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Urban Health in India: A Case Study

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Major Topics

- India’s urban health scenario
- Challenges in improving health of the urban poor
- Indore program case study
- Agra program case study
Section A

India’s Urban Scene
India’s Urban Health Scenario

- Urbanization, urban poverty, and vulnerability
- Health care system in India: an overview
- Rural-urban and intra-urban health disparities
- Characteristics of slum populations
Questions for Discussion

- Is urbanization uniform across cities?

- Where do the poor stay in cities?

- There are many large hospitals in cities
  - Is there still a need of new health care investments?

- Urban health indicators are generally better than rural health indicators
  - Then what is the rationale of advocating for urban health?
Urbanization

Photo by Lee LeFever. Creative Commons By-NC.
World Population, 1804-2054 (In Billions)

Urban Population

Maximum Urban Growth in Poor Countries

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% 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+ cities likely to increase from 194 to 288 by 2015

Urban Growth and Poverty in India

- 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% urban (550 million) by 2026
    - Census, 2001 population, projections, 2001-2026
  - 2-3-4-5 phenomenon of population growth
  - Urban poor estimated at 80.74-100 million
    - National Population Policy, 2000
  - Estimated annual births among urban poor: 2 million
    - Based on CBR 19.1 for urban population and 100 million urban poor population

Source: Planning Commission. Poverty estimates for 2004-05, based on URP.
Greater Population in Small and Medium-Sized Cities

Percentage Distribution of Urban Population by Size of Towns/UA (Census of India, 2001)

- Below 100,000: 31 cities (4,622)
- 100,000 to 499,999: 21 cities (354)
- 500,000 to 1 million: 9 cities (39)
- 1 million to 5 million: 17 cities (29)
- 5 million to 10 million: 6 cities (3)
- 10 million and above: 15 cities (3)
Urban Scenario in EAG States

- EAG (Empowered Action Group, Government of India, 2001) identified eight states that lag behind on demographic and health indicators.
  - These are UP, MP, Rajasthan, Bihar, Orissa, Jharkhand, Chhatisgarh, and Uttarakhand.

Source: Data from Census 2001 and NSSO 55th round, 1999-2000.
Key Messages

- Urbanization is a fast growing phenomenon
- Maximum urban population growth is concentrated in less developed countries
- India’s future growth will largely be concentrated in urban areas, and growth will be fastest in slums
- Most growth and population will be in small and medium-sized cities
- Mega-cities continue to grow and have importance beyond their proportion of urban population
Section B

India’s Urban Health Scenario
Urban-Rural Contrasts

- Health care has been largely rural biased
- Rural-urban and intra-urban health disparities exist
- Characteristics of slum population
Health Care System in Rural India

- Organized health care system largely limited to rural areas
Health Care System in Urban Areas

- Health posts and urban family welfare centers (UFWCs) provide primary health care for 50,000 population as government norm.

- State government in smaller cities and municipal bodies in large cities manage health services.

- ICDS provides nutrition and health services—in urban areas its coverage is far less (18.1%) than in rural areas (69.1%).
  - Based on 523 urban ICDS projects and 285 urban population.

- ICDS operates through Anganwadi Centre (AWC); one for every 1,000 population.

- AWCs provide both preschool education and health and nutrition counseling.
Poor Child Health and Survival

- Health conditions of urban poor are similar to or worse than rural population and far worse than urban averages.

![Under 5 Mortality Graph](source)

Childhood Under-Nutrition

Children <3 Years, Underweight by -2 SD

- Rural average: 49.6%
- Urban average: 38.6%
- Urban poor: 56%

In India, nearly 1 million babies are born every year in slum homes.

Conditions Worse in Less Developed States

- Madhya Pradesh

![Bar chart showing conditions in Madhya Pradesh](chart.png)
Poor Environmental Health Conditions

- About two thirds (65.9%) urban poor households do not have a toilet
Poor Environment

- Among urban high-income group, almost all households have toilets

Photo by Siddharth Agarwal.
Water Supply Situation

- Thirty-eight percent of urban poor households do not receive piped water at home as compared to 18% in urban rich households.

Photos by Siddharth Agarwal.
Substantial Economic Contribution of Urban Poor

- Almost 90% of urban poor are involved in urban informal sector


Photo by Steve Evans. Creative Commons BY.
Yet Urban Poor Are Underserved

- Urban sector contributes 60% of gross domestic product (GDP)

- Informal sector’s contribution to non-agricultural GDP is 45%

Photo by Siddharth Agarwal.
Key Messages

- Health care system is inadequate in urban areas and highly rural focused

- Urban poor are far underserved by health and nutrition services as compared to rural areas

- Urban health indicator averages mask the inequities suffered by the urban poor

- Availability of safe drinking water and toilets to urban poor is unsatisfactory

- A multitude of factors affect vulnerability of slum populations
Section C

Challenges in Improving Health of Urban Poor in India
Challenges

- Improving health of the urban poor
  - Programmatic challenges
  - Opportunities in urban areas
  - UHRC’s response
What from your experience are the main challenges in improving health of the urban poor?
Challenge #1: Invisible Slums

- According to NSSO 58th Round (2002), 49.4% of slums are non-notified in India

780 slums (total)

- 452 listed slums (population 820,139)
- 328 unlisted slums (population 510,397)
Large Proportion of Slums Are Uncounted, Invisible

- Listed vs. unlisted slums
  - Agra (215 vs. 178)
  - Dehradun (78 vs. 28)
  - Bally (75 vs. 45)
  - Jamshedpur (84 vs. 77)

- Besides unlisted slum settlements, urban poor also include pavement dwellers, population residing in construction sites, brick and lime kilns, fringes of the city, floating population, etc.
Challenge #2: Inadequate Services

- Inadequate primary health and nutrition services
  - There is one UFWC/HP for about 0.23 million urban population\(^1\) against the government norm of 1 for 50,000 population
  - Absenteeism, inconvenient timings, lack of medicines, and apathy at public facilities discourages the poor to use them
  - About half (48\%) the 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

Note: \(^1\)Based on an urban population of 285 million (2001 Census) and 1,197 government urban primary health facilities (Department of Family Welfare, MoHFW, GOI); \(^2\)Based on 100 million urban poor population (NPP, 2000) and 523 ICDS projects.
Challenge #3: Weak Services

- Weak coordination, capacity; scarce program experience
  - 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 #4: Weak Referral

- Weak referral mechanisms
  - Low access of health services to the poor
  - High usage of hospitals for minor ailments
  - Weak referral linkages from community and primary facilities
  - Lack of health insurance mechanisms for the poor
  - High usage of public referral hospitals by middle and higher income segments
Challenge #5: Weak Demand

- Weak demand among urban poor
  - Low awareness about services and provisions
  - Low awareness about healthy behaviors
  - Weak community organization and social cohesion
  - Weak negotiation capacity
  - Low level of trust in public sector services owing to irregularity and low quality
Challenge #6: Struggle for Subsistence

- Struggle for subsistence and weak family support
  - Pressing need to resume wage earning
  - Lack of family support to mother/care giver
  - Sub-optimal household behaviors
  - Preoccupied with struggle of livelihood
  - Constant threat of eviction
Challenge #7: Multi-Dimensional Vulnerability

- Factors and situations resulting in health vulnerability in slums
  - Irregular employment, low access to fair credit
  - Poor access to water and sanitation services, overcrowding, poor housing, and insecure land tenure
  - Lack of access to ICDS and primary health care services
  - Unlisted slums often outside the purview of civic and health services

Source: Taneja, S., and Agarwal, S. (2004). *Situational analysis for guiding USAID/EHP India’s technical assistance efforts in Indore, MP.*
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  - Unlisted slums often outside the purview of civic and health services
  - 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

Source: Taneja, S., and Agarwal, S. (2004). Situational analysis for guiding USAID/EHP India’s technical assistance efforts in Indore, MP.
Summary of Challenges

- **Policy gaps**
  - Urban health remained a low priority with greater focus on rural areas
  - Lack of credible data for urban poor related planning
  - Urban slums face social exclusion, illegality, and many overlooked by official enumeration systems

- **Supply, service convergence gaps**
  - Urban poor grossly underserved and having low access to health services
  - Greater focus on curative services resulting in neglect of primary and preventive health care
  - Existing services underutilized by the urban poor
  - Lack of coordination among multiple stakeholders
Summary of Challenges

- Low demand and struggle on multiple levels
  - Weak knowledge and social capital among slum dwellers—sense of resignation
  - Urban poor struggle against multidimensional vulnerability

- Gap in capacity and program experience
  - Weak capacity among government and NGO managers on urban health
  - Very few examples of coordinated, planned slum health programs in most states
Opportunities in Urban Areas

- Growing recognition of the problem among government agencies
  - Growing interest among donors
  - Large presence of experienced and interested NGOs in urban areas
  - Increased financial allocation and investment in slum development and health programs
  - Growing body of urban-poor-specific research and data
UHRC’s Response

Influencing national and state policy and program and other stakeholders

City TA cum demonstration and learning programs
Indore, Agra, Meerut, Delhi

National- and state-level technical assistance
UP, MP, Bihar, Uttarakhand, Jharkhand, Rajasthan, Maharashtra

Research, knowledge management, and advocacy
UH conference Symposia
Publications, reports
Web site

Source: Urban Health Resource Centre, New Delhi.
Section D

Indore Urban Health Program
Urban Population 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
  - Number of slums: 539 (314 not part of official slum lists)
Urban Health Situation in Indore

- Inadequate health care service for the urban poor
  - Seventeen 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

- Improper coordination among different service providers
Issue for Discussion

- How would you approach the situation in Indore to ensure health care for the urban poor?
How Did Program Directions Evolve?

- Program planning
  - Stakeholder consultations
  - Situation analysis
  - Health vulnerability assessment of slums
Key Findings

- NGO-CBO potential
- Multiplicity of stakeholders
- Public sector technical support needs
- Priority technical areas
- Sustainability is key
- Insufficient community demand for services
- Underserved slums identified and targeted
Program Approaches in Indore

- NGO-CBO partnership approach
- Ward coordination model
- Technical support to public sector
Assessment of Slums in the City

- Understanding the local context through needs assessment and situation analysis
- Identification, assessment, and plotting of slums in the city
Plotting Slums, Facilities

- City map with slums, facilities plotted an important planning and monitoring tool
Identifying and Targeting Underserved Slums

- 539 slums
  Pop: 600,000

- 157 most underserved slums

- 225 slums
  (official list)

- 79 slums
  NGO-CBO partnership
  Pop: 150,000

Indore population: 1,800,000
Program Approaches in Indore

- Approach 1
  - NGO-CBO partnership approach
    - Enhancing demand, supply, capacity, and fostering linkage

- Approach 2
  - Ward coordination approach
    - Convergence among stakeholders to optimize resources and improve reach
Approach 1

- Linking slum communities with public and private providers

Coverage
150,000 slum population

Community—Provider—Linkage

Improved health outcome

Capacity building, supervision, and coordination by NGO and technical agency
Building Sustainable Institutions

- Building sustainable institutions in underserved urban communities

- NGOs with support from technical agency (UHRC, formerly EHP India) undertake periodic program review and implement appropriate improvement measures as identified during review
Cluster Coordination Team

- Nine cluster coordination teams
- Also called lead CBOs; 7-9 slums per cluster
- Seven registered as voluntary organizations
- Plan and negotiate for regular health services
  - Referral linkages and coordination with service providers (health, water, sanitation, etc.)
  - Monitoring, supervision, and support to basti CBOs in health activities as necessary
Basti-Level CBOs

- Ninety community groups of 7-12 members, including dais across 75 bastis (slums), ensure reach of services and community-based monitoring by …
  - Counseling slum families on healthy behaviors
  - Identifying unreached families and ensuring access for them
  - Supporting regular MCH camps in slums
Community at Work

- Registration of beneficiaries—identifying left-outs and dropouts
- Linkage with the auxiliary nurse-midwife for vaccine administration
- Information and community motivation—women arrive for immunization day
Improved Health Indicators in Indore Slums

- Mothers who received 3 ANC: Baseline 55, Midline 69
- Mothers who delivered in health facilities: Baseline 38, Midline 52
- Infants breastfed within one day of birth: Baseline 59, Midline 85
- Children 0-3 mos. who are exclusively breastfed: Baseline 23, Midline 43
- Underweight children under 2 yrs. (less than -2 SD): Baseline 46, Midline 29
- Children 12-23 mos. completely immunized by 1 year of age: Baseline 32, Midline 72

Legend:
- Baseline (October 2003)
- 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 removed: 41.4%
- Clean cord tie: 100%
- New blade: 96.6%
- Clean cord stump: 50%

Baseline survey (Oct-Nov 2003)
MNH survey (Jan-Sep 2005) (N=312)
Place of Delivery

- Slum-home (56.4%)
- Government, charitable hospital (21.2%)
- 15.7%
- 6.7%
Approach 2

- Multi-stakeholder ward coordination approach

- **Municipal corporation (zonal office)**
- **NGOs & CBOs**
- **Elected representatives**
- **Charitable organizations**
- **Health dept.**
- **ICDS**
- **Local resources (local clubs, schools)**
- **DUDA***

*Total coverage: 70,000 slum population in two wards in Indore

*District Urban Development Authority
Present Status

- Expanded reach of services to 48 slums in two wards covering more than 70,000 underserved populations

- Reorganization of catchment areas of existing health centers improved access for left-out/newly identified slums

- Private sector involvement: private schools and private doctors have made their premises available for outreach camps

- Approach replicated from September 2005 in Ward 7, where monthly camps cover about 35,000 vulnerable population across 24 slums
Improved Health Indicators in Ward 5 of Indore

- Children 12-23 mos. completely immunized by 1 yr. of age: Baseline (32%), Midline (64%)
- Children 12-23 mos. received measles by 12 mos.: Baseline (65%), Midline (76%)
- Children 12-23 mos. dropping out from UIP (DPT1-DPT3): Baseline (53%), Midline (9%)
Lessons Learned

- Situation analysis (participatory mapping, transect and group discussions) helps identify underserved slums, priority needs and local resources

- NGO-CBO consortia has been an effective strategy in enabling the partners to utilize complementary skills and capacities

- Slum-level institutional and individual capacity building is important for sustainability and stabilizing community-level institutions and strengthening linkage with government program
Lessons Learned

- Cluster coordination teams comprising of slum leaders evolved as a potent institutional mechanism for slum health (and development) programs.

- Partnership and coordination among multiple stakeholders facilitate the use of resources from varied sources and eliminate duplication of efforts.

- A combination of the two approaches is useful for sustaining improved reach of services to urban poor.
Section E

Agra Urban Health Program—A Case Study
Urban Poverty Situation in Agra

- Growing urban poor population in Agra
  - Population: 1.33 million (2001 census); 2004 estimate: 1.6 million
  - Decadal growth rate (1991-2001): 42%
  - Estimated slum population: 0.8 million

- Total slums: 393
  - Officially listed: 215 (population 0.5 million)
  - Unlisted: 178 (population 0.3 million)

- Of 393 slums, 183 are most vulnerable, 173 moderately vulnerable, and 37 less vulnerable

- Weak coordination among different service providers
Urban Health Care Situation in Agra

- Public sector health facilities
- Fifteen primary-level health centers, large parts of city unserved
- Outreach services weak, irregular, inconvenient timing of primary-level health facilities
- District hospital-1, district women hospital-1, and medical college-1
- ICDS centers: 95 ICDS centers in the city, 43 located in slums
- Low access to health care, weak demand and low usage of services by slum communities; sub-optimal health behaviors
Private and NGO Sector

- Presence of NGOs, some with health program experience
- Two charitable hospitals, many private practitioners, few private hospitals
- Informal sector preferred due to convenient location and flexible time
Based on the needs, service gaps and options, what would you as a public health program manager do for optimizing public health gains in Agra slums?
Program Approaches

- Approach 1
  - NGO-managed service delivery and community mobilization

- Approach 2
  - NGO-facilitated demand generation and service linkage
Clearly Define Unserved Areas and Plan Accordingly

- Map clearly defined unserved areas and plan accordingly
Approach 1

- NGO-managed service delivery, community mobilization
  - Two such UHCs are operational, covering 53 slums with approximately 106,252 people

Note: Other organizations, such as Arpana Trust (Delhi), Sumangli Seva Ashram, Shri Sharan Seva Samaja, Lions Club Trust, and others in Bangalore (as well as several NGOs in Chennai) are involved in similar partnerships.
Note: Outreach services include treatment of minor illnesses, ANC, immunization, birth spacing, health education; Through this approach community linkages are being established with two UHCs covering approximately 65,060 population.
Selection of Slum Link Volunteers

- Identification of CLV (community link volunteer)

- Women from the slum, preferably married, identified as CLVs through a participative and transparent process
Role of Community Link Volunteers

- Track beneficiaries and monitor coverage, support in organizing outreach camps
- Conduct health behavior promotion activities
- Identify special attention households in slums, counsel individual and family, motivate for behavior change and availing health services
- Support promotion of women’s health groups
- Identify and refer cases requiring medical attention to UHC, escort women to hospitals
Formation of Women’s Health Groups

- Group formation

- Slum-level women’s health groups formed with help of CLVs and NGOs from active, interested members of the slum community, encouraged to work collectively
Role of Women’s Help Groups

- Support link volunteer in tracking and monitoring of coverage of key services

- Motivate target women for attending group counseling sessions

- Help organizing outreach camps and ensuring presence of target groups

- Linkage with service providers (UHCS)

- Collect, manage, utilize community health fund
Preliminary Process Level Outcomes

- May 2005 to May 2007
Process Outcomes

- 22 regular monthly outreach sessions cover 47 slums with 82,400 population

- 108 link volunteers in place, each covering 1,500-1,800 population

- 69 women’s health groups formed in 58 slums

- Link volunteers and women’s group members encourage early adopters to motivate resistant women and support special attention households

- Community health fund: 52 groups across 43 slums have initiated health fund
Process Outcomes

- Improved quality of MCH services through NGO partnership
  - Improved regularity of service: two new UHCs catering to 106,000 slum population
  - More comprehensive ANC and other services
  - Improved availability of medicines, e.g., antibiotics, RTI medicines

- Enhanced capacity of NGO partners to generate resources locally (about 10-15% of grant value)

- Improved capacity of women’s health groups to meet health emergencies at slum level—29 health loans disbursed so far
Slum-Level Activities

- Dissemination of health messages—
  MAS members counseling pregnant women during outreach session

- Immunization tracking—identifying left-outs and dropouts through slum mapping
Improving Health Services and Behaviors

- CLV and MAS members encourage women for ANC checkups during outreach camps
- Information and community motivation—MAS members singing health songs
Early Lessons

- NGOs can effectively complement government’s efforts to...
  - Quickly expand health services to unserved areas
  - Strengthen outreach services from existing government facilities

- Link volunteers and women’s health groups, mobilize slum communities, and improve linkages with and access to services
More Lessons

- City map with slums and facilities plotted helps effectively plan new health centers and outreach services

- Intersectoral linkages to address water and sanitation issues are difficult in weak governance situations like Agra

- Multipronged persuasive advocacy required to overcome resistance to change among government stakeholders
“A small body of determined spirits fired by an unquenchable faith in their mission, can alter the course of history”

Mohandas Karamchand Gandhi

With Hope and Confidence

Accountable, effective urban health governance

Long lever of ...  
a) Commitment motivation  
b) Knowledge, experience  
c) Proximity to problems  
d) Accountability, responsibility

Public health professionals, civil society, government, slum communities

Source: Urban Health Resource Centre.  www.uhrc.in