STUDY ON THE STATUS OF IMPLEMENTATION OF NUHM AND HEALTHCARE NEEDS, UTILIZATION OF HEALTH SERVICES AND BARRIERS TO ACCESS AMONG THE INHABITANTS OF AN IDENTIFIED SLUM IN SHIMLA

Dissertation
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By
Akanksha Sood

Under the guidance of
Dr. S.D. Gupta

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
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This is to certify that **Dr. Akanksha Sood,** student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at **National Health Systems Resource Centre, New Delhi.**

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.
I wish her success in all her future endeavors.

COL, (Dr.) Ashok Kaushik
Dean, Academics and Student Affairs
IIHMR, Jaipur

Dr. S.D Gupta
President
IIHMR, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141- 3924738, E-mail: iihmr@iihmr.org, Web.: www.iihmr.org

National Health Systems Resource Centre
Technical Support Institution with National Rural Health Mission
Ministry of Health & Family Welfare Government of India

CERTIFICATE

This certificate is awarded to **Dr. Akanksha Sood**, in recognition of having successfully completed her Internship in the **Public Health Planning Division** at **National Health Systems Resource Centre, New Delhi** for a period of three months from **February, 2015 to May, 2015.**

During her Internship she has completed a study titled '***Status of Implementation of National Urban Health Mission (NUHM) in Shimla and Healthcare Needs, Utilization of Health Services and Barriers to Access among the Inhabitants of an Identified Slum in Shimla***.'

Other major assignments undertaken by her during her internship include:

- Contribution towards drafting the Implementation Framework of National Health policy, 2015.
- Active involvement in the analysis of the comments received on Draft National Health Policy,2015

Her approach towards the work assigned to her during the Internship was very methodical, organised, analytical and marked by attention to details and quality of work assigned.

Satish Kumar

Dr. Satish Kumar

Advisor, Public Health Planning Division

NHSRC, New Delhi

Address: National Health System Resource Centre, NIHFW Campus, Baba Gangnath Marg, Munirka, New Delhi 110067
Phones: 011-26108982/83/84/92/93 Fax: 011-26108994 e-mail: nhsrc.india@gmail.com Website: www.nhsrcindia.org

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled ***'Status of Implementation of National Urban Health Mission and Healthcare Needs, Utilization of Health Services and Barriers to Access among Inhabitants of an Identified Slum in Shimla'*** submitted by **Dr. Akanksha Sood**, Enrollment No. IIHMR-U/01/2013-2015/0005 under the supervision of Dr. **S.D Gupta, President, IIHMR University** for award of **MBA Hospital and Health Management** of the university carried out during the period from April, 2015 to May, 2015 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.

Akanksha.

Dr. Akanksha Sood

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141- 3924738, E-mail: iihmr@iihmr.org, Web.: www.iihmr.org

ABSTRACT

Context:

Urban slum dwellers are most vulnerable to lack of access to health care. In order to effectively address the health concerns of the urban population the Ministry of Health and Family Welfare launched National Urban Health Mission as a sub mission in May 2013, under the wider umbrella of National Health Mission

Aim:

To study the key healthcare needs, pattern of utilization of health services, barriers to access health services among dwellers of Krishna Nagar, an identified slum in the urban Shimla, Himachal Pradesh and to document the status of implementation of National Urban Health Mission in the city with special focus on the poor and vulnerable population.

Setting and Design:

A cross-sectional household survey in an identified urban slum in Shimla.

Materials and Methods:

A closed ended questionnaire was used to collect information on the healthcare needs, utilization of health services, barriers to access health services from 70 households comprising of 304 individuals of both sexes and all ages selected randomly from the identified urban slum- Krishnanagar. Access to basic determinants of good health such as housing, water, and sanitation was also elicited. Besides, health needs based on self-reported disease conditions were compiled. Interviews were help with state health department officials, urban local body officials, medical officers and other health staff

using interview guides to document the extent to services available and status of implementation of NUHM in Shimla.

Results:

Majority of respondents were living in poor housing and insanitary conditions. Besides the burden of communicable diseases (especially in children), incidence of non communicable diseases was found to be as high as 42 percent in the survey population. Private medical practitioners were more accessible than government facilities. More than 60% sought treatment from private medical facilities for their own ailments as well as for sickness in children. The main barriers to health care identified were time constraints, long waiting time, affordability and attitude of health workers.

Conclusion:

The underprivileged in Shimla continue to have poor access to basic determinants of good health as well as to curative services from government sources during illness. The efforts in the planning and implementation of National Urban Health Mission have still to see the wide light of the day.

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LIST OF ABBREVIATIONS

NUHM	**National Urban Health Mission**
NHSRC	**National Health Systems Resource Centre**
UNFPA	**United Nations Population Fund**
NFHS	**National Family Health Survey**
U5MR	**Under Five Mortaliy Rate**
U-PHC	**Urban- Primary Health Centre**
SPSS	**Statistical Package for Social Sciences**
BPL	**Below Poverty Line**
OBC	**Other Backward Classes**
SC	**Scgeduled Caste**
ST	**Scheduled Tribe**
MAS	**Mahila Arogya Samiti**
ULB	**Urban Local Body**
ANC	**Ante Natal care**
RNTCP	**Revised national Tuberculosis Control Programme**
JnNURM	**Jawaharlal Nehru National Urban Renewal Mission**
ASHA	**Accredited Social Health Worker**
ANM	**Auxiliary Nurse Midwife**

1. INTRODUCTION

1.1 Background

India is witnessing rapid urbanization. As per the 2001 Census, 28.53% of the population resided in urban areas, and by 2011 Census, the figure had reached 31.16%. UNFPA estimates that by 2030, 40.76% of country's population will be urban. Unprepared for such rapid growth, the cities lack infrastructure and basic services. Nearly one-third of urban inhabitants are living in slums or slum-like conditions. NFHS-3 (2005-06) figures highlighted that nearly 100,000 babies in Indian slums die every year before their fifth birthday. Poor access to healthcare, poor nutrition and health-seeking behaviour, poor environmental conditions and high prevalence of infectious diseases contribute to the high maternal and child morbidity and mortality among the urban poor.

Despite the supposed proximity of the urban poor to urban health facilities their access to them is severely restricted. This is on account of their being “crowded out” because of the inadequacy of the urban public health delivery system. Ineffective outreach and weak referral system also limits the access of urban poor to health care services. The social exclusion and lack of information and assistance at the secondary and tertiary hospitals makes them unfamiliar to the modern environment of hospitals, thus restricting their access. The lack of economic resources inhibits/ restricts their access to the available private facilities. Further, the lack of standards and norms for the urban health delivery system when contrasted with the rural network makes the urban poor more vulnerable and worse off than his rural counterpart.

The urban poor suffer from poor health status, as per NFHS III data under 5 Mortality Rate (U5MR) among the urban poor at 72.7, is significantly higher than the urban average of 51.9, More than 50% of urban poor children are underweight and almost 60% of urban poor children miss total immunization before completing 1 year. Poor environmental condition in the slums along with high population density makes them vulnerable to lung diseases like Asthma; Tuberculosis (TB) etc. Slums also have a high-incidence of vector borne diseases (VBDs) and cases of malaria among the urban poor are twice as many than other urbanites.

In order to effectively address the health concerns of the urban population the Ministry of Health and Family Welfare launched National urban Health Mission as a sub mission in May 2013, under the wider umbrella of National Health Mission. The National Urban Health Mission therefore aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. The NUHM lays special emphasis and focus on the urban population living in listed and unlisted slums and all other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers and other temporary migrants. Keeping in view the broad aim and objectives of NUHM the present study intends to focus on the healthcare needs, pattern of utilization and barriers to access to the healthcare services in an identified urban slum population and vulnerable groups in Shimla and document the status of implementation of NUHM with special reference to the study population.

1.2 Research Questions

1. What are the key healthcare needs of the population in the identified slum area in Shimla?
2. What is the availability and the pattern of utilization of health services and the barriers to access the healthcare Services in the identified slum area of Shimla?
3. What is the status of Implementation of NUHM in Shimla?

1.3 General Objective

To find out the key primary health needs and pattern of utilization of health services and barriers to access in the identified urban slum populations in Shimla and document the extent of implementation of National Urban Health Mission (NUHM) to meet the healthcare needs of the study population.

1.4 Specific Objectives

1. To find out the key health needs of the identified slum population in Shimla.
2. To map the availability of healthcare providers to the identified slum population.
3. To delineate the pattern of utilization of healthcare services and barriers to access.
4. To document the status of implementation of strategies and activities proposed under NUHM to meet the healthcare needs of the identified slum populations in Shimla.

2. METHODOLOGY

2.1 Study Design and Study Area

This study is mixed method study conducted in the months of April, 2015- May, 2015 in the city of Shimla, Himachal Pradesh. The study population is the inhabitant of an identified urban slum – Krishna Nagar, in the city of Shimla, Himachal Pradesh. Krishna Nagar was chosen as the study area because of its status as the largest identified urban slum in Shimla. It is situated near Old Bus Stand. 40% of the total slum population of Shimla resides in this particular slum. Settlement is around 90 years old and is scattered in 4 sq. km. of area. Here people came from different states of the country and most of them are engaged in blue collar job in the nearby area.

2.2 Sampling and Data Collection

Information on the key healthcare needs, utilization pattern of health services and barriers to access is obtained through a household survey. The sample size of 70 households which comprised of 304 individuals is covered under this study. Table 1 depicts the population size and the sample size of the study area. According to figures available from officials at Municipal Corporation, Shimla the Krishna Nagar ward consists of more than 1,200 households and the estimated population of the identified slum area is approximately 9000.

The households are randomly selected. Starting from the third household (a random number selected from the last digit of the currency note) every seventeenth household to the right side of the direction of navigation was included in the sample. In case of unavailability of any of the household members the house next to it was included in the

sample. At the entrance of the households surveyed the survey household number was marked with chalk to facilitate the proceedings of next day.

A close-ended questionnaire was used for the purpose of data collection. (Annexe 1) which was pre-tested in the same locality by collecting data from 10 households and required modifications were subsequently made. The households where pretesting of the instrument was done have not been included in the data analysis.

To collect data from the state health officials, urban local body officials, Medical officers and other health staff an interview guide suitably adapted from the Programme Monitoring Tool for NUHM, developed by NHSRC was used. During the study personal interviews were conducted with two State Health Department Officials, one ULB (Municipal Corporation, Shimla) official, seven Medical Officers posted at U-PHC's in Shimla, two pharmacists and 15 other individuals from the Health Staff of U-PHC's. The respondents for in-depth interviews were selected purposively.

Table 2.1 : Population and Sample Size of Study Area

Study Area Total		**Sample Size**	
Household	Population(Estimated)	Household	Population
1213	9200	70	304

2.3 Data Entry and Analysis

The data from household survey was entered into Microsoft Excel template and analysed using Microsoft Excel and SPSS at the end of the data collection. The notes from the interviews with state health officials, urban local body officials, Medical officers and other health staff were expanded at the end of the interview and were manually analysed and compiled to form a report.

3. RESULTS

3.1 Demographic characteristics of the sample population

Table 3.1 presents the demographic characteristics of the sample covered under the study. Of the 304 individuals covered under the study around 57 percent were males and 43 percent females. More than half of the individuals comprising the sample belonged to schedule caste whereas around 29 percent belonged to the general category. The percentage of respondents belonging to the OBC, ST categories was 13 percent and 4.2 percent respectively. The BPL status of the survey population was determined by possession of a BPL card and more than 40 percent of the population was categorized as BPL. Close to 40 percent of the sample population falls in the age group of 20 to 39 years. The elderly, 60 years and above, formed approximately 5 percent of the sample. The currently married population among the sample was found to be greater than 46 percent and the never married population comprised of more than 16 percent of the sample. The Educational Level of the survey population was found to be poor with more than three-forth of the individuals who had studied up to or below Secondary Level of Education. 12.5 percent of the individuals had completed Higher Secondary education and less than 10 percent of the sample population was either graduate or post-graduate. Nearly one-fourth of the sample population worked as door to door garbage collectors under the Municipal Corporation, Shimla. Approximately 19 percent worked as domestic helpers and 14 percent were employed as Safai-Karamcharis. Another 8.5 percent worked as construction workers. The percentage of those unemployed was close to 4 percent.

Table 3.1: Demographic Characteristics of the study sample (N=304)

	Number	Percentage
Sex		
Male	173	56.90
Female	131	43.09
Caste Category		
General	87	28.66
SC	158	51.97
OBC	39	12.8
ST	13	4.27
Others	7	2.30
BPL Status		
Yes	129	42.44
No	175	57.56
Age (in Completed Years)		
Less than 1 year	8	2.63
1-5 years	27	8.88
6-9 years	24	7.89
10-19 years	33	10.85
20-29 years	64	21.05
30-39 years	57	18.75
40-49 years	42	13.81
50-59 years	33	10.8
60 years and above	16	5.26
Marital Status		
Currently Married	142	46.71
Widow/Widower	26	8.55
Divorced/Seperated	9	2.96
Never Married	51	16.77
Not Applicable	76	25.00
Educational Level		
Uneducated	78	25.65
Primary education	85	27.96
Secondary Education	76	25.00
Higher Secondary	38	12.5
Graduate	19	6.25
Post Graduate	8	2.63

Table 3.1 continued : Demographic Characteristics of the study sample (N=304)

Occupation		
Safai Karamchari	42	13.81
Door to Door Garbage Collectors	73	24.01
Domestic Helpers	57	18.75
ConstructionWorkers	26	8.55
Unemployed	12	3.94
Others (including N.A)	94	30.92

3.2 Physical Environment and Determinants of Health

Table 3.2 reflects upon the status of physical environment and determinants of health in the study population. Out of the 70 households covered under the study majority of the houses, close to 60 percent were Semi-Pukka type of Houses with Bricked walls and roof made up of sheets of steel. Nearly 30 percent of houses were pukka constructions. Structures for housing are single storied, one to two room houses. About 37 percent of the households had piped supply of water, whereas for more than 30 percent of households public tap was the source of water. One quarter of the households surveyed depended upon the "Local Bawdi" for their supply of water which according to the respondents was inadequate to meet the requirements of all the dependent households especially in the summer season. Close to 35 percent of the households did not have Toilets and the percentage of households which reported open defecation was alarmingly higher than 25 percent. Sixty five percent of the households had toilets. Close to seven percent of households use public toilets. The Waste disposal and Garbage collection is under the responsibilities of Municipal Corporation, Shimla. It was found during the survey that more than two-third of the households dispose of their garbage through door to door garbage collection, although the members interviewed

reported that the garbage collectors are not regular in their services. Close to 17 percent of the households dispose of the household garbage into an 'Open Nullah' situated at one extreme end of the locality. The entire waste of the Mall road and the Lower Bazar areas flows into the 'Nullah'. During the rainy season, the water level is so high that the 'Nullah' flowing in this ward gets choked and the dirty water enters into the houses of people. According to the figures available from Municipal Corporation, Shimla, more than half of the houses in the Krishna Nagar Slum area are either public or private land encroachments. The sewerage system is open at places and is threatened to become a public health hazard.

Table 3.2: Physical Environment and Determinants of Health (N=70)

	Number	Percentage
Type of House		
Kuccha	9	12.86
Semi Pukka	41	58.57
Pukka	20	28.57
Source of Water		
Piped water	26	37.14
Public Tap	22	31.42
Bawdi	18	25.71
Other	4	5.71
Use of Toilets		
Household Toilets	46	65.71
Public Toilets	5	7.14
Open Defecation	19	27.14
Waste Disposal		
Door to Door garbage Collection	47	67.14
Public dustbin	11	15.71
Open	12	17.14

3.3 Healthcare Needs, Utilization of Healthcare Services and Barriers to Access

To determine key the healthcare needs of the population a sickness record of last one month from the date of visit was taken from the sample households. Of the sample population other than children aged less than five years a high percentage of the individuals were reported sick. A list of symptoms and diseases was used to determine the nature of sickness or disease. Out of the 269 individuals in the sample aged more than 5 years 84 were reported sick (Refer Table 3.3). This figure stands out to be close to one third of the sample population. Of those reported sick, the symptoms of more than 46 percent of individuals related to communicable diseases and water/food borne diseases. The findings suggest that more than 40 percent of the individuals who were reported sick presented with the symptoms of non communicable diseases such as Hypertension, Diabetes, Heart Diseases and Chronic Obstructive Pulmonary Disease. The high incidence of non communicable disease could be linked to high rates of smoking and alcoholism observed in the study population. The incidence of non-communicable diseases was surprisingly high not only in the elderly but in the middle aged population as well. Other diseases such as infestations, burns, allergies, weakness contributed towards 10 percent of the reported sickness.

The health seeking behavior of the population shows that majority of the population seeks treatment for their healthcare needs with more than seventy percent of the individuals reported sick within last one month having accessed some type of healthcare facility. Those who did not seek treatment mentioned time constraint and long waiting hours at the health facilities as the predominant reasons for not seeking health services, 61 and 57 percent respectively. Other reasons for not seeking treatment were rude

behavior of healthcare providers as mentioned by 35 percent of cases and issues of affordability faced by 35 percent of respondents.

It was found that for the reported events of sickness in the sample households in the previous one month, 63 percent had accessed Private Hospitals/ Clinics including Ayurvedic and Homeopathic Clinics for their treatment. Close to 35 percent sought treatment from the government hospital. The government facility most commonly accessed by the slum population is the Din Dayal Upadhyay Zonal Hospital, Shimla; situated at a distance of about 500 m from the slum. Others visited the Indira Gandhi Medical College and Hospital for treatment. Only two of the individuals reported sick had accessed U-PHC for treatment. This could be related to the location of the U-PHC within the premises of the Government Institution they were working at.

For children aged less than five years, the incidence sickness was again as high as 35 percent. Diarrhoea and Acute Respiratory Infection were found out to be rampant in childhood illnesses. Out of the 11 reported events of childhood illness treatment was sought in 8 cases and majority of them were treated at Private Hospitals/ Clinics with only one third of the children who received treatment at Government facilities.

Table 3.3: Sickness Record of last one month from the date of visit reflecting the Healthcare Needs of study population, Utilization of Services and Barriers to Access.

3.3.1 Other than Children less than 5 years of age (N= 269)

	Number	Percentage
Number of Respondents Reported sick in the last 30 days	84	31.22
Type of Disease (N=84)		
Communicable Diseases	39	46.42
Non Communicable Diseases	36	42.85
Others	9	10.71

Table 3.3 (contd.): Sickness Record of last one month from the date of visit

Whether treatment was taken?(N=84)		
Yes	61	72.61
No	23	27.38
Reasons for Not seeking Treatment* (N=23)		
Not Required	4	17.39
Time Constraint	14	60.86
Financial Constraint (Affordability)	8	34.78
Behaviour of Healthcare Providers is rude	11	47.82
Waiting Time Too Long	13	56.52
Others	7	30.43
Utilization of Health Services (N=84)		
Primary Health Centre	2	2.38
Government Hospital	29	34.52
Private Clinic / Hospital	53	63.09

3.3.2 Children Less than 5 years of age (N=31)

Number of Children Less than 5 years of age reported sick	11	35.4
Type of Illness (N=11)		
Fever	5	45.45
Acute Respiratory Infection	4	36.36
Diarrhoea	4	36.37
Others	1	09.09
Whether Treatment was taken? (N=11)		
Yes	8	72.73
No	3	27.27
Utilization of Health Services (N=11)		
Primary Health Centre	0	0.00
Government Hospital	4	36.36
Private Clinic / Hospital	7	63.64

*Multiple answer question

For maternal care services (Table 3.4) the utilization pattern of healthcare services varied from the utilization pattern of services in case of common diseases and ailments. All the four currently pregnant women found in the sample households were registered for ANC services at the DDU Zonal Hospital, Shimla. And for all of them the preferred place of delivery is also Government Hospital. The reason sighted was availability of services at minimal cost. Of the women who had delivered in the previous three years, majority had delivered in the government facilities. Therefore, it can be concluded that the preference for Healthcare services in case of maternal care is for the Government Facilities.

Table 3.4: Utilization of Maternal Care Services

3.4.1 Currently Pregnant Women	
	Number
Number of Women Currently Pregnant in the sample Households.	4
Number of pregnancies registered for ANC	4
Place of Registration	
U-PHC	0
Government Hospital	4
Private Hospital	0
Preference for Delivery	
Home	0
Government Hospital	4
Private Clinic/ Hospital	0
3.4.2 Women who became pregnant in the last three years	
Number of women who became pregnant in the last three years	19
Outcome of Pregnancy	
Abortion	0
Still Birth	2
Live Birth	17

Table 3.4(Contnd.): Utilization of Maternal Care Services	
Place of Delivery	
Home	0
PHC	0
Government Hospital	14
Private Clinic/ Hospital	1
Deliveries conducted in other cities	4

Table 3.5 depicts that of the children under 3 years of age all were reported to be immunized as per the routine immunization schedule. Of the 16 children aged less than 3 years, thirteen were confirmed to be immunized as per the vaccination schedule for their age. The Immunization cards of three others could not be accessed. All of the children received vaccination at Government facilities. It was reported that the Health Sub Centre located in the Slum Area was destroyed in a land slide which occurred last year and has not been made functional since then. The nearest place for getting children immunized is the DDU Zonal hospital, Shimla.

Table 3.5: Immunization Record (Children < 3 years)	
Total Number of children in the age group of 0-3 years	16
Whether child has immunization Card?	
Yes	13
No	3
Place of Immunization	
Government Hospital	13
HSC*	3
*The HSC is in a non functional state following a land slide in the area last year.	

3.4 Availability of Healthcare Providers/ Services

Table 3.6 shows the availability of healthcare providers/ facilities to the study population. The U-PHC located within a distance of 1000 m from the slum area is located in the premises of a

Government institution and largely caters to the staff. The closest government facility is the DDU Zonal hospital, Shimla which is the government facility accessed by majority of the study population for their meeting healthcare needs. Apart from this eight Private practitioners are offering their services in the area of which one is an uregistered practitioner. The availability of 2 traditional faith healers was also noticed in the study area. However, none of the respondents reported sought treatment from the traditional faith healers, which are locally referred to as 'Babas'. One of the faith healer was himself found to be on treatment for Tuberculosis and majority of the people visiting him were from other cities and villages nearby Shimla.

Table 3.6: Availability of Health Care Providers/ Services to the Residents of Krishna Nagar Slum

Government Heath Facilities	4
U-PHC (within 1000m)	1
Din Dayal Upadhyay Zonal Hospital, Shimla	1
Kamla Nehru Hospital, Shimla	1
Indra Gandhi Medical College and Hospital, Shimla	1
Registered Private Clinics	**7**
Ayurvedic Clinics	2
Homeopathic Clinic	1
Allopathic Clinics	3
Dental Clinic	1
Unregistered Practitioner	1
Traditional Faith Healers	2

3.5 Status of Implementation of NUHM

3.5.1 Planning and Mapping

The Process of mapping the slum and vulnerable groups in the city of shimla has been undertaken and the list of the ward wise list of High Focus Areas/ Key Focus areas is p. The mapping is not Geographic Information Systems Based as informed by state health department official.

3.5.2 Scope and Extent of Healthcare Services Provided

The main arrangement for primary care is a number of urban dispensaries which were upgraded to urban Primary Health Centers two years back under the state department of health. There are in all 9 PHCs and 14 AYUSH dispensaries, one sub-center. The services available in these are ante natal services and immunization along with general OPD services and there is no active population coverage. A visit to 9 U-PHC's highlighted that two of the U-PHC's located in the premises of government institutions cater to the healthcare needs of these government institutions without any special emphasis on the poor and vulnerable and do not provide immunization, ante natal care services and services under any of the National Programmes. The National Programme which is being delivered through these PHC's is the RNTCP. The Medical Officers and the Pharmacists at U-PHC's reported that the drugs are adequate and the facilities faced no major stock outs. Whenever drugs are out of stock and requisitions demand time funds of Rogi Kalyan Samiti are utilized to purchase essential drugs. The average OPD at the U-PHC's ranged between 100 to 150.

3.5.3 Community Processes under National Urban Health Mission

The community services are lacking in Shimla. ASHA's have not been recruited in Himachal Pradesh and ANM's conduct the household visits. However during the study 4 ANM's were interviewed at the U-PHC's and all of them revealed that no household visits are being carried out in the city of Shimla due to heavy workload. The ANM at one of the U-PHC's remarked that the health seeking behavior even among the poor and vulnerable population has improved remarkably and none of the ANC cases or children to be immunized remain uncovered by the services.

The formation of Mahila Arogya Samitis is just in its nascent stage. The Rogi Kalyan Samitis under the NUHM are yet to be operationalised and a meeting with the Principal Secretary, the ward Councilors and Medical Officers of the U-PHC's was scheduled to discuss this issue in the week after the visit to the U-PHC's.

3.5.4 Outreach Services

The Anganwadi centres are operational in Shimla and provide Nutritional supplementation. However, Anganwadi centres are not being utilized for conducting routine immunization sessions or Urban Health and Nutrition Days and the state may look into such provisions. One of the Anganwadi workers mentioned that the attendance in these centers is less than satisfactory.

3.5.5 Programme Management Units

No additional staff has been recruited in the State Programme Management Unit. Nevertheless, State Programme Officer (NUHM) has the charge of planning and implementation of NUHM. Recruitments of Consultants dedicated towards

operationalising NUHM has not been done so far. The finances of NUHM are managed by finance assistant also taking care of funds allocated under National Health Mission.

3.5.6 Training and Capacity Building

The State Health Department has to look into state and district level training sessions for Urban Local Bodies, Municipal Health Officers, Medical Officers to orient them towards various objectives of NUHM.

3.5.7 Involvement of Local N.G.O's

The Involvement of Local NGOs is limited to extending some help through voluntary workers in conducting the immunization sessions by mobilizing communities. This engagement was seen at only one of the U-PHC's which serves High Focus colonies of migrant construction workers. Immunization sessions are held on every Wednesday, But Staff Nurse at this PHC reported that since two weeks these voluntary workers from the N.G.O named 'Archana' have not visited.

3.5.8 Convergence with Different Stakeholders

Specific actions for convergence with JnNURM and Rajiv Awaas Yojna were not reported by the State Health Department officials or the Urban Local Body officials. Although the study area, Krishna Nagar Slum, has been identified as the pilot area for implementation of the Rajiv Awas Yojana no system of convergence between the two programmes has been established so far. Provision of Tenure Security and Housing to slum dwellers, Provision of Roads, Water Supply, Sanitation & Sewerage and minimum Social Infrastructure (Basic Services) is covered under DPR, where as the provision of

social facilities like Health, Education and Social Security Interventions are proposed to be converged with ongoing state and central programmes.

3.5.9 Innovative Actions and PPP Projects

The state health department has entered into a PPP with SRL diagnostics to provide laboratory and diagnostic services at District Hospitals, Zonal Hospitals and Medical College and Hospitals and all 100 bedded Civil Hospitals from September 2013. The laboratory services are being provided to the beneficiaries at subsidized rates which is much below the price charged by Private Laboratories.

4. DISCUSSION

There is high rate of childhood illnesses which probably can be attributed to the improper sanitary conditions and deficient sources of water supply in the study area. There is also a remarkably high incidence of disease in population aged 5 and above. The survey has underlined an almost equal burden of communicable and non-communicable diseases in the study population. As the analysis of the occupation of sample population has reflected that majority of population works as door to door garbage collectors and safai-karamcharis there is an indication that the unhygienic working conditions could be one of the probable cause of the high rates of morbidity. One of the respondents who worked on contract under the Municipal Corporation and is involved in the segregation of the garbage collected from households had reported that he developed severe infection because of the insalubrious working conditions in his fingers and had to spend exorbitant amounts in the treatment, eventually his fingers had to be amputated. Insanitary living conditions coupled with deleterious nature of work of the slum inhabitants makes them prone to several infectious diseases. There are high rates of tobacco and alcohol consumption and high rates of drug abuse among the youth have been reported earlier. These conditions form the dwelling ground for chronic diseases which plague the population. Although, the maternal care services and immunization services are available to the population, the inhabitants have to access tertiary level hospitals to procure these services in the absence of Primary Health Care facilities within the slum area or close to it. As a result there is crowding of tertiary level of facilities. The rates of utilization of healthcare services are fairly high amongst the study population, despite of the absence of community processes to motivate them.

There is a clear predilection towards the private sector providers when it comes to seeking treatment for common illnesses and diseases. The major barriers to access the healthcare facilities are time constraints, long waiting time at facilities, affordability and non responsive service providers. However for ante natal, natal and immunization services the government facilities are the main providers of healthcare facilities apparently due to the availability of free services.

The planning and implementation of the National Urban Health Mission is in the very nascent stages. The Programme Management Units need to be better equipped with adequate and skilled staff. Although, the services are adequately available to the poor and vulnerable population through existent public and private sector providers, the lack of community processes and outreach services leads to an underestimation of the healthcare needs of the study population.

5. CONCLUSIONS

5.1 Limitations of the study

The present study was carried out within a strict time frame. The methods may provide less detailed or accurate information than would be provided by more rigorous methods. However, in spite of the inherent limitations we hope the results may be useful to emphasize the major health needs and difficulties in access to health care faced by the population living in the "dark underbelly" of "The Queen of Hills". It is better to have an approximate estimate of important health problems, rather than have a perfect estimate of insignificant health issues. Although the sample studied may not be representative of all slum areas in the state or even the city, it is important to note that this dismal situation prevails in majority of the slum dwellings. The situation elsewhere is likely to be worse than better.

5.2 Strengths of the Study

In absence of any household visits made by community workers/health staff in the study area, this study is first in its efforts to document the healthcare needs to the identified slum population. This study serves as an interim evaluation of the National Urban Health Mission in the city of Shimla to document the extent of and status of implementation of NUHM in the city.

5.3 Scope of Further Research

Factors arising in this study but not explored in detail included the out of pocket expenditure of the inhabitants in meeting their healthcare needs, factors responsible for preference for the private sector while seeking health care, exploring the conditions

which are the probable cause of high rates of morbidity in the sanitation workers or safai-karamcharis and door to door garbage collectors, rate of tobacco and alcohol consumption, drug abuse in the study population and factors precipitating such behavior, in-depth study of the healthcare behaviours of the study population.

5.4 Recommendations

More rigourous efforts to meet the specific healthcare needs of the slum population which are inherent in such dwellings because of the special character which has its own set of norms and values reflected in poor sanitation, health values, means of livelihood and deviant behaviour are required. Making operational Mahila Arogya Samitis in the identified High Risk Areas and training them could help in identifying and serving the healthcare needs of the population. Preference for private healthcare providers despite of the presence of a Zonal Hospital at a distance of about 500 m is indicative of barriers to access and high out of pocket expenditure on healthcare needs by the inhabitants already having meager means of income. Locating and operationalising a U-PHC within the boundary of the identified slum area is advisable. The engagement of stakeholders in operationalising NUHM needs to be focused upon and the mechanisms of convergence with the ongoing Rajiv Awaas Yojnaa Project in the district could be drawn out. The project under its umbrella aims at Provision basic Services with focus on of providing improved housing, water supply, sanitation and health facilities. There is a scope of involvement of local N.G.O's in the constitution and supervision of community bodies.

ANNEXURE 1:

TOOL FOR HEALTHCARE NEEDS, UTILIZATION OF HEALTH SERVICES, BARRIERS TO ACCESS SURVEY IN AN IDENTIFIED SLUM AREA OF SHIMLA

A. FAMILY INTRODUCTION

A1. Household Number ☐☐

A2. Caste ----------

A3. Caste Category: ☐

1. General 2. OBC 3. SC 4. ST 9. Other

A4. BPL

1. Yes 2. No ☐

A5. Total Members in the Family ☐

B. DEMOGRAPHIC DATA

S.No	Name of Family Members who permanently Stay in the household	Sex Male=1 Female=2	Age (in completed years)	Marital Status*	Educational Level**	Occupation
B1	**B2**	**B3**	**B4**	**B5**	**B6**	**B7**
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						

*Codes for Marital Status:

1. CM: Currently Married
2. W: Widow/ Widower
3. D/S Divorced/ Separated
4. Never Married
5. Not Applicable

** Codes for Educational Level

1. Uneducated
2. Primary Education
3. Secondary Education
4. Higher Secondary
5. Graduate
6. Post Graduate

C. PHYSICAL ENVIRONMENT RECORD

C1.	Type of House 1. Kaccha 2. Semi Pucca 3. Pucca	☐
C2	What is the source of water? 1. Piped water 2. Public Tap 3. Standpipe 4. Tube well 5. Hand pump 9. Other (Specify) ……..	☐
C3	Is there a toilet in the house? 1. Yes 2. No (If No Skip to C6)	☐
C3.a	If Yes, among family who use the toilet? 1. All members 2. Only Older people 3. Only women 4. Children 5. No one	☐
C3.b	If No, ask the place used for defecation. 1. Public toilet 2. Open Defecation 9. Other (Specify)…….	☐
C5	Where do you dispose the household garbage? 1. Dustbin in the house 2. Public dustbin 3. Outside house in open 9. Others (Specify) ……	☐

D. SICKNESS RECORD

D101. Total Number of Members (other than children less than 5 years of age) reported SICK in the last 30 days in the family ☐

	Sick Person	1	2	3
D1	Name / Serial Number from Family Record			
D2	Ask from any Symptom illness listed below (Multiple Response expected: Circle the number if present) 1. Fever 2. Loose Motion 3. Vomiting 4. Common Cold/Cough 5. Yellowish Discoloration of skin 6. Minor Injury/ Bruise 7. Fracture 8. Allergy 9. Burn 10. Worm Infestation 11. High Blood Pressure 12. Diabetes 13. Heart Related Problem 14. TB 15. Leprosy 16. Depression 17. Cancer 18. Others	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 …… ……	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 …… ……	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 …… ……..

	(Specify)			
D3	Was any treatment taken? 1. Yes 2. No 3. Don't know	1 2 3	1 2 3	1 2 3
D3. a	If not, why wasn't the treatment sought? 1. Not required 2. Time constraint 3. Financial Constraint 4. Behaviour of Healthcare providers is not friendly 5. Too much time is lost in facility 6. Loss of Wages 9. Others (Specify)	1 2 3 4 5 6 9 …… …….	1 2 3 4 5 6 9 …… …….	1 2 3 4 5 6 9 …… ……..
D3. b	If Yes, from where was the treatment taken? (Multiple Response expected: Circle the number if present) 1. Anganwadi Centre 2. Sub centre 3. PHC 4. CHC 5. Government Hospital 6. Ayurvedic Hospital 7. Homeopathic clinic	1 2 3 4 5 6 7 8 9 …… ……	1 2 3 4 5 6 7 8 9 …… ……	1 2 3 4 5 6 7 8 9 …… ……..

	8. Private Clinic 9. Other (Specify the Healthcare facility accessed)			

Record of Sick Child under 5 years of age reported in last one month from the date of visit

D101. Total Number of children below 5 years of age in the family ☐

	Sick Child	1	2	3
	Name/Serial Number from Family Record			
D4	Did the Child suffer from any illness in last one month? Multiple Response expected: Circle the number if present 1. Fever 2. Acute Respiratory Infection 3. Diarrhoea 4. None 9 Other (Specify) (If None for Skip to Section E)	1 2 3 4 9 …… ……	1 2 3 4 9 …… ……..	1 2 3 4 9 …… …….
D5	Did the child receive any treatment?	1 2	1 2	1 2

	1. Yes 2. No			
D5 .a	If yes where was the child taken for treatment? 1. Anganwadi centre 2. Sub centre 3. PHC 4. CHC 5. Government Hospital 6. Ayurvedic Hospital 7. Homeopathic clinic 8. Private Clinic 9. Other (Specify)	1 2 3 4 5 6 7 8 9 …… ……..	1 2 3 4 5 6 7 8 9 …… ……..	1 2 3 4 5 6 7 8 9 …… ……..

E. MATERNAL CARE RECORD

E101. Number of Currently Pregnant Women in the Family ☐

S.No	Detail of Pregnant women	1	2
E1	Name/ Serial Number from Family Record		
E2	Is the pregnancy Registered for ANC? 1. Yes 2. No (If No skip to E12)	 1 2	 1 2
E3	ANC card available? 1. Yes 2. No	 1 2	 1 2
E4	Place of Registration 1. Anganwadi Centre 2. Sub Centre 3. PHC 4. CHC 5. Government Hospital 6. Ayurvedic Hospital 7. Private Hospital 9. Other (Specify)	 1 2 3 4 5 6 7 9	 1 2 3 4 5 6 7 9
E5	Reason for not registering ANC. (Write down in Blank space)		
E6	Where will you get your Delivery done? 1. Home 2. Government Hospital 3. Private Hospital/Clinic	 1 2 3	 1 2 3

E7	If Home ask the reason		
E8	If Government Hospital, ask the reason		
E9	If Private Hospital/ Clinic , Ask the reason		

EB. RECORD OF WOMEN WHO DELIVERED IN PREVIOUS THREE YEARS

F101. Number of Women who delivered in last three years in the family ☐

S.No	Question	Response 1	Response 2
Eb1	Name of Woman/ Serial Number from family Record		
Eb2	Where was the delivery/ abortion conducted 1. Home 2. PHC/CHC 3. Government Hospital 4. Private Hospital	 1 2 3 4	 1 2 3 4
Eb3	If the Delivery was conducted at home ask the reason.		
Eb4	If the delivery was conducted at Private Hospital ask the reason.		

F. IMMUNIZATION RECORD

F101. Total Number of Children in the aged less than three years in family ☐

S.No		1	2
F1	Name of Child		
F2	Does the child has Immunization Card 1. Yes 2. No	 1 2	 1 2
F3	Where is the child taken for immunization? 1. Anganwadi Centre 2. Sub Centre 3. PHC 4. CHC 5. Government Hospital 6. Ayurvedic Hospital 7. Private Hospital 9.Other (Specify)	 1 2 3 4 5 6 7 9 …… ……..	 1 2 3 4 5 6 7 9 …… ……
F4	Reason for Partially Immunized or Unimmunized child. 1. Not Aware 2. Not required 3. Time constraints 4. Child sick 5. No one to take 6. No AD syringe 7. No vaccine 9.Other (Specify)	 1 2 3 4 5 6 7 9 …… ……	 1 2 3 4 5 6 7 9 …… …..

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