The Reproductive and Child Health (RCH) care program implemented in urban slum locations in Guwahati city of Assam is one such RCH experiment in urban slums targeting women and children. Over a period of time this RCH Guwahati program is being touted as one most practical and successful model for health service delivery for urban poor. Its unique partnership model of government - NGO collaboration to deliver timely health services of urban poor living in slums. In this case, the partnership is between Government of Assam and a Charitable Hospital (Marwari Maternity Hospital, Athgaon) supported by the European Commission for this urban health care program.
The RCH Guwahati is being implemented in 14 slum areas in and around Guwahati, mostly in South Guwahati. Majority of the slum population are daily wage earners (construction workers, domestic help, rickshaw pullers and vegetable vendors). Almost 70-80% of these populations residing in the plain areas are migrant population (from Bangladesh, Bengal and Bihar).

Because of the nature of shifting population it becomes at times difficult to ensure sustained compliance and regularization to health services. Almost 55% of the slums in the peri-urban, hilly areas are inhabited by tribal groups like the Bodos. A good size of this RCH targeted women population are Muslims which is an interesting development according to observers. There are records to prove that Muslim men and women are forthcoming in talking and adopting family planning services like sterilization though with initial hesitations and refusals.

Reaching out to RCH Guwahati

The largest city in northeast India, Guwahati has seen tremendous growth in the last three decades. The population has increased more than four fold from 122,981 in 1971 to 584,342 in 1991. The present urban agglomeration is estimated to be 14 lakhs (1.4 million).

Guwahati regarded, as the gateway to the northeastern states and South East Asia is easily accessible by air, rail and road.

According to an estimate prior start of services by MMH, almost 72% deliveries in these slum areas were conducted at home. Immunization rates were particularly poor. Only 43% children in the city in the age group 1-2 years were covered with complete doses and in slum areas total coverage was only 31%. Almost 40% of children were without a single dose of vaccination. There was a conspicuous lack of RCH services for these people.
The RCH Guwahati program initiated in 2002 has entered 6th year of its operation. The program launched in partnership mode was initiated to provide basic health and reproductive services to poor urban women and their children in and around Guwahati city in Assam. With well defined role of the stakeholders in implementing this project, RCH Guwahati is today touted as one of the good governance practice in health sector for further emulative prospect and replication.

The main thrust of the program envisaged under the State Action Plan of the European Commission was designed to address gaps in service delivery by providing outreach services to improve maternal and child health in slum areas where public health service delivery is extremely weak.

Objectives of RCH Guwahati

- To address gaps in RCH service delivery by providing outreach services to improve maternal and child health for the urban poor

- To provide maternal and child health services in the selected wards of the Guwahati Municipal Corporation

- The following services are to be provided in the selected wards/sites as well as through in-hospital services:
- Regular Vaccination services of the children

- Routine Ante-natal services to pregnant women

- Basic laboratory services (Blood, Urine & Stool examination for ante-natal mothers) through MM Hospital infrastructure

- Providing facility for delivery of the pregnant mothers in the hospital for these wards at marginal prescribed rates as decided upon

- Provision for Family planning services e.g. OC Pill, Condom, IUD insertion and Permanent sterilization for female and MTP services for safe abortion at the hospital premises regularly.

- RCH services to be provided in the slum areas of the selected wards at select Camp/clinics every fortnight and at regular intervals within the Hospital premises.

- Services requiring Hospital care shall be treated in the MM hospital.

- To take up regular monitoring and evaluation of RCH Services delivery and take midcourse corrections without delay

Achieving the Objectives

The RCH Guwahati program was started in 1 April, 2002 on a PPP mode. Initially the European Commission supported urban RCH outreach service program. The agreement was signed on 16 February 2002 between the State Health and
Family Welfare Society for Voluntary Sector (SCOVA) and the Department of Health and Family Welfare, Government of Assam.

The DEED OF AGREEMENT was made on 16th day of February 2002 between the State Health and Family Welfare Society for Voluntary Sector (SCOVA) which will act on behalf of the State Health & Family Welfare Sector Reform Cell (SRC), Dept. of Health & Family Welfare, Govt. of Assam, and Marwari Maternity Hospital, S.J. Road, Athgaon, Guwahati in the district of Kamrup Assam.

Duties and Responsibilities of Assam State Health & Family Welfare Department for the RCH Services in Slum is to manage the funds received for the implementation of the Sector Investment Programme (SIP) activities supported by the European Commission from the Dept. of Family Welfare, Govt. of India. The fund is deposited to the SCOVA account under separate head of Sector Reform Fund. Account for this purpose is maintained separately and funds released to the MM Hospital. The private party role is provided by Marwari Maternity Hospital Trust. Its role is to provide maternal and child health services in the selected wards of the Guwahati Municipal Corporation

| Responsibilities of Marwari Maternity Hospital: Provision of medical, paramedical – staff for the sessions and their payment |
| provision and maintenance of existing infrastructure and equipment for outreach patients |
| charging concessional rate (at least 50 % less) for the patient coming from slums under this agreement. |

Sustainability

The sustainability of the RCH Guwahati program is being explored. Minimal charges are asked from users for the services delivery. There is no fee for services under family planning or counseling. The sustainability of RCH Guwahati is very much possible. There is strength in the PPP model with sharing of responsibilities and resources. There is opportunity to involve more than stipulated parties in this kind of health service delivery program. Instead of one NGO, one can have couple of NGOs taking responsibility of defined locations. Yes there is threat in such model like parties withdrawing from such program instantly, indifference of community, slackening of role of health professionals, and so on.
Achieving the objectives of RCH was not easy and is still a challenge from time to time. Steps were taken to achieve the RCH objectives:

- Preliminary survey was taken up for site selection; one criteria was greater absence of RCH services for people in the nearby vicinity

- As a part of this exercise household survey were undertaken - for baseline information, data collation, community health status

- Services were identified for delivery as per priority

**Requirement for initial execution**

1. Identify suitable organisation – preferably a charitable trust hospital having 1500 – 2000 deliveries per annum.
2. Identify suitable needy sites – (where complete vaccination penetration low – < 50%) & poor health facilities available.
4. Setting up of easy protocols both in the outreach camp & hospital so that there is ease & simplicity in availing of the facilities for the patient in the hospital.

**Uniqueness of RCH Guwahati**

RCH Guwahati is today recognized as one unique initiative in public health service delivery to a large section of population who are at the receiving end in society. The uniqueness of this project stems from the following:

- RCH Guwahati is initiated on Public-Private Partnership mode. In this case the parties are – Government of Assam, NRHM, European Commission and Marwari Maternity Hospital

- RCH Guwahati is based on cluster based model. In this case communities of urban slums are selected for RCH Services
**RCH Guwahati** is based on role of Civil Society Body (in this case Marwari Maternity Hospital)

**Drawbacks/ Limitations for RCH Guwahati**

Limitations are inherent in this RCH Guwahati Program:

- Site selection is a difficult terrain with household surveys and suspicion and skepticism of people
- There are objections for family planning services like Sterilization or abortion practices
- The present success is dependent only on the commitment of few doctors which is not healthy practice in terms of continuation of the program
- Establishing healthy Community contacts require regularization for establishing faith in the community and improving utilization of services.

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<table>
<thead>
<tr>
<th>THE INITIATIVE SECTOR INVESTMENT PROGRAMME (RCH)</th>
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<tbody>
<tr>
<td>BACKGROUN OF M.M. HOSPITAL</td>
</tr>
<tr>
<td>1. 100 BEDDED HOSPITAL RUN BY CHARITABLE</td>
</tr>
<tr>
<td>2. TOTAL NOS. OF DELIVERIES 4570 (01-02),</td>
</tr>
<tr>
<td>3. TOTAL NOS. OF STERILIZATIONS 602 (01-02),</td>
</tr>
<tr>
<td>4. TOTAL NOS. OF VACCINATION MORE THAN</td>
</tr>
<tr>
<td>5. TOTAL NOS. OF OBSTETRICIANS (TWELVE)</td>
</tr>
<tr>
<td>6. TOTAL NOS. OF PAEDIATRICIANS (THREE)</td>
</tr>
<tr>
<td>7. TOTAL NOS. OF ANAESTHETISTS (THREE)</td>
</tr>
</tbody>
</table>

The population served under the RCH Guwahati is a mixed one with Hindus, Muslims comprising the majority. The cultural practices as such are mixed one.

Operations initially began in five selected municipal wards covering a population of 2.5 lakh in south Guwahati.
Evaluating RCH Guwahati

Monitoring and evaluation of any scheme has great significance as it helps one to know whether the scheme is on the right track or in proper perspective. Monitoring and evaluation (M&E) are at the heart of the principles and practices of development programs. This helps to contribute positively to both decision-making (improving planning, periodic review, and enhancing implementation), and accountability (routine reporting and assessing impacts). M&E are two of the most valuable tools that help in, i) Project planning for and guiding changes, and ii) keep timely track of progress, results and impacts to improve.

The RCH Guwahati program can be evaluated on the following parameters:

PROBLEM ADDRESSED TO BY THE PRACTICE

The RCH Program has helped to address the following:
Address gaps in RCH service delivery by providing outreach services to improvememtal and child health for the urban poor living in slums of Guwahati

- Addressing needs of family planning
- Facilitating role of State Health department in providing RCH services with partners through PPP model
- Addressing the challenge of Public health service infrastructure through this PPP partnership
- Addressing a vital need of the poor people – health services at minimal or free of costs

Source: Marwari Maternity Hospital, Guwahati

<table>
<thead>
<tr>
<th>Year</th>
<th>OPVVDPT1</th>
<th>OPVVDPT2</th>
<th>OPVVDPT3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-2001</td>
<td>1200</td>
<td>1100</td>
<td>1000</td>
</tr>
<tr>
<td>2001-2002</td>
<td>1150</td>
<td>1200</td>
<td>1150</td>
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<td>2002-2003</td>
<td>1050</td>
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<td>2004-2005</td>
<td>950</td>
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<tr>
<td>2005-2006</td>
<td>900</td>
<td>850</td>
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<tr>
<td>2006-2007</td>
<td>850</td>
<td>800</td>
<td>850</td>
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Bar Diagram Presenting the Status of OPVVDPT 2002-2007
Table showing the Immunization Status of BCG & D.T

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<tbody>
<tr>
<td>1st Booster D.PH/DPT</td>
<td>425</td>
<td>425</td>
<td>425</td>
<td>425</td>
</tr>
<tr>
<td>D.T.</td>
<td>275</td>
<td>280</td>
<td>280</td>
<td>280</td>
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</table>

Source: Marwari Maternity Hospital, Guwahati

Bar Diagram presenting the Status of 1st Booster & D.T

Table showing the Immunization Status of BCG & Measles

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<tbody>
<tr>
<td>B.C.G.</td>
<td>882</td>
<td>882</td>
<td>882</td>
<td>882</td>
</tr>
<tr>
<td>Measles</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Marwari Maternity Hospital, Guwahati
The above mentioned graphic presentation of statistics shows that immunization, health of women in terms of check ups and sterilization programmes have found support through RCH best practice implementation. The immunization rates have gone up. In places like Gorchuk the rate is more than 50 per cent. There is more traffic of women and men for family planning services especially among Muslim couples. There is change of perceptions among women on maintaining and their children’s health. There is a relief of service delivery pressure for the State Health & Family welfare department.

A more participatory approach:
At present MMH covers 7 municipal wards which include 14 session sites. In most of these areas, the outreach camps comprise the only medical facilities for the inhabitants of the area. The selected sites are Fatasil Ambari, Udal Bakra, Lal Ganesh, Dhirenpara, Garchuk, Itabhatta, Datalpara, Kotabari, Deosotal, Adagudam, Jyotikuchi, Dakhingaon, Itabhatta, and Betkuchi. The site selection was done by MMH and was based on population structure (density and tribal, Muslim and migrant configurations), socio-economic profile of the people of the area (extent of poverty), needs of the population, and presence of basic infrastructure (access to services). These detail information was collated prior to site finalization and launch of RCH.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Status</th>
<th>No.</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Total Population Covered</td>
<td>1.5 Lakhs</td>
</tr>
<tr>
<td>2</td>
<td>Total Children Covered 2 years at onset (2002)</td>
<td>7,500</td>
</tr>
<tr>
<td>3</td>
<td>Total Children in Year 2006</td>
<td>9100</td>
</tr>
<tr>
<td>4</td>
<td>Complete immunization at beginning of programme (2002) from random sampling of 661 families with 1521 children 204 was giving a percentage</td>
<td>14%</td>
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<table>
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<tr>
<th>In Year 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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</table>

764%

Initial consultation and meetings were held with the local target population for grassroots and detail information on health services conditions. Several rounds of consultations were held with religious and community leaders to carry forward this program and to instill confidence in RCH services through MMH. For instance, the support from religious and community leaders in Itabhata has proved effective in bringing in Muslim women and men for RCH and family planning services.
A community key resource person is selected as RCH Motivator to mobilize, launch awareness drive, motivate and bring people to the clinics for RCH Services. In most of the sites, the motivators are private health practitioners. For instance, the motivator of Itabhata RCH camp is a private health practitioner running his own health clinic.

**Increased Accountability Of Service Providers To The Beneficiaries Of The Service**

There is quarterly survey of outreach sites. The doctor in charge is assisted by junior colleagues in undertaking this survey and collation of data. The survey report is then submitted the Hospital management authority. The management body of MMH comprises the Trust members of the hospital, - the President, Secretary, Treasurer, Assistant Secretary, Vice President and the executive body members. There are separate committees within the executive body which look after different components of the program like purchasing of products, allocation of duties to nursing staff, payment to staff, monitoring of services etc.

The survey report is then verified by State Health and Family Welfare Department officials and by officials of National Rural Health Mission (NRHM). One accountability tool is yearly signing of contracts for continuation of services by MM Hospital depending on this outcome and services. One copy each of the monthly report goes to hospital management, State Government, NRHM and State Coordinator for Dept. of Health & Family welfare, Govt. of India.

**OPERATIONAL ISSUES**

1. 14 regular sites, 28 camps in 8 selected wards are covered
2. Sessions are held every fortnight in each site at a predetermined time.
3. Senior doctors and nursing staff with vaccines and other logistics attend the camps.
4. Mobility support for the team by the sip funds.
Surveys of the outreach wards are done quarterly. At present the senior doctor in charge of the program is assisted by the junior doctor in collating this data. The data is then handed over to the management body of the hospital.

**SPEED & EASE OF SERVICE DELIVERY:**
The Marwari maternity hospital provides first tier health services including outreach camps in slums. Simultaneously, it also functions as a second tier health facility for outreach patients. In the hospital, sterilisation, spacing and abortion services are provided free of cost to patients, while deliveries, operations and diagnostic tests are charged at concessionary rates.

The RCH Services carried out by MMH is at regular intervals and in time. A fixed time and day is fixed for every RCH camp. The MMH performs these activities through active camps/clinics every fortnightly in 14 selected session sites and 28 camps regularly in the hospital premises. A senior gynecologist assisted by a junior gynecologist along with two nursing staff is engaged in service delivery. There is a roster according to which each site is visited once every fourteen days. The day and the time of visit to each site were fixed on the basis of meetings with the local community members of the area. Separate information for each service pertaining to the selected wards, and records of hospital care from these wards for RCH activities, are maintained by the hospital authority. Irrespective of rain or flood, the RCH camp is being held and even on national holidays. This gives a special reason for community people to approach RCH facility because of this regularity and timeliness.

There is routine immunization of children and routine ante-natal care for pregnant women. There is ambulance facility to uplift cases needing hospital care. Concessional rates are charged for deliveries of pregnant women. Family planning services are provided free of cost. Regular counseling for the appropriate method is undertaken. IUD insertions, permanent female sterilizations and MTP services for safe abortion are referred back to the hospital for further action.

The cost of handling caseloads of patients in the hospital is borne by the MM hospital. This cost is generated by the charges collected from the patients at the hospital at minimal charges.

**Targeting**

At present MMH covers 7 municipal wards which include 14 session sites. In most of these areas, the outreach camps comprise the only medical facilities for the inhabitants of the area. The selected sites are Fatasil Ambari, Udal Bakra, Lal Ganesh, Dhirenpura, Garchuk, Itabhatta, Datapara, Kotabari, Deosotal, Adagudam, Jyotikuchi, Dakhingao, Itabhatta, and Etkuchi.
The initial agreement set a target of coverage of fully immunized children would be increased by 25% after 6 months of starting the program and by 50% by one year of service in the selected slums. This target has been achieved in the first three months of operation (between April-June 2002)

Transparency
The monthly report generated and distributed is a mechanism to maintain activity and transparency with timely verifications.

Replicability
RCH Guwahati is cited as a replicable model of health service delivery governance. So far the RCH Program has been very satisfactory, according to the doctors and the management body. An average number of 70-120 clients visit the outreach camps every day. Conversations with users at the hospital and outreach sites conveys a sense of awareness on immunization, post natal treatment, abortion, sterilization and other family planning services. The Guwahati RCH model is cited as an example of successful Public-private sector partnership for delivery of basic health services to the common man. The program has been implemented with little infrastructure investment, small capital expenditure and the program has got off to a quick start without any major hurdle. The latest information is the National Rural Health Mission (NRHM) Directorate in Guwahati has decided to replicate this PPP model in select districts of Assam. Already agreements have been signed with Red Cross Society and CNES to provide RCH services. The service delivery model has now been replicated at another 90 sites by the State Government in Guwahati city, using available state government staff. The staffs (both medical and paramedical) were earlier based in various city dispensaries and were under-used. Another 10 sites are also be added.

The main challenge in replicating such a model is ensuring sustained compliance to the services as well as maintaining the momentum of service delivery from the management side. Other challenges include:

1. Involvement of more health professionals or doctors and nurses in sustaining a program like RCH Guwahati. The reason being running such number of outreach camps cannot rely on one or two senior health practitioners or doctors.

2. Selecting and engaging more local volunteers in such program

3. Tracking of services delivery mechanism can be more strengthened

4. Use of Information Communication Technology (ICT) tools seems to be necessary for more transparency and information delivery on update and progress of this kind of program. RCH Guwahati do not have any website to showcase its program and activities
5. On many occasions, there is reluctance of private facility to get involved with government programmes

6. Then one needs the government cooperation: Delays and non-cooperation generally kill such initiatives very quickly - particularly delays in funds transfers.

COST-BENEFIT ASSESSMENT OF PRACTICE:
The RCH Guwahati program is a joint venture in the form of PPP between MMH and State Government with involvement of NRHM and EC. As of now the cost sharing is 50:50. for instance in 2007, the MM Hospital has sought Rs 15,00,000 for the State government and rest 8-10,00,000 lakhs is supposed to be pumped by the Hospital authority in cash and kind.

<table>
<thead>
<tr>
<th>Rate of outreach services:</th>
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<tbody>
<tr>
<td>- Normal delivery – Rs. 560/-</td>
</tr>
<tr>
<td>- Assisted delivery – Rs. 660/-</td>
</tr>
<tr>
<td>- ISC -- Rs. 1560/-</td>
</tr>
<tr>
<td>- Family planning services &amp; MTP free of cost.</td>
</tr>
<tr>
<td>- BPL patients are exempted from charges</td>
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</tbody>
</table>

To make up cost recovery nominal charges are sought from users of RCH health services. These charges are 3-4 times lower than in private hospitals as well as in government run hospital if one counts the purchase lists given out by the government doctors.

Partnership

Lessons Learnt:

There are few lessons to be learnt from the RCH Guwahati Program:

- Government health services for the urban poor are still not reachable to many.

- Problems like physical distance, time, cost of health services, complex processes deters urban poor to avail services from government run health institutions

- There is still a greater need for public and community awareness on the need and importance of availing health services including RCH services
Targeted programs like this RCH Guwahati program is always flooded with additional health case loads and these cannot be ignored.

Manpower and sufficient health professionals including doctors and nurses must be in place to deliver such outreach services.

Health services can be successfully delivered using the PPP mode.

Community involvement must be complete in such practices.

Use of ICT is equally important for greater accountability and transparency of such programs.

Flexibility of programmes in regards to site & timings.

Maintaining fluid & easy lines of communication between motivators, local volunteers, community leaders & also patients.

Importance of back up system in regards to – i) ambulance, 2) outreach staff including ambulance driver etc.

Always stress the importance of the girl child in the sessions.

When motivating for sterilization avoid tunnel vision of fallopian tubes. Attention should be paid primarily towards problem & needs of the women and family.

The programme should not be regarded as a profit making venture for the NGO undertaking the project. The NGO should be prepared to infuse money into the project if needed sometimes.

### LESSONS LEARNT

1. Regularity of sessions.
2. Commitment of staff to serve the slums.
3. Building of faith and trust initially. The programme should not be target oriented. Patient flow especially in regards to vaccination & sterilization will automatically build up later.
4. Awareness of the local needs (both medical & general) & knowledge of the customs of the area.

Voices
The Reproductive and Child Health (RCH) Guwahati program is today cited as a replicable governance practice in public health service delivery using the Public Private Partnership mode. In its 6th year of its operation, the project is targeted at 14 sites and in 28 camps covering a population of 3 thousand in an average for 1 site. The role and responsibility of Marwari Maternity Hospital has come in for both praise as well as faced with limitations. Managing this urban health care program is no less stupendous task. Heading this program since 2002, Dr. Milan Baruah today is a busy gynecologist dividing his busy schedule between day to day affairs in the hospital, time spared for RCH program and time for this own activities. In a conversation in Guwahati on December 14th, Mr. Baruah tells the various angles of this RCH program to Syed S. Kazi from Centre for the Study of Law & Governance, JNU.

Experts

Dr. Milan Baruah, MD

Q. How do you see this entire RCH program being run by Marwari Maternity Hospital under Public-Private Partnership mode?
We see this entire program in totality. It means we not only cater to the Reproductive and Child Health needs, but also catering to the normal health related problems of non-target groups or else this program may not run successfully. So our program coverage is comprehensive and macroscopic.

This is one program that is running for 6 years in a row under Public-Private partnership mode which is unique. So far the European Commission, the State Government, National Rural Health Mission and Marwari Maternity Hospital is involved in this health service delivery program in urban slums in Guwahati.

Q. How did Marwari Maternity Hospital come into the picture?
It is very simple. M M Hospital came to the picture through a normal selection process of a private party (NGO/Charitable Institute) to run and manage this program. MM Hospital got selected for mainly two reasons- one, it is a charitable institute and second, it has a strong infrastructural and financial base to run this program even in lean time periods due to delay in financial sanctioning and so on. And also our track record in running the biggest maternity institute in North East helped us to take responsibility of the RCH program. Selection of MMH. Because it has financial scale on the higher side and basic infrastructure. 1500-2000 deliveries per annum which is quite a high figure. You have to have capacity to take up such responsibility

Q. What was your mandate then and now?
Our mandate has remained the same then and now:
To address gaps in RCH service delivery by providing outreach services to improve maternal and child health for the urban poor

To provide maternal and child health services in the selected wards

The provide the following RCH services in the selected wards/sites as well as through in-hospital services:

Regular Vaccination services of the children

Routine Ante-natal services to pregnant women

Basic laboratory services (Blood, Urine & Stool examination for ante-natal mothers) through MM Hospital infrastructure

Providing facility for delivery of the pregnant mothers in the hospital for these wards at marginal prescribed rates as decided upon

Provision for Family planning services e.g. OC Pill, Condom, IUD insertion and Permanent sterilization for female and MTP services for safe abortion at the hospital premises regularly.

Free counseling services

Orientation programs

Q. How is the RCH Guwahati program being run?
We have about 28 camps in 14 sites in South Guwahati. The first task is site selection. One main criterion to select sites is low vaccination rate at around 20 per cent (now the slab has been increased to 50 per cent as a criterion). Once selection of site is done, then baseline and household survey is done. We have community consultations to explore health services requirements and their socioeconomic status. Our target population is urban slum population especially women and children. Ours is basically a floating population and mostly migrants. We fix time and days with some flexibility for our outreach camps. For example in Katabari camp, we run our program post noon time as people are go the local bazaar during the first half as most of them are vegetable vendors.
One doctor visits per camp along with a vaccinator, ambulance driver, project officer and sometimes a sister or a ward boy. Since we have 28 camps now, it is almost one camp is visited every day. The outreach camps are located in existing pharmacies, or schools and our motivators is mostly health practitioner and in some cases he/she is a teacher like in the Gorchuk camp. We have stock of medicines for a week in the custody of the motivator who deal with minor cases during the off days. Serious patients are referred to the MM Hospital and treatment are done at rates initially fixed between partners which is very nominal for say, Rs. 550 for a normal delivery and Rs. 1500 for a caesarean operation which is 4-5 times low than in private and government run institutions.

Q. What are the Challenges and limitations being faced?
There is high level of impermanency in the program due to temporary nature of the camps. There is still lack of proper awareness and motivation among people to avail such services. Many women are still ignorant, suspicious as well as indifferent. In recent times, the institutional delivery has gone down which is a cause of concern for us. Then there is excessive dependency on one or two persons to run and manage this program which becomes taxing at times. There is need for a bigger space and sufficient human resources.  
Thus there is the need of some amount of permanency in the program. This can be ensured through- (1) Medicines: stock of medicines must be available for at least a week in each camp. We provide and prescribe six or seven medicines in common and these must be available to our motivators who can handle minor cases; (2) Human resources: there is need to train the government accredited ASHA workers in basic health services so that they can be involved in this RCH program as well; and (3) Permanency in communication: There is need for regular communication linkages between the people and the hospital staff. As of now we have 3 doctors attending to the needs. We are thinking of introducing a community mobile only for the purpose of maintaining this communication linkage in the hands of the motivators.

Q. Is there any sustainability angle in this program?
We are charging minimal rates to partly bear the cost involved although the entire program is heavily subsidy based. Also through our RCH outreach camps we get reference of patients to our hospital for serious cases. There will be a challenge once this program gets over. In that case we at MM Hospital are exploring options to run and continue this program if not in all 30 camps (which may not be required) but in around 15 camps. We can continue the camps with services like vaccination, family planning, basic delivery, ante-natal services, and basic investigations and orientation cases.

Lessons learnt
Access to health services is linked to poverty reduction and employment. This practice aims to improve access and ease in getting medical support. There is no doubt this model can be replicated. The only required factors are the agency responsible for implementation has to be community oriented, have a reasonable
infrastructural and financial base. At least administration should plan to adopt a village this time to run this RCH Program.