Summer Training at
Indian Institute of Public Health, Gandhinagar (IIPHG)
(April1, 2014-May31, 2014)

Baseline Assessment of Knowledge and Practices of Selected Health Issues in Slums of Ahmedabad

By
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MBA- Hospital & Health Management (MBA-HM)
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CERTIFICATE

This is to certify that **Dr. Dineshkumar Mangilal Prajapati** has completed the summer training at **Indian Institute of Public Health Gandhinagar, Ahmedabad, Gujarat** from 1.04.2014 to 31.05.2014 and has conducted the following projects under my personal guidance and supervision. All the data related to the study is the first hand data collected by him.

Project:

- "Baseline assessment of knowledge and practices of selected health issues in slums of Ahmedabad"

His approach to the project has been sincere, scientific and analytical. This work is partial fulfillment to the course requirements, recommended for the Post Graduate Diploma in Health and Hospital with specialization in Health Management.

I wish him all the success in future endeavors.

Col. (Dr.) Ashok Kaushik
Dean (Academic & Students Affairs)
IIHMR, Jaipur

Col. (Dr.) Ashok Kaushik (mentor)
Dean (Academic & Students Affairs)
IIHMR, Jaipur

1. Executive Summery

Summer Internship is an integral part of the PGDHM curriculum. As a part of the course, the student of the 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 summer training programme are as follows:

1) To understand the health delivery system (public and private sectors) and functional units like Sub center, Primary Health Care, Community Health center, District Hospital and Tertiary Care Center, etc.
2) To have in-depth knowledge of different field of operation of a health care organization.
3) To learn the roles and responsibilities of different functionaries and organizations effort for manpower development and deployment.
4) To observe the implementation of various National Health Programmes at State/District/Block levels.
5) To work on the projects/task assigned by summer training organization.

During the training period we had an Overview of NMEW project (National Mission for Empowerment of Women under Ministry of Child & Women Development, GOI). Besides understanding the organization structure of Indian Institute of Public Health, Ghandhinagar I also carried out a small research study entitled Baseline Assessment of Knowledge and Practices of Selected Health Issue in Slums of Ahmedabad with Darpana Academy & I worked as a supervisor for data collection of research.

The aim of the project was to analyze basic health related knowledge likes:

1. General information of education status, household size, estimated monthly family income, major source of family income, dwelling unit and it‟s type, main source of drinking water and practice about purification of water, whether they having toilet facility or not.
2. Perception about hygiene, sanitation, common factors that lead to diseases, water borne diseases, infection/illness cause by house fly, common disease caused by mosquito bites and their breeding sites, protection from mosquito bite. It also includes knowledge about various government scheme/department in hygiene, sanitation & health inputs.
3. Knowledge related to breast feeding practices, family planning, reproductive and child health, vaccination and anemia.

2. Acknowledgement

I extend my sincere gratitude to Professor Dileep Mavalankar Director Indian Institute of Public Health,Gandhinagar (IIPH-G), for giving me the opportunity for my summer internship.

I extend sincere gratitude towards Dr.Mayur Trivedi Assistant Professor Indian Institute of Public Health,Ghandhinagar (IIPH-G), who has been my mentor for the summer internship program & giving knowledge regarding project & how to work on this project & also thanks for who giving me opportunity for supervision of data collection.

I would also like to thank Mr.Gaurav Kumar (Research Associate), at IIPH-G for supporting my work all along.
Last but not the least; I would like to thank the entire staff of Indian Institute of Public Health Gandhinagar, for their support.

I would like to express my sincere thanks to Dr.S.D.Gupta, Director, IHMR, and my mentor Dr.Ashok Kaushik, Dean (Academics and Student Affairs), IHMR for the proper guidance. I am also grateful to my parents, my family and my friends for giving me moral support.

3. List of Acronyms/Abbreviations

ANC	Antenatal care
GOI	Government of India
IPH	Institute of Public Health
IIPH-G	Indian Institute of Public Health, Gandhinagar
NABARD	National Bank for Agriculture and Rural Development
JSY	Janany Suraksha Yojana
NGO	Non Government Organization
NMEW	National Mission for Empowerment of Women
NRDC	National Research Development Corporation
NRHM	National Rural Health Mission
PHFI	Public Health Foundation of India
PNC	Postnatal care
UHC	Urban Health Center

4. SECTION A

4.1 About PHFI (Public Health Foundation of India)

The Public Health Foundation of India (PHFI) is a public private initiative that has collaboratively evolved through consultations with multiple constituencies including Indian and international academia, state and central governments, multi & bi-lateral agencies and civil society groups. PHFI is a response to redress the limited institutional capacity in India for strengthening training, research and policy development in the area of Public Health.
Structured as an independent foundation, PHFI adopts a broad, integrative approach to public health, tailoring its endeavors to Indian conditions and bearing relevance to countries facing similar challenges and concerns. The PHFI focuses on broad dimensions of public health that encompass promotive, preventive and therapeutic services, many of which are frequently lost sight of in policy planning as well as in popular understanding.
The Prime Minister of India, Dr. Manmohan Singh, launched PHFI on March 28, 2006 at New Delhi. PHFI recognizes the fact that meeting the shortfall of health professionals is imperative to a sustained and holistic response to the public health concerns in the country which in turn requires health care to be addressed not only from the scientific perspective of what works, but also from the social perspective of, who needs it the most.

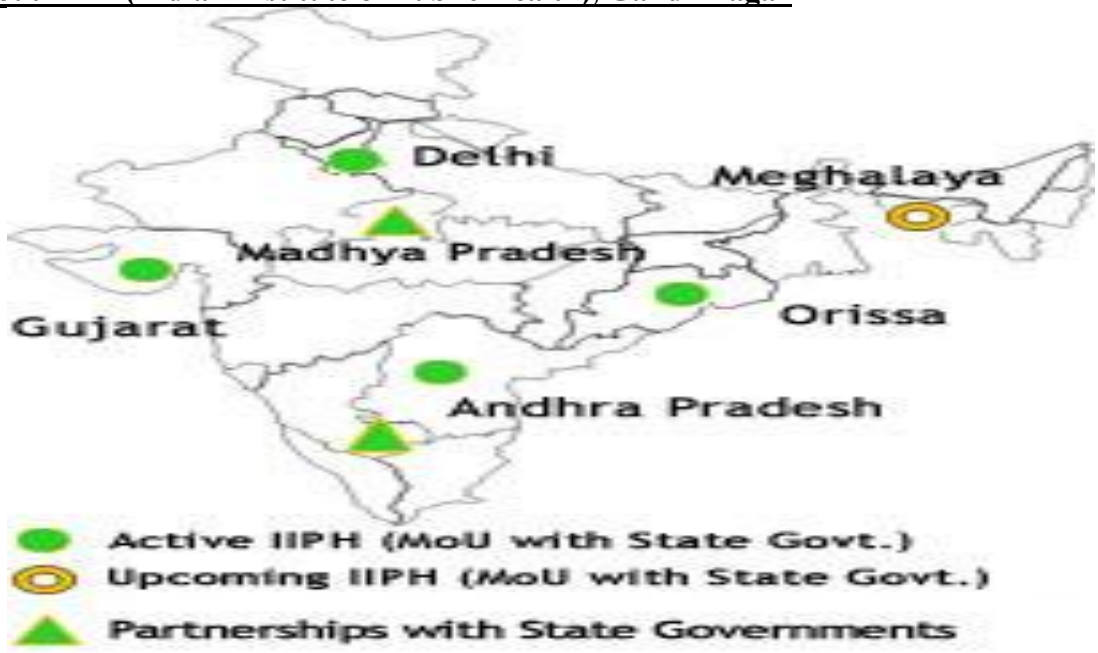
4.2 Charter of PHFI

- Establish new institute of public health
- Assist existing institutes to enhance their capacity and output
- Promote research in prioritized areas of public health, to inform policy and empower programmes
- Facilitate policy development, programme evaluation & advocacy on public health related issues
- Enable the development of standards & adoption of a credible accreditation system for public health course

4.3 Mandate

- The PHFI is working towards building public health capacity by:
- Establishing a network of new institutes of public health in India
- Establishing strong national networks and international partnerships for research
- Generating policy recommendations and developing vigorous advocacy platform
- Facilitating the establishment of an independent accreditation body for degrees in public health which are awarded by training institutions across India
- Assisting the growth of existing public health training institutions

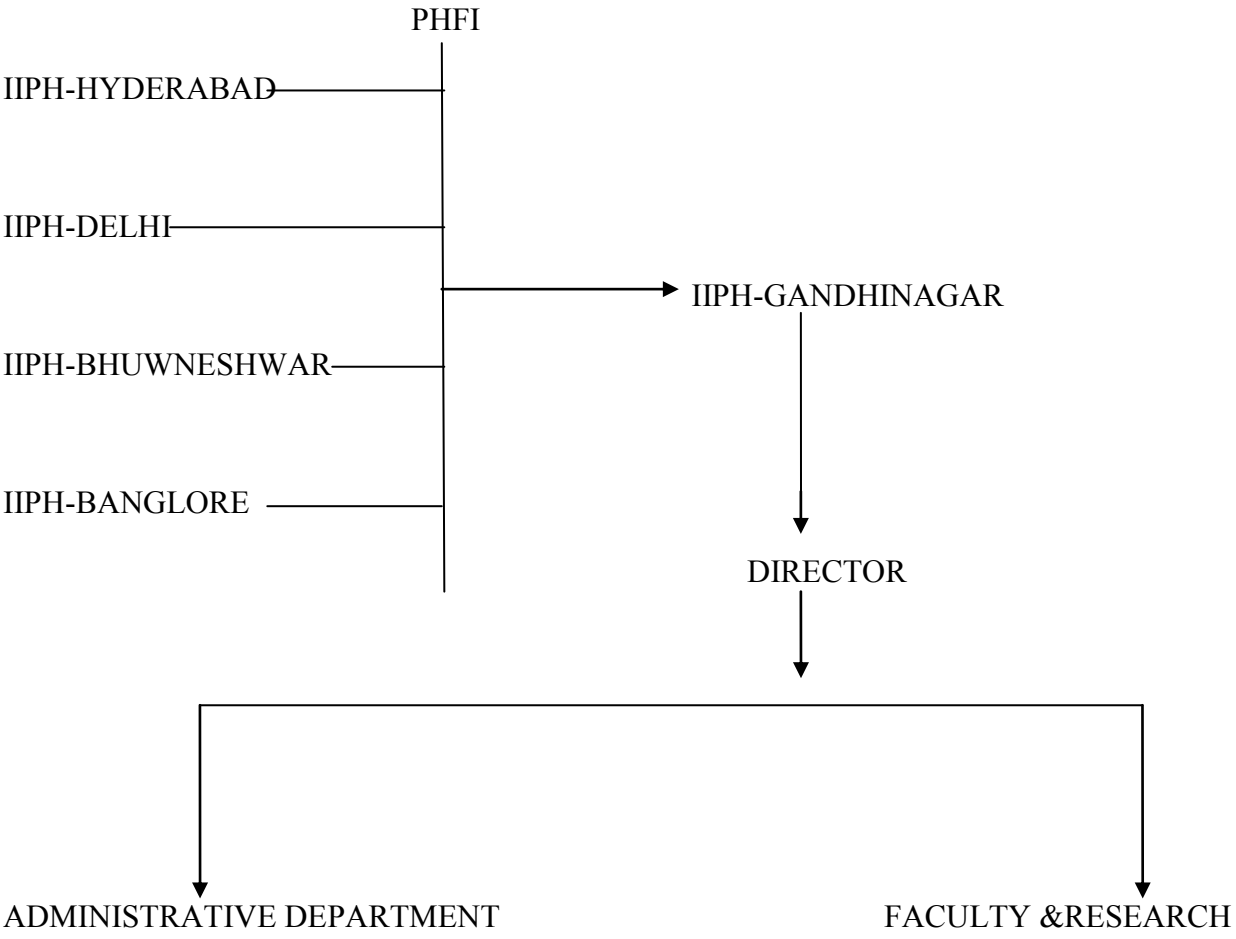
4.4 About IIPH (Indian Institute of Public Health), Gandhinagar



The Indian Institute of Public Health –Gandhinagar (IIPHG) started on World Health Day- 7th April 2008. The institute‟s activities received funding
Support from NRHM/Ministry of Health and Family Welfare, and Medical Council of India, CSIR, NABARD, Karoliska Institute, NRDC, IPH Bangalore,
Etc.

IIPH G has been providing research based policy advice to Government of Gujarat in its health policy making process. Institute faculties are on various government committees, NGO boards and international advisory committees. The faculty also helps in teaching programs and conducting workshops at other IIPHs and other academic institutions.

4.5 Organization structure of IIPH-G



4.6 About project NMEW (National Mission for Empowerment of Women)

NMEW is also known as a MISSION PURANA SHAKTI

About the Mission

The National Mission for Empowerment of Women (NMEW) was launched by the Government of India (GoI) on International Women‟s Day in 2010 with the aim to strengthen overall processes that promote all-round Development of women.

It has the mandate to strengthen the inter-sector convergence; facilitate the process of coordinating all the women‟s welfare and socio-economic development programmes across ministries and departments. The Mission aims to provide a single window service for all programmes run by the Government for Women under aegis of various Central Ministries.

In light with its mandate, the Mission has been named Mission Poorna Shakti, implying a vision for holistic empowerment of women.

The National Resource Center for Women has been set up which functions as a national convergence center for all schemes and programmes for women. It acts as a central repository of knowledge, information, research and data on all gender related issues and is the main body servicing the National and State Mission Authority.

Mission Statement

NMEW will achieve gender equality, and gender justice and holistic development of women through inter-sectoral convergence of programmes relating to women, forging synergy between various stakeholders and creating an enabling environment conducive to social change.

Focus areas of the Mission

- Access to health, drinking water, sanitation and hygiene facilities for women
- Coverage of all girls especially those belonging to vulnerable groups in schools from primary to class 12
- Higher and Professional education for girls/women
- Skill development, Micro credit, Vocational Training, Entrepreneurship, SHG development
- Gender sensitization and dissemination of information
- Taking steps to prevent crime against women and taking steps for a safe environment for women

Key Strategies

- Facilitating inter-sector convergence of schemes meant for women, monitor and review the progress on regular basis
- Strengthening institutional framework offering support service for women
- At policy level commission research, evaluation studies, review schemes, programmes and legislation, do gender audit and outcome assessment to build the evidence for policy and programme reform and scale up implementation of the initiatives
- Enhance economic empowerment of girls and women through skill development, micro credit, vocational training and entrepreneurship and SHG development
- Evolve with the support of community representatives and groups appropriate and localized communication to strengthen public education on gender, behavior change and social mobilization using 360 degree approach on media and communication

Convergence Model

The CONVERGENCE MODEL is a project to test a model of delivery for convergent implementation of programmes intended for welfare and development of women. It has been originally intended to test this model in 30 districts spanning all states and UTs (Except Delhi), covering 640 identified villages. The model would include introduction of convergence cum facilitation centers at the district (few urban agglomerations), tehsil / ward and village/ area levels. The existing structural arrangements of participating departments wherever available shall be used and the PRIs shall be used as far as possible. The women centre at the village level, the first point of contact for women will be known as the POORNA SHAKTI KENDRA (PSK).

The Poorna Shakti Kendra (PSK) is the point of focal point action on ground through which the services to grassroots women would be facilitated. Village coordinators at the Kendras would reach out to the women with the motto "***HUM SUNENGE NAARI KI BAAT!"***

What the Kendra can offer?

- Information on all the government schemes/services/programmes for women
- Maintain a database of target population
- Awareness generation on legal rights and entitlements
- Facilitate the availability and access to government schemes/services/programmes across health, education and livelihood sectors
- Training and capacity building on various issues like leadership, legal rights etc.
- Organize women into collectives to access various resources
- Coordinate the outreach of services of various departments

Partner Ministries & Departments

Partner Ministries & Departments for programmes related to empowerment of women facilitated by NMEW:

- Ministry of Human Resource Development
- Ministry of Finance
- Ministry of Housing & Urban Poverty Alleviation
- Ministry of Rural Development
- Ministry of Panchayati Raj
- Department of Agriculture and Cooperation
- Ministry of Health & Family Welfare
- Ministry of Micro, Small & Medium Enterprises
- Ministry of Law & Justice
- Ministry of Environment & Forests
- Ministry of Labour & Employment
- Ministry of Social Justice & Empowerment

Schemes & Programmes

- **Poverty Alleviation and Economic Empowerment of Women**
    - Assistance to States for Feed and Fodder Development
    - Schemes of Department of Animal Husbandry Dairying Fisheries
    - Scheme on Development of Inland Fisheries and Aquaculture
    - Scheme on Development of Marine Fisheries, Infrastructure and Post harvest Operations
    - Scheme on Fisheries Training and Extension
    - Assistance to Cooperatives
    - National Bamboo Mission
    - Central Poultry Development Organisation
    - Development of Commercial Horticulture through Production and Post-Harvest Management
    - Promotion and Strengthening of Agricultural Mechanization through Training, Testing & Demonstration

- Gramin Bhandaran Yojna
- Capacity Building to enhance Competitiveness of Indian Agriculture and Registration of Organic Products
- Technology Development and Transfer for Promotion of Horticulture
- Marketing Assistance Scheme
- Scheme of Support to Voluntary Agencies for Adult Education and Skill Development
- Scheme of Fund for Regeneration of Traditional Industries (SFURTI)
- Performance & Credit Rating Scheme for Small Industries
- Entrepreneurship Development Institutions (EDIs) Scheme
- National Award Scheme/ Guidelines [Launched by Ministry of Micro, Small & Medium Enterprise (MSME)]
- Credit Linked Capital Subsidy Scheme (CLCSS) for Technology Upgradation of the Small Scale Industrie
- Management Training Programmes
- Scheme For Market Development Assistance For MSME Exporters
- Credit Guarantee Cover Fund Scheme for Small Industries
- Rajiv Gandhi Udyami Mitra Yojana (RGUMY)
- Raw Material Assistance Scheme
- Bamboo Cultivation
- Organic Farming
- Swarnajayanti Gram Swarozgar Yojana (SGSY)
- Mushroom Farming
- Scheme of Financial Assistance for Preparing Young Professional in Rural Areas
- Mahatma Gandhi National Rural Employment Guarantee Scheme
- Pottery Technology
- Technopreneur Promotion Programme
- Consultancy Promotion Programme
- Technology Development & Utilization Programme for Women
- Industrial R&D Promotion Programme (IRDPP)
- National Backward Classes Finance and Development Corporation
- National Scheduled Castes Finance & Development Corporation
- Marketing and Export Promotion Scheme
- Grant in Aid Scheme - Export
- Diversified Handloom Development Scheme (DHDS)
- Grant in Aid Scheme - Ambedkar Hastshilp Vikas Yojna
- Jute Manufactures Development Council Schemes
- Scheme for Integrated Textile Parks
- Grant in Aid Scheme - HRD Scheme
- Technology Upgradation Fund Scheme
- Technology Upgradation Fund Scheme (Handloom Sector)
- Dairy/Poultry Venture Capital Fund
- Assistance to Cooperatives Scheme
- Strengthening Infrastructure for Quality & Clean Milk Production
- Rajiv Gandhi National Creche Scheme
- Total Sanitation Campaign (TSC)

- National Rural Drinking Water Programme
- Mid Day Meal
- Kishori Shakti Yogana
- Targeted Public Distribution System (TPDS)
- Antyodaya Anna Yojna (AAY)
- Old and Infirm Persons Annapurna
- National Iodine Deficiency Disorders Control Programme (NIDDCP)
- Nutrition Education and Extension
- Rashtriya Swasthya Bima Yojana(RSBY)
- Indira Gandhi Matritva Sahyog Yojana (IGMSY) - A Conditional Maternity Benefit Scheme
- Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) Sabla
- SwayamSiddha
- Scheme for Working Women Hostel
- Short Stay Home For Women and Girls (SSH)
- STEP (Support to Training and Employment Programme for Women)

- **Social Empowerment And Education**
  - Elementary Education
  - Secondary Education
  - Vocationalization of Secondary Education
  - Adult Education
  - Higher and Technical Education
- **Health & Nutrition**
  - Integrated Child Development Scheme
  - Reproductive & Child Health Programme, Ph.II (RCH II)
  - National Rural Health Mission
  - Janani Suraksha Yojana
  - Indira Gandhi Matritva Sahyog Yojana (IGMSY)
  - Integrated Child Protection Scheme
  - Rajiv Gandhi National Creche Scheme
  - Total Sanitation Campaign (TSC)
  - National Rural Drinking Water Programme
  - Mid Day Meal
  - Sabla
  - Kishori Shakti Yogana
  - Targeted Public Distribution System (TPDS)
  - Antyodaya Anna Yojna (AAY)
  - Old and Infirm Persons Annapurna
  - Food Security Mission
  - National Iodine Deficiency Disorders Control Programme (NIDDCP)
  - Nutrition Education and Extension
  - Rashtriya Swasthya Bima Yojana(RSBY)
  - Sarva Shiksha Abhiyan

- **Empowerment of Vulnerable and Marginalized Groups and Women in Difficult Circumstances**
    - Schemes of National Scheduled Tribes Finance and development Corporation (NSTFDC)
    - Integrated Child Development Scheme
    - National Rural Health Mission
    - Janani Suraksha Yojana
    - Integrated Child Protection Scheme
    - Swadhar - A scheme for Women in Difficult Circumstances
    - Targeted Public Distribution System (TPDS)
    - Antyodaya Anna Yojna (AAY)
    - Ujjawala- A Scheme for Prevention of Trafficking and Rescue, Rehabilitation and Reintegration
    - Rashtriya Swasthya Bima Yojana(RSBY)
    - Sarva Shiksha Abhiyan
    - Indira Gandhi Matritva Sahyog Yojana (IGMSY) - A Conditional Maternity Benefit Scheme
    - Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) Sabla
    - SwayamSiddha
    - Scheme for Working Women Hostel
    - STEP (Support to Training and Employment Programme for Women)
    - Swarnjayanti Gram Swarozgar Yojana
    - Indira Awaas Yojana (IAY)

Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)

- **Domain area: -**
    - ✓ Poverty Alleviation and Economic Empowerment of Women
    - ✓ Social Empowerment And Education
    - ✓ Health & Nutrition
    - ✓ Gender Rights, Gender Based Violence and Law Enforcement
    - ✓ Gender Budgeting, Gender Mainstreaming & Gender Audit
    - ✓ Empowerment of Vulnerable and Marginalized Groups and Women in Difficult Circumstances

5. Section B

5.1 Title: "Baseline assessment of knowledge and practices of selected health issues in slums of Ahmedabad"

Partners for this project: Darpana Art Academy, Government of India (GOI).
Research proposal: wrote by Darpana Art Academy.
IIPH-G: act as a consultancy for this project and help to the Darpana Art Academy to find out basic health related issues and they prepared theme for street play.

Basic aim for this project is improve knowledge related health through street play.

For this project two slums identified Kubernagar and Vasana.

5.2 Task Assigned: -

- Identify basic health issue in urban slums.
- Listing of household for data collection of pre intervention and control group.
- Work as supervisor and coordinator of survey.
- Visit urban heath center and aganwadi.

5.3 ABOUT DARPANA ART ACADEMY:

The Darpana Academy of Performing Arts was founded in Ahmedabad, Gujarat, India by Vikram Sarabhai and his wife Mrinalini Sarabhai.

It has been directed by their daughter Malika Sarabhai for the last three decades. The school organizes a three- day Interart, the "Vikram Sarabhai International Arts Festival" at Ahmedabad, and every year.

The Academy‟s vision is a contemporary symbiosis affirming the role of creativity in culture, researching into our origins and reaching out to the unsaid or unthought of, with a language that is universal. Darpana today is a center for artists commited to excellence, innovation and the excitement of using the arts for change.

Darpana‟s audiences range from arts-lovers to people in position of power, the less privileged across the world, children, women, tribal populations and more. With over 25,000 graduates, nearly 11000 performances, audiences in 90 countries, a vibrant arts environment, managed by a strong staff, Darpana is known around the world as an institution of innovation in performance and the arts.

For this project I have been worked as a researcher for collecting basic health issues in slums of Ahmedabad.

Discussion related to health issues also done with the Medical Officers of Kubernagar Urban Health Center & Vasana Urban Health Center.

For this project areas were visited namely Kubernagar and Vasana of Ahmedabad.

Basic health related issues identified and presented below:

5.4 Health related issue in slums area

Health related issue	**Kubernagar** **Kuber nagar urban health center:** **1. Shantisagar chapara** **2. Kumbhaji chali**	**Vasana** **Vasana urban heath center:** **1. Mangal talavadi** **2. Sorai nagar**
1. Hand washing method	• Nobody knows the correct method for hand washing. • Children are not washing their hand regularly. • After using toilet many of the elder people are washing their hand only with plain water in shantisagar chapara. • Education related to hand washing are given by AGANWADI worker especially in Kumbhaji chali.	• Nobody knows the correct method for hand washing. • Children are not washing their hand regularly. • Here most of the elder people are washing their hand with soap or with sand. • Education related hand washing are given by link worker.
2. Source of water	• Tap water	• Tap water & hand pump, some of the community like rajasthani who lives in slums are collecting water from somebody"s nearer house.
3. Sanitation	• Most of the households are having toilet & bathroom facility.	• Most of the households are having toilet & bathroom facility. Bathrooms are open. • For DANTANI community: - They have common toilet. Majority are of them are using & some of them are also going for open

		defecation. • This toilet is prepared by government.
4. Drainage system	• Closed	• Open & closed
5. Occupation	• Selling vegetables & fruits, egg & fish. • Private Job worker. • Auto rickshaw driver.	• Selling vegetables & fruits, • Labor worker. • Government servant in VS HOSPITAL (house keeping)
6. Diet pattern	• Vegetarian & non vegetarian	• Vegetarian & non vegetarian
7. Children		
a.) Diet habit	• Not proper & mal nourished children also find.	• Not proper & mal nourished children also find.
b.) Education of children	• Municipality school. • Private school. • GYAN SCHOOL(free school) • Pre-schooling at AGANWADI	• Municipality school. • Private school. • Pre-schooling at AGANWADI
8. Common diseases	• TB • pneumonia, • typhoid, • Viral fever, • acute gastro-enteritis	• TB • respiratory tract infection likes cold & coryza. • viral fever, • Acute gastro enteritis.
9. Taking treatment from	• For acute condition:- private clinics • For chronic condition: - government hospital, urban health center	• Private as well as government center. • urban health center
10. Maternal and child health care a.) Delivery: -	• **In shantisagar chapara**: - most of deliveries are done by aya ben (traditional birth attendant-TBA) at her house. Complicated pregnancy cases are treated by private as well as civil hospitals. Normally TBA charge according to mother‟s financial condition (normaly Rs.500 to 1000), after immediate delivery	• Take place in government hospital & many of them having BPL card and takes all benefit from government. Those who don‟t have BPL card take treatment from private hospital. • **Benefits like: -** a.) For ANC –Rs. 700 For PNC- Rs.700 For Immunization of

	she sent patient to home. Sometimes Private Doctor also visits at TBA"s delivery place to attend complicated delivery and to check new born baby. & if any treatment required is given by doctor. (charges of doctor Rs. 150 to 300) • **In kumbhaji chali**:- private hospital as well as some are in government hospital (civil).	Children after delivery to 1 year of age – Rs.700 gets. b.) JSY-Rs. 600 according to link worker.
c.) ANC care:-	• Mostly pregnant women visit once to the private hospital or government hospital before delivery, but they visit to TBA regularly and follow instruction of her.	• Almost all women are visiting to vasana urban health center regularly. Taking all vaccination during pregnancy.
d.) Breast feeding practice	• Well	• Well
e.) Vaccination during Pregnancy	• **shantisagar chapara**: - may or may not • **In kumbhaji chali** : - every pregnant women are taking vaccines regularly.	• All pregnant women who are having BPL card they are taking vaccines regularly at urban heath center.
f.) High risk pregnancy	• Not such issue found.	• Present due to many women got early marriage. * Most of pregnant women are using tobacco & gutaka.
11. Reproductive & child health		
a.) Menstruation cycle	• Most of girls are using traditional method as they don"t have enough knowledge about using sanitary pad due to illiteracy according to private doctor.	• Most of girls are using traditional method as they don"t have enough knowledge about using sanitary pad due to illiteracy according to private doctor.

b.) Knowledge related HIV / AIDS	• Lack of knowledge and awareness.	• Lack of knowledge and awareness
12. Addiction	• alcohol, • Chewing tobacco & gutaka.	• alcohol, • Chewing tobacco & gutaka.
13. Family planning methods	• not a single family uses family planning methods and the main reason found that male child preferences.(for patny community)	• Not used by many couple. • Some women are following calendar method. • Due to religious restrictions they don't use family planning methods. Also because of family restriction and denial of elder people like father- in -law & mother-in-law & also by husband.
14. Dog bite cases	• Dog bites are very common. • Only few people take treatment for it and rest of others are not due to religious superstition (MATA JI KI BADHA)	• Dog bites are very common. • Only few people take treatment for it and rest of others are not due to religious superstition (MATA JI KI BADHA)
15. Measles cases	• As religious superstition prevails over the medical treatment, majority people prefer to go to temple (Mataji Ki Badha) rather than hospital for treatment.	• As religious superstition prevails over the medical treatment, majority people prefer to go to temple (Mataji Ki Badha) rather than hospital for treatment.
16. Current cases		
a.) Chicken pox	• Not founded	• 3 cases were founded in sorai nagar, • 3cases were founded in mangal talavdi • For that they keep MATAJI KI BADHA. • These cases were taking treatment from vasana urban health center through link worker.

17. Dental problem	• Present	• Present
18. Socio economic status a.) Having TV & REFRIGEREATOR b.) Having vehicle c.) condition of house d.) having animal	• Yes • Not many of them have vehicle. • Kacha , pakka & semi pakka • Most of them have animal like goat.	• Yes • Not many of them have vehicle. • Kacha , pakka & semi pakka • Few of them have animal like goat.
19. food safety	• Such type of question was not asked.	• majority of them cover the food with cloth & keep in closed vessels
20. for purification of water	• Purify water through linen cloth. Some of them are not taking any precaution for water purification	• **Through chlorine tablet given by link worker.** Some of them are not taking any precaution for water purification.
21. cooking through	• Chula, • Gas stove, • Kerosene primase.	• Chula • gas stove. • kerosene primase.

Kubernagar – slum area ***1. shantisagar chapara***	• Community visited 1. patny community – 2. bhaiyaji community- 3. bihari community- 4. parmar community	Household visited 7 5 4 (1 not responded) 3
a.) private doctors	Doctors visited	3
	Local Shopkeeper visited	1
	Ayaben (Traditional birth attainder)	2
b.) Key person	Nimesh bahi	Kubernagar

		ward(**late shree babusigh j. tomar urban health center**)
c.) Doctor at urban health center ***3. Kumbhaji chali*** a.) Aganwadi b.) Private doctor visited	Dr. Rupal mam Community visited 1. Patny community 2. Bhaiyaji community 3. Vankar community 4. Darbar community Doctor	Medical officer at Kubernagar ward(late shree babusigh j. tomar urban health center) Household visited 15 4 5 2 7 1
Vasana urban health center- slum area ***1. Mangal talavadi***	Community visited 1. Dantani community 2. Patny community 3. Kathya wadi community 4. Vankar community	Household visited 7 3 4 2
	Private doctor visited	1
a.) Link worker	Hansaben	1
2. Shorai nagar	Community visited 1. Dantani community 2. Rajasthani (marwadi)community 3. Bahiyaji community	Household visited 5 5 2
a.) Link worker	Bhanuben	1
b.) Doctor at vasana urban health	Dr .hardik mevada	1

center		
c.) Private doctor visited	Doctors	3
d.) Local shop keeper e.) Aganwadi	1	1 2

These issues also discussed with Malika Sarabhai (Darpana Academy) and Dr. Mayur Trivedi(IIPHG).So, it could help to them understanding health issues in slums.

5.5 RESEARCH TOPIC: "Baseline assessment of knowledge and practices of selected health issues in slums of Ahmedabad"

5.6 Introduction

Under Section-3 of the Slum Area Improvement and Clearance Act, 1956, slums have been defined as mainly those residential areas where dwellings are in any respect unfit for human habitation by reasons of dilapidation, overcrowding, faulty arrangements and designs of such buildings, narrowness or faulty arrangement of streets, lack of ventilation, light, sanitation facilities or any combination of these factors which are detrimental to safety, health and morals.

As per UN Habitat a slum is characterized by lack of durable housing, insufficient living area, and lack of access to clean water, inadequate sanitation and insecure tenure.

The slum population in India has increased during 2001-11.

Probable reasons for upcoming slums INDIA

- Urbanization
- Industrialization
- Higher productivity in the secondary/tertiary sector against primary sector makes cities and towns centers of economic growth and jobs
- Cities act as beacons for the rural population as they represent a higher standard of living and offer opportunities to people not available in rural areas. This results in large scale migration from rural to urban areas.
- Negative consequences of urban pull results in upcoming of slums characterized by housing shortage and critical inadequacies in public utilities, overcrowding, unhygienic conditions, etc

Slum - Census of India

Census 2001

- For the first time in Census 2001, slum areas were earmarked across the country, particularly, in cities and towns having population of 50,000 or above in 1991 Census.

- Subsequently, the slum data was culled out also for towns with 20,000 to 49,999 population in 2001 and statutory towns having population less than 50,000 in 1991 but reported more than 50,000 populations in 2001 and were not considered for carving slum EBs earlier.

Census 2011

- Slums have been earmarked in all the statutory towns irrespective of their population size based on the same definition as in 2001.

- Three types of slums have been defined in Census, namely, Notified, Recognized and Identified.

Definition and types of slums – Census 2011

1. All notified areas in a town or city notified as „Slum" by State, Union territories Administration or Local Government under any Act Including a „Slum Act" may be considered as Notified slums

2. All areas recognized as „Slum" by State, Union territories Administration or Local Government, Housing and Slum Boards, which may have not been formally notified as slum under any act may be considered as Recognized slums

3. A compact area of at least 300 populations or about 60-70 households of poorly built congested tenements, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities. Such areas should be identified personally by the Charge Officer and also inspected by an officer nominated by Directorate of Census Operations. This fact must be duly recorded in the charge register. Such areas may be considered as Identified slums

Number of Towns having slums INDIA

Census 2001
Total Number of Towns reported slums– 1743
1st phase – 640 towns
2nd phase – 1103 towns

Census 2011
Total Number of Towns reported slums– 2613[1]

5.7 About Ahmedabad City:

[1] (Source: Primary Census Abstract for Slum, 2011
Office of the Registrar General & Census Commissioner, India)
(http://www.censusindia.gov.in/2011-Documents/Slum-26-09-13.pdf)

Ahmedabad City (also known as Ahmedabad Municipal Corporation, AMC) is the largest city in Gujarat State and the seventh largest city in India with a population of 3.5 million, spread across 192 sq.km.

The city of Ahmedabad has nearly 7 million dwelling units, of which 50% are situated in 2500 slums (and chawls) housing approximately 1.5 million people. This is the vulnerable group of the society which needs a special attention.

The civic affairs of the city are governed by Ahmedabad Municipal Corporation (AMC). Besides standard civic amenities such as water supply, waste disposal, maintenance of roads, provision of street lights etc, AMC also provides several additional services. Some of the additional services are City transport, and medical services through a network of Family Welfare centers, Dispensaries, Maternity Homes, Referral hospital, and four large teaching hospitals (VS, LG, SCL, and Nagari hospitals).

The project was carried to the city of Ahmedabad.

Study population:-
For this project study areas are selected prior discussed with two UHC Medical Officers of Kubernagar and Vasana.

Under Kubernagar ward there are 2 slums area namely Shantisagar chhapra, Kumbhji chhali.

Under Vasana ward there are 2 slums are namely Mangal talavadi and Sorainagar.

Areas selected for this project are Kumbhaji chhali where intervention will make& Mangal talavadi will remain for control group.

5.8 About Kubernagar ward: -

Kubernagar election ward in the North Zone of Ahmedabad has a population of 87540 living in 2.33 sq km of area. It has 20 slums having 8200 huts & tenements. Average household size is 4.9. Overall literacy level of Kubernagar is 80.19% and female literacy is 71.3%.

Socio – Economic profile: Fourty eight percent of population live in slums & chawls. Occupation is mainly vegetable business, fruit business, small-scale business and cloth business, provision shops, private jobs worker.

Public Health Infrastructure: Most of the household have legal water supply out of which 71% have individual connections. Average duration for water supply is one and half hour per day. About 70% household have individual toilet facilities, and 10% have a community or common toilets. Though Kubernagar ward is developed as a township, the raod network is very poor.

Health Facilities in Kubernagar:

There is a one urban health center in Kubernagar ward. Nearby it there is a Government hospital (Civil Hospital).

About Kumbhji chali:-

There are many link workers and 7 aganwadi in Kumbhaji chali.
Link worker made the due list for vaccination as well as giving knowledge regarding of vaccination and helping slum dwellers for limiting family size by giving proper knowledge regarding family planning method and taking care of ANC and PNC.

In Aganwadi there are aganwadi worker & helper worker. Aganwadi worker also take care of child nutrition and also distribute pre food package for adolescent, pregnant mother & child. They also make the record of the pregnant mother & child.

1 aganwadi covered 1000 population.

Total population in this chali is near about 7000.

There are a many small pockets in kumbhji ni chhali.

1. Navdurga chhali
2. Jay khodiyarnagar
3. Sughadnagar
4. Hanumannnnagar
5. Kumbhaji chhali
6. Shivshakti nagar
7. Jay yogheswar nagar

5.9 Vasana Ward:-

Vasana ward located in the West Zone of Ahmedabad, has a population of 1, 03, 526 and covers an area of 5.5 square kilometers: population density is 18.823 persons per square kilometer and region contains 24 slums with a population of 39.367 persons accounting for 38% of total population.

There is an urban health center call Vasana Urban Health center which is a working through NGO. This urban health center runs by Akhand Jyot Foundation. Mainly it is working on Family planning, Vaccination, communicable disease, non communicable disease, on HIV/AIDS programme.
Under Vasana ward covers 2 slums namely Mangal talavadi, Sorainagar.
Mangal talavdi was selected for **Controal group.**

Aganwadi: - one
Link worker: - one
Knowledge related to family planning, vaccination, hand washing, hygiene, sanitation, water purification is given by link worker.

5.10 REVIEW OF LITRATURE:

- Many developing economies are characterized by rapid population growth that is partly attributed to high fertility rate, high birth rates accompanied by steady declines in death rates, low contraceptive prevalence rate and high but declining mortality rate [1]
- Contraceptive knowledge and practice by women attending antenatal clinic in Nigeria, by Ogunjuyige et al (1996), was to examine whether attendance at antenatal clinics does increase the knowledge and attitude of women who attend antenatal Health clinics and consequently increased their use of modern contraceptives**.** [2]
- A few intracountry multivariate studies found small program effects, decreasing the number of children that couples want. An intensive multimethod study in India found plausible larger effects. [3]

5.11 RATIONALE OF STUDY:

- To assess the knowledge related to family planning in slums dwellers
- Though there are free scheme available on family planning why slums dwellers are not using it
- To assess knowledge related to family planning methods that can be used for limiting family size

5.12 Research question:

- What are the existing level of knowledge and practices of family planning in slum dwellers of Kubernagar, Ahmedabad?

5.13 OBJECTIVES:

- To assess knowledge related to family planning in slum dwellers
- To study awareness of slum dwellers regarding limiting of family size

5.14 Methods and materials:

MAPPING & LISTING:

Selection criteria: For this project a women who is currently pregnant or experienced any child birth during one year preceding the survey. The respondents need to be the women the woman who has delivered / is pregnant. The investigator for this section was also being a woman.

To carry out this project MSW (Master of Social Worker) students selected and proper guidance and knowledge related to health issue also discussed and demonstrations done related to questionnaire on 30th April 2014.

On 1st March, 2014 pretesting done & according to it some modification done in questionnaire for logical sequences of question.

Study areas & population: for this project areas selected were Kubernagar, Ahmedabad.

Sampling Method for Project:

Sampling Design: Non probability sampling (snowball sampling)
Sample Size: 100 house hold.
Techniques: Face to Face interview
Tool: Semi structured (open-closed ended) questionnaire.
Questionnaire is in local language (Gujarati) as well as English language.

5.15 Data collection:

The purpose of survey and procedure of data collection was explained to the beneficiaries and written consent was taken from them. A working schedule was prepared including dates and timing for distribution and filling questionnaires in slum area of Kubernagar, Ahmedabad, Gujarat
For Kubernagar ward: 2 to 10 May 2014

5.16 Ethical Considerations:

Respect of people‟s right and dignity.
Respondents‟ participation required voluntary.
The study was maintaining the confidentiality of the respondent.
Information received was not being misused in any form.
The research work tried to maximize the benefits of the respondent.

5.17 Data Entry and Cleaning: - Epi Info software.

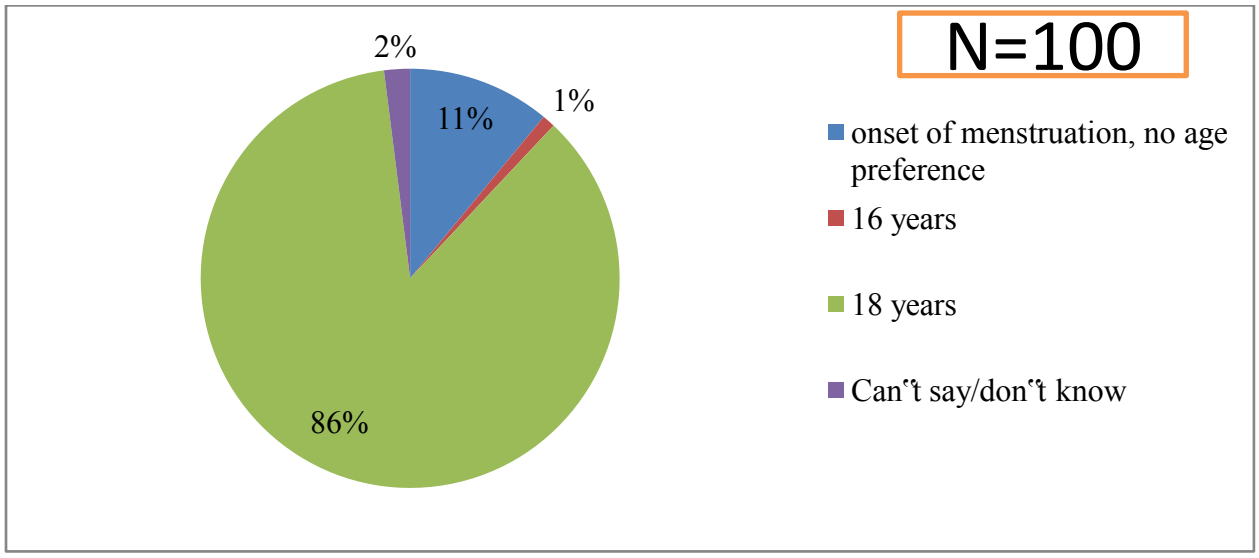
5.18 Data Analysis:

Data analysis was done for intervention group on family planning methods by spss software.

6. Section C:

This section shows the results and percentage distribution of family planning methods.

Figure:-1 Perception of minimum age for 1st pregnancy of women.



Eleven percent of respondents said that minimum age for 1st pregnancy after the onset of menstruation. One percent of respondents said that during the age of 16 years and eighty six percent of respondents had knowledge regarding minimum age of pregnancy 18 years.

Table: 2 age of respondent when she became pregnant.

N= 100

Age	Percentage
15	1%
16	1%
17	4%
18	17%
19	14%
20	21%
21	15%
22	9%
23	8%
24	3%
25	6%
26	1%
Total	100%

Maximum no of respondent became pregnant at age of 18, 19, 20, and 21.

Table: 3 Awareness regarding family planning methods

N=100

Yes	No
62%	38%

+

Sixty two percent of respondents were aware regarding family planning methods.

Table: 4 Knowledge related to spacing method.

N= 62

	1. Mention without probing	2. Agree after probing	3. Disagree after probing	4. Don‟t know after probing
Oral pills	37.1%(23)	62.9%(39)	-	-
Condoms	34.5%(22)	64.5%(40)	-	-
IUD	32.3%(20)	66.1%(41)	-	1.6%(1)
Male sterilization(vasectomy)	-	96.8%(60)	3.2%(2)	-
Female sterilization(tubectomy)	1.6%(1)	95.2%(59)	3.2%(2)	-
Others(specify)	98.4%(61)	1.6%(1)	-	-

Oral pills: Thirty seven percent of respondents mention without probing. Almost sixty three percent agreed after probing.

Condoms: Almost thirty five percent of respondents mention without probing. Almost Sixty five percent of respondents agreed after probing.

IUD: Thirty two percent of respondent were self aware of it. Sixty six percent agreed after probing. Almost two percent of them didn‟t know after probing.

Male sterilization: Almost ninety seven percent of respondents agreed after probing. Three percent of them disagreed after probing

Female sterilization: Almost two percent of respondents were self aware of it. Ninety five percent of respondents agreed after probing. Three percent disagreed after probing.

Others (specify): Ninety eight percent of respondents said that they didn‟t use any methods for family planning. Almost two percent of respondents agreed after probing didn‟t use any method.

Table: 5 Knowledge related to Limiting method

N=62

	1. Mention without probing	2. Agree after probing	3. Disagree after probing	4. Don‟t know after probing
Oral pills	54.8% (34)	45.2%(28)	-	-
Condoms	50% (31)	50% (31)	-	-
IUD	46.8% (29)	53.2% (33)	-	-
Male sterilization(vasectomy)	6.5%(4)	91.9%(57)	1.6%(1)	-
Female sterilization(tubectomy)	6.5%(4)	91.9%(57)	1.6%(1)	-
Others(specify)	-	-	-	-

Oral pills: Almost fifty percent of respondents mention without probing. Forty five percent of respondents agreed after probing.

Condoms: Fifty percent of respondents mention without probing. Fifty percent of respondents agreed after probing.

IUD: Almost forty seven percent of respondent were self aware about it. Sixty six percent agreed after probing. Fifty three percent of them agreed after probing.

Male sterilization: Almost seven percent of respondents were self aware about it. Almost ninety two percent of respondents agreed after probing. Almost two percent of respondents agreed after probing.

Female sterilization: Almost seven percent of respondents were self aware about it. Almost ninety two percent of respondents agreed after probing. Almost two percent of respondents agreed after probing.

Table: 6 Family planning methods can be used during breast feeding

N=62

	1. Mention without probing	2. Agree after probing	3. Disagree after probing	4. Don‟t know after probing
No need of methods till breast feeding continues		11.3%(7)	80.6%(50)	8.1%(5)
Oral pills	11.3%(7)	29%(18)	51.6%(32)	8.1%(5)
Condoms	16.1%(10)	82.3(51)		1.6%(1)
IUD	17.7%(11)	77.4%(48)	1.6%(1)	3.2%(2)
sterilization	9.7%(6)	72.6%(45)	6.5%(4)	11.3%(7)

No need of methods till breast feeding continues: Eleven percent of respondents agreed after probing. Almost eighty one percent of respondents disagreed after probing and eight percent didn‟t know after probing.

Oral pills: Eleven percent of respondents mentioned without probing and twenty nine percent agreed after probing. Almost fifty two percent of respondents disagreed after probing and eight percent didn‟t know after probing.

Condoms: Sixteen percent of respondents were self aware about it. Eighty two percent of respondents agreed after probing. Almost two percent of respondents were didn‟t know after probing.

IUD: Almost eighty percent of respondents were self aware of it. Seventy seven percent of respondents agreed after probing. Almost two percent of respondents disagreed after probing. Three percent of didn‟t know after probing.

Sterilization: Almost ten percent of respondents were self aware about it. Almost seventy three percent of respondents agreed after probing. Almost seven percent of respondents disagreed after probing. Eleven percent of didn‟t know after probing.

Table: 7 Time periods between births

N=62

12 months	18 months	24 months	36 months	Can‟t say / can‟t remember
-	-	37.1% (23)	61.3% (38)	1.6%(1)

Thirty seven percent of respondents said that it should be twenty four months. Sixty one percent of respondents said that it should be thirty six months. Almost two percent didn't say anything.

Table: 8 discussing family planning methods with their husband

N=62

Yes	No
87.1%(54)	12.9%(8)

Eighty seven of respondents discussed family planning methods with their husband.

Table: 9 Decision taken for family planning method

N= 62

She	1.6%(1)
Her husband	29%(18)
Both of us together	38.7%(24)
Other(specify)- do not using anything	30.6%(19)
Total	100%(62)

She: Almost two percent of respondents took decision by her.

Her husband: In twenty nine percent of cases respondent's husband took decision.

Decision taken by both: Almost thirty nine percent of cases decision regarding family planning methods taken together by them.

Others: Almost thirty one percent of respondents said that they didn't use anything regarding family planning methods.

Conclusion:

The present project was a descriptive & to assess the knowledge level of related to family planning & vaccination in slums dwellers of Kubernagar, Ahmedabad, Gujarat. The project was conducted in the month of May 2014. A set of semi structured (open – closed ended question) questionnaires was filled by MSW (Master of Social Worker) students along with Face to Face interview. The sample size for this project is 600 in numbers including 15per cent of non – response rate. Understanding related to family planning & vaccination is found to be low. Knowledge related to minimum age for 1st pregnancy of any women is low. Knowledge related to spacing method found to be good but limiting method is found to be low. Knowledge related to family planning methods can be used during breast feeding is low.

Majority of the respondents were aware of time period between two births. Though they are aware of it they did not follow. It has been seen that they believe in superstition and also found to be Male child preference. Respondent were also know about child vaccination & about her vaccination. Majority of respondents are not used family planning method. It has been seen that knowledge regarding family planning and vaccination is given by ICDS worker and LINK worker.

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