KUSP
FOOTFALLS OF FUTURE

KOLKATA URBAN SERVICES FOR THE POOR
CHANGE MANAGEMENT UNIT

Arnab Roy, IAS
Project Director

Memo No. CMU – 51/2003(Pt.-II)/2245 **Dated...04.11.08**

To

M/s ARTISAN
107 A, B.B. Ganguly Street,
Kolkata – 700 012.

Sub: **Printing, production, binding and delivery of Books.**

Ref: 1. **NIQ No. CMU – 26/2003(Pt.-III)/2095, dated 20.10.2008.**

2. **Your offer No. TA/277/10/08, dated 29.10.08**

Sir,

Your offer for the works mentioned under the subject has been accepted by me on behalf of CMU. You are accordingly requested to please take up the works according to the specification, terms and conditions and rates etc. stated below:

Sl. No.	Item	Qty.	Rate (Rs. P.)	Amount (Rs. P.)
1.	Printing, production, binding and delivery of books "The Urban Health Strategy" of West Bengal Govt. (English version): • Size : 16.5 c.m. x 24 c.m. finish • Paper : Text 130 GSM Art Paper Cover 250 GSM Art Board. • Pages : Text 16 pages and Cover 4 pages. • Binding: Centre Stitch. • Colour : All four-colour printing. Total production includes lay out, design development, paper processing etc., as necessary.	400 pcs. (English)	51.67	**20,670.00** (Rupees twenty thousand six hundred and seventy)
2.	Printing, production, binding and delivery of books "The Urban Health Strategy" of West Bengal Govt. (Bengali version): • Size : 16.5 c.m. x 24 c.m. finish • Paper : Text 130 GSM Art Paper Cover 250 GSM Art Board. • Pages : Text 20 pages and Cover 4 pages. • Binding: Centre Stitch. • Colour : All four-colour printing. Total production includes lay out, design development, paper processing etc., as necessary.	400 pcs. (Bengali)	27.75	**11,100.00** (Rupees eleven thousand and one hundred)

Contd..2

Sl. No	Item	Qty.	Rate (Rs. P.)	Amount (Rs. P.)
3.	Printing, production, binding and delivery of books "Poverty Alleviation Mission" in urban West Bengal (Bengali version): • Size : D-1/8 • Paper : 170 GSM Art Paper. Cover 250 GSM Art Board. • Pages : 4 pages. • Binding: Centre Stitch. • Colour : Coloured Cover. Total production includes lay out, design development, paper processing etc., as necessary.	500 pcs.	10.66	**5,330.00** (Rupees five thousand three hundred and thirty)
			Total Price :	**37,100.00**

Terms & Conditions:

Delivery	: Within 7 days from the date of receipt of this order.
Payment	: After delivery.
Taxes	: The above price is inclusive of all taxes and duties.
Delivery Charges	: Free of cost.
Submission of IT PAN No., VAT No. & PT Enrolment No.	: Payment shall be made on production of copies of documents through which IT PAN No., VAT No. & PT Enrolment Number have been issued by the respective authorities.
I.T. Deduction at source	: As per rules.

Yours faithfully,

(Arnab Roy)
Project Director, CMU

Copy forwarded to:

1. Project Manager, CMU, for information
2. Financial Adviser, CMU, for information and necessary action
3. Accounts Officer, CMU, for information and necessary action
4. Procurement Consultant, CMU for information and necessary action
5. Health Expert, CMU, CMU for information and necessary action

Project Director, CMU

F.O, CBPHC
31.12.07

CONSOLIDATED REVISED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total
I Provision of community based primary health care services in 63 Non – KMA municipalities									
Staff-at ULB level									
Health officer	63	18000	1134000	13608000	13608000	13608000	13608000	13608000	68040000
Asst Health officer	1	15000	15000	180000	180000	180000	180000	180000	900000
Sanitary Inspector	63	6000	378000	4536000	4536000	4536000	4536000	4536000	22680000
Accounts Assistant	63	5500	346500	4158000	4158000	4158000	4158000	4158000	20790000
Health Assistant	63	5500	346500	4158000	4158000	4158000	4158000	4158000	20790000
Computer Asst	63	5500	346500	4158000	4158000	4158000	4158000	4158000	20790000
Store Keeper	63	5500	346500	4158000	4158000	4158000	4158000	4158000	20790000
PHN	64	8000	512000	6144000	6144000	6144000	6144000	6144000	30720000
FTS PH	117	1920	224640	2695680	2695680	2695680	2695680	2695680	13478400
sub total				**43795680**	**43795680**	**43795680**	**43795680**	**43795680**	**218978400**
Sundries incl. Vehicle	63	30000	1890000	22680000	22680000	22680000	22680000	22680000	113400000
sub total staff and vehicles				**66475680**	**66475680**	**66475680**	**66475680**	**66475680**	**332378400**
Program costs									
additional funds to reach unreached	63	200000	12600000	12600000	12600000	12600000	12600000	12600000	63000000
HMIS format-family	1122.993	2	12687.944	152255	152255	152255.328	152255.328	152255.328	761277
Family schedule	224598.6	14	3144380.4	3144380	3144380	3144380	3144380	3144380	15721902
kitbag	1270	450	571500	571500	0	0	0	0	571500
Cold chain at ULBs	63	75000	4725000	4725000					4725000
capital costs									
furniture	0	0	0	0	0	0	0	0	0
equipment	0	0	0	0	0	0	0	0	0
sub total pgm and cap cost - ULB level				**21193136**	**15896636**	**15896636**	**15896636**	**15896636**	**84779679**
									0
Urban health clinic									0
UHC rental	15	12000	180000	180000	180000	180000	180000	180000	900000
UHC furniture	15	52,350	785250	785250	0	0	0	0	785250
UHC level staff	15	1355880	20338200	20338200	20338200	20338200	20338200	20338200	101691000
UHC equipment	15	41500	622500	622500	0	0	0	0	622500
sub total urban health clinic				**21925950**	**20518200**	**20518200**	**20518200**	**20518200**	**103998750**
Sub centre level									
FTS	283	1920	543360	6520320	6520320	6520320	6520320	6520320	32601600
HHW	1270	1750	2222500	26670000	26670000	26670000	26670000	26670000	133350000
Consultant Medical officer-Rs.500/clinic*10 cl per sc	283	500	1415000	16980000	16980000	16980000	16980000	16980000	84900000
sundries	283	1000	283000	3396000	3396000	3396000	3396000	3396000	16980000

Sent to DMPH Mr. S. K Sen, Mr. Mozumdar & Rajmozumi Thro fax on 3.7.08

3.7.08

CONSOLIDATED REVISED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total
sub centre rent	283	1000	283000	3396000	3396000	3396000	3396000	3396000	16980000
mobility	400	150	60000	720000	720000	720000	720000	720000	3600000
mtg expenses-30 pers	1387	5	208050	2496600	2496600	2496600	2496600	2496600	12483000
Repair and renovation	137	31000	4247000	4247000	0	0	0	0	4247000
Equipment	0	0	0	0	0	0	0	0	0
furniture	0	0	0	0	0	0	0	0	0
sub total sub centre				**64425920**	**60178920**	**60178920**	**60178920**	**60178920**	**305141600**
SUB TOTAL - I				**174020686**	**163069436**	**163069436**	**163069436**	**163069436**	**826298429**

II Strengthening of Public Health services in 63 municipalities (41 KMA and 22 non KMA municipalities

Staff at ULB level	**No**	**rate/month**	**total**	**1st yr**	**2ndyr**	**3rd yr**	**4th yr**	**5th yr**	**total**
PHN	72	8000	576000		6912000	6912000	6912000	6912000	27648000
FTS PH	540	1920	1036762		12441140	12441140	12441140	12441140	49764560
Data assistant	63	5500	346500		4158000	4158000	4158000	4158000	16632000
sub total staff				**0**	**23511140**	**23511140**	**23511140**	**23511140**	**94044560**
ULB									
sen.of stakeholder-	63	5000	315000		315000	315000	315000	315000	1260000
State HQ level-4	4	10000	40000		40000	40000	40000	40000	160000
Ref Trg for HHWs	63	50000	3150000		3150000	3150000	3150000	3150000	12600000
Refresher trg for MO,FTS	63	50000	3150000		3150000	3150000	3150000	3150000	12600000
sub total cap bldg				**0**	**6655000**	**6655000**	**6655000**	**6655000**	**26620000**
Devt of PH action plan in covered ULBs									
workshops at 63 ULBs	63	50000	3150000		3150000				3150000
Consultant cost	1	500000	500000	500000					500000
workshops at 63 ULBs (uncovered)	63	50000	3150000	3150000	3150000				6300000
sub total PH action plan				**3650000**	**6300000**	**0**	**0**	**0**	**9950000**
cold chain at ULBs	63	75000	4725000	4725000					**4725000**
SUB TOTAL - II				**8375000**	**36466140**	**30166140**	**30166140**	**30166140**	**135339560**

III Institutional strengthening and capacity building

SUDA level									
staff									
Project officer	1	25000	25000	300000	300000	300000	300000	300000	1500000
Asst PO	4	20000	80000	960000	960000	960000	960000	960000	4800000
Medical officer	6	15000	90000	1080000	1080000	1080000	1080000	1080000	5400000
FO	1	15000	15000	180000	180000	180000	180000	180000	900000

CONSOLIDATED REVISED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total
Accounts asst	2	5500	11000	132000	132000	132000	132000	132000	660000
Additional accountant	1	8000	8000	96000	96000	96000	96000	96000	480000
Additional cashier	1	8000	8000	96000	96000	96000	96000	96000	480000
MIES officer	2	14000	28000	336000	336000	336000	336000	336000	1680000
Comp.asst	5	7000	35000	420000	420000	420000	420000	420000	2100000
clerk cum store keepr	2	7000	14000	168000	168000	168000	168000	168000	840000
Multi purpose helper	2	5500	11000	132000	132000	132000	132000	132000	660000
Accounts support agency	1	300000	300000	3600000	3600000	3600000	3600000	3600000	18000000
total incremental staff SUDA		**430000**	**625000**	**7500000**	**7500000**	**7500000**	**7500000**	**7500000**	**37500000**
vehicle	5	12000	60000	720000	720000	720000	720000	720000	3600000
sundries	1	25000	25000	300000	300000	300000	300000	300000	1500000
furniture	1	100000	100000	100000					100000
eqpt	1	500000	500000	500000					500000
sub total SUDA				**9120000**	**8520000**	**8520000**	**8520000**	**8520000**	**43200000**
Preparation of UH strategy	1	1500000	1500000	1500000	0	0	0	0	**1500000**
capacity building									
SUDA									
Mgrl trg	2	50000	100000	100000	100000	100000	100000	100000	500000
staff devt	2	200000	400000	400000	400000	400000	400000	400000	2000000
exposure visit	2	500000	1000000	1000000	1000000	1000000	1000000	1000000	5000000
ULB									
sen.of stakeholder-2	63	5000	630000	630000	630000	630000	630000	630000	3150000
State HQ level-4	4	10000	40000	40000	40000	40000	40000	40000	200000
Trg for HHWs	63	50000	3150000	3150000	3150000	3150000	3150000	3150000	15750000
Local trg for MO,FTS	63	50000	3150000	3150000	3150000	3150000	3150000	3150000	15750000
Cap bldg eqpt	63	50000	3150000	3150000					3150000
ULB cap.bldg				**11620000**	**8470000**	**8470000**	**8470000**	**8470000**	**45500000**
Strengthening of existing MH	6	5000000	30000000	10000000	20000000				30000000
IEC for covered-6 mtg/yr*1602 wards*150/mtg - gp mtg/ward/month	1602	150	240300	2883600	2883600	2883600	2883600	2883600	14418000
IEC for uncov-12 mtg/yr*1053 wards * 150/mtg	1053	150	157950	1895400	1895400	1895400	1895400	1895400	9477000
printing	126	25000	3150000	3150000	3150000	3150000	3150000	3150000	15750000
SUB TOTAL - III				**40169000**	**44919000**	**24919000**	**24919000**	**24919000**	**159845000**

IV Monitoring and Evaluation

Documentation									
Base,mid and endline	1	2000000	2000000	2000000		2000000		2000000	6000000
SUB TOTAL - IV				**2000000**	**0**	**2000000**	**0**	**2000000**	6000000
GRAND TOTAL I - IV				**224564686**	**244454576**	**220154576**	**218154576**	**220154576**	**1127482989**
									1127482989
									1127482989

CONSOLIDATED REVISED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total

Note:

Construction of sub-centre @ 1 per ULB in un-covered 63 ULBs @Rs.10.00 lakhs per sub-centre - Total Cost 63,00,000.00

Devt. of PH action plan in un-covered ULBs have not taken into account. Shall we keep this provision in the budget?

CONSOLIDATED REVISED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total
I Provision of community based primary health care services in 63 Non – KMA municipalities									
Staff-at ULB level									
Health officer	63	18000	1134000	13608000	13608000	13608000	13608000	13608000	68040000
Asst Health officer	1	15000	15000	180000	180000	180000	180000	180000	900000
Sanitary Inspector	63	5500	346500	4158000	4158000	4158000	4158000	4158000	20790000
Accounts Assistant	63	5000	315000	3780000	3780000	3780000	3780000	3780000	18900000
Health Assistant	63	5000	315000	3780000	3780000	3780000	3780000	3780000	18900000
Computer Asst	63	5000	315000	3780000	3780000	3780000	3780000	3780000	18900000
Store Keeper	63	5000	315000	3780000	3780000	3780000	3780000	3780000	18900000
PHN	64	7500	480000	5760000	5760000	5760000	5760000	5760000	28800000
FTS PH	117	1920	224640	2695680	2695680	2695680	2695680	2695680	13478400
sub total				**41521680**	**41521680**	**41521680**	**41521680**	**41521680**	**207608400**
Sundries incl. Vehicle	63	30000	1890000	22680000	22680000	22680000	22680000	22680000	113400000
sub total staff and vehicles				**64201680**	**64201680**	**64201680**	**64201680**	**64201680**	**321008400**
Program costs									
additional funds to reach unreached	63	200000	12600000	12600000	12600000	12600000	12600000	12600000	63000000
HMIS format-family	1122.993	2	12687.944	152255	152255	152255.328	152255.328	152255.328	761277
Family schedule	224598.6	14	3144380.4	3144380	3144380	3144380	3144380	3144380	15721902
kitbag	1270	450	571500	571500	0	0	0	0	571500
Cold chain at ULBs	63	75000	4725000	4725000					4725000
capital costs									
furniture	0	0	0	0	0	0	0	0	0
equipment	0	0	0	0	0	0	0	0	0
sub total pgm and cap cost - ULB level				**21193136**	**15896636**	**15896636**	**15896636**	**15896636**	**84779679**
									0
Urban health clinic									0
UHC rental	15	12000	180000	180000	180000	180000	180000	180000	900000
UHC furniture	15	52,350	785250	785250	0	0	0	0	785250
UHC level staff	15	1355880	20338200	20338200	20338200	20338200	20338200	20338200	101691000
UHC equipment	15	41500	622500	622500	0	0	0	0	622500
sub total urban health clinic				**21925950**	**20518200**	**20518200**	**20518200**	**20518200**	**103998750**
Sub centre level									
FTS	283	1920	543360	6520320	6520320	6520320	6520320	6520320	32601600
HHW	1270	1750	2222500	26670000	26670000	26670000	26670000	26670000	133350000
Consultant Medical officer-Rs.500/clinic*10 cl per sc	283	500	1415000	16980000	16980000	16980000	16980000	16980000	84900000
sundries	283	1000	283000	3396000	3396000	3396000	3396000	3396000	16980000
sub centre rent	283	1000	283000	3396000	3396000	3396000	3396000	3396000	16980000
mobility	400	150	60000	720000	720000	720000	720000	720000	3600000
mtg expenses-30 pers	1387	5	208050	2496600	2496600	2496600	2496600	2496600	12483000
Repair and renovation	137	31000	4247000	4247000	0	0	0	0	4247000
Equipment	0	0	0	0	0	0	0	0	0
furniture	0	0	0	0	0	0	0	0	0
sub total sub centre				**64425920**	**60178920**	**60178920**	**60178920**	**60178920**	**305141600**
SUB TOTAL - I				**171746686**	**160795436**	**160795436**	**160795436**	**160795436**	**814928429**

CONSOLIDATED REVISED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total
II Strengthening of Public Health services in 63 municipalities (41 KMA and 22 non KMA municipalities									
Staff at ULB level	**No**	**rate/month**	**total**	**1st yr**	**2ndyr**	**3rd yr**	**4th yr**	**5th yr**	**total**
PHN	72	7500	540000		6480000	6480000	6480000	6480000	25920000
FTS PH	540	1920	1036762		12441140	12441140	12441140	12441140	49764560
Data assistant	63	5000	315000		3780000	3780000	3780000	3780000	15120000
sub total staff				**0**	**22701140**	**22701140**	**22701140**	**22701140**	**90804560**
ULB									
sen.of stakeholder-	63	5000	315000		315000	315000	315000	315000	1260000
State HQ level-4	4	10000	40000		40000	40000	40000	40000	160000
Ref Trg for HHWs	63	50000	3150000		3150000	3150000	3150000	3150000	12600000
Refresher trg for MO,FTS	63	50000	3150000		3150000	3150000	3150000	3150000	12600000
sub total cap bldg				**0**	**6655000**	**6655000**	**6655000**	**6655000**	**26620000**
Devt of PH action plan in covered ULBs									
workshops at 63 ULBs	63	50000	3150000		3150000				3150000
Consultant cost	1	500000	500000	500000					500000
workshops at 63 ULBs (uncovered)	63	50000	3150000	3150000	3150000				6300000
sub total PH action plan				**3650000**	**6300000**	**0**	**0**	**0**	**9950000**
cold chain at ULBs	63	75000	4725000	4725000					**4725000**
SUB TOTAL - II				**8375000**	**35656140**	**29356140**	**29356140**	**29356140**	**132099560**

CONSOLIDATED REVISED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total
III Institutional strengthening and capacity building									
SUDA level									
staff									
Tech.adviser,	1	23000	23000	276000	276000	276000	276000	276000	1380000
Project officer	1	22000	22000	264000	264000	264000	264000	264000	1320000
Asst PO	1	20000	20000	240000	240000	240000	240000	240000	1200000
Medical officer	12	15000	180000	2160000	2160000	2160000	2160000	2160000	10800000
FO	1	15000	15000	180000	180000	180000	180000	180000	900000
Accounts asst	2	3350	6700	80400	80400	80400	80400	80400	402000
Additional accountant	1	7000	7000	84000	84000	84000	84000	84000	420000
Additional cashier	1	7000	7000	84000	84000	84000	84000	84000	420000
MIES officer	2	14000	28000	336000	336000	336000	336000	336000	1680000
Comp.asst	3	6500	19500	234000	234000	234000	234000	234000	1170000
clerk cum store keepr	2	6500	13000	156000	156000	156000	156000	156000	780000
Multi purpose helper	2	5000	10000	120000	120000	120000	120000	120000	600000
Accounts support agency	1	300000	300000	3600000	3600000	3600000	3600000	3600000	18000000
total incremental staff SUDA		**444350**	**651200**	**7814400**	**7814400**	**7814400**	**7814400**	**7814400**	**39072000**
vehicle	5	12000	60000	720000	720000	720000	720000	720000	3600000
sundries	1	25000	25000	300000	300000	300000	300000	300000	1500000
furniture	1	100000	100000	100000					100000
eqpt	1	500000	500000	500000					500000
sub total SUDA				**9434400**	**8834400**	**8834400**	**8834400**	**8834400**	**44772000**
Preparation of UH strategy	1	1500000	1500000	1500000	0	0	0	0	**1500000**
capacity building									
SUDA									
Mgnl trg	2	50000	100000	100000	100000	100000	100000	100000	500000
staff devt	2	200000	400000	400000	400000	400000	400000	400000	2000000
exposure visit	2	500000	1000000	1000000	1000000	1000000	1000000	1000000	5000000
ULB									
sen.of stakeholder-2	63	5000	630000	630000	630000	630000	630000	630000	3150000
State HQ level-4	4	10000	40000	40000	40000	40000	40000	40000	200000
Trg for HHWs	63	50000	3150000	3150000	3150000	3150000	3150000	3150000	15750000
Local trg for MO,FTS	63	50000	3150000	3150000	3150000	3150000	3150000	3150000	15750000
Cap bldg eqpt	63	50000	3150000	3150000					3150000
ULB cap.bldg				**11620000**	**8470000**	**8470000**	**8470000**	**8470000**	**45500000**
Strengthening of existing MH	6	5000000	30000000	10000000	20000000				30000000
IEC for covered-6 mtg/yr*1602 wards*150/mtg - gp mtg/ward/month	1602	150	240300	2883600	2883600	2883600	2883600	2883600	14418000
IEC for uncov-12 mtg/yr*1053 wards * 150/mtg	1053	150	157950	1895400	1895400	1895400	1895400	1895400	9477000
printing	126	25000	3150000	3150000	3150000	3150000	3150000	3150000	15750000
SUB TOTAL - III				**40483400**	**45233400**	**25233400**	**25233400**	**25233400**	**161417000**
IV Monitoring and Evaluation									
Documentation									
Base,mid and endline	1	2000000	2000000	2000000		2000000		2000000	6000000
SUB TOTAL - IV				**2000000**	**0**	**2000000**	**0**	**2000000**	6000000
GRAND TOTAL I - IV				**222605086**	**241684976**	**217384976**	**215384976**	**217384976**	**1114444989**

1114444989

1114444989

পশ্চিমবঙ্গ শহরাঞ্চলের স্বাস্থ্য সংক্রান্ত পরিকাঠামো

২০০৮

স্বাস্থ্য ও পরিবার পরিকল্পনা বিভাগ
পৌর বিষয়ক বিভাগ
পশ্চিমবঙ্গ সরকার

প্রেক্ষাপট ঃ-

পশ্চিমবঙ্গ সরকার রাজ্যবাসীর স্বাস্থ্যসংক্রান্ত ক্ষেত্রে ২০০৪-২০১৫ সাল ব্যাপী যে কর্মপদ্ধতি প্রণয়ণ করেন তার মূল লক্ষ্য হল শ্রেণীনির্বিশেষে রাজ্যের সকল অধিবাসীর স্বাস্থ্যের মান উন্নয়ন ঘটানো, বিশেষ করে যারা দরিদ্রতম এবং যাদের প্রয়োজন সর্বাধিক।

২০০১ সালের জনগণনা অনুযায়ী পৌর এলাকার জনসংখ্যা মোট জনসংখ্যার শতকরা ২৮ ভাগ। পশ্চিমবঙ্গের মোট জনসংখ্যা ৮ কোটি ২ লক্ষ, যার মধ্যে পৌর এলাকার জনসংখ্যা ২ কোটি ২৪ লক্ষ। রাজ্যের পৌর বাসীর সংখ্যা জাতীয় গড়ের উর্দ্ধে এবং জন বসতির ঘনত্ব দেশের অন্যান্য রাজ্যের তুলনায় সবচেয়ে বেশী (প্রতি বর্গকিলোমাটারে প্রায় ৬৭৪৫ জন)। শহরবাসীর মোট সংখ্যার হিসাবে পশ্চিমবঙ্গের স্থান দেশে চতুর্থ।

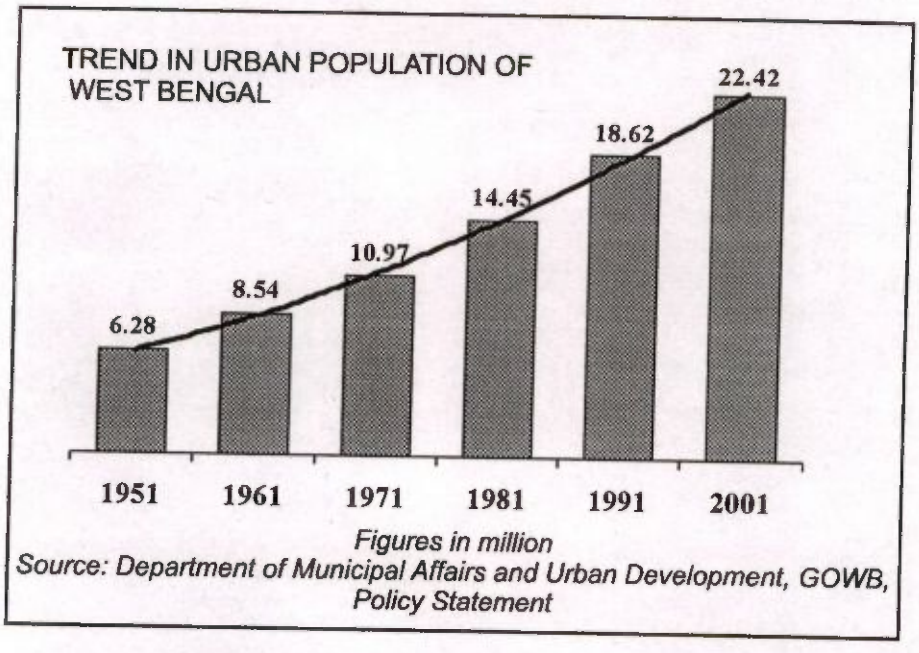
আমাদের রাজ্যে কিছু পৌর এলাকায় বিভিন্ন স্বাস্থ্য প্রকল্প সার্থকভাবে রূপায়িত হয়েছে। কিন্তু রাজ্যে কোন সুসংহত ও নির্দিষ্ট পৌর পরিষেবা প্রদানের পদ্ধতি প্রায় নেই। পৌর স্বাস্থ্য পরিষেবা প্রদানের জন্য রয়েছে বহু সংস্থা যাদের কাজ করবার এলাকা ও আইনগত ক্ষমতা বিভিন্ন। এর ফলে পরিচালনা ও রূপায়ণের ক্ষেত্রে দেখা যাচ্ছে বহুবিধ সমস্যা। এই সব বিচ্ছিন্ন প্রচেষ্টার মাধ্যমে কখনো শহরবাসীর সার্বিক স্বাস্থ্যের উন্নতি সাধন করা যেতে পারে না। এছাড়া পৌর অঞ্চলে অভাব আছে সুসংহত ও সুপরিচালিত প্রাথমিক স্বাস্থ্য পরিষেবা পরিকাঠামোর। ফলে পৌর অঞ্চলে নাগরিক স্বাস্থ্য পরিষেবার উন্নয়নে একটি সুসংহত ও সুনির্দিষ্ট স্বাস্থ্য কর্ম-পরিকল্পনা রচনা ও রূপায়ন করা আবশ্যিক হয়ে পড়েছে।

সরকার নাগরিকদের জন্য একটি আয়াসলভ্য উন্নতমানের স্বাস্থ্য পরিষেবা প্রদানে দায়বদ্ধ। এই উদ্দেশ্যে রাজ্যের স্বাস্থ্য ও পরিবার কল্যাণ বিভাগ এবং পৌর বিষয়ক ও নগরোন্নয়ন বিভাগ যৌথ ভাবে এমন একটি স্বাস্থ্য পরিকাঠামোর বাস্তবায়ন করতে চলেছে, যাতে দরিদ্র শহরবাসীর স্বাস্থ্য সুরক্ষার বিষয়টি সমধিক গুরুত্ব পায়।

পশ্চিমবঙ্গে বর্তমান স্বাস্থ্য পরিকাঠামোর চিত্র ঃ-

নগরায়নের ফলে রাজ্যে শহরবাসীর সংখ্যা ক্রমশঃ বেড়ে চলেছে যদিও ইদানীং এই বৃদ্ধির হার কমের দিকে। এরজন্য আংশিক কৃতিত্ব সরকারের কৃষি নীতির যার ফলে কৃষিতে প্রভূত উন্নতি ঘটেছে এবং গ্রাম থেকে কাজের সন্ধানে শহরে লোক আসার প্রবণতা কমেছে।

নীচের পরিসংখ্যানে শহরে জনসংখ্যা বৃদ্ধির প্রবণতার একটি চিত্র দেওয়া হল ঃ-



পশ্চিমবঙ্গে পৌর নিগম ও পৌরসভা ঃ

- রাজ্যে ৬টি পৌরনিগম ও ১১৭টি পৌরসভা এবং ৩টি নোটিফায়েড এরিয়া অথরিটি বা প্রজ্ঞাপিত অঞ্চল আছে।

- **পশ্চিমবঙ্গে স্বাস্থ্যের পরিকাঠামো**

  স্বাস্থ্য পরিকাঠামোতে আছে বিবিধ প্রতিষেধকমূলক চিকিৎসা ব্যবস্থা যার ফলে ক্রমবর্দ্ধমান জনসংখ্যার চাপ সরকারী স্বাস্থ্য পরিকাঠামোতেই সর্বাধিক। রাজ্যের শতকার ৭৬ ভাগ স্বাস্থ্য প্রতিষ্ঠান সরকার পরিচালিত। অন্যান্য রাজ্যে এই হার হল শতকরা ৪০ (পশ্চিমবঙ্গ মান উন্নয়ন প্রতিবেদন - ২০০৪)।

  পশ্চিমবঙ্গ মিউনিসিপ্যাল এসোসিয়েশন পৌর এলকায় স্বাস্থ্য পরিকাঠামোর যে মানচিত্র তৈরী করেছে তাতে দেখা যায় যে কোন পৌর এলাকায় রয়েছে স্বাস্থ্য পরিষেবা দেবার জন্য পর্যাপ্ত ব্যবস্থা, আবার কোন পৌরসভাতে এই স্বাস্থ্য পরিষেবা দেবার জন্য ব্যবস্থা অত্যন্ত সীমিত। এমন অনেক পৌরসভা আছে যেখানে স্বাস্থ্য পরিষেবা দেবার জন্য সরকারী, বেসরকারী ও সমষ্টি ভিত্তিক বহুবিধ ব্যবস্থা আছে। অন্যদিকে এমন সব পৌরসভাও আছে যেখানে ন্যুনতম স্বাস্থ্য পরিষেবা প্রদানের পরিকাঠামোই নেই।

পৌর অঞ্চলে স্বাস্থ্য পরিকাঠামোকে চার ভাগে ভাগ করা যায় যথা ঃ-

১) পৌর অঞ্চলে স্বাস্থ্যবিভাগ পরিচালিত হাসপাতাল, স্বাস্থ্যকেন্দ্র, উপস্বাস্থ্য কেন্দ্র।

২) সরকারের অন্যান্য বিভাগ পরিচালিত স্বাস্থ্য পরিষেবা।

৩) পৌরসভা/পৌরনিগমের নিয়ন্ত্রণাধীন স্বাস্থ্য পরিষেবা।

৪) বেসরকারী স্বাস্থ্য পরিষেবা।

প্রধান সমস্যা হচ্ছে পৌর এলাকায় স্বাস্থ্য সংক্রান্ত সুযোগ সুবিধার অসমবন্টন। এটা বিশেষ ভাবে পরিলক্ষিত হয় পৌরসভার নিয়ন্ত্রণাধীন স্বাস্থ্য পরিকাঠামোর ক্ষেত্রে। শতকরা ৪ ভাগ পৌর সভা নিজ নিজ এলাকার ২৫ ভাগ স্বাস্থ্য পরিষেবার সুযোগ সুবিধা নিয়ন্ত্রণ করছে, অন্যদিকে শতকরা ৫০ ভাগ স্বাস্থ্য পরিষেবার সুযোগ-সুবিধা উপভোগ করছে শতকরা ১২ ভাগ পৌরসভা।

ভ্যাকসিনের কার্যকারিতার ক্ষেত্রে কোল্ডচেনের গুরুত্ব সর্বাধিক। দেখা যাচ্ছে যে শতকরা ৪০ ভাগ পৌরসভার কোল্ডচেনের ওপর নিয়ন্ত্রণ আছে, অন্যান্যরা সরকারী স্বাস্থ্য দপ্তরের ওপর নির্ভরশীল (ওয়েস্টবেঙ্গল মিউনিসিপ্যাল এসোসিয়েশন, ২০০৫)। এটাও পরিষ্কার যে সরকারী স্বাস্থ্য দপ্তরের যে সব পরিষেবা শহরে রয়েছে তার শতকরা ৪২ ভাগই গ্রামীণ স্বাস্থ্য পরিষেবার অংশ। অন্যান্য সরকারী দপ্তরের যে সব স্বাস্থ্য পরিষেবা পৌর অঞ্চলে রয়েছে যেমন জেল হাসপাতাল, ই. এস. আই. হাসপাতাল তারা পরিষেবা দেয় বিশেষভাবে চিহ্নিত জনসমষ্টিকে।

কিছু কিছু পৌরসভায় বেসরকারী স্বাস্থ্য পরিষেবার সুযোগ আছে। এরাই চাহিদা ও যোগানের মধ্যে সমতা রক্ষা করে। এদের মধ্যে রয়েছে বেসরকারী নার্সিংহোম, উল্লেখযোগ্য সংখ্যক বেসরকারী চিকিৎসক, কিছু কিছু বেসরকারী সংগঠন পরিচালিত স্বাস্থ্য সেবা কেন্দ্র এবং হাতুড়ে ডাক্তার। এই সব সুবিধা সুযোগ পাওয়া যায় বড় বড় শহরে। ছোট ছোট পৌর এলাকায় শহরবাসীরা গ্রামীণ স্বাস্থ্য পরিকাঠামোর ওপর নির্ভরশীল। এই সব এলাকায় বিশেষজ্ঞ ডাক্তাররা কোন পাশ না করা রেজিষ্টার্ড মেডিকেল প্র্যাক্টিশনার (আর. এম. পি.) পাশাপাশি চিকিৎসা করে যাচ্ছেন। বেসরকারী সংস্থাসমূহ থেকে কোন তথ্য না পাওয়ার ফলে তারা যে সব স্বাস্থ্য পরিষেবা দেয় সেগুলি হিসাবের মধ্যে আনা যাচ্ছে না। যেহেতু স্বাস্থ্য পরিষেবার মান পরিমাপের কোন ব্যবস্থা নেই, সেহেতু বেসরকারী ব্যবস্থায় যে স্বাস্থ্য পরিষেবা দেওয়া হয় তার গুণগত মান অনেকসময় একটা প্রশ্নের সামনে পড়ে যায়।

- **শহরবাসীদের স্বাস্থ্য ও রোগের চিত্র ঃ-**

দুর্ভাগ্যবশতঃ নীতি প্রণয়ণকারীদের কাছে দরিদ্র শহরবাসীর স্বাস্থ্য সম্পর্কিত বিশেষ তথ্য নেই। শহরবাসীদের স্বাস্থ্য সম্পর্কিত যে সব পরিসংখ্যান পাওয়া যায় তাতে কিছু কিছু ত্রুটি থেকে যায়। এই স্বাস্থ্য সংক্রান্ত পরিসংখ্যান আয় অনুযায়ী ভাগ করা নেই, তার ফলে শহরবাসী দরিদ্রদের স্বাস্থ্য সংক্রান্ত অবস্থান ঢাকা পড়ে যায়। দ্বিতীয়তঃ এদের স্বাস্থ্যসংক্রান্ত অবস্থান অনেক ক্ষেত্রে উপেক্ষিত থেকে যায়।

বেআইনী বা জবরদখল এলাকায় বসবাসকারী দরিদ্র শহরবাসীদের স্বাস্থ্য সংক্রান্ত তথ্য সংগ্রহ বহু ক্ষেত্রে আইনি ও অন্যান্য বাধার সম্মুখীন হয়। এর ফলে আশ্রয়হীন অনেক দরিদ্র শহরবাসী এই সমীক্ষার বাইরে চলে যায়।

শহরের বস্তি অঞ্চলে ছোঁয়াচে রোগের প্রাদুর্ভাব একটি বিশেষ সমস্যা। বস্তি অঞ্চলে জনসংখ্যার আধিক্যহেতু দরিদ্র শহরবাসীদের মধ্যে যক্ষ্মা, শ্বাস কষ্ট জনিত রোগ, ম্যানেনজাইটিস্ ইত্যাদি প্রাদুর্ভাব বেশী। যে সব রোগ ভ্যাকসিন দিয়ে প্রতিরোধ করা যায় যেমন হাম, তা শহরাঞ্চলে যেখানে লোকসংখ্যার আধিক্য এবং যারা টিকা নেয়নি তাদের মধ্যে দ্রুত ছড়িয়ে যায়। নিকাশী ব্যবস্থা ভাল না থাকলে ম্যালেরিয়া হওয়ার সম্ভাবনা বেশী কারণ জমাজল হল ম্যালেরিয়ার মশা জন্মানোর আদর্শ জায়গা। শৌচাগারের সুবন্দ্যোবস্ত না থাকলে ডেঙ্গু ও পীত জ্বর হওয়ার সম্ভাবনা। কারণ এই রোগসমূহের বীজানু শৌচাগার, সোক্‌পীট এবং সেপটিক ট্যাংকেই জন্ম নেয়। উন্নয়নশীল দেশের শহরাঞ্চলে HIV/AIDS রোগের প্রাদুর্ভাব একটা দুশ্চিন্তার কারণ হয়ে দাঁড়িয়েছে (Lancet Millennium Project Series, March 2005)। কিছুদিন ধরে ভেক্টর সংক্রান্ত রোগ যথা ডেঙ্গু, ম্যালেরিয়া এবং জলবাহিত রোগ যথা হেপাটাইটিস ও ডায়েরিয়ার প্রাদুর্ভাব দেখা যাচ্ছে। এই রোগে স্বাস্থ্যহানি ছাড়া মৃত্যুও হয়েছে। এর ফলে সরকারী স্বাস্থ্য ব্যবস্থার ওপর চাপ আরও বেড়ে গেছে। এই সব রোগের প্রাদুর্ভাব পৌরসভার স্বাস্থ্য পরিষেবার অপ্রতুলতাকে প্রকট করে তুলেছে।

বর্তমানে SRS এর তথ্য থেকে জানা গেছে শহরাঞ্চলে ২০০৬ সালে জন্মের হার দাঁড়িয়েছ ১২.৩ ও শিশুমৃত্যুর হার প্রতি হাজার লাইভ বার্থে ২৯। মনে করা যেতে পারে যে এটা সম্ভব হয়েছে বৃহত্তর কলকাতা এলাকার ৪১টি পৌরসভা / পৌরনিগমে এবং ঐ এলাকার বাইরে ২২টি পৌরসভায় ১৯৯২ সাল থেকে বিদেশী অর্থ সাহায্যে জনমুখী স্বাস্থ্য পরিষেবা চালু করার ফলশ্রুতি হিসাবে। বাকী ৬৩টি পৌর প্রতিষ্ঠান যারা ভৌগলিকভাবে কলকাতা থেকে দূরে তাদের স্বাস্থ্য পরিকাঠামো অত্যন্ত দুর্বল (Mapping of Health Infrastructure in Urban Local Bodies, November 2005, West Bengal Municipal Association)। শহরবাসী দরিদ্র মহিলাদের প্রজনন ক্ষমতা, গর্ভনিরোধক ব্যবস্থা ও সন্তান প্রসবের তথ্য বর্তমানে নেই। তা সত্ত্বেও অস্বাস্থ্যের বিভিন্ন সূচক যথা MMR, NMR IMR এবং TFR – এই সবের ক্ষেত্রে পশ্চিমবঙ্গের অবস্থান জাতীয় সূচকসমূহ থেকে অপেক্ষাকৃত ভাল।

নীচের পরিসংখ্যানে রাজ্যের মুখ্য স্বাস্থ্য নির্দেশক সমূহ উল্লেখ করা হল ঃ-

পশ্চিমবঙ্গে গ্রাম ও শহরের জন্ম ও মৃত্যু হার

জন্মহার			মৃত্যুহার		
গ্রাম	শহর	মোট	গ্রাম	শহর	মোট
২০.৭	১২.৩	১৮.৪	৬.২	৬.৩	৬.২

পশ্চিমবঙ্গ ও ভারতের নিবাচিত স্বাস্থ্যসূচক —

Indicators	West Bengal			All India
	Rural	Urban	Combined	
Life expectancy at birth (years)(2000-04)(SRS)	63.0	69.4	64.4	63
Total Fertility Rate (SRS 2005)	2.4	1.4	2.1	2.9
Maternal Mortality Ratio (per 1,00,000 LB) (RGI Survey 2001-03)	–	–	194	301
Current use of contraception by any modern method (NFHS-3) 2005-06	49.9	49.9	49.9	48.5
Female literacy rate (2001 census)	53.2	75.7	59.6	53.7
Infant Mortality Rate (SRS 2006)	40.0	29.0	38.0	57
Neonatal mortality rate (per 1000 LB) SRS 2005	32	20	30	37
Child Mortality Rate (per 1000 LB) (1-5 years) NFHS-3	-	-	12.2	18.4
Child Vaccinations : complete 2002-04 (NFHS-3)	62.8	70.3	64.3	43.5
Perinatal Mortality Rate(SRS 2005)	34	21	31	37
Still Birth Rate (SRS 2005)	9	7	9	9

শহরের স্বাস্থ্য ব্যবস্থার যেসব মূল সমস্যার সমাধান দরকার তা হ'ল ঃ-

- সমস্ত পৌর এলাকায় একই ধরণের স্বাস্থ্য পরিকাঠামোর অভাব এবং কিছু শহর এলাকায় প্রাথমিক স্বাস্থ্য ব্যবস্থার অনুপস্থিতি।
- রোগীকে স্ক্রিন করা ও referral system এর কোন ব্যবস্থা নেই। কিছু এলাকায় দ্বিতীয় স্তরেও সহায়ক স্বাস্থ্য পরিষেবা অব্যবহৃত থাকছে এবং কিছু এলাকায় এই ধরণের পরিষেবার ওপর অত্যধিক চাপ বেড়ে যাচ্ছে।
- কিছু পৌরসভার অবস্থানগত কারণে প্রাইভেট চিকিৎসকের অভাব।
- বৃহত্তর কলকাতা এলাকার বাইরে অবস্থিত ৬৩টি পৌরসভায় স্বাস্থ্য পরিষেবা প্রদানের জন্য সাংগঠনিক অভিজ্ঞতার অভাব।
- জনসংখ্যাভিত্তিক স্বাস্থ্য পরিসংখ্যানের অভাব। এর ফলে ঠিকমতো পরিকল্পনা ও বেঞ্চমার্কিং করা যাচ্ছে না।
- অপ্রতুল রোগ নজরদারী-ব্যবস্থা এবং যথাবিহিত রোগ নির্ণয় ব্যবস্থার অনুপস্থিতির জন্য সরকারী স্বাস্থ্য ব্যবস্থাকে সমালোচনার মধ্যে পড়তে হচ্ছে। রোগের প্রাদুর্ভাব হওয়ার সম্ভাবনার সতর্কবার্তাকে উপেক্ষা করা হচ্ছে এবং রোগ ছড়িয়ে পড়ছে।

শহারাঞ্চলের স্বাস্থ্য পরিষেবা থেকে অভিজ্ঞতা ও শিক্ষা ঃ-

এই রাজ্যের বিভিন্ন রকম স্বাস্থ্য প্রকল্প (যেমন CUDP-III, IPP-VIII, IPP-VIII (Extn) CSIP, RCH Sub Purject এবং HHW'S Scheme) রূপায়ণের অভিজ্ঞতা আছে। এই প্রকল্প সমূহ ৬৩টি পৌরসভা / পৌরনিগমে রূপায়িত হয়েছে। স্বাস্থ্য ও পরিবার কল্যাণ বিভাগ বৃহত্তর কলকাতা এলাকাতে কে. এম.ডি.এ.-র সহযোগিতায় চারটি বৈদেশিক সাহায্যপ্রাপ্ত স্বাস্থ্য প্রকল্প রূপায়িত করেছে। এগুলি হলো বিশ্বব্যাঙ্কের অর্থসাহায্যে CUDP-III (১৯৮৪-১৯৯২), DFID এর অর্থ সাহায্যে CSIP (১৯৯২-১৯৯৮), বিশ্বব্যাঙ্কের অর্থসাহায্যে IPP-VIII (১৯৯৪-২০০২) এবং European Commission এর অর্থ সাহায্যে UHIP (Post IPP-VIII funding)। স্বাস্থ্য ও পরিবার কল্যাণ বিভাগ এইসব প্রকল্প সমূহ যা রক্ষণাবেক্ষণ পর্যায়ে আছে তার থেকেও অভিজ্ঞতা সঞ্চয় ও শিক্ষা গ্রহণ করেছে।

এইসব প্রকল্প শেষ হওয়ার পর এই প্রকল্পের ফলাফল যাচাই করার জন্য একটি নিরপেক্ষ সমীক্ষা হয়েছিল। এই সমীক্ষা থেকে জানা গেছে যে এইসব প্রকল্প রূপায়নের ফলে বস্তিবাসীদের মধ্যে জন্মের হার কমে গেছে, মা ও শিশুদের স্বাস্থ্যের উন্নতি ঘটেছে, শিশুমৃত্যুর হার কমে গেছে এবং RCH পরিষেবা দ্রুত প্রসারিত হচ্ছে। এই সব প্রকল্প সমূহ থেকে সার্থক প্রকল্প রূপায়ণ কি ভাবে সংগঠিত করতে হয় এবং কি ভাবে তা বাস্তবে কার্যকরী করতে হয় — সেই বিষয়ে অনেক গুরুত্বপূর্ণ অভিজ্ঞতা ও শিক্ষা লাভ করা গেছে।

প্রাতিষ্ঠানিক শিক্ষা ঃ-

ক) প্রশাসনিক ও আর্থিক ব্যবস্থা বিকেন্দ্রীকরণের ফলে পৌরসভাস্তরে একটা দায়বোধ জাগ্রত হয় এবং রাজনৈতিক দায়বদ্ধতা বর্দ্ধিত হয়। এর ফলে এই ধরণের কাজকর্ম সুচারুভাবে সম্পন্ন করার ক্ষমতা ও আত্মবিশ্বাস বৃদ্ধি পায়।

খ) সমষ্টিভিত্তিক সংগঠন (ওয়ার্ড কমিটি) পৌরস্তরে পৌরসভার নেতৃত্বে প্রকল্পের আওতা থেকে কোন জনগোষ্ঠীর বাদ পড়ে যাওয়া প্রতিরোধ করতে পারে এবং প্রকল্পের সার্থক রূপায়ণে অর্থ ও নাগরিক শক্তিকে সংগঠিত এবং প্রকল্প সম্বন্ধে জনচেতনা বৃদ্ধি করতে পারে। ওয়ার্ড কমিটি তৃণমূলস্তরে পরিকল্পনা রচনায় এবং স্বেচ্ছাসেবী স্বাস্থ্যকর্মীদের কাজে সার্থকভাবে সহায়তা করতে পারে।

গ) এই ওয়ার্ড কমিটির মাধ্যমে প্রকল্প রচনা, রূপায়ণ ও তদারকির কার্যে জনগণকে সার্থকভাবে যুক্ত করা যায়।

ঘ) প্রতি এক হাজার দরিদ্র শহরবাসী পিছু একজন স্বেচ্ছাসেবী মহিলা স্বাস্থ্যকর্মী নিয়োগ দরিদ্র শহরবাসীদের মধ্যে স্বাস্থ্য সচেতনাতা বৃদ্ধি করে ও সার্বিক স্বাস্থ্য উন্নয়নে সার্থক ভাবে সাহায্য করে।

ঙ) যেখানে বেসরকারী চিকিৎসক আছে সেখানে তাঁদের প্রাথমিক ক্লিনিক্যাল পরিষেবা ও উপস্বাস্থ্য কেন্দ্রে প্রতিষেধক টিকাকরণের সঙ্গে যুক্ত করলে ভাল ফল পাওয়া যায়।

চ) প্রকল্পের রূপরেখা নমনীয় হলে স্থানীয় আশাআকাঙ্খা ও স্থানীয় জনসাধারণের শক্তিকে প্রকল্পের সংঙ্গে যুক্ত করা যায়।

ছ) যেখানে বিভিন্নরকম সংস্থা স্বাস্থ্য পরিষেবার সঙ্গে যুক্ত আছে সেখানে তাদের নিজ নিজ ভূমিকা ও দায়িত্ব সম্যকরূপে নির্দিষ্ট করার প্রয়োজন আছে।

জ) স্বাস্থ্য পরিষেবার আওতা থেকে যাতে বাদ না পড়ে যায় এই জন্য প্রান্তিক শহরবাসী যথা রেলের জমিতে বসবাসকারী, রাস্তায় আবর্জনা সংগ্রহকারী এবং যারা জবরদখল কলোনীতে আছে তাদের চিহ্নিত করা দরকার।

ঝ) বাস্তবক্ষেত্রে যে সব সমস্যা উদ্ভূত হয় সেগুলি সফলভাবে মোকাবিলা করার জন্য স্বেচ্ছাসেবী স্বাস্থ্যকর্মীদের ধারাবাহিকভাবে প্রশিক্ষণের মাধ্যমে প্রস্তুত করা।

টেকনিক্যাল শিক্ষা ঃ-

ক) যে কোন স্বাস্থ্য পরিষেবা একক ভাবে টিকিয়ে রাখা সম্ভব নয় যদি না Referral Chain এর মাধ্যমে এটি কোন উচ্চতর স্বাস্থ্য পরিষেবার সঙ্গে

যুক্ত না হয়। একটি মাতৃসদন এককভাবে সঠিক স্বাস্থ্য পরিষেবা দিতে পারে না যদি Referral Chain এর মাধ্যমে এটি উচ্চতর স্বাস্থ্য পরিষেবার সঙ্গে যুক্ত না হয়। সুতরাং স্বাস্থ্য পরিষেবার ক্ষেত্রে একটি সুসংহত Referral Chain যথেষ্ট জরুরী।

খ) বৃহত্তর জনগোষ্ঠীকে প্রতিরোধকমূলক চিকিৎসা ব্যবস্থার সঙ্গে যুক্ত করার দরকার আছে।

গ) স্বাস্থ্য পরিষেবার মধ্যে প্রতিরোধ ও প্রতিষেধকমূলক চিকিৎসা ব্যবস্থার একটা সার্থক সম্মেলন হওয়া দরকার।

ঘ) জনসমষ্টি ভিত্তিক স্বাস্থ্য পরিসংখ্যান জরুরী এবং এলাকা ভিত্তিক পরিকল্পনা রচনার সময় এটা প্রয়োজন।

পৌর এলাকায় নাগরিক স্বাস্থ্য উন্নয়নের কর্ম পদ্ধতিতে কতগুলি সাধারণ উদ্দেশ্যে এবং রূপায়ণের পদ্ধতি সমস্ত পৌর অঞ্চলের জন্য বলা আছে। কিন্তু, প্রত্যেক পৌর অঞ্চল নিজেদের সামর্থ্য, প্রয়োজন, অর্থ ও জনবল অনুযায়ী এই কর্মপদ্ধতি রূপায়িত করবে।

লক্ষ্য ঃ-

নাকরিক স্বাস্থ্য উন্নয়ন কর্মপদ্ধতির লক্ষ্য হল দরিদ্র সমস্ত নাগরিকদের বিশেষভাবে যারা অবহেলিত ও দুর্বল, তাদের স্বাস্থ্যের উন্নয়ন ঘটানো।

উদ্দেশ্যসমূহ ঃ-

- উন্নততর স্বাস্থ্য পরিষেবার মাধ্যমে নাগরিকদের মধ্যেও শিশু মৃত্যুর হার কমানো। এই পরিষেবার বিশেষ লক্ষ্য থাকবে দরিদ্র, অবহেলিত ও দুর্বল নাগরিকদের ওপর।
- জাতীয় স্বাস্থ্য কর্মসূচীতে যে সব ছোঁয়াচে রোগের উল্লেখ আছে, সেগুলির প্রকোপ কমানো এবং যে সব রোগ মহামারী আকার ধারণ করে তাদের সার্থকভাবে মোকাবিলা করা।
- বিভিন্নস্তরের স্বাস্থ্যকর্মীদের প্রশাসনিক, কারিগরী ইত্যাদি দক্ষতা বৃদ্ধি করে প্রাথমিক স্বাস্থ্য পরিষেবার মান উন্নত করা।
- IEC/BCC এর মাধ্যমে এই সমস্ত স্বাস্ত্য পরিষেবা সম্বন্ধে নাগরিক সচেতনতা বৃদ্ধি করা এবং এই পরিষেবা সমূহের সার্থক রূপায়ণে নাগরিক সমাজের সমর্থন যুক্ত করা

মূল কর্মপদ্ধতি সমূহ ঃ-

- সকল গ্রামবাসীকে স্বাস্থ্য পরিষেবার আওতায় আনতে হবে, যদিও বিশেষভাবে লক্ষ্য থাকবে দারিদ্রসীমার নীচে অবস্থিত শহরবাসীর প্রতি।

- ত্রিস্তর সমন্বিত স্বাস্থ্য পরিষেবা পরিকাঠামো গড়ে তোলা যাতে একটা সার্বিক পরিষেবা জনগণকে দেওয়া যায়।
- প্রাতিষ্ঠানিক ব্যবস্থা ও আন্তঃ বিভাগীয় সমন্বয়কে জোরদার করা।
- নজরদারি ও মূল্যায়ন ব্যবস্থাকে শক্তিশালী করা।

মূলকর্মপদ্ধতি - ১

স্বাস্থ্য উন্নয়ন নীতির উদ্দেশ্য সকল শহরবাসীকে স্বাস্থ্য পরিষেবার আওতায় আনা, তবে বিশেষভাবে লক্ষ্য থাকবে দরিদ্র, অবহেলিত ও দুর্বল শহরবাসীদের প্রতি।

মূল কর্মপদ্ধতি - ২

একই রকম ত্রিস্তর স্বাস্থ্য পরিষেবা মডেলের মাধ্যমে স্বাস্থ্য পরিষেবাকে শক্তিশালী করা।

- একটি বহুমুখী প্রচেষ্টার মাধ্যমে স্বাস্থ্য পরিষেবাকে শক্তিশালী করা।
- বর্তমানে যে ত্রিস্তর স্বাস্থ্য পরিষেবা আছে তাকে নিম্নলিখিত উপায়ে প্রাতিষ্ঠানিকভাবে স্থায়ী করা (Appendix-1)
- উপস্বাস্থ্যকেন্দ্রে স্বেচ্ছাসেবী স্বাস্থ্য কর্মী ও প্রথম সারির পরিদর্শিকা (First Tier supervisor)-এর মাধ্যমে শহরবাসীর কাছে পৌঁছানোর ব্যবস্থাকে জোরদার করা।
- পরিকাঠামোকে শক্তিশালী করা। প্রয়োজনে First Tier supervisor-দের একটি পৃথক Cadre চালু করা।
- স্থানীয় জনসমষ্টি থেকে স্বেচ্ছাসেবী স্বাস্থ্যকর্মী নিয়োগ, সমষ্টি উন্নয়ন সমিতি এবং স্বনির্ভর গোষ্ঠীগুলিকে প্রাথমিক স্বাস্থ্য, পুষ্টি ইত্যাদি ব্যাপারে জনচেতনা বৃদ্ধির কাজে যুক্ত করা এবং ওয়ার্ড কমিটির কাজকর্মে এই গোষ্ঠীসমূহকে সার্থক ভাবে কাজে লাগানোর মাধ্যমে সমষ্টির ক্ষমতায়ন ও তাদের সহভাগী করতে হবে।
- পৌর এলাকায় চালু স্বাস্থ্য পরিষেবা ব্যবস্থাকে সহায়তা দিতে হবে ও উন্নততর করতে হবে।
- পৌরসভার জনস্বাস্থ্যজনিত কাজকর্ম বাড়াতে হবে এবং মহামারী নিয়ন্ত্রণ ব্যবস্থাকে জোরদার করতে হবে।
- প্রত্যেক পৌর অঞ্চলের নিজস্ব কর্ম পরিকল্পনা তৈরী করতে হবে যাতে কর্ম পদ্ধতির বিবরণ ও স্থানীয় স্বাস্থ্য সমস্যা মোকাবিলা করার উপায় বিশেষভাবে উল্লেখ থাকবে।

- স্বাস্থ্য পরিষেবার ক্ষেত্রে নতুন উপায় উদ্ভাবন ও কার্যকরী করতে হবে, যেমন বেসরকারী সংস্থার সঙ্গে যৌথ উদ্যোগ (PPP), সরকারী / বেসরকারী সংস্থাকে তথ্য আহরণ, প্রশিক্ষণ ইত্যাদির কাজে লাগানো।

- চলমান স্বাস্থ্য পরিষেবা চালু করা, যাতে দুর্গম এলাকার শহরবাসীর কাছে পৌঁছোনো যায়।

- দলগত সভা, প্রচার, ইত্যাদির মাধ্যমে স্বাস্থ্য সচেতনতা বৃদ্ধি করা।

লক্ষ্য -৩-প্রাতিষ্ঠানিক ব্যবস্থাকে সহজ করা ও আন্তর্বিভাগীয় সমন্বয়কে জোরদার করা।

প্রাতিষ্ঠানিক ব্যবস্থা সংহত করার মাধ্যমে বিভিন্ন স্বেচ্ছাসেবী সংস্থাকে যুক্ত করতে হবে এবং পরিকল্পনা এমনভাবে করতে হবে যাতে এই ধরণের কাজকর্ম আরও সুষ্ঠুভাবে করা যায়।

- স্বাস্থ্য ও পরিবার কল্যাণ বিভাগে Urban Health Cell তৈরী করা যাতে নাগরিক স্বাস্থ্য দেখাশোনার জন্য এই বিভাগ আরও শক্তিশালী হয়।

- অনুরূপভাবে নাগরিক স্বাস্থ্য সম্পর্কিত রাজ্য নগর উন্নয়ন সংস্থা (SUDA)-র কাজকর্ম তদারকি করার জন্য রাজ্যের পৌর বিষয়ক দপ্তরেও উপযুক্ত আধিকারিক দ্বারা পরিচালিত একটি Urban Health Cell করতে হবে।

- স্বাস্থ্য ও পরিবার কল্যাণ বিভাগ ও পৌরবিষয়ক দপ্তরের যৌথ উদ্যোগে জনস্বাস্থ্য কারগরী দপ্তর (PHE), মহিলা ও শিশু উন্নয়ন দপ্তর (Department of Women and Child Development), স্কুল শিক্ষা দপ্তর (School Education) এবং উচ্চ শিক্ষা দপ্তর (Higher Education)- দপ্তর সমূহকে দিয়ে একটি আন্তঃ বিভাগীয় সমন্বয় কমিটি গড়া হবে।

- পৌরসভার Health and Family Welfare Committee-এর সঙ্গে যোগাযোগ রক্ষার জন্য প্রতিটি জেলায় জেলাশাসকের নেতৃত্বাধীনে Health Committee গঠন। এই কমিটি জেলা স্বাস্থ্য ও পরিবার কল্যাণ সমিতি হিসেবে কাজ করবে।

- বিভিন্ন দপ্তরের ভূমিকা ও দায়িত্ব এবং অর্থযোগানোর পদ্ধতি সুনির্দিষ্ট করা হবে।

- পৌরসভা ও ওয়ার্ড কমিটিকে পরিশ্রুত জল সরবরাহ, বর্জ্য নিষ্কাষণ, স্যানিটেশন, স্বাস্থ্য এবং ঋতু পরিবর্তনের কারণে যে সব রোগ মহামারী আকার ধারণ করে - এই সব ব্যাপারে সংশ্লিষ্ট সংস্থা সমূহের মধ্যে যোগাযোগ রক্ষা করতে হবে।

- পৌরসভাতে প্রকল্প রূপায়ণ ও পরিচালনার ক্ষেত্রে বিকেন্দ্রীকরণ ব্যবস্থা চালু রাখতে হবে।

- সমষ্টি এবং পৌরসভা স্তরে ও রাজ্য নগর উন্নয়ন সংস্থায় মানব সম্পদকে উন্নত করতে হবে।
- জেলা ও ব্লকের স্বাস্থ্য পরিষেবা ব্যবস্থার সঙ্গে Referral Linkage স্থাপন করতে হবে।

মূল পন্থা ঃ- তদারকি ও মূল্যায়ণ ব্যবস্থাকে শক্তিশালী করা।

নাগরিক স্বাস্থ্য উন্নয়ন কর্মপদ্ধতির মাধ্যমে একটা জোরদার তদারকি ও মূল্যায়ন ব্যবস্থা চালু করার জন্য প্রাতিষ্ঠানিক এবং আর্থিক ব্যবস্থা করা হবে। এর ফলে কাজকর্মের তদারকি ও মূল্যায়ন প্রতিনিয়ত করা যাবে এবং এই ব্যবস্থা পরিকল্পনা প্রক্রিয়াকে সহায়তা করবে।

এই তদারকি ও মূল্যায়ন প্রক্রিয়া স্বাস্থ্য ও পরিবার কল্যাণ এবং নগরোন্নয়ন ও পৌর বিষয়ক দপ্তরের HMIS সার্বিক পরিকাঠামোর মধ্যেই কাজ করবে। এতে মোটামুটি এই ব্যবস্থাগুলি থাকবে ঃ

- দুই দপ্তরের সঙ্গে আলোচনার মাধ্যমে একটি দৈনন্দিন তদারকি ব্যবস্থা স্থাপন ও কার্যকরী করা।
- সম্ভাব্য মহামারী সম্বন্ধে আগাম সতর্ক বার্তা দেওয়ার জন্য একটি প্রক্রিয়া উদ্‌ভাবন করা যাতে মহামারী প্রতিরোধ তদারকি ব্যবস্থা শক্তিশালী হয়।
- নাগরিক স্বাস্থ্য সম্বন্ধে মূল্যায়ন করার জন্য মাঝে মাঝে সমীক্ষা করা হবে।

পরিশিষ্ট ...১ পরিষেবা দেওয়ার পদ্ধতি ঃ-

এই পরিকল্পনায় বহুমুখী পরিষেবা প্রদানের পদ্ধতিতে থাকবে; এই পদ্ধিতে নাগরিক সমাজের সক্রিয় অংশগ্রহণ থাকবে। এই পরিষেবাগুলির মধ্যে রোগ নিরাময় ও রোগ প্রতিরোধের উপর জোর দেওয়া ছাড়াও জনস্বাস্থ্য ও প্রাথমিক স্তরের স্বাস্থ্য ব্যবস্থার নিরাময় পদ্ধতিও থাকবে।

প্রথম ধাপ ঃ

সমষ্টির মধ্যে স্বাস্থ্য ব্যবস্থা ছড়িয়ে দেওয়ার উদ্দেশ্য হলো স্বাস্থ্য পরিষেবাকে স্বাস্থ্য পরিষেবা প্রদান সংস্থা থেকে প্রত্যেক শহরবাসীর দরজায় পৌঁছে দেওয়া যেখানে স্বাস্থ্যকর্মীরা তাদের দেখভাল করতে পারবে। সমষ্টি স্তরের এই কর্মপন্থা দরিদ্র শহরবাসী ছাড়াও সকল স্তরের নাগরিকদের মধ্যে প্রসারিত থাকবে। শহরের দরিদ্র মানুষের জন্য নিবিড় পর্যবেক্ষণ পদ্ধতি থাকবে, যেখানে প্রতিটি বাড়ী পরিদর্শন করা বাধ্যতামূলক হবে এবং একটি পারিবারিক স্বাস্থ্য কার্ড চালু করা হবে। সর্ব সাধারণের জন্য একটি ক্লিনিক স্থাপন করা হবে যেখানে জনসাধারণকে স্বাস্থ্যবিধি সম্বন্ধে সচেতনতার শিক্ষা দেওয়া হবে এবং সাথে সাথে স্বাস্থ্য

বিষয়ক প্রতিরোধ ব্যবস্থা সম্বন্ধেও সচেতনতা দেওয়া হবে। পরিষেবা কেন্দ্র স্থাপন করে স্বাস্থ্য পরিষেবা স্বাস্থ্যকর্মীর মাধ্যমে নাগরিকদের দেওয়া হবে। এই স্বাস্থ্য কর্মীদের সংশ্লিষ্ট শহর থেকেই নেওয়া হবে। এই পরিষেবা কেন্দ্রগুলি ওয়ার্ডভিত্তিক হবে। ওয়ার্ডের পৌরপ্রতিনিধি এবং স্বাস্থ্য উপ-সমিতিগুলি এই স্বাস্থ্য পরিষেবা কেন্দ্রগুলিকে সক্রিয় ভাবে সাহায্য করবে এবং এদের উপর নজরদারিও রাখবে।

সকল শহরবাসীকে জাতীয় স্বাস্থ্য পরিকল্পনার অন্তর্ভুক্ত যেসব শিক্ষামূলক ও পরিষেবামূলক পদ্ধতি রয়েছে সে সম্বন্ধে অবহিত করা।

প্রত্যেক পৌরসভার জন্য স্বাস্থ্যকর্মীর সংখ্যা ঠিক করা হবে ঐ পৌরসভার ওয়ার্ডের সংখ্যা অথবা প্রতি হাজার দরিদ্র শহরবাসী পিছু একজন - এর মধ্যে যেটা বেশী পৌরসভার যে এলাকার আর্থ-সামাজিক অবস্থা অনুন্নত, সেখানে স্বাস্থ্যকর্মীর সংখ্যা নির্ধারণের উপর বেশী গুরুত্ব দেওয়া হবে।

দ্বিতীয় ধাপ ঃ-

এই ধাপে থাকবে উপস্বাস্থ্যকেন্দ্র, যেখানে কয়েকটি ওয়ার্ডের ৫০০০ দরিদ্র শহরবাসীকে স্বাস্থ্য পরিষেবা দেওয়া হবে। এখানে আরও উন্নতধরণের স্বাস্থ্য পরিষেবা দেওয়া হবে এবং রোগী দেখার সময়ের মধ্যে বাধ্যবাধকতা থাকবে না।

পরিষেবা কেন্দ্রটি সংশ্লিষ্ট শহরবাসীর যাতায়াতের পক্ষে সুবিধাজনক জায়গায় এবং পৌরসভার কাছাকাছি হবে। জি.আই.এস. ম্যাপের মাধ্যমে এই পরিষেবা কেন্দ্রটির অবস্থান ঠিক করা যেতে পারে।

যে সব স্বাস্থ্যকর্মীর অন্ততঃ ৬মাসের কাজের অভিজ্ঞতা আছে এবং অতিরিক্ত ট্রেনিং পেয়েছে, তাদের মধ্য থেকে প্রথম ধাপের পরিদর্শিকা (FTS) নিয়োগ করা হবে। একজন পরিদর্শিকাকে একটি উপস্বাস্থ্য কেন্দ্রের দায়িত্ব দেওয়া হবে এবং তারা পাঁচজন স্বাস্থ্যকর্মীকে তাদের পরিষেবা প্রদানে সাহায্য দেবে এবং কেন্দ্রটি দেখাশুনা করবে।

প্রথম সারির পরিদর্শিকা স্বাস্থ্য বিষয়ে পরামর্শ দেবে এবং ন্যূনতম প্রাথমিক স্বাস্থ্য পরিষেবা দেবে। আরও একধরণের প্রথম সারির পরিদর্শিকা থাকবে যাদের বলা হবে জনস্বাস্থ্যের দায়িত্বপ্রাপ্ত প্রথম সারির পরিদর্শিকা-জনস্বাস্থ্য। এদের দায়িত্ব হবে ২০,০০০ শহরবাসীকে জনস্বাস্থ্য সম্পর্কিত পরিষেবা দেওয়া। এরা পৌরসভা স্তরের স্বাস্থ্য টিমের সঙ্গে যুক্ত থাকবে এবং স্বাস্থ্য আধিকারিকের (হেলথ আফিসারের) অধীনে কাজ করবে।

উপস্বাস্থ্য কেন্দ্রটিতে থাকবে প্রথম সারির পরিদর্শিকা ও আংশিক সময়ের একজন মেডিক্যাল অফিসার।

পর্যালোচনা ও তদারকির জন্য একটি সুনির্দিষ্ট পর্যালোচনা এবং নিরীক্ষণ পদ্ধতির কার্যক্রম তৈরী করা হবে। প্রথম সারির পরিদর্শিকাদের যে প্রশিক্ষণ দেওয়া হবে তার মধ্যে থাকবে কি কি পদ্ধতির মাধ্যমে কার্যাবলী নিরীক্ষণ করতে হবে।

তৃতীয় ধাপ ঃ- (রেফারাল ফেসিলিটি) ঃ- যে সব রোগীদের দ্বিতীয় ধাপে পরিষেবা দেওয়া সম্ভব হয়নি তাদের তৃতীয় ধাপে ব্লক প্রাথমিক স্বাস্থ্যকেন্দ্র/গ্রামীণ হাসপাতাল/মহকুমা স্বাস্থ্য হাসপাতাল/জেলা হাসপাতালে পাঠানো হবে। যেখানে কাছাকাছি কোন ব্লক প্রাথমিক স্বাস্থ্যকেন্দ্র অথবা গ্রামীণ / মহকুমা / জেলা হাসপাতাল নেই কিন্তু পৌরসভার কোনও ভাল মাতৃসদন আছে, সেখানে পৌরসভা পরিচালিত হাসপাতালে এদের পাঠানো যেতে পারে।

যে ১৫টি পৌরসভায় স্বাস্থ্য ও পরিবার পরিকল্পনা দপ্তরের কোন দ্বিতীয় স্তরের পরিষেবার সুযোগ-সুবিধা নেই, সেখানে স্বাস্থ্য ও পরিবার পরিকল্পনা দপ্তরের অধীনে একটি আর্বান হেলথ সেন্টার গঠন করা হবে।

প্রথম পর্যায়ে স্বেচ্ছাসেবী-পরিষেবাগুচ্ছ ঃ স্বাস্থ্যকর্মী ও স্বাস্থ্যকর্মীরা নিম্নলিখিত ন্যূনতম পরিষেবা দেবে। প্রত্যেকদিনে অন্ততঃ ২০০-৩০০ বাড়ী পরিদর্শন করবে। দৈনিক অন্ততঃ ১৫-২০টি বাড়ী পরিদর্শন করতে হবে এবং প্রতিটি পরিবারের বিস্তারিত বিবরণ যেমন জন্ম, মৃত্যু, নতুন অতিথি, যারা মারা গিয়েছে, পাকাপাকিভাবে চলে গিয়েছে, জন্ম নিরাপদে বা স্বাস্থ্য কেন্দ্রে হয়েছে কিনা এসব তথ্য লিপিবদ্ধ করতে হবে।

প্রসূতি মহিলাদের নথিভূক্তকরণ, গর্ভপাত অথবা স্বাস্থ্যের কারণে গর্ভপাত ইত্যাদি বিবরণও নথিভূক্ত করতে হবে।

প্রসব পরবর্তী সময়ে মায়েদের উপস্বাস্থ্য কেন্দ্রে যাওয়ার জন্য পরামর্শ দেওয়া।

মা, বাচ্চা ও শিশুদের টীকাকরণ হয়েছে কি না তার খবরও নথিভুক্ত করতে হবে।

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অপুষ্ট শিশুদের চিহ্নিতকরণ, তাদের পুষ্টির ব্যাপারে উৎসাহ দান এবং উপস্বাস্থ্য কেন্দ্রে যাওয়া ? referral slip প্রদান করা।

- গর্ভনিরোধক বন্টনের ব্যবস্থা করা।
- হাসপাতাল / স্বাস্থ্যকেন্দ্রে প্রসবের জন্য সুপারিশ করা / আপৎকালীন অবস্থা হলে উপযুক্ত জায়গায় রেফার করা।
- মা-দের উৎসাহ দেওয়া এবং মা / প্রসূতীদের / বাচ্চাদের প্রতিষেধক টীকা গ্রহণের জন্য উপস্বাস্থ্য কেন্দ্রে নিয়ে যাওয়া। আংশিক সময়ের মেডিক্যাল অফিসার দ্বারা চেক আপের জন্য প্রসূতি মায়েদের উপস্বাস্থ্য কেন্দ্রে যেতে উৎসাহিত করা।
- তথ্য, শিক্ষা এবং যোগাযোগ ঃ মাতৃদুগ্ধ পান, গর্ভনিরোধক ব্যবস্থা সুষম খাদ্য, ORS, ব্যক্তিগত স্বাস্থ্য, প্রতিষেধক টীকা, পরিচ্ছন্নতা ও সাধারণ পরিবেশ রক্ষা, প্রতিষ্ঠানগত প্রসবে উৎসাহ দান এবং স্বাস্থ্য কেন্দ্রগুলির পরিষেবা গ্রহণে উৎসাহিত করা বিষয়ে যথাযথ তথ্য প্রদান ও শিক্ষার ব্যবস্থা করা।

- প্রতিষ্ঠানগত প্রসবে মায়েদের উৎসাহদান।
- আর.সি.এইচ (RCH) সম্পর্কিত কার্যকলাপ জানানোর জন্য মায়েদের সভা আহ্বান করা।
- সুপারিশ ব্যবস্থা ঠিকমত চলছে কিনা তা খেয়াল রাখা।
- প্রতিষেধক টীকাকরণে সহায়তা করা।
- পালস্ পোলিও প্রভৃতি প্রতিষেধক টীকাকরণে সবরকমভাবে সহায়তা করা।

সরাসরি জনস্বাস্থ্য পরিষেবা ঃ-

- কোন পরিবার থেকে মৃত্যু সংক্রান্ত তথ্য সংগ্রহের সময় খেয়াল করতে হবে যে মৃত্যুর কারণ কোন নথিভুক্ত ছোঁয়াচে রোগ থেকে হয়েছে কিনা।
- প্রতিটি পরিবার থেকে স্বাস্থ্য সংক্রান্ত তথ্য সংগ্রহের সময় জানতে হবে এর পূর্বের তথ্য সংগ্রহের সময় থেকে বর্তমান সময় পর্যন্ত বাড়ির কেউ কোন ছোঁয়াচে রোগে আক্রান্ত হয়েছে কিনা বা অন্য কোন রোগে বর্তমানে ভুগছে কিনা। যদি এই ধরণের কোন তথ্য পাওযা যায় তা তৎক্ষণাৎ নথিবদ্ধ করা এবং সুশ্রুষার ব্যবস্থা করা।
- এইচ. আই. এম. এস (HMIS) এর রিপোর্ট তৈরী করা, আগে থেকে সতর্কবার্তাগুলিকে চিহ্নিত করা এবং তা উর্দ্ধতন কর্তৃপক্ষের নজরে আনা।
- এ.আর.আই. (ARI), ডায়েরিয়া প্রভৃতি রোগের বিপদ সম্ভাবনা চিহ্নিত করে সুশ্রুষার ব্যবস্থা করা এবং প্রয়োজন হলে অন্য কোথাও পাঠানোর জন্য সুপারিশ করা।
- ORS তৈরী করা শেখানো এবং ORS বন্টনের ব্যবস্থা করা।
- কিশোর-কিশোরীদের এবং পুরুষ ও নারীদের যথাযথ স্বাস্থ্যকেন্দ্রে যাবার জন্য উৎসাহিত করা।
- জনপ্রতিনিধিদের সাথে আলোচনা করা।
- ওয়ার্ড কমিটির সভাগুলিতে অংশগ্রহণ করা।

জনস্বাস্থ্য সম্পর্কিত পরিষেবা ঃ-

- জাতীয় স্বাস্থ্য পরিকল্পনা রূপায়নে সহায়তা করা।
- মহামারীর কারণ অনুসন্ধানে সহায়তা করা।
- স্বেচ্ছাসেবী স্বাস্থ্যকর্মীরা ওয়ার্ড কমিটি এবং কাউন্সিলারদের কাছে দায়বদ্ধ থাকবেন।

দ্বিতীয় ধাপ - উপস্বাস্থ্যকেন্দ্র ঃ-

উপস্বাস্থ্য কেন্দ্রগুলি শহরের ৫০০০ দরিদ্রকে পরিষেবা দেবে। যাতে তাদের প্রাথমিক স্বাস্থ্য পরিষেবা আরও ভালো ভাবে দেওয়া যায় তার জন্য সুবিধামত সময় ঠিক করবে।

উপস্বাস্থ্য কেন্দ্রগুলিতে একজন এফ.টি.এস (F.T.S), পৌরসভা থেকে নিযুক্ত একজন হেলথ অফিসার (Health Officer) অথবা একজন মেডিক্যাল অফিসার (Medical Officer) থাকবেন। এই উপস্বাস্থ্য কেন্দ্রগুলি নিম্নলিখিত পরিষেবাগুলি দান করবে ঃ-

- বিভিন্ন প্রকার শিশু স্বাস্থ্য সুরক্ষা পরিষেবা প্রদান যথা - IFA, Vitamin-A এবং ORS এর প্যাকেট বন্টন।
- ANC পরিষেবা গ্রহণ এবং প্রতিষ্ঠানগত প্রসবে উৎসাহিত করার জন্য জনগণকে বোঝানো।
- পরিবার পরিকল্পনায় উৎসাহিত করা এবং তার জন্য বিভিন্ন গর্ভনিরোধক ব্যবস্থা যেমন Oral pill, কণ্ডোমের ব্যবহার ও অন্যান্য পদ্ধতি সম্পর্কে মানুষকে সচেতন করা।

সাধারণ অসুস্থতার প্রাথমিক চিকিৎসা প্রদান ঃ-

উপরোক্ত পরিষেবাগুলি ছাড়াও উপস্বাস্থ্য কেন্দ্রগুলি পূর্ব নিদ্ধারিত দিনে কিছু বিশেষ পরিষেবা প্রদান করবে। যথা ঃ-

ক) ANC / PNC এবং পরিবার পরিকল্পনা সংক্রান্ত পরামর্শ দান – মাসে দুদিন।

খ) প্রতিষেধক টিকাকরণ – সপ্তাহে ১ দিন।

গ) ডাক্তার থাকবেন এমন সাধারণ চিকিৎসা প্রদান - সপ্তাহে ১ দিন।

ঘ) পাঁচ বছরের নীচের বাচ্চাদের বৃদ্ধির হার পর্যবেক্ষণ – মাসে ১ দিন।

ঙ) স্বাস্থ্য সচেতনতা অনুষ্ঠান – ১০ দিনে ১বার.

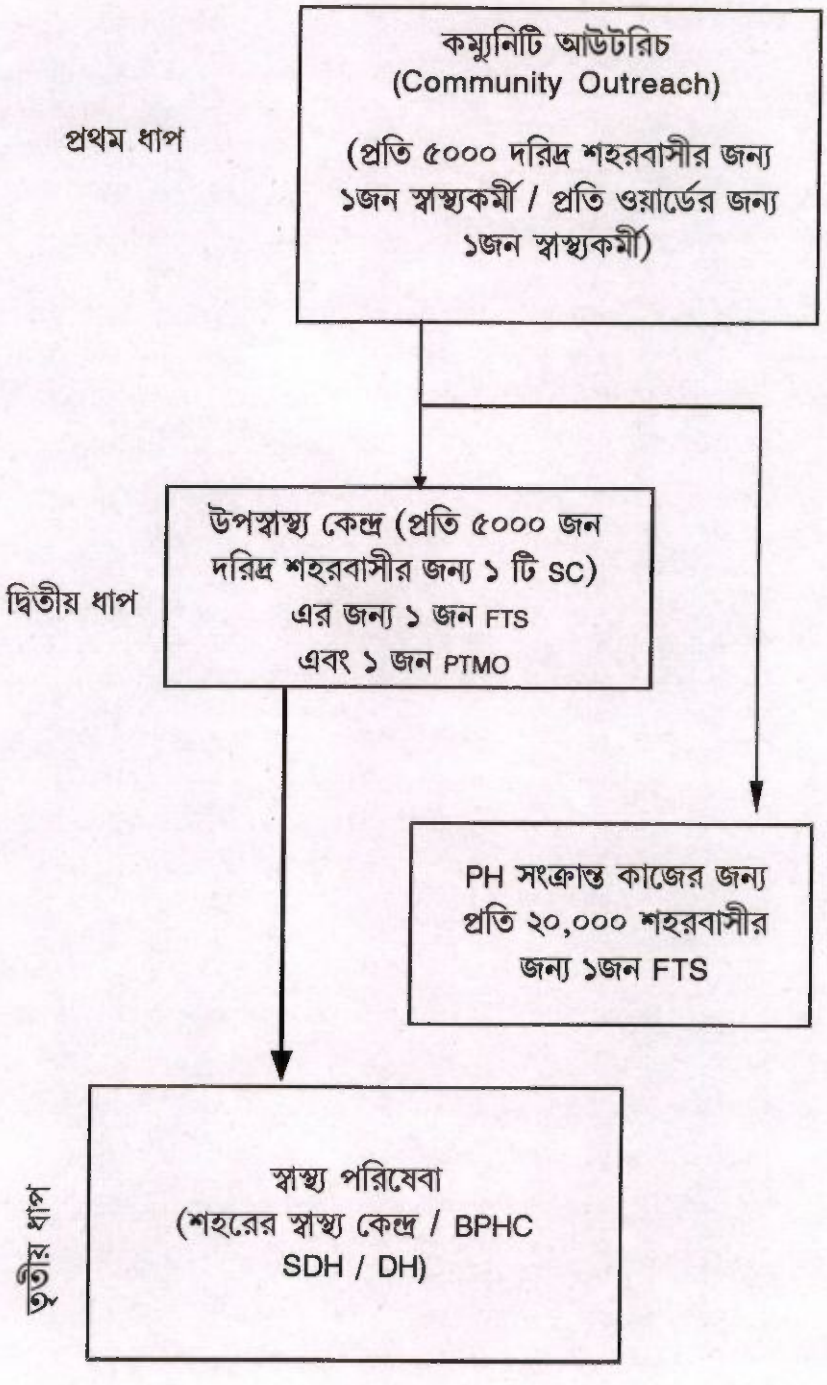
তৃতীয় ধাপ - সুপারিশ সংক্রান্ত সুবিধা ঃ-

তৃতীয় ধাপের সহায়তা হল ব্লক প্রাথমিক স্বাস্থ্যকেন্দ্র / গ্রামীন হাসপাতাল, মহকুমা হাসপাতাল অথবা জেলা হাসপাতালে যাবার জন্য সুপারিশ করা।

নিম্নলিখিত পরিষেবাগুলি এই ধরণের সুপারিশের অন্তর্ভুক্ত ঃ-

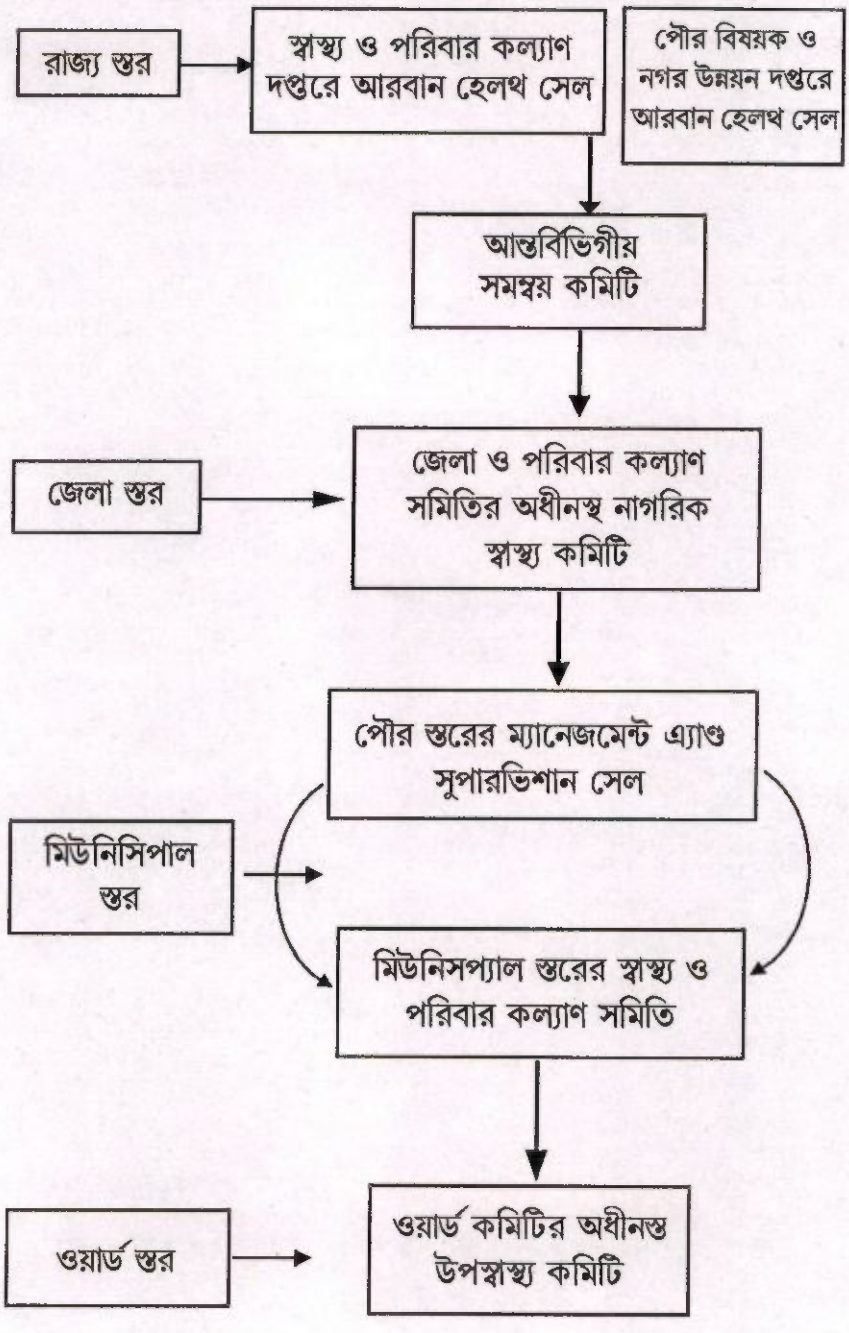
- পরিবার পরিকল্পনা সংক্রান্ত সর্বপ্রকার সহায়তা এবং ল্যাপ্রোস্কোপি (Laproscopy) করার জন্য সহায়তা।
- প্রতিষ্ঠানগত প্রসবে সহায়তা।
- প্রসব সংক্রান্ত প্রয়োজনীয় এবং আপৎকালীন সহায়তা।
- MTP পরিষেবা।
- নবজাতক ও শিশুদের স্বাস্থ্য সংক্রান্ত প্রয়োজনীয় এবং আপৎকালীন সহায়তা প্রদান ও প্রয়োজনে অন্য কোন স্বাস্থ্যকেন্দ্রে পাঠানোর সুপারিশ করা।
- মূল চিকিৎসা পরিষেবা এবং সার্জিকাল পরিষেবা প্রদান।
- জাতীয় রোগ প্রতিরোধ কার্যসূচীর অন্তর্গত পরিষেবা প্রদান।

পরিষেবা প্রদানের মডেল (Appendix-1) ঃ-



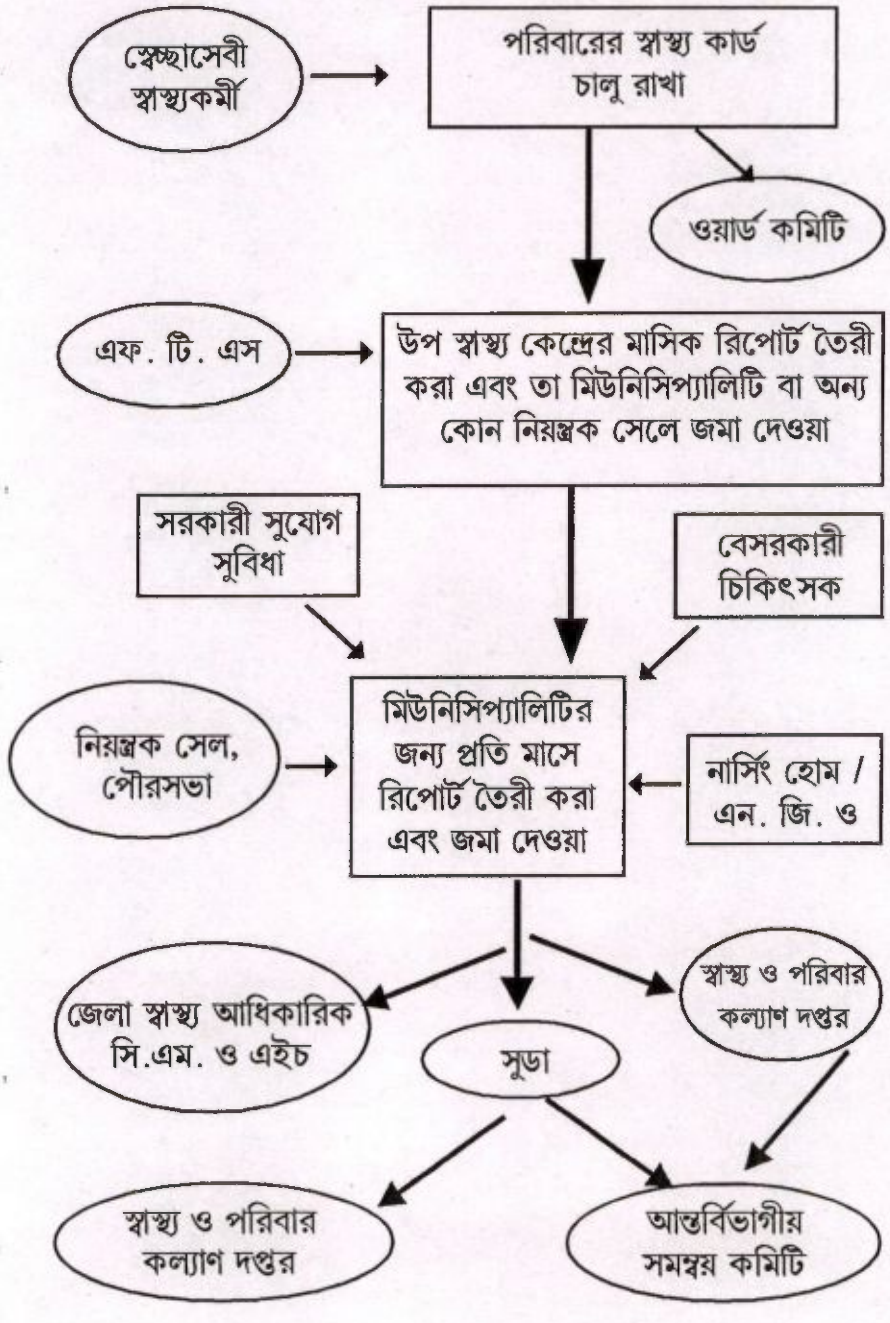
পরিশিষ্ট - ২

নাগরিক স্বাস্থ্য সুরক্ষার জন্য প্রতিষ্ঠানগত ব্যবস্থা



পরিশিষ্ট - ৩

এইচ এম আই এস



মুখ্য সংস্থাগুলির ভূমিকা ও দায়িত্বের বর্ণনা ঃ-

স্বাস্থ্য ও পরিবার কল্যাণ বিভাগ

স্বাস্থ্য ও পরিবার কল্যাণ বিভাগ কর্মপরিকল্পনা রূপায়ণের নীতি নির্দ্ধারণে, মাপকাঠি নির্দ্ধারণে এবং আন্তর্বিভাগীয় কার্যকলাপের সমন্বয় সাধনে মুখ্য ভূমিকা পালন করবে।

নাগরিক স্বাস্থ্য সুরক্ষা সংক্রান্ত কার্যকলাপ সঠিকভাবে করার জন্য স্বাস্থ্য ও পরিবার কল্যাণ দপ্তরে একটি স্বাস্থ্য সেল গঠিত হবে। জেলা স্তরে জেলা স্বাস্থ্য সমিতির অধীনে একটি স্বাস্থ্য কমিটি গঠিত হবে এবং জেলা স্তরে স্বাস্থ্য সংক্রান্ত কার্যকলাপ দেখাশোনা করার জন্য একজন মূল ব্যক্তিকে চিহ্নিত করা থাকবে।

পৌর বিষয়ক দপ্তর ঃ-

পশ্চিমবঙ্গের ১২৬টি পৌরসভাতে স্বাস্থ্য সংক্রান্ত কর্মসূচী রূপায়ণের জন্য দায়ী থাকবে এই বিভাগ। এই বিভাগ সার্বিক কর্মসূচী পালনে এবং পরিচালনা করতে সহায়তা করবে। এই কর্মসূচী রূপায়ণে কারিগরী সহায়তা, সক্ষমতা বৃদ্ধিতে সহায়তা প্রদান করবে সুডা। এই সমস্ত কার্যকলাপ যথাযথ ভাবে হচ্ছে কিনা তা পরিদর্শনের দায়িত্ব সুডার। এই দপ্তর রাজ্যের সমস্ত পৌর সংস্থাগুলিকে আইনী এবং প্রশাসনিক সহায়তা দান করবে এবং পৌরসভার মাধ্যমে পৌর উন্নয়ন পরিকল্পনা রূপায়ণ করবে। এই দপ্তরের প্রধান কাজগুলির অন্যতম হল পৌর সংস্থাগুলির কার্যকলাপ নিয়ন্ত্রণ করা, পৌর সংস্থাগুলি পরিচালনার কর্মসূচী নির্দ্ধারণ করা এবং পৌর সংস্থাগুলির সক্ষমতা বৃদ্ধি করা।

সুডা ঃ স্টেট আরবান ডেভেলপমেন্ট এজেন্সী

সমগ্র রাজ্যে দারিদ্র দূরীকরণ এবং কর্মসংস্থানের সুযোগ বৃদ্ধির লক্ষ্যে প্রণীত কেন্দ্রীয় কর্মসূচীগুলিকে রূপায়ণ এবং পরিচালনার উদ্দেশ্যে ১৯৯১ সালে সুডা গঠন করা হয়। সুডা প্রকৃতপক্ষে ১৯৬১ সালের ওয়েস্ট বেঙ্গল সোসাইটি রেজিষ্ট্রেশান আইনের অধীনে তৈরি একটি রেজিষ্ট্রার্ড সমিতি।

সুডার প্রধান কাজ হল, বিভিন্ন সংস্থা যথা পৌরবিষয়ক ও নগরউন্নয়ন দপ্তর পৌরসভা, স্বাস্থ্য ও পরিবার কল্যাণ দপ্তর প্রভৃতির মধ্যে সংযোগ রক্ষা করা। পৌরসংস্থাগুলিকে কারিগরী সহায়তা দেওয়া, কাজের তদারকি করা ও রিপোর্ট দেওয়া, সম্পদ যোগাড় করা এবং বিভিন্ন কর্মসূচীর মূল সংস্থা হিসেবে দায়িত্ব পালন করা। পৌরবিষয়ক বিভাগের অধীনে সুডা বিভিন্ন কর্মসূচী রূপায়ণের ক্ষেত্রে পৌরসংস্থাগুলিকে সহায়তা করবে।

সুডা বিশেষভাবে সহায়তা দেবে নীচের বিষয়গুলিতে ঃ-

১) পৌরসংস্থাগুলির সাথে সংযোগ রাখা।

২) পৌরসভাগুলির সক্ষমতা বৃদ্ধি করা।

৩) আই. ই. সি. / বি. সি. সি কার্যকলাপে সহায়তা প্রদান।

৪) প্রশাসনিক এবং কর্মী সম্পর্কিত বিষয়ে সহায়তা।

৫) হিসাব রাখা, অর্থকরী ব্যাপার এবং সরবরাহ ব্যবস্থা চালু রাখার কাজে সহায়তা।

পৌরসভা ঃ-

পৌরসভা স্তরে কারগরী সহায়তা দেবে রূপায়ণকারী সংস্থা। উদ্দেশ্য সফল করার জন্য কর্মী নিয়োগ যথাযথভাবে হবে।

স্বাস্থ্য কর্মসূচী রূপায়ণের মূল সংস্থা হিসাবে পৌরসভা যে সব কাজ করবে সেগুলি হ'ল ঃ-

- স্বাস্থ্যকর্মী নিয়োগ ও তাদের প্রশিক্ষণ দেওয়া।
- স্বাস্থ্য কর্মীদের চালনা করা।
- পৌরসভার অন্যান্য বিভাগ যেমন জঞ্জাল / রক্ষণাবেক্ষণ ইত্যাদির সাথে যোগাযোগ রক্ষা করা।
- উপস্বাস্থ্য কেন্দ্রে স্বাস্থ্যকর্মী নিয়োগ।
- নিয়মিত রিপোর্ট তৈরী করা ও যথাযথ কর্তৃপক্ষকে পাঠানো।
- উর্দ্ধতন কর্তৃপক্ষের কাছে হিসাব পাঠানো।
- সুডা ও স্বাস্থ্য পরিবার কল্যাণ দপ্তরের সাথে যোগাযোগ রক্ষা করা

Government of West Bengal
Health & Family Welfare Department
Strategic Planning & Sector Reform Cell
Swasthya Bhavan, GN-29, Sector-V,
Bidhannagar,Kolkata-700091.
Telefax: (033) 2357-0955

No. HF/SPSRC/HSDI/2/2008/ 56 Dated April 28, 2008

From : Program Director, BHP
& e.o. Special Secretary.

To : The Principal Secretary,
Municipal Affairs & Urban Development Department
Government of West Bengal.

Sub: Urban Health Strategy.

Sir,

With reference to the discussion of Additional Chief Secretary of our Department with you on the abovementioned subject, Urban Health Strategy as prepared by us is forwarded herewith for your kind perusal & taking necessary action.

Yours faithfully,

/

Program Director, BHP
& e.o. Special Secretary

No. HF/SPSRC/HSDI/2/2008/ 56 Dated April 28, 2008

Copy forwarded to :
Dr. Shibani Goswami, Health Expert, SUDA

Program Director, BHP
& e.o. Special Secretary

THE URBAN HEALTH STRATEGY
GOVERNMENT OF WEST BENGAL

Background:

The mission of the Government of West Bengal is **"To improve the health status of all the people of West Bengal, especially the poorest and those in greatest need"** as stated in the West Bengal Health Sector Strategy (2004-13).

According to the Census of India 2001, the urban population of the state stands at 22.4 million, which is 28% of its total population of 80.2 million. Historically, the percentage of urban population in the state has always been higher than the national average. The state ranks first in respect of the average population density in urban areas (approximately 6745 per Sq Km) and fourth in terms of absolute size of urban population amongst all Indian states.

West Bengal has experience of implementing successful urban health programmes in several parts of the state. However the state does not have a well structured and clearly articulated statewide urban health strategy. A multitude of health care providers exist with different jurisdictional areas and varying statutory responsibilities. This poses management and implementation problems and fragments efforts. Further, there is a lack of organized and coordinated primary health care services in urban areas. Hence a consistent and focused approach to urban health is imperative

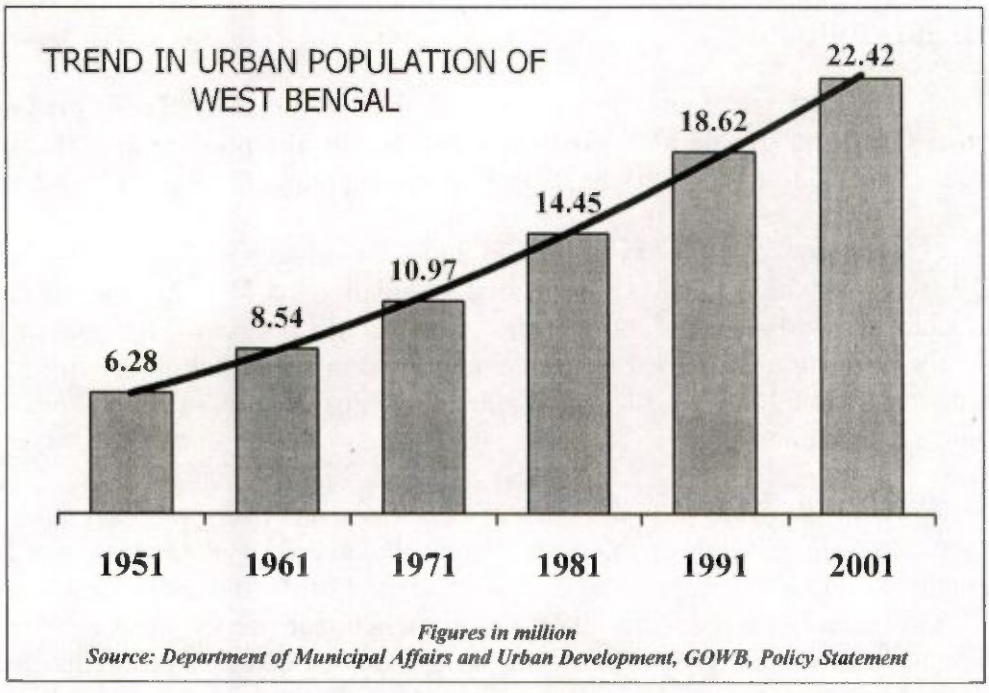
The Government is now committed to ensuring accessible, equitable and quality health care services to the urban population of the State. Towards this end the Department of Health & Family Welfare (DHFW) and Department of Municipal Affairs & Urban Development (DMA & UD) propose to contextualise the strategic framework within which the State shall seek to address the health concerns of the urban poor.

Current Urban Health Scenario in West Bengal

Urbanization in West Bengal

The urban population of West Bengal has had an upward spiral though the rate of increase has slowed down in recent years.

The trend in urban population is depicted in the following table :



Figures in million

Source: Department of Municipal Affairs and Urban Development, GOWB, Policy Statement

The number of various urban units in West Bengal in 2001 is as follows :

Municipal Corporation	Municipalities
6	120

Health Infrastructure in Urban West Bengal

The public health infrastructure of West Bengal is overstretched due to the huge population pressure on the state and because of the fact that a lot of curative services are also rendered through the public healthcare delivery system. 76% of all health institutes in the state are run by the government, compared to 40% in other parts of India (West Bengal Human Development Report 2004).

From the Mapping of Health Infrastructure in Urban Local Bodies in West Bengal (executed by West Bengal Municipal Association), it is found that the health infrastructure in the 126 municipalities is a collage with different combinations of facilities available, ranging from abundance to paucity. There are towns with plentiful health facilities – government, private and community-based interventions. On the other hand, there are towns, which do not have a minimum health infrastructure.

Health infrastructure in the municipalities is divided in four categories viz.

1. Hospitals, health centres and sub-centres supported by the State Health Department.

2. Facilities owned by the other government departments,

3. Municipality controlled facilities and

4. Private sector facilities.

A major problem is inequitable distribution of health facilities in the different categories of municipalities, especially the facilities owned by the municipalities. 25% of the facilities are taken away by the 4% of the municipalities and 50% of the facilities are enjoyed by only 12% of them. Cold chain is another factor that requires to be looked into to ensure efficacy of vaccines. It was found that only 40% of the municipalities have control over their cold chain, for others they depend on the State Health Department. (West Bengal Municipal Association, 2005).

Facilities owned by government organizations and other government departments, like jail hospitals and ESI hospitals, serve special groups of people and are hence inaccessible to the general population.

Private facilities are abundant in some municipalities and bridge the gap between demand and supply. These include private nursing homes, a large group of private practitioners, a few NGO initiatives and quacks. These available facilities are concentrated in bigger towns and small municipalities are dependent on rural infrastructure located in municipal areas. There are super specialists physicians practicing side by side with unqualified Rural Medical Practitioners (RMPs). No information flows from the private agencies to the government system. As a result services provided by them remain unaccounted for. In the absence of a stringent quality assurance system, the quality of health care in private sector is always under question.

Urban Health and Disease Burden

Unfortunately, policymakers do not have enough information on the health conditions of the urban poor. Where there is data specific to the health of the urban populations, it often suffers from at least some weaknesses. First, health data is usually aggregated to provide an average of all urban residents - wealthy and poor - rather than disaggregated by income or a wealth. It thus masks the health conditions of the urban poor. Second, the urban poor are often overlooked altogether. The informal or often illegal status of low-income urban settlements contributes to the fact that public health authorities often do not have the means or the mandate to collect data on urban poor populations. Further, health data are usually based on household surveys. This means that most surveys do not count the homeless.

Communicable diseases are a major problem in urban populations in general and slum populations in particular. "High levels of overcrowding also make poor urban residents vulnerable to contracting communicable diseases such as tuberculosis, acute respiratory infections, and meningitis. Vaccine-preventable diseases such as measles spread more rapidly in overcrowded urban areas among non immunised populations. Inadequate provision for drainage can increase risk of malaria as its mosquito vector breeds in flooded areas and ditches; inadequate provision for sanitation often raises the risk of urban dengue and yellow fever because the vector breeds in latrines, soakaway pits, and septic tanks... High rates of HIV/AIDS are becoming an increasingly distressing fact of urban life in developing countries. " (Lancet Millennium Project series, March 2005).

Recent years have seen a series of out break of vector borne diseases like Dengue, Malaria and water borne diseases like Hepatitis A and acute Diarrheal diseases in various Urban Local Bodies (ULBs). There have been reported deaths besides acute ill health, burdening the already stretched health system. This reflects the inadequacy of the ULBs to prevent these situations and to respond effectively and rapidly to contain the outbreaks.

Recent SRS data available for the year 2006 shows an appreciable improvement in the birth rate in the urban areas down to 12.3 and an infant mortality rate of 29 per 1000 live births. However, it is assumed that these averages are a result of the improved status in the 41 Kolkata Municipal Area municipalities and 22 others (a total of 63 municipalities) which has had dedicated programme with external assistance since 1992. The 63 municipalities, which do not have any dedicated health programme, are also the ones, which have a distinct disadvantage in terms of geographical location (further away from Kolkata), very poor health service facilities (Mapping Of Health Infrastructure In Urban Local Bodies, November 2005, West Bengal Municipal Association).

Disaggregated data for urban poor women's fertility, contraception usage and attended delivery data is not available currently however, the overall indicators for these outcomes is available for the state as a whole and several of the health indicators (notably MMR, NMR, IMR and TFR) for West Bengal are better than their national equivalents.

The following tables reveal the major health indicators for the state.

A comparison of the birth rate and death rate of West Bengal

Birth Rate			Death Rate		
Rural	Urban	Total	Rural	Urban	Total
20.7	12.3	18.4	6.2	6.3	6.2

Sample Registration System 2006

Selected Health and Demographic Indicators for India and West Bengal

Indicators	West Bengal			All India
	Rural	Urban	Combined	
Life expectancy at birth (years)(2000-04)(SRS)	63.0	69.4	64.4	63
Total Fertility Rate (SRS 2005)	2.4	1.4	2.1	2.9
Maternal Mortality Ratio (per 1,00,000 LB)(RGI Survey 2001-03)	-	-	194	301
Current use of contraception by any modern method (NFHS-3) 2005-06	49.9	49.9	49.9	48.5
Female literacy rate (2001 census)	53.2	75.7	59.6	53.7
Infant Mortality Rate (SRS 2006)	40.0	29.0	38.0	57
Neonatal mortality rate (per 1000 LB) SRS 2005	32	20	30	37
Child Mortality Rate (per 1000 LB) (1-5 years) NFHS-3	-	-	12.2	18.4
Child Vaccinations : complete 2002-04 (NFHS-3)	62.8	70.3	64.3	43.5
Perinatal Mortality Rate(SRS 2005)	34	21	31	37
Still Birth Rate (SRS 2005)	9	7	9	9

Strategic issues to be addressed in Urban Health

- Lack of uniform urban health infrastructure and non-availability of primary health care in some urban areas.
- Non existence of appropriate screening and referral system. Secondary and tertiary care often remain underutilized on one hand and on the other, several secondary and tertiary care facilities are often overcrowded in terms of outpatient attendance and inpatient bed occupancy leading to poor quality of services.
- The limited presence of private service providers due to locational disadvantages of some municipalities.

- The limited organizational experience in the delivery of health care in 63 non Kolkata Municipal Area (KMA) municipalities.

- The lack of population based health status data and its implication for planning and benchmarking.

- Poor disease surveillance, absence of appropriate diagnostic services etc. often putting the public health system under strong criticism when the early warning signals for impending outbreaks are not recognized and outbreaks spread.

Experiences and Lessons learnt in Urban Health Care in West Bengal

The State has the experience of various projects (CUDPIII, IPP-VIII, IPP-VIII (Extn.), CSIP RCH Sub Project and HHW's Scheme) covering 63 ULBs. In KMA areas, through the Kolkata Metropolitan Development Authority (KMDA), the Department of Health and Family Welfare (DHFW) has implemented four projects funded by external agencies. The projects are World Bank (WB) funded CUDP-III (1984 – 1992), DFID funded CSIP (1992-1998), WB funded IPP-VIII (1994-2002) and European Commission supported UHIP. Post IPP-VIII funding, DHFW also has the experience and learning from the maintenance phase, which continues till date.

An independent end line survey of IPP- VIII project showed a notable fertility decline among the slum population, marked improvement in maternal and child health as evidenced by a decrease in infant mortality and increased utilization of the RCH services. The projects provided lessons both in implementation and organizational front.

Institutional lessons:

a. Decentralization in administrative and financial matters can create both ownership and local political commitment at the Urban Local Body (ULB) level and lead to strengthened capacity and confidence in managing such programmes.

b. Various community structures (ward committees) along with adequate leadership of the local bodies can work on combating exclusion, mobilizing resources and energy, and achieving effective implementation. The ward committees can help in creating awareness about the project besides providing their inputs in the micro planning for their ward and help facilitate the work of the Honorary Health Workers.

c. Community participation can be encouraged through the ward/block committees in different stages of planning, implementation and monitoring of the programme in their respective wards/block.

d. The deployment of female honorary health workers (HHW) approximately @ 1 per 1000 poor population can be effective in bringing about a major change in the health seeking behaviour and help achieve desired heath outcomes.

e. Use of private practitioners to complement primary clinical care and immunization services through the sub centres work reasonably well, wherever they are available.

f. Flexibility in project design allows for accommodation of local needs and capacities.

g. It is important to clarify the roles and responsibilities of the multiple organizations providing urban health services.

h. It is needed to identify and recognize the marginalized populations like settlements along railway tracks, rag pickers, migrants in squatter colonies etc. to avoid being excluded from the benefits of such projects.

i. A system of repeated and continued refresher trainings for HHW and regular feedback mechanisms are required to make effective use of lessons learned from the field.

Technical Lessons:

a. A formal referral chain with linkages to facilities providing higher-level care should be ensured since stand-alone facilities like maternity homes are difficult to sustain.

b. There is need to include the larger urban population for preventive and public health intervention.

c. Service package should include a mix of public health and primary level curative care in addition to emphasis on preventive and promotive care.

d. There is need for population based health status data and it being factored in local planning.

The Urban Health Strategy outlines some broadly common objectives and operational strategies for all ULBs but it would be adequately adapted to the local needs, priorities and available resources depending on the commitment and capacities of the ULBs and other key stakeholders.

Goal:

The goal of the Urban Health Strategy of the Government of West Bengal is:

Improved health for all urban populations with special focus on poor, underserved and vulnerable population

Objectives:

- To decrease maternal, child and infant mortality by providing better and consistent quality services to families in urban areas with special focus on urban poor, underserved and vulnerable populations through enhanced demand and universal access to quality services.
- To reduce the prevalence of communicable diseases currently covered by the national health programmes and reduce the risk of epidemic outbreaks by reducing exposure to health risk factors.
- To improve the quality of basic health services by providing supervisory, managerial, technical and interpersonal skills to all levels of health functionaries.
- To generate awareness and enhance community mobilization through IEC/BCC to supplement and make the above interventions effective

Key strategies:

- ❖ Universal coverage – the entire urban population including both APL and BPL to be covered, while keeping the focus on BPL.
- ❖ Strengthening service delivery through a uniform 3-tier service delivery model.
- ❖ Strengthening institutional arrangements and inter departmental convergence.
- ❖ Strengthening monitoring and evaluation.

Key Strategy 1: Universal Coverage

The Urban Health Strategy proposes to target the entire urban population of West Bengal, while keeping the focus on the poor, the marginalized and the underserved.

Key Strategy 2: Strengthening service delivery through a uniform 3-tier service delivery model

A multi pronged approach will be taken to strengthen service delivery through a plethora of measures:

- Institutionalizing the existing 3-tier primary health care model (Appendix-1) by

- Strengthening community out reach through the Honorary Health Worker (HHW) and First Tier Supervisor (FTS) at the sub-center
- Strengthening infrastructure – physical and human resource related (Including introduction of a new cadre of personnel called First Tier Supervisor (FTS) – Public Health to be based at ULBs).

- Strengthening the public health role of the municipalities through establishing standardised outbreak control protocols, etc.
- Preparation of ULB specific action plan to reflect the operational strategies, and address the ULB specific determinants of health.
- Introducing newer models of service delivery where necessary like :
  - Public Private Partnerships (PPPs) with NGOs/private sector for training, data management etc
  - Mobile health care services in hard to reach areas etc
- Adopting and implementing appropriate Behaviour Change Communication (BCC) strategies to improve health communication – this will combine interactive group and interpersonal methods on the ground, mass media initiatives and advocacy with various stakeholders.

Key Strategy 3: Strengthening institutional arrangements and inter departmental convergence

The institutional arrangements will take into account the multiplicity of agencies that will form part of the arrangement and will be planned to be conducive to:

- Strengthening stewardship role of DHFW through establishment of Urban health cell in DHFW
- Strengthening the capacity of Department of Municipal Affairs (DMA) through establishment of an Urban Health Cell with dedicated officials to oversee urban health and strengthening the implementation capacity of the State Urban Development Agency
- Formation of an inter-departmental coordination committee with representation from other key stakeholders like Department of Public Health Engineering, Department of Urban Development, Kolkata Metropolitan Development Agency (KMDA) and Kolkata Municipal Corporation (refer Appendix-2 for chart on institutional arrangements for Urban Health)
- Formation of a health committee under the District Health and Family Welfare Samity, under the Chairmanship of the District Magistrate to liaise with the ULB level health and family welfare committees.
- Defining the roles and responsibilities of the departments, including patterns of fund flows.

- ULB and ward level health committees to coordinate multi departmental response including, but not limited to:
    - Water quality management, solid waste management, sanitation and hygiene, tracking of seasonal disease outbreaks, compulsory reporting of all notifiable disease from all health facilities and undertaking vector control measures.
- To continue with the decentralisation of management and implementation of the program to the municipalities
- Improved capacity of human resources at all levels – community level, ULB level and at the level of State Urban Development Agency
- To establish, at the Municipality level, mechanisms for referral linkages with the District and the Block facilities of the DHFW.

Key Strategy 4: Strengthening Monitoring and Evaluation

The UH strategy will enable establishment of the necessary institutional and financial requirements to have a well-functioning Monitoring and Evaluation (M&E) system ensuring measurement of performance and impact to become regular and hence able to continuously inform the planning process.

The M&E will work in the overall framework of the HMIS for the DHFW and MA & UD and will include, but not be limited to:

- Establishing routine monitoring systems and its implementation in consultation with both departments (Refer Appendix 3)
- Designing systems to record and capture early warning signals for impending outbreaks in order to improve epidemiological surveillance and disease prevention
- Periodic surveys to capture health status of the urban population

APPENDIX 1

SERVICE DELIVERY MODEL

Service Delivery Model:

The programme envisages implementation of a multi level service delivery model supporting a strong community outreach intervention. The service package will include apart from emphasis on preventive and promotive care a mix of public health and primary level curative care.

The First Tier – Community outreach through Honorary HealthWorkers(HHWs)

The objective of the community outreach is to move the health care from institutions to the doorstep with access of all beneficiary households to Honorary Health Workers (HHWs). The community level operational strategy will be to include both urban poor and the general population. For the Urban Poor an intensive approach including regular home visits and maintaining a Family Health Card will be initiated. A community outreach clinic providing basic preventive and promotive services will be provided close to their habitation. (refer to the 2nd tier – sub center)

The service delivery will be expanded to all municipal population through initiation of outreach services using female honorary health workers (HHWs) to be recruited from urban communities. This outreach will be organized with the Ward as the geographical unit. The Ward Councilor/ Ward Health sub committee would be providing support and oversight.

For the general population the approach would be to provide Public Health inputs through various educational and service strategies included under various National Health Programmes.

The number of HHWs per ULB will be determined by the number of urban poor in that ULB distributed at one HHW per 1000 poor population or the number of wards whichever is more. The municipalities will allocate the HHWs according to the agglomeration of low socio economic population in a ward.

The Second Tier - Sub Centre

This will be designated as Sub Centre and will cater to a population of 5000 urban poor from a cluster of wards, such that it provides a much better level of primary health care and introduce more flexibility in its timings. The sub centre will be closer to the community and the municipality, aided by the GIS maps for optimum location.

A First Tier Supervisor (FTS) will be selected from amongst the HHWs after at least six months experience and an additional training input. These FTS will be allocated

responsibility at the sub centres and provide support to five HHWs in their outreach work and will manage the sub centre. First Time Supervisor (FTS) will be providing counseling plus basic primary care.

There will be another category called the FTS – Public Health who will be responsible for 20,000 general population in terms of the public health inputs. They will be part of the ULB team and work under the supervision of the Health Officer (HO) of the ULB.

The Sub Centre will be manned by a FTS and a Medical Officer (part time).

A structured Monitoring and supervision schedule will be in place and training of the FTS will include developing skills for appropriate supportive supervision of work undertaken through monitoring Indicators.

The Third Tier- Referral Facility

The referral Facility - the third tier of support will be a Block Primary Health Centre (BPHC)/Rural Hospital/Sub Divisional Hospital/ District hospital. Where these are not accessible or the municipalities have successfully implemented maternity homes, then these can be used as referral facilities.

In 15 ULB where no such DHFW secondary facility exists, an Urban Health Centre under the management of the DHFW will be set up. This facility will serve as a daily OPD besides providing preventive interventions not available at the sub center.

Package of Services

First Tier : Community Outreach through Honorary Health Workers (HHWs)

The HHW will provide the following services, at the minimum,

- Fortnightly visit to at least 200-300 households. Daily at least 15-20 houses are required to be visited. The family schedule to be updated in every visit noting births and deaths including entry of newborns, new comers and deletion of those died or left permanently and whether the birth was under a safe hand or in a institute
- Enquiring about pregnancies and registering them. Enquiring about abortion and MTP and noting the same
- Focused counselling on antenatal care and providing them referral slips to visit the sub-centre.
- Enquiring about immunization status of mother and infants and children.

RCH

- Identifying malnourished children, motivation and referral slips to sub-centre

- To distribute contraceptives
- Referral for institutional delivery/ emergency referral
- Motivating and taking the mother / pregnant women / children to the sub centre for immunization.
- Encouraging the pregnant mothers to visit the sub centre for ANC check up by the PTMO
- Information, education and communication: breast feeding, contraceptives, diet, ORS, personal hygiene, immunization, environment including general cleanliness, promoting institutional delivery and utilization of existing institutions, etc
- Encouraging mothers to go in for institutional delivery.
- To hold mothers meeting

RCH- Linked activities

- Follow up of referrals
- To assist in outreach immunization activities
- To assist in immunisation campaign whenever undertaken: Pulse polio etc

Public Health – Direct

- While Enquiring about any death in the family; ascertain whether the death is from any listed communicable diseases.
- Enquiring for occurrence of important identified communicable diseases in the house during the period from last visit till present and looking for any current illness in the family ; noting the same and advising accordingly.
- Preparation of HMIS report including recognition of early warning signals and information to higher level.
- Recognizing danger sign with relation to ARI, Diarrhoea etc. and advising on initiation of treatment and referral whenever needed
- Distribution of ORS and demonstrating preparation of ORS
- To motivate adolescent boys and girls/men and women through referral to appropriate treatment centres
- Liaison with community leaders
- Participating in the ward committee meeting

Public health – Linked service

- Support to National Health programs
- Support to outbreak investigation etc
- HHW will be accountable to ward committee/ councillor

Second Tier: Sub Centre

This will be designated as Sub Centre and will cater to a population of 5000 urban poor such that it provides a much better level of primary health care and introduce more

flexibility in its timings. The Sub Centre will be manned by a FTS and a medical officer and will offer the following minimum services:

- Child health care services including immunization, distribution of IFA, Vitamin A, ORS packets etc.
- ANC services and counseling for institutional delivery.
- Promotion of Family Planning - oral pills, condom use, counseling for adoption of terminal methods.
- Primary treatment of common ailments

The specific services will be delivered through predetermined clinic days as follows:

1. ANC/PNC and Family Planning counseling clinic – two days in a month.
2. Immunization Clinic – Once a week.
3. General treatment clinic by Doctor – Once a week.
4. Growth Monitoring of U-5 children Clinic – Once a month.
5. Health Awareness Programme – Once in a fortnight.

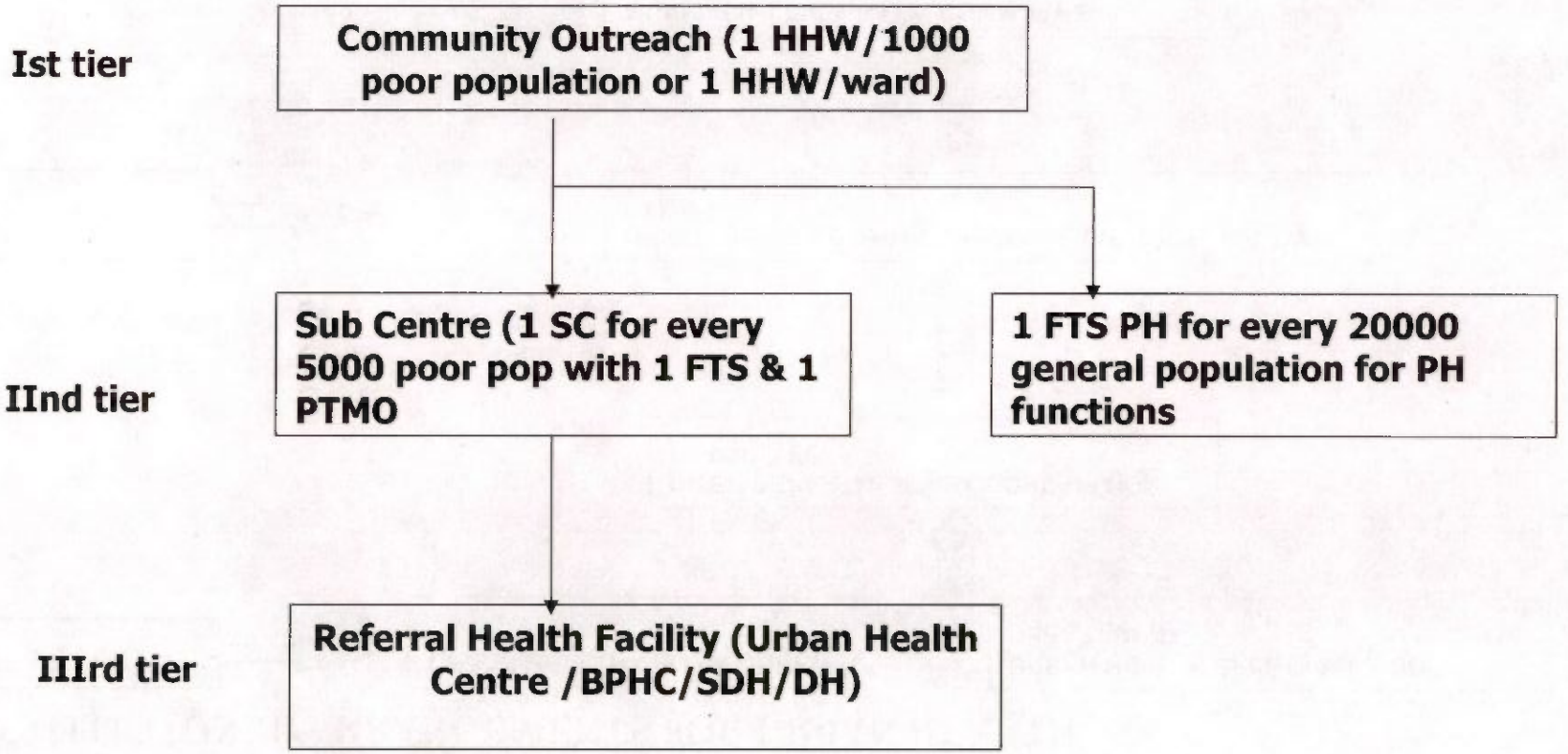
The Third Tier- Referral Facility:

The referral Facility the third tier of support will be a BPHC/Rural Hospital/Sub Divisional Hospital/ District hospital.

The facilities available will include a minimum of the following services:

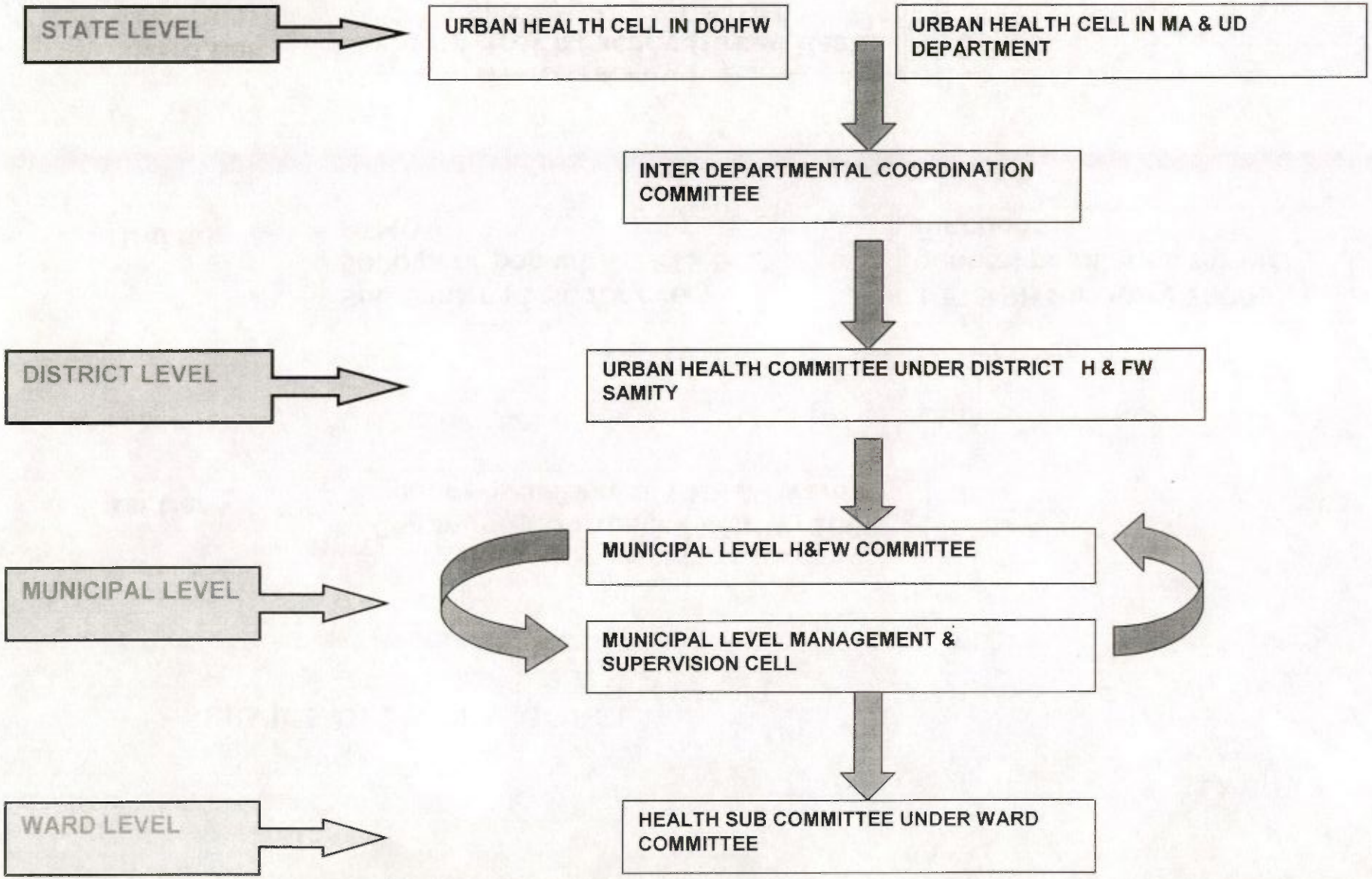
- Full range of Family Planning services including laparoscopic services.
- Institutional Delivery services
- Essential and Emergency Obstetric Care
- MTP services
- Child health referral services including essential and emergency newborn care.
- Basic medical and surgical services.
- Services under national disease control programmes

SERVICE DELIVERY MODEL

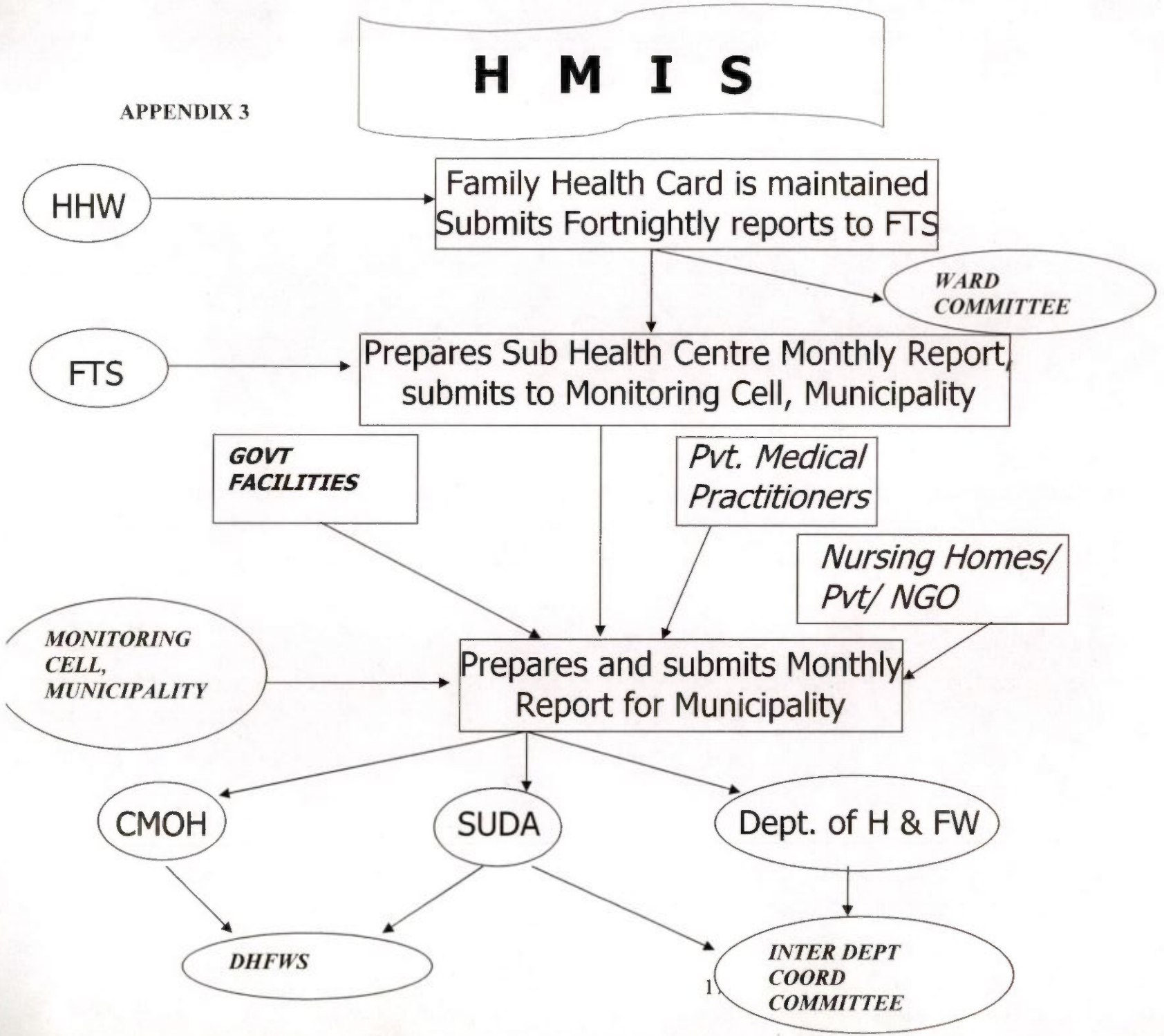


APPENDIX 2

INSTITUTIONAL ARRANGEMENTS FOR URBAN HEALTH



APPENDIX 3

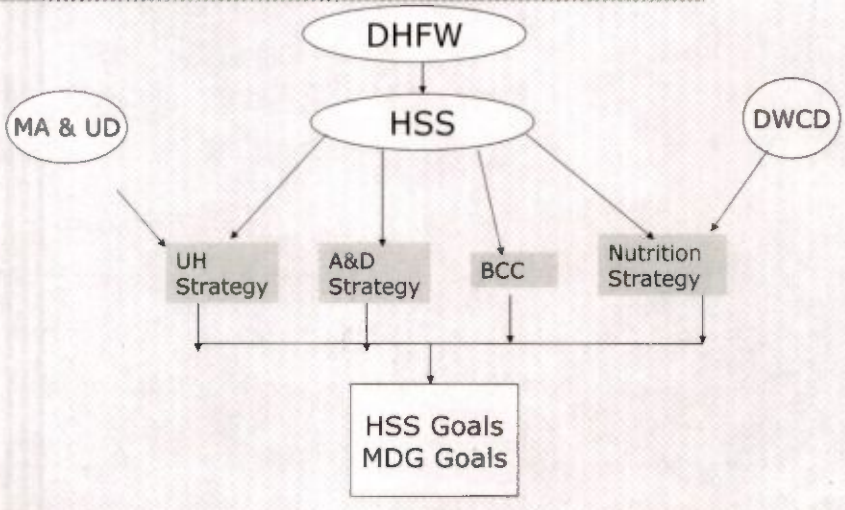

H M I S
HHW
Family Health Card is maintained
Submits Fortnightly reports to FTS
WARD COMMITTEE
FTS
Prepares Sub Health Centre Monthly Report, submits to Monitoring Cell, Municipality
GOVT FACILITIES
Pvt. Medical Practitioners
Nursing Homes/ Pvt/ NGO
MONITORING CELL, MUNICIPALITY
Prepares and submits Monthly Report for Municipality
CMOH
SUDA
Dept. of H & FW
DHFWS
INTER DEPT COORD COMMITTEE

Dr. Grewal
on
28/3

Draft Urban Health strategy – West Bengal

DoHFW

Linkage with HSS



Major Concerns in Urban Health

- Lack of uniform urban health infrastructure
- Non-availability of primary health care in many areas. No organized well-planned effort to provide properly linked primary, secondary and tertiary care services in geographically delineated urban areas.

Major Concerns in Urban Health(contd..)

- Poor disease surveillance, absence of appropriate diagnostic services etc often puts the public health system under strong criticism when the early warning signals for impending outbreaks are not recognized and outbreaks spread.

Goal

- Improved health for all urban population with special focus on poor, underserved, vulnerable population

Objectives

- To decrease maternal, child and infant mortality by providing better and consistent quality services to families in urban areas with special focus on Urban poor .
- To reduce the prevalence of communicable diseases currently covered by the national health programmes and reduce the risk of epidemic outbreaks by reducing exposure to health risk factors.

Objectives

- To improve the quality of basic health services by providing supervisory, managerial, technical and interpersonal skills to all levels of health functionaries.
- To create awareness generation and enhance community mobilization through IEC to supplement and make the above interventions effective

Lessons learnt

Independent end-line survey of IPP-VIII project (2002), CUDP-III, and PWC-Action Aid report

- Notable decline in fertility, reduction of IMR, marked improvement of MCH services and their enhanced utilization in urban slums.
- Fair degree of decentralization achieved
- HHW role was effective in bringing a major favorable change in health seeking behavior and developing linkage with health system

Lessons learnt...cont'd

- Wherever available Private Practitioners complemented primary clinical care and immunization services. However, there were issues related to their remuneration and nomenclature.
- A formal referral linkage with facilities providing higher level care could not be ensured.
- Marginalized populations like settlements along railway tracks, rag pickers, migrants workers have not been specially focused.

Key strategies

- Universal coverage - whole population of APL and BPL, while keeping the focus on BPL
- Strengthening service delivery through a uniform 3 tier model
- Strengthening institutional arrangements and inter departmental convergence
- Strengthening monitoring and evaluation including disease surveillance

Universal coverage

- Increase the reach of the program by bringing the whole population of APL and BPL, while keeping the focus on BPL

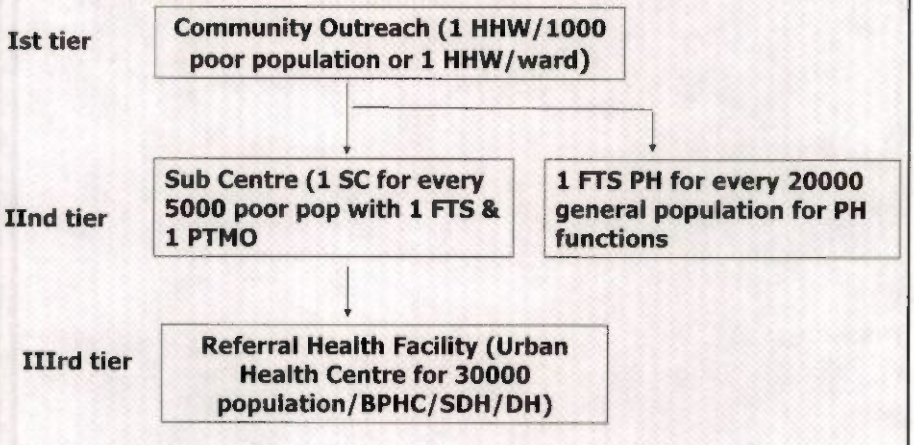
Strengthening service delivery

- Institutionalizing the existing 3 tiered primary health care model by strengthening community out reach (by HHW),Sub-center (FTS), and infrastructure – physical and professional
- Preparation of ULB specific action plan
- Renovation/ up gradation and re-organization of existing infrastructure support facilities at ULB level, (supporting existing hospitals/maternity homes run by ULBs)

Service Delivery (contd..)

- Introducing newer models of service delivery where necessary
  - PPP with NGOs/private sector for training, data management etc
  - Mobile health care services etc
- Strengthening the public health role of the municipalities through establishing standardised outbreak control protocols etc.
- Adopting and implementing appropriate IEC / BCC

Service Delivery Model

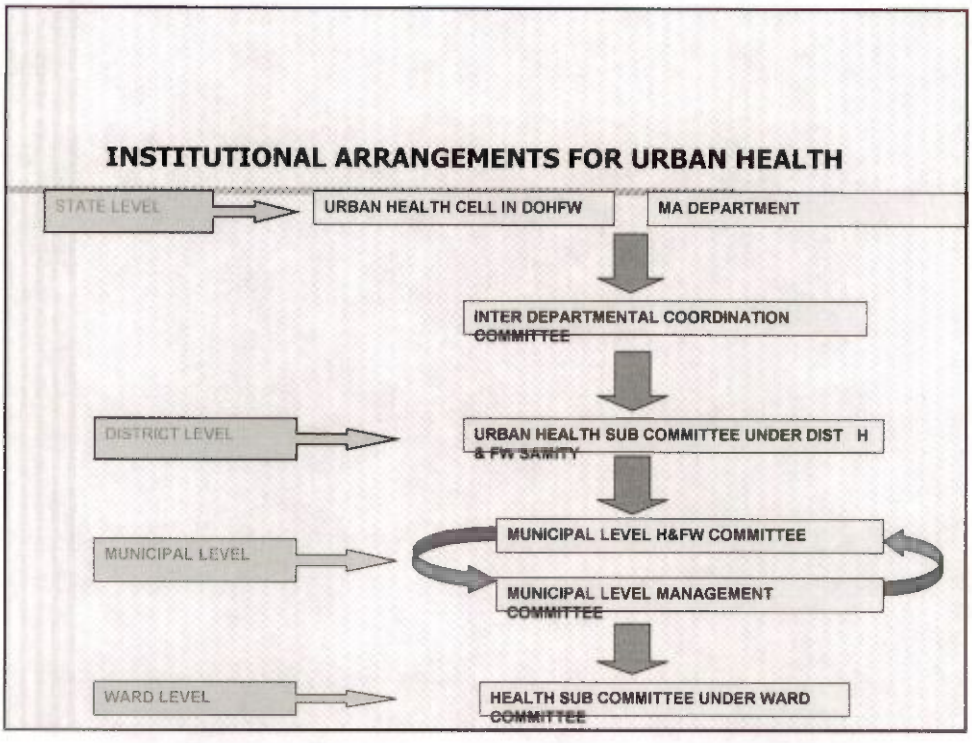


Institutional arrangements

- Strengthen steward ship role of DoHFW through establishment of
  - Urban health cell with dedicated officials
  - Interdepartmental coordination committee
- ULB and ward level health committees to coordinate multi departmental response including but not limited to :
  - Water quality management, solid waste management, sanitation and hygiene, vector control, tracking of seasonal disease outbreaks, compulsory reporting of all notifiable disease from all health facilities

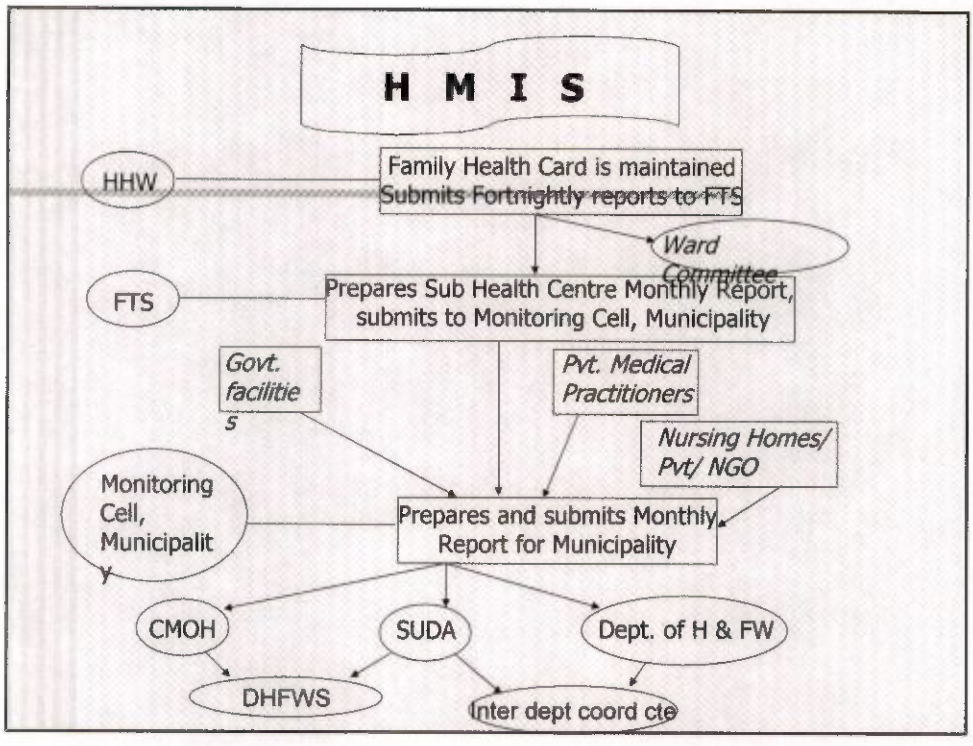
Institutional arrangements

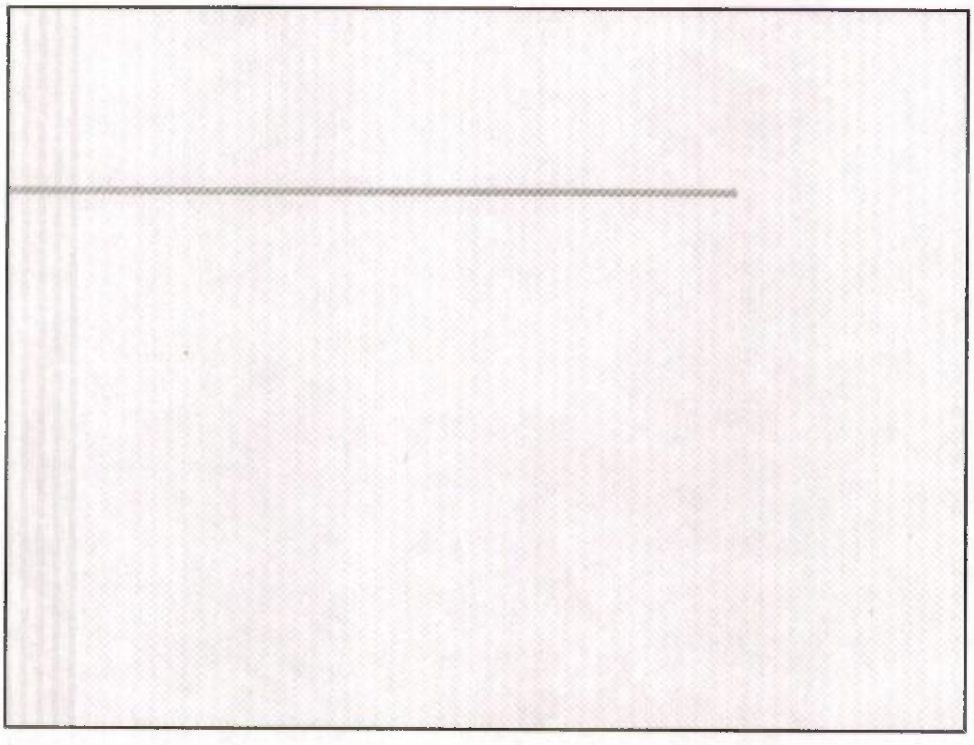
- To continue with the decentralisation of management and implementation of the program to the municipalities
- Improved capacity of human resources at all levels – community level, ULB level and SUDA
- To establish, at the Municipality level, mechanisms for referral linkages with the District and the Block facilities of the DHFW
- Delineating roles and responsibilities of the departments,including patterns of fund flows.
- Establishing mechanisms for inter departmental convergence(MA & UD,PHE and CMDA)



Monitoring and Evaluation

- Uniform monitoring systems to be designed and implemented in consultation with both departments
- Systems to record and capture early warning signals to be designed
- Periodic surveys to capture health status of the urban population


H M I S
HHW
Family Health Card is maintained
Submits Fortnightly reports to FTS
Ward Committee
FTS
Prepares Sub Health Centre Monthly Report, submits to Monitoring Cell, Municipality
Govt. facilities
Pvt. Medical Practitioners
Nursing Homes/ Pvt/ NGO
Monitoring Cell, Municipality
Prepares and submits Monthly Report for Municipality
CMOH
SUDA
Dept. of H & FW
DHFWS
Inter dept coord cte



Annexure-I

Confidential

Urban Health Strategy framework, West Bengal, India – Draft for discussion

Background:

West Bengal Government aims at contributing to the overall improvement of the health status of West Bengal population living in urban areas, with particular emphasis on poorer sections of urban municipalities. More specifically, it aims at providing comprehensive primary health care to all sections of urban communities through a decentralized health care delivery system. This state commitment is also echoed by the Government of India which has identified "Urban Health" as one of the thrust areas in National Population Policy, 2000; National Health Policy 2002 and in the current Phase of the Reproductive Child Health Program (RCH II).

West Bengal has experience of implementing good urban health programmes in the state however; there is no well structured and clearly articulated statewide urban health strategy. With a multitude of health care providers having different jurisdictional areas and varying statutory responsibility, there is not a consistent approach to urban health thus resulting in fragmentation and sometimes lack of focus. In the absence of a comprehensive urban health strategy multiplicity of agencies providing urban health services also poses management and implementation problems and fragments efforts thereby preventing the desired health outcomes. Concurrently, Rapid urbanization in India, and the significant growth of the urban population in absolute numbers, has made new and greater demands on urban infrastructure and service delivery.

West Bengal Government feels the need for the development of Comprehensive Urban Health Strategy to provide a logical framework and rationalize decision-making and achieve optimal potential of the urban health initiatives. The focus will be on empowering and mobilizing the ULBs to improve the health of communities by enabling the establishment of public health policies of the state, active community participation, the creation of supportive environments, the strengthening of health services, and the promotion of healthy lifestyles.

Cities and towns not only are growing in size and number, they also are gaining new influence. Political and fiscal decentralization, under way in all regions, means that municipal authorities now have greater authority—if insufficient capacity— to take charge of the local services that affect the daily lives of its population.

Cities are the engines of economic growth and the agents of cultural and political transformations in developing countries. Access to urban services is a key factor for improved quality of life among urban dwellers, particularly to the poor who make up from a fifth to more than half of citizens in Asian cities

Urban health risks and concerns involve many different sectors, including health, environment, housing, energy, transportation, urban planning, and others. These concerns have led to cities acquiring centrality in the achievement of the Millennium Development Goals. In recognition of this Mayors and Deputy Mayors of more than 125 cities from across the world, supported by representatives of Provincial and National Governments, Representatives of Academic, National, International Organizations and Associations, NGOs and Civil Society Stakeholders took the following resolution at the Conference on Millennium Development Goals and the Role of Cities held from 2-4 April 2005 in Cochin, India.

Resolution taken at Conference on Millennium Development Goals and the Role of Cities, 2-4 April 2005, Cochin, India

- To closely look at MDGs in our own city context and give to ourselves target that we shall commit to achieve.
- To frontload concerns in regard to poverty reduction, education, gender, child and maternal mortality, HIV/AIDS, malaria and other diseases and environmental sustainability in all city activity.
- To commit and allocate resources for the implementation of city targets focusing on slums and other vulnerable groups.
- To engage with city stakeholders and afford them space in decision-making
- To promote partnerships in all city initiatives, and
- To harness new, especially information and communication technology to re-engineer processes, improve service delivery and provide all citizens the fruits of good urban governance.

Urban poverty - Context and the people.

Of the world's 6.2 billion inhabitants, about 60 per cent live in Asia. The Asian region is only 54 per cent urban but its annual urban growth rate (3.2 per cent) is much higher than the rural (0.8 per cent). Between 2000 and 2030, cities and towns in less developed regions will absorb almost all of the world's urban population increase. In Asia, it is projected that by 2030, there will be 1.4 billion urban residents, a total larger than the combined urban population (1.2 billion) of Europe, North America, Latin America and the Caribbean, and Oceania (United Nations 2001:5). This will account for more than 90% of the world's urban population growth by 2030 and any effort to measurably improve global health outcomes will need to address urban reform.

The absolute numbers of urban residents continue to grow rapidly...

The urbanization of independent India

During the first census in 1951 India was primarily a rural country. Of the approximately 340 million population, 82.7 percent lived in as many as 557,409 villages. In contrast, there were only 2845 towns in 1951, and only 17.3 percent of the population was urbanized. Since then, over the last five decades, India's population has grown to more than 1000 million and the urban population has grown to 27.3 percent of the entire population, which means 285.3 million, a number close to the total population at the time of independence. The urban scenario here, and perhaps in all of South Asia, is drastically different from that in many other parts of the world. It is postulated that while the rural growth rate will drop, the urban growth rate will continue to rise in the next couple of decades. Population projections indicate that by 2025, about 40% of India's population will be urban. The urban scenario here, and perhaps in all of South Asia, is drastically different from that in many other parts of the world. It is postulated that while the rural growth rate will drop, the urban growth rate will continue to rise in the next couple of decades. Population projections indicate that by 2025, about 40% of India's population will be urban.

South Asian countries have high levels of urban poverty. The World Bank has estimated that the number of poor people in South Asia has increased from 474 million in 1987 to 522 million in 1998 (World Bank 2000).

Of the 1.2 billion people in the world classified as poor in 2000 about 800 million (67 per cent) were living in Asia. As in other developing regions, rural poverty in Asia is acknowledged to be more severe than urban poverty. However, because poverty in cities is much more visible, policy makers are increasingly becoming more concerned about urban poverty. This concern is also prompted by the growing disparity between the living conditions of the very rich and the very poor in cities and towns. Some people fear that this widening gap may pose threats of insecurity, instability, ethnic conflicts and violence.

Urbanization and Poverty Levels in Asian Counties

Table 1

Region and Country	Total Population (Millions)	Urban Population (Millions)	Per Cent Urban	Urban Population Below Poverty Line (Per Cent)
South Asia				
Bangladesh	129	31.6	24	37
India	1,082	288.0	28	31
Nepal	24	2.8	12	23
Pakistan	156	45.0	34	22
Sri Lanka	19	4.5	24	25
Southeast Asia				
Cambodia	11	1.7	16	21

Indonesia	212	86.8	41	18
Malaysia	24	12.4	53	4
Philippines	82	44.2	54	22
Thailand	63	13.0	21	10
Vietnam	83	19.0	23	10
East Asia				
China	1,300	408.0	34	10
Hong Kong	7	7.0	100	10
Korea (Republic of)	47	38.5	82	7

Sources: Information on Bangladesh, Cambodia, India, Indonesia, Nepal, Philippines, and Sri Lanka are from *Urban Profiles (2002)*, published by the US Agency for International Development (USAID). Other country data are from the UN Centre for Human Settlements (Habitat), the World Bank, and the UNDP Human Development Index.

Within the cities, the quantum of people living amidst poverty conditions is also growing. Official estimates of slum populations, which are generally accepted as being on the lower side, account 21% of the total urban population to be living in slums. In mega cities such as Mumbai, 54.1% of the population resides in slum settlements with a population of 6.5 million. In Kolkata, 32.5% of the population resides in slums with a population of 1.5 million. In Delhi, 18.7% of the population resides in slums with a population of 1.9 million while in Chennai the slum population is 0.8 million which is 18.9% of the total population (Census of India 2001).

Urbanization across the states:

Among the major states, Tamil Nadu is the most urbanized state with 43.9 % of the population living in urban areas followed by Maharashtra (42.4 %) and Gujarat (37.4 %). The proportion of urban population is the lowest in Himachal Pradesh with 9.8% followed by Bihar with 10.5 %, Assam (12.7 %) and Orissa (14.9 %). In terms of absolute number of persons living in urban areas, Maharashtra leads with 41 million persons, which is 14 % of the total population of the country. Uttar Pradesh accounts for about 35 million followed by Tamil Nadu with 27 million. (Ministry of Urban Development, Government of India).

The urban population of West Bengal has had an upward spiral though the rate of increase has slowed down in recent years. According to the Census 2001 (provisional), the urban population of the state stands at 22.5 million, which is 28% of its total population of 80.2 million.

In terms of the absolute numbers living in urban areas, Maharashtra leads with 41 million – 14 percent of the total Indian population. Uttar Pradesh accounts for about 35 million, followed by Tamil Nadu with 27 million. Overall, the rate of urban growth in India has decelerated from an accumulated 36.5 percent in 1981-1991 to 31.4 percent in 1991-2001. However, the absolute numbers of urban residents continue to grow rapidly with

the addition of 67.8 million urban residents in 2001 to the 1991 figure. Taken together, the urban poor in India would constitute the 14th largest country in the world.

The main causes of urbanization can be found in the natural increase; migration, both from rural and other urban areas; and the reclassification of formerly rural areas as urban.

Poverty in the urban context

Studies of urban poverty in Asia suggest that as countries achieve higher levels of economic development, the patterns of urban poverty changes. These changes are associated with key factors such as: (a) location of the poor in urban space; (b) time of migration; (c) educational level and types of skills; (d) gender and family structure; and (e) level of economic development.

Gender and Family Structure – Female headed households are more likely to be poorer than families where both parents are together. Lacking basic resources, poor families tend to give boys more opportunities for education and training than girls as girls can help in the home and look after younger siblings. Urban poor families also tend to have larger families because many women in urban poor areas often lack information about reproductive health and rarely have access to contraceptive methods. Studies of street children forced to fend for themselves in urban areas often cite breakdown of family ties as a primary reason for their being away from home.

Across the world, a rise in the numbers of the poor and the undernourished in urban areas have accompanied growing urbanization. According to an estimate by the Planning Commission of India for the year 1999-2000, the number of poor living in the urban areas was about 24 percent of the urban population – a substantial number despite the decline from about 32 percent in 1993-94. The ratio of poverty in urban areas in 1999-2000 (23.6 percent) was not all that much lower than that in rural areas (27.1 percent).

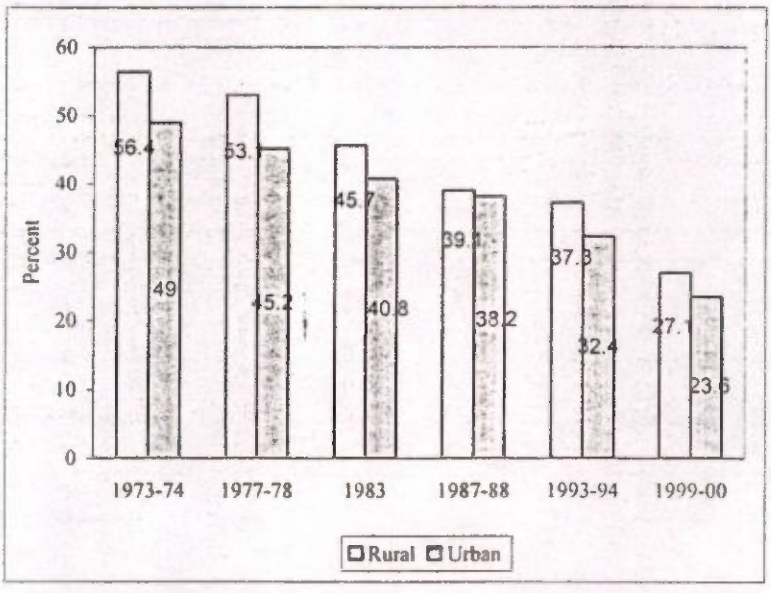
The nature of urban poverty

Poverty has many dimensions, with material deprivation (commonly measured in terms of income or consumption) being one important element. But urban poverty often has a broader meaning of cumulative deprivation, characterized by squalid living conditions; risks to life and health from poor sanitation, air pollution, crime and violence, traffic accidents, and natural disasters; and the breakdown of traditional family and community safety nets.

According to the ' Food Insecurity Atlas of Urban India' by the M.S. Swaminathan Research Foundation and the World Food Programme, 2002, more than 38% of children under the age of three in India 's cities and towns are underweight and more than 35% of

children in urban areas are stunted. The report mentions that the poor in India's expanding urban areas do not get the requisite amount of calories or nutrients specified by accepted Indian Council of Medical Research (ICMR) norms. It also suggests that absorption and assimilation of food by the urban poor is further impaired by non-food factors such as inadequate sanitation facilities, insufficient housing and woeful access to clean drinking water. It reminds us that more than 21% of India's urban population lives in slums, 23% of urban households do not have access to toilet facilities and nearly 8% of urban households are unable to find safe drinking water.

Figure 1 Trends in rural and urban poverty levels, 1973-74 to 1999-2000[1]



Source: Varma, 2003

Urban development that is geared to the needs of global capital displaces or excludes poorer segments of the population and leads to the social and spatial segmentation of the mega-city into citadels and ghettos. This aspect of urban poverty, not usually captured by surveys is dependent on census data for their sample structure, which is homelessness. Such surveys do not adequately reflect data on the poorest, who not only live in inaccessible areas, but also frequently relocate within the city. Thus the most vulnerable groups, such as rental groups living on the edges of existing slums, as well as homeless and squatter groups, are left out. These urban poor living in temporary and unrecognized dwellings – pavement dwellers and squatters – are seen to lead much more precarious lives compared to those living in recognized slums or urban villages.

The composition of the urban poor

Whether in slums or homeless, the urban poor do not make up a homogenous unit. There are wide variations among and within classes, castes, and states; and aggregate figures often do not reveal the extent of deprivation suffered by many disenfranchised segments.

Between 1991 and 2001, there was a remarkable increase in the number of female workers – 40.6 percent against the total increase in the urban female population of 21.2 percent. And of this increase, 77 percent (60 million) are in the marginal worker category.

Comparing the age distribution of the urban poor and rich (see Table 2), for every child below 14 years in the richest quintile, there are two children among the poorest 20 percent of the population. In contrast, for every two persons above the age of 60 among the poor, there are three people in the richer group.

Table 2

Age-wise distribution of the urban population by asset quintile, NSS 52, 1995-96

Age Category	Poorest 20%	Richest 20%
0 to 14 yrs	43.5	21.2
15 to 59 yrs	52.4	72.5
60 plus yrs	4.1	6.3

Source: Bhandari and Shresth, 2003

Rapid urbanization of India's population has been significant enough to make new and greater demands on urban infrastructure and service delivery. The urban poor comprise a heterogeneous group. While poverty in slums is stark, particularly for those who do not appear in any government listing, it is even worse for the marginalized groups who are either homeless or on the move from one temporary shelter to another. Urban poverty is characterized by food insecurity, extremely poor living conditions, unorganized labor and lack of job security. As a result, the urban poor are vulnerable in multiple ways.

The challenge before the policy makers is to respond with basic infrastructure and social services, including health. A policy to be effective has to take into account issues of the various segments of the urban poor. These issues of unorganized labour, poor income, poor living conditions including woefully inadequate sanitation, social exclusion, and increased vulnerability of women and children – are closely related to poor health outcomes. Since a large proportion of the urban poor are migrants who work in the informal sector without reliable social networks, identifying the associations and informal social institutions that represent the urban poor is the first step to approaching them. Special groups such as women-headed households and street children may remain left out

of benefits unless stronger positive action is taken to address their unique needs and problems.

Current Urban Health Scenario in West Bengal

Urbanization in West Bengal

The urban population of West Bengal has had an upward spiral though the rate of increase has slowed down in recent years. This is partially due to the state policy on agricultural prosperity that has significantly checked the process of rural to urban migration.

According to the Census of India 2001 (Provisional Population Totals), the urban population of the state stands at 22.5 million, which is 28% of its total population of 80.2 million. Historically, the percentage of urban population in the state has always been higher than the national average. The state ranks first in respect of the average population density in urban areas (6798 per sq km) and fourth in terms of absolute size of urban population amongst all Indian states. The sex ratio in the urban areas is 893 while the literacy rate is 81.63%[2].

The urban population of West Bengal stands at 22.5 million, which is 28% of its total population of 80.2

Urban areas in West Bengal are classified under three broad categories:

a) The statutory urban areas like Municipal Corporations, Municipalities, Notified Areas, Cantonment Boards, etc which are declared as urban areas by statute by the State Government.

b) The statutory non-urban areas which qualify to be treated as urban areas for the purpose of census based on the following demographic criteria:
   i. A minimum population of 5,000
   ii. At least 75 per cent of the male working population engaged in non-agricultural pursuits
   iii. A density of population of at least 400 per sq. km.

c) Urban outgrowths attached to a statutory town.

As per the Census of India 2001 (Provisional Population Totals), the various urban units in West Bengal are as follows:

[2] Census of India 2001 (Provisional Population Totals)

TABLE 3

Number of various urban units in West Bengal in 2001

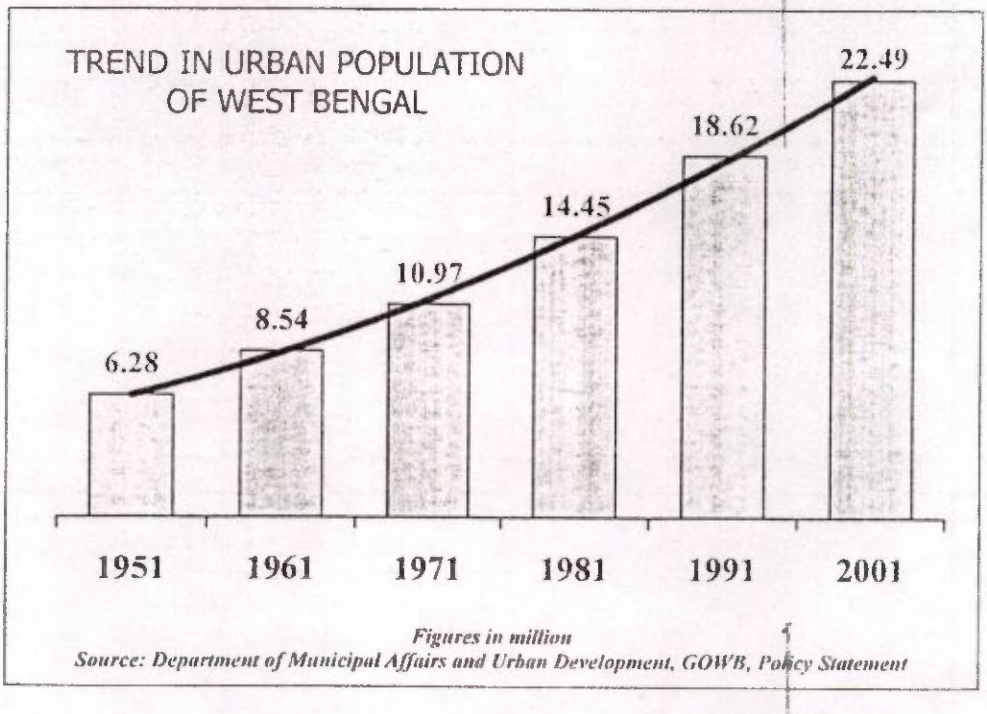
Municipal Corporation	Municipalities	Notified Areas	Cantonment Board	Census Town	Outgrowths
6	113	3	1	252	48

Source: Census of India 2001 (Provisional Population Totals)

As per Health on the March 2004-05, there are 120 Municipalities and 6 Municipal Corporations in West Bengal.
As per the Census of India 2001 (Provisional Population Totals), the various urban units in West Bengal are as follows:

The trend in urban population is depicted in the following table.

Fig 2



Figures in million
Source: Department of Municipal Affairs and Urban Development, GOWB, Policy Statement

Urban Health and Disease Burden

Unfortunately, policymakers do not have enough information on the health conditions of the urban poor. Where there is data specific to the health of the urban populations, it often suffers from at least some weaknesses. First, health data is usually aggregated to provide an average of all urban residents - wealthy and poor - rather than disaggregated by

income or a wealth. It thus masks the health conditions of the urban poor. Second, the urban poor are often overlooked altogether. The informal or often illegal status of low-income urban settlements contributes to the fact that public health authorities often do not have the means or the mandate to collect data on urban poor populations. Further, health data are usually based on household surveys. This means that most surveys do not count the homeless.

Communicable diseases are a major problem in urban populations in general and slum populations in particular. Close to half the urban population in Africa, Asia, and Latin America have one or more of the main communicable diseases associated with inadequate water and sanitation provision—including diarrhoeal diseases and worm infections (WHO. Creating healthy cities in the 21st century. 1999). "High levels of overcrowding also make poor urban residents vulnerable to contracting communicable diseases such as tuberculosis, acute respiratory infections, and meningitis. Vaccine-preventable diseases such as measles spread more rapidly in overcrowded urban areas among nonimmunised populations. Inadequate provision for drainage can increase risk of malaria as its mosquito vector breeds in flooded areas and ditches; inadequate provision for sanitation often raises the risk of urban dengue and yellow fever because the vector breeds in latrines, soakaway pits, and septic tanks... High rates of HIV/AIDS are becoming an increasingly distressing fact of urban life in developing countries. " (Lancet Millennium Project series, March 2005).

Though disaggregated data for various health parameters is not available for the urban areas in West Bengal the overall anaemia status in children, the nutritional status of women in the state, and the more than the average national prevalence of diseases like ARI (24.8 compared to National figure of 19.3), Measles (40% of all reported cases in India in 2001), Neonatal Tetanus (21% of all cases in India) and Diphtheria (17% of all reported cases in India) reflect the need for strengthening the RCH services both in rural and urban areas.

Recent years have seen a series of out break of vector borne diseases like Dengue, Malaria and water borne diseases like Hepatitis A and acute diarrhoeal diseases in various ULBs. There have been reported deaths besides acute ill health, burdening the already stretched health system. This reflects the inadequacy of the ULBs to prevent these situations and to respond effectively and rapidly to contain the outbreaks.

The PWC-Action Aid study (2002) reports, "diarrohea was ranked very highly by both the HHWs and the community people, followed by incidences of respiratory illness, fever and skin diseases. Injuries were another common complaint. Gastrointestinal disorders and genitourinary problems were also common. Tuberculosis also emerged as a serious health concern. One particular PHA exercise found cases of 18 TB patients from one site." The above pattern is typical of the poor who are living and working in largely unsanitary conditions and who are suffering from chronic malnutrition.

The report further revealed high levels of child malnutrition in the communities studied. "This was evident from both visual assessment and by weighing children. Almost all Children between 0-5 years of age were found to be severely malnourished. A detailed

Survey was not attempted. Such an assessment made in the PHA cannot be used to generalize the levels of child malnutrition in the whole population for the areas chosen for PHA were purposively chosen to be the poorer areas. It is only an indirect confirmation of the poor health status of KMDA's poorer sections. All the children assessed had multiple episodes of diarrhoea or recurrent respiratory infections - another concomitant of poor nutritional status."

Recent SRS data available for the year 2004 shows an appreciable improvement in the birth rate in the urban areas down to 12.9 and an infant mortality rate of 32 per 1000 live births. However, it is assumed that these averages are a result of the improved status in the 41 Kolkata Municipal Area municipalities and 22 others (a total of 63 municipalities) which has had dedicated programme with external assistance since 1992. The 63 municipalities, which do not have any dedicated health programme, are also the ones, which have a distinct disadvantage in terms of geographical location (further away from Kolkata), very poor health service facilities (Mapping Of Health Infrastructure In Urban Local Bodies. November 2005, West Bengal Municipal Association).

"Although in aggregate, women in cities have lower fertility rates and better sexual and reproductive health outcomes than in rural areas, findings of a disaggregated review show that poor urban women have worse outcomes than other urban women, in some cases rivaling those of rural residents. Poor urban women also have much higher fertility rates than do other urban women; again, in many regions, fertility rates for poor urban women are similar to those of rural women. Poor urban women are less likely to use Contraception than other urban women, and again in some regions (eg. southeast Asia) their usage rates resemble those of rural women. When poor urban women give birth, they are less likely than other urban women to have these births attended by a physician, nurse, or midwife. Moreover, they are at high risk of contracting sexually transmitted infections, including HIV/AIDS" (National Academy of Sciences. Cities transformed: demographic change and its implications for the developing world. New York: National Academies Press, 2003.)

Disaggregated data for urban poor women's fertility, contraception usage and attended delivery data is not available currently however, the overall indicators for these outcomes is available for the state as a whole and several of the health indicators (notably MMR, NMR, IMR, TFR and CPR) West Bengal are better than their national equivalents.

The following tables reveal the major health indicators for the state.

TABLE 4

A comparison of the birth rate, death rate and natural growth rate of West Bengal

Birth Rate			Death Rate			Natural Growth Rate		
Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
21.8	12.9	19.3	6.4	6.0	6.3	15.4	6.9	13.1

Sample Registration System 2004

TABLE 5

Selected Health and Demographic Indicators for India and West Bengal

Indicators	West Bengal	All India
Life expectancy at birth (years)(2001-06)	67	65
Total Fertility Rate 2003	2.3	3.0
Maternal Mortality Ratio (per 1,00,000 LB) 1998	266	400
Current use of contraception by any method	66.6%	48.2%
Female literacy rate (7+)	59.6%	53.7%
Neonatal mortality rate (per 1000 LB) 2003	30	37
Infant Mortality rate (per 1000 LB) 2004	40	58
Child Mortality Rate (per 1000 1-5 years) 1998	19.9	29.3
Child Vaccinations : complete 2002-04	54.4%	47.6%

Source: SRS, 2004. NFHS 2. DLHS 2002-04 The Health Sector Strategy 2004-2013

TABLE 6

Urban Fertility and Mortality Indicators of West Bengal

Indicator	Year	Urban
General Fertility Rate	2003	49.7
Total Fertility Rate	2003	1.6
Gross Reproduction Rate	2003	0.7
Total Marital Fertility Rate	2003	3.7
Neonatal Mortality Rate	2003	16
Infant Mortality Rate	2004	32
Perinatal Mortality Rate	2003	9
Still Birth Rate	2003	2

Source: Sample Registration System

Health seeking behaviour of the urban poor: -

The PWC-Action Aid study through its participatory health assessments revealed that for the poor, it is the state hospital, rather than the municipality maternity homes, which remains the most accessed referral health service for in hospital RCH services. There are various reasons for this. The poor perceives of the Municipality maternity homes or ESOPDs as either not having location advantages (situated too far away for quick access) or too expensive (cost of treatment perceived as too high for all services but especially for delivery and caesarean sections). Sometimes, especially in the excluded groups and the low access beneficiary groups, lack of knowledge about existing municipality referral centers have also contributed to not accessing of such services.

For outpatient care in illness all the communities with whom PHA was done reported a high dependence on private practitioners. In most cases the first resort to curative care is a private doctor. The respondents reported a high amount of expenditure in each visits.

including spending on drugs and fees. The expenses ranged from Rs.50-Rs.150 on a single visit.

Urban Health delivery framework: Institutional arrangements

Response to urban needs

In stark contrast to this response to the needs of rural areas, there have been few – and patchy – efforts to set up primary health care networks in town areas. In 1982, the Krishnan Committee established a Working Group to reorganize family welfare and primary health care services in urban areas. The Group recommended the development of an urban primary health care network, including the establishment of health posts in Indian cities. These recommendations have only been partially carried out.[3]

It is in recent times that Government of India has made Urban Health an important thrust area of the Tenth Five Year Plan, National Population Policy 2000, National Health Policy, 2002 and RCH-2.

The National Health Policy 2002 recognizes that "...in most urban areas, public health services are very meagre. ...Even the meagre public health services, which are available, do not percolate to such unplanned habitations, forcing people to avail of private health care through out-of-pocket expenditure. ...NHP-2002 will address itself to the need for providing this unserved urban population a minimum standard of broad-based health care facilities".

The Tenth Five Year Plan (2002-2007) states that " Ninth Plan recommendations regarding re-organization of urban primary health care institutions making them responsible for the health care of a population living in a defined geographic area and linking them to existing secondary and tertiary care institutions will be fully implemented during the Tenth Plan".

Health Infrastructure in Urban West Bengal

The public health infrastructure of West Bengal is overstretched due to the huge population pressure on the state and because of the fact that a lot of curative services are also rendered through the public healthcare delivery system. 76% of all health institutes in the state are run by the government, compared to 40% in other parts of India (West Bengal Human Development Report 2004).

The public health infrastructure of West Bengal is overstretched due to the huge population pressure on the state and because of the fact that a lot of curative services are also rendered through the public healthcare delivery system.

From the Mapping of Health Infrastructure in Urban Local Bodies in West Bengal (executed by West Bengal Municipal Association), it is found that the

[3] Report of the Steering Committee on Health, Tenth FiveYear Plan. See GOI, 2002c.

health infrastructure in the 126 municipalities is a collage with different combinations of facilities available, ranging from abundance to paucity. There are towns with plentiful health facilities – government, private and community-based interventions. On the other hand, there are towns, which do not have a minimum health infrastructure.

Health infrastructure in the municipalities is divided in four categories viz.

1. Hospitals, health centres and sub-centres supported by the State Health Department.
2. Facilities owned by the other government departments,
3. Municipality controlled facilities and
4. Private sector facilities.

A major problem is inequitable distribution of health facilities in the different categories of municipalities, especially the facilities owned by the municipalities. 25% of the facilities are taken away by the 4% of the municipalities and 50% of the facilities are enjoyed by only 12% of them. Cold chain is another factor that requires to be looked into to ensure efficacy of vaccines. It was found that only 40% of the municipalities have control over their cold chain, for others they depend on the State Health Department. (West Bengal Municipal Association, 2005).

It was found that 42% of all facilities supported by the State Health Department and situated within municipal boundaries are part of the rural health system. Though a segment of the municipal population accesses services from these facilities, the local bodies are always under apprehension that sooner or later they are going to be withdrawn from the municipal areas. Facilities owned by government organizations and other government departments, like jail hospitals and ESI hospitals, serve special groups of people and are hence inaccessible to the general population.

Private facilities are abundant in some municipalities and bridge the gap between demand and supply. These include private nursing homes, a large group of private practitioners, a few NGO initiatives and quacks. These available facilities are concentrated in bigger towns and small municipalities are dependent on rural infrastructure located in municipal areas. There are super specialists physicians practicing side by side with unqualified RMPs. Hospitals with state-of-the-art technology coexist with nursing homes run by RMPs even without a trained nurse. No information flows from the private agencies to the government system. As a result services provided by them remain unaccounted for. In

the absence of a stringent quality assurance system, the quality of health care in private sector is always under question.

There are approximately 25 hospital beds per 10,000 populations in urban areas, 53% of which belong to the State Health Department, 13% to other government departments and 29% to the private sector. Municipal facilities account for only 5% of the total number of beds. Similarly 51% of the qualified MBBS doctors and 59% of the trained nurses working in urban areas belong to the State Health Department. Municipal facilities account for only 6% of the qualified doctors and 4% of the trained nurses[4]. In 2003, there were 813 persons served per doctor in the urban areas[5].

The average number of private facilities (excluding doctors' chambers) per 10,000 population is around 0.58. Unlike government and municipal facilities, private facilities do not have any extraordinary high concentration in bigger towns. Though the number of private facilities is more in A-category towns (population over 2 lakhs), see Table 7, the average comes down to 0.49 while leveled against the population. In E- category towns, this average is 0.46. An unusually high density of private facilities i.e. 1.03 per 10,000 population is observed in D-category towns (population 0.25 to 0.75 lakh). Table 9 shows that the number of government and municipal facilities is abysmally low in this category.

Fig: 3 Average number of various health facilities in different category of towns

[4] Mapping Of Health Infrastructure In Urban Local Bodies, November 2005, West Bengal Municipal Association

[5] Source: DHFW

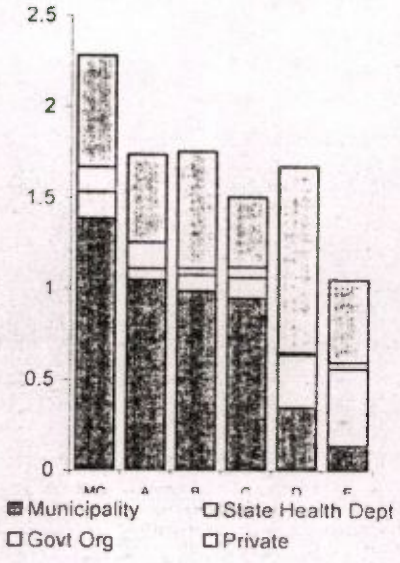

2.5
2
1.5
1
0.5
0
Municipality
State Health Dept
Govt Org
Private

TABLE 7

AVERAGE NUMBER OF HEALTH FACILITIES OFFERED BY DIFFERENT SERVICE PROVIDERS PER 10,000 POPULATION LOCATED IN DIFFERENT CATEGORY OF TOWNS							
Category of Towns	Number of towns	Municipality Controlled	State Health Dept		Other Govt Org	Total (public sector)	Pvt
			Part of Rural System	Part of Urban System			
Municipal Corporations	4	1.39	0.10	0.03	0.14	1.66	0.61
Above 2 lakhs (A)	15	1.05	0.01	0.05	0.14	1.25	0.49
1.5 lakhs-2.0 lakhs (B)	9	0.99	0.01	0.06	0.03	1.09	0.65
0.75 lakhs–1.5 lakhs (C)	31	0.95	0.03	0.07	0.06	1.11	0.39
0.25 lakhs–0.75 lakhs	45	0.35	0.15	0.10	0.01	0.61	1.03
Below 0.25 lakhs (E)	16	0.14	0.25	0.18	0.04	0.61	0.46
Total	**120**	**0.92**	**0.05**	**0.06**	**0.08**	**1.11**	**0.58**

Source: Mapping of Health Infrastructure in Urban Local Bodies in West Bengal

Most of the private facilities do not have a preventive or promotive component of healthcare and the government facilities for the same are also inadequate as is evident from the emergence of polio cases in West Bengal within the last four years. In 2001 there was one polio case in the state and it was from the urban part. In 2002, 7 out of 48 polio cases and in 2003, 5 out of 28 polio cases were detected in urban areas. Both the cases of 2004 belonged to urban West Bengal. Different surveys also indicate that there is much scope to improve urban health status of the state, particularly in respect of maternal and child health, more precisely in terms of immunization coverage of children and pregnant women.

One of the major problems is inequitable distribution of health facilities in the different categories of municipalities, especially the facilities owned by the municipalities. 25% of the facilities are taken away by the 4% of the municipalities and 50% of the facilities are enjoyed by only 12% of them. Cold chain is another factor that requires to be looked into to ensure efficacy of vaccines. It was found that only 40% of the municipalities have control over their cold chain, for others they depend on the State Health Department.

Health Interventions

The provision of preventive and promotive healthcare to urban population has emerged as a priority in view of increasing urbanization along with the increasing number of slum areas and low-income people in cities and towns. More so, as it has become mandatory for the local governments to ensure preventive and promotive health care services for their populations as a consequence of 74th constitutional amendment. The Government of India has recognized urban health as a thrust area under National Population Policy 2000, National Health Policy 2002, and Tenth Five Year Plan and in the second phase of RCH programme.

The provision of preventive and promotive healthcare to urban population has emerged as a priority in view of increasing urbanization along with the increasing number of slum areas and low-income people in

Since 1980 community based preventive health care projects in slum areas have become integral parts of slum development activities in urban areas. At present 52 municipalities, including 41 KMA (Kolkata Metropolitan Area) municipalities, are supported by community based health projects like CUDP-III, IPP-VIII etc. originally funded by World Bank and subsequently taken over by the Government of West Bengal. An additional 11 municipalities have recently started limited RCH intervention with support from DFID.

The reported performance figures in the project areas indicate tremendous improvements in health indicators among the beneficiaries of the project. The couple protection rate has gone up to 72%, infant mortality (IMR) has come down to 22.7 per 1000, immunization coverage has increased to 96% and the incidence of institutional delivery has reached the level of 95%. These statistics are true only for the direct beneficiaries of the project, which represent a small fraction of the total urban population. There is a dearth of information regarding the rest of the urban population.

Review: experiences and innovations in health care provision

An overview of innovations

The state has the experience of various projects (CUDPIII, IPPVIII and CSIP) covering 63 ULBs. In KMA areas, through the Kolkata Municipal Development Authority (KMDA), the GoWB and the Department of Health and Family Welfare (DHFW) have implemented three projects funded by external agencies (World Bank and DFID). The projects are World Bank (WB) funded CUDP III (1984 – 1992), DFID funded CSIP (1992-1998) and WB funded IPP-VIII (1994-2002). Post IPP-VIII funding, DHFW also has experience and learning from the maintenance phase, which continues till date. An independent end line survey of IPP- VIII project showed a notable fertility decline among the slum population, marked improvement in maternal and child health as evidenced by a decrease in infant mortality and increased utilization of the RCH services by women and children. The projects provided lessons both in implementation and organizational front.

The goals of the KMDA health programme and the HHW component has been stated thus: "A comprehensive community based preventive and promotive outreach health delivery system by involving the community and entrusting the responsibilities to Urban Local Bodies in a decentralized approach. It was a complete departure of health delivery system from institutional delivery to doorstep delivery. To provide quality services, easily accessible, acceptable and affordable to meet the prime needs of the health of the community especially the weaker section of the population, at a minimum cost. Within the overall objective of improving the health situation of the poor residing in urban slums or similar situation in KMA, the programme aimed towards two main objectives: To improve the maternal and child health status and to reduce the fertility rate amongst the target beneficiaries."

An independent end line survey of IPP- VIII project showed a notable fertility decline among the slum population, marked improvement in maternal and child health as evidenced by a decrease in infant mortality and increased utilization of the RCH services by women and children. The final achievement figures are by any standards impressive. The main achievements are highlighted through the tables below:

Table 8
Demographic Indicator

Item	**Baseline-1994 (All figures- per 1000)**	**Achievement -2001 (All figures – per 1000)**
Crude Birth Rate	19.6	14.8
Crude Death Rate	5.91	4.0
IMR	55.6	23
MMR	4.6	0.3

Table 9

Immunisation Coverage Status

	Base-line 1992 (All figures in percentages)	**Achievement -2002 (all figures in percentages)**
BCG (infant)	78	98
DPT (infant)	64	96
POLIO (infant)	70	98.6
Measles (infant)	54	90.0
TT (pregnant women)	76	97

Table 10

Utilisation of RCH Services

	Base-line 1992 (all figures in percentages)	Achievement 2002 (all figures in percentages)
Institutional Deliveries	53.9%	95.6%
Three Antenatal Visits	NA	96.0%
Contraceptive prevalence in couples with less than two children	NA	47.8%
Couple Protection Rate	45%	71.6%

The projects provided both Institutional and technical lessons .

Institutional lessons:

a) High degree of decentralization can create both ownership and local political commitment at the ULB level. Apart from implementation and monitoring the programme a considerable decentralization in administration and financial matters can lead to strengthened capacity and confidence in managing such programmes.

b) Various community structures (ward committees) along with adequate leadership of the local bodies can work at combating exclusion, mobilizing resources and energy, and achieving effective implementation. The ward committees can help in creating awareness about the project besides providing their inputs in the micro planning for their ward and help facilitate the work of the Honorary Health Workers.

c) The ward/block committees and through them the community at large can be involved in different stages of planning, implementation and monitoring of the programme in their respective wards/block.

d) The use of female honorary health (HHW) workers for bringing about a major change in the health seeking behaviour and linking up with health systems can be effective. These HHWs at one for 200 families and with little honorarium can help achieve desired health outcomes

e) Use of private practitioners to complement primary clinical care and immunization services through the sub centres can work reasonably well, wherever they were available.

f) Flexibility in project design allows modification of some and addition of certain new activities. The design also allows local level operational flexibility. Any strategy to address urban health issue has to build in flexibility and for factor in local needs and capacities, of the municipalities

g) The need to clarify the roles and responsibilities of the multiple organizations providing urban health services.

h) Need for recognizing the marginalized populations like settlements along railway tracks, rag pickers, migrants in squatter colonies etc to avoid being excluded from the benefits of such projects.

i) In the service delivery model the sub centre providing basic primary health care services by the part time medical officer and FTS the need to have a Health Administrative Unit (HAU) becomes superfluous.

Technical Lessons

a) A formal referral linkage with facilities providing higher-level care should be ensured since stand-alone facilities like maternity homes are difficult to sustain.

b) Need to include the larger urban population for preventive and public health intervention.

c) Service package to include apart from emphasis on preventive and promotive care a mix of public health and primary level curative care.

d) The absence of refresher trainings for HHW and the absence of learning from the field can lead to dilution and effectiveness of the HHW leading to stagnation.

e) The lack of population based health status data and it being factored in local planning.

A further challenge in municipalities, which does not have any dedicated urban health programme, would be: The lack of population based health status data and its implication for planning and benchmarking.

f) The location disadvantage of many municipalities and the near total absence of health infrastructure in some of these municipalities.

g) The limited organizational experience in the delivery of health care in 63 municipalities.

h) The limited presence of private service providers in most of the Municipalities making it difficult to have any PPP arrangements

Other innovations:

Again, in the Local Initiatives Program (LIP) in Kolkata run by the child health and nutrition NGO CINI, a referral network of qualified physicians who practice in the vicinity of slums has been established. CINI-LIP staff have sensitized and oriented these doctors to the needs of the slum residents. The network members treat patients at a highly

subsidized rate, Rs. 15 instead if the usual Rs. 50. which is reimbursed by CINI-LIP. These doctors follow standard management protocols for common ailments and prescribe generic drugs from the essential drug list provided by CINI-LIP. And to enhance service delivery. the CINI-LIP uses health vouchers given by the local health worker to the patient, who then takes it to the doctor for consultation. This voucher entitles the patient to free treatment and prescription drugs from the health center and the health provider, on the basis of a subsidized consultancy fee.

Urban Health Strategies for West Bengal:

"West Bengal Health Sector Strategy 2004-2013", the policy and strategy document states the mission of the Department is "To improve health status of all the people of the state especially the poorest and those in greatest need." Goals for health improvement are specified in the form of targets for the infant mortality rate (IMR). child mortality rate (CMR) and maternal mortality rate (MMR). Special attention is given to the importance of improving health conditions for financially and socially disadvantaged populations.

In the overall context of the Health Sector Strategy West Bengal Government aims at contributing to the improvement of the health status of West Bengal population living in urban areas, with particular emphasis on poorer sections of urban municipalities. More specifically, it aims at providing comprehensive primary health care to all sections of urban communities through a decentralized health care delivery system. This state (MA and UD statement) commitment is also echoed by the Government of India which has identified "Urban Health" as one of the thrust areas in National Population Policy, 2000: National Health Policy 2002 and in the current Phase of the Reproductive Child Health Program (RCH II). (NRHM)

In the absence of a comprehensive urban health strategy multiplicity of agencies providing urban health services poses management and implementation problems and fragments efforts thereby preventing the desired health outcomes. It is in the overall framework of the Health Sector Strategy that an Urban Health Strategy has been evolved in a participatory approach with all the stakeholders deliberating on it and contributing to it.

The 74th constitutional amendment enlarged political authority of local governments and brought under it the development agenda of the state. The new urban health strategy calls for a recognition of urban health development as a positive force for meeting national goals of improving living standards equitably and sustainably. for leadership to promote this recognition within the Health, Urban and Municipal departments and for resources commensurate with the strategic importance of urban health and hence overall development. It is realized that a much broader framework has to evolve for Strategically

effective solutions combining experience and expertise between medical services, public health, and urban planning.

Coverage:

According to 2001 Census, the urban population constituting the 126 ULBs stands at 19.3 millions accounting for 24.06% of its total population of 80.2 million. The percentage of urban population in West Bengal has always been higher than the national average. The state has the distinction of having the highest density in respect of the average population density in urban areas (6798 per sq km). The urban population of the state is spread over 126 municipalities and 252 census towns.

Aim and Objective

Aim is to contribute to the overall improvement of the health status of West Bengal population living in urban areas, with particular emphasis on poorer sections of urban municipalities. The objective is to provide comprehensive and sustainable primary health care to all sections of urban communities through a decentralized health care delivery system.

The UH strategy which, is guided by a vision of sustainable health through a decentralized approach will provide a logical framework and rationalise decision making for the achievement of the UH objectives by the Department of Health and Family Welfare (DHFW), the Department of Municipal Affairs (DMA), Urban Development (UD) and the Municipalities. The strategy also calls for a commitment by a wide coalition of forces within the state and among external partners to working together in new ways on the urban frontier. It is geared toward helping government at all levels, the private sector, community groups, and people in ways best suited to them.

The urban Strategy outlines some broadly common goals and operational strategies for all ULBs but it would be adequately adapted to the local needs, priorities and available resources depending on the commitment and capacities of the ULBs and other key stakeholders.

The UH strategy for the state of West Bengal is conceptualized at the heart of two interrelated processes:

Sustainable community based health care driven and managed by the ULB supporting them to work as partners with the urban poor.

- Strengthening of primary health care systems and services and where needed secondary care services.

These processes will be translated through three critical elements:

1. A community-supported and well-trained ward based woman volunteer called the **Honorary Health Worker (HHW)** who will

- Initiate and facilitate sustainable improvement in health, nutrition and caring practices and health seeking behaviour in her community thereby addressing household and community determinants of health, and Link community members to available health systems and services, thereby improving accessibility and appropriate utilization of services.

2. Ward and ULB level **Health Committees**, comprising of community members, elected councilors and health officials to collectively facilitate access to and delivery of effective healthcare for all residents of the municipality. They will play a crucial role by:

- Selecting and supporting ward based HHWs.
- Undertaking collective health actions for improved preventive and promotive care, as well as support and monitor health service providers.
- Coordinate the multi departmental response in the Public health domain, which will include but not limited to (i) Water quality management. (ii) Solid Waste management. (iii) Sanitation and Hygiene. (iv)Licensing of health facilities. (v) Tracking of Seasonal disease outbreaks. (vi)Ensuring reporting from all health facilities including Government and Private Practitioners and Path Labs for compulsory reporting of all notifiable disease
- Draw up ULB level plan.

3. A **responsive primary health care system** sensitized to the needs of the community, especially its most vulnerable members – women and children. This will operate through a tiered service delivery model as follows: –

- First tier services through sub centres provided by First Tier Supervisor and professionals on contract from private sector.
- Urban Health Clinic as the second tier services formalized through existing or creating new centres.
- Referral facilities as the third tier services formalized through existing facilities or upgrading where appropriate.

- Providing training and support to the HHW and ULBs and rationalizing convergent service delivery to optimize the impact of community-based support and health action.

- Improving quality by providing training to key health service providers and instituting a dynamic monitoring and evaluation framework.

- Institutionalizing the stewardship role of Department of Health and Family Welfare and establishing an Urban Health Cell at the state level. This would require the DHFW to reinvest internally in its own urban knowledge and capacity.

The implementation of the Urban Health strategy is an inherently complex and challenging undertaking, the success of which will hinge on the quality of key processes and systems at all levels of programme management and implementation. Thus the joint ownership and steering of the strategy by the DHFW, Municipal Affairs Department and the Urban Development Department will be mandatory for its translation and for achieving the Goals for urban health.

The proposed implementation strategy has been conceptualized keeping the following key principles in mind:

- The strategy draws on the strength of existing resources within the state and engage all potential stakeholders from civil society - The ULBs, NGOs, CBOs and faith-based organizations, government departments - DHFW, UD and DMA, Department of Social Welfare, Public Health Engineering and their programmes and technical partner agencies. A strong partnership between these stakeholders is a key element.

- They are adapted and implemented appropriately at the municipal level. Local government remains the everyday face of the public sector in the urban areas at which level essential public services are delivered to individuals and community and where policy meets the people.

- Given the geographic, social and cultural diversity of the state, the implementation strategy would enable an essential level of quality in key processes while encouraging contextual innovation and flexibility to ensure responsiveness to field realities and requirements. These variations need to be assessed within the context of cost; availability of qualified providers, sustainability; and health issues.

- Expand its mandate to include reproductive health, a full package for maternal and child health, and nutrition by expanding the technical intervention focus to include RCH 2 interventions as well as nutrition.

- Urban health program mandate remain open to identifying convergence points with other technical health areas including HIV/AIDS, tuberculosis and malaria.

Core Processes:

ULB level plan

The unique social, historic, and urban context in which the disease manifests itself must lead to the creation of solutions that suit local conditions. Hence the implementation strategy would enable an essential level of quality in key processes while encouraging contextual innovation and flexibility. Each ULB will have a plan, which will reflect the operational strategies to address the ULB specific determinants of health. It will take into account the public health issues important in the municipality, the nature of epidemic it faces seasonally/periodically and its possible determinants and will factor these in their intervention plan. The plan will also reflect the resources to be mobilized to bring and partnerships to be formed for the most effective outcome in the ULB health scenario. Thus each ULB would become responsible for the strategic planning and overseeing bf local-specific solutions to addressing the priority health issues of the ULB and also having innovative solutions to reach the poor and the marginalized in the ULB.

Targeting: Identifying and targeting the vulnerable urban populations

Services would be made available to registered and unregistered slum areas of the city. In this direction, targeting the least served slums is vital for optimum utilization of resources.

Vulnerability assessments would be carried out to identify the vulnerable clusters of the urban poor populations. Analyzing secondary data could do this (provision of water supply and sanitation facilities) to identify underserved settlements.

Further, UH strategy will take care to identify the poorest of poor including marginalized populations like settlements along railway tracks, rag pickers, migrants in squatter colonies, women headed household etc who have been mostly excluded from the benefits of past projects. Involving a sensitized organization to facilitate in identification of the "vulnerable" beneficiary would also be useful. This would in no way undermine the fact that the sanctioning and deciding authority would still be the ULB- but the ULB would be in a better position to target the needy and make a better health impact for the population under it.

Service Delivery Model:

The programme envisages implementation of a multi level service delivery model supporting a strong community outreach intervention. The service package will include apart from emphasis on preventive and promotive care a mix of public health and primary level curative care.

Community Level:

The service delivery will be expanded to all municipal population through initiation of outreach services using female honorary health workers (HHWs) to be recruited from urban communities. This outreach will be organized with the Ward as the geographical unit. The Ward Councilor/ Ward Health sub committee would be providing support and oversight.

The community level operational strategy will be to include both urban poor and the general population. For the Urban Poor an intensive approach including regular Home Visits and maintaining a Family Health Card will be initiated. A community outreach clinic (Sub Centre) providing basic preventive and promotive services will be provided close to their habitation.

For the general population the approach would be to provide Public Health inputs through various educational and service strategies included under various National Health Programmes.

A First Tier Supervisor (FTS) will be selected from amongst these HHWs after at least six months experience and an additional training input. One set of these FTS will be allocated responsibility at the sub centres and provide support to five HHWs in their outreach work and another set* (one per 20,000 general population) to provide public health services under the supervision of the Health Officer (HO) of the ULB.

The number of HHWs per ULB will be determined by the number of urban poor in that ULB distributed one per 1000 such poor population or the number of wards whichever is more. The municipalities will allocate the HHWs according to the agglomeration of low SE population in a ward.

The objective of the community outreach is to move the health care from institutions to the doorstep with access of all beneficiary households to HHWs. However, according to the PWC-Action Aid study regular access in some households and other houses, especially those belonging to migrant communities where women are working as domestic help or rag pickers showed lesser awareness about the HHW services. It is

important to avoid feeling of stagnation in the job and monotony of the same job with the same families over years.

Hence, need for constant supportive supervision and monitoring will be needed to make the HHW and the outreach effective. The PWC-Action Aid study points to the fact that almost 69% of FTSs spend less than 1 hour in the field per Week and other Supervisors are not making regular field visits. A structured Monitoring and supervision schedule will be in place and training of the FTS will include developing skills for appropriate supportive supervision work undertaken through monitoring and performance Indicators.

The First Tier

This will be designated as Sub Centre and will cater to a population of 5000 urban poor such that it provides a much better level of primary health care and introduce more flexibility in its timings. The sub centre will be closer to the community and the municipality aided by the GIS maps for optimum location will decide the location. Renovation/Up gradation of existing facilities will be done or alternatively, accommodation will be rented for establishing new sub centre. No new construction will be done.

First Time Supervisor (FTS) will be providing counseling plus basic primary care. FTS as in the current dispensation will be a HHW with a minimum of six months experience and receiving a further training of 30 days. She will be responsible for 5 HHWs and will manage a sub centre covering 5000 urban poor populations from a cluster of wards.

There will be another category called the FTS – Public Health who will be responsible for 20,000 general population in terms of the public health inputs. They will be part of the ULB team and deliver public health inputs.

The Sub Centre to be manned by a FTS and ULB Health Officer/ a part time medical officer (PTMO).

~~The Second Tier~~

Urban Health Centre

This would be at the ULB level and will provide back up support to the sub centres in terms of a more comprehensive package of services including clinical OPD care. In 48 ULBs these services will be provided by the DHFW secondary facility available in terms of Sub Divisional Hospital, District Hospital or Municipalities own facilities that exist in the municipality or in its vicinity.

In 15 ULB where no such DHFW secondary facility exists an Urban Health Centre under the management of the DHFW will be set up. This facility will serve as a daily OPD besides providing preventive interventions not available at the sub center. The Urban Health Centre will deliver services for approximately 30,000 populations (the norm may be suitably modified by the State to make it more ULB specific.) This centre, where needed, may be rented or upgraded/renovated, if an existing facility is available.

The manpower allocation will be as follows:
Medical Officer - 1
PHN/LHV - 1
GNM 2- 4 @ 12000-15000 population
Lab assistant - 1
Chowkidar - 1
Peon – 1

The Third Tier- Referral Facility

According to the participatory health assessments done by PWC- Action Aid (2005) revealed that for the poor, it is the state hospital, rather than the municipality maternity homes, which remains the most accessed referral health service in hospital RCH services. There are various reasons for this. The poor perceives of the Municipality maternity homes or ESOPDs as either not having location advantages (situated too far away for quick access) or too expensive (cost of treatment perceived as too high for all services but especially for delivery and caesarean sections).

The referral Facility the third tier of support will be a BPHC/Rural Hospital/Sub Divisional Hospital/ District hospital. Where these are not accessible or the municipalities have successfully implemented maternity home then these can be used as referral facilities.

A referral route will be established with each ULB having clear knowledge of the referral facility, which would serve the population of its municipalities. The specific referral facility will also know their command area, which is to include the said municipality.

Package of Services

First Tier:

This will be designated as Sub Centre and will cater to a population of 5000 urban poor such that it provides a much better level of primary health care and introduce more flexibility in its timings. The Sub Centre will be manned by a FTS and ULB Health Officer/ a part time medical officer (PTMO) and will offer the following minimum services:

- Child health care services including immunization, distribution of IFA, Vitamin A, ORS packets etc.
- ANC services and counseling for institutional delivery.
- Promotion of Family Planning - oral pills, condom use, counseling for adoption of terminal methods.
- Primary treatment of common ailments

The specific services will be delivered through predetermined clinic days as follows:

1. ANC/PNC and Family Planning counseling clinic – two days in a month.
2. Immunization Clinic – Once a week.
3. General treatment clinic by Doctor – Once a week.
4. Growth Monitoring of U-5 children Clinic – Once a month.
5. Health Awareness Programme – Once in a fortnight.

Second Tier:

This would be at the ULB level and will provide back up support to the sub centres in terms of a more comprehensive package of services including clinical OPD care. In 48 ULBs these services will be provided by the DHFW secondary facility available in terms of Sub Divisional Hospital, District Hospital or Municipalities own facilities that exist in the municipality or in its **vicinity. In** 15 ULB where no such DHFW secondary facility exists an Urban Health Centre under the management of the DHFW will be set up. The Urban Health Centre will deliver services for approximately 30,000 populations (the norm may be suitably modified by the State to make it more ULB specific.)

The facility will have a minimum of following services:

- Family planning services including IUD, referral for terminal methods
- Depot holder services for contraceptive and ORS
- Child Health services including Immunization.
- Antenatal care (urine and blood testing, TT immunization, IFA Supplements, nutrition counseling, early registration, weighing, Blood Pressure, position of the baby, check against danger signals and Identification of high-risk pregnancies, Referral for Institutional deliveries)
- Postnatal care
- Services under national disease control programmes
- A daily OPD

The Third Tier- Referral Facility:

The referral Facility the third tier of support will be a BPHC/Rural Hospital/Sub Divisional Hospital/ District hospital.

The facilities available will include a minimum of the following services:

- Full range of Family Planning services including laparoscopic services.
- Institutional Delivery services
- Essential and Emergency Obstetric Care
- MTP services
- Child health referral services including essential and emergency newborn care.
- Basic medical and surgical services.
- Services under national disease control programmes

Public Health Intervention at ULB level:

The public health functions in the ULBs will be within the overall framework of the state public health policy development, strategies and actions; prevention and control of disease: inter-sectoral action for better health; and human resource development and capacity building. • A wide range of activities fall within these basic categories of public health functions, such as surveillance, regulation, evaluation, social mobilization, disease prevention and control and workforce development.

Each ULB will have public health response capacity. This activity will be based on two approaches: (a) strengthening ULBs preparedness to address emergency public health situation and (b) improving routine public health measures at population level. The focus will be on strengthening of ULBs preparedness to address emergency and routine public health situations and will be achieved through (i) providing technical support to help develop the Public Health action plan building on the ULB specific action plan. (ii) ULBs

IFTS (PH) / 20000 general pop

Capacity building of existing staff in public health activities including orientation of ULB members to public health activities (iii) Introducing cadre of First Tier Supervisor – Public Health (FTS- PH) by reallocating and retraining from existing cadre of field workers. (iii) Strengthening data collection and compilation at ULB level iv) Protocols on communicable diseases and epidemic investigation guidelines including protocols during outbreaks to be followed.

More specifically the ULB specific action plan for public health will focus on the determinants in the respective ULBs and plan for a coordinated multi departmental response in the Public health domain and include (i) Water quality management. (ii) Solid Waste management. (iii) Sanitation and Hygiene. (iv)Licensing of health facilities. (v) Tracking of Seasonal disease outbreaks. (vi)Ensure reporting from all health facilities including Government and Private Practitioners and Path Labs for compulsory reporting of all notifiable disease.

This will focus on developing/strengthening mechanisms for effective linkages and coordination between various departments and the private sector at the ULB level, District level and state level for improving public health response capacity in ULBs.This

Management & Supervision all:- CIC(IT), ACMO, Supdt, SI.

Manpower at ULB level:

A team at the ULB level headed by a Health Officer (HO) and where the population is over three lakhs assisted by an Assistant Health Officer (AHO) and supported by 4/5 FTS and one Public health nurse and one additional PHN for more than 3 lakh population will support public health initiatives in the community. One Data Assistant and multipurpose helper cum storekeeper will be allocated to each team.

The team will help in integrating the National Health Programmes into the ULB programme. They will provide the oversight to the overall UH programme in their ULBs, provide supervisory support to the HHWs and initiate outbreak control protocol for common disease outbreaks.

The HO will be part of the management committee at the ULB level and will provide leadership to the UH programme of the ULB.

Institutional Framework for implementation:

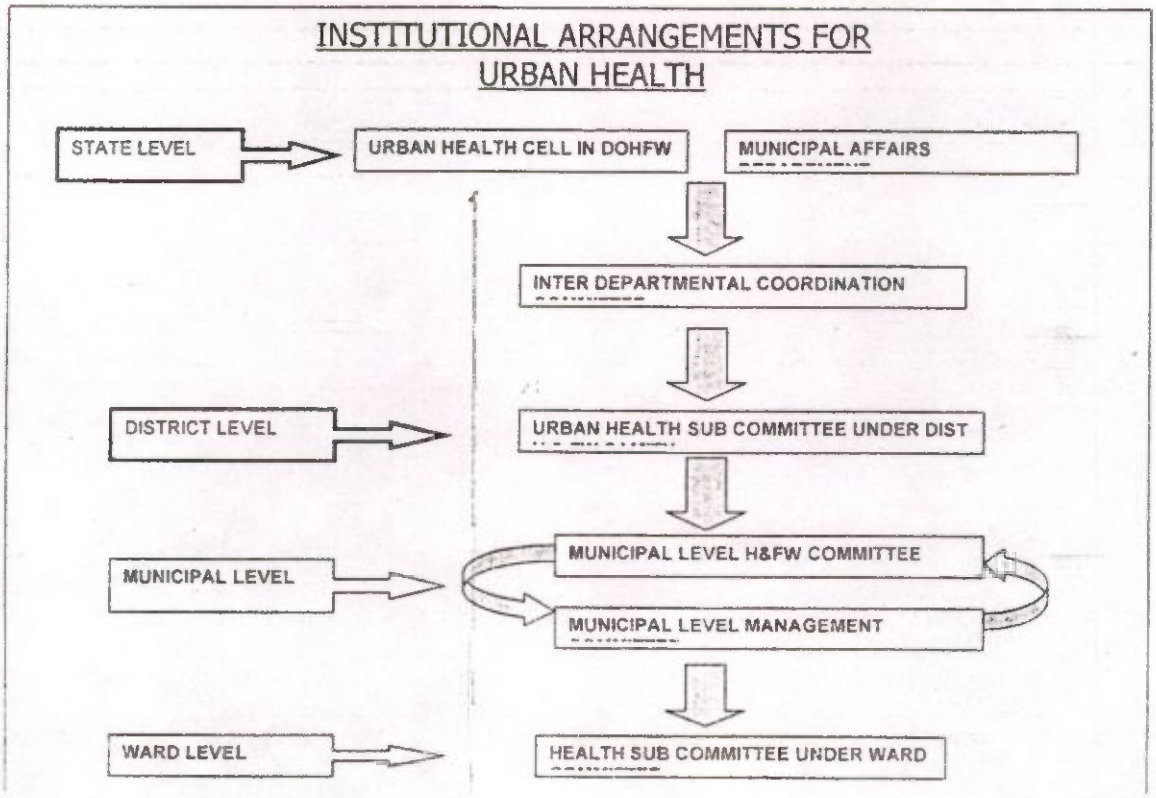
The institutional arrangements will take into account the multiplicity of agencies that will form part of the arrangement and will be planned to be conducive to: (i) institutional strengthening of the DOHFW and of institutional links across departments (specifically,

between the DHFW and the Department of Municipal Affairs) (ii) Institutional strengthening of the technical agency (SUDA) identified by Department of Municipal Affairs. (iii) Formal linkage between the state and the Municipal level functions.

Urban Health will be steered by the DHFW and implementation will be the responsibility of the Municipal Affairs department and the ULBs.In the DHFW an Urban Cell will be established to provide stewardship role and will be responsible for policy issues, formulation of standards and norms, operational guidelines, coordinating with department of municipal affairs, technical input during epidemics. The Principal Secretary will chair the Urban Health Cell.

The Municipal Affairs Department will be responsible for implementation of the programme through the 126 municipalities. It will be responsible for the overall execution of the programme and will provide management support. It will identify an agency (SUDA) to provide technical backstopping, capacity building and monitoring/supervision support to the implementation efforts. In the Kolkata Metropolitan Area (KMA) the Kolkata Metropolitan Development Agency (KMDA) provide the oversight and manage the funds received by the DHFW. In Non– KMA municipalities ULBs are responsible for implementation with capacity and supervision provided by the health unit of the State Urban Development Agency (SUDA). A series of committees starting from sub centre to ULB and District level will be set up and their capacities will be strengthened to effectively implement the urban health programme.

A series of committees from District to the Municipal level will help coordinate UH activities and provide oversight. These would be i) Urban Health sub committee under the District Health Samity. ii) Municipal level Health and Family Welfare Committee. iii) Municipal level management committee. iv) Health sub committee under the Ward Committee chaired by the Ward councilor.



State level Interdepartmental Coordination Committee

Members

The members of this committee will be drawn from the DoHFW and MA department.

The following will be the broad areas on which the coordination committee will function:

Policy and Strategy Support

The committee would provide support to Department of Health and Family Welfare (DH&FW) and the MA department, in framing policies and recommending strategic options to achieve the goals stated in the Health Sector Strategy and the Millennium Development Goals (MDGs). Specifically the tasks would include, but not be limited to, the following:

- Finalize Urban Health Strategy after consultation with all stakeholders and work towards its acceptance.
- Ensure that the approved strategy document is widely disseminated and understood by all the stakeholders.

In framing and evaluating policy options and strategic approaches, the committee would include the contribution of private and NGO sector and suggest ways of synergistic linkages, partnerships, quality assurance and regulation. It would also ensure that the recommendations are in line with the latest best practices in the field and that the concerns of equity and gender are adequately addressed in the policy and various programs.

Coordination between the two departments

In order to facilitate convergence between the efforts of the two departments so that there is no duplication of effort and a shared understanding of facts and approaches, the committee should leverage the inherent strengths of the two departments.

The committee would be required to coordinate the efforts of the two departments i.,e DHFW and MA department in order to facilitate more effective utilization of resources and to ensure that efforts are synergised. Specifically the tasks would include, but not be limited to, the following:

- Set up systems for systematic sharing of information in order to optimize utilization of resources.
- Determine modalities for harmonization of procedures and approaches in the covered and uncovered municipalities so that individual project structures are

phased out in favour of common strategy, approach and implementation mechanisms.

- The committee will harness the technical strengths of the DHFW in emerging health issues, so that a coordinated response can be initiated routinely and in the event of an outbreak of diseases.
- Ensuring streamlined collection of data and HMIS through inputs from the DHFW and the MA department, to facilitate evidence- based decision-making.
- Integration and effective implementation of various national programmes at the ULB level, through the joint efforts of the two departments.
- A well coordinated IEC/BCC strategy for urban health in tandem with the strategies of both the departments.
- To ensure institutional strengthening at various levels through
    1. Review and strengthening of the legal provisions of the various acts applicable
    2. Capacity building initiatives at various levels with technical inputs from the DHFW.

Urban health cell at the DHFW

Members

Principal Secretary, DOHFW – Chairperson
Commissioner Family Welfare
Director, Health Services
Joint Secretary (FW)
Joint Secretary (Public Health)
ED SH&FW Samity
SS (Public Health)
Finance- ADAAB rep.

The Joint Secretary (FW) will be the nodal person.

The cell will be responsible for policy issues, formulation of standards and norms, operational guidelines, funding, monitoring and evaluation, technical input during epidemics.

Specifically, the urban health Cell will be responsible for

1. Preparation of Urban Health Strategy after consultation with all stakeholders
2. Suggesting ways for harmonization of structures and resources in the covered and uncovered municipalities.
3. Formulation of operational guidelines for the program at various levels viz., the outreach, sub centre and ULB level.

4. Technical assistance and support to ULBs in policy planning & development

5. Technical inputs for the capacity building modules for different categories of personnel at the implementing agency, the ULB and the sub centre and outreach level
6. Specialist inputs on public health related issues during times of outbreaks and disasters
7. Formulation of an integrated monitoring and evaluation system in line with the regular HMIS, so as to enable the DHFW to get a comprehensive data on health indicators in the state along with helping in evidence based decision-making.
8. Suggestions for an overall IEC/BCC strategy encompassing the entire state and in line with the overall strategy of the DHFW and MA department.
9. Guidelines and support for epidemiological surveillance and monitoring health status including technical support for public health decisions.
10. Definition of standards and methods of evaluating the quality of public health services
11. Development of standards and guidelines that support emergency preparedness and disaster management
12. Setting up of standards and norms in terms of outbreak control protocols

- Establishing abilities, and skills to review, strengthen, and enforce laws and regulations
- Enforcement of laws and regulations, and associated training to enforcers

District level urban health sub committee under the District Health and Family Welfare Samity:

An urban health sub committee under the existing District Health Samity will be formed to coordinate the urban health programmes in the municipalities within the district.

Membership to include-

Sabhadhipati
District Magistrate
CMOH
ACMOH
Rep from Municipalities
Health Officer (nominated from Municipalities)

Specific terms of reference

1. Establish a coordinated approach at the district level and with the office of the ACMOH of respective subdivisions for monitoring and providing support in all disease management programmes and public health programmes.

2. Help establish linkages with secondary hospitals for providing referral services to all cases referred by medical units of their respective municipalities
3. Systematic sharing of information in terms of data collected during routine monitoring so as to enable better service quality and outbreak management.
4. Suggest ways of synergistic linkages and partnerships with NGOs and private sector where feasible.
5. Planning and coordination of health information, education, and promotion strategies

Municipal level Health and Family Welfare Committee

To enable planning and integration of all health activities between the Municipality and the Department of Health and Family Welfare, the 'Municipal level Health and Family Welfare Committee' will be formed in each municipality.

This committee constituted at the Municipality level includes the following members:

i. Chairperson of the Urban Local Body - President
ii. Councilor-in-Charge of Health
iii. One representative from the Government- Health and Administration
iv. 2 Representatives of local NGOs (one from IMA)
v. Assistant Chief Medical Officer of Health of the sub-division
vi. Superintendent of local Government hospital
vii. Representative of District Magistrate.
viii. Representative from Community Development Society (CDS)
ix. Health Officer of the Municipality - Secretary Convener

Rep. of SUDA — Member

This committee will be responsible for coordinating the entire existing health infrastructure both in the Government and Private sector including NGOs and private practitioners. This empowered committee will be responsible for:

- Review performance of the UH programme.
- Inspection of existing health and related facilities.
- Licensing of Health facilities.
- Tracking of seasonal disease outbreaks and initiating outbreak control protocol.
- Allocation of finance.
- Seeking reports from government, Municipal health institutions, NGO and private practitioners including path labs for compulsorily notifiable diseases.
- Review of work (including referrals) and provide solutions to problems at the UHC level.
- Monitor and ensure the contribution to the Health Development Fund from all possible sources.

Rather. UHC 2011 [illegible]:
[illegible] the MES all
towards wholesaling
of service [illegible]
OHC.
Thanks.

- Improving the quality of the public health system and public satisfaction with these services
- Decisions on locations of sub centers and Urban Health Clinics, where there is no DHFW facility available.

A municipal level management ~~committee~~ & supervision cell

This body will oversee the management functions of the ULB health programme. This will be responsible for monitoring of staff performance, plan out ward wise and sub centre level activities, liaise with DHFW and MA to access resource support, report preparation and submission to the appropriate authority.

The membership will include:

Councilor in Charge of Health , supdt. of nearest Govt. Hospital,
Health Officer ACMOH, SI, Comp. Asstt,
Asst Health Officer MH circle.
Public Health Nurse

Project Management

1. Coordination for day-to-day management of the project including activities at the outreach and sub center levels.
2. Overseeing recruitment and training of HHW, FTS, PHN, PTMO and other staff members
3. Ensuring that all sub centers are functional with adequate infrastructure and facilities.
4. Liaise with DHFW for getting the Urban Health Clinics operational.
5. Regular supervision over data collection, analysis and dissemination.
6. Be responsible for submission of monitoring reports to different agencies, viz., the ULB, the implementing agency, district level Samity (if applicable) and DHFW.
7. Monitoring staff performance including HHW, FTS, PHN, FTS PH, data entry operator and PTMO.
8. Ensuring regular capacity building for all the staff according to the needs.

Health Promotion

1. Development of an appropriate strategy for health promotion tailored to local needs
2. Facilitating partnerships for health promotion
3. Planning and coordination of health information, education, and promotion strategies
4. Support for community health promotion activities

What are the information gaps
required to be collected
and at which frequency
amongst PPL pop?

5. Advocacy and action to improve access to necessary health services

i. Reducing the impact of emergencies and disasters on health through epidemiological Surveillance and Public Health activities Ensure preventive measures like immunization, sanitization of outbreak prone areas.
ii. Surveillance systems to identify threats to public health
iii. Enhancing epidemiological capabilities and skills in staff
iv. Preparedness for an effective response to control threats to the environment and public health
v. Recognition of early warning signal
vi. Epidemic alert and response
vii. Implementation of standards and guidelines that support emergency preparedness and disaster management

Ward level health committee

There will be a health sub committee in the Ward Committee chaired by the Ward councilor and will be responsible for Ward level planning of health activities, monitoring HHWs, hold ward level BCC and IEC activities.

Members

The ward councilor
One HHW
FTS
Representative of Community Development Society and
One distinguished person from the community or a NGO.

Specific responsibilities

1. Ward level planning of activities ~~including distribution of HHWs amongst the BPL population.~~
2. Ensuring integration of health activities with those of Community Development Society/Neighbourhood groups.
3. Responsible for IEC/BCC at ward level.
4. Monitoring the activities of the HHWs.

2. Ensuring inclusion of marginalised & vulnerable groups of people of the ward.

~~Possx~~ 2APL of

Whether ^ Rural poli[cy] / ~~icting~~ ?

data are

reccesed ind by

DAFF'?

not practical

feasible?

possible?

Monitoring and evaluation

Unfortunately, in West Bengal there is not enough information on the health conditions of the urban poor. Where there is data specific to the health of the urban populations, it often suffers from at least some weaknesses. First, health data is usually aggregated to provide an average of all urban residents - wealthy and poor - rather than disaggregated by income or wealth masking the health of urban poor. Second, the informal or often illegal status of low-income urban settlements prevents the public health authorities from collecting data from this vulnerable population. Further, health data are usually based on household surveys. This means that most surveys do not count the homeless.

For effective planning and monitoring of the progress of any urban health initiative data on morbidity and mortality should be systematically collected, as they are generally unavailable at present. More research is also needed to learn more about treatment-seeking behaviour of the urban poor, quality of various urban health services, as well as perceptions of such care by its users.

As of today there is no mechanism for measuring the impact of service inputs by indicators. In the 63 municipalities data from the BPL families through the family health card exists but there is no data for the general population. There is no baseline data available from the 63 ULBs who do not have any dedicated programme. The utilization of the information collected through the current system is not systematically used for knowledge-based decision making due to lack of capacity and structure.

The UH strategy will enable establishment of the necessary institutional and financial requirements to have a well-functioning monitoring and evaluation system of the overall programme ensuring measurement of performance and impact to become regular and hence able to continuously inform the planning process. The M&E will work in the overall framework of the HMIS being planned for the department of Health and Family Welfare as a whole. Further, This component would support policy development and capacity building by providing technical assistance at the Institutional level (both at the Municipality and SUDA level), which will include sensitization, training and population, based surveys at the beginning, middle and end of an urban initiative.

Monitoring.

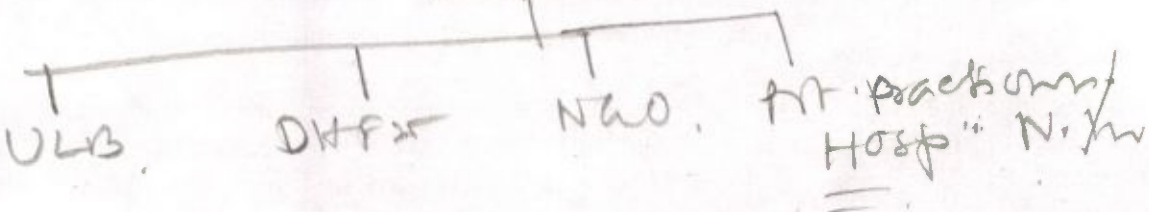
Monitoring will be routine monitoring to collect, collate and feedback data collected by the HHWs (demographic, disease prevalence data and details of services). Currently the municipalities have no mechanism in place to collect information from various health care providers including NGO and other private service providers. The municipalities will be empowered to collect information from these sources and personnel provided at the ULB level to collate this information.

Information required for routine monitoring will be collected by the HHWs through the family card. This will include demographic data, disease prevalence data. In addition, the registers and reports currently used to capture services delivered will also be continued,

Pop^{n}

APL BPL Non-recognised BPL.

Agency.



To make it clear:

(a) What are the information DHFW needs.

(b) who will collect?

(c) who will compile.

(d) " Submit to whom

(e) will the reporting formats same for all pop^{n}.

and information from these will also be sent for collation. The FTS will collate data of the respective HHW group and send it to the municipality. Since there might be a gestation time of about a year and half for the sub centres to come up, the data collected by the HHWs will be collated at the municipality level (by the proposed data assistant), along with data received from NGOs, private practitioners. A copy of the report will be sent to the DHFW with a copy to the respective districts.

Once the sub centres are functioning, the data can be collated at the sub centre level and then sent to the municipality for integration. In the M&E system the following will be incorporated:

1) The reports from Government and non-Government organizations submitted to the Municipality should mainly cover communicable diseases and RCH cases treated at the facilities. A pro forma will be developed for this purpose.

2) An annual report is to be prepared on the basis of updated Family Health Card once a year by each HHW.

3) Based on the monthly reports, survey, annual reports and other documents the municipality will publish a report on health status once in a year.

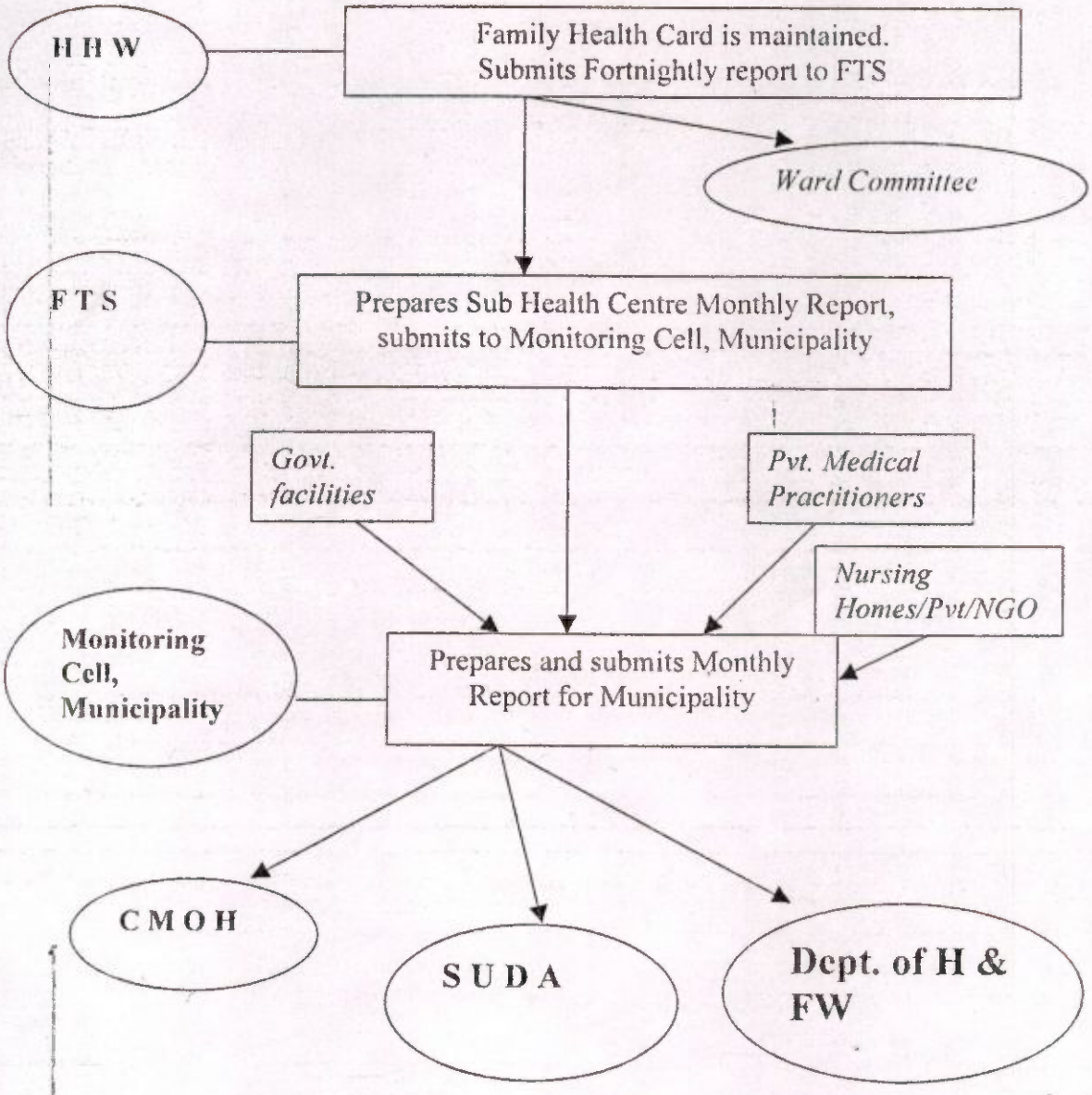
4) The time schedule of the routine reporting system explained in the flow chart will be changed in case of some selected communicable diseases. In such cases the HHW and the concerned units will transmit information immediately and thereafter as per requirement.

5) A set of process indicators (see annexure...) will be in place for monitoring and informing the programme.

Evaluation

To make the UH strategy more output oriented the first step is to have a firm baseline of measurement of outputs. The outputs related to people's health status will be captured through a population based survey at the beginning of the project to be followed after the third year by a midline survey in order to assess performance and make mid-course corrections and finally at the end of the project an end line survey in order to learn what works and inform future policy. All the surveys will be done by an independent survey firm .The evaluation tools will also include facility surveys one such facility survey was already conducted in the year 2005 by the Municipal Association, a key stakeholder in the UH strategy, will be used as a baseline information on the facilities. A detailed monitoring framework and output indicators will be decided in consultation with the stakeholders.

H M I S


H H W
Family Health Card is maintained.
Submits Fortnightly report to FTS
Ward Committee
F T S
Prepares Sub Health Centre Monthly Report,
submits to Monitoring Cell, Municipality
Govt. facilities
Pvt. Medical Practitioners
Nursing Homes/Pvt/NGO
Monitoring Cell, Municipality
Prepares and submits Monthly Report for Municipality
C M O H
S U D A
Dept. of H & FW

Capacity Building

The different agencies involved in the implementation, management, and monitoring of the proposed urban health program would need

1. Augmentation of in-house capacity in order to effectively manage the program and handle additional responsibilities

2. Training on a range of issues at different phases of the project to develop skills to work towards desired impact.

In house capacity at the implementing agency will be augmented through a team of professionals to be engaged with a mix of various skills, which are required in order to implement, manage and monitor the expanded programme. Managing the partnerships with ULBs, BCC/IEC activities, capacity building of ULBs and outreach workers etc are some of the key functions to be performed by the implementing agency. At the ULB level, technical support would be provided by the implementing agency, and staffing at ULB and outreach level would be optimized in order to achieve the program objectives efficiently and effectively.

It is proposed to do capacity building of various levels of functionaries in two waves:

- The first wave of capacity building will be based around the existing capacity building measures and training programmes, with a few modifications, as required. The DHFW will provide technical inputs for these trainings, especially in the area of public health. These programs range from the orientation / sensitization programs for ULBs to the intensive 45 day training for the HHWs on MCH and public health activities.
- Subsequent to the first wave, a capacity needs assessment would be undertaken across all categories of staff, in order to identify gap areas. Subsequent trainings and other capacity building measures would be based on the results of this assessment.

Augmentation of inhouse capacity

At the implementing agency level

As mentioned above, in view of the fact that the program has been scaled up . the capacity of the implementing agency would need to be suitably strengthened in order for it to be able to effectively deliver the following roles. The activities are suggestive and not exhaustive.

Managing the partnerships with ULBs

1. Support to ULBs in preparation of individual plans and approving them for release of funds
2. Support to the ULBs in setting up various systems including guidelines for operation at the outreach and sub center level, HMIS, procurement, finance and administrative systems etc.
3. In coordination with DHFW, to develop and implement uniform HMIS in all the ULB
4. Review and analysis of periodic reports received from the ULBs and concurrent feedback
5. Monitoring the program through field visits at periodic intervals.

Capacity building at ULB level

1. Be responsible for development and implementation of training modules for ULBs, outreach and sub center personnel for strengthening institutional and managerial capabilities.
2. Supporting ULBs in implementing IEC/BCC interventions
3. Encouraging networking among ULBs in order to exchange good practices and cross learning
4. Supporting ULBs in generating community awareness and public participation.
5. Supporting the ULBs in increasing access and demand to services through gender sensitive and improved program planning and implementation.
6. Technical assistance, coordination, and facilitation of stakeholders at the municipal level to address urban health;
7. technical assistance to municipal corporations and district health officers (Chief Medical Officers) on developing proposals and plans for implement urban health programs;
8. Capacity building and training for NGO partners on health promotion, behavior change, etc.;
9. Facilitation and development of public-private partnerships;
10. Coordination of study tours and visits to learning sites in model city programs;

Public Private Partnerships

The World Bank-assisted eighth India Population Project (IPP-VIII) has been particularly successful in engaging NGOs for service delivery; for IEC activities and implementation of other innovative schemes; and for involving them as intermediaries between government health staff and the community. The NGOs contracted by IPP VIII to run the urban health centers were made responsible for all field level activities. It also, contracted in services of Part Time Medical Officers (PTMO) at the subcentre level for clinical services. The UH strategy encourages PPP where such opportunity exists and where the ULB is willing to explore such partnerships. The following areas can be considered for partnership:

- Contracting out Sub Centres to NGOs in difficult areas.
- Contracting in general practitioners at the sub center level.
- Incentives built into financial arrangements as part of social franchising schemes for RH products and services.
- Population based surveys including the base line, midline and end line surveys.
- Technical training/capacity building at various levels.
- Data management at the ULB level.
- Mounting BCC campaigns/ IEC material development.

Partnership with NGOs in the above areas can be thought of in the context of the existing arrangements of the Mother NGO scheme (MNGO). The Mother NGO (MNGO) scheme was introduced in the Department of Family Welfare (DFW) on the 9th Five Year Plan, (1997-2000) under the Reproductive and Child Health (RCH) program. MNGOs and its complementary field NGOs (FNGOs) can complement the government system in service provision related to FP, Immunization, MCH and access to institutional delivery. RTI/STI, adolescent reproductive health care also can be addressed wherever required and as per community need.

Currently the State has 16 MNGOs covering all the Districts including Kolkata. Under these 16 MNGOs, 63 FNGOs have been selected and some has already started implementation. The ULBs can determine the areas to be covered, usually the un-served/underserved ones with the MNGOs and improve the basic preventive and promotive services in these backward wards of the ULBs. Expected Deliverables could

include increased maternal & child health service utilization (antenatal & post natal care services, institutional deliveries, utilization of JSY, routine immunization).

IEC/BCC activities

As an essential public health function, health communication is of strategic importance. It is an essential ingredient in a program of reform, and an important input of health service access and utilization improvement. Although newer technologies have been available in the urban context, these options have not been sufficiently exploited in implementing strategies and programs for the poor, or their health providers, in urban areas.

Strategic communication works best when it combines interactive group and interpersonal methods on the ground with mass media initiatives and advocacy. In the municipalities, a community structure exists from ward level upwards, which would enable key behavioural changes reflected in better utilization of services and adopting positive health action.

Communication, advocacy and social mobilization efforts planned at various levels in the municipalities will be seen as a process and will be synchronized to focus increase use of services and community ownership of programmes. Use of appropriate media (mass media, inter personal communication etc.) will be made in a well thought out process and design. Regional variations within the state, in terms of language and characteristics will be factored in and it would be ensured that each district and the municipalities under it receive specific communication instead of generic ones.

Different types of BCC materials and tools will be developed. There would be greater coordination with field publicity and broadcasting department and subgroup specific communication would be encouraged. These activities would facilitate behavior change, maternal, child health and adolescent health behaviors that are directly linked to RCH objectives.

A strategy for IEC/BCC will be developed based on the local situation. Private sector and NGO partnerships for IEC will be promoted, particularly where potential partners with skills and proven experience in IEC/BCC are available. The IEC plans will especially focus on interpersonal or group communication plans. Include a description of expected behavior change in different audience segments, and an outline of an IEC plan with benchmarks for monitoring implementation and estimated budget. IEC plans should focus on building community awareness and knowledge, enhancing skills to practice healthy behaviors, and strengthening confidence to access health services.

Sustainability of financing Urban Health

Subsidy for public health systems

Owing to the nature of services offered. The subsidy for public health systems will need to continue to be made available because of the recurrent costs of health delivery systems, whether established in the public or the private sector. This would entail significant budgetary allocations. Also, under a public health agenda, it is unlikely that out-of-pocket expenditure could be used to finance public goods such as communication programs and immunization infrastructure.

The Department of Municipal Affairs and Urban Development can mobilize additional resource particularly for addressing the larger determinants of health, e.g. Water supply, solid waste management, housing etc.

Self-sustaining strategies

Demand-side reforms including vouchers scheme can be used for health specific Vouchers and payments. Expanding the program focus beyond child health to include HIV/AIDS, TB, and malaria program also could potentially introduce other sources of funding for urban health. Additionally, several sources of contribution may be explored donations from business houses, individuals, banks, etc. and ~~National Slum Development Program of GOI contributions~~ not existing now

(1). What above. Funding. Flow. Strategy.

(2). All the manpower at State and at ULB level in respect of Urban Health should be provided on pay ... structure.

Agreement under UIDSSMT between SLNA & ULB

THIS SUBSIDIARY AGREEMENT is made between State Urban Development Agency, the Sate level Nodal Agency of Government of West Bengal; as Part I

AND,

, through its authorized person, as Part II

WHEREAS, the Part I has been appointed as State Level Nodal Agency (SLNA) vide Government of West Bengal in the Municipal Affairs Department Order No151/MA/P/C-10/3S-65/2005 dated 7.2.06 as per the Guidelines for Urban Infrastructure Development Scheme for Small and Medium towns (UIDSSMT);

AND WHEREAS Part II seeks financial assistance under the UIDSSMT;

AND WHEREAS Part II have undertaken to implement the reform agenda as per the guidelines of UIDSSMT as per the timelines indicated in detail in Annexure - A;

AND WHEREAS Part II has undertaken to raise funds in respect of its share as per the guidelines of UIDSSMT vide Annexure – B detailing the source of funds and confirmation of date by which funds would be made available with Part II;

AND WHEREAS Part I has entered into a Memorandum of Agreement with Ministry of Urban Development on dated as per the guidelines of UIDSSMT;

AND WHEREAS and per the said Memorandum of Agreement, Part I shall enter into Subsidiary Agreement with Urban Local Bodies (ULBs) for providing assistance as per the guidelines of UIDSSMT;

AND WHEREAS the Part I has considered the documents mentioned in Annexure –A and Annexure-B and found them consistent with the goals and objectives of UIDSSMT;

AND WHEREAS Part I agrees to provide financial assistance to Part II under the guidelines of UIDSSMT and in accordance with the terms and conditions specified here-in-after in this agreement.

NOW THE PARTIES WITNESSED as follows:

1. That the Part I shall release the financial assistance to Part II as per the provisions indicated in the guidelines of UIDSSMT ;
2. Any assistance under UIDSSMT shall be considered by Part I only if the timelines indicated in detail in Annexure A to this Subsidiary Agreement to implement the reform agenda as per the guidelines of UIDSSMT are adhered and utilization certificates (UCs) for previous releases of financial assistance under UIDSSMT are furnished to Part I by Part II ;
3. That the Part II shall follow all rules, guidelines and notifications made by Part I and State Level Sanctioning Committee in regard to grant of financial assistance in accordance with the guidelines of UIDSSMT from time to time;
4. That the Part II shall open a separate bank account for each project in a commercial bank for receipt and expenditure of all money to be received by Part II including its matching share for the project;
5. That the Part I or an agency nominated by it , may undertake site visits to ascertain the progress of the ongoing projects and also the reforms agenda through designated representatives periodically;
6. That the Part II shall submit a Quarterly Progress Report to Part I of the spending of the financial assistance comprising of Central and State grants and corresponding matching share by Part II along with the physical progress of the Project. In case Part II fails to

submit such a report further installment of financial assistance may be withheld until such submission.

7. That the Part II shall submit a half-yearly report of the progress in respect of the implementation of the reform agenda as per the guidelines of UIDSSMT and as per the timeline indicated in detail in Annexure – A;
8. That the Part II shall submit audited accounts in respect of each project funded under UIDSSMT within six months of close of the financial year to Part I;
9. In the event of requirement of additional funds due to unforeseen circumstances or cost overrun, Part II shall ensure that the projects are completed within the stipulated period without raising any additional demand for funding to Part I;
10. That Part II shall submit a complete report regarding the outcome of the UIDSSMT on the completion of the project;
11. That the parties to the agreement further covenant that in case of a dispute between the parties the matter will be resolved through mutual discussion;
12. That in case there is any delay in the implementation of the reforms agenda or submission of any periodic reports, etc. by the Part II , due to the circumstances beyond the control of Part II i.e, Force Majeure or any other reason , the decision on the matter of extension of time for the implementation of the goals and objectives of the UIDSSMT shall be at the discretion of Part I;
13. That in case any breach regarding the terms and conditions indicated in this Subsidiary Agreement, rules, guidelines and notifications made by Part I and State Level Sanctioning Committee in regard to grant of financial assistance under UIDSSMT and the terms and conditions of UIDSSMT, the Part I shall be entitled to withhold subsequent installments of the financial assistance.

IN WITNESS HEREOF all the parties have put their hands on these presents of Memorandum of Agreement in the presence of witnesses.

SIGNATORIES :

1. State Urban Development Agency ,On behalf of Government of West Bengal (Part –I)

2. On behalf of

WITNESS :

1.....

2.....

Memorandum of Understanding Between Paschim Banga Rajya Prarambhik Shiksha Unnayan Sanstha (PBRPSUS) and Shishu Shiksha Prakalpa Under Department of Municipal Affairs, Govt. of West-Bengal.

1. Shishu Shiksha Prakalpa (SSP), implemented by Department of Municipal Affairs in Urban areas or slum areas will be treated as a Government supported EGS (Education Guarantee Scheme) component for alternative primary education system in all urban areas of 20 educational districts in West-Bengal.

2. The existing Shishu Shiksha Prakalpa centers in urban / slum areas under department of Municipal Affairs will be brought under the purview of District Primary Education Programme (DPEP) and or Sarva Shiksha Abhiyan (SSA) from this year as per existing guideline of Education Guarantee Scheme and Alternative & Innovative Education.

3. Under DPEP and SSA programmes, Paschim Banga Rajya Prarambhik Shiksha Unnayan Sanstha and department of Municipal Affairs will jointly be responsible for planning, monitoring, supervision and administration of SSP centers in all the educational districts of West-Bengal.

4. The existing Shishu Shiksha Prakalpa Centre situated in Urban & Slum areas throughout the state which have at least 20 recorded out of school children as per child register maintained by each Ward Education Committee or other organization in municipal or municipal corporation areas will be funded from District Primary Education Programme (DPEP) and or Sarva Shiksha Abhiyan (SSA). The centres would function for a minimum of 4 hours a day during day time as per state norm. The names of those children shall not be enrolled in any other formal school or NGO run EGS centres / schools, bridge-course etc.

5. In case of the existing Shishu Shiksha Prakalpa Centres satisfying the conditions as mentioned in the guideline of Education Guarantee Scheme and Alternative & Innovative Education and having more than one Sahayikas (para teachers), only 2 Sahayikas will be remunerated @ Rs.1000/head/month from DPEP or SSA fund.

6. In case of the SSP centres with one Sahayika, the remuneration will be paid for the said Sahayika @ Rs.1000/- per month.

7. The fund for remuneration for 2 Sahayikas or 1 Sahayika, as the case may be, will be disbursed by the District Project Officer, DPEP/SSA on receipt of district wise picture containing no. of SSP centres, no. of Sahayikas, no. of learners to be covered from department of municipal affairs.

8. Officer-in-charge, Municipal affairs of the concerned district shall submit utilisation report to the District Project Officer, DPEP/SSA with a copy to SPO, PBRPSUS and Municipal Affairs Deptt. Similarly a requisition for fund relating to remuneration of Sahayikas shall be placed before DPO, DPEP/SSA by officer-in-charge, municipal affairs department for releasing necessary fund with a copy to SPO, PBRPSUS and Municipal Affairs Deptt.

9. Municipal Affairs Dept. shall also maintain the details as regards to no. of SSP with addresses, no. of Sahayikas. Compiled utilisation certificate shall be forwarded by Municipal Affairs department to SPO, PBRPSUS.

10. Proportionate fund will be released in favour of officer-in-charge, municipal affairs of the concerned districts by the concerned DPO, DPEP/SSA for running the Shishu Shiksh Prakalpa Centres in West Bengal keeping in conformity with the actual fund released by GoI. For the salary component of the Sahayikas, attempts shall be made to fulfill the monthly demand as far as practicable from the available funds at the disposal of SPO, PBRPSUS.

11. Syllabus, Curriculum and textbooks for existing SSP centers will be same as for formal primary education. The pedagogical issues including quality assurance relating to SSP centers will be addressed through joint collaboration of Department of Municipal Affairs, Paschim Banga Rajya Prarambhik Shiksha Unnayan Sanstha and West-Bengal Board of Primary Education at the state level and concerned District Project Office and concerned District Primary School Council at District level, but the training programme of Sahayikas, supervisors and other functionaries of the Department of Municipal Affairs at district/ state

level on DPEP and SSA, with special emphasis on quality assurance, will be provided by the Department of Municipal Affairs Govt. of West-Bengal independently.

12. The Department of Municipal Affairs, Govt. of West-Bengal will be responsible for submitting monthly / quarterly report (including DISE) on the status of existing Shishu Shiksha Prakalpa Centres in Urban / Slum areas throughout West-Bengal containing District / Town wise no. of centers, no. of Shiksha Sahayikas (Para Teacher), no. of learners covered (Age, Gender, Grade and Social Category wise) as required by MHRD, GoI to SPO, PBRPSUS for sharing information, onward transmission, future plan of activities and also preparation of plan document for each educational district in connection with District Primary Education Programme and Sarva Shiksha Abhiyan in West-Bengal each year.

13. There shall be strong linkage between PBRPSUS and the Department of Municipal Affairs in all relevant issues including planning for existing Shishu Shiksha Prakalpa Centres in different Urban/Slum areas, quality issues, data generation, MIS etc. There shall also be linkage at the municipal corporation or municipal and sub-municipal levels and more particularly between managing committees (MC) of existing Shishu Shiksha Prakalpa centers in Urban/Slum areas and Ward Education Committee.

14. All financial activities at the existing Shishu Shiksha Prakalpa Centres level in Urban/Slum areas will be executed by the Managing Committee of the existing Shishu Shiksha Prakalpa Centres in Urban/Slum areas and progress of work and utilization of funds will be reported by the MC to the WEC. Proposal for opening of new Shishu Shiksha Prakalpa Centres with at least 20 recorded out of school children as per child register, will be initiated by the local residents or the guardians of those recorded out of school children or the members of Ward Education Committees. On receipt of proposal, concerned municipality / Municipal Corporation shall examine the same and forward it to Municipal Affairs Department with specific views. If found suitable, Department of

Municipal Affairs may open new centres in consultation with SPD for necessary fund flow. It is further noted that concerned Municipality / Municipal Corporation, before sending the proposal shall also involve the DPO, DPEP / SSA of concerned district and his views shall be recorded in writing.

15. Proportionate fund will be released in favour of the Department of Municipal Affairs, Govt. of West-Bengal by SPO, PBRPSUS based on the actual sanctioned fund received from MHRD, GoI in instalments for administering Shishu Shiksha Prakalpa in the state and the said department will duly furnish necessary utilisation reports to SPO, PBRPSUS. For the instant issue, the special emphasis will be given on the remuneration of the Sahayikas by PBRPSUS.

16. Department of Municipal Affairs GoWB. shall release proportionate fund share in favour of SPO, PBRPSUS on the basis of actual fund released by PBRPSUS in the ratio of 75 : 25.

17. This memorandum of understanding between Paschim Banga Rajya Prrambhik Shiksha Unnayan Sanstha (PBRPSUS) and Shishu Shiksha Prakalpa under Department of Municipal Affairs, GoWB shall take effect from the date of its execution.

18. Any modification or change in this Memorandum of Understanding (MOU) shall be done through bilateral negotiations between PBRPSUS and the Department of Municipal Affairs, GoWB.

22/01/04

(S. Biswas)
Director Local Bodies
(For and on behalf of Deptt.
of Municipal Affairs)

22/01/04

(Dr. K. Gupta)
State Project Director

Countersigned

Principal Secretary
School Education Department

Countersigned

Secretary
Municipal Affairs Department

Urban Health File
8/11/6/08

Government of West Bengal
Health & Family Welfare Department
Strategic Planning & Sector Reform Cell
Swasthya Bhavan, GN-29, Sector-V,
Bidhannagar,Kolkata-700091.
Telefax: 2357- 0955/ 1896

EUSP CHANGE MANAGER 1644 10/6/08

No.HF/SPSRC/WBHSDP/115/2006/ 97 Dated June 3, 2008

From : S.K. Sen
Program Director, BHP
& e.o. Special Secretary

To :

1. Ms. Chhanda Sarkar, Director, SUDA
2. Dr. Shibani Goswami, Health Expert, SUDA
3. Dr. N.G. Gangopadhyay, Advisor, Health , SUDA
4. Ms. Bulbul Bakshi, Program Manager, GTZ Health Sector Support
5. Ms. Rajarshi Narayan, TAST

Dr. Goswami
I presume you have attended
10/6

Sub: Meeting with The World Bank Team visiting the State on 9-12 June, 2008 in connection with the proposed West Bengal Health Systems Development Project to be funded by The World Bank.

Sir /Madam,

A meeting will be held with The World Bank Team on June 9, 2008 at 11 am in the Conference Hall of WBSAP & CS in connection with the proposed West Bengal Health Systems Development Project to be funded by the World Bank.

You are requested to kindly make it convenient to attend the abovementioned meeting.

Yours faithfully,

S.K.Sen
Program Director, BHP &
e.o. Special Secretary

No.HF/SPSRC/WBHSDP/115/2006/ 97 Dated June 3, 2008

Copy forwarded to:
Sri Arnab Roy, IAS, Project Director, CMU & e.o. Special Secretary, Department of Municipal Affairs.

S.K.Sen
Program Director, BHP &
e.o. Special Secretary

State Urban Development Agency

A Brief Outline

State Urban Development Agency (SUDA)

State Urban Development Agency was set up in 1991 with a view to ensuring proper implementation and monitoring of the centrally assisted programmes for generating employment opportunities and alleviation of poverty throughout the State. SUDA is a Society registered under the West Bengal Societies Registration Act, 1961.

Functions of State Urban Development Agency

Functions of State Urban Development Agency can be broadly classified into those pertaining to:

- Urban Poverty Alleviation & Livelihood generation
- Low cost housing & sanitation
- Health
- Integrated Housing & Slum Development.
- Handholding support to facilitate access to various financial windows
- Others

Urban Poverty Alleviation & Livelihood generation (Swarna Jayanti Sahari Rozgar Yojana):

- To monitor and implement the state urban poverty programme and policy within the overall State urban strategy;
- To mobilise resources and determine allocations of poverty alleviation programme based on the need and performance;
- To provide technical support to districts / towns to achieve convergence targets and Participatory systems;
- To formulate, coordinate and monitor the state training plan pertaining to poverty alleviation and strengthen related capacity building framework;

Low cost housing & low cost sanitation (VAMBAY & ILCS):

- To function as State Level Nodal Agency for implementation & monitoring of the progress of Valmiki Ambedkar Awas Yojana (VAMBAY);
- To function as State Level Nodal Agency for implementation & monitoring of Integrated Low Cost Sanitation scheme (ILCS);

Kolkata Urban Services for the Poor (KUSP)

The Kolkata Urban Services for the Poor (KUSP) is an 8 year urban reforms programme for the Urban Local Bodies (ULBs) in the Kolkata Metropolitan Area. These include 38 Municipalities and 2 Municipal Corporation (namely, Howrah and Chandernagore) and exclude Kolkata Municipal Corporation. The programme is funded through a grant of around GBP 102m (consisting of Financial aid and Technical Cooperation) from the UK Department for International Development. The objectives of the programme are primarily three-fold :

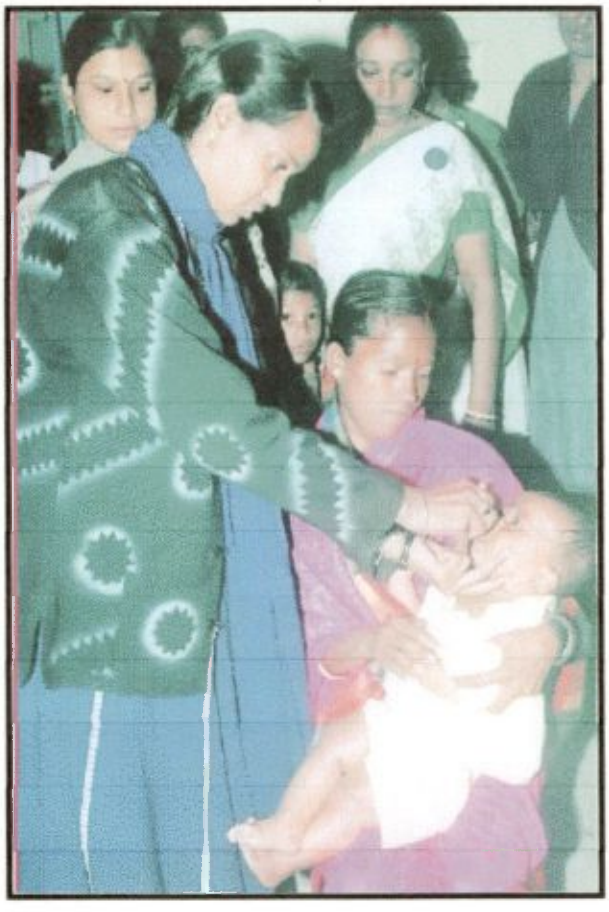
- Improve urban planning and governance
- Improve access to services for the poor
- Promote economic growth

In this programme emphasis have been given on the following areas:

- Developing ownership of community assets
- Bringing together diverse facets of urban infrastructure and service delivery improvements
- Use of technology like IT in the urban governance to improve efficiency, effectiveness, and transparency in ULB operations
- Capacity building of the Urban Local Bodies as well as of the Support Agencies through augmenting technical capacity in the Urban Local Bodies, conducting regular training programme for Municipal and support agency staff.
- Introduction of performance orientation within the Urban Local Bodies by encouraging the Urban Local Bodies by encouraging the Urban Local Bodies to consider innovative ways to enhance their financial sustainability and to improve their service delivery capabilities.
- Spreading the scope of citizen's interface through publication of Citizen's Charter, ensuring citizen's participation in formulation of Development5 Plans as well as in management of assets.
- An effective Public Grievance Redressal System is also being encouraged by this programme.

Health:

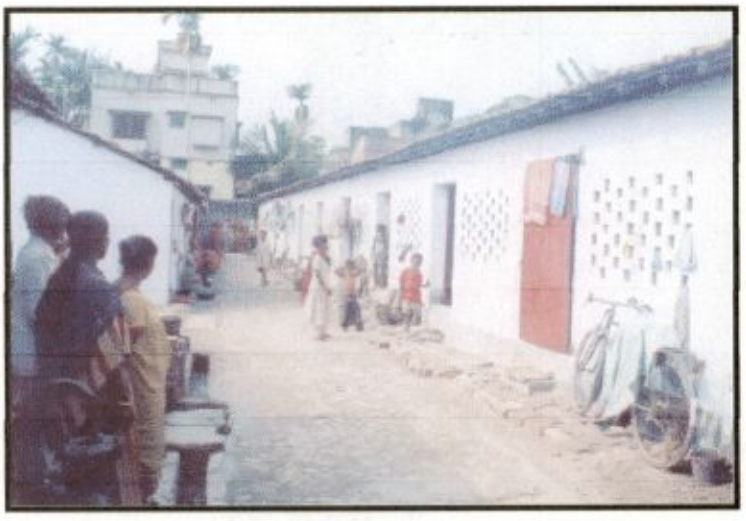
SUDA function as State Level Nodal Agency for implementation & monitoring of the following health programmes:



- IPP VIII (Extension). This programme is in the Operation & Maintenance Stage and is currently operative in 10 Urban Local Bodies in the State.
- Honorary Health Worker (HHW) Scheme. This programme is in the implementation stage and is operative in 11 Urban Local Bodies currently.
- Reproductive Child Health (RCH) Sub-Project currently operative in Asansol Municipal Corporation. The project is in the implementation stage.
- Community Based Primary Health Care Services. The programme is currently in the implementation stage and is operative in 63 Urban Local Bodies.
- Janani Suraksha Yojana (JSY). The programme is currently in the implementation stage, covering all 126 Urban Local Bodies of the State. *

* A detailed report is enclosed at Annexure 1

Integrated Housing & Slum Development: (IHSDP)



This scheme is aimed at having an integrated approach in slum development in urban areas and is applicable for all cities/towns excepting two Mission Cities (under JNNURM), i.e. Kolkata & Asansol. The target group under the scheme is slum dwellers from all sections of the community through a cluster approach. SUDA is the state level Nodal Agency for fund management, implementation & monitoring of IHSDP schemes.

Urban Infrasrtuscture Development Scheme for Small & Medium Towns (UIDSSMT)

This scheme aims at improvement in urban infrastructure in towns & cities in a planned manner and is applicable for ll towns/cities excepting cities/towns covered under JNNURM, i.e. Kolkata& Asansol. SUDA is the state level Nodal Agency for fund management, implementation & monitoring of this scheme.

National Urban Information System (NUIS) Scheme – National Urban Data Bank & Indicators (NUDB & I)

This scheme launched by GOI aims to develop GIS database for selected cities/ towns in the country. Apart from urban spatial information systems, the scheme has another componenet , i.e. National Urban Data Bank & Indicators. The spatial and attribute database thus generated will be useful for preperation of Master/ Development plans, detailed town planning schemes & serve as decision support for e-governance. Presently 7 cities/towns have been brought under the coverage of the scheme. SUDA has been identified as the state level Nodal Agency for implementation & monitoring of the scheme.

Handholding support to facilitate access to various financial windows:

- To act as a nodal agency for accessing loans from financial institutions with approval of the State Government;
- To act as a fund flow agency for various development programmes of the State Government;

Others:

- Report the programme status monthly, or as per requirement from time to time to the Department of Housing & Urban Poverty Alleviation (HUPA), Government of India;
- To supervise and coordinate with District Development Agencies (DUDAs);
- To act as a major support agency of Kolkata Urban Services for the Poor (KUSP)

The above-mentioned areas broadly constitute the area of work for SUDA.

Documents:

1. Current Activities of Health Wing, SUDA
   Enclosed at Annexure 1

2. Design and estimate of Sub-Centre & HAU
   Enclosed at Annexure 2 & 3

3. ULB staffing pattern
   Enclosed at Annexure 4

4. TOR for accounting support agency
   Enclosed at Annexure 5

5. IPP-VIII agreement copy.
   Enclosed at Annexure 6

Annexure 1

Current Activities of Health Wing, SUDA

IPP-VIII (Extn.)

India Population Project – VIII (Extn.) was launched with World Bank Assistance in 10 Non-KMA ULBs i.e. Alipurduar, Balurghat, Burdwan, Darjeeling, Durgapur, English Bazar, Jalpaiguri, Kharagpur, Raiganj & Siliguri during January, 2000, covering urban BPL population of 7.56 lakhs. The project cost was Rs. 3527.42 lakhs. The World Bank assistance ended on June, 2002. This project is being maintained by Municipal Affairs Department since July, 2002

The broad objectives are – (1) Improve maternal & child health by reducing morbidity and mortality of maternal & under-five children, (2) Reduce fertility.

The health facilities created under the project are 1090 Project Blocks (1 block cover 750 – 1000 BPL population), 250 Sub-Health Post, 35 Health Post, 11 Out Patient Department cum Maternity Homes and 11 Diagnostic Centres. The services are catered through grass root level Honorary Health Workers drafted from the community who are the Primary Health Care providers generating awareness on Family Welfare including pregnancy care, institutional delivery, immunization, nutrition, contraception & different health issues. Treatment of minor ailments are taken care off by the Honorary Health Workers at the door-step of the beneficiaries. Preventive, promotive & curative health care services are provided at Sub-Health Post, Health Post, Out Patient Department and referral services at Maternity Homes. They are also responsible for implementation of National Health Programmes.

Towards sustainability, health fund has been generated for an amount of Rs. 344.21 lakhs till date by the 10 ULBs concerned through imposition of user charges and realization of user fees.

Considerable impact & improvement have been observed with regard to health status of the beneficiaries as mentioned hereunder:

- Reduction of Crude Birth Rate from 20.3 to 15.3,
- Crude Death Rate from 7.6 to 3.8,
- Infant Mortality Rate from 54.0 to 21.9,
- Maternal Mortality Rate from 6.0 to 1.7 and
- Increase of Couple Protection Rate from 38.6 to 73.0,
- Coverage of pregnant women with tetanus toxoid from 47.2 to 96.7,
- Institutional Delivery from 46.8 to 95.4,
- Complete Immunization of Infant from 22.4 to 92.6.

The revised budget for FY 2006-07 is estimated at Rs. 417.55 lakhs. An amount of Rs. 314.05 lakhs was received towards O & M during FY 2006 – 07.

RCH Sub-Project, Asansol

The project was launched with World Bank assistance in Asansol Municipal Corporation during August, 1998 covering Urban BPL population of 2.55 lakhs with objective of reducing fertility and improving maternal & child health. World Bank assistance ended on 31st March, 2004. The project cost was Rs. 854.57 lakhs. The activities of the project is being maintained by Municipal Affairs Department since April, 2004.

The services are rendered through the health facilities created under the project i.e. 387 Blocks, 13 Health Administrative Unit, 97 Sub-Health Centres, 2 Out Patient Department cum Maternity Homes cum Diagnostic Centre and 1 Medical Store. 387 Honorary Health Workers are not only providing Primary Health Care services at the door-steps of the beneficiaries but also act as pivots towards disseminating preventive, promotive & curative services and implementation of National Health Programmes.

The impact of the services have been observed with regard to health status of the beneficiaries i.e. Reduction of Crude Birth Rate from 23.9 to 16.9, Crude Death Rate from 12.4 to 5.7, Infant Mortality Rate from 60.0 to 21.5, Maternal Mortality Rate from 3.0 to 0.7 and Increase of Couple Protection Rate from 41.4 to 72.0, Coverage of pregnant women with tetanus toxoid from 51.8 to 96.6, Institutional Delivery from 57.3 to 90.2, Complete Immunization of Infant from 30.9 to 88.8.

The ULB has generated health fund for an amount of Rs. 13.86 Lakh till date.

The revised budget for FY 2006–07 is estimated at Rs. 131.80 lakhs. An amount of Rs. 97.53 lakhs was received from MA Dept. towards O & M during FY 2006–07.

Honorary Health Worker Scheme in 11 Non-KMA ULBs

The Honorary Health Worker Scheme was piloted with the assistance of DFID in 11 Non-KMA Urban Local Bodies i.e. Cooch Behar, Jangipur, Berhampur, Suri, Bolpur, Purulia, Bankura, Bishnupur, Krishnagar, Kalna & Medinipur during the period February, 2004 to June, 2005. Implementation activities have been extended upto March, 2007 by Department of Health & Family Welfare.

2.86 lakhs of the BPL population have been covered under this scheme. The project period upto June, 2005 was meant for process development towards functioning of HHW Scheme. Constitution of Municipal Level Health & FW Committee, formation of Municipal Management Cell, detailment of Project Director i.e. ADM / SDO, Job Orientation Training for Health Worker & First Tier Supervisors have already been completed. There was no provision for new construction of health facilities. The health facilities created are 260 Project Blocks – each block is manned by the Honorary Health Worker, 55 Sub-Health Posts – each Sub-Health Post is in-charge of one First Tier supervisor. The accommodation for Sub-Health Post have been provided either by NGO / CBO or Urban Local Body. Different clinics like ANC / PNC clinic, Immunisation clinic, Growth Monitoring clinic, General Treatment clinic and Awareness programme have already been initiated in all the SHPs. Referral services have been linked with the nearest State Govt. Hospital.

The estimated budget for FY 2006-07 is s. 599.95 lakhs and has been prepared following the principle in line with recently launched community based primary health care services in 63 Non-KMA ULBs. A total amount of Rs. 256.90 lakhs have been received from HSDI of Department of Health & Family Welfare during FY 2006–07. Expenditure incurred for an amount of Rs. 106.01 lakhs till date during FY 2006-07.

Community Based Primary Health Care Services in 63 Non-KMA ULBs

A project on Community Based Primary Health Care Services in 63 Non-KMA Urban Local Bodies has been launched by the MIC, Health & Family Welfare Department and MIC, MA & UD Department on 24th February, 2006. This project will cover a total of 34.03 lakhs urban population with special focus to 11.23 lakhs BPL population.

The objective is – (a) to bring about an overall improvement in the Urban health scenario as a whole with reference to reduction in Crude Birth Rate (CBR), Crude Death Rate (CDR), Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR) and enhancement of Couple Protection Rate (CPR), (b) to provide Primary Health Care service delivery to the urban population with focus on Reproductive & Child Health of BPL population, (c) to implement National Health Programme for total population, (d) to ensure maximum utilisation of Government Institutions for referral services.

The preparatory process is sensitisation of ULBs, formation of Health & FW Committee at ULB, creation of Management & Supervision Cell at ULB & Head Quarter Level, selection of HHWs, job orientation training of HHWs, orientation training of other health manpower, identification of Sub-Centres for initiating service delivery at door-step of beneficiaries & Sub-Centres.

Package of primary health care services i.e. antenatal / postnatal care, promotion of institutional delivery, immunization, promotion of breast feeding and proper weaning, growth monitoring of under-five children, family welfare programme, RTIs, adolescent health care, treatment of minor ailments, surveillance of communicable diseases, conduction of various awareness programme will be provided to the urban population with focus to Below Poverty Line (BPL). Community participation will be ensured at all levels for successful implementation of this programme.

While the HHW shall be responsible for primary health care of the BPL families under her jurisdiction, she shall also be responsible for both public health services and health statistical data collection for the entire population within her geographic jurisdiction / project block. The Ward Councillor will monitor & supervise the activity at Ward level and co-ordinate the implementation of National Health Programme at ward level.

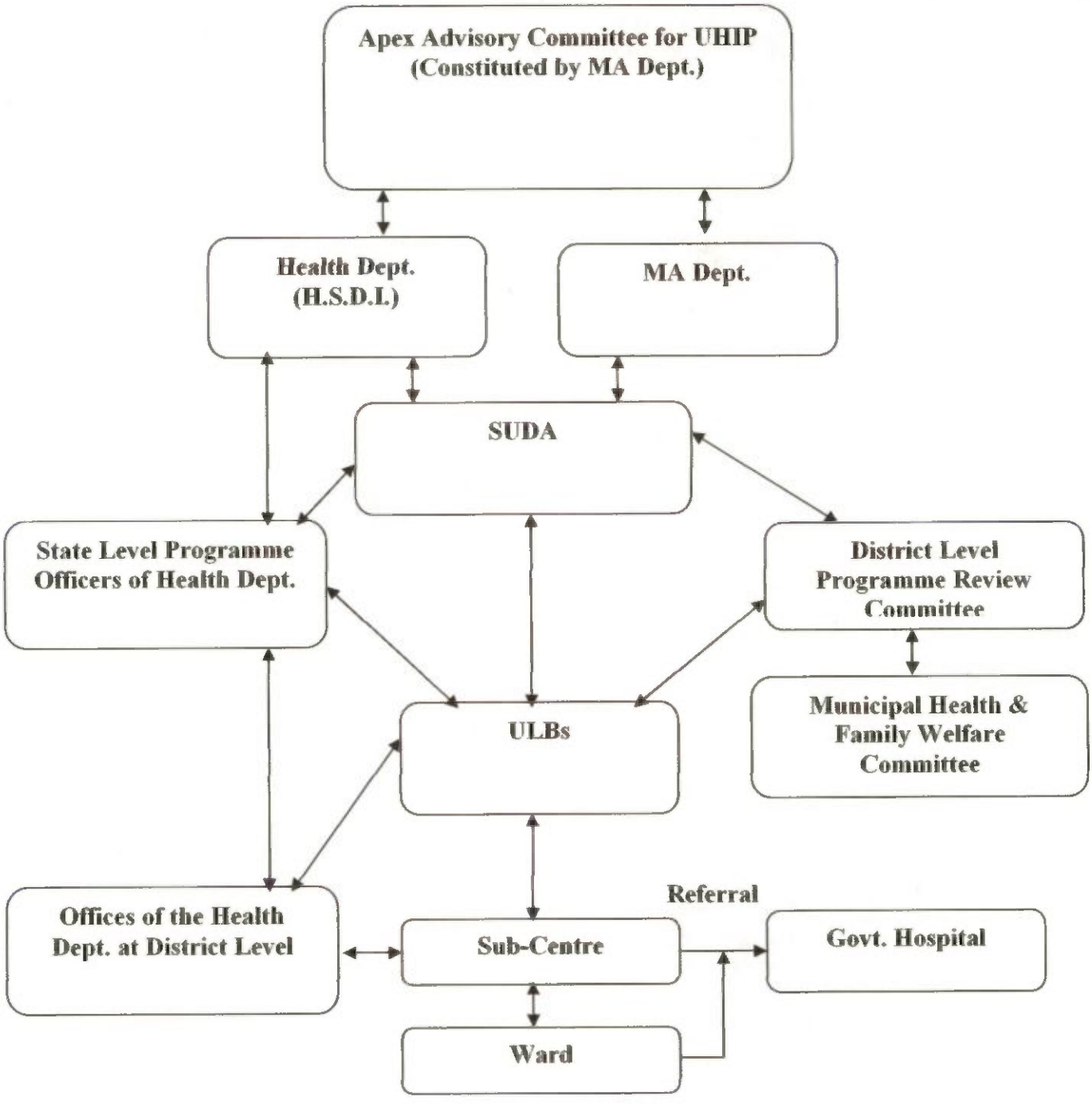
Activities	Status
Sensitisation of 63 ULBs by SUDA	Completed
Central procurement of HHW Kit Bag, Training manual for HHWs, Family Schedule, HMIS and Base line survey formats by SUDA and distribution to the ULBs	Completed
Constitution of Municipal Level Health & Family Welfare Committee by the ULBs	Completed
Opening of separate Bank A/C by the ULBs	Completed
Selection of HHWs by the ULBs	Completed in 57 ULBs
Forwarding the names of trainers by ULBs to SUDA	Completed by 57 ULBs
Completion of trainers training by SUDA for imparting training to HHWs at ULB level	Completed in 51 ULBs (those who have completed selection of HHWs)
Training of HHWs initiated by the ULBs	Training have been initiated by 22 ULBs

The estimated project budget is Rs. 5829.00 lakhs for three years. An amount of Rs. 300.00 lakhs has already been released by Department of Health & Family Welfare to State Urban Development Agency.

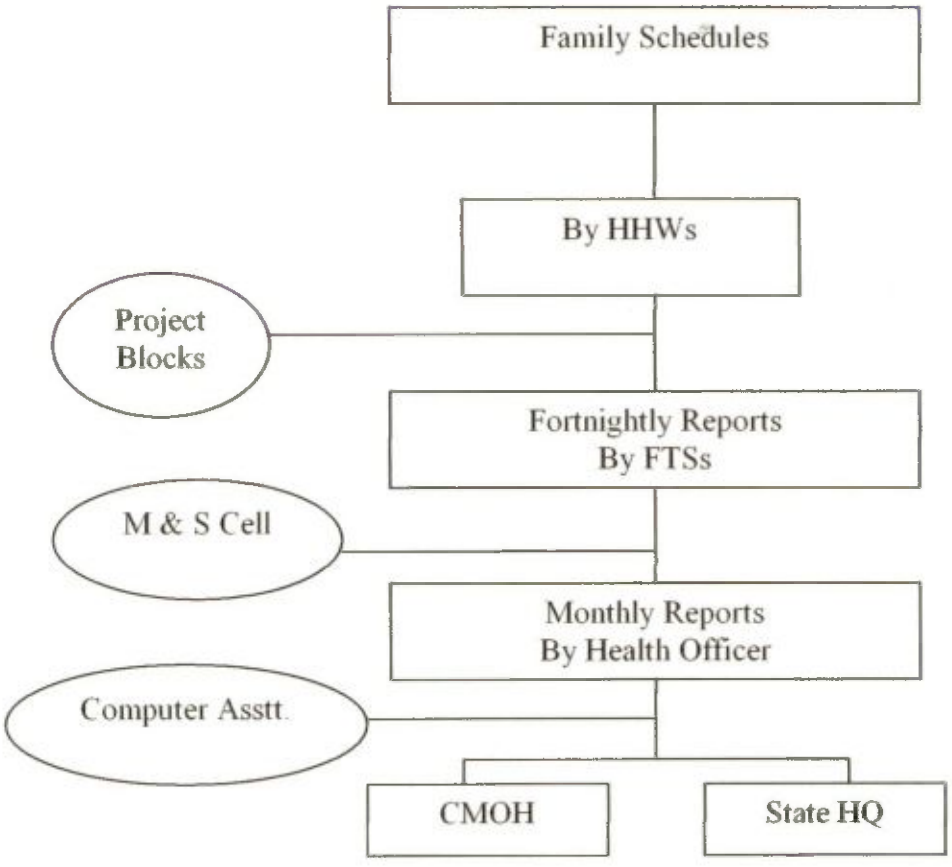
An initial fund for Rs. 148.89 lakhs have already been released to the ULBs to procure furniture & equipment for training, Management & Supervision Cell and conduction of HHWs training programme.

Monitoring system

Service Monitoring



HMIS : Flow Chart



O/C (1)

Accounting Support Agency

Terms of Reference

1.1.1 SUDA will be responsible for preparation of Statement of Expenditure (SOE) and Utilisation Certificates, and for submission of reimbursement claims along with SOE & UC. Initial accounts will be generated in the level of ULBs. Those accounts are to be collected and consolidated by SUDA and consolidated report is to be sent by SUDA to the Health Dept., GoWB.

The procedure suggested is as follows:

1) Each ULB has to maintain separate bank account for this fund.

2) Each ULB has to maintain a subsidiary cash book for the said fund. However some additional information as may be required has to be incorporated in the cash book. The total of the cash book will be carried over to the main cash book at the end of the month.

3) A support agency may be hired for one year for the present subject to extension on satisfactory performance on year to year basis to :

   a) help the fund handling bodies to write the cash books as per requirements and prepare bank reconciliation report;
   b) collect the required information from the cash books every month;
   d) prepare ULB-wise statement of expenditure, utilisation certificates;
   e) compilation of accounts at SUDA level and prepare consolidated SOE and UC as well as reimbursement claims;
   e) prepare monthly, quarterly as well as annual reports.

2. Scope of Work & Methodology

An Accounting Support Agency will be engaged for preparation of relavant reports after collection of information from the respective ULBs each month.

The said agency will be responsible for:

a) Designing the Cash Book to be maintained separately and exclusively for the fund by the individual ULBs;
b) On the spot training of the personnel entrusted with keeping the Cash Book of the concerned ULBs;
c) Providing regular guidance and help for writing the Cash Book, preparation of SOEs and UCs;
d) Preparing monthly Bank Reconciliation Statement of each ULB;
e) Verification of proper fund utilisation, collecting monthly Cash Trial by visiting

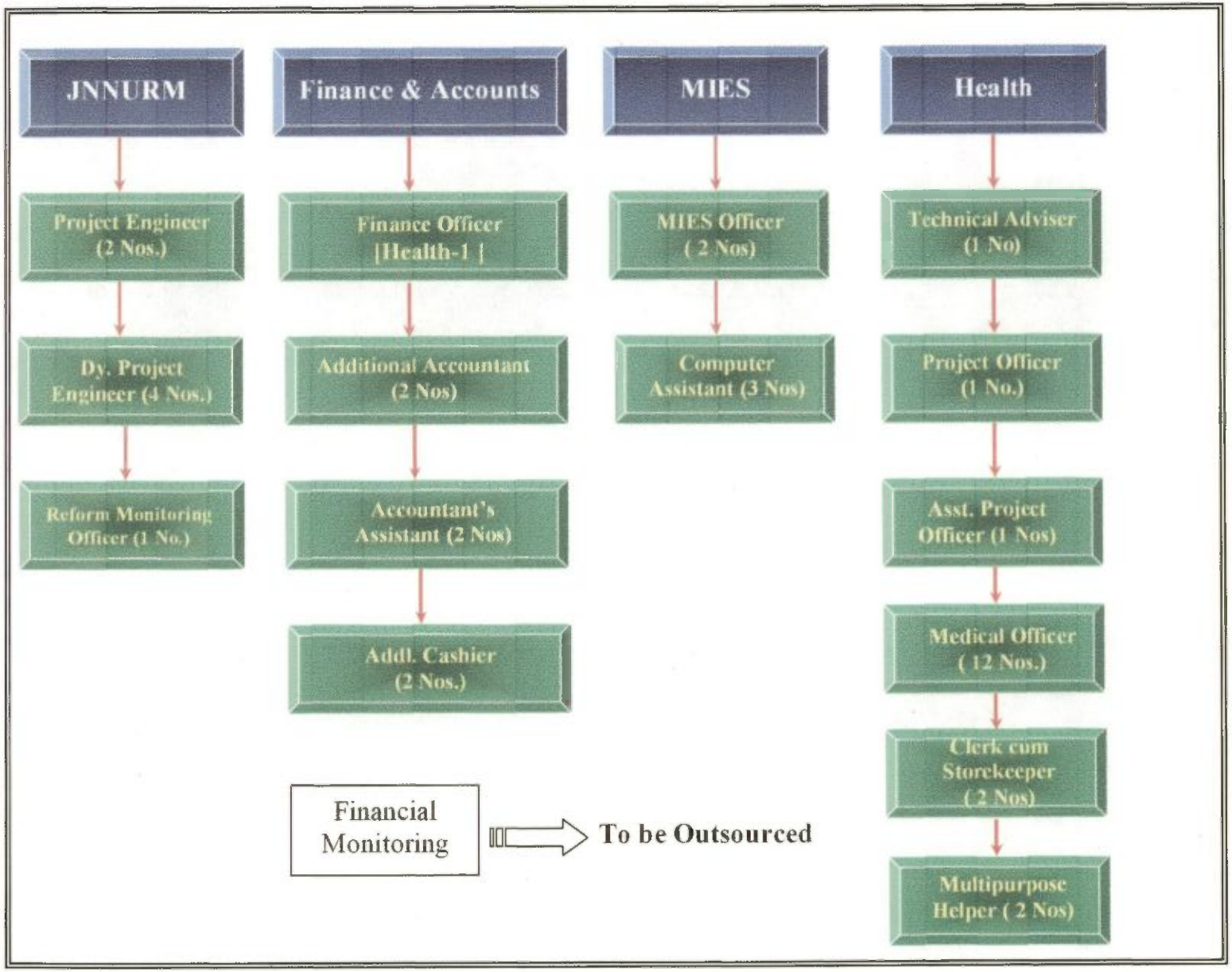
respective fund handling bodies, which is to be compiled by the agency itself, and other relevant/allied reports and documents from each ULB within seven days of conclusion of a calendar month;

f) Keeping accounts of the the fund at SUDA lelvel;
g) Compilation of monthly accounts incorporating monthly accounts of all the ULBs and generation of various accounting and statistical information, statements, reports, summery, etc.;
h) Preparing utilization certificates and reimbursement claims;
i) Preparing quarterly Receipts & Payments Account of the fund at SUDA level;
j) Any other correlated jobs to be assigned to the agency from time to time.

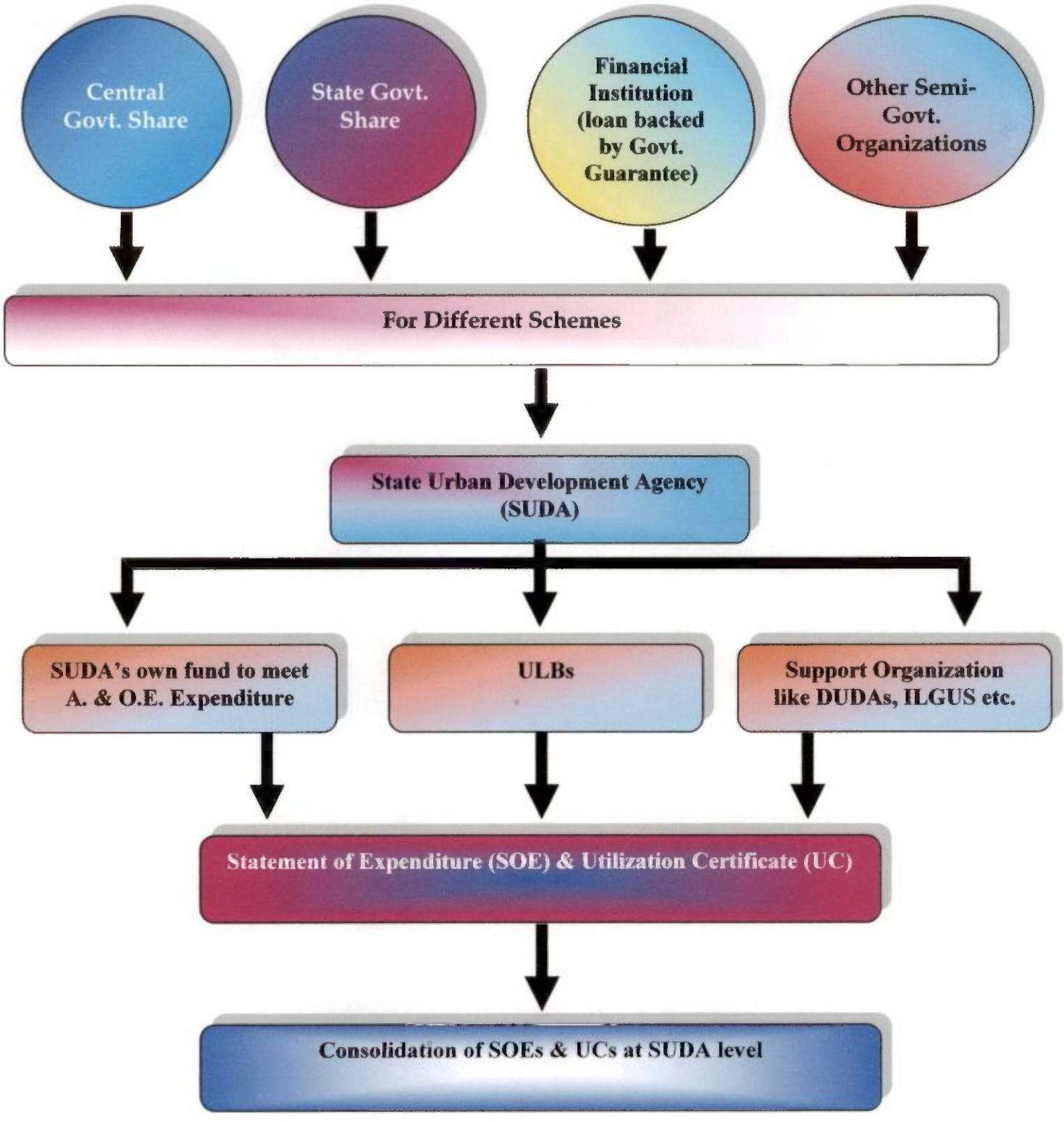
3. Eligibility:

The Accounting Support Agency should be a Chartered Accountant Firm enlisted with the CAG.

Additional Manpower Requirement



Fund Flow Mechanism



urban health proposal Inbox

from Rajashree Narayan <rnarayan@ipeglobal.com> hide details Nov 16 (4 c
to Shibani Goswami <dfidhhw@gmail.com>
cc "Executive Director, FW Samity" <ed_samity@wbhealth.gov.in>, ss_sen@wbhealth.gov.in
date Nov 16, 2007 1:49 AM
subject urban health proposal
mailed-by ipeglobal.com

Dear shibanidi,

As requested by Mr. Sen, please find enclosed the PIP version 7 including the urban h the component has been split under various chapters, for eg., under urban health cha and capacity building, financial management and reporting etc, i am sending the entire

The hard copy of the urban health strategy will be sent to you by Mr. Sen himself.

Regards

Rajashree Narayan

---

2 attachments — Download all attachments

WBHSDP PIP-Draft 7 _Nov 13.doc
2899K View as HTML Download

WBHSDP PIP-Draft 6 Annexures_Oct 11.doc
3157K View as HTML Download

urban health proposal Inbox

Rajashree Narayan Dear shibanidi, As reques Nov 16 (4 days ago)

Shibani Goswami show details 4:10 am (13 hours ago) Reply

Dear Sir,

Some observations in respect of the proposed Urban Health Programme of World Bank.

1. Under the head - Staff at ULB level -

- The post of Sanitary Inspector, Accounts Assistant and Health Assistant have not been reflected.
- The post of data assistant to be named as Computer Assistant.
- The post of Medical Officer should come under ULB level not at Sub-Centre level (there is no provision for part time Medical Officer, hence the word part time be deleted).

In this context, it is to intimate you that for 63 ULBs you have already sanctioned the proposal on staff at ULB level which includes Health Officer (Rs. 15,000/- p.m.) Medical Officer (Rs. 6,000/- p.m.), Sanitary Inspector (Rs. 5,500/- p.m.), Computer Assistant (Rs. 5,000/- p.m.), Accounts Assistant (Rs. 5,000/- p.m.), SK cum clerk (Rs. 5,000/- p.m.) and Health Assistant (Rs. 5,000/- p.m.). This is also to inform you that except Health Officer, rest 6 posts have already been filled up by 26 ULBs out of 63 as per the Dept. of Municipal Affairs order no. 111-MA/C-10/3S-55/2005 dt. 02.02.2007.

- It is also observed that the salary of PHN has been kept at Rs. 7,500/- p.m. where as that of MO is Rs. 6,000/- p.m. Would it be practical ? I apprehand no Medical Officer will work. Under the circumstances, the clinic based fee for Medical Officer which has been fixed at Rs. 300/- per clinic may be enhanced accordingly.

I have gone through some portion of the proposal on Urban Health hurridely and the above mentioned observations have been noticed. Before final submission to World Bank these points are to be checked.

Thanking you.

Dr. Goswami

- Show quoted text -

Recd: on 1.10.07

CONSOLIDATED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total	
I Provision of community based primary health care services in 63 Non – KMA municipalities										
Staff-at ULB level										
Health officer	63	15000	945000	11340000	11340000	11340000	11340000	11340000	56700000	
Asst Health officer	1	10000	10000	120000	120000	120000	120000	120000	600000	
PHN	64	7500	480000	5760000	5760000	5760000	5760000	5760000	28800000	
FTS PH	117	1420	166140	1993680	1993680	1993680	1993680	1993680	9968400	
Data Asst	63	5000	315000	3780000	3780000	3780000	3780000	3780000	18900000	
Store Keeper	63	3350	211050	2532600	2532600	2532600	2532600	2532600	12663000	
Attendant/sweeper(tobe pvd by ULB)										
sub total				**25526280**	**25526280**	**25526280**	**25526280**	**25526280**	**127631400**	
Sundries incl. Vehicle	63	30000	1890000	22680000	22680000	22680000	22680000	22680000	113400000	
sub total staff and vehicles				**48206280**	**48206280**	**48206280**	**48206280**	**48206280**	**241031400**	
Program costs										
additional funds to reach unreached	63	200000	12600000	12600000	12600000	12600000	12600000	12600000	63000000	
HMIS format-family	1123	2	12687.944	152255	152255	152255.328	152255.328	152255.328	761277	
Family schedule	224599	14	3144380.4	3144380	3144380	3144380	3144380	3144380	15721902	
kitbag	1270	450	571500	571500	0	0	0	0	571500	
Cold chain at ULBs	63	50000	3150000	3150000					3150000	
capital costs										
furniture	63	80000	5040000	5040000	0	0	0	0	5040000	
equipment	63	150000	9450000	9450000	0	0	0	0	9450000	
sub total pgm and cap cost - ULB level				**34108136**	**15896636**	**15896636**	**15896636**	**15896636**	**97694679**	
									0	
Urban health clinic									0	
UHC rental	15	12000	180000	180000	180000	180000	180000	180000	900000	
UHC furniture	15	52,350	785250	785250	0	0	0	0	785250	
UHC level staff	15	1355880	20338200	20338200	20338200	20338200	20338200	20338200	101691000	
UHC equipment	15	41500	622500	622500	0	0	0	0	622500	
sub total urban health clinic				**21925950**	**20518200**	**20518200**	**20518200**	**20518200**	**103998750**	
Sub centre level										
FTS	283	1420	401860	4822320	4822320	4822320	4822320	4822320	24111600	
HHW	1270	1250	1587500	19050000	19050000	19050000	19050000	19050000	95250000	
PTMO-Rs.300/clinic*8 cl per sc	283	300	679200	8150400	8150400	8150400	8150400	8150400	40752000	
sundries	283	750	212250	2547000	2547000	2547000	2547000	2547000	12735000	
sub centre rent	283	1000	283000	3396000	3396000	3396000	3396000	3396000	16980000	
mobility	400	150	60000	720000	720000	720000	720000	720000	3600000	
mtg expenses-30 pers	1387	5	208050	2496600	2496600	2496600	2496600	2496600	12483000	
Repair and renovation	137	31000	4247000	4247000	0	0	0	0	4247000	
Equipment	283	25,000	7,075,000	7075000	0	0	0	0	7075000	
furniture	283	20000	5,660,000	5660000	0	0	0	0	5660000	
sub total sub centre				**58164320**	**41182320**	**41182320**	**41182320**	**41182320**	**222893600**	
SUB TOTAL - I				**162404686**	**125803436**	**125803436**	**125803436**	**125803436**	**665618429**	

CONSOLIDATED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total	
II Strengthening of Public Health services in 63 municipalities (41 KMA and 22 non KMA municipalities										
Staff at ULB level	**No**	**rate/month**	**total**	**1st yr**	**2ndyr**	**3rd yr**	**4th yr**	**5th yr**	**total**	
PHN	72	7500	540000		6480000	6480000	6480000	6480000	25920000	
FTS PH	540	1420	766772		9201260	9201260	9201260	9201260	36805039	
Data assistant	63	5000	315000		3780000	3780000	3780000	3780000	15120000	
sub total staff				**0**	**19461260**	**19461260**	**19461260**	**19461260**	**77845039**	
ULB										
sen.of stakeholder-	63	5000	315000		315000	315000	315000	315000	1260000	
State HQ level-4	4	10000	40000		40000	40000	40000	40000	160000	
Ref Trg for HHWs	63	50000	3150000		3150000	3150000	3150000	3150000	12600000	
Refresher trg for MO,FTS	63	50000	3150000		3150000	3150000	3150000	3150000	12600000	
sub total cap bldg				**0**	**6655000**	**6655000**	**6655000**	**6655000**	**26620000**	
Devt of PH action plan in covered ULBs										
workshops at 63 ULBs	63	50000	3150000		3150000				3150000	
Consultant cost	1	500000	500000	500000					500000	
workshops at 63 ULBs (uncovered)	63	50000	3150000	3150000	3150000				6300000	
sub total PH action plan				**3650000**	**6300000**	**0**	**0**	**0**	**9950000**	
cold chain at ULBs	63	50000	3150000	3150000					**3150000**	
SUB TOTAL - II				**6800000**	**32416260**	**26116260**	**26116260**	**26116260**	**117565039**	

CONSOLIDATED BUDGET FOR THE URBAN HEALTH PROGRAM 2007-2012

	No	rate/month	total	1st yr	2ndyr	3rd yr	4th yr	5th yr	total	
III Institutional strengthening and capacity building										
SUDA level										
staff										
Tech.adviser	1	23000	23000	276000	276000	276000	276000	276000	1380000	
Project officer	1	22000	22000	264000	264000	264000	264000	264000	1320000	
Asst PO	1	20000	20000	240000	240000	240000	240000	240000	1200000	
Medical officer	12	15000	180000	2160000	2160000	2160000	2160000	2160000	10800000	
FO	1	15000	15000	180000	180000	180000	180000	180000	900000	
Accounts asst	3	3350	10050	120600	120600	120600	120600	120600	603000	
Additional accountant	2	7000	14000	168000	168000	168000	168000	168000	840000	
Additional cashier	2	7000	14000	168000	168000	168000	168000	168000	840000	
MIES officer	2	14000	28000	336000	336000	336000	336000	336000	1680000	
Comp.asst	3	6500	19500	234000	234000	234000	234000	234000	1170000	
clerk cum store keepr	2	6500	13000	156000	156000	156000	156000	156000	780000	
Multi purpose helper	2	5000	10000	120000	120000	120000	120000	120000	600000	
vehicle	5	12000	60000	720000	720000	720000	720000	720000	3600000	
sundries	1	25000	25000	300000	300000	300000	300000	300000	1500000	
furniture	1	100000	100000	100000					100000	
eqpt	1	425000	500000	500000					500000	
sub total SUDA				**6042600**	**5442600**	**5442600**	**5442600**	**5442600**	**27813000**	
accounts support agency	1	0	0	0	0	0	0	0	**0**	
capacity building										
SUDA										
Mgrl trg	2	50000	100000	100000	100000	100000	100000	100000	500000	
staff devt	2	200000	400000	400000	400000	400000	400000	400000	2000000	
exposure visit	2	500000	1000000	1000000	1000000	1000000	1000000	1000000	5000000	
ULB										
sen.of stakeholder-2	63	5000	630000	630000	630000	630000	630000	630000	3150000	
State HQ level-4	4	10000	40000	40000	40000	40000	40000	40000	200000	
Trg for HHWs	63	50000	3150000	3150000	3150000	3150000	3150000	3150000	15750000	
Local trg for MO,FTS	63	50000	3150000	3150000	3150000	3150000	3150000	3150000	15750000	
Cap bldg eqpt	63	50000	3150000	3150000					3150000	
sub total cap.bldg				**11620000**	**8470000**	**8470000**	**8470000**	**8470000**	**45500000**	
IEC/BCC - gp mtg/ward/month	1053	150	157950	1895400	1895400	1895400	1895400	1895400	9477000	
printing	63	50000	3150000	3150000	3150000	3150000	3150000	3150000	15750000	
SUB TOTAL - III				**22708000**	**18958000**	**18958000**	**18958000**	**18958000**	**98540000**	
IV Monitoring and Evaluation										
Documentation										
Base,mid and endline	1	2000000	2000000	2000000		2000000		2000000	6000000	
SUB TOTAL - IV				**2000000**	**0**	**2000000**	**0**	**2000000**	6000000	
GRAND TOTAL I - IV				**193912686**	**177177696**	**172877696**	**170877696**	**172877696**	**887723468**	

Fwd: Urban health budget - component wise and financial

from "Executive Director, FW Samity" <ed_samity@wbhealth.gov.in> hide d
to DR SHIBANI GOSWAMI <dfidhhw@gmail.com>
date Sep 28, 2007 4:32 AM
subject Fwd: Urban health budget - component wise and financial head wise
mailed-by wbhealth.gov.in

DEAR DR GOSWAMI SENDING THE MATERIAL .PLEASE CHECK UP AND LET MI

-----Original Message-----
From: "Rajashree Narayan" <rnarayan@ipeglobal.com>
To: "Executive Director, FW Samity" <ed_samity@wbhealth.gov.in>, ss_sen@wbh
Date: Fri, 28 Sep 2007 16:47:57 +0530
Subject: Urban health budget - component wise and financial head wise

Dear Sir,

As requested, please find enclosed the component wise and financial head wise bu

Rajashree

urban health budget for SUDA.xls.zip
12K Download

AUDIT PURVIEW:

1.	**Audit of ULB accounts**:	ULB accounts are subject to audit by the AGWB(LBA).
2.	**Audit of SUDA accounts:**	SUDA accounts are subject to audit by an external audit firm of Chartered Accounts and also by the AGWB.

Procurement Norms followed by SUDA

- At par with State Govt. procurement norms.

➢ Upto Rs. 500/-	=	Direct purchase
➢ Rs. 501/- to 20,000/-	=	At least 3 quotations
➢ Above Rs. 20,000/-	=	Wide circulation and tendering

key policy documents of the country, including the 10th National Five Year Plan.

The National Development Goals contain targets that are comparable with those laid down in the MDGs. Further, these goals are also clearly reflected in the commitments made in the National Common Minimum Program (2004-09).

	Millennium Development Goals (2000 – 2015)	National Development Goals (10th Five Year Plan)	National Common Minimum Programme (2004-2009)
1	**Goal 1:** Eradicate extreme poverty and hunger **Key Targets:** Reduce by half the proportion of people living on less than a dollar a day. Reduce by half the proportion of people who suffer from hunger.	Reduction of poverty ratio by 5 percentage points by 2007 and by 15 percentage points by 2012.	Enact the National Employment Guarantee Act 100 days employment every year at minimum wages for at least one able bodied person in every rural, urban poor and lower middle class house hold. Double the flow of rural credit Strengthen public distribution system in poorest and backward blocks of the country. Provide Antyodaya cards for all

1. Budget for IEC AIDs & Materials
   — @ Rs 13785/ award for 3 yrs.
   — 13785/- X 1053 wards = Rs 145.16 Lakhs.

2. Budget for renovation works for Sub-Centres
   No. of SCs - 273 . 50% of SCs may need renovation works @ provision of basic facilities like toilet, water facility etc.
   @ 31000 X 137 nos. of SCs = 42.47 lakhs

3. No. of ULBs - 126
   Corporation - 6
   Municipality - 117
   Notified Area - 3

   classification @ category:

Corporation	- 6
A	- 14
B	- 34
C	- 41
D	- 26.
E	

4. Status of community based primary Health Care Services in 63 Non-KMA ULBs.
   @ Refer. Pg-85 , Sl.No 1-4 - No change.
   Sl. No. 5 - Selection of HHWs → completed by 60 ULBs
   6 - Forwarding names of Trainers by ULBs → " 60 ULBs
   7 - Completion of Trainers Training — completed in 58 ULBs
   8 - Training of HHWs initiated by ULBs - 54
   9. Training of HHWs completed by ULBs - 52.
   10. " in progress - 2

To
Mr. S.K. Sen
Ex-Dir. WB H&FW Samity.

From: Dr. S. Goswami
17.08.07.

awareness generation and enhance community mobilisation through IEC to supplement and make the above interventions effective.

(c) **Strengthening of Public Health services in 63** covered **municipalities** (41 KMA and 22 non KMA municipalities) to include public health preparedness of the municipalities during disease outbreaks and improve routine public health measures at population level.

(d) **Setting up appropriate and effective institutional mechanisms and arrangements** to manage the programme and address the partnership issues in urban environment.

(e) **Public private partnerships to leverage benefits**

(f) **Specific and special efforts on public health challenges**

The proposed Urban Health Programme envisages implementation of Urban Health Projects in a phased manner:

Preparatory Phase - Development of Comprehensive Urban Health Strategy. This will be initiated in the current year and end before the March 2008, the close of the financial year. ULB level preparation in terms of recruiting and training HHWs, core ULB level staffing viz., Health Officer recruitment, ULB specific micro plan and baseline survey will be completed with the budgetary support from state government..

Status of completion of preparatory activities in the 63 uncovered ULBs.

Sl.No	Activities	Status
1.	Sensitisation of 63 ULBs by SUDA	Completed
2	Central procurement of HHW kit bag, training manual for HHWs, family schedule, HMIS and base line survey formats by SUDA and distribution to the ULBs	Completed
3	Constitution of Municipal Level health and Family Welfare Committee by ULBs	Completed
4	Opening of separate bank a/c by the ULBs	Completed
5	Selection of HHWs by ULBs	Completed in 63 ULBs
6	Forwarding the names of trainers by ULBs to SUDA	Completed by 63 ULBs
7	Completion of trainers training by SUDA for imparting training to HHWs at ULB level	Completed in 58 ULBs (those who have completed selection of HHWs)
8	Training of HHWs initiated by the ULBs	Training have been initiated by 54 ULBs

Training completed. 52, 2 in progress.

Phase 1 – Initiating the programme in the 63 municipalities, which does not have any dedicated programme currently and to continue it through out the life of the

S/C

From: Dr. Shibani Goswami
SUDA.

To: Sri S. K. Sen
Ex. Director, WB State Health & Family Welfare Samiti

Following information sheets are enclosed.

1. TOR – Accounting support Agency.
2. Audit Purview.
3. Fund Flow Mechanism.
4. Financial Guideline of CBPHC in 63 Non-KMA ULBs.
5. Procurement Norms.
6. Manpower at ULBs – Category A, B, C & D&E

Goswami
05.04.07

Information required by World Bank for its assistance in implementation of Urban Health in 63 Non-KMA ULBs and strengthening of existing Urban Health in rest of 63 ULBs.

1. Organisation structure of Health Wing, SUDA – Existing

Sanctioned Post	Nos. Sanctioned	Existing Position
Consultant	1	Acting as Adviser, Health
Project Officer	1	Health Expert, CMU is in dual charge.
Finance Officer	1	1
MIES Officer	1	1
Medical Specialist	2	1
Community Development Specialist	1	-
Clerk cum Store Keeper	1	1
Data Entry Operator	1	1
Attendant	1	-

Organisation structure of Health Wing, SUDA – Proposed

Post	Required Nos.	Salary Per Month Per Head (In. Rs.)
Technical Adviser	1	23,000/-
Project Officer	1	22,000/-
Assistant Project Officer	1	18,000/-
Medical Officer *	12	15,000/-
Finance Officer	1	15,000/-
Additional Accountant	1	
Additional Cashier	1	
Accounts Assistant	1	6,500/-
MIES Officer	2	14,000/-
Computer Assistant	3	6,500/-
Clerk cum Storekeeper	2	6,500/-
Multipurpose Helper	2	5,000/-

* Medical Officer will be stationed at Zonal Level i.e. Medinipur (East), Medinipur (West), North 24 Parganas, Nadia, Murshidabad, Burdwan, Cooch Behar, (Uttar Dinajpur, Dakshin Dinajpur, Malda), (Darjeeling, Jalpaiguri), (Bankura, Purulia), Birbhum, (Hooghly, South 24 Parganas) and will be responsible for monitoring & supervision of all the ULBs concerned under the district, implementing Urban Health Programmes.

2. Current Activities of Health Wing, SUDA

IPP-VIII (Extn.)

India Population Project – VIII (Extn.) was launched with World Bank Assistance in 10 Non-KMA ULBs i.e. Alipurduar, Balurghat, Burdwan, Darjeeling, Durgapur, English Bazar, Jalpaiguri, Kharagpur, Raiganj & Siliguri during January, 2000, covering urban BPL population of 7.56 lakhs. The project cost was Rs. 3527.42 lakhs. The World Bank assistance ended on June, 2002. This project is being maintained by Municipal Affairs Department since July, 2002

The broad objectives are – (1) Improve maternal & child health by reducing morbidity and mortality of maternal & under-five children, (2) Reduce fertility.

The health facilities created under the project are 1090 Project Blocks (1 block cover 750 – 1000 BPL population), 250 Sub-Health Post, 35 Health Post, 11 Out Patient Department cum Maternity Homes and 11 Diagnostic Centres. The services are catered through grass root level Honorary Health Workers drafted from the community who are the Primary Health Care providers generating awareness on Family Welfare including pregnancy care, institutional delivery, immunization, nutrition, contraception & different health issues. Treatment of minor ailments are taken care off by the Honorary Health Workers at the door-step of the beneficiaries. Preventive, promotive & curative health care services are provided at Sub-Health Post, Health Post, Out Patient Department and referral services at Maternity Homes. They are also responsible for implementation of National Health Programmes.

Towards sustainability, health fund has been generated for an amount of Rs. 344.21 lakhs till date by the 10 ULBs concerned through imposition of user charges and realization of user fees.

Considerable impact & improvement have been observed with regard to health status of the beneficiaries as mentioned hereunder :

Reduction of Crude Birth Rate from 20.3 to 15.3, Crude Death Rate from 7.6 to 3.8, Infant Mortality Rate from 54.0 to 21.9, Maternal Mortality Rate from 6.0 to 1.7 and Increase of Couple Protection Rate from 38.6 to 73.0, Coverage of pregnant women with tetanus toxoid from 47.2 to 96.7, Institutional Delivery from 46.8 to 95.4, Complete Immunization of Infant from 22.4 to 92.6.

The revised budget for FY 2006-07 is estimated at Rs. 417.55 lakhs. An amount of Rs. 314.05 lakhs was received towards O & M during FY 2006 – 07.

RCH Sub-Project, Asansol

The project was launched with World Bank assistance in Asansol Municipal Corporation during August, 1998 covering Urban BPL population of 2.55 lakhs with objective of reducing fertility and improving maternal & child health. World Bank assistance ended on 31st March, 2004. The project cost was Rs. 854.57 lakhs. The activities of the project is being maintained by Municipal Affairs Department since April, 2004.

The services are rendered through the health facilities created under the project i.e. 387 Blocks, 13 Health Administrative Unit, 97 Sub-Health Centres, 2 Out Patient Department cum Maternity Homes cum Diagnostic Centre and 1 Medical Store. 387 Honorary Health Workers are not only providing Primary Health Care services at the door-steps of the beneficiaries but also act as pivots towards disseminating preventive, promotive & curative services and implementation of National Health Programmes.

The impact of the services have been observed with regard to health status of the beneficiaries i.e. Reduction of Crude Birth Rate from 23.9 to 16.9, Crude Death Rate from 12.4 to 5.7, Infant Mortality Rate from 60.0 to 21.5, Maternal Mortality Rate from 3.0 to 0.7 and Increase of Couple Protection Rate from 41.4 to 72.0, Coverage of pregnant women with tetanus toxoid from 51.8 to 96.6, Institutional Delivery from 57.3 to 90.2, Complete Immunization of Infant from 30.9 to 88.8.

The ULB has generated health fund for an amount of Rs. 13.86 Lakh till date.

The revised budget for FY 2006–07 is estimated at Rs. 131.80 lakhs. An amount of Rs. 97.53 lakhs was received from MA Dept. towards O & M during FY 2006–07.

Honorary Health Worker Scheme in 11 Non-KMA ULBs

The Honorary Health Worker Scheme was piloted with the assistance of DFID in 11 Non-KMA Urban Local Bodies i.e. Cooch Behar, Jangipur, Berhampur, Suri, Bolpur, Purulia, Bankura, Bishnupur, Krishnagar, Kalna & Medinipur during the period February, 2004 to June, 2005. Implementation activities have been extended upto March, 2007 by Department of Health & Family Welfare.

2.86 lakhs of the BPL population have been covered under this scheme. The project period upto June, 2005 was meant for process development towards functioning of HHW Scheme. Constitution of Municipal Level Health & FW Committee, formation of Municipal Management Cell, detailment of Project Director i.e. ADM / SDO, Job Orientation Training for Health Worker & First Tier Supervisors have already been completed. There was no provision for new construction of health facilities. The health facilities created are 260 Project Blocks – each block is manned by the Honorary Health Worker, 55 Sub-Health Posts – each Sub-Health Post is in-charge of one First Tier supervisor. The accommodation for Sub-Health Post have been provided either by NGO / CBO or Urban Local Body. Different clinics like ANC / PNC clinic, Immunisation clinic, Growth Monitoring clinic, General Treatment clinic and Awareness programme have already been initiated in all the SHPs. Referral services have been linked with the nearest State Govt. Hospital.

The estimated budget for FY 2006-07 is s. 599.95 lakhs and has been prepared following the principle in line with recently launched community based primary health care services in 63 Non-KMA ULBs. A total amount of Rs. 256.90 lakhs have been received from HSDI of Department of Health & Family Welfare during FY 2006–07. Expenditure incurred for an amount of Rs. 106.01 lakhs till date during FY 2006-07.

Community Based Primary Health Care Services in 63 Non-KMA ULBs

A project on Community Based Primary Health Care Services in 63 Non-KMA Urban Local Bodies has been launched by the MIC, Health & Family Welfare Department and MIC, MA & UD Department on 24th February, 2006. This project will cover a total of 34.03 lakhs urban population with special focus to 11.23 lakhs BPL population.

The objective is – (a) to bring about an overall improvement in the Urban health scenario as a whole with reference to reduction in Crude Birth Rate (CBR), Crude Death Rate (CDR), Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR) and enhancement of Couple Protection Rate (CPR), (b) to provide Primary Health Care service delivery to the urban population with focus on Reproductive & Child Health of BPL population, (c) to implement National Health Programme for total population, (d) to ensure maximum utilisation of Government Institutions for referral services.

The preparatory process is sentisation of ULBs, formation of Health & FW Committee at ULB, creation of Management & Supervision Cell at ULB & Head Quarter Level, selection of HHWs, job orientation training of HHWs, orientation training of other health manpower, identification of Sub-Centres for initiating service delivery at door-step of beneficiaries & Sub-Centres.

Package of primary health care services i.e. antenatal / postnatal care, promotion of institutional delivery, immunization, promotion of breast feeding and proper weaning, growth monitoring of under-five children, family welfare programme, RTIs, adolescent health care, treatment of minor ailments, surveillance of communicable diseases, conduction of various awareness programme will be provided to the urban population with focus to Below Poverty Line (BPL). Community participation will be ensured at all levels for successful implementation of this programme.

While the HHW shall be responsible for primary health care of the BPL families under her jurisdiction, she shall also be responsible for both public health services and health statistical data collection for the entire population within her geographic jurisdiction / project block.The Ward Councillor will monitor & supervise the activity at Ward level and co-ordinate the implementation of National Health Programme at ward level.

Activities	Status
Sensitisation of 63 ULBs by SUDA	Completed
Central procurement of HHW Kit Bag, Training manual for HHWs, Family Schedule, HMIS and Base line survey formats by SUDA and distribution to the ULBs	Completed

Constitution of Municipal Level Health & Family Welfare Committee by the ULBs	Completed
Opening of separate Bank A/C by the ULBs	Completed
Selection of HHWs by the ULBs	Completed in 57 ULBs
Forwarding the names of trainers by ULBs to SUDA	Completed by 57 ULBs
Completion of trainers training by SUDA for imparting training to HHWs at ULB level	Completed in 51 ULBs (those who have completed selection of HHWs)
Training of HHWs initiated by the ULBs	Training have been initiated by 22 ULBs

The estimated project budget is Rs. 5829.00 lakhs for three years. An amount of Rs. 300.00 lakhs has already been released by Department of Health & Family Welfare to State Urban Development Agency.

An initial fund for Rs. 148.89 lakhs have already been released to the ULBs to procure furniture & equipment for training, Management & Supervision Cell and conduction of HHWs training programme.

3. Monitoring system

Service Monitoring