MASTER OF PUBLIC HEALTH

A cooperative Program of

JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

&

INDIAN INSTITUTE OF HEALTH MANAGEMENT RESEARCH

Capstone Project

By

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2014-2016

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On

Review of Provision and Utilization of Maternal and Child Health Services for the Urban Poor in Jaipur Slums, Rajasthan

By

Dr. Aditee KC

Under the guidance of

Dr. Dhirendra Kumar

Master of Public Health

2014-16

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Aditee KC**, *a student of Master of Public Health Program offered by with Johns Hopkins Bloomberg School of Public Health, Baltimore in cooperation with the Institute of Health Management Research, Jaipur, has successfully completed her capstone project titled* "**Review of Provision and Utilization of Maternal and Child Health Services for the Urban Poor in Jaipur Slums, Rajasthan**".

The student's approach to the study has been sincere, scientific and analytical. This Capstone is in fulfillment of the course requirements.

We wish her the best in all her future endeavors.

Dean, Academics and Student Affairs
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CERTIFICATE BY SCHOLAR

This is to certify that the Capstone Project titled **"Review of Provision and Utilization of Maternal and Child Health Services for the Urban Poor in Jaipur Slums, Rajasthan"** under the supervision of **Dr. Dhirendra Kumar** for award of Master of Public Health embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Aditee KC

MPH 2014-16

Roll no. **IIHMR-JHU/MPH/2014-16/2-11**

REVIEW OF PROVISION AND UTILIZATION OF MATERNAL AND CHILD HEALTH SERVICES FOR THE URBAN POOR IN JAIPUR SLUMS, RAJASTHAN

Capstone Advisor: Dr. Dhirendra Kumar

Aditee KC

Master's in Public Health-2

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Indian Institute of Health Management and Research

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Abbreviations and Acronyms

ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BCG	Bacillus Calmette-Guerin
BCT	Bhoruka Charitable Trust
CARE	Cooperative for Assistance and Relief Everywhere
CEDPA	Centre for Development and Population Activities
CHP	City Health Plan
DPT	Diphtheria Pertussis and Tetanus
FHW	Female Health Worker
GOI	Government of India
H2S	Hydrogen Sulfide
HBNC	Home Based Newborn Care
HBNCC	Home Based Newborn and Child Care
HHs	House Holds
HMIS	Health Management Information System
HUP	Health of the Urban Poor
HW	Health Worker
ICDS	Integrated Child Development Service
IEC	Information Education Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of neonatal and Childhood Illness
IUCD	Intrauterine Contraceptive Device
IYCF	Infant and Young Child Feeding
JMC	Jaipur Municipal Corporation
JSSK	Janani Sishu Suraksha Karyakaram
JSY	Janani Suraksha Yojana

LHV	Lady Health Visitor
LW	Link Worker
MAS	Mahila Arogya Samiti
MCH	Maternal and Child Health
MCTS	Mother and Child Tracking System
MNCH	Maternal Newborn and Child Health
MO	Medical Officer
NFHS	National Family Health Survey
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
ORS	Oral Rehydration Salts
PFI	Population Foundation India
PHC	Primary Health Centre
PHED	Public Health and Engineering Department
POU	Point of Use
PPTCT	Preventing Parent to Child Transmission
RCH	Reproductive Child Health
RMNCH+A	Reproductive Maternal Newborn Child and Adolescent Health
SEARCH	Society for Environmental Awareness and Rehabilitation of Child and Handicapped
TFR	Total Fertility Rate
TT	Tetanus Toxoid
U5MR	Under 5 Mortality Rate
UCHC	Urban Community Health Centre
UHND	Urban Health and Nutrition Day
USAID	United States Agency for International Development
WASH	Water Sanitation and Hygiene
MHealth	Mobile Health

Review of Provision and Utilization of Maternal and Child Health Services for Urban Poor in Jaipur Slums, Rajasthan.

Abstract

This paper focuses on the provision and utilization of the available maternal and child health care services for the urban poor in Jaipur city in the state of Rajasthan. Based on extensive review of literature, the paper provides insight on the various services of the Maternal and Child Health (MCH) component of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) among the urban poor in Jaipur. The paper also describes the reasons and factors that make the urban poor vulnerable and different health care services available in the vicinity for MCH. Additionally, the paper illustrates various issues in the provision of government health care services compelling the slum dwellers to avail private services despite a number of initiatives and programs focusing on this group exclusively. Furthermore, different strategies and initiatives established by the Health of the Urban Poor Program that suggest ways by which various services can be delivered and generate awareness amongst the people in the slums are discussed. Additionally, data from secondary sources on the utilization of services are illustrated and an insight on the newly launched National Urban Health Program, it's Health Care Delivery model and the structure of health care facilities that shall benefit the urban poor, through its comprehensive approach is provided. Lastly, the paper throws light on the poor health indicators in the state despite the presence of various schemes for community and few recommendations that may help to strengthen the NUHM.

Introduction

With the rapidly increasing urban population, it is estimated that 54% of the world's population live in urban areas and is further expected to increase to 66% by 2050 with maximum contribution of 404 million people by India followed by China and Nigeria.(1) One of the reason for increase in urban population is migration from the rural areas, result of which is slow decline of world rural population which shall descend to 3.1 billion by 2050 (1). The insuppressible growth of urban dwellers in India has compelled many to live in poverty and inadmissible conditions. Migration is considered as an important factor to change the demographic profile of a country. It greatly affects the social, political and economic aspect of people's lives (2). On one hand where the rural areas are losing out on their skilled individuals, on the other hand an emerging problem for the urban areas is the formation of slums as a result of rural to urban migration. It was found that among women marriage was the most important factor of migration while for men employment and family seemed to be the dominating cause (3). Other causes of slum formation are rapid urbanization that leads to growth in the economy attracting people from different areas to seek employment opportunities, but the lack of housing and increased expense compel people to live in poor environmental conditions. Furthermore, rural to urban migration also brings with it poverty which is an important factor towards the contribution of slum formation(4). Furthermore, while India is urbanizing at a faster pace, the mushrooming of the slums cannot be ignored. According to census 2011, 17.4% of the urban population in India lives in the slums. Though Rajasthan is the largest state in India, the health indicators are extremely poor. The total slums population of Rajasthan is 20,68,000 (5). Jaipur city, the capital of Rajasthan is comprised of 3.6 lakh population in the slums, that is almost 15% of the total population of the city(6). However, the result of migration or slums formation have an impact on the women and the children, particularly their health. Therefore, through extensive literature review, the paper tries to focus on the services available for the mother and child and the utilization rate of various services.

Aim

To describe the provision of health care services for the maternal and child component of Reproductive, Maternal, Newborn, Child and Adolescent Health Services for Urban Poor in Rajasthan and describe the utilization of various services by the mother and child in Jaipur Slums, Rajasthan.

Objectives

- To describe the maternal and child health components of RMNCH+A services available in the state of Rajasthan.
- To identify the provision of maternal and child health services in the state of Rajasthan.
- To identify the utilization of the services by the mother and child in the slums of Jaipur, Rajasthan.

Methodology

This paper is an extensive review of literature that describes the provision, availability and utilization of health care services of the maternal and child health component of RMNCH+A for which the search engines preferred were PubMed, Google Scholar and Google in the respective order. Initially PubMed was used, but it did not provide complete relevant data on the topic. Hence, due to lack of data about the slums in Jaipur, search engines like Google Scholar and Google were used. Over 100 articles were selected based on their content and abstract which was then further scrutinized to around 70 articles and based on them literature review was done.

Since, RMNCH+A is a very comprehensive program which gradually evolved from RCH and with maternal and child health being the core and critical component of RMNCH+A that forms its base, a descriptive study based on a thorough review of literature on these two components was done to identify the services available for mother and child and to describe the utilization of the service

in Jaipur city of Rajasthan. A baseline study conducted by HUP on sample chosen from the slums that were under the record of the government were also referred for this study. Various relevant articles and papers on the topic were found and reviewed and mentioned in the paper highlighting the utilization rate and forming a basis for further studies as very limited study on the urban poor are done. This section followed by the review of literature provides a basic concept of slums.

Review of Literature

Slums, the Urban Poor

Definition of slums under Section-3 of the Slum Area Improvement and Clearance Act 1956 are '*those residential areas where dwelling are in any respect unfit for human habitation by reasons of dilapidation, over- crowding, faulty arrangements and designs of such buildings narrowness or faulty arrangements of streets, lack of ventilation, light, sanitation facilities or any combination of these factors which are detrimental to safety, health and morals'* (5).

Additionally, as per UN Habitat, '*slum is characterized by lack of durable housing, insufficient living area, lack of access to clean water, inadequate sanitation and insecure tenure'* (5).

Census -2011 (5) has defined three types of slums, namely:

- ***Notified Slum****: 'all notified areas in a town or city notified as 'Slum' by State, Union Territories Administration of Local Government under any act including a 'Slum Act''* (5).

- ***Recognized Slums***: '*all areas recognized as Slum by State, Union Territories Administration or Local Government, Housing and Slum Boards, which may not have been formally notified as slum under any act*' (5).

- ***Identified Slums***: '*a compact area of at least 300 population or 60-70 households of poorly built congested tenements, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking facilities. Such areas should be identified personally by Charge officer and also inspected by an officer nominated by Directorate of Census Operations. This fact must be duly recorded in the charge register'* (5).

Why are the Urban Poor Vulnerable?

'Vulnerability' is defined as a '*situation where people are more prone to face negative situation and there is higher likelihood of succumbing to them. With reference to health, it implies to a situation with or leading to increased mortality and morbidity. Factors contributing to such state may or may not be within the control of the group'* (7).

Vulnerability of the poor in the urban areas are profound due to factors such as living in a degraded environment, inaccessibility to and lack of health care services, illiteracy, inconsistent employment, lack of awareness of services and lack of power to demand better services. Since many slums where considerable population resides are not listed, they are deprived off the public services including health, making them more vulnerable (7). The slum statistics from India shows that although there has been a decrease in the percentage of slum dwellers from 24% in 2001 to 22% in 2011, yet the population has increased from 52 million to 65 million (8). Despite a number of government and other health care facilities in the urban areas, the urban poor still have limited access to it. Additionally, there have not been many initiatives to address this issue (8). While Rajasthan can proudly claim to be the largest state in India, the health indicators have degraded over the past decade and the maternal child health indicators are far worse for the urban poor in the state (7). Table 1 below describes various factors contributing to vulnerability of urban poor.

Table 1: 'Factors that contribute to vulnerability of Urban Poor'

Factors	Situation Affecting Health Vulnerability in Slums
Economic condition	Irregular employment, poor access to fair credit
Social conditions	Widespread alcoholism, gender inequity and poor educational status
Living environment	Poor access to water supply and sanitation facilities, over- crowding, poor housing and insecure land tenure
Access and use of public health services	Lack of access to ICDS and primary health care services and poor quality of health services
Hidden/ Unlisted slums	Many slums are not notified in official records and remain outside the purview of civic and health services
Rapid mobility	Temporary migrants denied access to health services and other development programs, difficulty in tracking and providing follow up health services to recent migrants
Health an disease	High prevalence of diarrhea, fever and cough among children
Negotiating capacity	Lack of organized community collective effort in slum

Source: State of Urban Health in Rajasthan, 2007. (7)

Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) Program

The Reproductive Child Health (RCH) Program was first launched by the Government of India on 15th October 1997 with an aim to protect the lives of the reproductive women and children by enabling the women to regulate their fertility and undergo a safe pregnancy and deliver, the successful outcome of which shall lead to the survival and wellbeing of the mother and child. The second phase of the RCH program was launched on 1st April, 2005 with a goal of reducing the three crucial indicators that were Total Fertility Rate, Infant Mortality Rate and Maternal Mortality Rate so as to coincide with the Millennium Development Goals for the nation (9).

The RCH program became more comprehensive when adolescent health was included and it became RMNCH+A (Reproductive Maternal Newborn Child and Adolescent Health) in 2013 to address all the important causes of mortality among women and child and the possible problems associated with assessing and utilization of services. The RMNCH+A comprises of strategies that focus on the various stages of life from pre pregnancy until the delivery for women and stages of child health from the time of delivery until adolescence (9). Table 2 describes in detail, the various services of RMNCH+ A that address the different needs across different levels of health system.

Table 2: ' Continuum of care across life cycle and different levels of health system'

	Reproductive care	Pregnancy and child birth care	Newborn and child care
CLINICAL	• Comprehensive abortion care • RTI/STI case management • Postpartum IUCD and sterilization; interval IUCD • Procedures. • Adolescent friendly health • services	• Skilled obstetric care and immediate newborn care and resuscitation • Emergency obstetric care • Preventing Parent to Child Transmission (PPTCT)of HIV • Postpartum sterilization	• Essential newborn care • Care of sick newborn • Facility based care of childhood illness (IMNCI) • Care of children with severe acute malnutrition (NRC) • Immunization
	Reproductive health care	**Antenatal care**	**Post natal care** / **Child health care**
OUTREACH/SUBCENTER	• Family planning (including IUCD insertion, OCP and condoms) • Prevention and management of STIs • Pre conception folic acid supplementation	• full antenatal care package • PPTCT	• Early detection and management of illness in mother and new born • Immunization first level assessment and care of newborn and childhood illness Immunization micronutrient supplementation
FAMILY & COMMUNITY	• Weekly IFA supplementation Information and counselling on sexual reproductive health and family planning • Community based promotion and delivery of Contraceptives • Menstrual hygiene	• Counselling and preparation for newborn care, breastfeeding , birth preparedness • Demand generation for pregnancy care and institutional delivery (JSY, JSSK)	• Home-based newborn care and prompt referral (HBNC scheme) • Antibiotic for suspected case of newborn sepsis Infant and Young Child Feeding (IYCF), including exclusive breast feeding and complementary feeding • Child health screening and early intervention services (0–18 years) • Early childhood development • Danger sign recognition and care-seeking for illness • Use of ORS and Zinc in case of diarrhoea
INTERSECTORAL: water, sanitation, hygiene, nutrition, education, empowerment			
Adolescence/Pre pregnancy	Pregnancy	Birth	Newborn/Postnatal / Childhood

Source: A Strategic Approach to RMNCH+A in India, 2013 (10)

Health of the Urban Poor (HUP): An Overview

One of the approaches to address the underserved people of the urban population in India was through the Health of the Urban Poor Program, started in 2009 in eight states (Rajasthan, Madhya Pradesh, Orissa, Chhattisgarh, Bihar, Jharkhand, Uttarakhand and Uttar Pradesh) which was supported by USAID-India with Population Foundation of India as the prime recipient and Plan/India and IIHMR (Jaipur) as the sub recipient. The technical assistance was provided by CARE/India, CEDPA –India, Micro Assurance Academy, International institute of Population Studies and Bhorukha Charitable Trust was the implementation partner at the community level (11).

The goal of this program was to improve the health status of the urban poor by adopting effective, efficient and sustainable strategic intervention approaches, and the principle of convergence for various development programs (11).

The objectives of HUP (11) were:

- *'To provide quality assistance to the government of India, states and cities for effective implementation of proposed National Urban Health Mission (NUHM)'.*
- *'Expand partnership in Urban Health including engaging the commercial sector in public private partnership activities'.*
- *'Promote the convergence of different GOI urban health and development efforts'*
- *'Strengthen urban planning initiatives by the state through evidence based city level demonstration and learning efforts'*

The strategies that were applied to achieve the above objectives (11) were:

- *'Need based Technical Assistance for Operationalization of Urban Health Program within the Public Health System at all levels'.*
- *'Convergence at all levels for improved health (MNCH), nutrition, water, sanitation and hygiene through institutionalization'.*
- *'Capacity building for high Quality accessible and sustainable health, nutritional and water and sanitation services'.*
- *'Leveraging resources'.*
- *'Gender Equity and Male Engagement'.*
- *'Empowering community for improved negotiation and ownership'.*
- *'Fostering strategic alliances and partnership at all levels'.*
- *'Demonstration, documentation, systematic replication of successful urban health intervention models'.*

Initiatives by HUP

One of the states where HUP worked is Rajasthan. Though Rajasthan is the biggest state of India spreading to 342,239 square kilometers, it is also one of the least developed state(7). Jaipur city the capital is home to 33,55,070 people (12) of which around 15% dwell in slums according to 2012 data (6) and hence contributes to the poor health indicators and therefore, to improve the condition of the reproductive women and reduce the mortality of under 5 children, HUP tried to strengthen the services provided for maternal and child health through innovative strategies such as *advocating MCH, by providing technical support to the government in policies and interventions targeting maternal and child health, pre and post project surveys and evaluation to assess the impact of the interventions*, and other activities such as:

- *Mahila Arogya Samiti (MAS)*

MAS involves community participation at all levels- planning, implementation and monitoring of health programs. It is a women's group of 10-15 members covering around 50-100 households and facilitated by a link worker. A chairperson and a secretary is elected. This group addresses the health issues related to health, water, nutrition, sanitation and social determinants of health in the slums. ASHA acts as the Member Secretary. The objectives of MAS are to provide platform to act upon the social determinants and public services which are related to health, to act as a medium through which the community can put forward their needs and issues related to health services, to create an awareness amongst the people and motivate them to accept good practices in health, to focus on preventive care, assist ASHAs and other frontline health workers by acting as link between them and the community and inform the community regarding various health related programs by involving in planning and implementation of the programs and also organize community level services and provide referral links to people(13).

Source: Google

Source: Google

- *Urban Health and Nutrition Day (UHND)*

Urban Health and Nutrition Day organized by the Nation Health Mission provides maternal and child health care and nutrition services to the urban poor. These services are provided through the MAS, AWW, ANMs, ASHAs and other frontline health workers. Conducting UHND regularly would increase the accessibility of services to people making it more reachable. The objectives of UHND are to provide health and nutrition services to the target population from an identified point through a convergent manner, to generate awareness amongst the people about preventive and promotive care and to improve the health seeking behavior of the people. UHND is usually carried out once a month in any community health center and 1 ANM covers about 1000 population and they provide services related to health, nutrition and counseling (14).

- *City Health Plan (CHP)*

Under this plan detailed analysis of the health infrastructure, facilities available and the gaps between them are identified to improve the delivery of health services. Various departments of the government are brought in together to list out and develop a plan for current and future facilities (15).

- *HMIS/MCTS*

As the name suggests, it is a monitoring tool that enables data collection related to maternal, newborn and child health along with collection of water, sanitation and hygiene data by the health workers during their visit to the community which is regularly analyzed to monitor the progress of the program (15).

- *Integration with Health Determinants (WASH/SANITATION)* (16)

Source: Google Image

To prevent mortality due to water transmitted disease, HUP came up with Point of Use (POU). Since the source of the waster such as the community tap/tanker provided by the municipality is under the control of the government, similarly the source of the water for use by the community is under their control and hence the community were sensitized with proper water handling techniques (17). People were provided with H2S kits which would help detect bacteria in the water for use and different methods of water purification at home were also taught.

Source: Google Image

Source: Google Image

Similarly the community were also sensitized regarding health hazards due to open defecation by asking them to draw color coded maps of their community and to identify and mark the areas used for open defecation. They were then educated about the various ways and modes of disease transmission due to open defecation and their consequent health hazards (16). HUP also collaborated with JMC, PHED, ICDS and the health department by sharing ward and slum maps with the government, there were field visits by JMC officials to HUP slums, training and need

assessment of frontline health workers, capacity building of health workers on point of use of water and communicable and non-communicable diseases and holding annual meetings. HUP also conducted a baseline study on sample of the slums that were in the government's records.

Current Scenario of Jaipur Slums

Jaipur city, the capital of Rajasthan is a home to 30,73,350 people (18) of which many living in the so called *'basti'* as a result of migration from rural areas or slums from across the state/country. (19) There are about 247 listed slums and many more of which the government are unaware.(18) However, migration may not be the reason for their vulnerability, there may be services available, but the fact that whether their altered socio-economic status allows them to avail those services is questionable(19). Change in work, environment and nutrition seems to be important factors affecting the health of the reproductive maternal and child health leading to frequent disease occurrence and death in the under- five children(19). The general scenario of a *'basti'* is such that there is no safe water and sanitation facility. With an absence of a toilet in most houses, compelling people to defecate in the open and many young children even defecating on the door steps with open sewer and sewages getting blocked in front of the houses and over-crowding of people in the house and use of firewood and kerosene for cooking (19). Such unhygienic and degrading environmental conditions could be one of the important factors contributing to frequent reoccurrence of diarrhea, skin and lung infections.

Some of the most common diseases in the slums are pneumonia, diarrhea, fever, cough, jaundice, skin infections, rashes and shortness of breath and the incapability to treat such diseases, ultimately leading to death of the infant and children. However, it will be interesting to know whether child mortality is the cause or the effect of short intervals between children.

A study done in Jaipur slums showed that the house having proper water and sewerage facilities seemed to spend less on health care compared to those without the facilities(20). Another study conducted in the urban slums showed high malnutrition and stunting in the children below five and it was also found that the reason for stunting or malnutrition was not just lack of food, but also due to the social and the environmental conditions such as unavailability and inaccessibility to healthcare, clean water and sanitation facilities, frequent reoccurrence of infections and mother's natal and post natal nutrition and breastfeeding. A variation in antenatal check- ups among women living in slums and non-slums was found (21).

Health care services for the Urban Poor in Jaipur

Unlike the rural areas where the health services are provided through a vast network of health care facilities, such as the National Rural Health Mission (NRHM), there was nothing for the urban poor. Even, basic infrastructure and outreach services were also missing and although some services of the NRHM such as funding support for Urban Health and Family Welfare Centers, for Urban Health Posts, funds for national programs like TB, Immunization, malaria, implementing JSY did cover the urban areas, they still lacked a comprehensive program that focused solely on the urban poor setting. Finally, National Urban Health Mission (NUHM) a submission of National Health Mission (NHM) was passed in 2013 which is now being implemented targeted the urban poor (22).

However, in urban areas the services are provided by the Department of Family Welfare and the Department of Medical and Health, where the primary health care services like health posts, urban family welfare centers and mother and child welfare centers are provided by the department of family and welfare and other services like urban dispensaries and aid posts are stationed by the medical and health departments. Few PHCs are upgraded and came to be known as Urban PHCs

which provide basic services to people, but the first point of contact to the people are the Anganwadi centers which also provide out- reach services (7). These Anganwadi centers provide services to the urban poor through ASHAs who are chosen from their respective community (slums). Like in the rural settings, these ASHAs in the slums provide door to door services. However, immunization of the children and the pregnant women are done by the Auxiliary Midwives. She is not a member of the slum community and visits particular days in a week to provide services.

However, it is important to know that what are the various services provided for the Urban Poor that cover the MCH component of the earlier mentioned RMNCH+A Continuum of Care and the gaps in provision of those services. To begin with, Family Planning services and supplies are provided through a network government health care centers such as Urban Family Planning Welfare Centers and Urban PHCS. There are also new schemes that provide RMNCH+A services such as the 'Panchamrit' which have five programs dedicated for mother and child (23). They are:

1. Elimination of Vaccine Preventable Diseases: through universal immunization(24).

Under this program the eligible beneficiaries are vaccinated with all necessary vaccines (BCG, Polio, DPT, Measles for children and TT for mothers) at the correct age (24)

2. Elimination of Micronutrient Deficiency (24).

This is done through provision of micronutrient supplements (vitamin A, iron folic acid) and promotion of breastfeeding (24).

3. Family Welfare (24).

This program provides counseling on Family Planning, importance of spacing births, advocacy of IUD insertion and distribution of contraceptives like condoms and oral pills.

Counseling of Right Age at Marriage is also done through group meetings with leaders, mothers and other family members where issues on physical, social and mental problems related to early marriage are discussed and on death of any young mother or if a mentally challenged child is born to a young mother, they are presented as evidence and medium to reach out to people (24).

4. Safe Motherhood (24).

Under this program all mothers are registered and provided with Antenatal Check- ups on the spot by doing some basic examinations. The health worker also promotes institutional deliveries by counseling the women and family members about 1) '*un-predictability of pregnancy outcome'*. 2) '*Importance of its preparedness'.* 3) *'value of institutional delivery'* 4) *'institutions in vicinity where Emergency Obstetric Care services are available all the time'* and 5) *inform the community about the funds available with her for referral transportation for mothers in emergency to higher institutions'* (24).

5. Ensuring Healthy Newborn (24).

The last component of Panchamrit is registration of all births by the health worker and on the spot check up of the babies and inform about future check –ups(24).

Another comprehensive program for children is the Integrated Child Development Scheme (ICDS) launched on 2nd October 1975 in India to improve the health and the nutritional status of children and various approaches for their development by providing services comprised of supplementary nutrition, immunization, health check- up, referral services, preschool non formal education and nutrition and health education (25). The services that are delivered through this program are:

- Supplementary nutrition program to deal with malnutrition. The pregnant and the lactating mothers and children are provided with supplementary nutrition and micronutrient as per requirement. There is distribution of fixed amount of ration once every month. Malnourished children are given additional food at the Anganwadi centers (25).

- Immunization of pregnant women with tetanus and infants with all required vaccines is done (25).
- Health check-up of the women and children such as on the spot check up of weight, height, immunization, management of malnutrition, treatment of diarrhea, deworming and distribution of medicines are done by the health workers (25).
- Referral of pregnant women and children if required is done to medical officers and primary health centers (25).
- Nutrition and health education through counseling on breastfeeding, healthy nutrition, family planning, utilization of health services and sanitation is done (25).

However, this scheme in the urban poor setting is now conducted as Urban Health and Nutrition Days an initiative by HUP, which cover both women and the children on fixed days and fixed sites and a new component of Water Sanitation and Hygiene (WASH) is included with ICDS to promote the importance of safe drinking water, treatment of water at the Point of Use, safe handling of water, counseling on construction of toilets and hygiene by the Anganwadi workers (14).

Likewise another program for the mothers is the Janani Suraksha Yojana, though under the umbrella of the NRHM, the urban poor are also benefited by this scheme. The aim of this initiative is to increase the institutional deliveries of the poor and the reduction of maternal and infant mortality. The Mother and Child Health Card is given once the pregnant women is registered at the Anganwadi Centre and must go through all the antenatal check- up and postnatal once the baby is delivered. An incentive of amount 1000 is given to the mother and Rs. 200 to the health worker of which Rs.100 given after the antenatal check- ups and the remaining after postnatal checkups (23). A program for the mother and child is the Janani Sishu Suraksha Yojana launched on 12th September 2011 with an aim to reduce the maternal and infant mortality. This scheme promotes free maternity services and newborn care in all the public health care institutions by providing diet, free drugs, disposable, diagnostics, blood transfusion, referral transport and even

drop back facility (23). Thus, through various initiatives and routine health care facilities, services for the maternal and child are provided.

Gaps in the Accessibility of the Services

Things may not look as simple, as there are a lot of gaps in the provision of services such as the health centers are usually far from reach that is not in the proximity of the slums, sometime the maternal and child welfare centers are attached with the PHCs/ District Hospitals/ Female Hospitals and therefore are restricted from use by the needy. Many a times there is absence of healthcare providers like the ANMS, doctors or other community health workers and/or population to health worker ratio is too high leading to poor coverage(7). Although, the health facilities are present, yet they are inaccessible by the people as they are too far from reach and poorly staffed with scarce supply of medicines and equipment. The services provided by the Municipal Corporations and Nagar Panchayats are very limited and restricted due to lack of resources(7) Furthermore, since the public health services do not permeate to the slum dwellers, they are compelled to avail the private services through qualified/ unqualified health practitioners such as the quacks or TBAs and licensed/ unlicensed drug dealers primarily via out-of-pocket expenditure(7). Most importantly many slums are not recognized by the government meaning the government is unaware of the existence of the slums and hence, they are deprived off the services.

Despite a vast rage of comprehensive schemes, the results are still poor. HUP conducted a baseline study on a sample of slums that are in the Jaipur government's record, the results of which are mentioned in the paper. According to the data collected by HUP, the median age at marriage among women in Jaipur was only 16years and the average number of children born to women in Jaipur were 2.7 with only 57% of them having two or less than two children compared

to the non-slum areas. Interestingly the report showed that around 37% couples in Jaipur slums first used contraception after having three or more children (26). The survey also showed that the experience of child loss is inversely related to their education. Furthermore, the number of women who experienced loss of at least one child are more in the slums of Jaipur than the women in non-slum area and also the desire to have more children was also high among the slum dwelling women (26).

Antenatal care is the first component of maternal health which is very crucial. As regular check-ups help to identify any complications in the mother in addition to providing supplements necessary during pregnancy. The Table 3 below shows the percentage of women who had at least one birth in three years preceding survey by HUP by registration and visiting health professionals during pregnancy for last birth according to type of locality in Jaipur city, 2011.

Table 3: 'Percentage of women who received Antenatal check-ups'

Antenatal check ups	Slum	Non-slum	total
Women who registered pregnancy with ANM	63.8	70.6	67.9
Women who received registration card from ANM	87.0	95.0	92.0
Women who visited any health professional for ANC check up	99.4	99.4	99.5
Women who visited any health professional for ANC check- up in first trimester	69.9	81.5	76.9
Mean no of ANC visits	5.8	7.3	6.7
Number	95	285	380

Source: HUP Baseline Report, 2011(26)

From the above table it is evident that lesser number of women registered with ANM during pregnancy. However, we shall further see the health facilities they approach for the antenatal check-ups.

The Table 4 below shows the percentage of married women with at least one live birth in three years preceding the survey done by HUP by source/place of receiving ANC for most recent birth.

Table 4: 'Percentage of women who received antenatal care through different sources in Jaipur'

Source of health facility	slums	non-slums	total
Govt./ Municipal hospital	58.1	46.7	51.0
Govt. Dispensary/UHC/UHP/UFWC	14.3	9.4	11.3
Anganwadi/ ICDS/Village clinic	7.0	7.2	7.3
PHC/ Sub center	0.0	0.0	0.0
ANM/Other public sector			
Private medical sector	40.2	56.2	50.4
NGO/ Trust Hospital/clinic	0.0	1.2	0.7
Home	8.7	17.7	14.6
other	2.0	0.0	0.2
Number	87	272	359

Source: HUP Baseline Report, 2011 (26)

In the above table it is seen that majority of the women receive ANC check-ups municipal hospital or private medical sector.

Moving further, for a healthy pregnancy outcome, it is essential for women to take supplements like iron folic acid tablets, TT injections for at least 90 days. However in the Table 5 below it is seen that women in slums who went through antenatal check- ups, not all received complete supplements. Majority received TT injections compared to the IFA tablets.

Table 5:' Percentage of married women during pregnancy received TT injections, IFA tablets/syrup and deworming drugs'

TT injections & IFA tablets/syrup and deworming drugs	Slums	Non-slums	Total
Women who received TT **Number of TT** **1**	1.4	2.9	2.7
Number of TT 2+	98.6	97.1	97.3
Consume IFA tablets/syrup	67.1	75.1	71.9
Women who consumed IFA tablets/syrup for 90+ days	41.9	60.7	53.8
Women who took drugs to get rid of worms	6.6	7.7	7.1
Number	90	276	366

Source: HUP Baseline Report, 2011 (26)

From the table it is evident that maximum women took 2+ TT injections compared to women who took IFA tablets. Furthermore, it is seen that fewer women consume IFA tablets/ syrups for more than 90 days. Hence it is important to find out why women do not take IFA tablets and of those who take why many do not continue till the required dose.

Place of delivery has always been a critical factor for the lower income group. The report by HUP also mentions that majority of women prefer home delivery to institutional deliveries and those who deliver in the institutions prefer to get discharged sooner due to poor hygiene and lack of sanitation facilities. Additionally, the reason for choosing home over institutions were the unfriendly behavior of the staff and ill treatment faced by many especially the poor section of the community (26). An evaluation report on JSY by State Institute of Health and Family Welfare,

Jaipur reported that some beneficiaries paid certain amount to health professionals for treatment with majority of them being medical officers and that the money was usually demanded at the time of receiving the incentives by beneficiaries, while some demanded after delivery (27). There have also been number of cases with physical abuse, name calling and bribe taken by the doctors and other health professionals. Due to the horrible experience that the women face in the institution during delivery and the degraded hygiene of the health care center, the women prefer to deliver at home or at the private facilities despite the high cost. They seem to trust the private facilities more than the government (28).

Medical attention after delivery is equally important for the safety of the mother and her baby. However, it shall be interesting to see the type of heath care provider the women approach for post natal check-up and the timing of their approach.

Table 6: Percentage of women with at least 1 birth in institution according to the timing and type of provider for PNC'

Timing and type of health care provider	Slum	Non-slum	total
Timing of first post natal check up			
Check up within 48 hours	93.6	95.8	95.0
Check up within two weeks	100.0	100.0	100.0
Type of provider of first postnatal check ups			
Doctor	80.2	81.7	81.2
ANM/nurse/midwife/LHV	19.8	18.3	18.8
Other health professional	0.0	0.0	0.0
Dai/TBA	0.0	0.0	0.0
Others	0.0	0.0	0.0
Total	100.0	100.0	100.0
number	65	235	300

Source: HUP baseline Report, 2011 (26)

From Table 6 we can see that all women receive PNC check-up within two weeks of delivery and majority of them prefer to visit a doctor compared to ANM/ nurse/ midwife or LHV

Table 7: 'Vaccine coverage. Percentage of children age 12-23 months who received specific vaccine during the three years preceding the survey by HUP according to the vaccination card or mother's report by type of locality in Jaipur, 2011'

	Slum	Non-slum	Total
BCG	77.1	93.5	87.2
DPT 1	73.3	89.6	83.4
2	71.4	85.2	79.9
3	59.0	76.2	69.3
Polio 1	59.0	73.0	67.6
2	71.4	83.5	78.5
3	63.8	74.0	70.0
Measles	61.0	74.3	70.0
All vaccination	32.4	46.7	41.2
No vaccination	16.2	4.4	9.0
Vaccination card seen	26.1	37.9	33.1
Children age 12-23 months who received most of the vaccinations in public health facilities	87.4	73.3	78.8
Number	60	182	242

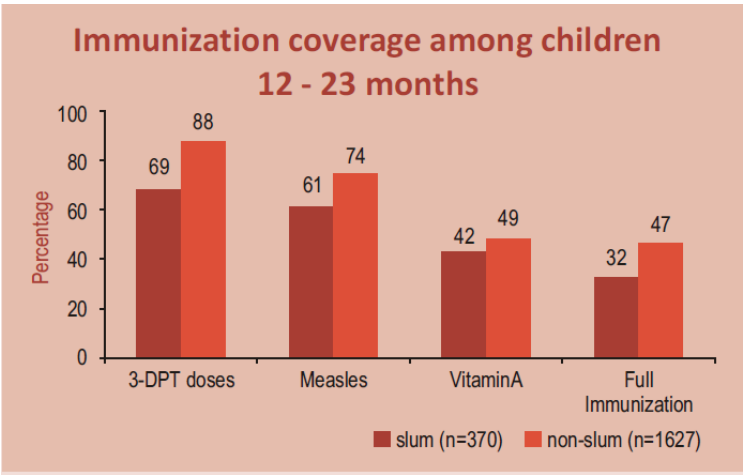
Source: HUP Baseline Report, 2011 (26)

According to the NFHS 3 data only 22.4% of the urban poor in Rajasthan delivered in health facilities while 77.6% people delivered at home(29). Therefore, those who get delivered at home remain unregistered particularly the people living in unlisted slums. These unlisted slums are not recognized by the government and hence are deprived off all the government health services and

facilities. Other reasons for poor immunization coverage are the poor health infrastructure facilities, the national level programs such as the polio divert the attention of the health workers from the regular immunizations (7). Other important core component of RMNCH+A is child health. Therefore, we shall further see the various components in child heath such as immunization coverage, the source of facility approached during illness and also the prevalence of diarrhea and ARI among children.

The data in Figure 1 shows that the vaccination coverage among children in slum is low for all vaccines. Additionally, it is also seen that there is fall in the percentage of children who received DPT 3 vaccine compared to the first two doses.

Figure 1: ' Immunization coverage among children in Jaipur slums'

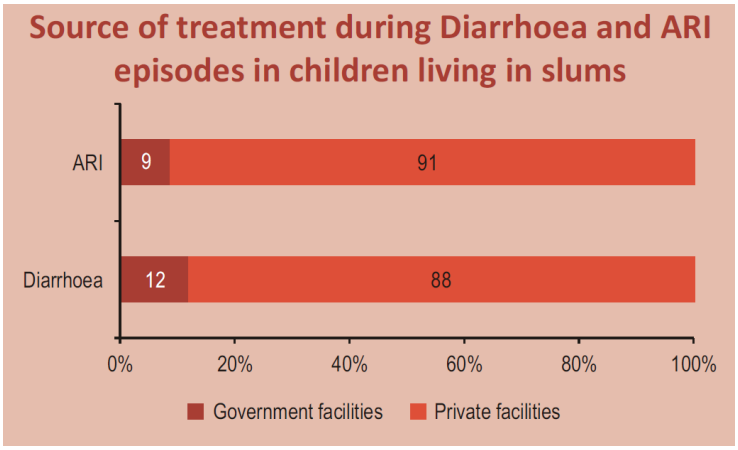


Source: HUP, Findings of Baseline Study, 2012 (6)

The report also mentions the vaccination coverage for Jaipur with only 32% of them being fully immunized. Furthermore, 16% of them did not receive any vaccination. Since majority of the immunization sessions would take place in the public health center and though many women would be aware of it, yet they would not get their children immunized because of reasons such as the hospital where they get their children immunized is far from reach, the daily wage earners would not be able to spare time to get their children immunized for the fear of losing their job. Many women who were laborers did not find the necessity of vaccination and thought their children were

as safe as those vaccinated and many also argued that since they were not vaccinated as children why should their get their children immunized and saw no need of it and that their work was more important else they would lose pay (26).

Figure 2: ' Source of services that the people avail during diarrhea and ARI prevalent among the children'



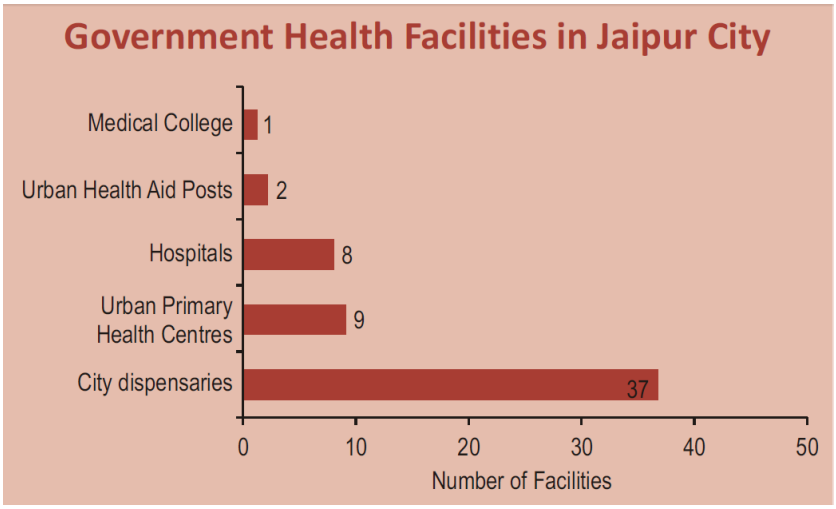
Source: HUP, Findings of Baseline Study, 2012 (6)

Diarrhea and acute respiratory infections are the two most common and serious cause of mortality among the children in the slums. Poor sanitation facility and unhygienic environment can be considered as one of the critical cause for these diseases.

Additionally, the knowledge of ORS administration for diarrhea treatment is low among the urban poor (7). According to the NFHS 3 data of the children who suffered from diarrhea in previous 2 weeks, only 11.1% of them received ORS treatment (29). As mentioned ARI in that particularly pneumonia is a prevalent cause of death among the children which is precipitated due to use of firewood, kerosene as fuel in addition to inadequate water supply, poor sanitation facility and overcrowding of houses(7). Furthermore, the availability and accessibility of health care services are very important for them to reach out to people. Though there may not be dearth of the healthcare center, yet they may be out of reach for many or may not be located as per the convenience of the slum dwellers also because the slums being opportunistic in nature settle where they get land and therefore the health care infrastructure and are far from reach for the

slum dwellers. Despite the government facilities being present, yet many women would prefer other source of services such as the private facilities or the unlicensed practitioners(26). Figure 3 below shows the various health care facilities in the vicinity of the slum dwellers in Jaipur city.

Figure 3: Government Health Facilities in Jaipur'



Source: HUP, Findings of Baseline Study, 2012 (6)

The below Table 8 shows the percentage distribution of households by source of health care that household members generally used in slums compared to non -slum areas in Jaipur.

Table 8: 'Source of Health Care Facilities used by the people in slums.

Source of health care	Slum	Non-slum	total
Govt. municipal hospital	19.9	19.9	19.9
Govt. dispensary/UHP	14.7	14.8	14.8
PHC/Sub-centers	**	1.6	1.1
ICDS/Anganwadi	**	**	**
Private Medical Sector	63.0	61.0	61.7
NGO/Trust hosp.	**	0.5*	0.5*
others	2.1*	2.2	2.1

*Note: * based on fewer than 10 unweighted cases. ** figure not shown; based on fewer than 5 unweighted cases*

Source: HUP Baseline Report, 2011 (26).

From Table 9 below we shall see the various reasons for the non- utilization of government health care facilities by the people.

Table 9: 'The percentage of households whose members do not generally use the government health facility for various reasons'

Reasons	Slums	Non-slums	Total
No nearby facility	60.1	48.9	52.7
Facility timing not convenient	9.5	12.4	11.4
Health personal often absent	5.7	8.7	7.7
Waiting time too long	51.0	47.8	49.0
Poor quality of care	34.6	35.4	35.1

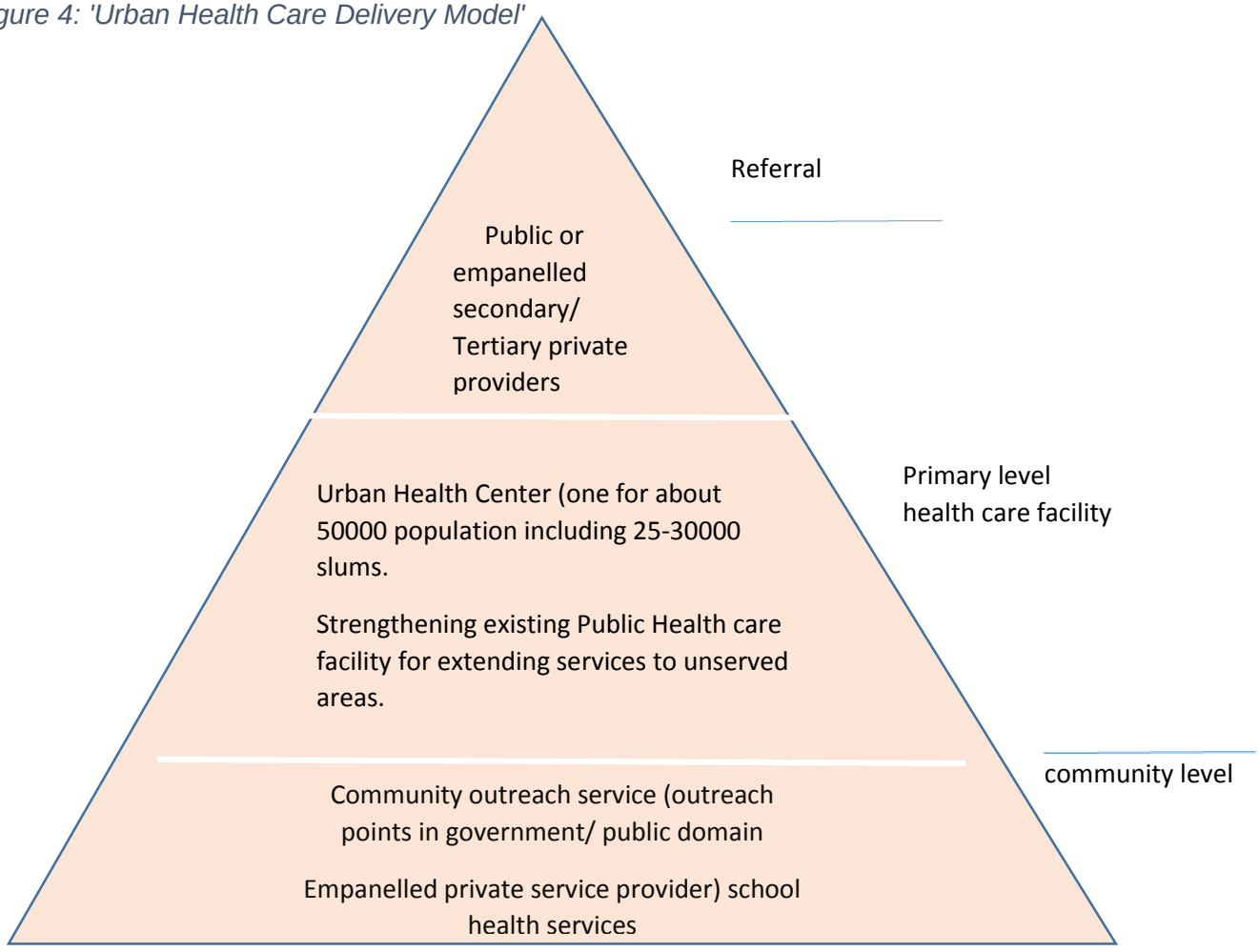
Source: HUP Baseline Report, 2011 (26)

Despite of number of schemes and initiatives, yet the health indicators of the urban poor in Rajasthan according to NFHS 3 data is on the downside with U5MR of 102.3, TFR of 3.35, only 22.4% deliveries taking place in health facility and only 42.3% women receiving three or more antenatal visits. Thus through various information and data available in the literature we are now aware of the types of services and facilities available for the maternal and child component of the RMNCH+A and the status of utilization of those services by the people. However with limited data source and studies done on the urban poor in Jaipur, it is about time that the focus is shifted and the gaps in the provision of health care are addressed.

National Urban Health Mission (NUHM)

The NUHM allows the all states in India to choose the health care delivery model according to the needs and the capacities that best suits the respective states. In general the health care delivery system of NUHM provides all services through the Urban PHCs and the Urban CHCs with the facility of outreach services especially for the slum dwellers and other vulnerable groups through monthly health, sanitation and nutrition day in addition to the routine outreach services(22). However, urban areas would not have the facility of sub-centers such as in their rural counterpart as the urban areas have good provision of commute(22).

Figure 4: 'Urban Health Care Delivery Model'



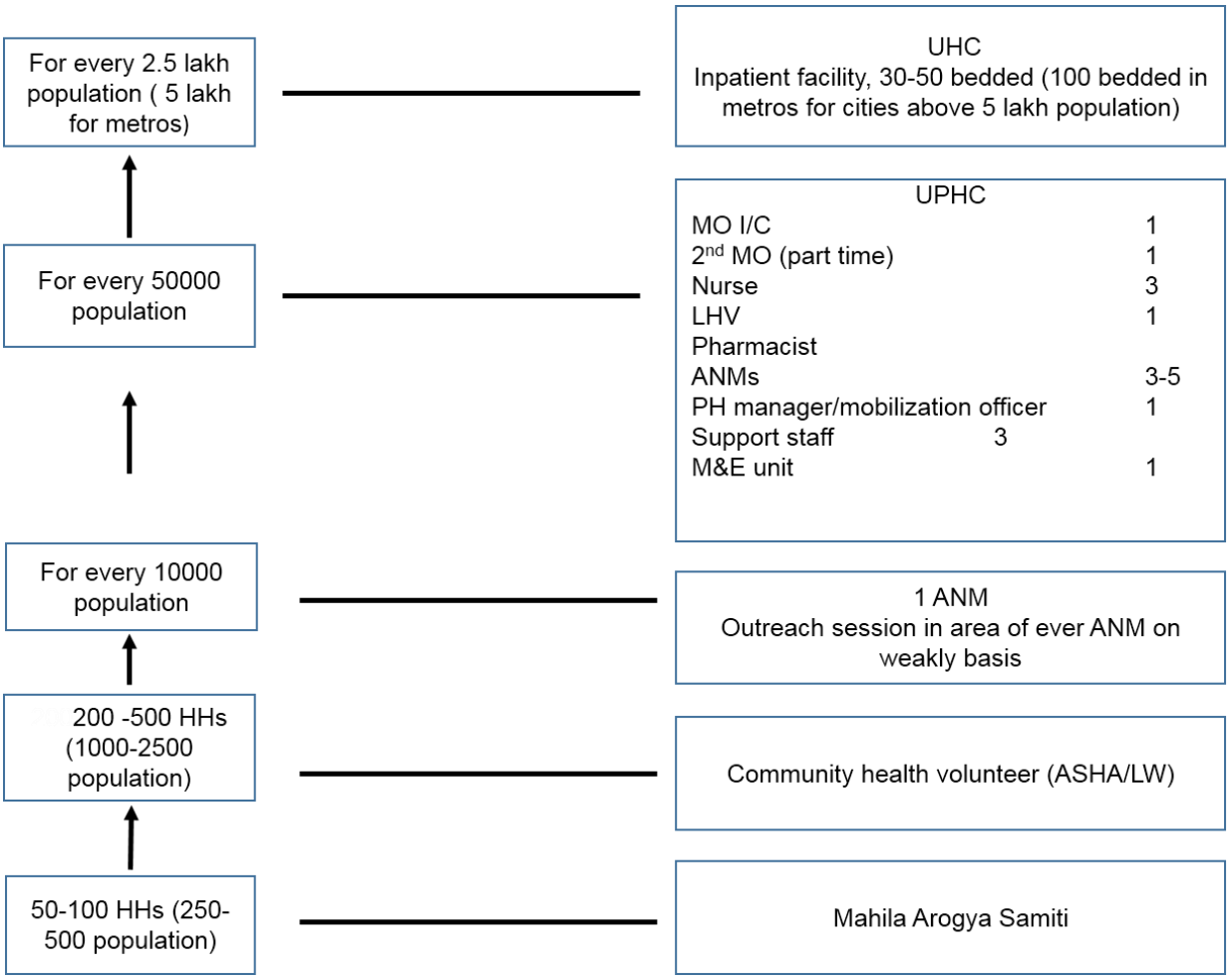
Source: National Urban Health Mission: Framework for Implementation, 2013 (22).

As mentioned earlier, the outreach services shall be provided by a Female Health Worker (FHW) mostly an ANM whose central station would be the Urban-PHC from where she is expected to commute to different areas including schools and provide services during certain days of the week while on the remaining days the ANMs would provide immunization and ANC services. Additionally, all the states would be expected to indulge the NGOs of the respective states with the communization process, capacity and skill building of the ASHAs and the MAS and also conduct the IEC/BCC activities(22).

Other health workers under the NUHM and the services provided by them are ASHAs or Link Workers (LW) with a ratio of 1 ASHA to 1000-2500 population covering 200-500 households. Additionally, as mentioned earlier the MAS committee an initiative by HUP covering 50-100 households and Rogi Kalyan Smities would also be a part of the NUHM.

The MAS group would be provided with an incentive of Rs.5000 annually to spend on organizing meetings of the MAS, sanitation, hygiene and on emergency health needs (22). We shall further see the health care facilities covering the urban poor population under NHUM.

Figure 5: 'Urban Health Care Facilities'



Source: National Urban Health Mission: Framework for Implementation, 2013 (22).

Summary of Findings

General

- As a result of rapid urbanization, there is an increase in the urban population, while a decrease in the rural population as a result of migration of the rural people to the urban setting.
- Some common reasons for migration are marriage, job/employment and social security.
- Poor housing facilities, rapid increase in the economy of the urban areas and the increased expense compel the formation of slums where people live in degraded environmental conditions.
- 17.4% of the urban India lives in slums.
- Rajasthan being the largest state in India lacks behind with its poor health indicators and Jaipur the capital of Rajasthan have 3.5 lakh people that is 15% of the total population of the city living in slums.
- Factors that contribute to make the urban poor vulnerable are degraded environmental conditions, illiteracy, inconsistent employment, inaccessibility to health care services and lack of awareness and power to demand better services.
- With the evolution of maternal and child health services from RCH program in India established in India in 1997 to RMNCH+A in 2013, it covers a various stages of life span of women from pre pregnancy to post delivery and stages of child health from the time of delivery until Adolescence.
- The paper describes the various services available for the mother and child as these are the core and one of the first components of RMNCH+A, and their rate of utilization as mentioned earlier.
- The paper further discusses the Health of the Urban Poor program that through its strategies and initiatives have tried to address the needs of urban poor in India.

- Some initiatives by HUP are formation of Mahila Arogya Samiti, a group of women from the community that help to address the issues related to Health, Water, Sanitation, Nutrition among the slum dwellers. Other initiatives like UHND, strengthening HMIS/MCTS and initiation of POU to prevent mortality due to water transmitted disease.

Scenario of Jaipur Slums.

- Total listed slums in Jaipur are 247 and many are not listed that is they are not recognized by the government and hence are deprived off all the government facilities that the recognized slums receive.
- The general scenario is such that there is lack of safe water and sanitation facility.
- There are absence of toilet facilities, poor drainage facilities compel the slum dwellers to defecate out in the open with many children defecating at the door steps and over-crowding of people in the houses with use of firewood and kerosene for cooking.
- Hence, frequent disease reoccurrence such as diarrhea, skin infections, boils on the skin and lung infections.
- A study showed that house with proper water and sanitation facilities spend less on health care compared to those without the facilities.
- Another study also found that stunting and malnutrition among children below five were not only due to lack of food, but also due to social and environmental conditions such as unavailability and inaccessibility to health care.
- Unlike rural areas which have a program dedicated to them (NRHM), it was lacking for the urban poor until 2013 when the submission of NUHM was passed.
- Basic infrastructure and outreach service and other facilities were missing for the urban poor. However, some components of the NRHM did cover the urban population.

- Basic services like Primary Health Centers, Health Posts, and Urban Family Welfare Centers were provided by the Department of Health and Family Welfare and the Department of Medical and Health. The first point of contact for the people are the Anganwadi centers.
- Health workers that provide the services are the ASHAs who are chosen from the community and the ANMs who also provide services like immunizations to women and children.
- Schemes that cover the maternal and child health component of RMNCH+A are Panchamrit which have programs dedicated to mother and child, ICDS that cover through the provision of various services like immunization, provision of supplements, health check- ups, referral cover the MCH component. Additionally, services like JSY and JSSY aim to reduce the maternal and infant mortality.

Gaps in the services

- Absence of health workers like ANMS, doctors or other community health workers.
- Though health facilities are present, yet they are inaccessible due to long distance.
- Health centers are poorly staffed with scare supply of drugs and equipment.
- Health services do not permeate to the slum dwellers and so they are attracted towards private health facilities and other unlicensed/unqualified health professionals.

Maternal health

- Despite comprehensive schemes and services the results are poor.
- Mean age of marriage among women in Jaipur is only 16years.
- Average number of children born to women is 2.7.
- First use of contraception was after having three or more children by 37% couples.
- The desire to have more children among the slum dwellers was high.

- In the survey done in Jaipur slums, majority of the women visited any health professionals for ANC check-ups, while only 63.8% women registered with ANM during pregnancy and only 69.9% women visited health professional for ANC check-up during 1st trimester
- During the same survey it was seen that the two health facilities the women approached for ANC check-up were government /municipal hospital with 58.1% and private medical sector with 40.2%.
- Anganwadi centers and PHCs were rarely or never used respectively.
- Furthermore, it was seen that more number of women received more than two TT injections while only 41.9% of the women consumed IFA for more than 90 days.
- For delivery it was observed that women preferred home to government facilities due to poor hygienic and sanitation facilities. Women also complained that they were ill- treated in the government hospitals with physical abuse and name callings. Those women eligible under JSY complained that the incentives they were to receive were taken away by the health professionals especially medical officers.
- Post natal checkups are as important as antenatal check -ups for the safety of mothers and their children and in Jaipur 100% mothers go for post natal check within two weeks while only 19.8% prefer the community health workers like ANM/nurses/ midwife and LHV.

Child health

- NFHS3 states that only 22.4% of the urban poor women deliver in health facilities while 77.6% deliver at home meaning of those who deliver at home they remain unregistered and also deprived of service that they otherwise should receive.
- The vaccine coverage for the children in Jaipur form the HUP survey show that the percentage of children who receive the third dose of DPT are only 59% while those who receive the first two doses are higher. Complete vaccination rate is just 32.45 while 16.2% children receive no vaccination.

- Reasons given by mothers for not getting their children immunized are that the facility where they go is far from their residence and most of them being daily wage earners would not be able to spare time with a fear of losing their job and many women who were laborers did not find the necessity to get their children immunized because since they as children were never immunized so they no necessity of it and also because felt their children were as safe as those vaccinated.
- Among the illness in prevalent in children, diarrhea and ARI were the most common, basically due to poor hygienic conditions, lack of safe water and sanitation facilities for diarrhea and use of firewood and kerosene for cooking for ARI.
- According to the NFHS3 data for Rajasthan, of the children who suffered from diarrhea in last two weeks only 11.1% received ORS treatment.
- According to HUP survey done in Jaipur only 9% of children for ARI and 12% for diarrhea were taken to government facilities while 91% and 88% respectively preferred private facilities. This shows the affinity towards private facilities.
- Additionally, the survey also depicts that the source of health care that people preferred in general are the private facilities with 63% and only 19.9% people using government/ municipal hospitals.
- The reasons for non-utilization of government facilities were the absence of facilities in the vicinity and that the waiting time was long.

The findings from the summary clearly shows the affinity towards private facilities compared to government and hence its high time that relevant and effective measures are taken to find out the reasons behind the gaps in the services and address them.

Challenges in delivering health care services

Though few health care services are present for the urban poor that comprised of the health center facilities and the health workers doing their work, yet there are lot of gaps between services supposed to be provided and the services actually provided. Apart from the gaps mentioned earlier in the paper, few challenges emerged during the discussion with officers working for HUP and BCT such as:

- The most important drawback for the slum dwellers is that the non-listed slums are not recognized. They are out of the purview of the government and hence, deprived off the health care services such as the services provided through various schemes, Anganwadi centers, presence of community health workers and other government health care services.
- Additionally, Mahila Arogya Samiti is not completely functional yet. It is currently in the training phase of the health workers.
- There is lack of awareness and knowledge among the people living in the slums about the various social and environmental determinants of health and the importance of health care services during the crucial phase of life.
- Most of the times the services are provided during the day when the people are not present to avail the services and hence are deprived off the opportunity.
- Likewise the pregnant women who are present in the community may not be able to go to the health care service center to avail services due to lack of support and confidence from the family.
- The myths and the taboos prevailing in the communities prevent the women from taking services.
- Many women prefer to avail the services from the main health facility like health centers or the hospitals as they are trusted more by the women compared to home to home or outreach services provided by the health care workers.

Conclusion

Having understood the scenario of provision of services for the reproductive mother and child in Jaipur, Rajasthan and therefore, it is very important to take a step further to help them lead a safe life by targeting their felt need, increasing their awareness and confidence to demand services they require with a hope that the National Urban Health Mission targets the needs and changes the fate of the mothers and their children living in the vulnerable environment. With a new focus on the urban poor which was lacking earlier, a lot is definitely expected out of NUHM. However, some recommendations that would help to increase the efficiency and effectiveness of the services delivered through NUHM are:

a) The work done and the policies laid down by NUHM must be monitored and evaluated on a regular basis in order to identify the gaps or the shortcoming in the provision of the services and make the necessary changes to strengthen the delivery of the services to increase the effectiveness of their program.

b) Additionally, it is important for NUHM to review its parallel NRHM program that targets the rural counterpart and identify the gaps in the program and see if the lessons learnt can be implied for the slum dwellers according to their setting to avoid the mistakes committed by NRHM.

c) For effective delivery of services and to strengthen the tracking system whether of the beneficiary or the health workers themselves by their superior for incentives, M-health can be introduced to not only increase effective learning and training of the health workers, but also for referral and as a tool for data collection, to help them identify and diagnose the complications and creating awareness in the community making the work of the HWs simpler, faster and burden free.

d) Most importantly, schemes such as the ICDS, JSY and immunization sessions to name a few must be expanded further and the capacity building and training of health workers must be done in a way that they are not only able to create awareness, motivate mothers and families about the positive results of availing the services, but also effectively communicate about why those services and health practices are important for them and their children.

As they say '*Better Late than Never*', a program targeting the urban poor is finally being launched. NUHM has a long way to go primarily from competing with the private practitioners, identifying all those slum which are not recognized by the government and winning the hearts of the urban poor to gaining confidence of the people and exhibiting more than what is expected from the program. However, with the positive results shown by its counterpart, the NRHM, comparison between the two programs is likely to happen, but with the health care challenges different from the rural settings, NUHM must gear up from the time of its inception as success in achieving its long terms goals is possible by mainly being transparent and honest in its services delivery.

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