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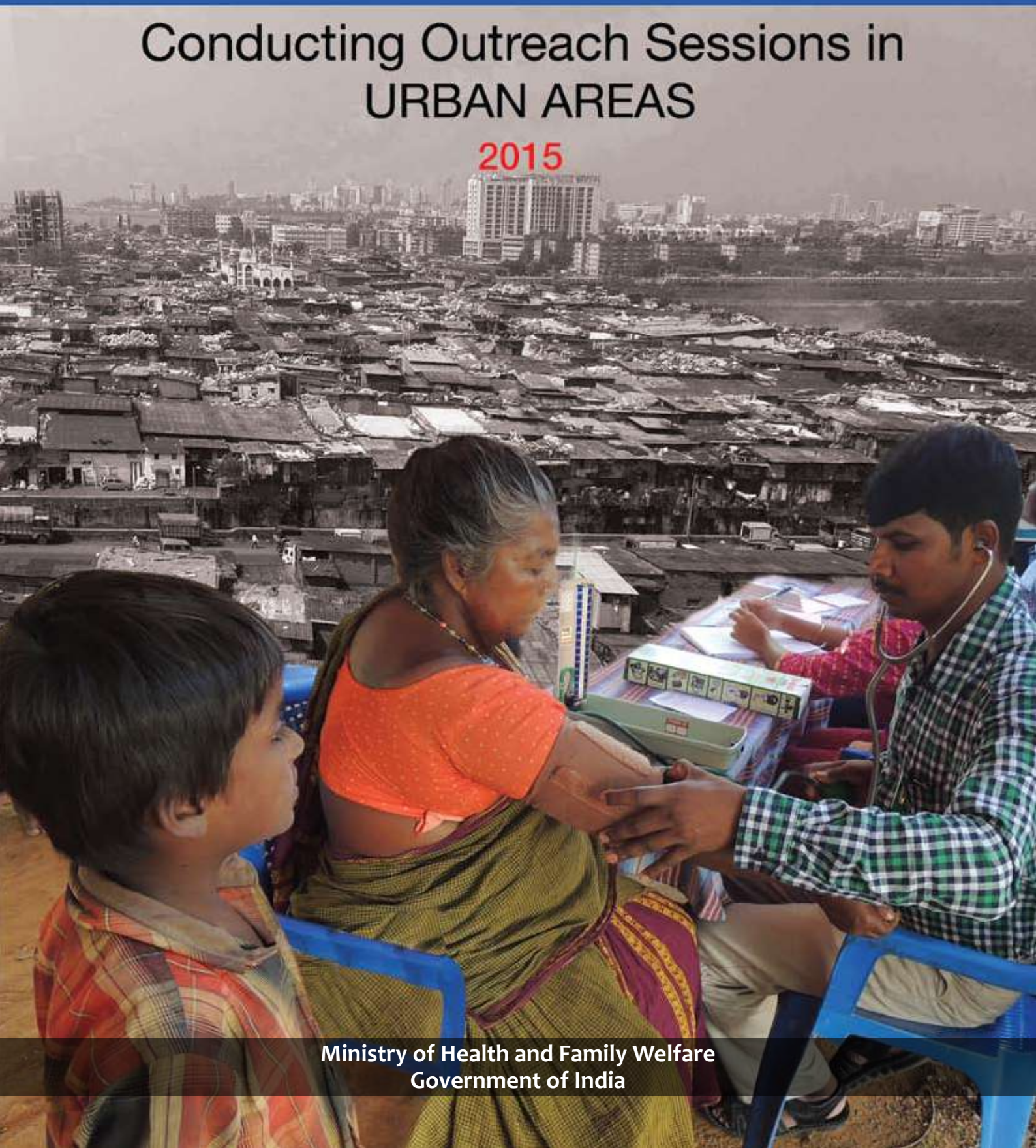
NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

OPERATIONAL GUIDELINES

Conducting Outreach Sessions in URBAN AREAS

2015



Ministry of Health and Family Welfare
Government of India

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भानु प्रताप शर्मा
सचिव
B.P. SHARMA
Secretary

भारत सरकार
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Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Foreword

The National Urban Health Mission (NUHM) was launched to address the specific, unique and diverse health care needs of the urban population, with a focus on the urban vulnerable population. Outreach activities have been an integral part of the National Health Mission. Necessary outreach activities are for overcoming the social, economic and geographic barriers faced by remote and marginalized population groups in accessing primary health care services.

In the context of urban areas, special outreach camps will be conducted for providing need-based services to the vulnerable population. Special Outreach Sessions are expected to provide health care services to the homeless and destitute, construction workers, rag pickers, brick kiln workers, rickshaw pullers and other socially vulnerable groups. Hence, these camps should be tailored to meet the special needs of these vulnerable groups.

Since delivery of health care services to the vulnerable population through special outreach camps is a new and innovative initiative, the current guidelines are only indicative. States may adopt these guidelines to meet the local requirements. Based on field experience during the implementation of these camps, the guidelines could be modified further.

(B.P. Sharma)

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Message

The National Urban Health Mission aims to address the health concerns of the urban poor and marginalized population through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. The underlying principle of the NUHM framework is that activities will be designed so that the health needs of the disadvantaged - the homeless, destitute and other vulnerable categories are addressed even as we endeavour to enable universal access.

National Urban Health Mission envisages provision of primary healthcare in the form of targeted Outreach Services to the slum dwellers and other vulnerable groups. The outreach sessions (both routine and special outreach) could be organized at designated locations in coordination with ASHA and MAS members. States are encouraged to involve community volunteers and social organizations for successful implementation of outreach services.

These guidelines have been developed after wide consultations with states and other stakeholders. States are encouraged to adapt the guidelines to meet the local need and to ensure improved coverage and access of the urban poor to primary health care services.

(C.K.Mishra)

New Delhi
14th September, 2015

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Message

The launch of National Urban Health Mission (NUHM) marks an important landmark in the country's step towards Universal Health Coverage. One of the main objectives of the National Urban Health Mission is to address the primary health care needs of the urban poor and marginalized population. The challenges in urban areas are very different from those in rural areas. One major challenge is that of social inclusion and ensuring that health interventions reach the most marginalized sections. There cannot be a more effective vehicle to facilitate this than special outreach services designed specifically for the vulnerable sections.

The Framework of the National Urban Health Mission envisages provision of primary healthcare to the slum dwellers and other vulnerable groups through targeted Outreach services. The outreach services are categorised in two types - Monthly outreach sessions / UHNDs and Special Outreach Sessions. Unlike rural areas, sub-centers are not being set up in the urban areas. Therefore active participation of community and Mahila Arogya Samiti is necessary for successful organizations of the outreach sessions.

These broad guidelines will help the States to plan and implement this vital modality of service provision through outreach. States may adapt the Guidelines, to meet the local requirements.

(Nikunja.B.Dhal)

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Operational Guidelines for Conducting Outreach Sessions in Urban Areas

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ABBREVIATIONS

AD	Auto Disable (syringes)
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infections
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CHC	Community Health Centre
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CPMU	City Programme Management Unit
DPMU	District Programme Management Unit
DPT	Diptheria, Pertussis and Tetanus
ECG	Electrocardiography
FHW	Female Health Worker
HIV	Human Immuno-deficiency Virus
HUPA	Housing and Urban Poverty Alleviation
IEC	Information,Education, and Communication
IFA	Iron and Folic Acid
IHSDP	Integrated Housing and Slum Development Programme
IUCD	Intra Uterine Contraceptive Device
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
LHV	Lady Health Visitor
MAS	Mahila Arogya Samiti (Women's Health Committee)
MCH	Maternal and Child Health
MMU	Mobile Medical Unit

MO	Medical Officer
MOIC	Medical Officer In-Charge
MS	Medical Superintendent
MTP	Medical Termination of Pregnancy
NGO	Non Government Organisation
NHM	National Health Mission
NIDDCP	National Iodine Deficiency Disorders Control Programme
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OCP	Oral Contraceptive Pills
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques (Act)
PHC	Primary Health Centre
PNC	Postnatal Care
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
RAY	Rajiv Awas Yojana
RCH	Reproductive and Child Health programme
RMP	Registered Medical Practitioners
RTI	Reproductive Tract Infections
RWA	Residents' Welfare Association
SHG	Self Help Group
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendants
UD	Urban Development
UHND	Urban Health and Nutrition Day
ULB	Urban Local Body
UPHC	Urban Primary Health Centre
WCD	Women and Child Development
VCTC	Voluntary Counselling and Testing Centre
VHND	Village Health and Nutrition Day
VVM	Vaccine Vial Monitor

CHAPTER 1

BACKGROUND

Urbanization is one of the most significant demographic trends of the 21st century. Unplanned and rapid urbanization has led to massive growth in the number of urban poor population, especially those living in slums and other vulnerable population pockets. Migrants are drawn to urban areas to seek work opportunities and to establish a better life for themselves and their families. However, most Indian cities, from mega cities to small cities, lack the necessary infrastructure in terms of housing, water and sanitation, and basic services such as health care and education to accommodate and meet the needs of migrants, having implications for their health, wellbeing and productivity. While on one hand the cities are considered full of opportunities and affluence, paradoxically enough, they can also become hubs of marginalization, poverty and disease, unless appropriate policies & programmes are put in place to address the needs arising out of rapid urbanization.

The urban poor suffer from poor health status with higher burdens of mortality and morbidity and under-nutrition compared to rest of the urban population. Incidence of vector borne diseases, Tuberculosis and respiratory infections is also significantly higher among the urban poor.

It is estimated that about a quarter of our urban population live in slums. Despite the supposed proximity of the urban poor to health facilities their access to them is severely restricted. Social exclusion and lack of information and assistance at the secondary and tertiary hospitals further restricts their access. Ineffective outreach and weak referral system prevents them from accessing the available healthcare facilities. The lack of economic resources limits their access to the available private facilities. Keeping this in view, one of the main objectives of the National Urban Health Mission is to address the primary health care needs of the urban poor and marginalized population.

The Framework of the National Urban Health Mission envisages provision of primary healthcare to the slum dwellers and other vulnerable groups through targeted Outreach services. Unlike rural areas, sub-centers are not being set up in the urban areas as distances are relatively small and transportation facilities are easily available. While routinely the services will be provided at the Urban PHCs, package of certain identified services shall be provided through targeted outreach services in population clusters which are not easily able to access available services due to distance or other reasons. ANM will provide these outreach services to these populations in slum/vulnerable areas. In addition, Special Outreach services will also be organized for these identified slum & vulnerable population pockets periodically as per the specific local healthcare needs. The following sections provide broad guidelines for the States to plan and implement this vital modality of service provision in community outreach.

2 CHAPTER

UNDERSTANDING VULNERABILITY

Since the entire exercise of planning, implementing and evaluating the provision of services in an outreach mode is for the vulnerable populations, it is essential to understand how to cover and include all vulnerable individuals/ population pockets while planning the outreach services for the health facility.

Identifying the vulnerable families/pockets/areas: Urban populations and the urban poor are far from being homogenous and comprise of several sub-groups that differ socially, economically, and geographically. Such vulnerability may be:

1. **Residential or habitat-based vulnerability:** This includes those residing in slums and Jhuggi Jhopdi Clusters and thereby not served by any form of public services like sanitation, clean drinking water and drainage. This category includes those living under road bypasses, on railway stations, under bridges and on footpaths, destitutes, beggars, street children, poor migrant workers. Slum dwellers near hazardous locations such as dumping grounds may also be prone to sanitation related diseases or vector borne diseases, apart from others.
2. **Social vulnerability** includes categories such as female-headed households, minor-headed households, the aged, and people with disability and illness.
3. **Occupational vulnerability** includes those who do not have access to regular employment, without skills or formal education and hence get engaged into informal and casual labour with uncertain earnings and/or subject to unsanitary, unhealthy and hazardous work conditions such as head loaders, coolies, rickshaw pullers, sex workers, brick kiln workers, sanitary workers, manual scavengers, domestic workers and construction workers, street vendors. The various categories of vulnerable groups are as follows:

a. **Homeless/Houseless:** As per the census definition, houseless population groups are those who do not live in buildings or census houses, but live in the open on roadside, pavements/under flyovers and staircases, open government lands open places/of worship, railway tracks, canal banks, etc. They can be living as single individuals or in families. They are vulnerable to a gamut of health related problems, including trauma from accidents, violence, attacks and protracted neglect, for want of spaces for recovery and rehabilitation etc, apart from ailments arising out of lack of basic facilities such as safe drinking water and sanitation. This segment also includes persons living in shelters (could even be night shelters) for the homeless run by charities, religious institutions and government. Women require special care during pregnancy and child birth. Street children in metro cities engage in a variety of unsafe occupations from rag-picking, to begging, to helping in shops and stalls, which put them at risk to physical and sexual abuse. Health workers, ASHAs and AWWs under the guidance of Medical Officer may wish to carry out a rapid survey to find out the morbidity profile and health care needs of this population group Organisation of special outreach sessions should be duly informed by findings of such surveys.

b. **Rickshaw pullers, construction workers, head loaders:** This group consists of urban poor and slum dwellers who are daily wage earners and unskilled labours engaged as construction workers, manually carrying heavy loads of goods and passengers as rickshaw pullers. Most of them are migrants from rural areas and do not possess any identity card and hence have very limited access to health care and social protection services. They have come to cities in search of livelihood, leaving their families behind and face vulnerabilities on multiple fronts.

c. **Domestic workers:** In cities, many poor women work as domestic help workers earning low monthly salaries and putting in long working hours daily. These women do not have easy access to health care or social protection services and their working hours usually prevent them from accessing the routine health centers.

d. **Elderly poor:** This is a highly vulnerable group in the urban settings and amongst this group elderly women are more vulnerable. The life in cities is hectic and every adult member of the family is busy making both ends meet and earn money for the family. Hence the old and dependent members of the family are left to fend for themselves. Elderly persons staying alone in their houses in urban areas face personal security problems. Physical, social and economic dependence render them vulnerable on many accounts. Besides, they also suffer from disease commonly found in old age like cataract, diabetes, osteoarthritis, hypertension, stroke and COPD. The old people in urban settings, in absence of social protection and emotional support are susceptible to psychiatric disorders like depression, Alzheimer's disease, anxiety, and suicidal tendencies. ASHAs and health workers should be knowledgeable and sensitive to the special health and emotional needs of elderly persons and accordingly make arrangements to address them through special outreach sessions and follow up with referral support and treatment at UPHC.

e. **Single women:** Single women, whether living alone, or with dependents face vulnerability on account of gender discrimination, difficulties in accessing social protection and health care schemes. Single women may be widowed, unmarried, separated or deserted and may in many instances face additional responsibility of supporting dependent parents and children. Thus they face multiple deprivations and vulnerabilities.

f. **Rag pickers:** With a lack of solid waste disposal management system in most cities in India, rag-picking is a common vocation among many vulnerable families and street children. They collect and sort recyclable waste materials such as plastics and metals from the public dustbins roads, parks, railway tracks and landfills. Most of these children are slum dwellers or from economically extremely poorer sections, who take to this occupation as a means of survival or supplementing family income. Usually working barefoot and without adequate tools to deal with extremely hazardous materials, these children are vulnerable to injuries, accidents and infections. They are often also exposed to substance abuse and have little access to health care, education, and other support services. This group also forms a specially vulnerable group to be consciously looked for .

g. **Street children:** A street child is someone for whom the street has become the 'habitual home' and a source of livelihood and who is inadequately protected, nurtured, supervised and directed by responsible adults. Mostly these children are orphans, abandoned or have left their families to take up odd jobs such as rag picking, begging, cleaning the railway bogies, etc. Some of them have no other choice but to spend night at shelter homes run by the government or NGOs. These children are highly vulnerable to infection, road side injuries, physical violence and substance abuse.

h. **Child-headed household:** It is a household managed by child, without presence of any elder member of family above 18 years to provide financial or emotional support. Such households are highly vulnerable as their members (children less than 18 years) are required to work as child labours under exploitative market conditions to make both ends meet. They also face multiple deprivations in terms of inadequate access to health care, education and social protection.

i. **Transgenders:** Commonly known as 'Hijras', persons in this category have a gender perception about themselves that does not match with conventional image and roles assigned to males or females. Transgenders face a lot of stigma and discrimination in society. They also have limited access to health care and educational facilities and often face economic hardships. In view of almost non-existent employment opportunities, members of this group take to odd jobs like begging, dancing and commercial sex work. As a consequence, they are exposed to sexually transmitted diseases and mental disorders. ASHAs and Health Workers need to adopt very supportive and sensitive approaches to organise special outreach sessions to ensure participation of transgenders and utilisation of health care services offered.

j. **Differently abled:** Persons with physical and mental disability face multiple vulnerabilities on account of limitations in physical movements, visual capacity, vocational options, level of dependence on others and special health needs. Multiple comorbidities may also occur in differently abled persons requiring specialists care and referrals. Physical disability and poverty are inter linked and therefore persons in this category face multiple vulnerabilities and deprivations.

k. **Debilitating illnesses- HIV/AIDS, TB, Asthma, Diabetes, Leprosy:** During outreach visits to families, persons with HIV & AIDS are generally 'invisible', as there is stigma associated with the disease. The ANM/ASHA should equip herself with basic knowledge and counselling skills needed to deal with HIV/AIDS cases in community. Similarly, cases of Diabetes, Tuberculosis and leprosy existing in a given family should be identified by the Health Workers during their domiciliary visits to ensure referrals to UPHC and treatment compliance.

l. **People living in institutions** Destitute women, elderly in old age homes, prisoners, juvenile offenders and mentally ill living in institutions face a range of vulnerabilities – firstly on account of their social status and social stigma attached to those who are compelled to stay in institutions and secondly on account of the poor living conditions in the institution. It has been noted that institutionalized persons face violence and discrimination, poor nutrition and unhygienic living conditions rampant in the institutions. In a few institutions, health care check- ups and services are organized for inmates but there is a strong need for these institutions to collaborate with the nearest UPHC to improve the quality and coverage of health care services for inmates.

m. **Households with severely/acute malnourished child and or an infant without mother or caregiver:** severely/ acute malnourished children could be a common sight in the slums or slum like settlements in urban areas. Children with visible signs of stunted growth, wasting and some deficiencies in visible forms of depigmentation/skin patches, copper coloured hair, liver enlargement, swollen feet, or emaciated body etc., can be given adequate information about the need for treatment and in consultation with the MO/ UPHC referred to Nutrition Rehabilitation Centres (NRC) depending upon the age group of the child and the severity of the condition. It is important to keep in mind that hospitalization may be needed in severe cases of malnutrition. Health workers and ASHAs should be able to identify and enlist children suffering from

severe acute malnutrition in their areas and ensure that proper treatment and follow up care is organised through Special Outreach sessions, UPHCs or Nutrition Rehabilitation Centres or through hospitals

These categories are not mutually exclusive and overlaps are more often the rule rather than the exception.

Morbidity and Mortality in the vulnerable population

The health burdens of the urban poor are well known. They are associated with a high mortality burden and multiple co-morbidities. There is high prevalence of under-five mortality and malnutrition, lung diseases, skin conditions, and vector-borne diseases. Immunization coverage rates in these populations, particularly the poorer and more vulnerable are also low. Disease epidemics are strongly correlated with cramped habitats, leading to rapid spread of vector-borne and respiratory diseases under the conditions of poor sanitation and exposure to environmental pollution.

Mental health problems are prevalent among such populations because of the stressful, lonely, and alienating environment. Deprivation of the traditional emotional and social security support systems also increase chances of co-morbidities and accompanying stigma. Diabetes, hypertension and to a lesser extent, asthma, are reported as being among the most common chronic diseases. Dog-bites, alcoholism, substance abuse and certain occupational diseases are more frequent in these populations.

Common vulnerabilities of children living on urban streets include substance abuse (generally of drugs, tobacco, pan masala and alcohol), hazardous working conditions, inadequate access to nutrition, clean water, sanitation and health care. Among people with disabilities, secondary conditions occur in addition to (and are related to) a primary health condition.

Understanding these prevalent morbidities is essential for planning of Special outreach sessions.

3 CHAPTER

OUTREACH SERVICES UNDER THE NATIONAL URBAN HEALTH MISSION (NUHM)

As stated earlier, the framework of the National Urban Health Mission lays significant emphasis on improving the reach of health care services to the vulnerable groups. Outreach Services will play an important role in systematically delivering various benefits of health services to those who need them the most and find it difficult to access the center based services. Outreach services under NUHM would consciously target the slum dwellers and other vulnerable groups in towns and cities.

Service delivery in urban areas is expected to be organized through a network of Urban-PHCs and Urban-CHCs. Most health centres function between 8:00 am and 2:00 pm which may lead to situation where workers such as domestic workers, daily wage workers, and self-employed workers are unable to avail health facilities since during this time of the day as they are engaged in earning their wages.

Geographic distance and costs of transport are also frequent barriers to healthcare seeking. Ignorance, cultural impediments and social stigma are particular issues that the vulnerable and urban poor face. For the urban poor, and even more among the marginalized, the first choice is not to seek care, but to self-medicate and to avoid approaching the public health system. They often opt for more accessible but poorly qualified private practitioners or the attendant in a pharmacy, who being untrained, follows irrational practices.

Outreach services in urban areas are limited to those who present themselves for care, or at best reach out to pregnant women and children with a restricted basket of antenatal, post natal care, immunization and family planning services. As a strong outreach program offers the best opportunity to penetrate down to the most vulnerable populations with the basic medical facilities, the reach and scope of the Outreach services will be expanded in the urban outreach component.

Community based Outreach Sessions/UHNDs in the slums is the first step in the continuum of care approach linking primary to secondary and tertiary care services and will primarily be targeting the slums and other vulnerable groups listed in the earlier section.

The guidelines for Outreach Services are intended to serve as a road map for states to design and strengthen the Monthly outreach sessions/UHNDs and Special Outreach Sessions. States are free to adapt these guidelines to the various contexts and sub populations for Monthly outreach sessions/ UHNDs and Special Outreach Sessions.

Types of outreach services envisaged under NUHM:

The outreach services can be categorised in two types - Monthly outreach sessions/UHNDs and Special Outreach Sessions to be held periodically as per the local requirements of the specific population subgroups.

Monthly Outreach Sessions/UHNDs

The Monthly outreach sessions/Urban Health and Nutrition Days are expected to be organized along the lines of the Village Health and Nutrition Days under NRHM. Monthly outreach sessions/UHNDs would cater to the entire population especially population living in slums/vulnerable populations within the catchment area of an Urban PHC (UPHC), to ensure universal coverage for a set of basic curative and a larger basket of preventive and promotive services

focusing on outreach components of RCH and other national health programs.

Monthly outreach sessions/UHNDs will be provided at the Anganwadi Centre (AWC) or other suitable community spaces where such services can be provided on a regular basis. ASHA and MAS members, women SHGs, youth clubs would be involved in mobilizing the community and enabling access to services provided at the Monthly outreach sessions/ UHNDs. The Monthly outreach session/UHND is intended as a convergence platform for services to be provided by the ANM and the Anganwadi Worker (AWW). Monthly Outreach Session/UHND will be used as an occasion for health communication on a number of key health issues as well.

ASHA and MAS of the area will play a key role in conducting mapping of these vulnerable populations, under the supervision of the ANM to identify such population, subgroups and understand their health needs.

The ANM with the support of the MAS & ASHA, will prepare the list of people requiring services at the Monthly Outreach Sessions/UHNDs and make a special effort to include individuals from families of new migrants and the homeless, those living in distant areas, and poor and marginalized families. She will also coordinate with the AWW, ASHA and the MAS to know in advance the day on which the Monthly Outreach Sessions/UHNDs is scheduled so that they can be inform those who need services. The Mahila Aarogya Samiti (MAS) members would be mobilised to ensure improved coverage and access.

Urban Health and Nutrition Day in Punjab

The ANM will also provide services to pregnant women, newborns, sick children, adolescents and eligible couples and a basic level of curative care for minor illness/injury with appropriate referral where needed. For screening and management of chronic diseases particularly common cancers, diabetes and hypertension referrals will be made to the Urban Primary Health centre on designated days, with monthly follow up and drug supply being provided by the ANM/ASHA at the Monthly outreach Sessions/ UHNDs or during home visits.

In order to address the issue of minimizing the barriers of geographic access, the Monthly outreach Sessions/UHNDs should be organized in areas which are distant from Urban PHC or other primary care facilities provided by the government, depending upon the locality and the occupational nature of its inhabitants, the timing of the Monthly outreach Sessions/UHNDs can also be varied.

The space for the Monthly outreach sessions/UHNDs is to be facilitated by the Urban PHC/City Health Society/Urban Local body. The MO/IC of the Urban PHC is responsible for ensuring the development of an annual calendar for the Monthly outreach sessions/ UHNDs in her/his catchment area, and reviewing the coverage and quality of Monthly outreach sessions/ UHNDs services and ensure timely submission of monthly and quarterly reports by ANM.

The service package for Monthly outreach sessions/ UHNDs and checklist for responsibilities are provided in Annexures I and II.

Special Outreach Sessions

As discussed earlier, certain vulnerable and marginalised groups, because of their circumstance, find it difficult to access the available services. Certain common health care needs of such groups require attention beyond the routine RCH/minor curative care provided by the ANM during Monthly outreach sessions/UHNDs. Special Outreach Sessions are expected to focus on ensuring such services to these populations. In some states, Special Outreach Sessions are being implemented focusing on healthcare issues like screening for chronic diseases, detection of developmental delays and childhood disability, geriatric care, dental services, etc. Such sessions can be held on a

Special outreach Camp for Eye Care in Delhi

biannual or an annual basis, but it must be ensured that the specific needs of the local vulnerable populations continue to be the focus. While the special outreach sessions are to provide specialized services, coverage of the population in terms of RCH services is a must and should be ensured on a regular basis.

The Special Outreach Sessions would provide curative, preventive & promotive services and would require services by specialists (including Gynaecologists, Dermatologists, Ophthalmologists, ENT specialist, Orthopaedic Surgeons, Psychiatrists, Dentists) relevant to the services to be provided in the outreach session. Other health professionals such as nurses, laboratory technicians, physiotherapists, occupational therapists, optometrists, clinical psychologists, medical social workers and pharmacists etc. will also be required. When such sessions are held in off/non duty hours, staff from the public health facilities would be encouraged to provide such services and could be incentivized as per local requirements of the State.

Special Outreach Sessions would also include basic diagnostic facilities wherever applicable. If samples are to be collected, test results must be reported back to the individual as soon as the result becomes available. The ASHA could serve as the focal point person for both communicating the test report and enabling follow up action and incentive could be provided accordingly.

Special outreach sessions cannot conform to a set pattern of services such as those available in routine RCH services. The actual services to be provided for each camp would be based on the need of the target population. Medical officers of the PHC could involve/seek help of Medical Officer of District Hospitals in planning special outreach sessions. The local UPHC would develop a calendar of such sessions with dates and services to be provided in these sessions, which could vary between different specialist services, rehabilitation, and other curative services.

All frontline workers and MAS members should be made aware that such special sessions are not intended to substitute primary and secondary outpatient services. So far as possible, effort must be made to ensure that the priority coverage populations for such sessions is the group of highly vulnerable and marginalized who have little or no access to resources of any kind and who are so disadvantaged that they are not able to access the facilities. The urban PHC must also have a plan for follow up between such sessions. Such follow up could be facilitated by the ANM/ASHA of the area. Planning and implementation of such special outreach sessions will require engaging with the relevant departments and NGOs to ensure that social support services are made available- such as access to food, clothing, shelter, prosthetic support, etc. For instance, Special Outreach Sessions for homeless population may also involve engagement with de-addiction centres if there is a coexistence of homelessness and substance abuse.

Over time, states should make serious efforts with a focus on sensitizing providers to the special needs of such populations, to ensure access, coverage and quality of facility based services so that such populations are able to access services at facilities and are treated with dignity and respect.

The suggestive service package for special outreach sessions and checklist for responsibilities are provided in Annexure III and IV.

Special outreach Camp for Eye Care in Delhi

CHAPTER 4

PLANNING AND IMPLEMENTING THE OUTREACH SESSIONS

Planning and implementing effective Outreach sessions involves following activities:

1. **Mapping the vulnerable (clusters/families/ individuals) and the available resources:** As the main focus of the outreach sessions is to provide services to such population which do not actively seek health care services, a mapping exercise is a mandatory requirement to identify and reach to these groups. In order to deliver healthcare services, mapping these populations and developing a systematic understanding of their health needs would require an understanding of the epidemiological profile of the local population, disease burden, and social determinants of health. The process of mapping enables identification of the vulnerable so that they become visible to the health care system, and an understanding of their problems regarding access and their health care needs. Mapping is not in term of geo-spatial distribution of populations alone, but also the social relationships and issues of access to health care.

   Targeting of population groups/households for special outreach camps would be based on 'Profile of Household in slum & vulnerable areas' such as availability of piped water supply, pakka houses, basic facilities like toilets, solid waste management, drains, government recognized identity, means of livelihood available, income status, accessibility to existing health services and education level of their family members etc. Vulnerable population would also be identified based on their means of livelihood and/or social status such as daily wage labourers, construction workers, rickshaw pullers, people involved in begging, domestic workers, elderly poor, widows/deserted women, rag pickers, destitute, widows, street children, trans-genders, beggars, street children, construction workers, coolies, sex workers, street vendors and migrant workers etc.

   In addition to identifying the vulnerable, mapping should also include identifying community resources (organizations or individuals) who could provide support to the UHNDs/Special Outreach Sessions, and non-medical essential social services. One of the competencies of the urban ASHA is in mapping the vulnerable, and she would be the point person for undertaking such mapping with support from MAS members. ASHA and MAS of the area will play a key role in conducting mapping of these vulnerable populations, under supervision of the ANM to identify such population, subgroups and understand their health needs.

   While conducting the survey, ASHA must make a special note of vulnerable clusters/families/ individuals as per the Annexure V.

2. **Deciding the services to be provided in the Special Outreach Sessions/Camps:** While a common defined basket of services will be delivered through UHNDs, the services for the Special Outreach will have to be carefully chosen keeping in mind the locally endemic conditions/ requirements of a specific population group ie. Elderly poor, homeless, headloaders, sex workers, rag pickers, street children, individuals with visual impairment, women for screening for common malignancies, adult population for screening for NCDs. etc.

3. **Identifying Sites for organizing UHNDs/ Special Outreach Sessions:** The UHNDs/Special Outreach Sessions should be organized as close as possible to where the marginalized and vulnerable live. Outreach Sessions will be organized at locations such as community structures, primary schools, anganwadi centers in coordination with ASHA and MAS members. Beside the above, buildings constructed under the schemes of the Department of UD, HUPA, WCD, Social Welfare, RAY, IHSDP and JnNURM could be utilized as fixed points for providing periodic outreach services.

   The sessions also might be required in the parts of the city where high concentrations of unorganised working populations work, such as wholesale markets, land-fills, labour *addas,* railway and bus stations. Most public health facilities as well as out-patient premises of medical colleges are usually vacant in the evenings. These spaces should be used for special outreach sessions, provided that geographic access is not a barrier.

4. **Listing out the requirements and arranging for the required manpower and logistics.**

5. **Ensuring sufficient IEC about the proposed Outreach sessions to the stakeholders and beneficiaries. (Annexure VIII).**

6. **Involvement of the Community Volunteers:** While the ASHA and MAS have an important role to play in mapping and supporting Special Outreach Sessions, the task of mapping, mobilization of community groups, accompanying those who need facility based care, and providing follow up care, would require the support of community resources. One important resource is a cadre of community volunteers who are willing and able to support the process. Such volunteers could either belong to the vulnerable community, be part of the general community and represent specific sub groups such as adolescents, or individuals in the community willing to extend domiciliary support to aged and disabled people. While no financial compensation is necessary, a badge of identification by the UPHC that not just facilitates but assures access to public health facilities and other support services could be provided. In addition to individual volunteers, groups such as the Indian Medical Associations, local clubs-Lions Club, Rotary, Residents Welfare Associations, and local Philanthropic organizations could be involved.

7. **Involvement of Male Health Workers:** Many cities have sizeable populations of single male migrants with unique health concerns. Given our cultural context, women health workers may not be able to address these. Many States and city corporations involve male health worker in urban health care and support them out of their own budget. NUHM does not support male health workers and wherever they are available they should be utilized in organizing routine and special outreach session in urban areas. Depending upon local situations and available resources states may wish to involve male community volunteers who may be engaged on the lines of ASHA.

8. **Enabling access to referrals beyond health facilities:** To enable continuity of care, mechanisms should be established to refer these groups to supportive care facilities other than U-PHCs and U-CHCs. However, in the meantime such population must have access to not just preventive and promotive services but also access to special services, rehabilitation therapy and social support including referral and follow-up for tertiary level institutional care. These may include: b) Free residential and out-patient Drug De-addiction Centres, c) Free residential mental health care recovery centre, d) Nutrition rehabilitation centres, e) Homeless recovery shelters, and f) Palliative care centres and hospices.

9. **Mobile Clinics:** Such special outreach sessions could also include services through "mobile clinics". Mobile units, whose package of services would be similar to special outreach, would provide services at a fixed date or time to unreached areas, such as remote slums, temporary migrant populations, and scattered homeless persons.

10. **Involvement of Union of Informal Groups (OccupationalOccupationallyVulnerableGroups):** It would be useful to involve trade unions and collectives of vulnerable groups – such as of

rickshaw pullers, construction workers, rag-pickers, homeless people, single women, disabled peoples collectives, organisations of the aged, homeless and street children to support the implementation of such session so as to build community ownership.

11. **Involvement of field workers dedicated to control of Malaria, TB, Leprosy** in Urban areas may also be explored. In many towns and cities urban malaria scheme is operational with dedicated vector control workers in field. Municipal Health officers may employ Sanitary inspectors for malaria surveillance. Male Health workers of UPHC may also be working at cluster level (covering 2 or 3 wards) to control spread of malaria.

    TB Health Visitor is placed to cover 1 lac population each. Tuberculosis Units, Designated Microscopy Centre and DOTS providers may also be located in urban areas to provide support to ASHA and ANMs to ensure diagnosis, treatment and follow up of suspected TB cases. ASHA gets incentive once the patient registered with her completes the course of treatment.

    Leprosy control in urban areas may have Non Medical Supervisors and Non Medical Assistants who monitor treatment and carry out field level activities. They are assisted in these tasks by ASHAs and ANMs.

12. **Involving Urban Local Bodies:** Such Special Outreach Sessions should seek active participation of the ULB that ensures ownership and accountability. Such engagement could include provision of monetary resources, space, mobility support, access to non-health facilities, and linkages with other departments such as housing, etc.

An Outreach Camp in Delhi

13. The resources required would go beyond those available through the NUHM. States are encouraged to leverage support from city corporations, philanthropic organizations, volunteer human resources from medical and nursing institutions, other academic institutions and civil society.

14. **Supportive Supervision and Follow up:** While the responsibility for implementing the UHNDs and Special Outreach Session is with the UPHC, the overall supervisory responsibility is with the City/District health authorities. Supervision involves support to the UPHC in annual planning, allocation of resources, identification of specialists to be deployed, and monitoring the actual conduct of sessions in terms of coverage, quality and follow up. At the level of the UPHC the MO would monitor each session held and ensure complete line listing of the catchment area, enable the provision of drugs and supplies coverage in terms of reach, and follow up of patients identified for treatment either at the community level or at the facility. Such follow up could be facilitated by the issue of health cards/health booklets.

Suggestive formats for reporting are given at Annexure VI &VII.

Table 1: Planning/Implementing UHNDs and Special Outreach sessions is summarized in the table given below:

	Urban Health & Nutrition Day (Monthly outreach sessions/UHNDs)	Special Outreach Sessions
WHO: Population to be covered	Slum and vulnerable population (predominantly women and children) in the catchment areas of the UPHC. The already identified patients needing follow-up may be catered to by providing medicines.	Vulnerable groups; emphasis on the most disadvantaged and hardest to reach (migrant labourers, homeless, etc.) Target population for the specific services ie. All women in a special outreach session being conducted for screening for breast/cervical cancer.
WHAT: Service Coverage	ANC, Immunisation, Health Education, Child Growth Monitoring, Nutrition Supplementation, Nutrition Counselling, education on Water Sanitation and Hygiene, Use of RDK, Drug Dispensing.	Health check-up/Specific services/set of services (for locally endemic diseases and population sub group with specific problems), screening and follow-up (for chronic and non-communicable diseases), basic laboratory investigations (using portable /disposable kits), and drug dispensing.
WHERE: Site of providing the Service	Anganwadi Centre (AWC) or any other community level structure in slum.	Space or structure at the community level in slum/ near vulnerable population (Community Centre, School which may be near Railway Station, railway tracks, city outskirts, Bus Stand, underpasses, outside place of worship, etc.).
BY WHOM:	ANM supported by team of ASHA, AWW, and MAS members.	Doctors/Specialists, Lab Tech, Pharmacist, physiotherapists, social workers. Supported by MO-UPHC, with ANM and ASHA, MAS members and community volunteers.
WHEN: Frequency	Monthly	Periodic (as per the local needs in community).

CASE STUDY

UHND: Sunita works in ASHOK Vihar UPHC. A part of her catchment area lies beyond the Ring Road and across the Drain - Bada Nala. The area is called Prem Badi Pul slum cluster where majority of those working in nearby Industrial area reside with their families. The population living here is around 4000 (800 households). She has decided that she would provide RCH and other preventive services through a regular monthly UHND in that area. For this the UPHC has tied with the AW No. 419 and AWW, Bimla. The first Monday of every month has been decided upon as the UHND for the Cluster. The area ASHAs/AWWs and MAS along with the potential beneficiaries have been made well aware of the monthly event/the venue/ services.

CASE STUDY

SPECIAL OUTREACH: Sunita holds a regular UHND in her slum pocket of 4000 population. During their surveys and mapping ASHAs found that many families have elderly with visual impairment and some children and adults also having some vision problems. The ANM has brought this to the notice of her MO I/C. A special outreach camp has been planned with the objective of screening of the elderly population for Cataract and others with impaired vision for refractory errors. The session has been organized with the help of Ophthalmologist and Optometrist from the district hospital. The ground floor hall of the Basti Vikas Kendra normally occupied by the DUSIB will be lent for the activity as it is a Sunday. ASHA along with MAS members will ensure that all potential line listed beneficiaries reach the camp and subsequent follow-up.

CHAPTER 5

FINANCIAL GUIDELINES

Monthly outreach sessions/UHNDs services involve outreach by the ANM to different geographic sites within the catchment area of the UPHC. The Monthly outreach sessions/UHNDs are expected to be organized along the lines of the Village Health and Nutrition Days under NRHM. VHSNC plays an active role in supporting the conduction of VHND. Similarly MAS will play a key role in conduct of Monthly outreach sessions/ UHNDs in urban areas. Since regular services will be provided at the UPHCs and peripheral primary level health facilities in the urban areas, through the ANMs headquartered at these facilities; separate financial provision has not been made, except for Rs. 500 per ANM per month as mobility support for conducting outreach in slum areas. The consumables and supplies (like ORS, IFA, diagnostic test kits, etc.) for the Monthly outreach sessions/ UHNDs will be provided through UPHC from the provisions made under NUHM-RCH on the lines of VHND, NRHM.

Special Outreach/Health Camps would cater to other special healthcare needs of the local community/vulnerable population, as per requirement. These would require doctors, specialists, pharmacist, lab technicians, relevant to the services being provided along with the procurement of the consumables and supplies for Special outreach sessions. Suggested budgeting pattern is given below for different components of a Special Outreach Session:

Cost norms for Special Outreach Sessions /Camps

The funds required for Special Outreach Sessions/ Camps may be budgeted under the budget "Outreach Camps/Sessions". The principle of differential allocation for each city/district will be followed, depending on utilization of funds. The MO-I/C will decide as per the utilization status. The suggestive cost heads could be:

Cost Head	Amount per session/camp (Rs.)
Doctors and Specialists (outsourced, for paying their fees)	3,000/-
Other paramedical staff (like Pharmacist, Lab Technician, etc. for paying their fees/ incentive)	1,500/-
Medicines, drugs and consumables (including consumables for rapid diagnostic kits)	3,500/-*
Transportation costs	1,000/-
Publicity (Annexure VIII)	1,000/-
Per Special Outreach Camp/Session	**10,000/-**

The above cost break-up is suggestive.

* This can also be supplemented from the budget provided for supply of drugs to the UPHCs and UCHCs. Other alternative resources may also be mobilized for drugs and other logistics.

States can also pool their available resources to have dedicated teams to conduct special outreach camps and provide equipment such as ECG, X-Ray, basic lab diagnostic and other facilities and have dedicated team of doctors, paramedics and vehicles etc. States and city corporations may enter into partnership with medical colleges, not for profit/charitable organisations and with private sector for conducting special outreach sessions/health camps. The municipalities/ corporations can also put additional funds out of their budgets for conducting outreach sessions.

Local volunteers/youth clubs/MAS/women's SHG groups can also be involved in organizing the cam ps.

Estimates suggest that the slum population in a catchment area of a UPHC would be around 25% and the other vulnerable population would be an additional 10% of the urban population.

The funding support for IEC includes the cost of mobilization and publicity to generate widespread awareness by ASHA, AWW, and MAS members on the objectives of the camp and services available

Outreach Camp in Karnataka

ANNEXURE I

SERVICE PACKAGE AT MONTHLY OUTREACH SESSIONS/UHNDs

The services will be provided monthly by the ANM in coordination with the ASHA and Anganwadi Worker (AWW) at a community structure in slum/ near vulnerable population (like Anganwadi Centre, School, Railway Station, Bus Stand, place of worship, etc.). The package of services will include the following:

A. Maternal Health

- Pregnancy testing, and Early registration of pregnancies.
- Provision of full complement of ANC services with quality and accuracy.
- Completed Mother and Child Protection Card.
- Referral for high risk women/women with signs of complications during pregnancy and those needing emergency care.
- Referral for safe abortion to approved MTP centres.
- Counselling on a range of topics such as: Education of girls, Age at marriage, Care during pregnancy, Danger signs during pregnancy, Birth preparedness, Importance of nutrition. Institutional delivery, awareness of the JSY and JSSK schemes, Post-natal care. Breastfeeding and complementary feeding, Care of a newborn, and Contraception.
- Organizing Maternal and infant death reviews.

B. Child Health

- Registration of new births.
- Counselling for care of newborns, exclusive breast feeding and Complementary feeding at six months.
- Complete routine immunization and all doses of Vitamin A along with Tracking and vaccination of missed children by ASHA and AWW.
- Weighing and Nutritional Surveillance– examination of all children for anemia/ Micronutrient and Vitamin deficiencies. Provision of Tablet IFA - (small) to children with clinical anaemia.
- Provision of supplementary food for grades of mild malnutrition and referral for cases of severe malnutrition.
- Case management of those suffering from diarrhoea and Acute Respiratory Infections, Counselling to all mothers on home management and where to go in event of complications, Provide ORS packets, Counselling on nutrition supplementation and balanced diet, Counselling on and management of worm infestations.

C. Adolescent Health (Age group 10-19 yrs)

- Screening for anemia and other Micronutrient and Vitamin deficiencies Iodine-deficiency, Protein Calorie Malnutrition, etc.), Supply of iron supplements, vitamins, and micronutrients.
- Counselling against substance abuse, promoting healthy life style and responsible sexual and social behaviour and practices

D. Family Planning

- Information on use of contraceptives.
- Distribution - provision of non-clinic contraceptives such as condoms and OCPs.

- Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

E. Reproductive Tract Infections and Other Related Conditions

- Counselling on prevention of RTIs and STIs, including HIV/AIDS, Information on transmission and prevention of HIV/AIDS.
- Referral of cases for diagnosis and treatment, and distribution of condoms for dual protection.
- Referral for ICTC and PPTCT services to the appropriate institutions.

F. Health Promotion

- Importance of clean drinking water, safe water handling practices, use of long handle ladle, and ways to keep the water clean at point-of-use, using chlorine tablets, boiling, water filters, etc.
- Education on Healthy food habits, hygienic and correct cooking practices, and hand washing.
- Testing of household salt sample for Iodine (using the testing kits supplied under NIDDCP programme).
- Prevention/elimination of breeding sites for mosquitoes.
- Mobilization of community action for safe disposal of household refuse and garbage.
- Gender issues: Communication activities related to PCPNDT, Communication on the Prevention of Violence against Women and Children, Domestic Violence Act, 2006, Age at marriage, especially the importance of appropriate age at marriage for girls, Issues of Alcohol and drug abuse, tobacco. Review of the AWC's daily activities at the centre, supplementary nutrition services being provided for children and pregnant and lactating mothers, and growth charts being recorded at AWC.
- Sanitation issues: Identification of space for community toilets, Guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the Jawaharlal Nehru National Urban Renewal Mission (JnNURM)/AMRUT.

ANNEXURE II

CHECKLIST FOR THE PERSONNEL INVOLVED (UHND)

Sl.No.	Actions	Tick when done
	MO I/C of the Center	
1.	Develop a calendar for Monthly outreach sessions/UHNDs and designate geographic areas for where it is to be held, ensuring complete coverage in the catchment area and familiarizing each member with the calendar.	
2.	Coordinate with the CDPO and ICDS Supervisors for availability of the Anganwadi Centre and the Anganwadi Worker.	
3.	Dialogue with ULB representatives (Ward member) on availability of community centres and other alternative facilities, along with support for the cleanliness, water, security and other support required at the site.	
4.	Ensure that the supplies of drugs, vaccines and consumables reachthe site well before the day's activities begin.	
5.	Ensure reporting of the Monthly outreach sessions/UHNDs to the UCHC and City/ District PMU (as per format suggested in Annexure VI).	
	ANM of the center	
1.	Ensure that all concerned ASHAs/AWWs know where the Monthly outreach sessions/UHNDs is to be held.	
2.	Ensure that the information about the outreach is available with the community through IEC.	
3.	Ensure that the supply of vaccines reaches the site well before the day's activities begin.	
4.	Ensure that all instruments, drugs, and other materials are in place.	
5.	Ensure reporting of the Monthly outreach sessions/UHNDs to the MO in charge of the Urban PHC (UPHC) (as per format suggested in Annexure VI).	
	ASHA : Actions to be taken before the Monthly outreach sessions/UHNDs	
1.	Visit all households and line list women and children needing Monthly Outreach Sessions/UHNDs services. - ANC, Immunization, Malnourished children, and particularly focus on those that were missed/drop-outs.	
2.	Ensure publicity of the event (as per Annexure VIII).	
	ASHA : On the day of Monthly outreach sessions/UHNDs	
3.	Ensure that all listed women and children report to the health centre and receive services.	
4.	Ensure participation by MAS members.	
	Anganwadi Worker (AWW)	
1.	Ensure that the Anganwadi Centre (AWC) is prepared for the Monthly outreach sessions/UHNDs (if it is to serve as the site for Monthly outreach sessions/UHNDs)- cleanliness, water supply, privacy for ANC/PNC.	
2.	Provide the Supplementary Nutrition and Take Home Ration (THR) and ensure arrangements for growth monitoring.	
3.	Coordinate activities with the ASHA and the ANM.	

ANNEXURE

SERVICE PACKAGE AT SPECIAL OUTREACH SESSIONS

Special Outreach Sessions will cover the most vulnerable and marginalised groups with special attention to their specific health needs. The package of services may include the following:

A. Curative services:

- Specialist Services such as Obstetric/ Gynaecology, Paediatrics, Ophthalmology, Dermatology, Dental and any other special services.
- Detection of TB, Malaria, Leprosy, Kala-Azar, and other locally endemic communicable diseases and non-communicable diseases such as hypertension, diabetes and cataract cases.
- Referral of complicated cases.

B. Diagnostic services:

- Investigation facilities like haemoglobin, blood sugar, urine examination for sugar and albumin.
- Screening for Hypertension, Diabetes and COPD.
- Vision screening
- Blood counts
- Urinalysis
- Clinical detection of leprosy, tuberculosis and locally endemic diseases.
- Screening for breast, cervical and oral cancers etc.
- ECG

C. Preventive and Promotive services:

If needed, routine RCH services may also be organised as discussed under routine Monthly outreach sessions/UHNDs.

d. Continuity of care for every chronic patient (such as diabetic, hypertensive or suffering from Chronic obstructive Pulmonary Disease (COPD) should be ensured with a health card and provision of essential medicines and clinical advice on a continuous basis.

ANNEXURE IV

RESPONSIBILITIES AND FUNCTIONS FOR SPECIAL OUTREACH

Sl. No.	Actions	Tick when done
MOIC (at the UPHC)/Public Health Manager & City Program Management Unit/ State Program Unit		
1.	City Program Management Unit/ State Program Unit to prepare calendar for Monthly Outreach Sessions/UHND sin consultation with MoIC of UPHC/ UCHC and designate geographic areas for where camps to be held, ensuring complete coverage in the catchment area and familiarizing each member with the calendar.	
2.	Coordinate with U-CHC/City-PMU/District-PMU for deputing MOs, Specialists, LTs and Pharmacists for the Special Outreach/Health Camp. Make alternative arrangements with the private providers, in case government providers are not available.	
3.	Ensure that adequate money is available for disbursement to the private providers, wherever they are engaged on a daily basis.	
4.	Ensure that the supply of diagnostic kits, equipment, drugs and consumables reaches the site well before the day's activities begin.	
5.	Dialogue with ULB representatives (Ward member) on availability of community centres and other alternative facilities, along with support for the cleanliness, water, security and other support required at the site.	
6.	Ensure that the Special Outreach/Health Camp is held on the stipulated day and time and also ensure the presence of the required health functionaries.	
7.	Ensure reporting of the Special Outreach Camp to the U-CHC and City/District PMU (as per format suggested in Annexure VII).	
ANM/ Male Health Worker (wherever available)		
1.	Ensure that the supply of diagnostic kits, equipment, drugs and consumables reaches the site well before the day's activities begin.	
2.	Carry communication materials.	
3.	Ensure reporting of the special outreach to the MO in charge of the Urban PHC (UPHC) (as per format suggested in Annexure VII).	
4.	Coordinate with the ASHA and the AWW to ensure publicity of the event, mobilization of the vulnerable groups and follow up.	
5.	Ensure publicity of the event as per Annexure VIII.	

Sl. No.	Actions	Tick when done
ASHA/ MAS/ other community groups (like SHG)/Local Volunteer : Actions to be taken before the Special outreach sessions		
1.	Visit all households and make a list of most vulnerable and marginalised identified with the help of vulnerability assessment tool. Dialogue with MAS members on mobilization support required from the community.	
2.	Make a list of potential beneficiaries for a given service/set of services ie. list of children with special needs, particularly girl children, Make a list of persons suffering from cough for more than 3 weeks, Make a list of those with visual impairment, make a list of all elderly in the cluster. Identify persons having symptoms of mental illness such as depression, anxiety, social withdrawal etc.	
3.	Make sure that the MAS and the target population is aware of the Camp – date/ venue/services.	
4.	Coordinate with the AWW and the ANM.	
5.	Share the calendar of Special Outreach/Health Sessions (if applicable), and the date/ day of next camp.	
6.	Ensure publicity of the event (as per Annexure VIII).	
ASHA/ MAS/ other community groups (like SHG)/Local Volunteer : Action on the day of Special outreach sessions and afterwards		
1.	Ensure that all potential beneficiaries report to the health camp and receive services.	
2.	Ensure followup of those where further action required.	

ANNEXURE V

LISTING THE VULNERABLE AREAS/ INDIVIDUALS/FAMILIES/SUB-GROUPS

The population being covered by an ASHA/ ANM is expected to be a heterogeneous mix of individuals/families/population groups with different demographic and socioeconomic backgrounds. Their vulnerability and need for help may be of varying severities. During the household surveys, the ANM/ASHA must be on the lookout for those with a higher vulnerability and mark them for special attention. More effort and time must be spent for the following areas/individuals/ sub populations and if required, the services must be provided through outreach component of the health center. During the survey, special note must be made of the following:

1. An area/population pocket in the periphery of the catchment area of the health center.
2. An area where nature/ timing of working hours prevents the group from accessing the services from available public health facility.
3. Area deficient in safe/piped water supply.
4. Habitation of Semi-pucca/katcha houses.
5. Areas with lack of basic facilities like toilets, solid waste management facilities, drains etc.
6. Unauthorized areas housing the poor with its lack of government recognized identity.
7. Household having no access to sanitation & water supply.
8. Slum dwellings near hazardous location (footpath, railway track, fly-overs, under bridge).
9. Homeless individuals/families/clusters.
10. People living in institutions like night shelters, homeless recovery shelters, beggars home, leprosy homes.
11. People involved in Begging
12. Daily wage laborers
13. Construction workers
14. Rickshaw pullers
15. Rag Picker
16. Head loaders
17. Domestic workers
18. Elderly poor
19. Street Children
20. Trans-genders
21. Sanitary workers
22. Widow/deserted women
23. Differently Abled
24. Individuals suffering from debilitating illnesses- HIV/AIDS, TB, Asthma, Diabetes, Leprosy etc.
25. People with mental illness
26. Women/child headed household
27. Household with severely/acute malnourished child or an infant without mother or caregiver.

29 Any other, Please specify .....

.....

.....

VI ANNEXURE

FORMAT FOR REPORTING INFORMATION ON MONTHLY OUTREACH SESSIONS/UHNDs

Date of Monthly outreach sessions/UHNDs: ...../...../.....

1. Name of the Urban PHC (UPHC): .....
2. Locality/Slum name: .....
3. Place where Monthly outreach sessions/UHNDs held: .....
   (AWC, school, any other – please specify)

Service Statistics

1. Total No. of women who received treatment:
2. Total no. of children who received treatment:
3. No. of pregnant women checked up for ANC:
4. No. of pregnant women immunized with TT:
5. No. of pregnant women with complications referred to higher facilities:
6. No. of Children vaccinated:
7. No. of women motivated and referred for IUCD:
8. No. of women motivated and referred for sterilization:
9. No. of men motivated and referred for sterilization:
10. No. of severely malnourished children identified, counselled and referred to higher facilities:
11. Any other services:
12. Line list of all the individuals with name, diagnosis and follow-upwho attended the camp attached: YES/NO

Verifications

Name & Sign of ANM: ..... Name & Sign of AWW: .....

Name & Sign of ASHA: .....

Name & Sign of Public Health Manager (if in-position): .....

Please note: ANM and ASHA should line list all the individualswith name, diagnosis and follow-upwho attended the camp and attach the list with this report.

Name & Sign of MO-I/C: .....

ANNEXURE VII

FORMAT FOR REPORTING INFORMATION ON SPECIAL OUTREACH SESSION

Date of Session: ...../...../.....

1. Name of the Urban PHC (UPHC): .....
2. Locality/Slum name: .....
3. Place where session was held: .....
4. No of specialists attended (indicate government and outsources specialists separately) .....
   .....
   .....
   .....
   .....
5. Number of individuals who received treatment in the camp: M ..... F .....
6. No of children who received treatment in the camp .....
7. Number of individuals diagnosed/screened with the disease (specification/condition wise):
   .....

   TB: .....
8. Diabetes Mellitus: .....

   Hypertension: .....

   COPD: .....

   Cervical cancer:

   Others:
9. Number of individuals referred to higher centre/ alternative referral unit: .....
10. No. of follow up cases attended: .....
11. No. of persons provided diagnostic services: X-Ray....., ECG.....,

    Blood glucose ....., B.P. ....., others .....;
12. Line list of all the individuals with name, diagnosis and follow-up who attended the camp attached: YES/NO

13. Approximate quantity and value of drugs distributed .....
.....
.....
.....

Verifications

Name & Sign of ANM: .....

Name & Sign of AWW: .....

Name & Sign of ASHA: .....

Please note: *ANM and ASHA should line list all the individuals* with name, diagnosis and follow-up *who attended the camp and attach the list with this report.*

Name & Sign of MO-I/C: .....

Quarterly Reporting by UPHC

1. Total No. of sessions organized in month: .....

   Monthly outreach sessions/UHNDs: .....

   Special Outreach sessions: .....
2. No. of pregnant women provided ANC & PNC services: .....
3. a. No. of children provided immunization.....

   b. No. of Sick Children provided health care services: .....
4. Total OPD & referral: .....
5. Lab tests conducted: .....
6. Details of specialist services provided: .....
7. Line list of all the individuals attended the camp with name, diagnosis and follow-upattached: YES/NO

ANNEXURE VIII

PUBLICITY FOR THE OUTREACH SESSION

Key Communication Objective

For the Outreach Session to be successful, it is imperative to make the community, especially women from vulnerable sections and other stakeholders in the community, aware of services being made available on fixed days at the site chosen for conduct of Outreach sessions (AWC or other venue).

Whom to Involve

1. ASHA
2. MAS members
3. Members of local RWAs/Mohalla Sabhas
4. Ward members
5. SHG members
6. Teachers and other community leaders
7. School children
8. Beneficiaries
9. Traditional Birth Attendants (TBA) and other Registered Medical Practitioners (RMP)

Media and Methods

- Wall writings in the local language
- Hoardings at one or two prominent places in the locality
- Handbills and pamphlets
- Munadi a day before the event.

Resources for publicity activities can also be accessed through the IEC fund made available and untied funds available with the Urban PHC, in addition to the amount indicated in the guidelines. ASHA can help and facilitate this whole process at different levels.

Notes

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सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

NATIONAL HEALTH MISSION
Ministry of Health and Family Welfare
Government of India
website : www.nrhm.gov.in