CME

Challenges and Options for the Delivery of Primary Health Care in Disadvantaged Urban Areas

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Introduction

India's commitment to provide primary health care to the masses dates back to the recommendations of the Bhore Committee in 1946. India's re-dedication to the primary health care approach in 1978, implicit in the signing'of the Alma Ata declaration of HFA 2000 AD redefined this approach for provision of health care to the masses. Considering the predominance of the rural population, great emphasis was placed on the development of infrastructure techniques and manpower for service delivery mainly in rural areas - rightly so!

But the demographic scenario is changing rapidly. India's urban population has been growing at a fast rate, the proportion of urban population was 11% in 1901, 26% in 1991 and is presently 30%. It is bound to show a rising trend in the future too. The transition from the agrarian to urban based economics necessitates a reorientation of the national polices and priorities. The urban slums are deprived human settlements, which are demographically, economically and environmentally vulnerable. They also include the small clusters of pavement dwellers as well as government resettlement colonies. In 1991, India had a total of 220 million urban population of which 40% lived in slums.

The health indicators always paint a better picture of the urban areas against the rural areas. Yet it must be realized that the average figures of urban areas hide the stark reality of the urban deprived slums.

Current Scenario

The need of developing urban health services was first mentioned in the sixth five-year plan. Since then some thought has been given to this aspect of health care provision. A crucial milestone was the appointment of the Krishnan Committee to work out an implementation programme for provision of primary heath care in urban areas in 1982. The committee report suggested the establishment of a health post run by a doctor, a Public Health Nurse, four Auxiliary Nurse Midwives, four multipurpose workers and twenty-five Community Health workers for a population of 50,000. The report recommended that the health post staff should reach out to the community and involve the community in the implementation of the primary health care programme. The implementation of these recommendations has been far from satisfactory. A review of the implementation of the Krishnan Committee recommendations by the Municipal Corporation of Greater Bombay (MCGB) in 1988 showed that the health post staff did not have a good understanding of the community and did not adapt themselves suitably to the changed health care system.

Today private providers, teaching hospitals and Nursing Homes mainly provide the medical care at first level of contact. The services of the private sector are costly and their quality questionable. The government provides health services through its network of urban family welfare centres and urban health posts which concentrate on provision of family welfare services and not primary health care. The overcrowded public hospitals faced with severe resource crunch are thus unable to provide the expected level of service.

Key Challenges

Some inherent characteristics of the urban slums pose challenges for evolving a plan for primary health care provision in this setup.

The heterogeneous character of the population makes it difficult to define 'the community' in urban slums. A majority of the population in the slums has migrated , and hence is in a sociocultural transition raising the risks of maladaptation. The urban slums are represented mainly by the poor and middle class and the slum dwellers are either self employed or engaged in labour which makes it difficult to contact them at fixed times. The economic pressures are such that anyone who can work, is employed making it difficult to get a purely voluntary worker in urban slums. The environmental sanitation is worse in urban slums. Less than 50% of the urban population is having sanitary excreta disposal systems. The present status of lack of adequate solid waste management is a potential health hazard. Pollution of urban environment from industrial, vehicular and domestic sources has assumed serious proportions.

There is an established dependence on curative services amongst the urban masses, especially from the private service providers making it difficult for the primary health care approach to achieve quick, instant credibility. Considering the high density of the population, the geographic distribution of the health centres also poses a challenge.

The health problems of the urban poor are related to a complex web of causation. The provision of Primary Health Care therefore cannot be compartmentalised, but has to be provided as a part of overall comprehensive urban slum development.

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The urban slum is a concentrated nest of epidemiological transition. The poor environmental sanitation makes the slum dwellers prone to many communicable diseases while the adverse sociocultural and economic conditions lead to lifestyle disorders and chronic diseases. In spite of these challenges, a few projects have been able to circumvent the problems and put forth models of successful plans in urban slums. These models provide useful lessons for public health personnel.

Lessons From Successful Models

The experiences of the Urban Community Development Project, Vishakapatnam Municipal Corporation, The Calcutta Metropolitan Development Authority (CMDA) program in Calcutta, the Slum Improvement Projects in Hyderabad and Indore have brought forth the some significant points. An integrated multisectoral approach is appropriate to ensure coordination between a range of activities. Low cost staff and infrastructure can be utilized and a single community mobilization infrastructure consisting of community organizers and social workers avoided duplication of efforts and staff. The community development component consisting of income generation activities, Pre School services, establishment of community councils and security of tenure should take a lead. The post project maintenance has to be considered at an early stage with agreements drawn up between the municipality and community, outlining division of responsibilities. In the Integrated Population Development Project (IPDP) Hyderabad, the slum women, NGOs and government agencies have worked together successfully. The Urban Slum Population Projects in Mumbai and Chennai have experimented with innovative outreach approach (e.g. through barbers shops) and IEC activities (puppets shows, street plays). In both these projects there was a shift from a top down, demographically driven approach to a more decentralized, participatory planning approach.

Taking into consideration the current scenario, the challenges in provision of primary health care and the lessons learnt from various projects the following conceptual plan and implementation strategy is suggested.

Conceptual Plan
Secondary & Tertiary Health Care

Feedback **Referral Services**

Community Development	**Primary Health Care**	**Environmental Sanitation**
- FCDS - Schools - Income Generation - Mahila Mandals - Youth Clubs	- Outreach Service - Preventive Service - Family Planning Service - Curative Services - Referral Services - Reports & Records - Promotive Srvices	- Housing - Water Suppy - Sewage, Sullage & Refused Disposal

Fig. I: Conceptual Plan Secondary & Tertiary Health Care

Operational Strategy

A comprehensive baseline survey using rapid appraisal techniques should be planned in the initial stages to collect information about the health status, socio-demographic variables, civic amenities, existing health facilities as well as the attitudes and beliefs of the target population.

Strategy For Community Participation And Intersectoral Coordination

The responsibility of seeking community participation and ensuring intersectoral coordination, which have been identified as key factors for the success of the program, can be integrated together. This responsibility can be shouldered by a single committee, which will be headed by the Project Officer. The Community Mobilization and Coordination Units and Neighbourhood Councils will be important components of this Committee. The former should have fresh, young, motivated and trained social workers and the latter should have representation from local Mahila Mandals, youth clubs, teachers apart form local leaders. The Neighborhood Councils each for a population of 5000 should be given the responsibility of health education on the key topics of MCH, Family planning, immunization and environmental sanitation. They will also be responsible for maintenance of the family folders. Each member of the council will be in possession of referral cards, which can be given to persons in need. Anyone with these cards should be treated on a priority basis throughout the referral system. Training programs for members of the neighborhood councils should be arranged regularly. The staff at the health posts and Urban Health Centre should guide them. The councils, which perform their work effectively, should be honored and a sense of prestige should be attached to the council. The formation and effective functioning of these councils will be the responsibility of the community mobilization and coordination units.

Strategy for Financing, Developing Infrastructure and Manpower

The required services in the urban slums cannot be provided by any one sector alone. Therefore public-private partnerships will prove to be an important alternative. All possible sources of financing will have to be tapped to ensure sustainability to the programme. The government will have to put in some additional investment to fill in critical gaps. The funds earmarked under Basic Minimum Services, RCH societies etc. can be utilized in the programme. Individual and institutional donations in kind in the form of furniture, stationary should be accepted and given tax exemptions. User charges can be collected from those who can afford to pay and the money should be used at the site of collection to meet recurring costs and for maintenance purpose.

The health posts, one for a population of 5000, should be run by two multipurpose workers, one male and one female who should be local residents of the slums. They should provide

preventive, promotive services along with treatment of minor illness and referral services. A medical officer, one supervisor, one laboratory technician and two support staff should run one Urban Health Centre for a population of 20,000. The medical officer should be appointed on a contractual basis through the NGO partner. The retired doctors, interested private practitioners practicing in the vicinity of the slum area can be recruited on an honorary basis. The medical officer should play the role of an ideal family physician. Interns can be posted at the health centre. This will serve two purposes- one is to provide hands-on community based training in the urban setup as per MCI recommendations and provision of additional staff at the centre.

Apart from the preventive, promotive and curative services the centre should supervise, monitor and coordinate the activities of the outreach activities. The health centre should be located within the slums so as to have easy access by the slum population. The local community halls can be utilized for running the health centre. Alternatively, if new centres are to be constructed, they can be leased for 4 commercial use on a part time basis. The Urban Health Centres can make a mark in the provision of Primary Health Care only if effective and timely referral services are provided. The referral system should be streamlined with Zonal Health Centers and District Health Centers at the second tier and third tier respectively. The feedback loop of the referral system should be strengthened with the help of the neighborhood councils.

The Zonal Health Centre, a 50-bedded hospital will provide speciality based polyclinic services to the referred cases with the help of honorary consultants. A private hospital can be identified for providing backup services. The District Health Centre, each for a population of ten lakhs will provide specialty based services, monitor, guide and coordinate the services of the centres under it. Each district level hospital should also have a Department of Community Medicine, which will conduct training sessions, evaluate the programme and provide inputs for planning and implementing community based interventions.

Five Urban Health Centres will be a part of one Urban Slum Development Project, which will be headed by a Project Officer appointed by an NGO, who will also be in charge of the neighborhood council and community mobilization and intersectoral coordination units. An Urban Slum Development Officer from the administrative services should be overall in charge of all projects. The social marketing and franchising programmes can be strengthened for provision of non-clinical services e.g. distribution of condoms, iron and folic tablets etc.

The health personnel recruited to work in the different units should receive orientation training as well as regular in-service training. Continued Medical Education through modules and regular meetings should be planned. The Department of Community Medicine, local bodies of medical associations like IAPSM, IPHA can play an important role in this aspect.

Strategy for Developing a Health Information System

An in-built health information system should be evolved in which each family should have an up-to-date family folder. Monthly reporting system by the Urban Health Centre should be scheduled. The urban slums are prone to outbreaks, disasters and accidents. A sensitive surveillance system should be designed which will include private practitioners and be able to detect problems at the earliest. Information technology can be of great value in maintaining, analyzing and interpreting the enormous data generated through active efforts.

Strategy for Information Education and Communication

Innovative approaches consisting of street plays, puppet shows, animation films and group discussion should be planned. The IEC activities can be linked to local festivals to enhance community participation. Competitions can be organized between slums, between projects areas on the topics of environmental sanitation, health status of different groups etc. Such activities will inculcate a sense of enthusiasm, motivation and cooperation within the community. They can be organized with the help of Municipal Corporation, NGOs, and local bodies of medical associations. These can be sponsored by local industries. The winners are awarded and the secret of their success is documented, publicized as model success stories for replication with the help of the media. The conferences organized by medical associations should provide a platform for presentation of the experiences. Many innovative ideas can come into limelight through this approach.

Strategy for Monitoring and Evaluation

Regular monitoring can be done by the supervisors, medical officers and NGO partners. The evaluation of the programme can be conducted by the Department of Community Medicine. The loopholes can be identified and corresponding corrections incorporated in the program.

District Health Centre → Urban Slum Development Officer
Zonal Health Centre → Project Officer
Urban Health Centre → Community mobilation and Coordination units
Urban Health post → Neighbourhood councils

Figure II: Flow Diagram of the Organizational Setup

Targeting Vulnerable Population

It is undeniable that healthy people are the best assets for overall development of the nation. Again, the quality of such human resources is determined largely by the quality of child development services. Optimal child development, however, cannot be attained without proper development of maternal attributes. Hence maternal and child health services should be taken up on a priority basis. Comprehensive RCH

services should be made available to the women through the Urban Health Centres. Income generation activities for women should be initiated. The children of the working women should be placed in Day Care Center /Creches which can be run in the anganwadis and supervised by two local elderly women.

Mother craft classes and nutrition education for mothers should be planned. Healthy baby contests, contests for preparing weaning foods can generate interest amongst the target population and spread relevant messages. The urban slum dwellers can purchase food at subsidised rates through the Public Distribution System[6]. The quality of food distributed under Public Distribution System needs to be improved. The working of the anganwadis needs to be strengthened. The distribution of supplementary food and regular growth monitoring needs to be strictly supervised. The medical officer of Urban Health Centre can take up this responsibility. The school health program should also be implemented effectively. High immunization coverage and integrated management of childhood illness (IMCI) - approach will keep a check on under five mortality.

Amongst the adolescent group, those from the urban slum are all the more vulnerable. They can be contacted through schools, Balika mandals linked to anganwadis, youth clubs etc. The Health checkup and IEC activities can be conducted for them. The opportunities for vocational training and healthy recreational activities should be planned. Counselors to guide the adolescents should make their services available to them when indicated. Peer to peer education techniques can be used effectively to spread messages. The working group in urban slums is often engaged in hazardous occupation. The employers should be involved in implementing organized schemes for provision of health services to the working group.

Issue of Sustainability

The will power of the politicians, support of the bureaucrats, guidance from NGOs and medical faculty can set the ball rolling in the right direction. But it is only the internal stability and sustainability, which will maintain the momentum in the future. The local capacity enhancement and community participation are two interventions, which are key for the attainment of sustainability. Equally important is the sense of ownership, a sense of self achievement which will also ensure sustainability, if the community perceives the positive impact of the interventions on their quality of life, the programme to a large extent will become self sustainable.

Undoubtedly overall rural development will have an indirect positive impact on the situation in urban slums. An assurance of a world that meets their needs, respects, protects and fulfills their rights enabling them to live to their full potential will interrupt the process of migration. Till this objective is achieved, we must realize that the problem of urban slums can no longer be neglected.

Table I: Organisational Setup of the proposed Plan

No.	Unit	Poluation	Staff Selection	Functions
1.	Urban Health	5000	Permanent	Preventive, promotive and curative for minor ailments, referrals
2.	Urban Health Centre	2,000	Contractual	Preventive, promotive and curative, Managerial services.
3.	Zonal Health	1 Lakh	Permanent & Honarary	Polyclinc Services
4.	District Health	10 lakh	Permanent & Honorary	Speciality based treatment, training, coordination
Overal administrative setup				
1.	Neighbour-hood	500	Voluntary	Communication for increasing awareness and behavioral change, referrals, community participation
2.	Community mobilization and coordina-tion units	20,000	Permanent	Community participation and intersectoral coordination
3.	Project Officer	1 lakh	Contractual	Supervision guidance, administration
4.	Urban Slum Development Officer	5-10 lakhs	State/Central administrative services	Overal in charge

Implementation Strategy

Table II:The Strategy and Outcome for the Different Activities

No.	Factor	Strategy	Outcome
1.	Comprehensive Baseline Survey	Rapid appraisal technique	Mortality, morbidity pattern, socioeconomic, demographic environmental conditions
2.	Community participation and Intersect oral coordination	- Project officer - Community mobilization and coordination units - Neighborhood councils	- Sustainability - Avoid duplication - Ensure smooth functioning - Key factors in success - Effective utilization of services
3.	Financing, Infrastructure,	- Public private partnerships - User charges	- Improve efficiency, access, reduce costs - Sustainability
4.	Training	- Orientation, in-service	- Enhance performance, efficienty
5.	Health Information System	- Family folders, surveillance systems - Information technology	- Aid monitoring, Surveilance
6.	IEC	- Innovative approaches	- Behavioural change - Improve knowledge attitude and practice
7.	Monitoring and evaluation	- Information technology - Monthly reports - Yearly evaluation	- Identify loopholes, suggest corrections

The urban slum dwellers leave their ancestral homes and migrate to cities with dreams in their eyes. Dreams of better education facilities, opportunities of employment: dreams of a better quality of life. But the present set of conditions pose

a picture of nightmare. Let's put in some active efforts to help them convert some of their dreams into reality.

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