Lessons from the Indore, India Urban Health Program

It is estimated that nearly one-third of India's urban population live in slums.

In India, 285 million people live in urban areas; 67 million of them are poor. These estimates are conservative, failing to account for population living in unlisted slum clusters. Average health indicators of urban areas mask the plight of the urban poor. A recent re-analysis of National Family Health Survey-II (1998-1999) data by economic groups revealed that health of the urban poor is worse than urban non-poor and urban averages.

The Urban Health Resource Center (UHRC) works closely with governments, civil society and slum communities for improving health of urban poor. In 2003, UHRC initiated a City Urban Health Program in Indore (population 1.8 million). The objectives of the program, operational in 79 slums, were a) to increase the access of health service in underserved slums and b) promote healthy household behaviors through effective community organization process.

Program planning included: situational analysis, mapping of listed and unlisted slums, vulnerability assessment of slums and stakeholder consultations. Two program approaches evolved. Implementation included encouraging slum-based community collectives or networks and strengthening their capacities and capacities of key stakeholders.

The first approach- the Demand Supply Linkage Approach entails building community based organizations (CBOs), encouraging services to be more responsive and improving community-provider linkages. This improves demand as well as supply of services. CBOs evolved women's groups comprising 10-15 active women from the slum. They were provided capacity building inputs on community organization, maternal and child health care. With training inputs they a) counsel mothers on healthy household behaviors, and b) identify and track eligible mothers and children.

Health service provision is improved by effectively motivating government and private providers to strengthen OPD services conducting monthly health camps in slums.

In the second approach a Ward Coordination Committee comprising local stakeholders (public sector, private service providers and civil society organizations) was constituted. It brings together key stakeholders to function in a coordinated manner for better provision of health services utilizing local resources and to monitor progress.

The program has enhanced service utilization by slum communities and improved health indicators. Evaluation data in demand, supply and linkage approaches indicated improved immunization of children by 12 months from 32% to 72%, TT immunization from 76% to 90 %. In the ward coordination approach area immunization by 12 months had increased from 27% to 64 %. Measles Vaccination by 12 months has increased from 60.7% to 76.4% and drop out rate for DPT had decreased from 55% to 21 %.

The program shows that strengthened community level institutions are able to negotiate and mediate for basic health services. This results in better demand for services and strong provider – community linkages. The ward coordination approach shows that convergence of multiple stakeholders and resources at ward level improves service provision. Enlisting support of like minded private health practitioners and coordinated planning for outreach health activities also emerged as important lessons. These can be adapted for similar initiatives.

For more information on UHRC's activities, visit http://www.uhrc.in/.