Urban Health Programme in Odisha : An Innovation for GO-NGO and Community Partnership

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It is now a well established fact in developmental literature that effective service delivery, the essence of Good Governance is a cooperative effort, and hence, can be realized through partnerships only. The planners, executors, change agents and the civil society organizations have come to the consensus that Govt. alone cannot achieve the goals of inclusive development; and, partnership with community and peoples' organizations will go a long way in launching a comprehensive strategy for delivery of services. The Urban Health Programme initiated under National Health Mission offers a wide scope for such partnership in delivery of health services to the disadvantaged and hither to excluded sections at the bottom level of population.

The Magnitude of the Problem in Odisha

As per 2011 Census, the urban areas in Odisha covers 107 Urban Local Bodies (ULB) including 3 Municipal Corporations, 37 Municipalities and 67 Notified Area Councils (NAC). The percentage of Urban population to total population of the State is around 16.68%. On an average, around 43% of the population living in these localities are below poverty line and around 23% of them live in slums. Speaking in a National Seminar on Water Management Chief Secretary to Govt. of Odisha Shri Jugal Kishore Mohapatra, IAS opined that urbanization in Odisha is likely to increase up to 30 to 40% from the present level of 17% in coming 10 years.[1]

Urban areas host to burgeoning unauthorized slums with floating population. This makes it difficult or even un-permissible to provide institutionalized health services in these unauthorized locations which leads to low level of health indicators almost at par with rural areas. The conditions of urban living with its low educational and awareness level are non-conducive for IEC and BCC activities. Weak linkage between service providers and communities, non-extension of services to these unauthorized locations, low level of investment by ULBs, poor environmental conditions, inadequate health and sanitation facilities are perpetual conditions. Poverty and low level of awareness lead to malnutrition which in turn, leads to diverse alarming consequences. A senior executive of Health for Urban Poor (HUP) in Mission Directorate, NHM observes , "Anemia is a major health problem in the slums especially among women and children. Further, the other health indicators like IMR, Institutional Delivery, ANC, PNC, TFR, immunization, anemia among the adolescent, US mortality, underweight children are very low. The disease outbreaks are also frequent."[2] The urban slum population is mostly

concentrated in 7 to 8 cities namely Balasore, Bhubaneswar, Cuttack, Ganjam, Puri, Sundargarh, Sambalpur and Berhampur. These slum dwellers have little to access to primary health care services and can hardly afford private hospitals. Health indicators in these areas are far lower than what the urban average data denotes. One in 10 children in urban slum does not love to see his/her first birth day. Child mortality is 103 per 1000. Many communicable diseases like Tuberculosis commonly prevalent in these areas adversely impact health of slum dwellers more particularly mother and children.[3] Increasing urbanization accompanied by growing slums makes it difficult for ULBs to provide institutionalized health services. All these conditions pose challenges before the State and calls for special intervention.[4]

Odisha Model of Urban Health Project (UHP)

To combat the perpetuating evil (as briefed above) Govt. of Odisha have evolved an innovative strategy of partnership among Bureaucracy-Urban Local Bodies-NGO and Community for implementation of Urban Health Project to extend the outreach of health services in urban area. The strategy has been viewed by experts as a model for adoption elsewhere. Of course, the trail is on, and, the end result will speak about its efficacy elsewhere. The author in the present article has tried to look into the strategy adopted in Odisha with its background, techniques of operation and visible outcomes.

The programme has been launched as Urban Slum Health Project (USHP) from 2011 on pilot basis in identified slums in 11 towns and cities of the State covering 922 slums served by 37 Urban Health Centres (UHC). Each USHP covers 20,000 to 25000 slum population including migrant labourers, homeless, street children, rickshaw pullers, construction and brick workers etc.

The Programme has been designed as a community health development strategy aimed at improving health standards of urban community by enhancing availability and accessibility of health services to the people. It envisages capacity building at community level for planning, monitoring and management of health problems by people themselves with Government only playing the role of a facilitator. The programme targets at promotion of safe motherhood, reduction of Maternal Mortality Rate (MMR), Reduction of Neo-natal Mortality Rate (NMR), prevention of Reproductive Tract Infection (RTI), Prevention of Sexually Transmitted Diseases (STD) and improve the health standards of the urban poor, especially in identified slum locations. The specific objectives of the programme are:

- To provide integrated primary health services for maternal & child care and prevention/ control of communicable diseases in slums areas.
- To promote health status of the urban poor through increased coverage of reproductive child health services, adoption of healthy behavioral practices and catering to unmet family planning needs.
- To undertake necessary activities for qualitative improvement of health determinants like water, sanitation, hygiene & nutrition.
- To generate community demand for health services and to enhance the accessibility to health institutions through capacity building at community level.

Approach and Activities

The programme adopts a multi-dimensional approach for realization of these

objectives viz. **preventive, curative, referral and extension of outreach services**. The preventive steps are taken by creating awareness through community involvement. Curative services are provided in urban health centres which is centrally located and easily accessible to the people from slums. The cases which are difficult to be managed at UHC are referred to referral hospitals and people are provided handholding support for availing the benefits of 108 ambulance service, emergency ambulance service, state treatment fund etc. Outreach services include organization of health & nutrition day, health camps, check up camps, immunization programmes, family planning promotion, IEC and BCC activities, sensitization of adolescent girls on life skill education, promotion of institutional delivery, capacity building of WSHGs, formation and strengthening of Ward Swasthya Samiti, promotion of Malaria control. These activities are managed by ANMs and link volunteers of the project.

Integration and Convergence

An artifice of integration and convergence has been evolved to make primary health care universally accessible. A good synergy between planning, execution and management of primary health care has been worked out through a partnership among Govt. of India, State Govt, HUP programme supported by USAID India, local community, urban local body and NGOs. Transparency, credibility and efficacy have been the guiding principle for selecting the partners. Service providers have been made accountable to the community.

Government has expertise in identifying social goals and crafting out programmes to achieve them. Government has also dovetailed funds to provide for incentives and medicines. The HUP of USAID India provides technical support. The voluntary/private sector has the skill of implementation and innovation with reliable ability to reach the targeted population and deliver services. Involvement of private and voluntary sector brings in more manpower and expertise for extending outreach of services of large number of people. The voluntary sector has also some reliable track record of working for good health among people and community since such an activity is entrenched in charity.

Considering all these, Government of Odisha have planned a synergy and integration of all the stakeholders for instilling a sense of programme ownership in them and making them a part of the system for harnessing community health. Govt. have made proactive policies and facilitating norms of public private partnership in health programmes. Department of Health and Family Welfare, in collaboration with National Health Mission have worked out the guidelines for partnership. The NGO and private partners were selected through inviting of the Expression of Interest (EOI) in open bidding process. The final selection of NGO and private partners were done on the basis of the track record of the organizations, their experience in health programmes, their expertise and ability to deliver the services. Attempt was made to ensure equity, transparency and accountability at each stage in the whole partnership.

In this synergetic strategy Government provides available infrastructural facilities, funds for salaries, operational expenses, equipment, furniture and pharmaceuticals etc. NGOs are also provided necessary training by expert and professional bodies of Government. Hiring of doctors, and support staff is the responsibility of NGOs. Opening of OPD, delivery of services, organization of outreach camps, health check-up programmes, mobilization of the community,

networking with people, empowering of the community to demand for health services, enabling the community to access the services, awareness and behavior change communication (BCC) are entrusted to NGO partners. Community has been activated through formation of Ward Swasthya Samities, Mahila Arogya Samities, Balika Mandals and Peer Groups. The similar health schemes and programmes like reproductive child health, mother & child care services have been converged and a holistic approach has been devised. The integration has been designed in such a manner that ownership of the project by ULB is ensured at every stage starting from signing of MoU(Memorandum of understanding), planning for establishment of urban health centre and release of funds to executing agencies for monitoring and evaluation. The Health Officer or the Medical Officer of the concerned ULB has been designated as the Nodal Officer for the project in their respective towns or cities. In the whole project NGOs have been involved as the real performing and delivering partner in the field. Attempt has been made to mobilize the local human, financial and infrastructural resources by way of convergence. The following figure presents a pictorial presentation of the process.

The programme is now put to pilot testing in 12 locations of 11 towns and cities. The detail of the present coverage of the programme is presented in table No.1 for a snap view.

Monitoring & Evaluation

In OUHP close monitoring and suggestive evaluations have been accepted as the keys for ensuring delivery of primary health services and improvement in health indicators. Three-tier monitoring system has been put in place. The first level of monitoring is done at the NGO level which is often called the internal monitoring. The Executive Committee and the Advisory Council of the NGOS are directly involved in the monitoring and evaluation. They mostly monitor the utilization of funds, organization of the programmes, working of OPD and other extension services. The second level of monitoring is done at the District level involving the ULBs, partner NGOs, Medical Officers, NRHM and RRC coordinators. The third level monitoring is done at the State level.

Detailed guideline and structure have been framed for adequate monitoring and dependable evaluation. The entire process is undertaken in the following manner.

1. Service providing NGOs, after having their internal evaluation, submit MPR in a prescribed format both in soft and hard copies.

2. At district level the progress of the project is reviewed monthly by the concerned ULB and District Health administration involving the Collector.

3. At the State level the project performance is reviewed on quarterly basis by the State Level Mission Director of NHM. The progress and bottlenecks in the process are also reviewed by the Apex Body State Health Society under the Chairmanship of Chief Secretary.

4. Apart from these mid-term evaluation (after one year) and final evaluation (after three years) of the project is done by the external independent agency.

Visible Outcomes

As told in the previous sections of this article this innovative approach is in the trial and end results are yet to be realized in their full potential. The end result, particularly in the context of long term impact, behavioral change of people, people's ownership and sustainability of the programme are yet to be seen. But the upcoming

results in terms of service delivery and outreach of the programme are clearly visible. The inter-sectoral collaboration among H & U D Dept, H & F W Dept. and W&CD Dept and other stakeholders have been institutionalized through formation of State Coordination Committee and City Coordination Committee. Some midterm evaluations done by independent agencies have clearly pointed out the upcoming results. The institutional mechanism which is offshoot of this innovation has also been put in place. The Table No.2 paragraphs point to some such outcomes of one year in 9 major cities and towns where the programme has been put to pilot.

It may be observed from the figures in table below that average patients treated as outdoor patients in UHC is 35 per day, average monthly referral of the patients to the referral hospital by UNHCs in 9 towns is 50 and average institutional delivery facilitated per month by the HUC is 25, average RTI and STI cases detected and treated are 6 per month. These achievements are over and above the normal treatment provided by health machinery. A focused discussion with MOs of the PHCs and hospitals of the nearby areas revealed that because of UHP interventions there has been observable difference in referral cases and institutional delivery. There are also visible outcomes in treatment of RTI ,STD, and TB patients. Motivation towards adoption of planning measures and prevention of Malaria have also been achieved in good numbers.

A Case Study of Bhubaneswar City.

In order to have a micro level deeper analysis of the outcomes, attempt was made to look into the grounding and outcomes of the project in Bhubaneswar city. A look into the operationalization of the project over last one year revealed the following achievements.

1. City Collaboration Committee has been institutionalized through coordination among NHM and Governmental departments and BMC.

2. Listing of slums and assessment of facilities to be provided have been done through collaborative efforts of NHM, Govt. Health machinery and NGOs.

3. A significant integration of OUHP with peoples' representatives, district administration, Govt and private doctors, AWC, field level health functionaries, SHGs has been achieved.

4. An encouraging level of peoples' acceptance has been noticed in the project. Slum dwellers have accepted the project whole-heartedly as the project caters to their felt needs which remained unmet due to lack of adequate Govt. facility.

5. 176 Mahila Arogya Samities and 5 ward coordination committees have been formed and made functional.

6. Awareness programmes on hand wash, general hygiene and sanitation practices have been organized for school children in 24 primary schools through demonstration, animation films, and magic shows. Street play on nutrition, health hygiene and growth monitoring of the child have been organized in 30 slums areas. Films on maternal health and safety motherhood have prepared and exhibited in 20 slums. HIMS have been developed and introduced in urban slum health centre.

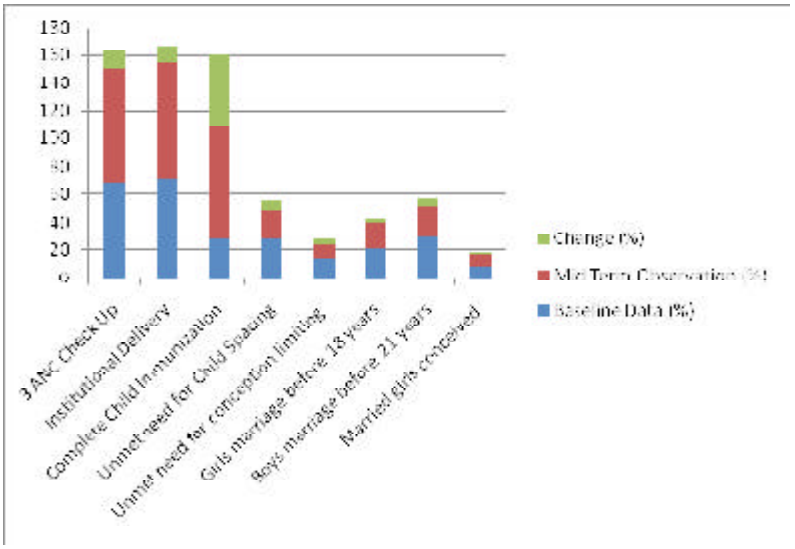
Apart from these administrative cohesion, dovetailing of resources and IEC activities the UHP interventions through partnership model has brought about visible changes in **institutional set up and service delivery**. The data availed in course of the preparation of this article are presented in the table No.3.

It can be inferred from the statistical analysis made in table that OUHP in Bhubaneswar city has provided preliminary health services to the additional 2.31,292 population living in 47,685 households across 242 slum locations within 39 wards of the corporation who otherwise were out of the reach of common health services. The services are being provided by 9 NGO partners spread thoughout the city. NGOs have been allotted specific wards to ensure inclusive coverage and accountability.

A look into the **Mid-Term Evaluation** done by Independent Agencies after completion of one and half a year of the project reveals the following outcomes of the programme.[1]

1. The average number outdoor patients in UHCs per day has increased to 41.

2. The average number of critical patients identified and referred to Hospitals has increased to 47 per month.



3. The percentage of institutional delivery increased by 23% in catchment area of the project.

4. Monthly average number of RTI /STI cases identified and treated per month is 6 who otherwise would have been the source of contamination.

5. In Post natal Care, on an average 13 PNC cases per month are flowed up and provided check up and other post natal services.

6. As Family Welfare measure, a total number of 114 cases have been motivated who opted for sterilization.

7. A total number of 29 TB cases have been identified and cured through proper service.

8. As Malaria prevention measure a total number of 54,789 bed nets have been impregnated in slums areas.

Project Impact on Identified Health Indicators-

Attempt was made to look into the performance of the project in the light of identified health indicators**.** An assessment of performance of the project in Patharbandha slum near Vanivihar was done through adoption of scientific methodology. Research tools like FGD (Focused Group discussion), narrative interview, examination of MIS (Management of Information System), validation reports and facility observation reveal the table No.4 impact of the project within a period of one and half a year.[2]

It can be observed from the table that a degree of improvement in key indicators of urban health is visible in project operation area which for a synaptic view can be seen in the diagram.

Sample Case Stories

1. Savitri Maharana, w/o- Rabindra Maharana is a resident of Patharbandha south slum. She got married during 2009 and was blessed with a male child who is now 2 years old. The OUHP was started in the said slum during January,2011. The project staff and the link volunteer came to her and explained her about the utility of keeping gap between two children and adoption of planning measures. They also motivated her to use contraceptives. Savitri said, "earlier she had a lot of mythical beliefs about the conception of a child, birth of a child." After constant persuasion by link volunteer and subsequently by ANM , Savitri took up the issue with her husband. She talked with her husband about the use of condoms and assured him that it will be available free of cost at their home without knowledge of parents and elders. Till now they are using contraceptives and taking good care of their first child.

2. Ojifa Bibi w/o Samsar Khan is a resident of Regional Science Park Bustee. She is aged about 26 years. She has been blessed with 2 children one boy and one girl. The project staff gave her proper information about conception of a child, prenatal postnatal care and utility of adopting family planning measures. She reported that at the initial level the sayings of project people was against her family norms and she knew that none of the elders including her husband would agree for this. However, after constant persuasion by project staff she and her husband became convinced and agreed to use condoms. It was made available to them at their home. Ojifa said that now she is happy and free from the fear of bearing another child. She also said that project staff have been persuading her to go for permanent sterilization. She has convinced her husband. They have planned to go for it during January, 2014

3. Kiranbala Mahapatra is now working as Angnawadi worker in Bisheswar Bustee. She says that there is no ASHA worker in her AWC area. She used to face a lot of problems in carrying out various mother & child care works and immunization. She had to do all works alone for which work was not being satisfactory. But now, because of the project she has got one sister as link volunteer who assists her in all these works. She is able to do the works and immunize all the children in her Anganwadi area.

Challenges and Suggestive Measures

Along with the success as pointed out in preceding paragraphs, the opereationalization of the project has also brought about some challenges as is revealed from the field situation. The challenges along with suggestive guidelines are put in the succeeding paragraphs.

1. The resources put in are quite inadequate to cater to diversified project objectives of a large population. There is need to increase the number of UHC and frequency of health camps. There is requirement for additional human resource and infrastructure. The medicine for various types of common ailment should be made available at UHCs. There should be improvement in quality and quantity of medicines supplied.

2. There is need to provide basic public utility facilities like toilet, water supply, drinking water, waiting space etc. in the UHCs.

3. There is need for providing technical hands for paramedical and pathological services in UHCs.

4. Though the project has been accepted by the slum dwellers, it seems that male participation is quite low and measures should be taken to promote male participation.

5. The link volunteers who play the most crucial role need to be imparted professional

training with practical exposures. The promised incentives should be released to the volunteers in time so that they do not lose their interest to deliver the services.

6. Various stakeholders of the project site and the opinion makers of the slum community need to be actively involved in the project.

7. The BCC and IEC activities need to be intensified through Public Relation Approach (PRA) to effect real changes in behavior of the people.

8. The CBOs (Community Based Organizations) existing or constituted in course of the project need to be mobilized and motivated through interpersonal techniques of public relation exercise.

9. Community ownership of the project should be promoted through qualitative service delivery, involvement of opinion makers and public relation activities so as to make the project sustainable.

The OUHP strategy of Odisha has grounded an innovative model of partnership among the Government machinery, Non Government Organizations, Urban Local Body in particular and civil society in general. But its effectiveness will depend on the extent to which these challenges are addressed and mitigated.

Table No.1

Pilot Coverage Status of OUHP

District	Name of the ULB	NGO Partner	No. of slums covered	Slum population covered
Cuttack	Cuttack	Lions Club of Mahanadi	34	29000
		Madhusudan Matrumangal Kendra	19	27744
		CHANGE	29	19301
		NIAHRD	26	20370
		SAI	19	21,059
		Utkal Sevak Samaj	17	20157
		Pragati Yuba Kendra	34	28541
		Suprativa	20	20,000
Khurdha	Bhubaneswar	My Heart	16	22,205
		FPAI	17	21,244
		Open Learning System	27	22,897
		Odisha Voluntary Health Association	17	26,320
		Bhairabi Club	42	26,702

		Gopinath Juba Sangha	60	24,367
		Nikhila Utkal Harijan Adivasi Seva Sangha	27	24,463
		VIKASH	45	24,020
		CARAM	24	24,955
		Viswa Jiban Seva Sangha	30	23,614
		Ashirbad Health Care Center	24	26,097
Sundargarh	Rourkela	SEWAK	18	23,002
		NISWAS	25	26,080
		BSS	21	23,879
Balasore	Balasore	Punaruthan Voluntary Organization	15	19,417
		May I Help You	10	20,025
Ganjam	Berhampur	Indian Red Cross Society	16	25,000
		CARD	40	25,292
		Govinda Pradhan Smruti Sansad	20	26,205
		Association for Rural Uplift & National Allegiance	28	26,800
Sambalpur	Sambalpur	Adarsa Sisu Mandir	32	22,875
		Aruna Institute of Rural Affairs	34	24,649
Jagatsinghpur	Paradeep	IRDMS	08	21,466
Jharsuguda	Brajarajnagar	LAVS	36	26,678
	Jharsuguda	SEWA	32	21,913
Mayurbhanj	Baripada	IMTS	35	24,602
Puri	Puri	PENCODE	3	30,000
		ISERD	7	22,000
Keonjhar	Joda	Aruna Institute of Rural Affairs	15	23856
Total 11 Dists.	**12 ULBs**	**37 NGOs**	**922 Slums**	**8,86,795 people**

Table No.2

Up coming Outcomes of the Project in 9 sampled cities.

City/Town	No of Projects	Key Activities and Outcomes.								
		Avg OPD per day	Avg. monthly Referral	Avg. inst. delivery per month	Avg No of RTI.STI referred	Avg. PNC Cases	TB cases treated	Sterili zation Cases moti vated	NSV cases moti vated	Bed nets Impreg nated
BBSR	11	41	47	23	6	13	29	114	0	45789
CTC	8	44	70	25	16	22	31	278	0	47587
Berhampur	4	38	76	34	7	17	12	229	3	10226
RKL	3	45	58	24	2	27	27	59	0	5650
Smblpr	2	35	30	27	—	30	0	20	0	5969
BLS	2	49	71	36	2	28	16	45	0	6428
Puri	2	23	15	14	10	9	1	3	0	9333
Jharsuguda	2	20	48	22	3	14	3	15	0	10532
Joda	1	20	39	19	4	15	7	33	0	27530
Total 9 ULBs	**35**	**35**	**50**	**25**	**6**	**19**	**126**	**796**	**3**	**169044**

Table No.3

Coverage Status of UHP in Bhubaneswar Municipal Corporation

NGO Partner	Location of UHC	Wards Covered	No of Slums allotted	Total House hold covered	Slum Population Covered
Ahribad	Bharatpur	17,18,28	22	5951	29,214
Bhairabi Club	Mundasahi,CRP	26,27,31,32,33,34,45	40	5189	26,702
CARAM	L-1875-Phase-II Dumuduma	29, 59 60	24	4052	24,955
FPA of India	Nilachakranagar Saliasahi	15	15	5943	20,521
Gopinath Yuba Sangh	Kargil Basti	30,46,47,52,53,54,56,57,58	60	6752	27,045
MY HEART	Swadhin nagar Saliasahi	16	12	5765	26,860

NUHASS	Patharbandha	12,13,14,22,23,24,37	27	4565	26,778
Open Learning System	Sandhyasathi Club Near Sriya Talkies	25,35,36,38,43,49	25	4130	22,897
OVHA	Panda Park Chandrasekharpur	9,11,15	17	5338	26,320
Total- 9	**9 UHC**	**39 Wards**	**242**	**47,685**	**2,31,292**

Source: Mission Directorate NHM Odisha

Table No.4

Impact of OUHP on Health Indicators

Sl.No	Key Health Indicators	Baseline Data (%)	Mid Term Observation (%)	Change (%)
1	3 ANC Check Up	69.3	81.3	12
2	Institutional Delivery	72.4	82.7	10.3
3	Complete Child Immunization	28.6	80.0	51.4
4	Unmet need for Child Spacing	28.0	21.3	6.7
5	Unmet need for conception limiting	14.0	9.7	4.3
6	Girls marriage before 18 years	21.6	18.7	2.9
7	Boys marriage before 21 years	28.7	22.3	6.4
8	Married girls conceived	9.1	7.9	1.2

Source-Mission Directorate NHM, Odisha

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