Primary Healthcare in Urban Slums

A look at the poor status of healthcare for urban slums in Maharashtra, and the differences between rural and urban areas of the state in terms of delivery of healthcare services.

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This paper addresses the underdevelopment of the urban health policy in Maharashtra, the state which has the highest number of slum dwellers in the country. Yet primary healthcare for urban slums remains in a state of neglect. Maharashtra faces the challenge of providing primary healthcare services to a slum population of more than 40 million [Census of India 2001]. The issue of primary healthcare for slums requires the immediate attention of policymakers given the rapidly growing urban population.

The paper describes the health status of slum dwellers in Maharashtra and discusses the constraints in the existing urban health delivery system. It examines the quality of primary services provided by the health posts in urban areas, outlines key areas for policy advocacy and recommends specific steps to improve primary healthcare services. The paper also highlights the differences within the urban sector, for example between recognised and unrecognised slums; and corporation and council towns, etc.

Health posts and post-partum centres in urban areas have by and large become hospital-based programmes which do not cater effectively to slum populations. The present scenario depicts a depressing picture where the poorest and most vulnerable groups residing in urban slums are outside the ambit of any public health coverage.

The health status in urban slums is presented in three sections – women's health, child health and emerging issues like HIV/AIDS and TB. The low health status of women can be seen from indicators such as antenatal care coverage, prevalence of anemia, prevalence of reproductive tract infections and violence against women. An assessment study on maternal and child health in urban Maharashtra (excluding Greater Mumbai) presents findings on slums, council towns and municipal corporations [Godbole and Talwalkar 2000].

The data for the urban study conducted by Godbole and Talwalkar comes from 8,575 women, who had delivered within 12 months or less of the survey. Table 1 provides antenatal care coverage by slums and non-slums, by type of municipal council and overall for urban and rural areas. The difference between slums and non-slums is quite high, especially for three or more ante-natal check-ups – 55 per cent for slum women compared with 74 per cent for non-slum women. Only 34 per cent women reported a birth interval of more than three years in slum areas as compared with 51 per cent non-slum women. About 58 per cent women in urban slums reported to have taken a complete dose of iron and folic tablets. Slums consistently report lower coverage than non-slum areas. Table 1 also indicates that the situation of A, B and C type councils is deplorable and is comparable to that of urban slums in larger cities.

Anemia is an underlying cause for a range of morbidities and severe anemia is a cause of maternal mortality. The consequences of anemia are severe, long term and often irreversible. A study conducted in the Pimpri-Chinchwad area indicated that out of a total of 1,797 women registered for antenatal care at the PCMC Bhosari hospital in 2000, about 83 per cent were anemic (hb < 11 gms/dl). The proportion of anemic pregnant women increases to 89.6 per cent for unrecognised slums [Khilare 2001].

Research conducted by the Institute of Health Management, Pachod (IHMP) in 27 slums of Pune indicates that women suffer from many preventible morbidities. Post-abortion complications are reported in 42 per cent of the cases (Table 2). As many as 44 per cent women from urban slums did not seek treatment for reproductive tract infections. Data also indicate that 68 per cent women harbour negative gender attitudes against themselves – a result of the process of socialisation. These attitudes have a direct impact on their treatment-seeking behaviour and utilisation of antenatal services [Kapadia-Kundu and Tupe 2001]. Violence against women is widely prevalent. Of the sample of 1526 women, about 28 per cent women were beaten by their husbands in the past one year. This was reported either by the women or their husbands [IHMP 1998a, 1998b].

The differences between slum and non-slum areas are also evident in the use of spacing methods and in the use of male contraceptive methods. While 18.6 per

Table 1: Antenatal Care of Mothers Delivered during Previous Year by Type of Urban Residence, 1998
(Per Cent Covered)

Antenatal care/ Residence	Slums	Non-Slums	Corpo-rations	Council Type			Urban	Rural
				A*	B*	C*	1998	1997
Booster Dose of TT	84	93	90	83	76	74	83	81
Three or more ANC check-ups	55	74	69	50	52	53	59	49
IFA full dose	58	63	62	60	63	68	63	31
Birth interval > 36 months	34	51	45	35	49	48	44	21

Notes: * Type A: consisted of councils having population of 1 lakh or more;
Type B: between 40,000 and 1 lakh;
Type C: below 40,000.
Source: Godbole and Talwalkar (1999).

Table 2 : Women's Health Indicators in Slums, Pune 1998

Indicators	Per Cent
Proportion of women reporting abortion in previous two years (n= 1,526)	4
Proportion of women reporting post abortion complications (n = 62)	42
Proportion of women reporting RTIs (reproductive tract infections) (n=1,526)	11
Treatment not taken for RTIs (n = 162)	44
Violence against women (n = 1,526)	28

Source: IHMP (1998a).

cent couples in non-slum areas use male methods, the figure drops to only 4.6 per cent in slum areas. Similarly, the use of spacing methods in non-slum areas is about three times higher (31.8 per cent) compared than in slum areas [PMC 2000].

The state of child health in urban slums is comparable to that in rural areas and in some cases even worse. This is especially so in immunisation. The data on immunisation comes from a sample of 8,571 children, 12-23 months [Godbole and Talwalkar 1999]. Table 3 indicates that while OPV3 (oral polio vaccine) coverage is 92 per cent in rural areas, it is only 79 per cent in urban slums. Measles coverage is the lowest in type B and C municipal councils (65 and 66 per cent); lower than the rural coverage (85 per cent, Table 4). Coverage levels of Vitamin A (first dose) are also much lower in urban areas than rural areas (Table 3). A possible reason for the low level of coverage for urban slums is that while immunisation services are provided at the village level in rural areas, in urban areas they are still largely provided in hospital or clinical settings.

Other child health indicators are presented in Table 4 based on a sample of 16,967 children of 0-23 months [Godbole and Talwalkar 1999]. Breastfeeding within the first hour is only 16 per cent in slums. The levels of breastfeeding within the first hour are lowest in the municipal councils (Table 4). The proportion of low birthweight babies is substantially higher in urban slums (27 per cent) than in non-slum areas (18 per cent). This finding is supported by another study in Pimpri-Chinchwad area where the proportion of low birth-weight babies born from slum and slum-like areas ranged between 26 per cent and 27 per cent [Khilare 2001]. This is much higher than the 10 per cent low birth weight goal set for the achievement of health for all by 2000. Table 4 indicates that slum areas have the highest proportion of underweight children (0-23 months) followed by type A council towns.

The urban poor are spending substantially on childhood illnesses such as diarrheoa and acute respiratory infections (ARI). Average monthly expenditure on diarrhoea in households with children under five years is Rs 76 in unrecognised slums against of age Rs 41 in recognised slums [IHMP 1996]. Only 10 per cent of the slum dwellers reported using government/corporation services to treat childhood illnesses such as diarrhoea and ARI [IHMP 1998].

The increasing incidence of TB and HIV/AIDs in urban areas represents another major concern for urban health. It is estimated that about 60-80 per cent HIV persons develop TB [Kulkarni 1999].

With a population of over one billion, India possibly has the highest number of HIV-infected people in the world, currently estimated at about 3.8 to 4 million ('Living with AIDS', *Indian Express*, June 7, 2001). This figure is doubling every 2-3 years. And women's burden of the disease is 50 per cent. Most of these cases have been reported from urban areas.

The interrelationship between TB, HIV and general morbidities indicates the need for an integrated healthcare system to address these problems. The need for providing primary health services for the management and control of TB and HIV requires intervention at the highest policy level.

The strongest rationale for a focus on urban slums comes from the growth of

Table 3: Percentage of Immunisation of Children (12-23 Months) by Type of Urban Residence

Immunisation/ Residence	Slums	Non-Slums	Corpo-rations	Council Type			Urban 1998	Rural 1997
				A*	B*	C*		
BCG	96	99	98	95	94	96	96	93
OPV3	79	94	93	95	88	92	93	92
DPT3	88	93	92	86	95	88	88	92
Measles	79	88	85	79	65	66	78	85
Vitamin A (First Dose)	48	56	53	63	61	56	57	80

Note: * As per Table 1.
Source: Godbole and Talwalker (1999).

Table 4: Percentage Coverage of Selected Indicators (0-23 Months Age) for Child Health

Indicators/ Residence	Slum	Non-Slum	Corpo-ration	Council Type			MICS	
				A	B	C	Urban (1998)	Rural (1997)
Breast feed within first hour	16	18	17	15	11	13	15	22
Low birth weight*	27	18	21	9	15	10	15	–
Under weight children	48	36	39	42	38	38	40	41

Note: * Goal for 2000 AD is reduction of percentage of low birth weight babies to below 10.
Source: Godbole and Talwalkar (1999).

Table 5: Some Important Health Indicators from 16 Recognised and Unrecognised Slums in Pune (1996)

Indicators	Recognised Slums	Unrecognised Slums
Immunisation:	n=196	n=190
BCG	99	85
DPT 3	81	67
Polio 3	59	55
Measles	79	61
Complete immunisaton	45	37
Antenatal care:	n=235	n=162
Per cent registered for ANC	94	84
Per cent receiving TT 2 times or more	78	55
Per cent of institutional delivery	78	65
Mean monthly expenditure on curative care for diarrhoea	n=161	n=162
on children under 3 years	Rs 42	Rs 77
Mean monthly expenditure on curative care for ARI	n=161	n=161
on children under 3 years	Rs 69	Rs 90

Source: IHMP (1996).

Table 6: Staffing Pattern for Health Posts as per Krishnan Committee Recommendations

	Health Post			
	Type A (Less than 40,000 Population)	Type B (40,000 to 1 lakh Population)	Type C (above 1 lakh Population)	Type D (above 3 lakh Population)
Voluntary women workers	1 per 2000 population	1 per 2000 population	1 per 2000 population	1 per 2000 population
Nurse Midwives	1	1	2	2
Male MPWs	–	1	2	3-4
PHN/LHV	–	–	2	3-4
Lady Doctor	–	–	–	1

they urban poor. Data indicate that levels of urban poverty are increasing while rural poverty is decreasing (Independent Commission on Health in India, 1998). Slum areas can be divided into recognised slums, unrecognised slums, temporary settlements and pavement dwellers. Temporary settlements and pavement dwellers are the poorest and neediest groups within the urban spectrum. There is very little information available on both these groups. Biswas and Roy (1998) highlight the need to set up a surveillance system for pavement dwellers to ensure early detection of epidemic outbreaks and to formulate provision of basic health services for this highly vulnerable group.

A study conducted by the Institute of Health Management, Pachod in 16 randomly selected slums in Pune indicates there is a distinct difference between recognised and unrecognised slums [IHMP 1996]. Immunisation coverage for measles was 78 per cent for recognised slums and 61 per cent for unrecognised slums (Table 5). Complete immunisation coverage figures are very low for both recognised and unrecognised slums. For antenatal services such as two TT injections, the coverage is only 54 per cent in unrecognised slums (Table 5).

Health Delivery System in Urban Slums

The government of India appointed the Krishnan Committee in 1982 to address the problems of urban health. The health post scheme was devised for urban areas based on the recommendations of the Krishnan Committee. Its report specifically outlines which services have to be provided by the health post (pp 9-11). These services have been divided into outreach, preventive, family planning, curative, support (referral) services and reporting and record keeping. Outreach services include population education, motivation for family planning, and health education. In the present context, very few outreach services are being provided to urban slums.

The health post (HP) scheme was launched in 1983-84. A deputy director and joint director were assigned to urban health, but functioned chiefly to promote family planning goals [Verma and Bhende 1986]. The scheme is centrally funded, and the financial provisions at present continue to be the same as those 15 years before.

According to the Krishnan Committee recommendations, the health post was to be located 'in' slum areas. The committee had recommended one voluntary health worker (VHW) per 2,000 population with an honorarium of Rs 100. When the health post scheme was initiated in Maharashtra, the VHWs were paid an honorarium of Rs 100. In 1986, the government of India, issued an order discontinuing the services of the VHW. The GoI recommendation was to continue the services of the VHW but without the honorarium. An evaluation of the health post scheme in Maharashtra states that the GoI order amounted to "...a virtual discontinuation of their services. This is what had exactly happened in all the health posts studied by the evaluation team, except for one or two local bodies which continued to pay the VHWs from their own funds" [Varma and Bhende 1986:62]. As a result, today, except for the Mumbai Municipal Corporation, most other urban areas in Maharashtra do not have VHWs.

There are 13 municipal corporations and 232 municipal councils in Maharashtra. A municipal corporation covers a population of above three lakh; there are three types of municipal councils – (A) 1 lakh population, (B) 40,000 to 1 lakh, and (C) less than 40,000. Primary health services are provided in urban areas through health posts. There are four types of health posts (A, B, C and D) according to population size (as per GoI guidelines). Table 6 presents the staffing pattern for the health posts as per the Krishnan Committee's recommendations (pp 13-16).

With rapid urban growth, health posts cover much larger populations than the stipulated criteria. For example, the number of health posts in urban Maharashtra is far fewer than what the current population requires (Directorate of Health Services, Government of Maharashtra, 1996).

Policy directives related to primary healthcare in India have so far been formulated for rural areas. These policy initiatives have been based on the rationale that it is rural areas of the country that require primary healthcare. The focus of policy formulation for health is on rural areas. This is best illustrated by the example of the reproductive and child health (RCH) programme, which was an already accepted policy in 1996, and its implementation process had begun in rural areas. However this programme is yet to be fully integrated into urban health posts even today.

An understanding of policy issues related to urban health. is essential prior to developing policy recommendations. The policy issues related to urban health are divided into five broad areas:

- Uniformity of norms for municipal corporations and councils;
- Expenditure on urban health;
- Coordination of urban health in the state;
- Basic amenities to unrecognised slums;
- Special focus on the municipal council towns.

Uniformity of Norms for Municipal Corporations and Councils: While the rural infrastructure and health delivery system are under the umbrella of the Directorate of Health Services, the same is not true for the urban areas. Each corporation functions independently, and merges crucial primary care services with a clinic-based health delivery system. Most importantly there is no uniform set of norms for urban health posts.

The norm of a D-type health post for a population of 50,000 is also not followed and the number of health posts is far less than the stipulated norms. An additional 110 D-type health posts and 34 A-type health posts are required in Maharashtra [Salunke 1996].

The norm of the health post being located in the slum is violated in most urban areas of the state. In rural areas, an ANM visits the village and provides community-based services. This is not true for

urban slums. Women have to go to a hospital or dispensary to avail of basic services such as immunisation of their children or antenatal care during pregnancy. As a result the urban poor have to spend time and money in travel to the hospital/dispensary to avail of services. Athough the health posts were originally conceived as community-based facilities by the Krishnan Committee in 1982, the reality is completely different. Clubbing preventive and promotive services within a clinical setting shuts out the poorest and neediest.

Decentralised services need to be provided to urban slums just as they are being provided in rural areas. This will help improve coverage figures for immunisation and maternal health. An integrated health delivery system as exists in rural areas needs to be put in place which connects primary, secondary and tertiary levels of service provision.

Expenditure on Urban Health: "The weakest component of the public system is the first-level care services. Only 15 per cent of the public health budget is spent on dispensaries, health posts and maternity homes" [Gill et al 1999:28]. The expenditure on urban health comes from the central government and municipal bodies. The health post scheme is a centrally-funded scheme. This indicates that the state government's expenditure on urban primary healthcare is limited. It is felt that since urban primary health is a core issue, the state government should also allot more money towards it.

Coordination of Urban Healthcare in the State: There are no mechanisms in place to enable the coordination of urban healthcare at the state level. As a result, all municipal bodies do not function under a set of common guidelines. The need to focus on urban health has been recognised by the government of Maharashtra [Narvekar 1997]. A proposal on 'Strengthening Urban Infrastructure' was prepared and submitted to the central government in 1996 [GoM 1996]. Unfortunately, the proposal has languished since. This proposal focuses primarily on expanding urban infrastructure and re-defining the responsibility of urban healthcare.

Basic amenities for unrecognised slums: There is an inherent contradiction in not providing basic health, ICDS (integrated child development scheme) and other services to unrecognised slums because it is here that the need is greatest. Policies and strategies need to be devised to ensure that health services reach those at the highest risk. In the urban context, the most vulnerable areas are unrecognised slums, temporary settlements and pavement dwellers.

Special focus on municipal council towns: The condition of the 232 municipal council towns in Maharashtra with populations of one lakh or less is far worse than that of the municipal corporations [Godbole and Talwalkar 1999]. These require immediate attention in terms of availability of infrastructure and quality of services. Not much data on the municipal towns is available. A special strategy for the council towns needs to be devised.

A perspective 10-year health plan incorporating urban growth trends needs to be developed by the state. At the same time, state funding for urban health needs to increase to ensure that new urban health infrastructure is in place. All planning at the state level (whether for adolescent health, training or TB control) should be done in the urban context too.

The following recommendations are suggested:

- There is a need to increase the urban infrastructure for health at all levels including big cities and small towns to cope with the growing urban population;
- Posts need to be created at various levels within the health department to ensure coordination, monitoring and review of all municipal bodies;
- All health posts should provide outreach services to slum and slum-like areas through the ANM and MPW;
- The recommendation of the Krishnan committee for a community health worker for population of 2,000 should be put into place;
- Ward committees should monitor and demand primary healthcare services from the health post system;
- There should be an intersectoral committee for public health for all municipal bodies;
- The provision of basic amenities for slum and slum like populations is required;
- Special provisions should be made for providing health services to pavement dwellers and temporary settlements;
- New guidelines on the role and functioning of the health post system in view of an integrated and decentralised primary healthcare programme need to be developed and implemented uniformly across all the municipal bodies in the state;
- There needs to be integration of all vertical programmes (such as TB, malaria, HIV/AIDs) with the primary healthcare system in urban areas.

Conclusions

The new draft health policy NHP-2001 recognises the need to provide basic primary care services to underserved populations. However the NHP-2001 recommends the establishment of one primary health centre for a population of 1,00,000 in urban areas. This is a step backwards from the Krishnan committee report which had recommended that there should be one health post for a population of 50,000. With a prolific growth in urban slums in the past 20 years, the new health policy should not advocate a change in the established norm of one health post from 50,000 to 1,00,000 lakh population.

The state government needs to develop health plans for the rapidly expanding urban population. Health policy formulation and implementation for the state must take into consideration urban conditions and needs. Urban growth is occurring primarily in slums and how slum dwellers are to be effectively reached and serviced is a challenge for the healthcare system in Maharashtra. EPW

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