ABSTRACT

Objective: To demonstrate feasible approaches of delivering health services in an urban poor setting of Bhopal city, India

Methods: Formative research and mapping exercises were undertaken to identify new delivery points in underserved slum areas. Based on these findings, community awareness generation activities were carried out to reach care-givers and health service-providers. Health workers and managers were reoriented on biannual child health round and trained on demand generation, counselling, estimation and management of supplies, programme review, monitoring and reporting. Private practitioners were also oriented. To measure programme impact, baseline and endline coverage evaluation surveys were conducted.

Results: VAS coverage in slum areas of Bhopal increased by around four-fold from 22% to 85% with an increase of three-folds in knowledge of vitamin A rounds (29% to 97%) during the project period.

Conclusion: Identification of inaccessible and vulnerable locations and implementation of key strategies such as establishing additional service delivery points led to increased access and coverage. Based on preliminary successes, various components of programme are being replicated in other locations of Bhopal city and were included in Government plans and budget.

BACKGROUND

• Growth Rate of urban population in India is nearly 2.5 times that of rural population. Decadal growth rate during 2001-11 was 31.8 % in urban areas and 12.3 % in rural areas [Census of India, 2011].
• Health service delivery in urban poor settings presents a number of challenges. These include a rapidly growing urban poor population, rapid migration, large pockets uncovered or thinly covered by health services.
• VAS coverage was only 22 % in urban poor settings of Bhopal city.
• Health indicators among urban poor are also considerably worse.

TABLE 1: KEY OUTCOME INDICATORS OF CHILD MORTALITY IN URBAN POOR AND URBAN NON-POOR SETTINGS

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<thead>
<tr>
<th></th>
<th>Urban Poor</th>
<th>Urban non-poor</th>
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<tbody>
<tr>
<td>Infant Mortality Rate</td>
<td>54.6</td>
<td>35.5</td>
</tr>
<tr>
<td>(per 1000 live births)</td>
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<tr>
<td>Under Five Mortality Rate</td>
<td>72.7</td>
<td>41.8</td>
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<tr>
<td>(per 1000 live births)</td>
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Source: NFHS 3, 2005-06

OBJECTIVE

To demonstrate effective strategies to improve coverage of Vitamin A supplementation during biannual child health months among urban poor in Bhopal city.

Project Location

• The project was implemented in Bhopal, India. The city has a population of 1.91 million of which 27 % reside in slums. Bhopal grew by 26.7 % during the decade 2001-11.
• Two administrative zones (Zone 2 & 6) with a high proportion of urban poor, were identified for the programme.

PROGRAMME STRATEGIES

Formative Research and Mapping to identify underserved areas and then establish additional service delivery points (SDPs) for vitamin A dosing in underserved areas.

Programme Planning and Implementation Support by facilitating due listing of children for the vitamin A rounds and recruitment, training and deployment of additional human resources.

Designing and implementing Behaviour Change Interventions through use of Short Messaging Services (SMSs) on mobile phones for health workers and radio jingles for awareness generation on vitamin A (Bal Suraksha Mah: Child health month) rounds for caregivers of children 9-59 months. Orientation of civil society organizations was also conducted for social mobilization.

Capacity building of frontline health workers through formal training on demand estimation, vitamin A administration, Standard Operating Procedures (SOPs). Orientations during monthly meetings and supportive supervision visits were also carried out.

Engaging Private Practitioners and orient them on vitamin A guidelines. Ensuring provision of vitamin A data management workshops, pre and post vitamin A round planning and review meetings.

SURVEY METHOD

• A baseline survey was conducted in March 2012 followed by an endline survey during November to December of 2013.
• Sample powered to measure change in coverage of Vitamin A supplementation over the project period (a targeted 20 percent improvement over 22.4 percent at start of project).
• The sample sizes were computed with a power (β) of 80 %, probability (α) of 95 % adjusted for a design effect of 1.5 and incremented for a probable non-response rate of 10%.

RESULT

CONCLUSION

• Mapping, identifying and establishing additional service delivery sites and capacity building of service providers resulted in improved access and utilization of Vitamin A services in urban slums.
• Engaging private practitioners requires sustained efforts and a formal mechanism of involvement by the Government.
• Use of resources to identify inaccessible and vulnerable locations and strategically focussing in these areas leads to better access and coverage.
• The components of programme are being replicated in other locations of Bhopal city and were included in annual government plans and budget.

ACKNOWLEDGEMENT

We would like to acknowledge the support from Government of Canada through the Department of Foreign Affairs, Trade and Development, health officials and workers of the Government of Madhya Pradesh, all the partners, stakeholders and caregivers for their efforts to achieve desired results.

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