

**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*

Revised: April, 2005

[Technical Support by USAID-EHP Urban Health Program]



Prasanna Hota
Secretary

Tel. : 23018432

Fax : 23018887

e-mail : secyfw@nb.nic.in

pruhota@hotmail.com

भारत सरकार
परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011

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 17th 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 10th 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'.

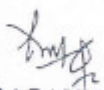
I would therefore request you to formulate Urban Health Projects for Urban slums/other vulnerable groups of population to provide RCH services in cities having high concentration of Urban Slum Population in your State. While formulating such projects, it may please be ensured that the existing health 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)
07/2

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 1027 million¹, 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 percent respectively. The slum population in 2001 is estimated to be to the tune of 60 million², comprising 21 percent 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.

Ministry of Health & Family Welfare
Government of India

¹ Census, 2001

² National Commission on Population, 2000, Ministry of Health and family Welfare, GoI

**GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE**

**GUIDELINES FOR
DEVELOPMENT OF CITY LEVEL URBAN SLUM HEALTH PROJECTS**

1. 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 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 2nd Phase of the Reproductive Child Health Program.

2. 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.

3. 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 4 main categories viz. i) Mega cities having population more than one crore ii) Million plus Cities iii) Large Cities with population between 1-10 lakhs and iv) Towns with Population less than 1.00 lakh. Keeping in view the type of Urban health infrastructure already available in the cities and the on going programmes already under implementation in cities by various agencies viz. GOI, State

Governments, Municipal Corporations, Private Nursing Homes/ Hospitals, NGOs / Trust run facilities etc., the proposed Urban Health Programme envisages implementation of Urban Health Projects a phased manner in all the states with priority being accorded to 8 Empowered Action Group (EAG) 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 10th Five Year Plan (2002-07). 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.

4. 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 urban slum population and other vulnerable groups, iv) Development of management implementation plan and budgets and 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.

5. 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 / establishment of a cell at the State level to plan, coordinate and supervise the Urban Health Projects in the identified cities.

5.1 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-gradation and re-organization of existing facilities, redeployment of available staff from State Govt's Health Dept. and ongoing programs and schemes and establishing new facilities wherever required with provision of 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 skill 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 usage, adoption of terminal methods, delivery care and child health services such as immunization and new born 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 1st Tier service delivery point and between the 1st Tier facility and referral units at 2nd Tier.
- vii. Strengthening Monitoring and Evaluation mechanisms

5.2 Service Delivery Model:

Under the ongoing program of the Ministry of Health & Family Welfare, different types of Urban Family Welfare Centres (UFWCs) and urban health posts (UHPs) are already functioning in different States/UTs. The Government of India is supporting 1083 UFWCs, 871 UHPs, 3239 beds under sterilization beds scheme. The post Partum centres (550 at district level and 1012 at sub-district level) supported till 2002 by GOI are now being funded by the State Governments with additional support from Planning Commission. In addition, the other programs run by State Governments/Municipalities/NGOs/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 / strengthening of the existing infrastructure, and c) establishing new facilities in rented building.

Though the programme 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 Centre) will be set up, one for approximately 50,000 population (the norm may be suitably modified by the State / City UH Task Force to ensure coverage and access by the most vulnerable populations) and 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 system should be reorganized and restructured to serve a defined geographical area for a defined population. Renovation / up-gradation of existing Government facilities should be proposed, rather than new constructions
- 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 8 hours. Each UHC may modify its timings after assessing the needs of the slums it is catering to. Outreach activities should be planned at least once a week.

5.3 Package of Services:

Minimum package of services should be provided in either tier. ***Improving quality of Family Welfare services entails focus on serving the mother as complete human individual and 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 2nd Tier) in order to encourage slum dwellers to utilize the 1st 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 under: -

5.3.1 Urban Health Centre

- ≈ 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

5.3.2 First Referral Centre (2nd tier)

- ≈ Terminal Family Planning Methods (tubal- ligation and vasectomy)
- ≈ Institutional Delivery services
- ≈ Emergency Obstetric Care
- ≈ MTP services
- ≈ Child and Newborn care

5.4 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 Govt, Urban Local Body and ongoing programs and schemes. Any new staff will need to be appointed through contractual appointment. 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.

<u>Urban Health Centre:</u>	Medical Officer (LMO)	- 1
	PHN/LHV	- 1
	ANMs	- 3-4@12000-15000 popln.
	Lab Assistant	- 1
	Staff Clerk with computer skills	- 1
	Chowkidar	- 1
	Peon	- 1

5.5 First Referral Centre:

Support may be extended by the Project at the referral centre such as maternity homes / hospitals for engagement of specialists / part time specialists on contractual basis. No regular staff at the referral centre 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.

6. 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 as under:-

6.1 First Tier: Urban Health Centre:

- Renovation/Up gradation of existing facilities
- Renting of accommodation for establishing new Urban Health Centres. This facility will include provision of space for services, office, minor OTs, Lab and storeroom for equipments etc. besides patient waiting area.
- No new construction will be supported under the program.
- Equipments & furniture for services to be provide from the urban health centre (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 contractual basis only after redeployment of the existing staff.
- Needs based drugs & supplies (excluding supplies being made under other programs/schemes)
- Mobility support (hired vehicle for referral services, outreach camps and other activities)

6.2 Second Tier: First Referral Centre i.e. Maternity Home / Hospital

- Renovation / Up gradation of existing referral facilities
- Support for need based additional add on / lab / Indoor facilities.
- Equipments & furniture for services to be provide from the referral centres (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)

6.3 Referral Systems

For each UHC catering to a specific population in a defined geographical area, options of 2nd tier facilities which can provide subsidized, affordable, and quality referral services should be identified, which may be public or private. Up gradation 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 2nd tier services through Private Nursing homes / Charitable Hospitals by entering into an agreement with them to provide services such as institutional deliveries, emergency obstetric care, terminal methods of family planning etc.

7. Community Level Activities

To develop and maintain a link between health facility and the community, the program envisages engagement of social community workers/link volunteers, 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, the emphasis is on her being acceptable to the community, preferably to be engaged through by 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 /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 and to minimize dependence on programme funding should be promoted. Activities should be aimed at fulfilling the unmet family welfare needs of the community.

7.1 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.

7.2 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 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.

8. 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 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 behaviour change and communication approaches, linkages with health service providers, etc. Public private partnerships for Capacity building should be promoted, wherever possible.

9. Public-Private Partnership

Successful implementation of the project will require a vibrant partnership between the Ministry of Health & Family Welfare, GOI, State Government and the Urban Local Bodies. While the Ministry of Health & Family Welfare 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 operationalised. Such partnerships are particularly 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

learnings of 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: e.g. (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 ; and (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, carrying out baseline and end-line surveys. Private medical practitioners could also be engaged on part-time basis for first as well as second tier facilities (based on the experience in IPP VIII in Kolkata and neighboring cities). 2nd tier services (including laparoscopic tubal ligation and no-scalpel vasectomy services) and diagnostic services may be outsourced to private medical facility on 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 including accreditation methods for ensuring quality, memorandum or partnership, reporting and monitoring systems.

10. 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, private sector and community. At the State level a Monitoring Committee /Task Force under the Chairmanship of Secretary (Health & Family Welfare) with representation from other Departments to review and monitor the progress of implementation and a Governing Council under the Chairmanship of Chief Secretary comprising Secretaries of the other concerned Departments, Ministries, NGOs, Donor Agencies and GOI and other stakeholders to oversee the programme implementation, approval of plan of action, budget and inter-sectoral coordination need 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.

11. Management, Monitoring and Time-plan

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

11.2 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 end-line evaluation. The baseline indicators may be estimated by using the data already available from District Health Survey /reports, other available reports. Benchmarking should specially focus on contraceptive usage, terminal methods adoption, immunization coverage, TT coverage, delivery care and infant care. At 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 6-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 donor agency (if applicable).

11.3 Management and HR plan: While formulating Projects, urban health program supported by other donor agencies / 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.

11.4 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, Health & FW Department will be the Nodal Department for implementation of Urban Health Programme, overall coordination, collection of SOEs from implementation agencies and their onward submission to the GOI, audit etc.

11.5 Budgets: The budget should be developed for activities defined in the proposal based on the above stated broad guidelines to justify resource request, keeping in view that the focus

remains on Family Planning acceptance and Child Health Services. The Project should indicate component wise and year-wise budget and also separately for activities linked directly with Family Planning and Child Health services.

The Project authorities should open a separate saving account for the Project and get the accounts audited every year. Audit report and utilization certificate in form of 19-A of the General Finance Rules should also be submitted to the ministry at the end of each financial year. Proper asset register is required to be maintained and equipment/furniture etc. purchased under the project should be entered in the register.

12. 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. Under IPP VIII, Kolkata levied differential user charges on services provided which was put in a corpus fund and was 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 after project completion. Such a fund can be built through several sources of contribution 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 National Slum Development Program of GOI (ULB can access 5 times the amount generated at local level by communities from NSDP), and portion of lease and rental income from Municipal or other Public sector buildings. A mechanism for periodically monitoring 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*³ (sponsored by Ministry of Urban Development, GOI) CDS scheme⁴, and b) enhancing

³ 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.

⁴ 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.

the capacity of the Urban Local Body to plan and manage such programs are approaches towards sustainability.

13. Recurrent Costs

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

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

Equipments & Furniture

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

* 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 Centres get

adequate supply of vaccines contraceptives, drugs and other consumable from the supplies received from GOI.

The cost for renovation & upgradation of the existing facility into a Health Centre will in the range of Rs.2-3 lakhs. The rent for a new facility will cost around Rs.50,000/- to Rs.1,20,000/- per annum (depending on the city standards). As regards the costing of services to be provided at the referral center and through public private partnership, the costing would depend upon the specific interventions to be supported and the agreement reached with the private institutions. **The above costing is only indicative in nature and State Governments may make suitable changes wherever necessary based on local needs/conditions.**

The Project should clearly indicate cost required (component-wise) separately for First Tier i.e. Urban Health Centre civil works, furniture, equipment, drugs, IEC, training and staff (whether regular or contractual). Cost of support to be provided at Second Tier may also be indicated separately. **No new construction is permissible.**

14. Project Implementation

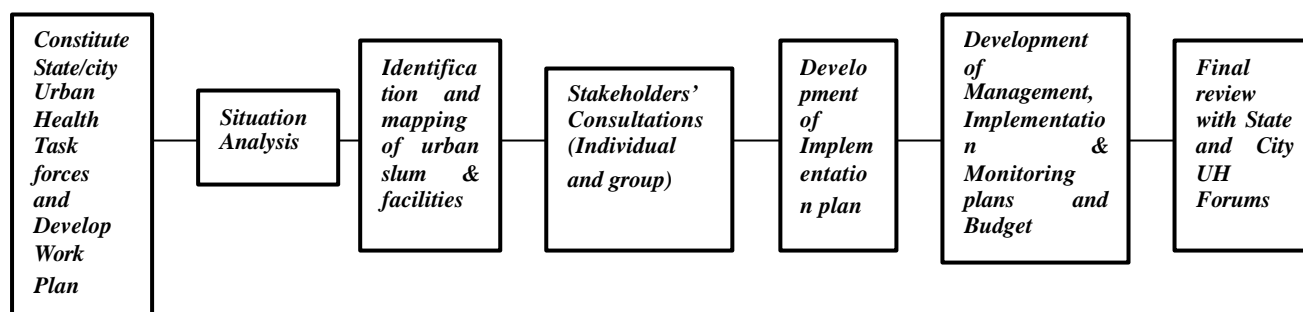
It is desirable that Urban Health Projects are approved, monitored and reviewed at the State level by an appropriate Committee. At the State level a Nodal Officer / Cell may be identified to be vested with responsibility of Urban Health Programme. At the city / municipality level, a Project Coordinator 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 report of the Urban Health Projects to the GOI.

LIST OF ANNEXURES

1. Process for Project Development
2. Outline of Five-year Proposal for Urban Health Program under RCH II
3. Outline of Budget Proposal for Urban Health Program under RCH II
4. Note on Public Private Partnerships
5. Executive Summary of Dehradun Proposal

Process for Project Development

The 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 and 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 below specified objectives.

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 which will facilitate effective participation from the officials from the concerned departments.
- Strengthened mechanism for inter-sectoral coordination among various departments at the State/ City and decentralized levels of the health centre.
- 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.
- Dept. of Women and Child Development (State, city and grass root functionaries)
- Employees State Insurance Services (ESI)

Private / Non-government sector:

- NGOs,
- Community Based Organisations,
- 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 non profit 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 Govt. and Non Governmental (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 / Not Functioning; services being provided and referral linkages, if any.

- **Utilization** of Govt. 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 Non utilization 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 (existing⁵, 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 viz.: Municipal lists, Slum Clearance and Rehabilitation Act list, Slum lists from the District Collector’s/Magistrate’s office, List at Mayor’s office or prepared by any developmental agency. It is possible that these lists will not include unregistered

⁵ 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.

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

Outline⁶ of Five-year Proposal for Urban Health Program under RCH II
(Name of City)

Abbreviations

Executive Summary

1.0 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
 - 1.4.1 Public Sector
 - 1.4.2 Charitable Organizations
 - 1.4.3 Non Governmental Organizations
- 1.5 Health Scenario in the Urban Slums

2.0 Objectives and key strategies

- 2.1 Goal
- 2.2 Objectives
- 2.3 Key Strategies

3.0 Service Delivery Model

- 3.1 Outreach service at grass root level
- 3.2 First Tier
- 3.3 Second tier

4.0 Activities

- 4.1 Establishing/Strengthening First Tier
 - 4.1.1 Location/relocation plan of Urban Health Centres
 - 4.1.2 Upgradation of First Tier
 - 4.1.3 Map and re-define catchment areas of health facilities
 - 4.1.3 Collaboration with charitable organizations/NGOs for new UHCs
 - 4.1.4 Package of services
 - 4.1.5 Additional Roles of Urban Health Centres
 - 4.1.6 Cost recovery mechanism
 - 4.1.7 Human Resources
 - 4.1.8 Timings of Urban Health Centre
- 4.2 Link Volunteers
 - 4.2.1 Process of identification
 - 4.2.2 Roles
 - 4.2.3 Remuneration/honorarium
 - 4.2.4 Training
 - 4.2.5 Federation of Link Volunteers
- 4.3 Women's/community Health Committee
 - 4.3.1 Process of promotion of Women's/community Health Committee
 - 4.3.2 Desired characteristics of members of Women's/community Health Committee
 - 4.3.3 Roles of the Women's/community Health Committee

⁶ This is an indicative outline which can be modified based on the activities being proposed.

- 4.4 Outreach Activities in Slums
 - 4.4.1 Outreach Plan
 - 4.4.2 Frequency of Outreach camps
 - 4.4.3 Guiding Principles for Outreach
 - 4.4.4 Camp Team
 - 4.4.5 Mobility Support
 - 4.4.6 Package of services
 - 4.4.7 Collaborating with NGOs for outreach
- 4.5 IEC/BCC and Social Mobilization Activities
 - 4.5.1 Strategy
 - 4.5.2 Key Issues for IEC/BCC
- 4.6 Strengthening of 2nd Tier Referral facilities
 - 4.6.1 Location of 2nd Tier facilities
 - 4.6.2 Strengthening of 2nd Tier facilities
 - 4.6.3 Strengthening of human resources
 - 4.6.4. Procedure to establish referral linkages from 1st Tier to 2nd Tier
- 4.7 Capacity Building/Training
- 4.8 Referrals to second tier institutions
 - 4.8.1 Package of services
 - 4.8.2 Mechanism of referral
 - 4.8.3 Form of support to be provided to 2nd tier private facilities
- 5.0 Inter-sectoral coordination
 - 5.1 Mechanisms
 - 5.1.1 UHC level Coordination forum
 - 5.1.2 City level Coordination Forum
- 6.0 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
- 7.0 Management Arrangements
- 8.0 Fund Flow
 - 8.1 Fund Flow mechanism
- 9.0 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 Programme officer (Urban Health)
 - 9.5 City Programme officer (Urban Health)
- 10.0 Budget
- 11.0 Time Plan
- 12.0 Description of Urban Health Proposal Development Process
 - 12.1 Steps and key activities
 - 12.2 Important sources of information
 - 12.3 Lessons and recommendations

Annexure-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	Staff salaries						
2	Honorarium to Link volunteers						
3	Strengthen Urban Health Infrastructure						
	Medical stores/Medicines						
	Urban Health Centres						
	Non recurrent						
	Recurrent						
4	Capacity Building						
	Capacity Building						
	IEC/BCC activities						
5	Partner NGO Operational Costs						
6	Outreach activities						
7	City Program management cost						
8	Upgradation of on Urban Post						
	TOTAL						

Year 1 link volunteers honorarium at 50% level

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, non-governmental 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 percent to 84 percent, and prenatal care coverage from 91 percent to 95 percent.

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.

For more information, please contact:

In India: Geetanjali Chopra, Phone: (91-11) 461-7241, E-mail: gchopra@worldbank.org

In Washington, D.C.: Karina Manasseh, Phone: (202) 473-1729, E-mail: kmanasseh@worldbank.org

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 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. Hospital has good infrastructures (100 beds) and manpower.
- The Trust entered in Agreement with Health & Family Welfare Department, Government of Assam, under the Sector Investment Programme following services in selected slums.
 - Immunisation of Children and pregnant women, Routine Ante-natal 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 organisation are mobilizing the people and help in holding the sessions providing sites.
 - Local volunteers motivate, organize, informs community.
 - Beneficiaries from the outreach act as motivator, organizer in the slums.
- Lessons learnt
 - Regularity of sessions to maintain the faith of the community.
 - Commitment of doctors to serve the slums.
 - Sessions are held in few location in private establishment and support from community.
 - Uniform services/reporting in session sites.
 - Involvement of local volunteers, NGOs to extend reach in community.
 - Base line information 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
- Replication possible through other non-profit organisation in the city or elsewhere of management in Trust
- Future Direction
 - Urban Health Management Society under chairmanship of Deputy Commissioner in Guwahati constituted.
 - Getting good response from MM Hospital contract, outreach services are being extended to entire city utilising 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, organisation strengthened.
 - Consultant (Public Health) engaged under this contract to track achievement and developing more local responsive programme/ 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

Annex V

EXECUTIVE SUMMARY OF THE FIVE YEAR URBAN HEALTH PROPOSAL
(UNDER RCH II) FOR
DEHRADUN⁷

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 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 the year 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 (labour, 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

⁷ This proposal has been developed in a participatory process through technical assistance from USAID-EHP, in partnership with and via active and enriching involvement and contribution of City, District and State level Stakeholders.

Existing Public Sector Health Facilities

Existing facilities in Dehradun are:

First Tier:

- Urban Health Posts – 9
- Urban Family Welfare Centres - 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 centres) and door to door information dissemination and surveys in their field areas.

Second Tier:

- District Hospital – Doon (includes Post Partum Centre 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, Unani, 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 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	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/TB A)
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 (9 HPs and 2 UFWCs) will be restructured to 9 'Urban Health Centres'. In Dehradun all the nine centres will be managed by the Health Department since human resources and infrastructure is already in place and requires up gradation. The upgraded Urban Health Centres 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 2nd Tier:

- With the strengthening of First Tier facilities, the OPD case load on the existing two hospitals will decrease.
- Collaborative linkage (for 2nd 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 2nd Tier facility.
- The Nagar Nigam Dispensary in Dharampur will be upgraded as a 2nd 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), 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 over 150 - 250 households. She will perform the tasks of tracking ante-natal 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 Activities

The present outreach of the 9 HPs and 2 UFWCs has been reviewed to strengthen the impact of this activity in particular 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, TT.

- Camps shall be conducted fortnightly in highly vulnerable slums and on a monthly basis in moderately vulnerable slums.
- Each UHC shall constitute 2 teams; one headed by the Lady Medical Officer and another by the PHN/HV/ANM as per availability.
- The LMO shall compulsorily attend one of the two camps conducted in the 'highly vulnerable' slums.
- Mobility support will be provided to the UHC staff for going on 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, newborn 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), programme coordination, community mobilization and behavior change, programme sustainability, urban issues and identification of referral beneficiaries, for programme 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 end line survey will be conducted by an external agency. A monthly reporting mechanism at different operational levels will be followed through review meeting and monitoring formats.