Operational Guidelines For conducting Outreach Services in Urban Areas

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1. Rationale for Outreach Services in Urban Areas

Urbanization is as one of the most significant demographic trends of the 21st century. Urbanization is often thought of as being beneficial for economic and social growth and gains. Migrants are drawn to urban areas for work opportunities and to establish a better life for themselves and their families. However, most Indian cities, from mega cities to small cities, lack the necessary infrastructure in terms of housing, water and sanitation, employment opportunities, and basic services such as health care and education to accommodate and meet the needs of migrants, having implications for their health, wellbeing and productivity. Paradoxically therefore, cities can become hubs of marginalization and poverty or "concentrated disadvantage" for the urban poor.

Urban populations and the urban poor are far from being homogenous and comprise several sub-groups that differ socially, economically, and geographically. Such groups have additional vulnerabilities beyond the poor in urban areas. These include:

i)**Residential or habitat-based vulnerability** includes urban poor who are homeless, facing insecurity of residential tenure, and are not served by any form of public services like sanitation, clean drinking water and drainage. These include those who live under bypass, on railway stations, under the bridges and on footpaths.

ii) **Social vulnerabilities** include female-headed households, minor-headed households and the aged, and people with disability and illness.

iii)**Occupational vulnerability** include those who do not have access to regular employment, without skills or formal education and who have no choice but get 'locked into' informal and casual labour with uncertain earningsand/or subject to unsanitary, unhealthy and hazardous work conditions such as head loaders, sex workers, bricklin workers, sanitary workers, manual scavengers, domestic workers and construction workers.

Vulnerability Based Health Burdens of the Urban Poor:

The health burdens of the urban poor are well known; while most are similar to those that affect urban populations, they are more pronounced among these sub groups and occur more frequently. They are associated with a high mortality burden and multiple co-morbidities. There is high prevalence of under-five mortality, underweight, lung diseases, and vector-borne diseases like malaria. Immunization coverage rates in these populations particularly the poorer and more vulnerable are also low.Disease epidemics are strongly correlated to site location and cramped space; vector-borne and respiratory diseases are easily spread, especially under conditions of poor sanitation and exposure to environmental pollution.

Mental health problems among such populations are more pervasive, because of the stressful, lonely, and alienating environment. Cut off from traditional emotional and social security support systems create ample opportunities for co-morbidity and reinforcing stigma.Diabetes, hypertension and to a lesser extent, asthma, are reported as being among the most common chronic diseases. Such populations also more frequently encounter dog-bites, alcoholism and

substance abuse and occupational diseases (sanitary workers, rag-pickers, head-loaders and sex workers).

Homeless persons particularly, are vulnerable to trauma from accidents, attacks of violence, and protracted neglect, for want of spaces for recovery and rehabilitation.Sex workers- both males and females have greater risk of exposure to sexual and reproductive health problems, but also need care during pregnancy and child birth and are also vulnerable to other morbidities like respiratory infections, diabetes, heart problems. Street children in metro cities engage in a variety of unsafe occupations from rag-picking, to begging, to helping in shops and stalls, which put them at risk to physical and sexual abuse. Common vulnerabilities of children living on urban streets include substance abuse (generally of drugs, tobacco, *pan masala* and alcohol), hazardous working conditions, abuse, and inadequate access to nutrition, clean water, sanitation and health care. Children and persons with disabilities are at special risk for certain health issues. Among people with disabilities, secondary conditions occur in addition to (and are related to) a primary health condition. Women domestic workers, living and working too far from government hospitals, rely on the advice of their employers with regard to medicines and providers, which may necessarily be not be rational.

Despite the supposed proximity of the urban poor to urban health facilities, their access is severely restricteddue to the lack of an organized primary health system and the absence of well-functional referral mechanisms. There are far too few health public facilities in urban areas providing services to such populations. Even among these, the existing package is limited to a very narrow range of reproductive and child health (RCH)services and at best symptomatic care for other illness. Most health centres have morning timings, which exclude all domestic workers and daily wage workers, even self-employed impoverished workers, indeed most of the urban poor populations. Geographic distance and costs of transport are also frequent barriers for health-seeking. Cultural impediments and social stigma are particular issues that the vulnerable and ultra poor face. Some urban dwellers are intentionally marginalized because of they belong to or are associated with a particular group such as sex workers, rag pickers or waste workers, transgenders, homeless, mentally ill, etc. These groups may then be *excluded from* accessing health care. The consequence of these factors for the urban poor, and even more among the marginalized is that the first choice is to not seek care, but to self-medicate and to avoid even having to approach the public health system. They often opt for more accessible but poorly qualified private practitioners, who often follow irrational practices, or even just the shop-attendant in a pharmacy.

The National Rural Health Mission (NRHM) experience shows that improved health status of the community is not achieved only by strengthening health systems. Access to health services is better availed with increased community outreach. Though existing health programmes in urban areas provide outreach services, this is limited to those who present themselves for care, or at best reaches out to pregnant women and children in need on immunization.

II. Special Outreach/ Health Camps

As has been discussed earlier certain vulnerable and marginalised groups because of their circumstances find it difficult to access these services even if they are provided within their vicinity. The health care needs of such service resistant groups would be those that require the attention of medical providers other than the routine RCH/minor curative care provided by the ANM during routine outreach services.

Special outreach session would be organized along the lines of integrated case management, involving periodic provision of services by other health professionals and specialists (including Gynaecologists,Cardiologists,Neurologists,Psychiatrists,Dentists),nurses,laboratorytechnicians, physiotherapists, occupational therapists and pharmacists. Such outreach camps should also include facilities for screening for Hypertension, Diabetes, COPD (Chronic Obstructive Pulmonary Diseases), Epilepsy, Cancer and other chronic diseases.

ASHA and MAS of the area will have to play a key role in conducting mapping of vulnerable population, facilitated by ANM to identify such population subgroups and understand their health needs. States should involve medical colleges in cities/district hospitals to undertake rapid epidemiological assessments to study specific mortality and morbidity loads and schools/departments of social work to understand social determinants. Medical officers of the PHC should also be engaged in disease epidemiology and planning special outreach services. The involvement also needs to extend to engagement with designing and providing services through these special outreach camps.

Special outreach camps cannot conform to a set pattern of services such as the routine RCH services. The actual services to be provided for each camp would be designed by the Urban PHC of the area based on the needs of these specific sub groups. The local PHC could develop a calendar of services to be provided each month, which could vary between different specialist services, rehabilitation, and other curative services. The urban PHC must also have a plan for follow up between such camps. Such follow up could be facilitated by the ANM/ASHA of the area. In addition such special outreach camps should engage with the relevant departments to ensure that social support services are made available- such as access to food, clothing, shelter, prosthetic support, etc.

In areas where the government health facilities do not have adequate reach in urban slums, involving NGOs in outreach and referral in the urban poor settings could be considered. The presence of active NGOs in several cities presents an opportunity to extend the reach of health services through various ways of outreach and enhancing utilization by raising community demand for the existing services. Many state governments have also contracted private hospitals to provide outreach activities (using the private partner's facilities and staff) in un-served areas and also provide referral support. States should make efforts over time that their facilities are able to be made welcoming to such populations. However in the meantime such populations must have access to not just outreach services but also access to specialist services, rehabilitation therapy, and social support including referral and follow up for tertiary level institutional care. Such outreach days should also involve organizations providing care through shelter homes, working on de-addiction since there is a correlation between homelessness and substance abuse.

Planning for Special Outreach Camps

There are specific ways in which such services should be provided.

1. Mapping the vulnerable: These marginalized people/families have little information and knowledge on their health rights, entitlements, and the benefits of preventive health services. Due to their complex circumstances, they remain out of reach and invisible to the health system or health service providers. Therefore, mapping exercise is needed to identify and reach to these groups which can be called as "Mapping". The process of mapping must essentially be a process of making the vulnerable visible to the health care system, and capture their problems regarding access and their health care needs. Thus it is not only the geo-spatial distribution of populations that is the object of such mapping, but also the social relationships and issues of access to health care. The process of mapping must also identify vulnerability with respect to access to piped water supply, sanitation facilities, food security entitlements, legal status of occupation of the land and rents and the recognition of their identity by governments. In addition to identifying vulnerable, mapping should also include identifying community organizations or individuals who can support this population for non-medical essential social services.

2. Introducing Community Volunteers: In order to facilitate mapping, mobilization of such groups and providing follow up care, community health volunteers of diverse backgrounds for diverse roles can be actively mobilised. Such volunteers could become peer educators belonging to specific vulnerable groups- for example rag-pickers, or sanitation workers, commercial sex workers, etc. Another set could be community volunteers who work in adolescent friendly clinics located in adolescent hang-out locations or amongst unorganised workers etc. A third set would be identifying young people who are willing to extend domiciliary support to aged and disabled people, and support to accompany them to health facilities. The U-PHC or MAS could give recognition they should be treated as voluntary entities, with no financial compensation. They will support ASHA and MAS in planning and organizing these special outreach sessions.

3. Involvement of Male Health Workers: Many cities have sizeable populations of single male migrants with unique health concerns- women health workers may not be able to address or perhaps even discuss these. This will require active participation of male health worker, working in close coordination with Mahila Arogya Samiti.

4. Alternative Outreach Points: Special Outreach camps should be planned to be organized in the areas where marginalized and vulnerable live. The mapping should also identify parts of the city where high concentrations of unorganised working populations work, such as wholesale markets, land-fills, labour *addas,* railway and bus stations etc. so that outreach camps can be organized at these alternative places other than Anganwadi or community centres.

5. Involvement of Union of Informal Groups (Occupational Vulnerable Groups): It would be useful to involve trade unions and collectives of vulnerable groups – such as of rickshaw pullers, construction workers, rag-pickers, sex workers, homeless people, single

women, disabled peoples collectives, organisations of the aged, homeless and street children to organize health camps .

6. Mobile Clinics for Homeless: Outreach services may also include services through "mobile clinics". Mobile units, whose package of services would be similar to special outreach, would provide services at a fixed date or time to unreached areas, such as remote slums, temporary migrant populations, and scattered homeless persons.

7. Comprehensive Referral Units from Special Outreach Camps: To enable continuity of care and ensure quality of care, mechanisms should be established to refer these groups to supportive health care facilities other than U-PHCs and U-CHCs. These may include: a) designated Public Poly-clinics or specialised diagnostic clinics, b) Free residential and out-patient Drug De-addiction Centres, c) Free residential mental health care recovery centre, d) Nutrition rehabilitation centres, e) Homeless recovery shelters, and f) Palliative care centres and hospices.

8. Utilizing available infrastructure for running special camps: Most of the public health facilities as well as out-patient premises of medical colleges are usually vacant in the evenings, which is the most useful time for health-seeking by urban poor populations. These spaces should be used for special outreach camps. These could also be deployed on Sundays such as for special geriatric clinics.

The service package of special outreachcamps and checklist for responsibilities are provided in Annexure Ia and Ib.

These are explained in the table below

Table 1: Types of Outreach Services under NUHM

	Special Outreach/Health Camps **Budget line: K.4.1.2**
WHERE: Site of providing the Service	Space or structure at the community level in slum/near vulnerable population (Community Centre, School, Railway Station, railway tracks, city outskirts, Bus Stand, underpasses, outside place of worship, etc.).
WHO: Population coverage	Vulnerable groups; emphasis on the hardest to reach (migrant labourers, homeless, etc.)
WHAT: Service Coverage	Health check-up (routine, for locally endemic diseases and population sub group specific problems), screening and follow-up (for chronic and non-communicable diseases), basic laboratory investigations (using portable /disposable kits), and drug dispensing
BY WHOM: Service Provider	Doctors/Specialists, Lab Tech, Pharmacist, physiotherapists, social workers,

	Special Outreach/Health Camps Budget line: K.4.1.2
Facilitated by	MO-UPHC, with ANM and ASHA
WHEN: Frequency	Periodic (monthly) – as per need

III. Cost Norms

Since "Routine Outreach" will be provided at the UPHCs and peripheral primary level health facilities in the urban areas, through the ANMs headquartered at these facilities; separate financial provision has not been made, except for Rs.500 per ANM per month as mobility support. The consumables and supplies (like ORS, IFA, diagnostic test kits, etc.) for the Routine Outreach will be provided under RCH. The RCH services to the women and children in slums would be provided under Routine Outreach and UHNDs. Special Outreach/Health Camps, apart from providing RCH services to women and children, would also cater to other special healthcare needs of the local community/ vulnerable population, as per requirement. These would have doctors, specialists, pharmacist, lab technicians, as per requirement; providing screening and check-up services.

As both the UHND/Health Camps, are envisaged for slums and vulnerable population, it may be budgeted under the budget "Outreach Camps/Sessions". The cost norm of Rs. 10,000 per UHND session/ Health Camp is as per the NUHM Framework for Implementation.

Cost norms for Special Outreach/Health Camps

Cost Head	Amount per session/camp (Rs.)
Doctors and Specialists (for paying their fees)	3,000/-
Other paramedical staff (like Pharmacist, Lab Technician, etc. - for paying their fees)	1,500/-
Medicines, drugs and consumables (including consumables for rapid diagnostic kits)	3,500/-
Transportation costs	1,000/-
Publicity (loudspeakers, etc.)	1,000/-
Per Special Outreach Camp/Session	**10,000/-**

The above cost break-up is suggestive.

As per estimation, the slum population would be around 25% and the other vulnerable population would be an additional 10% of the urban population. Thus not all ANMs would be required to undertake UHND/health camps (only 35% would be required), and the remaining would be available for providing Routine Outreach services in the UPHCs and peripheral primary level health facilities.

ANNEXURES

(Organising Special Outreach for Slums and Urban Vulnerable Populations)

Annexure 2a: Service Package at Special Outreach Camps

Special Outreach will cover the most vulnerable and marginalised groups with special attention to their specific health needs. The service would be provided monthly. The package of services may include among the following:

(a) Curative services:
- Specialist Services such as Obstetric/Gynaecology, Paediatric, Dermatologist, Dental and other special services.
- Early detection of TB, Malaria, Leprosy, Kala-Azar, and other locally endemic communicable diseases and non-communicable diseases such as hypertension, diabetes and cataract cases;
- Minor surgical procedures and suturing;
- Referral of complicated cases;

(b) Diagnostic services:
- Investigation facilities like haemoglobin, urine examination for sugar and albumin;
- Smear for malaria and vaginal smear for trichomonas;
- Clinical detection of leprosy, tuberculosis and locally endemic diseases;
- Screening of breast cancer, cervical cancer etc.
- ECG
- Ultrasound test (with due registration and clearance under PCPNDT Act)

(c) Reproductive & Child Health Services:
- Ante-natal check up and related services e.g. injection - tetanus toxoid, iron and folic acid tablets, basic laboratory tests such as haemoglobin, urine for sugar and albumin and referral for other tests as required;
- Referral for complicated pregnancies;
- Promotion of institutional delivery;
- Post-natal check up;
- Immunization clinics (to be coordinated with local Sub-centres/PHCs;
- Treatment of common childhood illness such as diarrhoea, ARI/Pneumonia, complication of measles etc.;
- Treatment of RTI/STI;
- Adolescents care such as lifestyle education, counselling, treatment of minor ailments and anaemia

(d) Family Planning Services:
- Counselling for spacing and permanent method;
- Distribution of Nirodh, oral contraceptives, emergency contraceptives;
- IUD insertion.

(e) Emergency services and care in times of disaster/epidemic/ public health emergency/ accidents

(f) Trauma care and injury

(g) Referral services to palliative care institutions, recovery shelters, counselling etc.

(h) IEC/BCC; Counselling on hygiene, mobilization for cleanliness drives, disinfection of water resources etc.

- Coordinate with the ASHA and the AWW to ensure publicity of the event, mobilization of the vulnerable groups and follow up.
- Dialogue with MAS members on mobilization support required from the community.
- Ensure publicity of the event as per Annexure III.

ASHA/ MAS/ other community groups (like SHG)

Actions to be taken before the Special Outreach:

- Visit all households and make a list of most vulnerable and marginalised identified with the help of vulnerability assessment tool. This may include groups like rickshaw pullers, domestic workers, labourers, informal workers, construction workers etc. This may also include sick men, women, children and old people, including persons suffering from chronic diseases and other disabilities.
- Make a list of children with special needs, particularly girl children.
- Make a list of TB patients who need anti-TB drugs.
- Coordinate with the AWW and the ANM.
- Share the calendar of Special Outreach/Health Camps (if applicable), and the date / day of next camp
- Ensure publicity of the event (as per Annexure III).

On the day of Special Outreach:

- Ensure that all listed men, women, children and old people come for services.
- Ensure that all listed TB patients collect their drugs
- Assist the doctors and the ANM at the site.

Annexure III

Reporting Formats for Special Outreach/Health Camp

Special Outreach/Health Camp

1. State: _____
2. District: _____
3. City: _____ 4. Date of Special Outreach: ___/___/20__
5. Name of the Urban PHC (UPHC):_____ 6. Name of MOIC of UPHC: _____
7. Located in Ward No.: _____
8. Locality/Slum name: _____ (in case more than one slum is covered, name all the slums)
9. Place where Special Outreach is held: _____ (AWC, school, any other – please specify)

A. POPULATION STATISTICS

10. Total Population of the locality/slum(s) covered:
11. Total Vulnerable Population in the locality/slum(s):
    (to include people like homeless, street-children, construction workers, beggars, etc.)
12. Total no. of Old people (60+ years) in the locality/slum(s):
13. Total no. DOTS cases in the locality/slum(s):

B. SERVICE STATISTICS

14. Total no. of persons registered and provided services: Males: Females:
    - No. of Adults (20-59 years): Males: Females:
    - No. of Infants (0-1 year): Males: Females:
    - No. of Children (1-12 years): Males: Females:
    - No. of Adolescents (13-19 years): Males: Females:
    - No. of Old people (60+ years): Males: Females:

15. Total no. of cases provided medical consultation: Males: Females
    Types of cases/diagnosis/provisional diagnosis
    - (a) _____: Total: Males: Females:
    - (b) _____: Total: Males: Females:
    - (c) _____: Total: Males: Females:
    - (d) _____: Total: Males: Females:
    - (e) _____: Total: Males: Females:
    - (f) _____: Total: Males: Females:
    - (g) _____: Total: Males: Females:
    - (h) _____: Total: Males: Females:
    - (i) _____: Total: Males: Females:
    - (j) _____: Total: Males: Females:
    - (k) _____: Total: Males: Females:
    - (l) _____: Total: Males: Females:

(m)_____: Total: Males: Females:
(n) _____: Total: Males: Females:
(o) _____: Total: Males: Females:

16. No. of persons provided diagnostic services
    (a) Lab Investigations Total: Males: Females:
    (b) Smear for malaria Total: Males: Females:
    (c) Vaginal smear for trichomonas Total:
    (d) Screening for (breast/cervical cancer) Total:
    (e) ECG Total: Males: Females:
    (f) Ultrasound test Total: Males: Females:

C. VERIFICATIONS

17. Name & Sign (with date and time) of ANM: _____
18. Name & Sign (with date and time) of ASHA: _____
19. Name & Sign (with date and time) of MOIC-UPHC: _____
20. Name & Sign (with date and time) of Ward member (if present): _____

Annexure III. Publicity

KEY COMMUNICATION OBJECTIVE

To make the community, especially women from vulnerable sections and other stakeholders in the community, aware of service availability on fixed days at AWC.

WHOM TO INVOLVE

- ASHA
- MAS members
- Members of local RWAs/Mohalla Sabhas
- Ward members
- SHG members
- Teachers and other informal leaders
- School children
- Beneficiaries
- Traditional Birth Attendants (TBA) and other Registered Medical Practitioners (RMP)

MEDIA AND METHODS

- Wall writings in the local language
- Hoardings at one or two prominent places in the locality
- Handbills and pamphlets

Resources for publicity activities can be accessed through the untied funds available with the Urban PHC. ASHA can help and facilitate in this whole process at different levels.