REACHING PRIMARY HEALTH SERVICES FOR THE URBAN POOR: LESSONS FROM INDIA URBAN SLUMS PROJECT

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The need and the challenge of providing PHC services to urban poor
Profiling urban areas
The India Urban Slums project – Objectives and Achievements
Key lessons learned
Rapid Urbanization

• For the first time in human history by 2015 more than a half of the world’s population will be living in urban centers
• Urban growth will be particularly rapid in developing countries, especially in Asia.
• UN projects that by 2025 nearly 2/3rds of the developing world will be living in cities
Inequities in health outcomes among urban residents
(India – NFHS 98-99)
Inequities in access to basic Reproductive and Child health Services among urban residents
(India – NFHS 98-99)
Actions for Urban Poor

- Enhance capacity and competence of City/Municipal authorities to manage urban development, safeguard environment and respond to the needs of all citizens especially urban squatters
- Improve 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 households
- Ensure balanced financing of infrastructure and services including equitable cost recovery
- Manage urban environment - Air, Water, Waste and Transport
The Challenges in providing Basic Services to Urban Poor

- Divisiveness of Urban Population
  Higher the heterogeneity of income, ethnicity and religion more the risk

- Rapid Population growth
  Higher growth in already densely populated areas

- Insufficient Economic Opportunities
  Growing number of well educated, unemployed youth

- Lack of life sustaining essentials -
  Potable water, sewage system, basic health and education

- Weak management -
  Ability of urban government to address, manage and fund growth

Development Objectives.

• Reduce fertility among slum populations
• Improve maternal and child health
• Improve contraceptive and maternal & child health supply logistics

Scope.
- 4 Metro Cities: Bangalore, Delhi, Hyderabad and Kolkata
- 94 Smaller Towns/Cities in the States of Andhra Pradesh (73), Karnataka (11) and West Bengal (10)
- States of Tamil Nadu & Uttar Pradesh (Logistics)

Cost.
- US$ 79 million equivalent
What has been achieved?

### Total Fertility Rate

- **Bangalore**: Baseline/SRS = 3.37, Endline = 2
- **Delhi**: Baseline/SRS = 5.1, Endline = 2.09
- **Hyderabad**: Baseline/SRS = 3.4, Endline = 1.9
- **Kolkata**: Baseline/SRS = 1.7

### Infant Mortality Rate

- **Bangalore**: Baseline/SRS = 78, Endline = 22
- **Delhi**: Baseline/SRS = 53, Endline = 69
- **Hyderabad**: Baseline/SRS = 81, Endline = 56
- **Kolkata**: Baseline/SRS = 26
**Contraceptive Prevalence Rate**

- **Baseline/SRS**
  - Bangalore: 40
  - Delhi: 33
  - Hyderabad: 42
  - Kolkata: 50

- **Endline**
  - Bangalore: 61
  - Delhi: 42
  - Hyderabad: 64
  - Kolkata: 52

**Children Fully Immunized (12-23 months)**

- **Baseline/SRS**
  - Bangalore: 50
  - Delhi: 56
  - Hyderabad: 50
  - Kolkata: 57

- **Endline**
  - Bangalore: 90
  - Delhi: 62
  - Hyderabad: 82
  - Kolkata: 89
Prenatal Care (3+Contacts)

<table>
<thead>
<tr>
<th>City</th>
<th>Baseline/SRS</th>
<th>Endline</th>
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<tbody>
<tr>
<td>Bangalore</td>
<td>71</td>
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Institutional Delivery

<table>
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<th>City</th>
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<td>72</td>
<td>54</td>
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<tr>
<td>Kolkata</td>
<td>89</td>
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Legend:
- Baseline/SRS
- Endline
How did the project contribute to the changes?

Improving access:
• 50-85% of antenatal services
• A third to half of contraceptive services
• More than a third of deliveries in Bangalore & Kolkata
• 17,401 Volunteer workers acting as change agents

Improving Quality:
• Skill based trainings to 13,127 paramedical and medical staff
• Uninterrupted supply of contraceptives and MCH supplies
• Client Responsive Services – Female Providers, Privacy, Cleanliness
• ISO 9002 Certification in Bangalore

Increasing Demand:
• Strategic focus on behavior change through IPC
• Early prenatal registration; Measles immunization, Safe deliveries; use of Spacing methods

Management Strengthening
TFR decline.

<table>
<thead>
<tr>
<th>City</th>
<th>Annual rate of change (NFHS) in Urban areas</th>
<th>Annual rate of Change in Project areas</th>
<th>Difference</th>
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<tbody>
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<td>-0.08</td>
<td>-0.17</td>
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<tr>
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<td>-0.08</td>
<td>-0.03</td>
<td>0.05</td>
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</table>
**IMR decline.**

<table>
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<th>Annual rate of Change in Project areas</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangalore</td>
<td>-2.28</td>
<td>-6.94</td>
<td>-4.66</td>
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<tr>
<td>Delhi</td>
<td>-2.72</td>
<td>-5.93</td>
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<td>Hyderabad</td>
<td>-2.58</td>
<td>-1.45</td>
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<tr>
<td>Kolkata</td>
<td>-6.18</td>
<td>-3.75</td>
<td>2.43</td>
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The Unmeasurables.

• Bringing health on to the Political Agenda through decentralization
  
  *Kolkata*

• Empowering the Adolescent Girls/women
  
  *Vocational Skill Training to 23,992*

• Building partnerships with Private sector
  
  *Kolkata (PTMOs and Specialists), Bangalore (IMA)*

• Contracting out clinical services
  
  *Andhra Pradesh in 192 health centers*

• Building management capacities of Municipal Health departments
  
  *Delhi – MIS, LACI, IEC, Bangalore – ISO 9002 Certification to 30 Health Centers*

• Using community based volunteers for Social Mobilization
  
  *All Project Cities*

• Focusing on Financial Viability – User fee, Health Development Fund
  
  *Kolkata, Andhra Pradesh, Bangalore*
Key design issues for Urban Primary Health Services

1. Identifying the beneficiaries
2. Assessing service needs
3. Interventions based on needs and local capacities
4. Monitoring and Evaluation
Identifying the beneficiaries.

*Income Criteria.*
Kolkata

*Geographic location.*
Bangalore, Hyderabad (Notified Slums)
Delhi (J J Clusters)
Income Criteria

Advantages.
Helps in identifying
• Urban Poor who are not residing in Slums and
• Some better off groups residing in slums

Constraints.
• Operational feasibility of carrying out reliable income assessment

Other Options.
• Identifying the poor using Asset Index – Use of basic amenities (Electricity, Water), type of cooking fuel used and possessions (Type of house, TV, Vehicle)
• Participatory appraisal to identify the poorest and most vulnerable
Assessing Service Needs

Stakeholder Consultations and Household Surveys

**Advantages.**
1. Identifies key service delivery gaps
2. Finds out reasons for not using services – Supply or Demand
3. Provides pre-intervention baseline

**Constraints.**
1. Weak Methodology giving dubious results (Sampling)
2. Quality depends on profile of the investigators & instruments (Non-sampling)

**Lessons.**
1. Identify the critical indicators upfront – Process, Output and Outcome/Impact
2. Use Standardized methodology
3. Complement quantitative data with qualitative information
Planning and implementing interventions.

Community Based.
- Social Mobilization
- Outreach

Referral Services

Clinic Based
Community based Services

Information & Social Mobilization
Distribution of contraceptives/ORS
Malaria smear
TB DOTs

Un paid Community Volunteer
- Hyderabad – Link Volunteers
- Karnataka - RCV
**Advantages.**
- No long term fiscal commitment
**Constraints.**
- Difficult to fix accountability
- How to sustain the interest
**Options.**
- Giving Identity
- Group incentives
- Dove-tail to ongoing program - SJSRY

Paid Community Volunteer
- Kolkata – Honorary Health Worker
- Delhi – Basti Sevikas
- Bangalore - Link Workers
**Advantages.**
- Better Accountability
**Constraints.**
- Long term sustainability
- Frustration due to lack of career growth
**Options.**
- Community co-payment
- Career growth – First Tier Supervisor
- Private Practice
What is the ideal Population per provider?
  • 7,500 – 15,000

Who should provide?
  • Paramedic – Male or Female

What are key Activities?
  • Listing of beneficiaries
  • Fixed day provision of services
  • Follow-up – Household visits

What range of Services?
  • Only RH
  • RCH, or
  • Basic Primary Health Services – RCH + TB + Malaria

From where the services are to be provided?
  • Permanent Facility Built
  • Temporary facility which can be shifted with slums
  • Existing community Center
  • Clinic of a Private Practitioner

What should be the frequency and timing?
  • Fixed day service – once a week/Fortnight/Month
  • Flexi- Timings to suit women beneficiaries

How to ensure referral Linkages?
  • Links with Referral Hospital critical –
    Monthly reviews; News Letter etc.
Clinic Based Services

- Counseling for Contraception
- Screening for Contraception
- IUD insertion
- Antenatal care for high risk
- RTI/STI management
- Treatment of minor ailments
- Simple Laboratory Tests

Who should provide?
- Doctor:
  - Full time doctor – Public /Contractual
  - Part time doctor – Private
- Senior Paramedic
- Sex: Male/Female
- Outsourcing to Private/NGO sector - Franchising

From where?
- Permanent Facility
- Temporary Facility
- Private Clinic

How frequently?
- Daily
- Periodically – Bi-Weekly-Weekly

How to ensure Focus on RCH services?
- Fixed day services for AN, Immunization, RTI/STI
- Only female providers
- Limit most supplies/consumables to RCH program
Referral Services

- Antenatal care for High Risk
- Skilled care for delivery
- Emergency Obstetric Care
- Management of Severe ARI/DIA
- Terminal FP Procedures

How to provide Services?
- Dedicated Maternity Homes
  *Site, Staffing, High Recurring Costs*
- Strengthening Existing Public Hospitals
  *Poor Responsiveness to Slum Res.*
- Contracting Private Hospitals
  *Profit Driven, Contract management*

Options for Strengthening referral linkages
- Referral Mapping and Referral protocols
- Common Management Structure
- Formal monthly reviews
- Written Feedback
- Priority to referred Clients
- Free services to referred Clients
Options for managing Urban Health Services.

**Municipality**

**Advantages.**
- More Comprehensive-
  *better integrated with development activities*
- Higher Local involvement likely

**Constraints.**
- Resource crunch
- Limited Technical capacities

**Health Department**

**Advantages.**
- Better Technical Capacity
- Comprehensive understanding of health issues

**Constraints.**
- Inadequate understanding of local needs
- Less integrated with other developmental activities

Megacities       Emerging Metro Regions       Small Towns
Monitoring Change.

- Rapid surveys - 30 Cluster evaluations.
- Periodic Third Party Evaluations - Baseline, Midline, Endline.
Key Challenges faced during the project implementation

- Poor coordination between different agencies providing RCH services *Teaching hospitals, specialist hospitals, general hospitals, postpartum units, Urban Family Welfare centers*
- Weak management and technical oversight capacities of municipal health departments
- Inadequate alignment of health interventions with slum development and relocation programs
- Challenge of finding sites for new structures
- Frequent transfers of crucial project staff
- Dependency of most Municipalities on other agencies for staff recruitment.
Lessons from the Project.

• There are no simple solutions for addressing Urban Primary Health Care services.
• Standardized service delivery models will not work. Flexibility depending on local needs is the key.
• Do not wait till facilities are built. Start service delivery early on with outreach activities.
• Focus on few critical services and monitor their delivery.
• Limited curative care is important. But do not lose focus on RCH services – Fixed days, Special clinics, provider accountability and incentives.
• There is tremendous opportunity to partner with community based organizations as well as private sector. Do exploit it through innovative partnerships.
• Avoid building large new structures. Align with slum development program and explore the options of renting/using existing private/community facilities.
Lessons from the Project.

- Interventions that actively engage local communities, elected representatives and technical staff are more sustainable but take longer time to institutionalize. There is need for continued engagement of development partners.

- From the beginning ensure management focus on outputs and outcomes rather than inputs. Focus on improving service statistics through incentives. Quick and dirty surveys are useful. Do not wait till formal evaluations are done.

- While planning the programs do consider
  - long term financial sustainability – Cost sharing/ Cross Subsidy/contracting
  - Institutional viability - management development, coordination, referral linkages