



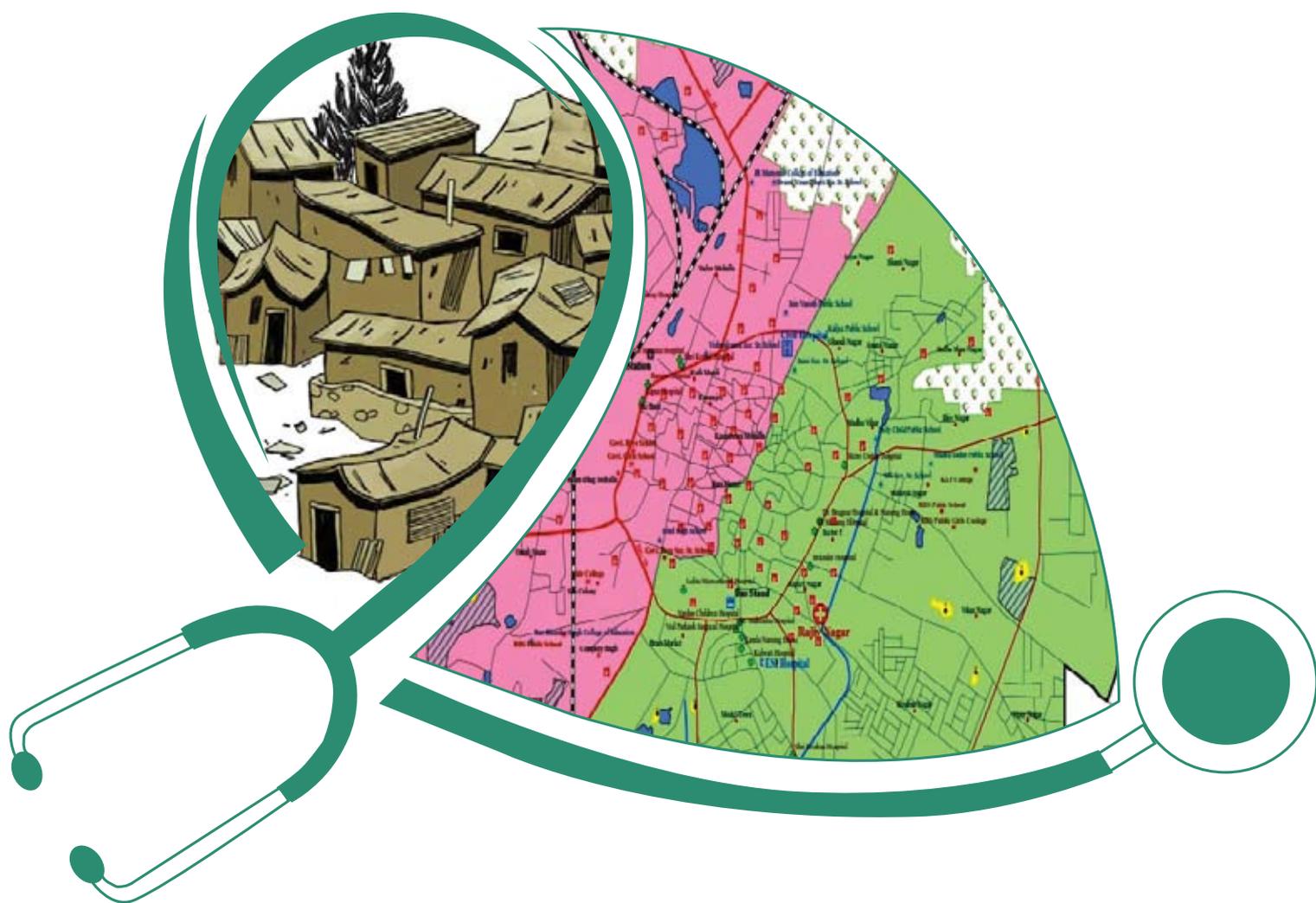
GUIDELINES AND TOOLS

for

Vulnerability Mapping & Assessment for

URBAN HEALTH

2017



NATIONAL URBAN HEALTH MISSION

**Ministry of Health and Family Welfare
Government of India**



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सी.के.मिश्रा
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Secretary



भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
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Government of India
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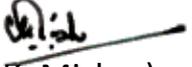
PREFACE

The goal of the National Urban Health Mission is to “improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality healthcare through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies”. As the urban poor are at the core of the Mission, the first essential step is to understand their needs and circumstances.

Inadequate basic amenities, exposure to infections, overcrowding, poor sanitation and lack of water, electricity, education, nutrition employment render the life of the urban poor extremely difficult and prone to ill-health. Infact, illness is a manifestation of the harsh urban conditions in which the urban poor live. Therefore, it is essential that these conditions are systematically understood and documented, to be addressed by the health system effectively.

Vulnerability Mapping and Assessment is the process by which the location, access to basic amenities and the susceptibility of the urban poor towards illness can be understood. Vulnerability mapping reflects the health administration’s approach to pro-actively reach out and understand the issues of the urban poor. It is the mechanism by which the actual needs of the urban poor are reflected in the plans and budgets of the health administration.

I hope this Gudeline will serve well in understanding the problems faced by the urban poor and help States and ULBs in planning for NUHM better.


(C.K. Mishra)



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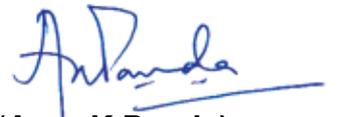
Foreword

Urban areas are quite heterogeneous. Each city, zone and ward have issues unique to that area. Within each city there are pockets where populations with special needs are concentrated – such as construction workers, domestic workers, commercial sex workers, rag pickers, migrants, domestic workers etc.

These groups face specific health challenges due to their occupation, location, type of housing. They have to cross various social, physical and financial barriers in accessing healthcare services. These groups need to be identified to understand their specific health needs and challenges faced in accessing health services, in addition to other basic services such as water, sanitation, nutrition etc. The process of vulnerability assessment underlines the interconnectedness of health and its many social determinants such as water, sanitation, solid waste disposal, access to electricity, livelihoods etc.

It is envisaged that the planning and implementation process under NUHM must start from conducting a baseline assessment of the vulnerabilities faced by the urban poor. This process, to be conducted by community health workers, guided by the UPHC team, in collaboration with the municipal administration shall also lay the foundation of convergence in the Mission.

I reckon that these Guidelines shall be a very useful resource for health planners, program officers as well as the UPHC team in developing a strong understanding of their target population and making effective plans for urban health.


(Arun K Panda)

Healthy Village, Healthy Nation





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Acknowledgement

To effectively respond to the needs of the urban poor and vulnerable, it is essential to have knowledge of the existing situation and the gaps in service delivery. Towards this end, the '*Vulnerability Mapping Guidelines and Tools under NUHM*' is a much-needed document by which we can not only locate the physical presence of our target population, but also 'map' their needs, barriers, disease profile, social determinants, coping mechanisms and perceptions towards public services.

The Guideline has been developed after several rounds of deliberations and discussions. The discussions highlighted that there have also been other schemes and programs in the past for the urban poor which have conducted similar assessments. It will be of course very valuable if States are able to utilize those assessments also to understand the status of health determinants.

In the process of development of the guideline, we received valuable inputs from several experts and officials. I am grateful for the tireless hardwork of the Urban Health team at the Ministry, in particular Ms. Preeti Pant (Director, UH), Dr. Adil Shafie and Ms. Seema Pati for reviewing and finalizing this Guideline. My sincere thanks to Dr. Himanshu Bhushan, Ms Aastha Sharma and the PHA team at NHSRC for defining the process of Vulnerability Assessment and giving the document its current shape. I also thank PwC consultants in developing the first draft of the Guideline. I also thank Dr. Basab Gupta (Deputy Commissioner, UH) and Dr. Ranjana Garg (Assistant Commissioner, UH) for their valuable inputs to the Guideline. I take this opportunity to thank all other experts who contributed in developing this Guideline.

The specific objectives of this guideline are to locate existing healthcare services, understand the accessibility and responsiveness to the needs of vulnerable populations, identify and map different categories of vulnerable groups, services, infrastructure and environmental issues and to understand health issues, health needs and health seeking behaviour of vulnerable groups.

I urge all States and ULBs to utilize this Guideline in mapping their urban populations, particularly the vulnerable and those living in slums and marginalized. Further, it is imperative that the outcome of the mapping process is duly utilized in focusing and improving health service delivery, especially outreach and referral services under NUHM and convergent actions required from other departments and ULBs.

(K. Rajeswara Rao)

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Introduction



The National Urban Health Mission (NUHM) is a sub-mission of National Health Mission (NHM) which envisages addressing the health care needs and reducing out of pocket expense of the urban population with a special focus on the urban poor and vulnerable. It aims to strengthen the urban primary health care system, establish strong outreach linkages with vulnerable population, and facilitate convergent action towards other social determinants of health.

Convergence with various schemes relating to the wider determinants of health such as urban development, drinking water, sanitation, education, nutrition implemented by other ministries and departments is the other pivotal strategy of this Mission (NUHM).

To effectively respond to the needs of the urban vulnerable, and plan for, efficient outreach, referral services, facility based services the knowledge of the following elements is essential:

- ◆ Identifying and mapping the vulnerable
- ◆ Awareness base of the habitat of the urban poor and other vulnerable groups
- ◆ Assessing the degree of their vulnerability
- ◆ Capacity and spread of existing public & private health facilities and their location and catchment area
- ◆ Services rendered by other departments especially those meant for the urban poor
- ◆ Geographical variations and other social as well as environmental determinants and convergent planning towards the same

To understand the above elements, NUHM envisages undertaking 'Vulnerability Mapping and Assessment' in urban areas so that the location of the Urban PHCs/CHCs and sites for Outreach Services may be optimally planned and health

care services can be organized as per the needs of these vulnerable groups.

PURPOSE OF CITY MAPPING AND VULNERABILITY ASSESSMENT

Mapping and Vulnerability Assessment is the first step in planning for urban outreach health services in the Cities/Towns. It is a process of understanding the available resources, service gaps and health needs of the urban residents, with a deliberate focus on the special needs of the vulnerable groups.

THE SPECIFIC OBJECTIVES OF THIS GUIDELINE ARE AS FOLLOWS

- ◆ To identify and map different categories of vulnerable groups (slums, mobile population, etc.) vis-à-vis services, infrastructure and environmental issues.
- ◆ To understand health issues, health needs and health seeking behavior of vulnerable groups.
- ◆ To understand the barriers faced by the poor and marginalized in accessing services.
- ◆ To locate existing healthcare services, understand the accessibility and responsiveness to needs of vulnerable populations.
- ◆ The utilization of maps and the information generated are to be detailed out in Chapter III.

It is essential to note that 'Vulnerability Mapping and Assessment' is not to be seen as one time activity. Cities may be required to revisit the exercise on a periodic basis so as to revise the plan for conducting Outreach and Special Outreach services. This may not be extensive exercise and can be conducted in a sampled way as an annual exercise which can be linked to the annual planning and budgeting process.

City Mapping & Vulnerability Assessment: Overview of Process



City Mapping and Vulnerability Assessment are two components of the 'Planning and Mapping' Component under NUHM. Although inherently linked, the two have different objectives and methodologies.

I. CITY MAPPING

This is a geographic or spatial mapping of the city specifically denoting aspects relevant to urban health (detailed in later section). The objective is to get an accurate map of the city with all geographic information relevant to NUHM. These include knowledge of location of all health facilities (public and private), their catchment areas, slums with population, Anganwadi centers, educational institutions (public and private) Municipal and ward boundaries, major road networks, major landmarks, agriculture land, major water bodies etc.

City Mapping will help the urban health team in understanding the location of slums vis-à-vis health facilities, spread and distribution of urban slums and vulnerable pockets, geography of the city. This will help in:

- ◆ Rationalizing the location of health facilities (UPHCs and health kiosks in particular).
- ◆ Ensuring that vulnerable populations are provided adequate services.

States may conduct city mapping either through GIS or through a manual consultative process. While GIS mapping of cities is recommended, it may also be undertaken through government departments specializing in remote sensing and spatial mapping or by outsourcing to private agencies. Alternatively, states may conduct the mapping exercise manually, by obtaining a current map from the city administration such as urban development municipal affairs etc and updating

it through physical verification. For physical verification, the city may be divided into zones or clusters, and a mapping team assigned to each cluster. This team shall update the map for their zone through discussions with key informants and field visits.

II. VULNERABILITY ASSESSMENT

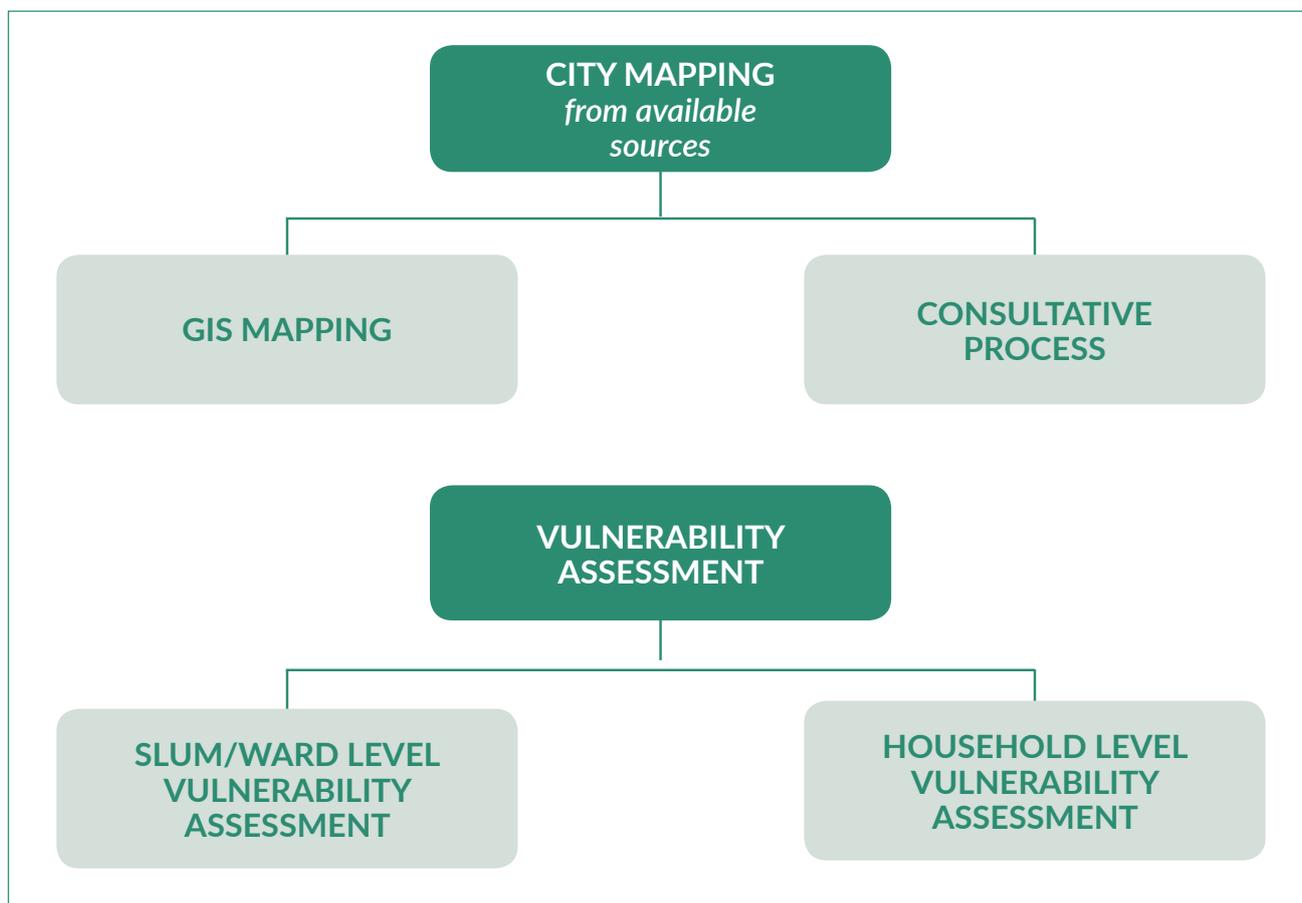
This is a qualitative assessment of the vulnerability status of wards, slums and slum households in the city, to understand the vulnerability status of a particular slum and each household in the slum. This process will be conducted at two levels, namely, Slum level vulnerability assessment and Household vulnerability Assessment:

1. Slum or ward level Vulnerability Assessment: Teams (comprising ASHA, ANM, PHM (Public Health Manager at UPHC), RKS members, ULB members) for each city zone (ward or UPHC catchment area, or cluster) need to be identified to undertake slum level group discussions. The tool for slum/ward level VA has been provided as an annexure in this document. It is also mentioned in the "Induction Training Module for ASHAs in Urban Areas (at Annexure 12)" and in "Induction module for Mahila Arogya Samiti (MAS) (at Annexure IV)."
2. Household level Vulnerability Assessment: States may decide whether to undertake survey of the entire urban population or of the urban slum and vulnerable population only. However, as part of the UPHC's mandate, the UPHC staff must visit each house for a survey to register the family and maintain health card. The exercise can be merged with the Vulnerability Assessment process and a common demographic and vulnerability survey may be conducted by the UPHC

team. Urban ASHAs may be incentivized to conduct the survey. It is also mentioned in the “Induction Training Module for ASHAs in

Urban Areas (at Annexure 12)” and in “Induction module for Mahila Arogya Samiti (MAS) (at Annexure IV).”

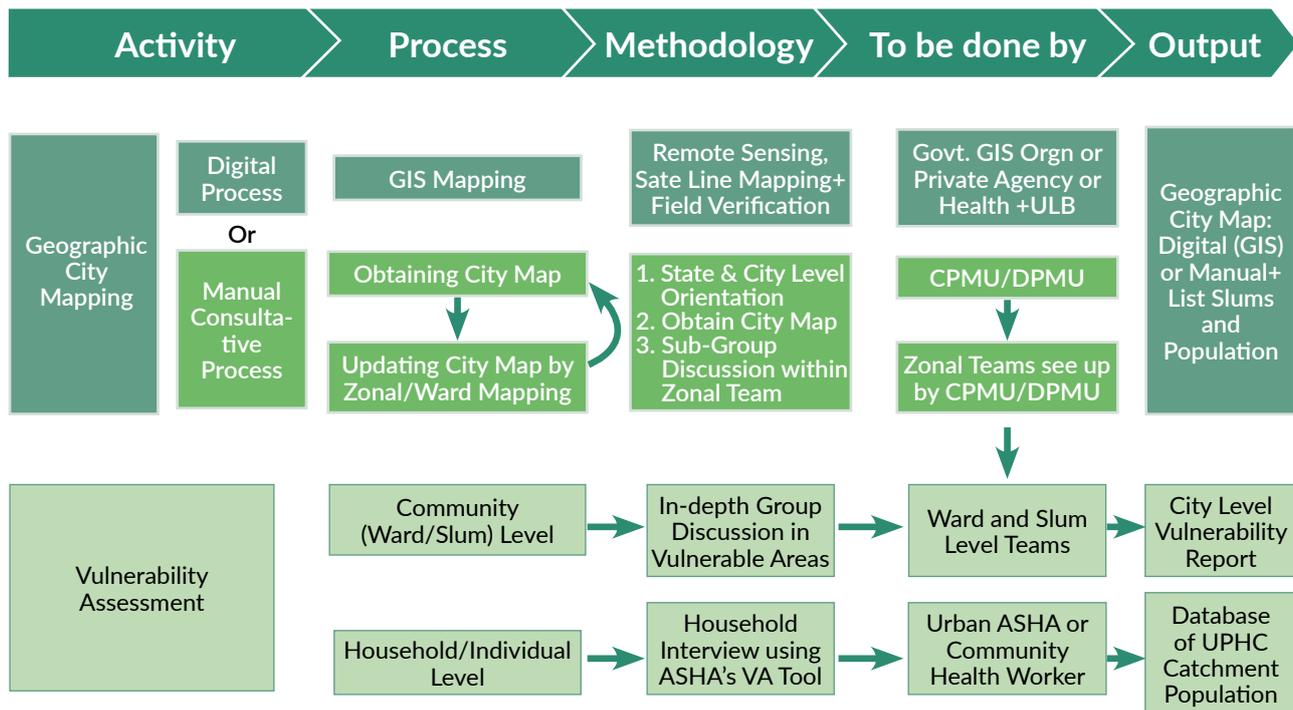
Figure 1: Flowchart of City Mapping and Vulnerability Assessment



A gist of activities for Mapping/Vulnerability Assessment:

- ◆ State orientation
- ◆ District Orientation
- ◆ Obtaining the city map from various available sources.
- ◆ Ideally the map should first be updated through GIS mapping or through consultation process by setting up zonal, ward or UPHC teams.
- ◆ Then with updated map, in-depth group discussions be held in the slums and vulnerable pockets.
- ◆ A parallel action for household assessment can be initiated, preferably for all households or for urban vulnerable only, as per the states specific need Capacity & Requirement.
- ◆ Additional information during household survey can be obtained by ASHAs in slums or vulnerable pockets.
- ◆ Steps such as FGDs and household survey can be undertaken concurrently with the existing map.

Figure 2: Process and Methodology of City Mapping and Vulnerability Assessment



City Mapping



City Mapping is geographic or spatial mapping of the city specifically denoting aspects relevant to urban health. The objective is to get an accurate map of the city with all geographic information relevant to NUHM. City Mapping will help the urban health team in understanding the location of slums vis-à-vis health facilities and other services, spread and distribution of urban slums and vulnerable pockets and the geography of the city etc. This is essential for:

- ◆ Rationalizing the location of health facilities (UPHCs and health kiosks in particular).
- ◆ Ensuring that vulnerable populations are provided adequate services within easy reach, through facility based and outreach services.
- ◆ Plan for referral services, adequate vehicles and referral transport network.

The city map may essentially depict the following elements:

- ◆ Location of slums, slum like habitation and vulnerable pockets with population: Spread and distribution of slum settlements (location of settlements of notified, un-notified, mobile population/migrants, etc.).
- ◆ Health facilities of all types (primary, secondary and tertiary, public, private, charitable) and their catchment areas (if demarcated).
- ◆ Anganwadi centers
- ◆ Administrative boundaries (administrative divisions such as zones, municipal ward boundaries, Government land, private land, etc.).
- ◆ Environmental features (agriculture land, water bodies, natural drains, landfill sites, low lying areas).
- ◆ Physical infrastructure (major road networks, major landmarks, factories).

In addition, it is desirable, though not essential to depict the following elements also:

- ◆ Community infrastructure developed under programmes such as RAY, JNNURM etc.
- ◆ Educational institutions (public and private).
- ◆ Other services (orphanages, old age homes, night shelters, de-addiction centers etc.).

METHODOLOGY FOR CITY MAPPING

For conducting City Mapping, the state may follow any of the two methodologies:

1. GIS Mapping
2. Manual Mapping

1) GIS Mapping

Geographical Information Systems (GIS) is a computer system for capturing, storing, checking, and displaying data related to positions on earth's surface. GIS can show many different kinds of data on one map, such as streets, buildings, and vegetation, which enables people to more easily see, analyze, and understand patterns and relationships. GIS mapping provides maps to scale of the city, with exact locations of slums, vulnerable areas, health facilities and all major infrastructure in the city.

These maps also indicate distances of vulnerable areas from health facilities and the approximate populations living in these habitations. GIS maps enable visualizing correlations and distances of multiple features on one map, through various 'layers' of elements mapped. Funds available under planning and mapping may be used for the above purpose. GIS mapping may be done by:

The following elements may be reflected on the map:

- ◆ List of all state, ULB/Govt. public health facilities in urban areas.
- ◆ List of all functional U-PHC with catering areas.
- ◆ List of Major Private Health Facilities.
- ◆ List of slums with population.
- ◆ List of community structures built under other deptt programmes like RAY, JNNURM etc.
- ◆ List of Anganwadi Centres in the slum areas.
- ◆ List of government and private educational institutes.
- ◆ Municipal and ward boundaries.
- ◆ Available major Road Network.
- ◆ Major Landmarks
- ◆ Agriculture Land
- ◆ Incorporation of available major water bodies.

The above figure shows the sample GIS mapping of Rewari City. The legend on the right shows the range of information depicted on the map. The map also shows a list of slums and their approximate population.

2) Manual Mapping

City Mapping may be done manually by holding an orientation at the state/district level where the requirement for having a vulnerability mapping can be explained to all stakeholders. The mapping exercise provides a good opportunity to involve

all the urban stakeholders and partners in the urban planning process, and sensitize them on the challenges of urban health. The broad steps for this process are detailed below:

1. State level orientation.
2. Obtaining existing city maps from relevant department.
3. City Level orientation.
4. Identification of Zone/Ward/Cluster in City.
5. Formation of Zonal Teams.
6. Preparation of maps by the teams.
7. Collating information from the area maps into the city map.

1. **State level Orientation:** To initiate the City Planning and Vulnerability Assessment Process in the state, the officials responsible for the process as well as all the supporting stakeholders need to be oriented on the process. It is recommended that the state organize a state level orientation for all urban health officers as well as other program officers at the state, city and district levels on the Mapping Process.

It is recommended that the orientation begins by developing a broader understanding of NUHM Program and urban health issues in the state. During the orientation the complete process of mapping and vulnerability assessment may be shared with all the stakeholders to enhance their involvement and participation in the process.

STATE LEVEL	
Objective	<ul style="list-style-type: none"> ◆ Orient officers in the SPMU, DPMU and CPMUs, ULBs, and other collaborating departments (WCD, Water and Sanitation, PHED etc.) on the process of mapping and vulnerability assessment. ◆ Entrust responsibility for undertaking the mapping and vulnerability assessment processes for the city.
Participants	<ul style="list-style-type: none"> ◆ State level urban health staff. ◆ City and district level urban health staff. ◆ State level program officers. ◆ ULB officials of larger cities. ◆ Representatives from ICDS, water and sanitation, PHED and other social determinants.

STATE LEVEL

Content/Process	<ul style="list-style-type: none"> ◆ Overview of NUHM program components. ◆ Overview and significance of mapping and vulnerability assessment. ◆ Orientation on the process of mapping and vulnerability assessment. ◆ Devolution of responsibilities for undertaking the exercise in respective cities.
Key Outputs	<ul style="list-style-type: none"> ◆ Clarity on the design and process of mapping and vulnerability to all the participants. ◆ Urban Local Bodies and other department facilitating the mapping process. ◆ Finalize timelines for taking up district/city orientations, mapping and VA.
Timeline	<ul style="list-style-type: none"> ◆ Consultation to be undertaken preferably prior to the initiation of the PIP process.

The responsibility of the mapping process at the city level shall be with the urban health team, with active participation of State/District/ULB, particularly in the case of metro cities. ULB officials who shall be in-charge of implementing NUHM need to be oriented as much as the health staff.

2. **Obtaining the City Map by Urban Health Team in city or district:** After the state level orientation, the Urban Health PMU (whether DPMU or CPMU) must start the process of city mapping for the given city. The first step in this direction would be to obtain the existing

city map from city or district administration. City maps available with the ULBs or other city development authorities may be obtained. These maps may be available either in form of a paper map or in a digital format. It may be ensured that the city maps will have to be updated to reflect the existing realities.

3. **City Level Orientation:** After the state level orientation, the city level orientation needs to take place. The city urban health staff, oriented at the state level, shall orient the city level stakeholders on the process of mapping. State may also undertake Joint orientation of the State/District/City teams wherever possible.

CITY LEVEL ORIENTATION

Objective	<ul style="list-style-type: none"> ◆ A one day orientation may be held with objective of explaining: <ul style="list-style-type: none"> ● Methodology of city mapping & vulnerability assessment. ● Roles and responsibilities of key stakeholders.
Participants	<ul style="list-style-type: none"> ◆ Representative from Urban local bodies. ◆ Representative from department of Women and Child, Water & sanitation etc. ◆ UPHC staff – MOs, PHM, ANMs. ◆ NGOs/CBOs and Others (as identified by DPMU/CPMU).
Responsibility	<ul style="list-style-type: none"> ◆ District/City -Urban Health Nodal Officer. ◆ District NHM Nodal Officer/Chief Medical & Health Officer CMHO under the guidance of State Urban Health Nodal Officer as the case may be.

CITY LEVEL ORIENTATION

Content/Process	<ul style="list-style-type: none"> ◆ Formation of city teams to conduct VM at Zonal/Ward level: <ul style="list-style-type: none"> ● Zone wise team for mega and million plus cities. ● Clusters wise team as available for polio micro plan, ICDS cluster, ward wise etc.
Key Outputs	<ul style="list-style-type: none"> ◆ Clarity of roles and responsibility of the stakeholders at the City, Ward and Slum (settlement) level. ◆ Division of City into zones. ◆ Formation of Zonal Teams. ◆ Detailed instructions to zonal teams shall be given on the specific elements to mark on the map, and the standard legend symbols to depict them. ◆ Planning of activities and consensus on timelines.
Timeline	City Level Orientation to be held immediately after the state level Orientation.

Each CPMU or urban health team at the DPMU shall be responsible for coordinating and managing the Mapping Process in their city or cities. Suitable arrangement may be made, in case there is more than one city under NUHM in a district. The DPMU must identify or designate the nodal person responsible for coordinating the mapping process for each city.

The District or City Level Orientation shall be similar in content to the State Level Orientation, with district and city level stakeholders, and a more in-depth and detailed description of the process specific to that city or district. The following steps may be followed for conducting mapping at the city level.

4. **Identification of Zone/Ward/Cluster in City:** The city may notionally be divided into zones/cluster/divisions for undertaking the mapping exercise, in consultation with all stakeholders. It is the prerogative of the states to decide the best of making the city divisions. Some of the suggested options are as follows:

- ◆ **Ward:** For small and medium sized cities, the health department may utilize the ward as the division. As a pre-existing division, it would be easy to get commitment from the ward members, and there would

be defined personnel responsible for a particular ward.

- ◆ **Group of Wards:** For larger cities, a division may also be a group of more than one wards, and may be called a cluster, zone or division.
- ◆ **UPHC Catchment Area:** The city may be divided in terms of UPHC catchment areas, with the conditionality that no pockets are omitted from inclusion. The entire city population must be covered by one UPHC or the other. This is also advantageous as there would be a defined team at the UPHC who can take the lead in the mapping process. This would facilitate vulnerability assessment, as detailed later, and serve a dual purpose. UPHCs already have dedicated staff, who would be directly involved in the mapping process.

It may be ensured that all areas have been covered while mapping and no area is left out.

5. **Formation of zone/cluster/ward teams at the City level:** Each team be assigned a division (zone/cluster/ward) to undertake the mapping in that zone. The team may comprise of 3-8 members, depending on the area to be mapped. The suggested members are as follows:

- ◆ Medical Officers from UPHCs in the zone.
- ◆ Public Health Manager from UPHC in the zone.
- ◆ ANMs from UPHCs in the zone.
- ◆ Officials from ULB/concerned department.
- ◆ NGO members.

The state, district or city may add any other members suited to the task, as per their requirement.

6. **Preparation of maps by the teams:** The objective of these teams is to get accurate detailed information so as to update the geographical map of the area. The teams shall gather, available services with location, infrastructure and geographical information i.e. forest water bodies etc., types of vulnerable population in their zone to update the map. The information/data may be obtained through other sources as:

- a. **Secondary sources:** viz., Census Data, ward maps, Data from Immunization Programme, ICDS, City Base Map City Base Map online maps (e.g. Google maps).

- b. **Internal Discussions:** among the team members familiar with the area/zones.
- c. **Discussions with other informants:** such as MAS members, ASHAs, ground level municipal staff, community leaders etc.
- d. **Conduct physical visits in the zone:** The Urban Local Body or the Town/City Planning Department or other similar bodies may be reached out to assist with the process.

The map may reflect approximate distance between the various points which are important for the delivery of health services.

7. **Collating information from the area maps into the city map:** The area wise map prepared by each of the teams to be collated/aggregated to get an overall map of the district/city. The CPMU/DPMU shall need to coordinate with each zonal team for aggregating information gathered by them. The final output shall be an updated city map.

Vulnerability Assessment



DEFINING VULNERABILITY

Vulnerability Assessment in the context of NUHM means assessing the level of vulnerability of a slum or household towards ill-health. *What factors put a household at a greater risk of falling sick?*

It has been well established that various vulnerable groups face disproportionate burdens of ill-health. Vulnerability is commonly associated with poor economic and nutritional status, but many other overlapping social vectors such as quality of housing and public services, occupation, gender, disability, marital status, age, stigmatized and debilitating ailments and many other aspects are not recognized.

The different criteria are as follows:

- i) **Residential or habitat-based (spatial) vulnerable** include persons/households vulnerable to ill-health because of their residential location and type of housing. These include persons who are homeless, mobile (migrants), living in kutcha/temporary houses, shanties, facing insecurity of tenure, unnerved or under-served with basic public services like sanitation, clean drinking water and drainage. This will also include population living near hazardous industries, sewage lines, in areas prone to landslides or flooding, people living on roadsides, under ridges, flyovers, along railway tracks, in institutions like night shelters, homeless recovery shelters, leprosy homes.
- ii) **Social vulnerability** is faced by people who are discriminated based on their social status, ie, their caste, class, ethnicity, religion, gender, age, disability or illness etc. Such vulnerabilities are faced by women, transgender, senior citizens, child-headed households, disabled persons, persons suffering from debilitating illnesses HIV/AIDS, Leprosy, TB, mental illness, persons belonging to scheduled castes and

scheduled tribes, migrant workers, religious minorities etc.

- iii) **Occupational vulnerability** is faced by persons/households who are without access to regular employment, susceptible to significant periods of unemployment, as well as those who face occupational hazards due to unsafe working environments. They may many times work as bonded, semi-bonded workers working in undignified and oppressive conditions. These include informal unorganized workers in hazardous occupations such as rag pickers, rickshaw pullers, head loaders, construction and factory workers, commercial sex workers, domestic workers and even self-employed service providers with marginal incomes such as vendors and beggars.

After having developed an understanding of vulnerability and its causes, States may undertake Vulnerability Assessment. Vulnerability Assessment has also been mentioned in the **Operational Guidelines for Conducting Outreach Services in Urban Areas**, and in **Induction Module for Urban ASHAs**. It may be conducted at two levels:

- A. Ward/Slum level
- B. Household Level

A. Ward/Slum Level Vulnerability Assessment

This entails collection of specific ward level information identifying concentration of vulnerable groups at the ward level. A toolkit may be used to collect the requisite information on vulnerability as mentioned in annexure I/II/III. As a part of the Ward Level vulnerability assessment, the following info may be collected:

- ◆ Social characteristics of population: literacy, presence of schools, presence of NGOs/CBOs, occupation.
- ◆ Healthcare services: availability and accessibility to primary health care, anganwadi centers, outreach services, barriers related to access all health related services.
- ◆ Infrastructure: housing, availability of water, electricity, sanitation facilities.
- ◆ Health conditions prevalent in community.
- ◆ Community expectations and preferences with regard to the organization and access to health care.
- ◆ Distribution of vulnerable groups, and concentration of homeless people.

a) Methodology for Ward/Slum Level Vulnerability Assessment

In order to roll out the process of ward/slum level Vulnerability Assessment, the following steps same as in the section of the city mapping may be undertaken:

1. **State Level Orientation:** As described in previous section.
2. **City Level Orientation:** As described in previous section.
3. **Formation of zonal teams:** As described in previous section.

The main objective is to divide the/District/ City into manageable divisions and assign team for each zone/division for holding group discussions in vulnerable areas.

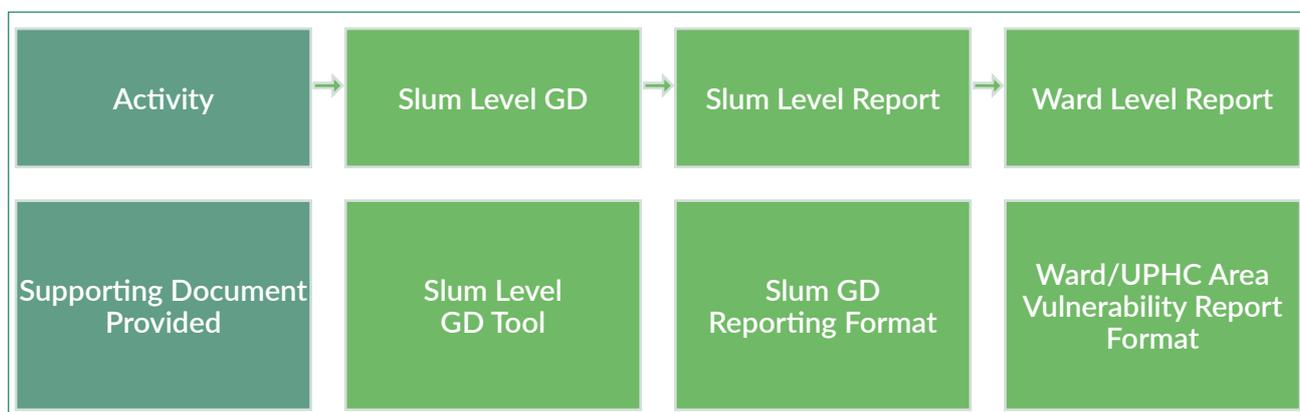
4. **Group Discussion by Ward/UPHC Teams:** The Ward/UPHC team, led by a team-leader, shall conduct group discussions in the area/each div/zone at each slum and vulnerable pocket in the division. Active MAS members may also be involved to support the Group Discussion (GD) activities.

Discussions may also be conducted with specific vulnerable groups such as ragpickers, elderly, commercial sex workers, domestic workers, street children, construction and factory workers, homeless persons (and others as specific to the city) to understand their specific and diverse health issues and health seeking behavior. For an effective discussion it is recommended to have 8-15 people per GD. State may also like to involve NGOs/CBOs in the process. **The findings of the GDs may be mentioned at the format given Annexure III.**

5. **Collating information of Ward/UPHC Area Vulnerability Report & Submission to CPMU/DPMU:** the DPMU/CPMU shall collate the area level vulnerability assessment for each area to enable outreach services accordingly.

The findings of all group discussions held within one area may be collated in the format as in annexure III.

6. **Collating information of all Ward/UPHC Area Vulnerability Reports into City Vulnerability Report by CPMU/DPMU:**



After receiving all the Ward/UPHC area vulnerability reports, the CPMU/DPMU shall compile all the reports into a City Vulnerability Assessment Report'. The suggested format for City Level Vulnerability Report is also attached in Annexure III and IV.

The following table summarizes the process of conducting this assessment.

VULNERABILITY ASSESSMENT AT WARD/UPHC AREA	
Key Respondents	Slum dwellers and other urban vulnerable communities as per local situation.
Responsibility	Each team may hold GDs in the identified area. Group Discussions to be facilitated by Zonal/Cluster/Ward/UPHC teams.
Process	The assessment will be through Group Discussions at each slum. The group discussion is to be carried out using the tools provided at Annexure II for reference.
Key Outputs	Area Vulnerability -Ward/UPHC. All Ward/UPHC Vulnerability Reports of each area to be collated for Outreach/special outreach compiled into City Vulnerability Assessment Report.
Timeline	The assessment may be conducted within a reasonable time frame.

B. Household/Individual Level Vulnerability Assessment

Household level vulnerability is essential to understand the service needs of the urban population. While the term household has been used to mean an 'individual' or family based survey, the survey shall also cover urban vulnerable who fall outside the purview of a household – such as the homeless, street children and other such groups.

The state may opt for a complete urban population survey (which is ideal) or only cover the urban poor and vulnerable population. It is highly recommended that the entire population be covered by the survey, with priority given to the urban poor, as NUHM is ultimately responsible for addressing the health needs of the entire urban population.

It is essential to undertake this survey to:

- ◆ Understand the population to be covered in terms of numbers and age groups.
- ◆ Understand the extent and type of existing morbidities among beneficiaries.
- ◆ Enroll all the urban households as beneficiary of the UPHC.
- ◆ Make the beneficiaries aware of the UPHC and its services, and encourage them to avail services.

a) Methodology of Household/Individual Level Vulnerability Assessment

States may choose to conduct assessment of either the entire urban population or only of the poor households. They may also outsource the activity to competent external agencies with appropriate instructions. These options are explained below:

1. **Complete Urban Population Survey:** States are recommended to conduct a survey of the entire urban population covered by NUHM. The survey must give priority to the urban poor and vulnerable, including migrants, homeless and those living in institutions. The survey shall collect information on social indicators, living conditions and morbidities. For this survey, the city may be divided as per their UPHC catchment area, and each UPHC made responsible for covering their catchment population.

A database of all households and individuals covered may be maintained by the UPHC. While the list may be obtained from existing sources (such as Census, Election Commissions House list, Pulse Polio list), a team comprising of the ASHA/link worker, community organizations/NGOs supervised by the ANM and the Public Health Manager must visit each house to obtain basic details of

demographic data in a prescribed format. The Vulnerability Assessment may be linked to the activity, and data for Vulnerability Assessment of the urban population may be collected during the process of household survey by the UPHC team.

The survey should capture:

- a) **Basic Demographic Data:** name of each member, age, sex, relationship with head of household, occupation, education, number of children under 5, immunization status, pregnant women with ANC history, eligible couples.
- b) **Vulnerability Data:** current access to primary healthcare services, living conditions (status of water, sanitation, residence, location), current and past morbidities.

The Urban ASHAs may be additionally incentivized for conducting the survey. Conducting this survey will also help the urban ASHA and other UPHC staff in understanding their catchment population.

2. **Household Survey of Urban Poor:** Only those residing in slums, slum-like habitation, low income groups, homeless and other categories of urban vulnerable shall be covered by this survey. It is very important that before conducting this survey, the mapping of the city has been completed, and line-listing of all slums and vulnerable pockets has been done. The program team should ensure that no vulnerable pockets are left out from the survey. Most likely, all the urban vulnerable population shall be covered by ASHAs, who shall conduct this survey under the supervision of the ANM. If some vulnerable pockets are not covered by any ASHA, the ASHAs may be additionally incentivized to cover them.
3. **Outsourcing to competent external agencies:** The state may also outsource the entire process of household/individual vulnerability assessment to a competent external agency, an NGO or an organization specializing in surveys. The state to ensure that the data is reported in appropriate formats.

HOUSEHOLD LEVEL VULNERABILITY ASSESSMENT	
Key Respondents	Households/Individuals from slums and vulnerable population.
Responsibility	UPHC Team or urban ASHAs (as decided by the state) (if all urban households).
Process	<p>The process shall differ in case the state is undertaking Complete Urban Household Survey or only Vulnerable Household Survey:</p> <ul style="list-style-type: none"> ◆ Complete Survey: Demographic data collection cum Vulnerability Assessment. ◆ Vulnerable Survey: The assessment will be done using the tool provided in the 'Induction Training Module for ASHAs in Urban Areas' (as annexure 12 in page 150). The tool is presented at Annexure IV for reference. <ol style="list-style-type: none"> 1. Listing of slum settlements in the U-PHC catchment with demographic details. 2. Orientation of ASHAs and MAS members. 3. Field data collection planning. 4. Data collection.
Key Outputs	Database of UPHC Catchment area population (complete or only vulnerable) according to level of vulnerability.
Timeline	10-15 days per ASHA catchment area. Accordingly, timeline will be planned for the entire slum settlement/U-PHC catchment area.

Utilizing Mapping & Vulnerability Assessment for Better Planning



Comprehensive baseline information on the slums, mapping of slums and vulnerable pockets around the city set the foundation for effective planning of delivery of health care services for a given area population.

The integration of the vulnerability mapping exercise with the mapping of the health facilities would complement the overall planning exercise and assist in the following areas:

- i. **Site Planning for new UPHCs:** The uncovered and the left out pockets of the vulnerable populations may be the priority for locating new UPHCs under NUHM. Alternatively, such pockets may need Mobile Medical Units - MMU (like PHC on wheels), till the time a new UPHC comes up. Also, existing facilities which have many vulnerable pockets and population, may need additional Human Resource and additional supplies of drugs and vaccines.
- ii. **UHND:** A detailed assessment would help prepare an effective micro plan for Urban Health & Nutrition day with a fixed site and personnel (AWW, ANM & ASHA) in the city.
- iii. **Special Outreach:** Specific interventions directed towards Outreach in the vulnerable pockets of the city would need data on characteristics of vulnerability and the need of these vulnerable groups. This would facilitate to better plan and organize Outreach and Special outreach service. The community structures available may be utilized might require setting up of make-shift kiosks, delivering opportunistic health care services systematized as per the migration cycles, seasonality of health risks and other key factors typical to the vulnerable groups.
- iv. **Community Process:** The mapping exercise will assist in robustly defining the catchment

area under the ASHA/ANM/PHC and also build capacity suited for delivering services as per the needs of the vulnerable groups under her coverage. It would additionally serve as a link towards demand-generation between the health facility and the urban slum population.

- v. **Public Private Partnerships:** Partnering with private providers especially non-profits to deliver innovative and efficient health care services to suit the population specific needs might be a useful strategy. Therefore, health service delivery could be strengthened by establishing effective linkages with private facility for uptake of those services which are not available at the UPHC.
 - vi. **Role of ULBs:** Vulnerable pockets reporting health issues related to drinking water, drainage, sanitation and solid wastes, may be taken up with the ULB for more focused preventive actions.
 - vii. **Convergence:** UPHC in urban areas may emerge as the hub for providing primary health care services under the various different national health programmes for eg. blindness, tuberculosis, vector borne diseases etc. besides providing comprehensive primary health care services.
- It is also essential to establish systems for Inter-sectoral convergence with Departments of Urban Development, Housing and Urban Poverty Alleviation, Women & Child Development, School Education, Minority Affairs, Labour through city level Urban Health Committees headed by the Municipal Commissioner/Deputy Commissioner/District Collector.
- viii. **Capacity Development:** The district/city would need to prioritize training and capacity

development for the officials and different categories of staff within the UPHC towards undertaking vulnerability assessment, service delivery, program management, HMIS etc. This exercise would assist the urban planners in shaping plans for resource mobilization and effective managerial and technical capacity building of clinical and non-clinical staff.

- ix. **Surveillance and Monitoring and Evaluation:** Vulnerable pockets with a history of frequent outbreak of diseases (like hepatitis, gastroenteritis, and dengue) may necessitate identification and notification of field health functionaries (for reporting on Form-S)

and laboratories (for reporting on Form-L) under IDSP.

- x. **Referral Transport Network:** City Mapping and Vulnerability Assessment shall provide an in-depth understanding of the location of available services vis-à-vis the location of vulnerable pockets. This will help the health officials in planning towards a robust referral network, connecting the supply with the demand. Based on population estimates and health burdens, the adequate number of vehicles, their location, human resources and best mechanism for coordinating referral chain can be planned better.

Tools for Vulnerability Mapping & Assessment for Urban Health

Guidelines and Tools for Vulnerability Mapping
& Assessment for Urban Health

VULNERABLE GROUPS AND COMMUNITY PROCESSES

II. About Vulnerable People as Community

S. No.	Questions and Probes
1. General Information	
1.1	Since when you all have been staying here?
1.2	Where do you all come from? Same place or distance places?
2. Social Category	
2.1	<p>Do you identify yourself as being part of a specific community? If yes, please tell which community you belong to?</p> <p><i>(This question reveals the understanding of members about their community identity with respect to caste, religion, occupation, geography, or any other shared services).</i></p>
3. Housing	
3.1	What kind of houses are mostly available in your community (Pakka/Kutchha)?
	Do most of the people live in self owned or rented houses?
3.2	Are there any threats of being displaced from here? Of fire, or floods or physical dangers of any other sort.
4. Occupation	
4.1	What is the common occupation or occupations of your community? Are there any other occupational groups in your area? (list different types of occupation of the community).
4.2	Are people living in your employed throughout the year? If not, how many days on an average do they work for a year?

III. About Health Issues and Health Services

S. No.	Questions and Probes
1. Health Issues	
1.1	What are the general health problems that your community face?
1.2	What do you think, are the causes for your health problems?
2. Access to Health Services	
2.1	How far is the nearest health facility? Does the community face any problems in access to care in these facilities?
2.2	Where do people from the community generally go at the time of any health problems (Public or Private Health facility)? Give reasons for why you chose the specific health facility?
2.3	Kindly list the services provided in the nearest public facility? <i>(Probe for availability of doctors, drugs, diagnostics, any other)</i>
2.4	Where do women often go for delivery services (Public/Private)? Why? <i>(Probe reasons w.r.t to availability of services, access, quality of care, cost, etc.)</i>
2.5	Are there any outreach camps like Immunization, ANC camps being organised in your area? If yes, then what is the frequency for the same? Do women and children from your community go to avail services from these outreach camps? <i>(probe for reasons)</i>
2.6	Is there any frontline staff (ASHA/ANM etc.) assigned for your community? <i>(Discuss to find in case there is an ASHA/ANM, is she from there community, how regularly she imparts the desired services and any other related issues)</i>
2.7	Are there patients suffering from Tuberculosis/Diabetes/Hypertension in your community? What is their experience with access to care and drugs?
2.8	Is there any insurance scheme available for the families in your community? Do you have a card for it? Which members of the family are covered and which are left out? Do you know what the sum assured is and in which hospitals you are eligible to free care? Have you made use of the card to get any free services so far? If so the details? If you or family members have been ill but despite this unable to access free services- what are the reasons?

IV. Access to Other Services

S. No.	Questions and Probes
1. Electricity Status	
1.1	Do most of the houses have metered electricity connections? If yes, how many hours' there is face power-cuts generally in a day?

S. No.	Questions and Probes
2. Availability of Water	
2.1	If there is availability of drinking water in your community? What are the different sources of water? Where do you go to if there are problems in access and how responsive are the authorities on this?
3. Availability of Toilets	
3.1	Are there toilets in your community (public or individual)? If yes, are they being used by the community? If no, why?
4. Waste Management System	
4.1	Where do people dispose their solid wastes/rubbish in your locality? If authority regular clears the waste from your locality? (<i>probe to understand if there is a designated place for waste disposal, frequency of clearance of waste and any other issue associated with waste</i>)
5. Public Distribution System	
5.1	Do people have ration card in your community? If yes, do they utilize the service of Fair price Shop? (<i>if, yes, probe for quality and availability of service, if no, probe for reasons for not utilizing the services</i>)
6. Anganwadi Centre	
6.1	Do you have an ICDS Centre (Anganwadi) in the neighbourhood? If yes, what service are available at the AWC? Do mothers and children regularly avail services from them? If no, why?
7. Schools	
7.1	Do children go to school in your community? If no, why? (<i>Probe for non-availability of school, issue pertaining to access, quality, drop-out, child labourer, etc.</i>) If yes, where does most of the children go for schooling (private/public/NGO/Trust school)? Why? How far is the school?
7.2	Are there school health programmes implemented in your community? If yes, how often does doctor or nurse come- are they aware of the school health programme at all?

V. NGOs in Action

S. No.	Questions and Probes
1.	Are there NGOs/CBOs in your areas?
2.	What are the different interventions NGOs/CBOs are working in your areas?
3.	Are there community groups (SHGs/others) made by NGOs/CBOs in your area? Please describe since how long they exist, what different activities it does and how?

Annexure B: Ward Level Vulnerability Assessment Tool



a. General Details

Name of the State				
Name of the City				
Name and number of ward :				
INTRODUCTION AND INFORMED CONSENT				
Namaste,				
My name is _____ and I am working with (NAME OF ORGANIZATION). Our organization is assisting the state government in conducting health vulnerability assessment as part of the National Urban. Health Mission (NUHM) in various cities across the country. One of the main objectives of the NUHM relates to ensuring that vulnerable population in a city have access to primary health care services. We are conducting this discussion to understand the health vulnerability of different wards of this city. We are trying to assess how different aspects related to a ward, such that would make the people living in the ward vulnerable with reference to health.				
(NAME OF ORGANIZATION) has invited you all for today's discussion to assess the vulnerability of the (WARD NAME) with reference to health. This assessment will be done by using a tool, which covers various aspects including location of slum and status of housing, availability and accessibility of basic services like water supply, drainage and toilets, nature of occupation/employment, access to health services, and education. We will discuss the ward's situation with reference to the questions of the tool and provide an answer that is agreeable to everyone. The information provided by you would be kept confidential and used only for the purpose of research and programme planning.				
S. No.	Participant Name	Designation	Dept./Organisation Representing	Duration of Work in the Area
Date of discussion				
Name of facilitator				
Name of recorder				

b. Demographic Details

S. No.	Questions	Response			
		Female	Male	Total	
1.	Total population of the ward				
2.	Number of slums in the ward	Listed	Unlisted	Total	
3.	Population of people living in slums	Listed	Unlisted	Total	
4.	Are there migrant population in the ward	Yes <input type="checkbox"/> No <input type="checkbox"/>			
5.	If Yes, population details of migrant in the ward	Outside state	Within state	Total	
6.	Are there homeless people in the ward? If yes please mention their approx. population. (People living in pavements, under flyovers, alongside railway track etc.)	Yes <input type="checkbox"/>	Population:		
		No <input type="checkbox"/>			
7.	Please mention approximate literacy in the ward	Non-Slum Location		Slum Location	
		Male	Female	Male	Female
8.	Number of public/Govt. and Private schools in the ward	Govt.		Non-Govt.	
9.	Number of AWC in the ward	Total	Functional	Non-Functional	
10.	Number of public health facilities in the ward	Primary		Secondary/tertiary	
11.	Number of Non-Governmental health facilities in the ward	Primary		Secondary/tertiary	
12.	Number of diagnostic centres/Labs with facilities like x-ray, blood and urine testing in the ward				
13.	Categorization of major disease outbreaks	Malaria.....1 Diarrhoea.....2 TB.....3 Dengue.....4 Other.....5 None6			
14.	Number of FLW in your ward	ANM:	ASHA:	AWW:	

15. S. No	23. Occupational Vulnerability Category			24. Location of closest PHC	25. Location of closest AWC	26. Location of closest Primary School	27. Availability of Potable water	28. System of Drainage	29. Availability of metered electricity connection
	23a. Informal/ Unorganized Sector	23b. Hazardous Industries	23c. Type of Work						
Instructions									
23a. Informal/Organized Sector: Mention for majority of the population, Rag picker/sanitation workers=1, Rickshaw pullers=2, head loaders/ construction worker=3, commercial sex workers=3, child labourers=4, street hawkers=5, others=6 (pl specify). Mention all that applies.									
23b. Hazardous Industries: Mention '1' if a majority of population work in hazardous industry (e.g. chemical, leather, firecracker, paint, pesticide, printing, etc.), else mention '0' if not applicable.									
23c. Type of Work: mention the category of work majority of population does, daily wage=1, seasonal=2, Self-employed permanent=3.									
24. Location of UPHC: 1=if less than half kilometre or 0=more than half kilometre.									
25. Location of closest AWC: 1=if less than half kilometre or 0=more than half kilometre.									
26. Location of closest Primary School: 1=if less than half kilometre or 0=more than half kilometre.									
27. Availability of Potable water: 1= there is regular availability of potable water through piped water of Govt. tankers or 0= if availability is not there or irregular.									
28. Drainage facility: 1=No drainage facility, 2=proper drainage facility, 3=available but not maintained.									
29. Availability of metered electricity: 1=available, 0=not available.									

Annexure C: Vulnerability Assessment Tool for ASHAs



Household Information

- | | | |
|-----------------------------|---|--|
| 1. Address/Location | : | |
| 2. Respondent Details | : | |
| 3. Date of Survey | : | |
| 4. Name of ASHA/MAS Members | : | |

Section I- Residential Vulnerability

1. Slum Status

- 0 Homeless shelters/roadside/railway tracks
- 1 Unauthorized Settlement/Land belonging to local authority/Leased Land
- 2 Own land/authorized quarters/Registered slum

2. Migration Status

- 0. Seasonal/Recent migration (Less than one year)
 - 1. Living in the area from last few years (1 to 5 years)
 - 2. Living in the area from more than 5 years

3. Location of the Household

- 0. Hazardous location besides dumping ground, polluted water, railway line or airport
 - 1. Slum dwelling with high population density, poor ventilation, limited space
 - 2. Adequate ventilation and space

4. Housing

- 0. Kutcha house with weak structure, No separate space for cooking, minimal ventilation
 - 1. Fairly pukka but with mud/tin roof and non-cemented walls/brick walls with plastic or thatch roof; marginally better than earlier category
 - 2. Permanent structure, ventilation present, separate space for cooking

5. Basic Services: Toilet

- 0. No toilet, defecation in the open by all-men, women and children
 - 1. Use common/community toilet, do not have bath facilities
 - 2. Majority have private/defined space for bathing and toileting

6. Basic Services: *Water*
 0. No piped water supply, use community taps/tankers etc., irregular supply
 1. Use community taps or hand pumps, have regular water supply
 2. Have individual water pipe
7. Basic Services: *Drainage*
 0. No drains, clogged drains with open pits
 1. Open drains-kutchra or pucca
 2. Underground connected drains and paved roads
8. Electricity
 0. No electricity connection at all
 1. Illegal electricity connection
 2. Metered individual electricity connection

Section II- Social Vulnerability

9. Type of Family
 0. Child Headed household/Women headed household/Single parent family/Single male
 1. Nuclear Family with only one earning member with informal employment
 2. Joint family with one earning member with regular income or more than one earning member with regular or irregular incomes
10. Social Support Mechanisms
 0. Living far from the family, no social support available at all
 1. Living alone in the area but people from your community are living nearby
 2. Living with family
11. Disability Status
 0. Member with chronic disability/debilitating illness like TB, AIDS, Cancer, Kidney failure
 1. Household member suffering from mild impairment but functional
 2. No member with disability
12. Identity Proof
 0. Do not have any documents
 1. Have at-least one legal documents (BPL Card, Ration card, voter ID, Aadhar Card etc.)
 2. Have all the necessary documents
13. Episodes of harassment by any Groups in Power
 0. Very often
 1. Rarely
 2. Not at all

14. Nutrition

- 0. Children are not enrolled in Anganwadi centre (AWC) and no access to PDS ration
- 1. Government ration not available but children are enrolled in Anganwadi centre
- 2. Children enrolled in AWC and access to PDS/Government ration

15. Education: Children and Adults

- 0. Children in the household do not attend school and adults are illiterate
- 1. Young children going to school but drop out in other children, adults with minimum/functional literacy
- 2. All children pursuing elementary education and adults also have minimum elementary condition

Section III- Occupational Vulnerability

16. Employment Pattern

- 0. Daily wage earner with irregular pattern, daily wages below Rs 150
- 1. Daily wage earner with regular employment, daily wages up to 150-500
- 2. Regular employment or irregular employment with daily wages more than Rs 500

17. Occupational Conditions

- 0. Hazardous working conditions like rag picking, sex trade, mining, recycling waste collectors, construction workers, engaged in bidi making, matchbox making
- 1. Engaged in unskilled and semi-skilled jobs like street vendors, casual labourers, domestic workers
- 2. Private or government regular job with monthly wages, shopkeepers

Section IV- Health Related Vulnerability

18. Proximity to the Health Facility

- 0. more than 2 kilometres
- 1. within the range of 2 km
- 2. Less than 1 km

19. Status of Health and Health Services

- 0. Reported history of maternal death/child death/death due to TB, Malaria or other infectious diseases in last five years
- 1. Poor health status of the family/individual e.g. Reported cases of diarrhea, TB or any other disease
- 2. No case of illness at the time of survey

20. ANM Visit

- 0. Never
- 1. Once in 3 months
- 2. Monthly

21. Health Seeking

0. Do not take treatment in case of illness
1. Go to local practitioners/quacks/stores
2. Go to government facilities/registered private doctor

<p>Cumulative Scoring 0-15= Most vulnerable 16-30= Highly Vulnerable 31-42= Vulnerable</p>

Section V- Categorization

Tick if you find the households/families falling in any of these categories:

Categorization	
Rag Picker	
Head loaders	
Daily wage labourers	
People involved in Begging	
Elderly poor	
Women/child headed household	
Debilitating illnesses- HIV/AIDS, TB, Leprosy etc.	
Street Children	
Sanitary workers	
People living in institutions like night shelters, homeless recovery shelters, beggars home, leprosy homes	
Rickshaw puller	
Construction workers	
Homeless	
Domestic workers	
Widow/deserted women	
Differently Abled	
Sex workers	
Trans-genders	
People with mental illness	
Any other, Please specify _____	



National Health Mission
Ministry of Health & Family Welfare
Government of India