

National Consultation

Improving the Health of the Urban Poor

Lessons Learned and the Way Forward

30 June – 1 July 2003

Bangalore



Ministry of Health and Family Welfare
Government of India



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Proceedings and Recommendations

Organised by

USAID-EHP Urban Health Programme

in collaboration with

Ministry of Health and Family Welfare

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About the Coordinating Team

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This report has been prepared by Anju Dadhwal Singh and Dr Siddharth Agarwal with inputs from Dr Masee Bateman

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Preface

India is rapidly urbanizing, and the health conditions of the urban poor represent an important public health priority. Urban centres are pivots for economic growth in India, as elsewhere. Today, almost a third of India is urban, and about a third of this population is made up of the urban poor. India is projected to be majority urban within 20 years. This rapid growth is being called the 2-3-4-5 phenomenon, where the all-India population is growing at 2 per cent, urban population at 2.75 per cent, large cities at 4 per cent and slums at 5-6 per cent. Rural to urban migration, along with growth of existing slum population, leads to this rapid urban population growth.

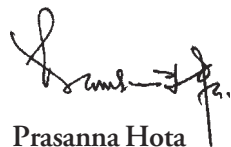
Amidst all this, the urban poor are especially vulnerable to health risks as they face congestion of living space, an unhealthy environment, and lack of access to health services, as measured by actual use rates. They are often poorer than their rural counterparts. Urban averages for health, and many other indicators, mask sharp disparities between the urban poor and those better off. While urban averages commonly reflect better health conditions than rural averages for most health indicators, those of the urban poor are typically similar or worse than rural populations in the same state. For example, under-five mortality rate for urban M.P. is an abysmal 131.9 for the urban poor (as per low standard of living index¹), while the urban M.P. average indicates a figure of 82.9. Similarly, disparity is evident in complete immunization coverage by age 12 months: only 21% of children of low SLI families are immunized fully by the age of one year as against 41% of children when you look at urban average data. The pathway to continued economic development which is sought will be well served if the health of India's urban poor populations – workers and their families – is afforded priority in national programmes over the next two decades.

There is great need and much to be done, but fortunately, a great deal has already been done, upon which we can build further. This consultation brought together practitioners and experiences from diverse settings to examine issues that are critical for improving the health of the urban poor. This report highlights key issues, challenges and options

¹ Standard of living index is an asset-based tool for categorizing the population into low, medium and high 'standard of living', used by NFHS II (1998 – 99).

for urban health programming, such as *targeting the urban poor* in order to maximize impact, *building on the experiences* of concluded and ongoing programmes, compiling and making available urban poor-specific information for better programming, *public-private partnerships* to include NGOs and other private providers in urban health care, integration of interventions for *addressing RCH issues effectively*, and *building capacities of stakeholders*, particularly urban local bodies, to plan and implement urban health programmes. It also outlines the importance of empowering *the urban poor to seek services and slowly become capable of managing preventive interventions* at community level, and other *sustainability and exit strategies*.

The Department of Family Welfare, MOHFW, is committed to enhancing interest in and capacities for urban health programming among state and city counterparts. As a step towards accomplishing this, the Government of India is collaborating with USAID's Environmental Health Project to develop sample proposals for different population categories from four cities. This we hope will further test and refine the process that is under development for preparing urban health proposals for RCH II; provide concrete examples for proper planning of health care delivery to the urban poor in different categories of cities; and provide input for development of budgets for urban health proposals for the various categories of cities. Following this meeting, the GOI and USAID will organize regional workshops using the sample proposals and other resource material for building capacities at the state level.



Prasanna Hota
Secretary (Family Welfare)
Ministry of Health and Family Welfare
Government of India



Walter North
Mission Director
USAID/India

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The efforts of many individuals and institutions were critical to the success of the consultation.

We are grateful to the Ministry of Health and Family Welfare for collaborating with us in organising the National Consultation on *Improving the Health of the Urban Poor*. The Secretary (Family Welfare), Mr PK Hota, consented to grace the Consultation and delivered the valedictory address. Mr SS Brar, Joint Secretary (Reproductive and Child Health Programme), gave the keynote address, which set the context and tone for the deliberations to follow. Dr VK Behal, Deputy Director General, and Mr AK Mehra, Director (Area Projects), provided continuous guidance in the preparation of the consultation.

The Government of Karnataka, particularly the Bangalore City Corporation, provided immense support in hosting the consultation in their city. Dr Mala Ramachandran provided generous use of the facilities of the Urban Health Research and Training Institute, and guided the coordination efforts from Bangalore. The staff of the institute toiled hard to ensure an efficient working environment.

The consultation plan was put together under the guidance of Dr Masee Bateman and Mr Samaresh Sengupta from USAID. The resource persons, Ms Nandita Chatterjee (WHO/India), Prof Amitabh Kundu (Jawaharlal Nehru University), Prof HPS Sachdev (Indian Academy of Paediatrics), Prof Tara Kanitkar (Institute of Health Management, Pachod), Ms Allison Barrett (Cities Alliance), Dr Amita Bhide (Tata Institute of Social Sciences), and Dr Rajesh Kumar (Post Graduate Institute of Medical Education and Research) conducted the sessions with focus and insight to ensure that the objectives of the Consultation were realised. Dr Dinesh Agarwal (United Nations Population Fund) coordinated the group work with remarkable élan with support from Dr Arvind Mathur (WHO/India), Dr Renu Khosla (National Institute of Urban Affairs), and Dr Karuna Singh (Municipal Corporation of Delhi). We are thankful to this core resource group for their immeasurable contributions in making this consultation a success.

We are grateful to Vidya Raghavan, Sudha Nair, Pravin Ramteke and the rest of the publishing team from New Concept Information Systems Private Limited for their important contribution in making this publication possible. The excellent presentations by all the presenters as well as the working groups were critical in informing the deliberations. Lastly, our heartfelt gratitude to the participants, whose unflagging attention and professional expertise were invaluable in producing significant outcomes and in providing impetus to national efforts for “Improving the Health of the Urban Poor”.

Acronyms

ANC	Antenatal Care
AMC	Ahmedabad Municipal Corporation
ANM	Auxiliary Nurse Midwife
APUSP	Andhra Pradesh Urban Services for the Poor Project
ARI	Acute Respiratory Infection
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BMC	Brihanmumbai Municipal Corporation
BPL	Below Poverty Line
CBO	Community-based Organisation
CHG	Community Health Guide
CHT	Community Health Team
CHW	Community Health Worker
DNSP	Draft National Slum Policy
DUDA	District Urban Development Authority
DWCD	Department of Women and Child Development
EAG	Empowered Action Group
EHP	Environmental Health Project
ESOPD	Extended Specialised Out Patient Department
FGD	Focused Group Discussion
IFA	Iron and Folic Acid
GDP	Gross Domestic Product
GOI	Government of India
HUDCO	Housing and Urban Development Corporation Limited
ICDS	Integrated Child Development Services
IEC	Information, Education, Communication
IMA	Indian Medical Association
IPD	Integrated Population Development (Project)

IPP VIII	India Population Project VIII
LCS	Low Cost Sanitation
M&E	Monitoring and Evaluation
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHP	National Health Policy
NIUA	National Institute of Urban Affairs
NNP	National Nutrition Policy
NPP	National Population Policy
NSDP	National Slum Development Programme
OPD	Out Patient Department
ORS	Oral Rehydration Solution
PPA	Participatory Poverty Assessment
RCH	Reproductive and Child Health Programme
RMK	Rashtriya Mahila Kosh
RMP	Registered Medical Practitioner
RNTCP	Revised National Tuberculosis Control Programme
SHG	Self-Help Group
SIP	Sector Investment Programme
SJSRY	Swaran Jayanti Shahari Rozgar Yojna
SPARC	Society for the Promotion of Area Resource Centres
SRS	Sample Registration Survey
SWM	Solid Waste Management
TPDA	Targeted Public Distribution System
UHC	Urban Health Centre
ULB	Urban Local Body
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAMBAY	Valmiki Ambedkar Awas Yojana
WB	World Bank
WHO	World Health Organization

Introduction



It is estimated that within a decade, the majority of the child diseases and malnutrition burden in India will be among the urban poor. Conversely, attention in India continues to be primarily focused on the health needs of the rural population. While these needs will continue to be important, the health indicators of the urban poor are falling, even as the proportion of urban poor is rising. Unless there is an increased understanding and coordinated planning towards the health needs of the urban poor at various levels, the health conditions of the urban poor will continue to deteriorate. An additional challenge is the lack of sharing of knowledge and experience among different players.

Urban health is recognised as a thrust area under the National Population Policy, 2000, National Health Policy, 2002, and the Tenth Five-Year Plan. Under the Tenth Five-Year Plan, as an integral part of RCH-II, urban health projects will be implemented in identified cities across the country. Also, an expert group on urban health has been constituted by the Government of India to formulate guidelines and help the state governments to develop proposals.

The USAID-supported Environment Health Project, in collaboration with the Ministry of Health and Family Welfare, Government of India, organised a National Consultation on “Improving the Health of the Urban Poor: Lessons Learned and the Way Forward”, on 30 June and 1 July 2003 at Bangalore.

Apart from creating a platform for exchange of information on recent developments in urban health,



Dr Masseur Bateman (USAID), Mr SS Brar (JS, GOI), Dr Siddharth Agarwal (EHP), and Dr Renu Khosla (NIUA) at the opening plenary

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programmes, successes and challenges, it provided an opportunity for discussion and dialogue among the policy makers, programme planners and implementers on effective strategies for addressing the concerns related to the health needs of the urban poor. The objective of the consultation was also to understand key programme issues, lessons and options for urban health delivery and draw lessons from experiences in addressing key child health priorities. Importantly, the consultation provided a space for drawing key recommendations for future urban health programming.

This document is a compilation of lessons and experiences in urban health programmes, as discussed under the national consultation, and serves as a reference for fostering improved

the strengths of the existing health system in urban areas such as availability of skilled human resources, including private practitioners, and presence of large number of NGOs and privately managed facilities. He also highlighted the need to learn from the experiences of IPP VIII urban health programmes in different cities.

GOI policies and provisions for urban health

The presentation by Dr Renu Khosla, NIUA, reviewed the existing policy and programmatic framework of the Government of India for urban health and offered recommendations for consideration at the consultation. It highlighted the health vulnerability of the urban poor and the high burden of ill-health among urban poor communities.

The recently shaped National Population Policy 2000, National Health Policy 2002, draft National Slum Policy 2002 and National Nutrition Policy 1993 were identified as policies that recognised health and nutritional fragility of the urban poor and had direct implication on their health. Provisions under these four policies support expansion of health infrastructure,

Key strategies proposed for urban health programme under RCH II, to be implemented in identified cities in a phased manner over five years include:

- Focusing on improving service delivery rather than construction of new facilities.
- Integration of existing government facilities by upgradation/relocation/reorganisation and using a uniform nomenclature.
- Outsourcing of service delivery at the primary level to NGOs/private sector, wherever feasible.
- Developing guidelines for contracting and outsourcing service delivery through public-private partnership.
- Establishment of management structure at the city/urban local body level with adequate administrative, financial and decision-making powers and constituting committees at different levels to involve various stakeholders.
- Initiating inter-sectoral coordination for cost-effective management and bringing about vertical and horizontal linkages.
- Identification and implementation of mechanism for sustainability and built-in accountability for sustainability after completion of the project period.
- Developing a results-based framework for planning and reviewing performance.



Building effective partnership among potential partners and stakeholders is going to be a key to going forward... and the partnerships themselves are likely to vary in different settings...

Dr Masee Bateman, USAID

Recognising the opportunities and challenges in urban areas, the presentation identified four key issues in delivering health care to the urban poor, namely, access to basic services, demand for and utilisation of services, capacity building and institutional strengthening of partners, and creating and managing the information needs for effective programmes. Thus, the presentation laid the context for the presentations and deliberations to follow.



Issues and options for health care delivery to the urban poor

Chair & Moderator – Ms Nandita Chatterjee,
Rapporteur – Dr Tara Kanitkar

Introduction

Delivering health care to the urban poor is a challenge for a variety of reasons. In spite of the apparent concentration and relative proximity of health facilities in cities, health conditions of the urban poor remain seriously compromised. Under-five mortality rates among the urban poor in EAG states like Madhya Pradesh and Uttar Pradesh are 149 and 131 respectively, as compared to urban averages of 84 and 86. These two large states constitute about 22% of India's total population, and 18% of India's urban population. Likewise, wide disparities in the nutritional status of children exist, with 72 and 58 per cent of undernourished children belonging to urban poor communities in MP and UP respectively, as compared to urban averages of 44 and 43 (Reanalysis of NFHS II data by EHP).

Those with the greatest need for health care often have least access to it. The urban poor are not the primary beneficiaries of public health infrastructure; only 9% of those accessing government health services belong to the poorest 20%. Unlike in rural areas, there is inadequate primary health care network due to lack of planned development of infrastructure for delivery of health care services to a burgeoning urban poor population. Resource constraints and the limited capacities of urban local bodies to effectively plan and deliver health care also contribute to inequity in access and resource allocation, resulting in very poor health indicators for the urban poor.

Improving the health of the urban poor in India will require the coordinated efforts of numerous stakeholders such as urban local bodies, Department of Health, Department of Women and Child Development, civil society, external support agencies, private health care providers, non-government organisations and the community. This will entail developing innovative institutional arrangements with several public and private providers. Efforts to ensure community participation and ownership will be critical for generating and sustaining demand for services. Concurrently, service-oriented

Subsidies available through the public health system do not reach the poorest. Rationalisation of staff and infrastructure and poor-friendly strategies would enable greater financial resources to be freed up.

Dr Suneeta Singh, The World Bank

strategies for increasing demand for and improving access to primary health care services were discussed.

investments to improve the quality of care being provided by public sector facilities will need to be focused on.

Approaches and experiences

Experiences of various partnerships for delivering primary health care to the urban poor were presented. These included partnerships with charitable hospitals, private providers, NGOs and CBOs. In addition, innovative

Partnership with charitable hospital

The partnership between the state government and a charitable hospital, the **Marwari Maternity Hospital**, Guwahati, demonstrated a model of effective health care delivery in urban slums. This partnership entailed clear demarcation of the roles and responsibilities of the two partners. The Government of Assam took the responsibility of free supply of vaccines, contraceptives and other RCH kits; capital investment for hospital equipment, furniture and vehicle; expenditure on mobility of staff for sessions, contingencies and POL; regular fund flow to the trust against achievements; and supportive supervision. The services provided by the MM Hospital include immunisation of children and pregnant women, routine ANC, basic laboratory services, institutional deliveries, family planning services, MTP services, and treatment of children and adults. The hospital made provision of medical and paramedical staff, provision and maintenance of existing infrastructure, and equipment for outreach patients. The trust levies concessional rate (25% less) for patients coming from slums under this agreement. While the BPL patients are exempted from charges altogether, family planning services and MTP are undertaken free of cost for all dwellers from identified slums.



Session on "Issues and options for health care delivery to the urban poor"

Lessons learned

This partnership demonstrated an economical model for widening the scope of health care services to the urban poor without investment in infrastructure or personnel by the government. Lessons from this experience indicate the importance of regular outreach sessions in the community and the need for involvement of local

volunteers and NGOs to extend reach within community. The experience highlighted significant improvements in ANC and immunisation coverage, as well as institutional deliveries. The experience also established the importance of regular community contact for effective service delivery. Using beneficiaries from outreach activities for organising communities and changing the timing of outreach session to suit the availability of the clients are examples of strategies for increasing coverage rates that were used in this model.

The timing of nine to twelve for outreach activities is ineffective.

*Dr AC Baishya,
Guwahati Medical College*

Sustaining health care delivery in slums

The **Kolkata IPP VIII experience** focused on the strategies for sustaining primary health care in the slums. The project covered 40 municipalities under the Kolkata Metropolitan Development Authority, catering to nearly 3.8 million poor. The physical infrastructure included one honorary health worker at the first tier catering to a population of 1000, a sub-centre for a population of 5000, a health administrative unit for a population of 35,000, extended specialised OPDs with 8 specialists working on a part-time and fee-sharing basis, 20-bed maternity homes providing round-the-clock obstetric and neonatal care, and regional diagnostic centres. The mainstay of the project was the role of local private providers at each level in providing health care to the slum dwellers and the generation of funds through user-fees and cross subsidy, particularly from the ESOPD, maternity homes and diagnostic centres. Assessment of the resource generation versus expenditure on health care revealed that most of the urban local bodies have reached the break-even point.

Lessons learned

The IPP experience elucidates clearly the effective reach of services through partnership with private practitioners. The health providers were recruited locally on fee-sharing and part-time basis, relieving substantial government expenditure on salaries. Non-poor also availed the services at a higher cost than beneficiaries, bearing a testimony to the quality of care. This experience shows how private sector partnership can complement public health services through provider incentive, and the generation and use of a health development fund can generate resources for sustaining the services. Importantly, the cost-effective service delivery approach was decentralised and made flexible to suit local requirements.

The experience also highlighted that service delivery commenced from rented premises, rather than waiting for infrastructure to be set up. A few service outlets were made operational initially in each ULB and civil construction in each ULB was initiated in a phased manner

Extended specialised OPDs are sources of income generation where beneficiaries are charged concessional rates and non-beneficiaries are charged a higher rate.

*Dr KL Mukherjee,
KMDA*

later on. Thus the IPP experience shows how quality service delivery is feasible at low operational cost through public-private partnership.

Partnership with NGOs for service delivery

The experience of IPP VIII in Bangalore highlighted the role of NGO-run facilities in enhancing access to and utilisation of primary health care. This presentation brought forward an example of partnership between the Bangalore Municipal Corporation and NGOs for running of health centres on behalf of the corporation. Under the project, guidelines for selecting NGOs, terms and conditions for running the health centres, as well as the package of services to be offered were clearly established to help in the smooth functioning of the centres. The NGOs were mandated to run the health centres from the BMC buildings for a minimum package of services. The government ensured free RCH supplies such as vaccines and contraceptives, and the NGO was free to levy user charges as applicable to BMC. The initial agreement was for a period of three years, which was renewable.

Lessons learned

The NGOs were able to mobilise additional resources and leverage public support for demanding basic amenities like water supply in the area. Replacement of non-functional staff was easier in this setup as was the engagement of highly competent and committed staff. Referral linkages were also found to be better in NGO-managed health centres. The NGOs were able to retain the link workers through their own resources after completion of the project, unlike the government. On the flip side, it was found that NGOs needed support on capacity building of leadership, supervisors and health personnel, and in applying for funding.

ICDS for the urban poor

A case for effective health service delivery through ICDS in urban areas and strategies for further promotion of health and nutrition in Madhya Pradesh was presented. The presentation touched on the current limitations of ICDS in terms of inadequate access, poor targeting and inadequate convergence with the health department and highlighted steps to overcome some these limitations to harness the potential of ICDS to reach out to the urban poor. Some of the innovative measures undertaken as part of the project

The advantage of NGO-run facilities was that additional resources, such as specialist services and referral linkages, were brought in.

Dr Mala Ramachandran, UHRTI

include appointment of *Bal Sanjivani* (adolescent girl volunteers) for growth monitoring, and relocation of *anganwadi centres* (AWCs) based on poverty mapping so that the really needy can access the AWC services. Other strategies that can be used for effective delivery in urban areas include replicating the mini-*anganwadi* (or *Poriyawadi*) concept, wherein a volunteer is paid Rs. 50 per month to deliver supplementary food in urban areas, and establishing *anganwadi* radio for effective communication.

The lessons learnt are that it is feasible to sustain the services, provided the quality and coverage is maintained, and that the poor also pay for services if they are need-based, as they are already paying for it to unqualified providers.

Ms Bhagyashree Dengle, CASP-PLAN

Lessons learned

The presentation highlighted the potential of ICDS to improve targeting of urban poor beneficiaries through relocation of AWCs based on poverty mapping. Another lesson learned in the urban scenario is that coordination between the Health Department and ICDS needs to be strengthened for maximising the strengths of both. Innovative use of ICDS provisions, such as investing in *Bal Sanjivani* for catering to mini-*anganwadi* areas helps enhance coverage. The presentation illustrated the need for implementing urban-specific approaches to expand the scope of ICDS to cater to the uniqueness of the urban environment

Mobilising communities for primary health care

CASP-Plan's presentation on mobilising communities for primary health care through NGOs highlighted the strategies to sustain the scale, coverage and quality of RCH services and activities implemented through a USAID-funded child survival project from 1995 to 1999 in Sangam Vihar, Delhi. Another aspect of the programme was to enhance the capacity of community groups to become financially more sustainable through cost recovery, cost saving, networking and revenue generation.

Unless we address the inadequacies of ICDS to reach out to not only urban or rural poor but everyone of the target group of this programme, we would be only superficially handling the issues concerning morbidity and mortality.

*Mr O P Rawat
WCD, Government of MP*

In order to achieve this, a three-pronged strategy of health promotion through IEC & counselling, health service provision, and demand generation through organising community was adopted. As part of the project, women from the community were trained to be community health guides (CHGs), for which they received incentives and payment. After the project

period, a social marketing programme helped the CHGs to be social entrepreneurs, which helped their retention without payment, yet ensured that they were paid for their services by the community. For reducing the cost of clinical operation, the activities of the clinic were restructured, and clinic hours were extended. Partnerships with other organisations working in the area also helped in reducing the cost. Part of the operational cost was met by levying charges for clinic, ambulatory and laboratory services. Conducting dental, eye camps and sale of health-related products by the CHGs helped in generating revenue.

Lessons learned

The important lesson of the project was that RCH services can be sustained if quality and coverage is maintained, and that the poor are also willing to pay for quality services. Strategies for cost reduction, cost recovery, revenue generation, continuous quality improvement, and youth participation were important for sustaining coverage rates. Also, that fostering community ownership, which is crucial for sustainability of any health delivery service, requires significant time.

Promoting partnerships for health of the urban poor

The presentation by **Environmental Health Project** focused on the partnership models being attempted in Indore. The evolution of the partnerships through stakeholder consultations, situational analysis and health vulnerability assessment were described. Through the stakeholder consultations, the potential of NGO-CBO partnerships in Indore was revealed. While the situational analysis revealed insufficient community demand for services and inequity in health sector resource allocation, the health vulnerability assessment led to identification of underserved slums for programme inputs. The NGO-CBO partnership model is being tested currently to enhance demand by the community, build capacity of the NGOs and CBOs and strengthen the community linkages. The NGOs provide guidance to the lead CBO, while the slum-based CBOs provide interface with the communities. NGOs and CBOs forge linkages with the municipal corporation, health department, ICDS, charitable hospitals, etc.

In the second partnership model, a ward is taken as the focal point of forging partnership and linkages. The Ward Coordination Model is a public sector driven effort for improving coordination and community linkages and for strengthening public and other non-profit sectors. It has representatives from the health department,

Programmes should utilise resources from various stakeholders, strengthen their utilisation, and reach out to the poor.

Dr Siddharth Aggarwal, EHP

municipal corporation, elected representatives, DUDA, ICDS, charitable hospitals, NGOs and CBOs in its core committee.

Baseline studies are very important, against which a new achievement can be measured and also they guide in the running of the project.

Prof Tara Kanitkar, IHMP

Lessons learned

The lessons learned from Indore are that an urban health programme can be on firm footing if it targets the most vulnerable urban settlements, focuses on slum-level institutional and individual capacities, is technically effective, coordinates with multiple stakeholders and utilises resources from various departments, evolves from stakeholders, enhances utilisation of government resources, and reaches out to the urban poor through outreach activities.

Recommendations

- Forging partnerships with different service providers such as NGOs, CBOs and charitable hospitals not only helps in cost reduction of the service delivery but also helps in effective outreach.
- Participatory approach for planning, implementation and monitoring with the involvement of different stakeholders such as municipal corporation, NGOs and community is essential. Participation of multiple stakeholders is important for development of an effective and sustainable urban health programme. A multi-stakeholder coordination committee at the ward/ city level is effective for implementation and monitoring.
- There is need for decentralised and demand-oriented implementation with the involvement of ULBs and CBOs. It is also important to have flexible mechanisms such as time of service delivery, and provision for involvement of different stakeholders that is open to modifications based on local needs.
- Targeting the least served slums is vital for optimum utilisation of resources and optimising impact.
- From the beginning, it is necessary to look at building sustainability of efforts and ensuring cost-effective service delivery so that the efforts can continue even after the funding is withdrawn. For this, creating strategies for cost recovery, community ownership and involvement in implementation and decision-making is crucial. Building individual and institutional capacities at the slum level is also crucial to sustain programme objectives.
- Consistent efforts must be made towards awareness generation and information dissemination for enhancing demand.
- Behaviour change promotion efforts should complement improved quality and reach of services to achieve desirable coverage rates of vital services such as ANC and immunisation.

- Sensitisation and capacity building of different stakeholders and partners (such as ULBs, NGOs, CBOs, youth, women, etc.) are important for ensuring a supportive and enabling environment for the programme.
- Financial contribution or user charges are necessary for eliciting a sense of ownership from the community.
- For effective monitoring and evaluation of the programme, it is important to have baseline data. Wherever possible and available, it is important to look at both primary and secondary data for urban programme design.

Identifying and targeting the vulnerable urban populations



Chair – Prof. Amitabh Kundu, Co-Chair- Dr VK Behal,
Moderator & Rapporteur – Ms Alison Barrett

Introduction

The urban poor constitute nearly a third of India's urban population. They live in organised slums, which may be recognised or unrecognised by the civic authorities, as well as in unorganised pockets or clusters scattered across the city. Missing or hidden pockets of the urban poor include the homeless, pavement dwellers, construction site workers, brick and lime kiln workers, and street children, who are amongst the most vulnerable. In addition, there are vulnerable clusters within larger slums, such as SC/ST slum pockets.

Urban poverty is multi-dimensional and complex (Amis, 2001). The most commonly used measures of poverty are based on the per capita income or consumption patterns of a household. There is broad agreement that the multiple dimensions of poverty cannot be adequately explained or addressed by definitions and measurements based only on income or consumption. The income-consumption approach to poverty fails to show the human development outcomes (Sen 1983). Measuring poverty should include income measures, health and education indicators and measures of vulnerability. Together, these deprivations severely restrict what Amartya Sen calls the "capabilities a person has, that is, the substantive freedoms he or she enjoys to lead the kind of life he or she values." Several assessments of urban poverty show that the poor themselves lay significance on livelihoods, household assets, savings and possessions, access to basic services, and social support systems, for defining vulnerability.

Rapid urbanisation and growing urban poverty are putting a strain on the available resources, and in the process, further pushing the marginalised section from the gamut of basic services. Much of the challenge of delivering basic services to the marginalised groups lies in identifying them and effectively approaching them so that limited resources are utilised well and

The poor are not in a position to access our (govt) services. There is less of demand. There is very little faith on what these services offer.

Mr Somesh Kumar, APUSP

There are inequalities in terms of gender in access and control over assets, and evidence of intra-household differences by gender and effects of crises on women and the responses that household implement.

Mr Ranjit Ambastha, Oxfam

programmes address real needs. Identifying and targeting the vulnerable poor populations are thus necessary steps for any effective programme intervention, as urban poverty is underestimated (UNDP, 1998).

There are limitations to using secondary data, such as the census, for identification of the poor, since there are large scale variations in the reporting of slum populations by city administrations resulting in under-or over-reporting of slums.

For example, cities like Lucknow reported no slums in the last census. Another key issue in the use of slum lists available with civic authorities for identifying the urban poor relates to the aspect of the actual residence of the vulnerable across the urban population. For instance, the 49th round of the National Sample Survey indicates that 38 per cent of the urban poor live outside slums.

Approaches and experiences

Three experiences of participatory vulnerability assessment were presented. Participatory methods for assessment of vulnerability are undertaken with the active involvement of the community to develop criteria for vulnerability and to identify vulnerable groups and their locations. This provides a holistic and people-centred determination of poverty and its ranking (Bilsborrow, 1994). The method asserts the primacy of local knowledge over externally determined measurement criteria (Falkingham & Namazie 2002). The process of vulnerability assessment is a dynamic one and needs to be periodically updated to capture associated fluctuations.



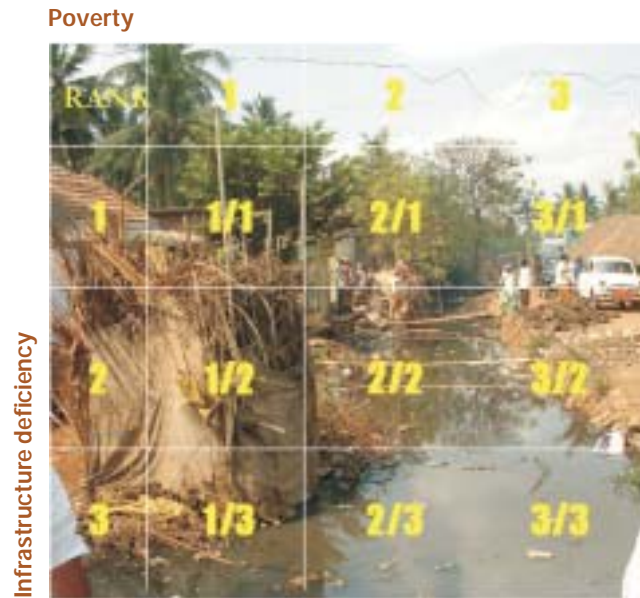
Prof. Amitabh Kundu (JNU) chairing the session on "Identifying and targeting the vulnerable urban populations". Others seated include Dr Siddharth Agarwal (EHP), Mr Ranjit Ambastha (Oxfam), Ms Alison Barret (Cities Alliance), Dr VK Behal (DDG, GOI), and Mr Somesh Kumar (APUSP)

The **Andhra Pradesh Urban Services for the Poor (APUSP)** project is an innovative partnership project between DFID and the Department of Municipal Administration and Urban Development, Government of Andhra Pradesh, for building lasting municipal reforms. The three components of the project – municipal reforms, basic environmental infrastructure for the poor, and strengthening civil society – are being implemented in 32 Class I cities of Andhra Pradesh. Participatory poverty assessment (PPA)

is conducted in each town for bringing out the perceptions of the community and their understanding of poverty.

Methodology: Poverty assessment, using a variety of participatory tools, results in the identification and prioritisation of health issues by the poor. These priorities are consolidated at the town level and incorporated in the Comprehensive Municipal Action Plans for Poverty Reduction. Targeting of the poor in various programmes is made possible through a 3 * 3 matrix by giving priority to localities with high poverty and deficiency in basic infrastructure. This example illustrates an approach that empowers poor communities to participate in the planning and implementation of state-led programmes.

Poverty Assessment Matrix



A study by **Oxfam GB** in collaboration with the University of Wisconsin utilised participatory urban appraisal for better understanding the lives of the urban poor in Lucknow.

Methodology: The study involved in-depth household interviews, which provided data about household economic portfolios (earnings, consumption, asset ownership, etc.), experiences of crisis events, perceptions of vulnerability and risk by different household members and the households' use of assets and credit in response to crisis events. The study highlighted the importance of using a mix of qualitative and quantitative data collection methods to understand the processes versus outcomes of poverty.

Vulnerability assessment enables programmes to target resources.

Dr Siddharth, EHP

The **USAID-supported Environmental Health Project** conducted a health vulnerability assessment among urban poor communities of Indore by using a participatory approach. The objectives of

Unless we employ the poor in these analyses, we will not get a clear picture.

Alison Barrett, Cities Alliance

Dimensions of poverty (as identified by communities in various assessments)

- Access to employment
- Opportunities and nature of work
- Access to fair credit
- Proportion of population BPL
- Possession of ration card / voter's card
- Tenure rights
- Access to education
- Alcoholism
- Gender equations
- Family size
- Water and sanitation facilities
- Structure of housing
- Access and usage of public health services
- Disease incidence
- Collective organised community effort /Social support system



the assessment were to identify key internal and external factors that predispose certain urban populations to health vulnerability, and to identify and map the vulnerable populations of Indore.

Methodology: Slum lists for secondary sources such as the municipal corporation office, mayor's office, district collector's office, etc, were used as the starting point for identifying the vulnerable urban populations. Focused group discussions were conducted with public sector staff, NGOs and CBOs to classify vulnerable and non-vulnerable slums. This was followed by slum visits to observe and understand the reality of criteria as lived by slum dwellers, and a review and validation exercise for development of detailed vulnerability criteria. Triangulation and mapping were done with primary and secondary sources and missing slums identified.

Recommendations

- Vulnerability assessment should be aimed at identifying the vulnerable clusters (such as pavement dwellers, migrants, etc) of urban poor population.
- Secondary data specific to urban poor should be analysed and used for planning when available. For example, municipal data on basic services (piped water, sanitation) can be effectively used to identify and target underserved slums.
- Involvement of local NGOs/ CBOs familiar with the slums for data collection is important for identification of the vulnerable population.



Ms Alison Barrett (Cities Alliance) moderating the session on "Identifying and targeting the vulnerable urban populations"

- Tools such as priority ranking (Indore experience) and matrix method (3*3 matrix used in APUSP) are useful for identification of the vulnerable sections within the urban poor.
- There is need to create mechanisms to ensure that the marginalised are able to avail of the existing resources and facilities. There is also a need to look at the drawbacks of some provisions for identification of the poor, such as BPL cards, etc., as the statistics on urban poor are grossly underestimated. Such mechanisms will ensure that public subsidies and safety nets are provided to the most vulnerable.
- There is a need to focus on building capacities of urban local bodies for identification and targeting of the urban poor.

The concept of vulnerability should be used for policy making and for resource allocation

Prof. Amitabh Kundu, JNU

Improving hygiene behaviour through community sanitation initiatives



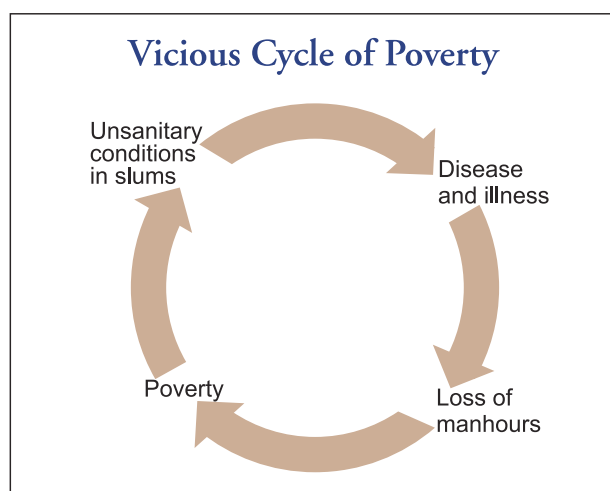
Chair & Moderator – Dr Masee Bateman,
Rapporteur – Dr Amita Bhide

Introduction

The urban poor, particularly young children, bear a disproportionate burden of infectious diseases related to water, sanitation, and hygiene. Open sewage, lack of garbage disposal methods, and lack of toilet facilities are deadly combinations that cause the spread of disease. As per the NSS 54th round (1998-99), 26% of urban households are without any toilet facilities, and thereby at significant risk of sanitation-related morbidity and mortality. Micro studies indicate that less than 40 per cent of households with a monthly per capita expenditure of Rs. 85 or less have a toilet facility, and about 70 per cent of those who do, share it with other households (Kundu, 1993). The challenge for planners and implementers is to identify approaches to address this looming health crisis.

Providing basic services requires the involvement of multiple stakeholders, including the public and private sectors and communities, as well as drawing from the existing provisions of various government programmes and schemes. Research has shown that access alone may bring little or no health impact (M. Favin, M. Yacoob, and D.

Bendahmane. 1999). For example, many people have access to a latrine but do not use it for practical and cultural reasons that were not taken into consideration when the latrine was built. Achieving and sustaining behavioural change requires community involvement, especially in the design of approaches and interventions. A combination of approaches that links hardware, hygiene promotion and an enabling environment is important for reducing the burden of diarrhoeal diseases (McGahey and Bateman, 2002).



Approaches and experiences

This session examined various community-based approaches to address sanitation issues and improve hygiene behaviour among the urban poor. The experiences presented in the session clearly established the critical role of NGOs and CBOs in the success of community sanitation programmes.

Community sanitation in urban slums

Sulabh International is a pioneer in construction of community toilets, operating more than 5000 toilet complexes in India. It combines software such as IEC, PRA, PAST and training, and hardware, which includes 14 efficient and effective toilet models. Community toilets are linked to biogas plants, which generate biogas from human excreta and may be used for lighting lamps, cooking, generating electricity, and body warming during winters. These units do not require scavengers to clean pits, thereby ensuring safe and hygienic disposal of human waste.

Lessons learned

Community contribution is a key component in the implementation of the project. Public toilet complexes are made self-sustainable with maintenance guaranteed through nominal user fees. Communities are mobilised and consensus sought from individual households for contributing towards the provision, operation, and maintenance of community toilets. Two key lessons are that environmental-friendly, safe, effective and affordable technologies for community sanitation in urban slums are available and that these should be used in combination with health and hygiene education.

Partnership for management of sanitation facilities

Recognising that adequate provision of basic facilities is a crucial factor for improving the health of the urban poor, **SPARC** has focused its intervention on ensuring provision of basic facilities along with sanitation. In Pune, it carried out successful implementation of installing community toilets. The slum sanitation programme in Pune was launched in late 1999 and in 18 months, more than 400 toilet blocks, or 7200 toilets, were built in slums. The municipal corporation spent Rs 44 crore over 18 months, leading to the construction of 7200 toilets in partnership with NGOs, as compared to a previous annual expenditure of Rs 20-25 lakh. The municipal corporation passed a resolution through its general body, authorising the commissioner to

Sanitation is a health-related package that includes safe disposal of different types of waste, safe drinking water and clean habitat.

Dr S. Nath, Sulabh International

Without community organisation to maintain basic facilities, health improvements may not be substantial...

Dr Meera Bapat, SPARC

involve NGOs in building toilets in slums on a large scale. For the first time, NGOs forayed into the construction of toilets, and the municipal corporation provided the financial support.

Lessons learned

The implementation of the programme marked a departure from the existing procedures. NGOs were contracted for design and construction of toilets, and for maintenance of toilets for 38 years. There were innovations in design such as squatting areas for children, provision of room for caretaker above the toilet blocks, etc. The costs incurred were 4-11% less than those quoted by conventional building contractors. Slum households are able to contribute monthly maintenance charges (of Rs 20 per family). Community-managed maintenance of the toilets has proved to be effective with a large proportion of users describing the toilets as “clean” or “very clean”, thus promoting hygiene sanitation practices.

Another key lesson is the importance of close coordination between various departments of the municipal corporation and the NGOs for the smooth and timely completion of toilet construction activities. To achieve this, regular weekly meetings involving heads of various departments, all NGO representatives and supervisory municipal staff to review progress and to resolve problems were held. In terms of community participation, the fast pace of the implementation did not provide NGOs the time and scope for involving slum communities. However, the NGOs are now forming people’s communities to take care of collection of service charges and maintenance of toilets. In Mumbai, SPARC has evolved a

more effective methodology of involving slum communities from the beginning, wherein a contribution of Rs 100 per adult, up to Rs 500 per family, as contribution towards a corpus for maintenance is a pre-requisite for construction to commence.



Group work on “Improving access to basic health services”

Role of NGOs and CBOs in slum sanitation

Saath, an NGO working for integrated development in Ahmedabad slums, presented a model for increasing the effectiveness of

urban development efforts through partnership with community-based groups. Saath promotes the formation of CBOs in slums and builds their technical and managerial capacities to sustain development activities and function independently. The NGO acts as a link between the ULB and the community (the primary stakeholders) through CBOs, to be able to demand for infrastructure and facilities from the municipal corporation. PRA exercises undertaken by the NGO helped understand various low-cost sanitation options in the slums and community ability and willingness to pay for sanitation facilities. The CBOs help sustain hygiene behaviour and regular maintenance of sanitation facilities through financial contributions from the community.

Lessons learned

Community ownership and participation can be enabled by maintaining transparency in the key processes involved in slum sanitation such as the design of infrastructure, quality control, and the use of financial contributions made by the communities. CBOs' capacities need to be built for planning, managing, and implementing development activities, and in establishing linkages with other development organisations and ULBs.

Recommendations

- Participation of several stakeholders such as ULBs, NGOs and CBOs is the key for effective and sustainable urban development.
- Efforts for promoting community and household level hygiene practices should complement investments in sanitation infrastructure. Provision of water and sanitation facilities alone, without appropriate hygiene practices, is inadequate to bring about health improvements.
- Consideration of technological appropriateness, operational feasibility and affordability of different models of community sanitation is important. NGOs and CBOs can play an important role in designing facilities, as shown in Mumbai and Pune.
- CBOs are capable of establishing linkages with urban local bodies for provision of infrastructure and services, and in eliciting community ownership for maintenance of facilities.
- Community ownership for sanitation programmes can be elicited by maintaining transparency in the processes of designing infrastructure, quality control, and in the usage of community contributions.
- User payment for services relieves pressure on municipal financing, ensures maintenance, and helps promote ownership.

Community capacities can be built to develop linkages with the municipal corporation for providing infrastructure in the slums...

Mr Rajendra Joshi, Saath

- However, affordability of services for communities should be kept in mind. NGOs can play a role in assessing communities' willingness and capacity to pay. To prevent exclusion from services, user fees/ community contributions should be rational and commensurate to the paying capacities of the urban poor.

Lessons from urban-specific health interventions



Chair & Moderator – Dr HPS Sachdev,
Rapporteur – Dr Rajesh Kumar

Introduction

There are no simple solutions to addressing health priorities in urban areas. On the face of it, urban health does not appear to be a major cause for concern. This is because available average health data do not reveal the wide disparities in the health indices across the urban population. The contamination of data on the health conditions of the urban poor by the better-off prevents targeted planning of interventions for those who are likely to benefit most from them.

The diversities in urban settings and the complexity of urban health stakeholders contribute to the challenges of working in urban health areas. While these and other challenges abound, opportunities for impacting urban health are several. Urban populations are concentrated geographically, are in closer physical proximity to hospitals, are more easily accessible for communication activities (particularly mass media), and are more likely to embrace change. There is also greater availability of resources and potential partners for providing health care in urban areas vis-à-vis rural areas. Owing to these inherent differences as compared to rural areas, urban health interventions will have to be implemented with approaches that are responsive to the urban environment.

Approaches and experiences

The session started with a presentation describing the health conditions of the urban poor, as revealed through the limited available urban poor-specific disaggregated data. A survey of Delhi slums conducted by Maulana Azad Medical College in 1991-92 revealed that 70 per cent of the neonatal deaths occurred in the slums within two-three km distance from major public hospitals. A case for collecting disaggregated urban poor data as part of routine health surveys was made to facilitate designing and monitoring of health interventions.

We do require routine health data, and among the various uses of collecting routine health data are advocacy, planning interventions, evaluating impact and monitoring.

Prof H P S Sachdev

Mass media can play a significant role in the behaviour change campaign as compared to rural areas because of better access to television, radio, and cinema.

*Mr Ramesh Singh,
Counterpart International*

Four examples of urban-specific interventions were presented. These small-scale projects demonstrated strong community participation, and laid stress on an effective communication strategy. They also adopted integrated approaches to tackle the issue of urban health, involving not only clinical services but also counselling, health education, awareness generation, and social marketing of products such as contraceptives, ORS, etc.

Immunisation promotion

The **Jeevan Daan Child Survival Programme** is being implemented by **Counterpart India** (a private voluntary organisation), **Sanchetana** (a local NGO) and the **Ahmedabad Municipal Corporation (AMC)**. The programme's core intervention areas are pneumonia management, control of diarrhoeal diseases, nutrition and immunisation. The focus is on reducing infant mortality in the urban slums of the AMC through improved care and better access to quality services; and strengthening the capacity of Counterpart and the NGO partner (Sanchetana) to plan, implement and evaluate child survival programmes in the targeted urban slums.

Multi-pronged strategies were adopted to promote immunisation in the slums and overcome social, economic and cultural barriers. These include consideration of suitable timings and venue for women working as domestic servants; focus on migrant and shifting population; factual and operational understanding of the situation through baseline assessment, community level announcements, household visits, introduction of referral chits, involvement of private practitioners, assisting the AMC and MoH in planning and organising national immunisation days (for pulse polio immunisation), organising periodic coordination committee meetings with AMC, forging CBO-ULB partnership for better coverage; and community mobilisation and behaviour change through the media to overcome cultural barriers. Some of the barriers in promoting immunisation among children in urban slums include lack of steady supply of electricity; distance and cost involved in commuting to the facility, geographical rigidity in providing services based on the ward boundaries, and overburdened staff.

Lessons learned

The Counterpart programme strategy clearly elucidated the importance of strong partnership with the public/government providers, linking and networking the public and private

providers for effective reach. Apart from these linkages, the emphasis on behaviour change communication to overcome the cultural barriers and mobilisation of community were other crucial factors for significant achievements. Continuous efforts in reviewing the operational strategy to make mid-course corrections based on lessons learnt, and monitoring quality also contributed to achieving the desired results.

Communities need to be involved in programme planning and needs assessment, and not just in implementation

Dr Geeta Sodhi, Swaasthya

Enhancing women's reproductive health in slums

Swaasthya, an NGO based in Delhi, has adopted an integrated approach for enhancing the reproductive health of women in urban slums. Its community-based reproductive health programme includes comprehensive clinical services, including counselling and health education; communications package; community-based social marketing of health products such as ORS, contraceptive pills, IFA tablets, etc.; and skill building and access to economic resources (micro-credit). In order to effectively reach out and enlist ownership, Swaasthya involved the target group at different stages of the project, namely, needs assessment, programme planning, implementation and evaluation. Other significant influencers such as males, older folks, and mothers-in-law were also involved.

Lessons learned

Swaasthya's experiences indicate that it is important to engage the target group in formative research for obtaining their commitment. Another learning is that an effective reproductive health care programme needs to include comprehensive clinical services in tandem with an appropriate communications package, skills building programme, and social and economic development initiatives. Sustainability can be ensured by encouraging the involvement of gatekeepers, NGO-GO-corporate partnership and economic viability of health care services.

Improving reproductive health through partnership with PMPs

The UNFPA-assisted **Integrated Population and Development (IPD) Project** works in partnership with private medical practitioners (PMPs)¹ to increase access to quality RCH services in urban slum areas, in five districts of Maharashtra. It also seeks to establish linkages between private providers and the municipal health system. IPD provides training and

¹ These include qualified allopathic doctors, ISM doctors, and the non-qualified informal providers

The opportunity to update knowledge and skills and improve credibility through linkages with health care delivery systems and CBOs are motivating factors for PMPs to participate in the delivery of RCH services.

Dr G S Chinde, IPD Project

capacity building programmes for PMPs as a strategy to enhance their skills and enlist their involvement in the programme. The PMPs' training consists of orientation on RCH programme, RTIs, STIs, HIV/AIDS, counselling for contraceptives, and prevention and management of ARIs and diarrhoea. After training, the PMPs are given a certificate and a kit containing condoms, oral contraceptive pills, ORS, and IEC materials.

Lessons learned

There is a significant presence of private providers in urban areas who can be trained to provide quality RCH care, particularly in the slums. A range of motivating factors contributed towards the participation of PMPs in the delivery of reproductive health services. The involvement of NGOs / Indian Medical Association / National Integrated Medical Association as implementing agencies, as well as linkages with the health care delivery system, has given greater acceptance to the PMPs. The linkages with CBOs and outreach activities have also brought in greater acceptability to the programme and brought the programme closer to the people. The opportunity to update knowledge and skills also attracted PMPs to participate in the trainings imparted by NGOs. The experience of utilising the existence and role of PMPs in urban slums illustrates the scope of private partnership for increasing outreach in slums.

ICDS in urban slums

In **Jamshedpur**, ICDS is initiating steps to extend its coverage in urban areas. Since ICDS is primarily a rural-based programme, urban-specific approaches are being piloted by **CARE** to identify best practices for maximising the scope of ICDS in urban areas. Unlike rural areas, anganwadi centres are not proportionate to the population and health services are not

In the rural areas, anganwadi centres are linked to a health unit, but in urban areas, there is no such system.

Dr Sanjay Pandey, CARE

linked to AWCs in urban areas. Four strategies are being tested in urban slums, which include training change agents from the community for community mobilisation and demand generation, formation of women's groups, community-based monitoring of health practices, and block level resource planning to identify slums which require increased attention.

Recommendations

- Health indicators are adverse for urban poor; average statistics mask inequalities. There is a need for re-analysing available data to obtain health information specific to the disadvantaged urban population. There is a need for collection of data for urban slums in future surveys / programmes for effective programming.
- Private medical practitioners can play an important role in urban health delivery. Their participation can be enhanced by organising training programmes at a time/venue suitable to them, giving certificates of recognition on completion of training and keeping the reporting requirement to the minimum.
- Community mobilisation and involvement of CBOs help in drawing the community, and enhance acceptability of the programme.
- Strong partnership between public providers and NGOs, and linking and networking with private providers are important.
- ICDS can be operationalised effectively in the urban areas by increasing community mobilisation, and forging linkages with allied groups at community level (youth groups, adolescent girls' groups, etc). However, the current reach of ICDS in urban slums is quite limited.
- Urban areas offer a potential for social marketing strategies for distribution of ORS, condoms, etc.
- The mass media can play a critical role in increasing the involvement of the urban population.
- Involvement of community at various stages of the project, namely, needs assessment, programme planning, implementation, evaluation, etc., will enlist and enhance ownership.
- Stable electricity supply can help improve the quality of immunisation services and maintenance of cold chain.
- Convenient location and timings of the health services are crucial for the success of any programme.



Group deliberations

Moderator - Dr Dinesh Agarwal, Co-Chair – Mr AK Mehra,
Rapporteur – Dr Rajesh Kumar

- F**our dominant and recurring themes emerged from the four scientific sessions, namely:
1. Improving access of basic health services to the urban poor
 2. Generating demand for basic health services
 3. Building capacities of partners
 4. Monitoring and evaluation

Along with the rapporteurs' notes from each session, with key issues identified and consensus recommendations, which provided the background notes, the groups deliberated on the key issues. The following recommendations were put forward by the consultation delegates as strategic approaches for addressing the health of the urban poor.

Group 1: Improving access of basic health services to the urban poor

The group discussed the barriers to accessing of basic health services by the urban poor. The group also discussed inter-sectoral convergence issues, public-private partnerships, community-based mechanisms, and alternate financing mechanisms as opportunities for improving access.

- The health department should develop city health plans with the participation of all stakeholders.
- Services should be made available to both recognised and unrecognised settlements.
- There is a need to address quality of services at the primary health centres. This includes quality of clinical services, timings, social distance, referral linkages, infrastructure, physical distance.
- Outreach services should be improved through a community-based mechanism.
- Inter-sectoral convergence needs to be strengthened for enhancing utilisation of existing government policies and provisions.
- Public-private partnership should be encouraged.
- A communications policy should be developed.

Group 2: Generating demand for basic health services

The group discussion on generating demand for basic health services reviewed the needs of different groups such as floating population, especially the pavement dwellers and other unapproachable groups that are generally left out, and discussed appropriate approaches for behaviour change communication. As part of the group discussion, strategies for community involvement and empowerment, convergence of different service providers and the ways and means to improve them, mechanism to build the interface between the community groups and the line departments were discussed. Issues relating to sustainability, relevant best practices and approaches for generating demand were also discussed.

- Meeting the unmet health needs of the urban poor, and reaching the marginalised such as pavement dwellers, construction workers, migrant labourers are critical.
- Micro-planning should be done to ensure quality, regular services with clear-cut geographical responsibilities.
- Regularity and quality of services should be improved and client perspective on quality should be sought.
- Convergence of services should be explored to fulfil demand already generated.
- Partners in demand generation should include decision makers, social and cultural groups, local practitioners and pharmacists.
- Culturally sensitive city-specific communication strategies should be developed.
- Behaviour change communication approaches should include peer education, interpersonal counselling, involvement of religious leaders, reinforcement of positive practices and remodulation of negative practices.
- Community empowerment strategies for ensuring community participation in design, implementation and monitoring should be developed and implemented.
- CBOs and self-help groups could sustain demand for services
- Alternate financing mechanisms such as user fee and cross subsidy can be explored for sustaining demand for quality services.

Group 3: Capacity building of partners

During the discussion on building capacities of partners, the group looked at identifying key areas for capacity building of partners, different training needs of partners, and developing training strategies. Best practices in capacity building were also shared.

- Begin with identifying and understanding roles of potential partners.



Dr Arvind Mathur (WHO/India) facilitating the group work on "Building capacities of partners"

- City stakeholder analysis of current capacities should be undertaken.
- Matrix of “capacity building needs of potential partners” for the city could be developed with information on current capacity, required capacity, and identified needs.
- Capacity building approaches can include exposure visits, cross-learning, peer-to-peer learning, competence focused hands-on training and periodic refreshers.
- Areas for capacity building can include programme planning, financial management, communication, leadership, team building, social mobilisation and coalition building,
- Capacity building of community must be an ongoing activity.
- Capacity building programmes must be customised based on local needs.

Group 4: Monitoring and evaluation

The group discussed some of the key principles and issues that should be considered for monitoring and evaluation, including identification of vulnerable urban groups and developing an MIS.

- The vulnerable groups must be identified through wider stakeholder consultations with involvement of the community.
- Norms for targeting of services should be developed based on the above.
- There is a need to review the existing data, norms, and process for identification of urban vulnerability. Mapping of vulnerability in slums needs to be undertaken prior to programme planning.
- Baseline surveys should be conducted where existing data is found to be inadequate or erroneous.
- Existing monitoring and evaluation tools should be strengthened rather than creating new sets of tools.
- Owing to multiplicity of stakeholders, there is a need for coordinated efforts and an independent body for monitoring and evaluation with representatives from different agencies.
- Process, output, and outcome indicators should be clearly articulated and measured.
- Guidelines for the implementation of the above should be developed.
- There is a need to adopt two-way flow of information at periodic interval.
- There should an in-built feedback mechanism at all levels to effectively use the MIS for strengthening the programme. Financial monitoring mechanism should also be built in the MIS.
- There should be capacity building of partners not just in generating but also in using and disseminating information for decision making.

Valedictory session



Key actions for the future

Dr Massee Bateman, USAID/India, facilitated the discussion on identifying key actions for the future. The following suggestions were proposed by the consultation delegates:

- Individual and institutional actions:
 - cross visits/cross learning
 - lessons from ongoing programmes
 - strengthening of networking and alliance for urban programmes.
- Dissemination plan for summarising the outputs and deliberations of the consultation:
 - Send documentation of the consultation reports to the planners and programmers who were unable to attend and participate in the deliberations.
 - Conduct regional echo workshops for state level planners and programmers.
- Communication arrangement to share experiences/information such as an e-group and/ or an urban health network.
- Creation of an urban-specific database or urban health resource centre for reference.
- Creation of a steering committee to manage the process of organising consultations. USAID open to supporting such annual consultation.
- Advocacy for:
 - inclusion of an appropriate methodology for data collection on urban poor in the next round of NFHS and other major national surveys.
 - increasing number of ANMs in urban areas
 - sensitising the elected representative, bureaucracy and service providers.
- Regional action planning workshops for state governments.
- Organisation of topical follow-up workshops
- Organisation of inter-department and interstate consultations.
- Urban health day to be announced.
- Cost effectiveness and replicability study of best practices for broader adaptation and scale-up.
- Adequate attention and priority to efforts for sanitation.

Valedictory address

Mr PK Hota, Secretary, Department of Family Welfare, highlighted some of the broad programme directions for improving health delivery for the urban poor in his valedictory address. These included developing simple roadmaps for launching the programme and pursuing tangible, feasible activities. He opined that the emphasis should be on speed and involvement of skilled personnel from various disciplines to strike the right balance. He stressed that future urban health programmes should build on the platform created by earlier programmes to ensure optimal utilisation of assets. The importance of dedication, passion and a commitment to time-bound achievements were other features that he stressed upon for building a positive attitude. Pointing to the need for convergence between different departments such as health and sanitation, collaboration with municipal bodies and allied departments for required input, he highlighted the need for developing and achieving efficiency-oriented outcomes of interventions.

Reflecting on the importance of sustainability, Mr Hota stressed the need to improve the living environment of the urban poor so that slum dwellers would be encouraged to invest in their habitat. He suggested outsourcing of second and third tier of health facilities to the private sector. He closed his address by stressing on the need for continuing deliberations not only to learn and share the collective experience but also to motivate the concerned service providers towards achieving the goal of catering to the underserved urban poor.

By utilising expertise, keeping reality in mind, working with zeal, passion and a sense of urgency, and using lateral thinking faculty,

Together We Can Deliver.

Annexes

Agenda

DAY 1

9:00 – 9:30	REGISTRATION	
9:30 – 10:15	Opening Plenary	
	Preface & Welcome	Dr Siddharth, EHP
	Lighting of the lamp	Mr S.S. Brar, Joint Secretary, MOHFW, Govt. Of India
	Keynote address: Urban Health Programme in India: Future Vision	Mr S.S. Brar, Joint Secretary, MOHFW, Govt. Of India
	GOI's policies and provisions for urban health	Dr Renu Khosla, NIUA
	Overview of health situation	Dr Masee Bateman, USAID
10:15 – 10:45	GROUP PHOTOGRAPH AND TEA BREAK	
10:45 - 1:15	Issues and options for health care delivery to the urban poor	
	Introducing the Session	Dr Siddharth, EHP
	Chair & Moderator	Ms Nandita Chatterjee, WHO
	Rapporteur	Prof Tara Kanitkar, IHMP
	Strategic options for health care delivery to the urban poor	Dr Suneeta Singh, World Bank
	Delivering primary health care for the urban poor through partnership with charitable hospital: The Guwahati experience	Dr Baishya, Guwahati Medical College
	Sustaining health care delivery for slum populations: The Kolkata IPP VIII experience	Dr KL Mukherjee, UHIP, Kolkatta
	Enhancing access and utilisation to primary health care through NGO run facilities	Dr Mala Ramachandra, UHRTI, Bangalore
	Reaching out to the urban poor through ICDS	Mr OP Rawat, WCD, Govt. of MP
	Mobilising communities for primary health care through NGOs: Lessons from CASP-Plan	Ms Bhagyashree Dengle, CASP PLAN

	Promoting partnerships for the health of the urban poor: Experiences from Indore	Dr Siddharth, EHP
1:15 – 2:00	LUNCH	
2:00 – 3:30	Identifying and targeting the vulnerable urban populations	
	Introducing the Session	Dr Masee Bateman, USAID
	Chair	Prof Amitabh Kundu, JNU
	Co-Chair	Dr V. K. Behal, DDG, MOHFW, Govt. Of India
	Moderator	Ms Alison Barrett, Cities Alliance
	Poverty and vulnerability assessment – APUSP	Mr Somesh Kumar, APUSP
	Participatory appraisal for understanding urban vulnerability in Lucknow	Mr Ranjit Ambastha, Oxfam
	Health vulnerability assessment in Indore	Dr Siddharth, EHP
3:30 – 3:45	TEA BREAK & POSTER VIEWING	
3:45 – 5:30	Improving hygiene behaviour through community sanitation initiatives	
	Introducing the Session	Mr Samaresh Sengupta, USAID
	Chair/Moderator	Dr Masee Bateman, USAID
	Rapporteur	Dr Amita Bhide, TISS
	Panelist	Mr Anand Jagtap, BMC
	Providing community sanitation facilities in urban slums	Dr S. Nath, Sulabh International
	Encouraging community ownership and partnership for managing community sanitation facilities	Dr Meera Bapat, SPARC
	Role of NGOs/CBOs in improving sanitation facilities in underserved slums	Mr Rajendra Joshi, Saath
7:30- 10:00	BANQUET	

DAY 2

9:00 – 9:10	RECAPITULATION	
9:10 -11:00	Addressing key urban health priorities among underserved urban populations: experience, lessons, and potential for replication	
	Introducing the Session	Dr Mala Ramachandra, UHRTI
	Chair/Moderator	Dr HPS Sachdev, President, IAP
	Rapporteur	Dr Rajesh Kumar, PGIMER
	Health conditions of the urban poor	Dr H. P. S. Sachdev
	Immunisation promotion in Ahmedabad	Mr Ramesh Singh, Counterpart International
	Improving health and nutrition of children through ICDS in urban slums	Dr Sanjay Pandey, CARE
	Enhancing women's reproductive health in urban slums	Dr Geeta Sodhi, Swaasthya
	Approach to engaging private medical providers in urban slums of Maharashtra	Dr G. S. Chinde, IPDP, Maharashtra
11:00 – 11:15	TEA	
11:15 -1:15	Group work: Recommendation on key strategic issues for urban health programming	
	Coordinator	Dr Dinesh Agarwal, UNFPA
	Summary of rapporteur's reports; Identification of strategic issues for group work; Outlining SOW for group work	
	Group deliberations	Group facilitator / rapporteur(to be chosen by group)
	Tentative issues for group work:	Core resource persons
	• Improving access of basic health services to the urban poor	Dr Arvind Mathur, WHO
	• Generating demand for basic health services	Dr Renu Khosla, NIUA
	• Capacity building	Dr Rajesh Kumar, PGIMER
	• Monitoring and evaluation	Dr Tara Kanitkar, IHMP

		Dr Karuna Singh, Delhi Municipal Corporation Dr Massee Bateman, USAID Dr Siddharth, EHP
1:15-2:00	LUNCH	
2:00 – 3:30	Future directions for addressing the health of the urban poor	
	Chair	Dr Massee Bateman, USAID
	Co-Chair	Mr AK Mehra, Director, MOHFW, Govt. Of India
	Moderator	Dr Dinesh Aggarwal, UNFPA
	Rapporteur	Dr Rajesh Kumar, PGIMER
	Group presentations	
3:30 – 3:45	TEA	
3:45 – 4:45	Valedictory session	
	Identifying key actions for the future	DrMassee Bateman , USAID
	Valedictory address	Mr PK Hota, Secretary, MOHFW, Govt. Of India
	Closing remarks	Mr Sreenivasa Murthy, Municipal Commissioner, Bangalore City Corporation
	Vote of thanks	Ms Anju Dadhwal Singh, EHP

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List of Urban Health Literature displayed at the Exhibition

EHP- India

1. Compendia on "Childhood death & disease burden among the urban poor" (Volume - 1); February 2003.
2. Compendia on "Childhood immunisation among the urban poor" (Volume - 2) February 2003.
3. Compendia on "Infant feeding practices among the urban poor" (Volume - 3); May 2003.
4. Compendia on "Addressing child malnutrition in urban slums" (Volume - 4); May 2003
5. Compendia on "Communicable diseases among the urban slums" (Volume - 5); May 2003
6. Compendia on "Addressing water, sanitation and hygiene issues in urban slums" (Volume - 6); May 2003
7. Compendia on "Health delivery systems for urban poor"; May 2003
8. Compendia on "Poverty & vulnerability assessment in urban areas"; May 2003
9. Technical assistance efforts in Indore, Madhya Pradesh
10. Situational Analysis for guiding USAID-EHP India's technical assistance efforts in Indore (M.P.) India – Draft Summary Report
11. Situational Analysis for guiding USAID-EHP India's technical assistance efforts in Indore (M.P.) India – Draft Report
12. Report of first expert group meeting on urban health programme under RCH II
13. Q and A on urban health: Based on the panel discussion at Urban Health Symposium at Belgaum

EHP- Washington

1. Ghana Urban Health Assessment: Environmental Health Project - Activity Report 114 by Patricia Taylor (2002)
2. Designing a Sanitation Programme for Urban Poor: Case study from Montego Bay, Jamaica, by Eduardo A. Perez & Betsy Reddaway; Environmental Health Project Activity Report No. 34 (1997)
3. Behaviour First: A minimum package of Environmental Health Behaviours to improve child health; Applied Study No. 10 by Michael Favin, Diane Bendahmane (1999)
4. The Environment and Children's Health: Measuring Impacts of Environmental Health Interventions – A practical guide (Report for the file # 256) by Patricia Billig, Elizabeth Creel and Eckhard Kleinau (1999)

5. Indicators for programmes to prevent diarrhoeal disease, malaria and acute respiratory infections – Report of a meeting of an EHP Technical Advisory Group July 30–31, 1997 (Activity Report No. 46) by Diane B. Bendahmane (1998)
6. Health of children living in urban slums in Asia and the Near East: Review of existing literature and data (Activity Report No. 109) by Sarah Fry, Bill Cousins and Ken Olivia (2002)

World Bank

1. Better Health Systems for India's Poor: Findings, Analysis, and Options Vol. -1 (2002) by David H. Peters, Abdo S. Yazbeck, Rashmi R. Sharma, G.N.V. Ramana, Lant H. Pritchett, Adam Wagstaff; Report No. 24124
2. If we walk together: Communities, NGOs, and Government in partnership for health: the IPP – VIII Hyderabad experience vol. 1 (1999); Report No. 19637
3. Health of the Poor in Urban India: A consultation; Report of the consultation, July 2002 India – Family Welfare (Urban Slums) Project Vol. 1, Report No. 24994- Implementation completion report
4. A Fine Balance: Some options for private and public health care in urban India Vol. 1, Report No. 22355- Working Paper
5. Health Care in India: Learning from experience, Report No. 22989- OED Evaluation Report

Water & Sanitation Programme (WSP)

1. Building Municipal Capacity to Deliver Services to the Poor/Nagari: Eighth Meeting of the Urban Think Tank, May 13, 1999, Nainital; UNDP-World Bank Water and Sanitation Programme-South Asia, 1999; Region: South Asia — Country: India — Language: English
2. Building Partnerships to Serve the Urban Poor: Summary Proceedings - Final Workshop of WUP Project No. 5; Water and Sanitation Programme - Africa, WUP, 2002; Region: East and Southern Africa — Country: General — Language: English; Workshop in Abidjan, Cote d'Ivoire, 19-21 November 2001
3. Community Initiatives in Operation and Maintenance of Urban Services, November 1998; Water and Sanitation Programme - South Asia, 1999; Region: South Asia — Country: General — Language: English
4. Costing Basic Services for the Urban Poor; Water and Sanitation Programme - South Asia, 2000; Region: South Asia — Country: Pakistan — Language: English; *Shehr-ki Duniya: Municipal Management Series Issue 2

5. Flow and Utilisation of Urban Poverty Funds: Tenth Meeting of the Urban Think Tank, February 25, 2000, Hyderabad (Nagari); Water and Sanitation Programme - South Asia, 2000; Region: South Asia — Country: India — Language: English
6. Good for Business: Women better customers of Urban Water Supply Services Water and Sanitation Programme - East Asia and the Pacific, 1999; Region: East Asia and the Pacific — Country: Indonesia — Language: English
7. Health in Your Hands: Lessons from Building Public-Private Partnerships for Washing Hands with Soap; WSP, 2002; Region: Global — Language: English
8. Hygiene Promotion in Burkina Faso and Zimbabwe: New Approaches to Behaviour Change; Water and Sanitation Programme - Africa, 2002; Region: East and Southern Africa — Country: Burkina Faso — Language: English; Blue Gold Series
9. Improving Peri-urban Water and Sanitation Services: Early Lessons from the El Alto Pilot Project; Mathys, Alain and Kristin Komives, 1999; Region: Andean Region — Country: Bolivia — Language: English
10. Improving Water Services through Small Scale Private Providers: Water Vending in Chennai; Water and Sanitation Programme - South Asia, 1999; Region: South Asia — Country: India — Language: English
11. Independent Water and Sanitation Providers in African Cities: Full Report of a Ten-Country Study; Collignon, Bernard and Marc Vezina, 2000; Region: East and Southern Africa — Country: General — Language: English
12. Is it selling toilets? No, A lifestyle; Mukherjee, Nilanjana and Ratna I Josodipoero, 2000; Region: East Asia and the Pacific — Country: Indonesia — Language: English
13. Learning the Fundamentals of Hygiene Promotion; Water and Sanitation Programme - South Asia, 2001; Region: South Asia — Country: India — Language: English; Sanitation and Hygiene Promotion Series
14. Managing the Process and Regulating the Sector: Nagari, December 5-6, 2001, Manesar, Haryana, India; Water and Sanitation Programme - South Asia, 2002; Region: South Asia — Country: India — Language: English
15. Myth vs. Reality in Sanitation and Hygiene Promotion; Mukherjee, Nilanjana, 2000; Region: East Asia and the Pacific — Country: Indonesia — Language: English
16. Private Sector Participation in Provision of Water and Sanitation Services to the Urban Poor: Nagari: Ninth Meeting Of The Urban Think Tank, October 29-30, 1999, Chennai; Water and Sanitation Programme - South Asia and DFID, 1999; Region: South Asia — Country: General — Language: English
17. Private Sector Participation in Urban Water and Sanitation: Managing the Process and Regulating the Sector, December 5-6, 2001, Manesar, Haryana, India; Water and Sanitation

- Programme - South Asia, 2002; Region: South Asia — Country: India — Language: English; Nagari Series
18. Privatising the Operation and Maintenance of Urban Water Supply: The Experience of Ajmer, Rajasthan, India; Water and Sanitation Programme - South Asia/UNICEF, 2000; Region: South Asia — Country: India — Language: English; Small Private Initiatives (SPI) Series
 19. Serving Poor Consumers in South Asian Cities; Brocklehurst, Clarissa and Barbara Evans, 2001; Region: South Asia — Country: General — Language: English; Private Sector Participation in Water and Sanitation
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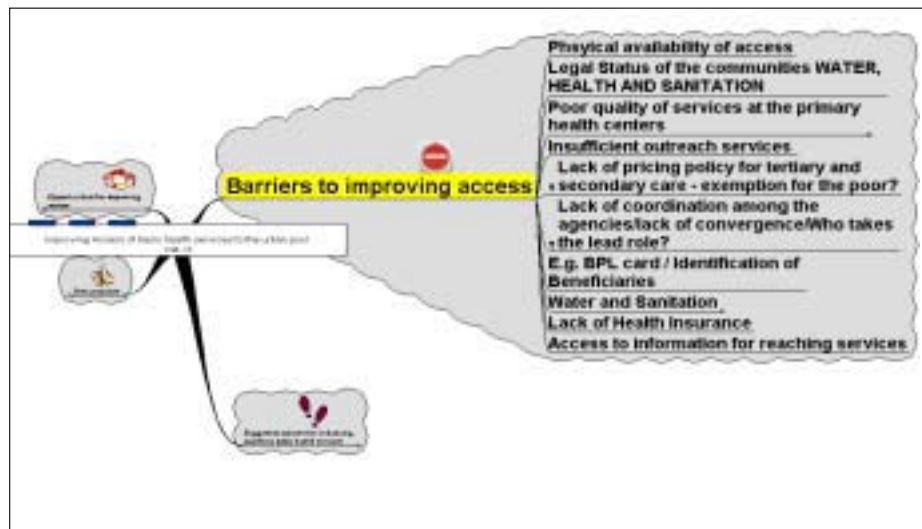
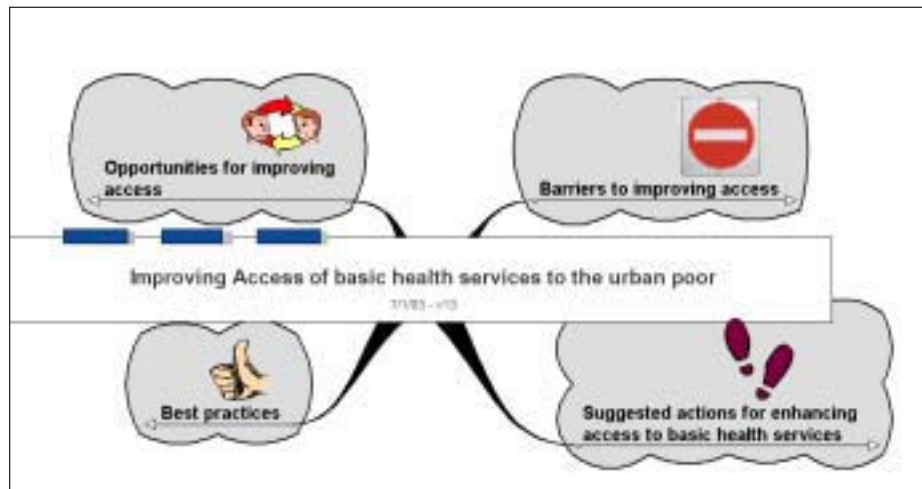
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Group Presentations

Group 1: Improving access of basic health services to the urban poor

Facilitators: Dr Renu Khosla/ Dr Masee Bateman

Rapporteur: Jost Wagner



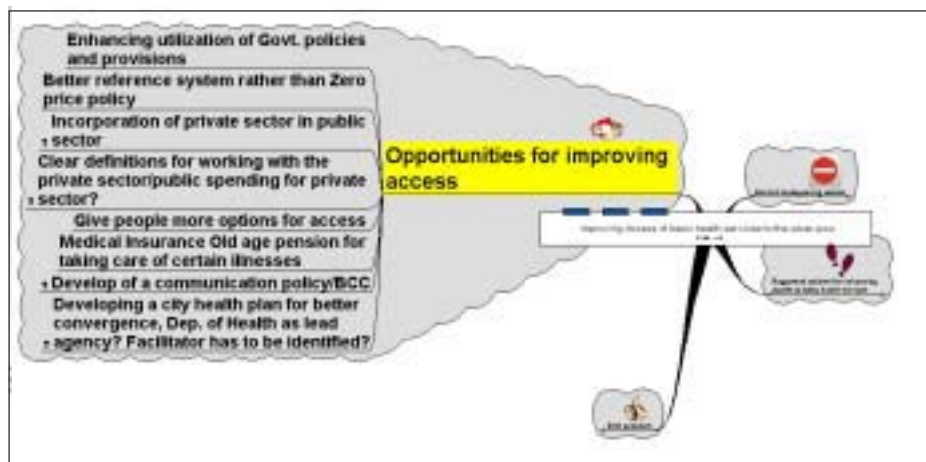
Poor quality of services at the primary health centres

- Poor quality of clinical services
- Timings
- Social distance
- Lack of referral linkages
- Infrastructure
- Physical Distance

Water and Sanitation

- Resources
- Technical capacity
- Loan servicing
- Legitimacy of tenure

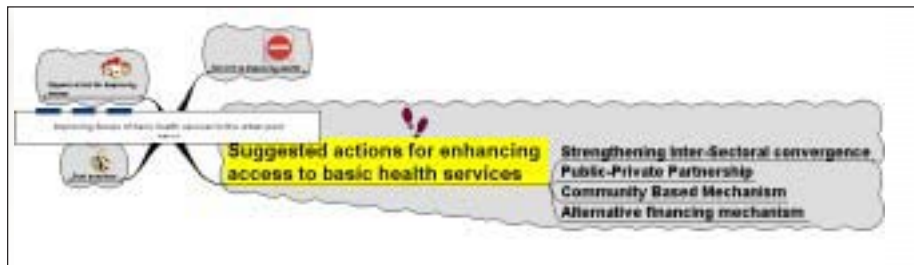
Opportunities for improving access



Best practices

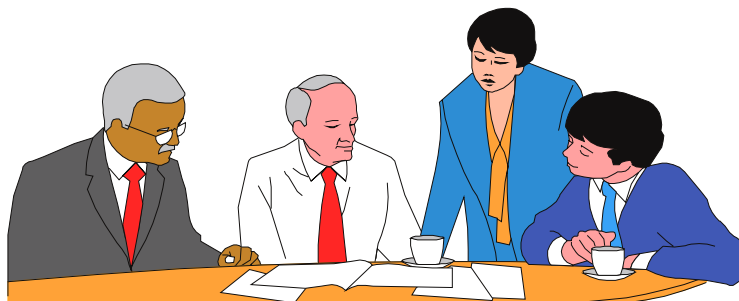


Suggested actions for enhancing access to basic health Services



Suggested actions for enhancing access to basic health services

Ministry of Health / Family Welfare and Ministry of Urban Development and Poverty Alleviation - Who speaks with whom on which level?



Group 2: Generating demand for basic health services

Facilitators: Dr Karuna Singh

Rapporteur: Dr K R Antony

Demand generation

Issues-I

- Design defect of Indian PHC system in not addressing the urban poor for health service delivery.
- Demand does exist already = UNMET NEEDS is the problem.
- Unarticulated needs also to be addressed.
- Inadequate information (IEC): Needs dissemination.

Demand generation

Issues-II

- Unreached poor segments. e.g., pavement dwellers
- Floating population like construction labourers
- Transit population, migrant labourers
- Specific role of NGOs and CBOs, e.g. link workers in addressing them.

Strategies for demand generation

- Quality of outreach services as a means of demand generation
- Good micro-planning: Assigning responsibility of defined slum area to particular institution
- Matching service delivery with demand already generated
- Convergence to fulfill such demand
- Improving the perspective of clients on quality of services.

Partners in demand generation

- Decision-makers/ “gatekeepers” to be involved
- Social and cultural groups
- Local practitioners/pharmacists
- Culturally sensitive communication strategies
- City-specific strategies/approaches:
 - Kolkata and Mumbai: Elected representatives, councillors are important
 - Delhi: House leader of Municipal Corporation.

Behavioural change communication (Different from conventional IEC)

- Peer education by mothers and community leaders
- Infotainment
- Interpersonal communication and counselling.
- Involvement of religious leaders
- Reinforcing the positive and remodulating negatives practices & culturally sensitive messages
- Participatory strategy designing and implementation.

Community empowerment strategies

- Ensuring participation in
 - Designing/organising
 - Implementation
 - Monitoring.

Example

1. SUDA/DUDA model, NHG, RCV,CDS
2. NGO/CBO model
3. SPARC- Community groups and networking with a committee
4. Micro-credit/ SHG groups - SEWA/*Shramik Bharati*, Kanpur
5. Community-based surveillance system - ANKUR/Lakshmi, Lucknow
6. Timely & efficient redressal of complaints from community by Health System e.g. Lucknow, CMO.
7. Mortality analysis: Verbal autopsy and community discussion on ways of preventing avoidable maternal & infant deaths

Sustainability

- Ensuring regularity and quality of services
- Convenient timings
- User charges for good quality services
- Cross subsidy to generate revenue
- Disaster preparedness
- Capacity for crisis management: Earthquakes, flood, and cyclone effects in slums

Group 3: Deliberations from the group work on building capacities of partners

Facilitators: Dr Arvind Mathur

Rapporteur: Ms Shakti Sharma

1. Identifying urban health partners

- a) **Centre** – A technical resource unit may be established with the primary objective of:
 - Providing technical reference material
 - Identifying and listing empanelled technical institutions (eg. Baseline survey)
 - Overall guidance and technical support
- b) **State** – A technical programme management unit
 - Health dept. (Coordinating training for baseline/end line, research etc.)
 - Other departments
 - Dept. of Women and Child development (ICDS)
 - Poverty alleviation and urban development
 - Education Dept.
 - Dept. of Mass media
 - District Urban Development Authority
- c) **City**
 - Municipal Corporation and its various departments. – engineering, sanitation and slum development boards
 - District Urban Development Authority
 - Private/corporate sector
 - Professional associations, e.g. IMA
- d) **Programme focus area/ community**
 - Charitable organisations

- Formal and informal health providers – private practitioners, ISMPs, pharmacies
- Ward committees
- Urban Basic Service Group
- Elected representatives
- NGOs and other civil society organisations (eg women/youth clubs)
- Community-based organisations

2. Assessing current capacities and identifying needs

Key features:

- a) Build on existing capacities
- b) Participatory assessment of partners
- c) Developing a matrix of CB needs through a situation analysis involving the stakeholders.

The thematic areas may include the following:

- **Institutional**
 - Leadership development
 - Community mobilisation
 - HMIS
 - Financial management
 - Sustainability, quality of service delivery
 - Communication counselling
 - **Community**
 - related services and practices (construction and maintenance of facilities)
 - objective would be to identify the current capacities, capacity requirements/ needs and resource requirements
- d) Identify champions/ excellence among stakeholders

3. Developing training strategies (from state to city) and identifying areas for capacity building

Flow of information and efforts from State to City to Programme partners

The process may involve formation of a state level committee comprising experts from the field of public health, communication, programme management, etc., representatives from various departments such as health, SUDA, education which will provide technical assistance to regional teams (number of regional teams may vary with the state) which in turn would support the city level teams. The city team may include members like the district magistrate, representatives from DUDA, zonal officers from municipal corporation, medical officers, etc.

The primary stakeholders/ implementers will provide continuous feedback on needs for capacity building to the city level team based on the execution of the programme. Thus a cyclic flow of information and capacity building efforts will evolve.

Key features:

- a) Capacity building for all levels of organisation and information sharing
- b) Techniques involving community participation

4. Best practices (successful examples from experiences)

4.1 Pakistan NGO initiative (PNI)

PNI was established in 1995 with funding support from USAID to strengthen the capacity of NGOs to work with local communities in improving access to and delivery of social services with a focus on community participation and women's empowerment. The capacity building for development and implementation of community-based maternal and child health programmes was realised through two interventions:

- Capacity building to conduct qualitative and formative research, including 24-hour recall, Trials for Improved Practices (TIPS) and in-depth interviews
- Capacity building for the development of counselling packages for breastfeeding and MCH and nutrition

Lessons learnt

- Multi-faceted training interventions for NGOs are necessary to facilitate the design and development of community-based interventions pertinent to the communities they serve.
- Changes in organisational behaviour are necessary in order to implement participatory approaches and design of innovative interventions for communities.

4.2 Andhra Pradesh Urban Services for the Poor (APUSP)

An essential feature of APUSP is the capacity building of municipalities to articulate the needs of the poor. The programme focuses on reforms directed towards participatory planning, ie, involvement of communities, civil societies, CBOs and NGOs in decision making. Concomitantly, it also addresses the need of institutional development through improved accountability, human resource development and improved municipal responsiveness.

4.3 Project Concern International

The primary objective of the capacity building initiative is to mitigate the spread and impact of HIV/ AIDS by strengthening NGOs. In India the programme targets six NGOs

focusing on capacity building at the organisational/management level. The primary areas for capacity building are:

Strategic planning, governance/leadership, administration/financial management, resource development/sustainability, state-of-the-art interventions, programme planning, implementation, monitoring, evaluation, reporting and networking.

The processes followed include organisational self-assessment, HIV/Aids intervention plans and sub grants, training, mentoring and networking.

Achievements and challenges of the programme

- NGOs: Nascent, Emerging, Expanding, Mature
- Increased HIV/AIDS services

Challenges

- Continuity: Crisis contexts; fragile and turbulent life of NGOs
- Long-term process/long-term commitment
- Measurement methodologies

Possible areas of capacity building	Target trainees provide training	Who will	Key methodologies
Technical Training (Knowledge, skills) <ul style="list-style-type: none"> • Antenatal, delivery, postnatal care • Newborn care • Infant health, immunisation • Family planning services • Detection & treatment of RTIs/STIs • Diarrhoea, ARI, fevers • Identification of leprosy, blindness 	Medical officers ANMs/HVs, NGOworkers Link volunteers, MAS reps.	Train NGO for city OR Regional Health and FW Training Centre	Group learning, handouts, practice, case study discussion Field trial of counselling skills, reflections, group learning, technical handouts, case studies, case scenario simulation Field trial, pictorial handouts, reflections, revision through role play, visual material and models, games.
Programme Coordination and monitoring	City UH Unit, MOs, ANMs	Specialised agency	Discussion, practice using representative cases from UHCs/cities, revision
Identification & follow-up, referral of beneficiaries	Link Volunteers, NGO workers.	Training NGO for city	Social mapping, Group discussions, visual material and models
Community needs assessment, mobilisation and behaviour change	ANMs, MOs, NGO workers, Link Volunteers	Specialised NGO With sustainability perspective	Mock exercise, reflections, practice at community level, discussion, pictorial handouts, case studies, cross visits.
Programme Sustainability <ul style="list-style-type: none"> • Institutional • Financial • Process 	Link Volunteers, NGO workers, UHC Coord. Forum	Specialised NGO With sustainability perspective	Case Study discussions, cross visit, facilitation and discussion
Urban Issues: Governance, Vulnerability, Sanitation	MOs, ANMs, NGO workers	Specialised NGO	Discussion, summation, revision, slum visits

Group 4: Monitoring and Evaluation

Facilitator: Dr Rajesh Kumar

Rapporteur: Mr O P Rawat

Issues to be grappled with

- Need to be responsive and dynamic to changing realities & vulnerabilities that may be group, local and time-specific.
- Need for uniformity to inform programmes.
- Involvement of people a must.
- Initial consultation with a wide variety of stakeholders to identify clusters & vulnerable groups, then evolve norms for targeting (definition & process of identification).
- Should not be a one-time process but periodic.
- The need to use and review system-generated norms, eg: BPL cards etc, but also move beyond.
- Need to co-ordinate with government & other systems; flexibility for local bodies.
- Monitoring of each formative stage.
- Monitoring of vulnerable identification steps.
- Review existing data first, surveys can be expensive.
- Need for baselines where data found to be inadequate or erroneous.
- Geographical mapping of the poor as a beginning point -GIS.
- Importance of both socio-economic and gender-specific data.
- Need to include community-specific issues and clients on quality of services.
- Need for triangulation with other data system, eg, NSS, NFHS.
- Baseline/periodic surveys could be part of or could be coupled with service provision management.
- Need for input, output and process indicators for programmes.
- Development of monitoring and evaluation tools after viewing the existing tools.

- Multiplication of agencies in urban areas; hence need for coordinated, independent body for monitoring and evaluation with representatives from different agencies.
- Monitoring indicators for the above steps need to be developed along with how these will be implemented.
- Review of channels of information, frequency as an important aspect of process of M&E.
- Capacity building of partners not just in generating but also using information dissemination and decision-making (should be based on tools with some perspectives).
- Based on the principle that local communities should have the right over information.
- Perhaps exploration of media/fora to put popular discourse in place.
- Channels for both upward and downward communication.
- Monitoring indicators need to be formulated for monitoring capacity building activities.



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