of the total number of beds. Similarly 51% of the qualified MBBS doctors and 59% of the trained nurses working in urban areas belong to the State Health Department[7]. Municipal facilities account for only 6% of the qualified doctors and 4% of the trained nurses. A total of 1149 immunisation facilities could be found located in 120 municipalities. Expectedly, immunisation facilities mostly belong to the government and municipal sectors. While 84% of all facilities supported by the State Health Department and 69% of those controlled by municipalities offer immunisation service for women and children, only 14% of the private sector has this facility[8]. Overall we observe that there is 0.87 immunisation facility per 10,000 populations in the urban area[9].

One of the 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[10].

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[11], for others they depend on the State Health Department.

PROPORTIONS OF DIFFERENT SERVICES OFFERED BY DIFFERENT CATEGORY OF SERVICE PROVIDERS



2. Some Important features during Implementation Period of the Project

Activation

The project was formally inaugurated by Mr Ashok Bhattacharya, the Hon'ble Minister-in-Charge, Urban Development and Municipal Affairs

The project started with advocacy meetings with the Chairpersons of municipalities and the Mayors of municipal corporations. The Chairpersons and Mayors present in these meetings played a very proactive role irrespective of their political allegiance. A series of training workshops with the enumerators - engaged by the municipalities for collection of information about the health facilities - followed the advocacy meetings.

Interactive Meetings

Interactive workshops with different groups (district wise) of municipalities have begun in order to share with them the findings of the project (which is also a part of the data cleaning process) and generate their viewpoints on various issues that might come in the way of implementation. Deliberations in these workshops are expected to bring out the key features of a comprehensive urban health strategy.

Methodology

One major purpose of the project was to ensure municipal participation in the urban health care delivery system by increasing accountability of all stakeholders in accordance with the 74th amendment of the constitution. As the municipalities were accountable to its population for rendering primary health services, all service providers (in government as well as in private sectors) should also remain accountable to the municipal authorities. The first step towards this was to know what healthcare services really exist within a municipal area, where the gaps were and finally, to develop a complete proposal for required infrastructure, IEC, social mobilisation and capacity building.

The first phase of the project concentrated on information collection about the existing health care facilities and further analysis of this information to identify the deficiencies. Information was collected from all categories of healthcare providers (municipal, state, central, private) - starting from hospitals and nursing homes to qualified private practitioners and unqualified RMPs.

For the purpose of information collection and subsequent analysis, the municipalities were divided in five zones. Zone-I consisted of all municipalities of North and South 24 Parganas and Nadia districts, Zone-II was made up of all municipalities of East and West Medinipur, Howrah and Hooghly districts, Zone-

III contained the municipalities of Burdwan, Birbhum, Bankura and Puruliya districts, Zone-IV the municipalities of Murshidabad, Malda, Uttar and Dakshin Dinajpur and Zone-V the municipalities of Darjeeling, Jalpaiguri and Kochbihar districts (A list of municipalities in each zone has been given in annexure-I).

The entire project was implemented through a process of participation. The project started with a state level inaugural meeting and five advocacy meetings in five different zones. The state level meeting was required to create awareness about the project among the state level functionaries of the Government. Zonal advocacy meetings were planned to sensitise and involve the Chairpersons and Mayors of the municipalities and municipal corporations of each particular zone. These meetings were useful to describe the purpose and explain the process of implementation of the project to the top leadership of urban local bodies and seek their endorsement for the project. A series of training workshops with groups of municipalities followed the advocacy meetings. The enumerators engaged by the municipalities for collection of information about the health facilities were trained in these workshops. Soon after the training workshops for the enumerators were over, the enumerators started working in the field under the supervision of Regional Coordinators engaged by West Bengal Municipal Association to coordinate and monitor the information collection process. The enumerators were also asked to denote the locations of the health facilities on the municipal maps.

A software was developed to enter the information thus collected to create a database of health infrastructure for individual municipalities and for GIS mapping.

Based on the availability of infrastructure vis-à-vis their population spread, municipalities will be grouped under several categories in order to develop the final proposals. However, the task of proposal development by the municipalities has been marked for the second phase of the project.
Two sets of schedules were developed for the purpose of information collection – one set for the municipalities, which are implementing community, based health projects and the other set for those who do not have any such project. The reason was to keep the schedule very precise and avoid questions, which were not relevant to a particular municipality. Each set comprises of four schedules.

- Form-I asking information about the health facilities and health staff available in the municipal building plus a total structure of the community based health project controlled by the municipality (if relevant)

- Form-IA asking detailed information about hospitals, nursing homes, maternity homes, health centres, Health Administrative Units (HAUs), Sub-centres, Health Posts, Sub-Health Posts, municipal dispensaries, Extended Service Out Patient Department (ESOPD) located in municipal areas. (one form for each unit)

- Form-IB to collect information about the qualified allopathic private practitioners and private polyclinics.

- Form-IC to collect information about the non-MBBS private practitioners in municipal areas.

Activation of the Process and Lessons Learnt

Though West Bengal Municipal Association is a coalition of all municipalities and municipal corporations cross cutting their political allegiance, it was initially difficult to stimulate the municipalities to undertake this project as health was apparently a non-issue to many of the them. They were also unaware of the implication of 74th constitutional amendment. Many of them had the impression that municipal health does not go beyond the birth and death registration and conservancy support and protecting health of the municipal population is the responsibility of the state government alone. The association was able to change the scenario in a very short time through constant advocacy. While we could assemble only 40 municipalities in five zonal level advocacy meetings, 95 municipalities participated in the training programmes for the enumerators. Ultimately every single municipality was reached through our Regional Coordinators and with the help of UNICEF consultants. In many cases the Chairpersons and Health Officers either issued letters or personally talked to the owners of nursing homes to elicit information from them.

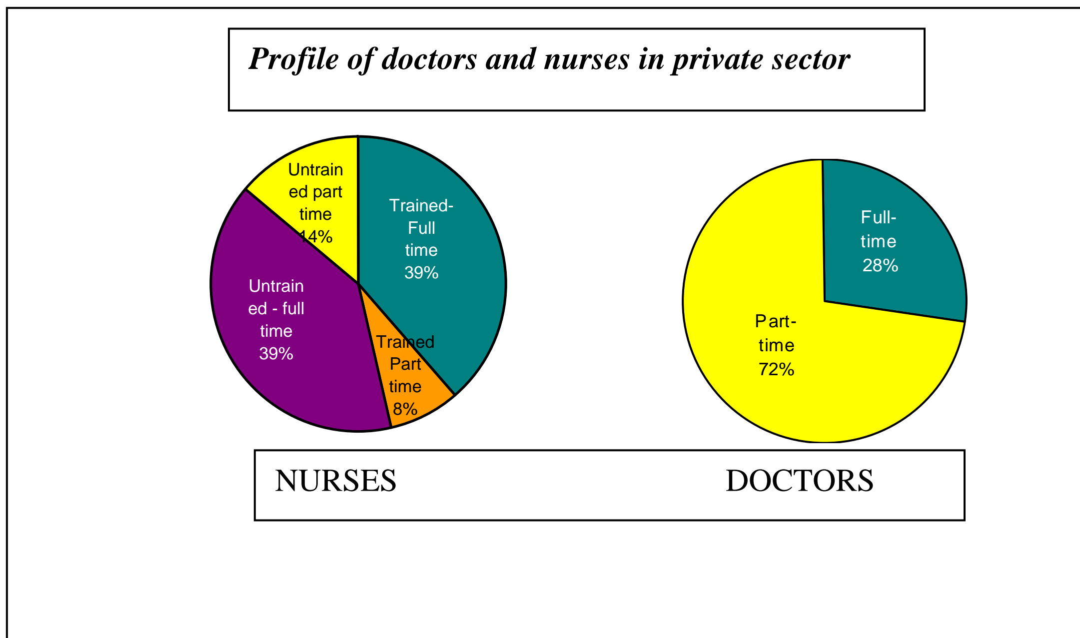
The project raised mixed reactions among the private practitioners and owners of the private health facilities like nursing homes. Most were very cooperative, but some of them were a bit scared to share information. They feared that this was an attempt to impose penalty on them or bring them deeper into the tax net. In some areas the doctors' nameplates were removed from the medicine shops on being enquired by the enumerators about the facilities available there. However, such erroneous impressions were removed after awareness from the municipal authorities.

Scope of the present study

Health facilities available in urban areas of West Bengal with 124 of the 126 urban local bodies of the state was the primary concern. Kolkata and Howrah Municipal Corporations were kept outside the purview of this project due to inadequate resources and dearth of time. The following analysis is based on the data received from these 120 urban local bodies. This includes 15 district towns, 36 sub-divisional towns and 69 other category of towns. Out of 120 urban local bodies there were four municipal corporations, 15 municipalities with more than 2 lakhs of population (Category-A), 9 municipalities with a population ranging between 1.5 and 2 lakhs (Category-B), 31 municipalities with a population

ranging between 75,000 and 1,50,000 (Category-C), 45 municipalities with a population ranging between 25,000 and 75,000 (Category-D) and 16 municipalities with less than 25,000 population (Category-E).

The analysis of health infrastructure of these municipalities portrays a perfect collage of different combinations ranging from abundance to paucity. There are towns with plenty of health facilities – government as well as private, together with community-based interventions reaching out to every corner of municipal area. On the other hand, there are towns, which do not even have an apology of a health infrastructure. This shows that we are yet to come up with a uniform strategy for urban health.



Health Infrastructure provided by the State Health Department

It was found that out of 120 municipalities and municipal corporations analysed so far, 101 have some kind of health infrastructure supported by the state health department. 15 district towns together have 24 health units[12]. But modern system of medicine (allopathic) is followed in 22 of them. 36 sub-divisional towns together have 60[13] health units, 55 of them follow allopathic system of medicine. 69 other category of towns together have 89 health units with 88 of them following allopathy. Though the infrastructure provided by the State Health Department is available in each of the 15 district towns and in 34[14] of the 36 sub-divisional towns, only 52 of the 69 other category of towns (i.e. 75% of them) are fortunate to have some sort of state government health facilities. **This means that 25% of such municipalities, which are neither district nor sub-divisional towns, are deprived of any health infrastructure supported by the State Health Department.**

TABLE-7 : NUMBER OF TOWNS IN DIFFERENT CATEGORY (ADMINISTRATIVE) WITH HEALTH INFRASTRUCTURE SUPPORTED BY THE STATE HEALTH DEPARTMENT

Category of Towns	Number of towns covered by the project	Number of towns with a Health Unit	%age of towns with a Health Unit	Number of Health Units	Number of Health Units with modern system of medicine (allopathic)
District Towns	15	15	100.00%	24	22
Sub-divisional Towns	36	34	94.44%	60	55
Others	69	52	75.36%	89	88
Total	**120**	**101**	**84.17%**	**173**	**165**

[12] A health unit or health facility is defined as a space with provision of some healthcare facilities. This includes all hospitals, nursing homes, dispensaries, sub-centres, health post, sub-health post, but excludes chambers of private practitioners.
[13] This excludes three SD hospitals viz. Ranaghat SD Hospital, Kalna SD Hospital and Rampurhat SD Hospital – which are located outside the municipal boundaries.
[14] Kalna and Rampurhat are two sub-divisional towns without any health infrastructure managed by the State Health Department. SD hospitals are located outside the municipal boundaries.

TABLE-8 : NUMBER OF TOWNS IN DIFFERENT CATEGORY (POPULATION WISE) WITH HEALTH INFRASTRUCTURE SUPPORTED BY THE STATE HEALTH DEPARTMENT					
Population category	Number of towns covered	Number of towns with a Health Unit	%age of towns with a Health Unit	Number of Health Units	Number of Health Units with modern system of medicine (allopathic)
Municipal Corporations	4	4	100.00%	23	22
Above 2 lakhs (A)	15	13	86.67%	27	27
1.5 lakhs-2.0 lakhs (B)	9	9	100.00%	13	12
0.75 lakhs–1.5 lakhs (C)	31	23	74.19%	39	37
0.25 lakhs–0.75 lakhs (D)	45	41	91.11%	61	55
Below 0.25 lakhs (E)	16	11	68.75%	12	12
Total	**120**	**101**	**84.17%**	**173**	**165**

Analysis based on population categories reaffirms the above findings. 72% of the health infrastructure located in category-A towns (population above 2 lakhs) and 75% of those located in category-B towns (population 1.5 lakhs – 2 lakhs) are meant for the urban population. For C, D and E-category of towns these proportions are 68%, 38% and 42% respectively. In municipal corporations, only 23% of the facilities are for the urban population.

It is worth mentioning once again that these so-called facilities for the urban people are not dedicatedly meant for them as they are equally (if not more) accessed by the rural population as well. Municipalities having health units supported by the State Health

TABLE-11 : PROPORTION OF INFRASTRUCTURE MEANT FOR THE URBAN POPULATION LOCATED IN DIFFERENT CATEGORY OF TOWNS (POPULATION WISE)

SUPPORTED BY THE STATE HEALTH DEPARTMENT

Category of Towns	No. of towns	Number of Health Units	Number of units for urban popln	Number of units for rural popln	Number of units in special category	% of units for urban popln
Municipal Corporations	4	22	5	16	1	22.73%
Above 2 lakhs (A)	15	27	21	5	1	77.78%
1.5 lakhs-2.0 lakhs (B)	9	12	9	1	2	75.00%
0.75 lakhs–1.5 lakhs (C)	31	37	25	10	2	67.57%
0.25 lakhs–0.75 lakhs (D)	45	55	21	31	3	38.18%
Below 0.25 lakhs (E)	16	12	5	7	0	41.67%
Total	**120**	**165**	**86**	**70**	**9**	**52.12%**

Department and which are parts of the rural health system are always under the apprehension that sooner or later they are going
to be taken away from the urban areas. There are many instances where such things have happened.

Though a significant part of the rural health infrastructure is situated in the urban area, institutional capacity of the urban infrastructure is much more than the rural counterpart. For example, where the mean number of beds per rural healthcare unit located in an urban area is only 13, it is 173 per urban healthcare unit. Mean number of beds per special category healthcare unit located in an urban area is around 202. This also explains why urban healthcare centres are burdened with rural population.

Health Infrastructure provided by the Other Government Organisations

Apart from the State Health Department, there are many other government organisations and government departments (Central as well as State) like Railway, Labour, Jail, Mines etc. which offer healthcare to the urban population. In many towns there are ESI and Railway hospitals. In industrial towns like Kulti

and Assansol ECL[15] provides a number of health facilities. However, these facilities are for special groups of people and not for the general population.

TABLE-12 : NUMBER OF HEALTH FACILITIES SUPPORTED BY GOVERNMENT ORGANISATIONS AND DEPARTMENTS OTHER THAN THE STATE HEALTH DEPARTMENT LOCATED IN DIFFERENT CATEGORY OF TOWNS (POPULATION WISE)

Category of Towns	Number of towns	Number of Health Facilities	Average number of Health Facilities in each town
Municipal Corporations	4	22	5.50
Above 2 lakhs (A)	15	60	4.00
1.5 lakhs-2.0 lakhs (B)	9	4	0.44
0.75 lakhs–1.5 lakhs (C)	31	17	0.55
0.25 lakhs–0.75 lakhs (D)	45	3	0.07
Below 0.25 lakhs (E)	16	1	0.06
Total	**120**	**107**	**0.89**

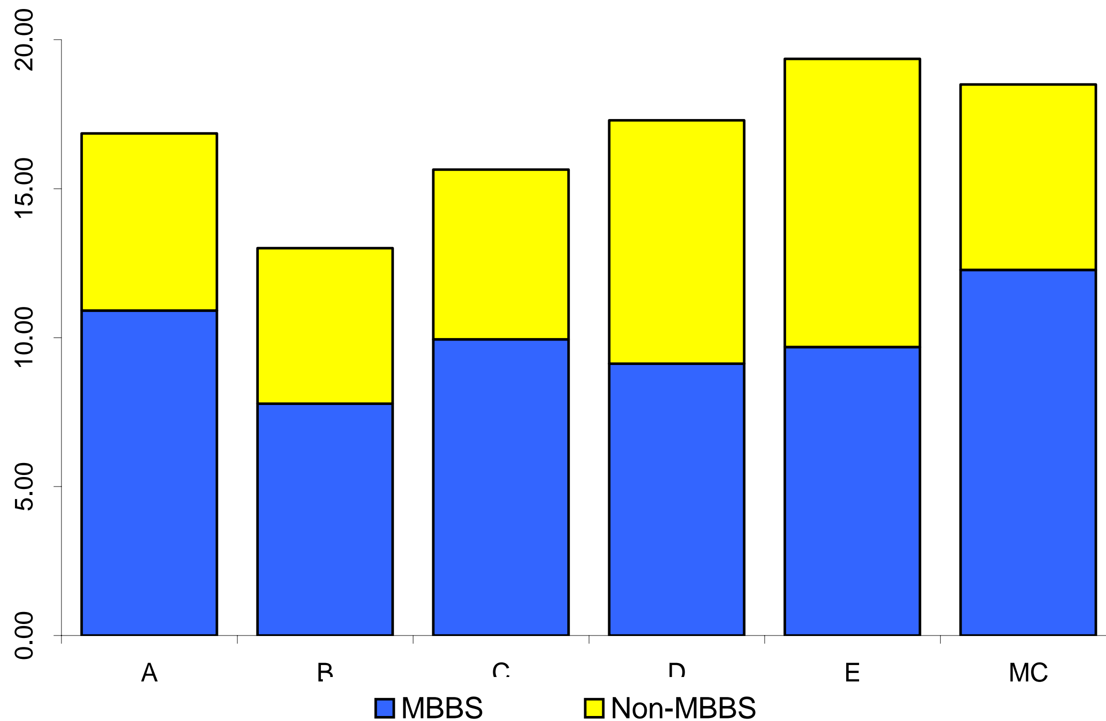
Among the health units owned by government departments and organisations other than the state health department, only ICDS- run health units cater to the vulnerable urban population. But medical units of ICDS exist only in few municipalities like Assansol Municipal Corporation and Kamarhati Municipality.

Municipality Controlled Health Interventions

Community based health interventions are ongoing in 52 of the 126 local bodies of the state. The interventions originally started with the help of World Bank under the aegis of CUDP-III[16], IPP-VIII[17], IPP-VIII Extension Projects and RCH sub-project. European Commission funded six municipalities (within Kolkata Metropolitan Area) for an interim period under the aegis of UHIP[18]. Selected parts of Kolkata Municipal Corporation, Barrackpore and Titagarh municipalities were included for intervention under CSIP[19] supported by the UK Government donor agency DFID[20]. All these projects were subsequently taken over by the Municipal Affairs Department, Government of West Bengal after the donor

[15] Eastern Coalfields Limited
[16] CUDP = Calcutta Urban Development Project
[17] IPP = Indian Population Project
[18] UHIP = Urban Health Improvement Project
[19] CSIP = Calcutta Slum Improvement Project
[20] DFID = Department For International Development

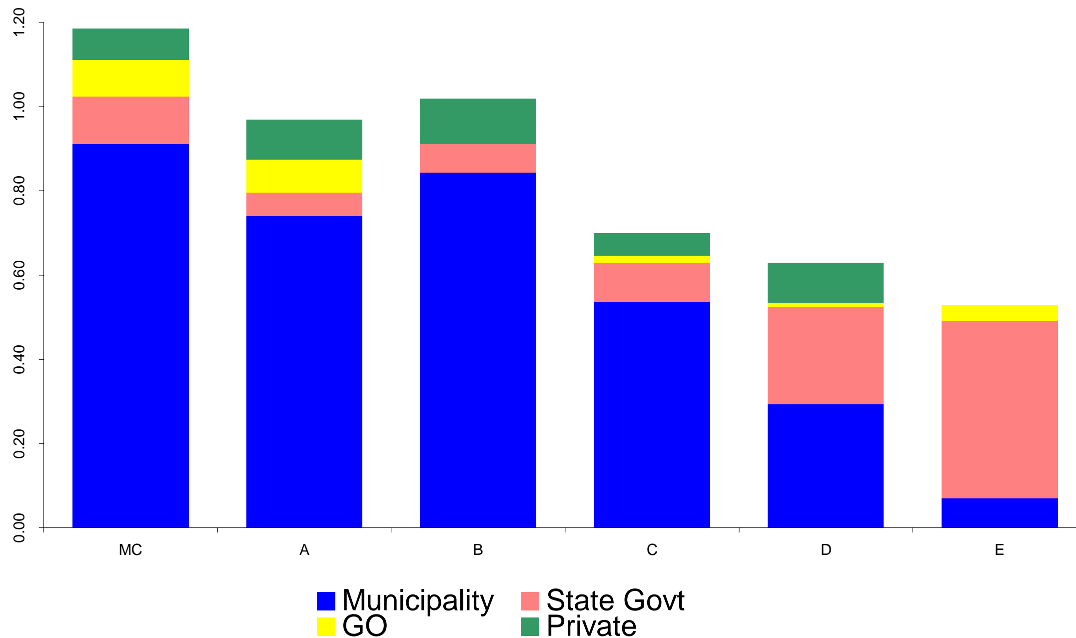
agencies phased out. In last one year 11 new municipalities have initiated limited RCH interventions supported by DFID. Very recently the state government has proposed an allocation of Rs 70 crores from DFID funding for improvement of urban health.



An extensive health infrastructure came into being in some of the municipalities and municipal corporations of the state as a result of these interventions. Larger part of this infrastructure consists of many outreaching sub-centres (also known as health-posts or sub health-posts) providing limited curative care and routine immunisations to the pregnant women and children. Outreach centres are housed in local clubs where these activities take place with a certain periodicity - ranging from once a week to once a month. Apart from these outreach-centres, the infrastructure also includes Maternity Homes, Extended Service Out-Patient Departments (ESOPDs) and Regional Diagnostic Centres (RDCs) offering facilities for institutional delivery, specialist doctors' services and diagnostic investigations at a much lower cost, primarily to the people living below the poverty line.

However, the key resource of the interventions is a large group of honorary health workers who go door-to-door and keep track of every pregnancy and child-birth in the community, follow up their immunisation status, distribute contraceptives and condoms to the eligible couples and educate them on preventive and promotive health care practices.

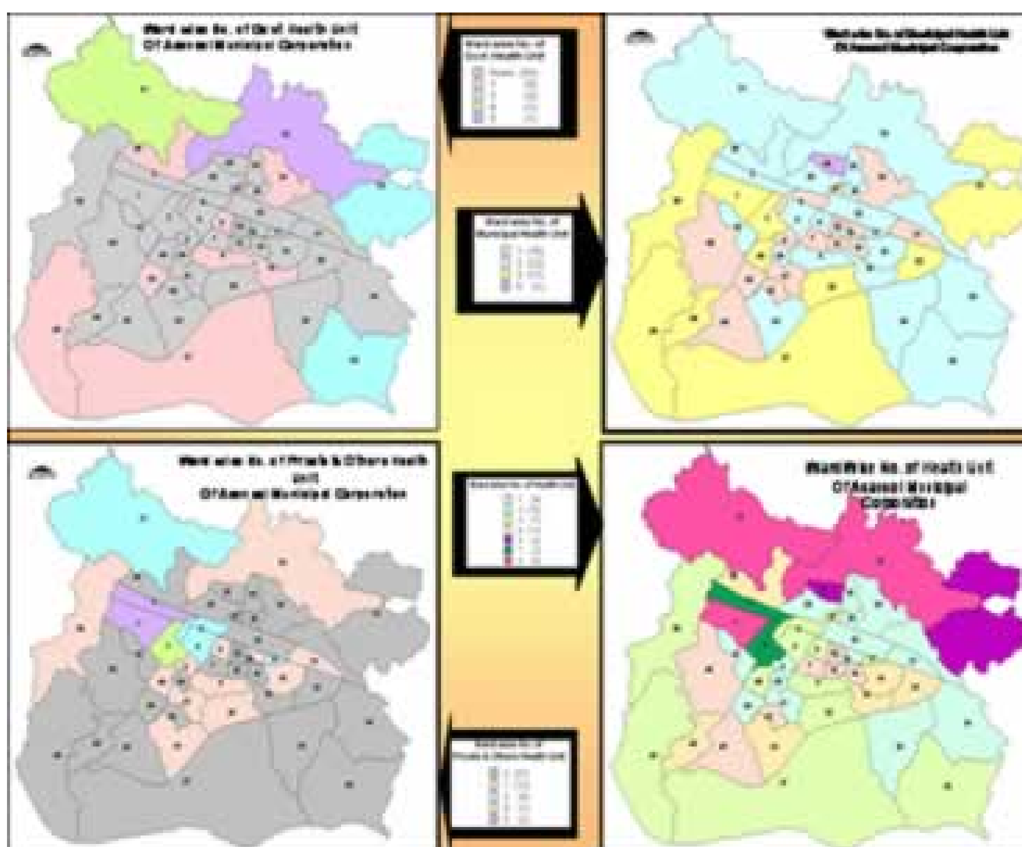
As reported by the municipalities with such community based health projects, the primary health indicators have tremendously improved among the



beneficiaries of the project. But the beneficiaries include only a small fraction of the population who are living below the poverty line and secondly, 50% of the municipal towns do not have any such health project even for the poorer population of the towns. Some municipalities do have some health facilities of their own even without a community based intervention. But such examples are only few and the municipalities are struggling to sustain these facilities without any external help.

Findings and Observations in the Post-survey Interactive Meetings with the Municipalities

The main objective of the post-survey interactive meetings was to generate viewpoints of the municipal Chairpersons on certain issues that might come in the way of implementation of a primary health intervention. Following a presentation on the findings of the project for respective municipalities, the meeting was opened for discussion on four key aspects of an intervention viz. service delivery, demand generation, capacity building and sustainability. The municipalities agreed that the package of service for the primary health care should include the following preventive care measures



Type of Distribution of Urban Health facilities in Asansol Municipal Corporation

- ❑ Ante-natal and Post-natal check up for pregnant women
- ❑ Routine Immunisation for children and pregnant women
- ❑ Institutional delivery
- ❑ Growth monitoring of children
- ❑ Family Planning
- ❑ Limited curative care with provision for drugs

Some municipalities also suggested that

- Urban population should have access to the benefits of all national programmes on communicable diseases such as malaria, leprosy, tuberculosis etc.
- Urban health infrastructure and various other public health issues like provision of safe drinking water, a good drainage system etc. ought to be included in the ambit of urban health.
- Ensuring preventive health care for the entire urban population should be the immediate priority of the municipalities as well as of the state government.

The discussion revolved around the issues namely technical and fiscal management, linkage with state owned and privately owned health system, social mobilisation and finally, the municipal capacity to handle the issues.

All municipalities were keen to have a preventive health care system based on the honourary health worker module with back-up of limited curative facility like maternity home and out-patient department.

The difficulties faced and apprehended were:

- Non-availability of qualified doctors and trained nurses for such curative facilities

- The cost of maintaining such facilities is difficult to recover from user-charges.

Suggested remedies:

- Doctors and nurses from health department be deputed to the municipal facilities

- Funding from NSDP[21] for BPL beneficiaries - according to the guideline of NSDP grant, a collection of one rupee from the beneficiary entitles ULB to spend Rs 5 on health and education from the project fund.

It was unanimously felt that there should be more institutional government facilities in the deficient municipalities; moreover it was apprehended by some of the municipalities that the already existing facilities in the municipal area but meant for service in rural areas may be shifted causing more deficiency in the future.

It was claimed that the municipalities with community-based health interventions have achieved wonderful results in terms of increased immunisation coverage and other vital health parameters. This is due to social mobilization done by a large group of honorary health workers who go door-to-door and follow up immunisation status of every child and pregnant woman in their beneficiary groups. All municipalities want to follow this model for total population of the municipality instead of only addressing weaker section of the society as has been done in the intervention designed under IPP-VIII and such other foreign donated projects. It was suggested that mobilization might now be entrusted with the RCVs of the community structure designed for BPL population under SJSRY project. This structure, it was claimed, was in existence in all ULBs. This might

[21] National Slum Development Programme

be achieved with proper training of the RCVs and a modest honorarium. Each RCV may be responsible for 100 families. The state might share the cost along with contribution from the beneficiaries.

It was stated that due to want of doctors or trained nurses immunization in all cases could not be carried out technically by doctors or trained nurses. It was suggested that it would be helpful if Health Department deputes the required technical people in the municipal immunization centres to meet the gaps where necessary.

While discussing fiscal management some municipalities like Balurghat and Shantipur stated that they had tried partnership with private entrepreneurs to provide curative and diagnostic health facilities. While Balurghat municipality is running a hospital in collaboration with "West Bank", Shantipur municipality runs a polyclinic with the help of part-time doctors who receive Rs 1,500-3,000 per month for once-a-week visit to the polyclinic. Patients are charged Rs 15 on their first visit and Rs 10 on the subsequent visits. Shantipur Municipality has come under agreement with two private agencies for the functioning of a pathological unit and a diagnostic centre. Under the agreement the municipality provides space and equipment for the pathological unit and diagnostic centre to the private entrepreneurs who employ the technicians & doctors and invest in the running cost. Revenues are shared between the municipality and the private parties on the basis of agreed terms and conditions. Rates for various services available from these pathological units and diagnostic centres are 30-40% less than the market rates.

The issue of demand generation and social mobilisation was discussed at length. The participant municipalities unanimously agree that community structure created under the project Swarna Jayanti Sahari Rojgar Yojana (SJSRY) provides the best platform for social mobilisation. This Yojana is existent in each municipality and covers the entire BPL population of the municipalities. If they are trained to mobilise families to access immunisation and other primary health care facilities they will form a wonderful resource group at the community level. A performance based incentive system can be developed to sustain their motivation in the job. However, the scope of this Yojana is limited to the extent of BPL families but it was opined by Chairperson's that the RCVs of this structure will also be acceptable to non –BPL families.

Regular surveillance of the quality of private healthcare was a felt need. Municipalities feel that there should be some kind of a reporting system for the private sector health facilities and private practitioners. This is required to ensure quality of care in private sector. The reporting system covering all the private, government and municipal health facilities, which have been identified under this survey, may successfully implement an early warning system for various communicable diseases like tuberculosis, malaria, dengue etc. to enable the local bodies and the State Health Department to take early action to control epidemic.

The Chairpersons were critical of the lack of coordination between health department and the municipalities. They felt that there should be institutionalised arrangement to introduce such coordination effectively.

Another moot point of discussion was the issue of ownership. Municipalities strongly felt that the Municipal Chairpersons should be the nodal authorities for coordinating all primary health activities in municipal areas as the 74th amendment of the constitution has made them liable to be so. It was also clear that technical and financial support should come from the state government. There should also be clear-cut guidelines defining the roles of different stakeholders and a strong collaboration between the municipal affairs and state health department in order to achieve desired results in urban health.

3.Comments on Implementation of Urban Health Policy

Health Infrastructure in Urban West Bengal- a Conclusion

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).

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.

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. Though a segment of the municipal population accesses services from these facilities, the local bodies are always under apprehension that sooner or later they are going to be withdrawn from the municipal areas. 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 RMPs. Hospitals with state-of-the-art technology coexist with nursing homes run by RMPs even without a trained nurse. 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.

There are approximately 25 hospital beds per 10,000 populations in urban areas, 53% of which belong to the State Health Department, 13% to other government departments and 29% to the private sector. Municipal facilities account for only 5% of the total number of beds. Similarly 51% of the qualified MBBS doctors and 59% of the trained nurses working in urban areas belong to the State Health Department. Municipal facilities account for only 6% of the qualified doctors and 4% of the trained nurses[22]. In 2003, there were 813 persons served per doctor in the urban areas[23].

The average number of private facilities (excluding doctors' chambers) per 10,000 population is around 0.58. Unlike government and municipal facilities, private facilities do not have any extraordinary high concentration in bigger

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[22] Mapping Of Health Infrastructure In Urban Local Bodies, November 2005, West Bengal Municipal Association

[23] Source: DHFW

towns. Though the number of private facilities is more in A-category towns (population over 2 lakhs), see Table 7, the average comes down to 0.49 while leveled against the population. In E- category towns, this average is 0.46. An unusually high density of private facilities i.e. 1.03 per 10,000 population is observed in D-category towns (population 0.25 to 0.75 lakh). Table 9 shows that the number of government and municipal facilities is abysmally low in this category.

Suggested Health Interventions

The provision of preventive and promotive healthcare to urban population has emerged as a priority in view of increasing urbanization along with the increasing number of slum areas and low-income people in cities and towns. More so, as it has become mandatory for the local governments to ensure preventive and promotive health care services for their populations as a consequence of 74th constitutional amendment. The Government of India has recognized urban health as a thrust area under National Population Policy 2000, National Health Policy 2002, and Tenth Five Year Plan and in the second phase of RCH programme.

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Since 1980 community based preventive health care projects in slum areas have become integral parts of slum development activities in urban areas. At present 52 municipalities, including 41 KMA (Kolkata Metropolitan Area) municipalities, are supported by community based health projects like CUDP-III, IPP-VIII etc. originally funded by World Bank and subsequently taken over by the Government of West Bengal. An additional 11 municipalities have recently started limited RCH intervention with support from DFID.

The reported performance figures in the project areas indicate tremendous improvements in health indicators among the beneficiaries of the project. The couple protection rate has gone up to 72%, infant mortality (IMR) has come down to 22.7 per 1000, immunization coverage has increased to 96% and the incidence of institutional delivery has reached the level of 95%. These statistics are true only for the direct beneficiaries of the project, which represent a small fraction of the total urban population. There is a dearth of information regarding the rest of the urban population.