DISSERTATION

IN

NUHM

(NATIONAL URBAN HEALTH MISSION)

(FEB 2014 – APRIL 2014)

A Report

ON

HEALTH SEEKING BEHAVIOR OF URBAN SLUM OF BHARUCH

SUBMITTED BY-

Dr Priya S. Mahajan

Post Graduate Programme in Hospital & Health Management

(2012-2014)

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH

NEW DELHI -110075

MAY, 2014

CERTIFICATE OF APPROVAL

The following summer intern project titled- "HEALTH SEEKING BEHAVIOR OF THE URBAN SLUM**"** is hereby approved as certified study in management carried out and presented in a manner satisfactory. It is understood that by this approval the undersigned do Not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the summer intern project report only for the purpose it is submitted.

_____

Sign of Mentor

Dr Preetha G S.

Date: _____

Submitted by-

Dr Priya S. Mahajan

CERTIFICATE

This is to certify that the dissertation titled **HEALTH SEEKING BEHAVIORS OF THE URBAN SLUM** and submitted by**DrPriya S. Mahajan**Enrollement No. **PG/12/065** under the supervision of **DrV.S.Tripati** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 4th Feb 2014 to 3rd May 2014 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

Mission Director and
ief District Health Officer
strict Panchayat-Bharuch.

Certificate Of Approval

The following dissertation titled **"HEALTH SEEKING BEHAVIOUR OF THE RESIDENTS OF URBAN SLUM OF BHARUCH** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
1. S. V. ADNISH	
2. Preetha GS	
3. Kisl Udaya	

NATIONAL URBAN HEALTH UNIT

The certificate is awarded to

DrPriya S. Mahajan

In recognition of having successfully completed her
Internship in the department of

URBAN HEALTH

and has successfully completed her Project on

Health Seeking Behavior of the residence of Urban Slum

Feb 4th 2014 – May 4th 2014

District Urban Health Unit, JhillaPanchayat, Bharuch. Guajarat

She comes across as a committed, sincere & diligent person who
has a strong drive & zeal for learning

We wish her all the best for future endeavors

Training & Development

Zonal Head-Human Resources

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled HEALTH SEEKING BEHAVIOR OF THE RESIDENCE OF URBAN SLUM and submitted byDrPriya S. Mahajan Enrollment No. PG/12/065under the supervision of Dr V. S. Tripatafor award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from Feb 4th 2014 to May 4th 2014embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Priya S. Mahajan

Signature

Certificate from Dissertation Advisory Committee

This is to certify that **Dr.Priya S. Mahajan,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled " **HEALTH SEEKING BEHAVIOUR OF THE RESIDENCE OF URBAN SLUM OF BHARUCH**" at "DISTRICT URBAN HEALTH UNIT, BHARUCH" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Institution Mentor

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Assistant Dean(Research),
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FEEDBACK FORM

Name of the Student: Dr. Reeja S. Mahajan.

Dissertation Organisation: District Urban Health Unit, Bharuch.

Area of Dissertation: Health seeking behavior of Urban Slum & Slum like area.

Attendance: - Complete & Regular

Objectives achieved: Yes.

Deliverables: Yes. Submitted and Complete.

Strengths: Sincere, Committed & Creative

Suggestions for Improvement: Think always positive & Do Hard work.

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Member Secretary
District Urban Health Unit.
District Panchayat, Bharuch

Date: 03/05/2014
Place: Bharuch.

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Preface

Dissertation is an integral part of the PGDHM curriculum. As a part of the course; the students of first year are required to undergo summer placement at any reputed organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system and its functions.

The major objectives of the dissertation

programme are as follows:

1) To better understand the existing healthcare delivery system including public and private sectors.
2) To observe the implementation of various National Health Programmes at State/District/Block levels.

3) To acquire more knowledge on roles and responsibilities of key players and stakeholders in health sector.

4) To understand various functions of health system by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.

5) To work on the project/task assigned by summer training organization.

Acknowledgement

I would like to express my heartfelt gratitude to The Government of Gujarat and National Urban Health Mission, Gujarat for providing me an opportunity to work in such a wonderful organization and for making all the facilities available and giving the support in every way for completion of internship & Dissertation.

I would like thank to National Urban Health Mission Gujarat & Chief District & Health Office, Bharuch for facilitating my internship work.

I would like to take this opportunity to express great indebtedness to Dr.V.S.Tripathi, CDHO and Dr. Keshav Kumar, THO (Inchagre ADHO), without whom this training could not have been accomplished. I would like to extend my sincere regards to Program Officers who despite other preoccupations and busy schedule shared their views.

I would like to thank the staff of NUHM, Bharuch for their support.

I would like to thank Dr Preetha G S., Institute of Health Management and Research, Delhi for his constant motivation, patience and valuable guidance.

I thank to my family and friends for their moral support.

Dr. Priya S. Mahajan

LIST OF ACRONYMS/ABBREVIATIONS

- **DDO-DISTRICT DEVELOPMENT OFFICER**
- **CDHO-CHIEF DISTRICT HEALTH OFFICER**
- **DRCHO- DISTRICT REPRODUCTIVE CHILD HEALTH OFFICER**
- **BHO- BLOCK HEALTH OFFICER**
- **UHO- URBAN HEALTH OFFICER**
- **DPM- DISTRICT PROGRAMME MANAGER**
- **MO- MEDICAL OFFICER**
- **ANM- AUXILLARY NURSE MIDWIFE**
- **ASHA- ACCREDITED SOCIAL HEALTH WORKER**
- **NRHM- NATIONAL RURAL HEALTH MISSION**
- **CHC- COMMUNITY HEALTH CENTRE**
- **PHC- PRIMARY HEALTH CENTRE**
- **UHC- URBAN HEALTH CENTER**
- **USC- URBAN SUB CENTER**
- **USHA- URBAN SOCIAL HEALTH ACTIVIST**
- **SC- SUB CENTRE**
- **AWW- ANGANWADI WORKER**
- **BPL- BELOW POVERTY LINE**
- **RSBY- RASHTRIYS SWASTHYA BIMA YOGANA**
- **HT- HYPERTENSION**
- **ICDS- INTEGRATED CHILD DEVELOPMENT SCHEME**
- **RCH- REPRODUCTIVE CHILD HEALTH**
- **TB- TUBERCULOSIS**
- **CHD- CORONARY HEART DISEASE**

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Executive Summary

The Government of India has launched the National Urban Health Mission (NUHM) as a sub-mission under the National Health Mission (NHM), the National Rural Health Mission (NRHM) being the other sub-mission.

NUHM seeks to improve the health status of the urban population particularly slum dwellers and other vulnerable sections by facilitating their access to quality health care. NUHM would cover all state capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will be covered under NRHM.

Universal health coverage is the single most powerful concept that public health has to offer" Dr Margaret Chan, Address to the Sixty-fifth.(World Health Assembly, May 2012). The goals of the National Health ission are attainment of equitable, affordable and quality health care , which is accountalble and responsive to the needs of the people.As Bharuch has been selected for a pilot study for the implementation if universal health coverage and the proprttion of people who are able to access these services which are quality effective and without any financial hardship . Where the financial hardship is defined as the cost of health care exceeding 10% of total family consumption expenditure or more than 40% of non-food family consumption expenditure. The ideal is 100%. However more pragmatic target is that at least 80% of the poorest 40% are able to access without financial hardship at least 20 services that they most frequently need. Bharuch district is shortlisted for initiating pilot for UHC in Gujarat. The main outcomes that are focused by the UHC is IMR, MMR, TFR and Life expectancy at birth and malnutrition levels

SECTION A

NATIONAL URBAN HEALTH MISSION

The Government of India has launched the National Urban Health Mission (NUHM) as a sub-mission under the National Health Mission (NHM), the National Rural Health Mission (NRHM) being the other sub-mission.

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Key features of NUHM are enumerated below:

- Creation of service delivery infrastructure :
  - Urban - Primary Health Centre (U-PHC): Functional for approximately 50,000 population, the U-PHC would be located within or near a slum. The services provided by U-PHC would include OPD (consultation), basic lab diagnosis, drug /contraceptive dispensing and delivery of Reproductive & Child Health (RCH) services, as well as preventive and promotive aspects of all communicable and non-communicable diseases.
  - Urban-Community Health Centre (U-CHC) and Referral Hospitals: 30-50 bedded U-CHC providing inpatient care in cities with population of above five lakhs, wherever required and 75-100 bedded U-CHC facilities in metros. Existing maternity homes, hospitals managed by the state government/ULB could be de;
- Outreach:
  - ANMs would provide preventive and promotive health care services to households through routine outreach sessions.
  - Expansion of services through outreach to children by covering at least all government schools and Anganwadi Centres. Other schools located in the slums would also be covered. During such sessions, screening for birth defects, diseases, disability and deficiency (4 Ds) would be carried out and follow-up actions would be initiated.
  - Various services to be delivered at the community level, UPHC and UCHC levels have been elaborated in Table 17-1 of the NUHM Implementation Framework.

- Targeted interventions for slum population and the urban poor:
  - Mahila Arogya Samiti (MAS) – will act as community based peer education group in slums, involved in community mobilization, monitoring and referral with focus on preventive and promotive care, facilitating access to identified facilities and management of grants received. Existing community based institutions could be utilized for this purpose.

- Capacity building of community – NUHM would provide capacity building support to MAS / Community Based Organisations for orientation, training, exposure visits, participation in workshops and seminars etc., apart from annual grant of Rs.5000 per MAS for mobilization, sanitation and hygiene, and emergency healthcare needs.
- Link Worker / ASHA - One frontline community worker (ASHA) would serve as an effective and demand–generating link between the health facility and the urban slum population. Each link worker/ASHA would have a well-defined service area of about 1000-2,500 beneficiaries/ between 200-500 households based on spatial consideration. However, the states would have the flexibility to either engage ASHA or entrust her responsibilities to MAS. In that case, the incentives accruing to ASHA would accrue to the MAS.
- Outreach services – Weekly medical camp would be organised in slum areas.

- Public Private Partnerships:

  In view of presence of larger number of private (for profit and not for profit) health service providers in urban areas, public – private partnerships particularly with not for profit service providers will be encouraged. NUHM will also support innovations in public health to address city and population specific needs. However, clear and monitorable Service Level Agreements (SLAs) need to be developed for engagement with Private Sector.

- Funding/budget mechanism

  Funds will flow to the City Urban Health Society/ District Health Society, through the State Government / State Health Society. The SHS/DHS will have to maintain separate accounts for NUHM.

- Convergence: Intra-sectoral convergence is envisaged to be established through integrated planning for implementation of various health programmes like RCH,RNTCP, NVBDCP, NPCB, National Mental Health Programme, National Programme for Health Care of the Elderly, etc. at the city level.

  Inter-sectoral convergence with Departments of Urban Development, Housing and Urban Poverty Alleviation, Women & Child Development, School Education, Minority Affairs, Labour will be established through city level Urban Health Committees headed by the Municipal Commissioner/Deputy Commissioner/District Collector.

- Other aspects:
  - Extensive use of Information Technology would be made for hospital management, reporting and monitoring as well as service delivery.
  - Public Health laboratories would also be strengthened for early detection and management of disease outbreaks.

PREPARATORY ACTIVITIES

All states and Union Territories have been requested to initiate various preparatory activities vide letter dated 16th May 2013 of Union Secretary, Health & Family Welfare addressed to State Chief Secretaries, and letter

dated 17th May 2013 of Additional Secretary & Mission Director, NHM addressed to State Health and Urban Development Secretaries.

States were requested to undertake the following activities, prior to submission of the PIP for 2013-14:

- Expand the Governing Body (GB) and the Executive Committee of the State Health Mission/Society to include Minister(s) in charge of Urban Development and Housing, and Secretaries in charge of the Urban Development and Housing departments.
- Mission Director NRHM to be re-designated as Mission Director National Health Mission (NHM)
- Appointment of Additional Mission Director, NUHM (especially for big states)
- Urban Health Cell to be operationalised in the State Health Society/SPMU
- District Health Society should also be appropriately expanded.
- City Urban Health Societies have to be put in place in the mega cities and other large cities/ corporations, where the responsibility of implementing NUHM is handed over to the City Urban Health Mission.

VARIOUS ACTIVITIES TO BE UNDERTAKEN IN 2013-14 FOR ROLL OUT OF NUHM

During 2013-14 the focus would be on establishing necessary program management structures and building capacities for implementation of NUHM, mapping of slums and public healthcare facilities, preparation of baselines for identifying areas of intervention and investment. Specific activities in 2013-14 would include:

- Prioritise cities for roll out of NUHM on the basis of appropriate criteria
- Strengthen program management structures at state level and selected districts and cities;
- Build necessary capacities through training and establishing systems for flow of funds.
- Carry out a baseline survey in the prioritised cities including listing and mapping of slums/ vulnerable pockets; mapping and facility survey of all public health facilities, which would lead to "situational analysis".
- Prepare plans for intervention during 2013-14.
- Recruitment of necessary program management staff. Capacities of staff would be built through training.
- Community processes i.e. MAS, ASHA/link-worker, targeted outreach services

- Strengthening of existing public healthcare facilities
- Convergence with other health programmes and wider determinants.

Prioritise cities/towns

Given the limited availability of funds during 2013-14, implementation of NUHM would necessarily take place in a phased manner. States would need to prioritise cities/ towns based on appropriate criteria including number and proportion of people living in slum and slum like conditions, existence of community based structures; capacity of ULB, etc. The States/UTs could also initiate NUHM in selected JnNURM cities as these cities would be better prepared to manage NUHM. However, the states are free to finalise the cities on the basis of objective criteria.

Carry out baseline survey and situational analysis in selected cities/ towns

The base line survey would (1) identify and map the slums listed as well as the unlisted, low income neighbourhoods, called Key Focus Areas (KFAs[1]) so that interventions can be targeted (2) list all public health facilities and conduct facility surveys (availability of infrastructure, HR, drugs, consumables and equipment) order to prepare estimates for up-gradation/strengthening the same as per norms and standards (3) provide an assessment of existing community based structures in order to determine whether these could take on the role of MAS (4) assess capacity (staff, systems) of the ULBs to manage NUHM.

Current status of KFAs in terms of health indicators may be obtained from existing secondary databases and/ or through baseline household survey.

The above analysis would determine gaps in availability public health services (in and around the KFAs), thus providing a basis for the City Health Plans and subsequent monitoring of progress.

GIS mapping of slums undertaken by Urban Development/HUPA Department under JNNURM/RAY would provide a good starting point for the mapping of KFAs. The National Polio Surveillance Project (NPSP-WHO) surveillance maps and micro-plans may also be used to identify vulnerable population/hard to reach pockets.

While preparation of a comprehensive City Health Plan may not be feasible before submission of the PIP for 2013-14, a plan is required to be prepared on the outlines indicated here.

Initiate community processes

Under NUHM, community processes include mobilising urban communities through structures such as MAS, deployment of ASHA and their capacity building. It may be noted that NUHM provides for ANMs for the entire urban population whereas ASHA and MAS will be mobilised only for population living in KFAs. NUHM would provide untied grants and capacity building support to MAS / CBO.

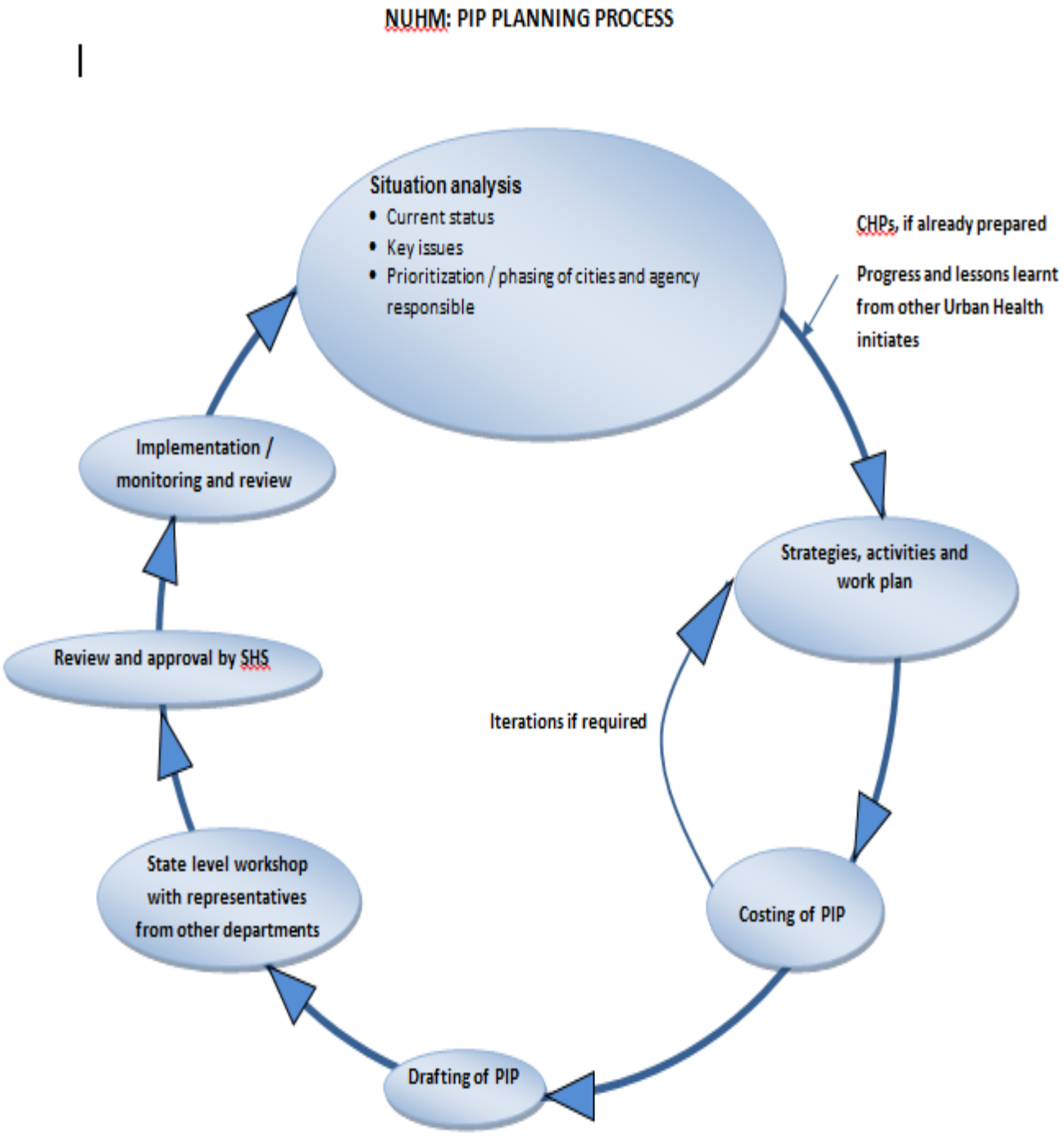
Strengthening of existing primary healthcare facilities

One urban primary health centre (UPHC) may be planned for every 50-60 thousand population. In case there is existing infrastructure of UFWC, UHC, UHP, etc., it may be upgraded and strengthened as UPHC. Where none exists, new UPHCs will have to be planned and the State could initiate the process of identification of location/ land. NUHM would provide both capital and recurrent cost for up gradation and maintenance of the UPHCs, as per the norms in the NUHM Framework for Implementation. The State could also hire premises for new UPHCs where land is not available. Mobile PHCs could be planned for unlisted slums and other KFAs, where it is not possible to establish a new UPHC as per requirement.

Convergence with other health programmes and wider determinants : State should work out the detailed modalities for convergence with wider determinants of health, especially housing and water supply and sanitation programmes and ICDS. Convergence could be in terms of planning, synchronised implementation and monitoring.

PLANNING PROCESS FOR NUHM.

State would need to constitute a planning team including representatives from other departments, in particular Urban Development Department / Directorate of Municipal Affairs/ Slum Board, etc. The State NUHM Plan would need to be presented and approved by the State Health Society prior to submission to Ministry of Health and Family Welfare. An overview of the process is depicted below.



INTRODUCTION TO THE CITY BHARUCH

ABOUT THE DISTRICT

Bharuch (formerly commonly known as Broach) is situated near the Bank of river Narmada in India, a district in the southern part of the Gujarat peninsula on the west coast of state of Gujarat with a size and population comparable to that of Greater Boston. The Narmada River outlets into the Gulf of Khambat through its lands and that shipping artery gave inland access to the kingdoms and empires located in the central and northern parts of the sub-continent of India.

Bharuch is the administrative headquaters of Bharuch District. Bharuch district derives its name from "Bhrigukachchha " the residence of the great saint Bhrigu Rishi. Bharuch is also known as Bhrigupur, Bhrigutirtha, Bhigukshetra, Bhrigukaksha as per Hindu Puranas. Bharuch District looks beautiful with forests and river banks covered by greeneries.

In 1997, Bharuch District is bifurcated into Two parts

(1) Narmada District and

(2) Bharuch District.

HISTORY

The city of Bharuch and its surrounds—today's district—has been settled far back into antiquity and was a major shipping building center and sea port in the important pre-compass coastal trading routes to points West, perhaps as far back as the days of the Pharaohs, which utilized the regular and predictable Monsoon winds or galleys. Many goods from the Far East (the famed Spice and Silk trade) were trans-shipped there for the annual monsoon winds making it a terminus for several key land-sea trade routes and Bharuch was definitely known to the Greeks, the various Persian Empires and in the Roman Republic and Empire and other Western centres of civilization right on through the end of the European Middle Ages. With the advent of the Age of Discovery, the presence of deep draft sea going shipping it began a long slow decline in importance as it was a bit too far north to be convenient to shipping not confined to keeping within sight of shore

DIVISIONS:

Talukas and divisions under Bharuch as follows:

1. Bharuch.
2. Valia.
3. Vagra.
4. Netrang.
5. Jaghadia
6. Amod.
7. Ankleshwar
8. Hansot
9. Jambusar

MAP OF BHARUCH

Location:

Bharuch district is located in the sourthern part of Gujarat ,near the Gulf of Khambhat in Arabian Sea. Bharuch is Situated between and 21.30° to 22.00° in N and 72.45° to 73.15° E. Bharuch District comes under seismic zone-III. There are 8 Talukas & 543 Gram Panchayat and 3 Municipalities in this district. It covers 5253.30 Sq.km. area. Bharuch District is bounded by Baroda and Anand on the North, Narmad District on the East, Surat district is on the south and gulf of Combay is on the west. The Eastern strip of the district is hilly and forest area.

DEMOGRAPHIC PROFILE:

CRITERIA	INDIA	GUJARAT	BHARUCH
Population	1,210,193,422	6,04,39,000	15,51,019
% of Urban Population	388,524,900	42.6	33.85
Birth Rate	21.6	21.1	21.66
Death Rate	7	6.6	6.8
IMR	42	38	50
MMR	212	148	160
TFR	2.4	2.3	2.3

INFRASTRUCTUE:

FACILITY	SANCTIONED	WORKING IN GOVT. BUILDING
DISTRICT HOSPITAL	1	1
SUB DISTRICT HOSPITAL	0	0
COMMUNITY HEALTH CENTER	8	8
PRIMARY HEALTH CENTER	37	34
SUB CENTER	220	113

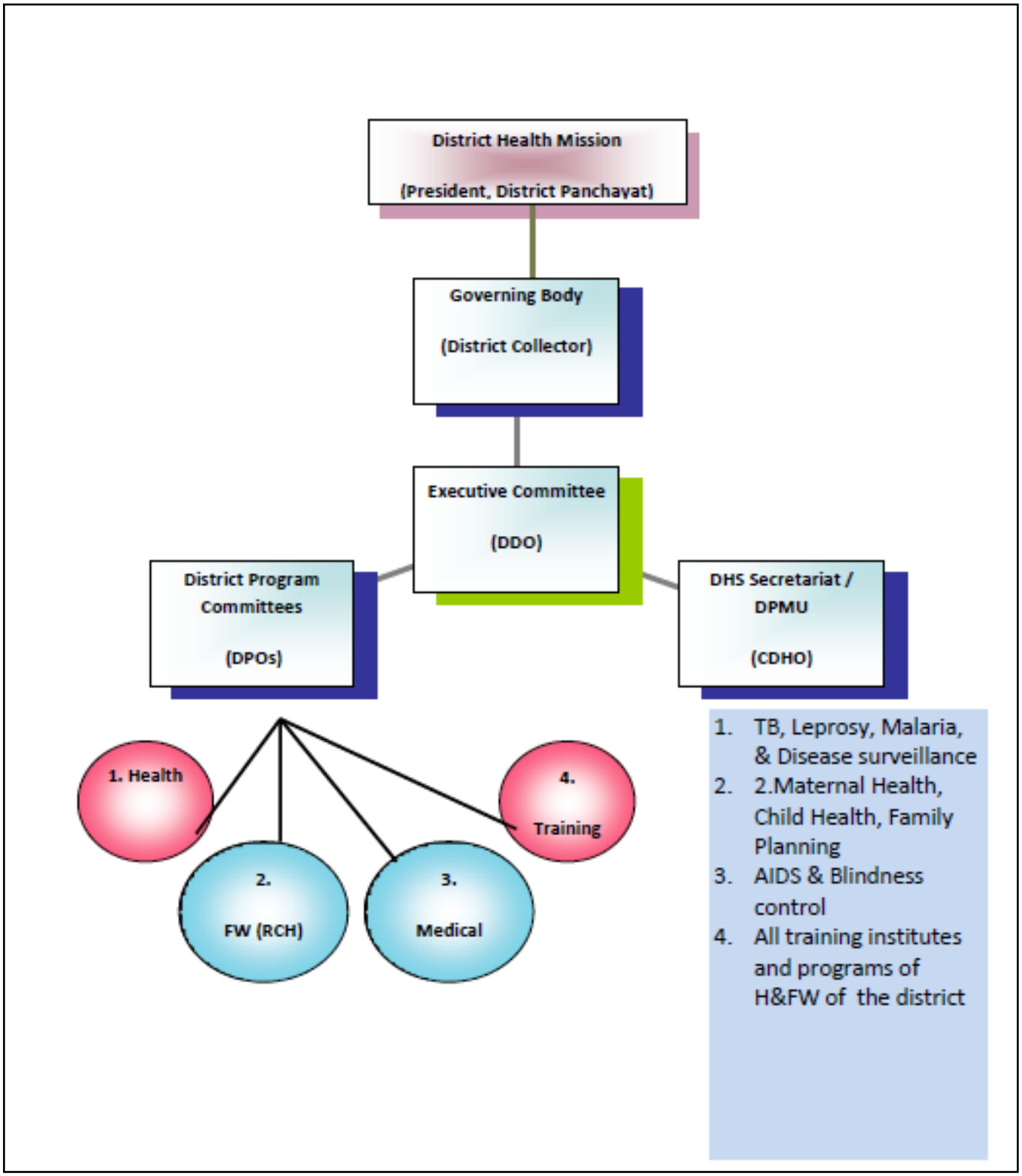
TALUKA WISE INFORMATION:

Name of TALUKA	Population	No. Of Revenue Villages	No. of PHC	No. of SCs
Bharuch	452517	96	6	32
Vagra	100044	63	3	14
Amod	93819	52	3	17
Jambusar	197038	69	5	27
Hansot	61268	46	2	11
Ankleshwar	315596	59	5	24
Valia	72888	49	3	15
Jhagadia	161508	73	7	36
Netrang	96341	38	4	24
Total	**1551019**	**545**	**38**	**200**

MORBIDITY PROFILE OF THE CITY:

Sr. No.	Name of Disease/ cause of morbidity (e.g. COPD, trauma, cardiovascular disease etc.)	Number of cases admitted in 2012
1.	Injuries and Trauma	655
2.	Self inflicted injuries/suicide	155
3.	Cardiovascular Disease	1240
4.	Cancer (Breast cancer)	-
5.	Cancer (cervical cancer)	-
6.	Cancer (other types)	-
7.	Mental health and depression	601
8.	Chronic Obstructive Pulmonary Disease (COPD)	358
9.	Malaria	248
10.	Dengue	02
11.	Infectious fever (like H1N1, avian influenza, etc.)	-
12.	TB	37
13.	MDR TB	15
14.	Diarrhea and gastroenteritis	1339
15.	Jaundice/Hepatitis	150
16.	Skin diseases	2491
17.	Severely Acute Malnourishment (SAM)	25
18.	Iron deficiency disorder	3480
19.	Others	19994

Organizational Structure of District Health Society, Bharuch District



INTRODUCTION

Bharuch is (formerly commonly known as Broach) in India, is a district in southern part of the Gujarat peninsula on the west coast of state of Gujarat with a size and population comparable to that of greater Boston. The Narmada river outlets into the Gulf of Khambhat through its lands and that shipping artery gave inland access to the kingdoms and empires located in the central and northern parts of the sub-continent of India. The goals of the national health mission are "attainment of universal access to equitable, affordable and quality health care, which is accountable and responsive to the needs of the people".

The proportion of persons in need of services, who are able to access these services, which are of quality (effective), and without financial hardship. Where the financial hardship is defined as the cost of health care exceeding 10% of total family consumption expenditure or more than 40% of non-food family consumption expenditure. The ideal is 100%. However more pragmatic target is that at least 80% of the poorest 40% are able to access without financial hardship at least 20 services that they most frequently need. Bharuch district is shortlisted for initiating pilot for UHC in Gujarat. The main outcomes that are focused by the UHC is IMR, MMR, TFR and Life expectancy at birth and malnutrition levels. Along with the Doctor to Nurse Ratio, % of population residing beyond the time to care and % of facilities which have minimum required quality scores against a national quality of care standards.

The NUHM document mentions an analysis of the NFHS III data stating that under 5 Mortality Rate (U5MR) among urban poor is at 72.7. This is significantly higher than the urban average of 51.9. About 47.1 per cent urban poor children aged below three years are underweight compared to the urban average of 32.8 percent and rural average of 45 percent. Among the urban poor, 71.4 per cent children are anaemic compared to the urban average of 62.9 percent. Sixty per cent of the urban poor children miss complete immunisation compared to the urban average of 42 percent. Only 18.5 percent of urban poor households have access to piped water supply at home. The average is 50 percent in overall urban population. Among the urban poor,

46.8 per cent women have received no education compared to 19.3 per cent in urban average. Among the urban poor, only 44 per cent deliveries are institutional, compared to the urban average of 67.5 percent.

The proposed national urban health service delivery model intends to make a concerted effort to rationalise and strengthen the existing public health care system in urban areas, promote effective engagement for better reach of the services to urban poor and strengthen the community participation in planning and management of health care service delivery.

Rationalie of the Study:

In 2001, India's total population was 1027 million individuals, compared to 846 million in 1991, 683 million in 1981, and 548 million in 1971. And though out of the 1 billion plus individuals in India in 2001, only 285 million (27.7 per cent) are consider urban, this figure constitute 10 per cent of total world urban population.

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The proposed national urban health service delivery model intends to make a concerted effort to rationalise and strengthen the existing public health care system in urban areas, promote effective engagement for better reach of the services to urban poor and strengthen the community participation in planning and management of health care service delivery.

Goal

The National Urban Health Mission aim 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 health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies.

General Objective

To assess the health status and health seeking behavior of the urban slum population.

Specific Objectives

- To assess the status of the people dwelling in the slum in terms of facility available, socio economic status, education, different addictions within the community, prevailing diseases.
- To analyze the health condition in terms of the adult population in urban slum in bharuch
- To access the health care spending of the slum people.
- To assess the level of financial hardship that the people in the urban slum are facing.

Methodology

STUDY DESIGN: Cross Sectional study

STUDY AREA: URBAN SLUM OF BHARUCH

STUDY POPULATION: URBAN SLUM POPULATION

SAMPLING AND SAMPLING DESIGN: A sample population of 300 approx.

TOOL: quantitative Questionnaire

TECHNIQUES: Cross sectional cohort study

REVIEW OF LITERATURE:

International Journal for Equity in Health 2014. (**RehmanA, Shaikh BT, and Ronis KA) Health care seeking patterns and out of pocket payments for children under five years of age living in Katchi Abadis (slums), in Islamabad, Pakistan.**

This cross-sectional quantitative study was conducted in Islamabad, using a semi-structured questionnaire with mothers of children 5 years of age. Average household income was found to be Pak Rupee 10,000 (approx.US$100) per month. Diarrhea, fever, common cold and cough were common illnesses among under 5 children. Approximately 43% of the mothers were illiterate and they preferred consulting a private doctor or a private dispenser in the katchi abadi. Mother's level of education was significantly associated with the type of health provider consulted. Majority had to spend out of pocket, while many either borrowed money from relatives or friends or sold a household item. Delay in seeking healthcare added to the out of pocket expense. A multi-sectoral approach is needed to address the provision of basic amenities, the availability of safety nets to pay for health care is crucial to avoid catastrophic expenditure and the provision of community-based health promotion programs are essential to improve health seeking behaviors whilst simultaneously promoting and protecting health.

BMC Health Services Research 2014**. (Mukalenge F Chenge, Jean Van der Vennet, Numbi O Luboya, Veerle Vanlerberghe, Mala A Mapatano and Bart Criel) Health-seeking behaviour in the city of Lubumbashi, Democratic Republic of the Congo: results from a cross-sectional household survey**

A cross-sectional survey of households in Lubumbashi was conducted in July 2010. Information was collected from a randomly selected sample of 251 households with at least one member who had been ill in the 2 weeks preceding the survey. Frequently used initial treatment-seeking options consist of self-medication based on modern medicines (54.6%), the use of first-linehealth services (23.1%) and hospitals (11.9%), with a perceived effectiveness of 51%, 83% and 91% respectively. If people go for a second option, then formal health care services are most often preferred. The majority (60%) of patients' spontaneous itineraries reflect the expected functioning of a local health care system, with a patient flow characterised by the use of a first line health facility prior to the use of hospital-based services. Chronicity of the disease is the main determ study indicates that poor patients face the same level of out-of-pocket payments as the more wealthy ones, hence the need for more equitable health care financing arrangements.

Am J Trop Med Hyg. Jul 10, 2013 **(Farheen Quadri, Dilruba Nasrin, Asia Khan, Tabassum Bokhari, Shiyam Sunder Tikmani, Muhammad Imran Nisar, Zaid Bhatti, Karen Kotloff, Myron M. Levine, and Anita K. M. Zaidi) Health Care Use Patterns for Diarrhea in Children in Low-Income Periurban Communities of Karachi, Pakistan**

Diarrhea causes 16% of all child deaths in Pakistan. We assessed patterns of healthcare use among caretakers of a randomly selected sample of 959 children ages 0–59 months in low-income periurban settlements of Karachi through a cross-sectional survey. A diarrheal episode was reported to have occurred in the previous 2 weeks among 298 (31.1%) children. Overall, 280 (80.3%) children sought care. Oral rehydration solution and zinc were used by 40.8% and 2%, respectively; 11% were admitted or received intravenous rehydration, and 29% sought care at health centers identified as sentinel centers for recruiting cases of diarrhea for a planned multicenter diarrheal etiology case-control study.

Indian Pediatr. April 2013 **(Nimbalkar AS1, Shukla VV, Phatak AG, Nimbalkar SM). Newborn care practices and health seeking behavior in urban slums and villages of Anand, Gujarat.**

Health status of neonates in urban slums has not been studied in smaller towns. A questionnaire was administered to 154 families of 10 urban slums of Anand (population - 197351) and 160 families from 6 villages of Anand district. The socioeconomic and education status of the slum dwellers versus rural participants were significantly lower. Antenatal care (79.9 vs 94.4%, P<0.001), hospital delivery (82.5 vs 93.8%, P=0.002), neonatal follow-up (27.9 vs 78.8%, P<0.001), health seeking (56.5 vs 91.3%, P<0.001), essential newborn care and exclusive breastfeeding (6.5 vs 85.6%, P<0.001) were also lower in urban slums, as compared to villages, Care seeking was low in urban slums, Hindus and illiterate mothers. Health care and socioeconomic status of neonates in slums of smaller cities is poorer than in surrounding villages.

J Infect Dev Ctries. Feb 2012**. (Shah MS1, Ahmad A, Khalique N, Afzal S, Ansari MA, Khan Z) Home-based management of acute diarrhoeal disease in an urban slum of Aligarh, India.**

Diarrhoea is a major cause of morbidity and mortality in children. Most deaths are caused by dehydration and are easily preventable by using oral rehydration therapy. Early management and recognition of danger signs are key strategies in treating diarrhoeal diseases at home. This study assessed the knowledge and health-care seeking behaviour of families regarding diarrhoeal illness in children aged under five years. Overall prevalence of diarrhoea in children under five was 36%. Life-threatening symptoms which the mothers knew

were watery stool (85%) and repeated vomiting (54%). Two thirds (69%) of the mothers continued breastfeeding their children during the episode, while the remaining either withheld or interrupted breastfeeding. The majority visited a nearby unsanctioned health practitioner. Less than half (46.5%) of the mothers knew about oral rehydration salt solution and only 29.8% of those knew the correct method of preparation. Only 38.7% of the respondents knew about suitable fluids available at home, out of which salt sugar solution was the choice in most cases. Educating mothers and caretakers regarding early home-based case management of childhood diarrhoea may substantially decrease morbidity and mortality due to diarrhoea.

BMC Health Services Res. Apr 2009 **(Srivastava NM1, Awasthi S, Agarwal GG) Care-seeking behavior and out-of-pocket expenditure for sick newborns among urban poor in Lucknow, northern India: a prospective follow-up study.**

The study was conducted at an urban Reproductive and Child Health (RCH) center and a District hospital. Neonates were enrolled within 48 hours of birth and were followed-up once at 6 weeks +/- 15 days at the OPD of the respective hospitals or at home. This study assessed (1) distribution of neonatal illnesses and different health providers sought (2) distribution of out-of-pocket expenditures by type of illness and type of health provider sought (3) socio-economic distribution of neonatal illnesses, care-seeking behavior and out-of-pocket expenditures. Five hundred and ten neonates were enrolled and 481(94.4%) were followed-up. Parents of 50.3% (242/481) neonates reported at least one symptom of illness. Of these 22.3% (107/481) neonates had illnesses with at least one reported Integrated Management of Neonatal and Childhood Illnesses (IMNCI) danger sign. Among IMNCI illnesses, point prevalence of septicemia was 6.2% and pneumonia was 5.2% while among non-IMNCI illnesses point prevalence of upper respiratory infection was 9.5%, and diarrhea was 7%. Community based non-government dispensers (NGDs) were leading health providers (37.6%). Mean monthly income of families was 2804 Indian Rupees (INR) (range: 800 to 14000; n = 510), where US$ 1 = 42 INR. Mean out-of-pocket expenditure on neonatal illness was 547.5 INR (range: 1 to 15000; n = 202) and mean out-of-pocket expenditure for hospitalization was 4993 INR (range: 41 to 15000; n = 17). All hospitalizations were for IMNCI illnesses. Since more than half of the neonates have morbidity and out-of-pocket expenditure on neonatal illnesses often exceeds the family income of the lower strata of the low income group in the community, there is a need to either introduce health insurance scheme or subsidize health care for them.

To explore the current situation of urban health service in terms of availability and accessibility, health facilities at different level were analyzed.

Understand the existing urban health services as per guidelines

One District hospital and three urban health centers were visited to find out whether they fulfill the guidelines established by IPHS for a district hospital and PHC. As per the guidelines few essential norms, such as physical infrastructure and manpower, were selected and checked in DH and UHC which are as follows.

Sr. No	Physical Infrastructure	Remarks	Indicators
1	Number Of Beds	Yes	1) >100
3	Signage's	Yes	1) Pictorial 2) local language
4	Condition of roads, path ways and drainages	Yes	Well illuminated in night
5	Entrance Area	Yes	1) Briar free 2) Ramp and 3) Proper lighting.
6	Residential Quarters	Yes	Present
7	Hospital Communication	Yes	Present
8	**OPD**		
8.1	Reception & Enquiry	Yes	Available with a local staff
8.2	Waiting Space		1) General waiting 2) Subsidiary waiting area.
8.3	Patient Amenities	Yes	1) Drinking water, 2) Fans 3) seating arrangement 4) Toilets
9	Injection Room/Vaccination room/Dressing room.	Yes	1) With in Hospital

			2) Adjacent to O.P.D room
10	**Support Services**		
10.1	Imagining	Yes	Present
10.2	Clinical Laboratory	Yes	Essential laboratory tests were being conducted
10.3	Blood bank	No	Present
11	**IPD**		
11.1	Male medicine ward	No	Separate Ward
11.2	Male Surgical ward	No	Separate Ward
11.3	Female medicine ward	No	Separate Ward
11.4	Female Surgical ward	No	Separate Ward
11.5	Maternity ward	Yes	Separate Ward
11.6	Pediatrician ward	No	Separate Ward
11.7	Isolation	Yes	Separate Ward
12	**Emergency Ward**		
12.1	Trauma Ward	-	Separate Ward
12.2	Burn Ward	Yes	Separate Ward
12.3	Post operative ward	Not Functional	Separate Ward
12.4	Other	-	
13	**I.C.U**	Yes	Present
13.1	Number of beds	6 Beds	< 10 > 10
13.2	Nursing unit	Yes	Present
14	Pharmacy	Yes	Present
	30	16	30

Human Resource for District Hospital:

Sr. No	Position	Sanctioned	Filled	Vacant
1)	CDMO	1	0	1
2)	Physician	1	0	1
3)	Gen. Surgeon	1	1	0
4)	Ortho. Surgeon	1	0	1
5)	Pathologist	1	1	0
6)	Gynecologist	1	1	0
7)	Pediatrist	1	0	1
8)	Opthalmologist	1	1	0
9)	RMO	1	1	0
10)	Anesthetist	2	1	1
11)	ENT	1	0	1
12)	Hon. Cardiologist	1	0	1
13)	Hon. Nephrologists	1	0	1
14)	Hon. ENT	1	0	1
15)	Psychiatrist	1	1	0
16)	Microbiologist	1	0	1
17)	Dentist (MDS)	1	1	0
18)	Medical Officer	14	14	0
19)	Staff Nurse	39	38	1
20)	Head Nurse	08	01	7
21)	Matron	01	01	0
	Total	**80**	**62**	**18**

Urban Health Center

Sr. No	Physical Infrastructure		UHC Dholi kui	UHC Lal Bazar	UHC Vejalpur	Remarks
1	PHC Building		1k.m away from DH and in rented house	1 k.m away from DH and in rented house	2 k.m away from DH and in rented house	
1.1	Electricity	Regular supply	Yes	Yes	Yes	Available
		Power back up	Yes	No	No	Available
1.2	Water supply		Yes	No	Yes	Available
1.3	Telephone		Yes	Yes	Yes	Available
2	Signage		Yes	Yes	Yes	Present
3	Entrance		Yes	No	Yes	Barrier Free, Ramp
4	Waiting Room		Present	Present	Present	Present
5	**O.P.D Room**					
5.1	Separate Area For Consultation		Yes	Yes	Yes	Present
5.2	Separate area for Examination		No	No	No	Present
5.3	Separate Consultation for AYUSH Doctor		No	No	No	Present
6	I.P.D		No	No	No	Present
7	Labour room		No	No	No	Present
8	Minor OT		No	No	No	Present
9	Laboratory		Yes	No	No	Present
10	Referral Services		No	No	No	Present
	16		9	5	7	

Human Resource:

Sr. No	Position	UHC Dhaulikui			UHC Lal Bazar			UHC Vejalpur		
		Sanctioned	Filled	Vacant	Sanctioned	Filled	Vacant	Sanctioned	Filled	Vacant
1	M.O	1	1	0	1	0	1	1	0	1
2	PHN	1	0	1	1	0	1	1	0	1
3	Pharmacist	1	1	0	1	0	1	1	0	1
4	Staff nurse	1	1	0	1	0	1	1	0	1
5	Lab. Tec	1	0	1	1	1	0	1	0	1
6	S.I	1	1	0	1	0	1	1	0	1
7	ANM/FHW	4	2	2	4	3	1	4	0	4
8	MPHW	4	1	3	4	1	3	4	0	4
9	Data Operator	1	1	0	1	1	0	1	1	0
10	Peon	1	1	0	1	0	1	1	0	1
11	Aaya	1	1	0	1	0	1	1	1	0
	Total	**17**	**10**	**7**	**17**	**6**	**11**	**17**	**2**	**15**

Availability of services :

To measure the availability of the urban health services total number of health facilities at different level that is Primary, Secondary, Tertiary, and Quaternary level along with the available number of doctors and total number of beds were analyzed.

1) **Primary level**:

Primary care is the term for the health care services which play a role in the local community. It refers to the work of health care professional who act as a first point of consultation for all patients within the health care system for primary level of health care 3 UHC was there which provided services to urban population of Bharuch district. The average monthly OPD of this UHC was 160 patients.

Sr. No	Facilities providing primary health services	Total number of facilities	No of doctors	Total number of beds
1	Urban health centers	3	1	0

2) Secondary Level:

Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for Bharuch city no such facilities are available like CHC.

3) Tertiary Level:

Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital For tertiary level of care District hospital and other private hospitals are there in Bharuch district. Private hospitals with I.P.D facilities and specialist doctors were consider as tertiary level hospital.

Sr. No	Facilities providing tertiary health services	Total number of facilities	No of doctors	Total number of beds
1	District Hospital and Private Practicnor	43	56	578

4) Quaternary Level:

The term **quaternary care** is also used sometimes as an extension of tertiary care in reference to medicine of advanced levels which are highly specialized for quaternary level hospitals with more than one specialist doctor was considered with I.P.D services.

Sr. No	Facilities providing primary health services	Total number of facilities	No of doctors	Total number of beds
1	Private Practice nor	12	28	363
2	Welfare hospitals	2	36	460

Accessibility:

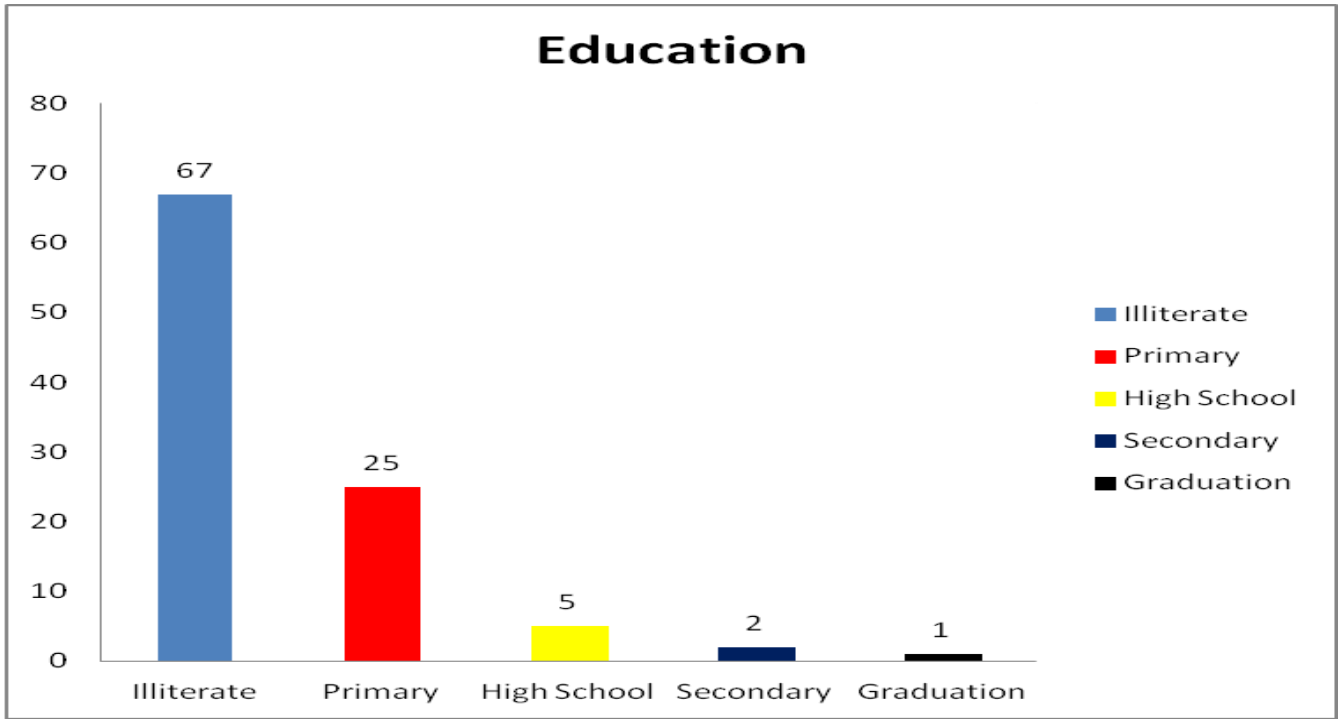
To measure the current situation in accessibility of the available services data of number of O.P.D and I.P.D in General medicine and gynecology ward for the month of April was collected from 4 private hospitals and District hospital.

Sr. No	Type of Hospital	Total Number of O.P.D			Total I.P.D		
		MED	GYN	URBAN	MED	GYN	URBAN
1	District Hospital	2397	513	1576	236	227	150
2	RSBY-Empanel(PVT)	331	201	208	48	89	33
3	Non RSBY Empanel(PVT)	776	287	645	120	102	187

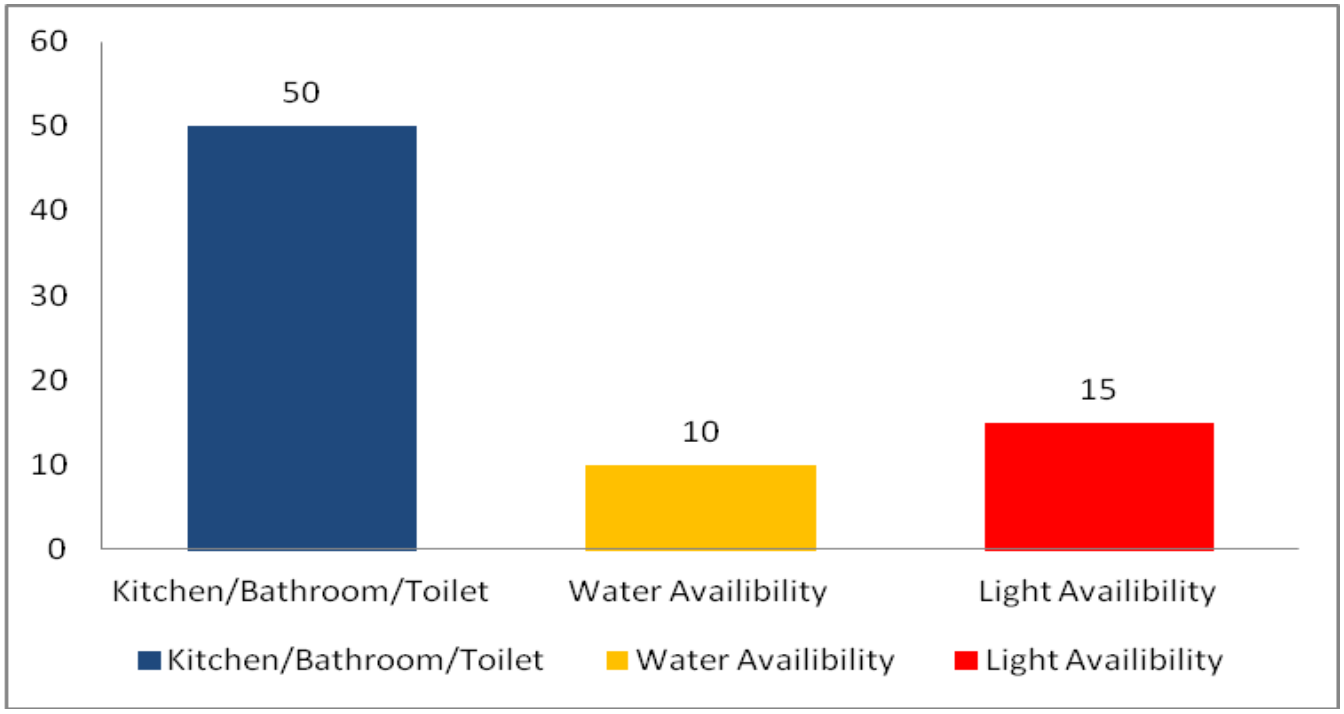
All the 5 facilities are placed in a radius of 2-3 k.m of the district hospital. These hospitals are located in main city.

FINDINGS:

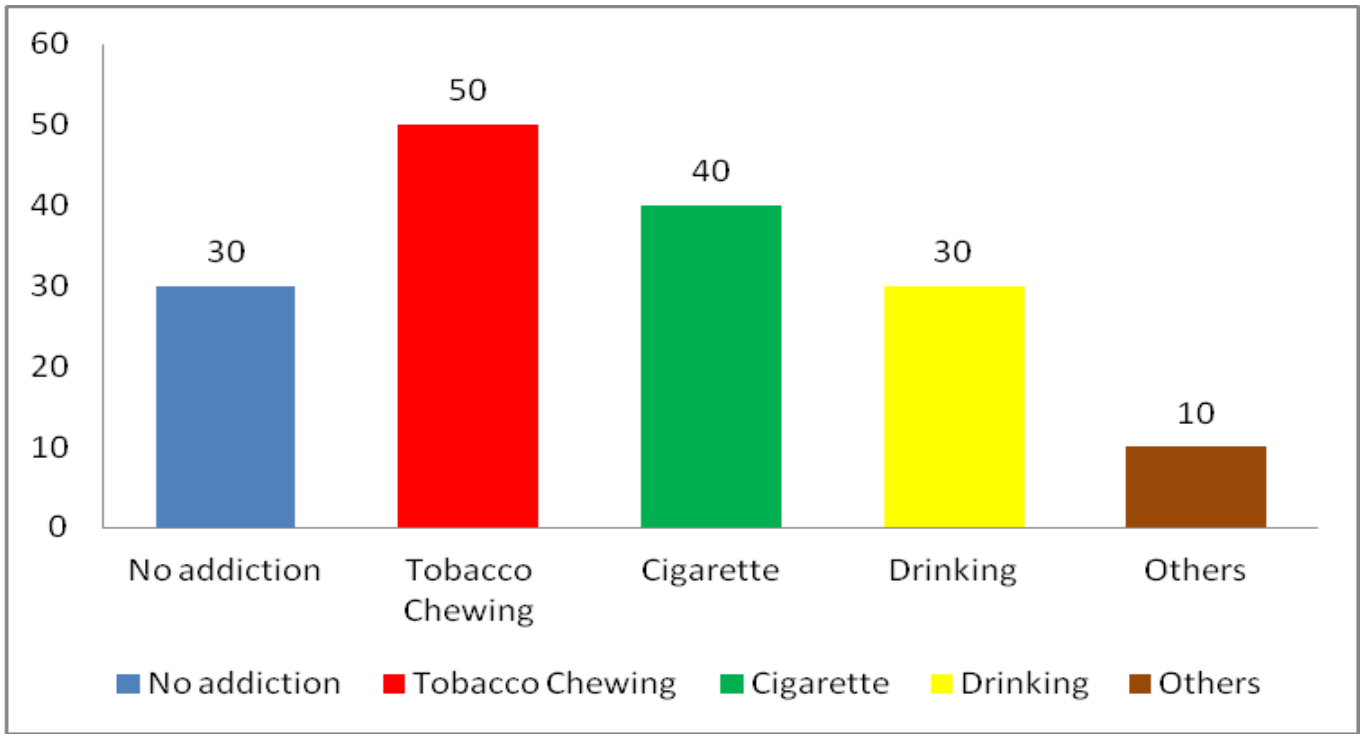
LITERACY LEVELS:



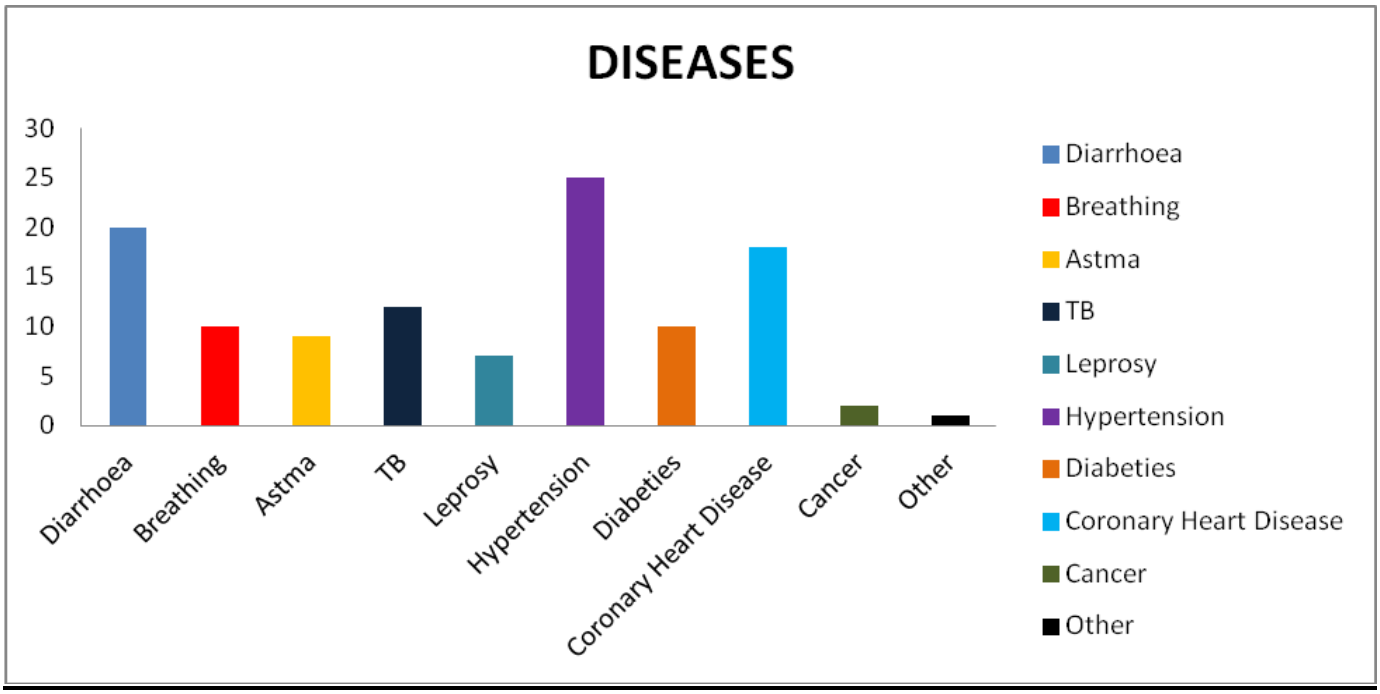
LEVEL OF FACILITY AVAILABLE:



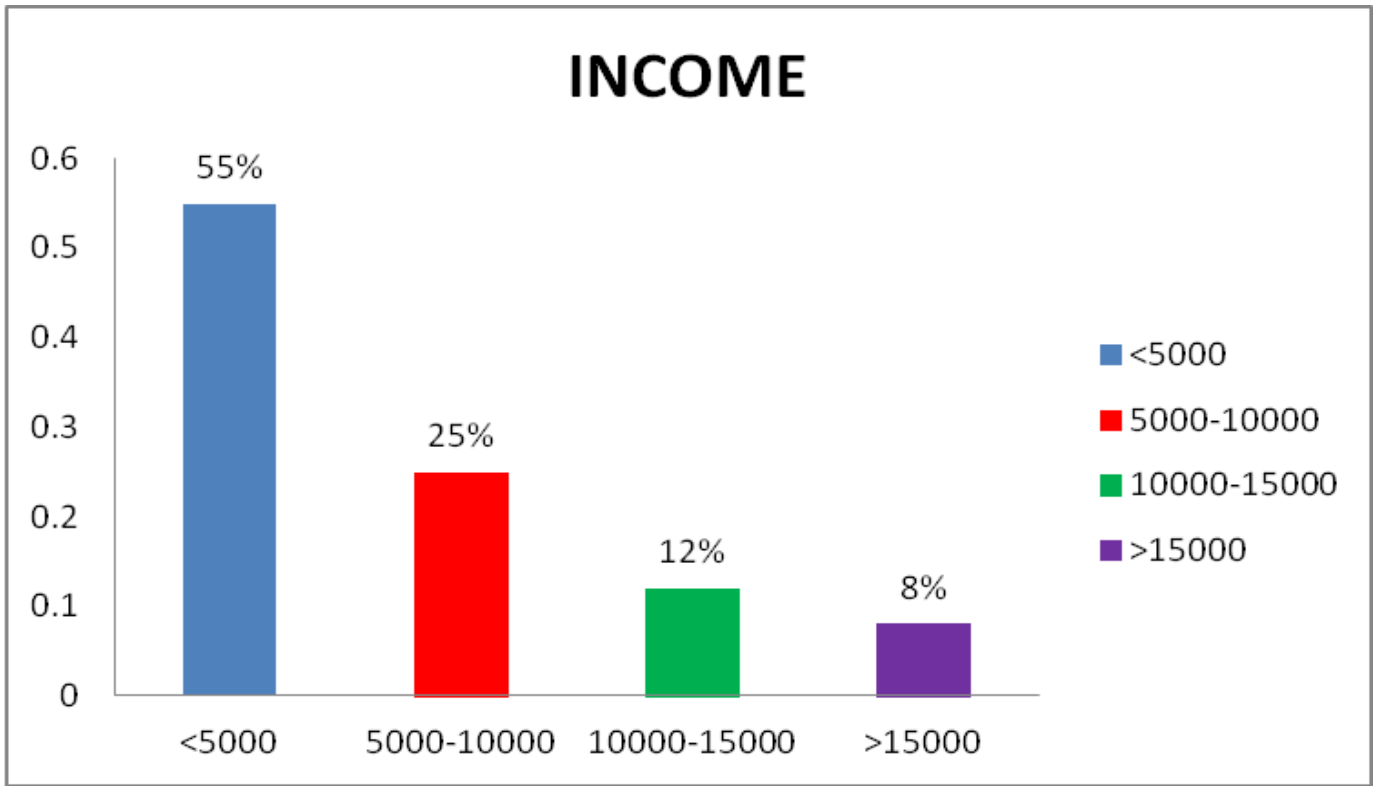
LEVEL OF ADDICTION:



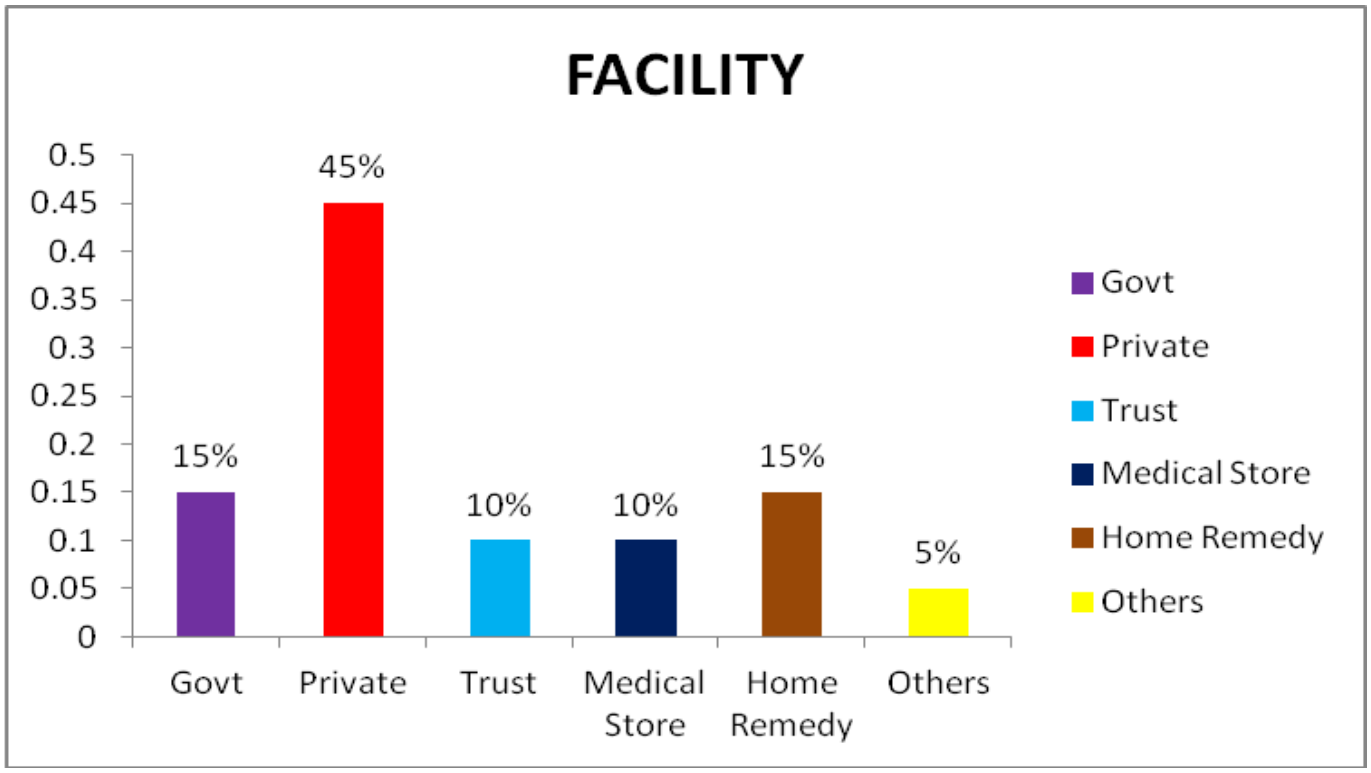
DIFFERENT MORBIDITY PRESENT:



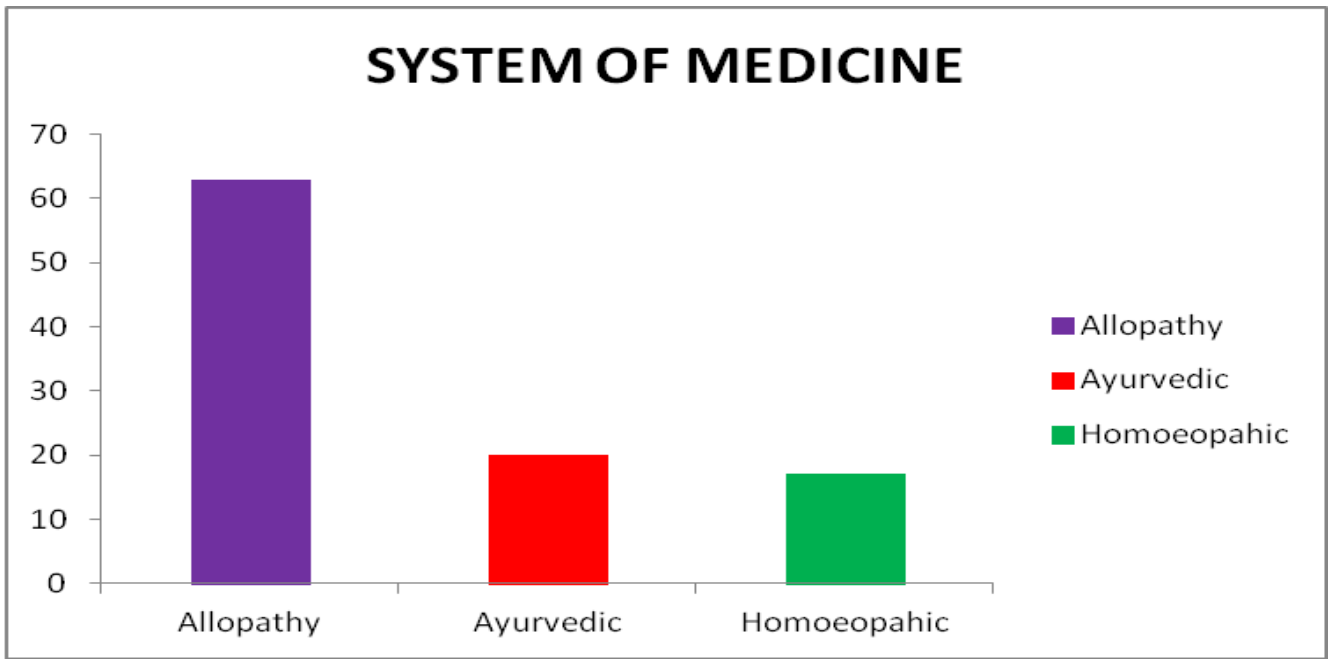
INCOME LEVEL:



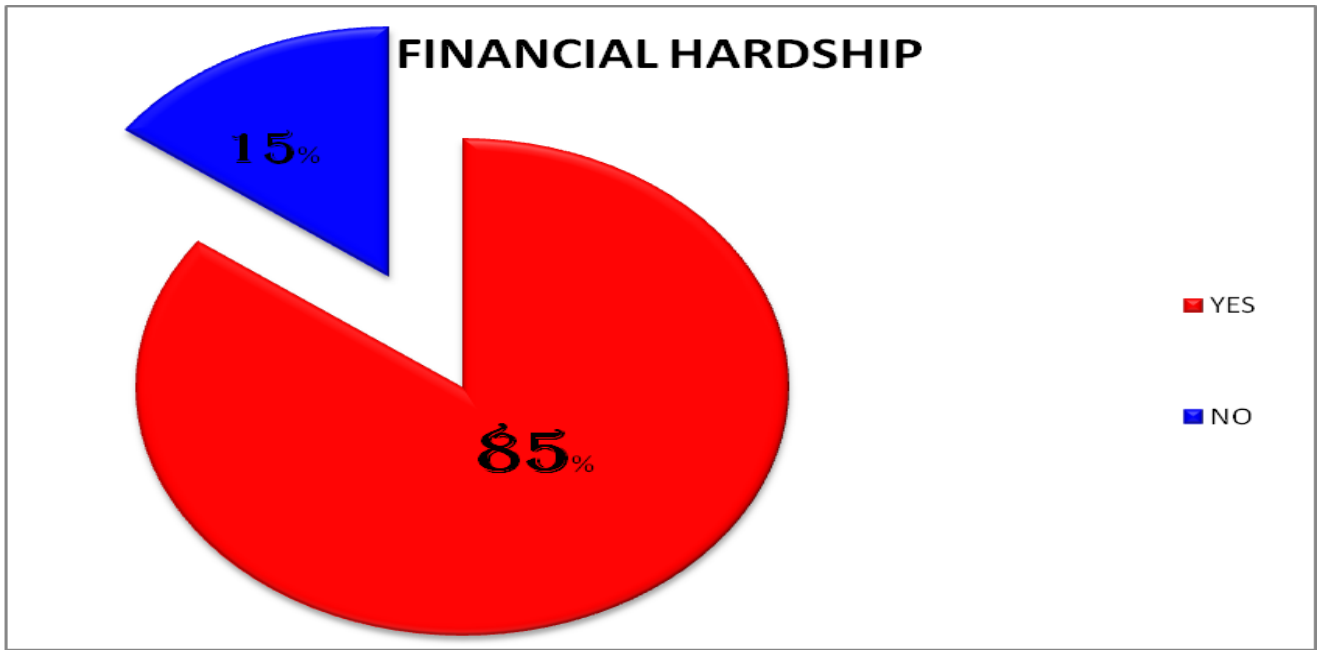
TYPE OF FACILITY:

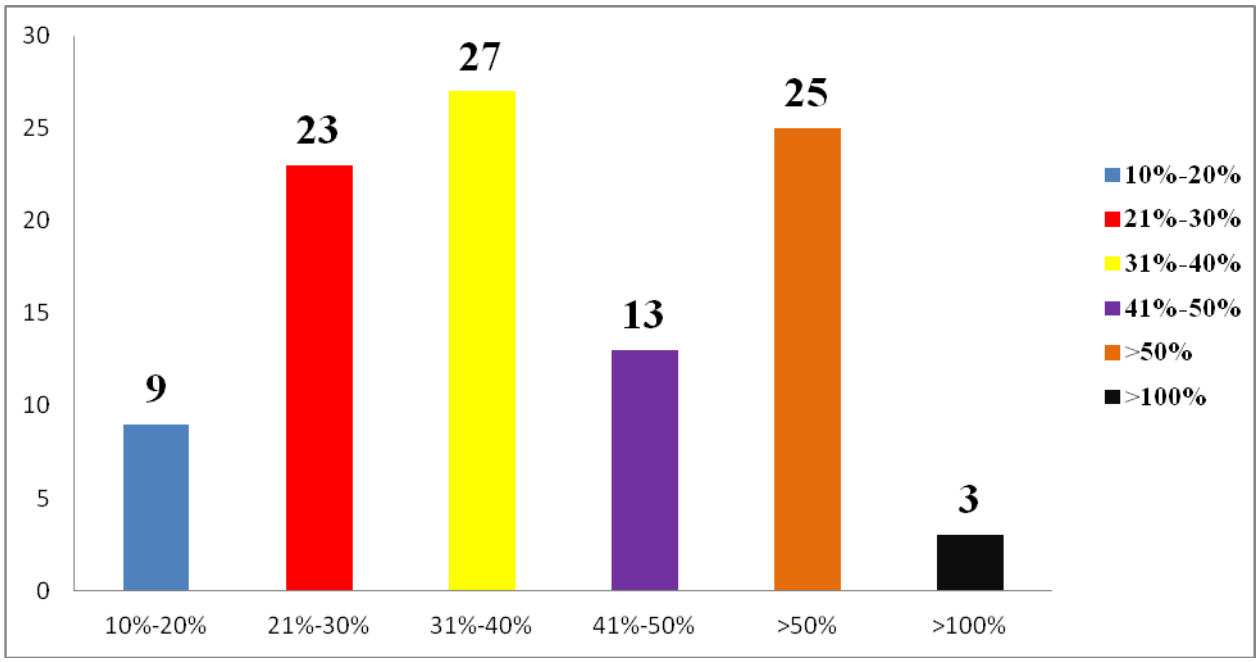


SYSTEM OF MEDICINE:



FINANCIAL HARDSHIP:





CHALLENGES:

- **Availability of necessary staff.**
- **Availability of specialist at the public facility.**
- **To increase the public institutional delivery from 48% to 60%.**
- **To decrease Home delivery by NON-SBA.**
- **To have full immunization coverage 85% to 95%.**
- **To decease the malnutrition among children**
- **To look for providing safe and clean drinking water**
- **Mobilising the people to public facility**
- **To create awareness among people for health related issues.**

RECOMMENDATIONS AND APPROACHES:

1. **Awareness**
2. **Mobilizing the community to the health facilitates.**
3. **Creating awareness about the different health related risk factors and problems by USHA**
4. **Conducting health activities so that the percentage of non communicable diseases can be under check.**
5. **Strengthening of public system and reorganization to replace private care for the poor and middle class.**

CASE STUDY:

Introduction:

India, like rest of the developing world, is witnessing rapid urbanisation. Almost 27.8% of its population of 285.4 million lives in urban areas. Population residing in urban area in India, according to 1901 census, was 11.4%.This count increased to 28.53% according to Census of India, 2001, and crossing 30% as per Census of India, 2011, standing at 31.16%. This means that urban population increased by 68 million people during this period. Population projections by the United Nations (2005) indicate that by 2030, urban population of India will grow to 538 million with more than half of the total population living in urban areas.

The near total absence of civic amenities coupled with lack of primary health care services, in proportion to the explosive growth of population in most urban poor settlements has an adverse impact on the health status of its residents. The health of the urban poor is significantly worse than the rest of the urban population and is often comparable to the health conditions in rural areas. Utilization and reach of primary health services is poor and vary among urban communities in India even though there may be physical proximity to advanced health care facilities.

Methodology-

This chapter discusses the methodology adopted for conducting the study. It includes the

Target respondents, sampling, study area etc. in detail.

Study Design-

A Cross Sectional study

Study Area

Bharuch Nagar palika, the wards vicinity to urban heath center.

Sample size

Total participants 60 respondents will be selected for 6 focus group discussion (10 in each group) and 2 from each ward having at least one UHC .The participants are selected basing on following criteria.

1. Random sampling: Using alternate house hold number assigned by the Nagar palika and assigning 20 individuals in to two groups.
2. Approximately Equal numbers of representatives from both the sex are taken.
3. Usually head of the family are consider if absent then any adult members were selected.

Study Area: Bharuch Nagar palika, the wards vicinity to urban heath center.

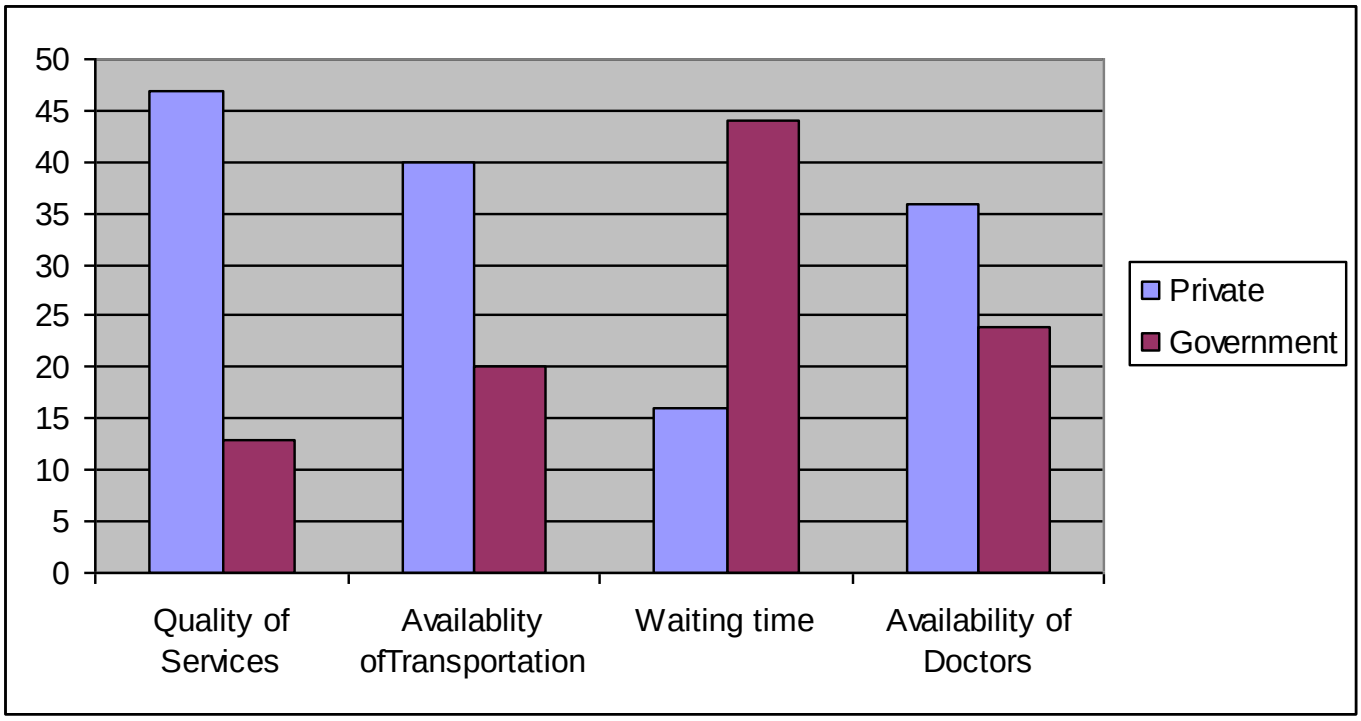
Data collection Tool –

- Primary data was collected by conducting FGD.
- Secondary data was collected from monthly performance records of district hospital and private hospital.
- Use IPH norms for accessing the urban health facilities(DH,UHC)
- Check list to access the health care facilities.

To understand the perception of people availing services from informal providers

FGD were conducted. Overall 6 FGD were conducted which included 60 participants from different age group. 6 FGD were conducted vicinity to 3 UHC. During the focus group discussion the responses of the participants were noted down. The FGD emphasized on 4 main points to understand the main reason of people availing services in any health facilities which were

- Quality of Services
- Transportation Facilities to the availing health facilities
- Waiting Period
- Availability of services



Recommendations-

- Establish fully functional UHC in Bharuch district to reduce the overcrowding of patients in District hospitals.
- Promote UHC in Bharuch district as many of the beneficiaries are unaware of the available facilities in UHC.
- Promote state and GOI initiated different schemes such as KPSY and JSSK to increase the flow of patients in government hospitals

QUESTIONAIIRE

શહેરી વિસ્તારનાં ગરીબલોકોમાં આરોગ્ય વિષયક સેવાઓ મેળવવાના વર્તન-વ્યવહાર

આ સંશોધનન નેશનલ અર્બન હેલ્થ મશિન હેઠળ કરવામાં અવી રહયુ છે જેમાં તમારી ભાગીદારી મહત્વની છે.

આ સંશોધનમાં તમારી ભાગીદારી ખુબ જ મહત્વની છે, આનાથી તમને ભવિષ્યમાં આરોગ્યલક્ષી સેવાઓનો લાભ મળી શકે છે.

આ પ્રશ્નાવલીમાં અમુક પશ્નો અંગત હોય શકે છે જે ના જવાબ આપવામાં તમને શરમ-સંકોચ અનુભવાય અને તમને જવાબ આપવાનુ અનુકુળ ન પણ લાગે પરંતુ તમે આવા પ્રશ્નોના જવાબ આપશો તો તમારી ભાગીદારી તમારા અને અમારા માટે લાભદાયી હશે.તેમજ તમારી વિગતો ગોપનીય રાખવામાં આવશે અને આ સંશોધનમાં તમારી ભાગીદારી સ્વેચ્છીક છે.

સંમતિ

હું આ સંશોધનમાં ભાગ લેવા માટે સહમત છુ.

સહભાગીની સહીં.....

ઈન્ટરવ્યુ લેનારની સહી.....

તારીખ.....

૧. નામઃ

૨. ઉંમરઃ

૩. ભણતરઃ

૪. છોકરો/છોકરીઃ

૫. પરણિત/અપરણિત/છુટાછેડા/વિધવા/વિધૂરઃ

૬. સરનામું:

૭. એસ.સી/એસ.ટી/ઓબીસી/અન્યઃ

૮. વિભકત કુંટુંબ/સંયુકત કુંટુબઃ

૯. ઘરમાં કુલ સદસ્યોની સંખ્યા :

૧૦. વ્યશન :

૧૧. રહેનાર ઘરમાં બાથરૂમ / સંડાસ / રસોડાની વ્યવસ્થા :

૧૨. રહેનાર ઘરમાં પાણીની વ્યવસ્થા છે? :

૧૩. રહેનાર ઘરમાં લાઇટની વ્યવસ્થા છે? :

૧૪. કુંટુંબમાં બધાનું રસીકરણ થયેલ છે?

૧૫. બીપીએલ કાર્ડ છે?

૧૬. આરએસબીવાય કાર્ડ છે?

૧૭. મહિનાની આવકઃ

૧૮. નજીકના સમયમાં તમારા કુંટુબમાં કોઇ બિમારી/અકસ્માત થયેલ છે?

૧૯. થયેલ છે તો કઇ ? :

૨૦. તમે તેના માટે શું સારવાર લીધી હતી, હા કે ના ?

૨૧. જો હા તો દવાલીધી/ઘરગથ્થુસારવાર/દાખલઃ

૨૨. સારવાર લીધી તો કયા?સરકારી દવાખાનામાં કે ખાનગી દવાખાનામાં..?

૨૩. આર્યૂવેદીક/એલોપેથીકઃ

૨૪. તમારી માંદગી કેટલા સમય સુધી રહી હતી?:

૨૫. માંદગી દરમ્યાન થયેલ કુલ ખર્ચઃ

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