

NEED ASSESSMENT FOR URBAN HEALTH IN SLUMS OF JAIPURDr. Manoj Kumar

ABSTRACT

This paper attempts to analyze the spatial distribution of Health Care Delivery System with a focus on Reproductive Child Health and its relation to geographical distance from the slum population. The socio- demographic profile and its correlation to the barriers for accessing the health-care is also attempted. The suggestions include removing spatial inequities, a region specific plan for health care for increasing accessibility of the inhabitants in the slum and designing an integrated and sustainable primary healthcare service delivery with emphasis on improved family planning, maternal health and child health services in the urban poor living in slums.

INTRODUCTION

Slum are characterized by poverty, dilapidated housing, over crowding, concentration of lower class, racial segregation, crime, health problems, broken houses, alienation and an unhygienic environment. Different terms have been used for slums in different cities and countries. In India, they are known by various names. For example, in Delhi they are known as *Katras*, *Gallis*, *Jhuggi- Jhopadpatti*. Similarly, they are known as *Chawls* in Mumbai, *Ahatas* in Kanpur, *Bustee* in Calcutta, *Cheris* in Chennai, *Keris* in Banglore and *Kachhi Basti* in Jaipur. A definition of slum is offered in the report on urban land policies of United Nations: “.....a building, group of buildings, or area characterized by over-crowding, deterioration, insanitary condition or absence of facilities or amenities which, because of these conditions or any of them, endanger the health, safety or morals of its inhabitants or the community”.

The word 'health' can be defined in terms of what people are able to do (i.e., functionally). It may be related as, optimal functionally, or the ability to do things (Dandiya, 1997), World Health Organization defines, "Health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity".

It has been observed that the health indicators (MMR, IMR, TFR, etc.) of the urban slums are far worse than the urban average. The provision of quality primary health services in urban areas has emerged as a priority in view of increasing urbanization and the growth of slums and low-income populations. Urban health is one of the identified thrust areas for RCH Programme. Special attention for improving health and family welfare services in urban areas, particularly in slums needs to given.

SOCIAL FRAMEWORK OF JAIPUR SLUMS

According to census, 2001 Jaipur slums has a population of 368,570 persons (about 16% of the city's population) including 194,762 males and 173,808 females; the sex ratio recorded is 892 females per 1000 males, inhabited in 211 slums (164 Municipal slums and 47 JDA slums) spread over an area of 467.32 sq km. The density of population recorded as 789 persons per sq km. There are 49.35 per cent literates. Nearly 181,885 persons literate and educated. Total numbers of slums household in the city are around 67,062. Total slum population among the cities is highest in Jaipur. Largest numbers of slum dwellers are living in the limits of the Jaipur municipal corporation, which alone account for 29 percent of slum population of the state.

The numbers of total health institutions in Jaipur city are 56 including 18 District Hospitals

(4288 beds) (Annexure-1), 1 Community Health Centre (30 beds) and 37 Dispensaries with the facilities of the family welfare centres.

Table: 1 Growth of Slums, Population, Households, Person Per Household and Comparison Between In Slums & Outside Slums (Years 1971-2001)

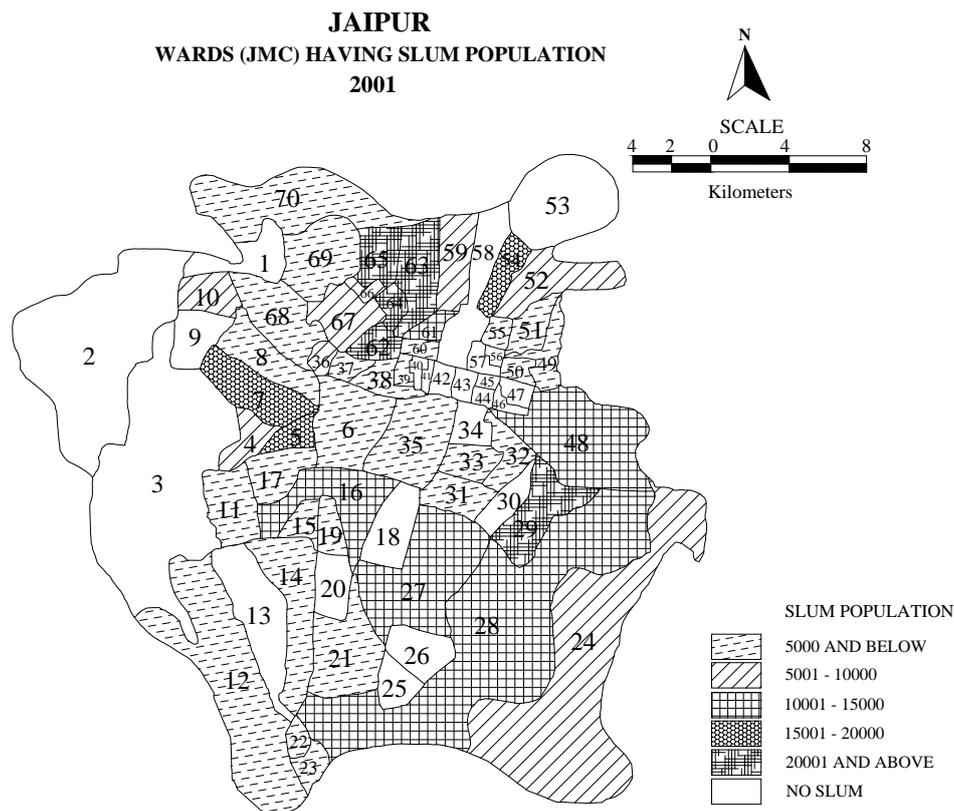
	Year- 1971	Year- 2001
No. of slums		
(i) Municipal	36 (33.03)	164 (77.73)
(ii) UIT/JDA	73 (66.97)	47 (22.27)
Total	109 (100)	211 (100)
City population		
(i) In slums	96604 (15.8)	368570 (15.16)
(ii) Outside slums	513968 (84.2)	1955749 (84.14)
Total	610572 (100)	2324319 (100)
No. of households in the city		
(i) In slums	20661 (28.4)	67062 (16.4)
(ii) Outside slums	87324 (71.6)	341826 (83.6)
Total	107985 (100)	408888 (100)
Persons per household in the city		
(i) In slums	4.8	5.5
(ii) Outside slums	5.9	5.7
Total	5.7	5.7

Source: Jaipur Profile of A Changing City, 1977 & Census, 2001

Table: 2 Numbers of Government Health Institutions and Their Bed Capacity

Health Institution	Year- 1971	Year- 2001
(i) District Hospitals	9 (2015 beds)	18 (4288 beds)
(ii) Other Health Institutions	30	38
Total	39	56

Source: Jaipur Profile of A Changing City, 1977 & Census, 2001



Source: Census, 2001

SOCIAL PROFILE

In this study in all 180 female respondents, 10 from each slum viz. haji colony, mali colony, sudamapuri, jhalana gram, jhalana talai, kishanbagh naya khera, fauji nagar, indra jyoti nagar, qureshi colony, harijan basti balanand path, bhomia basti, gujar ghati kachhi basti, firdos basti, kagdiwala kachhi basti, rajeev nagar, bajrang nagar, triveni nagar, saint kanwar nagar harijan basti have been studied.

So far as the age of respondents was concerned, they were found in various age categories. However, the number in lower age groups, that is between 25 years to 35 years were higher than in the age group above 35 years. The earlier notion was that only schedule caste and other backward caste people inhabited slums, but substantial number of general and schedule tribe people also reside slums. As the study revealed among the interviewed respondents, percentage of OBC (33%) and schedule caste (22%) respondents was found maximum, followed by other caste respondents, there were only 5.56% general caste and 11.11% schedule tribe respondents in the sample. Among other religious groups Muslim respondents residing in slums were found in substantial number (about 22%).

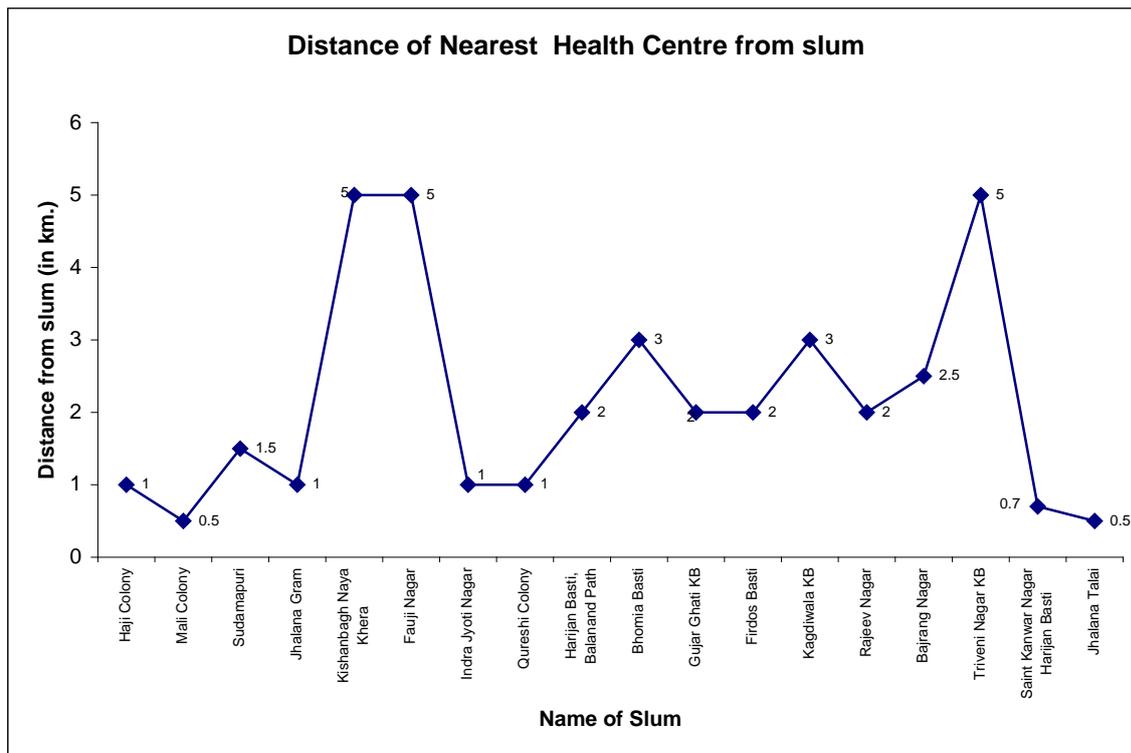
It was also revealed that about 27.8% sample respondent are educated, and the percentage of illiterates is 72.2%. The percentage of educated respondents was found maximum at mali colony, indra jyoti nagar, qureshi colony. While classifying literacy among the respondents on the basis of caste we find that the literacy among the general caste respondents is much higher than that of other castes.

HEALTH FACILITIES AND DISTANCE FROM SLUM

The spatial organization of health care facilities located in the urban areas is quite imbalanced in their distribution. Our data revealed that out of 18 slums, in 2 slums there is no government health institution in their vicinity. These slums are kishanbagh naya khera, triveni nagar kachhi basti. The data also revealed that there is no TB clinic in 4 slums, no Obstetricians and Gynecologist in 5 slums, no Aganwadi center in 5 slums (ie. kishanbagh naya khera, fauji nagar, gujar ghati kachhi basti, firdos basti and saint kanwar nagar harijan basti), and in 4 slums (ie. Jhalana gram, bhomia basti, bajrang nagar, saint kanwar nagar harijan basti) birth practices and deliveries were conducted by untrained birth attended.

The distance between the health centres and slums was found in the range below 3 km and in 1 slum namely fauji nagar the distance was above 5 km. The slum dwellers prefer to walk in 0-1 km and prefer to go by bus or auto in 1-3 km and in distance above 5 km they prefer by bus.

According to the satisfaction level of health institutions and the health staff, in Jhalana gram, the maternity home and obstetrician services is of very poor level, while in firdos basti gynecologist and mali colony, the Aganwadi centre is not satisfactory.



AILMENT IN THE FAMILY

Because of the poor unhygienic conditions respondent's family members suffer from one ailment or the other. Out of the total respondents interviewed, 35 percent families were suffering from one ailment or the other. The instances of ailment were recorded more at haji colony, qureshi colony, kishanbagh naya khera, harijan basti balanand path. Women and children, because of their longer duration of stay in hazardous environment of the slum were found to be more prone. The physical environment in the slum is not congenial for good health, and because women have to devote longer duration of time in slum environment because of their family obligations, they along with the children, are the greater sufferers of physical ailment.

Family members of the slum dwellers suffer from the various types of diseases. Maximum numbers of them suffer from vector borne disease (i.e. chickengunia (14.7%), malaria (11.8%), and dengue (3.0%). The major long-term diseases were tuberculosis (3.0%), blindness (1.9%) leprosy (0.8%). Other important diseases were fever, pneumonia and gastric ailments. The duration of the disease varies from few days to one year or more. The study revealed that more than 50% of the members were suffering for more than a year, whereas 30% members were suffering for more than 6 months duration. It is thus revealed that due to economic reasons the people do not go to the doctor for immediate treatment. They initially

take self-prescriptive medications; take advice from quacks and their number if maximum in the middle age group 30-45. Its only after the condition becomes too critical they visit a doctor. During course of field work it was noticed that a migrant family whose member was suffering from some chronic ailment, had gone back to the village to worship and appease a particular deity. This indicates that urban exposure has not changed their faith from traditional practices.

Though there are quite a number of hospitals and dispensaries, both government and private are available, yet large numbers of slum dwellers treating their patients at home. As private clinics are beyond the economic reach of these poor people, they prefer to go to the government hospital for treatment, which are usually affordable but qualitatively not up to the mark, moreover, it is time consuming also. This shows that quality treatment is beyond their economic reach. This is also one of the reasons of prolonging of illness.

MATERNAL HEALTH

The safe motherhood is one of the major components of Reproductive and Child Health (RCH) programme, initiated by the Ministry of Health & Family Welfare since 1996. Under the RCH programme antenatal care, natal care, post-natal care and management of unwanted pregnancies are provided through Government facilities. Provision of safe deliveries in the Government health institutions is one of the components of the RCH programme.

Maternal mortality is on average 18 times higher in developed countries compared to developing countries¹. In addition to the number of deaths each year, over 50 million women suffer from maternal morbidity due to acute complications from pregnancy².

Maternal mortality and morbidity continue to be high despite the existence of national programs for improving maternal and child health India. This could be related to several factors, an important one being non-utilization or under utilization of maternal health-care services, especially amongst the rural poor and urban slum population due to either lack of awareness or access to health-care services. Understanding of the knowledge and practices of the community regarding maternity care during pregnancy, delivery and postnatal period is required for program implementation. Perceived barriers to maternal health care utilization in hospitals/ health centres among the participants were (multiple responses) as follows: thinking that health checkup is not required (28%), long waiting time (19%), lack of knowledge about available services (17%), financial constraints (10%), working (9%), fear of hospital care (7%), none to accompany (7%), and objection from family (3%). The reasons

¹ Revised 1990 Estimates of Maternal Mortality: A new approach by WHO and UNICEF. WHO: Geneva; 1996

² The Progress of Nations. UNICEF: New York; 1996

for the differences might be due to differences in the literacy levels or presence of better primary health care facilities in the surrounding areas.

For timely identification of and treatment for pregnancy complications it is necessary to have a complete monitoring of pregnancy, for which a minimum of 3 ANC visits are required and the first visit has to be in the first trimester of pregnancy. In Jaipur slums about 66.7% of the women received some type of antenatal care during pregnancy. Only 27.8% of the women had the first ANC visit in the first trimester of pregnancy. 50% women had a minimum of 3 ANC visit. Nearly 47.2% of the women were given Iron and Folic Acid (IFA) tablets and 69% of women took a minimum of 1 Tetanus Toxoid (TT) injection during pregnancy. Other essential services like checking of blood pressure, weight and abdominal check up were received by comparatively less percent of women 32, 35 and 52 percent respectively. However, the complete package of ANC services as defined by minimum 3 ANC visits, receipts of IFA tablets and minimum 1 TT injection is received by about 30% of the women. The data indicates the higher number of home deliveries varying from 50-75% amongst urban poor exposes mothers to risks and complication and delay in referral to facilities. This suggests that pregnancy; deliveries practices and immediate care of newborns are critical factors for improving their chances of survival and thriving.

CHILD HEALTH

In a disturbing trend, there is a visible decline in mortality indicators seen over the past century, either stopping or even reversing in some developing countries. More than 10 million of the 10.5 million children under age 5 who died in 1999 lived in African Asian and Latin American Nations³. The overall distribution of deaths by regions and nations reflects the gravity if the situation in those geographies, but masks the differences within their boundaries⁴.

Infant and child mortality rates reflect the level of socio economic development and quality of life. They are useful indicators for monitoring and evaluating health programs and policies. Survival patterns among the urban poor, clearly point at the need for extra focus on this large segment of India's population. About 55% of slum children are underweight. In most slums, under nutrition among urban poor is worse than in rural areas. The reach and utilization of essential preventive health services to the urban poor is abysmal. About 45% of children are not completely immunized by 1 year of age and as few as 23% children affected with diarrhea receive ORS. The study shows that there is lack of awareness or interest among few

³ United Nations Children's Fund, 2000. (UNICEF)

⁴ Gatkin, 2000 in Cleason M., and C. Griffin , 2001. Health, Nutrition and Population

slum dwellers of Jaipur for infant and child health care in spite of the availability of the health facility in the vicinity.

FAMILY PLANNING

Slum residents in urban Jaipur tend to prefer permanent spacing methods. 22% of the respondent women preferred tubectomy while 15 % of the respondent men underwent vasectomy, thus accounting for a total of 37% family planning acceptors. The greater proportion of 44.5 % slum women (30.0% using oral pills and 14.5% accepting Copper T, also inserted free) have adopted these temporary, probably to space children under advice offered to them by others. Out of 180 Respondents, 120 (66.6%) said elders reacted favorably to the fertility control measures adopted by their married children, while the 60 (33.4%) reacted against what they termed “unnatural devices”

Table: 3 Temporary Birth Control Methods Adopted

Method adopted	Respondents	Percentage	Ranking
Against Family Planning (Non-acceptors)	71	39.4	
Oral Pills	54	30.0	I
Condom	29	16.1	II
Copper-T (IUCD)	26	14.5	III
Total	180	100	

WATER AND SANITATION SERVICES

Access to water supply and sanitation facilities among the slum dweller is very poor. Public taps were the source of drinking water for 65% households, while 35% used public hand pumps and other sources. With respect to sanitation, it was observed the garbage littered the surroundings of all the squatter settlements creating unhygienic conditions. Similarly, there was no drainage/ sewerage system for waste water in 90% these settlements. About 65% households do not have a toilet. In most of the slums, the service delivery capacity of Municipal Corporation is rapidly diminishing.

URBAN SLUMS HEALTH PROJECT STRATEGIES

Under the 12th Schedule of the 74th Amendment, health services are mandated as functions of Urban Local Bodies (ULBs). Health services for the urban poor should be reconfigured in order to improve access, coverage and quality. This should include strengthening linkages between health service delivery channels and the community, as well as improving referral systems and involving private practitioners for health camps, referral services, family welfare

services, immunization, training and ICDS services need to be located in the most vulnerable slums to improve the reach of public health services.

MAJOR INTERVENTIONS PROPOSED UNDER FOR THE URBAN AREAS ARE AS FOLLOWS:

Creation of Health and Sanitation Committees

Based on the Village and Health Sanitation Committee format, Local Health and Sanitation Committees are proposed to be formed to encourage community participation for different health and sanitation interventions. This committee will not only evaluate and monitor the package of services provided and ensure the timely implementation of different interventions but also help in identification of needs and priorities.

Strengthening Networking and Partnership with the Civil Society and Private Sector

The private sector can be fruitfully engaged for service delivery to fill in gaps. The donor agencies can provide technical assistance to the program by sharing experience across the globe in urban health development and facilitate program design. The main specific interventions envisaged for support under the program are as under: -

- NGOs and private nursing homes/ hospitals may be involved in tile program including service delivery through a framework of partnership.
- Accreditation methods can be followed for private and NGO operated facilities. All facilities with in the framework should follow uniform reporting system and referral system.
- Outsourcing/ franchising of discrete services (such as diagnostics) to NGOs/ Private Sectors.

The Provision of Untied Fund for Health Centres

Minor repairs and supply of drugs and equipments of existing health posts, UFWCs, Maternity Homes, support would be provided for minor repairs including arrangements of water, electricity, drugs and equipment in existing health posts, UFWCs, Maternity Homes and all other health facilities falling within the catchment area of Jaipur slums. This will be done in the RHSDP.

The more specifically, the Programme Strategies are:

- Ensuring convergence between various health activities including outreach camps within well defined geographical urban slums and priority target groups
- Promoting effective linkages and strengthening delivery system at community, sub centre and multi-level referral service points

- Adopting best practices for health information, education and communication (IEC) for raising awareness and behavioral change
- Train and develop community based health volunteers for more efficient and effective delivery of health service to the urban poor
- Efforts to focus on the needs of the front line workers and making service providers more accountable to the community they serve particularly the urban poor
- Strengthening competence and knowledge of community level obstetric care of those untrained persons who attend to large numbers of births
- There is a need for augmenting nutrition programs such as ICDS and PDS with targeted strategies to reach the vulnerable sections of urban populations. Efforts to better address household level care of young children are also required.
- Strengthen Municipal Health Programme Capacity
- Creation of Women Health Groups
- Creation of Urban Health Institution Covering 50,00- 10,000 Populations
- Strengthening Disease Control Program

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6. S. Hasan Ansari, *Spatial Organization of Health Care Facilities in Haryana, 2005.*
7. *Slum Population, Census of India, 2001.*
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9. Upreti, H. C., *Urban Slums and Dimensions of Poverty, 2004.*
10. www.rajswasthya.gov.in

Annexure: -

1. List of District hospitals in Jaipur City

1. SMS Hospital
2. Central Jail Hospital
3. Leprosy Hospital
4. Janana Hospital
5. T B Hospital

6. Rehabilitation & Research Centre
7. Police Hospital
8. Mobile Medical & Surgical Unit (City Hospital)
9. Mental Hospital
10. Mahila Hospital, Sanganeri Gate
11. Mobile Surgical Unit
12. Yoga & Research Hospital
13. Rukmani Devi Jaipuriya Hospital
14. Shri Haribaksh Kavtiya Hospital
15. Communicable Disease Hospital
16. Satellite Hospital, Bani Park
17. Satellite Hospital, Sethi Colony
18. Sir Padampat Maternal & Child Health Institute

Source: www.rajswasthya.gov.in