Women's Health in Urban Vadodara: Reflections based on SAHAJ's Experience

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The Context: Health Indicators in Gujarat

Gujarat is generally recognised as a 'developed' state. However, compared to other states at the similar level of development – the mid- range states in India (for example, Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu, Punjab, West Bengal) – Gujarat fares worse than most of them on several indicators (see Table 1).

• Gujarat's Infant Mortality Rate is higher than Maharashtra, Karnataka, Tamil Nadu Punjab, West Bengal

• Gujarat's Maternal Mortality Ratio is higher than Maharashtra, Andhra Pradesh, Tamil Nadu Punjab, West Bengal

• The Fertility Rate is higher than all the other comparable states

• The Sex Ratio is worse than all the other states, the Child Sex Ratio is worse than all the other states except Maharashtra and Punjab

• Anaemia in women (15-49 years) is worse in Gujarat than all other states except West Bengal and Andhra Pradesh.

• Female literacy rates are worse in Gujarat – only Karnataka and Andhra Pradesh have lower female literacy than in Gujarat.

About Vadodara

Vadodara, the third largest city of Gujarat, and 20th largest in India and is one of the metropolitan towns of Gujarat State. Presently, Vadodara Municipal Corporation is divided into four administrative zones and twenty eight wards.

During 1991 and 2001 the population growth rate in the district was almost 20% and between 2001 and 2011, it was 14.38 %. In 2011 the urban population in Vadodara District was 49.59%. The city itself has a population of 20.6 lakhs (2011 census). Increase in city population is probably due to migration of people from villages towards the city which in turn creates

Table 1: Demographic, Socio-economic and Health Profile of Gujarat State as compared to India and other Comparable States

Indicator	Gujarat	Maharashtra	Karnataka	Andhra Pradesh	Tamil Nadu	West Bengal	Punjab	India
Infant Mortality Rate (SRS 2013)	36	24	31	39	21	31	26	40
Maternal Mortality Rate (SRS 2010-12)	122	87	144	110	90	117	155	178
Total Fertility Rate (SRS 2012)	2.3	1.8	1.9	1.8	1.7	1.7	1.7	2.4
Crude Birth Rate (SRS 2013)	20.8	16.5	18.3	17.4	15.6	16	15.7	21.4
Sex Ratio (Census 2011)	918	925	968	992	995	947	893	940
Child Sex Ratio (Census 2011)	886	883	943	943	946	950	846	914
Schedule Caste population (In Core) (Census 2001)	0.35	0.98	0.85	1.23	1.18	1.84	0.74	16.6
Schedule Tribe population (In Core) (Census 2001)	0.74	0.85	0.34	0.50	0.065	0.44	Not Notified	8.4
Prevalence of anaemia in women 15-49 years (NFHS 3)	55.5	49.1	52.2	62.7	53.9	63.8	38.3	56.2
Total Literacy Rate (%) (Census 2011)	79.31	82.91	75.60	67.6	80.33	77.08	76.68	74.04
Male Literacy Rate (%) (Census 2011)	87.23	89.82	82.85	75.56	86.81	82.67	81.48	82.14
Female Literacy Rate (%) (Census 2001)	70.73	75.48	68.13	59.74	73.86	71.16	71.34	65.46

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Table 2: Status of Human Resources in Urban Primary Health Centre

Sr. No.	Name of the Cadre	Posts approved as per level of UPHC	Current status
1.	Medical Officer	1+1 part time	1+1 part time
2.	LHV(only in Corporation)	1	0
3.	Pharmacist	1	1
4.	Lab Technician	1	1
5.	Staff Nurse	3	2
6.	Public health manager / community mobilizer	1	0
7.	ANM/FHW(one @10000 population)	5 to 6	5 to 6
8.	M& E	2	1
9.	Support staff (peon + Aaya + Security)	3	1
	Total	19	13

(Source: Presentation by State Project Management Unit in orientation of MAS meeting on 21 November, 2015)

demand for provision of basic facilities like health, water and sanitation, to all the people.

Vadodara's Public Health Facilities

Vadodara has 336 slum areas. The health infrastructure managed by the Vadodara Municipal Corporation is as under:

• Government hospitals: 2

• Urban health centres: 19

• NGO centres: 6

• Integrated health centre and Nursing home: 1

• Staff dispensaries: 2

• Full time/Part time dispensaries: 15

• Mobile units: 4

Many health facilities are either working partially or are in a non-working condition. There are staff shortages when compared to the Human Resource norms for Urban Public Health Centres. Because of insufficient staff and lack of other resources in Urban Primary Health Centres, tertiary Government hospitals are getting overcrowded.

SAHAJ and its Field Areas

SAHAJ has been working with marginalised and deprived urban communities of Vadodara since 1984. We focus on health, education and developing responsible citizenship among the youth. At present SAHAJ covers about in 15,000 people in 18 slum areas. Based on a survey done by SAHAJ in 2011 of 12 slum areas, following points are indicative of the slums' status:

• 28% people are non-literate.

• 42% people are daily wage labours.

• 17% houses are permanent, 65% houses are semi-permanent and 10% houses are non-permanent and 32% houses do not have toilet-bathroom facility.

• Only 28% house-holds have drinking water facility.

• 5% households do not have electricity/light facility.

The survey revealed that 75% of families have ration cards and of them only 22% have the BPL card and 9% have the Antyoday card. The families even after living in a city lack basic facilities needed for a dignified life. These families should come under Below Poverty Line if we were to consider poverty as a multidimensional concept and not just based on incomes. Because of lack of the requisite 'cards', many poor families are unable to avail of the benefits of Government Schemes like the PDS, Janani Surakha Yoyana, Chiranjeevi Yoyana, Kasturba Sahay Yoyana.

Our Interventions

SAHAJ has been working in between 16 to 20 bastis in Vadodara on adolescents' rights issues since 2003, and on Comprehensive Women's Health since 2006. The objectives of our last 15 years' work are to create

awareness among community about health rights and entitlements and to generate demand for health services. The initiative also seeks to strengthen basti level committees to negotiate determinants of health and health care issues.

Participatory action research processes, awareness generation and community mobilization by peer educators and community health workers; provision of services through community health workers and advocacy through local people's groups comprising of basti development committees, health workers, peer educators etc., are some of the strategies being used.

Our data shows that most women go to the private sector for most of their reproductive health needs. After our early interventions, eligible/BPL women began availing of the benefits of the Chiranjeevi Scheme when it started in 2007 (one free ANC and delivery at a private maternity home that is reimbursed by the State Government). However, quality of care was/is an issue – the promise of Skilled Birth Attendants was belied because the doctors employed traditional dais to do the normal Chiranjeevi deliveries! For complications and serious gynaecological complaints, poor women went to the Medical College Hospital which was choked with patients from neighbouring and distant districts. The absence of secondary hospitals in the city where they can get affordable health care for their gynaecological problems is felt acutely.

In fact, affordability is a big issue – women who go the tertiary medical college hospital for Caesarian Sections complain that they incur up to Rs. 5500 for their surgery. Attitude and behaviour of services providers at Government hospitals make women opt for normal deliveries at private hospitals where the costs range from Rs. 3000 to Rs.5000. Cost of medical abortion at private hospitals range from Rs. 675 and Government hospitals is Rs. 300. Average cost of treatment for Reproductive Tract Infection is Rs. 372 in private hospitals and Rs. 100 in Government hospitals. Parents have to spend a minimum of Rs. 200 at private clinics for treatment of minor illness of their children. In special cases they have spent as much as Rs. 60,000. They have to shell out the cost of the first visit by the paediatrician for their newborn, when deliveries take place in private hospitals which is a minimum of Rs. 500. (Source of all cost data: Vyas, Swati. *Evidence Based Advocacy for Maternal and Child Health of the Urban Poor: A Case Study from Vadodara.* SAHAJ. 2009)

The following issues emerge from the experience of working on health of the urban poor in Vadodara City:

– Frequent demolition of bastis, resulting in poor people getting scattered and invisibilized, as they rent houses/rooms in different parts of the city.

– Lack of basic amenities for safe drinking water, sanitation, street lights, etc., even in bastis that have been in existence for many years. Lack of toilets in homes with adverse consequences particularly, safety of women and girls, as they use public toilets in and around their bastis.

– Public health facilities are inaccessible due to their distant locations, and require repeated visits and lengthy procedures to access services.

– People end up spending even in Government services, so they prefer private services. People going to hospitals feel lost, as there are no directions and

Table 3: Comparison of Health Indicators in Bastis with and without AWCs

Parameters	In bastis with Anganwadi	In bastis without Anganwadi
Home delivery	8 %	10 %
% of women accessing Ante Natal Care	63 %	44 %
% of women accessing Post Natal Care	30 %	42 %
Malnutrition	34 %	37 %
% of children receiving Vaccination	94 %	75%
Child deaths as a % of total live births	3%	10%

(Source: Annual data of child rights program of SAHAJ from October 2014 to September 2015)

they are not aware of all the services that they are entitled to and can obtain from various levels.

– Absence of maternity services at the primary level by the public health system, and lack of attention to adolescents' reproductive and sexual health (ARSH).

– Schemes like Chiranjeevi and Janani Suraksha Yojana (JSY) are available for people in the Below Poverty Line (BPL) category. However, many eligible families do not have a BPL card and there is a general lack of awareness of the various schemes - JSY, Chiranjeevi - that poor women can avail of.

– Non compliance of private providers with requirements of government schemes, for example the Chiranjeevi Scheme as mentioned above.

Right to Health Care

Availability of ICDS Services in SAHAJ's Working Area

AWCs are easily accessible and provide primary health care centre to pregnant woman and education to young children and girls. Our data shows the importance of the AWC for improving the health indicators. Table 3 shows the differences in health indicators in the bastis where we work, which have AWCs and those that do not: Home deliveries and Malnutrition are slightly higher, ANC and Immunisation lower, in bastis with no AWCs in comparison with bastis with AWCs. Child deaths are higher in bastis where there are no AWCs. Differences are significant in the terms immunisation and child deaths; others need more working upon.

Despite the recent Supreme Court Order on universalisation of the ICDS programme, out of the 18 existing work areas of SAHAJ, four bastis still do not have Anganwadi Centres. The communities in Subhashnagar and Hanuman Tekri have been constantly following up on their demand for an Anganwadi Centre (AWC) since last three years. Finally the sanction for an AWC in Hanuman Tekri came through in December 2015 and it started functioning recently. Gayatripura and Bhensasurnagar also, after constant follow-up action, ultimately got their AWCs. The Anganwadis in Jalaramnagar and Gayatripura got the appointment for the Helper after two years' follow-up by the community. Subhashnagar is a basti where people live in abject poverty and this basti has still not been successful in getting its Anganwadi.

Quality of Health Care

Health care services without the requisite quality, is a violation of health rights (ICESCR General Comment 14). The urban poor suffer from this violation very often.

Service Provision through the Mamta Diwas

Observations of 45 Village Health and Nutrition Days (Mamta Divas) in urban Vadodara showed

• Absence of doctors on Mamta Diwas.

• Poor quality ANC - tests and checkups are not done, for example, Blood Pressure measurement, blood tests, abdominal check-up of pregnant women.

• Information related to 'high risk' was given only during 7 Mamta Diwas out of the 45 Diwas observed.

• No referral facility was provided to sick children on any of the Mamta Diwas.

• Adolescent girls are deprived of Mamta Diwas services.

Weak Monitoring of Janani Shishu Suraksha Yojana

Government of Gujarat introduced the Janani Shishu Suraksha Karyakram (JSSK) in 2010 to provide cashless services for ANC, institutional deliveries and neonatal care in Public health care facilities. A study undertaken by SAHAJ during October 2014 to September 2015 found:

• 87% families incurred costs during pregnancy and delivery even though they were enrolled under this Yojana.

• 81% women had to bear the cost of transportation.

• 19% pregnant woman had to bear the cost of sonography.

• 16% pregnant woman had to bear the cost of medicines.

Women's Perceptions of Quality

Focus Group Discussions with women in around 12 bastis in 2011 and our sustained interaction with them over the last ten years give us an idea what the women in the bastis in Vadodara want from health services.

Systems or Processes for Regulation and Accountability

As indicated above, there is an absence of systems for regulation of the private providers both in terms of quality and cost of health care, just as in rural areas. There do not seem to be many models for promoting

What Urban Poor Women Want from the Health System

I. Services at the Primary Health Level

a. Quality and regular health services at the Anganwadi.

b. Proper follow up of maternal health at the basti level on Mamta Diwas.

• Health education (specific) to all pregnant and lactating mothers.

• Vaccination at basti level (women).

• Availability and distribution of IFA and Calcium tablets on Mamta Diwas.

c. Competent Link Workers/USHAs which implies appropriate training to link workers on follow up and documentation of cases.

d. Not being 'chased' repeatedly for permanent contraception. (Emphasis on temporary contraception rather than permanent contraception.)

II. Improvement in Ward Level Services.

a. Appointment of lady gynecologist in all the Ward clinics for 8 hours, all working days.

b. Deliveries, Ante Natal Care and Post Natal Care checkups (with Hb test, sonography, urine tests etc.), abortions and all contraceptive care including tubectomies at Ward level.

c. Availability of all medicines including IFA and Calcium tablets, pregnancy confirmation strips, medicines for reproductive tract and sexually transmitted diseases throughout the year. No prescription which means purchase of medicines from outside.

d. Appointment of pediatricians at all Ward level clinics for 8 hours, all days of the week.

e. Availability of treatment of child health at Ward level including incubators.

III. Tertiary Level Services

a. Protocol for emergency care to be followed in the Government hospitals.

b. Doctors should use I-cards or have name plates on their coats so that they can be identified.

c. Interns should not be given complicated cases without constant supervision of experts because majority of cases fail due to inability of handling them properly. The ICU Ward for the neonates should not have interns without experts.

d. Availability of all medicines at all times free of cost (nowadays medicines are prescribed from outside).

IV. Private Health Care

a. Protocol of quality health care for private practitioners including Chiranjeevi doctors.

b. Standard cost of care at private hospitals (because hospitals are charging any amount of money and it is not the same everywhere).

participation of urban 'communities'. The Constitution (74th Amendment) Act, 1992 has mandated grassroots level democracy in urban areas by assigning the task of preparation and implementation of plans for economic development and social justice to elected Municipal councils and wards committees, including public health facilities. The local governance structure proposed by the 74th Amendment and the Ward Committees once again mandated under JNNURM have not been operationalised, at least in Vadodara city. The National Urban Health Mission had proposed Mahila Arogya Samities, not with the aim of demanding accountability but from the perspective of promoting group health insurance and utilisation of services.

Thus, accountability mechanisms and processes are required to be implemented. Grievance redressal mechanisms, both for public sector and private sector violation of health rights should be implemented as well as monitored.

Conclusion

In this paper, we have tried to show that in the 'developed' state of Gujarat, in a big city like Vadodara, there are several problems from the perspective of equity, quality of care and accountability measures. Our experience of over a decade and engaging with women as partners in primary health care provision have provided important learnings. Training of outreach workers (Link Workers/ USHAs/ASHAs) and capacity building of Mahila Arogya Samitis must be carefully and creatively done so that they become vibrant agents of change. Women from the bastis have specific expectations from the health services which must be considered in any model of urban health care.