

Government-NGO-Community Partnership in Slum Health Service: Missing Link



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Abstract: The strategy of partnership among Government, voluntary agencies and community has been devised in Odisha for improving health standards in urban community (particularly slums) by enhancing the availability and access to the health services. The programmes envisage empowering the community to manage their health concerns with Government only playing the role of a facilitator. The present study has been undertaken to assess the real grounding of such 'doctrines of partnership' in today's socio-political context and its maneuvering towards realization of the targeted goals. The techniques of interview, focused group discussion (FGD), case analysis and field observation have been adopted for a holistic analysis of the project from the angles of its impact and sustainability. The findings point to the missing link of appropriate technology in creating a robust data base, 'tech-led disease surveillance system', 'telemedicine' and interactive video conferencing with audio, video, real time diagnosis and data transmission technologies. The study also points to a need for policy intervention for institutionalization of partnership among different departments and stakeholders.

Key Words: synergetic strategy, urban health, health index, intersectoral collaboration, service provider, accountable, ground zero level

I. INTRODUCTION

Contemporary developmental literature has reiterated that development, to be sustainable must partner with people for whom it is meant. Inclusive development is a cooperative effort, and hence, can be realized only through partnerships and collaborations among different actors like Government, academia, civil society and corporations. Partnership with community and peoples' organizations will go a long way in effective delivery of services and good governance. The Odisha Urban slum Health Programme (UHP) initiated under National Health Mission (NHM) envisages such partnership in delivery of health services to the underserved and hitherto excluded sections of urban population. The present study has been undertaken to assess the real grounding of such doctrines of partnership in today's socio-political context and its maneuvering towards realization of targeted goals.

1.1. Magnitude of urban health problem in Odisha

Though the percentage of Odisha's urban population to total population (16.68%) is comparatively lower than that of national average of (31.16%);

in terms of actual population, Odisha ranks 11th among the States having large urban population. Urbanization in Odisha is growing at a faster rate in recent years. While in 1941 Census, urban population in Odisha was around three percent of the State's total population (GoO, 2013); it grew up to 16.68% in last 2011 Census. There were only 39 urban centers in Odisha before 1951, which has grown to 223 in 2011 census (Praharaj, 2018). On an average, around 43% of the population living in urban localities is below poverty line and around 23% of them lives in slums (GoO, 2015). It is estimated that urbanization in Odisha is likely to increase up to 30 to 40% from the present level in coming ten years (Mohapatra, 2013).

Urban centers are hotspot of unauthorized slums. The urban slum population of Odisha is mostly concentrated in 12 towns, cities and industrial clusters namely Balasore, Bhubaneswar, Baripada, Berhampur, Cuttack, Rourkela, Sambalpur, Paradeep, Brajrajnagar, Jharsuguda, Puri and Joda. For administrative convenience these urban locations have been categorized in to three levels on the basis of population viz. Class-I (cities with population of 100,000 and above), Class-II towns (with population of 50,000 to 99,000), Class-III urban settlements (with population of 20,000 to 49,999). Majority of the class-III towns are in fact 'urban centers' (Khole and Dhote, 2016) from where there is constant migration of people towards Class-I cities (Patanaik, 2004). The slum dwellers in these urban locations have little to access to primary health care services and can hardly afford for private hospitals. The dynamics of the population is also quite unstable because of its socio-cultural diversity and ever fluctuating numbers. Owing to these reasons, it becomes difficult and even un-feasible to provide universal health services in these unauthorized locations resulting in low level of health indicators. The conditions of slum living with its low educational and awareness level are non-conducive for 'Information education and communication' (IEC) and 'Behavior change communication' (BCC) activities. The people remain underserved. Low level of investment by urban local bodies (ULBs) in these unauthorized locations perpetuates poor environmental conditions, inadequate health and sanitation facilities. Poverty and low level of awareness lead to malnutrition which in turn, leads to diverse alarming consequences. Anemia is a major health problem in the slums especially among women and children. Further, the other health indicators like IMR, institutional delivery, antenatal care (ANC), post natal care (PNC), complete immunization, anemia among the adolescent, infant mortality, underweight children are very low.

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The disease outbreaks are also frequent (Nayak, 2013). One in 10 children in urban slum does not live 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 (NHM Odisha, 2009). All these conditions pose challenges before the State and calls for special intervention.

1.2. The Empirical Contours of the UHP

To combat the perpetuating evil (as briefed above) an innovative strategy of partnership among Government actors-Urban Local Bodies (ULBs)-NGOs and Community has been piloted in Odisha for extending the outreach of health services in urban area.

The authors in the present article have tried to look in to the strategy adopted in Odisha with regard to its actual grounding, techniques of operation and outcomes at empirical level.

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. Different aspects of the programme includes capacity building of the community 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:

- Providing primary health services for upgrading health status of the urban poor.
- Integrated mother child care services including family planning measures.
- Prevention/control of communicable diseases in slums areas.
- Adoption of healthy behavioral practices among the slum dwellers.
- Scaling up qualitative improvement in general sanitation, hygiene and nutrition conditions.
- Generating community demand for health services through conscientization and awareness building.
- Enhancing the accessibility to health services through synergy and integration among the service providing departments.

1.3. Approach & Activities

The programme adopts a four-pronged 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 centers (UHCs) which are centrally located and easily accessible to the people from slums. The cases requiring secondary and tertiary clinical care 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 and nutrition day; health camps; check-up camps; immunization programmes; family planning promotion; IEC and BCC activities; promotion of institutional delivery; life-skill

education among adolescent; capacity building of women health groups and community level peoples' organizations; and, prevention of malaria. These activities are managed by ANMs and link volunteers at the ground level.

The strategy of **integration and convergence** has been envisaged to make primary health care universally accessible. A synergy among the institutions dealing with planning, execution and management of primary health care has been worked out through a partnership among Government of India, Government of Odisha, Health for Urban Poor (HUP) programme supported by USAID India, local community, urban local body and service providing agency. The service providing agencies have been selected from the NGOs and private partners through inviting of the Expression of Interest (EOI) in open bidding process, and, they have been made accountable to the community. Community has been activated through formation of Ward *Swasthya Samities* (ward health committees) *Mahila Arogya Samities* (Women Health Societies), *Balika Mandals* (adolescent girl circles) and Peer Groups.

In this synergetic strategy, Government provides the administrative support, staff and funds for incentives and medicines. The existing health infrastructure in the area is also made available. The HUP of USAID, India provides technical support. The voluntary/private sector provides the 'social skill' of implementation to reach the targeted population and deliver services. Involvement of private and voluntary sector brings in more manpower and social expertise for extending outreach of the services. The departments of Health and Family Welfare (H & FW), Housing, Urban Development (H & UD) and Women & Child Development (W & CD) in collaboration with NHM have worked out the guidelines for partnership. The similar health schemes and programmes like reproductive child health (RCH), integrated child development scheme (ICDS), *Mamata* (programme for financial assistance to pregnant women for nutritional care) *etc.* have been converged for a holistic approach. In the entire integration, ownership of the project by ULB has been highlighted. The Health Officer or the Medical Officers of the concerned ULB has been designated as the Nodal Officer for the project in their respective towns or cities.

In the entire project NGOs have been involved as the real performing and delivering partner at the ground zero level. Attempt has been made to mobilize the local human, financial and infrastructural resources by way of convergence. The following figure (Fig No-1) presents a pictorial presentation of the process.

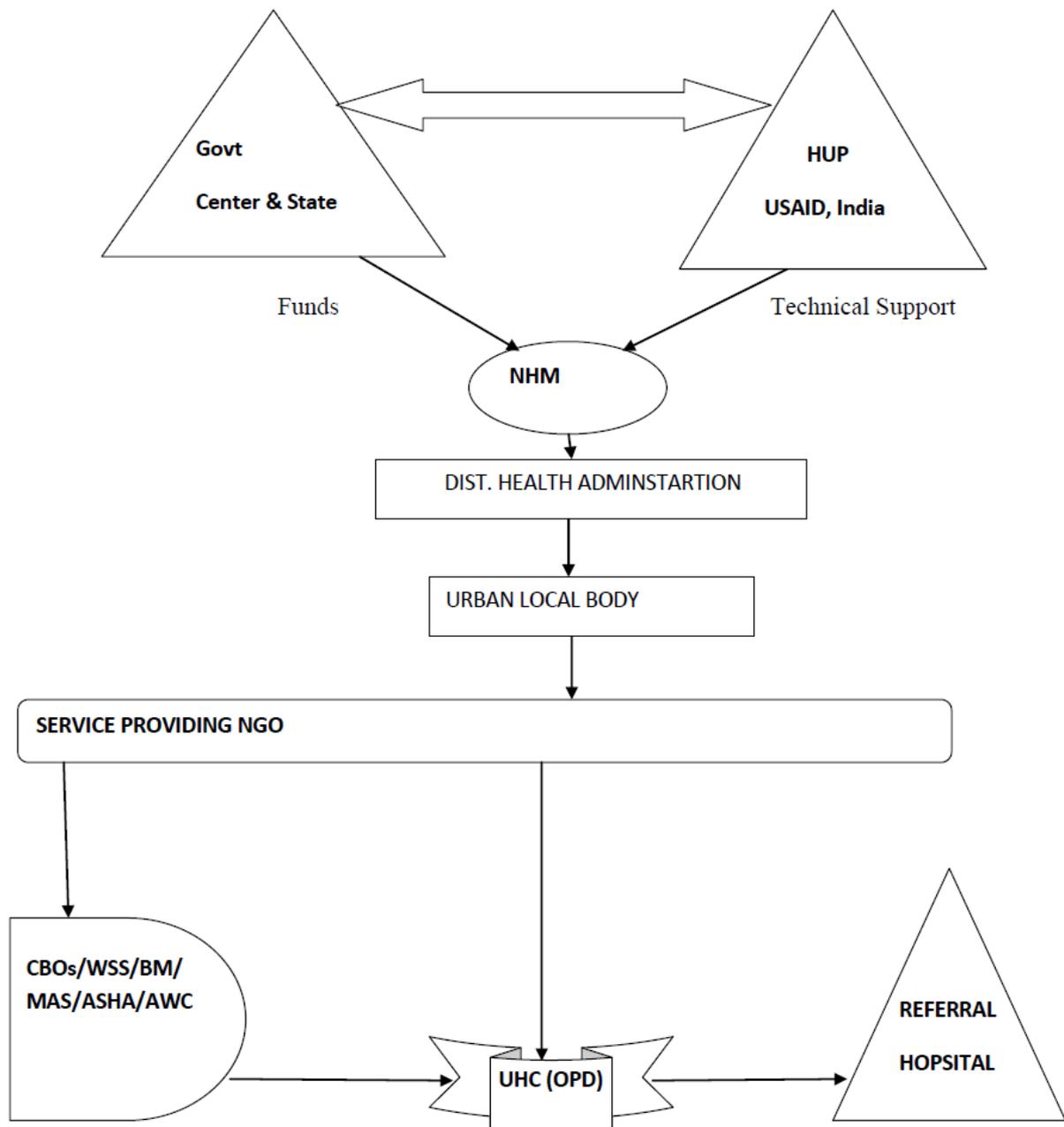


Fig.-1: Odisha Model of UHP

Source: Prepared by the researchers with inputs from policy documents.

2.0. The Universe under study

The programme has been launched under the banner of ‘Urban slum Health Project’ (UHP) from the year 2011 on pilot basis in 922 slum areas of 11 towns and cities served by 37 Urban Health Centers (UHC). Each UHP project covers 20,000 to 25000 slum population including migrant laborers, street children, construction workers rickshaw pullers, brick kiln labors etc. (Kumar, Sharma and Sood, 2016). The detail of the present coverage of the programme is presented in the Table No-1 (Annex-A).

A multi-stage sampling method has been adopted owing to the dispersed area of the slums. **In the first stage** (State to City) the city of Bhubaneswar has been selected from among 11 towns through purposive sampling method (around 9%) for case analysis. In Bhubaneswar city the programme is being implemented in 39 wards covering 242 slums, 47,685 HHs and 2.31,292 population served by nine UHCs. The details of the tagging of service providing

NGOs, wards and slums with UHCs is presented in Table-2 (Annex-A). **In the second stage** (City to Slum) one UHC area i.e. Sandhyasathi Club (11% of the total UHCs) have been selected on the basis of random sampling. This UHC serves 4130 households (HHs) living in 6 wards and 25 slums. **In the third stage** (Slum to HH) 415 HHs (10%) have been sampled on the basis of random sampling for interview.

2.1. Methodology.

The techniques of interview, FGD, case analysis and field observation have been adopted for a holistic analysis of the outcomes and impact of the intervention. Interview has been conducted with the head/eldest earning member of the HHs. A specially designed interview schedule containing both the open and close ended questions have been devised and administered on the sampled units.

FGD have been conducted with doctors, para-medical staff at UHC and peer groups in the locality, Case analysis of the UHC has been done through examination of its outdoor register, medicine supply records and monitoring information systems (MIS) reports. In addition to these, the present researchers have undertaken field observation to get a real time feel of locality and operation of the UHP.

Both the quantitative and qualitative methods of analysis have been followed. The data collected through interview schedule and case analysis of UHC have been processed through SPSS techniques for quantitative analysis and the data collected through FGD as well as field observation have been analyzed through qualitative techniques of 'interpretative understanding'. The analysis has been done on the basis of following seven parameters.

- P-1. Peoples' involvement and synergy among the stakeholders.
- P-2. Awareness building and outreach programmes.
- P-3. Public health and general sanitary condition in the wards.
- P-4. Habitual changes among the people.
- P-5. Functioning of the UHC and availability of the services.
- P-6. Performance on health indicators.
- P-7. Monitoring and evaluation of the Programme.

2.2. Findings.

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 derivations and inferences from the primary data collected through present study are enumerated below against each identified parameter.

(P-1): Peoples' involvement and synergy among the stakeholders

- ✓ The inter-sectoral collaboration among H & U D Department H & F W Dept. and W & CD Departments and other stakeholders have been given shape through formation of State Coordination Committee, District Level Committee and City collaboration Committee.
- ✓ City Collaboration Committee have been institutionalized through coordination among NHM and Governmental departments and Bhubaneswar Municipal Corporation (BMC).
- ✓ Listing of slums and assessment of facilities to be provided have been done through collaborative efforts of NHM, Government, State health machinery and NGOs.
- ✓ A significant integration of OUHP with peoples' representatives, district administration, Government and private doctors, AWC, field level health functionaries, SHGs has been achieved.
- ✓ 176 *Mahila Arogya Samities* (Women Health Societies) and ward coordination committees have been formed and made functional.
- ✓ Cross analyses of the data reveal that the functioning of these committees from district to ward level is irregular. The meetings at the district level are taken very irregularly as per wish of the administrative officers concerned. Around 65% of the meetings as per the guideline has not been held or has been postponed. No normative enforcement about the meetings and action upon their proceedings came to notice of the researchers.
- ✓ In spite of the limitations, an observable degree of peoples' acceptance of the project has been noticed. Around 81% of the slum dwellers have accepted the project as the project caters to their felt needs which

remained unmet for long due to lack of adequate Governmental facility.

(P-2): Awareness building and outreach programmes.

- ✓ Awareness programme on use of toilets, dangerous effects of open defecation, 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 children have been organized in all 27 slums.
- ✓ Films on maternal health and safety motherhood have prepared and exhibited in 20 slums.
- ✓ *Swasthyakanthas* (health walls) have been painted.
- ✓ Leaflets on health and hygiene have been distributed.
- ✓ The awareness programmes have been organized like events in the wards. No such regular activity is seen the area. Around 69% of the respondents have reported that there has been one meeting in their slum long back.

(P-3): Public health and general sanitary condition in the wards.

- ✓ The wards and slums look cleaner with improved road and street lighting. Around 79% of the HHs living in the area have reported about the improvement while 21% have cited about persisting problems. The practice of stealing away street light bulbs and fittings are on decline.
- ✓ Around 68% of the respondents have reported about door to door collection of garbage almost on daily/alternative day basis by the agencies deployed by BMC
- ✓ The individual household toilets have increased to around 80% from mere 30% at the time of baseline survey.
- ✓ The chokes in the drains spreading bad stinks which was almost a 'normal phenomena' identified with characteristic feature of urban slum have been cleaned to a great extent. Now, the bleaching powders and disinfectants are being used.
- ✓ The problem of storm and rain water flooding which was almost getting stranded for weeks together is now getting dissipated in hours and days. This has been possible because people have made some or other way for canalizing the water to some open space/ low laying space.
- ✓ Field observation shows no measure development has happened in terms of making the drains, water ways and natural water courses free of encroachments.
- ✓ The data do not show any arrangement for treatment of drain water, sewerage or domestic wastes in the area. Around 98% of the respondents have said that there is no such provision here. Around 2% report that the BMC may be doing it in some other place.
- ✓ No micro level arrangement has been done for treatment of construction and other garbage.

(P-4): Functioning of the UHC and availability of the services

- ✓ Around 69% of the people have reported that the functioning of the UHC has improved after introduction of HUP while 20% have replied negatively and 11% have replied 'don't know'.
- ✓ Around 60% of the respondents respond that the availability of the doctors and para-medical staff in the UHC has improved.

The coming of doctors to UHC has improved to 4 to 5 days a week. The average duration of the doctors' availability in the UHC has also increased from mere 1 or 2 hours to 4 to 5 hours during the day.

- ✓ Around 62% opine that availability of medicines in the UHC have also improved with the programme.
- ✓ The data further reveal that the common impression about Government supplied free medicines as 'low quality and ineffective' has started diluting. Around 54% of the people have responded that the medicines supplied at UHC works. Even around 48% of people have reported to have purchased generic medicines from *Januasadhi* counter where medicines are sold at subsidized prices.

(P-5): Habitual and behavioral changes among the people.

- ✓ The data reveal an observable degree of change in sanitary habits and behavioral pattern of the people.
- ✓ Around 80% of the people have started using the IHHL or public toilets provided by BMC.
- ✓ People have started using impregnated mosquito nets supplied to them through the programme. As per UHC data around 3500 impregnated nets have been distributed in the area. The HH level data show that around 72% of such nets are being used by the people. The main reason for not using the nets as elicited from sampled HHs have been 'worn out of the nets supplied' and 'lack of sufficient number of nets for the entire family'. Around 60% of the people not using the net report that it is not necessary as they are using the fans.
- ✓ The practice of hand wash before taking the meal is gaining popularity. But it is confined to just water washing. Only around 5% of the people use disinfectants like soap or liquid.
- ✓ The usual scene of the group of women/girls going to open field for defecation is now not seen so profusely. There has been a level of public awareness about the bad effects of open defecation.
- ✓ Throwing the food packs, snacks packs and used paper/leaf plates outside here and there have been curtailed. People have started using the dustbins put near their slums by the BMC. Littering outside on the street is gradually declining. Around 75% of the HHs has some or other type of dust bucket which they use to keep their household waste; and, later give it to the garbage collector or throw it in BMC dustbin.

(P-6): Performance in Health Indicators.

- ✓ Mother and child care scenario has marked a change. Around 78% of the people have reported about antenatal care (ANC), institutional delivery and PNC. Around 59% of the people have reported about increase in frequency of the visit of ANMs, ASHA volunteers and health workers.
- ✓ The case analysis of the UHC shows an increase of around 41% in per day outdoor patient and increase of 47% in average monthly referrals.
- ✓ The other health indicators show an observable degree of change in positive direction. ANC checkup has increased from 69.3% at the time of baseline survey in 2008-09 to 81.3% in 2017-18. Similarly, institutional delivery has increased from 72.4% to 82.7%; complete child immunization from 28.6% to 80%; unmet need for child spacing has decreased from 28.6% to 21%; unmet need for conception limiting reduced from 14% to 9%; and, Girls marriage before 18 years reduced from 22% to 18% during the same period. There has also been 13% increase

in PNC and 6% increase in in RTI/STD detection & referral. The functioning of AWCs for child care in the area has improved. Around 62% of the HHs respondents have reported about improvement in functioning of the AWCs.

(P-7): Monitoring and evaluation of the Programme

A perceptive analysis of the programme documents available at Government and District Level shows that a three-tire monitoring system has been put in place for ensuring close monitoring, suggestive evaluations and improvement in health indicators. As per the guideline, the first level of monitoring is to be done internally at the level of service providing NGO engaged for extension of services at community level. The second level of monitoring is done at the District level involving the ULBs, partner NGOs, Medical Officers, NRHM and Regional Research Center (RRC) coordinators. The third level monitoring is done at the State level by the Directorate of NHM. The Apex Body of State Health Society under the Chairmanship of Chief Secretary also oversees the programme.

Field observation and discussion with both the Government and non-government stake holders reveal that In actual practice it is seen that these monitoring and evaluation activities are carried on in a routine manner without any serious concern of the programme.

- ✓ The service providing NGO to earn 'good will' with the hope of getting future programme from the Government somewhat pushes the works at ground level. The reports generated by the NGO is sent to and computed in the district and state level.
- ✓ The so called third party evaluation is also a misnomer as the third party itself is engaged and paid by the Government machinery. Even it is observed that this evaluating agency collects the data through the programme functionaries who are in the incentive pay role of the programme.
- ✓ Around 55% of the sampled respondents have opined that the evaluation should be done by the real third party agency selected on the basis of their autonomy, expertise and credibility.
- ✓ The reports of the third party be discussed in the open forum of the people in all the wards.

3.0. Challenges and Suggestive Measures-The need for Technology

On the face of the array of data and empirical realities as analyzed above, the present researchers conclude that the UHP strategy of Odisha has grounded an innovative model of partnership among the GO-VO and Community in management of health programmes. This partnership has proved to be effective in stimulating the community life and extending primary health services in urban area. Though the programme has acquired peoples' acceptability and has achieved observable degree improvement in health indicators; many challenges have been noticed which need to mitigated for sustainability and scalability of the programme.

- The Programme needs a robust data base of the population dynamics particularly the HHs and population in different age, sex, education and income groups.

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This also needs continuous updating. As such, computerization of the entire data, their uploading on a web based intra connectivity system from ward to State is highly necessary for proper monitoring and intervention.

- Proper data about morbidity rate, area based common diseases need to be maintained and monitored through 'tech-based disease surveillance system' with application of modern technology.
- With increasing complexity in diseases in recent days, there is a 'felt need' among the people for specialty and super specialty services. Given the limited resources in terms of qualified doctors, infrastructure and health budget, such 'felt need' can be met only through the technology of 'telemedicine and interactive video conferencing'. Audio, video, real time diagnosis and data transmission technologies will enable the patients to get the specialty services.
- There is the need of pathological service facilities in UHCs which can be installed and managed through public private partnership (PPP) models.
- The monitoring and evaluation of the outcomes should be brought to priority agenda of the district and state level officials with real field feedback.
- Community ownership of the project need to be promoted through active involvement of various stake holders of the programme. Appropriate public relation exercises including social appreciation and award activities need to be undertaken at the community level for the purpose.
- 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.
- Awareness generation activities need to be continued through audio, visual and animation techniques through regular intervals.
- The technological applications like mobile health apps, SMS messaging *etc* need to triggered to keep the people health vigilant and stay them connected with the service providing system.
- Basic utility services like sewerage, drainage, drinking water, road connectivity, public transport facility need to be provided in peripheral parts of the city.

Gone are the days when slums in urban areas were considered to be a burden on urbanization and needed to be treated with humanism and charity. Slums are inseparable parts of the modern city today as it is the home of many service providers and workers who are essential for the urban dwellers. Getting all essential services are now the right of the slum dwellers. Under the changing conditions, GO-VO partnership embedded with advanced technological systems and empowered by an enforceable policy framework across all Governmental departments for convergence and collaboration is the only answer for meeting the emerging challenges of health care in urban settlements.

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