Toward Eliminating Urban Poverty Seminar Series
Improving Child Health and Nutrition in Urban Slums in India: A Consultative Program Approach

Dr. Siddharth Agarwal
Country Representative and Urban Health Director
EHP-USAID India Urban Health Program

The Challenge

Urbanization in India

Uncontrolled inward migration and increasing population density is resulting in the unplanned development of cities. Over the 1991-2001 decade, the rural population in India grew by 18 percent, whereas the urban population showed a growth of 31 percent.1 According to UN projections, it appears very likely that urban India will march ahead of rural India in terms of population by 2025.

The quest for better livelihood opportunities has led to large-scale migration and the mushrooming of slums in Indian cities. Unfortunately, the urban poor do not have access to many of the benefits of urban development.

In the last decade, as India grew at an average annual growth of two percent, urban India grew at three percent, mega cities at four percent and slum populations rose by five percent (aptly summarized by a demographer as the 2-3-4-5 syndrome). One of every four Indian citizens is now living in an urban area. Many live in slums or illegal squatter settlements without basic infrastructure and public services, and are currently defined as "poor" or "very poor."

Health of the urban poor

Recent studies have shown that the health of the urban poor is as bad as or worse than that of their rural counterparts. As a result, there are thousands of unnecessary maternal, child and adult deaths, and millions of days of disability and productivity lost each year.

Table: Determinants of Child Health among urban poor in India*

<table>
<thead>
<tr>
<th></th>
<th>Urban Poorest</th>
<th>Rural Poorest</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR</td>
<td>121.2</td>
<td>108.9</td>
</tr>
<tr>
<td>USMR</td>
<td>143.6</td>
<td>155.0</td>
</tr>
<tr>
<td>Children Stunted %</td>
<td>69.3</td>
<td>55.2</td>
</tr>
<tr>
<td>Complete Immunizations %</td>
<td>36.6</td>
<td>17.1</td>
</tr>
<tr>
<td>Home Deliveries %</td>
<td>80.5</td>
<td>93.5</td>
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</tbody>
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1 Census of India, 2001. Provisional Figures
3 Town and Country Planning Organization, quoted in MOHFW, Govt. of India presentation, 2002
4 Socio-economic differences in HNP, Gwatinke et al., World Bank, 2000
In the central Indian State of Madhya Pradesh, the initial site for this program, determinants of infant and child health show a dip for the worse in the low-income urban groups. Infant mortality is more than twice as high and child mortality is practically three times as high among children in households with a low standard of living index as among children in households with a high standard of living index.

Similar studies for Indore, industrial hub of Madhya Pradesh and the first project site, are not available. However, focus group discussions with slum dwellers, observations during transect walks and interactions during the past several months suggest that the picture in Indore would be very similar.

The state of health of the urban poor vis-à-vis the rich clearly underlines the significance of targeting resources and efforts where they are most required. This is all the more crucial in urban programming because (a) average statistics (which are the common form of data available) reflect a skewed image of the health of the urban poor and (b) poor urban dwellers very often reside in unrecognized pockets and hence are missed by development programs.

**Multiple Stakeholders**

With a backdrop of compromised child health status in urban slums, the India Urban Health program is presented with a large multitude of stakeholders in Indore:

- **Public sector services:**
  - Dept. of Public Health – principal public sector providers of preventive and curative health services
  - Municipal Corporation – responsible for water supply, sanitation, drainage and overall governance issues
  - Dept. of Women and Child Development – provide nutritional supplements (for pregnant and lactating women and children) and health and nutrition education at the community level.
  - Employees State Insurance Services (ESI) – these services have a good presence in some parts of the city and cater to a good proportion of slum population.

- **NGOs**, which represent organized civil society, and engage in efforts at community development and strengthening linkages with development schemes of the Government.

- **CBOs** that are the organized face of the community and have a large presence in the slums of Indore. Most of these began as self-help and micro-credit groups or neighborhood development associations and many now have significant development experience.

- **Private providers** (largely unorganized and belonging to the informal sector) – they serve a large proportion of urban slum dwellers;

- **Charitable hospitals** - provide preventive and curative services in several areas of the city, and could play a still more effective role in providing health services to the underserved urban poor.

- **Corporate sector** – potentially can have a sizable role. Several major Indian corporate entities have been considering the issue of “corporate social responsibility” more persistently over the last decade.

**The USAID-EHP India Urban Health Program:**

**Goal and objectives:**

The goal of the program is to bring about sustained improvement in child health in urban slums in select cities in India.

The main objectives are:

- Increased coverage of services and adoption of key health behaviors in neonatal survival, diarrhea control and other child health priorities

- Improved capacity of CBOs, NGOs, private and public sector health providers in health behavior promotion, use of child health data, and building partnerships.

- Better targeted policies and increased allocation of resources for urban slum health

- Development of replicable models for urban child health programs.
Technical focus of the program:
- Diarrhea prevention and management
- Care at birth and newborn care
- Immunization
- Malnutrition
- Pneumonia

Expected Outcomes
To serve as a guide to implementation, the program envisages the following as outcomes over the next two years.

A. Improved adoption of emphasis child health behaviors and coverage of key services
E.g.: Lowered diarrhea incidence, improved hand-washing and related practices; Greater child immunization coverage and reduced drop out; Increased tetanus vaccination coverage among pregnant women; Increased births by trained attendant; Improve neonatal care (early initiation of and exclusive breast feeding, warmth, infection prevention, recognition of danger signs and appropriate extra care of sick baby); Increased clean birth practices.

B. Urban Health Models evolved and documented
- UHP implemented and effectiveness of approach monitored in five slum clusters of two cities;
- Models for developing and implementing city urban health program documented.

C. Coordination mechanisms in place
- City Urban Health Alliance functional and ward level core groups active in two wards in Indore.

D. USAID supported TA and Capacity Building
- Neonatal care, BCC, and counseling included in training curricula of health workers, training modules available;
- Needs-based technical assistance provided to public sector agencies and others.

E. Private practitioners:
- One approach to working with private practitioners developed & tested in terms of improved quality of care.

F. Improved Capacity of CBOs
a. Twenty CBOs (Indore) show three of the following capacities:
   - Two representatives have adequate technical child health knowledge;
   - CBOs develop capacity to monitor and track practices;
   - CBOs demonstrate improved BCC capacity (e.g. composing and chanting health songs);
   - CBOs establish linkage with health service providers of at least two public sector departments.

b. Ten CBOs have a Health Fund dedicated for the basti (slum neighborhood) health program.

The Approach in Indore
The approach followed in Indore, the first program city, has been a consultative one focusing on learning from stakeholders and collectively identifying program directions. Three activities that have been going on simultaneously are:
- Situation analysis/data compilation;
- Health vulnerability assessment and mapping of slums; and
- Evolution of partnerships and coalitions.
Situation analysis included compilation and analysis of child health data from secondary sources, collection of primary data through rapid qualitative methods (primarily focus group discussions), assessment of capacities of NGOs and CBOs, assessment of service coverage and of the systems and structures that support these services. The vulnerability assessment was conducted as a participatory activity with the community represented by CBOs and NGOs and of public sector employees. The criteria of health vulnerability identified by the stakeholders were qualitative and were applied subjectively to groups or clusters of similar slums based on the local residents’ understanding of the slums. The consensus among all participants in the multi-stage assessment indicated that despite the qualitative and subjective method used, the list of health vulnerable slums is understood similarly and consistently by all. Through a series of consultations with several sets of stakeholders, some key partnerships are emerging. These are described below.

Two major program activities that will be undertaken by the program over the coming year are:
- Multiple Stakeholder Capacity Building involving systematic needs assessment, training, mentoring, and other capacity building activities;
- Behavior Change and Service Improvement through formative research and other information collection, and technical assistance to NGOs, CBOs, health service providers.

**Partnership Models**

The UHP, through its intensive and consultative interactions with the various stakeholders and players in Indore, is arriving at several models for working in partnership arrangements between the NGO/CBOs, the other service providers and municipal authorities and departments. Different models will be put into practice and the results documented for future similar efforts.

**Partnership Model I: NGO-CBO partnerships**

This partnership model aims at enhancing demand and strengthening community linkages with Auxiliary Nurse Midwives, Anganwadi Workers, charitable hospitals, and other providers. It is not based on geographic divisions of the city, but on the reach of CBOs and NGOs in the slums communities.

I a.

**NGO Builds Capacity of Lead CBO**

![Diagram: NGO with Health and Capacity Building Skills](image)
NGO Working Directly with Slum Based CBOs

Partnership Model II - Ward Level Core Group Model
Focused on improving quality and coverage of Public Sector services through better coordination and community linkage.

Envisaged role of the Ward-level Core Group:
- Review, monitoring and tracking of quality and coverage
- Strengthen information system
- Develop participatory monitoring tool
Partnership Model III: ESI and NGO-CBO Partnership

III. a. The Employees' State Insurance Services have nine outreach dispensaries in Indore that provide basic health services. ESI propose that coverage through these dispensaries and the quality and efficiency of services can be strengthened through partnership with NGOs and CBOs of the area.

III. b. ESI Mobile clinics:
ESI, in addition to the nine dispensaries, have a mobile van, which has been out of use for the past couple of years and can be revived with some effort. This van can provide basic preventive and first contact curative services at ten locations. The locations for this mobile dispensary can be planned for it to be effectively utilized to reach slums where the State Department of Health has insufficient reach. NGO-CBO partnerships can help in planning locations, establishing linkages with communities and also perhaps trying a system of cost recovery.

Conclusions/Findings/Lessons

The consultative process adopted has helped the team learn a good deal about programming options and likely effective approaches. Following are some early lessons:

Health Vulnerability in Slums:
- One-fourth of 325 Indore slums are vulnerable for child health. This understanding will help in targeting resources efficiently.
- Majority of vulnerable slums have CBOs, some active for more than ten years. CBOs will perhaps serve as the critical link with communities and families and also help in strengthening community capacity to positively contribute to urban health efforts.

Vulnerability as seen by the Community:
- Community representatives (CBOs and NGOs) defined criteria for assessing health vulnerability of different slums and identified the following as vital criteria: Economic and social issues, environment (water, drainage, and sanitation), access and quality of public health services.
access to fair credit and collective slum improvement (CBOs). Communities are able to identify issues associated with varying health vulnerability among different slums and such a participatory vulnerability mapping helps in targeting resources adequately.

- Some slums have been repeatedly been fortunate to benefit from slum development or related programs and schemes, whereas many slums are yet to have such benefit. This also contributes to the level of health vulnerability in different slums.

**Services and Linkages:**

- Public sector services, coverage and information systems require strengthening.
- Linkages between public sector and communities need strengthening and are crucial to improving the reach as well as the quality of these services.
- Currently, Integrated Child Development Scheme (ICDS), a grass-roots nutrition and health program of the Government, reaches a very small proportion of the identified vulnerable slums in Indore. Expansion of this program is important to enable the urban poor to benefit from the services.

**Partnerships and Coordination:**

- Partnerships and coordination among Public Sector and Civil Society Organizations and Corporate Sector is a workable way for programming and is essential for achieving positive child health outcomes. Several partnership options have emerged and a city level Urban Health Forum is likely to be institutionalized soon.

**The Private and Civil Society Sector:**

- Private not-so-qualified providers and Dais (TBAs) serve a large section of slum dwellers, and efforts and innovative approaches are required to integrate them in the quality service provision mechanism.
- Charitable hospitals are potential channels for strengthening slum health services. They could be motivated to take up preventive health services in identified clusters.
- A good mix of community mobilization and health skills is available among NGOs and CBOs. Several CBOs and NGOs are engaged in BCC activities and are keen to target such activities for promotion of child health among slum dwellers.

**Child Health in Slums:**

- Community child health priorities reaffirm program priorities. (Additional priorities that emerged are birth spacing, early child bearing among women and alcoholism).
- Urban averages disguise health inequities existing among different slums and delving deeper into urban poor specific data or using qualitative information helps to assess the real plight of the under-served urban slum dweller.
- Fifty percent of urban slum deliveries occur at home, and only 20 percent by trained personnel. Enhancing competence of birth attendants is critical.

**Awareness, Attitude, Traditions among Communities:**

- Breastfeeding, safe delivery practices, timely immunization are more likely to show an early positive trend through behavior change efforts than appropriate nutrition, birth spacing and early pregnancy, owing to a positive attitude among communities toward these practices.

**Approach:**

- Consultations with stakeholders is an important and instructive approach for program development, and help the program team better understand the situation and help stakeholders evolve a plan more responsive to the presenting challenge.
* Scoping out partnering arrangements and support requirements of the various city stakeholders engages them in the program. Despite the slow beginning and difficulties associated, such a process appears to best facilitate the emergence of partnerships.

Dr. Siddharth Raj Agarwal has worked for the past sixteen years in different positions and voluntary activities in the field of community and child health. He is currently the Environmental Health Project’s Country Representative and Urban Health Director for the USAID/India Urban Child Health Program, a multi-year effort to bring about sustainable improvement to child health in urban slums of India. Dr. Agarwal was part of USAID/India’s Review Team that examined options for “Enhancing Child Survival Impact” of the current PL480 Title II program and has been Project Manager for the Maternal and Infant Survival project in Madhya Pradesh for CARE India. This project targeted ten blocks in seven districts of Madhya Pradesh aimed at improving maternal and infant health through partnerships and building local capacities.