Workshop on Urban Health Programs in Madhya Pradesh

Program Review and Inputs

A Report

Government of Madhya Pradesh
NRHM / RCH II

February 2007
FOREWORD

The situation of urban poverty in Madhya Pradesh is worse than the rest of India. The health indicators of the urban poor in the state as in the rest of country are almost the same as the rural population and considerably worse than those of the average urban population. Average urban data often tends to hide the grim conditions of the urban poor. The child death rate among the urban poor in the state is nearly equal to that in rural areas and three times higher than the urban rich. The urban poor also lack access to essential health services. With provisioning of health care, services and personnel being inadequate on the one hand and the inability of poor populations to demand services due to their precarious conditions on the other, there has been a steady degradation of their health status. Besides this, there is limited coordination among different government agencies such as health, municipalities, Integrated Child Development Scheme (ICDS), urban development which are involved in slum development activities resulting in limited impact on the lives of the urban poor.

Keeping these factors in mind the need and scope of an urban health program with a focus on slum communities was outlined and there was a widespread consensus about the prospects that such a program held for the different stakeholders. Further, maternal and child health services to the urban poor have been recognized as an important thrust area by the Government of India and the state Government under the National Population Policy (NPP)-2000, National Health Policy (NHP)-2002, National Rural Health Mission (NRHM)/RCH II and the Tenth Five Year Plans. In Madhya Pradesh the Urban Health Program has been initiated as a separate component of the district action plan.

In 2002 during RCH – 1 urban health programs were initiated in the million plus cities of Indore, Bhopal and Jabalpur. During RCH-2 cities with population over 1 lakh comprising Gwalior, Sagar, Ratlam, Ujjain and Sagar were also included for planning and implementing urban health plans.

In February 2007, a review and inputs workshop was held in order to discuss the status of the urban health plans and their implementation in 8 cities of Madhya Pradesh. The cities included Indore, Bhopal, Jabalpur, Gwalior, Sagar, Ratlam, Ujjain and Sagar. The workshop also sought to strengthen the plans by inviting a number of individuals and groups involved in health programs aimed at
improving health of the urban poor in different cities of India. Held in Bhopal, the workshop was organized by Department of Public Health and Family Welfare, Government of Madhya Pradesh (GoMP) with the support of Urban Health Resource Centre (UHRC).

It is envisaged that a review of these plans would elucidate their current status and the efforts being undertaken by the respective cities to address the issues of health in an urban context and to provide inputs to improve and streamline the urban health program further into addressing the needs and issues of the urban poor.

In the workshop, a brief of the overall urban health program and its specific status in the 8 cities of the state was presented. A discussion of the challenges, opportunities and lessons learned by those working with urban communities on issues of health was also facilitated. Since efforts in this area, at least in Madhya Pradesh, are still nascent this engagement offered a platform for an exchange of strategies, ideas, practices and mechanisms adopted by different groups in and outside the state, to address the challenges of working in an urban environment on health.

This document is an assimilation of the proceedings and discussions facilitated in the workshop. It records the different inputs and experiences shared by various presenters in their course of work on urban health. It also provides examples on how the challenges have been addressed. While some of the inputs and learning from these sessions were immediately incorporated into the city plans, it is expected that these would be further detailed before presentation in the final district action plans.
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Ante Natal Check up</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse/ Midwife</td>
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<tr>
<td>ASHA</td>
<td>Accredited Social Worker and Health Activist</td>
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<tr>
<td>BPL</td>
<td>Below Poverty Line</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CC</td>
<td>Cluster Coordination</td>
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<td>CMO</td>
<td>Chief Medical Officers</td>
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<td>DPMU</td>
<td>District Project Management Unit</td>
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<td>DUDA</td>
<td>District Urban Development Authority</td>
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<td>EAG</td>
<td>Empowered Action Group</td>
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<td>ESI</td>
<td>Employees State Insurance</td>
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<td>FRCH</td>
<td>Foundation for Research in Community Health</td>
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<td>GOI/GoI</td>
<td>Government of India</td>
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<td>GoMP</td>
<td>Government of Madhya Pradesh</td>
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<tr>
<td>HIV-AIDS</td>
<td>Human Immunodeficiency Virus - Acquired Immune Deficiency Syndrome</td>
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<td>HP</td>
<td>Health Posts</td>
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<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
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<td>ICMR</td>
<td>Indian Council of Medical Research</td>
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<td>ICSSR</td>
<td>Indian Council of Social Science Research</td>
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<td>IEC</td>
<td>Information Education and Communication</td>
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<td>IFA</td>
<td>iron and folic acid</td>
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<td>IMC</td>
<td>Indore Municipal Corporation</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>JNNURM</td>
<td>Jawaharlal Nehru National Urban Renewal Mission</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDR-TB</td>
<td>Multi Drug Resistant Tuberculosis</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</td>
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<td>MoUD</td>
<td>Ministry of Urban Development</td>
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<td>MoUEPA</td>
<td>Ministry of Urban Employment and Poverty Alleviation</td>
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<td>MP</td>
<td>Madhya Pradesh</td>
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<td>NFHS</td>
<td>National family health Survey</td>
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<td>NGO/s</td>
<td>Non Government Organization/s</td>
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<td>NHP</td>
<td>National Health Policy</td>
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<td>NPP</td>
<td>National Population Policy</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<td>NSSO</td>
<td>National Sample Survey Organization</td>
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<td>OPD</td>
<td>Out Patient Department</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<td>RTI</td>
<td>Reproductive tract Infections</td>
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<td>STI</td>
<td>Sexually transmitted Infections</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>TT</td>
<td>Tetanus Toxoid</td>
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<td>U5MR</td>
<td>Under-five mortality rates</td>
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<td>UHP</td>
<td>Urban Health Project</td>
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<td>UHRC</td>
<td>Urban Health Resource Centre</td>
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Urban Health Program Review and Inputs Workshop

The workshop session began with a brief welcome to all the participants from the 8 cities of Madhya Pradesh. The objectives of the workshop were briefly shared and the first session and the panel for the same was introduced by Dr Jayshree. The Principal Secretary, Health Mr MM Upadhyay lit a lamp to begin the workshop proceedings.

**Workshop Objectives**

- Review ongoing urban health program activities being implemented in the different cities in Madhya Pradesh, and identify strengths and challenge areas
- Inform program management teams of various program implementation strategies for strengthening their ongoing programs to ensure better child and women’s health in the state.

The agenda for the workshop is included in *Annexure 1*

**Session 1**

**Opening Session**

**Presentation 1**

**Overview of the Urban Health Program in Madhya Pradesh**

Dr. Yogiraj Sharma  
*Director Public Health & Family Welfare, GoMP*

A brief demographic profile of Madhya Pradesh and the spread of its urban population were presented. More than half the urban population is centralized in the larger townships and majority of towns (227 out of 386) are small towns, each with a population of 20,000 or less.

The focus cities of the Urban Health Program initiated during RCH – 1 (2002) were million plus cities of Indore, Bhopal and Jabalpur. During RCH-2 as part of 1st phase cities with population over one lakh were included. These comprised
Gwalior, Sagar, Ratlam, Ujjain and Satna. For 2007 – 08, more cities with 1 lakh plus population, would be looked at and expansion into towns with less than 1 lakh population is also planned.

An overview of the health Conditions in M.P. was presented. Madhya Pradesh is one of the worst states on health equity. Conditions in urban areas of MP are worse than urban and rural parts of many other states. Adequate attention to planning and implementation is needed in urban and rural areas of a state, for development.

The conditions for the weaker socio-economic population groups within these physical area demarcations are much worse, particularly in towns and cities. It is a known fact that average urban data hides the grim conditions of the poor and services need to be better targeted for improvement in conditions. The RCH and Nutrition indicators in urban Madhya Pradesh are one of the worst in the country.

In order to improve health conditions in urban areas work needs to be urgently done on the development of health infrastructure and services. Shortage of field staff needs to be addressed and their sensitization towards people oriented/friendly service delivery needs to undertaken. Management issues like lack of organized infrastructure in towns, quantitative and qualitative improvement in supply of medicines and equipment and proper and complete identification of target population needs to be addressed.

The focused health interventions already undertaken in urban areas were presented city wise. While Bhopal, Indore and Jabalpur have started to implement their plans and reach out to target populations through a variety of strategies developed by them, the plans in the 5 other cities are still in their infancy stage. It is hoped that this review will help to strengthen the plans and efforts of all the cities concerned.

The presentation concluded with an elaboration of the expectations from the workshop
- Plans will be more service delivery oriented
- Community based planning
- Inter sector Coordination
- involvement of Private Sector for service delivery in Urban slums
- Incorporation of nutritional aspects in Urban Health Planning.
- Better Management in implementation of Urban Health Plans.

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Presentation 2
Brief Note on the Government of India Perspective on Urban Health

Ms Rekha Chauhan
_Under Secretary, Ministry of Health and Family Welfare, GoI_

It was highlighted that urban health is a priority area under RCH-II and NRHM. At the PMO’s initiative the Ministry of Health and Family Welfare, set up a Task force to advise the NRHM on “Strategies for Urban Health Care”. The Task Force after a series of consultation has submitted its report to the GoI which is under consideration.

Looking at the current Urban Health Status, towns having population below one lakh will be covered under NRHM district plans. Those areas, towns/Cities having population
more than one Lakh are supported through existing GOI’s schemes as part of state RCH-II PIP. This would be funded through RCH-II Flexi-pool

Under the proposed new initiative, construction of new health facilities has been proposed in the select cities under JNNURM.

Presentation 3
Urban Health Priorities, Challenges and Opportunities
Dr Sanjeev Upadhyaya
USAID

An overview of the demographic situation indicates that virtually all growth will be urban in the future. Growth is fastest in concentrations of urban poor – e.g. slums. Most growth and population will be in small and medium size cities. Mega-cities will continue to grow – and have importance beyond their proportion of the urban population

With regard to the urban health scenario it was emphasized that urban averages mask sharp disparities between the rich and poor in urban settings. By many health indicators, urban poor populations are comparable to nearby rural populations – or worse in many cases. Water supply and environmental sanitation is an area of grave concern.

While looking at the urban health challenges it becomes clear that there is a large amount of diversity in the urban setting - in every dimension. Further there are a large number of stakeholders and partners in urban settings. The lack of adequate water and sanitation are defining features, together with associated hygiene behaviors which complicate interventions. Here it was also pointed out that public sector
programs are often not well developed and function mostly in isolation from other departments directly or indirectly linked.

There are several opportunities in Urban Health, which need to be capitalized. These include:
- **Conducive environment:** Many resources/potential partners
- **Concentrated geographically:** More easily reached for communication and marketing activities
- **Physical proximity to hospitals**
- **Basic health issues are those with which we are familiar**
- **New technological interventions**
- **Examples of successful PPP models**

The presentation concluded by elaborating on the rationale for Working with Urban Populations. Demographics (2,3,4,5-6) indicate that it is where the people are located and growing. There is a large unmet need of the urban poor, which must be fulfilled. Epidemiological evidence indicates that there is high morbidity and mortality of common diseases but very poor basic health services. There are also many urban-Specific risks to health (HIV, Dengue & many other emerging diseases).

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**Keynote Address**

Mr M.M. Upadhyay  
*Public Health & Family Welfare, GoMP*

The Principal Secretary stressed on maximizing the reach of health services to urban slum communities. Stress was made on the need to dovetail resources and minimize the duplication of efforts. It was important to understand the working and the various schemes so that their effectiveness can be enhanced for beneficiaries.

In Madhya Pradesh 90 blocks already have sanction under National Rural Health Mission for mobile health vans. So far they have been restricted to tribal areas but it is possible to extend such services for urban areas as well.

It was also mentioned that in an effort to address the need of insufficient health infrastructure, hospitals had been increased and of these 11 hospitals were already functional and the rest of the 79 would also soon be complete.

The need for community mobilization was stressed. It was clear that people required services but the demand for public services was low and people preferred to use other facilities. It there was more awareness and better quality of service and also the service providers were approachable, the community would start to use public health facilities.

Looking at cities like Indore Bhopal Jabalpur, it can be seen that there are more number of slums. If we look at the geographical dispersal, Indore is small but is very dense. The Jabalpur urban areas are not large but they are also not so dense ad so geography and demography play and important role in developing strategies.

With regard to priorities it was mentioned that linkages with WCD, MCH etc. are imperative to streamline the efforts of the different departments working towards similar
goals or are an essential part of the overall process of health service provision. Establishing these linkages will be most advantageous to the beneficiaries and also help in addressing the health needs of the urban poor in a manner that is of more advantage to them rather than compartmentalizing the same. This should be addressed as a priority.

It was announced that in this years’ health plan there would be a separate chapter on urban health. Here components like strengthening workforce, identifying and building community leader, sensitizing elected leaders etc. on issues of health and education would be included. With the support of URHC and co-operation of other departments it was hoped that some headway would be made.

**Release of Booklet: “State of Urban Health in Madhya Pradesh”**

In order to bridge the information gap on urban poor specific data in Madhya Pradesh, the Ministry of Health and Family Welfare in collaboration with the Urban Health Resource Centre (UHRC) had prepared this booklet titled **State of Urban Health in Madhya Pradesh**. This booklet provides urban poor specific information in Madhya Pradesh based on analysis of the second round of the National Family Health Survey.

This report was formally released by Mr. M.M Upadhyay, Principal Secretary, Public Health and Family Welfare, GOMP and Dr. Yogiraj Sharma, Director, Public Health and Family Welfare, GOMP.

The session was then concluded with a quick summarization of the main points mentioned by the various speakers. The need to build health infrastructure and personnel, community mobilization for Nutrition and maternal health and inter-sectoral co-ordination was reiterated. Following this, the session ended with a vote of thanks to the panelists and the participants.
Session 2
Urban Health Program Activities in the Cities

Understanding city-specific background and interventions

The session sought to review the plans of the different cities. While sharing experiences of working with urban health in the cities, it was also envisaged that cross learning between the cities could take place and initiatives, which would be replicated be identified. Cities could give inputs on the work of others to strengthen their weak areas or suggest workable strategies.

The session began with presentations from those cities where the efforts are still nascent.

Presentation 1
Status of the Urban Health Program in Satna
Mr Mishra
Designation

The presentation began with a sharing of the vision, mission and objectives of the urban health program in the district. The approach of the program is based on building capacities of service providers; convergence of services with ICDS and Municipal Corporation; management of the work and team in accordance with the plans.

Health services that would be provided under the urban health plan were shared. A brief profile of the city was presented along with its current available health infrastructure. It was shared that there is a Ganda Nala, which passes through the middle of the city. Due to the choking of this last year there was a flood during the rains. There is an urgent need to address issues of environmental sanitation while speaking of urban health planning and these contextual issues were kept in mind while trying to make a plan of implementation.

The key Strategies for the plan included:
- Strengthen existing urban health infrastructure by renovation / upgradation of existing health facilities health facilities to cover all slum areas.
- Involve the NGOs/Private Sector in the provision of primary health care services and also part of the referral system.
- Provide affordable and integrated health services to vulnerable poor.
- Promote and strengthen capacities in communities to demand services. Convergence of efforts among public sector and private sector stakeholders to improve health of the urban poor.
Findings of a brief situational analysis carried out in Satna and a map made during the process were also presented. The proposed Plan for the city includes institutional Strengthening; Human Power; Outreach Health Camp; Training and Capacity Building; IEC/BCC Activities and setting up on a City Urban Health Management Unit. Deployment of health personnel is still on and still required.

Apart from working for Satna City in the Year 2007-08's planning the areas of Maihar, Amappatan and Nagod Cities of District Satna would be included.

**Comments**

Though the plan shows lot of work that has been planned, not much seems to have been carried out. Also the work done should be reflected in the spending. Most of the districts do not seem to have spent the amount allocated for the work. This aspect must also be given pace.

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**Presentation 2**

**Status of the Urban Health Program in Sagar**

Mr Ashish Mishra  
*DPM, Sagar*

A brief presentation on the profile of Sagar city and the available health infrastructure was made. This was followed by elaborating on the services provided at the primary, secondary and tertiary levels. Referral services and their reach was also discussed.

A profile of the slums and communities was shared. The main livelihoods of the people living in bastis were presented.

Ongoing Program Activities in urban health include running a City Dispensary & 2 slum centers which provides all basic RCH services.

Activities proposed (till March 2007) include establishing 2 Urban Health Units (office, recruiting staffs etc); Strengthening 2 existing units by recruiting staff; purchasing of Equipments and furniture for all 4 UHC and identification of most vulnerable pockets.
Proposed primary level urban health centers are in the areas of Gopal Gunj, Kakagunj, Indra I hospital area and Bhagwangunj. It was also shared that a mega outreach health camp would be organized before the end of this financial year.

**Comments**
When work begins though the planning is done on various fronts, some work may take off quite well and the other aspects may be a bit neglected. But these areas must also be worked upon. Constant review should be a part of the plans so that what works and what does not work can be identified and appropriate action can be taken.

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**Presentation 3**  
**Status of the Urban Health Program in Ratlam**

Mr Abhay Paramde  
*Designation*

The objectives of the urban health program of the city were presented, followed by demographic data and a brief profile of the urban centers of Ratlam and Jaora. There are about 32 slums identified in the urban areas of which 17 are vulnerable. However a more accurate figure would be possible after a slum mapping exercise planned in the near future.

So far ANM's have been hired for the Jaora Slums. Among the other activities referral services have been strengthened along with the organization of health camps.

Repair and Renovation work for two Urban Civil Dispensaries is also being planned. IEC Plan for Urban Slums through street Plays; orientation training for urban field staff (Ratlam & Jaora) on Behavior Change Communication (BCC) and Health Education and regular monthly meetings of urban field staff was also presented.

For the a baseline survey for Jaora and Ratlam to know the benchmarks of present health scenario is being planned in addition to the setting up of a new health centre posts for Jaora and Ratlam.

**Comments**
It is not clear how more in depth discussions can be carried out in communities. This is an area which most of the public providers need to work on, maybe through identification and training of link workers and other similar efforts. There seems to be a lot of load on the Civil Hospital, so 1st tier facilities are crucial to manage this.
Presentation 4
Status of the Urban Health Program in Ujjain
Ms Preeti Nigam

Along with the aims and objectives of the program, a brief introduction about the city with data on its population demography, and administrative functioning was given. ‘Tang’ bastis were identified as those located near a railway line, under a bridge, near markets, mills etc. The main livelihood of the people includes, daily wage work, making, agarbatti, brooms, selling vegetables and other wares etc.

The currently available health infrastructure was presented and the status of different programs linked directly or indirectly with urban health were elaborated.

Activities carried out in the urban health program in Ujjain included repair and renovation of infrastructure, recruiting of health personnel like ANM etc and their training. Community level activities included a survey in the tang bastis, outreach camps, competitions and rewards as on mother and child health issues as encouragement and incentive for pregnant and lactating mothers.

In collaboration with an NGOs in the Nagda urban area, a small project was taken up through a PPP intensive community mobilization in 25 slums on health issues was carried out. An exposure visit to Indore was also undertaken as a learning and motivational exercise. The future plan is to work through link workers in the area.

Proposed activities include - development of partnerships with non government organizations, selection of link workers, inter sectoral co-ordination, training and capacity building of health personnel, activities with adolescent girls and boys in the tang bastis, outreach camps, strengthening and building of additional health infrastructure, IEC activities and introduction of the urban RCH in other urban areas of the district.

The budget proposed for the activities was Rupees 2.5 crore of which Rs 30 lakhs were sanctioned within the district PIP. Expenditure has been on mostly administrative and on recruitment and remuneration of additional ANMs and training.

Comments
The good thing about these endeavors is that a lot of work on community mobilization has been done. The public – private partnership is also commendable.
Presentation 5
Status of the Urban Health Program in Gwalior

Mr Naveen Das
DPM, Gwalior

A background of the city and the current health and other city based programs related to it like ICDS, DUDA etc were presented. A comprehensive detail of the health infrastructure in terms of the government and semi government first, second and third tier facilities were also elaborated. The map of Gwalior with slum pockets was also discussed. However a more detailed vulnerability analysis of the slums would be carried out to refine the status of the slums along with their situation of access and provisioning.

The expenditure statement and status of activities undertaken was presented. It was shared that 100 new AWCs centers had been sanctioned and the results of the vulnerability assessment would be used for the location of these.

The main activities proposed included a detailed vulnerability assessment, relocation of health institutions to better located and equipped places and the conducting of RCH camps. RCH Camps are proposed in urban slum areas with the help of ANM, AWW and doctors of respective health institutions. Days and place shall be fixed for every camps and community shall be informed well in advance.

One of the problems shared by the group was that Rs. 300 per camp for ANM and not found people to work on this, even for 5 days a month, they want to take on contractual ANMs at 5000/- per month.

Comments
Besides the infrastructure improvement, there seems to be no specific and detailed plan for community mobilization or for forming partnerships to take the work forward. The idea of relocation of newly sanctioned health institutions based on the findings of the vulnerability assessment is a good one.
In Indore the Urban Health work had begun much earlier than the other cities. Along with the profile of the city and its infrastructure and personnel the activities and achievements of the project were presented. To begin with, a survey to assess the health needs of slum residents was carried out. Based on the results, outreach health camps were conducted through Public Private Partnership to bridge the supply demand gap in slums. Upgradation of district hospital and repair and renovation of civil dispensaries was also done.

Details of the development and activities carried out through public-private partnership were elaborated. The ward Co-ordination model which aimed at improving coordination among Ward level UH Stakeholders and linkage of community with public and private sector providers and converging services was also shared. An effort to strengthen anganwadis for Outreach Services was also initiated and OPDs are held even on Sundays to make it more convenient for people.

Several Training and Capacity Building endeavors for health personnel have been undertaken on topics concerning maternal and child health care. Along with this several community level awareness programs were also planned. Interesting initiatives has been the introduction of condom vending machines and the program on anemia prevention among adolescent girls and pregnant women.

For the future the plan is to consolidate gains of last two years; cover more slums for Outreach through Mobile Health Unit; extend the ward coordination model to more Wards; develop infrastructure and improve sanitation.

**Comments**
Indore has been one of the first cities to implement the Urban Health Plan and several activities have been carried out. It would be helpful for the other cities to study some of the initiatives and see if they can be used in their areas as well.
The profile of the city and its slums was presented. The identification of slums and the results of the vulnerability assessment were shared along with the main challenges in provisioning and servicing the urban poor with health services. Following this, the ongoing program initiatives were elaborated. These included the following:

- Improving antenatal care through mobile team: The focus was to provide quality gynecological care to women in the field to improve health conditions for women and newborns.

- Setting up health centres near re-located slums: The focus of the activity was to enhance access to government services for affordable and quality primary health care, and improve linkages with the communities.

- Adolescents' Health: The activities under this seek to better inform adolescents on RCH, and develop awareness in society through this generation. For this a series of 4 booklets have been printed and at present Adolescent Health Program is organized in 4 schools.

- Inter-Sectoral Coordination: A District Level Coordination Committee under the Chairmanship of the District Collector-Bhopal has been formed to cover the issues of maternal Care, immunization, integrated Disease Control, family Planning etc.

The expenditure Statement of the program for the above activities was also given briefly. The future plan includes a survey in Bhopal slums; adding 10 more centres for improving ANC; finalizing partnerships; identifying link workers for strengthening Community Linkages in very vulnerable slums and initiating workshops in more schools for the adolescent health program.
Jabalpur city has the total population of about 14 lakhs (2006) out of which 7.6 lakhs live in urban slums. The health services available in urban slums is negligible and there is a dire lack of basic amenities such as water, sanitation etc. There are about 550 slums in the city of which 328 slums are registered slums. In those slums which are not registered the conditions of all basic amenities including health are much worse.

A comparison between India, Madhya Pradesh and Jabalpur on select health indicators was made. Jabalpur is much worse that the state average as far as neonatal mortality, immunized children and women with anemia are concerned.

The public health centers available to the urban poor essentially included Aanganwadi Centers, Urban Family Welfare Centers and the first tier hospitals, but the former were few compared to the population and provided limited services like immunization and vaccination, nutrition related services and prevention of malnutrition etc. While these activities have been given impetus in the urban health plan, additional efforts in terms of infrastructure and personnel are crucial.

According to a vulnerability assessment of slums carried out by the health department in collaboration with local NGO's it was found that the condition of sanitation was very poor. Slum communities have extremely low access to sanitation facilities. An effort to collaborate with the Nagar Nigam to increase the number of community toilets is on.

The efforts in the city would be to improve all reproductive and child health services and provide timely and regular maternal services especially ANC and vaccination services.

**Summing Up**

The efforts of the cities were summed up. The newer cities had made a good start in terms of planning and slum mapping. There is still potential to improve the efforts in forming partnerships and community mobilization. The challenges had also come out quite clearly with regard to health infrastructure, personnel, monitoring etc. It would now be critical to look at convergence of services and the processes to involve stakeholders. Also outsourcing could be looked at as an option for some services though selection should be carefully done and regulation and monitoring will have to be closely worked out.

Dr Yogiraj mentioned that it will take some time to give the programs proper shape. The expenditure is not reflected in the expenditure reports and financial progress along with physical progress is very important. With this the session was concluded.
Session 3
Setting Priorities within the Urban Health Program

A set of case studies was distributed and the participants were asked to discuss these. The case studies were pertaining to actual experiences from slum families of pregnancy, delivery and neonatal care. They reflect the situations in which several decisions with regard to health care are taken. An understanding of these contexts would help to formulate plans that would be more suitable plans for the urban poor. It was envisaged that the discussions would be incorporated while preparing the health plans.

After these discussions the group dispersed for lunch. The case studies have been included in Annexure 2.
Session 4
Working with Communities for Maternal Health and Child Survival

The session was introduced with a brief recap of the case study discussions on health practices that need improvement at community level for maternal and neonatal survival.

Following this experiences and learning from community-level programs were shared by representatives of different organizations working in different cities.

Presentation 1
The City Initiative for Newborn Health

Ms Nina
Sneha, Mumbai

Sneha is an organization working on new born health in the slum areas of Mumbai. Mumbai has a population of 16 million. Over 50% of this population lives in slums. The problems with regard to health, sanitation, housing etc. discussed by the different cities of Madhya Pradesh are more acute in Mumbai.

In a baseline survey conducted in Dharavi it was found that only 18% of pregnant women were visited by a health worker, 33% of infants weighed < 2.5 Kg and for pregnancy-related illness 52% saw a private practitioners, 34% used government services and 14% did not seek care.

Keeping this in mind it was felt that if community mobilization inputs and public health service inputs were strengthened it would lead to improved community maternal and new born care and care seeking and services.

The details of the project area, objectives, characteristics of population in vulnerable slum localities and the core processes of appreciative inquiry were presented. A model based on these was developed which involved preparing members of the community to be sakhis; having women's galli groups; having meetings to discuss issues comprehensively; sequencing the group meetings in six phases and action research was prepared by the organization.
In partnership with the various stakeholders this initiative began to bring about a change through group participation, capacity building at all levels, behavior change through appreciative inquiry and multiple levels of feedback. The organization is currently networking with 5 NGOs, a research organization, a corporate body and the MCGM.

Appreciative inquiry (AI) refers to behavior change of people while emphasizing positive aspects and strengths. AI tries to reiterate where we have been successful and what are the strengths of others, how can strengths be used.

The project developments, evaluation, surveillance, procedures and roles of the stakeholders were explained. Data on the user population was given and conclusions with regard to new born health based on the work done so far along with the ongoing challenges was shared.

The relevant learning from the project included the following

- CHVs are a better source for vulnerability assessment than other stakeholders in the community or other NGO survey data. Consulting the community is not always a feasible strategy for a comprehensive assessment.
- Women do not recognize illnesses as a problem.
- Framing group rules in a participatory way with day to day examples increases the accountability of the group.
- Small inauguration and naming ceremony gives identity to the group.
- Need to respond to the needs of individual group members /families.

Though most NGOs try and work with community based organizations we have found that their spread is also very much and so we decided to go more micro and have galli groups. Also people come from such various backgrounds that it is not essential that all will be represented in community based groups. The diverse backgrounds of people also sometimes inhibit them from participating in activities of CBOs.
The presentation elaborated on complementing Governments Efforts to Reach Urban Poor through Trained Community Link Volunteers. A key strategy of the program was the promotion of community link volunteers to enhance demand and utilization of health care.

Identification of Community Link Volunteers:
Link Volunteers are women from same community and preferably married, identified through a participative and transparent process through community meetings and community recommendation considering their attitude, capabilities, sincerity and willingness to serve the community they represent.

Once selected, the CLVs are trained on both technical RCH issues and operational and programmatic aspects pertaining to reach of services to all beneficiaries. Link workers then form a bridge between the community and services. Some of their most important functions include:

- Tracking beneficiaries and monitoring coverage
- Providing support in organizing outreach camps
- Conducting IEC/BCC activities which include group counseling for mothers on different health topics
- Identify and refer cases requiring medical attention to UHC

Currently over 90 Link Volunteers have been trained, each covering 1500-1800 population. Among these negotiation and health promotion capacity has been developed among 50 of them. 43 women’s health groups promoted in 34 slums and negotiation and health promotion capacity developed among 25 of these groups.
Presentation 3
Linking Slum Communities with Public & Private Providers and Services

Mr Prabhat
UHRC

It is crucial to build sustainable institutions in underserved urban communities to garner services and negotiate for better health care. In the case of Indore, the demand for health services among slum communities is enhanced through capacity building of community based organizations (CBOs), called Basti CBO’s which are women’s groups comprising of 10-15 active women from the community. The Basti CBOs were given significant training inputs in order for them to undertake health promotion and demand generation activities in slums. These CBOs tracked eligible mothers and children in their slums and counseled them with regard to healthy behaviours and facilitated health camps.

A diagrammatic representation of how Slum Communities are linked with various service providers were displayed and explained.

It is important that there be some groups from within the community who will regularly give information about health services to others. The presence of these also ensure better immunization coverage and the ANMs are also helped in many of their tasks.

Some of the more experienced and capable CBOs were designated as Lead CBOs. The Lead CBOs provided monitoring, support and supervision to the activities of the Basti CBOs and engaged with health providers in the public and private sector to provide health services in slums. The activities of the CBOs are supported and supervised by NGOs who train the CBOs, facilitate their networking with health providers and provide supportive supervision.

Since slum level logistical support is provided by the CBOs and NGOs, it is easier for the government health facilities to provide services like camps etc., in slums previously not covered. Private doctors are also invited to provide antenatal care checkups and are given an honorarium that is collected from clients in the form of user fees. Organized slums members have also been able to effectively influence the Municipal Bodies to improve water, sanitation and drainage in slums, which have beneficial impact on health in slums.
There are 90 Basti CBOs, 9 Lead CBOs and 5 NGOs who have been actively pursuing the mission of better health in underserved slums of Indore. The NGOs-CBOs coordinate directly with the Health Department and Private/Charitable institutions to organize at least 50 Maternal and Child Health outreach camps each month. The program developed linkages with the private service providers and 10 ANC camps are organized to cover 25 slums where qualified private doctors provide ANC for pregnant women.

Discussion: Processes in community mobilization, behavior promotion and demand generation

A panel discussion followed the presentation and the participants dialogued with the presenters about the various aspects of community involvement and participation.

The participants felt that AWW make very good mobilisers and therefore the kind of roles envisaged for the link workers must be very clear. Also would the link workers be placed within any hierarchy and what kind of honourarium could be given to her?

The urban district plans should have NGOs involved so that they could help in the identification of link workers from within the community or the slum that they are working with. They can further help in the capacity building and training of these link workers.

Maybe a set of some basic norms for identification and selection of link workers can be developed or borrowed from those who are doing similar work. These can then be changed or modified according to our own slums and communities.

It was suggested that messages for IEC should be made simple so that all can understand them.

From the Mumbai experience of working with slums it was shared that those people who represent the service delivery aspect behave very differently and tend to have a superior or patronizing attitude towards the community. Also only the service that is being provided becomes the most important and we want people to put everything aside for that. If on the other hand we do not have any pre-decided service or go with the attitude of being “givers” of a service then the services will be developed around needs of the community. It is critical that we have an open mind when approaching the community.
As far as basic sets of norms for identification and selection of link workers goes - Sakhis (link workers) in the Sneha Program are mostly married except for 3 or 4 workers. But we did not consciously make such a selection. The most important thing is that they should be ready for work. Most importantly, the Sakhi should be a paid worker.

An important function of the link volunteers which was stated was their role as counselors. In times of a health problem people often do not know whom or where to turn to and at these times they can be of great help.

The link workers can facilitate a dialogue with the community with regard to the kind of services that are required by them. They can also act as health communicators.

It is very crucial that the link worker be someone who can be recognized by the community as one of them not as an external person coming in. at the same time she should be given recognition from the service providers whether they be doctors or administrative people.

Link workers will be the key persons for the planning as far as understanding the needs are concerned.

Sneha pays an honorarium of Rs 2000/- per month. This figure was reached after much discussion and the think tank suggested this, though we had budgeted an amount of Rs 3000/- per Sakhi. This fund is taken from the ICICI social initiatives groups.

It was pointed out that in Madhya Pradesh the salary of the link volunteers could be incorporated into the plan itself. In many places there is a budget head for protsahan rashi and this amount can be utilized. However, it is important to understand that the amount is not a salary, it is an honorarium.

Performance evaluation is a very crucial component and in Mumbai, the Sakhis take it very seriously. It is important to note that people want service. Though there are many service providers in Bombay, people are still not sure what service to use. They go to the service provider but are not able to discern what is to be done. Also several tests are prescribed to them so they get confused.

In Indore, the link volunteer act as a bridge between the service provider and community. They also help in indirectly monitoring the public services. It was suggested that the groups formed by DUDA in Indore should be given training so they can support the program there.
One of the main challenges and problems with population based service provision was that as soon as the population increases those many people get left out.

The discussion was then summarized and closed. It was pointed out that providing health services is only one part of healthy nations. There are many other dimensions. If some families are not getting services, then only that person who attaches herself and understands these families can determine why and then reach the services to them in a manner that is suitable to them. There are many reasons related to marginalization, social structures and biases, community dynamics etc. which are related to the access and provision of services.

An important aspect linked to the success or failure of the link worker is the kind and amount of support that she gets. If she has to overcome problems better, then she would require this support and if this is given then she will become better equipped to deal with these things.

One of the reasons why the system is not responsive is because the unit is so large. Decentralization becomes crucial and we have to understand this and act in this direction.

It was then suggested that the participants sit with their respective city teams and discuss what could be included in the city plans that are to be submitted in March based on the inputs of the day.

After the discussions the groups presented their plans highlighting components of community mobilization. These would be further refined and detailed later. Presentations of some cities are included herewith as samples.

Presentation 1
Community Level Interventions in Ujjain

- **Selection of link health volunteers**
  - Activity for behavior change communication
  - Inter linkages between different stacked holders.
  - Activity for community awareness
  - Demand Generation.

- **Selection area for link health volunteers**
  - Highly vulnerable slum
  - Unclear served slum pocket

- **Identification of area for link health volunteers**
  - Maternal health care
• Neonatal care / Breast feeding awareness
• Promotion of immunization

- Develop more participation of link health volunteers
  • Orientation of link health volunteers and service provider
  • Regular follow of service by staff in community
  • Provide identity cared to motivate our LHV

- Organize joint meeting of link health volunteer and service providers.
  • Awarded who perform better
  • Develop referral system
  • Shout out the problem of link health volunteer as soon as possible.

**WORK PLAN:-**

- Who work – Health worker / Aganwadi work / CBOs
- Who do play role for selection of Lin H.V.
  • By non profit organization
- Who provided training assistance
  • Joint team of trainers (Health / ICDS / DUDA / NGO)
- How do it :-
  • Home visit – per day 8 to house
  • Organize group meeting with help of AWW / ANM
  • IEC activity at level of community / slum
  • Develop knowledge and skill of L.H.V.
  • Exposure visit for link health volunteer
  • Monitoring and supervision support
  • Work plan for health and Nutrition

**Three monthly work plan chart**

<table>
<thead>
<tr>
<th>S.n.</th>
<th>Activities</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; month</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; month</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; month</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Survey and mapping</td>
<td>☑️</td>
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<tr>
<td>2</td>
<td>Preparation of plan</td>
<td>☑️</td>
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<tr>
<td>3</td>
<td>Selection NGO and training</td>
<td>☑️</td>
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<td></td>
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<tr>
<td>4</td>
<td>Selection of LHW</td>
<td>☑️</td>
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<tr>
<td>5</td>
<td>Training in LHW</td>
<td></td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td>6</td>
<td>Supervision and monitoring</td>
<td></td>
<td>☑️</td>
<td>☑️</td>
</tr>
</tbody>
</table>

**Presentation 2**

**Community Level Interventions in Indore**

- Selection of link health worker and forming of women health committee.
- Selection area trial 12 wards and 250 slums
- Activity: Health education / play role as bridge between community and service providers / maternal and child health issues, care of ANC to RCH service /
- Selection of link health volunteers by voluntary organization.
- Training by voluntary organization and joins team of health department / FCDS/ DUDA
- How – LHV done their work
- Home visit: per LHV done 300 to 400 home visit in a year
• Group meeting every week (slum level / cluster level)
• Community level invention through different meeting with CBOs and link health volunteers
• Behavior change activity:
  - Street play
  - Puppet show
  - Video show
  - To talk by doctors – NNF / IAP
  - Flip chart on specific issues

Presentation 3
Community Level Interventions in Gwalior

<table>
<thead>
<tr>
<th>Activities Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban slums</td>
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<tr>
<td>Focus of work</td>
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<tr>
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<tr>
<td>Who all will work at the community level</td>
</tr>
<tr>
<td>How the Work will be done</td>
</tr>
<tr>
<td>Monitoring and supportive supervision</td>
</tr>
<tr>
<td>How the community level health workers inclination issues towards their work could be improved by</td>
</tr>
</tbody>
</table>

Presentation 4
Community Level Interventions in Satna

Work at community level
- for better health services in the community
  o hygiene education
  o awareness programs
**Workers at community level**

Health workers / ANM / AWW / groups / link workers / mahila mandals

**Selection**

On the basis of the ‘anumodan’ of the district health society

Selection of link workers will be done by NGOs

**Training**

Training will be conducted regularly along with refresher courses every three months. The AWW and other staff will be the primary participants in the trainings. In these trainings, information dissemination about national programs and other health programs will be included so that field workers can reach this information to communities and demands for the same will be increased.

For increasing information in communities and influencing practices

- Communication with regard to the other non allopathic forms of medicine will be given. The presence of mahila mandals/ ayurvedic doctors/ uanani doctors/ jan swasthya rakshaks will be highlighted.
- Support from all the above mentioned groups and individuals will be taken for planning of training and exposure visits.

**Implementation mechanisms** (How will this work be done)

- Home visits by ANMs and AWW
- Group meetings of SHGs and Mahila Mandals
- IEC at the community level: awareness programs etc. will be held with the help of NGOs and interactive methods of awareness generation will be used.
- Regular health camps in communities

**Monitoring**

Will be done by CIS/ Nodal Officer, NRHM
- District Management Unit
- ICDS Program Officer
- Supervisor
- Urban Health Co-ordinator (Nominee)

**Three monthly work plan chart**

<table>
<thead>
<tr>
<th>S.n.</th>
<th>Activities</th>
<th>month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1st</td>
</tr>
<tr>
<td>1</td>
<td>Rent building for two new dispensaries</td>
<td>☑</td>
</tr>
<tr>
<td>2</td>
<td>Recruitment of staff for two new dispensaries</td>
<td>☑</td>
</tr>
<tr>
<td>3</td>
<td>Selection Link workers/ mahila mandals</td>
<td>☑</td>
</tr>
<tr>
<td>4</td>
<td>Training</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Camps</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Monitoring and evaluation</td>
<td></td>
</tr>
</tbody>
</table>

**Feedback and Comments**

It is very important to clarify who will actually work at the community level. The roles of this person should be detailed and specified to make the plans more workable. It such a technique is employed the problem of budget non spending will also reduce.

Who would work in which geographic area and the kind of work that they will do also need to be specified to avoid duplication.
There was a lot of discussion on the process of selection of NGOs. Those cities who have already gone through such a process could share it with others.

Promoting social confidence in community should be given impetus. Behavior change will also happen through this.

Absence of ANMs can be plugged by using trained nurses as Bhopal has done. From nursing colleges this work force can be used. The 3rd year 4th year students should be given Rs 300/- per session. They will get pocket money.

Training of ANMs should be more frequent than 3 months.

The method of giving awards or some incentive as suggested by Ujjain is a good one. Recognition of link volunteers will act as encouragement and also be a motivating factor. It was suggested that this could be adopted in other places as well.

Issuing identity cards to link workers is also a very good idea as it would help the service providers also to identify them.

Using tools like flip charts and posters helps to make trainings more interactive. As far as possible lecture method should be avoided. Also if flip charts are well designed and provided to the link workers they can use them to easily deliver important messages.

It is important that the link worker identify the services which match the needs of the community.

Building linkages with facilities is very critical. The most simple way is to have continuous and regular contact with the community. Other good examples have come from the presentations including having joint meetings with stakeholders; solving problems in time and on time; giving incentives and encouragement on doing good work.

Monitoring is an important component that needs to be added in the plans. It would be important to evaluate performance every 3 months wherein working methods and behavior should be given special attention

Following this discussion the workshop was closed for the day.
A quick re-cap of the previous day was presented by a participant from Gwalior. Following this the agenda for the day was presented.

Session 5
Ensuring Complete Service Coverage

The understanding with regard to the case studies distributed and analyzed the previous day clearly showed that constraints in accessing services for vulnerable populations were at several levels.

To begin with, there are family level constraints and problems, which have to be negotiated by those requiring health care. These could be economic, social or cultural or a combination of these.

The next challenge was the lack of awareness in the community and especially vulnerable groups about services available at health facility level. This often results in under utilization of services and there is a large communication and information gap between service providers and the community. It is important to note that since the services that are to be provided are best known to the providers, they need to take more initiative in making their services known. At the community level there is often a lot of confusion about where a particular service can be availed or what are the service components of a health care facility.

It was also apparent that even basic MCH services such as TT, child immunization etc. are not reached to vulnerable populations and unless the community itself takes initiative to find a public or private health care facility, they remain deprived even of these services. Service providers often fail to identify and reach services to these pockets or overlook them because they may be a small number. But it is important to note that the further a group is - in terms of physical distance or within the social structure the more vulnerable it becomes and therefore it becomes crucial to double the efforts of reaching services to these groups.

One issue that is quite commonly mentioned and is very relevant as was seen in the case studies was that of the attitude of service providers. It was pointed out that doctors and more qualified staff within the medical hierarchy are usually absent. This is either because the post is vacant or the doctors do not have the time to spend at the health facilities. Those personnel who are present have a large amount of work and patients to deal with. The treatment meted out universally by any of the health personnel irrespective of their position in the medical hierarchy to the community was rude and intimidating. It was also pointed out that there is a lack of accountability within the service providers, which leaves patients at a loss if treatment is not given or is inadequate.

In the light of these observations it becomes important that the service package needs to be ensured.
This session sought to identify methods and mechanisms by which this could be done and services could be reached to the most vulnerable slums. The session also covered issues regarding improvement and enhancement of the access, quantity and quality of services to vulnerable pockets. Efforts of government and non government organizations trying to improve service coverage were invited to share their experiences with the participants.

Presentation 1

Delivering Primary Health Care for Urban Poor through Partnership between the Government and Marwari Maternity Hospital (MMH), Guwahati

Dr. N.K. Barua
In-charge of Regional Resource Centre for North East, Guwahati

MMH in partnership with health & family welfare department government of Assam provides RCH outreach services in selected slums and peri-urban areas catering to a population of 1.5 - 2 lakhs mainly in south Guwahati.

Information with regard to the vulnerable population and the existing health status of the population was collected through a baseline survey. This enabled enumeration, social mobilisation & follow up with the community.

Through the partnership an initiative called the sector investment program (SIP) was introduced. The MMH is a 100-bed hospital run by a charitable trust since 1985. The hospital has more than 4500 deliveries a year and also provides sterilization and vaccination services. The staff includes specialists in gynecology (12 obstetricians), child health (3 pediatricians) and 3 anesthetists to provide reproductive and child health services.

Under the SIP 14 regular sites in 8 selected wards are covered. Sessions are held every fortnight at each site at a predetermined time. Senior doctors and nursing staff with vaccines and other logistics attend the camps. Mobility support for the team is provided by the RCH funds.

Provisions under the Partnership

<table>
<thead>
<tr>
<th>Government of Assam</th>
<th>Marwari Maternity Hospital</th>
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</thead>
<tbody>
<tr>
<td>1. Free supply of vaccine, contraceptives, other RCH Kits as available in health service.</td>
<td>Provision of medical, paramedical – staff for the sessions and their payment</td>
</tr>
<tr>
<td>2. Capital investment for hospital equipment, furniture, vehicle from SIP</td>
<td>Provision and maintenance of existing infrastructure and equipment for outreach patients</td>
</tr>
<tr>
<td>3. Expenditure on mobility of staff for sessions, contingencies etc. and supportive supervision.</td>
<td>Providing Outreach services including deliveries, Family planning and MTP services</td>
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Concessional rates (35% less) are charged for patients from slums under this agreement.

Some initial requirements while forming partnerships were discussed based on the experience of the MMH. It was better to ink up with a charitable institution having at least 1500 – 2000 deliveries per annum. Suitable needy sites should be identified based on parameters like low reach of complete immunization (< than 50%) and lack of other...
health facilities. It is also crucial that rapport between the two sides is sympathetic and communicative. Perhaps the most crucial element for ascertaining community utilization of services is to involve paid motivators from the community of that particular site for the project.

The presentation ended with the sharing of lessons learned. Some of these included:
- Regularity of sessions and commitment of staff to serve the slums is of vital importance. The timings and venue should be flexible and suitable for people not the doctor.
- Building of rapport with the community and gaining its trust. The program should not be target oriented. It must be noted that the patient flow for vaccination and sterilization will automatically build up later so pressure on the same should not be the focus of service providers.
- Awareness and sympathy to local needs (both medical & general) and knowledge of the customs of the area is important.
- With regard to internal functioning fluid & easy lines of communication between motivators, local volunteers, community leaders and patients must be maintained.
- When motivating for sterilization avoid tunnel vision of fallopian tubes. Attention should be paid primary towards problem and needs of the women and family and the importance of the girl child must be stressed.

Data on the achievements of the SIP since it began with regard to the different services was provided at the end of the presentation.

Presentation 2  
Strengthening Multi-stakeholder Ward Coordination Model to Improve Health of Slum Population  
Dr. Mukesh Bachawat  
District Immunization Officer, Indore

The Ward is the smallest administrative unit in a city and is recognized as the unit for planning and monitoring. The multi stakeholder ward co-ordination approach seeks to converge services for optimizing resources to improve immunization in the slum areas of Indore falling under the urban health program. A ward level co-ordination committee has been formed which consists of various stakeholders like the health department, municipal corporation, NGOs and CBOs, Charitable organizations, ICDS, elected representatives, DUDA, schools polyclinics etc.

The approach is essentially a public sector driven, Supply/ service improvement endeavour which is a facility based Immunization improvement model with outreach. It aims at improving coordination among Ward level UH Stakeholders and linkage of community with public and private sector providers. The overall purpose is to develop a replicable model and learn from this experience to apply in other wards and cities.

The approach was replicated from Sept. 2005 in Ward 7, where monthly camps cover about 35,000 vulnerable population across 24 slums. The technical inputs are provided by IAP & NNF for enhanced quality of services and community counseling.

**Future Directions**

Based on the success of this model, the Indore program is aiming to institutionalize Ward Coordination committees at the District level. Immediate scaling to another seven wards is also being planned. There is also a constant effort to strengthen convergence among various service providers e.g. Govt. providers and private providers.

Promotion of linkages between the community and government providers and encouragement of CBOs and Community leaders to mobilize community for seeking services also form an imperative part of the initiative. In order to strengthen this approach capacity building of Service Providers to strengthen HMIS and technical aspects is planned.

**Presentation 3**
**Promotion of Basti CBOs and their emergence as health groups in slums**

Nawal Singh  
*Jatan Sanstha, Indore*

Jatan Sanstha is an organization working in Rahul Gandhi Nagar of Indore. This organization was formed from within the community after working for a while with the EHP program informally. It is currently working with 2400 households in 5 bastis.

The organization worked towards linking the community with services providers like the Bapat Nursing Home, Bhandari Hospital etc. The most critical challenge in the establishment of these linkages was the negotiation of rates for delivery. Normally a rate of Rs 2000/- per delivery is charged, but this is quite expensive for people. However through negotiations these rates were reduced.

In places like the Aurbondo institute, another maternity centre the rate for delivery was agreed in Rs. 500/-. They gave us a 20% discount for services. Under the Vande Mataram Scheme from the Central government there is a cad issued for pregnant women. When this card is shown than the charges are completely waived. This worked well for the community. To increase services, an ambulance was also introduced under the Vande Mataram scheme, which could take people to the dispensary and back. This is a weekly service.

The organization also established linkages with public hospitals like MY, FMC etc. There was a definite preference of people for private health care providers, mainly because they are treated better than in the public hospitals there. And even if it is more expensive they would take a loan and go to private doctors.
They have made partnerships with 5 hospitals. Through individual efforts this organization has also contacted private providers.

Identity cards have been made for the volunteers so that they can be easily identified by the partner agencies and services are given according to the norms of the partnership to the community people accompanied or referred by the volunteers. The volunteer (BCBO member) goes with the patient with the cards, introduces the patient there and try to establish the best place for them. Now even those people who have gone to hospitals take others.

Through the Janani Suraksha Yojana also deliveries are done in the Aurobindo Institute and get the benefit out of that. Most of the deliveries are in MY and Nanda Nagar jajka khana. Institutional deliveries have increased.

Special efforts are made in Muslim pockets. The gynecologist is taken there to provide the service, as the women are hesitant to go to the hospital. The doctor is then reimbursed through the user fees given by the people who take the services.

**Open Discussion : Processes in outreach and indoor/OPD services**

The Bhopal group expressed the problems being faced by them in making private partnerships. Even though Rs. 800/- per delivery is being offered no private partner is coming forward to take this. We are offering 1500/- for Caesarian section but private providers are charging 4500/-.

In Guwahati Rs 500/- is being taken for deliveries and outreach services are also provided by MBBS doctors. They are paid Rs.400/- to 600/- for a session of 4 hours. One thing that has to be kept in mind while forming partnerships is the relationships between the two partners. Also it should be seen if the hospital interested in having more people coming to it or is the concern only the money. Usually we felt that if the hospital has some history of charitable work, then commitment of the doctors to the work is more.

The CMHO Bhopal mentioned that one problem being faced in Madhya Pradesh is the guidelines. It is said that the advance should not be given to private providers so why should they pay from their pockets. Only after the ANM comes they will be paid.

For this it was suggested that practical problems be worked out. The reimbursement could be given quickly or a small advance can be given to the private providers. The guidelines of the Janani Suraksha Yojana can be worked to see the practical convenience and the exact wordings should not discourage implementation. Solutions in the context should be worked out.

Dr Barwa shared that one of the simplest techniques of meeting demands of the people and also ensuing service coverage is to make the timings of heath camps/ check ups convenient for the people and not the doctor. In one of the areas of gawahati which we were covering we found that the weekly haat was at 3.30 in the evening and almost the entire population of the area went to that haat. So we also went there and the response was tremendous. In fact in one day more people came to the clinic than had come in the entire week in the mornings.
Further, it is important to sensitize doctors. If the doctor is not sensitive, people do not respond also he damages the relationship in the long run. They have to be sensitive to needs and requirements.

It was mentioned that in Sneha’s experience most workload falls on the NGO. When there are so many stakeholders how does the MMH involve people at all levels. Are there different levels of participation from different stakeholders? In Bombay, NGOs feel they should be involved in planning not just implementation but the BMC expects them to follow plans. For eg. During the floods that recently hit Bombay, NGOs felt they should have decided where the camps should be held and at what time but this was not done by BMC.

The Indore Municipal Corporation has been supportive. It is important to have clearly defined and demarcated roles for the different stakeholders. Facilitation and moderation of these becomes crucial. If this is done from the beginning those who do not want to play a role will not opt for it. Also once the commitment is done, it can be pointed out if someone is overstepping. Often government personnel are very wary of NGOs but they have to be convinced to work with them.

The group from Ratlam wanted to know what are the basic components or checklist to involve NGOs. What are the modalities be. Even though a meeting of private nursing homes to share the urban health plans and to enlist potential partners was held, no one came forward.

The slide about the PPP experience of Guwahati was displayed again for discussion. For government hospitals the Guwahati experience has been that if proper quality service is given to people they themselves become motivated. Further, where facilities increase the magnitude automatically increases and the demand also.

After incentive, overcrowding has happened in public hospitals. In the private nursing homes they will take money to do delivery. Usually the people who give money and those who want to keep it instead of giving it away. In most of the schemes this problem comes up. People cannot be blamed for wanting to spend as little as possible. They are given a lot of problem when giving them the cash. Also who is the right claimant cannot be determined at times.

Accreditation of service providers is still in its infancy stage. This will have to be worked out in a more systematic manner to ensure effectiveness. Also it will be crucial for regulation. This concept will also give people more confidence in private service providers. An example of a meeting was given where private providers had called a meeting of AWW and other health workers saying that they had been given accreditation and their clientele increased.

In Guwahati there is the Eetawardha slum area which is under serviced. People from here heard about the MMH outreach services and approached the hospital to cover their area as well. It was mainly through word of mouth that this information came to them. So the hospital extended services to this area as well. Directly linking with the community gives an excellent response. Sometimes even though we were clear about what services will/can be extended, it is difficult to keep restricted to those services only. This is mainly because there are so few services that are provided in these areas that it becomes imperative to broaden the scope of the services. For eg. in this very area we could not
ignore the problem of malaria and we tried to link up with other places to take on this problem. It is important to be sensitive to such situations.

In Indore, the Rs. 2000/- that was charged for delivery included ANC but still this is quite high. In places like Asha Deep and Bapat ANC is charged separately. In Aurobindo it is Rs. 10/- while in other places it varies from Rs. 25 to 50 for ANC. All other tests are also charged. The volunteers of Jatan Trust usually make it a point to tell the people what service is being given and how much is being charged so that they can choose the most convenient and cheap option. Perhaps the best service given so far is that of the ambulance that comes on the 9th of every month and takes people to the health center for all types of pregnancy related interventions. It has been very successful because it is an exclusive service and it is regular.

With regard to HIV testing of women it was discussed that it should be done along with ANC. Consent and counselor are extremely important in HIV testing. Training of the latter is important. We also need to understand the implication of such a test and its positive testing. In Bombay in the ANC clinic every mother is tested.

**Presentations by Groups**

Based on the above, the key issues for discussion and inclusion in the district plan were:
- Outreach service for vulnerable population
- Primary services at dispensary and health post level
- Strengthen referral systems
- Quality care at second tier health facility/hospital

Group work within the city groups to work out the modalities of the same was introduced. This was followed by presentations by the cities.

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**Presentation 1**

*Quality Services for Vulnerable Populations in Bhopal*

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Outreach services for vulnerable population</th>
<th>Activity</th>
<th>Who will do</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Slum level</td>
<td>Need identification (through HHS)</td>
<td>Link worker and field staff</td>
<td>Weekly reporting of daily home visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ANC Out Reach Camps Mobile Team</td>
<td>Through ANM with help of Link Volunteers</td>
<td>Once a month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Immunization Day</td>
<td>Through ANM and Link Volunteers</td>
<td>Once a month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Level Meeting</td>
<td>with the Help of AWW/Link Worker Pediatrician</td>
<td>Once a month</td>
</tr>
<tr>
<td>Integration of Services</td>
<td>Link Workers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>-------------------------</td>
<td>--------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop information centre</td>
<td>Link health worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2 Health Post Level</strong></td>
<td><strong>Routine Clinical Care</strong></td>
<td>Facility Team</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>All RCH Services</td>
<td>Facility Team</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All National Programs</td>
<td>Facility Team/ Nodal Officers / Link Workers</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Analysis/ Dissemination</td>
<td>Data Assistants, DPMU</td>
<td>Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inter-Sectoral Coordination</td>
<td>MO i/c</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stake Holders Meeting</td>
<td>Social Workers, CMHO/ DPMU DHO,</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Basic pathology services</td>
<td>Lab. Tach.</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Services</td>
<td>Referral Slip Mechanism,</td>
<td>Use bu link worker and different level of service providers</td>
<td>As per need</td>
<td></td>
</tr>
<tr>
<td>Referral Register</td>
<td>Link Volunteers &amp; related Health Centre (CDs).</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow Ups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication Linkages (Centric – Telephone Facility)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of Drug and Equipments/ Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion and comments**
- There should be more stress on improving attitude of service providers.
- Quality of care was also discussed in detail at the secondary level.
- There should be clearly defined protocols at every level and for every service provider.
- Refresher courses and training of every officer is a critical issue. Orientation and training of tertiary level is also essential and also we need to enhance the service quantity and quality otherwise the people will not have faith in us.
- Right to information is an important element that should be publicized.
- Service providers need to be sensitized where they get a positive attitude towards the beneficiaries.
- Review, referrals and feedback mechanisms should be clarified. Final referral units through RCH programs need to be put up. Smallest unit is the slum. If RCH is focusing on the health centre then it should also focus on the tertiary sector as well.
- Link workers and their selection and role must be clear as they will be the crucial point of service – community contact.

**Satna presentation on outreach????**
General Discussion
- To encourage sensitive behavior incentive rewards can be given.
- We need to give some basic services at the doorstep then the confidence of the patient will also develop. It is only then that they will come to the tertiary level.
- The hostility of the middle class and the respect for the poor is very prominent. The doctors will treat people of a higher socio-economic class well but not the poor person. This has to be broken in the sensitization sessions with the health personnel. If the leadership is sensitive people will also learn to be sensitive. How will we increase sensitivity is something that will have to be clearly outlined.
- It was discussed that courses will not help in sensitizing people. It was even suggested that action against misbehaviour or misconduct with patients must be taken. On the other hand it was felt that this is an issue that needs to be handled by many people and blaming only the doctor will not help. Further there is no comparison private and public practitioners as public health service providers especially doctors perform more than just the medical function. Many roles are expected out of them. There are many managerial, financial and administrative issues involved which need to be simultaneously addressed. It was pointed out here that this in itself is a problem and while the latter maybe true, the misbehavior of the doctor cannot be let off justified based on the fact that they have several roles to perform. If any change has to happen then that should be worked out.
- The plans should be advertised in the public. IEC should be strengthened and displays of timing and the services should be done.
- Public expectation vs services provided, the lesser the gap the better the service.

Due to lack of time not all groups were able to make presentations. It was suggested that the presentations of the other cities be finalized and the documents given at the end of the day. These have been included in Annexure 3.

The session was concluded and the group left for lunch.
Session 5
Strategies for Improving Nutrition Status amongst Impoverished Families

Presentation 1
Managing Severe Malnutrition
Dr Ramani Atkuri
UNICEF, Bhopal

India has worse malnutrition levels than even sub-Saharan Africa. Though it is often portrayed that Africa has the worst levels of malnutrition, it is India that has the largest number of malnourished children in the world.

Over 50% of under-five deaths happen in children who are malnourished as it increases the risk of death by all illnesses like diarrhoea, measles, pneumonia, malaria etc. In the recent years there has actually been an increase in malnutrition in many parts of India and Madhya Pradesh and this is a cause of concern.

There are varying degrees of malnutrition (mild, moderate and severe) and the management and interventions for these differs depending on the intensity. Severe malnutrition is also referred to as Grade III and IV malnutrition. Though the number of children falling in this category are few in number, many die. It is estimated that nearly 25% die due to wrong management in hospitals.

It was discussed that malnutrition is like an iceberg where the severely malnourished children which comprise only 1-5% of all malnourished can be identified. There are several which go unnoticed and therefore also uncared for.

There are several aspects and reasons which lead to malnutrition and then its severity. These include both direct and indirect factors. From the lack of food security to poor access to safe water and sanitation, from anemia and low birth
weight of mother to disease and infections – each of these individually or cumulatively add to malnutrition. The factors are often contextual and when these factors are identified then specific interventions can be planned. It must be noted that all the factors may not be in the control of health workers but the reduction in the others automatically reduces risk. The table below demonstrates the interventions planned by UNICEF in their program addressing severe malnutrition in Guna and Shivpuri for some of the factors affecting malnutrition.

<table>
<thead>
<tr>
<th>Factors leading to malnutrition addressed by UNICEF</th>
<th>Factors not addressed by UNICEF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disease and Immunisation Related</strong></td>
<td>Low age at marriage</td>
</tr>
<tr>
<td>TB, malaria, other infections</td>
<td>Sibling care</td>
</tr>
<tr>
<td>Recurrent diarrhoeal disease</td>
<td>Lack of food security</td>
</tr>
<tr>
<td>VPD – measles, pertussis</td>
<td>Incomplete immunization</td>
</tr>
<tr>
<td><strong>Environment Related</strong></td>
<td></td>
</tr>
<tr>
<td>Poor access to safe water and sanitation</td>
<td></td>
</tr>
<tr>
<td><strong>Feeding Related</strong></td>
<td></td>
</tr>
<tr>
<td>Insufficient food given</td>
<td></td>
</tr>
<tr>
<td>Late complementary feeding</td>
<td></td>
</tr>
<tr>
<td><strong>Maternal Health Related</strong></td>
<td></td>
</tr>
<tr>
<td>Poor maternal nutritional status</td>
<td></td>
</tr>
<tr>
<td>Malaria in pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

Dealing and managing malnutrition is not very difficult though it is specific and if people want to know how to deal with it, there are more intensive modules that should be undertaken by those interested. This discussion does not involve a very detailed presentation on the management of malnutrition. It was shared that most people were uncomfortable managing malnutrition because it is multi-factorial in origin, any single intervention will not improve it fully. Most don’t know how to deal with it – whether medical treatment or dietary counseling. In the UNICEF experience one of the most challenging tasks in managing malnutrition was the inter-sectoral co-ordination which was never easy.

Severely malnourished children usually have lesser weights for their heights. Besides this there is a swelling of both feet. The child looks pale (anaemic) and the skin folds over the buttocks and cheeks (no fat reserves). The Weight for age – Grade III and Grade IV and the weight for height is less than 70% median.

The weight for height chart being used in Guna was shown and explained. Caution regarding severely malnourished who were also sick was given. It was advised that any severely malnourished child with fever, diarrhoea / dysentery, cough (pneumonia) / quick breathing and boils all over the body needs admission in hospital as they can suddenly and quickly die. All severely malnourished children who are sick, need to be referred immediately to hospital and they cannot be managed at the village level or in the community. The medical and symptomatic picture of the problem was further discussed.
The Nutrition Rehabilitation Centre (NRC) introduced by UNICEF is a place where the severely malnourished child is kept for a few weeks till he/she starts gaining weight, the course of antibiotics and other treatment is over, and the mother has learnt how to prepare food for the child.

The presentation ended with sharing of costs of maintaining the centre. It works out to about 900 to 1000 pre child for 2 weeks. The lessons that were learnt from the Guna and Shivpuri experiences were then presented. It was found that small corporate bodies within the district can be tapped for funds. The micro level funds are not very high and in most cases it was found that they could be raised locally itself. When results were seen, a satisfied parent can be a motivator in herself.

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**Presentation 2**  
**Implementation of healthy practices among women in the Community**

Ms Sunita Rai  
*Organisation* Indore

In the Indore slums a small group began work with pregnant women and children. This was initially a community based organization consisting mostly of women which later registered itself.

A flip chart presentation on the intervention and activities at the community level were presented by them. The focus of the interventions has been antenatal care with a specific focus on nutrition and immunization of the mother and child.

With regard to maternal care the importance of antenatal checkups and intake of IFA is stressed upon and the pregnancy is closely monitored by the workers of the organization. The local customs are kept in mind while

With regard to breast feeding it was shared that earlier women gave honey or *gud ka pani*, gutti etc. to newly born children but as per learning the group is now trying to popularize breast feeding only for the first six months after the birth of the baby. Mothers are encouraged to give new born babies mothers milk only.

New born care forms an essential component of the groups program. Along with information on immunization, diarrhea training is also given so that mothers and other care givers can identify and manage it in the early stages itself.
The main IEC strategy used by the group is role plays and short information snippet dissemination. Almost all the interventions in the community are undertaken keeping in mind the cultural beliefs and norms to accelerate acceptance. Another strategy which has been very effective and popular is incentive rewards for children who have taken all immunization.

**Open Discussion**

It was pointed out that in the Bal Sanjeevini Abhiyaan grade III and IV children are targeted for treatment. However efforts must also be made to manage grade 1 and 2 children as they are many more in number and if unattended become weaker. It is important to look at grade 3 and 4 malnutrition as chances of dying are much more in these cases. Strategies like health education etc. must be used to educate people about malnourishment and management at least for those children falling in grade 1 and 2. Also immediate intervention must be made in the latter cases so they don’t slip into grade 3 or 4.

Only those children who are registered in ICDS get free treatment and if they are not registered the treatment has to be paid for. It was suggested that instead of waiting for registration to be done, those children who are malnourished should automatically be registered so that they can avail of the free treatment.

It was also pointed out that the Ayushmati scheme could be used to acquire medicines for girl children who were malnourished and this can be utilized for treatment.

In the Nutrition Rehabilitation Centers (NRC) developed by UNICEF, the main problem faced was that parents had to stay over for 15 days along with the child. Not all could take out that kind of time especially in families where both the parents needed to work for an income.

The Block level centers had more compliance and Guna had less of this kind of problem than Shivpuri as the socio economic level of people here is lower and people cannot spare that much time.

The other challenge was of follow up. Once the child leaves the center constant care for her/ him to become entirely well is crucial. Neglect often led to death. This was also seen more in Shivpuri.

Also trained workers have to be put in place for the management of malnutrition of any level. It is difficult to get volunteers. It was suggested that the remuneration of a contractual nurse can be arranged under RCH II. In the drafts guidelines it has been pointed out that money can also be taken from the RKS. But even if that is not possible it can be taken from RCH II.

There are several technicalities that need to be taken care of in the case of Grade 3 and 4 children. They become extremely susceptible to illness and the malnutrition gets further accentuated and vice versa. Special care has to be given by a specialist a pediatrician in this case. Dietary assessment is essential to determine the course of treatment. Even doctors need to be oriented for the management of malnutrition as the medical and social and preventive issues are different and extremely relevant for proper treatment.
One provision that has been made at work places is of on site crèches and care centers. There is a crèches act in the social welfare department which allows for these centers to be put in place at work places. A fund of Rs 2000/- per child per year has been earmarked for this effort.

This discussion was followed by group work where the participants worked on the incorporation of relevant approaches in dealing with malnutrition in their respective Urban RCH action plans.

Following this the cities regrouped and prepared their strategies for prevention and arrest of mild/moderate malnutrition. They also worked on incorporating relevant approaches in Urban RCH actions plans of each district. Samples of these are included herewith

Suggestions for Improving Nutrition Status in Slums - Ujjain

- Promote right age of marriage among community
- Organize counseling session for pregnant women.
- Develop and better implement IEC for exclusive breast feeding and regular 6 month Brest feeding.
- Through IEC create awareness about supplementary feeding after age of 6 month.
- Make sure the weight of newborn babies.
- Identification malnourished children thought regular monthly weighting and counseling with their family at AWCs.

Suggestions for Improving Nutrition Status in Slums – Satna

- Organize camps / meeting of Mahila Mendal.
- Refresher training on malnutrition management for ANM / AWW
- Taking help for manage malnutrition – municipal soft water supply / sanitation ) ICDS (Supplementary feeling per gramme)
- Co-ordination of all depts. on the level of supervision
- Identification of malnourished children through AWW / ANM / Mahila Mandal and admit at hospital for their health care.
- Rehabilitation of sever malnourished children
- Co-ordination of health / ICDS / Education/ DUDA / PHE Municipal co-ordination / NGO / and charitable club.
- Averring the community about locally available nutrition diets.
- Demonstration of cooking pattern for supplementary diets clots
- Regularly provided nutrition and health education
- Provided assist to all sever nourished children through various schemes like bal sanjeevanki / bal sakti yojana.
- Regular home visit throng AWW / ANW or commentary CBOs.
- Meeting : Ward level – Doctors / CDPO / ANW/ ICDS supervisor / DUDA’s community organizer / health worker
- Link up with service provider centres
  o Through coordination meeting
  o community level volunteers regular meeting develop mechanism of referral quality services

Following this, it was decided that the inputs for the workshop would be used in detailing of plans and these would be submitted by March 2007.

The workshop ended with a vote of thanks to all present.