



**ACTIVITY REPORT 135**

Technical Assistance to the  
Government of India for Urban  
Health Planning and National  
Guidelines

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# Contents

Acknowledgements .....	iii
About the Authors .....	v
Acronyms .....	vii
Executive Summary .....	ix
Purpose of this document .....	ix
Background .....	ix
Collaboration with GOI.....	ix
National urban health consultation.....	x
Technical assistance to the Government of Uttaranchal .....	x
Development of sample urban health proposals .....	x
Guidelines for development of slum health projects.....	xi
Urban health planning workshops for state governments .....	xii
1. Background and introduction .....	1
1.1 Urbanization and urban poverty .....	1
1.2 Urban health programs of the government.....	2
1.3 Emergence of urban health as a priority.....	2
2. Collaboration between Government of India and EHP on key urban health program activities .....	5
2.1 Expert group on urban health .....	5
2.2 National consultation on health of the urban poor .....	5
2.3 Technical assistance to State Government of Uttaranchal .....	8
2.4 Sample proposal development .....	9
2.5 Development of urban health guidelines.....	12
2.6 Urban health planning workshops for state governments and city authorities .....	12
3. Overview of urban health proposals.....	15
3.1 Key features of the sample proposals.....	17
3.2 Key features of Uttaranchal proposals .....	18
4. Summary of guidelines for developing urban health proposals within the RCH Program.....	19
4.1 Goal & objectives of the Urban Health Program .....	20
4.2 Coverage.....	20
4.3 Process for proposal development.....	21
4.4 Key strategies .....	21
4.5 Service delivery model.....	22

4.6 Package of services: .....	23
4.7 Human resources: .....	23
4.8 Referral systems .....	23
4.9 Community level activities.....	23
4.10 Outreach activities.....	23
4.11 BCC activities: .....	24
4.12 Capacity building/training.....	24
4.13 Public-private partnership .....	24
4.14 Coordination and convergence with other departments and private sector:.....	25
4.15 Management plan .....	25
4.16 Cost recovery mechanism and sustainability: .....	25
References .....	27
Appendix 1. Summaries of Dehradun, Haridwar, Bally and Haldwani Proposals .....	29
Summary of the Five-Year Urban Health Proposal (under RCH II) for Dehradun.....	29
Summary of the Five-Year Urban Health Proposal (under RCH II) for Haridwar .....	35
Summary of Five Year-Urban Health (Under RCH II) for Haldwani .....	41
Summary of Five-Year Urban Health Proposal (under RCH II) for Bally .....	45
Appendix 2. Guidelines for development of city-level urban slum health projects....	53
Preface.....	57
Government of India Ministry of Health & Family Welfare (Department of Family Welfare).....	59
<i>Guidelines for Development of City Level Urban Slum Health Projects</i> .....	59
Annex I. Process for project development .....	71
Annex II. Outline of Five-year Proposal for Urban Health Program under RCH II.....	75
Annex III. Outline of Budget Proposal for Urban Health Program under RCH II.....	79
Annex IV. For Reference .....	81

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This activity report has been prepared by Anju Dadhwal Singh, Shivani Taneja and Dr. Siddharth Agarwal.

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# Acronyms

ANM	Auxiliary Nurse Midwife
BCC	Behavior Change Communication
BFHI	Baby Friendly Hospital Initiative
BPL	Below Poverty Line
CDS	Community Development Society
DOFW	Department of Family Welfare
DWCUA	Development of Women and Children in Urban Areas
EAG	Empowered Action Group
EHP	Environmental Health Project
FP	Family Planning
FW	Family Welfare
GOI	Government of India
GOUA	Government of Uttaranchal
HMIS	Health Management Information System
HP	Health Post
ICMR	Indian Council for Medical Research
IEC	Information, Education, Communication
IFA	Iron and Folic Acid
IPP-VIII	India Population Project-VIII
IRMS	Institute for Research in Medical Statistics
IUD	Intra Uterine Device
LHV	Lady Health Visitor
LMO	Lady Medical Officer
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MOHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NHC	Neighborhood Committee
NHG	Neighborhood Group
NGO	Non Government Organization
OPD	Out Patient Department
PHN	Public Health Nurse

RCH	Reproductive and Child Health
RCV	Resident Community Volunteer
RTI	Reproductive Tract Infection
SLI	Standard of Living Index
STS	Second Tier Supervisor
SUDA	State Urban Development Agency
TA	Technical Assistance
TT	Tetanus Toxoid
UFWC	Urban Family Welfare Center
UHC	Urban Health Center
UH	Urban Health
UHIP	Urban Health Improvement Program
ULB	Urban Local Bodies

# Executive Summary

## Purpose of this document

This document presents the genesis and growth of the collaborative relationship between the Government of India and EHP over a two year period of operations in India, which resulted in building an enabling environment for city and state planners for the utilization of available financial resources under the Tenth Five-Year Plan and the second phase of the Reproductive and Child Health (RCH) Program.

This document outlines the technical assistance role played by EHP towards the Ministry of Health and Family Welfare, Government of India. It also provides planners with a model that could serve as a basis for developing Urban Health Programs in other countries.

## Background

India's urban population of 285 million<sup>1</sup> represents 27.8% of its total population. It is postulated that while the rural growth rate will drop, the urban growth rate will continue to rise in the next couple of decades. Population projections indicate that by 2025, about 40% of India's population will be urban<sup>2</sup>. The urban growth will account for over two-thirds of total population increases in the first quarter of this century. Slum population growth will continue to outpace growth rates of India, Urban India, and mega cities. This is currently being summarized as the 2-3-4-5 syndrome<sup>3</sup>. Slum populations, which are generally accepted as being underestimated, account for 21% of the total urban population as per official data. In mega cities such as Mumbai, 49% of the population resides in slum settlements with a population of 5.8 million<sup>4</sup>. India needs to be adequately prepared to respond to the enormous health and infrastructure challenges that beset this population group.

## Collaboration with GOI

Urban Health has emerged as a priority in recent Government policies and plans. Financial resources have been allocated by the Ministry of Health and Family Welfare, specifically towards the development of city-wide Urban Health Projects under the Tenth Five-Year plan. A collaborative relationship between the Government of India and EHP has evolved over the past two years on urban health programming issues. This has been ratified by the Government of India formally by way of identification of EHP as the nodal agency for assisting in the design of its urban health program.

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<sup>1</sup> Census of India, 2001

<sup>2</sup> Bhat, P.N. Mari (2001). India Demographic Scenario, 2025, Population Research Center, Institute of Economic Growth, New Delhi.

<sup>3</sup> In the 1991 – 2001 decade, as India grew at an average annual growth rate of 2 per cent, Urban India grew at 3 percent, mega cities at 4 percent and slum populations increased by 5 percent.(4)

<sup>4</sup> Census of India, 2001

Technical Assistance (TA) efforts have taken a practical shape in the form of conducting one national and three regional workshops for guiding urban health planning and direct assistance to Uttaranchal State Government for developing proposals for three cities. This activity took a further step with the decision by GOI to request EHP to develop sample proposals for four selected cities that have distinctly different dynamics in their background. These experiences, coupled with EHP's own experience in program planning and implementation in Indore along with the insight of program managers of other urban health programs, have contributed to the development of the Guidelines for Urban Health Programming.

## National urban health consultation

A two-day workshop was organized on “Improving the Health of the Urban Poor: Lessons Learned and the Way Forward” in June 2003 at Bangalore. The conference provided a platform for dialogue among policy makers, planners and implementers of urban health programs to review programs and policies related to urban health, and to make key recommendations for future urban health programming to the Government of India. The discussions marked an important starting point for the urban health component of the second phase of the RCH Program.

## Technical assistance to the Government of Uttaranchal

The Government of Uttaranchal was provided technical support in the development of urban health proposals for their prioritized cities of Dehradun, Haridwar and Haldwani. The background of each of these cities differed in the nature of local capacities, past inputs, nature and extent of slums. Thus, discussions among different city stakeholders helped develop context responsive strategies aimed at sustainable and comprehensive models of primary health care for the disadvantaged groups in these cities.

The proposal development processes (and the outcomes in the form of the strategies proposed in the urban health plans in Uttaranchal) were adapted and built on the lessons learned from the consultative and context-specific programming in Indore. The experience in Uttaranchal helped gain further lessons in urban health programming, specifically with regards to working out the operational aspects of the principles (such as community participation, ownership, stakeholders' participation in planning, etc.) that are enshrined in various documents. To support this activity in Uttaranchal, EHP enlisted the services of Muskaan, an NGO with experience in slum programs.

## Development of sample urban health proposals

With EHP being identified as the nodal agency for assisting in the design of the urban health component of GOI's Reproductive and Child health Program, EHP was requested to provide technical assistance for developing sample proposals that could be used as models by different states for developing their own city proposals. The need arose from the substandard quality of proposals being received by the Ministry. The decision was made to develop sample

proposals for four cities of different population sizes (to be able to understand the dynamics and forces in play within different kinds of cities). The identified cities were Delhi (a metropolis with a population over 10 million), Agra (one million plus in population), Bally (a city of 250,000) and Haldwani (a small city of about 100,000 in population).

The sample proposal development process was initiated by the GOI and then facilitated by the state governments with an eye toward providing active support from the city authorities. The proposals for Haldwani and Bally have been prepared, and activities are underway in the other two cities. EHP enlisted the services of two NGOs, CINI ASHA (for Bally) and Muskaan (for Haldwani) to support these activities.

## Guidelines for development of slum health projects

The “Guidelines for development of City-Level Urban Slum Health Projects” provide the policy framework for development of urban health projects in cities. They establish certain clear-cut mandates for sanctioning activities under the project, yet provide adequate flexibility for the states and cities to develop context specific programs. The guidelines also suggest a critical process for the development of proposals. The guidelines are the result of a consultative process with the incorporation of input from deliberations and lessons from various urban health programs, including the World Bank funded India Population Project VIII (IPP VIII), EC supported UH initiatives and EHP’s experiences in program development in Indore and other cities, and the years of experiences of the Government of India and state governments.

The main objective of the program is to provide an integrated and sustainable system for primary health care service delivery, with an emphasis on improved family planning and child health services in the urban areas of the country, for urban poor living in slums and other health vulnerable groups. A road map for the development of urban health plans in identified cities is recommended and includes:

- (i) situation analysis
- (ii) consultations with multiple service providers and stakeholders in the city
- (iii) identification and mapping of the urban slum population and other vulnerable groups
- (iv) development of management implementation plan and budgets
- (v) development of review, monitoring and evaluation mechanism

The following are to be developed by the cities in consonance with the broad directions suggested in the guidelines:

- (i) detailed strategies for improving demand for, access to and quality of family welfare and maternal and child health (MCH)

- (ii) involvement of NGOs and the private sector in various aspects of urban primary health care delivery
- (iii) promoting convergence of efforts among multiple stakeholders
- (iv) developing effective linkages between the communities and the first tier service delivery point and between the first tier facility and referral units at the second tier
- (v) strengthening monitoring and evaluation mechanisms

## Urban health planning workshops for state governments

The process for developing urban health proposals has been evolving through experiences in the three cities of Uttaranchal, Indore and Bally. These have taken the shape of the Urban Health Guidelines. A critical component of the TA to the Government has been the effort to share the lessons learned from these experiences with other state and city planners to help them develop comprehensive and effective plans for their respective cities. Capacity building workshops have, towards this end, been held in Kolkata (November 2003), Narendra Nagar (April 2004) and in Lucknow (May 2004). State and city-level officials from the West Bengal, Madhya Pradesh, Uttaranchal and Uttar Pradesh have participated in these events.

The workshops were useful in taking the participants through the process of planning by giving time to the rationale for the plan (why), the target groups (for whom), the need for multi-sectoral coordination (by whom), defining the problems (what and the gaps), the possible strategies by examining present capacities and learning from other urban health programs (how).

The workshop in Narendra Nagar was particularly useful since the sessions were planned as group exercises using examples from the participants' respective cities. Government officials came prepared with preliminary information from these cities, and the information was analyzed to further develop the follow-on action plans. The Lucknow workshop was organized at the request of the Government of Uttar Pradesh as a follow-up from the Narendra Nagar state-level workshop to further the urban health planning process in the identified cities of Uttar Pradesh.

# 1. Background and introduction

## 1.1. Urbanization and urban poverty

Urban growth in India presents a daunting picture. Of the total population of 1.027 billion in India<sup>5</sup>, about 742 million live in rural areas and 285 million in urban areas. The urban population equals 27.8% of the total population. If urban India was considered a separate country, it would be the fourth largest in the world after China, India and the United States. Population projections indicate that by 2025, about 40% of India's population is expected to be urban<sup>6</sup>. The urban growth would account for over two-thirds of total population increases in the first quarter of the 21st century. In 2001, there were 35 metros (million plus cities) and 393 cities above 100,000 in population. It is estimated that the number of million plus cities in India will grow to 51 by 2011 and 75 by 2021. In addition, there would be 500 large cities with populations above 100,000<sup>7</sup>. This spatial manifestation of urban growth represents formidable challenges. Demographers have described the Indian demographic scenario as the 2-3-4-5 syndrome<sup>8</sup>. In the last decade, as India grew at an average growth rate of 2%, Urban Indian grew at 3%, mega cities at 4% and slum populations increased by 5%.

The slum population in 2001 is estimated to be close to 60 million<sup>9</sup>, comprising 21% of the total urban population. However, these estimates do not reflect the true magnitude of urban poverty because of the “un-accounted” for and unrecognized squatter-settlements and other populations residing in inner-city areas, pavements, constructions sites, urban fringes, etc. Undoubtedly, a significant proportion of the population particularly in larger cities live in slums or slum-like conditions with seriously compromised health and sanitary conditions, putting them at a much higher morbidity and mortality risk than non-slum populations. Population projections postulate that slum growth in the future is expected to surpass the capacities of civic authorities to respond to the health and infrastructure needs of this population group.

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<sup>5</sup> Census of India, 2001

<sup>6</sup> Bhat, P.N. Mari (2001). India Demographic Scenario, 2025, Population Research Center, Institute of Economic Growth, New Delhi.

<sup>7</sup> KC Sivaramakrishnan and BN Singh, Urbanization, <http://planningcommission.nic.in/reports/sereport/ser/vision2025/urban.doc>

<sup>8</sup> Chatterjee, G (2002). Consensus Versus Confrontation, Urban Secretariat, United Nations Settlement Program, UN-HABITAT

<sup>9</sup> National Commission on Population, 2000

## 1.2. Urban health programs of the government

Urban health initiatives of the government have fallen short of the needs as illustrated below. The scheme on Urban Family Welfare Centers (UFWCs) has been functioning since 1950 to provide family welfare services in the urban areas through existing health institutions and newly established clinics. Also, through the Urban Revamping Scheme (1983), Health Posts have been established to provide outreach services, primary health care, and family welfare and MCH services in urban areas, particularly in slums<sup>10</sup>. Currently there are 1,083 UFWCs and 871 Health Posts, many of which are run by hospitals and are not proximal to slums. With the total urban population of 285 million, (with 1,954 UFWCs & HPs), this translates to one UFWC/HP per 148,413 urban population. In addition, there are 1,562 Postpartum Centers (PP Centers, 1966), and many are closing down due to a discontinuation of central funding. Through IPP VIII (1993–2003), which covered 7 million slum dwellers in four mega cities and 94 smaller towns in four states, new health centers were established. For example, in Bangalore city, 55 health centers were established in the project adding to the existing 37.

The World Bank assisted the nationwide RCH I Project, which included a local capacity enhancement component wherein sub-projects were implemented in seven cities for optimizing the use of available resources, strengthening infrastructure and implementing innovative approaches. Nevertheless, problems continue with delivering health services and improving reach. This has led to a gross imbalance in access to services by the poor. Consider the public sector share of total health expenditure in India: 22%. This is about the lowest in the world. The lowest figure for any developed nation is for the United States, but even that is 44% — double the Indian figure<sup>11</sup>.

## 1.3. Emergence of urban health as a priority

The provision of assured and credible primary health services of acceptable quality in urban areas has emerged as a priority for both the central and the state governments in view of the increasing urbanization along with the growth of slums and low income populations in the cities. Historically, the government focus has been on development of a rural health system, having a three tier health delivery structure (determined on the basis of the population) to cater to the largely rural population. On the other hand, efforts to create a well-organized health service delivery structure in urban areas especially for poor people living in slums have remained limited to a few cities based on pilot schemes and programs. Recognizing the seriousness of the problem, the Government of India has accorded a high priority to “Urban Health” in the Tenth Five-Year Plan; National Population Policy, 2000; National Health Policy 2002 and the second phase of the Reproductive Child Health (RCH) Program. The RCH Program is the umbrella program of the Department of Family Welfare, Government of India, within whose framework and approach all the services being coordinated by the department are to be planned and delivered. The proposed RCH II is based on the lessons

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<sup>10</sup> Annual report on special schemes 1999-2000. Special scheme section, Department of Family Welfare, Ministry of Health and Family welfare, Government of India.

<sup>11</sup> What Globalization does to People's Health, Book I and II (2000) National Coordination Committee, Jan Swasthya Sabha, Chennai



learned from RCH I (1997–2003) and includes a clearly articulated objective of expanding essential RCH services in urban areas.

This document presents the genesis and growth of the collaborative relationship between the Government of India and EHP over a two year period of operations in India, which resulted in building an enabling environment for City and State planners for the utilization of available financial resources under the Tenth Five-Year Plan and the second phase of the Reproductive and Child Health Program.

This document outlines the technical assistance role played by EHP towards the Ministry of Health and Family Welfare, Government of India. It also provides planners with a model that could serve as a basis for developing Urban Health Programs in other countries.



## 2. Collaboration between Government of India and EHP on key urban health program activities

### 2.1. Expert group on urban health

Recognizing the urgent need to focus on the health of the vulnerable urban populations, the Government of India has planned the implementation of urban health projects in identified cities under the second phase of the RCH Program. In order to provide guidance to the RCH II design team, GOI organized a national consultation in October 2002 with wide participation from the state governments, donor agencies, NGOs, research and academic institutions, etc. Subsequently, an Expert Group on Urban Health, comprising of experts from selected state governments, with experience in IPPP VIII projects, and donor agencies, was constituted by the Government of India for the formulation of guidelines to enable the development of urban health proposals by state governments. The recommendations of the Expert Group formed the basis for development of project implementation plans for urban projects. However, most of the state governments found it difficult to formulate urban health proposals due to insufficient experience and technical expertise.

### 2.2. National consultation on health of the urban poor

The first component of EHP technical assistance to the GOI and one of the key steps in the direction of building stakeholder capacities in urban health planning and implementation was the collaboration between the Government of India and EHP to organize a national consultation on “Improving the Health of the Urban Poor: Lessons Learned and the Way Forward” in June 2003. The consultation provided a platform for sharing experiences on urban health to develop an understanding of the strategies that had been effectively used in large-scale urban health programs in the country and the challenging factors. It was an effort that brought various people and experiences together instead of continuing the trend of analyzing one program only.

The two-day workshop examined several themes within health care for the urban poor, and the following key recommendations emerged.

## ***Issues and options for health care delivery to the urban poor***

- Urban poor specific health data
  - Health indicators are adverse for the urban poor. Average statistics mask inequalities.
  - It is important to have baseline data specific to slum dwelling populations for effective M&E.
  - Using subsidies to reach the neediest
  - User charges are necessary to build sustainability and enhance ownership. People are willing to pay for quality services.
  - Subsidies available through the public health system do not reach the poorest, and better systems need to be evolved for a graded user-fee and for addressing exclusion of the poorest.
- Partnerships for better health care
  - Forging partnerships with different stakeholders, as NGOs, CBOs and charitable institutes helps in effective outreach and also helps in unit cost reduction of the service delivery as more impact is achieved and human costs are lower.
  - Participation of the stakeholders should be brought in at as early a stage as possible.
  - The need to involve direct people representatives, as ULB<sup>12</sup> members and/or CBOs is critical.
  - Health program efforts should be supplemented through other government programs as ICDS (to strengthen community linkages), VAMBAY (to improve sanitation and other basic services).
- Mobilizing communities
  - Building individual and institutional capacities in the slums is crucial for sustainability.
  - Demand enhancement is possible through pro-active awareness generation and information dissemination matched with quality service. BCC approaches need to be diverse and culture-specific.
- Quality of services at the public sector facilities
  - The quality of services needs to be improved, with a focus on the social distance or the attitude towards poor people, quality of clinical service, timings (slum dwelling women and men earn their daily wage during usual day hours), regular availability of staff, infrastructure, referral linkages and physical locations.
  - Micro-planning should be done to have clear-cut geographical responsibilities.

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<sup>12</sup> ULB or Urban Local Body refers to elected Local Government in cities.

### ***Identifying and targeting the vulnerable urban populations***

- Services should be made available to registered and unregistered slum areas of the city. In this direction, targeting the least served slums is vital for optimum utilization of resources. In addition to urban health programs, identification of the poor should be done by all ULBs and other programmers for prioritizing interventions.
- Vulnerability assessments should be carried out to identify the vulnerable clusters of the urban poor populations. This could be done by analyzing secondary data (as provision of water supply and sanitation facilities) to identify underserved settlements. In case of a primary survey, involvement of local NGOs/CBOs for data collection will be a long-serving approach.
- There is a need to document the drawbacks of existing methods of identification of the poor, such as BPL<sup>13</sup> cards, and overcome these.

### ***Improving hygiene behavior through community sanitation initiatives***

- Participation of several stakeholders, such as ULBs, NGOs and CBOs is needed for a sanitation project. Community ownership should be built from the beginning, including involvement in the technical design.
- Efforts for promoting community and household level hygiene practices should complement the investments in sanitation infrastructure.
- User payment for services relieves pressure on municipal financing and ensures maintenance. However, affordability of services for the communities should be kept in mind, and the charge should be commensurate to the paying capacity of the poor.

### ***Lessons from urban-specific health interventions***

- Private medical practitioners can play an important role in urban health delivery. Their involvement could be built by keeping their reporting requirements to a minimum and by building an enabling logistical environment for them.
- Involvement of communities at various stages of the project (needs assessment, program planning, implementation, evaluation, etc.) will enlist and enhance ownership. Community contact and mobilizing people helps in building trust.
- Strong and transparent partnerships are needed between public providers and NGOs.
- The role of ICDS should be made more effective by reinvigorating its processes, utilizing it for strengthening community linkages and expanding urban ICDS services.
- Location and timing of the health services as per the convenience of the community are crucial.

The recommendations that emerged from the consultation have provided a momentum to urban health programming directions in India.

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<sup>13</sup> BPL or Below Poverty Line is the method for identifying the poorest based on criteria determined by State Governments within broad parameters set by the Government of India.

## 2.3. Technical assistance to State Government of Uttarakhand

The third component was the provision of technical assistance to the State Government of Uttarakhand, which requested assistance in the development of urban health proposals for the cities of Dehradun, Haridwar and Haldwani, as urban health was still a new field for them. This was during the same time when the above mentioned consultation was being planned with GOI, and the events led to the induction of EHP in this role.

The proposal development in these three cities was initiated with EHP acting as a facilitator, supporting the government to engage in a consultative dialogue with all stakeholders, while at the same time keeping in mind that the planning responds to the needs of the poor. The facilitator role included support in recording proceedings and outcomes of all consultations and meetings so that the entire process was adequately documented in the government files for future reference when key officials might be transferred or changed for other reasons. As the facilitator, EHP diplomatically encouraged government officials to seek the participation of stakeholders such as NGOs, private medical providers and the communities with a sense of openness and earnestness to win their confidence and build trust in the government system. This role also included bringing technically correct and complete information (such as health conditions of the urban poor and real conditions of slums of the city including identification and maps of listed as well as unlisted slums) into the discussion to enable stakeholders to analyze and plan more realistically.

The wide participation from key stakeholders has helped incorporate critical principles in the proposal:

- *Inclusion of the underserved and vulnerable urban poor population in the urban health program.* This has been a significant advocacy step wherein the urban health proposals have prioritized the delivery of primary health care to hitherto neglected, unauthorized slum settlements. It also gives recognition to the fact that strategies need to differ depending on the vulnerability of the slum. For instance, outreach efforts have been prioritized and intensified in “more” vulnerable slums.
- *Community mobilization and building linkages.* This has taken a more comprehensive shape by extending the concept of linking volunteers to women’s health committees in the slums providing for a wider community representation and the representatives of such committees having an important role in coordinating with the Urban Health Centers. Monetary support and capacity building inputs have been provisioned to strengthen these groups as sustainable institutions.
- *Inter-sectoral coordination.* This has been proposed through forums at the city and the urban health center whereby, in addition to issues pertaining to healthcare delivery, environmental health issues can also be addressed.
- *Capacity building.* The capacity building of all implementing partners (government and non-government) have been proposed through specialized training agencies.
- *Building primary health facilities on existing infrastructure and staff.* This has been the deciding factor for setting and/or strengthening of urban health centers. Where the capacity to run medical centers is available in the non-government sector, as in the

charitable trusts of Haridwar, the government would provide the financial support, but the effective functioning would be the responsibility of the contracted agencies.

- *Mapping of slums.* All slums (listed as well as unlisted) have been mapped and then the city divided into UHC zones with equitable distribution of slums to each UHC zone.

## 2.4. Sample proposal development

The collaborative relationship between GOI and EHP was further strengthened with the identification of the latter as the nodal agency<sup>14</sup> for assisting in the design of the urban health component of RCH II. Consultations with the Secretary of Family Welfare and other senior officials of MOHFW led to the identification and prioritization of areas for providing TA to GOI by EHP<sup>15</sup>. In this regard, GOI requested USAID to provide TA for urban health programming in India. The first step in this direction is the ongoing development of sample urban health proposals in four different categories of cities, namely Delhi (mega city — population more than 10 million), Agra (million plus city), Bally (city with population between 1–10 million) and Haldwani (city with population around 100,000). The Terms of Reference for developing sample proposals were developed jointly between the GOI and EHP and finalized by the Secretary of Family Welfare (GOI memo dated Oct. 10, 2003). These sample proposals are expected to serve as model proposals embracing a process that involves multiple local and state government stakeholders and develops context appropriate approaches to serve the basic health needs of urban poor.

The process followed during the development of these sample proposals began with GOI informing state governments about the objective and rationale for developing sample proposals for the four designated cities and on the technical assistance role of EHP. Dialogue was then initiated at the state level and with the city representatives. Beginning with a discussion on the significance of a dedicated health program for the urban poor and for a wider consultation for context responsive programming, key steps to be undertaken for developing the proposal were identified and agreed upon in meetings. The approach for a participatory planning process was determined with state and city level officials, with EHP continually playing the role of stimulant and facilitator in accordance with the TOR.

The urban health planning experience involving multiple stakeholders in all the cities has been enriching and valuable in several ways:

- Active involvement of the functionaries (grass root functionaries, middle level functionaries and senior officials) at different levels helped in involving their view points in the planning process. This was significant in that it contributed to identification of the urban poor, better understanding of the needs of the poor and the potential and restrictions of existing work-forces/platforms. Meetings with different stakeholders helped work out strategies for improving the conditions through a sustainability-focused approach.

The ANMs and Medical Officers of the Health Posts in Dehradun expressed the fact that their outreach schedules went haywire because they had to pick up the vaccines from a centralized location on the outreach day and then reach the slum.

<sup>14</sup> GOI memo M.15012/4/2001 – RCH (DC) dated 12 September 2003 based on meeting on 14 August 2003

<sup>15</sup> GOI memo 19017/11/2003 – APS dated 30 September 2003

For these trips, they had no support in the form of travel allowances, and hence they would not be interested in carrying heavy vaccination kits to the slums. This problem has been countered in the proposal by budgeting for a transport facility (on a weekly hire basis) that would start from the centralized store with the vaccines and then take the staff to the outreach point.

- EHP's role of bringing in evidence based on technically correct and complete information into the consultative process has helped stakeholders confer, analyze the real situation and plan better using that information and develop context-appropriate strategies. This has ensured their support during finalizing strategies that at times meant power changes and policy shifts.

In Bally, some of the Municipal Council members were skeptical about having any changes in the roles of the Honorary Health Workers (a team of people they had been supporting for over 10 years). When presented with the health data, which showed high service coverage, and the recommendations of the IPP VIII end-line reports, and the persuasion of the Vice-Chairperson (who had been involved in the planning process on a daily basis), the corporators<sup>16</sup> felt assured that the proposed augmentation in the role of HHWs (from motivating slum women to access health care to also mobilizing them into community-based organizations (CBOs) that could be trained to function as peer educators themselves) was for the better.

- Wider participation of departments/stakeholders beyond the Health Department helped in extending the efforts to a broader base and setting up platforms for stronger inter-sectoral coordination.

Workshops with charitable trusts in Haridwar showed that they had experience in running medical care centers for people who stayed in their ashrams. They also had a strong management capability and large financial back-up and were eager to gain further recognition as agencies serving the poor, which was already part of their mandate. On the other hand, the Department of Health and Family Welfare did not have adequate first tier health facilities in the city. It was thus envisaged in the proposal that the new Urban Health Centers would be established in close vicinity to slums and managed by the charitable trusts through a government-NGO partnership.

- Identification, assessment and mapping of the city's poor through involvement of grassroots functionaries of different government departments, clearly showed all stakeholders that it was vital to target the vulnerable and underserved urban settlements (many of which were not part of official slum lists), and propose specific strategies that could be effective in such slums.

While all meetings in Haldwani found a mention of the dismal conditions of the Dholak Basti, the decision to physically locate one of the Urban Health Centers in this slum was surprisingly not very well received. This was probably due to the implication that the UHC staff would find it difficult to sit amidst the squalor in this area. However, participation of staff in the Vulnerability Assessment of Slums, and gaining an understanding regarding the poor the health conditions in

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<sup>16</sup> Elected ward representatives in the Urban Local Body.



Dholak Basti, enabled the Health Department to make the “difficult” decision to propose a UHC in this slum.

- Focus on slum level institutional and individual capacities is important for sustainability. The aspect of “link volunteers”<sup>17</sup> for building linkages has been extended to build institutional capacities in the slums even though this would be a slow and fairly intensive process.

As the concept of link volunteer was discussed in various cities and also seen in the form of an honorary health worker (HHW) in the IPP VIII Kolkata, these individuals were (or had been) seen as extended “assistants” of the government set-up and were losing their identity as community representatives. It is imperative to build such a cadre in a manner that it represents enhancement of slum level capacities. Consequently, it becomes critical to identify appropriate persons, who essentially belong to the slum itself and are adequately representative of the community residing in the slum. Gradually their knowledge and competence on family welfare and primary health issues, as well as their linkage with service providers systems should be built. This way they are more likely to “sustain” as “resources” that are easily accessible to the community and lend technical knowledge as well as add to the negotiating capacity of the community. The concept has been introduced in the urban health proposals. While the task of building slum level institutional and individual capacities in Dehradun and Haridwar would be contracted to NGOs. In Bally, this would be done by the HHWs and in Haridwar by a social worker posted in each Urban Health Center.

- The process has helped EHP India to constantly revise and renew its own knowledge (using documentation of program experiences and precise details of government programs such as Swaran Jayanti Shahari Rojgar Yojana (SJSRY)) and skill base to be able to facilitate a consultative process involving multiple stakeholders. In this direction, giving practical shape to ideas required an intensive and time-consuming review of literature, drawing from observations during visits to urban programs and thinking through the definition of a workable plan to the extent possible in the proposal. It also implied learning from experiences of similar nature or on a similar concept.

All documents and urban policies find a mention of Community Development Societies promoted initially by the UNICEF program of Urban Basic Services for the Poor and then scaled up to all parts of the country under the aegis of SJSRY. However, workable models using this platform for other development programs have not been tried out extensively. In Bally, when the need to utilize the potential and resources within the SJSRY for the Urban Health Program came up, the workability of such a model had to be well-researched (from available documentation of experiences in Kerala and Karnataka) and conceptually and logistically planned.

A significant overall lesson is that whenever one is thinking through any strategies, it is vital to ensure that services reach the poorest among the urban poor. If this is assured, then it is very likely that the energy so generated in the “system” will lead to the services remaining

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<sup>17</sup> The concept of ‘link volunteers’ was outlined in Government of India’s PIP (Project Implementation Plan), which largely served as guidelines for urban health planning, at the time of developing the UA and Bally Proposals.

accessible to the slightly less-poor also. It is therefore imperative to remain committed to delineating operational pieces of the urban health plan and to dealing with the challenge of making it work for the most disadvantaged.

## 2.5. Development of urban health guidelines

The third component of the TA to GOI (as well as a key expected outcome of the national consultation) was to incorporate the recommendations from the national consultation, lessons from ongoing proposal development activities, and lessons learned from the implementation of earlier urban health projects in select cities, into concrete Urban Health Guidelines that would be useful to the state governments in developing urban health proposals in identified cities.

The mainstay of the development of guidelines has been the consultative process engaging key officials from the Department of Health and Family Welfare as well as the RCH II design team, which includes the bilateral donor agencies. The Urban Health Guidelines have been informed by an amalgamation of deliberations and lessons from activities in the past year as stated above. In addition to the critical role played by EHP technical assistance efforts through its city-based program in Indore and proposal development activities in various cities, lessons from implementation of the recently concluded urban health programs in India, particularly the World Bank-financed India Population Projects (IPP VIII), have been incorporated in the Urban Health Guidelines. This process has enriched the development of the guidelines and greatly contributed to its ownership by the Government of India and the state governments.

## 2.6. Urban health planning workshops for state governments and city authorities

The fourth component of the technical assistance to GOI is the capacity building of state and local governments through regional workshops. To this end, EHP conducted the first Urban Health Planning Workshop in Kolkata in November 2003. The purpose of the four-day workshop was to enable urban program planners to understand the process for developing urban health proposals/plans. The participants included key representatives from the government of West Bengal and Madhya Pradesh, apart from members of a local NGO, CINI ASHA. The workshop helped the participants identify possible urban health stakeholders in different cities, their potential roles and the relevance of involving them in planning. The workshop also helped them gain a practical understanding of the methodology of identification, assessment and plotting of slums. The EHP team's own capacity to facilitate such urban health planning workshops to help programmers to carry out participatory planning using GOI's Urban Health Guidelines also evolved significantly through this workshop.

Subsequent workshops were convened in Narenda Nagar and Lucknow in April and May 2004, respectively, with the Urban Health Guidelines being formally introduced to the participants. The workshop in Narenda Nagar was particularly useful since the consultation functioned as a capacity building exercise using examples of the participants' cities. They had come prepared with preliminary information from their cities and the information was analyzed to build on the next action plans. This was attended by state and city representatives of Uttar Pradesh, Uttaranchal and Madhya Pradesh. As an outcome of the Narenda Nagar

workshop, participating cities developed action plans for urban health planning in their cities. The workshop also led to the issuance of necessary orders by the State Government of Uttar Pradesh for the constitution of the state and district level task forces — the critical official platform for urban health planning discussions. The Lucknow workshop was a follow-up (from Narenda Nagar) state-level workshop to further the urban health planning process in the identified cities. Being a participative effort in which people had to analyze what they proposed for their cities, it enabled the process of building proposals by beginning with identification of needs and situations relevant for the city.

The workshops were useful in spreading the experience and lessons learned from the proposal development exercises in the state of Uttaranchal and Bally and the Urban Health Guidelines to other state and city planners, so they could build comprehensive and effective plans. The participants were taken through the process of establishing a rationale for urban health planning, defining the problems and the target groups, thinking through of the problems and thus working through possible strategies for countering the problems and having an effective health plan for the health vulnerable populations of their areas. Capacity building needs were also explored. The Lucknow workshop resulted in the refinement of city-level action plans for the cities, and in the articulation of specific commitments by the state government and the cities for initiating urban health planning. In both workshops, the importance of issuing guidelines for operationalizing public-private partnerships in city-level urban health projects was identified as a necessary step requiring action by the central/state government. Similar workshops have been planned, particularly for the Empowered Action Group (EAG)<sup>18</sup> and northeastern states, which have limited technical expertise in urban health planning.

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<sup>18</sup> The Government of India has constituted an Empowered Action Group in the Ministry of Health and Family Welfare w.e.f. 20<sup>th</sup> March, 2001 to facilitate the preparation of area-specific programs, with special emphasis on eight states that have been lagging behind in containing population growth (contributes 45% of the population of the country) to manageable limits. The eight states are Bihar, Jharkhand, Uttar Pradesh, Uttaranchal, Rajasthan, Orissa, Madhya Pradesh and Chhatisgarh.



### 3. Overview of urban health proposals

As discussed in Chapter 2, with EHP being identified as the nodal agency for assisting in the design of the urban health component of GOI's Reproductive and Child health Program, EHP was requested to provide technical assistance for developing sample proposals that could be used as models by different states for developing their own city proposals. The need arose from the substandard quality of proposals being received by the ministry. The decision was made to develop sample proposals for four cities of different population sizes (to be able to understand the dynamics and forces in play within different kinds of cities). The identified cities were Delhi (a metropolis with a population over 10 million), Agra (one million plus in population), Bally (a city of 250,000) and Haldwani (a small city of about 100,000 in population).

The sample proposal development process was initiated by the GOI and then facilitated by the state governments with an eye toward providing active support from the city authorities. The proposals for Haldwani and Bally have been prepared, and activities are underway in the other two cities. EHP enlisted the services of two NGOs, CINI ASHA (for Bally) and Muskaan (for Haldwani) to support these activities.

This chapter briefly summarizes the four sample proposals. Appendix 1 presents the complete proposal.

## Basic background of the cities

	<b>Bally</b>	<b>Haldwani</b>
<b>Population</b>	2,61,575 (42% growth rate in the ten-year period: 1991-2001)	129,140 (23% growth rate in the ten-year period: 1991-2001)
<b>City</b>	One of the municipalities of the Kolkatta Metropolitan Development Area	A municipality in the district of Nainital
<b>State</b>	West Bengal, a state with a stable communist government for nearly three decades	Uttaranchal, a newly formed state
<b>Poverty Pockets and Population</b>	122 specific pockets of poverty were identified during a Vulnerability Assessment in the city with field estimates of a population around 120,000	13 slums identified but spread in one continuation over large areas; field estimates show a population of about 70,000
<b>Existing Government/Municipal Health Facilities/Programs</b>	<i>Extensive</i>	<i>Negligible</i>
	<i>In communities:</i> Honorary Health Workers and Supervisors in large numbers; part-time private doctors provide services at community centers and in institutionalized OPDs	<i>In communities:</i> Negligible outreach health services at present.
	<i>First Tier care:</i> Dispensaries and UFWCs managed by the Municipality and the DOHFW respectively	<i>First Tier care:</i> State allopathic dispensaries, but with no regular RCH care
	<i>Second Tier:</i> Four hospitals	<i>Second Tier:</i> One post-partum center cum female hospital
<b>Health Indicators in slums</b>	Immunization (89%) and institutional delivery (89%); breastfeeding within one hour (42%); unmet FP needs (7%) (IPP VIII End line Survey)	Basic RCH services abysmally low; delivery by skilled health personnel in urban UA 54%. (NFHS 2, 1998-99)

## 3.1. Key features of the sample proposals

### Key strategies proposed

	<i>Bally</i>	<i>Haldwani</i>
<b>Program Focus</b>	Need to integrate present efforts, avoid duplication and better use of resources and to sustain service coverage	Need to build a primary health care system as per needs of the vulnerable and sustain improvements
<b>Management</b>	Active municipality; further integration of state government system with municipality proposed; state government has UH program management system in place	Health department managed facilities; municipality's role to be strengthened gradually; new UH program management structure /mechanism proposed
<b>Community Level Activities</b>	Integration and further enhancement of community linkage through honorary health workers and community development societies	Community organizers proposed at Urban Health Centers for promoting community linkages in the form of link volunteers and women's groups (Mahila Arogya Samiti)
<b>Outreach</b>	Not needed in the slums with demand in place	Biweekly outreach activities proposed in vulnerable slums
<b>First Tier</b>	Private doctors provide services at community level & at second tier	State government doctors and contractual staff proposed
<b>Second Tier</b>	Municipality managed second tier hospitals strengthened	No ULB managed hospital available; state government hospitals strengthened and a new one proposed
<b>Inter-sectoral coordination</b>	Sanitation proposal and urban poverty alleviation schemes linked with the health activities; UHC and municipality-level coordination forums	UHC and city-level coordination forums; health and sanitation related issues to be discussed on these fora.
<b>Sustainability<sup>19</sup></b>	Building demand in the communities through institutional capacity building within slum dwellers; cost-sharing by state government; health corpus to be built at municipality level	Building demand in the communities through institutional capacity building within slum dwellers; building health corpus at UHC level

<sup>19</sup> As a welfare state, provision of subsidized and/or free health care is a government mandate; sustainability does not imply that individuals and families have to bear the entire cost of services.

## 3.2. Key features of Uttaranchal proposals

### Basic background of Dehradun and Haridwar

	<i>Dehradun</i>	<i>Haridwar</i>
<b>Population</b>	447,808 (State capital)	220,433
<b>Poverty Pockets</b>	106 slums (Official slum population – 121,086)	76 slums (Official slum population – 126,779)
<b>Existing Government/Municipal Health Facilities/Programs</b>	<i>In communities:</i> Existing but focused on registered slums	<i>In communities:</i> Negligible community outreach
	<i>First tier care:</i> nine health posts and two urban family welfare Centers	<i>First tier care:</i> Negligible
	two second tier facilities	Only second tier facilities
<b>Health Indicators</b>	<i>Low income households in Dehradun</i> Delivery by skilled birth attendants — 39%; children fully vaccinated by one year — 42.4% <sup>20</sup>	<i>Urban Haridwar</i> Women who had home deliveries in — 45%; children who received full immunization – 65% <sup>21</sup>
<b>Difference in proposal strategies</b>		
<b>First Tier</b>	Re-organize existing facilities (staff, locations) to have nine urban health centers	Three private agencies (charitable trusts) proposed for establishing and managing first tier facilities; two UHCs in public sector
	Existing first tier relocated based on mapping of slums	New first tier proposed in rented buildings close to slums
<b>Second Tier</b>	One municipal health center to be up-graded for second tier and one partnership with a private hospital for providing subsidized care to poor	Rural PHC to be up-graded for second tier as it comes in the urban boundaries now and is in the midst of a dense slum area
<b>Target population</b>	In addition to registered slum sites, several hidden slums (lime kilns, construction sites) were identified	Large areas had been designated slum but within this area, there were distinctly separate small slums in the midst of colonies for higher-income groups; large floating population needs targeting

<sup>20</sup> Population Services International conducted a baseline survey on child health in low-income households of the towns in Dehradun and Haridwar District. The data reflects this survey results.

<sup>21</sup> Rapid RCH Survey under RCH Programme, Haridwar in North-west U.P. (Region – II), December 1999



## 4. Summary of guidelines for developing urban health proposals within the RCH Program

This chapter summarizes guidelines for developing urban health proposals. Appendix 2 presents the complete guidelines. The “Guidelines for Development of City-Level Urban Slum Health Projects” provide the policy framework for development of urban health projects in cities. They establish certain clear-cut mandates for sanctioning activities under the project, yet provide adequate flexibility for the states and cities to develop context specific programs. The guidelines also suggest a critical process for the development of proposals. The guidelines are the result of a consultative process with the incorporation of input from deliberations and lessons from various urban health programs, including the World Bank funded India Population Project VIII (IPP VIII), EC supported UH initiatives and EHP’s experiences in program development in Indore and other cities, and the years of experiences of the Government of India and state governments.

The main objective of the program is to provide an integrated and sustainable system for primary health care service delivery, with an emphasis on improved family planning and child health services in the urban areas of the country, for urban poor living in slums and other health vulnerable groups. A road map for the development of urban health plans in identified cities is recommended and includes:

- (i) situation analysis
- (ii) consultations with multiple service providers and stakeholders in the city
- (iii) identification and mapping of urban slum population and other vulnerable groups
- (iv) development of management implementation plan and budgets
- (v) development of review, monitoring and evaluation mechanism

The following are to be developed by the cities in consonance with the broad directions suggested in the guidelines:

- (i) detailed strategies for improving demand for, access to and quality of family welfare and maternal and child health (MCH)
- (ii) involvement of NGOs and the private sector in various aspects of urban primary health care delivery

- (iii) promoting convergence of efforts among multiple stakeholders
- (iv) developing effective linkages between the communities and the first tier service delivery point and between the first tier facility and referral units at the second tier
- (v) strengthening monitoring and evaluation mechanisms

*The guidelines were developed with technical assistance from the USAID/India Urban Slum Child Health Program over a series of meetings and workshops convened by GOI involving experienced urban health program managers from IPP VIII and other urban programs. The guidelines were also informed by the urban health planning exercise in Dehradun and Haridwar in the State of Uttaranchal with state and municipal officials.*

## 4.1. Goal & objectives of the Urban Health Program

### Goal

To improve the health status of the urban poor community by provision of quality primary health care services with focus on RCH services to achieve population stabilization.

### Objective

The main objective of the program is to provide an integrated and sustainable system for primary health care service delivery, with emphasis on improved family planning and child health services in the urban areas of the country, for urban poor living in slums and other health vulnerable groups.

## 4.2. Coverage

The proposed Urban Health Program envisages the implementation of urban health projects in a phased manner in all the cities with priority being accorded to eight Empowered Action Groups (EAG) and the Northeastern States. Under the program, states are required to prioritize the cities that bear the biggest burden of the urban slum population. These cities have been broadly classified into four main categories:

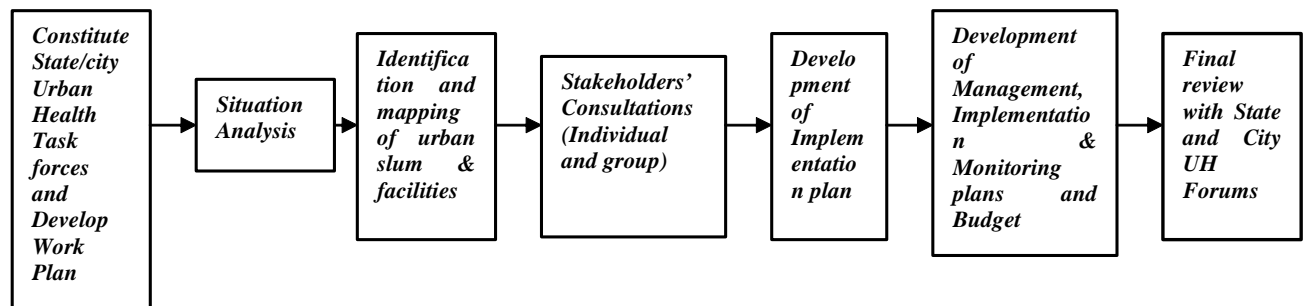
- a. mega cities with more than 10 million inhabitants
- b. million plus cities
- c. large cities between 100,000 and 1 million
- d. towns with less than 100,000

## 4.3. Process for proposal development

The process of formulation of urban health plans in the identified cities will include:

- a. situation analysis including assessment of health facilities (public/private/NGOs/Trusts, etc.) available in the city along with their functional status and type of services provided by them
- b. consultations with multiple service providers and stakeholders in the city
- c. identification and mapping of urban slum population and other vulnerable groups
- d. development of management implementation plans and budgets
- e. development of review, monitoring and evaluation mechanism

The illustration depicts the recommended road map to development of urban health proposals for identified cities.



## 4.4. Key strategies

Based on the information from the above activities, and identification of gaps in the existing system, urban health projects will be developed in close coordination with the city level Urban Health Task Force/Forum and the state level Urban Health Task Force. The process will also require identification of a nodal officer and the establishment of a cell at the state level to plan, coordinate and supervise the urban health projects in the identified cities. Detailed strategies for the following broad program directions are to be developed:

- (i) **Improving access to family welfare (FW) and maternal and child health (MCH) services** by the slum population through renovation/up-grading and re-organization of existing facilities and redeployment of available staff from the state government health department and ongoing programs and schemes
- (ii) **Improving the quality of family welfare services** through supervisory, managerial, technical and interpersonal skills to all levels of health functionaries

including training of female volunteers to help outreach service delivery through pre-service, in-service and on-the-job training.

- (iii) **Involving NGOs and the private sector** in various aspects of urban primary health care delivery.
- (iv) **Increasing the demand for family welfare services** comprising modern contraceptive usage, adoption of terminal methods, delivery care and child health services such as immunization and newborn care.
- (v) **Promoting convergence of efforts among multiple stakeholders**, including the private sector to improve the health of the urban poor.
- (vi) **Developing effective linkages** between the communities and first tier service delivery point and between the first tier facility and referral units at second tier.
- (vii) **Strengthening monitoring and evaluation mechanisms**

## 4.5. Service delivery model

The program proposes implementation of a uniform service delivery model with a common nomenclature by:

- a. integration of the facilities run by state governments/municipalities and other private agencies under various schemes
- b. upgrading/strengthening of the existing infrastructure
- c. establishing new facilities in a rented building

Though the program envisages flexibilities in implementation of different service delivery models suited to local situations, a suggestive model is described below:

- The first tier (i.e. Urban Health Center) will be set up, one for a population of approximately 50,000 (the norm may be suitably modified by the state/city UH task force to ensure coverage and access by the most vulnerable populations), and the second tier will be the referral hospital (city/district hospital/maternity home/private and NGO nursing homes). Existing service delivery systems should be reorganized and restructured to serve a defined geographical area for a defined population
- Potential private partners for either tier should be identified to improve the quality and standard of health among the urban poor, to capitalize on the skills of potential partners, encourage pooling of resources, and to reduce the investment burden on the government.
- Timings of UHC should be such that services can be made available to the target population at a time convenient to them. It is recommended that UHCs operate for eight hours a day.

## 4.6. Package of services

The minimum package of services should be provided in either tier. The first tier Urban Health Center will provide only outpatient services. The UHC will provide a comprehensive package of family welfare services (family planning, child health services, including immunization, treatment of minor ailments, basic lab facilities, counseling and referral to second tier) in order to encourage slum dwellers to utilize the first tier facility. The complicated referral cases and indoor services will be available only at the first referral institutions.

## 4.7. Human resources

Based on the vulnerability of slums, existing facilities may be relocated to ensure adequate coverage of the marginalized settlements. Efforts should be made to redeploy the existing staff from existing facilities of the state government, urban local body and ongoing programs and schemes. Any new staff will need to be appointed through contractual mechanism. An Urban Health Center would have one female medical officer, one public health nurse, three to four auxiliary nurse midwives (for population of 12-15,000 each), one lab assistant, one clerk, one guard, and one office boy. Second tier facilities could engage the services of part time or full time specialists on a contractual basis.

## 4.8. Referral systems

For each UHC catering to a specific population in a defined geographical area, options of second tier facilities that can provide subsidized, affordable, and quality referral services (such as institutional deliveries, emergency obstetric care, terminal methods of family planning) should be identified, which may be public or private. Upgrading of existing facilities may be considered, and linkages with central government/state government/corporate hospitals/charitable hospitals should be promoted. Mechanisms for referrals through UHCs should be developed.

## 4.9. Community level activities

To develop and maintain a link between the health facility and the community, the program envisages engagement of social community workers, link volunteers, and a female from the community able to spare 3-4 hours a day. The capacities of the link workers to facilitate health improvements in the community should be built through capacity building efforts, preferably by NGOs. Women's health groups may be formed by the link workers to expand the base of health promotion efforts at the community level and to build sustainable community processes. Efforts to stabilize link workers as well as women's health groups through linkages with slum welfare schemes and to minimize dependence on program funding should be promoted.

## 4.10. Outreach activities

Activities that reach out to the most vulnerable and the underserved should be planned as a means of increasing usage of critical health care services and for creating rapport with the

community. An outreach plan for each UHC focusing on the most vulnerable slum communities with poor health indicators should be developed. Collaboration with NGOs may be planned for outreach services, if required.

## 4.11. BCC activities

It is suggested that context-specific demand generation strategies should:

- a. focus on IEC for behavior change in RCH
- b. establish linkages, and if necessary, enhance selected activities of other schemes that provide benefit to the project beneficiaries

Private sector and NGO partnerships for IEC may also be promoted, particularly where potential partners with skills and proven experience in IEC/BCC are available.

## 4.12. Capacity building/training

The different agencies involved in the implementation, management, and monitoring of the proposed urban health program would need training on a range of issues at different phases of the project to handle additional responsibilities and to develop skills to work toward a desired impact. Training requirements at various levels of implementing agencies should be identified, and a capacity building plan proposed. Public-private partnerships for capacity building should be promoted wherever possible.

## 4.13. Public-private partnerships

Successful implementation of the project will require a vibrant partnership between the Department of Family Welfare (DFW), GOI, state government and the Urban Local Bodies (ULBs). While the DFW will provide technical assistance, the state government will provide leadership to the project facilitating ground implementation by the Urban Local Bodies. It is envisaged that the private sector can be economically and formally engaged for service delivery to fill in gaps. Cities are encouraged to develop context appropriate public-private partnership approaches (e.g., by contracting out first tier delivery systems to NGOs or the private sector where public infrastructure is not available; by engaging NGOs or specialized agencies for enhancing utilization of existing health services through BCC or other community level activities; by utilizing the services of private medical practitioners on a part-time basis for first tier and second tier facilities; by outsourcing laboratory and other diagnostic services to a private facility, etc.). Appropriate mechanisms for partnering (or entering into agreement) with the private sector need to be proposed including accreditation methods for ensuring quality, memorandum or partnerships, and reporting and monitoring systems.

## 4.14. Coordination and convergence with other departments and the private sector

This will focus on developing/strengthening mechanisms for effective linkages and coordination between various departments and the private sector at the health center level, city level and state level for improving access to quality health care services (e.g., sanitation, drainage and water services).

## 4.15. Management plan

- **Monitoring and evaluation plan:** The M&E plan should include: an appropriate process for benchmarking; development of an urban health management information system (HMIS) consistent with the national MIS; mechanisms for monitoring of key processes and results, pertaining to promotion of family planning and child health services; and periodic assessments of field activities and a final evaluation. A first tier facility monthly monitoring of key processes and outcomes by the city program management unit is envisioned.
- **Management and human resources plan:** A state program management unit may be established for the periodic review of program implementation and to undertake discussion and decisions on UH program activities. A city program management unit at the city level to review and strengthen program implementation should be established at the ULB wherever possible. Nodal urban health program officers at the state and city level would be responsible for coordinating the implementation of the Urban Health Program.
- **Fund flow mechanism:** The funds will be released to the state government/state RCH society who in turn will release funds to the implementing authority within one month of the receipt of funds. At the state level, the health & FW department will be the nodal department for implementation of the Urban Health Program, overall coordination, collection of SOEs from implementation agencies and their onward submission to the GOI, audit, etc.

## 4.16. Cost recovery mechanism and sustainability

Mechanisms for cost recovery, based on the principle of inclusion of the poorest and from experiences from previous projects, may be built as an integral part of the proposal. These funds may be utilized for building a corpus fund, which could partially sustain the recurrent costs after project completion. Several sources of contribution may be explored such as:

- user charges (from middle class and upper class families) for diagnostic services, surgeries, etc., at second tier
- registration fees/family health card charges from all families collected at first tier and during outreach camps

- donations from business houses, individuals, banks, etc.
- appropriation received from National Slum Development Program of GOI
- portion of lease and rental income from municipal or other public sector buildings

In addition to the corpus health fund, institutional capacity at community level (through federation of community groups for linkage with urban poverty alleviation schemes of the government and enhancing the capacity of the Urban Local Body to plan and manage such programs are approaches towards sustainability.



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# Appendix 1. Summaries of Dehradun, Haridwar, Bally and Haldwani Proposals

## Summary of the Five-Year Urban Health Proposal (under RCH II) for Dehradun

The 2001 Census proves that cities and particularly urban slums are the fastest growing areas of the country with a ten-year growth rate of 5–6% in slum areas as compared to the country's average of 2%. Health indicators for the urban poor are also far lower than what the urban average data denotes. Urban health is therefore emerging as a priority area for GOI and has found focus in the Tenth Five-Year Plan, National Population Policy, National Health Policy and in RCH-II. The Government of Uttaranchal has identified the cities of Dehradun, Haridwar and Haldwani for improving the public health service delivery systems within the RCH-II.

The following document is a proposed plan for

*Improving the health status of the urban poor communities by provision of quality integrated primary health services in the city of Dehradun by building on available experiences and expertise in the city in relation to the identified needs of the impoverished groups.*

### **City profile**

Spread over an area of 67 square kms., Dehradun lies in the Doon Valley at the foothills of the lower Shivalik range. The city has seen unprecedented growth rate of 66% over the decade, largely contributed by being declared the capital of Uttaranchal in 2000. The population figures stand at 4.5 lacs within the municipal boundaries and an additional 80,000 when the cantonment and adjoining urban areas are included.

### **Situation of the urban poor**

About one-third of the city's population is considered to be living at varying levels of poverty. Official estimates put urban poverty in the city at 121,086 across registered slum sites. The highest concentration of slums is along the banks of the two rivers, Rispana and Bindaal. The condition of these slums deteriorates progressively with their proximity to the river. Families living in the slums are primarily part of the unorganized sector (labor, lime kilns, recycling, vending on carts).

Starting with an official list of 78 slums, a process of identification, mapping and vulnerability assessment of slums was undertaken through a participative methodology. A total of 106 slums were identified and the following categorization of slums on the basis of health vulnerability emerged:

- Total Number of slums: 106
- Highly vulnerable: 28
- Moderately vulnerable: 48
- Less vulnerable: 30

**Existing Public Sector Health Facilities in Dehradun are:**

***First Tier***

- Urban Health Posts — 9
- Urban Family Welfare Centers — 2

The HPs and UFWCs offer antenatal care and immunization services at the clinic two days a week, and during outreach camps (predominantly at Anganwadi centers) and door to door information dissemination and surveys in their field areas.

***Second Tier***

- District Hospital – Doon (includes Post Partum Center and Women’s Hospital)
- Coronation Hospital
- The two state hospitals are reportedly running at full capacity

In addition to the Health Department, the Municipal Corporation also runs a total of twelve dispensaries — Ayurvedic, Yunani, homeopathic and allopathic operating from five locations. The dispensary doctors have been categorized as a “dying cadre.”

**Health scenario in the urban slums**

Data clearly shows that the poor are more vulnerable to mortality and morbidity than averages indicate. A child born to an urban poor family in Uttar Pradesh experiences a 90% higher probability of dying before one month of age as compared to a child born to a rich family (NFHS 1998-99 data).

Health Indicator	Low income households in Urban Dehradun, PSI, 2003	Urban Uttranchal, NFHS, 1998-99
Percentage of children who are underweight (below – 2 SD from the median weight-for-age)	43.6 (for children U2)	42.8 (for children U3)
Percentage of children whose births were attended by skilled health personnel (Doctor/Nurse)	39.1	54.1 (38.7%-dai/TBA)
Percentage of mothers who received at least two TT injections before the birth of last child	82.8 (for children U2)	76.9
Percentage of children age 12 – 23 months who were fully vaccinated before the first birthday	42.4*	
Percentage of children age 0 – 23 months who were born 24 months after the previous birth	36.5	69.7
Percentage currently pregnant during survey	12*	2.4

\* Average for Dehradun and Haridwar

## Service Delivery Model

### *First Tier Structure*

The present first tier (nine HPs and two UFWCs) will be restructured to nine “Urban Health Centers.” In Dehradun all the nine centers will be managed by the Health Department since human resources and infrastructure is already in place and requires up gradation. The upgraded Urban Health Centers will provide a larger base of activities and also service a larger population of about 50,000 (from the present average of 25,000).

The first tier will be following a community health promotion strategy, implemented in the form of building linkages and community ownership of the program through the link volunteers and community based organizations promoted at the slum level with the support of the NGOs.

The services available at first tier will be primarily in the nature of an out-patient department and outreach in the slums. The package of services: maternal health care, child immunizations, family planning services — temporary contraception methods and referrals for permanent methods, and first-contact care for basic ailments. There will also be facilities for laboratory testing. In addition to direct service provision, the first tier will be responsible for mobilizing people for uptake of services through various IEC and BCC methods. This will be done in partnership with private sector (NGOs) with social mobilization and communication expertise/skills.

Efforts will be directed to build financial sustainability of first tier services by the end of the program.

## ***Second tier structure***

The following approach will be undertaken in reference to the second tier:

- With the strengthening of first tier facilities, the OPD case load on the existing two hospitals will decrease.
- Collaborative linkage (for second tier facilities) will be undertaken with non-profit private sector to improve the referral support system in the city.
- The Coronation Hospital will be upgraded to a 24-hour second tier facility.
- The Nagar Nigam Dispensary in Dharampur will be upgraded as a second tier facility through a partnership between Dehradun Nagar Nigam and the State Health Department.
- The referral system will have poverty and vulnerability based user charge mechanism to be levied on the patients being referred by the UHCs.
- The second tier facilities will have the infrastructure (human resources and equipment) for deliveries (including emergencies), obstetrics care, terminal family planning methods, MTP services, child and newborn care, and first aid.

## **Community mobilization and linkages**

Community linkages will be strengthened through link volunteers and community based organizations — “Mahila Arogya Samitis.” The task of identification/formation and capacity building of link volunteers and Mahila Arogya Samitis will be contracted to NGOs.

The link volunteer will be a slum woman appointed to over 150–250 households. She will perform the tasks of tracking antenatal care and immunization, support outreach camps, represent the community in the UHC advisory committee, conduct group counseling sessions, follow-up for promoting healthy behaviors, support the community in linking with other health services (such as sanitation) and referral services, promote Mahila Arogya Samiti in the Basti and refer cases to the UHC. An honorarium of Rs 500 per month will be provided to each link volunteer. The Mahila Arogya Samiti will ensure a broader base of capacities and collective effort at the slum level.

The link volunteer will also serve as a depot for various contraceptive methods. She will be equipped (through training provided by NGOs) to handle queries that arise (before and after) regarding the usage of different FP methods and promote contraception and terminal method adoption.

## **Outreach activities**

The present outreach of the nine HPs and two UFWCs has been reviewed to strengthen the impact of this activity particularly in reference to the needs of the vulnerable populations and difficulties faced by the outreach staff. The following key issues have been decided:

- The package of services at the outreach sessions would be aimed at “total health” — identification, cure and prevention. Specific healthy behaviors, which will be promoted during the camps, include adoption of birth spacing methods, feeding of colostrum, child immunization, and TT.
- Camps shall be conducted fortnightly in highly vulnerable slums and on a monthly basis in moderately vulnerable slums.
- Each UHC shall constitute two teams; one headed by the Lady Medical Officer and another by the PHN/HV/ANM as per availability.
- The LMO shall be required to attend one of the two camps conducted in the “highly vulnerable” slums.
- Mobility support will be provided to the UHC staff for ongoing outreach.
- The NGO will enable the link volunteers and MAS to provide support to the UHC staff.

### **Information, education and communication/behavior change communication**

IEC/ BCC strategies will be adopted for information about location of UHC, outreach camps, appropriate antenatal care, delivery, postnatal care, new born care, infant health, immunization and family planning methods. IEC and BCC activities will be undertaken by the first tier units as well as link volunteers and Mahila Arogya Samitis.

### **Capacity building**

Capacity Building will be focused on technical content (contraceptive and terminal FP methods, immunization, birth and newborn care, infant feeding, TT), program coordination, community mobilization and behavior change, program sustainability, urban issues and identification of referral beneficiaries, for program implementers at different levels. A city–level training NGO will be hired based on expertise for specific trainings. Certain training sessions will be coordinated at the NGO and UHC level.

### **Inter-sectoral coordination**

Multi stakeholder partnerships will be developed to improve access, coverage and quality of health services for the urban poor. Coordination committees will be formed at UHC level and city level.

Each of the two committees will have representation, of different levels, from different departments of health, DUDA, Municipal Corporation, NGOs and the community. The committees will meet monthly to review the program progress and take decisions for improvement.

### **Management mechanisms**

At the UHC level, the medical officer will be responsible for management of operations under her purview. At the city level, the City Program Officer, Urban Health will manage the operational aspects of the program and work in guidance from the city program management

unit. A corresponding State Program Management Unit will support the city programs, seeking collaboration from the inter-sectoral coordination committee at the state level.

### **Fund flow**

The fund transfer will be from GOI to the state RCH society and then to the corresponding body at district level. From the district RCH body, it would be transferred to the urban health account and then to the implementing agencies.

### **Monitoring mechanisms**

The effectiveness of the program will be measured in terms of the change the program is able to bring in the target population, i.e., the urban poor of the city. The baseline and endline surveys will be conducted by an external agency. A monthly reporting mechanism at different operational levels will be followed through review meeting and monitoring formats.



# Summary of the Five-Year Urban Health Proposal (under RCH II) for Haridwar

The 2001 Census proves that cities and particularly urban slums are the fastest growing areas of the country with a decadal growth rate of 5–6% in slum areas as compared to the country's average of 2%. Health indicators for the urban poor are also far lower than what the urban average data denotes. Urban health is therefore emerging as a priority area for GOI and has found focus in the Tenth Five-Year Plan, National Population Policy, National Health Policy and in RCH II. The government of Uttaranchal has identified the cities of Dehradun, Haridwar and Haldwani for improving the public health service delivery systems within the RCH II.

The following document is a proposed plan for

*Improving the health status of the urban poor communities by provision of quality integrated primary health services in the city of Haridwar by building on available experiences and expertise in the city in relation to the identified needs of the impoverished groups.*

## **Haridwar City profile**

Spread over an area of 27 square kilometers, the city of Haridwar has a population of 2.20 lacs (including B.H.E.L population) as per Census, 2001. In addition to this, a substantial daily floating population enters the city, which is virtually overrun by pilgrims on special occasions in the year. Religious tourism is the mainstay of the city's economy.

## **Poverty situation in Haridwar**

Total slum population in the city is about 1.26 lacs (all sites). Though the city has 20 registered slum locations, there are several localities within these registered sites that are fairly better off areas, and on the other hand, several sites that have not been notified as yet. A vulnerability assessment study undertaken through a participatory methodology showed that slums were on varying levels of health vulnerability.

- Total Number of slums: 76
- Highly vulnerable: 31
- Moderately vulnerable: 35
- Less vulnerable: 10

## **Available Health Infrastructure**

In the current situation, the city has only institution-based facilities, which do not have any outreach component. District Harmilap Hospital, Women's Hospital, Infectious Diseases Hospital, TB Hospital and Female Hospital Jwalapur are health facilities available through the public sector. However, these hospitals primarily receive referrals from rural areas of Haridwar District, and the city's poor prefer and avail private sector facilities. A number of charitable organizations run dispensaries offering basic services for cure of common illnesses.

These dispensaries operate for 2-4 hours a day. Slum dwelling populations in need of in-patient health care prefer the larger charitable setup like Ram Krishna Mission. Charitable set ups offer subsidized services. No NGOs are working for health in the city.

### Health scenario in the slums

Data clearly shows that the poor are more vulnerable to mortality and morbidity than averages indicate. A child born to an urban poor family in Uttar Pradesh experiences a 90% higher probability of dying before one month of age as compared to a child born to a rich family (NFHS 1998-99 data).

Health Indicator	Low income households in Urban Haridwar, PSI, 2003	Urban Uttaranchal, NFHS, 1998-99
Percentage of children who are underweight (below – 2 SD from the median weight-for-age)	35.7 (for children U2)	42.8 (for children U3)
Percentage of children whose births were attended by skilled health personnel (Doctor/Nurse)	41.1	54.1 (38.7%-dai/TBA)
Percentage of mothers who received at least two TT injections before the birth of last child	61.1 (for children U2)	76.9
Percentage of children age 12 – 23 months who were fully vaccinated before the first birthday	42.4*	
Percentage of children age 0 – 23 months who were born 24 months after the previous birth	36.4	69.7
Percentage currently pregnant during survey	12*	2.4

\* Average for Dehradun and Haridwar

### Service delivery model

Service delivery model in Haridwar will include establishment of first tier units and strengthening of the second tier.

#### *First tier structure*

The city will be divided into six zones, with one UHC in each zone.

Five Urban Health Centers (UHC) and one sub UHC will form the first tier. UHCs for Haridwar are proposed at a facility-population proportion (1 for 20,000–40,000) owing to:

- Haridwar being spread longitudinally, which increases distances within the city
- Large influx of pilgrims' population all year round, which will be catered through established first tier

The following management set-ups are proposed for the first tier UHCs:

- Four UHCs to be managed by charitable organizations—these will be entirely new setups.
- One UHC and one sub-UHC will be managed by the Department of MHFW. In this case, the existing government health facility will be upgraded to serve as a UHC. Additional PHC, Jwalapur will serve as the UHC, and PPC premises and staff within the Female Hospital will be converted into a sub-UHC.
- Floating population, which enters the city, will be catered through UHC in Ward 1-3 and sub-UHC. These UHCs will have additional supplies to handle the load of floating population. The Urban Health Office will provide support on IEC activities and developing strong linkages with municipality for sanitation near Ghats and Melas on special occasions.

Package of services at the first tier will include:

- Antenatal care and post-natal care, referrals for institutional deliveries, immunization, family planning, inserting IUD, referral for terminal methods
- Lab services, treatment for minor ailments including RTI/STI, depot holder for contraceptive and ORS
- Health education and outreach through ANMs and link volunteers, services under DOTS, NMCP, etc., and demand generation — through targeted IEC and training. This will be done in partnership with private sector (NGOs) with social mobilization and communication expertise/skills

### ***Second Tier Structure***

The following second tier units are proposed for the city:

- Additional PHC, Jwalapur will be upgraded and strengthened for services as second tier referral unit.
- One partnership will be done with a private not-for-profit institution to provide subsidized services to referred patients from UHC. Ram Krishna Mission Hospital is being explored for this purpose.
- The second tier facilities will have the infrastructure (human resources and equipment) for deliveries (including emergencies), obstetric care, terminal family planning methods, MTP services, child and newborn care, and first aid.

### **Community mobilization and linkages**

Community linkages will be strengthened through link volunteers and Community Based Organizations — “Mahila Arogya Samitis.” The task of identification/formation and capacity building of link volunteers and Mahila Arogya Samitis will be contracted to NGOs.

The link volunteer will be a slum woman appointed to over 150–250 households. She will perform the tasks of tracking antenatal care and immunization, support outreach camps, represent the community in UHC advisory committee, conduct group counseling sessions, follow-up for promoting healthy behaviors, support community in linking with other health services (such as sanitation) and referral services, promote Mahila Arogya Samiti in the Basti and refer cases to UHC. An honorarium of Rs 500 per month will be provided to each link volunteer. The Mahila Arogya Samiti will ensure a broader base of capacities and collective effort at the slum level.

The link volunteer will also serve as a depot for various contraceptive methods. She will be equipped (through training provided by NGOs) to handle queries that arise (before and after) regarding the usage of different FP methods, and promote contraception and terminal method adoption.

### **Outreach plan**

Outreach plan will include “fixed day in a week approach.” Focus will be on the highly and moderately vulnerable slums. Fortnightly camps will be conducted in highly vulnerable slums. A medical officer will provide curative services once a month in highly vulnerable slums. Three teams from each UHC will conduct outreach camps on a fixed day in a week. Twelve outreach camps will thus be conducted through each UHC every month. Mobility support for camps will be provided through hired vehicles. Outreach will include immunization, antenatal services, first contact curative care, health education, counseling, identification/screening of leprosy and blindness, referrals. The package of services at the outreach sessions would be aimed at “total health” — identification, cure and prevention. Specific healthy behaviors, which will be promoted during the camps, include adoption of birth spacing methods, feeding of colostrum, child immunization, TT.

### **Referral mechanisms**

Referrals to second tier units will be through UHCs. A Pink referral card will be issued to identify poor patients. Services at the private second tier referral unit will be provided to pink referral card holders at rates negotiated between the DOMHFW and the private not-for-profit hospital. The department will be reimbursing the private facility the subsidy that it gives to the patient (not more than the prevailing government rates for the same service).

### **Information, education and communication/behavior change communication**

IEC/BCC strategies will be adopted for information about location of UHC, outreach camps, appropriate antenatal care, delivery, postnatal care, new born care, infant health, and immunization and family planning methods. IEC and BCC activities will be undertaken by the first tier units as well as link volunteers and Mahila Arogya Samitis.

### **Capacity building**

Capacity building will be focused on technical content (contraceptive and terminal FP methods, immunization, birth and newborn care, infant feeding, TT),, program coordination, community mobilization and behavior change, program sustainability, urban issues and identification of referral beneficiaries, for program implementers at different levels. A city–

level training NGO will be hired based on expertise for specific trainings. Certain training sessions will be coordinated at the NGO and UHC level.

### **Inter-sectoral coordination**

Multi stakeholder partnerships will be developed to improve access, coverage and quality of health services for the urban poor. Coordination committees will be formed at UHC level and city level.

Each of the two committees will have representation, of different levels, from different departments of health, DUDA, municipal corporation, NGOs and the community. The committees will meet monthly to review the program progress and take decisions for improvement.

### **Management mechanisms**

At the UHC level, the medical officer will be responsible for management of operations under her purview. At the city level, the City Program Officer, Urban Health will manage the operational aspects of the program and work in guidance from the city program management unit. A corresponding State Program Management Unit will support the city programs, seeking collaboration from the inter-sectoral coordination committee at the state level.

### **Fund flow**

The fund transfer will be from GOI to the State RCH Society and then to the corresponding body at district level. From the district RCH body, it would be transferred to the urban health account and then to the implementing agencies.

### **Monitoring mechanisms**

The effectiveness of the program will be measured in terms of the change the program is able to bring in the target population, i.e., the urban poor of the city. The baseline and endline surveys will be conducted by an external agency. A monthly reporting mechanism at different operational levels will be followed through review meeting and monitoring formats.



# Summary of Five Year-Urban Health (Under RCH II) for Haldwani

The 2001 Census proves that cities and particularly urban slums are the fastest growing areas of the country with a ten-year growth rate of 5–6% in slum areas as compared to the country's average of 2%. Health indicators for the urban poor are also far lower than what the urban average data denotes. Urban health is therefore emerging a priority area for GOI and has found focus in the Tenth Five-Year Plan, National Population Policy, National Health Policy and in RCH II. The Government of Uttaranchal has identified the cities of Dehradun, Haridwar and Haldwani for improving the public health service delivery systems within the RCH II.

The following document is a proposed plan for

*Improving the health status of the urban poor communities by provision of quality integrated primary health services in the city of Haldwani by strengthening the health infrastructure, services and capacities in the city in relation to the identified needs of the impoverished groups.*

## **City profile**

Haldwani is the last city in the plains before the heights of the Kumaon Himalayas. It is for administrative and practical purposes seen along with Kathgodam as one unit. The city has had a fairly slow growth rate of 2.3% over the 1991–2001 decade (Census 2001, 129,140). The economy of Haldwani is guided by the tourist inflow and also for commercial activities influenced by it being the last railway station in the area.

## **Situation of the urban poor**

Official slum population in the city is 38,265. The field estimates show that actual health-vulnerable populations will be around 70,000. This vast difference arises primarily from the fact that a large number of poverty-stricken households live on railway land, which is not recognized as a slum. Also, there is a considerable area that has extremely unhygienic living conditions even though the economic status is not as bad as others. In these areas, a high resistance to preventive health behaviors is also noted due to widespread myths. Another notable feature in Haldwani is the location of the slums, i.e., the majority are located in the south-west areas of the city, along the railway line.

## **Existing public sector health facilities**

The DOMHFW manages two state allopathic dispensaries, one post-partum center and the female hospital. The Soban Singh Jeena Base Hospital has recently come under the administration of the Uttaranchal Forest Hospital Trust. The PPC has two ANMs and one of the SAD has an additional two ANMs attached to it.

There is also the railway clinic (primarily for railway employees) and the Dr. Susheela Tiwari Memorial Forest Hospital. The latter is an initiative of the Uttaranchal Forest Hospital Trust. However, the rates here are much more than the Base Hospital. IT provided a wide range of specialized services (also for neonates).

## Health scenario in the urban slums

Data clearly shows that the poor are more vulnerable to mortality and morbidities than averages indicate. A child born to an urban poor family in Uttar Pradesh experiences a 90% higher probability of dying before one month of age as compared to a child born to a rich family (NFHS 1998–99 data).

Health Indicator	Urban Uttaranchal, NFHS, 1998-99
Percentage of children below 35 months who are underweight ( Below – 2 SD from the median weight-for-age)	42.8
Percentage of children whose births were attended by skilled health personnel (Doctor/Nurse)	54.1
Percentage of mothers who received at least two tetanus toxoid injections before the birth of last child	76.9
Percentage of children age 0 – 23 months who were born 24 months after the previous birth	69.7
Percentage currently pregnant during survey	2.4

## Service delivery model

### *First tier*

The first tier will constitute three Urban Health Centers Locations have been determined in keeping the vulnerable slum populations in perspective. The city has correspondingly been divided in three health zones. The staff structure in the UHC comprises the medical officer, ANMS, health visitor, lab assistant, community organizer and support staff.

The first tier will be following a community health promotion strategy, implemented in the form of building linkages and community ownership of the program through the link volunteers and Mahila Arogya Samitis level by the community organizer.

The UHC’s activities will be supervised by the medical officer, and also facilitated through a UHC Coordination Forum developed at that level.

The services available at first tier will be primarily in the nature of an out-patient department and outreach in the slums. The package of services: maternal health care, child immunizations, family planning services — temporary contraception methods and referrals for permanent methods, and first-contact care for basic ailments. There will also be facilities for laboratory testing. In addition to direct service provision, the first tier will be responsible for mobilizing people for uptake of services through various IEC and BCC methods. This will be done by the “Community Organizer” proposed at each UHC. She/he will be from a social development background with community mobilization and communication expertise/skills.

### *Second tier*

The following approach will be undertaken in reference to the second tier:



- With the strengthening of first tier facilities, the OPD case load on the existing two hospitals will decrease.
- The erstwhile slaughter house in the Banbhoolpura locality will be upgraded to serve as a second tier referral unit. (This property of the Nagar Palika has been given to the department for renovation and funds are available; formal procedures are underway)
- The Female Hospital shall continue as a second tier referral unit for pregnancy related cases, and the Base Hospital will be referred to for childhood illnesses.
- The second tier facilities will have the infrastructure (human resources and equipment) for deliveries (including emergencies), obstetric care, terminal family planning methods, MTP services, child and newborn care, and first aid.

### **Community mobilization and linkages**

Community linkages will be strengthened through link volunteers and Community Based Organizations — “Mahila Arogya Samitis.” The link volunteer will be a slum woman appointed over 150–250 households. She will perform the tasks of tracking antenatal care and immunization, support outreach camps, represent the community in UHC advisory committee, conduct group counseling sessions, follow-up for promoting healthy behaviors, support community in linking with other health services (such as sanitation) and referral services, promote Mahila Arogya Samiti in the Basti and refer cases to UHC. An honorarium of Rs 500 per month will be provided to each link volunteer. The Mahila Arogya Samiti will ensure a broader base of capacities and collective effort at the slum level.

The link volunteer will also serve as a depot for various contraceptive methods. She will be equipped (through training provided by the community organizers) to handle queries that arise (before and after) regarding the usage of different FP methods, and promote contraception and terminal method adoption. Community organizers and key health staff (LHV/PHN) will be trained by an experienced private agency (NGO) partnered with at the state level.

### **Outreach activities**

The current outreach activities in the cities are undertaken through the ANMs stationed in the PPC and one SAD, under the supervision of the health visitor. Camps are held at the same site on a monthly interval for three months at a stretch. A particular site’s chance comes again after all other sites have been covered (usually after a year and a half).

The proposed outreach plan will include “fixed day in a week approach.” Focus will be on various locations within the highly and moderately vulnerable slums. The Medical Officer will provide curative services once a month in highly vulnerable slums. Mobility support for camps will be provided through hired vehicles. Outreach will include immunization, antenatal services, adoption of birth spacing methods, first contact curative care, health education, counseling, identification/screening of leprosy and blindness, and referrals.

### **Referral mechanisms**

Referrals to second tier units will be through UHCs. A Pink referral card will be issued to identify poor patients. The medical officer will ensure a follow-up of the referred patients through the Link Volunteers and the ANMs. Referrals flow will be recorded on both sides.

### **Information, education and communication/behavior change communication**

IEC/BCC strategies will be adopted for information about location of UHC, outreach camps, appropriate antenatal care, delivery, postnatal care, new born care, infant health, and immunization and family planning methods. IEC and BCC activities will be undertaken by the first tier units as well as link volunteers and Mahila Arogya Samitis.

### **Capacity building**

Capacity building will be focused on technical content (contraceptive and terminal FP methods, immunization, birth and newborn care, infant feeding, TT), program coordination, community mobilization and behavior change, program sustainability, urban issues and identification of referral beneficiaries for program implementers at different levels. A private sector partnership through a city-level training NGO will be built based on expertise for specific trainings.

### **Inter-sectoral coordination**

Multi stakeholder partnerships will be developed to improve access, coverage and quality of health services for the urban poor. Coordination committees will be formed at UHC level and city level.

Each of the two committees will have representation, of different levels, from different departments of health, DUDA, municipal corporation, NGOs and the community. The committees will meet monthly to review the program progress and take decisions for improvement.

### **Management mechanisms**

At the UHC level, the medical officer will be responsible for management of operations under her purview. At the city level, the City Program Officer, Urban Health will manage the operational aspects of the program and work in guidance from the city program management unit. A corresponding State Program Management Unit will support the city programs, seeking collaboration from the inter-sectoral coordination committee at the state level.

### **Fund flow**

The fund transfer will be from GOI to the State RCH Society and then to the corresponding body at district level. From the district RCH body, it would be transferred to the urban health account and then to the implementing agencies.

### **Monitoring mechanisms**

The effectiveness of the program will be measured in terms of the change the program is able to bring in the target population, i.e., the urban poor of the city. The baseline and endline surveys will be conducted by an external agency. A monthly reporting mechanism at different operational levels will be followed through review meetings and monitoring formats.

# Summary of Five-Year Urban Health Proposal (under RCH II) for Bally

The 2001 Census proves that cities and particularly urban slums are the fastest growing areas of the country with a decadal growth rate of 5–6% in slum areas as compared to the country's average of 2%. Health indicators for the urban poor are also far lower than what the urban average data denotes. Urban health is therefore emerging as a priority area for GOI and has found focus in the Tenth Five-Year Plan, National Population Policy, National Health Policy and in RCH-II.

Bally was selected as one of the cities in which a sample proposal is being developed as an example for planning of sustainable systems that provide comprehensive primary and secondary health care to the vulnerable urban populations. This proposal has been developed in a participatory process through technical assistance from USAID-EHP, in partnership with CINI-ASHA a Kolkata based NGO, and via active and enriching involvement and contribution of city (specifically Bally Municipality), district and state level stakeholders.

The following document is a proposed plan for strengthening and sustaining improvements in the health status of the urban poor communities by continued provision of quality integrated primary health services in the city of Bally.

## **City profile**

The city of Bally comes within the district of Howrah, West Bengal. The aggregate urban population in the district increased at 16.5% over the past decade. In comparison, the population in Bally has grown at the rate of 41.8% over the same period. Bally is distinctly marked by industries, reflected also in the sex ratio here, which stands at 746 females per 1,000 males. The city has 29 wards, distributed over three administrative zones (Bally, Belur and Liluah). Bally is one of the municipalities that fall in the Kolkata Metropolitan Development Authority (KMDA) area.

## **Urban poverty in Bally**

The official recognition of poverty comes through the BPL listing (46,768 as per SJSRY standards) or the residence in registered slum pockets (i.e., 14,429 families = 72,145). Field estimates during the vulnerability assessment exercise carried out in the city during December 2003 put the urban poverty figures at about 1.2 lakhs. The urban poor population is more or less equally distributed in the three administrative zones. However, the vulnerability assessment does show that a large proportion of slums in Belur zone are highly vulnerable (see Table).

<b>Slums</b>	<b>Bally Zone</b>	<b>Belur Zone</b>	<b>Liluah Zone</b>	<b>Total Slums</b>
Less Vulnerable	4	2	1	7
Moderately Vulnerable	27	13	25	65
Highly Vulnerable	10	23	15	48
<b>Total Slums</b>	<b>41</b>	<b>38</b>	<b>41</b>	<b>120</b>

Beginning with an official list (Bally Municipality) of 75 slums, though filed visits, interaction with local residents, mapping and validation of draft map (with slums plotted), 120 slums have been identified and mapped.

The detailed vulnerability assessment showed that majority of the poor is living in rented premises or in quarters provided by industries and mills. Sanitation facilities are abysmal here with an average of 20–25 families using one toilet.

### **Existing health facilities and programs**

#### ***In the community***

Bally has a presence of field honorary health workers recruited and trained under the health programs (of CUDP III and IPP VIII) and of sub-centers staffed by first-tier supervisors and attended by part-time medical officers on a rotational basis, at the community level. The municipality runs dispensaries. The honorary health workers (1 for 1,000 population) mobilize slum-dwelling people at their doorsteps for accessing maternal and child care facilities and family planning options. They also provide basic curative care up to two days. The HHWs are coordinated by a first-tier supervisor.

#### ***At the first tier***

The municipality manages the Liluah Charitable Dispensary, an outpatient facility with various specialists and pathology. The DOHFW have three Urban Family Welfare Centers that provide outpatient care at the first tier. These function from the second tier hospitals of the DOHFW and Bally Municipality.

#### ***At the second tier***

There are two hospitals each under DOHFW and Bally Municipality that provide maternal and/or child care in the city.

### **Health scenario among the poor in Bally**

Data clearly shows that the poor are more vulnerable to mortality and morbidities than averages indicate. Various health interventions in West Bengal and Bally have tried to counter this difference. This shows in relatively better health indicators in this part of the country as compared to other areas.

Indicator	Kolkata IPP-VIII End Line Survey in Slums <sup>22</sup> 2002		West Bengal Urban Areas NFHS <sup>23</sup> 1998-99	
	Kolkata	Low SLI	Urban	Low SLI
Percentage distribution of currently married women using contraceptive methods	75.0	71.6	73.4	69.9
Percentage distribution of currently married women using traditional methods for spacing	23.4		27.0	18.4
Unmet need for family planning services	7.3	6.5		
Percentage of women receiving complete antenatal care	54.1	49.9		
Percentage of women who had an institutional delivery for the most recent birth	89.0		79.7	51.4
Percentage of children < 3 yrs breastfed within one hour of birth	42.4		22.3	21.9
Percentage of infants 12–23 months fully vaccinated	89.2		57.7	40.9
Incidence of diarrhea in past 2 weeks among children 0–2 years	17.6		6.9	14.0

The qualitative data derived through focused group discussions in the slums, and the end-line data of the IPP VIII Kolkata has highlighted the following issues that need intervention:

- High dependence on traditional methods of contraception
- High incidence of induced abortions
- Low adoption rate of “early initiation of breast feeding” in spite of the high rate of institutional deliveries (IPP VIII end line Survey 2002)
- Relatively higher incidence of diarrhea (among 0–2 year old children) in KMDA Municipalities as compared to other IPP VIII cities(as per IPP VIII end line survey, 2002)
- Demand for services in place

### **Swarna Jayanti Shahari Rozgar Yojana Structure in Bally**

In Bally, there are three Community Development Societies formed in the three zones of Bally, Liluah and Belur. Though their activity mandate is extensive and they are registered as

<sup>22</sup> Source: India Population Project – VIII End Line Survey MoHFW, IRMS, ICMR, New Delhi 2003. The study was carried out in sample slums selected from 40 municipalities in KMDA Area where IPP 8 had been implemented. The households in the slums were disaggregated on low, medium and high SLI.

<sup>23</sup> National Family Health Survey 1998-99 re-analysis by Standard of Living Index (SLI), EHP 2003.

independent societies, the functioning has remained around collection of monthly savings of Rs. 10 from the members and organizing income-generation training for DWCUA groups.

### **Needs analysis and pointers for improving the health delivery system**

In the situation of Bally, there remain issues of how the existing provisions could be used to further the benefits to specific un-reached populations and also sustain what is visible today. The proposal keeps in perspective the following issues:

- Appropriate location of the health facilities for unhindered access to slum dwellers
- Targeting of the vulnerable slum population
- Regularity in medical services at the community level: PTMOs and medicines
- Integration of Development Programs in the city
- Strengthen and Optimize usage of infrastructure

### **Proposed plan**

#### **Service delivery model**

##### *Community level*

The honorary health workers from the IPP-VIII and CUDP-III will carry out the roles envisaged for link volunteers. In keeping with the emerging program requirements, the work roles of the honorary health workers will be redefined to conduct group mobilization activities and health promotion efforts. The existing cadre of workers of the mentioned two projects will function together within one management structure. This distribution of slum population among the workforce will be re-structured to cover Bally's population comprehensively. This team shall be distributed from three points (referred to as Urban Health Centers) spread over the three zones of the city.

##### *Women's Collectives (or Neighborhood Groups)*

The Honorary Health Worker (Group Mobilization)<sup>24</sup> will be responsible for building institutional capacities in the community so that the (present) access to services is matched by an inherent demand in the communities and a sustainable ownership of the health program.

Since SJSRY has promoted neighborhood groups among the target women of the health programs, it has been proposed that the HHW (GM) will be strengthening the NHGs per se and use their capacities and grassroots reach for health enhancement in the community.

##### *Sub-centers level activities*

The sub-centers developed through the IPP VIII project provide for the PTMOs providing OPD and RCH services on a bi-weekly basis. To ensure regularity of services from PTMOs, based on the expressed and consensus need, an additional activity linked incentive has been

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<sup>24</sup> HHW (Group Mobilization) will promote and strengthen NHGs as Health Groups.

proposed for PTMOs. Specific healthy behaviors, which will be promoted at sub-centers, include adoption of birth spacing methods, feeding of colostrum, child immunization, TT.

### ***Linkages with private informal providers***

It is envisaged that identified private informal providers or RMPs, who are accessed most frequently by slum dwellers, will be involved in the program by way of: a) strengthened linkages with HHWs, FTS and PTMOs for improved referral; b) training for FW services including counseling; and c) functioning as depot holders in identified vulnerable slums.

### ***First tier***

The three Urban Family Welfare Centers will be relocated out of the existing hospital premises to function from available infrastructure (municipal buildings) in the vicinity of slums. The activities from these centers will be supplemented by the community-level demand generation efforts by HHWs. In addition to the above, one Additional Urban Health Centers will be managed through a public-private partnership in Belur.

The services available at community level and first tier (sub-centers and UHCs) will be primarily in the nature of an out-patient department. The package of services: maternal health care, child immunizations, family planning services — temporary contraception methods and referrals for permanent methods, and first-contact care for basic ailments. There will also be facilities for laboratory testing at the UHC. In addition to direct service provision, the first tier will be responsible for mobilizing people for uptake of services through various IEC and BCC methods. This will be done in partnership through HHWs, who will be further trained in social mobilization and communication expertise/skills by specialized private NGOs.

### ***Second tier***

Bally has two municipality hospitals and two hospitals managed by the DOHFW that provide maternity services. These will be strengthened through infrastructure support (differs unit to unit) and part-manpower support. This will be supplemented with monitored referral mechanisms. The Liluah Charitable Dispensary (of Bally Municipality) is strategically located and shall be given additional support for diagnostic services through this program.

The second tier facilities will have improved infrastructure (human resources and equipment) for deliveries (including emergencies), obstetric care, terminal family planning methods, MTP services, child and newborn care, and first aid.

### **Support to developing ‘Community Sanitation Proposal’**

The Municipality will develop a strong proposal and seek a grant for improving the sanitation facilities for the urban poor and thereby ensure basic conditions for improved health status.

### **Information, education and communication/behavior change communication**

IEC/BCC strategies will be adopted for information about program issues, technical areas (appropriate antenatal care, delivery, postnatal care, new born care, infant health, immunization and family planning methods) and basic information (as location of services). IEC and BCC activities will be undertaken by the first tier units as well as HHWs and first-

tier supervisors. The Bally Municipality will seek consultancy services from experts or capable private agencies for effective IEC/BCC, with support from KMDA.

### **Capacity building**

Capacity building will be focused on technical content (contraceptive and terminal FP methods, immunization, birth and newborn care, infant feeding, TT), program coordination, group mobilization and group strengthening, behavior change, program sustainability, urban issues and identification of referral beneficiaries, for program implementers at different levels. Specialized private training agencies will be hired based on expertise for different issues.

### **Inter-sectoral coordination**

Multi stakeholder partnerships are needed for sustaining access, coverage and quality of health services for the urban poor. The success of the activities proposed in this program depends on the space provided by different departments and agencies. Coordination activities will be promoted at:

#### **State level ‘Apex Advisory Committee’**

“Municipal Level Health and Family Welfare Committee” under the supervision of the District Health and Family Welfare Samiti

#### **Urban Health Center level Coordination Forum**

### ***Sustainability***

In view of the results of the end-line IPP 8 Survey, showing high coverage of health services, the sustainability issue is critical for health intervention in the city. With this end in view, this proposal is being built on various existing platforms. The key elements of the sustainability approach for bally urban health activities are:

- Financial sustainability for meeting part of recurrent expenditures of the Urban Health Program through regular increments in the Health Development Fund at the Municipality
- Institutional Capacity at Community level that will sustain the health improvement activities in the slums
- Enhanced capacities of the Municipality to innovate, manage and monitor health promotion activities

### **Management mechanisms**

With different levels of programming, the management of the program will be carried out at different levels of functioning. These are mentioned hereunder:

- Urban Health Center Level — managed by the Medical Officer



- Municipality Level — The Health Program Cell of the Bally Municipality (with C-I-C Health, Health Officer and team) will be responsible for the daily management and implementation of the program activities
- KMDA Level — managed by the Health Unit and Accounts Cell of KMDA

### **Monitoring mechanisms**

The effectiveness of the program will be measured in terms of the change the program is able to bring in key health indicators among the target population, i.e., the urban poor of the city. The rapid baseline and mid-term assessments and a detailed end line survey will be conducted by external agencies. A monthly reporting mechanism at different operational levels will be followed through review meeting and monitoring formats. Six monthly reviews will be carried out by state level teams of experts.

### **Fund flow**

The fund transfer will be from GOI to the State DOHFW and then to Bally Municipality through KMDA. KMDA is already the agency from which part of the health expenditure in Bally (i.e., post-project expenses of IPP VIII and CUDP III) are routed and shall continue along with the additional funds of this project.

### **Budget**

The total budget for five years is Rs.1.89 crores. The State Government through departments of Municipal Affairs and Health & Family Welfare are contributing Rs.1.84 crores by way of recurring expenditure.



# Appendix 2. Guidelines for development of city-level urban slum health projects



Area Projects Division, Department of Family  
Welfare

Ministry of Health & Family Welfare

Government of India

February, 2004

(Technical Support by USAID-EHP Urban Health  
Program)



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GOVERNMENT OF INDIA  
DEPARTMENT OF FAMILY WELFARE  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011  
D.O. No. V.18012/16/2002-APS

Dated the 17<sup>th</sup> February, 2004

Dear

As you are aware, no systematic and planned efforts have been made to provide primary health care services in most of the urban areas like in rural areas due to which health indicators of urban slums are worse than that of rural areas. Therefore, Urban Health Programmes for slum / other vulnerable urban groups is one of the thrust areas in the 10<sup>th</sup> Five Year Plan, RCH II, National Population Policy and National Health Policy. Accordingly it is proposed to take up Urban Health Projects for urban slums/other vulnerable groups of population in cities identified by the State Governments. Guidelines for Urban Health Projects based upon the experience of earlier World Bank assisted IPP-VIII Project and other ongoing projects have been prepared and a copy of the Guidelines is enclosed herewith for ready reference. These guidelines inter-alia includes a proposed two tier service delivery model, types of services/activities to be considered for support and other requisite details. However, the States are allowed to make suitable modifications depending upon existing infrastructure, support available from other sources and other local need based requirements/situations. USAID-EHP is also designated as the nodal technical agency for 'Urban Health Programme'.

I would therefore request you to formulate Urban Health Projects for Urban slums/other vulnerable groups of population to provide RCH services in cities having high concentration of Urban Slum Population in your State. While formulating such projects, it may please be ensured that the existing health infrastructure i.e. Urban Family Welfare Centres, Urban Health Posts, Dispensaries, staff available therein and support available from other programmes is taken into account.

Further, since 'Population Stabilization' is the main mandate of this Department, you also need to ensure that the projects formulated lay more thrusts (at least 50%) on activities relating to Family Planning and Immunization services. You will also agree that Urban areas/ cities have a large number of Private Health Providers /NGOs. This private sector has considerable 'Capacity and Potential' which, has not been tapped as yet. I, therefore, suggest you to kindly explore the possibilities of providing services particularly Family Planning and Immunization through Public Private Partnership.

We also understand that some States have limited technical capacity and financial constraints in formulation of requisite Urban Health Proposals. Therefore, if any additional technical/financial support for getting the proposals formulated through some agencies is required, we may please be intimated accordingly. I also send a copy of the Urban Health Project for Dehradun City formulated with technical assistance by EHP-USAID for your kind perusal.

With regards,

Yours sincerely,

  
(PRASANNA HOTA)

All State/UT Secretaries/Prin. Secretaries  
Department of Health & Family Welfare

Copy to Directors, RCH, all states and UTs.



# Preface

Urban growth in India presents a daunting picture. Of India's total population of 1.027 billion<sup>25</sup>, 285 million (27.8%) live in urban areas. The percentage decadal growth of population in rural and urban areas from 1991 to 2001 is 17.9% and 31.2% respectively. The slum population in 2001 is estimated to be to the tune of 60 million<sup>26</sup>, comprising 21% of the total urban population. However, these estimates do not reflect the true magnitude of urban poverty because of the "un-accounted" for and unrecognized squatter-settlements and other populations residing in inner-city areas, pavements, constructions sites, urban fringes, etc. Undoubtedly, a significant proportion of the urban population live in slums or slum-like conditions, which seriously compromise health and sanitary conditions, putting them at a much higher morbidity and mortality risk than non-slum populations.

In order to provide guidance to the RCH II design team, GOI organized a national consultation in October 2002. Subsequently, an Expert Group on Urban Health, comprising experts from selected State Governments and donor agencies was constituted for the formulation of guidelines to enable the development of Urban Slum Health proposals by State Governments. To provide further assistance to State Governments in formulating urban health proposals and to provide concrete examples for planning of health care delivery to the urban poor in different categories of cities, sample urban health proposals for the cities of Delhi (Mega city), Agra (Million plus City), Bally (10,000 to 100,000 population) and Haldwani (population less than 1.00 lakh) are being developed through technical assistance by USAID-EHP.

These Guidelines have been developed by the Ministry with technical support from USAID-EHP Urban Health Program.

Department of Family Welfare

Ministry of Health & Family Welfare

Government of India

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<sup>25</sup> Census, 2001

<sup>26</sup> National Commission on Population, 2000, Ministry of Health and family Welfare, GoI





# Government of India Ministry of Health & Family Welfare (Department of Family Welfare)

## *Guidelines for Development of City Level Urban Slum Health Projects*

### Background

The provision of assured and credible primary health services of acceptable quality in urban areas has emerged as a priority for both the central and the state governments in view of the increasing urbanization and growth of slums and low income population in the cities. The focus till now had been on development of a rural health system having a three tier health delivery structures. While on the other hand, no specific efforts had been made to create a well-organized health service delivery structure in urban areas especially for poor people living in slums. RCH indicators of urban slums are worse than the urban average. Recognizing the seriousness of the problem, the Government of India has identified “Urban Health” as one of the thrust areas in the Tenth Five-Year Plan; National Population Policy, 2000; National Health Policy 2002 and the forthcoming Second Phase of the Reproductive Child Health Program.

### Goal & Objectives of the Urban Health Program

#### Goal

To improve the health status of the urban poor community by provision of quality primary health care services with focus on RCH services to achieve population stabilization.

#### Objective

The main objective of the program is to provide an integrated and sustainable system for primary health care service delivery, with an emphasis on improved family planning and child health services in the urban areas of the country, for urban poor living in slums and other health vulnerable groups.

#### Coverage

The latest 2001 Census data reveal that there are 423 towns/cities having a population of more than 1.00 lakh. These cities have been broadly classified into four main categories:

- i. mega cities having population more than one crore
- ii. million plus cities
- iii. large cities with population between 1-10 lakhs
- iv. towns with population with less than 1.00 lakh.

Keeping in view the type of urban health infrastructure already available in the cities and the ongoing programs already under implementation in cities by various agencies. GOI, state governments, municipal corporations, private nursing homes/hospitals, NGOs/trust run facilities, etc., the proposed Urban Health Program envisages implementation of urban health projects through a phased manner in all the states with the priority being accorded to eight Empowered Action Groups (EAGs) and the northeastern states. A tentative allocation of Rs 700 crores (now reduced to Rs. 350 crores) has been earmarked for the implementation of urban health projects in identified cities in the Tenth Five-Year Plan (2002-2007). Under the program, states are required to prioritize the cities, which bear the biggest burden of the urban slum population. In the mega cities, projects would build up on to the platform created by earlier projects such as World Bank assisted IPP VIII Projects implemented in Kolkata, Bangalore, Delhi and Hyderabad.

## Process for project development

The process of project formulation in the identified cities will inter-alia involve:

- i. situation analysis including assessment of health facilities (public/private/NGOs/Trusts, etc.) available in the city along with their functional status and type of services provided by them
- ii. consultations with multiple service providers and stakeholders in the city
- iii. identification and mapping of the urban slum population and other vulnerable groups
- iv. development of management implementation plan and budgets
- v. development of review, monitoring and evaluation mechanism.

For this purpose, it would be necessary to constitute a city level task force for formulation of the urban health project.

## Urban Health Projects

Based on the information from the above activities and identification of gaps in the existing system, urban health projects will be developed in close coordination with the city level Urban Health Task Force/Forum and the state level Urban Health Task Force. The process will also require identification of a nodal officer and establishment of a cell at the state level to plan, coordinate and supervise the urban health projects in the identified cities.

## Strategies

Urban health Projects for identified cities should include the following key strategies:

- I. Improving access to family welfare (FW) and maternal and child health (MCH) services through renovation, up-grading and re-organization of existing facilities, redeployment of available staff from state government's health department. Ongoing programs and schemes and establishing new facilities wherever required with provisions for furniture, equipment

and need-based mobility support on hiring basis and utilizing trained female volunteers at the community level. Strengthening of existing urban health infrastructure at first tier and second tier to cover all slum areas.

- II. Improving the quality of family welfare services through supervisory, managerial, technical and interpersonal skills to all levels of health functionaries including training of female volunteers to help outreach service delivery through pre-service, in-service and on-the-job training.
- III. Involving of NGOs and the private sector in various aspects of urban primary health care delivery.
- IV. Increasing the demand for family welfare services comprising modern contraceptive use, adoption of terminal methods, delivery care and child health services such as immunization and newborn care. This would be done through IEC activities and enhancing the participation of communities and municipal leaders in the design, implementation and supervision of the services.
- V. Promoting convergence of efforts among multiple stakeholders, including the private sector to improve the health of the urban poor.
- VI. Developing effective linkages between the communities and first tier service delivery points and between the first tier facilities and referral units at second tier.
- VII. Strengthening monitoring and evaluation mechanisms

### Service delivery model

Under the ongoing program of the Ministry of Health & Family Welfare, different types of Urban Family Welfare Centers (UFWCs) and urban health posts (UHPs) are already functioning in different states/UTs. The Government of India is supporting 1,083 UFWCs, 871 UHPs, 3,239 beds under the sterilization beds scheme. The post partum centers (550 at district level and 1,012 at sub-district level) supported till 2002 by GOI are now being funded by the state governments with additional support from the Planning Commission. In addition, the other programs run by state governments, municipalities, NGOs, and the private sector are also available to provide primary health care services in urban areas. In view of the different nomenclatures and types of facilities, the program envisages implementation of a uniform service delivery model by:

- a. integration of the facilities run by state governments/municipalities and other private agencies
- b. upgrading and strengthening of the existing infrastructure
- c. establishing new facilities in a rented building

Though the program envisages flexibilities in implementation of different service delivery models suiting to local situations, a suggestive model is described as under:

- The first tier (i.e., Urban Health Center) will be set up, one for a population of approximately 50,000 (the norm may be suitably modified by the state/city UH Task Force to ensure coverage and access by the most vulnerable populations) and the second tier will be the referral hospital (city/district hospital/maternity home/private and NGO nursing homes). The number of second-tier facilities would depend on the population needs, existing facilities and the geographic spread of the existing cities.
- Existing service delivery systems should be reorganized and restructured to serve a defined geographical area for a defined population. Renovation/up-grading of existing government facilities should be proposed, rather than new construction.
- The location of the UHCs, and area coverage under each should be indicated on the map.
- Potential private partners for either tier should be identified to improve the quality and standard of health among the urban poor, to capitalize on the skills of potential partners, encourage pooling of resources, and to reduce the investment burden on the government.
- Timings of UHC should be such that services can be made available to the target population at a time convenient to them. It is recommended that UHCs operate for eight hours per day. Each UHC may modify its hours after assessing the needs of their respective slums. Outreach activities should be planned at least once a week.

## Package of services

A minimum package of services should be provided in either tier. Improving quality of family welfare services entails focus on serving the mother as a complete human individual and the family as a social unit. The first tier Urban Health Center will provide only OPD services. The UHC will provide a comprehensive package of family welfare services (family planning, child health services, including immunization, treatment of minor ailments, basic lab facilities, counseling and referral to second tier) in order to encourage slum dwellers to utilize the first tier facility. The complicated referral cases and indoor services will be available only at the first referral institutions. The details of the service provision at these two levels are as follows.

### ***Urban Health Center***

- Family planning services including IUD, referral for terminal methods
- Depot holder services for contraceptive and ORS
- Child health services including immunization
- Antenatal care (urine and blood testing, TT immunization, IFA supplements, nutrition counseling, early registration, weighing, blood pressure, position of the baby, check against danger signals and identification of high-risk pregnancies, Referral for Institutional deliveries)
- Postnatal care
- Lab services
- Treatment of minor ailments

### **Support activities such as**

- Coordinate outreach activities through link workers and women's health groups
- Demand generation through targeted IEC
- Coordinate with NGOs for training of link volunteers
- Incentive/compensation for family planning acceptance

### **First Referral Center (second tier )**

- Terminal family planning methods (tubal-ligation and vasectomy)
- Institutional delivery services
- Emergency obstetric care
- MTP services
- Child and newborn care

### Human resources (staff support under the project)

Based on the vulnerability of slums, existing facilities may be relocated to ensure adequate coverage of the marginalized settlements. Efforts should be made to redeploy the existing staff from existing facilities of the state government, urban local body and ongoing programs and schemes. Any new staff will need to be appointed through contractual appointments. ANMs should be given an identified and clearly demarcated area for outreach services. Clear cut roles and responsibilities should be defined for all staff to ensure their primary and exclusive utilization for delivering quality primary health care to the target population.

Urban Health Center: Medical Officer (LMO) — 1

PHN/LHV — 1

ANMs — 3-4 @ 12000-15000 population

Lab Assistant — 1

Staff Clerk with computer skills - 1

Chowkidar — 1

Peon — 1

### First referral center

Support may be extended by the project at the referral center such as maternity homes/hospitals for engagement of specialists/part time specialists on contractual basis. No regular staff at the referral center may be supported by the project. Experiences from IPP VIII Kolkata project in hiring of part-time specialists on a fee-sharing basis and other such examples may be considered.

## Support/inputs to be funded under the program

The financial support and interventions will depend upon the specific projects received from the state governments to meet the outlined objective of providing integrated primary health care & FW services in urban areas. However, the main activities/interventions to be considered for financial support to become an integral part of such projects are summarized below.

### ***First Tier: Urban Health Center***

- Renovation/Upgrading of existing facilities
- Renting of accommodation for establishing new Urban Health Centers. This facility will include provision of space for services, office, minor OTs, lab and storeroom for equipments, etc., besides a patient waiting area.
- No new construction will be supported under the program.
- Equipments & furniture for services to be provide from the urban health center (to be ascertained through a facility survey for the existing facility and as per the standard list for the new facilities to be established).
- Support for additional manpower on a contractual basis only after redeployment of the existing staff.
- Needs based drugs and supplies (excluding supplies being made under other programs/schemes).
- Mobility support (hired vehicle for referral services, outreach camps and other activities).

### ***Second Tier: First Referral Center, i.e. maternity home/hospital***

- Renovation/Up grading of existing referral facilities
- Support for need based additional add on/lab/indoor facilities
- Equipments & furniture for services to be provided from the referral centers (to be ascertained through a facility survey for the existing referral facilities)
- Support for local contractual arrangements for part time specialist medical officer
- Needs based drugs & supplies (excluding supplies being made under other programs/schemes)

## Referral Systems

For each UHC catering to a specific population in a defined geographical area, options of second tier facilities that can provide subsidized, affordable, and quality referral services should be identified, which may be public or private. Up grading of existing facilities may be considered, and linkages with central government/state government/corporate hospitals/charitable hospitals should be promoted. Mechanisms for referrals through UHCs should be developed. It is desirable to explore options to provide second tier services through private nursing homes/charitable hospitals by entering into an agreement with them to provide services such as institutional deliveries, emergency obstetrics care, terminal methods of family planning, etc.

## Community Level Activities

To develop and maintain a link between the health facility and the community, the program envisages engagement of social community workers/link volunteers, and a female from the community able to spare 3-4 hours a day. Several programs have tried to put down eligibility conditions for the link volunteer. However, it is stressed that this is a person belonging to the slums. Therefore the emphasis is on her being acceptable to the community, preferably to be engaged through local NGOs. The need for volunteers would be reassessed periodically. Possibilities should be explored to stabilize and integrate them with other slum development schemes/activities during the life of the project so as to make the system self-sufficient after the completion of the project period.

The capacities of the link workers to facilitate health improvements in the community should be built through capacity building efforts, preferably by NGOs. Women's health groups may be formed by the link workers to expand the base of health promotion efforts at the community level and to build sustainable community processes. Capacity building should focus on family planning, maternal and child health services, so that link volunteers and women's health groups are able to promote, modern contraceptive usage, immunization and other child survival practices. Remuneration or an honorarium may be paid to the link workers. This can be managed by the engaged NGO. Efforts to stabilize link workers as well as women's health groups through linkage with slum welfare schemes. Minimizing dependence on program funding should be promoted. Activities should be aimed at fulfilling the unmet family welfare needs of the community.

**Outreach activities:** Activities that reach out to the most vulnerable and the underserved should be planned as a means of increasing usage of critical health care services and for creating rapport with the community. An outreach plan for each UHC focusing on the most vulnerable slum communities with poor health indicators should be developed. The composition of the outreach team and the frequency of outreach activities should be outlined. Mobility support for outreach activities should be planned in the budget. The outreach service package may also be outlined, but at a minimum it should *be* directly linked to promotion of family planning (oral pills, condom use, counseling for adoption of terminal methods, child health services (including immunization), counseling for household level newborn care, delivery and ANC services). Collaboration with NGOs may be planned for outreach services, if required.

**IEC/BCC activities:** Health indicators of people living in slums are poor. Demand generation IEC activities should be designed specifically to facilitate behavior change, particularly for adoption of family planning methods as well as other maternal, child health and adolescent health behaviors that are directly linked to RCH objectives. It is suggested that project strategies should: (a) focus on IEC for behavior change in RCH; (b) establish linkages; and (c) if necessary, enhance selected activities of other schemes that provide benefit to the project beneficiaries. A strategy for IEC/BCC should be developed based on the local situation. Private sector and NGO partnerships for IEC may also be promoted, particularly where potential partners with skills and proven experience in IEC/BCC are available. The IEC plans should especially focus on interpersonal or group communication plans. Include a description of expected behavior change in different audience segments, and an outline of an IEC plan with benchmarks for monitoring implementation and estimated budget. IEC plans should focus on

building community awareness and knowledge, enhancing skills to practice healthy behaviors, and strengthening confidence to access health services.

## Capacity building/training

The different agencies involved in the implementation, management, and monitoring of the proposed urban health program would need training on a range of issues at different phases of the project to handle additional responsibilities and to develop skills to work towards a desired impact. Training requirements at various levels of implementing agencies should be identified, and a capacity building plan proposed. Management capacities can include management skills, finance and accounts, evaluation and documentation skills. Program capacities may include family planning services, child health and nutrition related technical skills, follow-up, monitoring and referrals, program processes — counseling, community-based monitoring, participatory approaches, IEC and behavior change and communication approaches, linkages with health service providers, etc. Public private partnerships for capacity building should be promoted, wherever possible.

## Public-private partnership

Successful implementation of the project will require a vibrant partnership between the DOFW, GOI, state government and the urban local bodies. While the DOFW will provide technical assistance, the state government will provide leadership to the project facilitating ground implementation by the urban local bodies. The private sector can be economically and formally engaged for service delivery to fill in gaps.

There is a considerable capacity among private providers (NGOs, medical practitioners and other agencies), which should be explored and operationalized. Such partnerships are more likely to be viable in urban areas. Focusing on activities that will yield results quickly is required so that the overall objective of population stabilization within the framework of family welfare may be achieved.

Public-private partnership (PPP) initiatives based on social marketing/social franchising and other experiences in India and other countries can be tried. States may find it helpful to gather lessons learned from various experiences in the country, which would be useful to provide concrete directions for expanding PPP efforts.

There is a need to develop context appropriate public-private partnership approaches, for example:

- (i) In cities or parts of a city where first tier public sector health infrastructure (by way of Health Posts or UFWCs) is already available, a partnership with NGOs could be proposed for enhancing utilization of these existing public sector services through training link volunteers, women's groups, social mobilization and BCC
- (ii) In cities or parts of a city where no public sector first tier facility is available, the entire first tier service delivery component may be contracted out through



partnership with a charitable hospitable or an NGO or any appropriate private agency with requisite capacity.

NGOs and specialized agencies may also be contracted for activities such as identification and training of link volunteers or similar community level institutions, supporting IEC/BCC and activities, providing training on specific program issues specially those pertaining to urban poverty and carrying out baseline and end-line surveys. Private medical practitioners could also be engaged on a part-time basis for first as well as second tier facilities (based on the experience in IPP VIII in Kolkatta and neighboring cities). Second tier services (including laparoscopic tubal ligation and no-scalpel vasectomy services) and diagnostic services may be outsourced to private medical facilities on a reimbursement basis. A uniform rate list needs to be enforced for such services.

Appropriate mechanisms for partnering (or entering into agreement) with the private sector needs to be proposed, which includes accreditation methods for ensuring quality, memorandum or partnership, reporting and monitoring systems.

## Coordination and convergence with other departments and private sector

This will focus on developing/strengthening mechanisms for effective linkages and coordination between various departments and the private sector for improving access to quality health care services (e.g., sanitation, drainage and water services). Coordination mechanisms should be proposed at the health center level, city level and state level. At the Urban Health Center and city level, a UHC level coordination forum and city level coordination forum respectively may be constituted to facilitate effective linkages and coordination between various departments, the private sector and the community. At the state level a monitoring committee/task force under the chairmanship of the Secretary of Family Welfare with representation from other departments to review and monitor the progress of implementation and a governing council under the chairmanship of the Chief Secretary comprising secretaries of the other concerned departments, ministries, NGOs, donor agencies and GOI and other stakeholders to oversee the program implementation, approval of plan of action, budget and inter-sectoral coordination needs to be set up. The governing council would meet once in six months as required and would issue necessary directives for inter-departmental coordination and release of funds.

## Management, monitoring and time-plan

**Time plan:** Define a time plan for each activity for a five-year period.

**Monitoring and evaluation plan:** The M&E plan should include an appropriate process for benchmarking, development of urban HMIS consistent with the national MIS, mechanism for monitoring of key processes and results, pertaining to promotion of family planning and child health services, and periodic assessments of field activities and an end-line evaluation. The baseline indicators may be estimated by using the data already available from District Health Survey reports, or other available reports. Benchmarking should specially focus on contraceptive usage, terminal methods adoption, immunization coverage, TT coverage, delivery care and infant care. A first tier facility monthly monitoring of key processes and

outcomes by the City Program Management Unit is envisaged. A quarterly progress compilation at the state level is envisaged to be sent to GOI. In-depth six-monthly reviews and a mid-term rapid assessment are also envisaged to ensure timely achievement of results and make mid-course corrections as required. State level review/empowered committee may include representatives from GOI and the donor agency (if applicable).

**Management and HR plan:** While formulating projects, urban health programs supported by other donor agencies and NGOs as well as activities supported through other programs will also be taken into account to ensure that there is no duplication of efforts in the same area. The roles of management units and key staff at each level will be clearly stated. A State Program Management Unit may be established for the periodic review of program implementation and to undertake discussion and decisions on UH program activities. A City Program Management Unit at the city level to review and strengthen program implementation should be established at the ULB wherever possible. A State UH Program Officer may be responsible for guiding and coordinating the UH program in various cities of the state. A City UH Program Officer shall be the nodal official for the implementation of the UH program at the city level. In addition, support staff may be requested based on requirements. All new positions under the urban health program would be contractual. Existing staff re-deployed in various capacities for the urban health program would continue to get their salaries from their original program/scheme.

**Fund flow mechanism:** The funds will be released to the state government or state RCH society who in turn will release funds to the implementing authority within one month of the receipt of funds. At the state level, health & FW department will be the nodal department for implementation of Urban Health Program, overall coordination, collection of SOEs from implementation agencies and their onward submission to the GOI, audit, etc.

**Budgets:** The budget should be developed for activities defined in the proposal based on the above stated broad guidelines to justify resource requests, keeping in view that the focus remains on family planning acceptance and child health services. The project should indicate component-wise and year-wise budgets separately for activities linked directly with family planning and child health services.

## Cost recovery mechanism and sustainability

Mechanisms for cost recovery may be built as an integral part into the proposal. However, this should be based on the principle of inclusion of the poorest. The experiences of the Kolkata IPP VIII project in cost recovery may be drawn upon as a good example. Under IPP VIII, Kolkata levied differential user charges on services provided, which was put in a corpus fund and utilized for sustaining the project activities after the project period. Such a corpus urban health fund at the city level is envisaged to be steadily built to partially sustain the recurrent costs that occur after project completion. Such a fund can be built through several sources of contributions, which inter-alia include: portion of user charges (from middle class and upper class families) from diagnostic services, surgeries, etc., at second tier, registration fees/family health card charges from all families collected at first tier and during outreach camps, donations from business houses, individuals, banks, etc., appropriation received from the National Slum Development Program of GOI (ULB can access five times the amount generated at the local level by communities from NSDP), and portions of lease and rental income from municipal or other public sector buildings. A mechanism for periodically monitoring the progress of such a

corpus fund should be put in place. In addition to the corpus health fund: a) institutional capacity at community level (through federation of community groups for linkage with Swarna Jayanti Shahari Rozgar Yojana<sup>27</sup> (sponsored by Ministry of Urban Development, GOI) CDS scheme<sup>28</sup>; and b) enhancing the capacity of the Urban Local Body to plan and manage such programs are approaches towards sustainability.

## Recurrent Costs

As regards the costs of a new Urban Health Center, the indicative costs of inputs based upon the IPP-VIII experience are as follows:

I. Category of Personnel (Each health center)	No. of post Sanctioned	Recurrent/ Capital	Monthly Exp.	Annual Expenditure
1) Lady Medical Officer	1	Recurrent/	12600/-pm	1,51,200
2) LHV/PHN	1	Recurrent/	6,500/-pm	78,000
3) ANMs	3	Recurrent/	5,500/-pm	1,98,000
4) Link workers	10	Recurrent/	500/-pm	60,000
5) Security Guard		Recurrent/	4,000/-pm	48,000
6) Clerk	1	Recurrent/	5,000/- pm	60,000
II . Annual maintenance of equipments, Furniture etc.,Each health center		Recurrent/		10,000
III Electrical, Water, Building Charges etc.,		Recurrent/		50,000
IV . Building Maintenance charges (Repair & Painting)		Recurrent/		1,00,000
V . Drugs *		Recurrent/		30,000
VI . Training		Recurrent/		1,00,000
VII . IEC materials		Recurrent/		10,000
VIII. Hiring of Vehicles		Recurrent		1,75,000
<b>GRAND TOTAL</b>		<b>Recurrent</b>		<b>10,70,200</b>

\* Funding for drugs may be estimated keeping in view the free supply of drugs and supplies received from GOI. However, state governments are to ensure that Urban Health Centers get adequate supplies of vaccines, contraceptives, drugs and other consumables as part of the supplies received from GOI.

<sup>27</sup> The Swarna Jayanti Shahari Rozgar Yojana of GOI directly targets the people below the poverty line (BPL) in urban India. 30 % beneficiaries of the program should be women, while 3 % should be the disabled.

<sup>28</sup> A Neighborhood (NHG) is an informal association of 10 to 40 women living in close proximity, who select one or more women volunteers from amongst themselves as Resident Community Volunteers (RCV). A Neighborhood Committee (NHC) is a formal association of all women from various Neighborhood Groups within the same electoral area, with the RCVs as their representatives. A Community Development Society (CDS) is a federation of NHCs sharing common goals and objectives at the ward, zone or city level. The CDS is the nodal agency through which all scheme based and institutional finance is channeled.

## Equipments & Furniture

Equipments		Non recurrent		10,00,000
Furniture		Non recurrent		1,00,000
<b>GRAND TOTAL</b>				<b>21,70,200</b>

The cost for renovation and upgrading the existing facility into an Urban Health Center will be in the range of Rs.2-3 lakhs. The rent for a new facility will cost around Rs.50,000 — Rs.120,000 per annum (depending on the city standards). As regards the cost of services to be provided at the referral center and through public-private partnerships, the cost would depend upon the specific interventions to be supported and the agreements reached with the private institutions. **The above costs are only indicative in nature and state governments may make suitable changes wherever necessary based on local needs/conditions.**

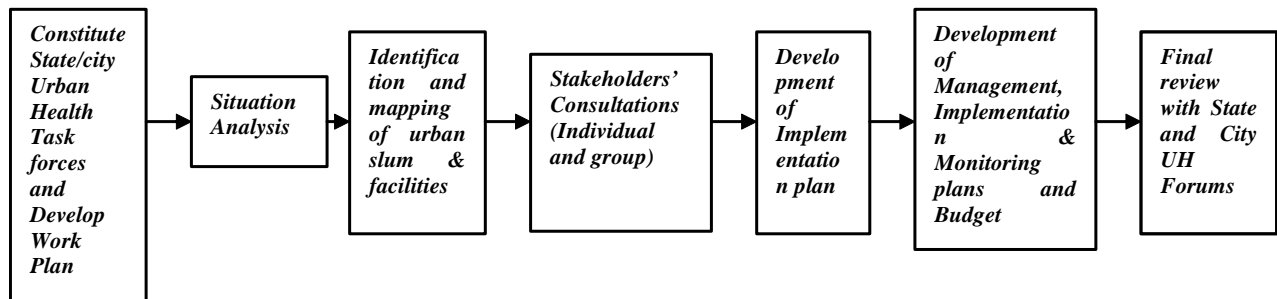
The project should clearly indicate costs involved (component-wise) separately for first tier (i.e., Urban Health Center civil works, furniture, equipment, drugs, IEC, training and staff — whether regular or contractual). The costs of support to be provided at second tier may also be indicated separately. **No new construction is permissible.**

## Project Implementation

It is desirable that Urban Health Projects are approved, monitored and reviewed at the state level by an appropriate committee. At the state level a nodal officer/cell may be identified to be vested with the responsibility of Urban Health Program. At the city/municipality level, a project coordinator should be appointed so as to ensure proper implementation of the project, monitor the project activities, and submit a monthly financial and physical progress report to the city executive committee/task force and to the state government. The state government should submit quarterly physical and financial progress reports of the Urban Health Projects to the GOI.

# Annex I. Process for project development

This illustration depicts the recommended road map to development of urban health proposals for identified cities.



## Stakeholders' consultations

There are multiple service-providers and stakeholders in a city. These represent government systems, civil society institutions and informal groups. The urban health proposal for the city should be built on the existing resources in the city (infrastructure as well as human). The involvement of the various stakeholders will enable the fulfillment of the specified objectives below.

## Objectives of stakeholders' consultations

- Identification of the stakeholders in the city: NGOs, community based organizations, and other partners who can play an active role in promoting urban health.
- Understand the present role and experiences of various stakeholders in improving the health of the urban poor and explore their possible roles in the urban health program.
- Constitution of an urban health task force at the state level and a city-level group as “urban health coordination forum.” These platforms may be constituted under the chairpersonship of an appropriate official, who will facilitate effective participation from the officials of the concerned departments.
- Strengthened mechanism for inter-sectoral coordination among various departments at the state/city and decentralized levels of the health center.
- Develop program directions based on collective thinking and discussions between all groups so that concerned people develop a stake and ownership about the program.

## Key sub-steps to be undertaken

A series of consultations need to be conducted with the stakeholders involved:

### ***Public sector***

- Department of Public Health (state-level, city-level and grass root functionaries)
- Urban Local Body (municipal corporation/ municipality officials) – responsible for water supply, sanitation, drainage and overall governance issues. The meetings should include directly designate officials as well as elected ward members.
- Department of Women and Child Development (state, city and grass root functionaries)
- Employees State Insurance Services (ESI)

### ***Private/Nongovernmental sector***

- NGOs
- Community Based Organizations
- Private providers (like private practitioners — registered/unregistered, traditional practitioners of Indian Systems of Medicine and Homeopathy, charitable hospitals, private for profit sector, corporate sector)
- Private nursing homes/hospitals

There may be certain meeting schedules decided between different levels (e.g., Anganwadi workers with supervisor, medical officers with chief medical officer) which could be used as forums for small discussions. In addition, there will be a need to have specific individual meetings, small group meetings and large group consultations at all levels.

## Situation analysis

An assessment of primary health care needs of the urban poor of the city, description of all existing health services run by public and private sector including nonprofit organizations along with their functional status and services being provided by them will be the critical information base for program development and planning.

### ***Key issues that need to be covered under this section***

- **Development indicators** pertaining to the cities (slum population (ward-wise if available), density, growth rate, literacy, etc.)
- **Indicators of MCH care** (ANC coverage, intra-natal coverage, nutritional indicators, morbidity indicators, family planning indicators, reproductive morbidity indicators)
- **Health facility survey:** List of government and nongovernmental (including private for profit sector) health care delivery institutions in urban areas (Hospitals, Dispensary, UFWC, health posts, Anganwadi centers, nursing and maternity homes) with available beds, posts sanctioned — filled — vacant, facilities

- available, equipment supplied — functioning/nonfunctioning; services being provided and referral linkages, if any.
- **Utilization** of Government Services (ANC, abortion/MTP, treatment for morbidity, FW services, bed turnover rate, bed occupancy ratio, OPD attendance, operations/delivery performed)
  - **Availability** of inventory management systems, client record systems, IEC materials
  - **Behavioral indicators** (reasons for nonutilization of services, awareness on RCH/RTI/STI, quality of care at service delivery centers)

### ***Identification and mapping of target population***

This task involves the identification of underserved and unrecognized slums for better targeting of efforts. A map depicting the location of the urban slum population across the city, the major health providers and other stakeholders would be developed to guide the implementation plan and serve as a monitoring tool. This will help define the catchment areas for first tier urban health facilities (existing<sup>29</sup>, or newly proposed) and outreach of health to underserved slum areas.

The underserved and needy urban slum dwellers in each city will be identified to adequately target the needy for optimum impact. This will be done using available data and appropriate methods.

- Mapping of slums, major health providers (both public and private) and other urban health stakeholders on the city map
- Identification of the underserved slums including the “un-recognized” settlements
- Categorization of slums based on different degrees of vulnerability to better target the program

### ***Key steps in the process***

- Build a list of all slums. This could be done through accessing slum lists: municipal lists, Slum Clearance and Rehabilitation Act list, slum lists from the district collector/magistrate’s office, list at mayor’s office or prepared by any developmental agency. It is possible that these lists will not include unregistered poverty pockets, and these can be identified through site visits and discussions with local people.
- Visit bastis of different levels of development to have a first hand understanding and infrastructure mapping (facility and manpower).
- Develop criteria to distinguish the most needy population based on available data from the situational analyses. Classify urban slums and triangulate with stakeholders.

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<sup>29</sup> Existing health facilities could be in the form of Urban Family Welfare Centers, Health Posts, Health Check Posts, State Allopathic Dispensaries, Civil Dispensaries or Post-partum Centers.

- On a city map, mark the location of all slums and health providers /facilities.



# Annex II. Outline<sup>30</sup> of Five-year Proposal for Urban Health Program under RCH II

(Name of City)

Abbreviations

Executive Summary

## 1. Background

1.1. Overview of the Process

1.2. City Profile

1.3. Situation of the Urban Poor

1.4. Health Infrastructure in the city

1.5. Public Sector

1.6. Charitable Organizations

1.7. Non Governmental Organizations

1.8. Health Scenario in the Urban Slums

## 2. Objectives and key strategies

2.1. Goal

2.2. Objectives

2.3. Key Strategies

## 3. Service Delivery Model

3.1. Outreach service at grassroot level

3.2. First Tier

3.3. Second tier

## 4. Activities

4.1. Establishing/Strengthening First Tier

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<sup>30</sup> This is an indicative outline which can be modified based on the activities being proposed.

- 4.1.1. Location/relocation plan of Urban Health Centers
- 4.2. Upgradation of First Tier
  - 4.2.1. Map and re-define catchment areas of health facilities
  - 4.2.2. Collaboration with charitable organizations/NGOs for new UHCs
  - 4.2.3. Package of services
  - 4.2.4. Additional Roles of Urban Health Centers
  - 4.2.5. Cost recovery mechanism
  - 4.2.6. Human Resources
  - 4.2.7. Timings of Urban Health Center
- 4.3. Link Volunteers
  - 4.3.1. Process of identification
  - 4.3.2. Roles
  - 4.3.3. Remuneration/honorarium
  - 4.3.4. Training
  - 4.3.5. Federation of Link Volunteers
- 4.4. Women's/community Health Committee
  - 4.4.1. Process of promotion of Women's/community Health Committee
  - 4.4.2. Desired characteristics of members of Women's/community Health Committee
  - 4.4.3. Roles of the Women's/community Health Committee
- 4.5. Outreach Activities in Slums
  - 4.4.1 Outreach Plan
    - 4.5.1. Frequency of Outreach camps
    - 4.5.2. Guiding Principles for Outreach
    - 4.5.3. Camp Team
    - 4.5.4. Mobility Support
    - 4.5.5. Package of services

- 4.5.6. Collaborating with NGOs for outreach
- 4.6. IEC/BCC and Social Mobilization Activities
  - 4.6.1. Strategy
  - 4.6.2. Key Issues for IEC/BCC
- 4.7. Strengthening of second tier Referral facilities
  - 4.7.1. Location of second tier facilities
  - 4.7.2. Strengthening of second tier facilities
  - 4.7.3. Strengthening of human resources
  - 4.7.4. Procedure to establish referral linkages from first tier to second tier
- 4.8. Capacity building/training
- 4.9. Referrals to second tier institutions
  - 4.9.1. Package of services
  - 4.9.2. Mechanism of referral
  - 4.9.3. Form of support to be provided to second tier private facilities
- 5. Inter-sectoral coordination
  - 5.1. Mechanisms
    - 5.1.1. UHC level coordination forum
    - 5.1.2. City level coordination Forum
- 6. Monitoring and Evaluation Plan
  - 6.1. Committee at state/city level
  - 6.2. Source of information
  - 6.3. Results framework
  - 6.4. Monitoring plan including surveys
  - 6.5. Mid-term and end-line evaluation plan
- 7. Management arrangements

8. Fund flow
  - 8.1. Fund flow mechanism
9. Roles and responsibilities
  - 9.1. Roles of the State Program Management Unit
  - 9.2. Roles of the City Program Management Unit
  - 9.3. City Unit for Inter-sectoral coordination
  - 9.4. State program officer (Urban Health)
  - 9.5. City program officer (Urban Health)
10. Budget
11. Time plan
12. Description of urban health proposal development process
  - 12.1. Steps and key activities
  - 12.2. Important sources of information
  - 12.3. Lessons and recommendations

## Annex III. Outline of Budget Proposal for Urban Health Program under RCH II

	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	<b>Staff salaries</b>						
2	<b>Honararium to Link volunteers</b>						
3	<b>Strengthen Urban Health Infrastructure</b>						
	Medical stores/Medicines						
	Urban Health Centers						
	Non recurrent						
	Recurrent						
4	<b>Capacity Building</b>						
	Capacity Building						
	IEC/BCC activities						
5	<b>Partner NGO Operational Costs</b>						
6	<b>Outreach activities</b>						
7	<b>City Program management cost</b>						
8	<b>Upgradation of on Urban Post</b>						
	<b>TOTAL</b>						

Year 1 link volunteers honararium at 50% level



## Annex IV. For Reference

Other city urban health experiences may be visited or related documents may be referred to for learning and ideas for developing a comprehensive urban health proposal that optimizes the resources and inputs into the program. Synopsis of some such experiences are provided here.

*“If We Walk Together: Partnerships for Health in Hyderabad,” India*

### **Communities, NGOs, and Government in Partnership for Health —The IPP VIII Hyderabad Experience**

#### Summary

In the slum communities of the city of Hyderabad, the capital of the southern Indian state of Andhra Pradesh, a remarkable partnership is taking place between the women of the slums, nongovernmental organizations (NGOs), and government health workers. These three groups have joined together to work toward improving the health and well-being of women and children in some of the poorest neighborhoods of the city. This partnership is occurring under the Government of India's Family Welfare Urban Slums Project (in Bangalore, Calcutta, Delhi, and Hyderabad), also known as India Population Project VIII (IPP VIII). This World Bank-supported project is collaborating with NGOs and communities to make a qualitative change in the lives of women and children who live in the slums of four major Indian cities.

Link Volunteers do not receive individual payment for their work. Instead, their communities are given a financial incentive through women's health groups and community revolving funds. This money has enabled the women of the slums—perhaps for the first time—to finance improvements in their neighborhoods. They have used these seedling funds to improve civic amenities, such as sanitation systems, wells, and toilets, and to establish income generation schemes, such as tailoring centers. NGOs help the women identify and carry out these initiatives.

The IPP VIII experience in Hyderabad is exceptional because it has succeeded in gaining an unusually high extent of both NGO and community participation and has shown strong health-related results. There are 22 NGOs delivering family planning and maternal and child health services in 662 slums of the city, with each NGO having autonomous authority over all project activities in 20 or more slums. Women from the communities have formed 586 women's health groups (WHGs) and more than 5,500 have become Link Volunteers. Thousands of other community members have joined the project's innovative schemes, such as workshops for first-time mothers, nutrition education programs for girls, and nursery schools for children. Since the start of the project in 1994, outpatient registration has increased from about 615,000 to 908,000, the rate of institutional deliveries from 70% to 84%, and prenatal care coverage from 91% to 95%.

This booklet describes the partnership between the government, communities, and NGOs. It examines NGO and community involvement in Hyderabad and explains how the partnership functions and how, by using an integrated development approach, the partnership helps the project reach the women and children of the slums. It elaborates on the roles of the Link Volunteers, women's health groups, and NGOs and provides details on IPP VIII activities and the other community development schemes begun by the project. Engaging people's participation in a development project is not an easy process. Few projects have been able to achieve meaningful involvement of communities, and even fewer have tapped the potential of NGOs. This booklet describes how IPP VIII in Hyderabad has been able to succeed. It identifies some of the factors that enabled IPP VIII in Hyderabad to engage both communities and NGOs, making partnership with the people a reality.

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### ***Delivering Primary Health Care for Urban Poor through Partnership with Charitable Hospital***

*Dr A C Baishya, Guwahati Medical College*

This presentation focuses on the experiences of a partnership with a charitable hospital for the delivery of primary health care services to slum populations in Guwahati.

## Main Highlights

- The Marwari Maternity Hospital, run by a Charitable Trust since 1986, evinced a strong interest in providing RCH outreach services. The hospital has a good infrastructures (100 beds) and manpower.
- The Trust entered in Agreement with Health & Family Welfare Department, Government of Assam, under the Sector Investment Program following services in selected slums.
- Immunization of children and pregnant women, routine antenatal care, basic laboratory services, delivery of pregnant women in the M.M. Hospital from the slums including surgical interventions, family planning services , MTP service for women from the selected slums, and treatment of children and adult in the sites.
- Commitment from the Government of Assam under SIP
- Free supply of Vaccine, contraceptives, other RCH Kits as available in Health services.
- Capital investment for hospital equipment, furniture, vehicle from SIP.
- Expenditures on mobility of staff for sessions, contingencies, POL.



- Regular fund flow to the trust against achievements.
- Supportive supervision.
- Responsibilities of Marwari Maternity Hospital were:
  - Provision of medical, paramedical — staff for the sessions and their payment.
  - Provision and maintenance of existing infrastructures, equipment for outreach patients. Senior Doctors, nursing staff with vaccines, other logistics attend the camps.
  - Mobility support for the team by the SIP funds.
  - Concessional rate (25% less) for the patient coming from slums under this agreement
- Experiences in the Public-Private Partnership Sessions are held every fortnight in each of the 14 sites in 8 selected wards.
- Local NGO, Clubs, social organization are mobilizing the people and help in holding the sessions providing sites.
- Local volunteers motivate, organize, inform community.
- Beneficiaries from the outreach act as motivators organizers in the slums.
- Lessons learned
  - Regularity of sessions to maintain the faith of the community.
  - Commitment of doctors to serve the slums.
  - Sessions are held in few locations in private establishments with support from the community.
  - Uniform services/reporting in session sites.
  - Involvement of local volunteers, NGOs to extend reach in the community.
  - Baseline information with beneficiaries to determine the coverage.
  - Permanent community contact necessary.

## Challenges

- Present success is dependent only on commitment of few doctors.
- Outreach service team building necessary.
- Potential clients of services not known in sessions.
- Assessment of service coverage not possible for baseline information.
- Non-availability of regular community contact.
- Communication to session sites.
- Frequent changes in management in Trust

- Urban Health Management Society under chairmanship of Deputy Commissioner in Guwahati constituted.
- Getting a good response from MM Hospital contract, outreach services are being extended to entire city utilizing existing health infrastructures from current month.
- Engagement of field level contact (ANM) to keep record of beneficiaries/coverage of services done.
- Involvement of local NGO, volunteers in IEC, organization strengthened.
- Consultant (Public Health) engaged under this contract to track achievement and developing more local responsive program/activities.
- Trust management has exclusive committee for outreach and extending services to other slums/peri-urban areas of the city.
- Hospitals with indoor facilities in different slum localities are planned by the district administration under SIP/Urban Health