

Urban health reading pack C: Interventions and pro-poor service provision

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Introduction to the topic

This is the third in the series of urban health reading packs. It builds on the urban health [reading pack A](#) on the data and evidence available on urban health, and on the experiences and challenges of inter-sectoral responses outlined in [reading pack B](#). This pack focuses on service provision within urban areas describing key challenges and pointing out interventions that may improve the health of the urban poor.

Limited public healthcare

While it is often thought that urban residents have greater access to healthcare than their rural counterparts, evidence shows that proximity does not equate to access. Unlike rural areas, urban areas do not have a history of a well-supported structure of primary healthcare clinics accessible to the poor. Instead, the poor utilises private providers, which can be expensive, be of poor quality and exploitative. For example, an assessment of 20 urban health centres in Kathmandu found gaps in maintaining a minimum standard of care due to poor basic health service infrastructure, such as running water, appropriate space, refrigeration, and limited capacity of health workers to deliver essential healthcare due to lack of training and support ([HERD, 2014](#)). A review of capacity of 25 maternal health facilities used by urban slum residents in Nairobi found many facilities lacked essential equipment and many health providers lacked critical skills needed to conduct deliveries with minor complications ([Ziraba et. al., 2009](#)).

About the authors

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High levels of undernutrition including stunting among the urban poor in low- and middle-income countries (LMICs) indicates susceptibility to infections owing to poor access to water supply and sanitation, a suboptimal physical environment, poor feeding practices, and also high levels of food insecurity among this segment of the population.

Coordination across government

In many countries there are several interlinked factors driving these poor conditions; the assumption of the 'urban advantage' has led to continued under-investment in urban public healthcare leading to limited facilities, particularly maternity hospitals that are open 24x7hrs. The assumption of quality urban services and availability of specialist services encourages rural patients to travel to the city further over-burdening the constrained system. These problems are exacerbated by the division of responsibility for urban healthcare between departments of health and municipal authorities, and the lack of regulatory capacity and a sizable market for informal and formal private care. The demand for private healthcare continues to be high in part due to the assumption that it is better quality than public facilities. Basic services such as sewage systems, piped water supplies, and the construction and cleaning of drains also suffer from not being able to meet the rapidly growing needs of urban disadvantaged populations.

In many South Asian cities, the Ministry of Health (MoH) is responsible for recruiting and training health workers, nutrition related department for nutrition workers, and the municipality for employment of other health staff. There is insufficient clarity of roles, and little coordination between MoH, municipal bodies, and other agencies responsible for health, nutrition, food subsidy and environment improvement services in a city. In addition, within MoH, there is insufficient coordination among divisions dealing with vector-borne diseases, tuberculosis, adolescent health, MCH, nutrition programmes and other vertical units. Poor coordination leads to service areas of different agencies overlapping and large areas without services ([Agarwal et al 2007](#); [ADB, n.d](#)).

Patient perspectives on quality and ease of access

A study of eight Indian cities (Mumbai, Kolkata, Chennai, Hyderabad, Delhi, Indore, Nagpur, and Meerut) found that the commonly reported reasons for slum dwellers not using government facilities were poor quality of care, excessive waiting times, inconvenient opening times and lack of nearby government facilities ([Gupta et al., 2009](#)). Women perceive quality of facility-based care to be poor and choose to avoid facility-based deliveries, where life-saving interventions could be available ([Austin et al., 2014](#); [Hulton, Matthews, and Stones, 2007](#); [Gupta et al., 2009](#)). Urban migrant women (particularly recent and seasonal migrants) have limited awareness of the availability of maternal healthcare, danger signs of complications, urgency of care seeking, and where and how to avail service at appropriate government hospitals. This, together with their vulnerable living status, contributes to poor maternal healthcare, and maternal mortality ([International Organisation of Migration, 2013](#); [Agarwal, 2016](#)).

Opening times of health facilities are key to service provision in urban areas; with slum dwellers and the urban poor (both men, and increasingly women), engaging in wage-labour during the day, the availability of health facilities every day in early mornings and evening is crucial. A recent mapping of public and private health services available to the urban poor in Dhaka, Bangladesh, found most public and NGO clinics opened five to six days a week but had limited opening hours from 10am to 4pm. Private clinics were the only facilities offering evening opening time, however, only 37 per cent of private sector health staff had any kind of formal medical qualification ([Adams, Islam and Ahmed, 2015](#)).

Poor sanitation services in urban areas have particularly gendered impacts. With lack of toilets in slum houses, women and girls force themselves to eat less (contributing to undernutrition) and drink less water to reduce the urge for defecation and urination. They pass urine or stools before dawn to experience whatever little privacy is possible ([Agarwal, 2014](#)).

Findings from Myanmar slums suggest considerable delay between onset of TB symptoms and seeking treatment, not suspecting cough to indicate TB. Many patients chose private providers since government facilities entailed longer time and wage-loss ([Saw et al., 2009](#)). Barrier to consulting a medical doctor were cost, distance from clinic and difficulty in taking time off from work ([Thu et al., 2012](#)). Using inter-

personal communication and pharmacies substantially increased registration of TB cases, showing that the strategy was able to reach previously unreachable TB cases.

There is a lack of literature on the presence, regularity and quality of outreach health services including preventive care and health behaviour promotion which have a far larger number of users since these are for all persons rather than for those who are sick or unwell.

Public private partnerships

With a greater supply of private and NGO service providers in urban areas, governments have turned to the private sector to help expand primary, secondary (including 24x7 maternity centres), and tertiary services. Public private partnerships (PPP) have been taken up by local governments in India (see National Urban Health Mission Framework for Implementation: [MoHFW Govt. of India 2013](#) and [MoHFW Govt. of India 2006](#)) and partnerships have been forged between private service providers, NGOs, and slum community groups. In Bangladesh ([Heard, Nath, and Loevinsohn, 2013](#)), different forms of private service providers participate – both for profit and not-for-profit. PPP approaches to augment supply side include: contracting ('in' and 'out') for healthcare; diagnostics, building/rehabilitating, operationalising or, transferring of new or less functional health facilities; joint ventures for new health facilities and services; mobile health units for reaching out to urban areas where services and diagnostics are not available, and for covering peri-urban areas (Raman and Björkman, 2009)

Dependence on the unregulated informal system calls for attention to issues of quality, appropriate care and rational use of drugs ([Zulu et al., 2011](#)). In Bangladesh, Social Marketing Company (SMC) and Smiling Sun Train engage private practitioners and community health workers to provide contraceptive services and timely referral ([Schlein and Montagu, 2012](#)). Lessons demand prioritising provision of affordable and comprehensive quality care close to where the poor reside, and at hours convenient to the working population. Learnings also point to community-based outreach focused on increasing the health literacy of the urban poor, and familiarity with the advantages of formal services in terms of quality and referral, as critical in encouraging utilisation of quality healthcare ([Adams, Islam and Ahmed, 2015](#)).

Public private mix (PPM) interventions for tuberculosis in urban areas showed improved case detection and treatment outcomes among patients seeking care with private providers. PPM services located predominantly in poor areas or engaging providers who are primary agents for urban poor seeking healthcare have a greater potential than others for increasing equity in access to TB services as observed in Nepal, South Africa, Myanmar, Mumbai, and Hyderabad (Malmborg, Mann and Squire, 2011).

Examples of public private partnerships

At the Sawai Man Singh (SMS) Hospital, Jaipur, a Life Line Fluid Drug Store was contracted for providing low cost high quality medicines and surgical items 24-hours. The agency was selected through bidding; the successful bidder was a proprietary agency, and the medical superintendent was the supervisor in charge of monitoring the drug store. The contractor appointed staff and provided staff salaries, was responsible for the daily operations and distribution of medicine; maintenance of records and monthly reports to SMS Hospital from the sales receipts. SMS Hospital shares resources with the drug store such as electricity, water, computers for daily operations, physical space, stationery and medicines ([R4D Report on PPP in India by TI-UP Resource Centre and Total Synergy n.d., London](#)).

In Delhi, the Municipal Corporation of Delhi (MCD) partnered with Arpana (a private trust) to run a dysfunctional MCD urban health center in an urban poor community since July 2003. An MoU was signed, whereby MCD provided the building, some medicines and vaccines; Arpana Trust was in-charge of staff salaries, running expenses and community volunteers. Arpana Trust also mobilised additional resources from nominal user fees, corporate, individual and other donations including the Prince of Wales Trust. Arpana Trust expanded reach of healthcare to slums, improved the quality of services by providing affordable diagnostic services, services of part-time, visiting specialists and outreach services ([Agarwal 2016](#)). In Guwahati, Assam, the government partnered with Marwari Maternity Hospital, a charitable hospital, to provide outpatient services at the hospital and outreach services in eight low-income wards of the city. The state government provided financial assistance to the hospital to add to its facilities in return for services to the identified slum clusters. Vaccines and contraceptives were provided by the

government. The outreach team included a doctor who treated minor ailments and referred patients to the hospital. Maternal, infant, child health and family planning needs of hitherto unreached urban poor were addressed. In MMH, family planning and abortion services were provided free to patients, while deliveries, operations and diagnostic tests were charged at concessional rates improving access of hospital services to urban poor ([HS-PROD India, 2006](#)).

The Rajiv Gandhi Super-specialty Hospital, Raichur, Karnataka, is a joint venture of the Government of Karnataka and the Apollo Hospitals Group, with financial support from the Organization of Petroleum Exporting Countries (OPEC). The partnership aims to provide super specialty healthcare at low cost to those below the poverty line. The Government of Karnataka provided land, hospital buildings, staff quarters, roads, power, water, and infrastructure. Apollo provided qualified, experienced and competent medical staff and facilities for operating the hospital ([R4D Report on PPP in India by TI-UP Resource Centre and Total Synergy n.d., London](#)). In the 1990s, through the Private Finance Initiative (PFI), the UK built approximately 100 new NHS hospitals in 12 years. Private funding was used to design, build and operate hospital buildings, including ancillary (non-clinical) services, such as cleaning and catering. Clinical, medical and nursing services, including doctors and nurses, continue to be provided by NHS. The PFI Trust pays an annual 'unitary charge' for the contracted period, which has two components: (i) availability charge, a payment for provision and management of buildings and equipment; and (ii) service charge, a payment for provision of facilities management and ancillary services. This PPP approach aimed to i) transfer risk to the private sector, and accordingly, greater cost certainty for the government; ii) achieve better value for money (VfM), on which many say that the PFI method was not efficient; and iii) on time and on budget delivery relative to other options ([Hamilton et al., 2012](#))

There are challenges with both forms of PPM – the for-profit and not-for-profit approaches. The private-for-profit sector has no incentive to reach out to the urban poor and is not keen to partner for outreach healthcare, which is key to preventive healthcare and most crucial for urban deprived communities. Non-profit agencies usually have few resources.

Initiatives to increase access of urban poor to private facilities/providers with fees have been tried in many countries. For example a "voucher scheme" was implemented in Uttar Pradesh during 2007 to 2012 to improve access to maternal healthcare, associated diagnostic services and family planning services from a selected panel of private providers, paid by a government agency. Vouchers provided limited purchasing power to obtain a designated set of private health services ([ITAP, 2012](#)). In Kenya, vouchers for family planning, safe motherhood and gender-based violence services have been used to help urban poor women access private services ([GIZ and KFW, 2012](#)). Accredited and contracted private providers offered services in exchange for vouchers. They were reimbursed at a negotiated rate reflecting cost of service provision and a small yet reasonable profit to motivate their participation ([Obare et al., 2015](#)).

A DfID review by [Meyer et al. \(2011\)](#), one by [Bellows et al. \(2011\)](#) and a review of 43 voucher schemes by [Grainger et al. \(2014\)](#), show that vouchers are an increasingly visible approach to enable access, target subsidies and enable contracting of the private sector building in the supply side dimension. Vouchers provide a package of safe motherhood (including antenatal and postnatal care, normal and complicated deliveries, and post-natal FP) and broader family planning (FP) services in India, Bangladesh, Pakistan, Cambodia, Kenya, Tanzania, Uganda, and Cambodia. Vouchers also included diagnosis and treatment of sexually transmitted infections, child health services (in Armenia and China), sexual and reproductive services for young people, safe abortion, and cervical cancer screening services. They have also been used for additional non-medical benefits such as transport, nutrition (food) and cash ([Grainger et al., 2014](#)).

Tools for operationalising public-private partnerships for enhancing services for the urban poor include examples of terms of reference and methods for selecting private health providers, expression of interest documents, and an MoU or agreement between the government agency and private healthcare providers, along with details of the roles of personnel and managers engaged by the private service provider used in different states in India. These are available at Government of India's Central Bureau of Health Intelligence website and on the Bihar Health Society website. Some of the most successful partnerships have been with private non-profit organisations or NGOs. However where there is insufficient consultation and coordination with facility-level managers, operational issues arise. Continuity of provision is a particular concern as PPM arrangements may not evolve into a stable long-term mechanism. This is often

due to challenges within the government system to effectively manage a partnership in terms of contracting-out, contracting-in or a partnership with a non-profit entity. The withdrawal of external agency funding further undermines long-term stability of PPP schemes and has been noted in India and Bangladesh (Raman and Björkman, 2009; [Adams, Nababan, and Hanifi, 2015](#)).

Social protection schemes and Universal Health Coverage

There is evidence that social protection and cash transfer schemes can improve dietary diversity, but there is a lack of evidence of the impact on nutritional status of children under five years of age ([Nutrition Works, 2012](#)). The Nairobi Urban Cash Transfer Programme (2009-2011) in Korogocho and Mukuru slums in Nairobi is an example of a successful cash transfer scheme. During the 2009 food crisis in Kenya, Oxfam GB and Concern implemented a programme using M-PESA, a mobile phone bank transfer system common in Kenya. Households were assessed for need, and recipients could spend the monthly transfers as they wished. However, social workers encouraged them to spend on food, and once these basic needs were met, they were encouraged to set up and grow businesses. Five thousand households received 1,500 Kenyan Shillings per month (USD 12.5) meeting around 20 per cent of households' immediate needs. Evaluation points motivated increase in quantity and variety of food bought and eaten. Transfers were also used for school fees, paying rent, and savings in merry-go-rounds. Most (86 per cent) of transfers went to women, negative coping strategies reduced, and relations within households improved. A key success factor was the close working relationship with government authorities to develop an urban social protection stream ([MacAuslan and Schofield, 2011](#)).

Most health insurance schemes for the poor in LMICs required no premium payment from beneficiaries but charge some co-payment at point of use. Evidence showed that health insurance schemes increased utilisation in outpatient visits and hospitalisation ([Acharya et al., 2012](#)). A review of universal health coverage (UHC) in 24 developing countries ([Cotlear et al., 2015](#)), most including a social health insurance (SHI) component, showed substantial growth in the last 15 years. These programmes cover a third of the world's population, are operated nationally at scale and designed to transform the health system serving urban, peri-urban and rural populations. All the 24 country UHC programmes described under two broad approaches: supply-side and demand-side acknowledged that different population sets had different needs. To expand coverage, programmes implemented measures to overcoming anonymity through use of citizen ID and targeting systems. The UHC programmes were expanding benefits, explicitly defining benefits and developing new contracts and payment systems.

[Cotlear et al. \(2015\)](#), based on review of programmes of 24 countries, note that in terms of financing of urban and rural health services and those used by both urban and rural populations, coverage of the poor was always non-contributory, with programmes complementing rather than replacing the MoH. Most countries use a combined approach where demand-side financing is complemented by supply-side subsidies. There is an increasing emphasis on improving the supply of services. To achieve this, i) greater flexibility was adopted in public hiring and management of public clinics and hospitals; ii) about half of the programmes engaged private providers; and iii) programmes developed and implemented accreditation systems.

Another common lesson was the need to strengthen accountability. Programmes changed the way stakeholders interact keeping with more delegation, moving from input based financing to output-based financing, and working towards greater data collection to improve accountability to outputs.

A critical dimension of making the supply side accountable was to empower citizens. Interventions to achieve greater client voice or power typically involved measures providing greater access to information and to grievance-redress mechanisms. The former include access-to-information legislation, information campaigns, report cards providing information on service performance to citizens, scorecards, and social audits. The latter are sometimes established in government agencies or independent organisations. In some countries courts form the main redress mechanism.

Three financing modalities of UHC were identified. The first aimed at protecting aggregate UHC expenditures, with caps on benefits, either budgetary amounts or quantitative restrictions. Examples include China, India, Georgia, and Vietnam, all having ceilings on total amounts reimbursed from insurance programmes; e.g. Vietnam had a per episode cap of 40 months of the minimum monthly salary (about US\$35 per episode per member). Other countries implemented quantitative limits: Brazil's UHC programme had explicit caps on inpatient admission rates by state.

The second aimed at keeping costs down by managing beneficiary utilisation. For example, Georgia's UHC programme required co-payments for outpatient drugs, Jamaica's programme required beneficiary cost sharing for non-communicable disease (NCD) drug coverage. In the Kyrgyz Republic, primary care was free for everyone, with most inpatient care requiring co-payments. In some countries, co-payments were levied only for high-end care.

The third is designed to prevent adverse financial impact of direct payments. Eleven of the 24 countries had no explicit co-payments and no budgetary or quantitative restrictions. Under Colombia's UHC programme, co-payments were required for surgery, hospitalisation, and diagnostic imaging, but were capped per visit and per year, and some disease categories and vulnerable population subgroups were exempt completely, as were indigent beneficiaries in Chile, Mexico, and Tunisia ([Cotlear et al., 2015](#)).

Community capability, power, advocacy and mobilisation

Where urban poor community associations and groups develop strong negotiation capability they are able to exert a "pull" effect, by negotiating with tact, without complaints and confrontation, on health access, environmental improvement, nutrition schemes, entitlements and services ([Agarwal et al., 2016](#)). Building capabilities of community groups is the most sustainable urban vulnerability alleviation approach since it invests in human capability enhancement over long periods of time. Experience in slums in Bangladesh and India shows community networks, community groups and trained community health workers (CHWs) can improve maternal and new-born health behaviours and service access. Empowered slum women's groups are a direction to greater autonomy of women in deciding on healthcare and associated expenditure. This empowerment can change social norms (such as the norm of males making decisions for treatment), and influence care seeking behaviour ([Roy et al., 2014](#); [Agarwal et al., 2016](#)).

Experience shows that in cities with multiple health providers but inequitable access to services, improvements are realised with greater community mobilisation. This requires a move beyond models of clinical service delivery by medical providers, to an approach that nurtures the power of social networks in slums as a means to support the poorest and the most marginalised in changing behaviour and effectively accessing appropriate maternal services ([Adams, Nabban and Hanifi, 2015](#); [Agarwal et al., 2016](#)).

Health and nutrition promotion

Given the limitations of health services in meeting the growing needs of urban populations, infection and illness prevention, promotion of nutrition, physical activity and health to mitigate NCDs are vital. Helping people remain healthy and not needing treatment is a fundamental goal of any urban health strategy. While there is evidence on approaches to change behaviour relating to water and sanitation (see reading pack B), there is lack of evidence on health promotion approaches effective in changing 'lifestyle behaviours' such as tobacco use, diet and exercise among the urban poor. Thai People Flat Belly public awareness campaign, a collaborative effort of the Department of Health and Thai Health Promotion Foundation, is directed at individuals, organisations, and communities. It encourages waist measurement, promotes desired diet, reduced salt intake, physical activity and mental wellbeing. Peer education approaches to nutrition and physical activity promote optimal behaviours in schools ([WHO & Food Standards Agency, UK, 2010](#)). The most effective school interventions are multi-component, include a curriculum taught by trained teachers, supportive school policies, a physical activity programme, and healthy food served by the school canteen ([WHO, 2012](#); Hawkes, 2013).

Approaches that build on local know-how and expertise of urban poor communities have shown success. For example, in Ethiopia, in the Urban Health Extension (UHE) Program diploma, nurses, each covering 500 urban poor households, enable communities to control their health by training 'model' families. Model families are encouraged to designate a family member to receive further training and motivate other families as community volunteers. UHE professionals prepare a hand-drawn map of their respective catchment areas to track service coverage. They link communities to government health facilities for preventive services, maternal, infant and child healthcare, HIV testing, and other treatment ([Health Systems 20/20, 2012](#); [Sibamo and Berheto, 2015](#)).

In Bangladesh, BRAC's network of Shasthya Shebika (community health volunteers) promote maternal and newborn child health (MNCH) in the Manoshi Project, a community based MNCH programme targeting 6.9 million urban slum dwellers in 10 cities of Bangladesh. Sustainability of the BRAC model lies in the ability of Shasthya Shebika to generate income from services that they provide to slum communities. Robust evaluations of such approaches in the urban context would help assuage fears of uncertainty about the income generating aspect ([Roy et al., 2014](#)).

Mass media through print, radio, and television have wide audience reach in urban centres ([Barbiero, 2014](#)). Television and radio are effective in persuading target audiences to adopt new behaviours, or to remind them of critical information. It is possible to reach about 65 per cent of the Indian audience by at least one mass media channel, i.e. either television, cable, newspapers, radio, magazines, cinema or the fledgling internet. Overall, television reaches 56 per cent in the country. A total of 92 per cent respondents were aware of public service advertisements, and 86 per cent of respondents were aware of pulse polio advertisements ([Naveena, 2015](#)). A study in Malawi showed that husbands of women exposed to the Maternal Health radio program were more likely to participate in antenatal care, be involved in childbirth and to participate in postnatal care than their counterparts ([Zamawe, Banda, and Dube, 2015](#)). In Tanzania, Wazazi Nipendeni ("Love me parents") was initiated in 2012 to provide a healthy pregnancy and healthy baby SMS service offering free interactive text messages with healthcare information for pregnant women, mothers of newborns and caregiver. Evaluation of Wazazi Nipendeni's first phase showed that it significantly impacted maternal and child health outcomes, including the number of antenatal care visits, HIV testing, mosquito net use, receipt of two or more doses of SP (an antimalarial drug), and birth planning. Wazazi Nipendeni phase II (2015) expands its scope to include post-partum care for newborns and up to a child's first birthday, focus on malaria, anaemia and tetanus prevention, life-long ART for HIV positive pregnant and lactating women, vitamin A, post-natal care attendance, danger signs, early and exclusive breastfeeding, immunisations, and post-partum family planning ([JHUCCP, 2015](#)).

Identifying and defining the urban poor for service provision

Urban poverty is multidimensional with urban poor living with many deprivations. It is a dynamic condition of changing vulnerability. Many problems of the urban poverty are rooted in the lack of employability skills, low access to employment opportunities and income, capacity and resource constraints, inadequate and insecure housing and services, little or no social protection mechanisms, violent and unhealthy environments, and limited access to adequate health and education opportunities. These are aggravated by inadequate government policies at central and local level, and a lack of planning for urban growth and management (World Bank, 2016). As described in reading pack A, there are grounds for suggesting that the scale of urban poverty is systematically under-estimated in the official statistics produced and used by governments ([Satterthwaite, 2004](#); [Vlahov et al., 2011](#); [Agarwal and Taneja, 2005](#)).

Like many countries, India sets its poverty line based on the average monthly per capita expenditure (MPCE) for obtaining a modest caloric intake. A fundamental concern with these urban poverty figures is that they are misleading, adopting what [Chandrasekhar \(2013\)](#) calls a "minimalist notion of survival". Fortunately, there is an example of a government policy providing an estimate of urban deprived population, which can be adapted as a working approach. The Government of India's National Food Security Act of 2013 designates 50 per cent of India's urban population as vulnerable and eligible for a minimum quantity of assured food grains per month at highly subsidised prices. NGOs have further contributed to this debate by raising the importance of mapping urban poverty ([BRAC's Manoshi Project](#))

and using local volunteers and social workers to identify vulnerable households ([MacAuslan and Schofield \(2011\)](#) on Cash Transfers in Nairobi). Technology plays a role with spatial and GIS mapping crowd-sourcing apps such as 'OpenStreetMap' enabling any community to ensure that both listed and unlisted informal settlements and poverty clusters appear on maps and not be ignored.

Meeting the needs of children, young people and women

While at aggregate level, primary education is more readily available in urban than in rural areas, it remains beyond the reach of most children in slums in African and Asian LMICs. Eighteen per cent of slum children/youth attended secondary school, compared with 53 per cent in urban Bangladesh as a whole and 48 per cent in rural areas ([UNICEF, 2012](#)). While enrolment improved in the rural and non-slum urban areas of Tanzania, Zambia, and Zimbabwe in the late 1990s, it worsened in urban slums ([UNICEF, 2012](#)). Girls are less likely to attend school due to many underlying factors of the slum environment. With such a situation, the urban advantage no longer extends to girls living in slums. In the Korogocho Slum in Nairobi, Kenya, for instance, an estimated 200,000 people live in crowded conditions, hundreds of girls grow up in a circumstances of extreme poverty and absence of essential basic services ([Nyange, 2014](#)). A study of urban migrants conducted in 2015 shows that of the 493 migrants with families surveyed, just 20 per cent (101) used temporary birth-spacing measures, including condoms, oral contraceptives and injections, all available free at government health facilities ([Agarwal, 2016](#)).

A large number of girls (referred to as kayayees) work on the street markets in Accra, Ghana, engaging in odd wage-earning roles such as "head porters". A census conducted with support from the Italian Ministry of Foreign Affairs counted 61,492 street children in the Greater Accra alone. Most of these children live in Agbogboloshie, a major slum which houses a busy market ([Department of Social Welfare, Accra, Ghana, 2011](#)). In the Greater Accra 42.4 per cent of girls between 15-19 years were not attending school ([UNFPA, 2012](#)). Girls also suffer from the Trokosi system (ritual servitude/enslavement of girls) and commercial sexual exploitation ([Dept. of Social Welfare, Ghana, 2011](#); [UNICEF, 2011](#)). In India, among the poorest urban quartile, 26 per cent women age 20-24 became mothers before age 18 years against 8 per cent among the rest of the urban population ([Agarwal et al, 2016](#)).

With more urban poor women working outside home, services to support them through safe and productive care of their children are vital, but are often overlooked. In urban India, women working outside the home can access the National Crèche Scheme under which modest efforts have met with success ([Planning Commission, Govt. of India, 2013](#)). Mobile Crèches, an Indian non-government organisation, runs day care centres in partnership with the government. They continue crèches during intervals of absence of government support through support from other sources. Mobile Crèche staff work closely with builders and contractors and operate crèches at construction sites. Mobile Crèches' day care centres aim to ensure holistic development of children, so its impact can be assessed against a number of different outcomes (keeping children healthy, nourished, safe and in school). Mobile Crèches encounters challenges in sustaining their efforts (New Philanthropy Capital and Copal Partners, 2008).

There is a mandate to blend Anganwadi Centres (under ICDS) and the crèche scheme to provide a community level facility where trained government or NGO recruited workers (where government partners with an NGO) provide early childhood development (ECD) services, toys, a vibrant environment and crèche services. However, the reach has been very limited. In Kerala, developmental therapists (diploma holders in Clinical Child Development from the Child Development Centre) have trained Anganwadi workers to provide child stimulation, care and detect developmental delay.

Constraints to provision of child care in urban slums include high cost of land for renting suitable venues. In Kenya, the Kidogo social enterprise overcomes these challenges and operate at scale within Nairobi's slum communities. They use a 'hub & spoke' model which combines 'hubs' – centres with early childhood development expertise with a microfinance model where women residents in the slum are provided with a 'crèche in a box' with equipment needed to care for a small number of children in their home (see <http://www.kidogo.co/> for details). Evaluation of these approaches to understand their sustainability and impact on health and nutrition outcomes and early childhood development are much needed.

Urban poor women's groups promoting girl child and youth education and children-youth groups in urban poor neighbourhoods/communities have demonstrated promise in reducing gender inequity. Education

embodies inclusion as well as teaching about the risks of exclusion has an important role in changing long standing social norms that perpetuate and reinforce social inequalities ([Agarwal et al 2016](#)). Formation and steadily empowering informal settlement women's groups across 410,000 slum/informal settlement populations in Indore and Agra and UHRC's capacity building input to help them generate and manage collective social needs funds has gradually given them power to gently and tactfully negotiate for services and infrastructure from civic authorities and improve family economics, health, education, nutrition, housing and the overall social well-being of large entire neighbourhood clusters. NGOs play the important role of supporting urban poor community groups in negotiations with the civic authorities – data driven, gentle, specific, solutions requesting community petitions signed by several community representatives/community groups, reminders formally submitted to civic authorities, and maintaining a paper trail – to enhance empowerment, demonstrate existence of unlisted needy pockets and co-produce solutions (UHRC). Social capital in the form of neighbourhood associations or groups of the urban poor in India have provided the poor with effective “voice” and negotiation avenues in local bureaucratic and political circles ([Agarwal et al., 2016](#); [Appadurai, 2001](#); [Garau et al., 2005](#); [D'Cruz and Satterthwaite, 2005](#); [Karanja, 2010](#); [Pervaiz et al., 2008](#))

Key readings

The six 'must-reads' are in bold below:

Reducing exclusion

Rashid, S. F., (2009) Strategies to Reduce Exclusion among Populations Living in Urban Slum Settlements in Bangladesh, *JHPN*, http://www.heart-resources.org/doc_lib/strategies-reduce-exclusion-among-populations-living-urban-slum-settlements-bangladesh/

Health service delivery in urban areas

Health Research and Social Development Forum (2014) The Urban Health Project: Developing Strategy to Improve Health Care Services in Urban Areas of Nepal.

<http://www.herd.org.np/sites/default/files/resources/Urban%20Health.pdf>

Ziraba, A., Mills, S., Madise, N. Saliku, T. and Fotso J-C (2009) The state of emergency obstetric care services in Nairobi informal settlements and environs: Results from a maternity health facility survey. *BMC Health Services Research* 9, 9:46 DOI: 10.1186/1472-6963-9-4

<http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-9-46>

Adams A. M., Islam R, Ahmed T. (2015) Who serves the urban poor? A geospatial and descriptive analysis of health services in slum settlements in Dhaka, Bangladesh. *Health Policy and Planning*. 2015;30(Suppl 1):i32-i45. doi:10.1093/heapol/czu094. http://www.heart-resources.org/doc_lib/serves-urban-poor-geospatial-descriptive-analysis-health-services-slum-settlements-dhaka-bangladesh/

Urban community volunteers

Alam, K. and Oliveras, E. (2014). Retention of female volunteer community health workers in Dhaka urban slums: a prospective cohort study. *Human Resources for Health*, 12, 1-11.

http://www.heart-resources.org/doc_lib/retention-female-volunteer-community-health-workers-dhaka-urban-slums-prospective-cohort-study/

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Questions for discussion

- What approaches improve confidence and self-reliance among vulnerable urban dwellers such that they can access basic services?
- What programme methods will enable and empower urban poor to adopt optimal health, nutrition and hygiene practices at household and community levels?
- How should donor/aid agencies support 'de-projectised' interventions to facilitate efforts towards building self-reliance and cross-generational capability among urban poor to tread their own path of overcoming vulnerabilities?
- What strategies can catalyse processes causing the urban disadvantaged to steadily become their own voice at negotiating platforms at city, provincial and national levels?
- How can policy makers and authorities be encouraged to include a greed index (or suitable measure) in monitoring progress in social equity dimension of policies/programmes, such that service provision benefits the needy, rather than a larger benefit accruing to the rich eager to become richer?
- What role can NGOs play in identifying and reaching out to the vulnerable settlements, unlisted and hidden settlements with preventive care, health and hygiene behaviour promotion and in community-provider linkage?
- How can donor agencies collaborate with national, state and city governments to provide a sustained dose of catalytic stimulus in cities across DfID priority LMICs to develop working examples of need responsive demonstration programmes?
- How can external agencies involve the urban poor community as active stakeholders in planning and implementation of PPP approaches to help them be more need responsive?