MASTER OF PUBLIC HEALTH

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JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH
&
INDIAN INSTITUTE OF HEALTH MANAGEMENT RESEARCH

Practicum Report

On

Health of Slum Dwellers-Some Evidences

By

DR. PRASHANT TIWARI

IIHMR/JHSPH MPH
2013-2015

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At

IIHMR

By

Dr. Prashant Tiwari

Under the guidance of
Dr.Nutan Jain

Master of Public Health
Year: 2013-2015

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr. Prashant Tiwari student of Master of Public Health Program offered by Institute of Health Management Research University; Jaipur in cooperation with Johns Hopkins Bloomberg School of Public Health, Baltimore has undergone Practicum training at IIHMR University, Jaipur India on the topic

Health of Slum Dwellers- Some Evidences

(From 20th October 2014 to 15th April 2015)

The Candidate has successfully carried out the study designated to him during Practicum training and his approach to the study has been sincere, scientific and analytical.

The Practicum is in fulfillment of the course requirements.
I wish him all success in all his future endeavors.

Dean, Academics and Student Affairs
IIHMR, Jaipur

Practicum Advisor
IIHMR, Jaipur / JHSPH, Baltimore

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Health of Slum Dwellers-Some Evidences

This report is a part of MPH course. In the second year of the course, the students are supposed to complete practicum. For fulfillment of the course and the capstone I have worked on urban health in Surat. To continue my interest and the work, I contacted Health for Urban Poor team at IIHMR to learn from them. I learned that HUP started in the year 2010 for four year duration and ended in December 2014.

1. Introduction

Slums have been defined as mainly those residential areas where dwellings are in any respect unfit for human habitation by reasons of dilapidation, overcrowding, faulty arrangements and designs of such buildings, narrowness or faulty arrangement of streets, lack of ventilation, light, sanitation facilities or any combination of these factors which are detrimental to safety, health and morals. (Under Section-3 of the Slum Area Improvement and Clearance Act, 1956)

As per UN Habitat a slum is characterized by lack of durable housing, insufficient living area, and lack of access to clean water, inadequate sanitation and insecure tenure.[1]

1.1 Global Scenario

The growth of slums in the last 15 years has been exceptional. In 1990, there were nearly 715 million slum dwellers in the world. By 2000 – when world leaders set the target of improving the lives of at least 100 million slum dwellers by 2020 – the slum population had increased to 912 million. Today, there are approximately 998 million slum dwellers in the world. If current trends continue, the slum population will reach 1.4 billion by 2020.

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Over 25 per cent of the developing world's urban population – or 560 million city residents – lack adequate sanitation. Asia alone accounts for over 70 per cent of this group, mainly because of the large populations of China and India; in 2000, sanitation coverage in Chinese cities was reported to be approximately 33 per cent.

Studies shows that while cities in South-Eastern Asia and Southern Asia have made significant progress in recent years to improve sanitation coverage in urban areas, access lags far behind in sub-Saharan Africa and Eastern Asia, where 45 per cent and 31 per cent of the urban population still lacks access to improved sanitation, respectively. However, some countries in Southern Asia have extremely low coverage, notably Afghanistan, where only 16 per cent of the urban population has access to a proper toilet. Lack of access to an adequate toilet not only violates the dignity of the urban poor, but also affects their health. Every year, hundreds of thousands of people die as a result of living conditions made unhealthy by lack of clean water and sanitation. The number of deaths attributable to poor sanitation and hygiene alone may be as high as 1.6 million per year – five times as many people who died in the 2004 Indian Ocean tsunami[2].

1.2 Indian Scenario

As India is still a developing country, there is large number of people living below the poverty line. These people usually live in slum areas connected to any big/small city. According to Government sources, the Slum Population of India have exceeds the population of Britain. It has doubled in last two decades. According to last census in 2011, the slum-dwelling population of India had risen with a decadal growth of 32 percent from 52 million in 2001 to 65 million in 2011. Increase in Indian Population over a period of time has also resulted in slum population

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growth. Despite of Government efforts to build new houses and other basic infrastructure, most of the people living in slum areas do not have electricity, water supply and cooking gas.

Slums have risen dramatically since 1947. There were main two reasons for slum development. One is Partition of India and the other is Industrial revolution after independence. Before 1950 slums were predominantly found around the mills, factories etc. They were mostly industrial workers in one room tenements. Health and Services provisions to these areas rose as main issues. Instead of going farther, the density of the slums started growing in and around the cities. From 1950 to1968 the number of slums increased to 18%, in the 1970s they had a huge surge and by 1980 slum dwellers were half of the entire city's population.[3]

1.3 Rajasthan Scenario

The urban population in Rajasthan is fast growing. As per the Census of India 2001, 1.32 crores people means that 23.4% from the population were living in urban areas. It is estimated that the urban population in state will grow to 2,40 crores in 2026.This fast urbanization has resulted in a rapid increase in the number of urban poor population and most of them live at slums. As per the Census of India 2001, 47.51 lakh persons including 32.9% of the urban population of the state lives under the poverty line..

One of the major problem that has been arise due to the rapidly increasing population of slum dwellers is health that is critically been ignored both by the receivers and service providers.

Most of the health, sanitation and drinking water problems in slums arouse from the lack of access to or demand for basic amenities. Service provisions are either absent or inadequate in slums. Lack of drinking water, clean, sanitary environment and adequate housing and garbage disposal pose series of threats to the health of slum dwellers.

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The demands for basic services is missing, because there is no agency, organization or institution (state or central) that is willing to evaluate the needs and on that basis identify and meet the terms of demand because people living there are probably don't have big share in economy of any area. Therefore, the urban poor see the futility in expressing their demands to those with the capacity to fulfill them. However, supply-side alone cannot solve these problems.

Inadequate nutritional intake due to non-availability of subsidized ration or availability of poor quality ration and non availability of safe/pure drinking water and proper sanitation makes the slum dwellers prone to large number of infections and water borne diseases. To overcome these problems of slum dwellers, service providers should take initiative and do some baseline studies covering their main problems of daily amenities and develop a concrete plan to resolve the issues to make their life somewhat positive with regard to basic needs like water, sanitation and health.

1.4 Jaipur Scenario

Jaipur is the capital of Rajasthan state in India. The city area is 467 km.sq. There are total 77 wards in the city and 294 slums (HUP notes). 14% of population lives in slums (Census of India, 2011). The population of Jaipur is 3.7 million and urbanization trend is increasing. From the population 1.62 million are women and 1.45 million men (Census of India, 2011). Literacy rate is 84.3 % from which male are 90.6 % and female are 77.4 %. Density of population is 8,053 persons/sq meter (Census of India, 2011). Fast urbanization has passed and overstretched the current public health infrastructure, giving result that in situation a large number of urban poor don't have access to basic healthcare services. That has caused that urban poor has poor health indicators. The urban poor experience greater health hazards for example overcrowding, poor

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sanitation, lack of access to safe drinking water and environmental pollution. Bad environmental condition in the slums together with high population density makes them vulnerable to serious diseases. The urban poor are four times more vulnerable to these risks than other urban inhabitants.

1.5 About the Health for Urban Poor (HUP)

The goal of the programme is to improve health status of the urban poor by adopting effective, efficient and sustainable strategic intervention approaches, adopting the principle of convergence of the many development programmes. HUP had five approaches.

One is Mahila Arogya Samiti (MAS). It's 10-15 women's group from community. Group's aim was to create awareness of community on health issues. MAS acted as the focal community group in each slum area for implementation of the HUP Program interventions. Specifically, the MAS have facilitated the HUP Program to fulfill the following goals.

a. Organize or facilitate community level health services and referral linkages for Maternal, Newborn, Child Health and Nutrition (MNCHN), and Water Sanitation and Hygiene (WASH) services including private health care providers for increased access to service

b. Generate community awareness on MNCHN, WASH and locally relevant health issues.

c. Develop community based monitoring of MNCHN services using a Health Resource Map

d. Promote the acceptance of best practices in MNCHN and WASH by the community members.

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e. Promote community level awareness on safe drinking water, effective sanitation and hygiene behaviors for promoting preventive health.

f. Facilitate the promotion of health risk pooling by the community members.

Second approach was UHND which means Urban Health Nutrition Day.

Objectives of UHND

1. To provide health, nutrition and WASH (water, sanitation and hygiene) services to the target community from an identified point through a convergent mechanism.
2. To generate awareness among the target population about preventive and promotive aspects of health care.
3. To improve the health seeking behavior of the target population.

Operational Details of UHND

Frequency- Once a month at a fixed post on fixed day of the month for a population of approx.

1,000 slum dwellers Venue- Anganwadi Centre (AWC)/ Community Centre/ School premises/ any other appropriate place provided by the ULB/ Any appropriate place suggested by the community.

Services provided on UHND

1. Supplementary Nutrition.
2. Immunization.
3. Health Check-up.
4. Referral Services.
5. Pre – School Education.

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6. Nutrition & Health Education.
7. Water, Sanitation and Hygiene. (WASH)

One other approach was City Health Planning which is at government level. Last approach was Ward Coordination Committee. That works for institutional level. MIS is the last approach. MIS means Management Information System. That works state level.
HUP had three strategy components for pregnant woman. First is Antenatal care (ANC). It means care before delivery during nine pregnancy months. Woman used to get TT1 and 2 (tetanus toxoid vaccinations), 100 IFA (Iron Folic Acid) tablets and three check-ups. Second is natal care which is delivery. Third is post natal care which is after delivery.

The fact is that quality of healthcare of the urban poor can't be improved unless their health's social determinant conditions like (water, sanitation, nutrition, hygiene etc.) are improved. The goal of the programme is to improve health status of the urban poor by adopting effective, efficient and sustainable strategic intervention approaches, adopting the principle of convergence of the many development programmes.

2. Rational

This study is an effort towards documentation of the efforts made under the HUP project/ programme, and to what extent the changes are perceived by the potential beneficiaries along with what went well which can be replicated; and yet to make a dent. With the help of this study the researcher come to know about the various experiences (good or otherwise/ not so good) of community and workers involved in the implementation of health of urban poor programme. This study also described the utilization of the health of urban poor programme by its beneficiaries. The results of the present study can be used as a tool for internal documentation

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(education), tool for external use to help others learn from one institution's experience, tool for external review/audit (evaluator). It also identifies areas of successes and document what people have done.

3. Objectives

The objectives of study are:

A. To study the changes in awareness of better health perceived by community due to HUP programme in Jaipur Slums.
B. To identify Facilitating factors in implementation of HUP programme in Jaipur Slums.
C. To identify hindering factors in implementation of HUP programme in Jaipur Slums.

4. Review of Literature

There are some evidences that cover the issues related to the **p**resent study. Some researchers have tried to focus on the area of health and sanitation of slum dwellers. Some of them are mentioned below:

A report by Save the Children reveals that the poor are disproportionately affected and the charity accuses the country of failing to provide adequate healthcare for the impoverished majority of its one billion people. While the World Bank predicts that India's economy will be the fastest-growing by next year and the country is an influential force within the G20, World Health Organization figures show it ranks 171st out of 175 countries for public health spending.[4]

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In another study, researcher found appreciable prevalence of obesity, dyslipidaemia, diabetes mellitus, substantial increase in body fat, generalized and regional obesity in middle age, particularly in females, need immediate attention in terms of prevention and health education in such economically deprived populations.[5]

One study sampled in the slums of Lucknow revealed that the status of complete immunization is about half of what was proposed to be achieved under the Universal Immunization Program. This emphasizes the imperative need for urgent intervention to address the issues of both dropout and lack of access, which are mainly responsible for partial immunization and non-immunization respectively.[6]

Recent research has indicated that the malaria burden in Asia may have been vastly underestimated. A geographic analysis of the spatial distribution of malaria and typhoid fever cases detected high-risk neighborhoods for each disease. Focal interventions to minimize human vector contact and improved personal hygiene and targeted vaccination campaigns could help to prevent malaria and typhoid fever.[7]

With the help of such evidences, we can say that there is a direct relationship between the heath of an individual and its living conditions. Researcher by keeping these outcomes in mind and by following some of the suggestions in the past studies has focused to find out the health situation of slum dwellers in current set of sample.

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5. Methodology

5.1 Study area

Field work for present study has been done in the slums of Jagatpura, of Jaipur City. We randomly choose 4 Teela i.e. 1, 6, 8, & 9 out of total 12 Teela.

The Jagatpura slums come under the area of ward no 23 of Jaipur Municipal Corporation and have around 1500 households. Most of them are settled in the area from around three to four decades. Most of the households have migrated from within the state; some are from west Bengal, Tamil Nadu and Andhra Pradesh. Most of them are Dalits, Berwa and Regar who have their own hamlets within the settlement. Most of the households contribute to the informal economy, predominant amongst the occupation groups are daily wage laborers, vegetable vendors, rickshaw pullers, balloon sellers and puppet makers. In terms of basic amenities, the locality is electrified. As the locality is located near the Jagatpura bus stand it is well connected by a pucca road, however inside the locality the by lanes are kuccha. The post office and government hospital are located within a km.[8].

5.2 Study period

Data collection for the present study was completed during the period of two months started from December 20, 2014.

5.3 Sampling

It is a Descriptive study & Qualitative study. In current study, first respondent was selected using the information provided by the link worker and cluster coordinator working in the community. After the initial contact, further respondents were selected for the study.[9]

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Snow ball sampling technique was used to collect the data in present research work with help of link worker and cluster coordinator with prior permission of concerned organization/authority.

Snowball sampling uses a small pool of initial informants to nominate, through their social networks, other participants who meet the eligibility criteria and could potentially contribute to a specific study. The term "snowball sampling" reflects an analogy to a snowball increasing in size as it rolls downhill.

5.4 Study Respondents

Two types of respondents were interviewed for present study that mentioned below:

- Women working as link worker in HUP programme. Total 10 link workers were interviewed
- Potential women Beneficiaries of HUP programme. Total 30 beneficiaries were interviewed.

5.5 Methods of data collection

Direct observation of the situation of sanitation and other relevant issues was done during the study to get an overall idea. Review of relevant documents had also been done to collect different opinion and views regarding the present theme.

Further, to collect primary data for the study, in depth interviews were performed with link workers and beneficiaries who are community members of the slum.

The in-depth interview is a qualitative method of analysis, which proceeds as a confidential and secure conversation between an interviewer and a respondent. By means of a thorough composed interview guide, which is approved by the client, the interviewer ensures that

the conversation encompasses the topics that are crucial to ask for the sake of the purpose and the issue of the study.[10]

5.6 Tools of data collection

Following tools and techniques were used for data collection in the present study:

- In-depth Interview checklist: Two sets of 15 questions had been developed for in depth interview for link workers and beneficiaries separately covering issues related to objectives.

5.7 Ethical issues

A written Information consent form was developed by the researcher and was approved by the appropriate authority. It was agreed and signed by participants to ensure their privacy, confidentiality and anonymity.

Institutional Review Board (IRB) approval has been taken for the preset study from the IIHMR University ethical committee prior to start the fieldwork.

5.8 Data analysis

After completion of in depth interviews of the respondents, all the responses had been translated into English as interviews were taken in local language. Questions wise sheet was developed to frame responses from all the respondents and analyzed accordingly.

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6. Results & Discussion

Overall 10 link workers and 30 beneficiaries were interviewed for the present study and analyzed to get the results. There were many responses received and observations noticed during the fieldwork that is interesting and unique in a way to see the outcomes of any project in a particular area in relation to the study objectives. Researcher is discussing here the findings of present work keeping objectives in mind.

6.1 Profile of Link Workers

Link Workers are women at least 10^{th} pass members of the community itself who are taken by the HUP to provide basic health, hygiene and sanitation related awareness trainings and care to their locality and playing same role as equivalent to Urban ASHA.

Most of them were married, 25 to 35 aged women who are migrated after marriage only. They were the main link between the service providers and the beneficiaries (community members); and also like pillars of the programme. In field as a link worker it is their first job experience. Most of them select this profession because of poverty and to get social recognition in their society.

6.2 Profile of Beneficiaries

In this group, we have chosen all those married women who received any of HUP service during the programme duration. Whether it was ANC service, PNC service or they were the member of any group formed under the programme strategy to get the whole idea of that particular activity. We have talked 23 to 40 aged women. Most of them are housewives and mother of at least one children of under age of 5. They are also migrated in this slum after marriage only.

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6.3 Perception about the Programme

Main activities performed during the programme are mentioned below as prescribed by the respondents in personal interview:

Mahila Arogya Samiti (MAS), as discussed above, it's a group of 10-15 women from community. Group's aim is to create awareness of community on health issues. *Mahila Arogya Samiti (MAS)* has been playing a crucial role in generating demand to get the health, nutrition and Water & Sanitation (WASH) services from key departments. Under National Health Mission (NUHM), central government has kept untied fund of Rs. 5000.00 for MAS so that they can take corrective decision for betterment of the ward.

Link Workers' Perspective:

"Saheb chije pahle se bahut sari badal gayi hai, sach batao to pahle mai ghar se nikal kar bus mai jane ke liye dar lagta tha par ab darn nahi lagta hai, mai kahin bhi akele ja sakti huian".

25/fTeela#6

The first issue taken by MAS was to resolve the health services issues, in the community and resolving water connection to the individual household.

As a Link worker they oriented MAS regarding their role in community empowerment and testing of water at Point of Use (PoU) and Point of point of Source (PoS) in consultation with HUP and shared the findings for sensitizing the community as well as MAS members.

MAS as a group understand the differences and approached the ward counselor of ward no 48 to connect individual pipelines in the home. For the first time he did not get convinced and gave assured, but later on, when they approached four to five times and forced to renovate the

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pipeline, ward counselor gets agreed and now individual pipelines are connected to the households.

Now, good quality of water is available at every doorstep of the Teela no.6 and the water problems are no more."

Other activities like ***Urban Health Nutrition Day (UHND), God Bharai and Annprashan*** to promote ANC services and first feeding of child.

Beneficiaries Perspective During the UHND day women and children get vaccinations and link worker facilitates the community to receive Antenatal care (ANC). Woman gets TT1 and 2 (tetanus toxoid vaccinations), 100 IFA (Iron Folic Acid) tablets and three ANC check-ups in the programme.

"Jab mera bachcha hone wala tha mujhe god bharai ke karykram me bulaya gaya tha jahan pure riti rivajon ke sath meri god bharai ki gait hi. Jo bahut hi achchha tha"

24/f Tella#9

God bharai is event for pregnant women. They get gifts from BCT if they have taken T1 and T2 vaccinations (tetanus toxoid vaccination), completed IFA tablets and finished ANC (antenatal care). They tell about IFA tablets and danger signals during pregnancy. Gift Packet included water ladle, sweets, raw coconut, few bangles, lip balm, pins, make-up pen and henna colour.

Apart from these activities, HUP organized different kind of events like breastfeed week, Children's Day, world toilet day, world water day, world hand wash day etc.

"Bachchon ko 6 mahine ka hone par pahli baar upri ahaar dene ka karykram annaprashan ke roop me manaya jata tha"24/fTeela#9

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6.4 Situation before HUP

Link Workers' Perspective:

"sahib, pahle to gharwale bhi naraj hote the, bolte the ki kya do do ghante bahar jakar baithti ho , ghar ka kaam koun karega"28/fTeela#6

It was found during the interviews of link workers that at the beginning of the programme or when they have started their work; they faced lots of difficulties to make their family understand about the work. They said that it was hard to come out from home to work for the community as no one was doing this kind of work. On the other hand, they also felt that community members were not supportive or open initially. Also, people were not aware about the basic needs of healthy life.

Beneficiaries Perspective:

In the words of community members earlier people were not demanding such facilities due to lack of knowledge. There was no one to tell people what to do or what not to do to seek health services or to generate knowledge regarding personal/community hygiene.Community members were asked about the situation before the HUP programme in their locality.

"Ab hame pata chala ki bachchon ko tika nahi lagwane se kaun kaun si bimariyan hoti hain. Agar date nikal jati hai to ham khud se hi puch lete hain aspatal me ki kab kaun sa tika lagwana hai"25/fTeela#9

Most of the respondents were of the similar opinion that they were not bothered whether government is providing services or not. They were on their own to collect the information and receive the services. As there were no one to tell them about where to go and what to do? They also felt that community itself responsible for their problem if they are not getting facilities. They

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had to form groups and discuss about their situation to resolve the issues but no one cares until any mishappening had happened.

"Pahle hame nahi pata tha ke saaf safai rakhne se kya kya fayde hote hain"24/fTeela#9

"hamare paas sarkaar se koi nahi ata tha jo ye bata sake ke hame bimari me kya karna chahiye yak kha jana chahiye"30/fTeela#8

6.5 Changes during the Years

Link Workers' Perspective:

As HUP programme initiated in 2012, representatives from the programme came to the locality to setup initial contact and after some time they have recruited few people as link workers. Respondents have also informed that they were from the community and known to the community; that's why it was easy for them to build trust and go for initial contacts. The situation of the location "Teela No 6 of Ward no 48 of Jaipur city" was not good as it has been seen today, and this "significant change" is due to the active involvement of MAS in ward development. Link worker Says, "In initial time when she came to the Teela, it was very difficult to contact people. The atmosphere was neither friendly nor safe and she felt a little bit uneasy to contact women to for the community Group." She approached the Anganwadi Center (AWC) who collected the women and facilitated to conduct series of community group meeting but slowly and slowly community behavior gets changed and now-a-days they supported us to take lead role in the slum development program.

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"Ab to who log khud agae badhkar bolte hai, hame bhi group mai samil karlo, hum bhi apni yoogdan denge"29/fTeela#8

Beneficiaries Perspective:

Respondents were asked about the changes they feel that had happened during the programme implementation period. Few of them told that earlier community members were not aware about the health facilities in general. Before this programme they were also not aware that from where they should go to complaint about the sanitation issues. No one was there from the side of the government to help them for health and sanitation issues. But according to them situation has changed now and people are aware about health and sanitation issues and they have started demanding services.

"Kyu ki kaam karne wale hamare bich me se hi the to samajhne me asaani rahi"24/fTella#6

In general, on the basis of personal interviews, below are the major achievements and changes in the community due to the HUP programme:

- There is more awareness for vaccination in the community and parents are more concern now for their children.
- Demand of proper health services has been created by this programme. There were examples during the programme in which people have raised voices if health functionaries were not giving services or delaying the services.
- Due to the successful practice of events like, God Bharai and Annaprashan, community involvement and participation has increased significantly. Now they feel attached to the programmes and understand that these programmes are made for them and they are responsible for success and failure of these programmes.

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- Community members especially women are feeling empowered due to the samitis made under the programme. They can get loans on low interest rates (or without interest) for their betterment. The group innovatively contributed Rs. 100.00 per month from every member and generated a sum of Rs. 20,250.00 to address the health, nutrition and WASH issues for the Teela no 6 in two years. The members of the group decided comprehensively to whom the money can be given and how to recover. Since two years, the group is lending money to the needy person of the community to fulfill their health related expenditure. They told :

"hamari izzat ab badh gayi hai aur hame lagta ahi ki kum bahut kuch kar skate hai".27/fTella#1

"ham kam se kam apne kaam ke liye paise ikatthe kar ke ek sath le sakte the, or sath hi sath samiti me apni bate bhi rakh sakte the jo ki samsyaon ko suljhane me sahayak thi"30/fTella#8

Apart from the few positives of the programme mentioned above, main change observed in the community's health seeking behavior was that they are associated with the government programmes and feeling of ownership has developed in them.

"god bharai or annaprashan jaise karyakram hame hamare ghar ke karyakram jaise lagte the. Inka or vistaar kiya jana chahiye"31/fTeela#9

"Kuchh had tak ham ab apnea as paas ki safai ko lekar or apne swasthya ko lekar jaagruk huye hain"27/fTeela#1

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6.6 Some Facilitating Factors

Link worker Perspective:

Health of the Urban Poor (HUP) Program in line of National Urban Health Mission (NUHM) framework, focused to generate demand by strengthening the community. Mahila Arogya Samiti (MAS) found to playing a crucial role in generating demand and empowering community to get the health, nutrition and Water & Sanitation (WASH) services from key departments in HUP program. Through MAS, members started mobilizing the local resources and started sensitizing the neighbor houses by visiting door to door. The biggest push factor was that all MAS members and Link workers were part of that community only so all small and big things related to life style, culture and customs of that particular slum were known to them. In a short period of time, the females collectively sits together to discuss the WASH and HEALTH issues and approached the Urban Local body (ULB) twice to open the community toilet immediately so that females can use the resources effectively. As a result of this, the closed community toilet had opened and renovated by the authorities which results in reduction of open defecation numbers in the area. Now, the members of the group feels happy and told with excited expression on face

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" ab to hum samajh chuke hai ki kya karna hai uar kya nahi. Hamari taquat badh chuki hai"24/fTella#1

Apart from this, MAS also give importance to the issues like, cleanliness, 24 X 7 hours running water facility and overall management health services. This is what actually empowerment and leadership needs and is not the end of the story.

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Beneficiaries Perspective:

In connection to this, people got benefitted by the community based events organized to seek their involvement and ownership for activities meant for them. Events like, *God Bharai and Annprashan* were organized with celebration to connect community members to the government services. During these events activities like ANC check-ups and first food for child had been done with counseling on nutritional food, institutional delivery, immunization, first milk, excessive breast feeding, supplementary food and other relevant themes. These events seem to be the main activity to connect people with the program.

Apart from the service delivery program, other key of success was the money saving initiative through MAS in which after joining the group, the women were motivated for small savings. Initially there were lesser women who started saving small amounts. As soon as contribution of each woman reached to 500 rupees they started internal loaning to the needy members in drastic situations, such as required for delivery etc. In all these ways rapport could be established among the members. Loan to the non-members was given at a rate of 2 percent interest and at a rate of 1.5 percent to those who are members. Earned interest is also circulated among the members. It was really a positive step to make a pool and use it in need. The real scenario of Empowerment through capacity building and exposure are one of the key factors which keep on motivated and shows positive change within and outside the community. The group says loudly.

"... ab to aap hame kahi bhi le chalo hum sath sath hai aur hum chijo ko badal kar rakehnge."28/fTella#1

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6.7 Some Hindering Factors

Heterogeneity among the slum dwellers due to in-migration from different areas, instability of slums, varied cultures and fewer extended family connections, has led to lesser willingness and fewer occasions to build urban slum community as a strong collective unit, which is seen as one of the major public health challenges in improving services in these areas.

Link Workers' Perspective:

Every task has some challenges at the starting level that gets minimize with the time and efforts. As far as HUP programme is concerned, there were issues mainly at the side of link workers, which was the main connection between the programme strategy at the higher side and the community. It was found by the analysis of personal interviews of link workers that they have faced difficulties initially as their families were not in the favor of their work. They had to go outside to communicate with the community members and to do their job but it was not easy to any woman of these families to avoid their home and household activities. But they somehow managed and it was encouraging for the programme that their families have now understood the importance of the work they are doing for the betterment of the community.

"Shuruat me hamare ghar wale hame ghar se bahar nahi jane dete the. Wo kahte the ki dusron ke ghar ghar jaa kar kaam karne ki jarurat nahi hai. Par dhire dhire wo samajhne lage ki ye achchha kaam hai"30/fTeela#8

Another difficulty reported by the link workers was the unavailability of a permanent office/shelter. This would help them to stay there in the days of rain and bad weather. According to them a place should also be provided to them for meeting with "MAS" members.

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"Ham meetings ke liye kisi ke ghar me ya kisi samudayik sthan ka chayan karte the jo ki lambe samay ke liye upyukt nahi hai. Kuch pakka sthan hona chahiye"24/fTeela#9

"Barish ke samay mukhya samasya hoti thi"24/fTeela#6

Apart from these specific issues there were other difficulties as well like, peer pressure, problematic behavior of alcoholic husbands, and initial discomfort during the work, slow acceptance of the community etc.

Beneficiaries Perspective:

If we look further at beneficiaries' level, the money should be deposited in a bank account and it should be registered as well for the better transparency, but at present it is a big problem because the most of them are not familiar with the bank formalities and other issue like ownership of the account.

"Un logon ko jyada samasya hui jo padhne likhne me asamarth the. Bank ki bhi kuch nitiyan hoti hain"29/fTeela#6

7. Conclusion

After completing the personal interviews, analyzing the responses and discuss it with the available resources and programme documents, it can be said that HUP programme has made a positive impact on community's health seeking behavior. Though there are some issues regarding sustainability of the programme as doubts are a reality of the time that how such initiative will run without any external support (both financial as well as technical). Practices like

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god bharai and annaprashan were the best examples to connect the community to the programme and generate ownership of people/beneficiaries in the programme. However, few constraints like initial rapport building and other social/family issues are need to be avoided in future experiments for better implementation of the programme.

8. Key Learning's from Practicum

Practicum was started on Oct 20, 2014 and continued till April 15, 2015. Practicum activities included designing of the synopsis with methodology and proposed plan of field work. After that interview tools have been developed and tested accordingly. Fieldwork was done at the study location and analyzed later. Current practicum incorporated me with core competencies of Analytical/ Assessment, Communication and Community dimension of practical skills in Public Health Practice.

Further, I can agree with myself that because of this practicum my understanding of community related public health issues is improved a lot and also this experience enhanced my ability to function as a Public Health Professional.

Again I can connect myself in agreement of the fact that "the practicum experience" and "learning" through the practicum was relevant to my academic knowledge of MPH and fulfilled my expectations.

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