KOLKATA FOR MOTHER AND CHILD
A case study
M. Badrud Duza
In collaboration with
G.N.V. Ramana and Sanchita Chowdhury

The World Bank
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### Abbreviations and Acronyms

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<th>Abbreviation</th>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare (GOI)</td>
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<td>MTR</td>
<td>Mid-Term Review</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<td>ODA</td>
<td>Overseas Development Association (United Kingdom)</td>
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<td>PMP</td>
<td>Private Medical Practitioner</td>
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<td>PTMO</td>
<td>Part Time Medical officer</td>
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<td>PVO</td>
<td>Private Voluntary Organization</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<td>RDC</td>
<td>Regional Diagnostic Center</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<tr>
<td>TMC</td>
<td>Trina Mul Congress (Political Party)</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Acknowledgments

The present research has been a great learning experience for us. We have been fortunate to be scribes for an inspiring tale told by many actors. This is a case study in exemplary delivery of family welfare and public health care against the backdrop of desperate poverty in the vast slums of Kolkata city.

Our greatest debt is owed to the numerous slum residents who were the recipients of services and their grass-roots service providers - both groups mainly comprising of poor women in the urban slums -- who presented the materials that enrich our work. The municipal chairmen and other local leaders and dedicated professionals shared with us the process of community mobilization and ownership of the low-cost innovations, and equally deserve our deep appreciation. Our warmest congratulations are accorded to the Kolkata Metropolitan Development Authority (KMDA) that implemented the Kolkata city part of the India Population Project VIII (IPP VIII) and facilitated the present documentation. Senior KMDA officials including Mr. Prabh Das, IAS, Chief Executive Officer and Ms. Roshni Sen, Special Secretary, KMDA and Project Director, and Mrs. Nandita Chatterjee, IAS, former Project Director, provided valuable insights for our understanding. We are particularly thankful to Dr. B. Bhattacharjee, Chief of Health and a key driving force of IPP VIII Kolkata, and his colleagues for the infinite help at the field phase of the study and for hours of invaluable deliberations on various important topics.

We are also grateful to the Ministry of Health and Family Welfare (MOHFW), New Delhi, for the extensive support extended at every stage of the study. Particular mention must be made of Mr. Gautam Basu, former Joint Secretary and Mr. A. K. Mehra, Director, Area Projects. The Kolkata Experience Sharing Workshop organized by KMDA and MOHFW was attended by IPP VIII officials from the project cities, representatives of development partners, and several members of the cabinet from the Government of West Bengal. This provided an opportune forum for reflections over the genesis and vision underlying the project, the achievements and the outlook, and for gleaning the
Acknowledgments

lessons learnt in the process. Finally, we do appreciate the long support from the World Bank -- the New Delhi Office for various operational matters; and the Human Development Unit for the South Asia Region, Washington, D.C., for financial support and substantive guidance.

The participatory research and deliberations within the study team proved highly productive. Dr. G. N. V. Ramana, Task Leader for IPP VIII, brought in great analytical rigor to the design and write-up. He also provided an extremely useful comparative perspective vis-à-vis other IPP VIII cities. Ms. Sanchita Chowdhury, Anthropologist-Consultant, took meticulous care and ensured exceptional quality control during weeks of arduous field investigations, including a series of focus group and in-depth interviews at various levels. Their genuine contributions and excellent collaboration are warmly acknowledged. Together we were able to orchestrate a very complex story line from many angles, and feel fully rewarded in the prospect for wider sharing of our findings and conclusions. We all in the study team would remain nostalgic about this satisfying venture.
Why is the Kolkata Experience Salient?

This is a story of partnership between beneficiaries and providers of Reproductive and Child Health (RCH) services successfully orchestrated by dedicated local leaders. Indeed, this is a story of proactive community ownership of low cost interventions for the urban poor and under-served, the voiceless women, children and men. And this is the essence of why India Population Project 8 (IPP 8) Kolkata has been acclaimed as an innovative approach to addressing needs of the poorest of the poor from the disadvantaged urban slums, with possibilities for emulation elsewhere.

The experience has been resonated as a laudable success by independent reviewers, in-depth studies undertaken by the Kolkata Metropolitan Development Authority (KMDA), and reports of the Government of India (GOI), the World Bank, and several development partners. The achievements evidenced in the present document speak for themselves in absolute terms of outputs and outcomes as well as several non-measurable changes the program could successfully bring about, against the backdrop of the desperate milieu. They are corroborated by key stakeholders at all levels, starting from the beneficiaries at the family level to the community leaders, local service providers, and KMDA managers, and GOI policy makers.
A Success Story from India Family Welfare Urban Slums Project:

Key Findings

The poor people's turn always comes at the end. They are made to feel that they are placed at the receiving end only. This must change. The services must literally reach their doorsteps. The cost of service should be such that these poor people can afford without constraints. The services must also take into account the convenience of the poor people to access them. The timing of the services will be such that the poor beneficiaries need not waste their productive time to avail them.

- Dr. B. Bhattacharjee, Chief of Health, IPP VIII Kolkata

The Setting

This is a documentation of effective partnership that helped to improve Reproductive and Child Health (RCH) outcomes for the urban poor in Kolkata, India. This partnership was supported by the IDA financed (US$ 71.4 million) Family Welfare Urban Slums Project. The project was implemented concurrently in four metro cities of India under the stewardship of Union Ministry of Health and Family Welfare over an eight year period (1994 to 2002). The Kolkata Metropolitan Development Authority (KMDA) implemented the project using a Credit of about US$17 million.

A total of 3.8 million urban poor (family income less than US$ 32 per month) from three municipal corporations (Howrah and Chandan Nagar, and part of Kolkata), and 37 smaller municipalities benefited from this partnership.

The Model

The project provided basic community outreach as well as facility based RCH services including counseling to the urban poor. Subsequently, "non-beneficiaries" (above poverty line) also received services on payment of costs at lower-than-market rate. This model has subsequently been extended to 20 more cities in the state of West Bengal with support from the Department for International Development (DFID) and IDA.

A large fleet of trained neighborhood workers, designated as Honorary Health Workers (HHWs), mobilized the poor communities for immunization, family planning and other basic and referral services. They were also actively involved in women's empowerment initiatives supported under the project, including reproductive health education for young women and training women in vocational skills and entrepreneurship.
development. The HWWs, were drawn for the same community they served and paid a token monthly honorarium of about Five Hundred Rupees (about Ten US Dollars)

These workers were supported by a limited contingent of paramedics and Part Time Medical Officers (PTMOs) providing services. They were supported by two levels of supervisors. The first level included HWWs who excelled in their performance and the second level, trained paraprofessionals (either Auxiliary Nurse Midwives or male health workers). The PTMOs, drawn from the private sector on contract, provided medical care during specified hours at the clinics. Maternity and obstetric care, diagnostic facilities, and specialized care were provided at the out patient departments at a modest cost. For this, the project strategically used services of specialists with community orientation and yearnings available in the locality through convenient scheduling of services during their lean hours. The KMDA fully decentralized the program and limited its role for technical oversight and trouble shooting. This made the elected representatives of local bodies fully accountable for program implementation.

The Impact

Independent evaluations during project implementation and at the end indicate significant improvements in RCH outcomes and processes.

Changes in Key Impact Indicators

![Graph showing changes in infant mortality rate and total fertility rate from 1993 to 2002.]

Changes in Key Process Indicators

![Graph showing changes in key process indicators such as prenatal care, institutional delivery, fully immunized children, use of terminal methods of contraception, and contraceptive prevalence rate from 1993 to 2002.]

* Baseline Data from mid term review 1998
In addition to the changes which could be measured, there were several gains which are difficult to measure. These include strong community ownership and development of broad political consensus on positioning reproductive and child health as an important social priority cutting across party lines.

**Key lessons**

Some of the critical features and underlying processes from Kolkata initiative are worth noting for possible emulation elsewhere:

- No single agency can effectively address the growing health needs of the urban poor. There is need for strategic partnerships between public and private sectors working closely with the communities. Such partnerships among honorary workers, part-time doctors and specialists from the private sector, local bodies and KMDA not only improves access to the poor but also can help keeping the program recurring costs low.

- Demonstrating change requires long-term societal commitment and support to health and equity in the context of the urban poor, with synergic linkages among ongoing health and development programs. The Kolkata initiative was built on successive Bank and DFID supported community development programs during two preceding decades. An agency which is development oriented (such as KMDA in this case) is better suited to engage the communities in a dialogue than the agencies that provide civic amenities routinely.

- To firmly institutionalize the reform, there is need to decentralize the program and fully engage local self governments in the process. Ownership by local municipalities is one of the critical factors contributing to the observed changes.

- Although providing basic health services continues to be the primary responsibility of the government, identifying and targeting these services to the poor is important to improve health outcomes. Provided the poor have been well identified, differential user fee could be an effective instrument to protect and cross subsidize the poor.

- It is important to ensure appropriate essential referral back-up (small neighborhood maternity homes) beyond home based RCH care, with optimal cost-sharing.

- Empowering women about their reproductive rights and inputs for making them more economically self-reliant should go hand in hand with supply driven initiatives to improve physical access to RCH services.
KOLKATA: Mega City of Great Challenges and Unique Opportunities

Kolkata, capital of the State of West Bengal, has been a mega city since decades. It has long been a pre-eminent seat of culture as well as a commercial and industrial center attracting huge multi-ethnic populations from all parts of India. Independence from British and partition of Bengal in 1947 resulted in the influx of millions of refugees from East Bengal to Kolkata. The resulting overcrowding and strained public utilities became highly pronounced in the form of vast stretches of slums in greater Kolkata. In recent times, the situation got aggravated by fresh population movements during and following the war of liberation for the creation of Bangladesh (1971). The oceans of slum population Below Poverty Line (BPL) posed high volatility, and social and political pressures. The challenge for provision of minimal and decent RCH care in such a milieu - and the implications for failure to do so - drew the attention of policy makers, planners and societal leaders in early 1970s.

At the same time, Kolkata also has been a city of perennial hope and rejuvenation. It is the city of Mother Teresa. It is a city of exquisite traditions, with a long history of pro-people social movements. As underscored by many respondents in the present investigation, these movements had been led by outstanding saints, reformers, and leaders in politics and culture. Ram Krishna Paramhansa, Swami Vivekananda, Acharya Prafulla Chandra, Raja Ram Mohan Rai, Iswar Chandra Vidyasagar, Rabindra Nath Tagore, Sarat Chandra Chatterjee, and Netajee Subhash Chandra Bose are part of the galaxy that has kindled beacons of inspiration and reforms for the disadvantaged and the downtrodden over the generations. All these create an enabling environment and optimism for the millions of women, children and men below the poverty line, more than 40 per cent out of greater Kolkata’s population of nearly ten million.
Advent of IPP 8 Kolkata

Kolkata is one of the four sister cities covered under Family Welfare Urban Slums Project, known as India Population Project 8 (IPP 8). The other three cities were Bangalore, Hyderabad and Delhi. Carried out under the auspices of the Union Ministry of Health and Family Welfare (MOHFW), Government of India (GOI), and supported by the World Bank, IPP 8 Kolkata was a major Urban Slums Project to address the RCH issues mentioned above. It was implemented by the Kolkata Metropolitan Development Authority (KMDA) between 1994 and 2002.

A total of 3.8 million urban poor - about 40 percent population in two Municipal Corporations (Howrah and Chandan Nagar) and part of Kolkata Corporation, and 37 smaller municipalities - were covered under the project. For the first time, quality basic health care at low or no cost was provided to Below Poverty Line (BPL) beneficiaries at their doorstep complemented by referral back up for essential services. These would have been inconceivable without the strides made under IPP 8.

The focus was on providing basic community outreach as well as facility based RCH services including counseling to women, men and children belonging to poor families ("the beneficiaries") at no or minimal cost. At a later stage, "non-beneficiaries" (above poverty line) also received services on payment of costs at lower-than-market rate. This added credibility to the free or minimal cost care extended to the poor and also helped to generate revenues for maintenance and further support to the beneficiaries. During the final phase of the Project, this model was extended to 20 more cities outside the KMDA areas (half supported by the UK Department of International Development/ DIFID), which is not part of the present analysis.

The advent of IPP 8 was preceded by years of learning and evolution on urban issues, side by side with a number of projects that were implemented in related fields. The GOI policy context, which flagged comprehensive urban needs, included:

- Krishnan Committee Report (1982)
- Urban Revamping Scheme (under the Seventh and Eighth Five Year Plans)
- Urban Basic Services for the Poor
- Environmental Improvement in Urban Slums Program
Nehru Employment Scheme
• Seven World Bank (IDA)-assisted Population Projects since 1973, including one urban slums project (IPP V -1988), covering Bombay and Madras cities
• Calcutta Urban Development Projects (CUDP I, II and III) since the late 1980s
• Calcutta Slum Improvement Project supported by British Overseas Development Agency (ODA)

The significant achievements made by IPP VIII Kolkata deserve recognition by their own right. Nonetheless, the project was enormously benefited by the strong foundation laid by the above milestones during two preceding decades. Enhanced insight into the dynamics of community mobilization and growing involvement of the local community in urban health and development programs for the poor were most pivotal in the process. These paved the way for innovative RCH programs responsive and adaptive to local needs, with flexibility to link them to broader community contexts and demands. In view of the above developments and historical backdrop, Kolkata did enjoy a comparative advantage over the other three IPP 8 project cities, and had a better edge for results on the ground.

Kolkata Innovations

To understand the genesis of IPP 8, the building blocks of urban health programs layed by three successive Bank-supported CUDPs from the 1970s to the early 1990s would appear to be specially relevant:

• CUDP I (IDA funding of US $35 million), 1970-71 to 1978-79; This included the Bustee (Slum) Improvement Program (BIP), with focus on upgrading existing infrastructure rather than on creation of new ones, with a view to arresting the rapid deterioration in the urban environment, especially in the metropolitan core. Calcutta Metropolitan Development Authority (CMDA which has been lately designated as KMDA) was in charge of budgeting, supervising and coordinating the interventions, while the actual execution was done by a number of line agencies in the field.

• CUDP II (IDA funding of US $87 million), 1978-79 to 1983-84: It followed a poly-nodal strategy of urban growth and pruning of service delivery norms for design of infrastructure to cover a wider population for a given investment. Programs for income and employment generation for the urban poor received more attention, as these would help improve sustainability of the assets created, particularly in the slum areas. Accordingly, the project included interventions for health, employment
generation and primary education, with the urban poor as the target group.

- **CUDP III (IDA funding of US$147 million), 1983-84 to 1991-92:** This proved to be a further sharpening of important processes and developments. Financial and institutional strengthening of the municipalities was more systematic during this phase, along with improved management of outreach and extension services; cost recoveries for certain services were introduced; and there was emphasis on community based health care facilities and on schemes for generation of employment through small scale enterprises. Evaluated by WHO in September 1991, it was rated as one of the most successful health service schemes in the world, which concentrated on urban slum populations. Implementation experience with variants of this model, especially with ODA-assisted health projects in Kolkata and Hyderabad as well as the evaluated experiences of UNICEF, Private Voluntary Organizations (PVOs), and Private Medical Practitioners (PMPs) in the provision of health services to urban slum populations was also taken into account.

IP 8 Kolkata was a culmination of the above antecedents and processes. With IDA support of about US$17 million out of the total project outlay of US$71.4 million, it was implemented between 1994 and 2002. The overarching rationale for the RCH interventions during this period was the continued development and further reinforcement of human capital as a strategy to alleviate urban poverty targeting the most vulnerable: poor women and children who ran the perpetual risk of falling through the already tenuous safety net. Some counseling and educational programs were developed also for adolescent girls. It was a holistic, innovative and flexible approach to RCH aimed at:

- **Crystallizing and strengthening demand**
- **Augmenting supply**
- **Enhancing access, equity, and affordability**
- **Promoting women’s empowerment**

The intervention package included family welfare with basic health services, enhancing community awareness on public health and hygiene, and women's welfare and income earning opportunities. Sustainable partnerships were built among local communities, PVOs and the private health providers.

The design of the program provided for targeted interventions that delivered quality RCH services at doorstep to the urban poor (with monthly family income of less than Rs. 1,500.00/US$32.00, defined as the poverty line). Toward this
end, it was a volunteer-based approach to RCH delivery, with a large fleet of trained neighborhood workers, designated as Honorary Health Workers (HHWs) and supported by a limited contingent of paramedic and Part Time Medical Officers (PTMOs). The HHWs, paid a token monthly honorarium of about Five Hundred Rupees (about Ten US Dollars), were drawn from the same community they served as social mobilizers for immunization, family planning and other basic and referral services. They were supported by two levels of supervisors. The first level included those HHWs who excelled in their performance and the second level paramedics (either Auxiliary Nurse Midwives: ANMs or male health workers). The Part Time Medical Officers (PTMOs) provided medical care during specified hours at the clinics. Maternity and obstetric care, diagnostic facilities, and specialized care at the Extended Special Out Patent Departments (ESOPDs) were also made available locally at a modest cost, mostly utilizing local private practitioners with community orientation and yearnings, on a part time basis through convenient scheduling of services during their lean hours. These were later expanded to non-beneficiaries above the poverty line on cost sharing basis. Such an extensive network of well-functioning services in the urban slum environment would have been inconceivable without the developments made under IPP 8. Annex 1 provides the structure of service delivery under the Project.
MEASURING SUCCESS: Outputs and Outcomes

Methodology
The study gleans relevant documents from various secondary sources and refers to key output and outcome indicators from primary data for the Project collected by independent agencies. Numerous studies and reports ranging from the Project design phase to regular World Bank-GOI-KMDA monitoring visits have been analyzed and utilized. These have been complemented by additional primary data from 29 Focus Group discussions and 23 in-depth interviews covering a total of about 300 key actors. They included program managers, community leaders, service providers and their supervisors, and beneficiaries at the grass-roots levels. Extensive field visits by the authors have gone into critical implementation issues and modalities, crosschecking and corroborating the findings through dialogue with key stakeholders. Finally, the preliminary findings of the study were shared with a cross section of participants in a major national workshop held in Kolkata in February 2002, which was organized by KMDA in collaboration with MOHFW. Besides representation of IPP 8 Kolkata, this was attended by four members of the West Bengal Cabinet, managers of the other three IPP 8 cities, and donor representatives.

Improving Access to Basic RCH services
In a near stagnant setting and despite a slow start-off, IPP 8 Kolkata was able to bring in truly substantial changes in the RCH indicators and performance in the course of a few years. As noted earlier, nearly four million beneficiaries below the poverty line (BPL) received doorstep service, for the first time in their life and in the life of the slum communities. It is a tribute to the Project that well-equipped and well-staffed facilities also attracted clients above the poverty line, ready to pay for the services.

Access to quality RCH services improved significantly through the

Box 2. Project Inputs to improve Access

- Health Administrative Units (HAUs): 116
- Health Sub-Centers: 273
- Maternity Centers: 23
- ESOPDs: 25
- Regional Diagnostic Centers: 8
- School improvement (toilet facilities for female students): 297
establishment of a network of about 445 conveniently located service outlets with well-equipped physical infrastructure. This enhanced institutional capacity for service delivery significantly, besides providing suitable venues for quality care. In addition, nearly 300 schools received toilet facilities for female students. The targets for physical infrastructure were achieved 100 per cent or more (See: Box 2).

Vastly expanded client access to RCH services and personnel is also spelled out by the beneficiaries themselves in Box 3.

### Box 3. Beneficiaries: On Doorstep Services

- **We are receiving the services at our doorstep. The Didis/Elder Sisters (HHWs) always inquire about our health. We discuss our health related troubles with the HHWs. They provide us medicines for the common ailments and give ORS packets for diarrhoea. We don’t need to go to the clinic for such diseases most of the time.**
  
  - Beneficiary, Bali Municipality

- **The HHWs give us MALA-N and always remind us to take it regularly. Earlier, we were not so much aware of how to prevent pregnancy. Even if we knew some of the methods, we did not know how to use them. Moreover, we felt shy to buy them from the medicine shop. We knew that we could get them from the Government hospital, but it is too far from our place and takes a lot of time. Now we are getting these at our home. Definitely these services have helped us a lot.**
  
  - Beneficiary, Naihati Municipality

- **When she (HHW) visits our houses, we can ask her privately about our (reproductive and sexual) health without any hesitation. We could not think of receiving this kind of service earlier. Moreover, she stays in (our) locality, and we can approach her at any point of time in case of emergency.**
  
  - Beneficiaries, Sreerampur Municipality

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**Generating Demand for RCH Services**

Profound improvement also took place in client behaviors with cumulative effect on the RCH outcomes. There was a pronounced change in the health seeking behavior; demand for services; and more important, in the public awareness of individual rights to the community health facilities. The project used innovative and indigenous Behavior Change Communication (BCC) approaches, including direct provider-client trust and reinforcements, for generating and sustaining demand for RCH services. Empowering women
Box 4. Emerging RCH Norms and Behavior Change

- Pronounced improvement in RCH/ Health seeking behavior since the baseline
- Better appreciation of Quality of Services
- Resultant changes in family size norms (about two; among many, one: even with a single girl child); preference for higher age at marriage; later age at first birth; wider child spacing; and increased value of girl child

and adolescent girls through income generating enterprises, female education, and counseling further complemented the BCC initiatives. Boxes 4 and 5 provide a glimpse of the emerging transformation.

RCH Outcomes

There was a significant improvement in the RCH indicators. Compared to the baseline figures at Project inception or Mid-Term Review, the End Line Surveys revealed considerable progress in both mortality and fertility decline, and the accompanying levels of immunization, institutional delivery, contraceptive prevalence, and delayed age at marriage. The figures that follow may, thus, be deemed as nontrivial achievements, even in absolute terms. Judged against formidable levels of poverty and the slum setting, the accomplishments
Box 5. Beneficiaries: On RCH Norms and Changing Health Seeking Behavior

- We live in the tiny shanties jostling on each other. We have very little space to live in. But we know that if we keep it clean, we can prevent some of the diseases. So, we try to keep our houses clean and the surrounding areas too.
  
  - Beneficiaries, Bali Municipality

- Now a days almost all of the mothers in our area know the positive aspects of keeping their family small. We have realized that it is difficult to manage the expenses of a large family with our limited earning. Now most of us have either one or two children. As we have small number of children, we are able to take care of them better. We can pay more attention to their health and education. We are sending our children to school.
  
  - Beneficiaries, Baranagar Municipality

- We went to our native place, Bihar, for some time. During that time I felt that I was pregnant. Traditionally in our village all the deliveries take place at home. There are no doctors and the Dai conducts these deliveries. People never feel that they should go to a hospital for deliveries. But I felt hospital is much safer than home. If I would have any problem during delivery, I will not get doctors or nurses at my home in my native place. The facilities available at the hospital cannot be arranged at home. My first child was born at hospital in this area. I faced no problem at that time. This time also I wanted to go to the hospital for my delivery. Hence, I have returned from my native place in a hurry. I have got examined at the Sub-Center, and I have received a card. The HHW and doctor told me that they would arrange for the same hospital for me where my first child was born.
  
  - Beneficiary, Titagarh Municipality

- The HHW had told me repeatedly to get my delivery at the hospital. But I was scared to go to the hospital, because I had heard from my relatives that the doctors slit the birth passage at the hospital. My mother-in-law and other elderly relatives told me that they gave birth to a number of babies at home without any problem. So they decided that my delivery would be at home. My baby was born at our home. A trained Dai conducted the delivery. I do not want my next baby within three years. Our HHW has brought me here and I have been inserted Copper T today. I was so scared that it would be painful. But it is not like that. Our HHW was always with me. The Doctor has also discussed with me as to why it is not safe to give birth at home.
  
  - Beneficiary, Titagarh Municipality
Previously we heard from our elderly relatives that the Copper-T pierces through the internal organs after its insertion and so it causes severe bleeding. We were scared. But we have seen that lots of women have inserted copper T, and they have no problem. We felt convinced. Our HHW has taken us to the clinic for insertion of Copper-T. Now a few months later, we are facing no problem.

- Beneficiaries, Bali Municipality

Some of the elderly women said that if we give immunization to our babies they would become impotent when they grow up. We did not believe these, because the HHWs told us that each and every child is getting immunized, and immunization helps the children grow necessary strength to fight against some serious illnesses. The HHWs said that children in their families have also received immunization. Now every child in our neighborhood area receives immunization.

- Beneficiaries, Bali Municipality

appear to be genuinely worthwhile. Relative to the earlier stage of poor demand for and highly inadequate access to the rudimentary RCH service outlets and the services themselves, they were now within reach of the urban poor -- at an affordable cost and within the local community itself. For the first time, the vision of the Project architects proved to be a reality, exceeding expectations on many fronts. There was a synergic blending and matching of the demand and the supply sides of the RCH equations in Kolkata slums. Some highlights of the outcome are summed up in Box 6.

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<th>Box 6. Key Outcome Indicators</th>
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<tr>
<td>Increased Contraceptive Prevalence Rate among eligible couples (45 to 72%)</td>
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<tr>
<td>Increased immunization (About 70 to nearly 100% of eligible children fully immunized)</td>
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<tr>
<td>Increased Antenatal and Postnatal care (nearly 100%)</td>
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<tr>
<td>Nearly complete institutional delivery (approaching 100%)</td>
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<tr>
<td>Early identification and referral of high risk pregnancies by the HHWs</td>
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<tr>
<td>Improved sanitation and community health through collective help</td>
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<tr>
<td>Significant declines in fertility (TFR 1.9 to 1.7), and infant mortality (IMR 56 to 26/00), and maternal mortality increasingly rare in Project sites</td>
</tr>
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What made Kolkata a Success?

A vast and intricate mosaic of unique processes provided the route map in Kolkata to realize the vision of the policy makers and planners. These helped translate the thrust on community ownership and commitment to the cause of the urban poor, especially their needs for basic health care, hygiene and sanitation. Large-scale acceptance of the new RCH norms and the corresponding health seeking behavior were reinforced and sustained by systematic operational modalities.

Focus on Outcomes: There was a vital point of departure from the previous preoccupation with Project inputs to outputs and outcomes. The prime focus now was on outcomes, results on the ground -- ensuring the delivery of the stipulated quality and quantity of the services to the beneficiaries. This was also evident in the deliberations of the Honorable Ministers referred to before and was widely shared by all actors and agencies involved in implementation.

Client responsive services: The overarching emphasis was on expanding access to doorstep and client-friendly service delivery at affordable cost. This was done by the use of an essentially volunteer-based outfit (HHWs and their supervisors) for the outreach, covering selective counseling, services (including early identification and referral of high risk pregnancies), and follow-up at household, community and clinic levels. Deployment of the Part Time Medical Officers (PTMOs) and strategic use of specialists at selected hours helped provide quality care at low cost. The basic diagnostic, maternity and some specialized services were made available to the beneficiaries on a modest cost sharing basis. The support was made possible by additional revenues generated through opening up some of the services at lower-than-market costs to non-beneficiaries above the poverty level. All in all, the key underpinning was for a demand-driven mode, reinforced by streamlined and salient supplies.

Public-Private Partnership and Curative Back-up: In view of their special importance in the present context, some additional elaborations are called for. The earlier experience with CUDPs evidenced that the public sector in the outlying areas was highly constrained with respect to availability of doctors, particularly specialists. This resulted in inadequate care for the urban poor and gross under-utilization of the existing health infrastructures. IPP 8 effectively exploited the huge potential to make use of both generalist and specialist doctors living
in the vicinity during their free time. It resulted in a Win-Win situation for all concerned: the private practitioners (in terms of added credibility in the community and personal business); the common people (better access to doctors and reputed specialists); and the municipalities (increased utilization of services and facilities created). Positive outcomes accrued to beneficiaries as well as to non-beneficiaries above the poverty line.

Another important issue related to curative back up for RCH and basic health care. The project was aware of the national and international experience that a strong/minimal curative back up is essential for primary health care to fully succeed. This has been widely documented - for example, in Jhamkhed in Maharashtra; Child in Needs Institute (CINI) in Kolkata and Janani in Bihar; and International Center for Diarrheal Disease Research, Bangladesh, (ICDDR, B) in Dhaka. In the absence of such back-up, RCH or primary health care would appear to be interventions in isolation from clients’ broader health needs and security. By ensuring such back up for essential referral services, the project brought in high credibility for the outreach volunteers (HHWs) and, at the same time, immense benefit and satisfaction to the clients. This was a vastly superior arrangement, compared to the primary care systems elsewhere in the state or the country where the referral services are provided by other divisions or units of the health systems, with very weak linkages and support.

Well-defined Program, with Supportive Supervision and Monitoring:
A distinct feature was that it was a simple but well-defined field program, meticulously implemented and carefully monitored. A good deal of accountability was built in, starting from providers and supervisors at the ground level to the medical personnel, community leaders, and managers at KMDA and GOI. Systematic micro planning was characteristic of the Project. Advance time-bound action plans included protocols of daily, weekly and monthly work plans, and schedules for service delivery, and review and supervision of household, community and clinic based work. These proved useful for all concerned, including the beneficiaries themselves.

Supportive supervision in the field and weekly review meetings helped resolve implementation issues and strengthened staff development, with practical feedback to program improvement. It is also unique that program monitoring was not limited to external managers making field visits occasionally. Rather, the inherent strength was continual vigilance by the leadership and other stakeholders ever present in the community and, importantly, by the empowered and vocal clientele themselves who were made conscious that the expected
services should indeed be in place and were delivered on time and to their satisfaction.

The mode of community ownership played a decisive role in the process, with the Municipal Chairmen and leaders at the Ward level Committees taking a special responsibility and pride on the positive outcomes. Strong implementation guidance and technical support was readily available from the KMDA Project Team. The MIS reporting format was also kept user-friendly and minimal, keeping in view its practical use and utilization. Finally, regular World Bank review missions helped make the supervision and monitoring process highly transparent, educative and productive for all concerned - the community leaders, the managers, the technical supervisors, and the service providers. Such a system was a prerequisite for the efficient functioning of a volunteer-based outreach setting and medical care provided essentially by Part Time Medical Officers and private practitioners under constant community oversight.

**Participatory Mode and Leaders-Client-Provider Bonding:** The community based volunteers were selected with due attention to their track record of community work and came from the clients' own socio-cultural setting. This allowed for a spontaneous sense of mutual identification and affection in service delivery. Service round the clock was not a matter of official requirement but a natural extension of community and good-neighborly bonding, an element commonly in abeyance in most public sector interventions. Leaders, providers and clients - and in many cases, the managers - were all from the same soil, with common interest and a shared vision with respect to defining a holistic agenda of community needs, RCH and health. These also included broader aspects of neighborhood hygiene and sanitation, women's empowerment, income generation and self-reliance; and adolescent counseling. The decentralized implementation and engagement of the local bodies noted above were found most fruitful.

**Satisfied Stakeholders:** At all levels - leaders, providers and clients - there was a good deal of contentment and gratification on their respective perspective. The leaders obviously had altruistic as well as political interests satisfied. Many providers had a new meaning of life as well, derived from their rather rare opportunity to serve and receive community commendation. Clients - beneficiaries and non-beneficiaries (above poverty line) -- previously unhappy because of the inadequate care available, were now satisfied with the service they received within easy reach and affordability. These factors brought in broad societal commitment in favor the Project.
Box 7. Providers: On Satisfaction and New Meaning of Life

- Previously we used to waste time during the noon, either gossiping or sleeping. Now we are utilizing the time more fruitfully. We have satisfaction that we are a small part of this vast social service. We never thought that we could get this much of respect and love from the general people. They respect us as doctors. We have an opportunity to share our feelings amongst ourselves as colleagues. The program has given a new meaning to our life.

   -- HHWs, Sreerampur Municipality

Box 8. Beneficiaries: On Participatory Decisions and as Satisfied Clients

- We have seen that the HHWs and other staff members of the program try to realize our needs. They don't impose their opinions on us but give adequate importance to our views. We also feel encouraged to give our opinions and at the same time we try to follow their advice.

- The programs like nutrition program, mothers' meeting, magic show, and drama are very informative and at the same time very enjoyable. Although we didn't want to participate in these programs previously, now with increasing participation we have learnt a lot from these programs. Now we encourage others to take part in these programs. Inspired by the role of HHWs, a few mothers are voluntarily motivating others to receive the services and spreading health awareness messages. We have realized that the program has benefited the poor people. We want these programs to continue.

   Beneficiaries, Naihati Municipality
Box 9. Successful Entrepreneur: The New Opportunities

+ This training has helped me a lot to become self-sufficient. I had to leave my education when I studied at Class VIII due to financial constraints. I am now earning Rs. 3000.00 to 4000.00 per month and looking after my family. I have started a trainer agency and presently I am providing training in different municipalities under the program of Swarna Jayanti Rojgar Yojana and IPP8. I never thought of leading such a prosperous life. I am sure that I will continue with the same after my marriage too.
- Successful Entrepreneur, South Dumdum Municipality

Box 10. Satisfied Adolescent Beneficiaries: On Adolescent Sexual and RH Program

+ On the first day of the training program, we felt shy, but Madam (RH Educator) was so friendly with us that we did not hesitate later.
+ I never thought that I could talk openly about sex. I had a lot of questions in my mind. But I did not find any body to ask. I was scared to ask a few questions that I always wanted answers to, but could not ask anyone fearing to be marked as a "bad girl." We got an opportunity to know so many things that we never knew earlier.
+ I thought menstruation is dirty. There are so many myths related to this. We are not allowed to work in kitchen and touch the idols. Now we know that as we are growing, this is quite normal.
+ I had heard about AIDS. But I didn't know what it was. I thought AIDS and STDs are the same. Now I understand clearly. I know how it is transmitted; how it could be prevented; what should be our attitude towards an HIV positive person.
+ I was told that if any boy misbehaves with me I would get pregnant. I felt so nervous. Now it has become clear to me what actually happens. I have come to know about our body and reproductive systems. Madam has taught us why early pregnancy is harmful to health. I do not want to get married before I am 20.
+ I got married early. If I had the knowledge before, I would not have the baby at an early age. However, I will try to have the second baby at least five years later. Then I will take some permanent family planning method. I shall pass this knowledge on to my daughter when she grows up.
+ We already have discussed with our friends regarding what we have learnt from this training. The training is really helpful to us. We can protect ourselves in future. This type of training should be arranged for all girls of our age. The boys should also get this training. Otherwise, we cannot utilize the knowledge fully.
- Adolescent Girls in South Dumdum, Madhayamgram and Naihati Municipalities
Box 11. The Satisfied Non-Beneficiaries

We won’t get such specialized treatment facilities at this cost charged at the Municipality Health Clinics (ESOPDs). The cost of services is even less than half than in other private medical institutions in the locality. The doctors and other staff take care of patients adequately and they are well behaved. The specialist treatment facility with a moderate charge was a demand in our area for a long time. We are happy that these facilities are being provided by the municipality under IPP 8.

- Non-Beneficiary Service Recipient
The Immeasurables that made a Difference

A number of rather intangible factors created an enabling environment, helped build strong commitment, and sustained the RCH initiatives across the urban slums. They were:

- **Community ownership** of the interventions, institutionalized by the Municipal Chairpersons and shared by the community leaders

- **Broad consensus on the RCH and basic health programs at the local level across political divides**, ensuring uninterrupted implementation regardless of political contours and changes in the local government

- **Women's and child health placed on a high profile community and State political agenda**, increasingly seen as an intrinsic and irreversible right, and blended with a mix of:
  - Altruistic motives of community service
  - Keenly perceived political stake at local, city and State levels
  - Empowered and vocal clientele demanding quality service and accountability in health care delivery

The leaders were keenly aware of the high political stake and volatility of failings in health care access and delivery for the mass and, concurrently, the enormous political capital that could be made by serving the people. It was a mutually reinforcing platform for both the leaders and the led in the local community. A satisfied client was also a guaranteed voter in the local and State elections. It was no wonder that the presence of the Municipal Chairperson in the service outlets became an increasingly common sight. In many instances, a Chairperson was found to have an office in the health facilities, spending hours monitoring the service providers and maintaining direct client contact.

As repeatedly echoed in the in-depth interviews and focus group sessions, the above thrusts were reinforced in view of the critical power base of the cabinet and the politicians in the Kolkata municipalities. Indeed, apart from representing their political constituencies, the Project areas include residences and long drawn connections of several ministers and members of the State Assembly as well as opposition politicians. These provide a very distinct fabric of opportunities and personal as well official policy and programmatic commitment on the part of key leaders and decision makers in community and family.
health. The recent expansion of the program to 20 more municipalities (10 supported from the project and 10 by DFID) and keenness of GOWB to follow a similar model even in rural areas, reflect the positive internalization process by the decision makers.

Leadership driven with a vision: A lofty vision for providing basic health care at the doorstep of the slum dwellers and an unimpeachable sense of commitment to make that happen were most phenomenal in the project. This was especially true at the level of senior professional management of KMDA. The dynamic role played by the Chief of Health, IPP 8 Kolkata, Dr. B. Bhattacharjee, deserves special mention in this regard (The opening

<table>
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<th>Box 12. Community Leadership and Pillars: Ownership and Commitment</th>
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<td>✷ Strong but friendly administration and supervision is being internalized in our program monitoring and it has been made possible by our Chairman. He is always beside us. He personally takes care of each and every aspect of program implementation. His involvement stimulates us to feel more encouraged. The Chairman visits Health Administrative Unit (HAU) at least once in a month and visits ESOPD, Maternity Center and Regional Diagnostic Center very frequently. He also visits the Sub-Centers and the field. Besides the visits, he regularly keeps track of program activities through the councilors. He knows most of the health workers personally and they also can approach him directly.</td>
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<tr>
<td>- Health Officer and Assistant Health Officer, Bhadreswar Municipality</td>
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<td>✷ People are getting services, which they never received earlier. Their expectation has increased. At this juncture, we cannot move away. We have to continue the program any way.</td>
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<tr>
<td>- Chairman, Naibati Municipality</td>
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<td>✷ Fortunately, we are able to cater to the people’s satisfaction. The demand for service is growing. We have to maintain the services that we are rendering now. Not only that, we have to surge ahead. We believe, If we do something good for the people, we will definitely get the support from them as we have been receiving and will be able to generate resources necessary to continue the program.</td>
</tr>
<tr>
<td>- Chairman, Bhadreswar Municipality</td>
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The Immeasurables that made a Difference

remarks in Box 1 of the present write-up - The Challenge and the Vision - are excerpts from him). Backed with a strong public health background and long experience with the earlier CUDP III interventions, his unflinching mission proved to be equally inspiring to the senior project management, the community leaders, the service providers at all levels, and the technical team that he led. Starting from the design stage and throughout the implementation phase, his singular dedication and determination were always found to be far beyond the calls of duty. The project was very fortunate in receiving his services without any interruption. Similar projects elsewhere should also explore and identify leaders with such vision and drive.

The above comments (Box 12) were reverberated at the highest levels of the State polity. As many as four members of the cabinet of the West Bengal State Government attended the Experience Sharing and Dissemination Workshop for IPP VIII Kolkata, held in the city, on February 14 and 15, 2002. Here are a few quotes (Boxes 13 to 16 tracing the Project's community focus and strategies.

**Box 13. Honorable Dr. Asim Das Gupta, Minister of Finance, West Bengal: Milestone in Community Management**

*IPP 8 Kolkata is a milestone in participatory community management. . . . We posed the health problems through the eyes of the common man. Shall we allow them to fall sick and then treat them? Or ensure that they do not fall sick and lose income? We realized that at least 50 percent of the morbidity is preventable through provision of safe drinking water and immunization; and nearly 85 percent of the people can be treated locally. As a sequel to CUDP III, we have involved and empowered the local community, decentralizing program management and implementation at that level. . . . The basic contours of the program have been the use of female community volunteer workers providing health care, surveillance and referral for 200 households, on token honorariums; seven such workers are supervised by a supervisor, also a female volunteer from the community itself. . . . On the basis of certification by the local municipality, health cards were issued to the BPL beneficiaries - initially for totally free service, later on adding a small charge for diagnostic and relatively specialized care. The venture has been enormously cost-effective; financially feasible; with enormous pay-off . . .
Box 14. Honorable Dr. Surya Kanti Misra, Minister of Health and Family Welfare, West Bengal: Safety of Community Health

IPP 8 is a landmark in community based interventions. As a physician I must say, health of the community is not safe with the Ministry of Health; it is not safe with health professionals alone. Health professionals around the world have a curative emphasis (rather than a holistic and preventive thrust). Community health is safe only in the hand of the community. Health workers from the community, available at any hour, odd hour, has been the key to the success (of IPP 8). Decentralization (of health interventions) does not simply mean decentralization from the Center to the State to Local Bodies. Decentralization must not stop until involvement of the people. They can help their health more than any one else. Planners and specialists are not substitutes for the people. In participatory programs, people formulate, implement and monitor (health interventions) activities while the Government participates.
The urban poor contribute significantly to the economy; and women make a very substantial contribution. Yet the fruits of development remained beyond the reach of the urban poor. In particular, the health facilities did not cater to the demand profile of the poor. The community based efforts in IPP8 made a breakthrough for the first time, opening up the facilities to the slum dwellers. There was also a healthy blending of bottom-up and top-down planning. The interventions were made demand-driven, with effective community protected safety nets. This was a big departure from the previous supply-driven efforts, which did not attract and serve the poor.

The success of the Project was rooted in the community based design, a design by the community, for the community. . . . Women members of the community proved to be the pivot -- both as beneficiaries and providers, both from the same community. They were the pillars.
Cascading Partnership among the Key Stakeholders

A very distinguishing mark and achievement of IPP 8 Kolkata has been a great orchestration of a grand symphony with a cascading partnership of many key actors:

- **Institutional Level - GOI-GOWB-KMDA-World Bank:**
  The continuing policy dialogue and critique among these key partners proved mutually reinforcing and inspiring, and most central in the design and execution of the operations. The process helped identify and resolve major implementation issues and take corrective steps during the life of the Project, especially following the Mid-Term Review (MTR). The crucial roles played by these four agencies included the following agenda.

  - **GOI:**
    - Enabling RCH policy environment
    - Interface between KMDA, Government of West Bengal (GOWB) and World Bank
    - Assured and steady fund flow
    - Commitment to urban RCH at national, State and city levels

  - **GOWB:**
    - Demonstrating strong political commitment supported by state policies
    - Ensuring uninterrupted funds flow to the project
    - Committing financial sustainability after the project
    - Supporting expansion of the Kolkata model to other towns and rural areas

  - **KMDA Management:**
    - Catalytic guidance and technical assistance to the municipalities and its leadership and concerned health functionaries
    - Institutional arrangements and training of the service providers, supervisors, and professional staff
    - Supportive monitoring and quality control
    - Inter-municipality coordination, exchange and experience sharing
    - Accelerated implementation, especially following the MTR

  - **World Bank:**
    - Policy dialogue at GOI, State and KMDA levels
• Funding support
• Coordination, monitoring and review missions
• Technical support and quality control
• Gleaning and sharing best practices among the four IPP 8 sister cities
• Flexible operations and program adaptation
• Following up on demanding benchmarks
• Mitigating bottlenecks and expediting implementation

Community Level-KMDA-Municipalities-Wards: This was the operational arena of the Project.

Strong commitment, effective mobilization and coordination of myriad input, outputs and outcomes at this level proved to be the decisive factors in the Kolkata success story, as harped upon throughout this report. KMDA provided overall guidance and support. The Municipal Chairmen spearheaded the process of community ownership and vigilance that became the heart and soul of the interventions, which the Municipal Councilors and Members of the Ward Committees were expected to emulate.

Enduring and strategic partnerships among the local bodies, the private sector and the community have proved to be the crux of a viable operation.
Lessons Learnt and the Replicability Riddle

Throughout the preceding analysis, we have captured many insights emerging out of the Kolkata innovations in RCH interventions for the urban poor in the city slums. Let us recapitulate the highlights:

Pillars and Heroes

The Honorary Health Workers (HHWs) and their supervisors, and the municipal chairpersons clearly come to the fore. The empowered clients - previously voiceless and unnoticed - follow interactively; without their active and collaborative participation, the success story would have remained a mirage. And so do the KMDA management; their conscientious and catalytic interface with GOI and the State Government, on the one hand, and with the cross-section of community stakeholders, on the other, accounted for a good deal of the accomplishments on the ground. In this wider perspective, the dynamic confluence of contributions made individually and collectively by these latter agencies made the difference. In that sense, it has also been pointed out during our in-depth deliberations that there perhaps are no specific heroes - and heroines, if one would wish to add - in this venture. It was an artifact of teams and teamwork, and an exquisite orchestration of a grand partnership, laced with inspiring commitment at all levels and a proud sense of ownership at the community level.

Accent on Start from the Outset

A number of activities should be flagged for an early start-off:

- Start service delivery early on. Do not wait for the infrastructures to be completed.
- Blend volunteer-based community mobilization and follow-up programs with a back up of good quality clinical care, which is affordable and easily accessible.
- Identify and acquire suitable land/venue for construction, with good client catchments, failing which expensive infrastructures remain unavailable most of the Project period and under-utilized later on.
- Focus initial project efforts in communities that are ready institutionally and politically; and expand to more challenging and less ready areas following due preparation in them and demonstrated success elsewhere -- consolidate achievements before unwieldy and non-responsive expansion.
Lessons Learnt and the Replicability Riddle

- Ensure decentralization, devolution and community empowerment.

Participatory Process
Building in a broad constituency of the partners is most critical. Toward this end:
- Reinforce the alliance of the principal stakeholders at the community, city, State, GOI and donor levels.
- Beneficiary participation is a key to results on the ground and ultimate success.
- Development agency (like KMDA) is in a better position to implement such innovations than a municipal administrative authority (like Kolkata Metropolitan Authority: KMA), as used in some other IPP 8 Project cities.

Provider Supervision
Since the great bulk of the workforce (HHWs) is comprised of non-paramedic volunteers, it is most crucial that their supervisors - at least the second/more senior of the two tiers of supervisors - be paramedics. This would ensure better support to the HHWs and help provide better quality of client care.

Replicability Issues
The strides made by IPP 8 in effectively addressing the RCH challenge for the urban poor in desperate slum settings have raised expectations elsewhere. How can the innovations be replicated? Or can they really be replicated? Is Kolkata too unique in terms of its historical backdrop of pro-people social awareness and movements? Is it too special with respect to the political attention and volatility of the huge urban slums, which are also critical seats of power? Are opportunity costs of alternative time use different in other metropolitan areas (such as Delhi) whereby token honoraria and small payments may not be able to attract volunteers or part timers for several hours of service a day in health care delivery? Answers to these complex questions are also complex, and issues relating to replicability and transfer of the Kolkata innovations to other cities in India and beyond would need to be carefully thought through.

At the same time, the foregoing discussions on the lessons learnt do provide considerable optimism. Some of the vital processes underlying the interventions deserve special consideration. Foremost among them are those relating to: institutional arrangements; community ownership; empowerment of the traditionally voiceless poor slum dwellers; low cost service protocols, backed by meticulous micro-planning; the inherent value of locally recruited service providers; strategic alliances of the key stakeholders and development partners; public-private mix in client-friendly service delivery at affordable costs; and above all, an uncompromising framework of strict
monitoring and accountability, coupled with a strong emphasis on results on the ground. These are profoundly inspiring elements of best practices that Kolkata has evidenced; and are certainly worth emulating in different combinations or collectively, depending on the particular circumstances and community contexts of the urban slums, poverty and RCH indicators. In other words, leaders and planners may plan programs based on these valuable insights from Kolkata, with appropriate flexibility for local adaptations.

In this context, one could also conceive replication of selective elements of the above innovations to rural RCH and health interventions, taking them to local bodies like "vibrant panchayet samity" (Remarks of the Honorable Minister of Finance, Government of West Bengal, at the Kolkata Workshop).

Some holistic perspective on the Project's evolution, achievements, outlook and challenges are seen through the eyes of two senior program managers associated with IPP 8 Kolkata in Annex 2 and 3.
Looking Forward

The Unfinished Agenda

During its relatively short life span, the Kolkata Project has received many commendations for making a difference in the life of the poor slum dwellers. The RCH indicators have registered remarkable improvements, especially since the Mid-Term Review five years ago (1998). During the coming phase, the city managers and community leaders would have to devote attention to special targeted interventions. These should include:

- Focusing on inaccessible areas or disadvantaged population groups where the fruits of RCH care still remain largely tangential;
- Addressing the needs of sub-populations, such as adolescent boys (and girls already being covered) and the floating populations that remain particularly vulnerable to the new generation of challenges like STIs and HIV/AIDS;
- Involvement of the male population in contraceptive partnership with the females and sensitized on violence against women.

This could be supplemented by special surveys and in-depth studies in order to identify the target populations.

Such selectivity would also help reduce the cost of the present program, which may have to give relatively less attention to population groups where the new RCH norms and health seeking behavior are firmly in place. With a view to reducing operational costs, it would be worthwhile to review and rationalize the worker-population density. This density may perhaps be substantially reduced in future, since the basic demand for RCH is largely in place; the work load of the providers has also significantly reduced in some areas as a result of lower service coverage needed - following from reduced number of deliveries and smaller number of children being born. Thus, one would envisage that in the changed normative and behavioral setting, less frequent home visits would suffice; and only selective home based services would be called for. Such modalities would also allow for savings that could be targeted at new intervention groups referred to above.

Sustainability

The Kolkata innovations have already built in several important foundations for sustainability in terms of institutional, human resource, and financial resources. It would be
important to sustain these features, covering the following:

- A strong demand base for RCH
  - Positive RCH norms and continuing health seeking behavior
  - Women’s empowerment through sensitization on RCH rights and programs of economic self-reliance
  - Continuing emphasis on equity and affordable service

- An equally strong political commitment in support of the urban poor
  - Health as a continuing and unquestionable priority on the community, city (KMDA), State and GOI political/policy agenda
  - Ensured RCH funding support for the urban poor
  - Determination of the Municipal Chairmen and the Ministers that “there is no going back” on the above political agenda

- Innovative resource mobilization
  - Women and child health mapped firmly for investment at the community level
  - Cost sharing, health funds and community donations already in place in many municipalities
  - Visibility and support of BPL/RCH needs at the State level: outlay at the State budget
  - Linkage of the future urban RCH programs with other ongoing and prospective interventions in the field

- Low operational costs and determination of the municipalities to carry on the program with local resources (community, individual charity), with supplementary assistance from the State

- Institutional and human resource mechanisms
  - Strong community ownership, reinforced by State and city level support
  - Trained and committed local providers as permanent resource for the community, beyond the life cycle of the Project
  - Provider-client bonding
  - Enduring partnerships among the local bodies, the private sector and the community
  - Network of newly built, refurbished and well-equipped local service outlets to sustain the demand base

All in all, however, it needs to be appreciated that major RCH and public health programs for the urban poor would need continued support and nurturing beyond the relatively brief time frame of the Project. The Kolkata success story could come to fruition following the pathway of salient interventions for at least two preceding decades. Their continuation, likewise, would remain a challenge and opportunity for many years to come. When one talks of health equity and access of the poorest of the poor, it would be critical to find a viable balance.
between fully market-driven and fully-Government operated facilities on a relatively long time horizon. Access of the slum dwellers in Kolkata has been traditionally very limited under both these scenarios. This is where IPP 8 has made a difference.

It is in this context that the Honorable Minister of Health and Family Welfare, Government of West Bengal, underscored in the workshop referred to earlier: "You cannot leave public health entirely to the market, where people with no purchasing power won't be able to purchase health. Community participation is not a substitute for Government intervention." Thus, a judicious and pragmatic blending of both public and private sector efforts with community stakeholders emerged as the central message of the project, with pre-eminence and bonding of the local client with the local providers in the entire process. As aptly remarked by a senior GOI official (Mr. Gautam Basu, Joint Secretary, MOHFW) in the above mentioned workshop: "IPP 8 opened up new vistas in reaching out to the common people in urban slums with an affordable and accessible model of health care. It made a departure from the previous efforts. It has dealt with hearts and minds of the people." By leading this unique venture, IPP 8 Kolkata has also made a lasting contribution to a successful and innovative clue to serving the urban poor and the under-served slum dwellers in a low-income country.
STRUCTURE OF SERVICE DELIVERY
IPP VIII Kolkata

**Block**
Caters to 1000 population
Staffed by one HHW

**Sub Center**
Caters to 5000 population
Staffed by 2 PTMOs who attend
Sub Centers by rotation and
One First Tier Supervisor

**Health Administrative Unit**
Caters to 20 - 35,000 population
Staffed by Health Officer, 2 PTMOs &
Two Second Tier Supervisors

**Maternity Home & Ess. Specialist Out Patient Dept.**
Caters to about 100,000 population
Delivery, in-patient and Specialist services

**Local Coordination Committee**
Chaired by Mayor of Municipal Corporation
Members: Municipal Commissioners,
Health Officers, Ward Councilors
PROJECT DIRECTOR: Holistic View of Project Evolution and Outlook

- Structural arrangements made a difference with the functional outcome for IPP8 Kolkata. The Project was implemented under CMDA, not under CMA, unlike some other City Corporations, as in the case of IPP 8 Delhi.

- There were several critical factors in the success of the Project. The decentralized mode, including community ownership proved very important. So was the physical proximity and close linkage with the political power-base at the State level. A number of important Ministers and Members of the State Assembly hailed from the nearby municipalities covered by the Project. These brought in a lot of political visibility and political pressure that helped the Project’s success. It drew even the personal attention and commitment from the Chief Minister himself.

- Successful implementation of IPP 8 has been an issue in both State and local elections. However, despite such politicization of the implementation process, service delivery and beneficiary access remained above politics. The Project received strong support across political parties - such as from TMC in Madhyamgram and the Communist Party in New Barrackpore.

- Cost sharing collections through the Local Bodies - rather than through State Government mechanisms -- proved a strategic modality, avoiding the audit restrictions that would have been involved if the proceeds had to be retained by the service providing institutions.

- The Project was initially designed for the BPL beneficiaries. Later, when the standard of care improved, it was opened to non-beneficiaries. This added valuable credibility to the services provided to the poorest of the poor and also generated good revenue to sustaining the quantity and quality of care for the community.

- Vocational and skill development training provided a strategic entry point activity for the Project, with a lot of exposure and empowerment to the poor women.

- The turning point for the Project was about the time of the Mid-Term Review. Shortly before that, the new Project Director had taken over at the CMDA level. There was a close scrutiny of the extremely slow implementation by that time. Construction of physical infrastructure, rather than service delivery, received major attention. Yet construction itself was very
slow. Identification and acquisition of sites took a long time. On the side of the World Bank, procedures for clearances for procurement took too long. There was a change in the Bank’s Project Management following the Mid-Term Review. Implementation escalated because of proactive collaboration between CMDA and the Bank. 1996 onward, many civil works; since 1999, even more numerous. Lot of innovations at this time, including GIS, given to 10 municipalities in the post-MTR period.

Lessons learnt?

- Ground Rules: The Project management may need to prepare the urban local bodies to receive and accept the Project. Readiness of the urban local bodies is an important factor. Initiating activities in too many urban local bodies will involve long gestation and also the Project management may feel that it is running into too many blank walls. Let the role models be built from pioneering municipalities. Other municipalities will gradually learn from the experience of the early starters, and will be ultimately motivated.

- Start with service delivery: Over-concentration on hardware activities should not lead to less priority to service delivery. It is better to start services early on in rented premises, consolidate service delivery, and thereafter transfer the mature service delivery to a newly constructed premise.

- Local girls working for the municipalities are loyal to the municipalities. Their new role was a big fillip for their social status.

- Provide timely and required skill training to HHWs and other grass roots workers. The selection of the HHWs should be careful and, and if necessary, even strict. Unless the workers have some commitment to social/ community work, their priorities may be different.

- Start with demand generation. Without this, service delivery efforts will remain under-utilized. Don’t overload the service providers. Be selective and go for targeted interventions.

- HHWs and the First Tier Supervisors might start getting stereotyped and stagnated in routine things, which may not be as important as before. Ensure professionalism by appointing ANMs as second tier supervisors.

- Teamwork is most important. This is true at all levels - CMDA, municipalities, others.

- Health indicators are encouraging. Couples are now satisfied with one (girl) child only. Couples are increasingly resorting to spacing methods and contraceptive choice.
- **Flexibility and speedier Project restructuring during Mid Term Review** would have led to improved consolidation of outputs by additional cities, which started receiving Project inputs after Mid Term Review.

- CMDA has been innovative with the modality of *technical management* of the Project. It has utilized highly experienced superannuated professionals, many with CUDP III background at a *modest cost* and good track record of *commitment to community work*.

- **Sustainability?** Build in sustainability from the beginning. Don't start thinking of it at the end of a Project.

- **Kolkata without IPP 8?** Addressing urban issues at this scale and speed would have been inconceivable . . . It has created demand and raised quality of services. It has been an exemplary Project - improved hygiene and sanitation, created new role models for the slum women, have empowered them. There was increasing limelight, with a spurt of inauguration of many new facilities and messages by Ministers and other political influentials.

- **The challenge ahead?** Don't be complacent. Avoid stagnation. When the Project Management changes in June 2002, "Life in the Project" can be ensured through orchestrated work and commitment. Let there be a consortium, a club . . . CMDA Team . . . Team of Municipal Chairmen. Integrate Project activities with other ongoing development programs - ICDS, CUDP - not stand-alone . . . It is a continuum - there will be an element of good and bad apples. It will work where Municipal Chairmen are dynamic.

- **Replicability?** The package will have to be carefully defined. Urban based model: Difficult unless local bodies involved. Begin with pilots; see if there is readiness; if it works. Don't get bureaucrat-dependent. Political actors need to be the bosses, in the driving seat. Urban areas that are virgin in the field can experiment with alternative models.

  – Mrs. Nandita Chatterjee,  
  Former Project Director,  
  IPP 8 Kolkata
Key Achievements: Success story in (1) network of quality infrastructures; (2) provision and utilization of service delivery; and (3) community ownership.

Factors behind Success: (1) Community involvement; (2) Part-time doctors (Toms); (3) Continuation of the Project Team and commitment of the key personnel; (4) Powers delegated to the Project Director.

Replicability: This may not be straightforward and would depend on the specific context: (1) Kolkata slums are stationary - vis-à-vis Delhi where ten slums shifted after the construction of Health Posts, adversely affecting utilization; (2) Because of vastly different alternative opportunities in cities like Delhi, the Kolkata Model of using part-time doctors on modest compensation and volunteers on payment of nominal honoraria is unlikely to work automatically; (3) In the absence of social and political mobilization and pressure, the community-based low-cost and cost sharing arrangements may not work easily; and (4) The ethnic composition of the Kolkata slums also is more varied, allowing for a wide mix of interventions. Thus, in many ways, the Kolkata experience is unique. However, the positive lessons learnt would be valuable in all circumstances - the value of community ownership; use of local providers; close monitoring of the work by the managers, supervisors and community leaders; steady flow of funds, which was a problem for Delhi (having a City as well as State Governments as part of the institutional framework) and Hyderabad.

Could Kolkata have done better? Overall, IPP 8 should have involved the Urban Affairs Department from the design stage itself. Besides substantive program support during the life of the Project, this would have enhanced subsequent sustainability. Kolkata could also utilize the NGOs more extensively as done in some other cities. The private sector should also have been involved from the beginning. Some of the
physical facilities that came up under the Project remain unutilized at some hours. These could be made available to private medical practitioners during such hours against fixed charges. Similarly, one could also think of movable structures for certain kinds of service delivery. This would save costs and enhance utilization.

- Mr. A. K. Mehra, Director, Area Projects, MOHFW