COMMUNITY HEALTH FELLOWSHIP REPORT

- RAKESH CHANDORE

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CONTENT

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Acknowledgement

I am heartily indebted to Dr. Thelma Narayan and Dr. Ravi Narayan and all the staff team of the CHC for providing me an opportunity to explore my ~~carrier~~ career in the community health.

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I would also like to thank village health workers and the care taker at the Phulwari centers in the villages.

Thanks to all of them

Rakesh Chandore

1.Concept

For the last three years I have been working in Indore slums among the rag-pickers. During my work, I realized that health status and facilities for the slum (urban poor) people is worse than rural areas. Since then I have had a desire to work on health issues of the urban poor.

Though many agencies like Government / NGO's / trusts etc are working in the field of urban health but their intervention is only up to the organizing the awareness sessions, health camp, immunization camp and RCH based activities. These activities were mainly carried out through a service-based approach.

So there is a need to do interventions with a rights based approach and bring health on the agenda of local groups and NGO's. So that people become capable to ask about their rights and services by the government institutions and they can also think in the direction of health as their right.

Background

After 53 years of independence the Government has gradually given up the trend of people friendly development. The current trend of development by corporate is causing people to loose control over productive assets like land forest water etc. There is increasing tendency of concentration of resources in fewer hands. While more and more people are getting disposed and displaced, these policies are pushing people out of villages into urban areas. In the town and cities also land is being taken over for development of multiplexes, widening roads, flyovers etc - there is no space for the poor. The basic services like water, sanitation, education and health are being privatized and priced.

In today's context community level health services is still far from the people and not able to meet the need in the context of increasing urbanization and growth of slums. As of now health services in urban areas are mainly based on hospital based services, and there was very less focus on community level health care services, as strategies for developing health care for urban poor are often framed but implementation is a big challenge for all of us.

State Profile of MP[1]

MP is considered as one of the backward states of India with a large Tribal population, which comprises 1/5 of the total population (20.3%). The total population of the state is 6.04 crores as per 2001 census. Area wise the state is 2nd largest in India. Administratively the state has been divided into 48 Districts and 313 Developmental Blocks (89 Tribal Blocks). The state has 73.3% of its population residing in 52143 villages and the rest in 394 towns and cities. Out of the total urban population 24.31% resides in slums as against all India figures of 14.1 %. The percentage of the population reported to be below the poverty line is 37, as against the all India figure of 27%. The overall literacy rate is 64%, female literacy rate is 50%. While the Gender Ratio is 920 female as against 1000 male but the Juvenile sex ratio is much higher at 929.The life expectancy is 55.2, Infant Mortality rate is 89.5 as against the all India figure of 70.

Western region of MP

Western region of M.P. comprises of Nimar region with 5 districts (Districts-Barwani, Khargone, Khandwa and Burhanpur) and Jhabua. This region is Schedule V area and are economically underdeveloped inhabited by Bhil and Bhilala Tribes and has been suffering from repeated droughts. The area has also been an area of constant neglect with very poor penetration of Govt. schemes, including very poor health and education infrastructure. The people of this area do not have sustainable livelihood options they seasonally migrate every year in neighboring states of Maharashtra and Gujarat and are exploited by the contractors and moneylenders. Studies have also shown that due to poverty, lack of adequate nutrition and health care facilities the people suffer from chronic hunger and malnutrition. It is also the region where big dams on the Narmada are being built.

Indore is the regional center of this region. In the present situation migration to urban areas especially Indore has increased substantially. There are two trends regarding displacement and slum growth:
a) From rural areas because of Push-Pull factors;
b) From urban areas in the name of urban renewal mission and beautification of the city.

Besides this with increase trend of capital intensive technological development and mechanization, the organized labour is coming down

[1] Profile has been written on the basis of HDR 2002 and www.mp.nic.in

and more and more trend is towards casual unorganized labour employment, with very little social security and proper housing.

The slum population in 2001 is estimated to be close to 60 million comprising 21% of the total urban population. However this may be an underestimate. In Indore the total population is reportedly 2.6 lakhs, in Jan 2002. Rapidly growing population in cities is a major constraint for govt. institutions to provide basic infrastructure and amenities for both rich and poor.

Access to health services and facilities for the slum dwellers / poor in Indore is a big challenge. The major and basic problem is to access of primary health services and facilities available for the people in the city and also the quality of services. Overall health indicator of Indore is in bad shape and if we analyses the situation of slum dwellers it is very worse.

Past work and present linkage

I had my first exposure in working in peoples' health issues at Jhabua where I was attached with a doctor of the organization, the Adivasi Sevaashram Trust to help out in health education and training of peoples on health. The exposure in health was continue in my next placement with Adivasi Mukti Sanghatana where I learnt little bit about health as a peoples right and about the Jan Swasthya Abhiyan (JSA) and about its activities and ideology.

For last three years I have been intensively working with slum dwellers of Indore city. While working with rag-pickers I developed interest on working with people's health intensively.

The approaches made by the different agencies in the slums have stimulated my thinking to take different path of right-based initiatives in this particular area

Support group in Indore

In Indore we are also trying to build a support group for people's movements. I and the other group members would be playing a supporting role for the people's movement in the future already the group has some presence in the area and by staying in Indore I personally feel that this support would continue and expand.

2. My Objectives are: -

1. To enhance the knowledge and skills on Rights based work on health
2. Prepare a database of 2-3 slums for develop a health programme for these communities and develop a health profile of slum dwellers in Indore city.
3. To understand the issues of women's health and child health and nutrition.
4. Develop linkages between health and its determinants (water, nutrition and sanitation.)
5. Participate in JSA activities, meetings, seminar, public hearings etc.
6. Document the experience and learning.

3. CHFS Orientation Programme at CHC

07/08/06

It was the first day of six month fellowship scheme at CHC. Dr. Thelma gave the introduction of CHC and about its functioning. After that we had a introductory session with all the CHC staff.

Dr. Ravi took session on learning methods in the scheme. He talked about two methods.

1) Banking Method: generally it is one way method with power relation, lots of theory includes and less discussion in it.
2) Interactive participatory: this is also called problem solving method. Participatory approach is main part of method. he also taught about the looking inside and looking outside. I also find this theory very important for evaluating ourselves. Discussion, slide show, Focus group discussion, case study, films are the main processes.

08/0/06 RN

Exploring health / Community health / Primary health /Public heath:

HEALTH: - According to the WHO "Health is a state of physical, mental and social well being and not only the absence of disease". Though the medicine is the important part of health but not enough, health is much more than medical. It depends upon many things and we call it – "Determinants".
Some main determinants of health are

1) Poverty	2) Education	3) Nutrition
4) Agriculture	5) Water	6) Sanitation
7) Employment	8) Housing	9) Environment pollution
10) Economic	11) Cultural etc.	

These are the basic determinants of health. We can't think about the health without these determinants.
The human being required three basic things, which are Roti, Kapda and Makan, and for poor (Urban/Rural), to meet these things are challenge. These three things are the bases of all the determinants. If the people don't have regular employment they will not get food, housing, safe drinking water etc, means they will not get HEALTH".

Public Health: -
One of the key principles of Public Health that the state is responsible for the health of its people. What the government made provide for the better health like, safe drinking water, employment clean environment, Education, disease control programme like Malaria, TB, HIV/AIDS and all the national programmes comes under public health.

In public health a population-based approach is taken focusing on disease pattern, distribution funds of disease and risk factors. Public health interventions are organized usually through government as larger collective action required. The scope is wide and includes health protection, promotion, disease preventions, cure and rehabilitation.

It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective actions.

Primary Health Care: -

It is the first level of contact of individuals, the family and the community with the public health system bringing health care as close as possible to where people live and work constitute the first element of health care process.
The primary health care approach as a strategy to attain the international goal of health for all by 2000 A.D was articulated and accepted at a WHO-UNICEF conference in Alma Ata in 1979. There are four underlying principles of Primary Health care, these are:
1) Equity 2) Appropriate technology 3) International Action
4) Community participation

1) Equity: Equity through equitable distribution of health resources means health care services should be accessible to all, irrespective to their capacity to pay specially to the marginalized/ disadvantaged/ poor people or family.
2) Appropriate Technology: use of appropriate technology for health. There is no need of CT scan machine and EMI in PHC's,

because it will not sustain and maintenance of this Machine is difficult for PHC & its staff.

3) Intersectoral Action: Intersectoral coordination should be there between health and development. Your intervention should not be fully based on medical cure but more than that in terms of water, wages food employment etc.
4) Community participation: Community participation and involvement is the most important thing of these structures. Without community participation it is difficult to provide successfully Primary health care to the society. In today's context all the planning and schemes/ programmes completed by buearocrates/ politicians and people don't have their voice in these activities. The natures of this entire programme are top down rather bottom up. Community involvement is the base of this entire programme because all these for the community but unfortunately does not have any role in the structure.

Community Health: -

Community health is more than Primary health care and more than Public health. Community health is a concept for achieving the goal of health for all. Community health is a process to enabling people to exercise collectively their responsibility to their own health and to demand health as their right. But in this process people has to take some responsibilities of services provide by government and of Health factors like cleanliness etc. In this process involvement and participation of the community, family and individual is necessary and essential part to achieve the goal of Health.

This process/ approach also include an attempt to integrate development activities including education, agriculture extension and income generation programme with the health.

It also involved local, indigenous, health resources like traditional healers, folk medicine practitioners etc. Reorganization of these individuals and group is also a part of process of community health. It involves training and involvement of village health workers, dais and an attempt to organize the community through farmer's, youth and women's groups.

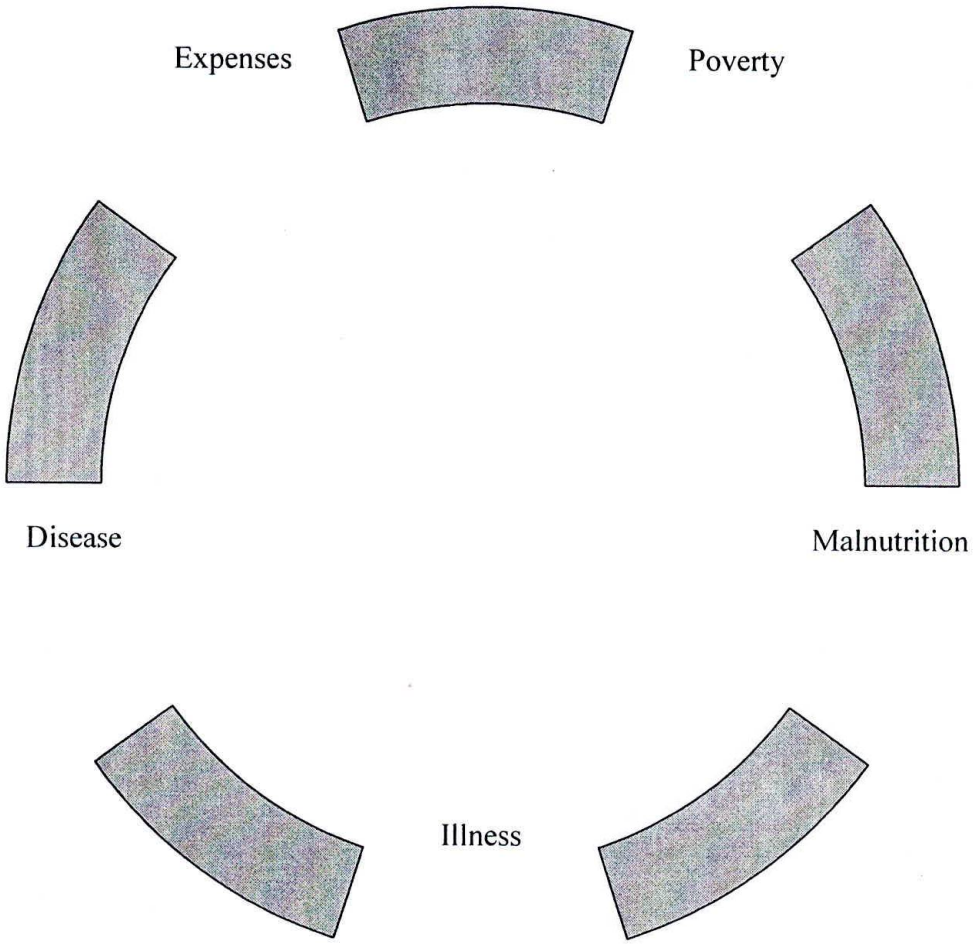
This is a process, which includes increased involvement and participation of community through formal and informal groups, organizations, health committees etc., in decision making for health action including Planning finance and evaluation of health actions.

This approach must be a democratic, decentralized, participatory, people building and empowering the community.

Community health includes primary health care and public health with people's action and initiative to attain the goal of health for a

Urban Health

We had a session on urban health by Mr. Chander. Through two case studies we started discussion on the urban health and we came to know the urban health situation. Specially we learnt how the poverty and health are interlinked.



Rural Poverty Migration over crowing is the Major challenges for urban health.

APSA

Afternoon we went to APSA. It was quite a good experience. The main thing about APSA which we learnt from them is their

approach to handling the issues at different levels. As they providing the services to the needy children and the same time they are working at the community level to solve the problems. Especially through child labor free self help groups. They also adopt the intersectoral right based approaches as well. We also had some discussion on campaign against Water privatization and land issues.

29.08.2006

Today morning we discussed about the Environment health and challenges. The main thing about this issue that we learnt how it affect health and how difficult to prove its consequences mainly we discussed about the industrial pollution and pesticide pollution and complicity of the issues.

Mobility India

Afternoon we visited the Mobility India. This visit was based on information about the Mobility India and discussion on CBR was not enough. Dr.Thelma and Dr.Rakhal gave some information on the issue especially about the DRC, VRC, PMR & RCI.

30.08.2006

Today we had a session on alternative approach to health. We learnt about it like participatory decision making, Awareness building, Accountability, Community audit, building social analysis people oriental and physical dimension of health.
After that we had a session on Gender. It was quite and sensible session. The main thing about the gender which I realize that gender is not social issue but it start from personal level and gender is relationship of mutual understanding and equal opportunities.

PUCL

Afternoon we went to Prof. Hassan Mansur's house, where we discussed about the human rights and they are violated. It was quite a good visit. He also shared his personal experience in the campaign. The main thing about their rights we learnt that state has no right to recall this rights whether its matter of emergency, independence or security etc. We also came to know that how different Act came in power like Preventive detection act, Maintenance of Internal Security, National security act and Armed force special court in name of security.

Communalism and fundamentalism is the greatest threat for Human Rights.

Mental Health

Mr. Mohan Isaac delivered his lecture on Mental Health in a very simplest way and it was good to understand the issue initially. He classified the mental health in three types 1) Severe mental disorder
2) Common mental disorder
3) The group of substance use/ personality disorder.
Mental health is inner sense of comfort and wellbeing and to make other people happy.
Mental health is concept of who I am?

Basic Needs

Afternoon we visited the Basic Need. Where we got some idea about the mental health and how to intervene at community level. We also visited the slum where Basic Needs working through APD and also did the family visit. The main thing we like that is their approach. They are working on four levels.
1) Individual 2) Family level 3) Community level 4) Research, Documentation and advocacy.
We also discussed about the traditional healer and their practice and we realize that purely rational approach doesn't work.

01.09.2006

The CHESS Initiative - Promoting lay Epidemiology:
This morning we had a session on CHESS and CHESS Initiative. Dr.Ravi Narayan gave the background of CHESS and how it works, when Bhopal tragedy happened and government suddenly introduced the "Official Secrecy Act". After that we discussed CHESS Initiatives especially in Kaddalur Industrial pollution, Kasargod Pesticide spray and Tea plantation in Iduki district of Kerala. The main thing we learnt about this issue is how to study the effects on health of pesticide, Chemicals etc, and importance of community level information gathering.
We also understand that these issues are more political and there are more involvement of capitalism, because its matter of globalization.

4.Right to health and health care.

Health Right Training Organized by Sathi Cehat

Indore, 28-30th

Objective of the training

1. To make understanding about the Health Rights
2. To develop perspective to see health right as a human right.
3. Ways to implement health rights.
4. Coordination with different movements on health issues.

Need of the health rights

To understand the need of the health rights we have to analyze the health situation. We can classified it into two parts

1) Negative Conditions 2) Positive Conditions

1) Negative Conditions: -

In these section we specially analyze the situation during the 1990s and afterwards. It's the period of Globalization, Privatization and liberalization.

The Alma Ata commitment did the lead to some renewed attempts at achieving this goal. Soon after this, the Indian government passed in parliament a national health policy in 1983. In this policy all the process element of primary health care as understood at Alma Ata was highlighted. The National Health policy went further to talk of large scale of transfer of knowledge and skill to health volunteers. It talked of a nationwide chain of sanitary cum epidemiological station. It also

talked of decentralization in health care and referral system. It talked of inter- sectoral cooperation and even a better utilization traditional Indian medicine. It even explicitly promised to phase out private practice by medicos in government.

Unfortunately it was all only talk.

Still we have very poor indicators in health like as

- 22 lakhs infants died every
- 3 children die (U-5) every minute.
- 5 lakhs deaths due to T. B. every year
- increase in Malaria, Dengue, Leptospirosis etc which can be generally controlled
- 3 lakhs deaths due to cancer (Tobacco related)

Condition of primary Health Centers:

- Only 38% PHC Have adequate staff
- Only 31% PHC have enough infrastructures etc.

Inequalities in health services:

- IMR in BPL families is almost 2.5 times in comparison to rich families.
- U-5 mortality is 1.5 times in girls in comparison to boys.
- Hospitalization of poor patients 6 times less than others.
- Per capita expenditure in rural areas on health is 7 times less in comparison to urban areas.
- Expenditure on public health is only 0.9% of the GDP.

2) Positive Conditions:-

There are some positive changes were taken place in the field of public health, like:

- Justice Anand and the NHRC accept that health right is the people's right.
- Launching of National Rural Health Mission.
- Health Budget increased by 22%.
- Central Government listed the minimum guaranteed health services at PHC level.
- Community monitoring of the health. (1/3rd NGO representative, 1/3rd Govt and 1/3rd Panchayat representative.)
- Public health act in Gujarat is in process.

Failure of policies, schemes and to reach the peoples are enough reason to raise the issue of health rights. In these process people should be in the centre of public health, they should be involved in management, monitoring etc means the whole process will be decentralized like in Kerala there is 40% of budget channelized through the Panchayat. We have to also monitor the Rogi Kalyan Samiti.

Health and all the services like PDS (public distribution system) and others should be free from BPL criteria.

Right of Health and Health Services:

We would try to understand the issue of health Right under the following points

1. Service Based Approach 2. Right Based Approach

I would like here to put a question that what is the difference between rights based and service based attitude. Is right based attitude means to be away from the services. There is lot of institutions, groups and individuals who are full filling unseen and basic needs of vulnerable and marginalized group of the society. Like Baba Amte, mother Teresa who comes first when we think about it. In our

society there are social beliefs to fulfill the needs of vulnerable groups but if we continue to provide the services in the same way then somewhere we are not able to address the actual cause for the lagging. Second thing is that service based work has many limitations in providing, means we can provide the services to the very limited population and for very limited time also. But the actual thing is that we can't depend on the well wishers are providers rather we have to work in the direction that basic health services should be available for every one as their basic right.

Third thing is that right based approach is base to address the basic reason for the inequalities. The success in this approach is does not matter it's depend upon many things.

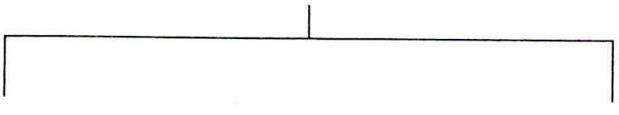
And lastly every individual, institution and group can develop their own model of service and can demand for universal implementation.

Healthy Conditions: - Getting health services is not the only indicator of healthy society. We can't think of it without healthy conditions. There are some necessarily condition

1. Safe drinking water
2. Enough Food, Nutrition and Housing,
3. Safe and healthy Environment,
4. Safe working place
5. Education for all
6. Provide health information to all
7. Employment

Now we can easily understand the difference between the right to health and right to health services. Right to health means, every person has right to get all the necessary conditions and services for the health.

Health Right



Right of healthy condition for all Right of health services

Patients Rights: -

Every patient has right whether he is getting the treatment in public hospital in private hospital. He has the right to know his illness, diagnosis and regarding the treatment etc. Especially in the private sector provider should disseminate all the information about his services, rates of services and other conditions so that everyone can get the information same as at government sector all the information about the services at different level should disseminate so that people can demand for the same.

Apart from these patients has some other rights like

- Right of confidentiality
- Non Discrimination in behavior
- Right of human values
- Right of second opinion
- Right of complaint.

Private Health Services and Health Right:-

Right of health services comes under the subject human rights and to protect this right is responsibility of both the public and private sector. Here we are especially talking about the private sector, why public sector is responsible for it, because:

- Entitlement provided by the government
- Expenses on students of medical colleges
- Many institutions are registered under society registration so they are getting tax exemptions. For these exemptions they have to provide free services to 20 -30 % patients of weaker

section of the society. But most of the times these institutions are ignore the conditions.

Standardization of private health services and social control:-

Today in our country private sector is major part of our health sector and they are providing services at large scale but quality of these services is not satisfactory. In this concern it's consider that there should be some rules, regulations and standards. Standard regarding the resource like infrastructure, equipments, operation theatre, beds, medicines, diagnosis, treatment etc. So that people can get the appropriate and scientific treatment. National Health Policy had decided in 2002 that such type of measurement and standards will be implementing to the entire nation upto 2003 for private sectors. Under the National Rural Health Mission the formation legal structure is in the process for implement this measurement and standard. It will ensure that as we have the rights of health services in public sector in the same we are having rights in private sectors. Now it is needed to give a legal framework to save the right of community. There is also a need of social control on private sector. It will be possible through a committee of doctors, peoples and representatives of NGOs or other social groups.

In brief we can write

- Provision for basic facilities for patients like place, electricity, sanitation, water etc.
- Trained and enough staff.
- Health services related facilities like X-ray, sonography, blood test.
- Appropriate mechanism of diagnosis and treatment of illness.
- Standard rates for services.

- Communication mechanism between doctors and patients to solve problems.
- Price controlling on essential drugs
- Ban on unscientific medicine
- Social control on advertising of pharmaceutical company

Primary Health Services for all- what does it mean:-

Primary Health for all is what we want. We want

- Availability of Health resources.
- Trained human resources.
- National Health Program
- Facilities for treatment and services.
- Control of communicable disease.
- Services for pregnant women and children.
- Services related to nutrition.
- Health education.
- Means of family planning.
- Services with respect.
- Participation of public in health services.
- Provision for complaints and grievance redressal and compassion.
- Sensitive health services for women like women's illness, domestic violence, rape, female feticide and issues related to miscarriage.
- Include men in family planning.

Public Health Services at different level

A civil hospital district level

↑

Community Health Centre

(For 4-5 Primary Health centre)

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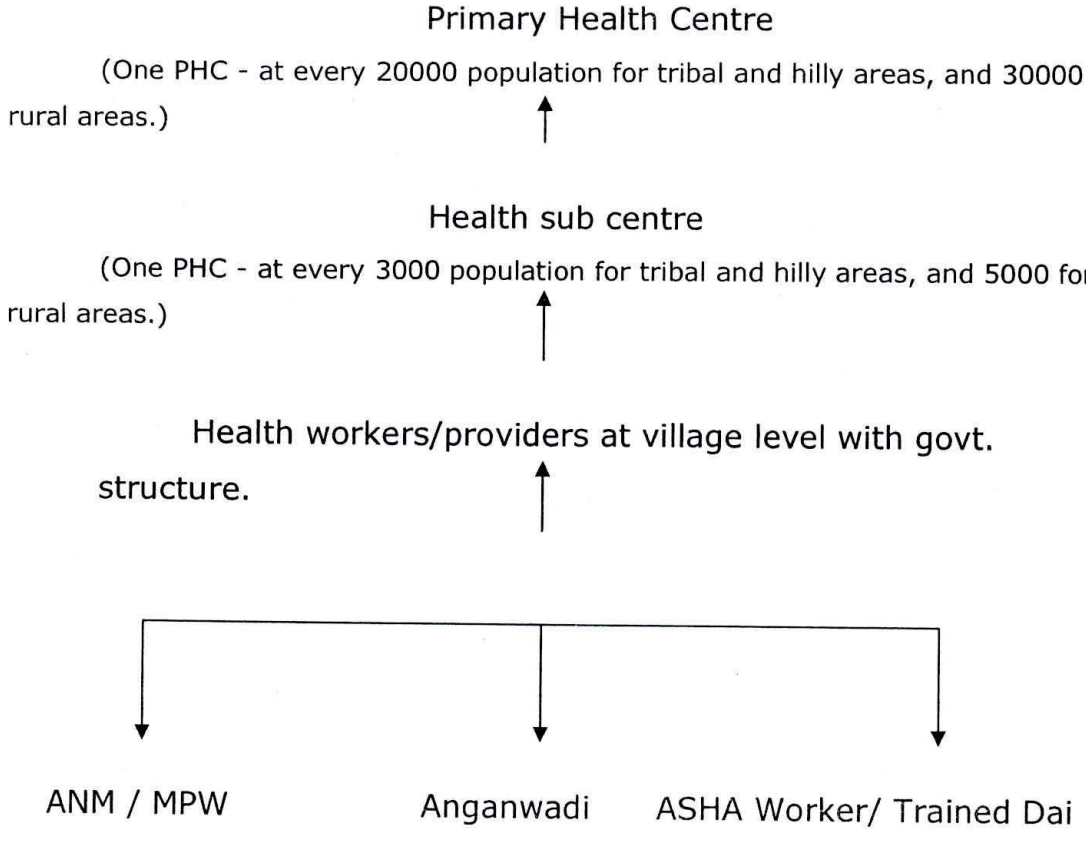

Community monitoring on public health services

We have to monitor at two levels

a. Inside monitoring of public system
b. Outside monitoring of public system

1 **Inside monitoring of public system: -** In National Rural Health Mission there is a national advisory committee on community action (AGCA). Through the AGCA mechanisms for community monitoring of primary health care have been developed. This is one way of monitoring the public services including primary health care. There is some other ways also for inside monitoring like using of Right to Information Act.

2 **Outside monitoring of public system: -** In this the community monitors the services or system through active participation in implementation. There are many ways of monitoring like through Panchayat, Community based organizations, people movements etc. monitoring through committees is also an effective way, and this consists of Panchayat representatives, NGO representatives, health officers and representatives from the communities. These committees will organize public hearing at least once in a year.

National Rural Health Mission: Information and Critique

After the 1990s there is a stagnation (and a fall for sections of society) in health indicators. To improve the health situation Govt started the RCH II programme and after that they also committed to achieve the millennium development goal. In 2004 Jan Swasthya Abhiyan organized public hearings with National Human Rights Commission. In addition to the campaign on Right to Health Care by JSA with NHRC, JSA decided to go with political parties just before the election to advocate the issue of health at national level. JSA met many political parties like Congress, CPI, and CPM etc and put the agenda before these parties. Agenda includes health worker in every village, to increase health budget, health guarantee etc. UPA alliance took this agenda in their common minimum agenda after formation of government they launched National Rural Health Mission (NRHM).

One of the important component of NRHM is ASHA program. The first draft of NRHM comes in Dec 2004 it was based on family planning. Again JSA took initiative through dialogue to correct the approach.

After many changes this program was launched on 12th April 2005 with a focus on primary health care and public health. But in this program content is not clearly defined such as the nature of ASHA. The unfair condition about selection of ASHA is she should be 8th pass.

Main Content of NRHM

1 ASHA program: accredited social health activist. She should from the village, selection of the ASHA will do by gram Sabha. She should be at least 8th passed. But there is clear indication about her duties.

2 To improve the quality of services at PHC / CHC level. For this there is provision of untied fund Rs10000/. It will be channelised through sarpanch and ANM.

3 CHC /PHC should fulfill the criteria of IPHS.

4 provision of decentralized planning at dist level. There will be a dist health planning unit and dist health society.

5 promotion of AYUSH.

6 provision for public private partnerships. This concept is based Rogi Kalyan Samiti. To receive the untied fund first we have to register the Rogi Kalyan Samiti. There is also provision for contract services of health services.

5. Meeting cum discussion on water privatization and JNNURM

On 5th Oct. 2006 I had organized a discussion in collaboration with Jhuggi Basti sangharsh Morcha on water privatization and Jawaharlal Nehru Urban Renewal Mission at Visarjan Ashram Navlakha Chauk Indore.

First session started with discussion on **water privatization**, Mr. Shripad Dharmadhikari was the resource person.

Process of water privatization was started three years before in Indore with Asian Development Bank. This was mentioned by Asian Development Bank in their annual report 2003. Though these whole processes like privatization and liberalization was started in India in 1991 with new economics policy as structural adjustment programme. That was the time when gaps between rich and poor being started increased.

The logic behind the privatization and liberalization given by government was that government system is corrupt, system is destroyed, the services given by govt. are very cheap that's why govt is in debt and due to all these reason Govt is unable to provide all the services so these all the welfare and basic responsibility should handed over to private companies.

At the same time international agencies wanted to spread their business in the developing countries because these countries have big market. Because of this pressure these process of the privatization started in early nineties in these developing countries.

In India privatization of electricity was the first area of the privatization. In this process some parts of the govt services got privatized, like meter reading, collection of the bills, etc. privatization of the water is directly affects to every section of the society. In this process govt. adopt very moderate way to privatized water.

The loan from the Asian Development Bank was taken on following conditions:

a. Water supply should be done by the companies only
b. To close down all the public resources
c. Reducing the staff
d. Those who are not able to pay will not get the water.

Though the privatization of water is not an easy thing it's a very sensitive issue, so govt go in slightly different way which is marketization of water. Reducing subsidy or completely withdraw from it, increasing in the rate of supply all these things were done in the name of reform means Govt prepare a ground for the private company.

The main stated goal of every loan of Asian Development Bank is to reduce poverty but the contract between Asian Development Bank and Municipal Corporation directly said that services will provide in the outskirt of the slum periphery. About the public sources contract says they will continue if the community take responsibility to pay or they can take prepaid billing system otherwise connection will cut down.

We can easily understand the principle of the Asian Development Bank.

The cost of the whole project is 1300 cr. but for the slum area they allocated only 30cr while 40 % population of the city is residing in the slums and 77cr allocated for the consultant.

Jawaharlal Nehru Urban Renewal Mission

The ground for this mission was prepared in tenth five year plan. This plan was launched in Nov 2005. The main objective of the mission is to reform infrastructure based on public private partnership.

- Population growth rate in the urban India 2% and in the mega cities 3% but growth rate of the urban poor is 4.5-5 %. Mission says in its first Para there is high pressure on infrastructure and governance due high increasing in urban poor population but no poverty alleviation funds in the first round of the JNNURM project approvals. The govt of India approved many projects for 23 cities in the initial lists but only infrastructure development and no allocation made for poverty alleviation.

JNNURM Mission & Objectives

- An Rs.50, 000 crores initiative with a stated objective to improve urban governance, service provision and alleviate urban poverty. The 2005-06 budgets allocated an initial 5500 cr. (which was partially disbursed end of March 06)
- JNNURM funding will provide seed money to kick-start other forms of commercial funding and project development in 63 cities are now subsumed under JNNURM and linked to reforms
- Conditionalities: City government must submit city Development plans to the non-elected designated parastatal agency to receive for JNNURM funds, state will have to enact and modify legislation, Municipalities will have to undergo several institutional reforms, other reforms such as public -private partnership, will encouraged.
- JNNURM consists of two parts: 65% of the fund for urban infrastructure and Governance (Under the ministry of Urban Development –MoUD) and 35 % of the fund to basic services to

the urban poor (under the Ministry of Urban Employment and Poverty alleviation - MUEPA).

- Under Urban Infrastructure and Governance, the main thrust will be on water supply including sanitation, sewerage, solid waste management, urban transport, road network and re-development of inner (old) cities. The focus will include –

  Integrated development of and adequate investment in urban infrastructure service.

  Planned development of cities to scale up the delivery of civic amenities.

  Urban renewal program: re-development of inner (old) cities area to reduce

  Congestion.

- Under the basic services to the urban poor, previous GoI scheme will be consolidated and funds will cover programmes like slum improvement, rehabilitation, environment, night shelters, community toilets and housing at affordable prices for economic weaker section and low income group categories.

JNNURM adversely impacts Urban Poor and their livelihoods:

- The entrepreneurial approach underlying JNNURM signals an unconditional surrender to corporate interest.
- Disempowers municipal government by financial conditions, unconstitutional decision making removing almost all possibilities for effective poverty removal and livelihood generation.
- Places at severe risk, poor and chronically poor groups who might be evicted by regressive master planning and repressive zoning regulation.
- Opens political and administrative spaces for the elite to usurp valuable public resources and high cost infrastructure at little or no cost.

- JNNURM promotes e-governance and land titling which reverse the gains made hitherto by more progressive ways to strengthen de-facto tenure.

Private Finance Driven Investment Model

JNNURM funds will be allocated as grants; States / ULBs contribution; and loans from financial institutions / commercial banks in the following ratios

7 mega cities (> 40 lakhs),	35:15:50
28 metro cities (10-40 lakhs)	50:20:30
25 other cities	80:10:10

Little Scope for Social projects or welfare orientation

- No funding for Health or Education related support activities.
- No funding for power or telecom projects.
- No wage employment programme and staff component.

6. Water Testing Report

S.No.	Name of the parameter	Test Result		
		Sample 1	Sample 2	Sample 3
1	PH Value	8.2	8.4	8.1
2	Turbidity in NTU	06	04	05
3	Total Alkalinity as CaCo3 in mg/l	240	425	250
4	Phenolphthalein	-	20	-

	alkalinity as CaCo3 in mg/l			
5	Total hardness as CaCo3 in mg/l	50	110	130
6	Calcium hardness as CaCo3 in mg/l	25	95	105
7	Magnesium hardness asCaCo3 in mg/l	25	15	25
8	Calcium as chloride in mg/l	30	105	50
9	Total solids in mg/l	155	461	210
10	Total dissolved solids in mg/l	127	448	190
11	Suspended solids in mg/l	28	13	20
12	Sulphate as So4- - in mg/l	240	226	235
13	Fluoride as F- - in mg/l	Below 1.5	Below 1.5	Below 1.5
14	Dissolved Oxygen (D.O.) in mg/l	7.2	7.3	7.0
15	M.P.N. index /100ml (presumptive Test)	00	00	00

7. Preparation of health profile

1 Ramabai Nagar:

Majority of the population are the followers of Baba saheb Ambedkar. Majority of the population are Buddhist and Balai, they are migrated from Nimar region of MP and Buldhana & Akola dist of Maharashtra. Their main occupation is rag picking and domestic work. Men are mainly involved in fruits selling and catering.

Firstly they had evicted from Krishnapura Bridge to CP Shekhar on 24th May 1995 in the name of beautification of the lake and again they evicted from this place to near Bicholi Hapsi road on 15% reserve land for weaker section. There are no basic services available like school, anganwadi, water and sanitation, cards. Still they are trying to get Patta. Only 32% households have ration card. 70% people have voter ID card and 25% have health card. Only three widows are getting pension, six people are getting old age pension. Water supply is not enough they are bringing the water from a kilometer far.

The near by Govt school is 3km far from the community and across the ring road. Only 25% children are going to the school. Only 5% children are going to the Govt School and 20% children are going to private school and they are paying 100rs per month. The near by Govt hospital is 6km far from the slum. Generally people goes to private clinic or private practitioner for treatment. ANM visit the once a while for immunization, ANC, Family planning promotion etc. the immunization rate is very low it is nearly 36%. Still they are living in threat of eviction.

2. Ishwarchandra Vidhyasagar Nagar:

They are evicted from Bangali Chauraha to near Piplyahana Talab in the year 2003 during the rain. Presently there are no basic

facilities as well as services available like school, anganwadi, sanitation, immunization facility, ration card, voter Identity cards and still they are trying to get Patta.

Only 18% households have ration cards.11percentage households are having health cards but they do not about use of cards. 26% households are having BPL card. Nobody is receiving any kind of social security. There is no Govt school within community. The nearest Govt School is 2.5km far from the community and nearly one private school is there. Total 35% children are going to school but the only 8% children are going to the Govt School, rests of 27% children are going to the private school. The behavior with children in private school is not good. The monthly fee of this private school is 70 per month. The nearest Govt hospital is Maharaja Yashwant Rao Hospital but people generally go to the private clinics or they get treatment from the local practitioner. For serious cases they go to the M Y Hospital. Malaria and Diarrhea are the prevalent disease in the slum. ANM visit the slum once a moth. She comes under routine tour and she does the immunization but the very few children getting the immunized because the dwellers are unaware about her visit. The immunization rate in this slum is nearly 30%. Pregnant women only get the immunization not Iron and folic acid tablets.

The community comprises with different caste like tribal, schedule caste and others, mainly they are daily laborers.

They are still facing the false cases filed by Corporation during eviction.

3. Vidur Nagar:

The residents of this slum were evicted from piplyapala chauraha, asharam bapu chauraha and ashok nagar on 17th June

2003. The community comprises with different caste like tribal, scheduled caste and others, mainly they are daily laborers and domestic servant. This resettled site is in outskirt of the city there is no other source of livelihood and no basic services available like school, anganwadi, water and sanitation, ration card, voter Identity cards. Still they are trying to get Patta.

4. Piplya Rao Nai Basti:

They are evicted on 28th May 2000 from professor colony, Bhanvar kuna. This resettled site is also in outskirt of the city. Presently there are no basic facilities available like school, anganwadi, sanitation, immunization facility. Few dwellers have ration card and voter Identity cards. Mainly they are from Scheduled caste (Balai).

Women are mainly involved in domestic work and rag picking and men are engaged in daily laborers.

Profile of Slums

S No	Slums name	Ward no.	Caste	Occupation	No. of family/ pop	Residential status	School availability	Health facility	P a e b w
1	Ramabai Nagar	36	Mahar, Balai,	rag pickers, domestic workers, Fruit sellers, catering	155/701 Male - 358 Female- 321 Boys- 161 Girls-	15% reserve land	3km far across the ring road	none	

					139				
2	Ishwarchandra Vidhyasagar Nagar	36	Kumhar, Banjara,Bhil, Dhobi,	daily wage labour	85/283 Male-89 Female-83 Boys-57 Girls-54	Resettlement	2.5 km far across the ring road	none	n
3.	Vidur Nagar	69	Balai, Bhil,	Rag pickers, daily wage workers, domestic worker	145/668 Male-341 Female-327 Boys-161 Girls-139	resettlement		none	n
4.	Piplyaraonai Basti	69	Balai	Rag pickers, Domestic workers, labour	280/1400 Male-334 Female-296 Boys-416 Girls-354	Patta		none	n

Profile of Indore City

1- Total area of city 130.17 Sq Km

2- Total population of city 16,37,461

3-	Population Density	12579 p/SQKm
4-	Sex Ratio	901
5-	Percentage of urban poor	25.57 (Govt.)
6-	No of wards	69
7-	No. of Zone	11
8-	Water supply	42 MGD
9-	Solid waste generated	476 T
10-	Education level	89% (M), 74% (F)

Health Profile in Indore District

Ante Natal Check up	I.F.A tab	Institutional Delivery	Immunization	Diarrhea	Pneumonia
No ANC 13.6%	only 39.8% taking Regular tab	only 25% delivery in govt hospital	12-35 months -49.65 Full immunization	20.3% Children	22.8% Children

R.T.I	Govt services during complicated delivery	Govt Services Post delivery complications
36.4%	26.7%	44%

8. National tour linking the urban poor

On 18th Oct I coordinated the Indore meeting of the NAPM organized national tour linking the urban poor, with the help of support group in Indore.

A meeting was organized at Manasi clinic with tour team and representatives from different organizations. Meeting started with introduction. After the introduction tour coordinator Mr Maju gave the information about the tour and purpose of the tour. The main purpose of tour was to strengthen the fight against different forces and integrate the different initiatives around the India and create awareness about the JNNURM and SEZ.

Mr. Basant Sinthre gave the brief information about the situation in Indore. Especially about the master plan that how the master plan is going to affect the urban poor in Indore and forthcoming eviction which will in the name of the beautification of the city. At the meeting there was a sharing by participants from different towns/ cities eg Bhusaval, Nasik, Mumbai

After the meeting I had organized field visit in the community named Naya Basera. We entered in the slum in form of rally. There we discussed the situation of the urban poor in Indore and in the other cities of the India.

9. JSA meeting

I had attended the meeting of Jan Swasthya Abhiyan held on 1st oct 2006 at BGVS office Bhopal. The main agenda of the meeting was to finalize the issues for NHA II.

Many issues discussed in the meeting like health services at PHC and CHC level women health, occupational health, urban health mission, Rogi Kalyan Samiti,Organizational capacities of JSA, network with other campaign, follow up of denial cases etc.

After that discussion was held on the peoples rural health watch survey.

10.Indian Social Forum 9-13 Nov 2006

Campaign issues on child health 10/11/06

This was the first session which I had attended and it was on child health issues in campaign. Different people present their views on different aspect of child health. The first presentation was on street children. She talked about the two types of children on the street and off the street children. Juvenile justice act is a progressive act but it also talk about the institutionalization of the children but the best place for the children is their home. Institutionalization means you are keeping the children away from the home which is not good for rehabilitation for the children.

These children are very soft target for abusing for anyone either it will be police, mafia or somewhere else. Girls are not seen on platform or on street. The railway staff also uses these children for picking up death bodies from the railway lines.

These children are facing the sexual harassment; drug mafia uses these children for drug supply.

There is urgently need of change in our approach. For example we have to open the centers close to the railway stations. To provide health services we have to organize health camps, clinical health facilities.

Health of migrant Children

To provide health services to the migrant population is really a challenging task. The nature of group is their mobility and because of this nature they are not getting regularly any kind of services. Mobile camps / medical camps are the short term solutions but there is urgent need for long term solutions or campaign. For that there is need to revamping the existing health services, regular mobile outreach program. Other main problem with group is identification so the state govt should provide the ID card to each migrant. Because of no identity there is no registration facility for this group. The children of these groups are also not getting education and other recreation facility. Migration is basically related with livelihood issues so if we want to solve the problem we have to concentrate the root cause of this problem means livelihood issues. We have to talk about their rights, fight for bill for unorganized sector.

Health of SAHARIYA children

The health of the SAHARIYA children is in bed condition, malnutrition rate among these children are 93%. They live in outskirt of the village. They are getting exploitation from the local landlords. Their livelihood based on forest after forest stone mines as an alternative. There is high prevalence of T.B. in these groups because of their working condition in stone mines. They are also not getting minimum food security.

Parents are giving thick roti to their children so that chewing the whole day. They aren't goes out in search of their livelihood, and hunger effects adversely on their health and result of this they are very prone to disease, infections, skin disease. Health services are totally unavailable for this group. There is no special quota for the health services of SAHARIYA tribes. So there is need of campaign at large scale to advocate the issues of SAHARIYA tribes at state and policy level.

Pulse Polio Campaign

Mr Rajeev Dasgupta of JNU gave the information about whole issue. He stared with polio virus infection and its three main outcomes. He shared that in 92-95% cases there is sub clinical infection and only 1-2% cases facing major illness. 1% of total paralytic polio reached 10% deaths. 50% recover and 40% permanent paralyzed.

Polio is water born disease but in the whole campaign this was never addressed at all. He also explain the meaning the word eradication. Through some intervention there should be removing and new cases will be zero and there is no further need of any additional measures but we are still having polio cases. He adds that the children having polio virus have more chance to get polio if he got injection.

He also discussed the data of polio cases. If we are not taking epidemic cases of polio there are huge number of cases. In 1959 there was an epidemic in USA at that time near about 20000 people are paralyzed and 400 were dead. He said after a huge campaign we are still having significant cases of polio. According to the November 2006 data there are 1400 cases identified globally and in India near about

490 cases are identified and nearly 75% cases from the Bihar and Uttar Pradesh and 72 districts are affected from polio all over India.
Ms Indira added that this pulse polio campaign basically a WHO program which is implemented by Government of India. It was started in 1988 by WHO (world health organization). The rational behind the campaign was that routine immunization is not enough for eradication of polio so there is intensive need of intervention and this was pulse polio campaign. Immunized all the children together are main principle of this program.

In this campaign the whole intervention was based on immunization but there is no focus on other issues like malnutrition , social issues etc. malnourished children are more prone to get polio there are 30% more chances of conversion of polio because in these children defense mechanism are weak. According to Dr.Shridhar 50% children are malnourished and 100% children are partially malnourished.
The major failure of this program that it is never been the part of people.

Seminar on Urban Health in Context of Globalization 10/11/06

The session starts with Mr.Dunu Roy's presentation. This presentation was focused on JNNURM. This talks especially urban reform. The total budget of this scheme is nearly 1.5 thousands crores for 60 cities. Under this production process is closing in the pollution and shows it's dangerous for health. It talks about reducing the labor, reducing the work etc. The whole planning was based on the cost of poor. It's strongly talks about the eviction of slums in the name of beautification of the city. After the implementation of this program every service will be paid and every thing will be the marketized like

water, housing, health services etc. the basic concept of this program is privatization. On the one hand there is many problems like poverty, hunger, safe drinking water, food etc but on other hand this program include nothing for this it talks about super specialty hospitals and medical tourism.

In 2001 their 40 lakhs labor in Delhi and it is estimated that three will be 80 labor in 2021 in Delhi itself but master plan says that we will not do anything for employment generation at large scale. Nobody wants that this group will come under formal sector. We can easily imagine the future of this targeted group.

Mr. Rajeev Dasgupta focused his presentation on water access and water borne disease. In 1988 cholera was the major epidemic but the cases identified of water borne disease in 1994 were much more than in 1988. It does clearly indicate the approach towards community health. This type epidemic was repeated in vulnerable colonies.

Dr. Mira Shiva talked on malaria and chikanguniya. Today the nature of this type of disease is different from the earlier but we not doing any research. Still we fail in diagnosis. So we also demand for diagnosis facilities and research and development should be based on needs of public health.

Right to Education Bill: Myth or Reality 11/11/06

Why today we are taking about the right to education and of Need of right to education bill. As Indian citizens it is basic right and Constitution also provide the right to education to all the children without any kind of discrimination. But today we are struggling to get this right as our right. This is responsibility of states to provide free and compulsory education to all the children between the age group 6-14 years. But there is lack of political will to provide the education to all the children.

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4th draft of right to education bill was come in 2003 and it was rejected by everyone because this bill was promoting discrimination. In the next draft few good things was there but it was not implemented and in this year 6th draft came out but this draft has also many irrational things in it. Through this draft all the major responsibility handed over to State government and their no provision for free education for children form weaker section of the society. There is also no provision of residential school where their any school available because of this disabled children will not able to get education easily so its directly attempt for this group to keep away from education. There is also lacking of to fight for barriers like economic, cultural and social but in 5th draft few provision was their. There is no provision for nursery education.

This draft also legalizes the capitation fee. But this bill says school, neighborhood school, residential school, transport etc will not be providing by the government.

This draft does not have any space for working children or child labor. This draft also says Government will not open new school where there are private school is available but dept will give support through vouchers for selective population. We may call this approach is silent promotion of privatization of education.

In the entire situation if children will not get the education then parents will responsible for the same but not Government and have to ready for punishment.

Girl Child Education

The situation of the girl child is worse in backward areas. There are many girls working as a bonded labor but the works which they are doing not comes under the child labor. Girl children are out of child labor definition. The jobs they are doing also not recognized as

hazardous work. There is no special provision for education of these girls.

A study was conducted by Child Right Protection Forum in Nalgonda on child marriage. The results of the study are

- Two girls came to suicide.
- Five cases of miscarriage.
- 75 girls were suffered with abortion.
- 20 girls facing mental health problems or ill health.
- Seven girls were return to parents home.
- The husband of six girls made second marriage.
- One girl got natural death.

We can easily imagine the situation child marriage especially of the girls.

Education of Dalit Children

In the ancient period there were four section of society Brahmin, Kshatriya, Vaishya and shudra (Dalit) and that time dalits were not allowed to get education. After the independence every citizens has got the right to equality constitutionally. But till today the dream of equality for a special section of the society is very far. In the some feudal and religious state like Gujarat, Rajasthan the situation of the dalits are worse. Earlier the budget for education of this group was little bit high but from the early 90s there were significant downfall in budgeting.

In the remote area of the Rajasthan the condition of the Dalit children in school is very bad, they still facing the discrimination. In these area children have to sit alone they can not sit with general class students. Drinking water for these children is also kept separate. In these areas Dalit students are doing the cleaning the school, surroundings etc. they called by

caste in role call. The ministry of education of Rajasthan is largely in the hands of elite people right from the beginning.

Saving India's Public Healthcare system 11/11/06

This session was organized by Jan Swasthya Abhiyan. Public health care system is only system to serve the services to the people. But today main challenge is to get the service from these institutions, they becomes more bureaucratized and not functioning well.

The national common minimum programme of the united progressive alliance (UPA) govt. identifies health as an important thrust area. At 0.9% of the GDP, which translate into Rs. 200 per capita, the total investment on health in India is among the lowest, in the family of the world nations. In fact the allocations for health have decreased from the level of 1.3 % of the GDP in 1990 to o.9% in 1999. Even this outlay is not being effectively utilized and access to health care services are not uniform due to inefficiencies of the public health system, poor maintenance of the public health infrastructure, manpower problems, lack of accountability, unregulated private sector health care cost and multiplicity of vertical programmes, dissipate energies at the operational levels.

Despite the impressive public health infrastructure, it is cause of concern that only about 20 % services are being provided by the public health sector, while the private sector provides almost 80 % of the health care services. Studies demonstrate that curative services largely favor the rich over the poor. It is estimated that health expenditure is the major cause of the rural indebtedness.

The govt. of India has launched National Rural Health Mission (NRHM) on the 12th April 2005. The mission covers the entire country with

especial focus on the most vulnerable 18 states where the challenges of strengthening weak public health system and improving key health indicators.

Jan Swasthya Abhiyan has played an important role in NRHM through various ways at different levels.

Different stages in the development of the NRHM are as follows:

i. pre national consultation
ii. national consultation phase
iii. post national consultation phase

JSA was involved at different level like meeting with Govt officials, works as a task group and action for redrafting the NRHM.

1st draft of NRHM came in Oct 2004 this was mainly based on family but the other areas of the health were absent. That was the main cause of reaction on it. One of the main focus areas of the NRHM is ASHA. The concept of rural health worker basically brought from barefoot doctor of China. This model program is being implemented. But mobilization not has done.

NRHM said PHC, CHC should be improved according to the Indian Public Health Standard (IPHS) but IPHS mainly concern about the infrastructure. There is discussion about the services. There is no clarity about the citizen charter. There is also lacking of other health determinants like water, environment, nutrition etc. its also promotes public private partnership in the form of contracting, franchising, recognition to the private clinics and paid services from these clinics. But NRHM is not talk about the regulation of private sector. Infrastructure is essential but there is no explanation of patient's right, standard of services.

Some positive indicators are also their like district level planning, community monitoring with involvement of NGOs and other local institutions like panchayat, gram Sabha etc and public hearings at every district, block level once in a year.

State wise presentation on NRHM

Uttar Pradesh by Dr. C. S. Verma

National Rural Health Mission was launched in Uttar Pradesh in September 2005. The officials are not willing to give the information about the progress of mission though they are demanding the under the Right to Information Act.

There are many irregularities in selection of ASHA like bribe, non democratic selection, misguiding the ASHA about the remuneration etc.

Selection of monitoring committees is done till November 2005.

Shortage of doctors is another main problem their. Contract basis appointments are taking place in hospitals on call duty.

The training of ASHA was held in only five districts with junior doctors only. They are working as assistant of ANM; she is also working for routine immunization campaign.

The two selected ASHA from Raibareli were come and shared their experience. According to both of them after the selection and training no meeting was held. They are still confused about there works. They don't know what to do. Even ANM and MPW are not much sure. They also shared about corruption in selection process.

Madhya Pradesh by Dr. Shailendra Patne

Dr Patne started with health infrastructure in M.P. there are

5 medical colleges

2 private colleges

178 CHC

1194 PHC

8835 Sub Center

8 doctors per lakh population (on doctors in remote areas)

After that he presented the draft report of study rural health watch. The study was conducted in 11 district of MP. Some main findings are:

73% CHC are situated under the range of 5 KM.

27% CHC are situated far, beyond the 5 KM

Selections of ASHA were done by ANM, MPW, Panchayats, no involvement of community.

44% selection of ASHA were done by Anganwadi

20% selection of ASHA were done by health workers ANM/ MPW

About the duties and responsibilities she is confirmed.

They have less information about Janani Suraksha Yojna.

Tables, chairs, mattresses, torch were purchased from untied fund.

Health committees exist in every village but involvement in planning.

There is no gynecologist.

Bihar

Black listed NGOs are involved in planning. 29 were selected in Bihar but presentation from ST, SC and other weaker section are negligible. The breakup of ASHA according to the class is

2	Brahmin
1	General
1	landless
19	Other backward classes
3	schedule caste
3	minorities

Defending the Health Rights of People in the era of Globalization 12/11/06

This was organized by JSA. In this event the campaign themes of national health assembly were introduced. Four themes

were introduced and are Globalization and Health, Health System in India: Crisis and Alternatives, Women's Health, Campaign in Child Health.

Globalization and Health:

In period of time funding of public sector in health are reduced and private sector still spreading his hands and covering almost 80% of services in health. In this period expenses on health are increased. There is increase in hunger. In 1991per capita food availability were 178 kg it reduced up to 154 kg in 2000. The conditions of half of the population are worse than the South African poor countries.

According to studies conducted in health services there are huge increase in private hospitals and are 55- 57%. There is also increase in out care patients and it gone up to 80%. The increase in expenditure of rural patients on health by 142% and in urban areas is increased by 150%.

Expenses in government hospital are also increased three times.

Now Government is talking about the improvement in health services but their efforts are limited to RCH or in AIDS and it is only up to the primary level. For this government is saying there is not enough fund but if we on other hand there significant downfall in money collected through. In 1991 the amount collected through taxes was 13% of our GDP but it reduced in 2001 up to 9%, decline of 4% which four times our health budget.

Globalization and Women's Health

Health is a state of physical, mental and social well being and not only the absence of disease. Women's health is integrally linked to women's access to available resource and Women's productive and reproductive role in our society.

11 Experiences with Jan Swasthya Sahayog (JSS)

I spent one month with JSS ,Ganiyari. Objective of the working with the JSS were

1 To understand the community health with practical experiences.

2 To conduct the study on malnutrition in the children between the age group of 6month to 36 month.

3. To understand the Jan Swasthya Sahayog

About the Study- the study was conducted in 30 villages of Kota and Lormi block of Bilaspur district. I examine the 478 children at the phulwari centers and in villages.

Intensive examination was done by the fellow and it is found that nutritional condition of the children is not good.

12. Conclusion

This whole period of fellowship was full of learning through discussion, visits, and exposures. This fellowship also helped in build up personal capacities in terms of knowledge, skill, confidence, technical etc.

Through the intensive efforts at Jan Swasthya Sahayog in the field gave me a reach experience in term of practical, knowledge and about the community.

Annexure-1 Survey Form

HEALTH PROFILE OF SLUM DWELLERS

(A) General Information

1. Name of the Slum. _____
2. Name of the Ward. _____
3. Ward No. _____
4. Population of Slum. Adult: - Male. _____
   Female. _____
   Children: - Boys _____
   Girls_____
5. Total No. of houses/huts.
6. Present residential Status ------ With / Without Patta
7. Religion (%) _____

8. Casts (%) _____

9. Details of common Property recourses of the dwellers

1. Community Hall. 2. Temple 3. Garden 4. Open Place. 5. Other Details.

10. Percentage of household having ---

1) Ration Card _____ 2) BPL Card _____

3) Any other Govt. given Card. _____

11.. Where do you buy Ration from ---

1) Ration Shop 2) Other

12. Social Security Pension _____

(B) Basic Needs

13. Source of water _____

14. Availability of water _____ daily/weekly/every 2-3 days.

15. Drainage System. _____ Present/Absent

16. Toilet facility: -

1) Individual 2) Shared 3) Public 4) Open place

(C) Education.

17. Near by School: -

Public_____ Distance from Basti _____ Monthly Fees_____ Private _____ Distance from Basti _____ Monthly Fees_____

18. Percentage of School going Children.

(1) Boys _____ (2) Girls _____

19. Anganwadi / Balwadi facility _____ Present/Absent.

20. If Present, No of Children regularly attending Anganwadi. _____

21. under whose management. _____

22. Literacy Rate

(1) Male _____ (2) Female _____

(D) Health.

23. Nearly hospital/health post.

Govt. _____

Private _____

Others _____

24. Diseases prevalent in Slums

(1) Malaria. (2) Jaundice. (3) T.B. (4) Diarrhea (5) Others.

25. Where do the dwellers usually go for treatments?

_____

26. Does any health worker visit your home?

(1) Yes. (2) No.

27. If Yes. Who. _____?

28. How frequently do they visit the slum?

1) More than once a month

2) Once in 2-3 month

3) Other. _____

29. What do they come for? _____

30. Does anybody provide you education concerning prevailing health problems?

    1. Yes 2. No.

31. Where were the children Immunized.

    _____

    _____

32. Percentage of Immunization in Slums.

33. Did the women receive ante-natal care?

    1. Yes 2. No.

34. If yes what type of services they get?