

**Improving health outcomes among urban poor- The challenges and opportunities  
Lessons from India Family Welfare Urban Slums Project**

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***Abstract***

*Future global population growth will be mostly in urban areas of developing world<sup>1</sup>. By 2035 more than a half of world's poor population will be living in urban areas<sup>2</sup>. In developing countries averages suggest better health status among urban residents compared to rural dwellers. However, urban poor face many more health risks and their health status is even worse than the rural poor<sup>3</sup>. Several household surveys highlight inequalities in use of basic services among urban populations<sup>4</sup>*

*Recognizing the importance of improving access of basic health services for the poor, the World Bank supported a Family Welfare urban slums project that helped nurture new partnerships between local communities, municipalities and non government sector to improve health outcomes of 11.3 million urban poor population in India. The project was implemented in 4 metro cities under the stewardship of Union Ministry of Health and Family Welfare over 1994-2002 and the model has now been extended to 94 smaller towns in 3 states. Independent surveys indicate improvements in key Reproductive and Child Health (RCH) outcomes in project areas. The findings also suggest increased use of RCH services by the urban poor. Based on the lessons from the project, this paper discusses policy and program options for enhancing demand for healthcare by giving voice to urban poor and increase their use of basic health services.*

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<sup>1</sup> Population Reports. Meeting the Urban Challenge; Volume XXX, Number 4, Series M, Number 16, May- June 2003.

<sup>2</sup> Ravallion M. One the urbanization of poverty, Washington DC., World Bank July 2001 (<[http://econ.worldbank.org/files.1695\\_wps2586.pdf](http://econ.worldbank.org/files.1695_wps2586.pdf)>)

<sup>3</sup> Bicego. G and Ahmad OB; Infant and child mortality; Demographic and Health Surveys - Comparative Studies No., 20; Calverton, Maryland, Macro International, Aug. 1996.

<sup>4</sup> Davidson R. Gwatkin, Shea Rustein, Kiersten Johnson, Rohini P. Pande, and Adam Wagstaff; Socio-Economic Differences in Health, Nutrition and Population; Health Nutrition and Population Thematic Group of the World Bank, May 2000.

## Urban Reproductive health – the emerging challenge.

World over, urban areas are growing very fast and every week nearly 1.3 million population get added to already overcrowded urban settlements. The urban population of developing countries is projected to grow at an average annual rate of 2.4%, twice the annual population growth rate of 1.2% in the developing world<sup>5</sup>. Because of this rapid population growth, rising poverty levels, weak policy frameworks and inadequate public institutions, urban areas in developing countries face an enormous challenge to provide adequate infrastructure; shelter; basic services including access to safe water, sanitation, education and basic health services, employment opportunities; and ensure food security. .

Growing urban poverty is becoming a major concern. Nearly 495 million urban poor in developing countries are estimated to be living on less than US\$ 1 a day<sup>6</sup>. On average, the health status of urban residents appears better than their rural counterparts but, averages mask growing disparities and inequalities between the poor and rich even while the proportion of those living in poverty appears to be declining. Within urban areas, the urban poor face many more health risks than the average urban residents<sup>7</sup>. Analysis of household data from Demographic and Health Surveys (DHS) indicate higher infant mortality among poorest urban populations compared to richest in 17 out of 18 countries studied<sup>8</sup>. Health conditions of urban poor are sometimes even worse than they are for the rural poor<sup>9</sup>. Social exclusion and lack of voice for poor urban women increases their vulnerability, to ill-health and violence. As a result, the urban poor especially poor women carry higher risks of sexually transmitted infections and HIV/AIDS and poor reproductive health. While availability and access of reproductive, maternal and health

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<sup>5</sup> United Nations Population Division (2002) . World Urbanization Prospects: The 2001 revision. New York.

<sup>6</sup> The World Bank (1999). The World Development Report 1999: Entering the 21 st century. Oxford University Press. New York.

<sup>7</sup> Population Reports (2003); Meeting the Urban Challenge; Population Information Program, Center for Communication Programs, The Johns Hopkins Bloomberg School of Public Health; Series M. Number 16

<sup>8</sup> Bicego G and Ahmad O. B; (1996); Infant and child mortality. Demographic and Health Surveys Comparative studies No. 20. Calverton, Maryland, Macro international

<sup>9</sup> World Health Organization (1998). Health and Urbanization in developing countries - Proceedings of United Nations Expert Group meeting on population distribution and migration, Santa Cruz, Bolivia in preparation of Conference on population and development Cairo. United Nations. New York p. 364-369.

services may be better in urban than rural areas settings, the capability of public institutions to expand outreach to the urban poor and slum dwellers in informal dwellings is limited. Even if outreach services are provided, the timings often do not suit poor working women..

Duly realizing the importance of meeting the reproductive health needs of the urban poor, the International Conference on Population and Development (1994)<sup>10</sup> suggested specific actions for :

- Enhancing capacity and competence of City/Municipal authorities to manage urban development, safe guard environment and respond to the needs of all citizens especially urban squatters;
- Improving status of urban poor mostly working in informal sector by enhancing income earning capacity, access to credit, production and marketing arrangements, basic health, education giving special focus to women workers, women headed house holds;
- Ensuring balanced financing of infrastructure and services including equitable cost recovery;
- Ensuring access to reproductive health information and services, education and promoting gender equality; and
- Managing the urban environment, particularly air, water, waste and transport

By 2030, India's urban population is expected to reach 297 million which poses new challenges to ensure basic services for the urban poor. This paper shares Indian experiences in responding to this emerging challenge.

#### India's response.

India started responding to this challenge as early as 1982 by developing policy framework for urban primary health care<sup>11</sup>. A new initiative known as Urban Revamping Scheme was started in 1984 with strong focus on improving linkages of primary health and family planning services with other urban basic services such as clean

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<sup>10</sup> International Conference on Population and Development (1994). Program of Action; United Nations Population Fund ; 2001

<sup>11</sup> Government of India, Report of Krishnan Committee (1982)

drinking water and sanitation. This was followed by several other initiatives including the Bank supported urban primary care project in Bombay and Chennai during 1988 and 1995 and the current project which closed in 2002..

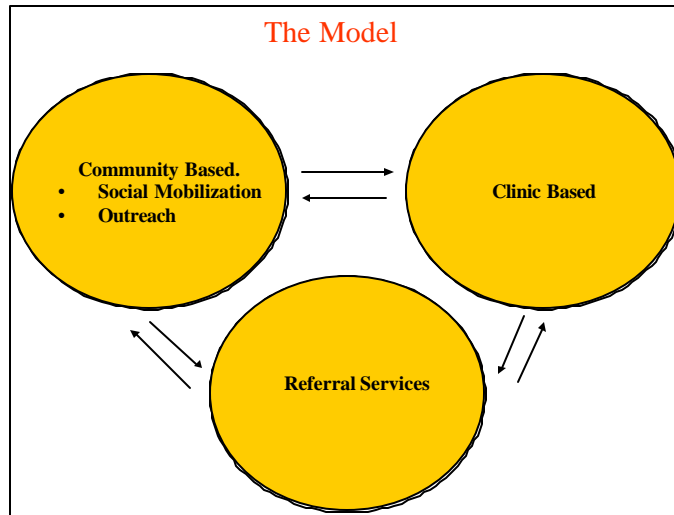
The Government of India's US\$ 81 million Family Welfare Urban Slums project supported by the World Bank helped to develop new partnerships between local communities, municipalities and non-government sector to improve reproductive and child health outcomes among 11.3 urban poor populations of India. Implemented during 1994-2002 under the stewardship of Ministry of Health & Family Welfare, the project aimed to (a) reduce fertility by improving access and demand for family planning services; and (b) improve maternal and child health by decreasing maternal and infant mortality rates among slum residents of Bangalore, Delhi, Hyderabad and Kolkata. The project scope was subsequently extended to 94 smaller towns in the states of Andhra Pradesh, Karnataka and West Bengal.

#### The strategy.

The key strategy was to gradually decentralize the program management to municipalities and empower the slum communities through a network of women mobilizers. This was complemented by sustained supply of basic services through strategic partnerships with private sector.

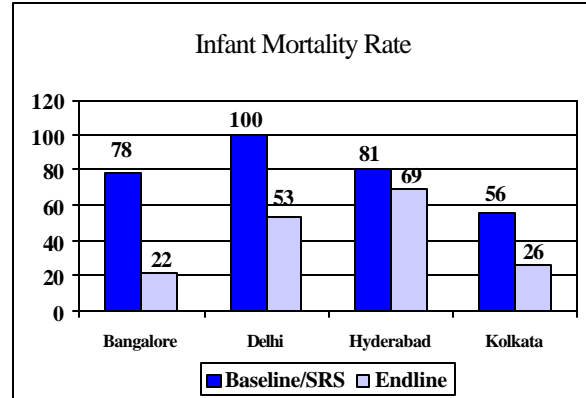
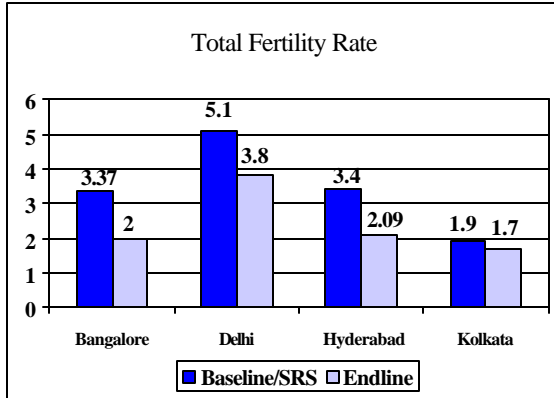
The project helped the local municipalities to improve access to basic community outreach as well as facility based services for women and children residing in urban slums. Innovative partnerships and service delivery contracts were used to involve community based organizations and private sector to mobilize communities as well as deliver services. This was complemented by inputs aimed at improving quality such as skill enhancement training to the providers, systems for ensuring uninterrupted supply of essential drugs, consumables and contraceptives, construction of health posts and maternity homes closer to urban slum settlements. In addition, special inputs were provided to develop institutional capacities of municipal health departments in program management with special focus on planning, budgeting, financial management and

monitoring and evaluation. The participating municipalities were encouraged to implement innovative schemes with specific focus on creating awareness about reproductive health issues among adolescent girls and young women and enhancing their income earning potential through vocational training.



As shown in the figure, the service delivery model operated at three levels – (a) community, where emphasis was on building social capital through network of women mobilizers supported by periodic outreach services provided by paraprofessionals; (c) fixed facility based clinic services provided by professionals either from public or on contract from private sector; (c) maternity homes providing referral back-up for comprehensive obstetric care and surgical family planning services.

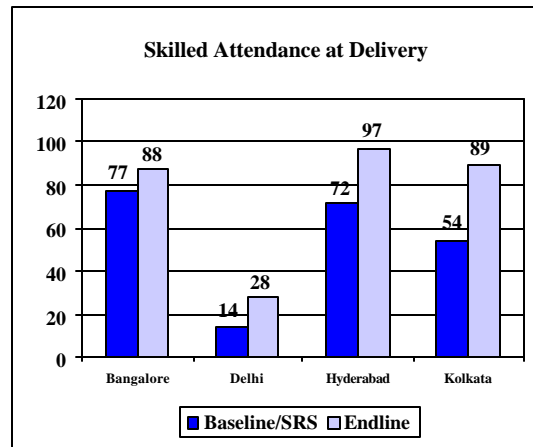
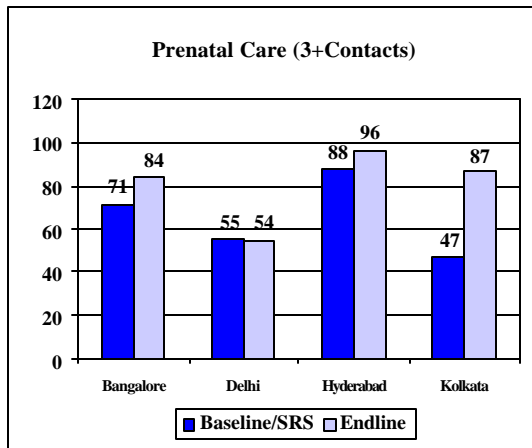
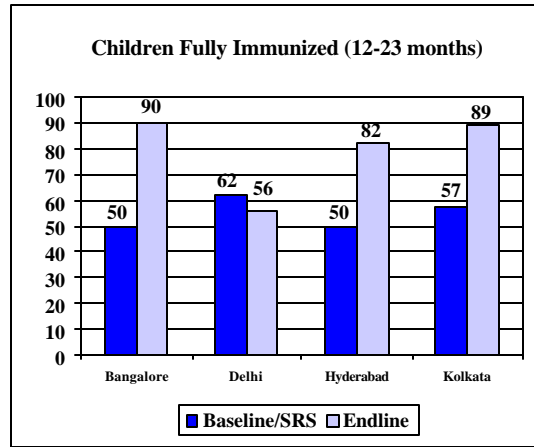
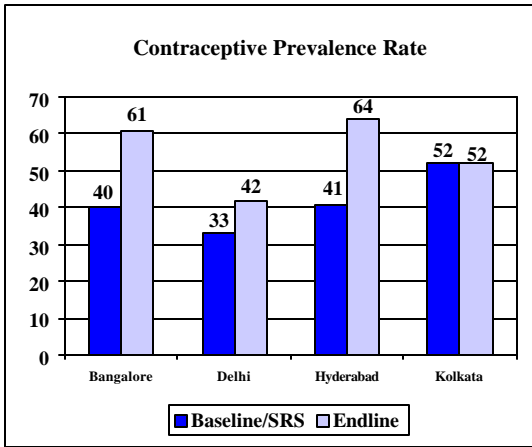
## The Impact.



A comparison of findings from surveys undertaken by independent agencies at the beginning of the project, midline and closure, suggest a notable fertility decline among slum population (first objective); and markedly improved maternal and child health outcomes as evidenced by a decrease in infant mortality and increased use of essential RCH services (second objective). These improvements are more pronounced in Kolkata, Bangalore and Hyderabad and less marked in Delhi and new towns included subsequently.

The Maternal Mortality Rates were not used in assessing impact as it is not possible to note significant changes in this indicator over short periods of time. Instead, skilled attendance which is a process indicator recommended by special session of the United Nations general Assembly in July 1999 in its report on the five-year review of Program of Action of the International Conference on Population and Development, Cairo 1994<sup>12</sup>.

<sup>12</sup> World Health Organization (2001); Maternal Mortality in 1995: Estimates developed by WHO, UNICEF, UNFPA, WHO/RHR/01.9. Geneva



As the observed improvements could also be due to secular trends in these cities, annual rates of changes for these indicators were compared with that of urban populations in the project states between two rounds of National Family Health Survey (NFHS) conducted in 1992-93 and 1998-99. This comparison suggest much steeper decline in Total Fertility Rates in Hyderabad, Bangalore and Delhi while IMR decline was more marked in Bangalore and Delhi.

Estimated project's contribution to TFR decline

	Annual rate of change (NFHS) in Urban areas	Annual rate of Change in Project areas	Difference
Bangalore	-0.08	-0.17	-0.09
Delhi	-0.11	-0.17	-0.06
Hyderabad	-0.05	-0.16	-0.11
Kolkata	-0.08	-0.03	0.05

Estimated Project's Contribution to IMR decline

	Annual rate of change (NFHS) in Urban areas	Annual rate of Change in Project areas	Difference
Bangalore	-2.28	-6.94	-4.66
Delhi	-2.72	-5.93	-3.21
Hyderabad	-2.58	-1.45	-1.13
Kolkata	-6.18	-3.75	2.43

Processes contributing to impact.

The project helped in building a huge social capital for 11.35 million urban poor populations (double the planned number) residing in 2,247 slums by training nearly 17,000 neighborhood workers drawn for the same community. Designated as Honorary Health Workers (HHWs)/ Link Volunteers/Basti Sevikas, these workers mobilized the poor communities for immunization, safe motherhood, family planning and other basic health services. Some cities effectively used them for identifying the slum residents in need of other primary care services for tuberculosis, leprosy and cataract blindness. They were also actively involved in women's empowerment initiatives supported under the project including reproductive health education for young women and training women in vocational skills and entrepreneurship development. The option to make formal payments for their services was left to the municipalities. While most cities preferred to pay a token monthly honorarium of about Five Hundred Rupees (about Ten US Dollars), the states of Andhra Pradesh (both in Hyderabad and in 74 smaller towns) and Karnataka (in smaller towns) preferred not to pay. Instead, the volunteers were given identity and recognition for services rendered. In Kolkata, the mobilizers who excelled in their performance were promoted as supervisors. These community based workers were supported by a limited contingent of paramedics providing periodic outreach services supported by supervisors for monitoring quality.

The project helped to rehabilitate 720 existing health facilities and build 614 new facilities closer to slums. Part or full time medical officers provided clinical services from these facilities. In West Bengal, strategic partnerships with private sector were established and services of doctors and specialists practicing in the towns and cities were used to provide clinical services at health centers and maternity homes. Karnataka appointed the doctors on contract while AP entered in to innovative service delivery contracts with 192 community based organizations to provide RCH services to poor populations residing in defined geographic populations. Thus, the project provided an important platform for testing new models for public private partnerships.

The project helped in providing systematic training for the community mobilizers, community leaders besides, medical and technical and paramedical personnel. To enhance responsiveness of the service providers to clients special trainings in community needs assessment and communication were also provided. Advanced training in clinical skills was given by nationally reputed institutions for the medical officers. The project helped to establish sustainable supply systems by improving procurement and supply logistics in municipalities. For the first time in the public sector, 30 urban health centers supported under the project received ISO 9002 certification .

Program management skills of municipalities were strengthened with training of 366 program managers in quality assurance, procurement, financial management and health sector reforms. In West Bengal the program management was fully decentralized to the local bodies which made the elected representatives fully accountable for implementation and results. West Bengal introduced cost recovery for the first time cross subsidizing the poor and a municipality level health development fund was established to use the funds locally. All project cities have strengthened the Management Information Systems focusing on outputs. In Delhi, grading of health centers by performance was started and Geographic Information System pilot was successfully implemented in Kolkata.

### Key lessons learnt.

- To firmly institutionalize reforms there is need to decentralize the program and fully engage local self governments in the process. Ownership by local municipalities is one of the critical factors contributing to the observed changes.
- Empowering women about their reproductive rights and making them more economically self-reliant should go hand in hand with supply driven initiatives for improving physical access to RCH services. Development of social capital through community based mobilizers is critical for giving voice for urban poor and generate demand for RCH services. However, there is no single solution that can fully address reproductive health needs of urban poor. The suggested model only identifies key service delivery modes – household/community, intermittent paraprofessional and continuous clinical care. Appropriate strategies need to developed based on local needs and capacities.
- No single agency can effectively address the growing health needs of urban poor. There is need for strategic partnerships between public and private sectors working closely with the communities. There is also need for stronger collaboration between different municipal departments such as slum development, education, health, women’s development, youth etc. Such partnerships among honorary workers, part-time doctors and specialists from private sector and municipalities not only improves access to poor but also enhances sustainability by keeping program recurring costs low.
- Demonstrating change requires long-term societal commitment and support to health and equity in the context of the urban poor, with synergic linkages among ongoing health and development programs The Kolkata initiative was built on successive Bank and DFID supported community development programs during past decade.
- Though providing basic health services continues to be the primary responsibility of the government, identifying and targeting these services to the poor is important to improve health outcomes. Provided the poor have been identified through a

transparent process, appropriate exemption mechanisms could be developed - as done in West Bengal - to ensure safety nets while implementing the cost recovery programs.

- It is critical to complement home based care with appropriate referral back-up. However, the option of using existing facilities - both public and private - should be adequately explored before embarking on new constructions. It is difficult to find suitable sites near urban slums and it will be even difficult to sustain the newly built facilities.

In conclusion, the India case study demonstrates potential for improving health outcomes among urban poor, especially women and children, in challenging urban environment. It also highlights the important role local municipalities can play in implementing pro-poor social and economic policies and programs, especially in education and health sectors, and in promoting gender equality. Decentralization and devolution to local government is critical to better planning, building management capacity and effective use of resources. Additionally, community participation and partnerships between public, private and civil society promote ownership and inclusion, necessary ingredients for successful programs. This case study contributes to increasing knowledge and understanding of what works and helps in scaling up of pro-poor services and policies for urban poor in other parts of the world.