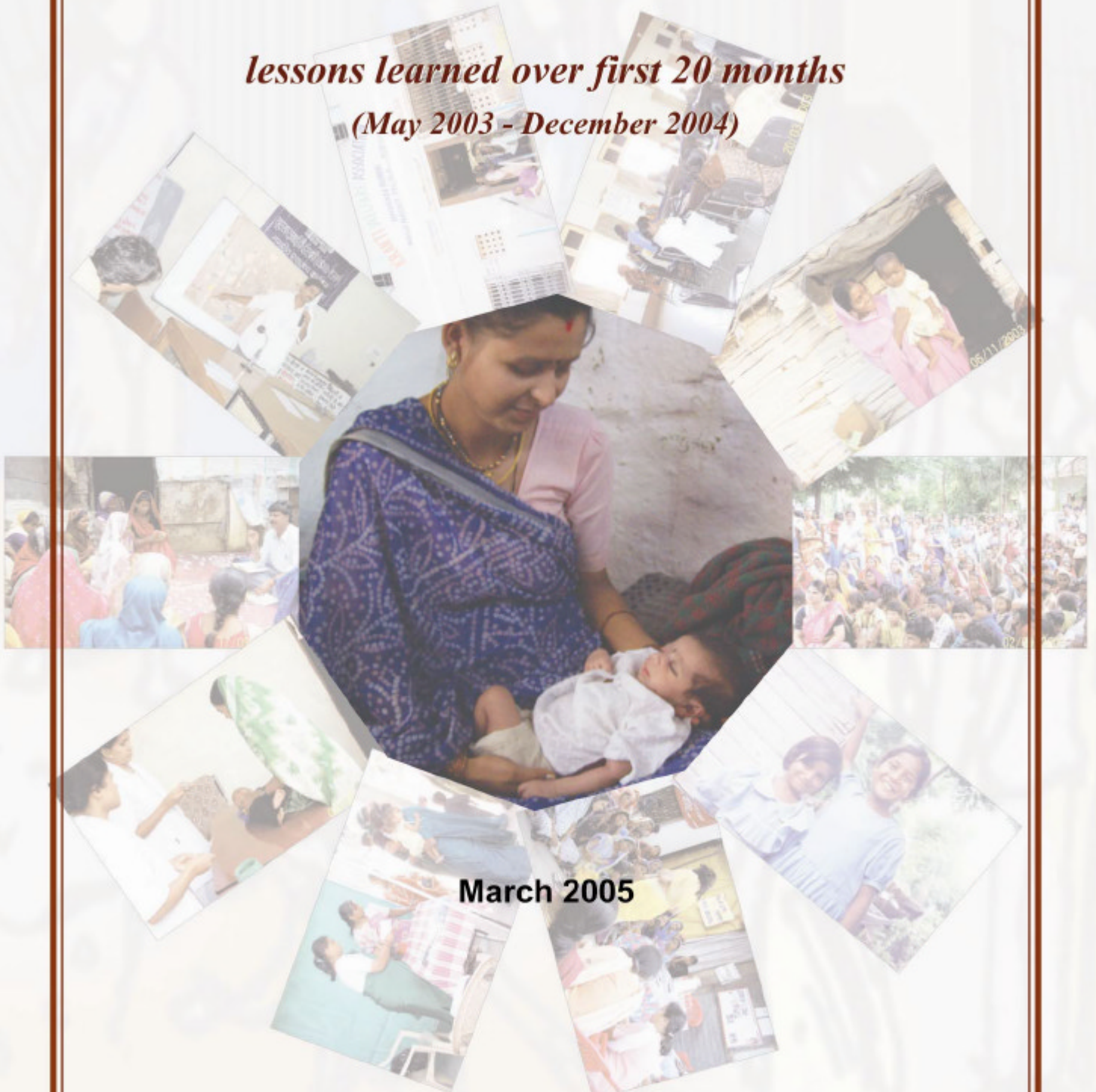


# Partnerships for Improving Health in Vulnerable Slums of Indore

*lessons learned over first 20 months*  
(May 2003 - December 2004)



March 2005

**Indore Urban Health Program**

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We hope that the lessons learned during the first 20 months of our Indore Urban Health Program will help both designers and implementers of urban health programs elsewhere in the country.

**March 2005  
New Delhi**

**Dr Siddharth Agarwal  
Country Representative  
USAID -EHP**

**PARTNERSHIPS FOR IMPROVING HEALTH IN VULNERABLE SLUMS OF  
INDORE**

***LESSONS LEARNED OVER FIRST 20 MONTHS***

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**PARTNERSHIPS FOR IMPROVING HEALTH IN VULNERABLE SLUMS OF  
INDORE  
LESSONS LEARNED OVER THE FIRST TWENTY MONTHS  
MARCH 2005**

*Executive Summary*

***Introduction:*** USAID-EHP (India) is supporting implementation of an urban child health program in 75 slums of Indore through five Non Government Organizations – Community Based Organizations (NGO-CBO) consortia, since April 2003. The five NGOs are Bal Niketan Sangh (BNS), Pushpkunj Family Helper Project Trust (PFHPT), Bhartiya Grameen Mahila Sangh (BGMS), Centre for Development Economics and Development Consultants Society (CECOEDECON) and Indore Diocese Social Services Society (IDSSS). These NGOs have been implementing the program in collaboration with nine Lead CBOs (LCBOs) and 87 Basti CBOs (BCBOs). A public sector driven approach, focussing on supply/ service improvement- “Ward Coordination Model” is also being promoted by EHP. The main objectives of the program are: (a) to increase coverage of services and adoption of key health behaviors in neo-natal survival, diarrhea control and other child health priorities; (b) to improve capacities of CBOs, NGOs, private and public sector health providers in health behavior promotion, to use child health data and for building partnerships; (c) to ensure better targeted policies and increased allocation of resources for urban slum health; and (d) to develop replicable models for urban child health programs.

**This Document:** The Indore Urban Child Health Program completes twenty months of implementation in March 2005. During this period, it has evolved from the conceptualization/preparatory stage and is now in its fully functional stage of program implementation. The program has provided many learning tools and approaches that can be effectively applied or adapted in conceptualization and implementation of urban child health programs in other cities of India. This document is based on experiences and lessons learned from Indore Urban Health Program and its processes. This document also examines the importance of how the various forums evolved including their reach, tools which developed and their effectiveness. It also includes some of the modalities that would ensure good management of the health initiatives for urban poor. The document is divided into five sections. Section I gives the background on urban poverty and on the health scenario in Indore. Section II focuses on the lessons from the information based and consultative program planning process followed in Indore. Section III forms the core of this document and draws the lessons learnt from the NGO-CBO partnership program. Section IV draws out the lessons that have emerged from the Ward Coordination Model. Finally, in Section V, an attempt is made to bring out the implications for replication and the conclusions from this document.

In **Section I**, being the background the focus is on: (a) the macro level situation of urban poverty in India; (b) policies related to urban poverty, and urban reproductive child health services in Madhya Pradesh; and (c) Indore city and its slums.

The lessons which have emerged from the information based and consultative program planning process of the Indore Urban Child Health Program are detailed in **Section II**. The key lesson makes a case for bringing in technically correct and complete information/evidence into the planning process as this helps stakeholders better understand and analyze the context and develop a more responsive program plan, better target the needy, and utilize and build on available resources/platforms in the city. Specifically, the lessons that emerged are: (a) a systematic situational analysis helps understand the reasons for the rapid increase in slum population and the consequences of this on the basic and health services in the urban slums; (b) it also helps understand the health needs of the slum population, factors that affect health behaviors and identifies the technical child priorities with reference to the city; (c) group discussions in the slums, interaction with the health workers at the grassroots and with slum based CBOs help understand and reinforce technical child health priorities; (d) urban average data masks inequities that affect the poor. The real health conditions and service access of the poor is considerably worse than and often similar to rural conditions; (e) several public and private providers and multiple channels/platforms play different roles in mother and child health services and efforts should aim to utilize their potential for expanding reach and access of services to the urban poor; and (f) there is a need to strengthen linkage of public and private health providers with slum communities to improve access and utilization of mother and child health services.

The second part of this section relates to assessment and plotting of slums and the key lesson is that all slums are not equal, and most vulnerable pockets are often not included in the official slum lists; therefore, it is vital to identify and plot on the city map all slums and prioritise the un-reached, vulnerable urban settlements to efficiently target resources. The lessons mentioned in the second part include: (a) local representatives from various NGOs, the public sector and community institutions can provide a rich information base regarding slums and their various facets; (b) evolution of criteria of health vulnerability with the slum dwellers and others working in the slums helps determine the most important and pertinent criteria for assessing vulnerability; and (c) when slum stakeholders such as CBOs, grassroots workers analyse and delineate consensus findings regarding slum situation, a clear understanding about the inequality of slums can help target needy slums/vulnerable pockets.

**Section III** draws out the lessons learnt from the NGO-CBO program and has six subsections. In the **first subsection**, the process and lessons learnt from the building of the NGO-CBO alliance are detailed. The most important lesson which has emerged is that it is important to identify partners who are committed to working for the well-being of vulnerable populations, have credibility among the slum community and amongst other stakeholders, and are committed to and have the potential of being long-term contributors to and supporting vulnerable slum communities.

The **second subsection** relates to the lessons learnt from the implementation of the program relating to evidence based approaches. The key lesson which has surfaced is that coverage of evidence based key child survival interventions such as TT, safe delivery practices, breast-feeding and immunization can be increased among the slum communities through a planned two-pronged strategy of: (a) context-responsive behavior

promotion and (b) improved reach and quality of services. The first part of this subsection has lessons relating to counseling strategies using early adopters, the importance of investment in slum based groups, the advantages of facilitating interaction between the program staff and the key influencers such as mothers-in-law, neighbors, men and traditional birth attendants and the advantages of well-designed community level events for encouraging healthy behaviors. The second part of this subsection focuses on the lessons learnt on improving service coverage. These lessons are: (a) organizing of quality outreach camps is an effective way of increasing coverage to un-reached and special-need slums; and (b) building capacity of the community goes a long way in increasing service utilization. The lessons, which have emerged in reaching difficult-to-reach migrant communities and families, are also discussed here. Relocation of slums, and addressing the issues that emerge from this are also looked into.

The **third subsection** of Section III relates to the use of the NGO-CBO consortia as a strategy to build effective partnerships. The key lesson is that making the most of the consortia has been an effective strategy in enabling the partners to utilize complementary skills and capacities, and develop synergistic potential as the program evolved. This has led to enhanced program management, and institution building capacity among NGOs and emergence of the lead CBO as a potent institutional mechanism for implementation of slum health programs. The lessons emerged include those on capacity building, the importance of the roles of the NGOs, the critical role of the lead CBOs, including their role in nurturing BCBOs and their emerging as a capable program planning and implementing institution.

The lessons learnt from the *Basti* CBO emerging as an important slum level program institution are discussed in the **fourth subsection** of Section III. The key lesson is that the BCBOs are credible institutions in the slum, and they often serve as role models, empower slum families to adopt behaviors, avail services, negotiate (with support) for other slum improvement services and are a motivated institution/platform with a vision for improving well-being in the slum and for ensuring reach of future programs. The lessons in this subsection relate to: (a) the *Basti* CBO developing credibility to serve as role models and thereby empowering slum families to adopt healthy behaviors and avail services provided at the slum; (b) BCBOs negotiating with key government officials and elected representatives to access basic services like water and drainage for their slums; (c) continued nurturing and mentoring has helped BCBOs to start thinking in terms of improving well-being of slum families by enhancing livelihood options through creation of self-help groups and developing emergency health funds; and (d) adequate representation of the slum is important to ensure that the *Basti* CBO is able to envision and work for the welfare of the slum.

The **fifth subsection** of Section III centres on the lessons learnt from developing linkages of the existing health system with the community. The key lesson here is that focused program efforts to foster linkages of the community, represented by BCBOs, and LCBOs with public and private health providers, have helped improve the community's access to health services. The lessons in this subsection relate to: (a) the importance of continued and persuasive dialogue of the program along with NGO partners with the Department of Health has helped evolve a functional coordination mechanism for linkage between “demand” from slum communities and “supply” of health services; (b) usage of alternative providers where the Department of Health has been deficient; and (c) regular follow-up and continued negotiation with ANMs and supervisors has helped establish regular outreach camps in the slums.

The lessons learnt from the hygiene improvement component are delved in the **sixth subsection** of section III. Here, the lessons learnt include: (a) the importance of participatory hygiene enquiry in the development of context-appropriate strategy to promote hygiene behaviours in the program slums; (b) careful planning and conducting of formative research overcomes the problems relating to over-reporting of positive behaviours especially during interpersonal contacts; (c) CBOs are capable of developing context appropriate strategy for promotion of hygiene behaviours when steered through a process of interactive learning and participatory planning; (d) participatory and consultative process of developing communication material gives a sense of ownership to the community and enables them to channelise their efforts towards promotion of healthy behaviour; (e) mothers/families, even with limited access to hardware such as sanitary facilities, the availability of soap, chlorine tablets, etc, are able to identify and are willing to try feasible and appropriate practices associated with hygiene behaviours; (f) regular and frequent interpersonal contacts with the families is crucial in bringing about positive change in adoption of behaviours, as also in keeping motivational levels high; (g) the behaviour interventions need to be reinforced and sustained over time, at least until they become social norms; and (h) in an enabling environment, communities can develop a viable system of operation and maintenance of slum based toilet complex.

The Ward Coordination Model is an important component of the Indore Urban Child Program and the lessons drawn from its setting up and implementation can be found in **Section IV**. The two key lessons here are: (a) holding discussions with the stakeholders at the ward level and using situational analysis facilitates co-ordinated collective action, which helps to reach underserved slums of the ward; and (b) available local public and private resources are adequate to support guided efforts for child health improvement. The lessons emerged to date relate to: (a) preparatory work (situational analysis, mapping and assessment of slums) and involvement of key government officials right from the outset helps to establish credibility and stimulate the stakeholders to initiate a dialogue for some co-ordinated action for improving health services; (b) the preoperative phase is critical, because this results in generating adequate interest among the stakeholders to come together; (c) continued support and facilitation needs to be maintained to ensure that the coordination mechanism remains functional and active; (d) establishment of a credible forum provides a mechanism for collaborating with external institutions to bring expertise to the community; (e) once the platform is in place, convergence among various resources leads to synergistic efforts, effective utilisation of different resources and optimises the expected outcomes; and (f) regularity of meetings and gradual expansion of activities has helped in institutionalisation of the platform.

The final section i.e. **Section V**, deals with implications for replication of lessons learnt from the Indore Urban Child Health Program. The 20-month implementation of the program has provided many learning tools and approaches that can be effectively applied or adapted/replicated in health programs in other cities of India. The important learning tools and approaches are: (a) the need for having a well-designed preparatory phase, which is implemented systematically; (b) the need for building an appropriate implementing mechanism is vital; (c) the two-pronged strategy of (i) context-responsive behaviour promotion activities in slums; and (ii) improved outreach and quality of services, is effective in child survival interventions; (d) multi-stakeholder coordination is required to optimally utilise the available resources; (e) community-based women collectives and volunteers can be encouraged, promoted and developed as credible slum level institutions; and (f) participatory health enquiry and planning is an effective



technique to develop context-appropriate strategies for behavioural change and improved service coverage.

In conclusion, it can be said that the Indore Urban Child Health Program has provided a number of vital lessons, which can be of immense aid to program designers and implementers who are working on health issues in other cities of India. However, it must be mentioned here, that the context and the local situation may vary from city to city, and thus some of these lessons may be suitably adapted to other programs, both in terms of design and implementation.



## Section I

### *Urban Poverty and Health Scenario in Indore*

#### **Background and Overview**

##### **Urban Poverty and the Health Situation of the Urban Poor in India**

In the last decade, as India grew at an average annual growth rate of 2%, urban India grew at 3%, mega cities at 4% and slum populations rose by 5%. Of this, a large chunk will be living in abysmal conditions of poverty.

The process of rapid urbanization in India has led to an alarming deterioration in the quality of life of city dwellers. The lack of attention to rural-urban migration and the natural increase of urban population have led to large segments of underserved and disenfranchised people living in urban poverty. Cities suffer multiple problems such as infrastructure deficiencies, poor sanitation and solid waste disposal, water shortage, polluted natural water courses, dust and air pollution, frequent epidemics, inadequate health care and issues relating to proliferation of slums. The aggregate impact of the distress is especially debilitating for the urban poor living in slums<sup>1</sup>. And it is estimated that *over one fourth of the urban population of India today lives in slums*<sup>2</sup>.

##### **Government of India's Focus on Health of the Urban Poor**

The National Health Policy (NHP) 2002 envisages setting up of an organized two-tier Urban Primary Health Care structure. Although the urban poor find a mention in the National Population Policy (NPP) 2000, Reproductive and Child Health (RCH) II and the Tenth Five Year Plan, infrastructure and programs for delivering RCH services to urban poor are inadequate. In an attempt to address some of the above problems, RCH II envisages a specific focus on Empowered Action Group (EAG) states like Madhya Pradesh (M.P.) for the delivery of RCH services with a focus on urban poor.

##### **USAID-EHP Urban Health Program**

United States Agency for International Development (USAID) India has declared its commitment to addressing the needs of the urban poor. To this end, the Environmental Health Project (EHP) was tasked with implementing a program to initiate action towards improving child health and nutrition among urban slum dwellers in select cities of India.

The USAID-EHP Urban Health Program aims to learn from and develop replicable models of urban health programming aimed at bringing sustained improvement in child health in urban slums. Efforts in Indore have helped glean some lessons on several fronts.

In Indore, the program has worked towards strengthening linkages between service providers and the community and building partnerships and capacities of the public sector, Non Government Organizations (NGOs) and Community Based Organizations (CBOs) to improve coverage and behavior adoption for birth and new born care, diarrhea prevention, immunization and malnutrition prevention.

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<sup>1</sup> Slum Networking – A Holistic Approach for Improvement of Urban Infrastructure and Environment. Available at <http://www.efm.leeds.ac.uk/CIVE/Sewerage/articles/Slum%20Networking.htm>

<sup>2</sup> Sarosh Ankelesaria (2002) *Improving Urban Shantytowns*. Available at [http://www.architectureweek.com/2002/0821/building\\_1-1.html](http://www.architectureweek.com/2002/0821/building_1-1.html)

## **Urban Poverty, Policies and Urban Reproductive Child Health (RCH) services in Madhya Pradesh (MP)**

M.P. is the 2<sup>nd</sup> largest state in India with respect to surface area, accounting for 8% of the population in the country. Urban population comprises 27% of the total population and 37% of the urban population belongs to the 'below poverty line' category. The Infant Mortality Rate (IMR) and the Under- five Mortality Rate (U5 MR) of M.P. are at 86.1 and 137.6 per 1000 live births respectively (National Family Health Survey (NFHS) II) showing a marginal increase compared to previous NFHS data (1992) when IMR was 85.2 and U5MR 130.3. Further, IMR and U5MR in M.P. are significantly (27% and 45% respectively) higher than the all-India IMR of 68/1000 live births and U5MR of 95/1000 live births.

*The State Government is largely responsible for the delivery of public health services in urban areas. Official aid agencies and development banks also generally draw on the reach of government bodies and use them as their 'local implementers'.*

M.P. Government has formulated its own policy level mandate related to RCH. The State Population Policy, Nutrition Policy and Women's Policy focus on various aspects of Reproductive and Child Health. However, a review of the Five Year Plan budgets and actual expenditure of the local bodies shows a declining trend in health sector expenditure in the State. Of the Government expenditure on health, about 80% goes towards maintenance of existing levels of services<sup>3</sup>. Further, of those accessing the Government health sector, 9% belong to the poorest economic quintile, and 35% are from the richest economic quintile<sup>4</sup>. Consequently, the per capita public benefit of this Government health expenditure for urban poor is much lower than that for a well-off urban dweller. Moreover, conservative estimates put inpatient health costs for low-income groups at 20% of annual family income<sup>5</sup>. The disparity continues with low income households spending 8.3% of their annual household income on treatment of illness whereas higher income households spend only 1.6% of their household income.<sup>6</sup> These situations bear consideration when debating the growing focus on privatization, wherein India already stands with one of most privatized health care systems (at 22%).

### **Indore: The Program City**

Indore is the largest city of Madhya Pradesh in terms of population and also the economic capital of the State. The decadal population growth (1991 -2001) has been 47%. It has a large slum population, a big proportion of which is under-served for health services - representing a significant need among the urban poor. Therefore, the city of Indore was a natural choice for the demonstration model.

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<sup>3</sup> Tata Consultancy Services for ADB(2002)Madhya Pradesh Public Finance Reform and Institutional Strengthening

<sup>4</sup> Reanalysis of NFHS II, 1998-99 Madhya Pradesh by Standard of Living Index (SLI) By EHP, April 2003.

<sup>5</sup> International Institute for Population Sciences (IIPS) and ORG (2001) National Family Health Survey (NFHS-2), India 1998-99: Madhya Pradesh, IIPS, Mumbai

<sup>6</sup> NCAER Sharaef A. 1999. India HDR: A profile of the Indian states in the 1990s. New Delhi: Oxford University Press.

## Section II

### *Lessons from Information-based and Consultative Program Planning Process in Indore*

#### **Background and Overview**

Technical assistance efforts in Indore were aimed at developing a context-appropriate program for the city, based on a detailed analysis of the health situation in slums, existing platforms in the city and identification of gaps that need to be filled. The process adopted involved the following steps:

- Situational Analysis
- Assessment and Mapping of Slums
- Consultative Planning with Stakeholders

#### **1. Urban Health Situational Analysis of Indore**

**Key Lesson: Bringing in technically correct and complete information/evidence into the planning process helps stakeholders better understand and analyse the context and develop a more responsive program plan, thereby better targeting the needy, and utilizing and building on available resources/platforms in the city.**

To adequately understand Indore, the most populous city and the economic hub of MP, EHP carried out a systematic situational analysis from August to December 2002 to assess needs of the urban poor, reach of and gaps in the health service delivery system and existing capacities and potential of agencies in the city. Such an in-depth analysis along with consultations with stakeholders and assessment and mapping of slums helped develop a program responsive to the real needs of the urban poor in the city.

**Lesson 1:** A systematic Situational Analysis helps understand that rapid increase in slum population is contributed by i) medium to large cities as economic centres attracting immigration from nearby rural areas or smaller cities, ii) natural growth of existing slum population and iii) expansion of city limits; and that such rapid increase leads to the city not being able to cope with such increasing numbers for basic and health services. This has resulted in poor access and reach of RCH services and in poor environmental conditions in slums, calling for concerted and coordinated efforts to provide the services.

***Slum population has grown very rapidly in Indore over the past two decades:***

Indore, being the financial capital of the state, exercises a great pull on adjoining hinterlands. This, coupled with natural increases in population, and expansion of city limits, has led to a mushrooming growth of slums with mixed socio-economic profiles and unhygienic living conditions. Although the city population doubled from 1971 to 1991, the slum population almost quadrupled over the same period. (Census of India, Government of India).

The slum area comprises 19.42 sq km (15% of the city area).<sup>7</sup> 68% of the slum dwellers live below the poverty line<sup>8</sup>. Population density of Indore slums is 33,742 (2.7 times higher than the city density).<sup>9</sup>

The city's infrastructure, resources and existing basic and health services are not able to cope within such increased population resulting in poor access and utilization of health services and poor environmental conditions in slums.

This calls for greater priority to urban poor when allocating health sector resources; analysis of fund allocations shows an imbalance between rural–urban allocations and also within economic groups in urban settings.

**Lesson 2:** Situational Analysis helps understand the health needs of the slum population, factors that affect health behaviors and reinforces the technical child priorities in reference to a specific city.

*Maternal and Child Health behaviors are sub-optimal and service access is weak in the slums of Indore:*

- Important causes of child mortality as revealed during qualitative surveys include fever, diarrhea, low birth weight, seizures and premature deliveries.
- Immunization sessions were either not held or irregularly held, resulting in very poor coverage.
- Adequate antenatal and prenatal care was not provided in the slums, which fell outside the Integrated Child Development Services (ICDS) area, finally leading to unsafe delivery practices.
- The use of temporary contraceptive measures (oral pills, condoms, IUDs) was almost absent owing to a) fear of side effects of pills and IUD b) low confidence to approach hospitals for IUD and c) grossly inadequate participation of men on this front. While there is information among slum dwellers about these methods, there is a near absence of friendly and perseverant counseling which is critical for dispelling their doubts or allaying fears and anxieties, or building their confidence to approach health facilities for these services.
- Focus Group Discussions (FGDs) also showed that pregnant women go to an obstetrician or a health worker only in the case of an evident problem (a common symptom identified is bleeding or when they need to register themselves for delivery (when an institutional delivery is planned). Moreover, a large number of births (especially in families that cannot afford hospitalization) take place at home, either with the assistance of Traditional Birth Attendants (TBAs) or more often, family members and neighbors. A large number of TBAs are not adequately trained and needless to say, family members are not likely to be trained personnel.

***Poor Environmental Health (Water, Sanitation, Drainage) affect health of slum population:***

- Only 11% (Oxfam, 1999) of the slum dwellers have optimal water facilities. In many cases family members had to walk a distance of 200 meters or more to get water.
- Environmental health conditions including sanitation were poor.
- Toilet facilities were poor. Public toilets, where they existed, suffered from bad maintenance. Open fields or vacant plots were common places for defecation.

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<sup>7</sup> Indore Census 1991.

<sup>8</sup> Urban Poverty and Deprivation. Available at <http://www.undp.org.in/report/IDF98/idfurpov.htm>

<sup>9</sup> Indore Census 1991

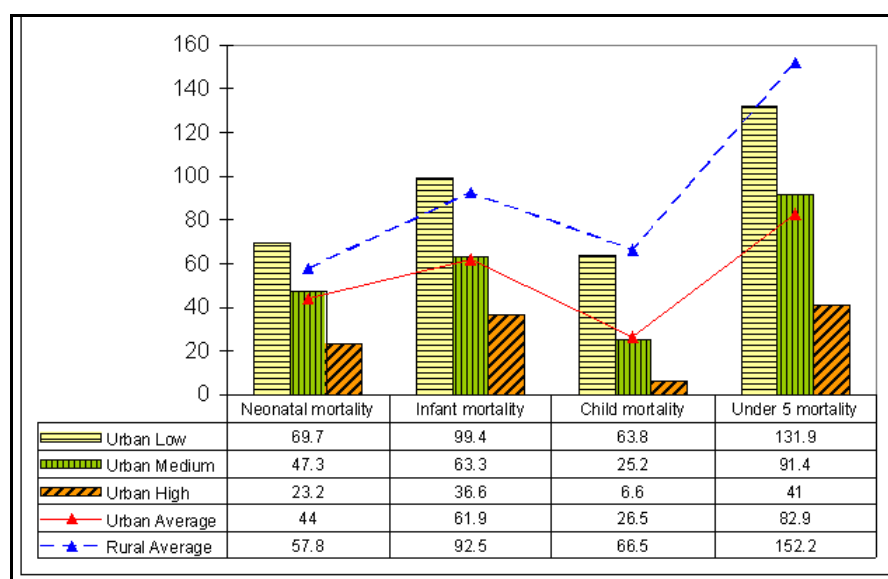
**Lesson 3:** Urban average data (which is the common form of available data) mask inequities that affect the poor. The real health conditions and service access of the poor is considerably worse and often similar to rural conditions.

While the 1998-99 NFHS urban averages signify some improvement in service delivery of MCH services as compared to the earlier (1992-93) NFHS data, the figures emerging from re-analysis<sup>10</sup> of NFHS 2 data by Standard of Living Index (SLI), taking low SLI as representative of the urban poor, clearly show that the urban poor continue to remain left out from mainstream public MCH delivery system and consequently suffer high mortality and morbidity.

Infant and child mortality rates reflect the level of socio economic development and quality of life. They are useful indicators for monitoring and evaluating health programs and policies.

In Madhya Pradesh, among the urban low income group (Low Standard of Living Index segment of NFHS 2 being taken as representative of the urban low socio-economic bracket), child, infant and neonatal survival are far lower than urban average data which is the common form of statistics available, suggests.

Figure 1 - Child, Infant and Neonatal Mortality in Madhya Pradesh – NFHS 2 Re-analysis, EHP 2003



It emerges from the reanalysis of Madhya Pradesh NFHS 2 data that neonatal mortality is significantly high among the urban poor (Urban low SLI<sup>11</sup>) at 69.7 in comparison to the urban average of 44. Also, the infant mortality rate among the urban poor is 99.4 as against the urban average of 61.9. The Child Mortality Rate varies dramatically among the various categories of urban areas from 63.8 among the urban low SLI to the urban

<sup>10</sup> Re-analysis of NFHS 2 data using ISSA package was carried out in 2003 by EHP. This used the NFHS SLI, an asset based index of 27 variables to disaggregate NFHS data into 3 socio-economic categories.

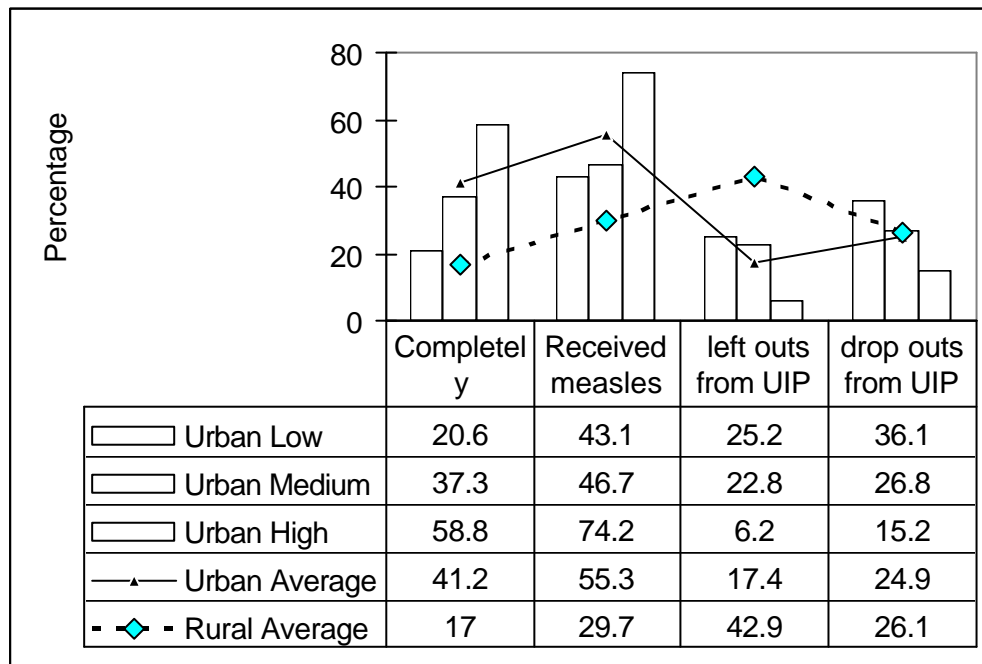
<sup>11</sup> Standard of Living Index (SLI) is an asset-based index developed by considering many socioeconomic parameters. The SLI is a summary household measure and is calculated by adding the scores for house type, toilet facility, source of lighting, main fuel for cooking, source of drinking water, separate room for cooking, ownership of house, ownership of agricultural land, ownership of irrigated land, ownership of livestock and ownership of durable goods. The index is calculated by summing the weights, which have been developed by IIPS, Mumbai for NFHS-II. These weights are based upon the relative significance of ownership of these items, rather than on a more formal analysis.

average of 26.5. The U5MR is 131.0 among the urban poor as compared to the urban average of 82.9 which is a consequence of the family's compromised ability to recover from the existing limiting environment, paucity of time to seek health care as parents/caretakers are daily wagers and often pre-occupied with younger (often more vulnerable) children and low health awareness.

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.

The vaccination of children against six serious preventable diseases (Tuberculosis, Diphtheria, Pertussis, Tetanus, Polio and Measles) has been a cornerstone of the child health care system in India. The reanalysis of NFHS 2 data, Madhya Pradesh reveals that only one-fifth of all children aged 12-23 months had received complete immunization (Fig below).

Figure 2 - Immunization Coverage by Age 1 among Children 12-23 months Madhya Pradesh – NFHS 2 Re-analysis, EHP 2003



The reach and effectiveness of immunization services in urban slums are constrained by a number of challenges. Disease transmission can be interrupted with a lower immunization coverage rate in less densely populated areas, whereas the coverage rate needs to be much higher in urban areas to have the same effect, owing to higher population density and the consequent ease of disease transmission.

**Lesson 4:** Group Discussions in slums, interactions with grassroots health workers (ANMs and AWWs) and with



A women's group meeting in progress as children look on



slum based CBOs help reinforce technical child health priorities.

During the situational analysis and the consultations that followed, the core child health problems in Indore were identified. There are umpteen health priorities such as skilled attendance at deliver, improved home-based care of the vulnerable newborn owing to increased number of domiciliary deliveries, promotion of age-appropriate immunization through strengthened outreach camps and better quality and tracking, malnutrition prevention through improved infant feeding practices; diarrhea prevention through better hand washing, soap availability, use of latrines, access to safe drinking water.

**The following technical priorities were reinforced:**

- Improved ANC, delivery care (institutional and trained home delivery), neonatal care
- Immunization of children
- Improved feeding practices for preventing malnutrition
- Improved household hygiene practices for diarrhea prevention

In addition to the above, promotion of birth spacing and the problem of Acute Respiratory Infection (ARI) also emerged as technical priorities. The program determined the above four technical areas with the perspective that it was reasonable to start with these key priorities and then add other vital interventions as systems are set in place.

**Lesson 5:** Several public and private providers and multiple channels/platforms play different roles in MCH services and efforts should aim to utilize their potential for expanding reach and access of services to the urban poor.

*Public Sector Primary Health Care Services:*

- Health service delivery system is a multi-tiered system of dispensaries (32 dispensaries and UFWCs) and tertiary referral hospitals (District Hospital, Medical College, Maternity Home and poly-clinics) that have been organized around administrative wards and zones.
- Health services in Indore are provided by the Department of Health and Family Welfare (DoHFW), Department of Women and Child Development (DWCD) and private sector agencies (hospitals, nursing homes and clinics) and charitable hospitals/dispensaries.
- A Ward Medical Officer is responsible for service delivery in each ward. S/he is in some cases supported by another doctor and an ANM for each area.
- The population covered by a health worker approximates 20,000 to 25,000 for each ANM/ MPW, which is far greater than government norms. This results in insufficient contacts at the community level and a heavy institutional structure
- Regular community outreach services were not maintained.
- People perceive quality of care in government hospitals not to be of high order.

***Community based Nutrition and Health services: ICDS:***

- ICDS serves as the main channel for delivering child health services. But it is reachable to only 70% of the population in the district and to less than 50% among the urban poor. There are two urban *ICDS (Integrated Child Development Schemes) projects in Indore*. One managed by an NGO (Bal Niketan Sangh) has 111 AWCs, while the other directly managed by the Department of Women and Child Development (DWCD) has 190 AWCs; these AWCs cover only 110 slums out of more than 500 slums. An analysis of the distribution of these services in Indore again shows a disproportion between the urban and rural areas of the district. Also within

the urban set-up, the Anganwadi Centers (AWCs) are clearly located in slums which are reasonably 'better-off'. Weak linkages between the public sector managed ICDS and DoHFW in several slums reduce the synergistic benefit of these programs i.e. of ANMs and AWWs working in tandem.

**Other Health Service providers in Indore:**

- In addition, there are charitable hospitals, and the Employees State Insurance (ESI) hospital and the network of its nine dispensaries.
- *Private sector* remains by far the most preferred source of treatment. Informal private sector that surpasses the public system consists predominantly of unqualified medical practitioners owing to easy access, availability of credit, quick cure and personalized treatment. Qualified medical doctors are also accessed in several areas for maternity services and treatment of women and children.

**Civil Society Urban Health Stakeholders**

- *Non Government Organizations (NGOs):* More than 20 NGOs are based in Indore. They have predominantly focused on promoting savings and credit groups and more so in rural areas. Some of them are working on the promotion of self-help groups. Organizing health activities do not form part of their core strategy.
- *Social Clubs* such as Rotary, Lions' and their associated units are active in several health activities in the city.
- *Community Based Organizations (CBOs):* Their activities are largely restricted to finance and savings. They could serve as entry points for reducing poverty and/or improving health. Several groups have expressed their interest in working on health related fields.

**Lesson 6:** There is a need to strengthen linkage of Public and Private Health providers with slum communities to improve access and utilization of MCH services

Health infrastructure is weak; quality of preventive and curative services is poor due to increasing population pressure on existing resources. Improving service coverage involves improvement in availability and enhanced demand for health services through:

- A more pro-active service provision including outreach camps in slums, better quality of existing services and strengthening post-natal care, improving referral system, inclusion of private options for service delivery. This would entail motivation and support to ANMs, the key provider of preventive services.
- Foster linkages and coordination between community and providers and among the providers themselves to improve service regularity and coverage. E.g. (a) strengthening linkages between ANM and CBOs; (b) between traditional birth attendants and maternity services etc.
- Facilitating training and follow-up of key health providers such as traditional birth attendants and RMPs (unqualified medical practitioners) whose services are utilised by the slum community.
- Develop systems to continually counsel and encourage the slum community to adopt optimal behaviors and better utilize



Identifying unlisted slums

services

## 2. Assessment and Plotting of Slums

**Key Lesson: All slums are not equal and most vulnerable pockets are often not included in official slum lists; it is vital to identify and plot on the city map all slums and prioritize the un-reached, vulnerable urban settlements to efficiently target resources.**

A vulnerability assessment was carried out to understand the urban poverty situation in Indore, identify factors that enhance vulnerability in slums and prioritise slum areas requiring health interventions.

**Lesson 1: Methodology** - Local representative from various public sector, NGOs and community institutions can provide a rich information base regarding slums, which otherwise remain incompletely understood owing the dynamic nature of slums (frequent new growth, re-allocation, official eviction and resettlement etc.

*Group Discussions* were held with public sector staff, NGO and CBO representatives who had a good understanding of the city's slums, to develop assessment criteria; and to divide the list into two groups: vulnerable and not so vulnerable.



### Glimpses of the approach

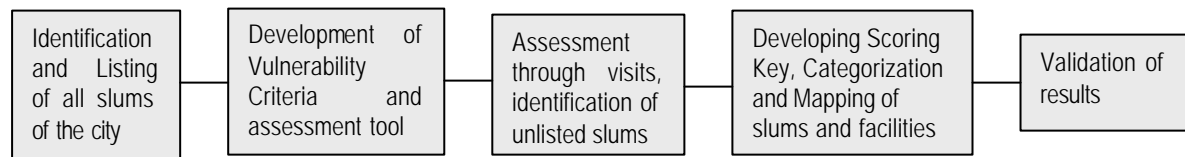
**Lesson 2:** Evolving criteria of health vulnerability with slum dwellers (primary stakeholders) and others directly working in slums (such as AWWs/ ANMs) helps determine most pertinent criteria for assessing vulnerability.

Visits were then conducted in *bastis* at different levels of development e.g. old vs new; city center vs periphery; recognized vs unrecognized etc. This was felt necessary for the

facilitator of the process to have an understanding of the conditions in which slum dwellers live, as many people found the actuality difficult to comprehend and visualize. Seven “Indore slum knowers” then viewed the work to date. They helped to validate the identified categories of slums, as well as developing detailed key determinant of health vulnerability of slums:

- Economic conditions – regularity and constraints of livelihood/occupation, access to fair credit
- Social conditions – alcoholism, gender equity, education
- Living environment – water and drainage systems, sanitation facilities, housing and land tenancy
- Access and usage of public health services – ICDS and DHFW
- Health status and morbidity– prevalence of diarrhea, fever and cough among children, and service coverage
- Community confidence and negotiating capacity – Presence of organized community collective effort

### **Methodology**



Data was collected from the slums against the developed criteria by teams of trained people. A ranking key was developed denoting the levels of conditions within each criterion. A score of 0-2 was given to each criterion, with a score of 0 on the criteria denoting an extremely vulnerable condition, and a maximum score of 2 showing a fairly better off condition. The total scores were distributed in three categories (range of scores depended on the number of criteria built in relevance to the different cities): Less vulnerable slums, moderately vulnerable slums and highly vulnerable slums. Slums were thus consolidated in these three categories depending on their cumulative score based on the assessment on each criterion. The results were shared and refined in meetings with various stakeholders so that the information was cross-validated.

**Lesson 3:** When slum stakeholders such as slum CBOs, grassroots workers analyse and delineate consensus findings regarding slums situation, the clear understanding about the inequality of slums can help target needy slums/vulnerable pockets.

The qualitative slum assessment with involvement of slum based stakeholders helped understand the real conditions of slums. Poor urban dwellers typically reside in underserved and very often unrecognized pockets. The participatory and qualitative process adopted to assess health vulnerability of slums and other underserved clusters proved a valuable tool for identifying and targeting the underserved/ un-reached for more effective health programming.

Most past programs in the urban slums of Indore have largely been incentive-based or focused only on service delivery and have not adequately focused on fostering broader community cohesion and social capital among vulnerable slum communities to address

needs beyond specified and pre-determined program objectives (e.g. savings)<sup>12</sup>. Owing to this nature of the programs and because the vulnerable were not actively identified, disadvantaged people have continued to remain underserved. This is further aggravated by limited time commitments and prerequisite of showing results.

- Beginning with an official list of 438 slums, the slum assessment exercise helped identify and locate 539 slums. Of these 539 slums, 157 were categorized as highly to moderately vulnerable while the remaining fell into the categories of less vulnerable, and marginally vulnerable. The total slum population of Indore is estimated at over 600,000, approximately one third of the total city population<sup>13</sup> of 1.8 million.
- Poverty levels have been reported at 68% in the slums of Indore<sup>14</sup>

Indore program targets vulnerable slums: *75 slum locations finally became the focus of NGO-CBO partnership program in Indore of which 53 slums are highly to moderately vulnerable and 20 were from other slum category; the Ward Coordination approach targets 24 highly to moderately vulnerable slums of the 54 slums in ward 5.*

## Program implications

a. Implications of the Situational Analysis: The city-based situational analysis and assessment of needs and capacities can be done through interactions with government and non-government personnel. Discussions with community leaders and slum based CBOs help gain a good insight into the slum health situation. Review of the Government departments' documents and studies of slum projects and situations in the city helps giving a background to the city. Group and individual stakeholder consultations with Department of Medical, Health and Family Welfare, Municipal Corporation, District Urban Development Agency, Integrated Child Development Services, NGOs, Charitable Institutions etc. enables the development of context responsive urban health plans.

Urban Health situational analysis in a city helps in:

1. Identification of existing programs and resources in the city that could be utilized for the common goals, thereby providing an opportunity for improved coordination and complementarity of resources.
2. An understanding of existing CBOs or similar slum-based networks or groups any other form of community leadership in the area, as a specific objective of the situational analysis, is useful while thinking through strategies towards program goal fulfilment.
3. Analysis of existing health facilities enables understanding the gaps in



### Bringing thoughts together for action

<sup>12</sup> SHG activities or the State Bank of Indore and other similar agencies have been driven by a much-directed "savings" component, which served as the incentive, and was effective in promoting savings. However, the focus on collective, coordinated community discussion and need-based action was very weak. On another front, ICDS has largely remained a service delivery program (providing food supplements).

<sup>13</sup> Taneja S and Agarwal S (2003), Situational Analysis for Guiding USAID/EHP India's Technical Assistance Efforts in Indore, Madhya Pradesh, India, Environmental Health Project.

<sup>14</sup> George R., B. Rajeev, and T. Sarwal. (1999) Poverty and Vulnerability in Indore: A Research Report. Nagpur: Oxfam India Trust

health delivery system, and suggesting appropriate strategies.

4. An understanding of the past and current experiences of NGOs and government departments helps in outlining their possible roles in the urban health programs and also the kind of support these institutions would need for pursuance of their roles.
5. More complete understanding of slums and urban poor settlements for addressing inequities and exclusion issues.

**b. Implications of Stakeholder Consultations:** In Indore, consultations were organized with different groups: NGOs, government functionaries i.e. Urban Local Bodies and Health Department, ICDS workers, CBOs and some common meetings also.

Such a guided, consultative planning process is useful in:

1. Building ownership of program objectives – while the broad goal of improvement of child health in slums may be outlined, the further specificities of this overall purpose are worked out in the city, with the people, and this helps in building ownership to the program. This is in reference to different aspects of the work.
2. The sharing of experiences of the government departments, NGOs and the CBOs helps both the program team and these stakeholders to understand the issues from several viewpoints, and develop feasible and effective plans. It also leads to building an appreciation for each other's work, capacities and concerns and subsequently works through collaboration and in developing partnering arrangements.
3. Stakeholder consultations were facilitated through workshops, as a result of which the program strategies evolve and get concretised. Similarly, the Terms of Reference (ToR) for inviting proposals in Indore were shared through a workshop. All such efforts in the program development phase have served as a capacity-building experience for the stakeholders involved in these consultations.

**c. Implications of Slum Assessment:** The slum identification and assessment approach has emerged as a valuable tool for targeting efforts and resources where most needed. The more vulnerable slums are the focus of EHP's interventions. In addition to slum visits, the assessment process involved discussions with different groups of individuals in determining the vulnerability criteria, understanding the different conditions across slums, categorizing the city slums on the basis of their features and finally verifying the results of this 'vulnerability assessment' effort.

Such a slum assessment exercise is a valuable tool for:

1. Identification of the vulnerable clusters in the city (and plotting these on a city map) and targeting of resources to such more needy areas
2. Making hidden or unlisted slums visible and plotted on the city map and ensuring their inclusion in the program plan. This addresses inequity that these unrecognized slums have suffered over time.
3. Capacity building of primary and secondary stakeholders by opening up and discussing diverse issues affecting urban vulnerability, and building this thought at a broader city level.
4. Helping identify champions who are interested in the program objectives and people's needs as against those keen purely on funding and also for building ownership of program objectives among community groups, NGOs as well as other stakeholders, which has a positive effect on program sustainability.



## Section III

### *Lessons from NGO-CBO Partnership Program*

#### **1. Building the NGO-CBO Alliance: The process and lessons**

##### **Background and Overview**

It is widely recognized that *local institutions* having a strong presence in the program area are more accountable to and informed about the different dimensions of deprivation among the urban poor and hence their involvement in development programs helps address issues in a more effective and sustainable manner. Such an approach facilitates a greater ability of the program to adapt and be responsive to problems that impinge upon the development of vulnerable urban communities.

The urban health situational analysis carried out by the program team showed that Indore had a rich culture of community level processes which contributed to: (a) the formation of a large number of CBOs in the city's slums; and (b) capability enhancement of NGOs to build capacity of slum-based CBOs largely focused on promoting savings and credit. Some NGOs and CBOs also had experience in health programs. Even those, which had no or little health experience, had a significant and strong presence in the slums pertaining to SHG linked activities.

Several CBOs displayed the confidence, inclination and capability of contributing to the well-being of vulnerable and needy slum communities often beyond their own slums. Despite the seeming impenetrability of formal systems, these groups of slum dwellers have learned that they can effectively access resources through their elected municipal representatives (ward councillors), by using vote bargaining and also through lower level bureaucratic channels.

During initial meetings in November and December 2002, NGOs and CBOs expressed interest in working on other issues (beyond savings) that could contribute to the holistic development of their slums. It was decided, based on the above, that consortia of NGOs and CBOs be created.

The consortia of NGOs and CBOs: (a) would enable entry to vulnerable or difficult to reach communities, (b) CBOs would be the voice of vulnerable communities, (c) CBOs would remain as resources for slum communities beyond project life, (d) owing to an understanding of the slum context of the city, the NGOs and CBOs could better respond to specific needs of different categories of people living in the slums; (e) being local and having program experience, NGOs could effectively coordinate with health providers, (f) involvement of NGOs and CBOs would contribute to the vital element of community ownership and sustainability.

Envisaged roles:

- *The NGO* would receive funds (and fulfil contractual requirements) and would be in-charge of guiding and supervising the project through the lead CBO.
- *The Lead CBO* which was formed as a community group from one or more slums working for slum welfare for over two years would implement activities at slum level and gradually gain in capacity.

The purpose/aim was to have such a partnership to then promote/strengthen slum-based CBOs in the vulnerable slums identified for the program.

***Complementing/Supporting roles of stakeholders***

<b>EHP</b>	<b>NGO</b>	<b>LCBO</b>	<b>Slum-based CBO</b>
-Capacity building of NGO, LCBO -Coordination with public sector, need-based support	-Capacity/institution building of LCBOs/BCBOs - Facilitating on the ground linkages - Training for midwives - Helping to develop linkages with public health sector	-Mobilising community, promoting and strengthening BCBOs -Pursuing and nurturing linkages with health providers and IMC - Maintaining records - Capacity Building for BCBOs, supporting BCBOs in counselling sessions and other BCC activities	-Identifying the target group - Tracking coverage - Identifying special-attention households - Discussing and negotiating with <i>dai</i> providers - Negotiating with providers - Generating a health fund which can be used at the time of emergency

**Lesson 1: Building the NGO-CBO Alliance:** It is important to identify partners who are committed to working for the well-being of vulnerable populations, have credibility among the slum communities and among other stakeholders, and are committed to and have the potential of being long-term contributors and supporters to vulnerable slum communities.

The possibility of an NGO-CBO partnership emanated from stakeholder consultations that helped understand the present functioning and capacities of the potential program partners. It emerged that NGOs and CBOs in Indore could play complementary roles of skills, knowledge, experience and reach. With capacity building and support, they could adequately serve the crucial functions of enhancing demand, building capacities and strengthening community linkages as part of the Urban Health Program.

Many agencies interacted with by the program team were not necessarily fully representative or inclusive. Centralized leadership was often masked in the form of an institution at the community level, and could become self-serving over time. In some cases, community processes excluded minority groups and the poorest. The program, therefore, endeavoured to identify organizations representing the needs of vulnerable slums and having a long-term commitment towards upliftment of the poor.

**Evolution of NGO-LCBO Partnership**

***Process of forging the partnership:***

1. Encouraging dialogue: Many NGOs and CBOs were introduced to each other and could identify common issues and areas of concern during consultations and meetings. Continued interactions/discussions gradually helped NGOs to identify the strengths of CBOs they would eventually partner with and to see them truly as partners in the program.

2. Request for proposal: Pursuant to consensus on supporting the program through NGO-CBO consortia, a modified RFP model in view of the limited capacity of NGOs to prepare full proposal and other advantages was developed in consultation with USAID. 12 NGO-CBO consortia responded to the “request for pre-proposals” in December 2002.



3. Screening and selection process (January 2003): The process for appraising pre-proposals was kept neutral and consultative. A screening committee (including public and private sector representatives of the city) was constituted to evaluate the NGO-CBO consortia using a comprehensive checklist. The first step involved assessment of administrative and financial capacity, reach and current activities of the NGO-LCBO in vulnerable slum communities and linkage with the people, organizational and staff capacity, staff involvement and commitment in project planning, current programmatic focus, transparency and credibility among the community. The second step involved presentations by short-listed consortia to the screening committee (who had already reviewed pre-proposals). At the end of the screening process, the committee selected five NGOs along with their respective partner CBOs, who are now implementing the program.



A proposal development workshop in process

4. Development of proposal and implementation plan and contracts/partnership: A three-day workshop was held with the selected NGO-CBO consortia to guide them in development of a final proposal and implementation plan. This approach helped; (a) develop consultative plans with the implementing agencies; (b) provide capacity building inputs to partners; and (c) aid the program team better understand partners to begin the envisaged relationship.

#### ***NGOs and CBOs partnering for the Indore UHP***

Consequent to this process, 5 NGOs along with partner CBOs were selected and began implementing the program in 75 slums of Indore covering approximately 26,500 households or 1.3 lakh population. Of these 75 slums, 55 belong to the vulnerable category (inclusive of most, moderately and less vulnerable slums) and 20 to the “other slums” category. These partner NGOs and lead CBOs are –

1. Bhartiya Grameen Mahila Sangh with Tulsi Self Help Group and Vaishnavi Self Help Group
2. CECOEDECON (Centre for Development Economics and Development Consultants Society) with: (a) Rehbar Mahila Mandal; (b) Rahul Gandhi Nagar Vikas Samiti; (c) Shanti Nagar Vikas Samiti; and (d) Mahila Sandesh Vikas Samiti
3. Indore Diocese Social Service Society (IDSSS) with Jagruti
4. Pushpkunj Family Helper Project Trust (PFHPT) with Jan Vikas Samithi
5. Bal Niketan Sangh (BNS) with Pratibha Swayam Sahayata Samooha

#### ***Contracting/partnering arrangements***

- EHP’s contract with NGOs: also process of pre-proposal (modified RFP approach) and then proposal development together with partners
- Joint expression of interest in partnering, with well-defined roles for both NGOs and LCBOs

### ***Status of partnerships***

NGOs play the important role of management, facilitating linkages and coordination, institution building, mentoring role for lead and *Basti* CBOs. Over the last 18 months NGOs have strengthened their capacity to manage a community based health program, to effectively coordinate with public and private service providers and in building capacity of CBOs. LCBOs have also steadily evolved into capable cluster-level slum organizations effectively supporting the slum-based CBOs in improving health and well-being of their communities.

## **2. Evidence-based approaches: Lessons from Implementation**

### **Background and Overview**

The priority evidence-based interventions in context of the Indore slum situation identified during the situational analysis and the consultations held with key stakeholders were: (a) trained attendance at delivery; (b) improved home-based care of newborns owing to a high incidence of domiciliary deliveries; (c) promotion of age-appropriate immunization through effective outreach camps; (d) improved tracking, malnutrition prevention through improved infant feeding practices; and (e) diarrhea prevention through improved hygiene behavior practices.

The Indore Urban Child Health Program has reinforced the following technical priorities:

- Improved ANC, delivery care (institutional and safe domiciliary delivery), newborn care
- Age- appropriate immunization of children
- Improved feeding practices (focus on initiating breastfeeding within an hour of delivery) for preventing malnutrition
- Improved household hygiene practices for diarrhea prevention

75 slum locations finally became the focus of NGO-CBO partnership program in Indore, of which over 70% slums are highly to moderately vulnerable- where, needless to state, the health conditions were abysmal. The reanalysis of MP NFHS-2 data, EHP (2003) also reveals the dismal health conditions of the urban low SLI where breastfeeding within 1 hour of birth was as low as 8.2%, Antenatal checkups amounted to only 32%, and only 20.6% children were completely immunized by 12 months (age-appropriate obviously would be further low).

The findings of the child health survey conducted in November 2003 by EHP in Indore also corroborate these data. The findings show that percentage of completely immunized children by 12 months was 34% in the most vulnerable slums, in case of three antenatal contacts, it was at 62%, but complete ANC (comprising 3 antenatal checkups, 2 TTs and 100 IFA) was as low as 7 % in the vulnerable slums.

***Overall/Key Lesson: Coverage of evidence-based key child survival interventions such as TT, safe delivery practices, breast feeding, and immunization can be increased among slum communities through a planned two-pronged strategy of a) context-responsive behavior promotion; and (b) improved reach and quality of services.***

**A.I Improving behavior adoption:** Training enabled community groups/individuals to appreciate persuasive family based counseling and enhancing community capacity as key to improving behavior adoption among slum families.

### **A.1: Behavior promotion for key child health practices**

**Lesson 1:** When communities are counselled for healthy behaviors, early adopters are willing to serve as counsellors (as BCBOs) for others; after appropriate training these early adopters develop confidence and conviction and with support from elder women in the family/community are able to increase safe delivery practices, and behaviors such as early initiation of breastfeeding among other mothers.

A planned strategy of using early adopters has been instrumental in bringing about significant improvement in health behavior practices in the slum communities. Many of the *Basti* CBO members were themselves early adopters, and therefore have greater confidence to motivate and convince other women in the community to adopt appropriate behaviors. This is evident in the case of BCBO members Leela Bai, Serrai<sup>15</sup> Bai, Umla Bai and many more.

Leela Bai is a member of 'Shiv Shakti', a slum-based CBO of Ahirkhedi. She has a nine-month old baby girl Sneha, and a son Navratan who is three and half years of age. It is with delight (and some remorse) that she narrates about her gains of being associated as a BCBO member, now for a year. Before her association with the group she was like many other women of her *basti*, ignorant about appropriate healthy behaviours; following practices, which she saw, were followed in her family and her neighborhood. Subsequent to her association with 'Shiv-Shakti' group, she was exposed to frequent interactions with LCBO members and NGO staff, thus acquiring knowledge on technical areas and skills, through the capacity building programs, to counsel women. She got the opportunity of trying out her newly-acquired knowledge on immediate breastfeeding on Sneha. She happily mentions that Sneha was given no jaggery water, and put to her breast within an hour of her birth, and that '*Sneha suckled well*'. (Initially in almost all slum communities, the baby was put to breast on day three or later). The remorse, '*I couldn't do this for my elder son!*'

**Lesson 2:** Investment in institution-building (or program capacity building) of slum-based groups who promote health behaviors through counseling yields high returns in coverage of healthy behaviors

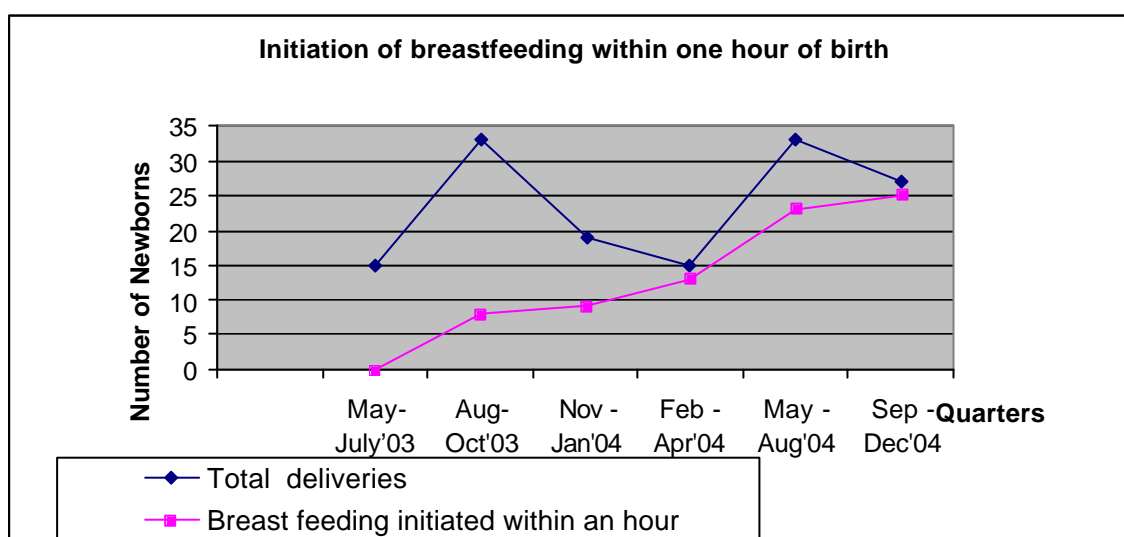
Context-responsive behavior promotion strategies of training motivated community groups/individuals and enhancing community capacity are key to improving behavior adoption among slum families. In the program, the community activities were initiated by Lead CBOs who were provided capacity building and on-site guidance by EHP initially, and the respective NGO as a follow up. Slowly as BCBOs were promoted and strengthened, NGOs and LCBOs provided similar capacity building inputs on technical

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<sup>15</sup> In the same slum Ahirkhedi, resides Serrai Bai wife of Sevak Ram. She has five children; the youngest child Megha is five months of age. The last delivery was conducted by Genda bai, a TBA (trained by BGMS a year back) who made Serrai bai immediately put the baby to breast. Adopting this practice was not difficult as Serrai Bai is a member of the BCBO '*Maa Vijyasan Samooh*', and by then had learnt about the benefits of early initiation of breastfeeding. The bathing of her neonate was also delayed by five days. She had not followed these practices in her earlier four children's cases as neither she nor the *dai* was aware of these healthy practices. Megha, now five months of age, has received on time, BCG, DPT I, II and III doses at the immunization camp held in the Basti.

content (e.g. early breastfeeding) and on-site support to the *Basti* CBOs. The Lead and BCBOs hold regular counseling sessions with mothers and other family members to discuss optimal practices and also help clarify their benefits. This enables mothers and families to think about amending traditional behaviors and try suggested optimal behaviors. The presence of trained BCBOs close at hand acts as a potent and vital force and a constant re-assurance, which goes a long way in effecting suggested behavior improvements. The trained BCBO member is always accessible as a ‘knowledgeable’ person of the same neighborhood and hence a pillar of strength in the behavior changes process.

The graph below from two slums Jeet Nagar and Sonia Gandhi Nagar shows that in the first quarter of the program none of the newborns delivered were breastfed within an hour of birth, which progressively increased in the subsequent quarters, with formation and strengthening of slum-based CBOs and their capacities.



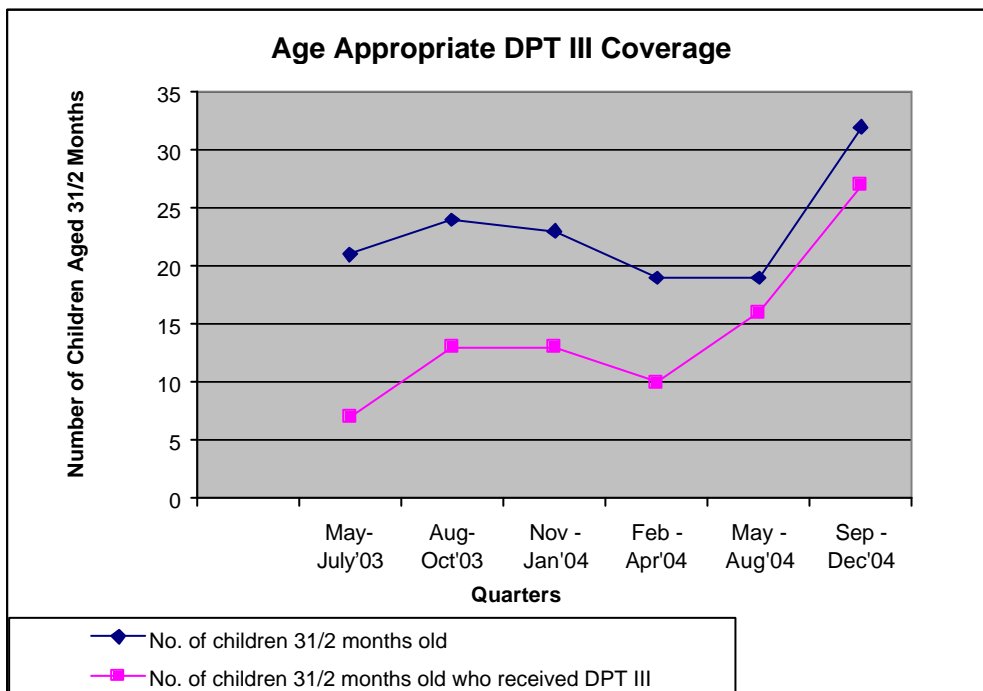
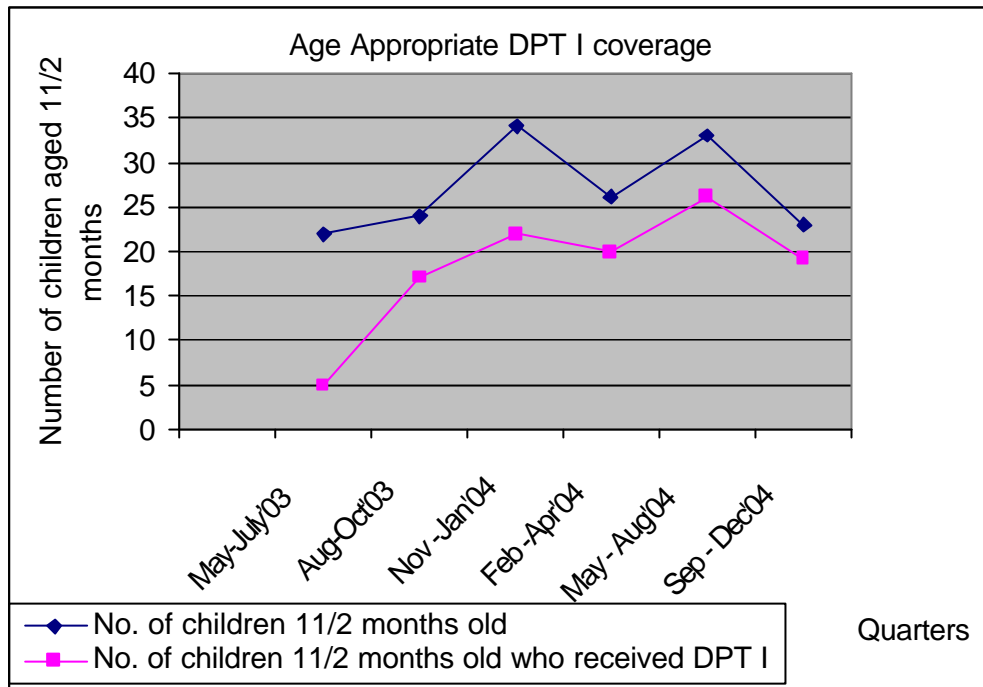
The following three graphs show data from 3 slums of BGMS (Pawanputra Nagar, Annapoorna Thana Basti and Ahirkhedi) for age appropriate DPT I, DPT III coverage and TT coverage by 6th month of pregnancy. DPT I coverage or left out rate (Children not receiving DPT I of the total eligible – completed 1.5 months) is a good indicator of reach of services while DPT III or drop out rate (Children not receiving DPT III of the total eligible – completed 3.5 months) indicates the quality of services.

As is evident from the graphs for age-appropriate DPT I and DPT III coverage, the gap between the number of eligible children and those receiving DPT I and DPT III in time is decreasing which indicates that both reach and quality of services is improving.

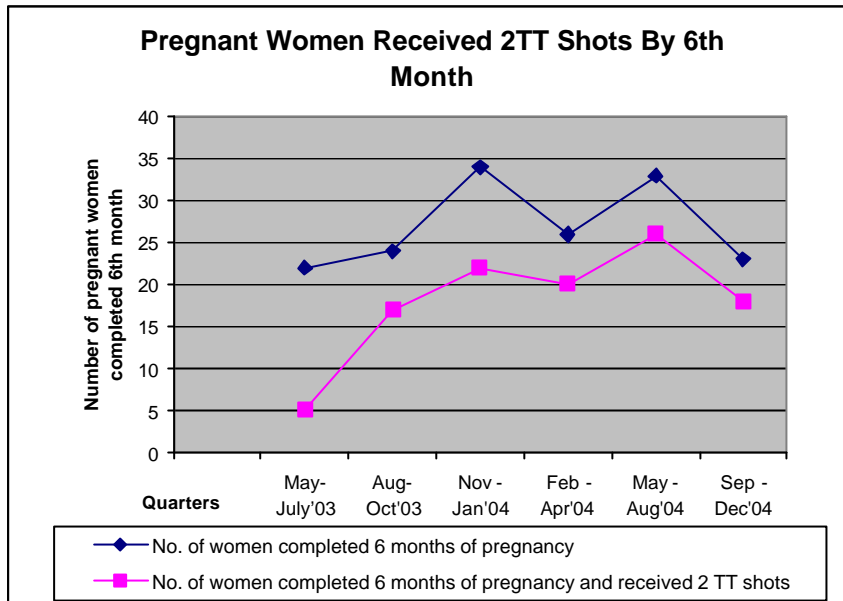
Program efforts are directed to promote age-appropriate childhood immunization. Timely identification of children enables timely initiation of their immunization schedule and subsequent timely receipt of the remaining vaccines.

The decreasing left-out rate also indicates that the program has been successful in mobilizing communities and increasing usage of available immunization services and the decreasing drop-out rate indicates active follow up and tracking by the *Basti* CBOs. Thus it also reflects the increasing capacity of *basti* groups to promote usage of services.

Amongst these three slums, Ahirkhedi has a significant *Paardi* community, which is resistant to availing immunization services due to cultural factors. A declining left-out and drop-out indicates a change in this age-old practice as well.



The monitoring of 2TT shots by the 6<sup>th</sup> month of pregnancy is a program intervention to track pregnant women who have not received the shots and could still be counselled and convinced to receive the shots by the 8<sup>th</sup> month of pregnancy.



**Lesson 3:** Interaction of program facilitators with key influencers (including mothers-in-law, neighbors, men, *dais*) empowers mothers to overcome family resistance and enables specific communities overcome traditional beliefs thereby adopting healthy behaviors.

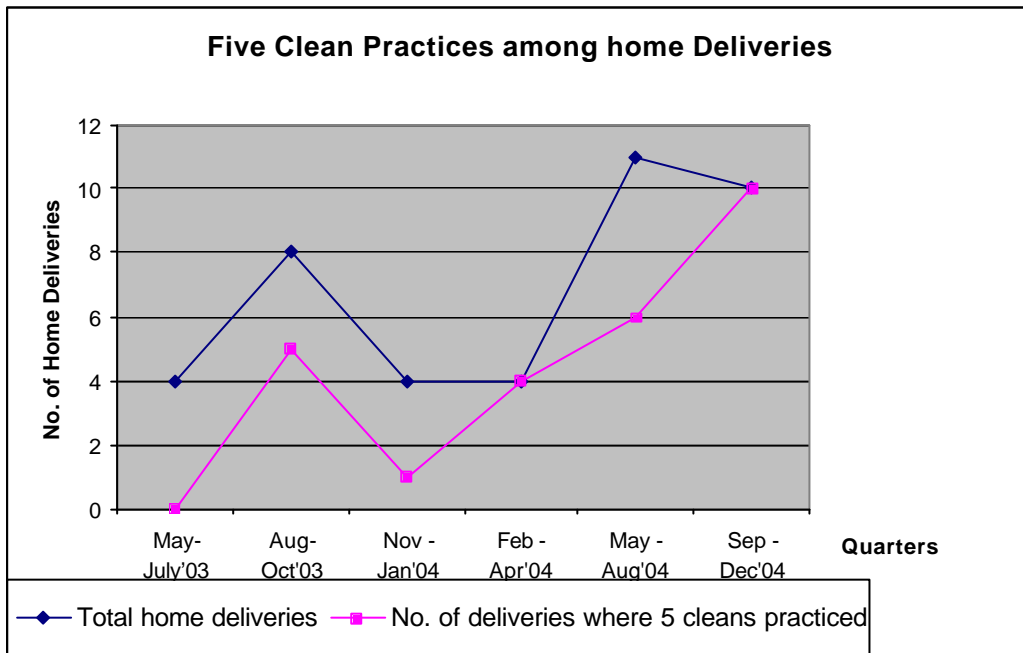
The behavior promotion efforts of the LCBO members initially focused on targeting mothers whose practices were to be influenced, which in most cases were not very successful. The efforts to convince mothers to adopt safe delivery practices, initiate breastfeeding within an hour, delay bathing of newborns were enormous as it involved communicating the desired practice and its benefits, and the adverse effects of the traditional inappropriate practices (which were not evident to many or they failed to link the harmful practices with such effects). The mothers would get motivated to adopt the desired practices but the untrained *dais* attending to the deliveries, mothers-in-law or other elder members who have or are practicing the inappropriate behaviors would act as a deterrent to the motivated mothers who unwillingly would succumb to such influences.

The LCBO and BCBO members modified their home visits to provide family-based counseling sessions rather than individual counseling; identifying key influencers, convincing them on desired practices and motivating them to support such practices in their families. Training and refreshers for *dais*, and co-opting mothers-in-law/other older women influencing behaviors as BCBO members were other successful approaches adopted in the program by the NGO-LCBOs.

Umla Bai, of the *banjara* community, has never followed any safe delivery practices or other desired behaviors being promoted by the program in her slum Ahirkhedi. She had a rationale for every inappropriate practice. For instance she believed that a baby should be put to breast on or after the third day of birth as in her words, that is the time when ‘*milk comes down in the breast*’, or that application of oil on the cord stump is important for it to fall off on time with no discomfort to the newborn. After inclusion in the *Basti* CBO (*Maa Vijyasan Samooh*), she learned of things never heard before and all contrary to her beliefs and practices. She along with other BCBO members initiated counseling sessions with mothers and her confidence rose after successful adoption of healthy behaviors by women in her slum. Umla’s daughter-in-law Maya is now pregnant with her first child. She is in her fifth month of pregnancy and has received TTI at the outreach camp, and

went for an ANC checkup at Rajendra Nagar government health facility. Serrai Bai's is another success story, where her being a BCBO member and her fifth and last delivery conducted by a trained *dai* Genda bai, were instrumental in the practice of five cleans, early initiation of breastfeeding, delayed bathing, and provision of warmth for her newborn.

Sonia Gandhi Nagar is a slum where all deliveries are domiciliary. The graph below shows the practice of five cleans at delivery over a period of 6 quarters.



## Investing in training of Traditional Birth Attendant: A case study of Draupadi from Jawahar Nagar

Draupadi Bai cannot recollect how many years it has been since she came to live in Jawahar Nagar. She says that she has been married for fifty years and that she started conducting deliveries soon after the birth of her second son.



Unlike most other traditional birth attendants, an older family member did not initiate Draupadi Bai into this work. The first time she ever conducted a delivery was when she assisted her sister-in-law who was in so much pain that she refused to let the village *dai* touch her. Even all those years ago, she used a new blade to cut the umbilical cord, though she is honest enough to admit that she did so because she was not very adept at using the sickle, which is what is traditionally used to cut the cord, and not because of any concerns about hygiene.

She talks excitedly about the training that she has received from BGMS, and says that she would go for trainings as often as they called her. As she describes in detail all she has learnt at the training she marvels about how simple things can make such a difference. She repeatedly stresses on the fact that she now washes her hands every time she touches the mother. She has also stopped applying pressure to help the placenta be expelled; instead she now puts the baby to the breast.

The most valuable thing she feels she has learnt is how to identify high risk cases. Now Draupadi Bai refuses to take risks and refers women to the hospital as soon as she feels that something may be wrong. When the assessment team met her, she was returning from the home of a woman whom she had accompanied to the hospital two days ago because of a threatened premature delivery.

Draupadi Bai says that it is important to invest in refresher courses for traditional birth attendants as it is then much easier for them to convince both the new mother and her mother-in-law to do away with the traditional customs such as waiting three days before initiating breast-feeding.

It is by investing in training women such as Draupadi Bai that the program can ensure that its investments in its core activities like changing behaviours to promote neonatal and maternal survival are optimized.

**Lesson 4:** Community level events for promoting healthy behaviors: Recognition to positive families through ‘healthy baby’ and ‘healthy mother’ competitions has served as incentive (to improve self-esteem) for other families to adopt healthy behaviors and also helped spread awareness to a larger section of the community.

All the project partners of EHP are regularly conducting ‘healthy baby’ competitions in the *bastis* they are working in. Many of them organise such competitions together with ‘healthy pregnant mother’ competitions.

During the period July 2003 and December 2004, Pushpkunj had organized a total of 21 such competitions in their area.

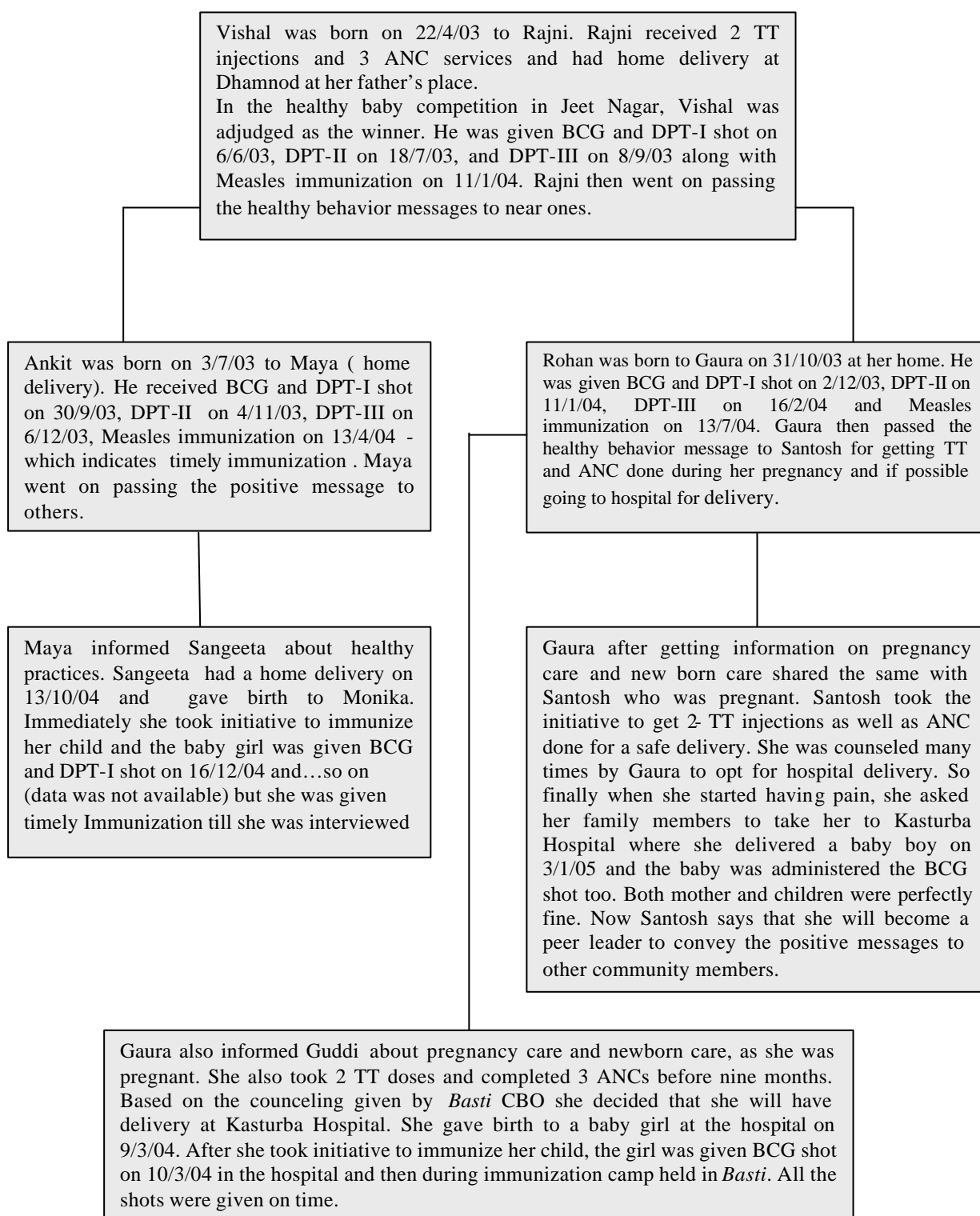
S.N.	Name of Basti	No. of Healthy Baby competitions held
01	Jeet Nagar	05
02	Bhawna Nagar	03
03	Piplia Rao	02
04	Ekta Nagar	02
05	Rahul Gandhi Nagar	03
06	Sonia Gandhi Nagar	04
07	Chitawat kumharbhatta	02
	<b>Total</b>	<b>21</b>



These competitions provide an opportunity to disseminate all positive messages related to healthy behaviors amongst community members. Also through organizing such competitions, peer leaders in community groups are identified and they go one step further and inform others about adopting such behaviors. Moreover, the competition itself motivates them to change their health behaviors in order to get a prize and recognition within the slums.

The flow chart given below shows the snowballing effect of the positive messages of such competitions in creating awareness amongst the people and bringing about positive changes in health behaviors. It is important to understand here that immunization of children and pregnant mothers continued because of continual re-enforcement of messages through Lead and *Basti* CBO along with the peer pressure from individuals. As one can notice, whereas in earlier cases it was home delivery that was the norm, at a later stage, as messages kept on reaching the communities, institutional delivery too became an option of choice.

## The snowballing effect of Information dissemination through peers.



### Seek a role model or become one ?

Indu Jagdish lives in Chirad Mohalla. She has been affected by Polio in both legs, since birth. Indu's mother-in-law is an active member of the *Basti* CBO of Chirad Mohalla. As soon as Indu became pregnant, she and her mother-in-law consulted the LCBO and got her immunized with TT. She also took advice on nutritional aspects and the other *Basti* CBOs helped her to get timely checkups done by the doctor, who told her that she had twins. At the last moment, unable to reach the hospital for delivery, the delivery took place at home itself. The *dai* who conducted the delivery had been trained at a *dai* training program by IDSSS and she took special care to practise the five cleans and ensure essential neonatal care. Consequently, today both the children are healthy and their immunization is also being done on time. The family members are at the same moment appreciative of the fact that they were properly guided and supported by the LCBO as well as the *Basti* CBO. In the *Basti* this incident spread a positive message and now with her own family experience the mother in-law gives example of her daughter-in-law Indu, when talking about healthy behaviors to other pregnant women.

### Implications for future

- During initial stages of behavior promotion efforts, a few mothers or families are more willing to embrace change. These are often those who are more self-confident, more aware, have family support and are hence able to challenge traditional practices. With continual support, these early adopters become confident of the benefits of these practices and also of their own capacity of carrying out these practices. Some of these early adopters can be motivated and trained to become peer counsellors to influence other women and families. The late adopters are more open to helping out in the suggested behavior change when counselled/persuaded by live examples of success (i.e. the early adopters) from their own community/neighborhood.
- Investing in technical, skill and institutional capacity building of slum-based institutions/individuals or similar networks are effective since they are more acceptable to the community and therefore more effective in promoting optimal behaviors.
- It is a viable strategy to promote capable slum-based groups or individuals who are likely to continue to serve as a resource to the community even after a 'project' ends.
- In different cities, possible slum-based institutions or networks could take the form of NHGs, SHGs, *Basti Vikas Samitis* etc. Slum-based individuals have been tried by many health programs/organizations in the country. ALERT India-Mumbai, Jamkhed-Maharashtra, CASP-PLAN- New Delhi, IPP VIII- Kolkata (World Bank), are some of the health programs/organizations that have promoted health workers from within the communities.
- These key influencers once convinced, are instrumental in enabling the young mothers in adopting/trying out suggested practices that are contrary to traditional beliefs. Program efforts should proactively target engagement with these groups of influencers to more effectively promote optimal behaviors.
- Effective approaches to engage with mothers-in-law and *dais* include:
  - a. Include *dais* in thematic meetings/counselling sessions (themes such as safe delivery practices, newborn care) with mothers at slum level
  - b. Specific capacity building and exposure to *dais*
  - c. Mothers-in-law as active CBO members themselves emerge as counselors and champions.
- These approaches are adaptable and replicable in different cultural contexts.

- While it is important to keep promoting healthy behaviors as appropriate to local conditions through different means, someone from amongst the community needs to take a step forward and become a role model, in order to send a positive message across.

**A.2 Improving Service coverage: reaching the un-serviced, establishing outreach sessions and improving community demand and utilization of services**

At the time of initiation of the program, there was limited presence of public sector health providers in the slums, the situation being “marginally” promising in recognized slums than the newly identified slums as evident during the vulnerability assessment process. This was compounded by an even more limited demand and inertia amongst the vulnerable urban poor to seek services. With the slum-based groups not having a good network in most slums, there was no means of linking the people to their rightfully deserved health services. Initial visits and interactions revealed that there was no opposition to services like immunization amongst slum dwellers with the exception of certain tribal groups; the problem was related to low awareness about benefits and service providers for immunization and related services. Those who were informed were trapped in the struggle for existence in the slum environment with no time and financial resources to avail these services from a distant health facility at the expense of losing their daily wage.

**1. Lessons around establishing effective quality outreach camps ensuring increased coverage to un-reached special need slums**

**Planned outreach camps on fixed day and site in/near slums, with prior information to families and friendly linkage with ANM helped in increased service coverage and reach to special need clusters.** This reduced the mother’s dependence on an escort to take the child till the facility as well as prevented the loss of daily wages and waiting time for employed mothers/ laborers.

- Division of work area by *Basti* CBOs such that each member takes responsibility of reaching all target children and pregnant women in their lanes or vicinity of their house and as far as possible ensures representation of all pockets, castes and occupation groups within the slum in the *Basti* CBO guaranteed reach to all sections of the *basti* including the perpetually left out and difficult to reach pockets. The ever-evolving *Basti* CBO of Annapurna Thana Basti, also known as Sudama Nagar, is a befitting example of bringing together members from different slum pockets of an otherwise homogenous population comprising the *Nemadis*. There are about 250 households located on one side of the main Annapurna Road, of which 40-45 households are situated remote to the main slum separated by a big ‘*maidan*’. The latter group of households were far from the reach of services until recently when the women from this section were encouraged by existing *Basti* CBO members with support from lead CBO and NGO to form a new CBO to attend to the needs of this pocket of 40 – 45 households.
- Regular contact of *Basti* CBOs with the community breeds familiarity and faith in advice/ counseling. Visits by Medical Officers, Ward Councillors etc coordinated by the *Basti*/ Lead CBO adds to the credibility and acceptance of the *Basti* and Lead CBO and also motivates the ANMs. This was particularly evident in the IDSSS area over and above the advantage of this NGO having a longer presence in these slums.

- Having a fixed camp site, well-accepted by all members of the community and preferably in the centre of the *basti*, has enabled association of a particular area within the slum with immunization services and greater visibility and awareness about these services among the slum dwellers. Of particular interest is the case of Bhawna Nagar in Pushpkunj area. It comprises approximately 850 households spread across a vast expanse of land. Initially camps were held in the AWC situated at one end of the *basti* resulting in a low reach of services with 80% of children being left out. Once the site was shifted to a more central location, the reach increased to 60% or the number of left-outs was reduced to half. Identifying a central location for the immunization camp may not be feasible under the slum conditions and sometimes not even applicable as in the case of Ahirkhedi (BGMS area) where a segment of the slum dwellers distant to the camp site prefer to use the nearer rural PHC. There may not be any benefit in shifting the campsite under such circumstances. Schools and private practitioners' clinics as in Jalla Colony amongst other places are being used successfully as campsites.
- Complete and correct information to mothers about camp dates, repeat visits and sources of immunization services in and near the slum, has been the cornerstone of increasing complete childhood immunization by twelve months of age. Many of them have been motivated to the extent of choosing to travel to a distant facility in case the outreach camp was delayed or cancelled to provide complete immunization protection to their child.
- Record keeping at the slum level by the *Basti* CBOs on a simple and easy-to-understand format enables them to track their own progress. The lead CBO checks this data and then consolidates the figures. At the NGO level, this data is reviewed before the monthly and quarterly reports are presented.
- Developing cordial relations with public sector service providers to achieve common goals and through mutually acceptable processes has been a big win. The *Basti* CBOs help in identifying the beneficiaries and also support the ANMs during Pulse Polio rounds and organization of regular outreach camps. The ANMs recognize their efforts and promote the CBO members as good samaritans and leaders who can be looked up to. This alleviates the community's antagonistic feelings and false impressions about monetary or other benefits to the *Basti* CBO members who are actually volunteering collectively for the betterment of their *basti* and forming a vital link between the people and the services. Bringing together public health providers and the NGO-CBO consortia on a common meeting ground on a regular basis enables better planning, discussion on concerns and resolution of conflicts, if any. A particular case is of Sister Joseph posted at Sindhi Colony PHC, which has one of the largest catchment areas. She provides outreach services to slums in both BGMS and Pushpkunj area. BGMS staff was perplexed with the fact that Sister Joseph would conduct camps regularly in the Pushpkunj area but was hesitant to visit Professor Colony in BGMS area. A closer investigation by the BGMS team revealed that the issue was the absence of support from the community to identify and bring to the camp the target population when she would arrive. BGMS initiated a discussion with her and assured their presence at camps till the time these activities regularized and *Basti* CBOs competence to independently conduct these activities was established.
- Approaching all stakeholders and developing linkage mechanism with them was mastered by a few NGO-CBO consortia. CEOEDECON has developed a linkage with ESI, whereby ESI provides mobile immunization services to areas beyond ANM's catchment area. Some of the most under-served pockets have been reached through this effort. They are on the road to a long-term relationship. In some slums such as Jalla Colony, the CBOs have been successful in using private practitioners'

clinics as immunization sites. There are more examples of transient partnerships such as with private providers and professional bodies, which have a possibility of strengthening and emerging as collaborations in the future.

- Providing multiple services at camps; using the opportunity to conduct BCC activities or discuss concerned issues has enabled CBOs to reach the people collectively at a common place and allowed better utilization of the waiting time.

## 2. Community capacity increases service utilization

**Planned outreach alone may not suffice if there is inertia amongst people to utilise services. Increased awareness about and linkages with service delivery options helps communities /families overcome barriers to seeking services.** It is advisable to simultaneously promote fixed facility usage particularly in events of “missed cases” of immunization or cancellation of/ delay in organization of camps for long-term sustainability.

The *Basti* and Lead CBO equipped with correct information on immunization benefits, dosage and related information were lent a ear by the people. Many of the *Basti* CBO members were themselves early adopters who had first hand experience in receiving immunization services and the benefits of preventive care. In cases where opposition towards immunization was very strong, innovative techniques based on fear model (CD shows on VPD symptoms and consequences followed by discussion) and peer group counselling were used. There are two examples of successful peer group counselling and the following case study illustrates one of them<sup>16</sup>.

An example of a lucid communication mechanism involving peers is that of Gajabai in Mahdev Nagar. Gajabai feared immunization like many of her “*Paardi*” community members, to the extent that she kept shying away on immunization camp days, escaping the eyes of CBO members who might take the child to the camp by force. The CBO members were made to believe that she is not in the slum by her husband and neighbors. Finally, she was spotted by the lead CBO who tried to persuade her to get the newborn immunized; but in vain. It was then that her relative from the native village arrived and learnt about the situation. Equipped with information about the benefits of immunization, she along with the *Basti* and Lead CBO members convinced Gajabai to get the child immunized. With the support of someone from her own community, seeing no adverse effects and gaining understanding on how her other children are threatened because of being non-immunized, Gajabai has now become a front runner in promoting immunization-related awareness among her community members.

## 3. Lessons around reaching difficult-to-reach migrant communities and families

Mass migration in slums is a common occurrence in Indore. There is movement of relatives (who generally inhabit the same or nearby *Bastis* for security and maintaining the social fabric) or compatriots from the same community to native villages, particularly amongst newer migrants when there is sufficient earning to sustain them for a few months. Another form of mass movement is seen among particular tribes or sects like the *Banjaras* and the *Paardis*. In such tribes, movement is a part of cultural existence. The labour class follows the third type of mass movement, which is associated with income generation. When work prospects are bleak in the city, contractors offer them work in bigger cities where daily wages are much better and in anticipation of better earnings the entire community may be hired and taken off to cities like Mumbai or Delhi. Within

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<sup>16</sup> Neeta Bai also from the *Paardi* community provides a similar example of successful peer group counselling which enabled her ninth-born child to be immunized in the Ahirkhedi camp. For the first time ever, albeit slightly delayed for age, a child in a family of eight older non-immunized siblings received vaccination.

Madhya Pradesh, many labourers from neighboring districts such as Jhabua settle down in Indore as the daily wage is only Rs 30 in their native place as compared to around Rs 100 in Indore.

Small group or individual migrations from one slum to another can be attributed to many reasons. Families who have a regular income now leave the more vulnerable slums to ones with better facilities. They are generally on rent and can now afford to pay higher rentals or even get a *Patta*. Some families have left a slum due to constant pressure from unwanted elements or the general violent atmosphere of the slum. The third type of migration within slums is associated with eviction and resettlement. When government authorities or private landowners whose lands have been encroached evict these slum dwellers, they find shelter in peripheral slums. Migration is also common during festivals like *Navratri* and *Gangaur Puja*.

Once people migrate, either temporarily or permanently, the process of interaction and possibility of behavior adoption or utilization of service while they are away in the village or new city is generally abandoned. By the time they return, the child may have missed immunization dates. Women generally leave behind children's immunization card, leaving no record to confirm the child's immunization status by the ANM in the native village or new city. Also, since currently services are utilized or behaviors are adopted not entirely because of people's felt need but because of the presence of motivated CBOs, people may not demand services in their native village or other cities.

Similar or worse to the situation of people who migrate out is the situation of those who move in. The new migrants are not inducted by the CBOs till the time it is ascertained that the family will stay there for a long span of time if not permanently. Also it is only if during this time the family has met others in the slum with a similar background relating to caste, religion, occupation, that they would get a clue to existing services or initiate interaction with the CBOs.

The *Paardis* and *Banjaras* are feared and ostracized by the other slum dwellers due to their reported ancestral association with criminal activities. Their temporariness compounded by the prejudice of other people in the community against them leaves limited scope of any effort at the grassroots level reaching them.

**Special attention through persuasive counselling by CBOs regarding preserving cards, availing services in place of migration and significance of timely immunization helps improve immunization coverage among such migrant families.** More focus is being paid on ensuring continuation of healthy practices and availing services among migratory population. Geeta Bai, mother of 4 children, frequently moves in and out of Ahirkhedi to promote her small business in village *melas*. Since one of her four children is yet to complete the immunization series, she makes it a point to inform the *Basti* CBO about her schedule and takes necessary actions as suggested by the CBO members if she misses the camp date.

#### **4. Lessons learned from relocation of slums done by the local administration from time to time:**

- During the course of the program, some slums have been shifted while others such as Buddha Nagar and Arjunpura are in the process of in-situ development. The biggest challenge has been to track the displaced slum-dwellers and providing services to them at their new destinations. It is important to follow up each individual as s/he is like an investment of multiple resources for the program.
- People get occupied with resuming livelihoods, particularly when they are relocated from the heart of the city to a peripheral hinterland, much remote to their work place and with other relocation related hardships, health takes a backseat. Program needs to re-invest in CBO mobilization efforts and reinforce BCC. Temporary relocation contributes to continued uncertainty. e.g. people from Dusshera Maidaan Basti situated in the centre of the city, now had to go to a peri-urban site about 12 km away near the airport at Vyas Nagar.
- In the case of in-situ development, there is disintegration of the *Basti* CBO as with new dwellings, come new neighbors and different target groups, which are unknown to a particular BCBO member. Not to mention, that they also are trapped in the above-mentioned problems of de-settlement. Efforts have been made to orient all *Basti* CBO members to the entire gamut of target population and obtain advance allotment list from the concerned authority to know the exact location of the *Basti* CBO members and their new areas of work “*from the lanes to the staircases*”. Not to deny that forging these new linkages means an investment of time; the CBO members help each other in making these contacts with their original target groups.

#### **Implications for future**

- Women are not depending completely upon the immunization camps. In case they are not present in the slum on the day of the camp, they are being encouraged to go to nearby clinics for vaccination. Promoting use of fixed facility and linkage of the *Basti* CBOs with the ANMs and, if possible, the Medical Officer will be a step towards sustaining the efforts of improving immunization coverage. The access to a fixed facility also provides information about and access to other health services (both preventive and curative) resulting in improved health awareness.
- Easy and effective tracking mechanisms with special focus on difficult-to-reach groups such as new migrants are being evolved. The emphasis will be on tribes/families having strong notions against immunization.
- The NGO-CBO partners should continue to look out for innovative methods to promote optimal behaviors and identify champions within the community to effectively expand their approaches for counselling.
- More effort is needed to build sustainable linkages with bigger health facilities/hospitals will provide both preventive and curative services. NGOs will need to think of pooling resources for this.
- Focus on age-appropriateness needs to be gradually strengthened as a recent survey in eight slums indicates that while the overall coverage of DPTI has reached 75%, only 35% of the children receive it by two months of age. The program though focusing on children less than one year of age, does not aim at limiting services to just that age group. This needs to be emphasized repeatedly amongst stakeholders. Opportunities to address health needs of older children should not be missed.



### 3. NGO-CBO Consortia as an effective partnership strategy

#### Background and Overview:

NGO-CBO Partnership has proved to be an effective mechanism for sustainable programming aimed at developing slum-based capacities for ensuring continued improvements in health coverage through increased demand and effective linkages of the community with health providers. It was evident to the program team during situational analysis and stakeholders' consultations that NGOs in the city had management and financial capacity and the credibility to coordinate with public and private providers. A partnership with slum-based groups for implementation would lend the program a strong community base. Such a base is ideal to invest capacity building inputs since the Lead CBOs from local slums would be: (a) able to take program closer to the vulnerable communities more effectively and efficiently, and (b) able to help establish a sustainable capacity that the program would be able to leave behind. The past two years of programming experience through the NGO-CBO consortia has produced some lessons.

*Overall/Key Lesson: The formation of NGO-CBO Consortia has been an effective strategy in enabling the partners to utilise complementary skills and capacities, and develop synergistic potential. This has led to enhanced program management and institution building capacity among NGOs. Also the LCBOs have evolved as a potent institutional mechanism for slum health (and development) programs.*

**Lesson 1:** Efforts aimed at capacity building and creating an environment of learning together in the initial phase of the partnership, (and hand holding along with continued support to partners), are critical for enabling partners move towards a productive and fructifying direction.

During the initial stages of the program, i.e. during March – April 2003, specifically designed capacity building inputs, and then subsequently inputs and guidance as part of ongoing program activities, a mentoring role played by EHP has facilitated the strengthening of the partnerships between the NGOs and LCBOs.

**Capacity Building:** Based on capacity building needs assessment, capacity enhancement workshops and exposure visits were organized keeping NGO workers and Lead CBO members on the same platform. The specific objectives of these initial exercises were to: (a) build skills in participatory approaches, community mobilization, counseling, and facilitation; (b) learn context-specific planning with slum communities such as the learning which emerged during the PCHEP Workshop<sup>17</sup> – 20<sup>th</sup>–30<sup>th</sup> March, 2003; (c) enhance information base on technical issues (i.e. newborn care, immunization, diarrhea prevention, prevention of malnutrition and promotion of hygiene and sanitation ) and use of related training material; (d) enhance motivation and faith in community processes, and to see community mobilization tools in action such as the Mumbai and Pune exposure

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<sup>17</sup> The purpose of the PCHEP was to enhance program partners' skills in conducting a participatory community enquiry with triangulation of findings and use findings to determine program plans in consultation with the community. Such a process enables the community to take ownership of the program's objectives and processes. This workshop was designed for guiding the urban health program in those slums of Indore, which have limited access to health services.

visits<sup>18</sup> April 2003; and (e) assist in institution building approaches and skills.

**Regular Review and Support through EHP's program team:**

1. Ongoing support to in-house capacity building sessions, support in health camps and community meetings in slums and facilitating coordination meetings with public sector.
2. Monthly review meetings: Day long monthly meetings hosted by different NGOs on a rotational basis to share their experiences and learning among program partners provides an opportunity to the Lead CBO members (of host NGO) to participate in and contribute to the discussions in a non-threatening environment.
3. Quarterly Review involving field visit, and more detailed discussion with NGO and Lead CBOs, followed by feedback for building on lessons learned and experiences gained, to facilitate continual improvements.

**Lesson 2** - NGOs play the important role of: (a) management, facilitating linkages and coordination and also (b) institution building and mentoring of community based organizations (the Lead CBO and the *Basti* CBOs).

The NGOs have taken on the administrative responsibilities required in any partnership with a contracting agency. Thus, management issues of finance and documentation are carried out by the NGOs. There are other responsibilities within the program mandate such as of establishing linkages with the public sector for service provision in the slums. Such linkages and coordination efforts have been possible because of these NGOs. For instance, to have vaccinations conducted regularly in the slums, BGMS, a partner NGO, had to actively persuade the concerned ANM. This was done through constant follow-ups and also through liaison with Pushpkunj, another NGO for whose region the particular ANM was responsible.

The other critical contribution is the role of NGOs in the area of building community capacities. While the NGOs have worked on strengthening the institutional and program capacities of the Lead CBOs to serve as the primary implementers of the program in Indore slums, the Lead CBOs in turn have helped develop CBOs in their respective slums as a tangible long-term resource for the community.

The empowerment process and the capacity building done through the program by NGOs for their Lead CBOs have together provided an exposure for these groups to develop themselves. Also, the Lead CBOs have developed their identity to work for the communities for longer duration of time. **Mahila Ekta Vikas Samiti** and **Rahul Gandhi Nagar Vikas Samiti** have taken steps to be registered as formal organizations with the support of their partner NGO and CECOEDECON.

Vaisnavi and Tulsi Samooha are two Lead CBOs partnering with Bhartiya Grameen Mahila Sangh. These Lead CBOs have 14 and 10 members respectively. Four members from each of the two work more actively in the Indore Urban Health Program. These slum women were promoted as the CBOs by BGMS in a previous project in 1994-95, as a mobilization tool. While being strong community-based groups in terms of implementation and regularity in meetings, the members had not ventured into development issues beyond their own slum and were largely dependent on BGMS for their program

<sup>18</sup> The objective of the visit by 17 NGO and Lead CBO members to Pune (FRCH) and Mumbai (Apanalaya, SPARC and Mahila Milan) was to interact and understand: (a) the concept of *Basti* level institutions and community leadership as a mechanism for negotiating and ensuring improved health delivery; (b) to understand community- NGO- Municipal linkages and negotiations undertaken for community sanitation services in slum settings.

decisions.

Sensitive mentoring and nurturing of the LCBOs by BGMS (the NGO) as partners in the Urban Health Program, has boosted their confidence level considerably. The Lead CBOs are looked upon by both service providers and community members as their intermediary and an important link. Both the Lead CBOs are also involved in promoting income generation activities at slum level. With their institutional capacity growing as a group, BGMS provides the training in other areas also, such as microfinance, government schemes. In days to come, the CBOs could well take a stride-continuing the efforts on the health front beyond the project period as well as keep serving as important intermediaries between different providers and community, for all kinds of services.

**Lesson 3** - The strategy of NGOs to facilitate the gradual evolution of LCBOs as the coordinating agency with the service providers (initially with support from NGOs) is effective and viable in improving service coverage. LCBOs have emerged as capable facilitators in bridging the gap between the providers and BCBOs to increase access to underserved slum populations.

In the early phase of the program, it was seen that in several slums, the NGO, LCBO and even the service providers were not sure about the catchments area of the dispensaries. The confusion was exacerbated by the fact that many of the (program areas) slums were not part of the official list and some of the slums were expected to be covered by the rural PHC. Through a continuous dialogue by EHP and the NGOs with the Public Health Department, better clarity was achieved on the issue. Subsequently, NGOs facilitated the process of establishing linkages between LCBO members and the concerned health unit/dispensary and their outreach staff. This took time as both parties faced initial hurdles in understanding each other's point of view and as they learned from each other's experience a better relationship gradually evolved. This



At an outreach camp – the ANM, Lead and *Basti* CBO members ensuring service reach

vibrant relationship between LCBOs and service providers was nurtured and mentored by the respective NGOs. Over a period of time, the Lead CBOs have developed their capacities to independently maintain this relationship. For the last few months, Lead CBOs have been able to plan logistics and coordinate outreach health activities with service providers even through telephonic conversations. This whole process has helped in conducting need-based and regular health activities in collaboration with service providers at the slum level.

### The window of Functional Linkage

Rahul Gandhi Vikas Samiti, a Lead CBO of CECEOEDCON has negotiated with the neighboring rural PHC (Talawadi Chanda) to provide services for peri-urban slum (Bajrang Nagar).

LCBO of BGMS (Tulsi Samooaha) with support of NGO has negotiated for immunization services for peri-urban slum of Ahirkhedi with Hatod rural PHC. This is being organised in the last week of the month in Ahirkhedi.

**Lesson 4** – Lead CBOs have demonstrated capacities to further build, mentor and nurture BCBOs in slums; the strategy to mobilise communities in vulnerable areas through existing community groups has been an effective investment.

Community mobilization in one slum through experienced residents of another slum has been effective. Lead CBOs were groups, which had been functional for over two years, some going back to about ten years, but comprised individuals living in slums and working for the development of their areas. This was the **another** opportunity for them to mobilise people they had not interacted with earlier, and with an objective that was not necessarily a felt need of these new communities. The Lead CBOs' members have been successful in doing the above and have ventured into slum areas (new to them), initially accompanied by the NGO staff, but later on their own. They constantly serve as an example and model for why poor communities should work collectively for the improvement of their conditions. Thus, more than 80 *Basti* CBOs have been promoted, of which about half are considered fairly 'strong'.<sup>19</sup> The LCBOs' members have been able to establish regular contact in slums through health related discussions with the community. These focused discussions around health issues, are conducted in a manner that is understandable to the slum women. Also, the Lead CBOs participate in the *Basti* CBO meetings.

**Lesson 5** - LCBOs are emerging as a capable program planning and implementation institution. With opportunities, resources and appropriate capacity building, community groups are capable of charting their own growth curve and mobilising other vulnerable groups towards improvement in living conditions.

LCBOs have demonstrated that they are capable of acquiring requisite programming skills and utilising them in the field for development objectives. These capacities have been seen with specific reference to:

- a) Skills in participatory facilitation, enquiry and planning with the people
- b) Skill of mobilising communities and organising groups
- c) Planning and coordinating service coverage activities with service providers
- d) Supporting BCBO in planning BCC activities and in enhancing motivation for services. Several IEC / small media / awareness activities have been carried out by LCBO and BCBO.
- e) Monitoring of program progress through analysis of collected monitoring data.

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<sup>19</sup> Capacities of *Basti* CBOs have been gauged through their institutional and programmatic capacities.

**Mahila Sandesh Vikas Samiti** is effectively coordinating, implementing and monitoring the urban health program along with the BCBOs promoted by them. They have evolved an innovative immunization tracking method using a simple family chit method; this chit is distributed amongst the target families prior to each camp. All eligible families are thus reminded of their vaccination. The *Basti* CBO and the Lead CBO have the counterfoil of this chit. Thus, those children who have not come are identified during the camp timings only, and efforts are made to get them on that day itself.

**Pratibha SHG** has shown immense institutional capacity:

- a. Proactive and strong capacity to promote SHGs: 160 SHGs
- b. Linkages for sustainability: Lifeline Hosp; Choithram Trust; Ministry of HRD (Jan Shikshan Santhan)
- c. Future plans include a vision building exercise

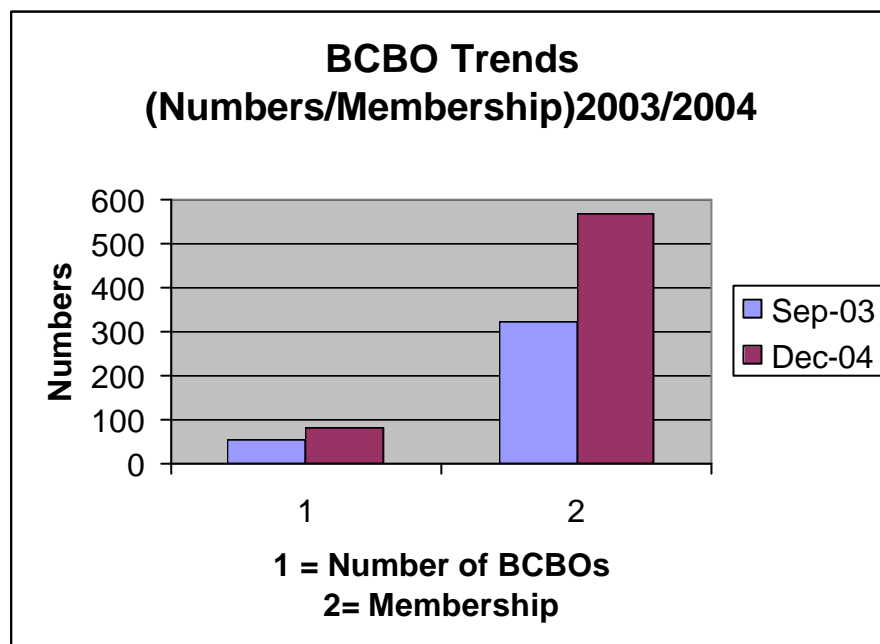
### **Implications for future:**

- Building the institutional capacity of CBOs: As LCBOs (and BCBOs) are growing in confidence, they are evolving into vehicles/institutions with their own respective vision and now plan to fructify their vision. For example, LCBOs are now expressing the desire to be registered as NGOs. They represent a force with a vision for slum improvement and the well-being of slums communities of Indore.
- Sustainability of their efforts would involve building linkages with service providers and strengthening their financial and institutional capacities to be able to liaison with other agencies.
- The strategy to implement programs in vulnerable areas through existing community groups is effective and should be attempted in development efforts. While it may be possible to work directly with the CBOs, the EHP Indore Model is an example of working through NGO-CBO consortia for building on the NGO's expertise also. Indore had an experience of community processes of some form, and therefore the urban health program could build on it. Possible platforms in other cities are of Self-Help Groups, structures within the Community Development Societies promoted by DUDA, groups promoted by AWWs, or any groups promoted through any past (or ongoing) development program. If groups are not found in the envisaged shape, then leaders can be identified from slums and encouraged to form a collective and accordingly groomed. Exploring community groups or leaders for networking is a worthwhile effort as working with community representatives is a more sustainable investment and helps in enhancing community capacities at each level.
- Partnerships, between whichever groups such as between the NGOs and Lead CBOs or the consortia and the public sector health service providers, need to be groomed. Hand-holding and sensitive handling of relationships is needed until the partnership has matured and people (of different agencies) have built mutual trust and clarity on expectations from each other. Thus, facilitation during program implementation becomes equally important as an active input.
- Public sector health service provision is lacking in quality on various aspects, and particularly in terms of motivation at the field level. Effective service coverage is possible only with a strong community demand and functional linkages so as to ensure timely access.

#### 4. *Basti* CBO as an important slum level program institution – Lessons Learned

As a part of the program design, the NGO-Lead CBO consortia were pre-identified. Since the inception of the program, the consortia have moved ahead in the various facets of activity including the most important one of promotion and strengthening of *Basti* CBOs (BCBOs). It is through these small groups of slum-based women (in exceptional cases men too are members) that immunization and health camps are being organised to increase coverage of services. Capacity building is being provided to the members with focus on: (a) orientation to the urban health program; (b) orientation to community mobilization techniques; (c) community based monitoring for tracking behaviors and services; and (d) technical issues pertaining to all aspects of mother and child health including the importance of immunization.

There is clear evidence that the NGO-LCBO consortia have been forging ahead in their programmatic endeavors of formation of BCBOs since the beginning of the program and this can be seen in the following table:



Month	No of BCBOs	No of Members
September 2003	54	323
December 2004	83	567
<b>Percent increase</b>	<b>53%</b>	<b>76%</b>

Although there are 83 BCBOs with 567 members, all of them have developed varying capacities over time. These capacities are in the areas of record keeping, providing information to beneficiaries about date and venue of the forthcoming camp, providing logistical support for conducting the camp, support to ANMs in record keeping during the camp, providing counselling to beneficiaries, improving quality of home visits, ensuring regularity of meetings etc.

**Key Lesson: BCBO is a credible institution in the slum. Members often function as role models, empower slum families to adopt behaviors, avail services, negotiate (with support) for other slum improvement services and are a motivated institution/platform with a vision for improving well-being in the slum and for ensuring reach of future programs.**

A large number of BCBOs have become part of the Self Help Group (SHG) movement in the slums. While some of the SHGs were already present in the slums before the BCBOs started, in others the BCBOs themselves with help of the LCBOs, set up SHGs. These SHGs meet regularly and have promoted the habit of saving among their members and in many cases have also started extending the facility of loans. It is expected that over time, when the group savings reaches a certain amount, these SHGs could be linked to banks for leveraging finance. Loans could then be sought for livelihood activities.

The BCBOs formed are also showing potential for providing impetus to women of other slums who have observed their activities. These women have been impressed by the outcome of their efforts and want to start a slum level institution in their own *bastis*. Some of the slums whose women residents have shown keen interest include: Kundannagar (near Ahirkhedi having approximately 200 households), Suryadevnagar (near BGMS office, having approximately 300 households), Rajraninagar having approximately 400 households), Amar Palace (near Pawanputranagar having approximately 500 households), Barabhai-ka-Mohalla (near Arjunpura having approximately 200 households), and Narain Seth Ka Compound (near Rustam Ka Bagicha having approximately 100 households). It is also interesting to note that women from slums adjoining Rishinagar and Pushpnagar get themselves and their children immunised at the camps, motivated by the activities taking place in these slums.

**Lesson 1** - BCBOs have emerged as credible slum level institutions commanding respect of the community, often functioning as role models and empowering slum families to adopt health behaviors and avail services.

In order to see how a BCBO has emerged as a credible slum level institution, the BCBO at Rustam Ka Bagicha - Jai Shrikrishna Swasthya Samiti is taken as an example. The first table gives the frequency and attendance details of the meetings held between July and December 2004. The second table gives the immunization details of the camps that this BCBO (jointly with two other BCBOs in this slum) organised during the same period.

**Jai Shrikrishna Swasthya Samiti, a BCBO located at Rustam Ka Baghicha - Frequency and attendance details of meetings between July and December 2004**

Date of the Meeting	No of Members Present (Total 6)
10 <sup>th</sup> July 2004	6
17 <sup>th</sup> July 2004	6
24 <sup>th</sup> July 2004	6
27 <sup>th</sup> July 2004	6
19 <sup>th</sup> August 2004	5
27 <sup>th</sup> August 2004	6
11 <sup>th</sup> September 2004	6
25 <sup>th</sup> September 2004	6
2 <sup>nd</sup> October 2004	6
9 <sup>th</sup> October 2004	6

16 <sup>th</sup> October 2004	6
30 <sup>th</sup> October 2004	6
6 <sup>th</sup> November 2004	6
22 <sup>nd</sup> November 2004	6
27 <sup>th</sup> November 2004	6
4 <sup>th</sup> December 2004	6
11 <sup>th</sup> December 2004	6
18 <sup>th</sup> December 2004	5

In the six-month period the BCBO met 18 times, indicating an average of three meetings per month. Also, in almost all the meetings the six members were present indicating a high level of participation. Given the fact that it is a voluntary endeavour, this is clearly a sign of a vibrant slum-based institution.

### Rustam ka Bageecha – Immunization Details

S.No.	Month	Completed 6th month of pregnancy	TT2/Booster by 6th month of Pregnancy	No. Of Children of 1 1/2 - 2 months of age	DPT-I by 2 months of age	No. Of Children of 3 1/2 - 4 months of age	DPT-III by 4 months of age	No. Of Children of 9-10 months of age	Measles vaccine by 10 months of age
1	Jul. 04	2	2	0	0	0	0	13	7
2	Aug. 04	4	3	0	0	0	0	3	2
3	Sep. 04	4	4	0	0	0	0	2	2
4	Oct. 04	5	3	3	2	5	3	5	3
5	Nov. 04	6	3	3	2	3	2	5	3
6	Dec. 04	16	11	3	2	4	3	5	4

It is clear from the above that the BCBO has been a credible institution and encourages slum families to adopt health behaviors and avail services. Another interesting feature that has been introduced by some BCBOs has been *Annaprashan* which encourages introduction of cereals to a child at the appropriate time as can be seen in the following boxes.

Shradhashree Mahila Mandal is a BCBO located at Mumtaz Bagh. It carries out different activities such as organising immunization camps. Its members meet regularly. The members are particularly happy about their *Annaprashan* program and feel that this has resulted in mothers being aware of the importance of supplementary feeding. The following table gives the data of the children provided supplementary feed as a part of the *Annaprashan* camp during the three-month period November 2004- January 2005.

Date	Number
24 Nov 2004	8 children
10 Dec 2004	7 children
6 Jan 2005	11 children

*Annaprashan* is a ritual celebrated when a child turns six months of age. The child is fed cereal or solid foods for the first time, usually by her /his father or an elder from the family. In poorer families living in slums, mothers are unaware of the importance of the introduction of cereals or solid foods and it is in this context that one of the NGOs has used this traditional custom to disseminate information about initiation of supplementary feeding after six months of age. In all the Hindu families, likewise in all the other religions, the coming of a newborn is regarded sacred and with this new chapter in the family life history, various rituals are performed from time to time when the child is young. Many of these rituals have a positive implication on the health of the baby and her/his mother, and many are just observed to keep the tradition alive. One such prestigious occasion is the *Annaprashan* ceremony, which is celebrated along with near and dear ones in a traditional fashion.

In case of CECEOEDCON, they have utilized the opportunity to do the following.

- By organizing the event through *Basti* CBO, better community mobilization at *basti* level takes place.



- *Basti* CBO gets a chance to organise an event where in all the healthy behaviors related to mother and children can be discussed amongst them.
- They also make use of this opportunity to invite a resource person to discuss the importance of supplementary feeding to a child and other related behaviors for better health.
- *Basti* CBO tries to invite important personalities at local level like Corporators, Medical Officers etc.
- The activity also gives a chance to develop linkages with service providers.
- Weighing of child is done to assess whether or not the child is healthy and accordingly the child's family is counselled.
- The *basti* community also gets a chance to know and prepare nutritive food recipes from locally available materials, which are then given to child.
- Overall, the NGO-CBO members view this event as an occasion to reinforce healthy behavior messages in front of the community.

**Lesson 2** - With support from Lead CBOs and NGOs, BCBOs have negotiated with key government officials and elected representatives (Ward Councillors) to access basic services like water, drainage, and community halls for their slums.

The following examples illustrate as to how BCBOs have been instrumental in negotiating with key government officials in improvement of drinking water facilities in their slums.

### **Availing Water Services in Ahirkhedi – Through Mobilization of Community Efforts**

In Ahirkhedi slum, which is situated on the rural-urban fringe area in southwestern part of Indore, people have been settling for last eight to nine years. There are four major clusters of habitation in this slum. Under the program in Ahirkhedi, four different CBOs namely *Jai Bijasani*, *Jai Ambey*, *Jai Shiv Shakti* and *Jai Ganga Sammoha* were formed, promoted, and are being strengthened on a regular basis. There were five hand pumps and two bore wells in the slum and all were dysfunctional. So people used to buy water from farmers owning agricultural wells nearby. In the last few months, the CBOs in their respective areas (clusters) discussed the issue of mobilising people to approach the nearest zonal office of the IMC. Their mobilization efforts worked and they were able to put forth their grievance on the issue by submitting a written memorandum signed by all to the concerned authority. They also contacted the nearby Ahirkhedi village *Sarpanch* and requested him to put pressure on IMC- zonal office so that all the hand pumps and bore wells could be repaired. Meanwhile, BGMS organised a hand pump repair training for rural youth from their other project and for getting practical experience, the trainees were requested by the *Basti* CBO to come to their *basti* and do the actual repair work of a hand pump. This helped the quick repair of one of the hand pumps from where people started taking water. But this was not enough to cater to the whole *basti*, and the *Basti* CBO members again visited the zonal office to demand speedy repair of other hand pumps. They also consulted the *Sarpanch* and other political leaders and when pressure was applied on the zonal office of IMC, they came and repaired three other hand pumps situated in different parts of the slum. This prompted the *Sarpanch* to meet the Zonal Officer once again to have the borewell repaired. The authorities then visited the site and came to the conclusion that one of the bore wells was beyond repair. Therefore, they converted the same into a hand pump for use. After this, the *Sarpanch* arranged, from other sources, the cost of a new motor and pipe and this, along with retrofitted tank with taps, was installed in the middle of the slum. Today, there are five hand pumps and one bore well connected to an overhead tank with taps for 24 hour supply working in the slum and it is taking care of the water needs of the *basti* population.

### **Hand Pump Repair in Vyas Nagar (erstwhile Dusshera Maidan Basti) Moving from Dependence to Sustainability for Drinking Water**

When the EHP Program started in the city of Indore, BGMS- a partner NGO, selected Dusshera Maidan Basti as one of the slums to carry out direct intervention of the program activities through a CBO. The more-than-a-decade-old *basti* was situated in the Annapurna area, one kilometer away from the Annapurna Police Station. In the month of June 2003, on a day's notice, the slum community was asked to vacate the *basti* and given assurance by the government authorities that they would be relocated nearby where they will be provided all the basic facilities and given a *Patta* (tenure rights). Based on these assurances, the

whole *basti* was shifted to the new place, which comes under Ward No. 2 and is called Vyasnagar. But when the people started living there, they faced severe shortage of drinking water and had virtually no toilet facility. There was one hand pump, which also got defunct because of overuse. People started paying money (Rs 50 per month per family) to nearby agriculture landowners to get water for domestic purposes. The *Basti* CBO that was formed in Dusshera Maidan continued its activities here too in Vyasnagar to mobilise the communities for their betterment and in the process raised the issue of a common contribution fund. Meanwhile, BGMS with support of other projects- that it runs through another donor, organized a hand pump repairing training for the people from rural areas. It so happened that for exposure purpose, the training team visited Vyasnagar and found that the hand pump needed to be completely overhauled. Through a consultative process, it was decided that a part of the *Basti* CBO fund may be utilized for this purpose and with support from the CBO members, in terms of labor, the hand pump was repaired. In the month of December 2004, owing to lot of water being extracted from the community hand pump by all households, the water table receded. The *Basti* CBO again took up the issue with the community members, requesting them to contribute money for increasing the length of the pipe so that even during summers, the water could be easily extracted. The community members agreed and they decided to pay—a nominal amount Rs 30-50 per family to the *Basti* CBO. This has not only promoted collective ownership of the community resource but has also reduced the community's dependence on outsiders.

**Lesson 3** – Looking towards and Planning for the Future: Continued nurturing and mentoring has helped BCBOs evolve as a motivated institution eager to further improve well-being of slum families by enhancing livelihood options through creation of SHGs, and through developing emergency health funds.

As mentioned earlier, a large number of BCBOs have become parts of SHGs in their slums and have started saving. It is interesting that some of these SHGs have started after the BCBOs have been established. One such example is in Jagdish Nagar. The slum has three SHGs and the BCBO is a part of one SHG which has 23 members and was set up on 11<sup>th</sup> January 2004. After one year, the total savings stand at Rs. 13, 650/-, the total loans sanctioned are to the tune of Rs. 21,000/- and the total outstanding loans stand at Rs. 6,300/-. The records are well maintained. Each individual is given a passbook and at the SHG level, the loan register and other records are also maintained. The loans are given for different activities related to health, consumption and livelihood. Over time, these groups could be linked to banks so that members could avail larger amounts as loans.

Another innovation by some of the BCBOs, has been that of “health” or “medical” funds. The need of health fund was found in slums, after it was realized that at the time of medical emergency, especially in the case of “institutional” delivery, the women do not have enough financial resources. They have to avail of loans from moneylenders at exorbitant interest rates. After the *Basti* CBOs were formed, steps to avert this high interest bearing loans were taken in some of the slums. These *Basti* CBOs have opened a “Medical Fund” in the bank and have different rules and regulations about repayment of loans.

**Table Giving Details of Performance of Medical Funds Formed By BCBOs**

S.No.	Name of the Slum	Name of the BCBOs	No. Of members in the group	No. Of cases supplemented	Total amount loaned (Rs.)
1.	Shivnagar Musakhedi	Priya Swastha Samiti	08	05	1700.00
2.	Chitavad Kakkad	1. Satya Swastha Samiti	09	00	00.00
		2. Sahayta Swastha Samiti	06	02	500.00
3.	Indira Ekta Nagar	Ma Bhavani Swastha Samiti	08	02	400.00

### **Shivnagar Musakhedi**

Shivnagar Musakhedi slum has about 520 households with an approximate population of 3,300. It is situated at some distance from the Ring Road, on the outskirts of the city. Most of the people here are daily wage workers. Before the start of the EHP program, there were no immunization camps held in this slum nor were there any linkages with the health service providers. 80% of the deliveries were home deliveries, performed by untrained *dais*, and the people used to avail loans on high interest rates for meeting related medical expenses. They used to spend most of their earnings to pay back the loan and could not even think of opting for institutional deliveries because of the high expenses involved.

*Under the program, two Basti CBOs have been formed in Shivnagar Musakhedi viz. Priya Swastha Samiti, having eight members and Akansha Swastha Samiti having six members. The Basti CBO in Shivnagar Musakhedi decided to start a Medical Fund to help the pregnant women at the time of medical emergencies. With this objective, a "Medical Fund" was formed in the slum in February 2004 by Priya Swasthya Samiti and on March 11, 2004, an account was opened in the bank, by collecting Rs. 5/- per pregnant woman per month. Initially the Basti CBO members also contributed to the fund. An amount of Rs. 300/- was collected and an equivalent amount was contributed by IDSSS. This practice was continued for the first couple of months. Initially the loan was interest free, but due to difficulty in recovery, the Basti CBO has decided to charge a nominal interest of 2% per month on the amount. Around five women have benefited from the loans till now, of which three availed the loan for institutional deliveries.*

### **Medical Fund: Serves as a Distress Fund**

Twenty-two year old Sulochana is the wife of a daily wage earner. Her labor pains started on 17<sup>th</sup> March 2004, and her husband Bhurelal approached the local *dai* for the delivery. The *dai*, Babita Chudela had been trained under the *dai* training program of the NGO-CBO model of the program. Sulochana was weak and anemic and this was her first delivery. Foreseeing the risk involved and the condition of the woman, the *dai* advised that the woman be immediately rushed to the hospital. The couple did not have enough money to do the same and the husband approached his relatives and neighbors for help which was not forthcoming. Then, the husband was told about the Medical Fund and on approaching the *Basti* CBO members, he was without delay loaned Rs. 400/-. The woman was rushed to the Mission Hospital and delivered a girl child late evening on the same day. Both the mother and the child were safe due to timely medical care. The loaned amount was interest-free and was returned after one month by the beneficiary.

**Lesson 4** - Adequate representation of the slum is important to ensure that the *Basti* CBO is able to envision and work for the well-being of the slum. Even if this meets difficulty at times owing to disruption of a BCBO due to various reasons, other women from the slum itself should be encouraged to enlist in the BCBO, then nurtured again to activate the CBO.

## **Future Strategy for strengthening of BCBOs**

- Encouraging sustainability of BCBOs through a two-pronged strategy of: (a) linkage with SHGs so that livelihood activities can be taken up; and (b) linkage with existing government/ IMC programs
- Strengthening weaker BCBOs with capacity building programs
- Encouraging BCBOs to use their institutions for furthering the common good of their slums by taking up non-health related activities
- Encouraging more and more BCBOs to start a Medical Fund as part of their activities.

## **5. Linkages of existing health system with community – Lessons Learned**

Health services in Indore are provided by the public sector (Department of Health and Family Welfare (DHFV) and Department of Women and Child Development (DWCD) and private sector agencies (hospitals, nursing homes and clinics). In addition, there are charitable hospitals and also Employees State Insurance Hospital. The DHFV in Indore functions through 33 service delivery channels- dispensaries and Urban Family Welfare Centres. There are a plethora of polyclinics and nursing homes and a district hospital. The heavy workload on the Department of Public Health and the limited outreach staff (predominantly ANMs and LHVs), results in insufficient contact or interaction at community level; thereby limiting the scope of outreach services.

There are two urban ICDS projects operating in Indore, one through an NGO and another directly by the Department of Women and Child development. Within the urban set-up, the Anganwadi centres are clearly located in the better off slums. Inadequate linkages between ICDS and DHFV impede health services reaching through the ANM to the Anganwadi centres.

EHP's Indore Urban Child Health Program entails forging and strengthening linkages between service providers and the community and building partnerships and capacities of the public sector, non government organizations and community based organizations to improve service coverage and behavior adoption for birth and new born care, diarrhea prevention, immunization and prevention of malnutrition amongst the urban poor. In reference to the above, linkages are being developed and strengthened by program partners (NGOs and CBOs) with the Department of Public Health and their various outreach services through hospitals and dispensaries and Employees State Insurance Hospital in the city. Efforts are on to form and strengthen linkages with private providers too, in order to give better quality of services to slum communities at a subsidized rate.

Health conditions of the urban poor are similar to or worse than their rural counterparts and far worse than urban averages. Moreover, there is low utilization of public health services in urban slums as revealed by the NFHS survey, which reflects the fact that immunization services reach only 1/3<sup>rd</sup> of the urban poor children in less developed states like Madhya Pradesh. By building linkages between the service providers and underserved slum communities through the CBOs, this component of the program attempts to ensure that an increased willingness and demand for services at slum level is matched by the provision of quality services. It is so, because the complexity of health problems of the urban slum communities requires a comprehensive action and any slum development program must provide a platform for interface between the public and private sector with the necessary sensitivity, continuity and commitment for enhancing the quality of life for urban poor in the slums.

***Key Lesson: Focused program efforts to foster linkages of community (represented by BCBOs, LCBOs) with public and private health providers have helped improve access to health services.***

Lesson 1: Continued and persuasive dialogue of the program along with NGO partners with health department has helped evolve a functional coordination mechanism for linkage between 'demand' from slum communities and 'supply' of health services.

- a) Series of regular meetings with senior city level officials like the Chief Medical Officer (CMO), District Immunization Officer (DIO), Nodal officer (Urban) of Department of Public Health and follow-up dialogue with supervisors (Lady Health Volunteers (LHV)) and Medical Officers at ward level by the program team, helped both sides gradually understand the barriers to effective service delivery and in due course of time, develop functional strategy for operational issues like increasing the outreach of various services.
- b) Larger coordination meeting (NGOs, LCBOs, ANMs, Supervisors): Dec 18<sup>th</sup> 2003 meeting.

On 18<sup>th</sup> December 2003, EHP office, in collaboration with the Department of Public Health organised a daylong city-level workshop for developing a suitable coordination mechanism for and increasing the motivation levels of both service providers and NGO-CBOs. 44 persons from the Department of Public Health including the CMO, DIO, Nodal Officer-Urban, 22 ANM/LHVs who are positioned at different dispensaries/ hospitals of the government in Indore and representatives from NGOs and CBOs participated in the workshop. The EHP team facilitated the workshop and both the service providers and NGO-CBOs were able to appreciate each other's viewpoints, difficulties and the plight of slums. The resultant effect of the workshop was that the coordination mechanism for outreach activities was eased out and with better coordination there was a visible improvement in the quality and number of immunization camps.

- c) The NGO-CBO partners regularly organise immunization camps in all the 75 identified slums of Indore in collaboration with service providers. A considerable focus of the program was on improving the coordination mechanism and conducting regular immunization camps for mothers and children in the slums. The data below shows that during this span of 15 months, more than **91%** of planned immunization camps were conducted in the slums.

*Immunization camps Organized between April 03- June-04 by NGOs*

<b>Partner NGO</b>	<b>Planned</b>	<b>Achieved</b>
IDSSS	150	175
BNS	90	90
CECOEDECON	199	172
BGMS	135	100
Pushpkunj	105	82
Total	679	619

Source: NGOs' Annual Report for first phase submitted to EHP

Lesson 2: Follow-up and continued negotiation and persuasion with ANMs and supervisors has helped establish regular outreach camps in slums.

- **Follow-up for vaccine supply, dates, venue, transportation and related logistics:** Lead CBOs and *Basti* CBOs, over a period of time, have developed a good rapport with the nearby dispensaries and the staff posted there. The actual need of vaccines is known beforehand to the CBOs. Accordingly, the demand for the same is sent to dispensaries with pre-decided dates and venue. This along with other logistical support that is provided to ANM during camp days, helps her to do her work.
- **Overcoming logistical difficulties (carrying vaccine carrier, transportation support by CBOs):** Since the camps are jointly organised by the ANMs/LHVs and CBO members, it paves the way at both the ends to divide the responsibilities of carrying the vaccine box and maintaining the cold chain. In many cases, the transportation support to ANMs/LHVs is provided through community contributions.

- **Establish clarity on responsibility for slum catchment area for ANM – Ahirkhedi between Hatod PHC and Rajendra Nagar dispensary.**

Ahirkhedi is a large slum, situated in the fringe area in the south western part of Indore. It is a resettled slum where many relocated people reside. There are four to five clusters of habitation in Ahirkhedi and people from various castes/tribes/geographical regions are residing in it. The boundary of the slum is connected with agricultural land and people do not have access to any basic amenities. There was a lot of confusion as to whether it would come under the purview of the rural or urban health care centre operated by government due to which no services used to reach them. After the initiation of the program activities, CBO formation and constant discussion and dialogue with public health authorities by NGO-CBO members, it was decided that the ANM from Hathod Rural Dispensary will visit the slum regularly.

- **ANMs beginning to value efforts of the LCBOs and the BCBOs**

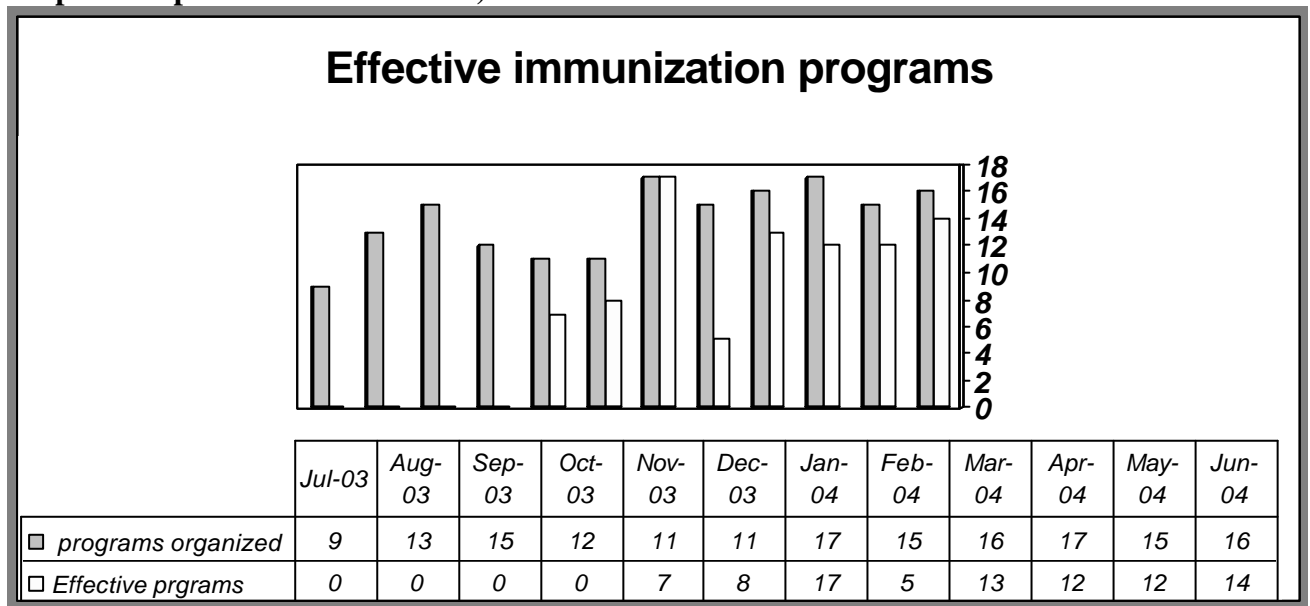
The ANMs have now started valuing the efforts of the BCBOs. During the interview conducted by the assessment team in 2004, one of them proudly said that she had to do more work as can be seen in the following box.

*“Medicines used to expire and I used to burn them. Now I constantly run short of medicines and have been forced to requisition extra supplies.”*

- An ANM

Source: Indore Assessment Report of EHP, 2004

- **Data on progressively improving quality of camps (CECOEDECON for the period April 2004 to June 2004)**



As per the initial plan, 199 immunization camps had to be organised during the period April 2003 – June 2004, against which 172 immunization camps were organized according to the revised action plan. The graph above on effective immunization programs illustrates frequent ups and downs. This is because the NGO had to depend on the public health department for organising the same. In certain months, the quality of immunization program suffered because of : (a) shortage of vaccines; (b) frequent change in dates; (c) reluctance of grassroots level health department functionaries to organise programs as per people’s convenience. However, due to the continuous dialogue process with public health department officials and gradual increase in awareness level of communities, by the time the first phase of the program was completed, the number of quality camps increased.

**Lesson 3:** Where the health department has been deficient in terms of reach, the program has created linkages with alternative providers such as ESI. To enhance the quality of maternity services, program partners have forged linkages with private doctors.

### **Linkages with private providers: The IDSSS Experience**

Before moving to Indore, Dr. Monika Jain's practice had included industrial workers and their families in Bombay. She missed that aspect of her practice and was looking for ways to get back in touch with it. She attempted to do some volunteer work with another organization but eventually gave up because she was not satisfied with the manner in which the camps were being conducted.

At IDSSS, her experiences have been very different. Camps are conducted in each slum every second month, and therefore it is possible for her to follow-up on each patient. This, she believes, is instrumental in making the camps successful, as women relax and ask questions only after the second session. And, because the camps have been so regular, she has also been motivated to develop a follow-up system with the support of the *Basti* CBO members.

Dr. Jain has developed a strategy that enables each woman to get the most out of each camp. This includes having the women sit around while she conducts examinations, so that they can overhear the advice that she gives. Each camp ends with a prize for the healthiest woman, and an awareness session on pregnancy, with information that she has collected of her own initiative. While she encourages home deliveries wherever possible, she also refers women to the MY Hospital, both for deliveries and for regular screening.

Compared to the number of women who benefit from these camps, the cost is minimal. The camps are conducted in people's homes, the IFA and calcium tablets come from the government supply, and iron syrup is donated from another IDSSS project. The doctor spends around four hours for each camp and is given an honorarium of Rs. 300 plus transportation costs and this amount is billed to the program.

The following table relates to the data of the camps conducted by IDSSS in Rustam ka Bagicha. All the women attending these camps were residents of Rustam ka Bagicha (approximate households- 1000, population-5143)

Date of the camp	No. of women provided antenatal care by Dr. Monika Jain
30-10-2003	15
31-12-2003	16
16-2-2004	23
2-4-2004	18
10-6-2004	26

The last camp of Dr. Jain was organized in the month of December 2004, in which 29 women received checkups. (Due to some logistical problem camps could not be held between July 2004 and October 2004).

Two important things that emerge from the above table are: (a) that the camps are being held consistently every two months since the start of the camps in October 2003; and (b) they are popular among the residents of the slum as, on an average, around 20 pregnant women seem to be availing of the services in each camp.

This experience only goes to show as to how, with a little bit of systematic planning, it is possible to convince doctors to volunteer their services. While IDSSS has already established three such linkages, other NGOs need to be encouraged to follow suit. Such linkages could be developed with paediatricians too. However, IDSSS needs to carefully address the issue of sustainability and think in terms of charging user fees to at least partially cover the costs of the doctor's honorarium.



The partner NGO IDSSS, through this program has forged linkages with private providers and in the period January 2004 –December 2004 organized 37 ANC camps in its area in which 756 pregnant women were given ANC services and the identified difficult cases were referred to MY hospital and other nursing homes for deliveries. Out of these 15 camps were conducted by Dr. Monika Jain, 15 other by Dr. Radha Goel, six by Dr. Kamini Rane and one by Dr. Kirti Chaturvedi.

#### **Linkage with other service provider for Sanitation issue.**

One of EHP's program partners, Pushpkunj works in Jeet Nagar and Sonia Gandhi Nagar slums, which are situated on the outskirts in the south eastern part of the city. In both the slums, *Basti* CBOs were promoted and were given intensive inputs and exposure to carry out hygiene promotion activities apart from other program related activities. Since hygiene promotion activities cannot sustain in the absence of toilet facilities, they started a dialogue with local inhabitants to motivate them for construction of toilets. Meanwhile Pushpkunj negotiated and developed linkages of CBO with another agency called World Vision. Knowing that the Indore branch of the organization helps families and communities in the construction of toilet complexes, the *Basti* CBO with the help of NGO and Lead CBO negotiated for individual toilet construction in both *bastis*. Meetings were organized in the *basti* to discuss the financial implication of construction. The family contribution was finalized at Rs 1400/- each and it was agreed that World Vision will construct the toilet and hand over to the families through the *Basti* CBO. Initially 15 families in Jeet Nagar and 12 families in Sonia Gandhi Nagar agreed and they deposited their fixed contribution to *Basti* CBOs. All the 27 toilets were constructed by the World vision and handed over to respective families and the excess expenditure on the actual construction work was provided by World Vision. Similarly, 36 more individual toilet complexes are to be constructed in Sonia Gandhi Nagar.

#### **Implications for future**

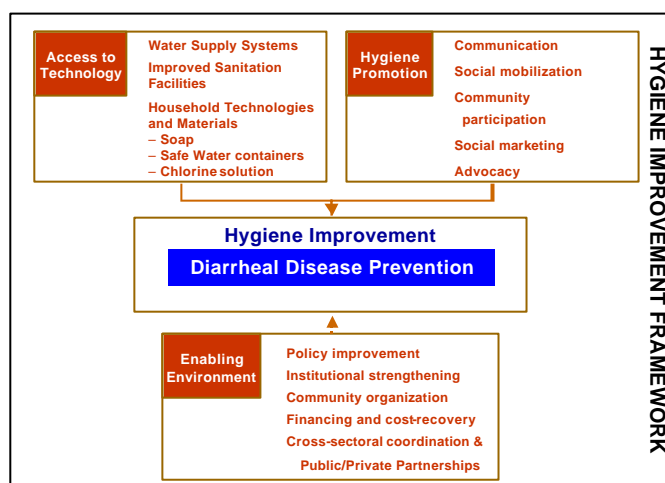
There is a need to identify and tap all the resources available in a particular area for delivering any kind of services to the community. Following would be the other challenges in the future:

- Continuation of dialogue of the NGO-LCBO partners with the Department of Health to enhance the functional coordination system developed.
- Regular follow-up with the health workers to ensure logistical difficulties are minimized and quality of camps are improved.
- To encourage NGOs to seek assistance of private service providers especially in the area of ANC care and pediatric care children under three years of age.

## 6. Hygiene Improvement in urban slums of Indore

### Background and Overview:

Diarrheal diseases are responsible for over a quarter of the deaths of children in the world today<sup>20</sup>. Diarrhea is known to be the second most serious killer of children under five – an estimated 1.9 million deaths annually<sup>21</sup>. In developing countries, young children experience an average of four to five diarrheal episodes annually<sup>22</sup>. The reanalysis of NHFS-II shows that urban MP has a high incidence of diarrhea with one quarter (26.6%)<sup>23</sup> of the children found to be suffering from the infection. The situation is even worse among the children living in low SLI areas with a rate of 30.7%<sup>24</sup>. According to an estimate, as much as 88% of diarrheal deaths occur due to lack of safe water, basic sanitation and hygiene and nearly 50 % of the urban child mortality is the result of poor sanitation and lack of infrastructure in the urban slums<sup>25</sup>. In the year 2000, 1.1 billion people lacked access to safe drinking water, and 2.4 billion people did not have access to basic sanitation<sup>26</sup>. According to the 2001 Census<sup>27</sup>, about 736 million people in India lack basic sanitation facilities resulting in high mortality and morbidity and poor economic growth. In Indore, only one third of the families living in urban slums own an individual toilet facility, with only a tenth having access to private water tap connections<sup>28</sup>. The current lack of infrastructure facilities and inhuman living conditions pose a serious health risk especially to the urban poor. This public health problem could be addressed with attention to hygiene improvement intervention. A recent paper<sup>29</sup> showed that improved water quality reduces childhood diarrhea by 15-20%, better hygiene through handwashing and safe food handling reduces it by 35% and safe disposal of children's feces leads to a reduction of nearly 40%.



With the appalling burden of Diarrheal Disease among urban poor children and potential of simple hygiene interventions in reducing diarrheal incidences, a community-based 'Hygiene Promotion Pilot' was proposed for the urban slums of Indore.

<sup>20</sup> WHO (1996). The World Health Report 1996. WHO, Geneva

<sup>21</sup> Murray C and Lopez A D (1996). Global Health Statistics, WHO, Harvard School of Public Health, and the World Bank

<sup>22</sup> Ibid

<sup>23</sup> International Institute for Population Sciences (IIPS) and ORG, 2001. National Family Health Survey (NFHS-2), India, 1998-99: Madhya Pradesh, Mumbai: IIPS

<sup>24</sup> Environmental Health Project. April 2003. Reanalysis of NFHS II, 1998-99 Madhya Pradesh by Standard of Living Index (SLI). Arlington, Va.: Environmental Health Project (EHP)

<sup>25</sup> Urban Poverty and Deprivation. Available at <http://www.undp.org.in/Report/IDF98/idfurpov.htm>

<sup>26</sup> WHO/UNICEF. *Joint Monitoring Programme for Water Supply and Sanitation*. Global Water Supply and Sanitation Assessment 2000 Report

<sup>27</sup> Census of India, 1991-2001.

<sup>28</sup> George, R., B. Rajeev, and T. Sarwal. 1999. Poverty and vulnerability in Indore: A research report. Nagpur: Oxfam India Trust.

<sup>29</sup> Appleton, B., and C. Van Wijk. 2003. Hygiene promotion: Thematic overview paper. Delft, the Netherlands: IRC International Water and Sanitation Center.

## Hygiene Promotion Pilot (HPP)

The effort was initiated with a participatory hygiene enquiry, which was an objective-driven process. It consisted of an in-depth analysis of the operating context in terms of current community and household level practices, constraints and opportunity for the program. The qualitative findings derived from the participatory health enquiry were supported by rapid assessment of hygiene conditions through a quantitative survey. The enquiry was conducted in 14 selected program slums. The information was gathered by the field team with full involvement of the community level implementers (LCBOs and BCBOs).

The findings of the participatory hygiene enquiry were shared with the program partners during the participatory hygiene analysis and planning workshop. The purpose of organising the workshop was to sensitise the participants with current prevalent hygiene practices in the community and determinants of these practices. The capacity-building sessions enabled the participants to understand the feeco-oral pathway of transmission through the F-diagram. These interactive sessions helped in building a clear understanding and consensus list of potential hygiene interventions to block the pathway of infection. A comprehensive approach for sustainable hygiene promotion through a 'Hygiene Improvement Framework (HIF)' was introduced and discussed in detail. Out of the total three components of HIF, hygiene promotion was the one, which could merge easily with the program objectives and focus. The process helped in narrowing down the key hygiene interventions, which need to be promoted at the community level.

During the four-day capacity building sessions a context-relevant behavior change communication material 'Job Aids' was developed to promote adoption of key hygiene behaviors at the community/household level. The intended users for the material were NGOs, Lead/BCBOs. The technical information provided in 'Job Aids' served as a training guide for enhancing the knowledge of intended users for facilitating the capacity building sessions on hygiene promotion. The steps described in the 'Job Aids' would guide the users for facilitating interactive group counselling sessions. With feedback from the field staff, who were using the 'Job Aids' with the community, a more pictorial tool with shorter messages was desired for more frequent use. Therefore, the 'flip book' was developed for follow up on family based counselling, after a few initial more intense group counselling sessions using 'Job Aids'.

To implement the hygiene pilot, a series of consultative meetings were conducted with NGOs and community level implementers (LCBOs and BCBOs). Progressively, planning meetings resulted in identification of 5 pilot slums (1 slum/NGO) to

"Till five months ago, I used to take my baby to the doctor at least three times a month because he constantly had Diarrhea. I haven't been to doctor in the last five months, since I started being more careful about cleanliness and practising what I have learnt from the CBO"

*Kiran, Jagdish Nagar*

implement the Hygiene Promotion Pilot. The key hygiene interventions were targeted in small groups (10-12 members) of mothers of under-three year children who had agreed to volunteer for adoption of behaviors. The small groups were preferred because these mothers could act as early adopters and motivate other mothers of their slum to adopt desired behaviors. In all the selected five pilot slums, intensive hygiene Behavior Change Communication (BCC) activities were conducted by the program partners. BCC activities

mainly included family- based counselling, group counselling, demonstration of desired practices such as correct technique of hand washing, awareness rally involving school children, video shows, street plays etc. Along with BCC activities, one NGO (BGMS) agreed to provide support for increasing access to hardware by renovation of the community toilet complex in the intervention slum 'Pawanputra Nagar' (details in next part). To provide an enabling environment to all the activities, they have established linkages with the Indore Municipal Corporation (IMC) and the health department and managing community organization.



Street plays being used for promoting hygiene

### ***Lessons learned***

**Lesson 1:** The findings from the entire process of participatory hygiene enquiry facilitated the development of context-appropriate strategies to promote hygiene behaviors in the program slums. It gave an understanding of the current community practices, determinants of these practices and specific barriers in adoption of desired practices and helped identify feasible options that promote appropriate behaviors.

**Lesson 2:** Formative research pertaining to hygiene should be planned and conducted carefully because it was observed that people have a natural tendency to over report positive behaviors especially during interpersonal contacts.

For example, in the rapid quantitative survey, 98% households reported that they throw household waste in garbage bins whereas it was observed that most of the families do not have personal bins and throw waste in the open space available in the slum. To minimize personal bias and false reporting of behaviours, the research methodology should include a triangulation method. Therefore, an observation method (if feasible) works best to produce accurate and correct results. Establishing a good rapport with the researched before enquiring about their hygiene practices would also help the field team in getting accurate responses.

**Lesson 3:** Slum-based/grassroots organizations, when steered through a process of interactive learning and participatory planning, are capable of developing a context-relevant strategy for promotion of key hygiene behaviors.

For example, LCBOs/BCBOs were involved in hygiene promotion efforts since their conception. The LCBOs/BCBOs developed ownership for increasing awareness regarding hygiene behaviours and thereby adoption of behaviors. Through a series of informal and formal discussions, they suggested initiating the approach with a small group of slum women. This small group of mothers became the early adopters of behaviors and influenced other families in their locality to adopt these behaviors. In this way, hygiene promotion activities are being scaled up to cover the entire slum.

**Lesson 4:** The participatory and consultative process of developing the communication material gave a sense of ownership to the women and helped them channelise their efforts towards promotion of hygiene behavior.

Pictorial material has proved to be an excellent tool for interactive discussion on hygiene related issues among small groups of slum women. The program assessment team tested the material with pregnant women and mothers of children less than one year of age in *Jalla Colony* in *Khajrana Area* to observe their understanding of the messages given in the pictorial form. They found that semi-literate and literate women were able to absorb the message and the material is a stand alone BCC tool for the group, whereas illiterate women had difficulty in comprehending the messages. The slum-based CBO told the assessment team that this is an excellent tool for conducting counselling sessions with small groups of women.

**Lesson 5:** If stimulated adequately, mothers/families even with limited access to hardware (sanitary facilities, availability of soap, chlorine tablets etc.) are able to identify, and willing to try, feasible and appropriate practices associated with hygiene behaviors.

Out of the total 65 mothers/families selected to adopt hygiene behaviors, 55 mothers are constantly practising hygiene behaviors. Of these 55 mothers, ten already had private toilets at home, which they were not using for disposing children's feces. But now, after being counselled, they have started disposing children's feces in toilets. Two mothers/families got an individual toilet constructed at home with support from the community level implementers (LCBOs and Slum level CBOs). Therefore, it pays to have program implementation with the help of a motivated group of early adopter mothers who have the potential of in-turn counselling other target families. The early adopter mothers motivated the other slum mothers to adopt these behaviors. A significant improvement was seen in the adoption of behaviors.



The magical effect of different stakeholders coming together: The “before” and “after” pictures of the toilet blocks in Pawanputra

**Lesson 6 :** A regular and frequent interpersonal contact with the families is crucial in bringing about a positive change in adoption of behaviors. This is important for maintaining high motivational levels among women for adoption of behaviors.

Suman Suganchand works as a domestic help and resides in *Jeet Nagar*. She has three children. Her youngest child 'Sonu' is two years old. Sonu used to defecate just about anywhere in and around the house, in open drainage outside the house, roadside, etc. His feces used to lie unattended in open for long time. Suman did not practise safe disposal of child's feces; most of the time she used to dispose off the feces in front of the house in a garbage pile without putting ash or mud over it. Moreover, she would never wash her hands with soap after disposing off the child's feces. She believed that child's feces is not dangerous. During the Hygiene Promotion Pilot, Suman had agreed to try out hygiene behaviors. Since then, she has been contacted by slum level BCBOs regularly. Constant sharing of information and reinforcement by NGO staff, LCBO and *Basti* CBO helped her to develop awareness regarding the importance of hygiene behaviors and the need to adopt desired behaviors. After regular contact, she started practising safe disposal of her child feces by not leaving it in open for a long time. Her family felt the need to construct a private toilet. With the help of CBO members, she took the initiative and approached an agency (World Vision) that supports construction of private toilets. She deposited the money with the agency and got the toilet constructed. Now she has started disposing the child's feces in the toilet and washing her hands with soap after handling it. In one of the group meetings, she acknowledged the interest taken by the BCBO members and their continued support to her. She has become an early adopter of the promoted behaviors and actively participates in the BCC activities like advising other women, participating in awareness rallies etc. Now, she is happy with the overall improvement in the hygiene practices and with the reduced incidence of diarrhea in the slum.

**Lesson 7:** Sustaining behaviors is the greatest challenge encountered because hygiene behavior adoption is not a one-time practice like the timely initiation of breast feeding. It is not mandatory that once people have adopted 'improved behaviors', they will continue to practice it regularly. So, behavior interventions need to be reinforced and sustained over time, at least until they become social norms.

**Lesson 8 :** In an enabling environment, the community can develop a viable system of operation and maintenance of slum-based toilet complex

It all started in April 2003 under a mango tree, when BGMS personnel met with a few residents of the Pawanputra Nagar slum, primarily *Dalits*, engaged in manual work of different kinds. They discussed the need for cleanliness and for repair of the public latrines, lying dysfunctional in the slum for over a decade. In May 2003, a committee was formed from amongst the residents to discuss the problems in the slum, the lack of functional services, and to look for suitable remedies. In July 2003, with support from EHP, Raju, a member of the committee, went to Mumbai and Pune for an exposure visit to a number of NGOs. During the visit, among other things, he along with the officials of IMC was exposed to community-owned and operated toilets. Based on the learning from this exposure visit, it was decided between EHP and IMC that community based maintenance of toilets be undertaken on a pilot basis in Indore. This idea was shared by Raju with the NGO members at the slum level. As this was a long-time demand of the slum dwellers, the community members readily agreed and assured all possible support in this regard. The issue was followed up with IMC. It was decided in a meeting with IMC that EHP will do the internal renovation of the toilet complex while the IMC will bear the cost involved in the construction of its boundary wall and approach road and provide electricity connection near the toilet complex. It was after a lot of persuasion and insistence of the BCBO that IMC agreed for including squatting blocks for children. Even when the internal renovation was completed, the BCBO members insisted that only after the IMC completes its work, will the toilet be used by community members. There were some procedural delays on the part of IMC. At this point of time, the BCBO and other community members met the local corporator a number of times to ensure early initiation of the construction work and the quality of the construction. Infact, the construction work was stopped twice as the BCBO members were not satisfied with the quality of construction done by the contractor appointed by IMC. The CBO has 11 members (6 women and 5 men) who have taken the responsibility for the operation and maintenance of this renovated toilet complex. Bhaiyalal has been appointed as a sweeper by the committee to keep not only the toilets, but also the slum clean. Each household would contribute

Rs 20 per month towards his salary. Receipt books have been printed and systems for maintenance conceptualized. The community members have been able to establish a good rapport with the zonal Office of IMC.

As one of the committee members said, “Earlier when we went to the Municipal Corporation, no one spoke to us. Now, we have a letter pad and an organized group; hence they are forced to listen. With help from the Corporation, EHP and Indore Development Authority, we have now been able to initiate some work in the slum”.

The toilet block has been inaugurated by the local corporator and the IDA chairperson, Mr. Madhu Verma on 4<sup>th</sup> January 2005. It has become operational in the month of February 2005.

The Pawanputra model is a good example of developing linkages among NGOs, CBOs, funding agencies and government agencies, to get work done at the grassroots level.

## **Future Steps**

An external assessment team has done the mid-term evaluation of the Indore Urban health Program. After making field visits and interacting with the early adopters and other slum women, the team has strongly recommended scaling up hygiene efforts in other program slums of Indore. Therefore, in this phase of the program, an operations research titled ‘Hygiene Promotion Trial’ is being implemented in five new slums of Indore. The consolidated learning from the Hygiene Promotion Trial will serve as a useful resource in providing more empirical evidences to replicate the model in other program slums and other urban health programs. This scientific approach is especially designed to measure the quantitative change in hygiene practices and reduction in diarrheal incidence in the sample group.





## Section IV

### *Lessons from the Ward Coordination Model*

– A sustainable approach for improving health delivery for urban poor

#### **Background and Overview:**

The Ward Coordination Model was promoted to address the need to have a mechanism to develop linkages and co-ordination among the government, private providers and civil society organizations. Situational Analysis of Indore carried out by USAID-EHP revealed that health services are not reaching all the underserved settlements: (a) one ANM was catering to one ward - often having a population of 20-25,000 that affected her capability to deliver; (b) There was lack of coordination and linkages among various stakeholders.

It also highlighted the importance of multi-stakeholder partnerships to improve access, coverage and quality of health services for the underserved urban poor. There is a need to integrate multiple stakeholders for effective health delivery and utilization through linkages between health service delivery channels like ICDS and the community.

The ward coordination approach is a public sector driven approach. The idea of having a Ward Coordination Committee was suggested by the District Immunization Officer, Dr. Bhachawat, as a Ward is the smallest administrative unit in the city and all departments have appointed personnel at the ward level.

The main aim of the approach was to improve the access and reach of primary public and private sector services to the slum community through coordination among ward level urban health stakeholders and linkage of the community with public and private sector providers.

The external assessment of Indore program found this approach commendable and successful in addressing the health service delivery. More than *85 immunization camps have been organised from May 2003 to December 2004*. This is the approach, which can be adapted and replicated in other wards or in other urban health programs to address health service delivery for underserved urban settlements with support from multiple stakeholders at local level.

***Overall/Key Lesson: Discussions with the stakeholders at the ward level, using situational analysis, facilitated coordinated collective action (Ward Coordination Committee) and emergence of roles helped to reach the underserved slums of the ward. Available local resources (public and private) are adequate to support guided effort for child health improvement.***

**Lesson 1** - Identification and situation analysis of ward: Preparatory work (situation analysis, mapping and assessment of slums, etc.) and involvement of key government officials (District Immunization Officer and IMC zonal officers) right from the beginning helped establish credibility and stimulated the stakeholders to begin dialogue for some coordinated action for improving health services.

Situational analysis conducted for a particular ward (Ward 5) emphasized the importance of multi-stakeholder partnerships to improve access, coverage and quality of health services for the underserved sections at the ward level. It also brought out the fact that resources of the health department alone at the ward level were inadequate to reach the vulnerable slums of the ward. Even the idea of categorization of slums into different levels, came with the interaction of elected representatives and key government officials. It emerged from the consultative process that focus has to be in the most vulnerable slums where larger numbers of children are outside the loop of complete immunization.

Consultations with public and private stakeholders revealed the strong need for a mechanism for effective linkages and coordination among the public sector (Indore Municipal Corporation, Department of Public Health, Elected representatives, District Urban Development Authority, Department of Women and Child Development), private health service health providers and civil society organizations (NGOs and community based workers) for improving maternal and child health services in slum settlements of Ward 5.

Since a ward is the smallest administrative unit in the city and all departments have appointed personnel at the ward level to cater to the needs of slum dwellers, it was chosen as the basic unit to initiate the process.

Ward No. 5 was selected in consultation with the Department of Public Health officials namely the District Immunization Officer, Public Health Nursing Officers, Lady Health Visitors and the Zonal Officer of IMC's Kila Maiden Zone, as it is one of the largest wards of the city, with an approximate population of more than 45,000. Since one ANM is appointed at a ward level and is supposed to cater to a population of 7,500, it is not possible for this ward's ANM to reach all the settlements in the ward to provide essential maternal and child health services. Also, the child health indicators for this particular ward were low.

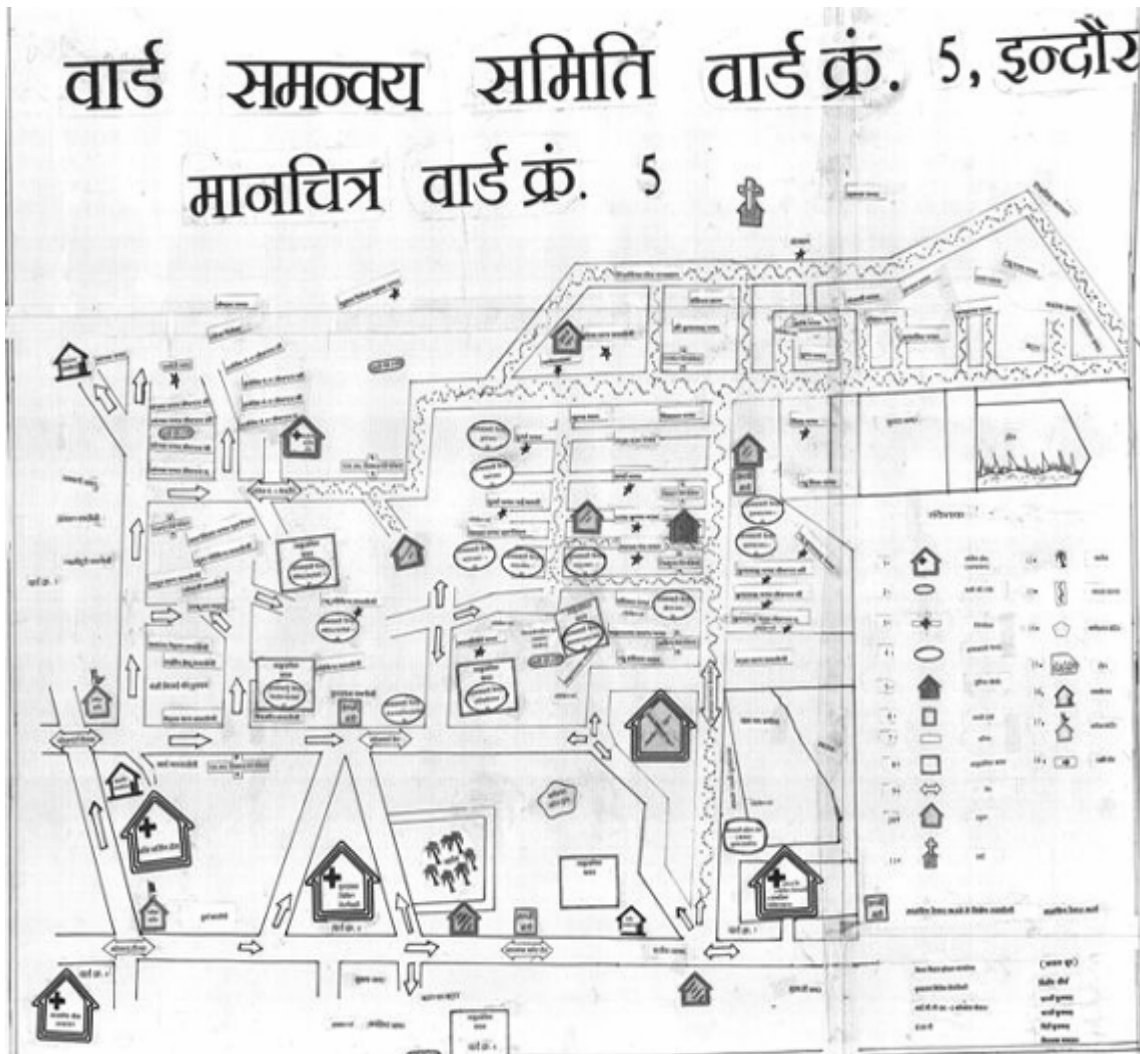
Through series of discussions with the stakeholders, it was clear that the Department of Public Health is not being able to cover a large proportion of population in this particular ward. Hence, the need was felt to evolve a mechanism in a way that support and coordination from multiple stakeholders in the ward could complement the resources of the health department for effective delivery of services and serve as a model to be followed in other wards. Also, this ward had a large number of private health service providers with whom linkage and partnership could help in improving the child health indicators of the Ward.

In this process of evolution of coordinated efforts, some key elected representatives and government officials played critical roles. To begin with, it was Dr. Bachawat's idea to take up the entire ward and develop it as a model of coordinated effort of government departments, statutory and non-statutory bodies as well as involve civil society organizations. As Chairperson of the Women and Child Development Committee of MiC (Mayor-in-Council), Dr Uma Shashi



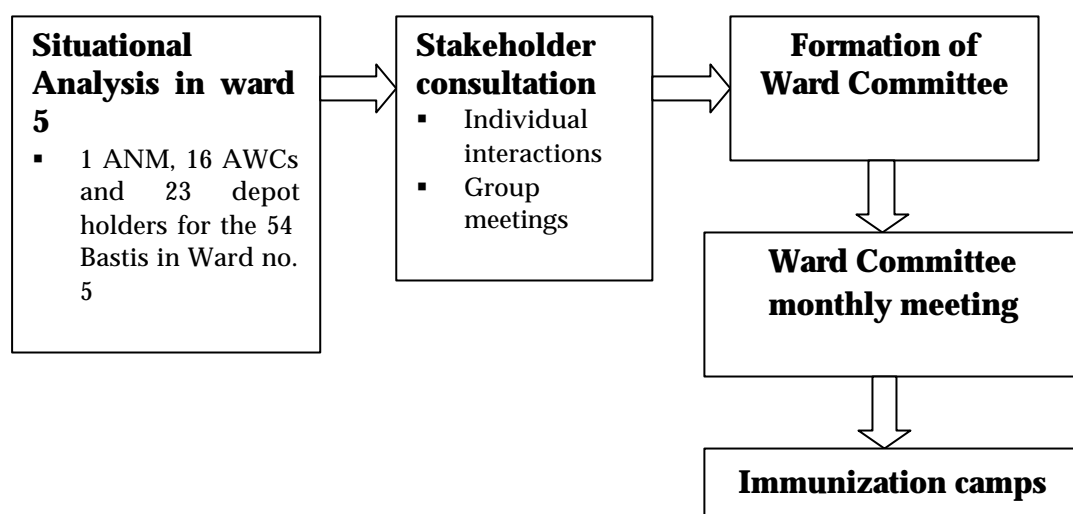
The Mayor of Indore attending a special meeting of the Ward Coordination Committee

Sharma, appreciated the idea and helped in the evolution process. The Zonal Officer, Mr. Solanki, not only provided logistic support for the various consultative meetings but also ensured all possible help on the part of the IMC. The involvement of the local MLA and Corporator of the Ward also helped in establishing the credibility of efforts aimed at having some kind of coordinated action. The involvement of elected representatives and key government officials helped in establishing rapport with other stakeholders. It also ensured commitment of all the stakeholders for the purpose. This stimulated all the stakeholders to think in a focused manner to evolve a mechanism for collective coordinated efforts.



The whole mechanism has evolved over a period of time through discussions with multiple stakeholders and practical experience of carrying out these activities at slum level.

## Flow Chart of the Process of Functioning of the Ward Coordination Model



Individual and group meetings with ANMs, LHVs, ICDS workers etc. helped stakeholders identify: (a) communities located in five different clusters in the ward; and (b) the large number of communities that were not covered by the Department of Public Health.

**Lesson 2** - Evolution process: Start-up efforts including individual interactions with stakeholders, group meetings using the map and situational analysis slowly generated adequate interest among the stakeholders to come together; therefore this pre-operative phase served a crucial purpose.

Once rapport was built with elected representatives and key government officials, meetings were held with the departmental heads of government, such as ICDS and DUDA. This helped in establishing contact with their ward level officials and workers. Also Bal Niketan Sangh, an NGO working in the area and *Aasara*, a confederation of SHGs active in the area, also got associated with the entire process. Their involvement helped in the initiation of comprehensive mapping of the ward. Several FGDs were held with the staff of Department of Public Health (PHNO, LHV, ANM), Department of Women and Child Development (Anganwadi workers, Supervisor), Community Based Organization representatives, Ward Councilor to map the settlements in the ward. All the Stakeholders and resources of the ward, which provide primary maternal and child health services for delivery, post natal care, immunization, curative services, referral or can be the potential sources for the same were identified and geographically shown on map through detailed Focus Group Discussions with ANM, LHV, Anganwadi workers, and with people in communities and physical/exploratory survey of the ward.

A list of all the slums in the ward was also compiled from various sources (Department of Public Health, Department of Women and Child Development, *Nai Duniya* Map, Mayor's Office). It was found that this ward could be divided into five clusters.

This process helped in developing a good understanding among the stakeholders. It also helped them to visualise their own roles and responsibilities in the coordination committee.

### **Roles, Responsibilities and Key activities of Ward Stakeholders**

The Ward Co-ordination Committee held its first meeting on 9 May 2003. Fourteen meetings had been conducted by June 2004. The Committee meets on the second Saturday of every month at the zonal office at Kila Maidan.

**Lesson 3** - Continued support and facilitation needs to be maintained to ensure that the coordination mechanism involving several stakeholders remains functional and active.

The role of EHP has been to act as facilitator of the Ward Co-ordination Model in giving shape to the agenda of the meeting and in documentation of the activity reports. Currently, EHP facilitates the Ward Coordination Committee by helping with the plan of action, follow up, participation in immunization camps, and providing support on specific issues as assigned by the Ward Coordination Committee. EHP is also involved in sharing the documents relating to achievements with the departmental heads of various government departments at the ward and district levels. The travel expense for the coordinator of the ward committee is borne by EHP. The coordinator heads a CBO, *Aasara*, which is a federation of Self Help Groups of women in the Ward No.5. Some of the women of these SHGs help in ensuring interdepartmental coordination and strengthen the committee's linkage with lower level functionaries of various departments. The committee reviews service delivery at the meeting and decides the slums to be covered through outreach activities. The roles and responsibilities as well as sharing of resources of various stakeholders are determined. The information dissemination on date and venue is done through pamphlets in the slums, to be covered, at least a day prior to the immunization camp. This is done with the help of CBOs, SHGs, *Anganwadi* workers and volunteers.

The functional status of Ward Coordination Committee is reflected in the credibility it has gained in Ward No.5. This is clearly visible in the fact that schools and polyclinics (local resources) are made easily available for conducting outreach, immunization and other health activities. Also, there has been a decrease in the number of children visiting the dispensary for immunization from some of the slums of Ward No.5, as is reflected in the case study of LHV.

### **Case study of LHV, Shobha Patil**

Sister Shobha Patil has been working as a LHV (Lady Health Visitor) in the Vrindavan dispensary for the last ten years. As LHV, she looks after the overall immunization work of six wards. All these six wards have one ANM each. She is so active that she acts as a substitute, if any of the ANMs is not available and visits the outreach camps when they require her support. In the initial period, she provided support in listing and mapping of the slums of Ward No.5. She has a good understanding of the resources available at the ward level. She also enjoys a good rapport with most of the stakeholders of the ward. When EHP initiated the process of consultation with the stakeholders, she facilitated the preliminary meeting with Dr. Jangde of the Lions' Club and others. Her commitment and sensitivity to the cause to reach out to vulnerable pockets within the slum is exemplary. She says, "There has been substantial change in the child health status in this ward because of this combined effort. Now with less effort, we have increased our reach even to the most vulnerable pockets of the ward." There has been a substantial increase in number of pregnant women and children getting completely immunized within a year. Apart from this, she as well as the Department of Health admits that the ward committee has been extremely helpful in reaching the target groups, who were missed earlier, and that there has been an increase in the number of the Polio booths in the ward. Expressing her satisfaction in seeing the ward committee evolving and achieving its stated objectives, she is of the opinion that earlier in the outreach camps, children of that specific slum only, where the camp was conducted, used to come - that too in fewer numbers. Moreover, there were lesser children in the 0-1 year age group than those in the age group of 5-10 years. Now, when the camp is held, children of the nearby slum also come and most of them fall in the age group of 0-1 years. The other difference she sees is that children of slums like Durga Nagar, Karma Nagar, Nandbagh etc., where immunization camps are organized each month on a regular basis, have stopped coming to the dispensary for these services. Another remarkable change has been that Vrindavan dispensary is not getting any letter regarding outbreak of diseases like diarrhea, Pneumonia, Diphtheria etc from the District Hospital or the Department of Health. Apart from immunization, the ANM counsels about the general hygiene to be followed at home. Also, chlorine tablets are given to mothers on a regular basis. She also admitted the fact that the ward committee has ensured that ANMs conduct the outreach camp on a given date on a regular basis which stands in sharp contrast with the other nearby wards covered by the Vrindavan Dispensary. Her exemplary enthusiasm and dedication towards her work makes her a perfect role model and motivates other ward committee members to play a more proactive role in attaining the common goal.

### **Elected representative takes the lead**

Initially the Councilor did not show much interest in the process and did not discuss in detail about the issues and concerns linked with status of health services in the ward. The zonal office, Municipal Corporation, showed a keen interest in the process and appreciated the efforts being made towards federating the various stakeholders in the ward. Zonal office informed the MLA of that constituency, Mr. Ram Lal Yadav who further directed the Councilor to understand the process and undertake the necessary steps. This got the Councilor interested. He was really impressed to see a detailed map of the resources and communities in the ward. It was an eye opener for him to know about the status of health services in the ward settlements. He actively participated in formation of a ward coordination mechanism to address the needs and problems of vulnerable *bastis*.

All the activities carried out by ward coordination committee are reviewed on a regular basis to improve the quality of services and reach the un-reached.

**Lesson 4** - Establishment of a credible forum at the ward level provides a mechanism for collaborating with academic institutes such as NNF and ESI to bring the benefits of these experts to the community.

The Ward Coordination Committee, with the support of Health Department has been able to forge linkage with agencies like the NNF, and ESI. These associations have supported in organising various health camps in the underserved slums of Ward No. 5. Apart from health checkups, the doctors from these associations and organizations provide inputs to the target groups on issues like newborn care, diarrhea management, pregnancy care, malnutrition and safe delivery practices. The presence of these doctors during the immunization camp also boosts the morale of the ANM involved in the immunization

activities. The presence of the doctors ensures that the target groups take the advice given by the ANM to the pregnant mothers and children seriously. These collaborations have complemented the role of the Department of Health and helped in providing better health services at the slum level. The Ward Coordination Committee collaborates with the ESI on various national programs including family planning.



**Lesson 5** - Once the common platform is active, convergence among various resources leads to synergistic efforts, better utilization of different resources and better outcomes in terms of outreach camps.

Advice from a lady doctor is welcome

The regularity of the meetings and increased number of immunization camps covering the vulnerable slums of the ward and linkage with NNF and ESI clearly indicate that the committee has emerged as a vibrant platform. The support from various stakeholders varies from time to time, based on the resources available and the needs of the coordination committee. In the initial period, most of the financial support for organizing the immunization camps came from zonal office. Over a period of time, Lions' club and DUDA also began providing financial support in organising the camps. IDSSS (Nand Bagh) provides the vehicle for commuting of ANMs for the camp held in Nand Bagh, which in other camps is provided by the zonal office. Bal Niketan Sangh, which has been conducting 3 camps each month since November 2003, by covering 10-12 slums in Ward No.5 uses its own ANM and other facilities for holding the camps as it runs the ICDS program in a nearby ward. Thus, the coordination committee has increased its coverage from one camp per month (May 2003- July 2003) covering 5 slums to 7 camps to covering 29 slums (from November 2003 onwards). Moreover, in January 2005, ICDS wanted to organize a 'women awareness camp' in which a 'healthy baby competition' was to be held in Ward No. 5. As the ICDS had limited budget for the event, it requested the Ward Coordination Committee to support the event so that it could be organized in an extensive way. The coordination committee supported the event and it was a huge success. The case study of the Lions' Club also shows how other stakeholders complement the resources of the Department of Health, which has helped in improving the reach of health facilities for pregnant mothers.



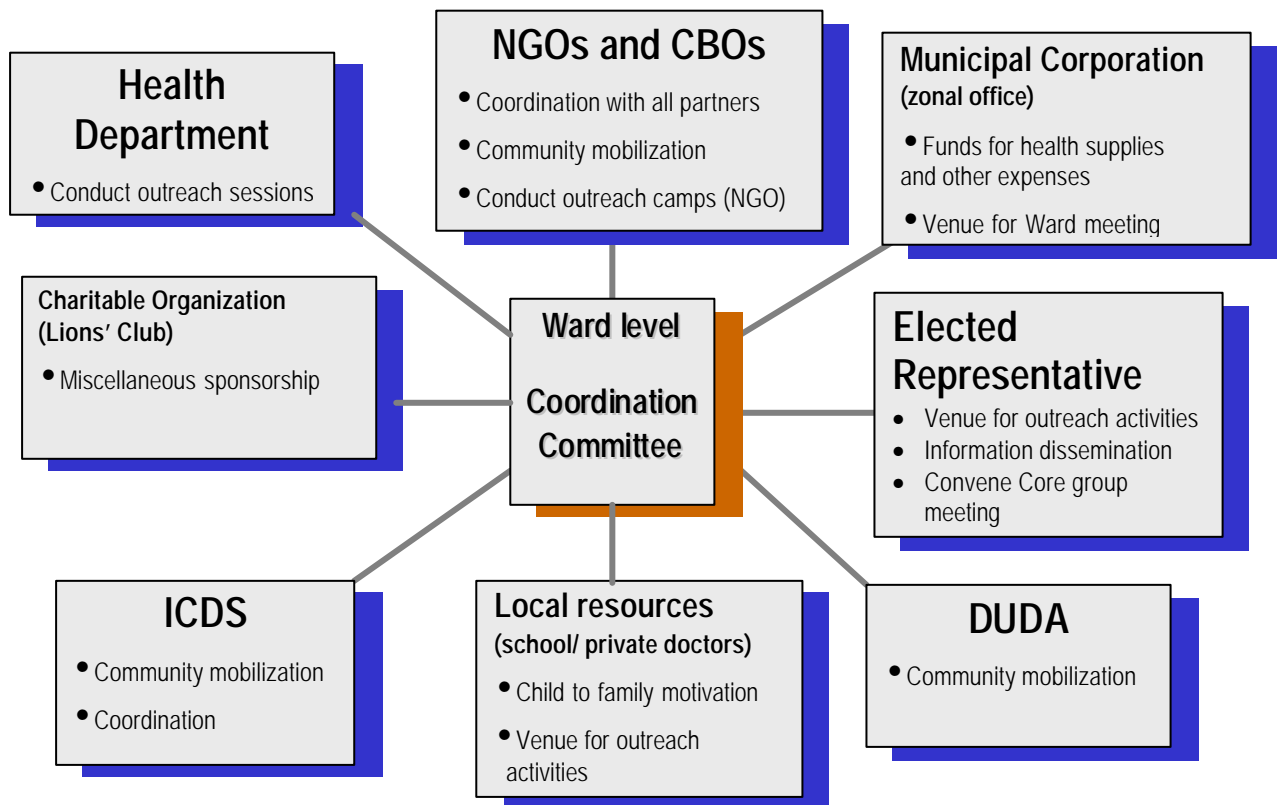
### **Lions' Club shows the way**

The Lions' club of Indore has the motto of working for the upliftment of the underprivileged sections of the society. So when the initial idea of having some kind of a coordinated effort at the ward level to reach out to the vulnerable slums of Ward No. 5 was discussed, Dr Jhangde of the Lions' Club expressed his willingness to be part of such an endeavor. Health is one of the priority areas for the Lions' Club. The entire process of listing the slums based on the vulnerability criteria and focusing on the most vulnerable slums was endorsed by the Lions' Club. Dr. Jhangde sees the Ward Committee as a platform through which the Club can achieve its mission on serving the neediest people. Dr. Jhangde not only actively participates in the meetings of the Ward Coordination Committee, but also takes sessions on importance of immunization, newborn care and other related issues during the outreach immunization camps. Lions' Club also provides financial support to the Ward Committee by sharing the cost of printing of pamphlets and other costs as per the need of the committee. At his private clinic, also located in the ward, he provides free immunization services on the fixed date.

The Lions' Club has appreciated the efforts of the Ward Coordination Committee. In its annual meeting held in August 2004, the Club felicitated the ward committee members for their efforts. In the October and November 2004 meeting, concern was raised on the shortage of weighing and blood pressure measuring instruments, which hampered ANC check-ups in the outreach camps. Dr. Jhangde followed it up at the Club level and two sets of the instruments for weighing and measuring blood pressure were handed to the ward committee in the month of December 2004. Complete check-ups of pregnant women are now being done on a regular basis during the outreach camps.

The active involvement of Lions' Club, right from the beginning, has helped in their understanding of the committee's objectives in a better manner and this is clearly reflected in the promptness with which they provided the much-needed instruments.

Ward stakeholders took up specific roles and responsibilities to make arrangements for the immunization camps.



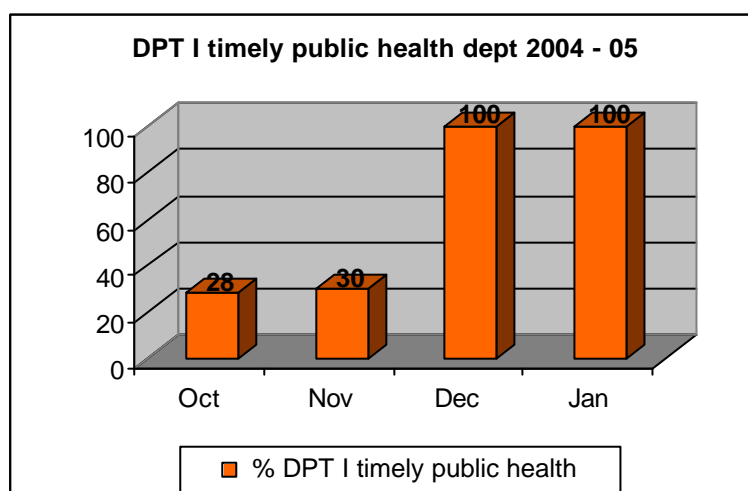


## Achievements of the Ward Coordination Committee

As per the external assessment undertaken in August 2004, during the period between May 2003 and April 2004, the Ward Coordination Committee had undertaken the following activities:

- Organised **85 free immunization camps** for pregnant women and children between the ages of zero to five in 24 slums of Ward No. 5
- Organised Tubectomy camp for women at Nandanagar dispensary.
- Conducted programs on child health and safe delivery as a part of child rights week.
- Organised programs on maternal health and malnutrition through Lions' Club and ICDS
- Conducted a survey of children between the ages of zero to five in the slums
- Created a resource map for Ward No. 5.

The following graph illustrates the progress made in timely immunization (DPT I)



**Lesson 6** - Regularity of meetings of the Ward Coordination Committee and gradual expansion of activities has helped in the process of institutionalization of the ward committee.

Annexure gives a table with the dates of some of the meetings, the number of participants and the important decisions taken. As can be seen, 11 meetings were held during the period May 2003- December 2004. Attendance varied between 8 and 18. Besides the regular review and planning related discussions, some of the important decisions, which the committee took during this period were:

- Decision on timing and frequency of meetings of the Ward Coordination Committee
- Decision to introduce family planning services
- Linkages with private providers for the above
- Decision to make a resource map for the ward
- Create a team of private doctors and TBAs in the ward
- Decision to open a bank account
- Decision to conduct a minimum of four outreach camps each month
- Decision to conduct a detailed survey of slums in the ward
- Appreciation of the zonal office's decision to provide a separate room and a computer

- Discussion on holding an eye camp in collaboration with the Choithram Foundation Trust
- Discussion on having a felicitation program for the newly-elected Mayor, who has been part of the Ward Coordination Committee since its inception. It was decided to use the occasion to share the experiences of the Ward Coordination Committee with some of the newly-elected Corporators for advocating replication in their respective wards.

## 5. Challenges and envisaged future actions

### a. Challenges / Difficulties

- Lack of a database of the number of children in the age group 0-1yr, 0-3yrs: In the absence of an accurate database, it is not possible to track and monitor the drop-outs and left-outs and their follow up.
- Lack of human resources (especially ANMs) in the Department of Public Health at the ward level: There is one ANM in each ward irrespective of its size. Ward No. 5 is one of the biggest wards with a large number of underserved slums (24). Moreover, there is no mechanism of replacement / substitution even if the ANM goes on a long leave. They have other duties as they are attached to the health institutions. Hence, regular outreach services are not a priority.
- The training (e.g. for 15days) for the ANMs on urban RCH does not take into account their workload or substitution mechanism. Activities like 'health *mela*' at district level directly affect regular outreach activities by the ANM.
- Underserved slums are at a considerable distance from Vrindavan Colony Civil Dispensary. There is a lack of transport facilities to reach vulnerable slums. Moreover, ANMs are not provided with any conveyance allowance to visit vulnerable slums. Hence, these slums are deprived of the essential health services.

### b. Envisaged future actions

- Replication of the Ward Model activities in two of the wards
- Strengthen convergence with the service providers
- Build capacity of the service providers to collect data and use it for program strengthening
- Identification of community volunteers and linkages with the Department of Health
- Identification of community volunteers in the *bastis* of Ward No. 5 wherever there are no volunteers. These volunteers can be trained and equipped as depot holders by the Department of Health. They can be provided with requisite essentials such as medicines like Paracetamol, ORS packets, contraceptive/pills, which will help them in social recognition
- Creating a baseline/database of the target group (number of children in the age group 0-1yr, 0-3yrs and pregnant women) - for better planning to reach all the unreached. In order to have an effective monitoring of the service coverage, baseline data is required. Data collection can be done with the help of the community volunteers
- Consolidation of service coverage data from private health service providers in the ward: A system needs to be evolved at the ward level so that routine health service data, especially immunization data is compiled regularly to track the left-outs and drop-outs in the area.
- Program sustainability: Currently EHP plays a facilitating and supportive role in nearly all aspects of the functioning of the Ward Coordination Committee. Various possible options need to be explored for program sustainability like appointment of

ANMs in the dispensary to support the ward coordination activities, coordination role for monthly meetings and similar issues. The assessment team's suggestion is that in terms of sustainability, EHP draws up a month-by-month withdrawal plan to be implemented over the next one year. There is need to give a deep thought to working towards a sustainable model.

### **Program Implications:**

1. An administrative unit based coordination mechanism is a feasible option for adaptation in different cities. Such a supportive mechanism is capable of energizing public sector stakeholders and also in bringing the public and non-government sector as well as civil society together to collectively address the needs of the disadvantaged. In different cities, the unit may vary: it could be a sub-division of the ward (where wards are very large, as in Mumbai) or the Urban Health Centre (where municipal governance is not strong enough to drive such a process).
2. Adequate preparatory phase, stimulation of stakeholders to value the significance of convergence and identifying useful roles for themselves, is crucial. Continued facilitation is also important to enable the coordination mechanisms to sustain over time and gain strength from its success.
3. As the coordination mechanism gains strength, it is recognized as a credible forum. At this stage a) potential stakeholders with resources are more eager to collaborate and contribute resources and b) other administrative units begin to get interested in replicating the approach.
4. There is a need to provide support for documenting process learning and collating, compiling monitoring data pertaining to coverage outcomes. This is one front on which the Indore Ward Coordination approach has not yet focused adequate attention.



## Section V

### *Issues Relating to for Replication of Lessons*

The Indore Urban Child Health Program completes twenty months of implementation in March 2005. During this period, it has evolved from the conceptualization/preparatory stage and is now in its fully functional stage of program implementation. The program has provided many learning tools and approaches that can be effectively applied or adapted in conceptualization and implementation of urban child health programs in other cities of India. The following are some of the issues relating to replication of the Indore Urban Health Program Model to other cities:

**1. *The need for having a well-designed preparatory phase, which is implemented systematically:*** This lesson is vital to develop, design and implement in any urban health program. A major implication emerged from the Indore urban health program that a well designed preparatory phase consisting of: (a) situational analysis; (b) assessment and mapping of slums; and (c) consultative planning with stakeholders, lays a strong foundation for the success of the program. It helps all concerned to understand the local context, to develop ownership of the program and to implement the program in the needy areas.

It is noted in many cities, that services exist and remain under utilized. The approach of nurturing such institutions and a responsive approach for the provider can improve utilization of existing services. Focused program efforts to foster linkages of the community (represented by *basti* level CBOs, LCBOs) with public and private health providers through community level platforms have helped improve access to health services. These platforms are vital to improve community level capacities to negotiate with providers. Slum level institutions are also critical to sustain program efforts, make them more effective, and to reach the marginalized and voiceless.

**2. *The need for building an appropriate implementing mechanism:*** It is vital to identify an appropriate implementation mechanism, which strengthens community networks and builds functional bridges between slum communities and health services. In Indore, it has been observed that NGOs and CBOs had a strong presence and had a comparative advantage in implementing programs. NGO-CBO Consortia has been an effective strategy in enabling the partners to utilise complementary skills and capacities, and develop synergistic potential as the program evolved. Similar implementation mechanism may be available or could be promoted in other cities. The principle is to focus on capacities enhancement at local city level including capacity of slum level groups or networks.

**3. *Two-pronged strategy of a) encouraging optimal behavior promotion activities in slums which are context-responsive and b) improving reach (outreach) and quality of services in order to ensure effective in child survival interventions:*** There is evidence that key child survival interventions such as TT, safe delivery practices, breast feeding, and immunization have increased among slum communities and this has been achieved by the program. Investing in technical, skill and institutional capacity building of slum based institutions/ individuals or similar networks is effective since they are more acceptable to the community and therefore more effective on promoting optimal behaviors. Planned outreach camps on fixed day and fixed site in/near slums, with prior information to families and friendly linkages with ANM helped in increased service coverage and reach to special need clusters.

***4. Multi-stakeholder coordination for optimal use of available resources:***

An important approach is to explore an appropriate coordination mechanism at systems level to help to reach the underserved slums of a defined boundary: In Indore, the Ward Coordination Committee of Ward No. 5 emerged as such a coordination mechanism. Discussions with the stakeholders at the ward level, using situational analysis, facilitate coordinated collective action. The emergence of roles in the Ward Coordination Committee helps reach the underserved slums of the ward. Available local resources (public and private) are adequate to support guided effort for the child health improvement.

***5. Community-based women collectives and volunteers can be promoted and developed as credible slum level institutions:*** BCBOs are emerging as a credible institution in the slum, often functioning as role models. They empower slum families to adopt behaviors, avail services, negotiate with external agencies (with support from NGOs/LCBOs) for other slum improvement services and are a motivated institution with a vision for improving well-being in the slum and for ensuring reach of future programs.

***6. Participatory health enquiry and planning is an effective technique to develop context-appropriate strategies for behavior change and improved service coverage:*** Slum level context-appropriate behaviors and services improvement steps can be identified through the participatory health enquiry planning process. For example, the findings from the entire process of participatory hygiene enquiry facilitated the development of context-appropriate strategy to promote hygiene behaviors in the program slums. It gave an understanding of current community practices, determinants of these practices, specific barriers in adoption of desired practices and feasible options to thus promote appropriate behaviors.

## Annexure

### Details of Meetings held by the Ward Coordination Committee

Date	No. of members present	Important decisions taken
9 May 2003	10	<ul style="list-style-type: none"> <li>- Formation of co-ordination committee with membership</li> <li>- First camp to be organized on 21<sup>st</sup> May 2003</li> </ul>
14 June 2003	12	<ul style="list-style-type: none"> <li>- Immunization related decisions</li> <li>- Logistics for next camps</li> <li>- Decision on timing and frequency of meetings of the Ward Co-ordination Committee</li> </ul>
13 September 2003	13	<ul style="list-style-type: none"> <li>- Decision to introduce family planning services</li> <li>- Linkages with private providers for above</li> <li>- Plan for conducting health survey in three slums</li> </ul>
15 November 2003	15	<ul style="list-style-type: none"> <li>- Primary focus area to be immunization</li> <li>- Linkage with IMC for distribution of birth certificates</li> <li>- Decision to make resource map for the ward</li> <li>- Create team of private doctors and TBAs in the ward</li> <li>- File on activities to be kept at zonal office</li> <li>- Plan for next four months</li> </ul>
21 February 2004	10	<ul style="list-style-type: none"> <li>- Review of activities conducted in January and February</li> <li>- Decision to pay honorarium of Rs 25/- to <i>Anganwadi</i> workers and volunteers from <i>Basti</i> CBOs for two days a month, to assist in organizing camps and maintaining records. Funds to be provided by EHP</li> <li>- Decision not to get formally registered</li> <li>- Decision to open bank account</li> </ul>
13 March 2004	NA	<ul style="list-style-type: none"> <li>- Review of meetings and plan for March and April</li> <li>- Inclusion of new areas for immunization coverage</li> <li>- Discussion on transfer of ICDS sector supervisor</li> </ul>
17 April 2004	8	<ul style="list-style-type: none"> <li>- Presentation of report on activities till March 2004</li> <li>- Decision to conduct awareness talks at immunization camps</li> <li>- Decision to include new areas and to conduct five outreach camps</li> <li>- Decision to conduct meeting with <i>Anganwadi</i> workers in program area</li> <li>- Volunteers provided by both zonal office and EHP to assist in collection of data</li> <li>- Discussion about opening new <i>Anganwadi</i> centers and promoting community based groups</li> <li>- Decision to provide information about camps to zonal officer 3-4 days in advance so that arrangements for transportation and publicity can be made.</li> </ul>
19 May 2004	9	<ul style="list-style-type: none"> <li>- Review of activities for the previous month and plan for the next month</li> <li>- Discussion about logistical problems and decision to provide information about camps to Zonal Officer two days in advance so that arrangements for transportation and publicity can be made.</li> <li>- Decision to conduct a minimum of four outreach camps each month</li> <li>- Decision to conduct a detailed survey of slums in the ward.</li> <li>- Decision to conduct awareness sessions at camps from this</li> </ul>

		<p>month onwards</p> <ul style="list-style-type: none"> <li>- Create list of doctors in Ward No. 5 and organize meeting with them</li> <li>- Syringes and needles for all camps organized henceforth will be provided by the Lions' Club</li> </ul>
12 June 2004	9	<ul style="list-style-type: none"> <li>- Plan for the month</li> <li>- Survey of slums to be conducted in the month of July</li> <li>- Doctors in the ward to be contacted within the month</li> <li>- Honorarium to <i>anganwadi</i> workers assisting in camps to be withdrawn</li> <li>- Needles and syringes for all camps organized henceforth to be provided by the Lions' Club</li> </ul>
7 August 2004	18	<ul style="list-style-type: none"> <li>- Review of the activities of previous month as well as of the action plan for next month</li> <li>- Discussion on having a separate Fund for the activities of the Ward Coordination Committee</li> <li>- Discussion on having meeting with the departmental heads of the government departments involved in the Ward Coordination Committee for better and effective coordination</li> <li>- Zonal office's decision to provide a separate room and a computer</li> <li>- Distribution of the Award given by the Lions' Club to all Ward Committee members by corporators</li> </ul>
11 December 2004	18	<ul style="list-style-type: none"> <li>- Review of the activities of the previous month including detailed discussion on the immunisation coverage, and planning for the next month</li> <li>- Felicitations of the re-elected corporator of the ward, the newly elected President and Secretary of the Lions' Club as well as sharing of the experience of the Ward Committee activities, including the problems being faced</li> <li>- Assurance by the Lions' Club President to provide equipments for the ANC – check Up during the outreach Camps on a priority basis</li> <li>- Assurance on the part of the zonal office to provide support in the information dissemination process at the sum level which was hampered due the municipal elections</li> <li>- Discussion on holding eye camp in the month in collaboration with the 'Choithram Foundation Trust'</li> <li>- Discussion on having felicitation programme for the newly-elected Mayor, who has been part of the Ward Coordination Committee since its inception. This occasion is also be used to share the experiences of the Ward Coordination Committee with some of the newly elected corporators for the purpose of replication in their respective wards.</li> </ul>