

Nutrition and Health Services to the Urban Poor

Urban Poor is a rapidly increasing segment of India's population: With more than 90 million people living in urban poor settlements, the rate of urban poverty in India is staggering. An analysis of population growth trends between 1991 and 2001, show that while India grew at an average annual growth rate of 2%, urban India grew at 3%, mega cities at 4% and slum populations rose by 5 to 6%. These numbers are expected to rise and if the predictions are correct, then in the next 25 years the number of urban poor could end up in excess of 200 million .

Childhood malnutrition among urban poor is similar to or higher than rural poor: Prevalence of malnutrition among the urban poor is a cause of major concern. Based on re-analysis of National Family Health Survey 2 (1998-99) data by Standard of Living Index, 56.8% of less than 3 years old children (about 4.5 million), among the urban poor are malnourished. This figure is similar to malnutrition rates among rural poor. The situation is far worse in lesser developed states like Madhya Pradesh where 72.4% urban poor children are malnourished. But the magnitude of the problem is diluted by the misleading urban average data that we generally see.

Poor Living Environment further adds to health challenges of slum dwellers: Inadequate sanitation, hygiene and water (a predominant feature of urban slums), results not only in more sickness and death but also in higher health costs, lower school enrollment and retention rates and lower work productivity. Poor living environment in urban slums therefore, calls for greater attention of service providers and coordinated action by the Integrated Child Development Services (ICDS) and other concerned departments.

Current Urban ICDS Coverage grossly inadequate: As per official data (from the Dept. of Women and Child Development, Govt. of India) of September 2005, there are 360 Urban ICDS projects catering to about 90 million urban poor. This would mean coverage of a little over one-third. The program has added 82 projects since the recommendations on ICDS by the National Advisory Council in 2004 which indicated a requirement of 2,970 projects to universalize ICDS in urban India. The present coverage, however, is still woefully short of the requirements of this rapidly growing and vulnerable population.

Many Urban Poor remain left out from nutrition and health benefits of ICDS: As high as 40 % of slums in cities remain excluded from official slum and ICDS lists. The BPL lists and slum lists used to identify beneficiaries may exclude the 'hidden' construction site workers, pavement dwellers and yet to be notified slums.

Such exclusion leaves these vulnerable sections out of the ambit of many government programs including ICDS. Further, the lack of flexibility within the system to relocate an AWC from a no longer vulnerable area, in dynamically evolving urban scenario, results in several AWCs operating in better off areas leaving many a needy clusters bereft of such services..

Moreover, since ICDS has traditionally followed a target-based approach owing the focus on supplementary food (which had to be supplied as per the number of beneficiaries) Anganwadi workers (AWW) often stop listing children/families beyond the mandatory number of beneficiaries. In many instances it is the socially more powerful families that get listed. In urban slums there is a gross

scarcity of space and in many cities AWCs have been noted to operate in small spaces of 6'x6' which is the best that the AWW is able to arrange in a slum house. Such situations also impacts functional efficiency of ICDS program .

Suggestions for the Way Forward:

Expand ICDS coverage to left-out slums and needy areas: Following the Supreme Court decision of universalization of food security (nutrition) programs ICDS is being expanded to several urban areas. However the process of proposals for expansion of ICDS services coming from Districts, via State Governments to the Central Government contributes to the tardy progress. Given the current political commitment including focus on the urban poor under NRHM / RCH II, the Department of Women and Child Development is proactively processing and sanctioning all proposals received. Civil society uproar generated from time to time will help expedite this process by providing the necessary social push.

Reach the un-reached and prioritize the more vulnerable: To reach the benefits of ICDS to the all urban poor it is vital to update ICDS lists through identification and mapping all listed and unlisted slums/urban poor clusters. It is also vital to identify the neediest for prioritisation. It is in this segment that childhood under-nutrition is highest. Criteria for priority ranking could include factors, such as access to safe water and sanitation facility, existing program interventions, presence of collective community efforts, average family size, rather than solely relying on income surveys.

Achieve quick expansion of services through Public-Private-Partnerships: Examples from Gujarat, Madhya Pradesh, Karnataka, Delhi and other States show that NGOs can very efficiently manage one-two ICDS projects in a city. There are several clear benefits of partnership with a non-profit organization for running ICDS projects: a) This can be an important strategy for quick expansion of ICDS programs to needy slums. b) Further, contracting out urban ICDS projects to NGOs / charitable institutions / trusts would avoid program disruptions owing to transfer of officers as is commonly noted in the Govt. system. c) The private institution can link the community with its other programs (such as SHG program of Sumangli Sewa Ashram in Bangalore) maximising benefits to people. d) If the NGO entrusted with managing an ICDS project also runs a health facility, the community would receive greater benefits in terms of the health services. Such partnerships should be proactively encouraged.

Urban situation responsive adaptations could be considered: Urban poor habitations are normally heavily dense settlements. Hence the local authorities should have a scope for considering a situation specific norm for population coverage per AWC. Depending on the situation the following options may be considered:

In medium sized cities e.g. Agra, Indore, Patna, Meerut, an AWC could cover a slum catchment of 175-200 households which would mean approximately 1000 to 1200 population. In small slums there may be one AWC but in large slums the number of centres may be 2 to 3 depending on the slum population. Such an AWC would have the usual one AWW and one helper.

In large cities (e.g. Delhi, Mumbai, Kolkata, Bangalore) in some very dense areas the population density may be as high as 29.397 persons per sq. km. as is the case in Shahadra North zone of Delhi. In such densely populated slum areas, it may not be feasible to find adequate space for an AWC for every 1000 population. Hence, an need based adaptation of one AWC covering 2000 to 2500

population could possibly be tried out. If community halls or similar places are available within the slum, coverage of this population could be done by an AWW and two helpers. A somewhat similar adaptation in the form of Anganwadi Sub-centres, has been implemented in tribal areas in Madhya Pradesh, Chhatisgarh and some other States. Instead of the additional helper, school going adolescent girls could also assist the AWW in covering the larger than usual population. In the absence of a community centre or a large space which is usual in a slum context, the AWC may have to be run in two shifts each managed by one AWW and a helper.

Construction site settlements which are usually small but vulnerable unlisted clusters could be catered through extension services of a nearby AWC. Considering working mothers in urban poor clusters it may be worthwhile to pilot ICDS centres run as crèches with a linkage to the Rajiv Gandhi National Chreche Scheme. These could be part of Public Private Partnership initiatives where the crèches could be managed by NGOs.

Special Training to AWWs and change agents to build social capital among slum communities: Issues like illegality, social exclusion, uncertainty of land tenure, threat of eviction, and being forced to live in a disabling environment result in a sense of resignation among slum dwellers about their surroundings and wellbeing. Other factors like heterogeneity among slum dwellers due to in-migration from different areas, varied cultures, fewer extended family connections, and more women engaged in work leads to lesser willingness and fewer occasions to build urban slum community as a strong collective unit. Five action points clearly emerge: i) Training of AWWs should include a urban specific focus on issues and challenges faced by slum communities in the wake of vulnerabilities mentioned above. This section of the Urban AWW training curriculum could be developed in consultation with organizations working with urban poor communities and will enable the worker in better supporting their communities evolve into cohesive social units and thus lend them a stronger negotiating force for various services and challenges they face. ii) It is crucial for the AWW to involve change agents and/or community groups representing all segments/clusters of the slum, and build their capacity on maternal-child health and related matters. iii) It is very crucial to have AWW and helper from the slum/locality (those having experience in Government or Non-Government programs) to build social capital in the slums. iv) Involvement of adolescent girls from slums, for example, under the Kishori Shakti Yojana or Balika Samridhhi Yojana should be encouraged. These girls can be trained to support the AWW besides being provided nutritional supplements. v) Promoting women's group and strengthening their capacities to collectively address RCH issues within their slum catchments, has been successfully tried out in many health program. Women's groups can support AWW in improving delivery of ICDS service package within the slum.

Strengthen monitoring: The relevance of regular and high quality monitoring is not under any debate. A robust mechanism at City level for training CDPOs, supervisors in monitoring in a fashion that is supportive to the AWWs and helpers in enhancing the quality of their services is crucial. An action group involving representatives from agencies which can support such monitoring as well as training of officials in supportive supervision could be worth considering. Now that our country is in no real resource constraint in terms of its ability to spend on expansion of grassroots public health programs, it is vital to ensure that the resources are well spent and attain the envisaged goal.

Partnership with Academic Bodies and Training Institutions: Several cities have Home Science (Nutrition) Colleges, Social Work Institutions, which could be , partnered with for running model ICDS projects through their respective extension departments. The field projects under their curricula may be in the same area so as to facilitate close monitoring and handholding of the AWWs.

Partnership with training Institutions for help in building capacity of AWWs, Supervisors and the community can also be an important approach as we move towards expanding urban ICDS services.

Interdepartmental convergence: Interdepartmental convergence at city/district or sub-city level coordination forums with representation from various departments such as Health, Education, DUDA, Municipal Corporation/Council would help achieve a synergistic impact as well as expansion of interventions e.g. convergence between ICDS and Rajiv Gandhi National Crèche Scheme – wherever ICDS projects are being contracted out to NGOs, the latter scheme also could be implemented in the area by the same partner to facilitate convergence at slum level.

Together we can; let us commit ourselves:

The urban poor who are already at risk of disease from poor environment, malnutrition and other ailments are forced to sacrifice their irregular and uncertain livelihood to attend to the ailing children and mothers. These entire circumstances act together to ruin the urban poor who, from their meagre resources (or from borrowings at grossly unfair interest rates), must spend whatever they can to deal with that which is of greatest importance to them — namely their health. And they get hit both by the continuation of illness and economic ruination. A well implemented urban ICDS program can prevent a large proportion of such ruination by a) preventing a substantial proportion of disease and under-nutrition, b) proving guidance to pregnant mothers to take adequate care, c) linking families to essential health services in the vicinity and helping the slum communities evolve into a socially more confident and cohesive unit which can support the families in need and help them lead a healthier and happier future.

Let us commit ourselves to take the world's most far-reaching community based public health program to reach the millions of underprivileged city dwellers who despite being in the neighborhood of India's growing millionaires continue to suffer social, nutritional, health and capability deprivation.

Authors:

Dr Siddharth Agarwal, Anuj Srivastava, Karishma Srivastava, Kirti Sangar, Ayushi Agnihotri