ENGAGING URBAN COMMUNITIES FOR HEALTHCARE

What Do We Know, What Can We Do?

A UNICEF-BHS-IIMU Policy Brief

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Basic HealthCare Services

Centre for Healthcare
An IIM Udaipur Initiative

Community engagement is a crucial component of effective healthcare programs to attain the goalsof 'health for all'. "Health for all" means removing barriers to health, such as food insecurity, ignorance, contaminated water, and inadequate housing, just as much as it means addressing health system issues, such as a shortage of doctors, hospital beds, pharmaceuticals, and immunizations.1

Community engagement and participation in public health are essential for the broaderdissemination of knowledge on health schemes and programs, for the organization of services, for maintaning attention to the community needs, and for greater ownership on the part of thecommunity for their own health. People are more likely to respond positively when they areinvolved in the decision-making process and planning. Further, numerous studies have demonstrated that community engagement is essential in decreasing inequities, strengtheningsocial justice providing greater benefits, and sharing responsibility for public health.2

The right of individuals "to participate individually and collectively in the design and execution of their healthcare" was a crucial tenet emphasized in the Alma-Ata Declaration. In India, the Bhore Committee Report of 1946, which laid the foundation of the country's primary care-based health system, underscored an individual's responsibility to their health. To inculcate the idea of an individual's health as their responsibility, the report proposed the need to stimulatehealth consciousness among the population by providing health education, and opportunities for individuals' and communities' active participation in local health programs.3

In India, non-governmental organizations (NGOs) and civil society organizations (CSOs) have often brought in their expertise and experience of working at the grassroots level to effectively mobilize and engage communities for health. Community and civil society participation in health care in India expanded under many priority programs such as HIV/AIDS Control, Polio Elimination, Universal Immunization Program (UIP), and National Tuberculosis Control Program. Numerous NGOs and CSOs participated actively in tackling HIV/AIDS, especially among highly vulnerable groups in the country.4

Some of the earliest community mobilization and engagement efforts were focused onrural communities. Due to the stark health inequities between urban and rural populations, rural health has been a reform priority in the country. In 2005, the Government of India (GoI) launched the National Rural Health Mission (NRHM) to provide accessible, affordable, and quality healthcareto the rural population, especially the vulnerable groups in the country. The NRHM envisaged the creation of a new cadre of female community health workers - Accredited Social Health Activists(ASHAs);

1 Mahler H. (2016). The Meaning of "Health for All by the Year 2000". https://doi.org/10.2105/AJPH.2016.106136 *American journal of public health*,*106* (1), 36–38.

2 Yuan, M., Lin, H., Wu, H., Yu, M., Tu, J., & Lü, Y. (2021). Community engagement in public health: a bibliometric mapping of global research. *Archives of public health = Archives belges de sante publique*, *79*(1), 6. https://doi.org/10.1186/s13690-021-00525-3

3 State Institute of Health and Family Welfare. (n.d.). Sihfwrajasthan. http://sihfwrajasthan.com/Reports/Bajaj%20Committee%20report.pdf

4 Lahariya, C., Roy, B., Shukla, A., Chatterjee, M., De Graeve, H., Jhalani, M., & Bekedam, H. (2020). Community action for health in India: Evolution, lessons learnt and ways forward to achieve universal health coverage. *WHO South-East Asia journal of public health*, *9*(1), 82-91.

the formation of village health, sanitation, and nutrition committees(VHSNCs); and the formation of"Rogi Kalyan Samitis" (patient welfare committees). With the introduction of the NRHM, a formalsystem of community action for health (CAH) was established. It was, however, only in 2013 thatthe urban counterpart of NRHM, the National Urban Health Mission (NUHM), was launched as a sub-mission under the National Health Mission (NHM).4

Why is urban health important?

Urbanization is one of the leading trends of the 21st century that significantly impacts health. Asper the 2011 census, 31% of the Indian population lived in urban areas5 - a proportion expected toincrease to 43.2% by 2035.6 And it is pertinent to guide urbanization in a way that protects and promotes health. About 40% of urban dwellers do not have basic amenities, and about 90% of people in urban areas breathe polluted air. Further, the urban population suffers a significantly higher burden of non-communicable disease risk factors. As per the National Family Health Survey(NFHS) 5, 33% of the urban women are overweight/obese compared to only 20% of the women in rural areas. One in ten children born in slums did not live to see their fifth birthday, according to a re-analysis of the third NFHS; only 40% of slum children received all the recommended vaccinations; more than half of the 2.25 million births among urban poor people each year occurredat home; 54% of children under five were stunted, and 47% were underweight. Poor children in urban settings have higher malnutrition rates than those in rural regions.7

To this end, to effectively address the health concerns of the urban population, the National Urban Health Mission (NUHM) was launched in 2013. One of the core objectives of the mission includes partnering with community and local bodies for more proactive involvement in the planning, implementation, and monitoring of health activities.8

How is urban health different from rural health?

Rural areas have a dedicated three-tier government health structure, which the urban areas lack.The three pillars of the primary healthcare system in rural areas include subcenters, primaryhealth centres (PHCs), and community health centres (CHCs). With the private healthcare industry primarily serving urban settings, the reliance of the rural population on governmenthealthcare is much more. As per NFHS-5, 46.9% of the urban populace and 51.7% of the ruralfamilies use public health facilities.9 For instance, the urban elder population uses private

5 PTI. (2016, July 27). *60% of India's population to live in cities by 2050: Government*. Mint. https://www.livemint.com/Politics/CyaMfUgL7r9dEAPKIRYMkI/60-of-Indias-population-to-live-in-cities-by-2050-governm.html 6 PTI. (2022, June 30). *India's urban population to stand at 675 million in 2035, behind China's 1 Billion: U.N.* The Hindu. https://www.thehindu.com/news/national/indias-urban-population-to-stand-at-675-million-in-2035-behind-chinas-1-billion-un/article65584707.ece 7 Yadav, K., Nikhil, S. V., & Pandav, C. S. (2011). Urbanization and health challenges: need to fast track launch of the national urban health mission. *Indian Journal of Community Medicine*, *36*(1), 3-7.

8 National Urban Health Mission :: National health mission. (n.d.-a). https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=970&lid=137 9 *NFHS-5 survey shows decline in young population and half of them don't seek Govt Healthcare*. IndiaTimes. (2022, May 14). https://www.indiatimes.com/explainers/news/nfhs-5-survey-shows-decline-in-young-population-and-half-of-them-dont-seek-govt-healthcare- 569563.html

facilities more often than their rural counterparts - forty percent of elderly patients in rural India utilize healthcare services provided by government facilities - in contrast, only 25% of the elderly inurban India primarily use government facilities.10

Furthermore, it is also important to note that even though NUHM is solely responsible for providingurban health care, the mission still lags behind in terms of coverage, funding, and staff size. Funds given to NUHM are insignificant compared to the rising demands in urban health. More than 65% of the human capital in urban health clinics throughout India remains vacant. Lack of sufficient financial support has often resulted in low personnel levels and inadequate efficacy in the deliveryof urban health services.11

Health wise, migrants are even more vulnerable than other urban groups. Every year, tens ofthousands of people from the villages move to the city for better livelihood. Many ultimately end upliving in congested slums with no title to the land or the property, without even the most basic amenities.12 Even though slums are so widespread that they constitute 65% of Indian towns, slumresidents remain the most neglected group in society. The slum dwellers, who are mostly migrants, face unique health challenges. Migrants often tend to be more vulnerable to the kind of diseases unique to urban spatialities. The health issues migrants grapple with can be attributed to poor housing, lack of knowledge about local healthcare services, unsafe sex practices, frequent movement between cities and villages or within the cities, and the psychological stress of moving to a new place and hazardous work conditions.13 Migrants from rural areas are unable to utilize healthcare services in urban areas due to changes in the experience of residence, culture, language, and people.14 Being alien to the new place and healthcare system also leads to reliance on unqualified medical practitioners and more out-of-pocket health expenses. Furthermore, a lack of local identity, which is often a prerequisite to avail oneself of government health and ration schemes, contributes to poor migrant health.14

Community engagement in health: rural versus urban communities

Despite attempts to include communities, urban health participation projects may not reach all urban populations, especially those in isolated or difficult-to-reach or overcrowded locations. This can lead to certain disadvantaged groups being excluded, resulting in uneven healthcare access. For instance,within slums, migrants' participation in public health interventions and access to healthcare varysharply.

10 Banerjee, S. Determinants of rural-urban differential in healthcare utilization among the elderly population in India. *BMC Public Health* 21, 939 (2021). https://doi.org/10.1186/s12889-021-10773-1

11 Gangadharan, K., & Kumar, S. (2020). Improving public health care in India through urban primary health centres—trends, progress, and concerns.

Indian J Public Health Res Dev, *11*(5), 147-54.

12 *This Indian state is giving slum-dwellers the right to their own land*. World Economic Forum. (n.d.).

https://www.weforum.org/agenda/2018/05/a- million-slum-dwellers-to-benefit-as-indian-state-gives-away-titles

13 Nitika, Lohiya, A., Nongkynrih, B., & Gupta, S. K. (2014). Migrants to urban India: need for public health action. *Indian journal of community medicine : official publication of Indian Association of Preventive & Social Medicine*, *39*(2), 73–75. https://doi.org/10.4103/0970-0218.132718 14 Babu, B. V., Swain, B. K., Mishra, S., & Kar, S. K. (2010). Primary healthcare services among a migrant indigenous population living in an eastern Indian city. *Journal of immigrant and minority health*, *12*, 53-59.

The degree of involvement, power/influence, type of participation, and support for initiatives among community-level stakeholders frequently vary.15 Recent migrants and settled migrants living withtheir families often form the core group, while single male migrants are often relegated to the margins.15

Contrary to the promise of a better livelihood and proximity and accessibility to hospitals in cities, research shows that the urban poor have difficulties sustaining a healthy lifestyle compared to theirrural counterparts. Living at the intersection of industrialization and underdevelopment and exclusion, they are often prone to diseases peculiar to urban spatialities. But how can urban poor, who often migrate tocities on the lookout for better livelihood, sometimes for the sustenance of their families living backin the villages and often engaged in menial jobs as daily wage labourers be mobilized when they arealready confronted with the limitations of time and resources?

A survey conducted in 105 villages of Rajasthan and 80 slum settlements in Jaipur and Bhopal reveals how rural and urban citizens view and engage with their local governments. The survey shows that slum dwellers are usually more skeptical of their local governments than their rural counterparts. In comparison to rural dwellers, they are less likely to believe that they would get a response if they approach a public official and frequently turn to mediated channels like politically connected slum leaders in case of assistance.16 On the contrary, rural residents are more likely to approach the panchayat or the elected officials directly. The survey attributes the division of rural and urban decentralization to the attitudes of the urban and rural residents toward their respective local governments. The strengthening of the panchayats and the relatively small constitutional sizes make them more visible and accessible, making them the first point of contact for 60% of the rural residents, as per the survey. On the other hand, due to large constituency sizes, urban bodies like municipalities and corporations are less accessible to urban residents, especially urban slum dwellers. Consequently, the residents' attitude towards the effectiveness and responsiveness of their local bodies directly impacts the community's participation in their development, including their health16. Another plausible argument for better community participation in villages from a sociological perspective could be the 'sense of belonging and the ability to identify with the community.' In stark contrast to rural communities, which are made up of people who frequently have centuries-old roots, traditions, social structures, values, and behavioral patterns, which in turn contribute to a greater sense of identity, urban dwellers are much more mobile, especially people experiencing poverty who arrive to make ends meet.

In this policy brief, we explore and review some exemplary urban community engagement efforts as a public health practice effectuated in India and other countries that have witnessed extensive urban growth. We have only considered examples post-1970s. From this review, we identify takeaways to forge ahead community participation in urban health programs in India, which is still in its early stages.

15 Gawde, N. C., Sivakami, M., & Babu, B. V. (2015). Building Partnership to Improve Migrants' Access to Healthcare in Mumbai.

health, *3*, 255. https://doi.org/10.3389/fpubh.2015.00255 *Frontiers in public*

16 Gabrielle Kruks-Wisner, A. A. (2020, March 19). *India's urban and rural poor expect different things from their local govts, and why it matters*.

ThePrint. https://theprint.in/opinion/indias-urban-and-rural-poor-expect-different-things-from-their-local-govts-and-why-it-matters/383037/

Urban initiatives that engage communities for promoting their own health

Although the NUHM has conceived and implemented frameworks to enhance the active participation of the community and its representatives, limited research evaluating them isavailable. In view of the scarcity of published research on this theme, we relied on published reports and case studies-evaluation and documentation of urban health initiatives, some of whichare from as far back as forty years.

In the subsequent section, we share a summary of some of these reports and research papers oncommunity participation in urban health. The section also highlights how these interventions fared, what worked, and, if not, why.

1. *Complementing healthcare services with community involvement*

A community health project that embodies the principles of urban participatory health is Hong Kong's Kwun Tong Community Health Project, an effort to enhance Kwun Tong's population's health and well-being. Kwun Tong, in Hong Kong, is a largely industrial district with more than halfa million inhabitants and the highest poverty rate. It was shunned a 'disaster area.' Inthe 1960s, the town had no hospitals and only one government primary care clinic with 24 maternity beds until the United Christian Hospital Committee decided to build a 545-bed acute care hospital in the town. Acknowledging that a hospital alone would not solve diseases such as cancer, hypertension, chronic bronchitis, peptic ulcer, and diabetes that were plaguing the town, a community health project to help the people of Kwun Tong manage their health was integrated with the hospital service. The initiative addressed levels of prevention, education, good health, and curing and care. It actively incorporated local leaders and residents in project planning and execution, solicited their feedback, and involved them in decision-making processes. The project also emphasized capacity building by preparing volunteers and local health workers to provide services and participate in health promotion initiatives. Health problems were addressed with quick medical help, treatment, and care, which solidified the program's credibility.17

Today, the Kwun Tong Community Project is merged with the Nethersole Community Health Service as the United Christian Nethersole Community Health Service, continuing to engage the population in promoting their health and the health of the community.18

2. *Working with faith-based organizations*

Considering human and social dimensions such as faith are integral to a people-centered approach and effectively engaging communities. An example of how faith-based organizations can be an ally in health promotion is the Makapawa parish project. Implemented in the Philippines in 1974, the project targeted parishes that are spread out and have little access to medical facilities. The project actively involved the community, such as community organizers, clergypersons, medical professionals, and government officials, in the decision-makingprocess.

17 Paterson E. H. (1978). The Kwun Tong community health project. *Tropical doctor*, *8*(2), 85–89. https://doi.org/10.1177/004947557800800214

A Community Health Worker (CHW) is elected and trained in preventive healthcare to deliver tailored interventions recognizing the community's unique challenges. Frequent small group meetings and assemblies, where community members actively participate in conversations to solve concerns and challenges in the community, are held.19 With this participatory methodology, decisions on the project's courseand activities are made based on input from the community. The project exemplifies the tenets ofurban participatory health by integrating participatory decision-making and designing tailored interventions through dialogue.

3. *Liaising with the Vulnerable*

Community empowerment and engagement are often credited for altering the trajectory of HIVinfections in India. India has managed to prevent at least 3 million HIV infections in large part by empowering key populations most at risk, such as sex workers, men who have sex with men, drugusers, and migrants, to take charge of the epidemic by offering peer support, care, treatment, andadvocacy while also providing for their needs. In order to lower the risk of exposure to HIV, several programs aimed at sex workers also offer training for substitute income-generating vocations,such as sewing.20

Ashodaya Samiti is a community-based organization in Mysore that trains sex workers in HIV prevention, leadership, and community mobilization. Operating in one of the four high-prevalence states that account for 55% of all HIV infections in India, the organization has been instrumental in reversing the epidemic in Karnataka through its more than 8,000 female, male, and transgender sex worker memberships. Its members act as peer educators and support condom usage, offer HIV testing and counseling, connect HIV-positive sex workers with treatment facilities for antiretroviral medication, and volunteer in hospitals to make sure other sex workers receive sufficient care and are not subjected to prejudice.21

The organization has also adopted a social entrepreneurship strategy to grow its services,operating serviced apartments in addition to a café since 2008. Profits go towards funding acommunity care facility for sex workers who are HIV positive. Ashodaya Samiti, carrying out itsown interventions and creating long-lasting mechanisms for health promotion, stands tall as anexample of a community-owned approach.22

Sonagachi is a red-light district in Kolkata and among Asia's largest brothel districts. Sonagachi project aimed to ascertain and arrest the incidence and spread of Sexually Transmitted Diseases(STDs) and HIV/AIDS in the district. The high incidence of HIV/AIDS was promulgated as a community-level problem so that mitigation of it could be articulated as a community-level responsibility.

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18 https://www.ucn.org.hk/en/about-ucn/history-and-milestones/

19 Barrion L, (0000).The Makapawa: a diocesan community-based health programme on the island of Leyte, Republic of the Philippines. Contact, (), 20 World Bank Group. (2013, April 1). *India: Community empowerment key to turning tide on HIV*. World Bank. https://www.worldbank.org/en/news/feature/2012/11/27/india-community-empowerment-key-to-turning-tide-on-hiv

At the group-level, sex workers were mobilized and trained as peer outreach workers to disseminate information on safe sexual practices among their colleagues. The interventions also bear testimony to the empowerment of sex workers at an individual-level. Theoutreach workers were examples to their sex worker colleagues, demonstrating possibilities of gaining literacy, respect, and employment. The identification of HIV/ AIDS as a shared problem led to the effectiveness of a participatory approach.

The project did not prioritize safe sexual practices or adopting condom usage because, for the sexworkers, the primary focus was to obtain healthcare facilities for themselves and their children. The success of the approach could be attributed to addressing the primary needs of the sexworkers over directing the project solely as an occupational health initiative. There were no efforts to rehabilitate the sex workers. Instead, they were accepted and embraced without anyattempts to change who they were.23

The program was funded by a national healthcare research institute and later by the state-based West Bengal AIDS Prevention Council. Although initially spearheaded by a group comprising local physicians, an Ethiopian public health worker, healthcare professionals, and social workers from Calcutta, the project is currently steered solely by the sex workers functioning as peer outreach workers.23

Promoting safe behaviour among Nepali migrants in Mumbai. With 30-35% of the HIV burden in Nepal attributed to migration, the Nepali migrant community actively engaged in a collective effort involving multiple stakeholders, including United States Agency for International Development (USAID), Family Health International (FHI), and Tata Institute of Social Sciences (TISS), to address the issue of HIV vulnerability among them in Mumbai. The project employed peer educators and community engagement to implement behavior change communication activities (BCC), enhancing access to Sexually Transmitted Infections (STIs) services and providing psychosocial support. The initiative actively mobilized the Nepali migrant community through celebrations of festivals and cultural events such as Diwali, Dussehra, Janmashtami, Nepali New Year, World AIDS Day, and International Migrants Day. These events served as forums to raise awareness, reduce stigma and discrimination, and foster community engagement. Despite several challenges that marred the initiative, including the non-availability of time among the migrant to attend the sessions, the wide geographical distribution of the community, and frequent relocations, the project successfully overcame the obstacles by planning sessions with prior appointments, providing incentives to peer educators, and recording sessions.24

24 Mukherjee, K. (n.d.). Nepal-India safe migration initiative for reducing vulnerability to STI/HIV among Nepali migrants in Mumbai[PowerPoint slides]. Tata Institute of Social Sciences, Centre for Health Policy, Planning and Management, School of Health Systems Studies.

4. *Enhancing Accountability of healthcare services to urban communities*

A bottom-up reform strategy has been implemented in Peru to increase primary healthcare services' accountability, openness, and efficiency. The Comunidades Locales de Administración de Salud (CLAS) is a form of community-based management where non-profit organizations co-manage government funding to provide primary healthcare (PHC)services. The model employs mechanisms and strategies that foster effective collaboration,such as citizen participation, accountability, and transparency. The design successfully empowered people and promoted a feeling of ownership and responsibility for healthcare results, enhanced access to essential healthcare services, particularly in disadvantaged communities, and encouraged accountability and transparency by including community people in supervision and monitoring tasks. It led to improved disease prevention, higher immunization rates, and better overall health indicators, all contributing to favorable health outcomes. The successful implementation of CLAS led to its official adoption by the Peruvian system, increasing the accessibility of participatory and community-driven healthcare.21

5. *Empowering Community women's groups*

The NUHM, similar to the VHSNCs in rural settings, has rolled out Mahila Arogya Samitis(MAS), community-based all-female groups to raise awareness on water, sanitation, and health-related concerns that are pertinent to slum and slum-like localities. MAS constituted across the country have attempted to leverage the platform for convergent actions pertaining to health issues.22

In Gujarat, a partnership initiated between eight municipal corporations (Surat, Vadodara,Jamnagar, Bhavnagar, Junagadh, Gandhi Nagar, and Ahmedabad) and 14 NGOs to build capacity of MAS members reported a significant improvement in community-level health outcomes. In Jamnagar, MAS members organised a cleanliness drive to raise hygiene and sanitation awareness in the community.23

As a result, people no longer dump trash on the roads or lanes. Ahmedabad MAS members addressed their polluted water supply problem by submitting an application to the Municipal Corporation. Department personnel restored the pipeline after diligent follow-up,assuring safe water for the members. Similarly, members of the MAS in Vadodara complained about a shortage of waste pickup in their neighbourhood. They filed a complaint and followed up regularly. Consequently, the garbage collection truck now visits their area regularly, alleviating the problem of collected rubbish.23

21 Toyama, M. et al. (2017) Peruvian Mental Health Reform: A Framework for scaling-up mental health services, International Journal of Health Policy and Management. Available at: https://www.ijhpm.com/article_3313.html

22 Home | Ministry of Health and Family Welfare | Goi. (n.d.). https://main.mohfw.gov.in/sites/default/files/Mahila%20Arogya%20Samiti%20Urban%20Immunization%20%28MASUM%29%20for%20Routine%20Immunization.pdf Building capacities of - chetnaindia.org. (n.d.-b). http://chetnaindia.org/wp-content/uploads/2019/04/mas-report-final-for-print-12-10-16_opt.pdf

23 Building capacities of - chetnaindia.org. (n.d.-b). http://chetnaindia.org/wp-content/uploads/2019/04/mas-report-final-for-print-12-10-16_opt.pdf

In 2016, the National Health Mission (NHM), Maharashtra partnered with SNEHA, a non-profit organization working in public health to initiate the establishment of MAS across the Urban Local Bodies (ULBs) in the state. SNEHA, designated as the 'Mother NGO', partneredwith local NGOs in the state to form 9,393 MASs, equipped with a bank account, spanning 95 ULBs. As a part of the programme, 1,600 state, NGO and ULB workers and 3,600 ASHAs received training. Further, SNEHA incentivized local NGOs with Rs 500 for every MAS instituted with a bank account.24

The active cooperation of the Mira-Bhayander Municipal Corporation in the programme cascaded in the enthusiastic participation of Medical Officers and UPHCs staff in training, formation and initiation of MAS across the ULBs. SNEHA attributes the success of the program, focused on establishment of MAS, to the UPHCs staff and diligent follow-up by the senior health officials with the bank concerning the account creation. Notably, thecorporation promptly released the annual untied fund of Rs 5,000 earmarked for each MAS in every MAS account created. The MAS platform successfully leveraged the funds to buy matsfor ICDS Aanganwadis and conduct awareness activities in the community, among others.24

6. *Setting up community resource centres*

SNEHA has also established community resource centers to provide comprehensive healthcare to marginalized populations in urban settlements. These community centersimplemented a lifecycle approach, offering services related to maternal and newborn health, child health and nutrition, adolescent health, gender equality, and prevention of violence against women and children. Strategies employed include micro planning, community group action, and collaboration with other agencies to maximize impact.

Various health indicators assessed for women and children as part of the intervention include ante-natal care, institutional delivery, contraception prevalence rate, fully immunized children, and malnutrition rates. The intervention significantly improved several health indicators among the target population. Women who received services from the centers showed higher rates of ante-natal care and institutional delivery. Similarly, fully immunized children and children with healthier nutritional status were observed in households with access to community resource centers. The effectiveness of the intervention is attributed to the multifaceted approach, targeted interventions, home visits, community engagement, and collaboration with local stakeholders. The intervention bearstestimony to the potential of community resource centers in empo,wering and improving the health and well-being of vulnerable populations in informal settlements.

24 *Mahila Arogya samiti*. Society for Nutrition, Education & Health Action (SNEHA). (n.d.). https://www.snehamumbai.org/mahila-arogya-samiti/

7. Community-based primary healthcare services:

In Punjab and Delhi, the government has opened 400 Mohalla clinics, with essential medicines and tests available, intending to provide primary health care to disadvantaged urban populations. *Mohalla* Clinics fill the gap in health service delivery and offer medical care and diagnosis in socially inaccessible and remote urban pockets. With the opening of *Mohalla* clinics, the time savings are enormous for patients compared to what they spent earlier commuting and waiting. Mohalla clinics in the neighborhood have made quick diagnosis and treatment feasible, reducing reliance on quacks.25

Similar to *Mohalla* clinics in Delhi and Punjab, to reduce out-of-pocket expenditure, reduce travel/waiting time, and reduce the burden on secondary/ tertiary facilities, the Greater Hyderabad Municipal Corporation (GHMC) has set up *Basti Dawakhanas* in slums in Hyderabad per 5,000-10,000 population. The *Basti Dawakhanas* have lightened the load of outpatient services in the city's major hospitals. Osmania Medical College's OP number decreased from 12 lakhs in 2019 to 5 lakhs in 2022, Gandhi Hospital's from 6.5 lakhs to 3.7 lakhs, Niloufer's from 8 lakhs to 5.3 lakhs, and Fever Hospital's from 4.3 lakhs to 1.12 lakhs.26

While these clinics are located closer to or within the communities, there is limited community participation.

8. Engaging other stakeholders

a. Real estate developers and contractors:

Mobile Creches (MC), an NGO working for the rights of marginalized children, partners with real estate developers and contractors in Delhi to institutionalize setting up creches in all construction sites to ensure adequate health, nutrition, and learning for children up to 12 years living in the construction sites. The intervention has improved nutrition and immunization rates among children living in the construction sites. The initiative has contributed to enhanced literacy skills and easy mainstreaming into schools.27

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25 Saving Time. Saving Money Benefits and Impact | Mohalla Clinics - Delhi | Official Website | Healthcare delivered to your neighborhood. (n.d.).https://mohallaclinic.in/impact

26 Bureau, T. H. (2023, February 12). *Basti dawakhanas reducing op burden on major hospitals: Minister*. The Hindu. https://www.thehindu.com/news/national/telangana/basti-dawakhanas-reducing-op-burden-on-major-hospitals-minister/article66500138.ece

27 Bajaj, M. (n.d.). Effective early childcare interventions for children of migrant workers in cities: Migration, vulnerability and health: Experiences of Mobile Creches [PowerPoint slides]. Mobile Creches.

b. Creating Citizens forums:

In Surat, Gujarat, where thousands of people migrate yearly to make a living in the city'sflourishing textile, diamond, and construction industries, the slum areas have become the epicenter for epidemics. The Urban Health and Climate Resilience Centre (UHCRC), an interdisciplinary research, training, advocacy, and network initiative under the Surat Municipal Corporation, conceptualized community-based forums to facilitate urban inclusion in urban healthand climate resilience. Surat, a coastal city prone to floods, is constantly threatened by vector and water-borne diseases. Besides, from time to time, the city also had to grapple with rising HIV rates among migrants and the high prevalence of non-communicable diseases (NCDs). Heatwaves also sweep the city annually, bringing heat-induced health impacts.28

One of the community-based forums conceived by the UHCRC is the Surat Arogaya Samvad that extends scholarly information on climate and health among the citizens. The event is publicizedthrough local newspapers, social media, and pamphlets. The samvads are organized occasionallyat a prime spot in the city and deal with specific themes. Some prominent themes include gender linkages with health and climate, heat waves, epidemics, etc.28

Another community forum developed by the UCRC is the Healthy Surat Working Group (HSWP), aforum for technical experts such as urban planners, public health professionals, and academicians who put forward their recommendations to the municipality. The Climate Smart Healthy Children: Peer Educators program was initiated to engage the next generation through peer educators. Peereducators from one school creatively and effectively provide information about healthy lifestyles to students from another school.28

Conclusions:

One clear insight from this review is that there is a stark dearth of published experience and evidence oncommunity engagement in urban health initiatives in contrast to evidence for rural areas. This dearth of experience and evidence reflects two facts. Firstly, engaging urban communities for health is complex and therefore, only a few organizations or projects have attempted to do so. Our reviewand experience identify some key constraints that explain limited efforts to engage urban communities: absence of a sense of community, limited availability of time and energy due to heavy work for long hours, and the inability of local public systems to reach out to migrants and other vulnerable city populations.

The other fact is that even those urban health initiatives that have attempted to engage communities have not documented them adequately. The lack of documentation and evaluationwas clear from our review: there were very few accounts, fewer published reports, and scarce evaluations or research articles.

28 Ghanekar, A. & Desai, V.K. (2019). Urban health and climate resilience: a case of Surat City, India. IIHS Case No 1-0034. Bangalore. Indian Institute for Human Settlements.

Despite the constraints, there are various ways in which communities have been engaged in theirown health. Using the skills people possess for health initiatives, forming formal structures to interface with local governments, and complementing mobilization with an extension of servicesare some of the strategies employed over the years in different settings. One lesson is not to see the vulnerable populations as beneficiaries alone but as partners in development.

Engaging communities and community members from the planning phase appears to be one common factor among most successful initiatives. Most community health initiatives in urban areasalso involve CSOs as an interface between services and communities. Engaging other stakeholders, such as employers and faith-based organizations, also appears to be critical.

Most successful initiatives were those where community engagement was coupled with responsive services.

As India faces growing urbanization, there is a need for affirmative action to promote the implementation of research and action on urban health in general and community participation in particular. This review provides a basket of strategies that have been used to engage communities in urban health and can be used by all urban health planners, practitioners, and researchers to design, implement, and evaluate urban community health initiatives.

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