URBAN HEALTH RESOURCE CENTRE

Health Concerns and Organizing Health Care Delivery to Urban Slums

Ranbaxy Science Foundation's 16th Roundtable Conference:
November 11th , 2005, IIC, Delhi

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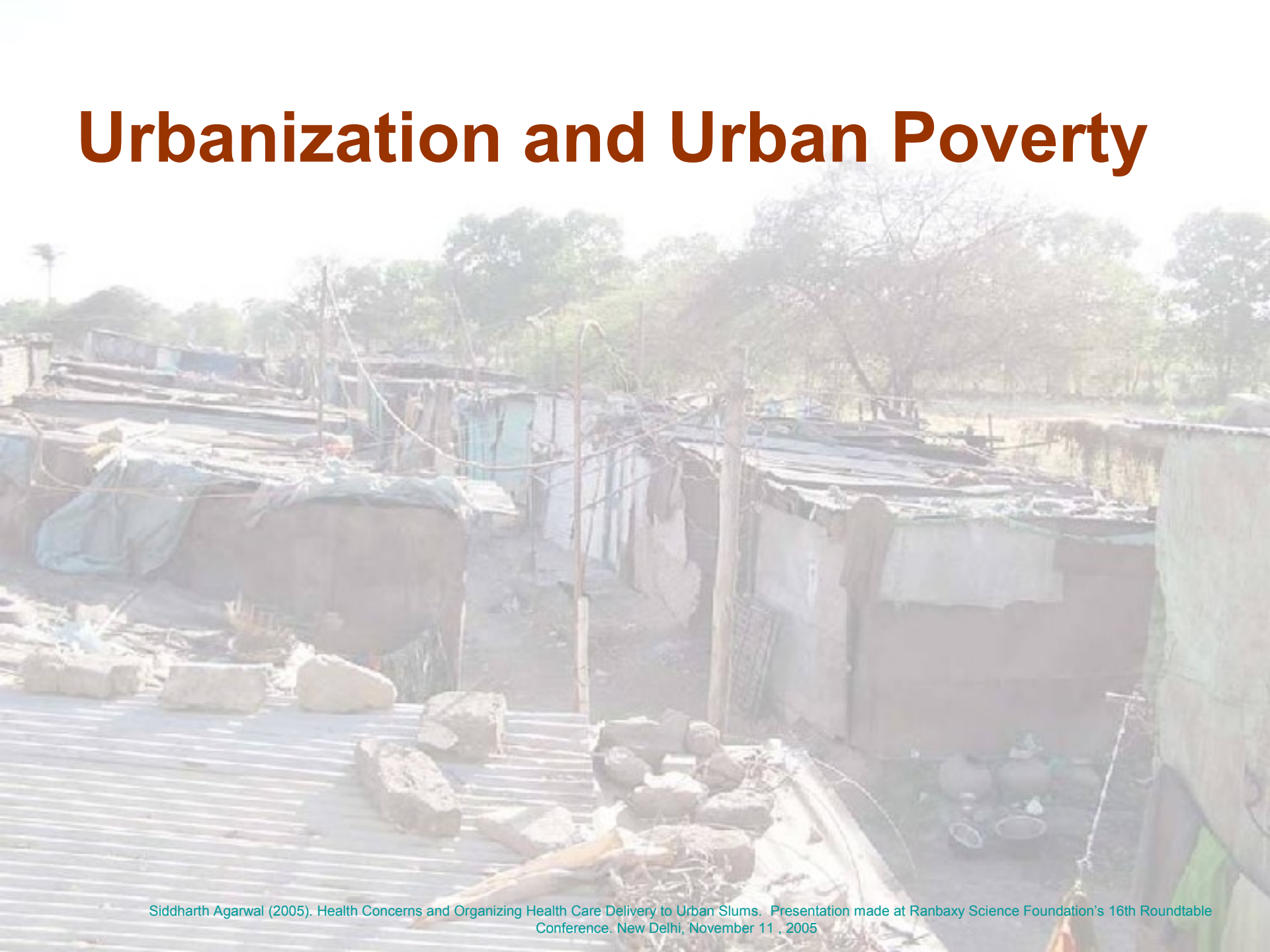
Outline

- **Urbanization and Urban Poverty**
- **Health Concerns of the Urban Poor**
- **Challenges and Opportunities**
- **Some Possible Approaches**

Urbanization and Urban Poverty



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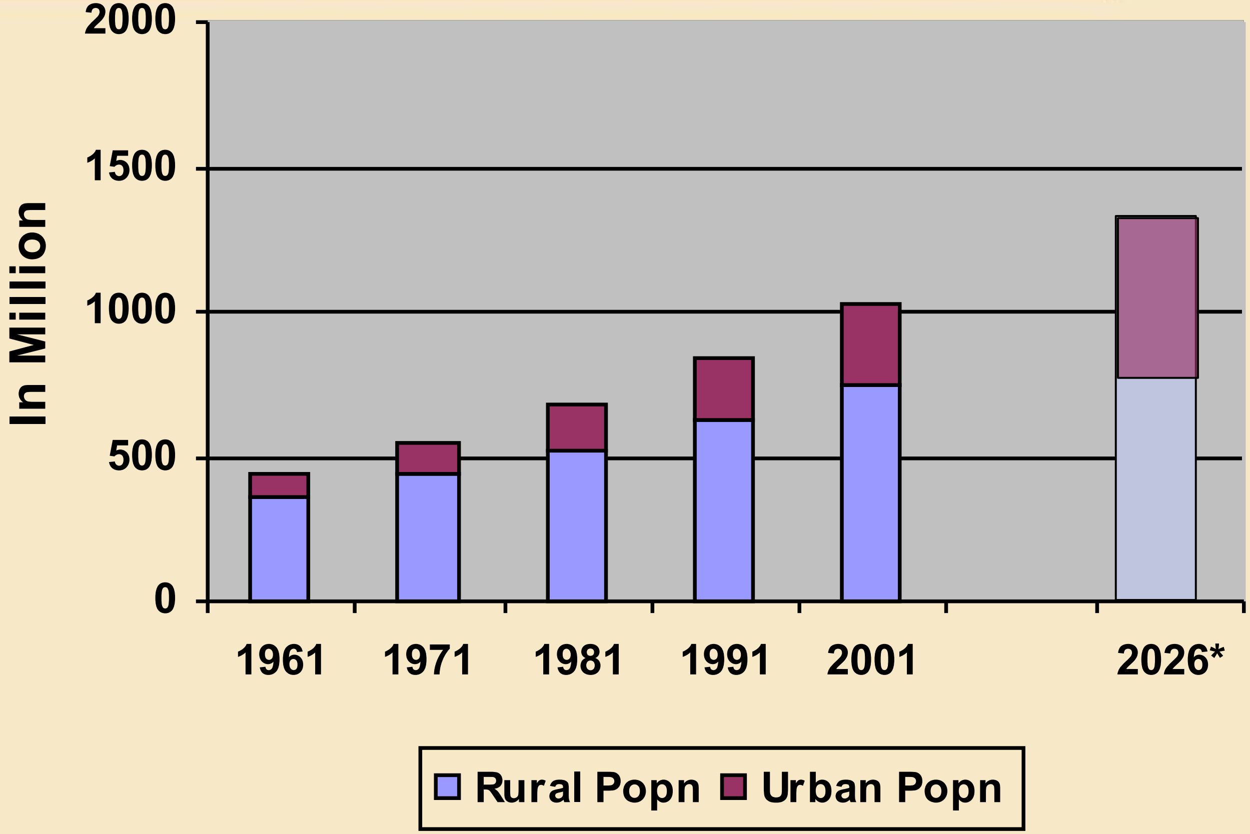
Growth in India's Urban and Rural Population over Last Four Decades



India's urban population of 285 million will almost double by 2026.

Most urban population growth will be in smaller towns and cities

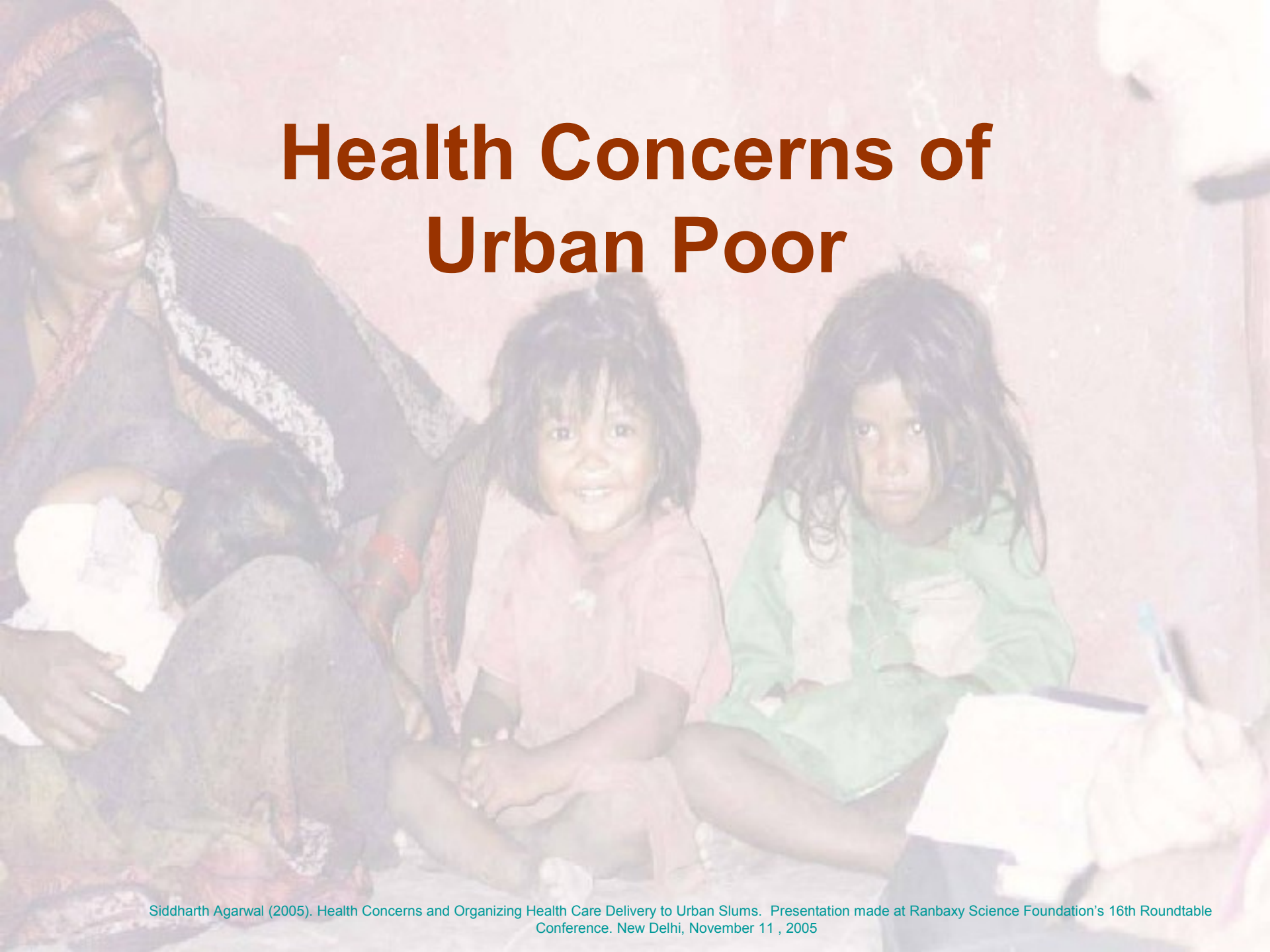
*Source: 21st Century India: Population Economy, Human Development and Environment. Edited by Tim Dyson, Robert Cassen, Leela Visaria. Oxford University Presss, New Delhi, Page 120

Unabated Growth of the Urban Poor

- 2-3-4-5 phenomenon of population growth
- Urban population - 285 million[1]
- Urban poor estimated at 70[2] -90[3] million
- Estimated annual births among urban poor-2 million[4]

[1] 2001 Census of India.
[2] 1999-2000 NSSO (55th round) using 30 day recall of consumption expenditure.
[3] Lawrence Haddad, Marie T. Ruel, and James L. Garrett, 1999. Are Urban Poverty And Under nutrition Growing? Some Newly Assembled Evidence.
[4] Laveesh Bhandari and Shruti Shresth, Health of the Poor and their Subgroups in Urban areas, June 2003. (Calculated on fertility rate of 3.0 for the urban poorest quintile)

Health Concerns of Urban Poor



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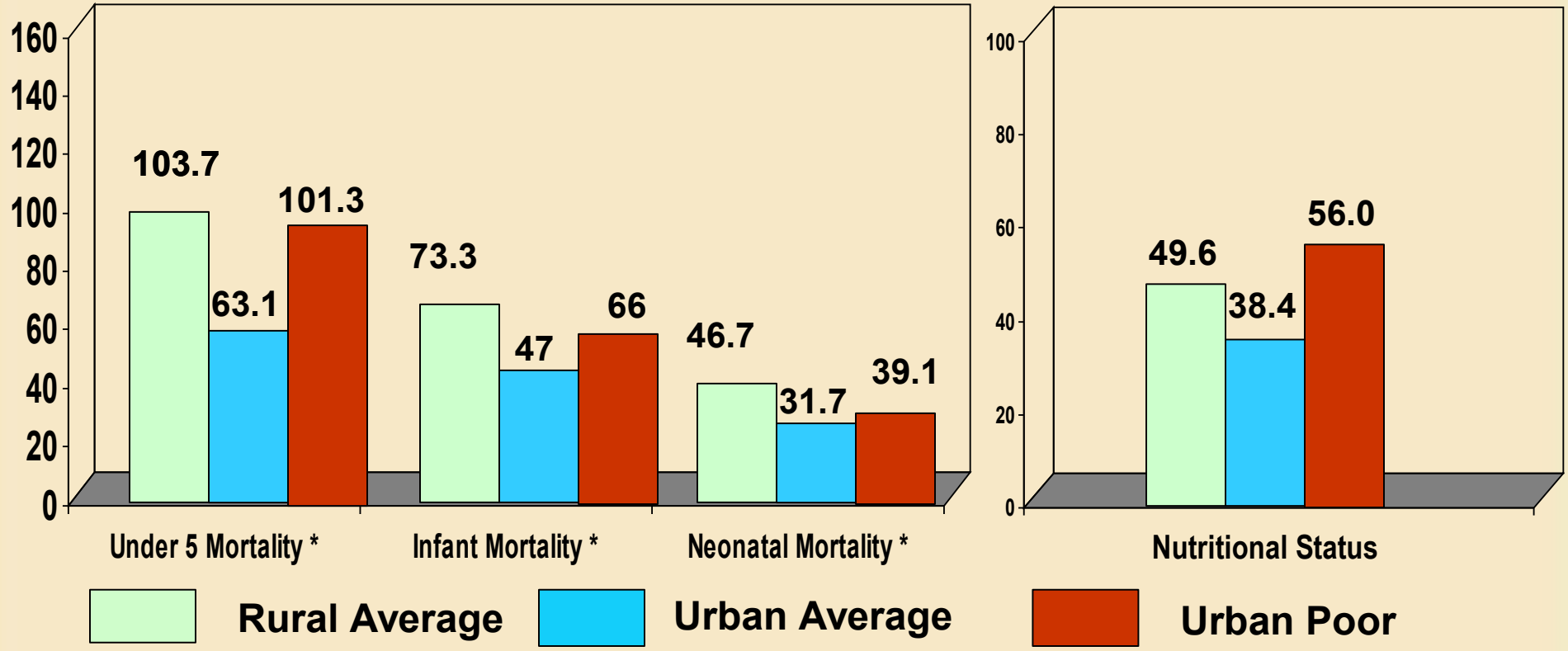
Poor Child Health and Survival

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



* Mortality per 1000 live births

[Re-analysis of NFHS 2 (1998-99) by Standard of Living Index, EHP: 2003]

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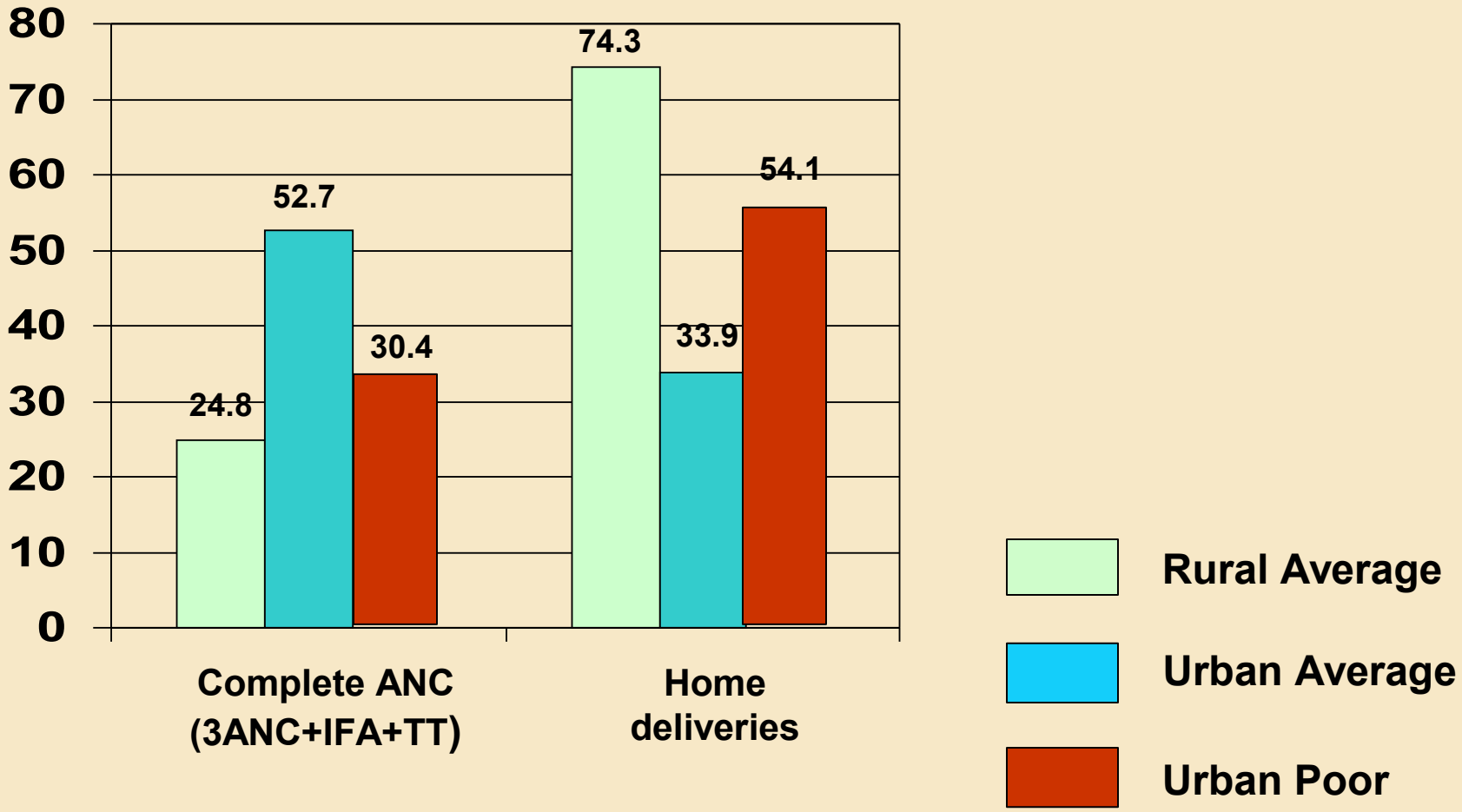
Poor Access to Health Services



> 1million babies are born every year in slum homes

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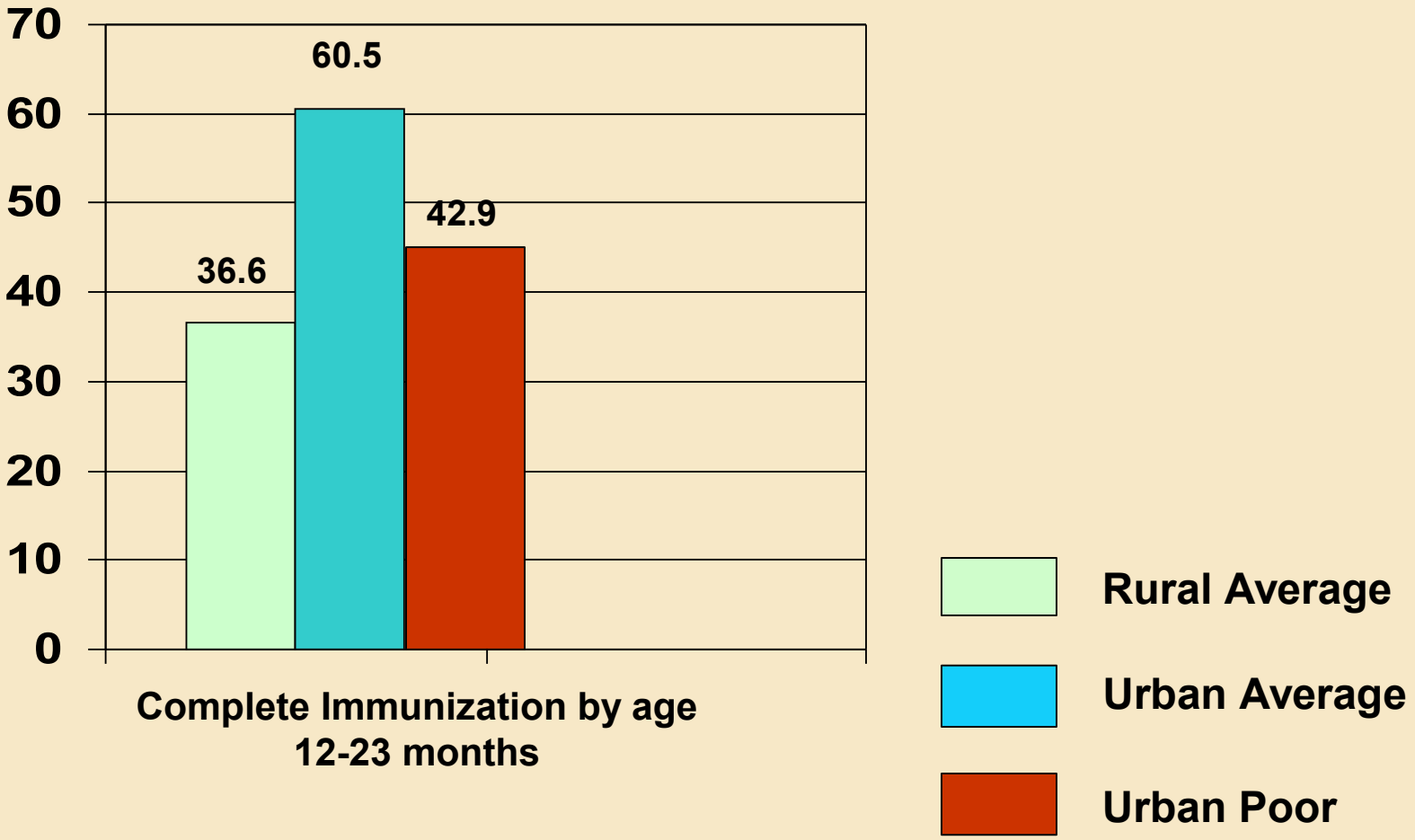
Re-analysis of NFHS 2 (1998-99) by Standard of Living Index, EHP: 2003

Poor Access to Health Services



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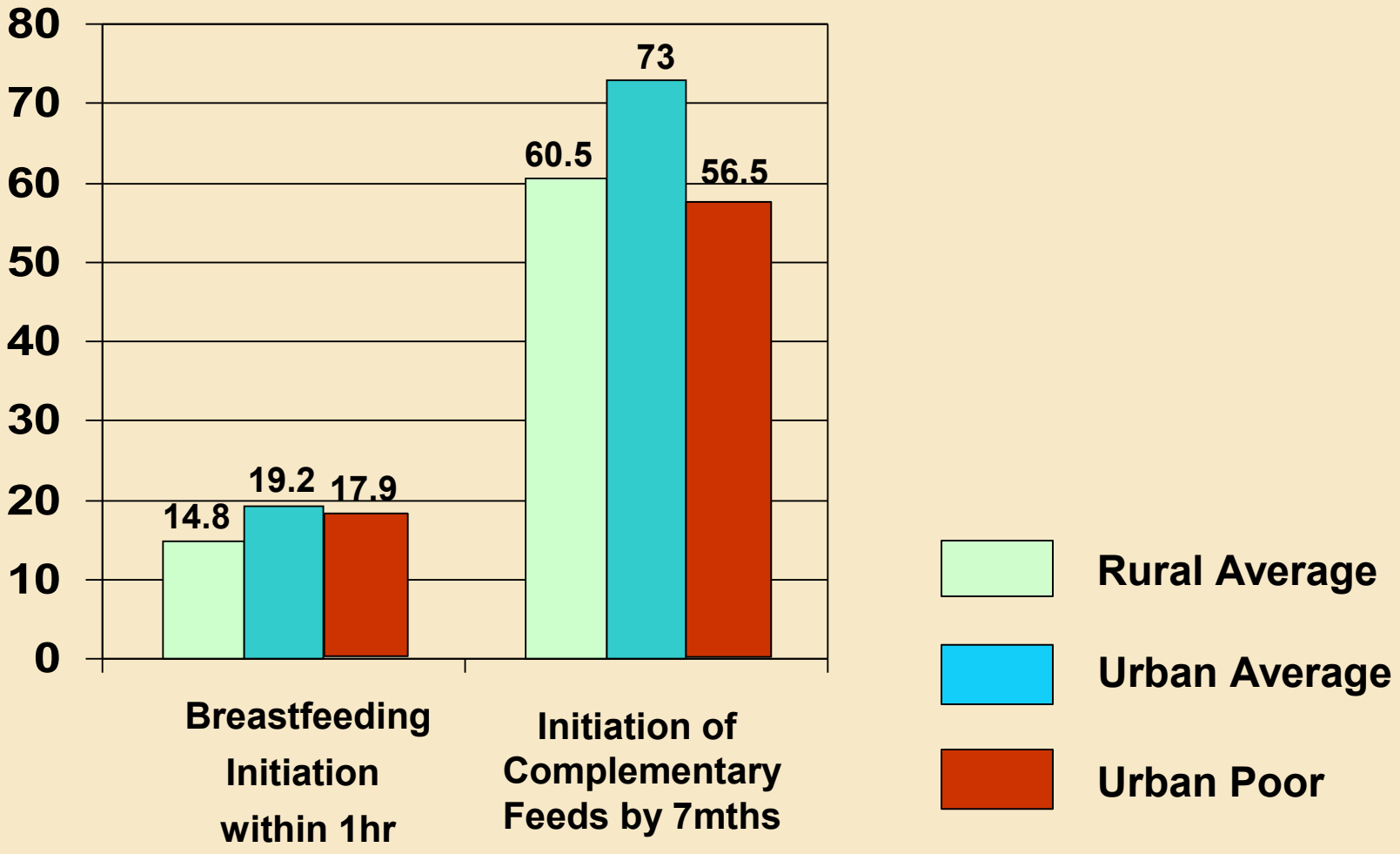
Sub-optimal Health Behaviors



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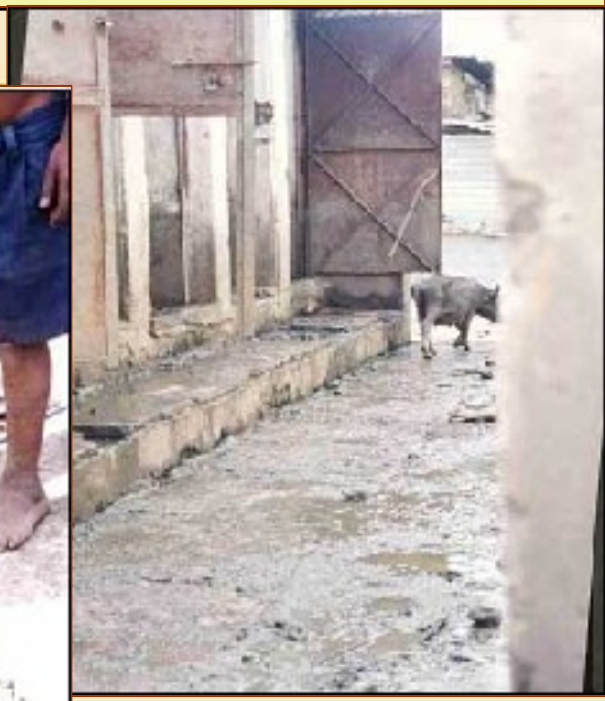
Poor Environmental Conditions

About two thirds urban poor households do not have access to piped water supply and toilet facility



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High Prevalence of HIV/AIDS in Urban Areas

Estimated Prevalence of HIV+ cases in urban areas is almost double that in rural areas

	HIV estimates 2004 (in lakhs)
Rural	**30.07**
Urban	**21.27**
Total	**51.34**

High risk categories include sex workers, migrant laborers, truck drivers

http://www.nacoonline.org/facts_hivestimates.htm

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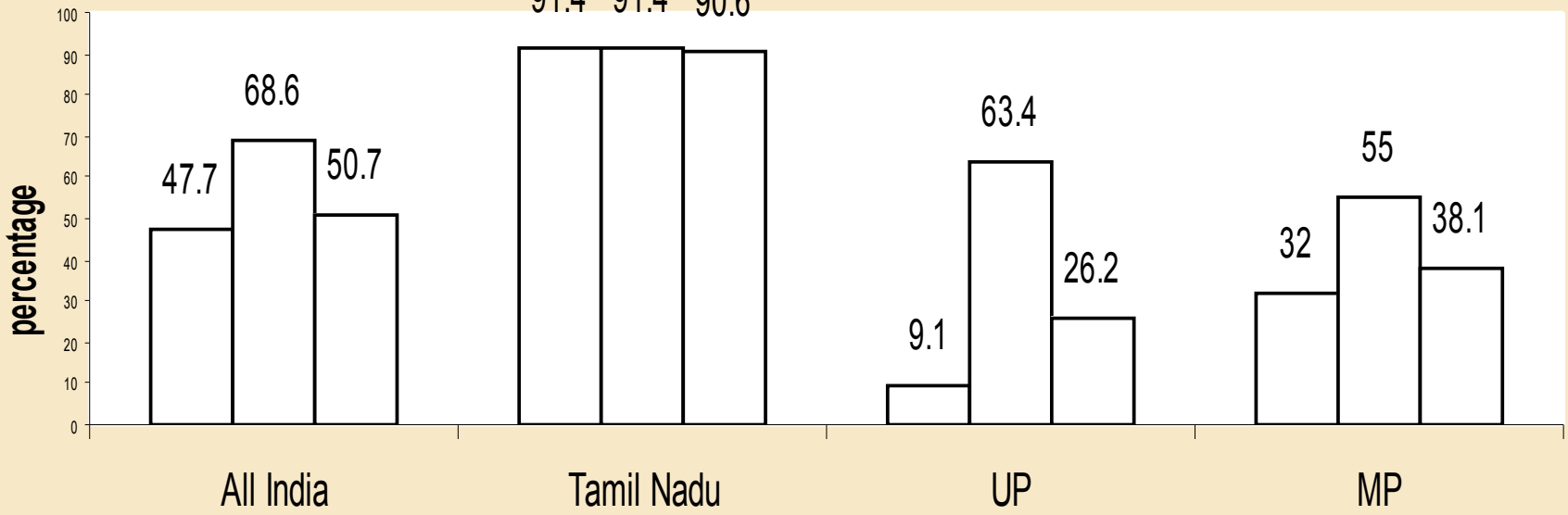
Less developed States considerably worse than National Situation



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Take home messages

1. Urban Poor constitute one-fourth of India's poor
2. Growth rate of Urban slum population is almost double that of urban population in India
3. Health conditions of urban poor are similar to or worse than rural population
4. With lack of sanitation, drainage and water services slum settlements are the most life threatening environments
5. Health conditions of urban poor in less developed States worse-off than the national situation

Challenges and Opportunities

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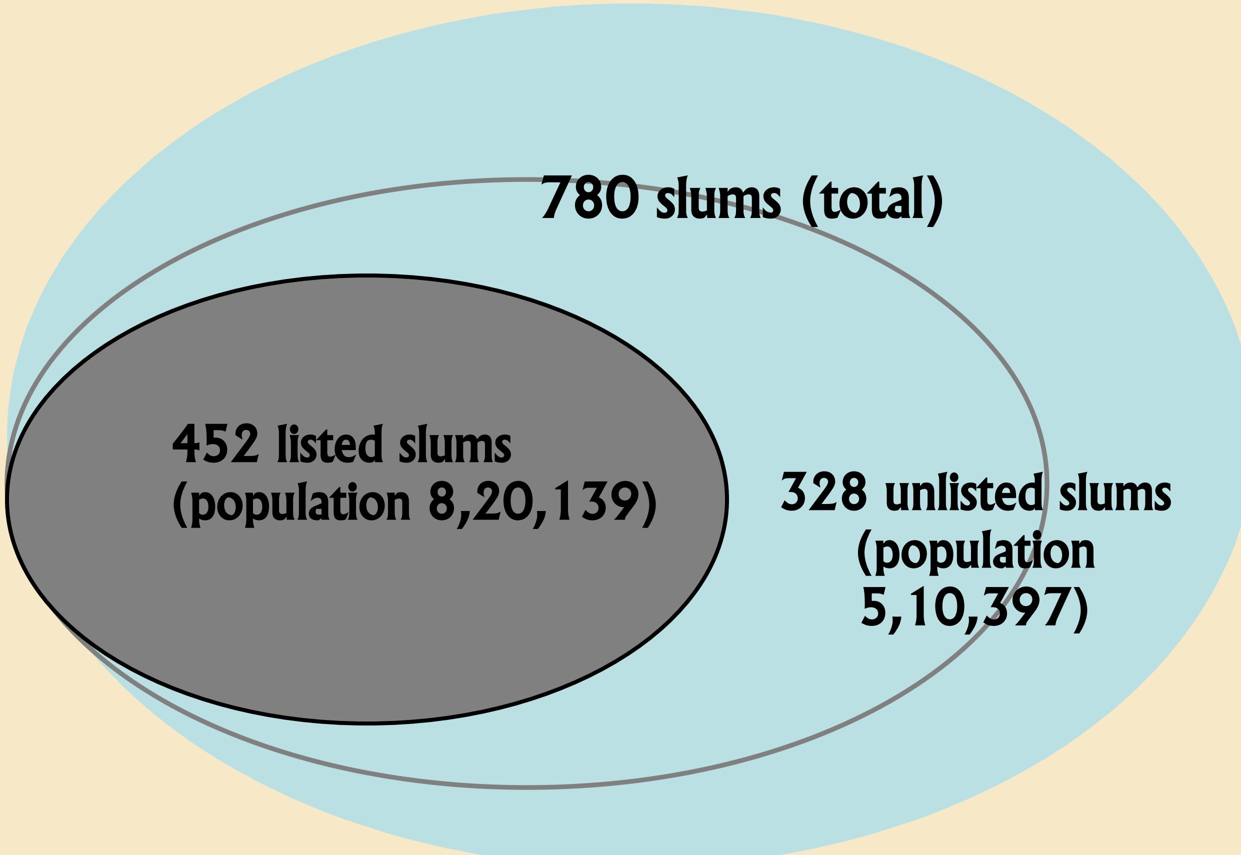
Challenge 1

Urban poor searching for citizenship

Considered ‘Illegal’ and unwanted despite the vital contribution of this large informal work force

Few rights as urban citizens and consequently little power to influence their circumstances

Challenge 2:
Large proportion of slums are invisible



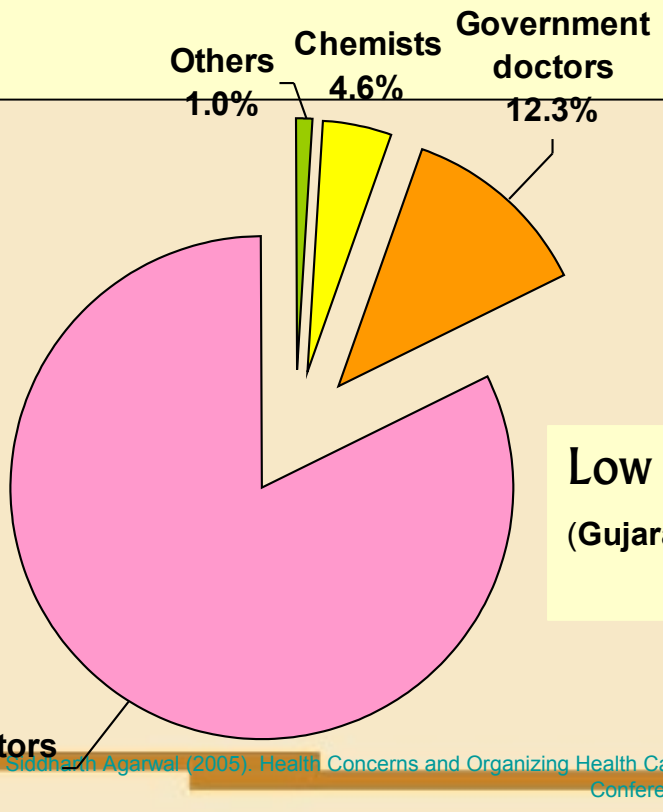
Findings (listed vs un-listed slums) from Agra (215 vs 178), Dehradun (78 vs 28), Bally (75 vs 45), Jamshedpur (438 vs 101)

Besides unrlisted slum settlements, urban poor also include pavement dwellers, population residing in construction sites, fringes of the city, floating population etc

Challenge 3:
Inadequate Urban Primary Health Infrastructure

There is one UFWC/HP for about

1.5 lakh urban population



Low utilization of public health services in urban slums

(**Gujarat State-wide Multi-Indicator Cluster Surveys (MICSs), 1996)**

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Challenge 4:
Weak Demand Among Urban Poor

- Low awareness about services, behaviours and provisions
- Weak community organization and social cohesion
- Weak negotiation capacity

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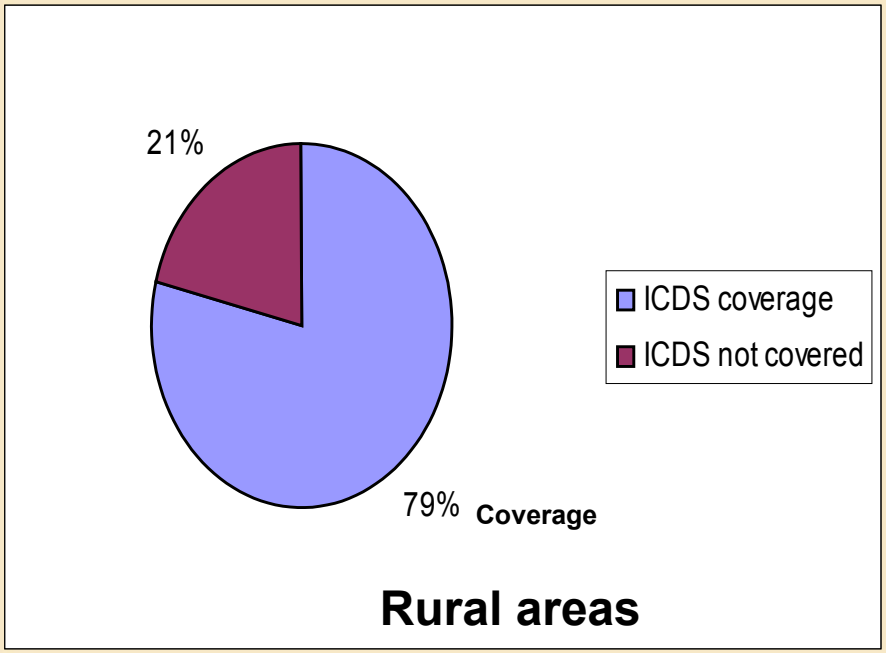
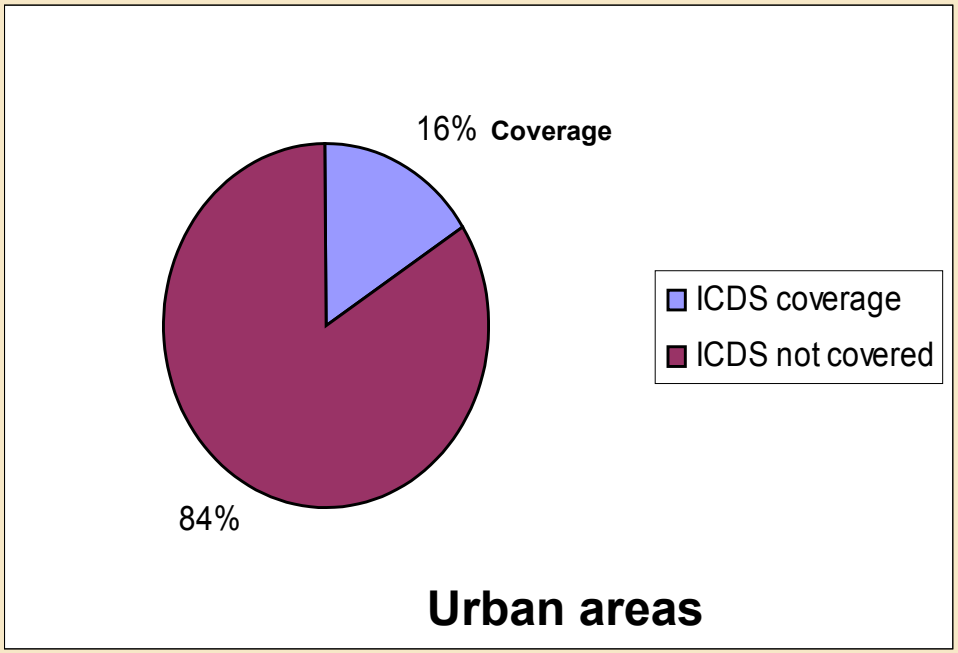
Challenge 5:
Greater focus on rural areas

ICDS Coverage Differentials





Source: Department of Women and Child Development, Ministry of Human Resource Development. Integrated Child Development Services (ICDS), New Delhi.2000.

Challenge 6:

All slums are not equal…

Most Vulnerable

Moderately Vulnerable

Less Vulnerable

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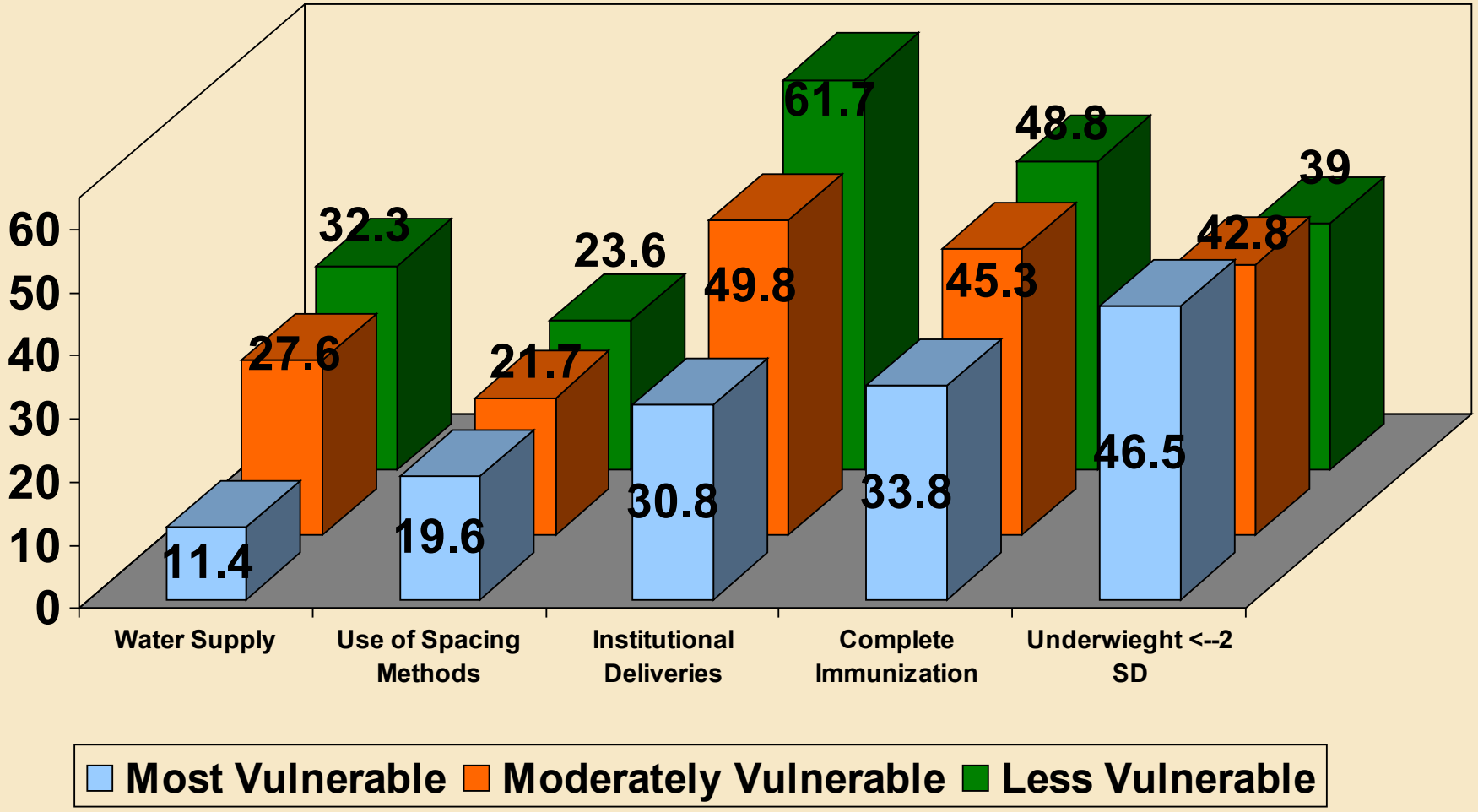
…Hence the Need to Prioritize Most Vulnerable



Reference: EHP, 2004:Indore Slum Maternal and Child Health Survey

Take home messages

- Issues like illegality, social exclusion, threat of eviction result in a sense of resignation among slum dwellers about their surroundings and wellbeing.
- Inadequate public Urban Primary Health Infrastructure makes urban poor more dependent on unequipped informal sector or expensive private sector.
- Urban poverty has been neglected while most attention has been on rural areas
- There is a need to prioritize the most vulnerable urban poor within cities

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Opportunities in Urban Areas

- Growing recognition of the problem and burgeoning interest among Government agencies, corporate sector, donors and NGOs
- Resources and Potential Partners available for collaboration
- NRHM has projected a separate financial outlay for Urban Health
- Urban Poor clusters geographically approachable
- Easier to reach with communication activities

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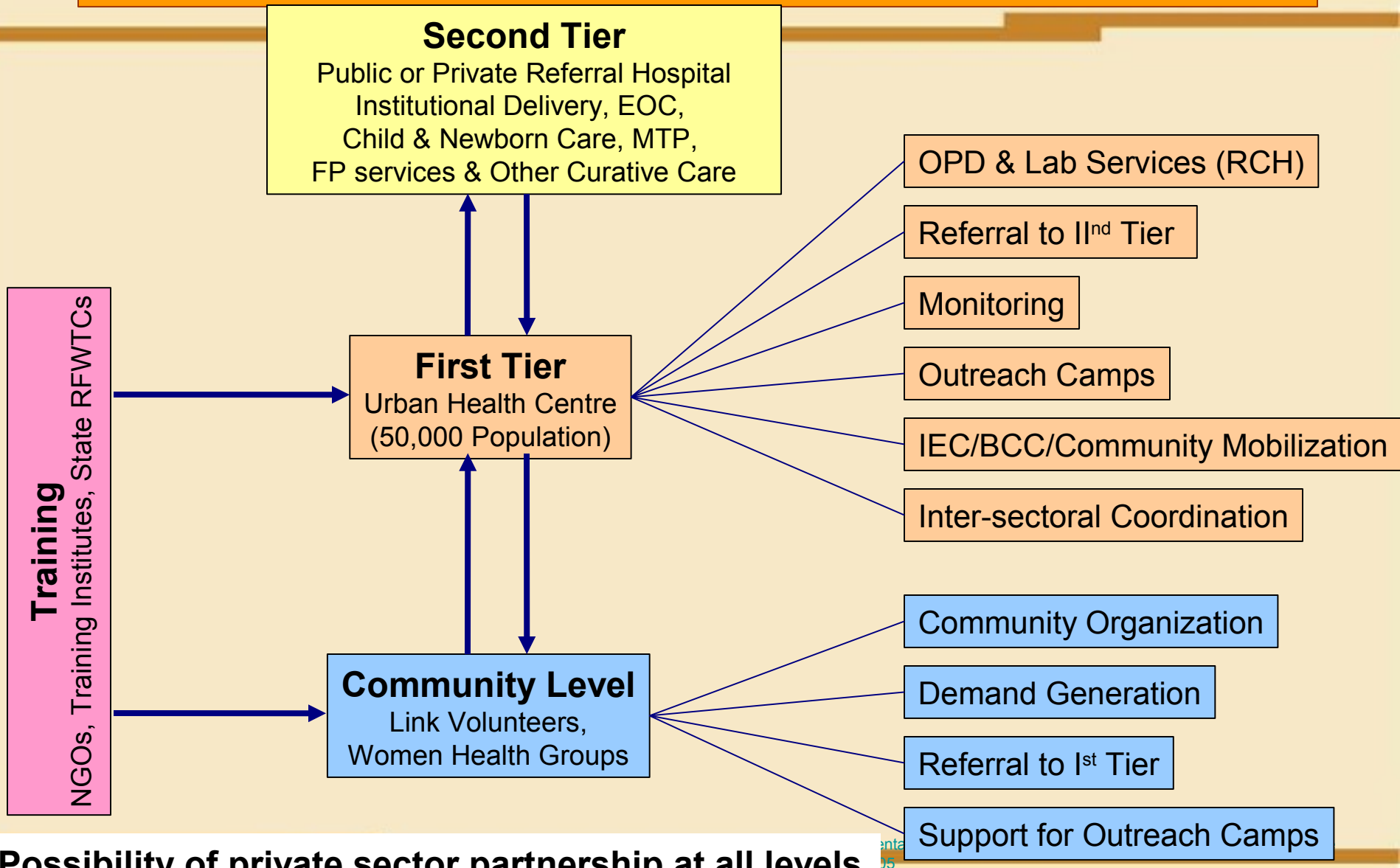
MOHFW's Urban Health Guidelines (2004)
Proposed service delivery model



Possibility of private sector partnership at all levels

The Possible Approaches

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Approach 1:
Strengthen Supply/Services

- Identify and map all urban poor **(e.g. Map of Agra)**
- Strengthen Urban Health services including outreach activities with focus on vulnerable urban settlements
- Promote Public Private Partnership for expanding and improving health service delivery
- Develop inter-sectoral mechanism at different levels
- Motivational training to health providers (ANMs, Supervisors, MOs)

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Approach 2:

Strengthen Demand and Community Behaviour

- Increase awareness about optimal behaviors, services and provisions
- Enhance capacity of slum communities to negotiate, improve behavior by strengthening CBOs (youth clubs, Mohalla Samitis, SHGs)
- Identify and train Community Health Volunteers in slums to strengthen community-provider linkages through NGOs
- Ensure that demand is met with increased availability

Approach 3:
Public Private Partnership

Private sector caters to most of the health needs even among the poor

- PPP can be an important strategy for meeting the critical public health challenge of quickly expanding services in urban areas.
- Utilizing existing private infrastructure (where available) rather than building new infrastructure saves time and costs eg. in Guwahati
- PPP can help in improving quality and broadening range of services
- Most vulnerable slums can be covered through Public Private Partnerships eg. Bangalore
- Private NGOs can help improve community demand and hence increase utilization of existing services

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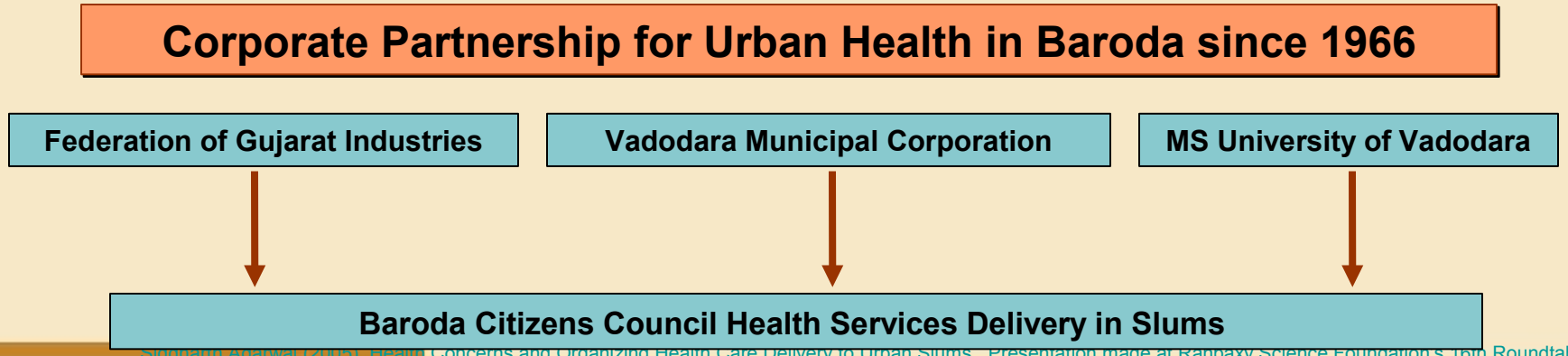
Approach 4:
Better Policies and Policy Implementation

- Increased attention and resources to the urban poor
- Improve policies to make them more urban poor friendly, practical and measurable
- Ensure energetic policy implementation by training of officers and increased information to urban poor
- Real progress on inter-sectoral approaches is vital
- Identify and address policy constraints to PPP

Potential Role of Corporate Sector

- Supplement Health Investments and services needed to address urban health challenge
- Sharing of expertise pertaining to demand generation, marketing and management
- Advocacy for enhanced attention to health of urban poor population

Example of Corporate supported Urban Health Efforts



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Possible Strategies for Corporate Partnership in Urban Health

Strategy 1 :

Setting up a Urban Health Centre (in a rented building) with annual recurring costs ranging between Rs. 12-15 lacs

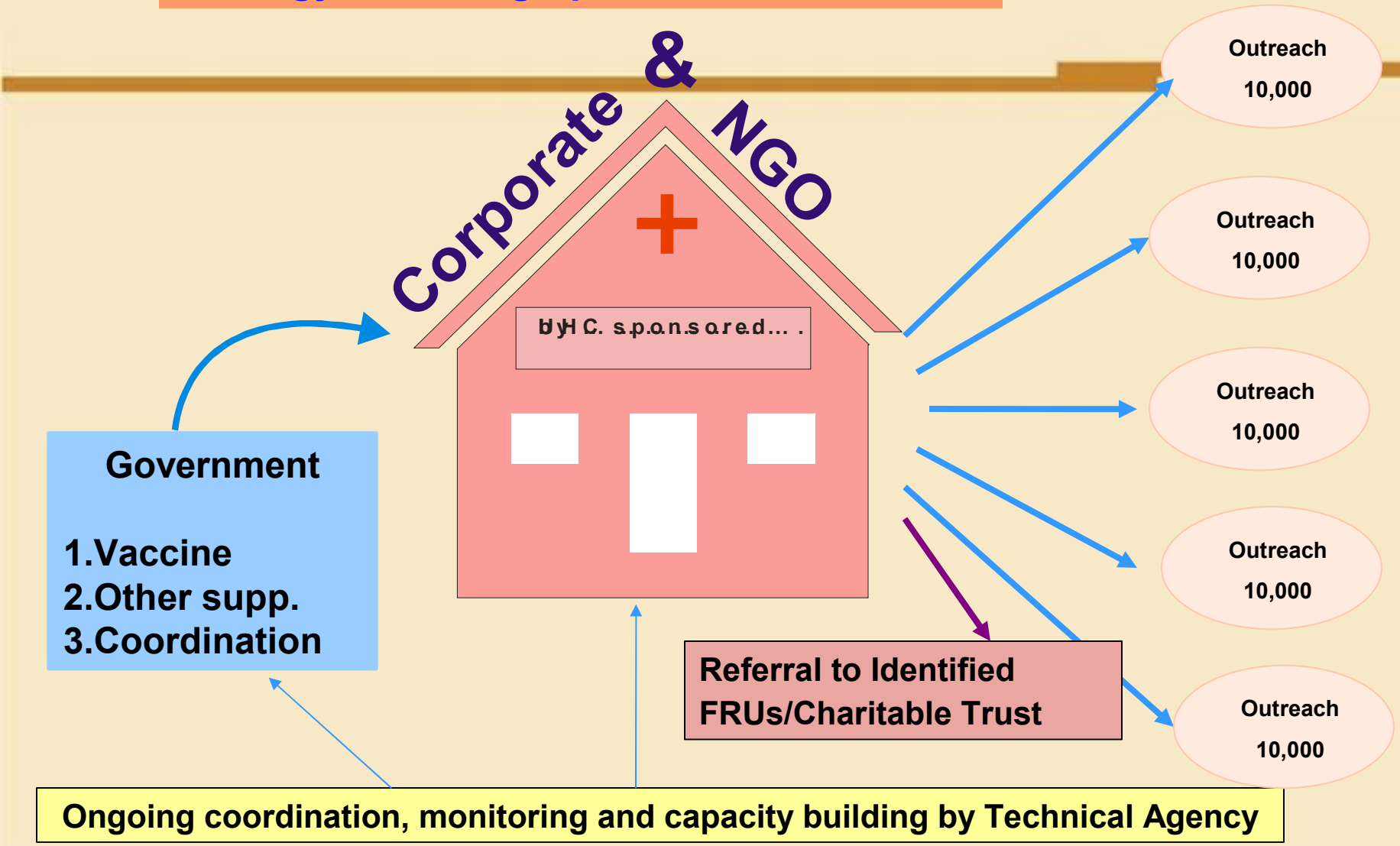
Strategy 2:

Strengthening service delivery through outreach by supporting a Mobile Health Care Van with an estimated capital cost of Rs. 7.5 lacs and an annual recurring expenditure of Rs. 10.5 lacs

Strategy 3:

Adoption of Slum Clusters for Improved demand generation, strengthening of community-health facility linkages at an annual recurring cost of Rs. 2 lacs

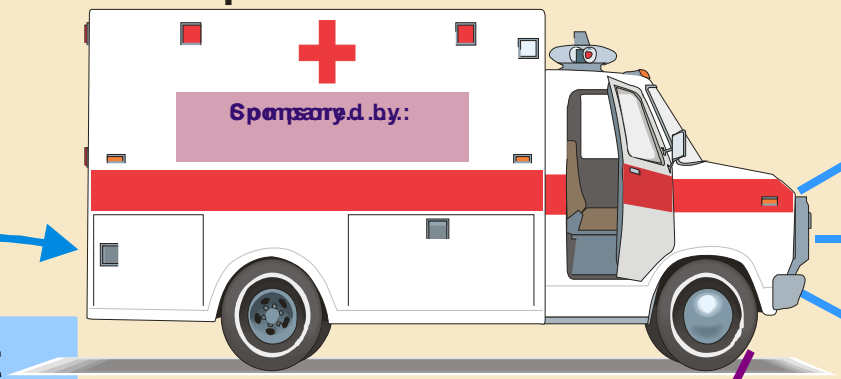
Strategy 1: Setting up a New UHC



Eg.Tata Steel Family Initiative Foundation operates 21 MCH clinics in urban Jamshedpur

Strategy 2: Bringing Health Services to Un-reached Slums

Corporate & NGO



Government

1.Vaccine
2.Other supp.
3.Coordination

Outreach
10,000

Outreach
10,000

Outreach
10,000

Referral to Identified
FRUs/Charitable Trust

Ongoing coordination, monitoring and capacity building by Technical Agency

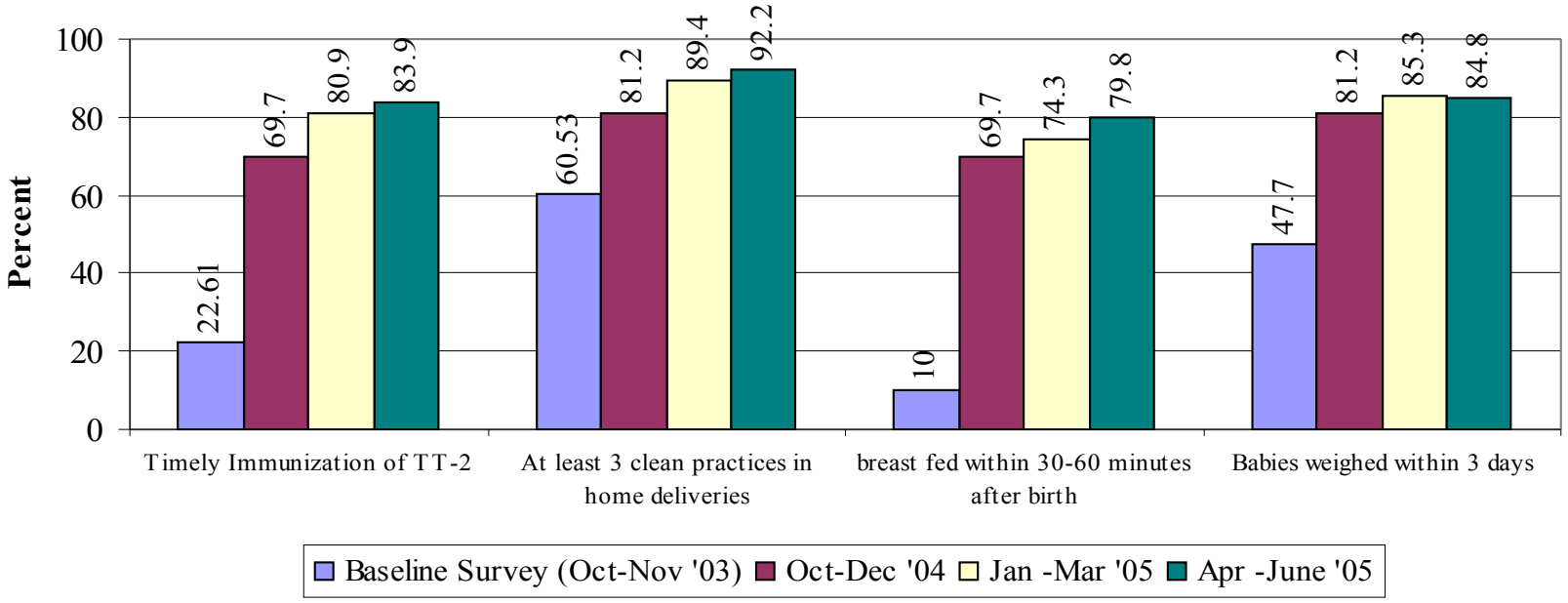
Eg. Ranbaxy RCH Society currently operates 7 mobile health care vans in different parts of India

Strategy 3: Adoption of slums for demand generation, strengthening of community-provider linkages and improved services

Demand, Supply and Linkage Approach in Indore

Improved Health Outcomes in Indore Nov -03 to June 05

Figure 1 : Select Health Service Coverage and Behaviour Indicators - Pre-Post Comparision (Oct-Nov '03 to Apr-June '05)[1]



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Let us build bridges of enablement for a healthier tomorrow

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