

BUILDING HEALTHY CITIES



BUILDING HEALTHY CITIES

DATA VALIDATION & SYSTEMS MAPPING WORKSHOP-INDORE

29-30 August, 2018

Building Healthy Cities

Building Healthy Cities is a three-year cooperative agreement funded by the United States Agency for International Development (USAID) under Agreement No. AID-OAA-A-17-00028, beginning September 30, 2017. Building Healthy Cities is implemented by JSI Research & Training Institute, Inc. (JSI) with partners Urban Institute, International Organization for Migration, and PricewaterhouseCoopers Pvt Ltd.

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ACRONYMS

BHC	Building Healthy Cities
CMHO	Chief Medical and Health Officer
ICDS	Integrated Child Development Services
IMC	Indore Municipal Corporation
IOM	International Organization for Migration
ISCDL	Indore Smart City Development Limited
JSI	JSI Research & Training Institute, Inc.
JSIPL	John Snow India Private Limited
NCD	noncommunicable disease
PwC	PricewaterhouseCoopers Pvt Ltd
UPHC	urban primary health center
USAID	United States Agency for International Development

DAY 1: 29TH AUGUST 2018

The Data Validation and Systems Mapping Workshop was organized at the Radisson Blu, Indore on 29-30 August, 2018. Resource persons were briefed about the methodology and tools. The agenda of the Workshop is provided in Annexure 1. A list of participants is provided in Annexure 2.

Session 1: Opening Session

In the first session, Dr. Sanjay Kapur, MD, John Snow India Private Limited (JSIPL) gave an overview of activities and projects being carried out by JSIPL. Dr. Neeta Rao, Senior Health Specialist, United States Agency for International Development (USAID) also addressed the participants. Ms. Amanda Pomeroy-Stevens, Project Director, Building Healthy Cities (BHC), JSI Research & Training Institute, Inc. (JSI) sent a video message which was telecast in this session. Text of her message is provided in Annexure 3.

Dr. Damodar Bachani, BHC Deputy Project Director, presented an overview of BHC and the objectives and expected outcomes of the Data Validation and Systems Mapping Workshop. Mr. Rohan Saxena, CEO, Indore Smart City Development Limited (ISCDL) gave opening remarks. Following this, deviating from the scheduled agenda, the floor was given to senior officers from the Departments of Education, Women and Child Development and Traffic Police. They raised issues relating to their departments in the presence of the CEO of ISCDL. Many of the issues and action points were agreed to for support under the Smart City Mission.

Officers from Traffic Police spoke in Hindi and made the following key points:

- Smart City is not consulting with their department at all, and they are unaware of ISCDL's plans.
- There are four E's that are necessary. The first two are engineering (proper planning and construction of roads, highways, street lights, parking, etc.), and education (educating people about traffic rules). If these two were taken care of, the third 'E,' the environment, would automatically become safe and conducive to public safety. Then the traffic department could focus attention on their main responsibility, the fourth 'E,' enforcement. Currently, the first two 'E's are severely lacking, leading to unsafe road conditions, serious road accidents, road rage, etc.
- One officer mentioned a few points of congestion in Indore that were draining resources. For example, at one major intersection, there is no signal for a left turn. This keeps vehicles idling for up to 3 minutes, thereby leading to increased petrol use and needless wastage.
- One officer's top recommendation was that students from class 1 to 12 be given continuous training/education on traffic and road rules. He said there was no way for them to engage with the Education Department to make this happen.

The following are the main points raised by officers of the Women and Child Development Department:

- There is a shortage of anganwadi centers.
- Only 20 percent of anganwadi centers have their own buildings. The remaining are in rented spaces that are tiny and ill-kept. Most anganwadi centers do not have parks nearby, or playgrounds for children.
- Malnutrition remains high because of a lack of awareness among mothers, who feed their children tea with biscuits or chips. These fast food items are also readily available since you can buy small packets for as little as Rs10.
- If there is an outbreak of typhoid or cholera that is reported, anganwadi centers do not have water safety kits to check on whether the child is drinking unclean water.

Session 2: Presentations on Baseline Assessments

In the second session, four presentations on assessments undertaken by BHC were made in the following order:

1. Political Economy Analysis: Dr. Monica Biradavolu
2. Data Use and Access Assessment: Ms. Swati Narayan
3. Health Needs Assessment: Dr. Damodar Bachani
4. Noncommunicable Disease (NCD) Risk Factor and Environment Survey: Dr. Ritvik

The presentations made in this session are included in Annexure 4.

One of the more interesting exchanges was between the Chief Medical and Health Officer (CMHO) and Mr. Saxena, with Damodar as the intermediary. The CMHO said that the shortage of doctors at urban primary health centers (UPHCs) in Indore was being addressed at the state level. Mr. Saxena was interested in finding out how ISCDL could help improve UPHCs. One aspect that is within the ambit of ISCDL is to improve infrastructure, but they can do nothing in facilities that are in rented buildings (50 percent% of UPHCS in Indore). Two solutions were proposed:

1. Improve infrastructure of UPHCs that are in government facilities right away.
2. Consider moving out of rented spaces and into government-owned buildings.

Presentations on the health related assessments were delayed as the CMHO was busy in other meetings and informed that he would be joining late. He also addressed the participants after these presentations and briefed about issues relating to health care services in the public health sector in Indore city.

Session 3: Data Validation

Following this, 10 charts were displayed containing data validation cards, with information taken from the four assessments (Annexure 5). Key issues on data validation from each of the assessments were discussed (Annexure 6). Participants in small groups participated in a “gallery walk,” in which they walked from one chart to another and gave their views in a prescribed format regarding key barriers, key enablers, missing issues, what needed to be deepened and what surprised them (Annexure 7). It was observed that while the above issues were understood by the participants, it would be better to re-phrase “deepened.” It could be in two parts (a) what barriers need to be

studied in depth and (b) what enablers would require deeper understanding. The groups used worksheets which were collected and later analyzed to identify barriers and enablers for each theme.

DAY 2: 30TH AUGUST 2018

On Day 2, we had about 30 participants. Worksheets containing 38 barriers (including a few which were termed as missing) were given to each participant. They were asked to identify the top 10 barriers important to them on the worksheet. These responses were collected and quickly analyzed in terms of frequencies. Of these, the top eight with the highest frequency were identified and displayed (Annexure 8).

This was followed by a presentation introducing the concept of upstream and downstream analysis and its use in systems mapping. Each small group of three participants was allotted to one of the top eight barriers and given instructions to write upstream causes and downstream effects. This was followed by presentations by each small group, and discussion. These worksheets were used for upstream-downstream analysis to identify interventions that need to be submitted to concerned authorities for support under Smart City Mission / BHC. The completed upstream/downstream analysis worksheets are included in Annexure 9.

Press releases in English (Annexure 10) and Hindi (Annexure 11) were issued.

Some departments gave written notes in Hindi with suggestions, which have been translated and are provided in Annexure 12.

SUMMARY AND KEY TAKEAWAYS

- Overall, it was a productive workshop, though the number of participants/sectors represented was less than expected. The workshop was an opportunity for sectors that are feeling underrepresented at ISCDL to voice their views directly with the CEO, Mr. Saxena.
- Concrete action items emerged from the one-on-one discussions between the CEO and traffic, education, health, women and child development, and integrated child development services (ICDS) officials.
- It seems that ISCDL is very keen to start implementing health-related programs.
- The workshop participants who did the gallery walk participated with enthusiasm and came up with several important points under the issues of "what is missing" and "what surprises you."
- The workshop raised many issues and opportunities that need to be considered for support under BHC and investment by ISCDL. Action points identified during the workshop for consideration for inclusion in the BHC workplans for years two and three are summarized below:

Action Points	BHC Support
Strengthen UPHCs and civil dispensaries through infrastructure development and training of health care personnel and developing tools and mechanism for referral	<ul style="list-style-type: none"> Mapping and situation analysis of primary health care facilities Training needs assessment Organize and conduct training of health care personnel
Support ISCDL for developing network of Health ATMs	<ul style="list-style-type: none"> Identify strategic location of Health ATMs Tools for monitoring of their utilization
Universal health care for urban poor communities	<ul style="list-style-type: none"> Consultant to conduct participatory research in urban poor settlements
Screen for lifestyle diseases	<ul style="list-style-type: none"> Identify public health care facilities for screening program Train health care personnel on screening procedures Plan and conduct screening of lifestyle diseases
Develop health promoting schools: guidelines, tools, training of teachers, and periodic assessment of schools covered	<ul style="list-style-type: none"> Develop guidelines on health promoting schools Prepare tools for assessment of health promoting schools Organize, conduct and monitor training of teachers from government schools in Indore in batches in coordination with the Education Department Baseline and post-training assessment of selected schools covered under the project
Develop messages and materials for public awareness on health lifestyles, food hygiene, traffic rules	<ul style="list-style-type: none"> Organize meeting of subject experts and communication experts to identify key messages and methods of dissemination Engage an agency for development of public awareness materials Support ISCDL and health sector in dissemination of materials
Improve data management and analysis for effective monitoring, planning, and decision making	<ul style="list-style-type: none"> Support in developing hospital management information system for PC Sethi Hospital Analysis of water pollution data and water-borne diseases Develop monitoring indicators on urban development activities impacting health of citizens (outcome and impact indicators) Analyze NCD Risk Factor and Environment Survey data and city specific morbidity data from health centers and hospitals and report on health profile of citizens
Share BHC approach with other Smart Cities	<ul style="list-style-type: none"> Organize orientation workshop for other Smart Cities

ANNEXURE 1

Agenda

Day 1: 29 August 2018		
9:30 – 10:00am	Registration	
10:00 – 10:40am	Opening Session	
	Welcome & Objectives of Workshop	Dr. Sanjay Kapur, MD, JSIPL, New Delhi
	Opening Remarks	Mr. Rohan Saxena, CEO, ISCDL
	Address	Dr. H.N. Nayak, Chief Medical & Health Officer
	Key Note Address	Mr. Asheesh Singh, Commissioner, Indore Municipal Corporation (IMC)
10:40 – 11:00am	Tea Break	
11:00 – 11:30	Overview: Social Determinants of Health, and Systems Thinking- Why Understanding Context Matters	
11:30 – 12:30pm	City Assessments under BHC Project: Objectives and Key findings	
	Health Needs Assessment	Dr. Damodar Bachani, JSIPL, New Delhi
	NCD Risk Factor & Environment Survey	Dr. Ritvik, AIIMS, New Delhi
	Political Economy Analysis	Dr. Monica Biradavolu, CEO, QualAnalytics
	Data Use Assessment	Ms. Swati Narayan, JSIPL, New Delhi
12:30 – 1:30pm	Lunch	
1:30 – 1:45pm	Give instructions and allow participants to move to their first station in the room.	
1:45 – 3:30pm	<p>Small group “gallery walk” to explore data and validate findings: On large paper, assessment findings are displayed around the room in appropriate groupings (about 8-12 stations). Participants are given 10 minutes at each station where they will first take a few minutes to read/review the content individually (they will already have been introduced to it during the earlier presentations), and then will discuss within their small groups by responding to the following questions: 1) what jumps out to you as particularly important or meaningful? 2) What surprises you? 3) What could be deepened? 4) What is missing altogether? Groups will write their responses to these questions on a paper beside the station, building on what previous groups have described.</p>	
3.30 – 3.45pm	Tea Break	
3:45 – 4:45pm	Share Enablers/Inhibitors- Participants: Does this feel right? Anything to add?	

4:45 – 5.00pm	Summary of Day 1 and, briefly, what to expect tomorrow	
Day 2: 30 August 2018		
09:30 – 10:00am	Welcome and overview of the day to come. Brief review of key elements of Systems Practice.	Presentation followed by discussion Resource Persons: Ms. Karen Gratten, Engaging Inquiry Group Ms. Amanda Pomeroy-Stevens, JSI Facilitators: JSIPL team Damodar Bachani, Swati Narayan, Fareed Uddin
10.00– 10:30am	Review and prioritization of Enablers/Inhibitors (themes)	Outcome: key themes for small group analysis
10:30 – 11:00pm	Give instructions for conducting an Upstream/Downstream analysis, and demonstrate one process together as a group. Participants select themes and break into groups of 3 people.	
11:00 – 11:15	Tea	
11:15 – 11:45	Conduct Analysis: In small groups, participants will explore the upstream causes of a theme, and its downstream impacts.	
11:45 – 12:15	Participants “zoom out” on their analysis: Name at least 3 major stories that representing patterns found in the system. Capture them at the bottom of the up/down analysis.	
12:15 – 1:15pm	Group presentation- 1) Each team has a chance to share the major stories/patterns found in their analysis, 2) as a group, what factors (elements of a story) showed up in multiple areas across the system?	
1:15 – 1.30pm	Concluding remarks and vote of thanks	
1.30	Lunch	

Materials List:

- Name tags
- Large print-outs of key data/findings- for data validation exercise.
- Large paper, 25-30 sheets (approx. 25x30 inches) - for recording responses to data and upstream/downstream analysis.
- Fine-tip markers, about 1 per participant (Sharpie, or something similar) - for small group work, individual note taking.
- Thick-tip markers of various colors, 1-2 per group (about 20-25) - for highlighting key ideas that will be shared with the room.
- Masking tape, 1-2 rolls- for posting large paper.
- Large index cards or Post-Its of various colors, 1-2 packs- for writing key themes that will then be distributed to participants.

- OPTIONAL: Post-Its (3x3 or 4x6), about 15 stacks- for participants who may prefer to share thoughts/feedback anonymously or make their own notes, and recording key insights.

Room Set-Up

- Environment should be easy to change/modify during the day- there will be times when participants will need to sit comfortably to view presentations, and other times when they will need to move freely around the room in small groups. Engagement and meaningful conversation are essential!
- Plenty of clean wall or large table space for group work- room for 8-12 group work stations.

ANNEXURE 2

List of Participants

29-30 August 2018 Hotel Radisson Blu, Indore

S. No.	Name	Gender	Designation/ Position	Department/ Organization	Place	Contact No.	E Mail ID
1	Rohan Saxena	M	CEO	ISCDL / IMC	Indore	9827781765	rohan007saxena@gmail.com
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ANNEXURE 3

Text of Video Message by Ms. Amanda Pomeroy-Stevens, Project Director-BHC, JSI

Good morning and welcome. My name is Amanda Pomeroy-Stevens, and I am Director for the USAID-funded Building Healthy Cities project. My apologies that I cannot join you today, but due to unforeseen circumstances, I am unable to travel.

On behalf of the project, I would like to thank you, not just for attending this event, but also for the valuable insights and information you have shared about Indore with our staff for the last year as we have gathered baseline information and survey data. Today we will be able to share back with you the information we have gathered, make sure it is correct, and think about how the many moving pieces of city planning interact to improve citizen's health and well-being, even beyond the health sector.

Before we get into these data, you will hear from our partners at Indore Smart City Development Limited, as well as our collaborators at the office of the Chief Medical and Health Officer and the Indore Municipal Corporation. USAID has funded this collaborative learning project to work in concert with these city agencies to help bring urban planning and health closer together. JSI India is the implementing partner for this project in Indore and is committed to improving urban health across the country. We are all working toward the goal of making Indore a smart, clean, livable and healthy city for all.

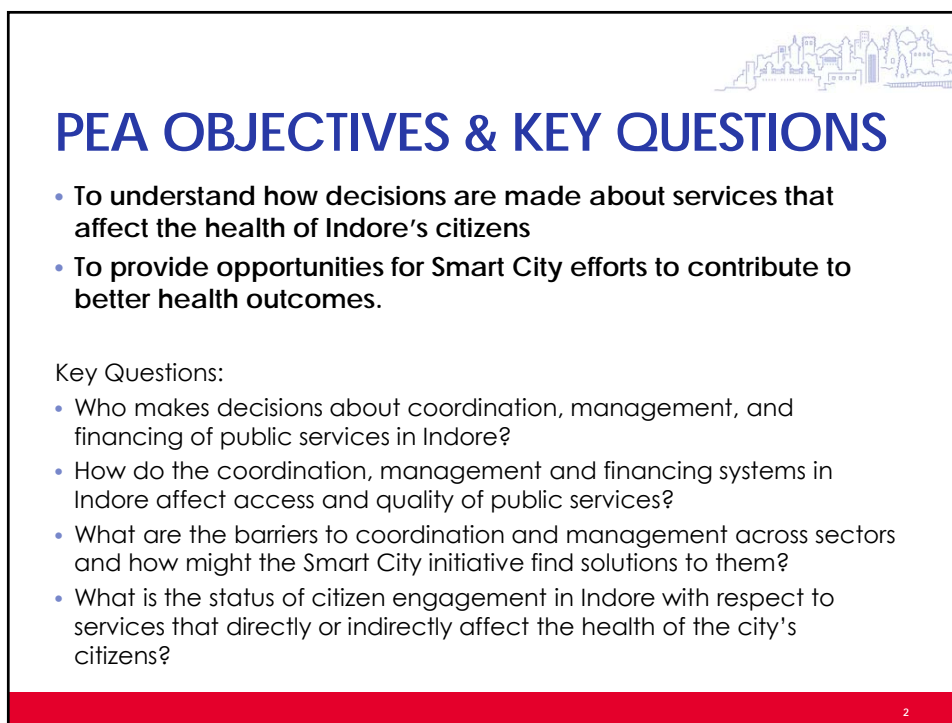
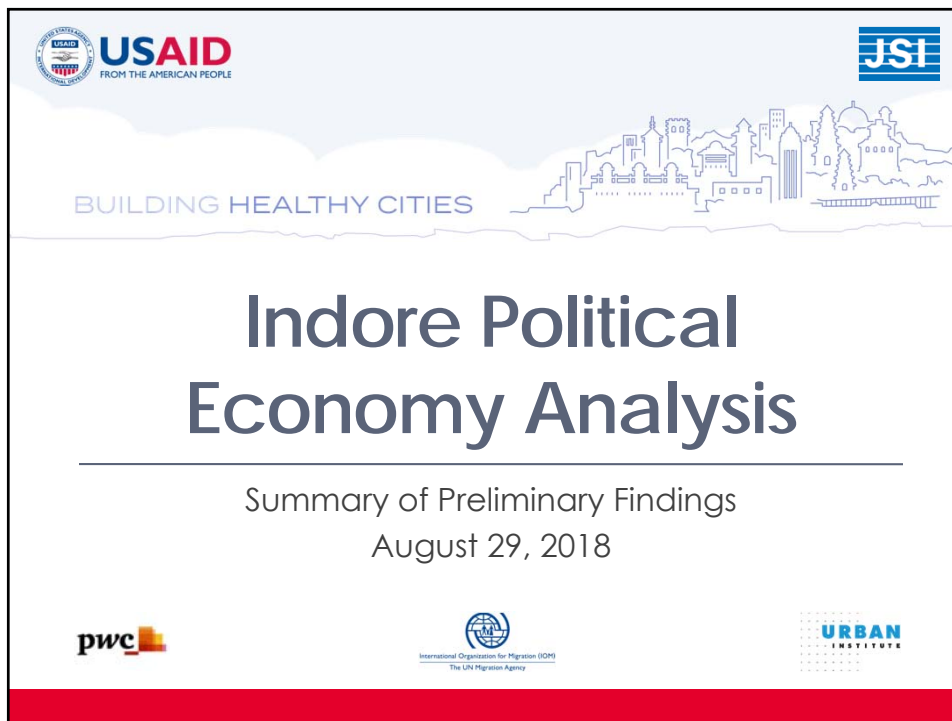
Thank you again, and I hope to be in Indore soon for our next data sharing meeting. Until then, I turn this workshop over to my esteemed colleagues at BHC and JSI.

Link to video message:

https://www.youtube.com/watch?v=l4waLmcwTJY&feature=youtu.be&list=PLThD7cnn5IxHu7LJWqH4JSXgwJ4rQV6c_

ANNEXURE 4

Presentations on Assessment Findings





PEA METHODOLOGY

- USAID's Political Economy Assessment framework calls for an assessment of 1) fundamental factors, 2) institutional arrangements, 3) interests related to public policy or services, and 4) events underway here and now.
- PEAs rely on qualitative research
- PEAs are used to identify opportunities for interventions, and understand possible obstacles so that they can be overcome.

3



PEA in Indore

Methodology in Indore

- Extensive desk review of prior reports and analyses of health and other service delivery issues in India, in Madhya Pradesh, and Indore.
- 21 key informant interviews in June 2018 with Smart City officials, NGO leaders, political leaders, state and national officials and consultants involved on supporting Smart Cities in Indore and in other cities. Included key informants in Bhopal and Delhi.
- Initial observations were reviewed with experts involved in multiple Smart City efforts in India and Ministry Smart City staff.
- Limitations: In-depth review of individual sectors (water, sanitation, roads, housing, nutrition etc.) not feasible at this first high-level review.



Summary of Findings

Indore decision-making related to public services

- Several agencies and sectors have responsibility for urban service delivery.
- Inadequate revenue base.
- Many "local" programs still require approval from state entities.
- Issues common to many cities in India vis-à-vis implementation of 74th Amendment and intergovernmental finance.

Effectiveness of coordination, management in Indore

- Coordination challenges have been well-known for a long time (Indore Urban Plan 2006).
- Political intervention appears to be preferred method of resolving service issues.
- Inadequate monitoring of performance.
- Data on health not widely shared across departments.
- Neighborhood level data not readily available to public.



Summary of Findings

Indore Smart City Options to improve health focus of urban services in Indore

- Diverse agencies into one room for making decisions.
- Staff and consultant flexibility is valuable asset.
- But not yet how this focus and flexibility will be extended to rest of the city.
- Lack of baseline and progress data on outcomes of SC programmes.
- Role of private sector is low.
- Unclear (as of now) how SC will be integrated with IMC.

Citizen voice in decisionmaking about services

- High voter turnout but elected officials have limited role in many services.
- Wide public consultation at outset of ICSDL was very useful
- Unclear as to extent of engagement with citizens and NGOs in implementation.
- 311 service mostly useful to middle class, concerns that performance is declining.
- Citizen support for Swachh Bharat seems strong, may be an example.



WE WOULD LIKE TO KNOW MORE ABOUT...

- Is there data on service delivery performance by neighborhoods?
- To what extent is there informal data-sharing among health and other sectors (whose work affects health outcomes)?
- What are the opportunities for greater collaboration with NGOs and other civil society organizations?
- What are the opportunities presented by the Livability Indications developed by the Ministry of Urban Development?
- What is the strategy for institutionalizing Smart City innovations?

7



THANK YOU




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BUILDING HEALTHY CITIES

DATA USE ASSESSMENT (DUA)

Swati Narayan
August 29, 2018



Objectives of the DUA

- To understand current access to, and use of, data in Indore.
- To inform more detailed city work plans relating to data system interoperability and citizen reporting systems (CRS) in the city.

Data use can be difficult to define - it means that within an organization people demand data, understand their role as data producers and users, and are motivated to act on those data for programming and/or decisionmaking



Key DUA Questions

- *Existing Data Systems:* What are the data systems for key sectors? Are new systems being planned to support Smart Cities?
- *Use of Data for City Planning:* How are data and information systems being used now? What is the culture of data use? How is data shared?
- *Citizen Access to Data/ICT:* Do citizens have access to city data and ICT? Is that access fair for all? How do citizens participate in data collection? How do citizens communicate via ICT?
- *Barriers:* What barriers are there to increasing data use in Indore for all?



Methodology

- Formative assessment
- Qualitative methods including Key informant interviews (KIs), focus group discussions (FGDs), and desk review
- Data collection tools were adapted from the MEASURE Evaluation “Tools for Data Demand and Use in the Health Sector” manual and the Cities Alliance report “An Innovative Data Toolkit for City Management”
- IRB sought from JSI IRB, exemption given as no sensitive topics or populations included.



Methodology (cont'd)

- Data collection occurred from April – May 2018. Several additional interviews collected Summer 2018.
 - **KIIs:** 21 interviews with 23 individuals were conducted across sectors. Purposeful selection of individuals who worked on ICT, data, or use data for decisionmaking.
 - **FGDs:** 4 FGDs were also conducted with key citizen sub-populations. Mix of literate and illiterate, those with mobile phones and those without.
 - **Desk Review:** Over 30 sources (English, Hindi) reviewed for existing statistics and information on the data systems that already are in use in Indore.
- **Limitations:** some non-response due to concerns on confidentiality. 7 sectors included, may be more involved in ISCDL.



Summary of Findings

Existing Data Systems

- Moderate penetration of national ICT infrastructure
- Systems are slowly digitizing, including citizen data
- Smart City data systems developing, but centred outside Indore (SmartNet, ICC)
- Good internal MIS for Smart City projects in ISCDL; monthly
- At least 7 Health IS ((HMIS, MCTS, HRMIS, ASHAMIS, FMIS, IDSP, e-VIN), but not linked/inter-operable
- VTMS and ITMS, successful examples of city-level IS

Use of Data for City Planning

- Within each sector, there is demand for data
- Use of that data at Indore level varies widely by sector
- Financial/physical progress tracked closely, outcomes/impacts less so, especially for ISCDL
- National SC M&E framework not yet launched, so low motivation for Indore to define their own list to track, as it may change.
- Technical and manpower constraints to inter-operability?



Summary of Findings (cont'd)

Citizen Access

- Physical access increasing, but many still do not have internet/mobile phone access, especially low-income homes
- ISCDL and IMC have invested in online options to allow for grievance redressal (GR)– very good uptake
- Those without online access/literacy cannot communicate that way – prefer GR via *Nagar Parishad* /similar
- CM helpline has had good uptake, especially with community health workers.

Other Barriers

- How is privacy of citizen data being handled across platforms?
- Private sector data missing for most sectors, especially health.
- Unclear how workforce is being trained for data USE, beyond creation of data systems
- Many critical systems for ICCCC may be controlled/designed at state or national level, making it hard for Indore to re-structure for better city use.



Key Issues for DUA Validation

- Are there Indore-specific e-governance guidelines?
- What IS are used in private sector health facilities?
Are they compatible with Public sector systems?
- What ICT specifications or privacy firewalls across systems might affect inter-operability with ICCCC?
- How do citizens receive response/resolution from grievance redressal systems other than 311?
- Are there other online citizens communication or advocacy platforms not captured?



THANK YOU

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BUILDING HEALTHY CITIES

HEALTH NEEDS ASSESSMENT (HNA)

Dr. Damodar Bachani
August 29, 2018



Objectives of the HNA

- To improve understanding of access, barriers, knowledge, and opportunities for healthy living in the city of Indore across a range of stakeholders.
- To investigate multi-sectoral activities related to health and urban planning within Indore's Smart City Initiative.

"A healthy lifestyle is a way of living that lowers the risk of being seriously ill or dying early... Health is not just about avoiding disease. It is also about physical, mental and social well-being."

– WHO 1999



Key HNA Questions

- *Health sector and services:* How is the health system organized? What current health services are provided in the city? How does the health sector promote healthy lifestyles?
- *Underserved populations:* Who is underserved? Who are the current representatives of the underserved?
- *Health engagement:* How receptive are city officials and municipal decision-makers to improving healthy lifestyles in their communities?
- *Coordination, management, and funding:* How are city services (including health) coordinated, selected, funded, and distributed, especially within the Smart Cities structure? Which sectors and stakeholders are represented in these choices?



Methodology

- Formative research
- Qualitative methods including Key informant interviews (KIs), focus group discussions (FGDs), direct observation, and desk review.
- Methods were deployed to reach saturation on the key themes and to triangulate data where possible.
- Structured interview tools were used to collect all data, and Excel and Nvivo were used for analysis.



Methodology (cont'd)

- JSI conducted initial data collection in April 2017. Second round of data collection occurred in February 2018, after BHC began.
 - **KIIs:** 28 interviews with 51 individuals. Purposeful selection of state and municipal representatives, civil society, and private-sector stakeholders across health, education, urban planning, ICT, waste management and sanitation, social protection, communications and civil society.
 - **FGDs:** 4 FGDs conducted with key citizen sub-populations. Mix of income level, housing type and property rights, religious and caste composition, and migrant and non-migrant populations.
 - **Direct Observation:** 12 service delivery points observed - 2 hospitals, 3 Anganwadi centers, 4 UPHCs, 2 private providers, and 1 newly built CHC.
 - **Desk Review:** Over 30 sources reviewed for existing statistics and information on Indore's health system and Smart City structure.
- **Limitations:**
 - Some perspectives from Indore are not captured here, in particular those of youth. Further exploration is needed to capture these perspectives.



Summary of Findings

Health Sector and Services

- UPHCs and CHCs established; not always in convenient locations
- Many lower income citizens unaware of free public services
- Major challenge is lack of qualified workforce; impacts open times, quality of care, community health outreach
- Passive privatization of health care due to constraints in public sector; low regulation
- Positive developments in health insurance nationally; 1/5 of urban MP currently covered

Underserved Populations

- Wide variety of populations living in informal settlements
- Low awareness/use of social protection schemes by low-income citizens
- Multiple threats to health in built environment of settlements
- UPHCs and Anganwadi centers insufficient to reach all informal settlements
- Low awareness of lifestyle health risks in settlements
- High exposure to infectious and non-communicable disease



Summary of Findings (cont'd)

Health Engagement

- 6 of the 7 city sectors interviewed said that they have a role to play in improving urban health.
- Opportunities to engage appear to be related to prevention and health advocacy
- Investment case is needed to develop more deliberate engagement of other sectors

Coordination, Management, and Funding

- Many sectors already involved in ISCDL, but several key health-related ones are not (e.g. health, ICDS, pollution control)
- Funding flexibility has increased via ISCDL, though procurement still goes through MP state
- Interest in engaging health sector in Smart Cities – question is how best to connect
- Reporting on outcomes/impacts across sectors via ISCDL is to be determined



Key Issues for Validation

- Environmental health emerged as a key issue – have we captured key concerns?
- How can the private health sector engage?
- What incentives are being put into place to reduce vacancies in public health sector?
- Are there Indore-specific social protection schemes beyond the national campaigns?
- Is there a need for more food and nutrition policies and programs in Indore? At schools, in settlements?
- How do lack of housing rights impact the health in settlements?



THANK YOU

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NCD RISK FACTORS & ENVIRONMENT SURVEY

PROF. ANAND KRISHNAN & DR RITVIK

CENTRE FOR COMMUNITY MEDICINE, AIIMS – NEW DELHI

OBJECTIVES

- To measure baseline risk factors for major NCDs
 - Behavioral
 - Environmental
 - Biological
- The same survey will be repeated at the end of the project to measure changes from baseline to measure the effectiveness of the intervention.

SCOPE

- Survey of Adults (18-69 years) for NCD risk factors including STEP 3 (Urine for Sodium/Blood Sugar)
- Mapping of community environmental risk factors for NCD (diet and physical activity) and related parameters under Smart City

METHODOLOGY

- Out of 80 wards in Indore 30 wards selected by PPS method (stratification by presence of slums)
- Within each ward, 3 colonies were be selected again by PPS
- Within each colony 35 participants were to be selected by systematic random sampling however due to paucity of resources EPI methodology was used to select households in the colonies
- Total of 105 respondents chosen per ward.
- Thus, 90 colonies provided 3150 sample subjects.
- Urinary sample collection for sodium testing was attempted in a sub-sample of 900 subjects (one randomly selected colony in a ward)

METHODOLOGY

In each colony :

- 35 households were selected
- In each selected household a household form was filled and one adult (18-69 years old) was chosen for survey – written informed consent was taken
- The chosen adult was administered a questionnaire to capture NCD risk factors and subject to anthropometry, blood pressure measurements and blood sugar testing
- In selected clusters the chosen participants were also asked to provide morning's first urine sample for sodium testing
- Environmental survey was carried out in the selected colonies (still underway) looking at walkability, store density, physical activity sites, density, etc.

RESULTS

- Complex survey analysis with colony as the primary sampling units was carried out
- Standardization was done based on age & sex distribution of urban Madhya Pradesh for all individual level indicators
- Results are presented as point estimates with 95% CI except for the household level indicators
- Weighted analysis based on sampling strategy is being planned

RESPONSE RATE

Levels	
Total households approached	3150
Household forms filled	3131 (99.3%)
Adult forms filled (STEP I)	3070 (97.4%)
Anthropometry (STEP II)	2997 (95.1%)
Blood sugar estimation (STEP III)	2453 (77.9%)

HOUSEHOLD LEVEL CHARACTERISTICS

Characteristic	(N=1070)
% of Pucca House	70.6%
% of Households using shared latrines	11.14%
% of Households with BPL ration card	17.7%
% of Households using more than one type of cooking oil	47.61
% of Households using solid fuels	4.96

AGE & SEX DISTRIBUTION OF THE SAMPLE

Age Groups	Males (n, row%)	Females (n, row%)	Total
18-29	293 (34.0%)	568 (66.0%)	861
30-39	241 (32.9%)	492 (67.1%)	733
40-49	242 (34.9%)	451 (65.1%)	693
50-59	184 (39.5%)	282 (60.5%)	466
60-69	132 (41.6%)	185 (58.4%)	317
Total	1092 (35.6%)	1978 (64.4%)	3070

SOCIO DEMOGRAPHIC CHARACTERISTICS

	Males	Females	Total
Mean Age	36.5 (36.4 36.6)	36.3 (36.2 36.4)	36.4 (36.3 36.5)
% Following Hinduism	83.6 (77.1 88.5)	79.2 (71.7 85.2)	81.4 (74.8 86.6)
% Following Islam	11.2 (6.7 18.1)	14.9 (9.4 22.9)	13.0 (8.1 20.2)
% Currently Married	24.8 (18.5 32.3)	26.5 (19.9 34.3)	25.6 (19.6 32.9)
% Ever attended School or, Madrassa	91.5 (88.3 94.0)	79.9 (75.6 83.6)	85.7 (82.2 88.6)

TOBACCO USE

	Males	Females	Total
% Current Tobacco users (Smoked or, Smokeless)	37.2 (33.1 41.5)	5.8 (4.0 8.1)	21.5 (18.9 24.3)
% Current Daily Tobacco users (Smoked or, Smokeless)	33.6 (29.4 38.2)	5.2 (3.6 7.5)	19.4 (16.8 22.4)
% Current Daily Tobacco Smokers	9.8 (7.8 12.3)	0.1 (0.04 0.5)	5.0 (4.0 6.3)
% Smoke Manufactured cigarettes daily*	63.0 (54.0 71.2)	31.3 (- -)	54.4 (48.0 60.6)
% Smoke Bidis daily*	51.1 (41.7 60.1)	55.2 (- -)	52.2 (45.3 59.0)

* Among those who smoke tobacco daily

TOBACCO USE & SECOND HAND SMOKE

	Males	Females	Total
% Current Daily Smokeless Tobacco users	26.8 (22.7 31.4)	5.1 (3.5 7.5)	16.0 (13.4 18.9)
% Daily Dual Tobacco users	3.0 (2.1 4.3)	0.04 (0.006 0.3)	1.5 (1.1 2.2)
% Exposed to second hand smoke at home	25.2 (20.7 30.3)	18.0 (13.9 22.8)	21.5 (17.8 26.0)
% Exposed to second hand smoke at workplace / during travel	59.5 (53.6 65.0)	35.6 (29.7 42.1)	47.5 (42.3 52.9)

ALCOHOL

	Males	Females	Total
% Life time Alcohol Abstainers	86.8 (83.3 89.6)	99.9 (99.7 99.9)	93.4 (91.6 94.8)
% Consumed Alcohol in last 30 days	10.4 (8.2 13.2)	0.07 (0.01 0.3)	5.2 (4.1 6.6)
% Engaged in Heavy drinking in last 30 days*	3.7 (2.5 5.5)	NIL	1.9 (1.2 2.8)

* Six or more standard drinks in a single drinking occasion

FRUITS & VEGETABLES CONSUMPTION

	Males	Females	Total
Mean servings of fruits and vegetables consumed in a day	2.5 (2.1 2.9)	2.9 (2.1 3.6)	2.7 (2.2 3.3)
% With inadequate consumption of fruits and vegetables *	93.1 (88.6 95.9)	89.2 (81.7 93.8)	91.1 (85.5 94.7)

* Less than 5 servings in a day

DIETARY SALT

	Males	Females	Total
% who often / always add extra salt right before eating	22.2 (18.9 25.9)	22.6 (19.5 26.1)	22.4 (19.6 25.5)
% People who think that lowering salt consumption is somewhat or very important	73.5 (67.1 79.1)	66.8 (60.4 72.6)	70.1 (64.2 75.4)
% who took steps to reduce salt intake	70.4 (62.5 77.1)	74.0 (67.4 79.7)	72.2 (65.2 78.3)

PHYSICAL ACTIVITY

	Males	Females	Total
%who do insufficient physical activity (Less than 600 met minutes a week)	27.4 (22.0 33.4)	20.4 (16.4 25.2)	23.9 (19.7 28.6)
Mean hours spent in sedentary activities in a day	3.2 (2.7 3.7)	3.1 (2.6 3.7)	3.1 (2.6 3.6)
Median hours spent in physical activity in a day among those active*	1.7 (0.7 5.2)	2.0 (0.1 4.0)	2.0 (0.7 4.1)
% who do voluntary physical activity	10.9 (8.3 14.1)	2.3 (1.6 3.3)	6.6 (5.1 8.4)
% who do Yoga	5.2 (3.2 8.3)	5.3 (3.5 7.8)	5.2 (3.6 7.5)

* Median (IQR) - not standardized

BODY MASS INDEX & OBESITY

	Males	Females	Total
Mean Body Mass Index kg/m ²	24.3 (23.9 24.6)	24.6 (24.2 24.9)	24.4 (24.1 24.7)
% Overweight (30 kg/m ² > BMI ≥25kg/m ²)	28.5 (25.2 31.9)	26.2 (24.2 28.3)	27.3 (25.3 29.4)
% Obese (BMI ≥30 kg/m ²)	10.7 (8.6 13.3)	16.5 (14.5 18.7)	13.6 (12.0 15.4)
Mean Waist Circumference (centimeters)	91.5 (89.8 93.3)	88.9 (87.2 90.5)	90.2 (88.7 91.7)
% with Central Obesity (Waist circumference in males ≥90cm, Females ≥80 cm)	50.9 (46.5 55.4)	73.2 (69.1 77.0)	62.1 (58.5 65.5)

BLOOD PRESSURE & BLOOD SUGAR

	Males	Females	Total
Mean Systolic Blood Pressure (mm HG)	129.2 (128.0 130.4)	123.7 (122.8 124.6)	126.4 (125.6 127.3)
Mean Diastolic Blood Pressure (mm HG)	81.1 (80.3 82.0)	77.5 (76.9 78.1)	79.3 (78.7 79.9)
% with raised Blood Pressure (SBP ≥130 & or, DBP ≥90 or known hypertensives)	29.7 (26.7 32.9)	25.0 (26.7 32.9)	27.3 (25.3 29.5)
Mean Blood Sugar (mg/dl)	105.4 (102.4 108.4)	109.1 (106.5 111.7)	107.3 (104.8 109.7)
% with raised fasting blood sugar (≥ 126 mg/dl)	11.6 (9.4 14.2)	13.9 (12.0 16.2)	12.8 (11.0 14.7)

HEATH SYSTEM LINKS

	Males	Females	Total
% whose Blood Pressure was measured in last 12 months	27.0 (22.9 31.6)	41.3 (37.0 45.7)	34.2 (30.4 38.1)
% whose Blood sugar was measured in last 12 months	15.6 (12.5 19.3)	20.4 (17.6 23.6)	18.0 (15.5 20.9)
% Ever screened for oral cancer	0.6 (0.2 1.5)	0.2 (0.08 0.9)	0.4 (0.2 0.9)
% Ever screened for cervical cancer	-	0.2 (0.07 0.7)	0.2 (0.07 0.7)

ONGOING ANALYSIS

- Salt intake estimation
- Weighted analysis
- Environment survey

THANK YOU

This study was jointly funded by Indore Smart City Development Limited (ISC DL) and USAID's Building Healthy Cities project. Building Healthy Cities is a three-year cooperative agreement funded by the United States Agency for International Development (USAID) under Agreement No. AID-OAA-A-17-00028, beginning September 30, 2017. Building Healthy Cities is implemented by JSI Research & Training Institute, Inc. (JSI) with partners Urban Institute, International Organization for Migration, and PricewaterhouseCoopers Pvt Ltd.

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Data Validation Cards

1. Political Economy Analysis

Decision-making processes that directly or indirectly affect the health of Indore's citizens

Enablers

- 74th Amendment of the Indian Constitution (passed in 1992) gives autonomy to urban local bodies
- State budgetary support
- State monitoring of local performance
- ISCDL brings together leadership of multiple sectors involved in local services
- ISCDL has independence and flexibility in staffing and operation

Barriers

- Incomplete implementation of 74th Amendment
- Elected leadership with limited power, local administration appointed by state
- Urban services come under several different sectors, agencies etc., each with different chain of command
- Inadequate revenue base
- State oversight of performance

Coordination, management and financing of services that affect the health of Indore's citizens

Enablers

- Urban Plan identifies issues and opportunities
- Data available on health and other services at the neighborhood (locality) level
- Local elected leaders engage with the administration on behalf of citizens
- ISCDL brings together multiple local and state urban service bodies at one table
- ABD approach focuses action of all sectors within the designated area

Barriers

- Urban Plan is 12 years old
- Health and service performance data is not shared between sectors nor is it made public
- Service access often requires political intervention
- Leadership of many entities with urban responsibility is not accountable to elected officials
- ABD approach does not include tracking performance of services within the ABD, or, to-date, evaluating impact of SC effort.

Opportunities for Smart City to address coordination and management issues

Enablers

- ISCDL brings many actors to one table.
- Emphasis is on infrastructure, not only on "smart"
- Targets one area with multiple types of projects ("Area Based Development" or ABD), and a smaller set of "pan-city" programs
- SPV gives flexibility, including ability to improve capacity by hiring consultants
- Significant funding.

Barriers

- Unclear who Smart City leaders are accountable to or the longer term relationship between the SPV and the IMC
- Steps not yet (publicly) identified to extend operating flexibility for work in the ABD to other parts of the city and public administration
- Limited attention to data collection and analysis on the impact of the Smart City efforts on different neighborhoods and populations groups
- Limited private sector engagement to date.

Engagement of citizens, especially the poor, in matters affecting their health

Enablers

- Large numbers of Indore citizens vote, including in slums.
- High technical capacity of ISCDL staff and consultants, ability to retain expertise focused on outreach
- 311 phone line functions
- Example of success of the Swachh Bharat – Clean Indore effort.
- MP law on Public Service Guarantee to be implemented

Barriers

- NGOs focus on supporting access to services, less on changing policy or priorities.
- 311 line more trusted by middle class residents. Declining use of (confidence in?) city complaint mechanisms.
- Wide public consultations in design of Indore SC plan, not followed by wide consultation on implementation, unclear reach into poor communities
- Little data on distributional effects of budget and policy decisions in Indore

2. Data Use and Access Assessment

Existing Data Systems

Enablers

- NII is expanding infrastructure in MP
- Usage of Aadhaar/UID platform for streamlining delivery of government scheme benefits and services
- ISCDL has access to SmartNet , soon to have ICCC
- ISCDL has good internal tracking of Smart City Indore projects, updated monthly
- Health Facilities in Indore have access to at least 7 IS via NHM (HMIS, MCTS, HRMIS, ASHAMIS, FMIS, IDSP, e-VIN)
- VTMS and ITMS, successful examples of city-level IS, ITMS is already reporting into Bhopal ICCC.

Barriers

- BharatNet has only reached half of GPs with Fiberoptic Cable
- Privacy laws and enforcement is needed as Aadhaar and other digital systems for citizens expand
- Both SmartNet and ICCC run from state or above, ISCDL will need coordinate to customize these systems to their needs
- Smart City M&E indicators still not set, no way to monitor Smart city project impact
- None of the 7 health IS are integrated, and many are paper-based at Indore level. Data quality and usability are also issues.

Use of Data for City Planning

Enablers

- Health sector does demand data from their own systems
- Within sectors, there is use of data for implementation and planning
- ICCC is funded and set to launch in late 2018, should increase cross-sector data use
- Financial and physical data on progress of Smart City projects tracked monthly by ISCDL to make decisions

Barriers

- Few requests for data outside of one's sector.
- Pre-ICCC, no regular cross-sector data review meetings in ISCDL or Health, only at IMC.
- Lack of M&E framework means no data on Smart City outcomes, and no benefit to city to start tracking these indicators until national M&E standards have been set
- May be a shortage of trained ICT staff to support increased electronic data collection, analysis and use
- May be technical constraints to improving ICT system interoperability?

Citizen Access to Data/ICT

Enablers

- Multiple broadband providers in Indore
- Very good policy and guidelines issued by Dept. of Administrative Reforms and Public Grievances
- ISCDL and IMC have invested in online apps to allow for grievance redressal (GR)– very good uptake
- Health and other sectors also have multiple GR options
- Many slum residents are happy to channel complaints through *Nagar Parishad* /similar representatives
- Good uptake of *CM-Helpline* especially among community health workers

Barriers

- Only 8% Indore HHs have internet, 63% have mobile phones; access leans toward wealthier homes, men.
- Those with basic phones or low/no literacy cannot participate in online GR or Smart City surveys.
- Unclear how privacy would be handled as more citizen data is collected/digitized for city planning use
- Except for 311-App, there are no clear response/feedback mechanisms for complaints/suggestions lodged via other channels.

3. Health Needs Assessment

Health Sector and Services in Indore

Enablers

- Building of new CHC, upgrades to PC Sethi Hospital.
- NHM mandates free care for all citizens.
- Private sector provides additional capacity.
- ASHA and Anganwadi services have grown in Indore.
- NHM has helped to bring in support for many essential health services.
- NCDs are catered to in two public clinics and several private facilities.
- Multiple public health insurance schemes available to urban poor, and new "Modicare" Ayushman Bharat should expand coverage.

Barriers

- UPHC open-times and locations not accessible to many citizens.
- Lack of awareness/use by lower income patients of free services.
- Delayed payments/compensation for free public care.
- Little connection between public and private sector.
- Private sector lacks regulation.
- Lack of qualified providers, particularly in public sector.
- High vacancies among UPHCs, ASHA and other primary health workers.
- Stockouts of key medicines, both for infectious diseases and NCDs.
- Only 23% of urban MP households were covered by insurance schemes (IIPS and ICF 2017).

Services for Underserved Populations

Enablers

- Informal settlements located close to middle-class neighborhoods benefit from improved city services and infrastructure.
- Social protection schemes including ration cards, old age pension, Aadhar program, health schemes, employment schemes, housing assistance, skill training, disability pension.
- Interest in participating in community incentives for physical activity/exercise.
- Smart Cities engaged community groups on issues of waste management and in some cases, sanitation.

Barriers

- Dangerous conditions in neighborhoods - poor drainage and infrastructure for storm and waste water, narrow roads and lanes, unsafe pedestrian infrastructure.
- Lack of land rights for informal settlements and housing tenure for those with undocumented status.
- Low knowledge of social protection schemes among lower income brackets.
- Many UPHCs and Anganwadi centers are not accessible for these communities, due to distance and operating hours.
- In informal settlements, focus on and understanding of healthy environments was limited to immediate risks.
- Understanding of the long term risks of malnutrition, tobacco chewing, smoking, and alcohol consumption was low.
- Lack of continuity of care and low compliance with clinical care recommendations for chronic disease.

Health Engagement by Non-health Actors

Enablers

- 6 of the 7 city sectors interviewed said that they have a role to play in improving urban health.
- City officials suggested ideas for their sectors to engage with health, focused on prevention and advocacy.
- City officials suggested ideas to improve health and quality of life in Indore including: female empowerment; making health for all a universal right; improving equity through area-based allotments; and supporting the health sector by improving retention of specialists in outreach centers and enhancing training and support for frontline workers.
- Initial provision by the MP state government to provide counselors in all departments of all hospitals.
- Happiness is an important measure of Smart City's success, and health is tied to happiness.
- Interviewees suggested any future work for Smart Health should cover youth to old age.

Barriers

- Need for an investment case to be made for more routine engagement
- Skilled health workers still needed to provide prevention services, even if provided via workplace, city campaign.
- Doctors being called away by the state government for other tasks further strains the health system.
- MP state government provision to provide counselors was reduced to one counselor per facility.

Coordination, Management, and Funding of Smart City Indore and the Sectors Related to Health

Enablers

- Smart Cities funds programs in education, housing, transport, environment, solid waste management, water and sanitation, public safety, and social protection. Good multi-sector engagement on SPV committee and forum.
- Smart City special purpose vehicle (SPV) increases funding flexibility.
- Interest in involving the health sector in Smart City initiatives in the future.
- Public-private partnerships in solid waste management, water and sanitation, and transport and parking.
- Online portals for tendering process and bid tracking – MP procurement system and SMARTNET.
- Indore has performed well in spending allocated funds, coming in second in 2017.

Barriers

- Five sectors are not included in Smart Cities – 1) ICDS, 2) pollution control (their data are used for Smart City reporting), 3) field publicity, 4) commerce, and 5) health.
- Health sector stakeholders are not invited to participate in any public policy processes—not just Smart Cities.
- Top-down policy process, from the state and national levels.
- Health is managed through the district rather than the municipality, complicating decisions about who should represent Indore.
- Smart City M&E framework are still in development, with current reporting only on procurements.

Environmental Health (Water, Air, Soil)

Enablers

- ISCDL plans to clean the Saraswati and Kanh tributaries to the Kshipra River.
- Indore was designated as the cleanest city in India in 2017 and 2018.
- Good municipal treatment facilities and household connection to waste-water city systems.
- Recent advances in access to improved toilets for slum dwellers contributed to an "open defecation free" designation in the city.
- Indore has built more than 17,000 household toilets and nearly 200,000 community toilets.
- Mechanized road sweeping reduces air pollution.
- Middle-class residential areas and slums alike are receiving attention.
- ISCDL has made reduction of air pollution a priority.
- The city has experienced modest improvements in air, noise, and water pollution.

Barriers

- Only moderate plans for technological interventions improving low air and water pollution scores.
- Poor storm drainage.
- Water improvement plays a small role in Smart City activities.
- Lack of knowledge of air, water, noise, and soil pollution as a barrier to healthy living.
- Pollution control sector is not involved in Smart Cities.

ANNEXURE 6

Key Issues for Validation:

- What other Indore data are available on environmental health? Any other concerns about this issue?
- How can the private health sector engage in Indore? Any data available?
- What incentives are being put into place to reduce worker vacancies in the public health sector?
- Are there Indore-specific social protection schemes beyond the national campaigns?
- Is there a need for more food and nutrition policies and programs in Indore? At schools, in settlements?
- How does housing rights impact people's health in settlements?
- Are there Indore e-governance guidelines?
- What information systems are used in private sector health facilities? Are they compatible with public sector systems?
- What ICT specifications or privacy firewalls across systems might affect interoperability with ICCC?
- How do citizens receive response from grievance redressal systems other than using the 311 application?
- Are there other online citizen's communication or advocacy platforms we have not captured?
- Is there data available at the neighborhood level for water, sanitation, air, and road safety?
- Is there any one sector in Indore that has fully decentralized planning and budget power?
- What information on city plans, budgets, and implementation is available to the public in Indore?
- Are there informal data sharing practices among departments that can be expanded or made routine?
- Are there opportunities for greater collective action among NGOs, CSOs?
- How will the new Livability Indicators from the Ministry of Urban Development be used in Indore/ISCDL?
- How will Smart City innovations/activities be sustained once national Smart City funds run out?
- Is there any cross-Smart City learning or sharing happening with the other 99 cities?

ANNEXURE 8

Analysis Day 1

Topic		Barriers	Enablers
Decision-making processes that directly or indirectly affect the health of Indore's citizens	1	Incomplete implementation of 74th Amendment which gives autonomy to urban local bodies	State budgetary support
	2	State oversight of performance	
Coordination, management and financing of services that affect the health of Indore's citizens	3	Urban Plan is 12 years old	ISCDL brings together multiple local and state urban service bodies at one table
	4	Health and service performance data is not shared between sectors nor is it made public	Urban Plan identifies issues and opportunities
	5	Service access often requires political intervention	Data available on health and other services at the neighborhood (locality) level
Opportunities for Smart City to address coordination and management issues	6	Limited private sector engagement to date	Significant funding
	7	Steps not yet (publicly) identified to extend operating flexibility for work in the ABD to other parts of the city and public administration	Targets one area with multiple types of projects ("Area Based Development" or ABD), and a smaller set of "pan-city" programs
Engagement of citizens, especially the poor, in matters affecting their health	8	NGOs focus on supporting access to services, less on changing policy or priorities	MP law on Public Service Guarantee to be implemented
	9	311 line more trusted by middle class residents	311 phone line functions
Citizen access to data/ICT	10	Except for 311 app, there are no clear response/ feedback mechanisms for complaints/suggestions lodged via other channels	Good uptake of CM-Helpline especially among community health workers
	11	Only 8% Indore HHs have internet, 63% have mobile phones; access leans toward wealthier homes, men	Multiple broadband providers in Indore
Use of data for city planning	12	Pre-ICCC, no regular cross-sector data review meetings in ISCDL or health, only at IMC.	ICCC is funded and set to launch in late 2018, should increase cross-sector data use
	13	Lack of M&E framework means no data on Smart City outcomes, and no benefit to city to start tracking these indicators until national M&E standards have been set	Within sectors, there is use of data for implementation and planning
	14	Shortage of trained ICT staff to support increased electronic data collection, analysis and use	Financial and physical data on progress of Smart City projects tracked monthly by ISCDL to make decisions

Topic		Barriers	Enablers
Health sector and services in Indore	15	Lack of qualified providers, particularly in public sector	ASHA and anganwadi services have grown in Indore
	16	High vacancies among UPHCs, ASHAs and other primary health workers	NHM mandates free care for all citizens
	17	UPHC open-times and locations not accessible to many citizens	Multiple public health insurance schemes available to urban poor, and new "Modicare" Ayushman Bharat should expand coverage
			Private sector provides additional capacity
Services for underserved populations	18	Many UPHCs and anganwadi centers are not accessible for these communities, due to distance and operating hours	Smart Cities engaged community groups on issues of waste management and in some cases, sanitation
	19	Low knowledge of social protection schemes among lower income brackets	Informal settlements located close to middle-class neighborhoods benefit from improved city services and infrastructure
	20	Dangerous conditions in neighborhoods - poor drainage and infrastructure for storm and waste water, narrow roads and lanes, unsafe pedestrian infrastructure	Social protection schemes including ration cards, old age pension, Aadhar program, health schemes, employment schemes, housing assistance, skill training, disability pension
	21	Understanding of the long term risks of malnutrition, tobacco chewing, smoking, and alcohol consumption is low	Interest in participating in community incentives for physical activity/exercise
Health engagement by non-health actors	22	Doctors being called away by the state government for other tasks further strains the health system	Six of the seven city sectors interviewed said that they have a role to play in improving urban health
	23	Skilled health workers needed to provide prevention services, even if provided via workplace, city campaign	City officials suggested ideas for their sectors to engage with health, focused on prevention and advocacy
Coordination, management, and funding of Smart City Indore and the sectors related to health	24	Health is managed through the district rather than the municipality, complicating decisions about who should represent Indore	Public-private partnerships in solid waste management, water and sanitation, and transport and parking.
	25	Five sectors are not included in Smart Cities – 1) ICDS, 2) pollution control (their data are used for Smart City reporting), 3) field publicity, 4) commerce, and 5) health	Smart City special purpose vehicle increases funding flexibility
			Interest in involving the health sector in Smart City initiatives in the future

Topic	Barriers		Enablers
Environmental health	26	Pollution control sector is not involved in Smart Cities	Indore was designated as the cleanest city in India in 2017 and 2018
	27	Water improvement plays a small role in Smart City activities	The city has experienced modest improvements in air, noise, and water pollution
	28	Poor storm drainage	Good municipal treatment facilities and household connection to waste-water city systems
Non-communicable diseases	29	Exposure to second hand smoke at own house or workplace or during travel is common	
	30	Extremely low (less than 1%) of eligible persons reported being screened for oral cancer or cervical cancer	

Consolidated List of Top Eight Barriers

Rank	Barriers	Max 20	%
1	High vacancies among UPHCs, ASHA and other primary health workers	16	80
2	Five sectors are not included in Smart Cities – 1) ICDS, 2) pollution control, 3) field publicity, 4) commerce, and 5) health	12	60
3	Low understanding of the long term risks of malnutrition, tobacco chewing, smoking, and alcohol consumption	10	50
4	Lack of training for non-health workers	10	50
5	Health and service performance data is not shared between sectors nor is it made public	9	45
6	Low knowledge of social protection schemes among lower income brackets	9	45
7	Dangerous conditions in neighborhoods - poor drainage and infrastructure for storm and waste water, narrow roads and lanes, unsafe pedestrian infrastructure	9	45
8	Task-based accountability for better coordination and management	9	45

ANNEXURE 9

Upstream/Downstream Analysis Worksheets

Theme #: 4 Names of Group Members (3): Trupti, Neeraj

THEME: Health & Service performance Data is not shared between sectors nor is it made public

Upstream Causes:	Downstream Effects:
1. Lack of Coordination between sectors	1. Poor utilization of resources
2. Differences in priorities	2. Lack of public participation
3. Lack of transparency	3. Lack of convergences (of facilities & services)
4. Data ownership issues	4. Poor (evidence based) planning, poor quality/less authentic data
5. Poor performance (reluctant to make public)	5. Poor performance of programs
6. Poor data handling, lack of skills for analysis	
7. Fear of Media and Elected Leaders	

Theme #: 4 Names of Group Members (3): Trupti, Neeraj

THEME: Health & Service performance Data is not shared between sectors nor is it made public

Upstream Causes:	Downstream Effects:
1. Lack of Coordination between sectors	1. Poor utilization of resources
2. Differences in priorities	2. Lack of public participation
3. Lack of transparency	3. Lack of convergences (of facilities & services)
4. Data ownership issues	4. Poor (evidence based) planning, poor quality/less authentic data
5. Poor performance (reluctant to make public)	5. Poor performance of programs
6. Poor data handling, lack of skills for analysis	
7. Fear of Media and Elected Leaders	

Theme #: 16	Names of Group Members (3): Satish Saroshe, Priyanka Bhaskar, Akanksha Kalra
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THEME: High vacancies among Urban PHCs, ASHA & other primary health workers

Upstream Causes:	Downstream Effects:
1. Overburdened job profiling	1. Inadequate number of health workers
2. Lack of recruitment over the years	2. Existing staff over-burdened
3. Inadequate incentives (monetary/facilities)	3. Quality of health facility/services affected
4. Low production of doctors from medical colleges	4. Overall healthcare delivery affected
5. Long curriculum	

Suggestions:

1. Better pay, infrastructure
2. Conducting working conditions (flexible work time)

Theme #: 19	Names of Group Members (3): Minakshi Kar, S.K.Sharma
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THEME: Low knowledge of Social Protection schemes

Upstream Causes:	Downstream Effects:
1. Lack of training for all staff	1. Coverage of poor citizens with social protection schemes low
2. Service providers do not have complete knowledge of social protection schemes	2. Poor are socially unprotected
3. Staff reluctant towards their responsibilities, roles and not accountable	3. Development failure
4. Staff overburdened	4. Poor quality of life
5. Lack /under-utilization of resources (Personnel, material, financial)	5. Misuse of resources
6. Lack of coordination among staff/departments	6. Exploitation
7. Lack of publicity about schemes	

Theme #: 20	Names of Group Members (3): PS Meena, Basant Kaul
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THEME: Dangerous conditions in neighborhood-poor drainage, infrastructure for storm and waste water, unsafe narrow roads and lanes

Upstream Causes:	Downstream Effects:
1. Lack of work at grassroots level for solid and liquid waste collection and disposal in some communities	1. Water pollution and stagnation leading to breeding conditions for mosquitos
2. Inadequate infrastructure for drainage of storm and waste water	2. Health problems related to above conditions
3. Value of water not understood by citizens	3. Low coverage of beneficiaries due to non-participation
4. Inadequate collection of water after use	4. Obstacles in transport system due to above conditions further leading to air pollution
5. Encroachment of roads and lanes for various purposes	5. Poor drainage may lead to injuries, accidents
6. Lack of planning for footpaths and roads in residential settlements	

Suggestions:

1. People made aware of value of water
2. Developing water recharge system
3. Treatment of waste water for reuse

Theme #: 21	Names of Group Members (3): Sanjay Dixit, Rahul Rokade, Yogesh Choudhary,
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THEME: Low understanding of long-term risks of tobacco and alcohol use

Upstream Causes:	Downstream Effects:
1. Illiteracy and lack of awareness especially in lower socio-economic strata about harmful effects of tobacco/alcohol	1. High use of tobacco products and alcohol
2. Lack of Information-Education-Communication to control tobacco/alcohol use	2. Diseases attributable to tobacco/alcohol
3. Lack of media involvement in public awareness	3. Crime, domestic violence, road-traffic accidents (due to alcohol consumption)
4. Citizens more interested in fashion and fads	4. Unnecessary wastage of resources
5. Peer pressure (tobacco & alcohol use)	5. Economic loss
6. Easy availability of tobacco/alcohol throughout the city	
7. Government consider tobacco and alcohol products important sources of revenue	
8. Lack of stringent enforcement of COTPA and alcohol related regulations	

Suggestions:

1. More emphasis on public awareness (IEC/BCC)
2. Better media involvement
3. Stringent enforcement of existing laws; deterrent laws
4. Better utilization of available resources
5. Targeted interventions for affected persons
6. ICT interventions

Theme #: 25	Names of Group Members (3): Ravi Sharma, Rajendra Mandloi, Veena Srivastava
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THEME: Five sectors not included in Smart City Board-ICDS, Pollution, Field Publicity, Commerce & Health

Upstream Causes:	Downstream Effects:
1. Planning body do not understand these sectors important compared to other sectors	1. Interventions for these sectors not included in Smart City Plan
2. These sectors did not show interest and did not collaborate	2. Inadequate Infrastructure and low coverage of beneficiaries under ICDS
3. No mechanism to share data by these sectors with Smart City	3. Less number of air pollution measurement stations for fast-growing city of Indore
4. Less emphasis on Information-Education-Communication (publicity)	4. Citizens are aware of "Clean City-Indore" but not fully aware about "Smart City-Indore"
5. Lack of coordination with pollution board	5. Commerce sector of Indore, the commercial capital of M.P. State, not aware of Smart City Mission
6. No collaboration with commerce sector	
7. Health sector vertically funded by the State Govt. and Central Govt. Schemes	
8. Barriers and needs of Health and other sectors not shared with Smart City	

Theme #: 32	Names of Group Members (3): Sunil Sharma, Fareed Uddin
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THEME: Task based accountability for better coordination and management

Upstream Causes:	Downstream Effects:
1. Planning lacks practical aspects of intra/inter-departmental linkages	1. Unsuccessful implementation leading to public (beneficiaries) dissatisfaction
2. Poor implementation of plans	2. Poor implementation and lack of infrastructure leading to unsatisfactory results
3. Lack of infrastructure	3. Setbacks in implementation (due to ego differences)
4. Ego of different agencies	4. Wastage of time and money
5. Poor supervision and monitoring	

Theme #: 36	Names of Group Members (3): Ishant Sanodiya, Bakul Sharma
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THEME: Lack of Training of non-health workers

Upstream Causes:	Downstream Effects:
1. Lack of Policy	1. Lower accessibility of services
2. Lack of time for non-health workers	2. Low awareness about health and health facilities
3. Training of non-health workers on low priority	3. Inappropriate implementation of public health laws
4. Lack of inter-sectoral coordination	

ANNEXURE 10

Press Release

DATA VALIDATION AND SYSTEMS MAPPING WORKSHOP TO IMPROVE THE SOCIAL & ENVIRONMENTAL DETERMINANTS OF HEALTH

INDORE, INDIA, August 20, 2018: The United States Agency for International Development (USAID)-funded **Building Healthy Cities (BHC)** project in collaboration with Indore Smart City Development Limited will hold a workshop from 29-30 August, 2018 at the Radisson Blue, Indore (MP), India to explore key barriers, drivers, and leverage points to improve the social and environmental determinants of health.

The *Data Validation and Systems Mapping Workshop* will validate data gathered by baseline assessments that have been undertaken to identify key leverage points to improve health. The outputs will be used to refocus city policies, planning, and services with a health equity lens while encouraging data-driven decision-making as part of Smart City activities.

The upcoming workshop will offer an opportunity to bring together stakeholders representing government, civil society, the private sector, academia, communities, and donors, to provide a range of insights. Participants will review and provide input on BHC's data, and engage in interactive sessions to develop a systems map highlighting key leverage points for addressing social and environmental determinants of health. As stated by Amanda Pomeroy-Stevens, BHC Project Director, "This collaborative mapping process is a great way to move data off the page and into the decision-making process for the city of Indore."

Mr. Rohan Saxena, CEO of Indore Smart City Development Limited, will update the audience on various Smart City Mission development activities. This partnership project in Indore will provide an evidence-based approach to embed health within the framework of Smart Cities, ensuring that development and health go hand-in-hand. This requires sustained commitment from government departments, NGOs, private health care institutions, academia, the private sector, and citizens themselves.

According to Dr. Damodar Bachani, BHC Deputy Project Director, "Being a demonstration project, various baseline assessments were undertaken to identify issues and key leverage points to improve health, and determine opportunities for activities in the coming years. These assessments have given us useful information which will be discussed with stakeholders in this workshop and lead us to construct systems mapping and lay the groundwork for long-term, sustainable initiatives to help make Indore a Smart, Healthy and Livable City."

About the Building Healthy Cities Project

Planning for a Smart City is intrinsically linked to health: transportation, the environment, sanitation, education, recreation, technology, and the built environment all influence the health of an urban population.

Building Healthy Cities works in partnership with Smart Cities initiatives and urban health coordination structures to achieve health goals and improve metrics in infrastructure and information and communication technology projects, enhance interoperability of data systems, and increase efficiency of multisector urban spending. The project's goal is to ensure health is appropriately accounted for within the Smart City context, reduce time and costs of producing data that can influence policy decisions, and empower citizens to demand better health-related services.

Led by JSI Research & Training Institute, BHC works in three cities – Indore, India; Makassar, Indonesia; and one city to be determined in Vietnam. In Indore, activities are conducted in partnership with Indore Smart City Development Limited, which implements under the Smart City Mission of the Government of India. In April 2018, a Memorandum of Understanding was signed between Indore Smart City Development Limited and JSI, BHC's prime implementing partner, recognizing JSI's role in providing technical guidance and support to Indore Smart City activities. Additional BHC implementing partners include Urban Institute, International Organization for Migration, and PricewaterhouseCoopers Pvt Ltd.

For more information, please contact Dr. Damodar Bachani (BHC Deputy Project Director, JSI) at damodar_bachani@in.jsi.com

Building Healthy Cities (BHC) is a three-year cooperative agreement funded by the United States Agency for International Development (USAID) under Agreement No. AID-OAA-A-17-00028, beginning September 30, 2017. BHC is implemented by JSI Research & Training Institute, Inc. (JSI) with partners Urban Institute, International Organization for Migration, and PricewaterhouseCoopers Pvt Ltd. This Project is made possible by the generous support of the American people through USAID. USAID administers the U.S. foreign assistance program providing economic and humanitarian assistance in more than 80 countries worldwide.

ANNEXURE 11

प्रेस विज्ञप्ति

स्वास्थ्य मूल्यांकन और स्वास्थ्य के पर्यावरणीय रोगियों को सुधारने के लिए

डाटा मान्यता और सिस्टम मैपिंग वर्कशॉप

संयुक्त राज्य एजेंसी फॉर इंटरनेशनल डेवलपमेंट (यूएसएआईडी) -फंडेड बिल्डिंग स्वस्थ शहरों का निर्माण परियोजना के अंतर्गत जॉन स्नो इंडिया प्राइवेट लिमिटेड (जेएसआईपीएल), इंदौर स्मार्ट सिटी डेवलपमेंट लिमिटेड के सहयोग से 29-30 अगस्त, 2018 एक कार्यशाला आयोजित करेगी। इस कार्यशाला का लक्ष्य है स्वास्थ्य के सामाजिक और पर्यावरणीय निर्धारकों को सुधारने के लिए प्रमुख बाधाओं, अनुकूल स्थितियों और लीवरेज बिंदुओं का पता लगाना। डाटा वैलिडेशन एंड सिस्टम्स मैपिंग वर्कशॉप बेसलाइन आकलनों द्वारा एकत्र किए गए आंकड़ों को मान्य करेगा। बेसलाइन सर्वेक्षण के परिणाम का उपयोग स्मार्ट सिटी मिशन के अंतर्गत गतिविधियों, नीतियों, योजनाओं और सेवाओं के लिए किया जाएगा।

कार्यशाला अंतर्दृष्टि प्रदान करने के लिए सरकार, नागरिक समाज, निजी क्षेत्र, अकादमिक, समुदायों और दाताओं का प्रतिनिधित्व करने वाले हितधारकों को एक साथ लाने का अवसर प्रदान करेगी। प्रतिभागी बीएचसी के डेटा की समीक्षा करेंगे और स्वास्थ्य के सामाजिक और पर्यावरणीय निर्धारकों को संबोधित करने के लिए प्रमुख लीवरेज बिंदुओं का उपयोग करते हुए सिस्टम मैप विकसित करने के लिए इंटरैक्टिव सत्रों में संलग्न होंगे। बीएचसी परियोजना निदेशक ने कहा, "यह सहयोगी मैपिंग प्रक्रिया इंदौर शहर के लिए निर्णय लेने की प्रक्रिया में एक शानदार तरीका है।"

इंदौर स्मार्ट सिटी डेवलपमेंट लिमिटेड के सीईओ श्री रोहन सक्सेना ने स्मार्ट सिटी मिशन के अंतर्गत विभिन्न गतिविधियों पर प्रतिभागियों को अपडेट किया। इंदौर में यह साझेदारी परियोजना स्मार्ट शहरों के ढांचे के भीतर स्वास्थ्य को शामिल करने के लिए सबूत-आधारित दृष्टिकोण प्रदान करेगी, यह सुनिश्चित करने के लिए कि विकास और स्वास्थ्य साथ साथ प्रगतिशील हों। इसके लिए सरकारी विभागों, गैर सरकारी संगठनों, निजी स्वास्थ्य संस्थानों, अकादमिक, निजी क्षेत्र और नागरिकों से निरंतर प्रतिबद्धता की आवश्यकता है।

बीएचसी परियोजना के उप निदेशक डॉ दामोदर बचानी के मुताबिक, "एक प्रदर्शन परियोजना होने के नाते, मुद्दों को पहचानने के लिए विभिन्न आधारभूत आकलन किए गए और ये आकलन स्वास्थ्य में सुधार के लिए आने वाले वर्षों में गतिविधियों के अवसर निर्धारित करते हैं।

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ANNEXURE 12

Translated version of written notes given by various departments on Day 2.

Education Department

- Improvement in infrastructure of existing building of schools.
- Supply of equipment for physical activity in school garden.
- Help desk number in zonal offices of Municipal Corporation.
- Organizing awareness camps on health, nutrition, etc.
- Compulsory registration of play schools/pre-primary schools by IMC.

Integrated Child Development Services (ICDS)

- Improvement in buildings of anganwadi centers.
- New anganwadi centers in place of community buildings constructed in 1989.
- Provision of carpets, small chairs, tables, shoe rack, play-tools for anganwadi centers.
- Children-friendly paintings in government buildings and anganwadi centers.
- Building for training center with all facilities for AWW and helpers.
- Micro-plan for training based on needs and organizing training sessions.
- Health check-up of malnourished children by pediatricians (government/private).
- Health check-up of adolescent girls, pregnant and lactating women and provision of iron-folic acid and calcium tablets.

Traffic Police Department

- For smooth and safe traffic, four “E’s” are important (engineering, education, environment, enforcement).
- Identification of major crossings for building flyovers.
- Safety and required facilities in public carrier buses with affordable fares.
- Construction of cement-concrete roads is leading to increase in ambient temperature.
- Controlling alcohol consumption by reducing bars, hukka lounges, government wine outlets to reduce road-traffic accidents due to drunken driving.
- Development of transport park.
- Compulsory wearing of helmets by two-wheeler drivers.
- Three month training of persons applying for driving licenses.
- Fixed deposit money by each driver. In case of a default of not obeying traffic rules, appropriate money would be deducted from the deposit.
- Include traffic rules formally in school curriculum.

Other Points Identified for Support under BHC Project

- Organize workshop with communication and subject experts to identify key health messages and means for public awareness.
- Analysis of data on alcohol-induced violence and accidents (from City Crime Record Bureau).
- Organize thematic workshops in project year 2 with key stakeholders.

BUILDING HEALTHY CITIES



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