Growing Health Needs of the Urban Poor: Challenges and Program Experiences from India

Siddharth Agarwal siddharth@uhrc.in
Urban Health Resource Centre, India
Outline

- Growing health needs of the urban poor in India
- Challenges in Improving Health of the Urban Poor
- Program Experiences and Lessons from India
Urbanization
Urban Population


Total, Urban, and Rural Population (Medium Variant)

World Total

Urbanization Trends in Asia

- In Asia urban population is expected to increase from 1.55 billion to 2 billion by 2016
- Asia (excluding Japan) is projected to become 50 per cent urban by 2025 from the current 38%
- The urban population growth in Asia is 2.3 compared to 0.14 in Europe
- Number of million plus cities likely to increase from 194 to 288 by 2015

Source: World Urbanization Prospects, 2003 Revision
Urban Growth and Poverty in India

- Urban population - 328 million
  - Projections for 2007 by Technical Group on Population Projections

- India is expected to be approximately 40% (550 million) urban by 2026
  - Census, 2001 population, Projections, 2001-26

- 2-3-4-5 phenomenon of population growth

- Urban poor estimated at 80.74 -100 million

- Estimated annual births among urban poor: 2 million
  - Based on CBR 19.1 for urban population and 100 million urban poor population
Greater Population in Small, Medium Sized Cities

Percentage Distribution of urban population by size of Towns/UA (Census of India, 2001)

- Below 100,000: 31 cities
- 100,000 to 499,999: 21 cities
- 500,000 to 1 million: 9 cities
- 1 million to 5 million: 17 cities
- 5 million to 10 million: 6 cities
- 10 million and above: 15 cities

The chart illustrates the percentage distribution of urban population across different size categories of towns and urban agglomerations according to the 2001 Census of India.
**Urban Scenario in EAG states***

**Urban Poverty in EAG States**

- **Rest of India**: 57%
- **EAG states**: 43%

**Urban Population in EAG States**

- **Rest of India**: 68%
- **EAG states**: 32%

*Data from Census 2001 and NSSO 55th round, 1999-2000
*EAG (Empowered Action Group, Govt. of India, 2001) identified 8 states that lag behind on demographic and health indicators. These are: UP, MP, Rajasthan, Bihar, Orissa,, Jharkhand, Chhatisgarh, Uttarakhand
Health Needs of the Urban Poor
Health conditions of urban poor are similar to or worse than rural population and far worse than urban averages.

* Mortality per 1000 live births

Childhood Under-nutrition

Poor Access to Health Services

Institutional deliveries

Rural Average: 24.8
Urban Average: 30.4
Urban Poor: 24.6

Complete ANC (3ANC+IFA+TT)

Rural Average: 52.7
Urban Average: 30.4
Urban Poor: 24.6

Nearly 1 million babies are born every year in slum homes in India

Conditions Worse in Less Developed States

Madhya Pradesh

- **Under 5 Mortality**
  - Rural Average: 152.2
  - Urban Average: 82.9
  - Urban Poor: 31.9

- **Nutritional Status**
  - Rural Average: 58.4
  - Urban Average: 44.3
  - Urban Poor: 72.4

- **Institutional Delivery**
  - Rural Average: 12.1
  - Urban Average: 49.1
  - Urban Poor: 24.8

Legend:
- Rural Average
- Urban Average
- Urban Poor
Contribution of Urban Poor to National Economy

- Almost 90% of urban poor are involved in urban informal sector.¹
- Urban sector contributes 60% of Gross Domestic Product (GDP).²
- Informal sector’s contribution to non agricultural GDP is 45%.³

¹ USAID (2002). Making cities work, India Urban Profile.
² Chaudhary O. New vistas in financing for development of real state. National Real Estate Summit. FICCI-3rd September 2004
Challenges in Improving Health of Urban Poor in India
Urban Health remained a low priority with greater focus on rural areas.

Lack of credible data for urban poor related planning.

Urban poor face illegality and many clusters overlooked by official enumeration systems.
Challenge # 2: Invisible and Un-counted Slums

452 listed slums (population 820,139)

328 unlisted slums (population 510,397)

According to NSSO 58th Round (2002) 49.4% slums are non-notified in India
Challenge # 3: Inadequate Services

Inadequate Primary Health and Nutrition Services

- There is one UFWC/HP for about 0.23 million urban population\(^1\) against government norm of 1 for 50,000 population

- Absenteeism, inconvenient timings, apathy at public facilities discourages the poor

- About half slum population is not covered by ICDS, a key maternal and child nutrition and health program in India\(^2\)

- Greater focus and investment on curative services

---

1 Based on urban population -285 million (2001 Census) And 1197 Govt. urban primary health facilities (Department of Family Welfare, MoHFW, GOI);

2 Based on 100 million Urban poor population (National Population Policy, 2000) and 523 ICDS projects
Challenge # 4: Weak Services

- Weak coordination among various stakeholders
- Weak capacity among government and NGO managers on urban health
- Very few examples of coordinated, planned slum health programs in most States.
Challenge # 5: Weak Referral Mechanisms

- Low access of Public health services to the poor
- Weak referral linkages from community and Primary facilities
- Lack of risk pooling and health insurance mechanisms for the poor
- High usage of public hospitals by middle and higher income segments
- High usage of hospitals for minor ailments
Challenge  # 6: Weak Community Demand

- Low awareness about services, entitlements
- Low awareness about healthy behaviours
- Weak community organization and social cohesion; weak negotiation capacity
- Lack of trust in public sector services owing to irregularity and low quality
- Lack of family support to Mother/care giver
- Pressing need to resume wage earning after delivery
Factors and Situations resulting in Health Vulnerability among urban poor$^1$

- Irregular employment, struggle of livelihood
- Low access to fair credit
- Poor access to water and sanitation services, overcrowding, poor housing, insecure land tenure
- Unlisted slums often outside the purview of civic and health services
- Constant threat of eviction

$^1$Taneja S and Agarwal S. 2004. *Situational Analysis for guiding USAID/EHP India’s Technical Assistance Efforts in Indore, MP*
Temporary and recent migrants often denied access to health services, difficult to track for follow-up health services

High prevalence of diarrhea, fever and cough among children

Lack of organized community collective efforts in slums

Widespread alcoholism, substance abuse, gender inequity, poor educational status

Taneja S and Agarwal S. 2004. Situational Analysis for guiding USAID/EHP India’s Technical Assistance Efforts in Indore, MP
Challenge # 8 Poor Environmental Conditions

About two thirds (65.9%) urban poor households do not have a toilet.
38% urban poor households do not receive piped water at home as compared to 18% in urban rich households.
Opportunities in Urban Areas

- Growing recognition of the issue and increasing interest among Government, donors and NGOs.
  - National “Task Force to advise the National Rural Health Mission on Urban Health Care” has submitted recommendations to the Ministry of Health and Family Welfare.
  - JNNURM presents opportunities in terms of health infrastructure and basic services to the poor

- Large presence of experienced and interested NGO in urban areas
- Growing body of urban poor specific research & data.
- Geographical accessibility in urban areas is an advantage.
Program Experiences and Lessons from India
Identification, plotting and assessment of urban poor clusters in a city
Assessment of Slums in the City

- Listing of Slums ensuring Identification of all Poverty Pockets
- Developing Vulnerability Criteria through Slum Visits and Discussions
- Slum-based Data Collection
- Consolidation of Data and Categorization of Slums; Mapping
- Triangulation of Results for Vulnerability, Slum Location and Hidden Areas

- Understanding the local context through needs assessment and situation analysis
City map with slums, facilities plotted an important planning and monitoring tool
Program Approaches

Approach 1: Indore
- **NGO-CBO Partnership Approach**
  Enhancing Demand, Supply, Capacity and fostering Linkage

Approach 2: Indore, Agra, Bhopal,
- **Ward Coordination Approach**
  Convergence among Stakeholders to optimize resources and improve reach

Approach 3: Agra
- **NGO Managed Urban Health Centre**
  Public Sector-Private non-profit partnership for expanding services and Social Mobilization in un-served areas
Urban Health Situation in Indore

- **Growing Urban Poor Population in Indore:**
  - Population - 1.8 million (2001 Census)
  - Decadal Growth rate- (1991-2001) - 47%
  - Estimated slum population - 0.6 million
  - No. of slums – 539; 314 not part of official slum lists

- **Inadequate Health Care Service for the Urban Poor:**
  - 17 primary health care facilities, many functioning sub-optimally
  - Poor Access of urban poor to Health Care
  - Heavy workload on limited outreach staff → insufficient interaction with community, irregular outreach sessions

- **Low Demand and sub-optimal behaviors among the Urban Poor**

- **Lack of coordination among different service providers**
The partnership is based on the principle of enabling and connecting people (slum communities) to health providers (public and private) with capacity building support from trained local NGOs.

Community level organizations have strong community presence, are more accountable and informed about urban poverty. Their involvement in development programs helps address issues in a more effective and sustainable manner.
Linking Slum Communities with Public & Private Providers

**Improve Community Demand for Services**

**Improve Supply and Quality of Services**

**Improved Health Outcome**

Coverage
1,50,000 slum population

Community- Provider- Linkage

- Slum CBOs
- Cluster Coordination Team (Lead CBO)

- Health Dept.& ICDS
- Municipal Corporation
- Charitable Organizations
- Private Doctors

Capacity Building, supervision & coordination by NGO and Technical Agency
9 CLUSTER COORDINATION TEAMS
(also called Lead CBOs; 7-9 slums per cluster)

- Seven registered as voluntary organizations.
- Plan and negotiate regular health services
  - Referral linkages & coordination with service providers (Health, Water & Sanitation, drainage)
  - Monitor and support Basti CBOs in health activities as necessary

NGOs with support from UHRC undertake periodic program review and implement appropriate improvement measures as identified during review
**BASTI** (Slum) LEVEL CBOs

(90 community groups of 7-12 members, including *dais* across 75 slums or *bastis*)

- Community based monitoring
- Counsel slum families on healthy behaviours
- Identify un-reached families and ensure access for them
- Support regular MCH camps in slums
Improved Health Indicators in Indore Slums

- % mothers received 3 ANC: Baseline 55, Midline 69
- % mothers delivered in health facilities: Baseline 38, Midline 52
- % infants breast fed within one day of birth: Baseline 59, Midline 85
- Children 0-3 months who are exclusively breastfed: Baseline 23, Midline 43
- % children <2 yrs underweight for age (<–2 SD): Baseline 46, Midline 29
- % children (12-23 mths) completely immunized by 1 yr of age: Baseline 32, Midline 72

Baseline (October 2003) vs. Midline (After Intervention—March 2006)
Program Outcome: Delivery Related Practices

- Trained BA: 72.9%
- Warm Birth Room: 38%
- Clean Surface: 36.1%
- Clean Hands: 28.2%
- Newborn wrapped until placenta was removed: 33.5%
- Clean Cord tie: 43.9%
- New Blade: 49.6%
- Clean Cord Stump: 50%

Baseline survey (Oct - Nov 2003)

MNH Survey (Jan - Sept 2005) (N=312)
Program Approaches

Approach 1: Indore
- NGO-CBO Partnership Approach
  Enhancing Demand, Supply, Capacity and fostering Linkage

Approach 2: Indore, Agra, Bhopal,
- Ward Coordination Approach
  Convergence among Stakeholders to optimize resources and improve reach

Approach 3: Agra
- NGO Managed Urban Health Centre
  Public Sector-Private non-profit partnership for expanding services and Social Mobilization in un-served areas
Approach 2
Multi-stakeholder Ward Coordination Approach

Ward level Core Group

Municipal Corporation (Zonal office)

NGOs & CBOs

Charitable organizations

ICDS

Local Resources (Local Clubs, Schools)

Elected Representatives

DUDA*

Health dept

Total Coverage: 70,000 slum population in 2 wards in Indore

*District Urban Development Authority
Improved Health Indicators in Ward 5 of Indore

- % Children (12-23 months) completely immunized by 1 yr of age: Baseline (October-November 2003) = 32, Midline (After Intervention- March-April 2006) = 64
- % of children (12-23 months) receiving measles by 12 mths: Baseline (October-November 2003) = 65, Midline (After Intervention- March-April 2006) = 76
Program Approaches

Approach 1: Indore
- **NGO-CBO Partnership Approach**
  Enhancing Demand, Supply, Capacity and fostering Linkage

Approach 2: Indore, Agra, Bhopal,
- **Ward Coordination Approach**
  Convergence among Stakeholders to optimize resources and improve reach

Approach 3: Agra
- **NGO Managed Urban Health Centre**
  Public Sector-Private non-profit partnership for expanding services and Social Mobilization in un-served areas
Approach #3
NGO Managed Service Delivery, Community Mobilization

2 such UHCs are operational covering 53 slums with approximately 106,252 population, in Agra

UHRC provides support for capacity building, coordination and system strengthening.
Lessons Learned

- Situation analysis helps identify underserved slums, priority needs and local resources
- City map with slums and facilities plotted helps effectively plan new Health Centres and outreach services
- Building capacity of slum-level institutions and facilitating linkage with public and private providers is important for sustainability
- Inter-sectoral linkages to address water and sanitation issues are difficult in weak governance situations like Agra
Lessons Learned continued

- Existing slum leaders/networks evolved as a potent institutional mechanism for slum health (and development) programs.

- Partnership & coordination among multiple stakeholders helps utilize resources from varied sources and eliminate duplication of efforts.

- NGOs can effectively complement Government’s efforts to
  - Quickly expand health services to un-served areas
  - Strengthening outreach services from existing Govt facilities
“A small body of determined spirits fired by an unquenchable faith in their mission, can alter the course of history”

- Mohandas Karamchand Gandhi

Accountable, Effective Urban Health Governance

Long Lever of:

a) Commitment, Motivation
b) Knowledge, Experience
c) Proximity to problems
d) Accountability, responsibility

With Hope and Confidence