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REPRODUCTIVE AND CHILD HEALTH PROGRAMMES IN THE URBAN SLUMS OF BANGALORE CITY: A STUDY ON UNMET NEEDS FOR FAMILY WELFARE SERVICES

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Abstract

The Reproductive and Child Health Programme introduced in 1997 differs from the earlier family welfare programmes and it incorporates all the family welfare aspects in a broader and comprehensive manner. The study on unmet needs for family welfare services indicates the potential demand for family welfare services. The main objective of this paper is to understand the reproductive health programmes operating in Bangalore city slums, wherein there is highest prevalence of unmet needs for family welfare services. Data were collected through interviews. The unmet need for complete dosage of full MCH and Reproductive health ranged from 50 to 60 percent and there was an unmet need of 26.8 percent for family planning. This was found mostly among women till the age of 25 years who preferred largely spacing methods, which suggests that there is greater demand for unmet need for spacing methods in the slums.

Introduction

The concept of urban slums is an important issue in the context of urbanization. Urban areas of developing countries are growing much faster and their population is becoming larger. In 1970s only 27 percent of the people in the developing world lived in urban areas whereas this proportion increased in the year 2000 to 40 percent, and projection suggests that by 2030 that this would be 56 percent (Population Report

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2003a). By comparing urban population during 1970s and 2000 it has been observed that the percentages of urban population for developing countries were 27 and 40 percent respectively. The corresponding figures for India are 20 and 28 percent and for Karnataka they are 24 and 34 percent. Thus, the proportion of urban population in Karnataka has always been higher than it had been in the country as a whole.

Rapid urban growth reflects migration of people to cities as well as natural population increase among urban residents. This rapid growth without proper improvement in quality of life may lead to urban poverty, which will become a major concern in future. Because most of the urban poor live in slums without adequate access to clean water, sanitation and health care. How government and communities meet the challenge of rapid urbanization is a big question mark and that would largely determine the world's future. Thus meeting the challenges posed by rapid urbanization will be as important as addressing rapid population growth in the future.

Although considerable progress has been made in developing countries in expanding health facilities and services, the morbidity and mortality rates of women continue to remain unsatisfactory. Malnutrition caused by a combination of low income, inadequate or poorly balanced diet and poor food hygiene has been one of the key determinants of ill-health among the poor, and women are at greater risk than men. Women's health relates to a wide range of conditions which are influenced by socio-economic status, educational attainment, cultural and social norms governing female sexuality, power relations within a marriage or other union, domestic and sexual violence, the availability, cost and quality of services (World Bank 2000).

In the last decade, the 3 International Conferences 1993 (World Conference on Human Rights held at Vienna), 1994 (International Conference on Population and Development at Cairo), and 1995 (World Conference on Women held at Beijing), sought to reshape the vision of women's lives by placing their right, empowerment, health and quality of

life at the center of population and sustainable development policies for programmes. Almost all countries/regions as signatories of the action agendas of the conference have attempted to move closer in fulfilling many of these commitments.

The RCH programme which is the outcome of ICPD Conference was formally launched by the Ministry of Health and Family Welfare, Government of India in October 1997. Reproductive health approach differs from the earlier approaches such as family planning, mother and child health and safe motherhood. All the approaches have so far focused on specific aspects of the reproductive health. For e.g. family planning programme concentrated on providing information and services on contraception, MCH programme focused on promoting the health of the mothers and children, whereas safe motherhood programme focused on the need to ensure that the pregnant women receive adequate and timely pre-natal care, safe delivery and post natal care. The present RCH programme incorporates all the family welfare aspects in a broader sense and also in a comprehensive manner.

The National Population Policy (NPP) 2000 provides a framework for advancing goals and to prioritise strategies to meet the reproductive and child health needs of the people for the next decade and to achieve net replacement level by 2010. The policy addresses simultaneously issues of child survival, maternal health and contraception. The immediate objective is to address the unmet needs of contraception and health care. In addition to this the policy also has long-term objective such as achieving stable population by 2045 with sustainable economic growth, social development and environment protection. If the NPP 2000 is fully implemented we can anticipate a population of 1,107 million [110 crores] in 2010, instead of 1162 million [116 crores as projected by the Technical Group on Population Projections (NPP 2000)].

India Population Project VIII Bangalore was launched in 1994-95 and continued up to 2001. Bangalore Mahanagara Palike launched the project with financial aid (Rs.390 million) from the World Bank on

behalf of the State Government. The project was to cover 0.851 million urban poor population residing in about 500 slums. The components of the project was mainly to improve quality of MCH, strengthening the existing services, doorstep services for the urban poor, female education and employment, by involving community leaders, NGOs and medical practitioners. A training centre was developed at Kodandarampura for medical personnel, para-medical workers, NGOs, teachers, community leaders and link workers. Information Education Community Wing was set up not only to provide information but also to change the behaviour of the beneficiary community. The infrastructural development include development of 55 health centres, 32 urban family welfare centres, 5 post partum centres and additional posts were created for the improvement in services (India Population Project 2003).

The Concept of Unmet Need

Earlier the concept of unmet need addressed only contraception. Unlike the earlier concept, National Commission on Population (2000) hopes to address issue of unmet need in a broader framework including different sectors such as maternal and child health, safe drinking water, sanitation, nutrition, empowerment of women, development of children and issues relating to adolescent etc.

Unmet need has been interpreted in different ways in different studies. Under the present study unmet need refers to the contraceptive behaviour and other reproductive health services. If unmet need is measured effectively, the potential demand for family planning services and the likely impact on fertility can be identified. The study also attempts to give reasons why some women do not accept it even though they are aware of contraceptive availability, and moreover having accepted some do not continue it. The reasons could be attributed to fertility related, method related and opposition from family members and finally the lack of information on access and background characteristics such as income, degree of autonomy, education etc., which indicate that the programme effect is not the only sufficient criteria.

Since 1990, 120 surveys were conducted in 71 countries as part of Demographic and Reproductive Health Surveys. These surveys have reported on contraceptive use, child survival and other key reproductive health topics. Based on such surveys in 60 developing countries it was estimated that 21 per cent of married women of reproductive age had an unmet need for family planning (12 per cent for limiting and 9 per cent for spacing). According to an estimate (2000) 105 million married women and 8 million unmarried women had unmet need (Population Report 2003). For India, at present unmet need totals about 40 million married women. If all women space or limit births, the contraceptive prevalence rate would increase from 48 percent to 64 percent (NCP 2001).

With reference to Karnataka a total of 15 percent of the women are found to have unmet need for family planning and it is greater for limiting (8.5 percent) than spacing (6.6 percent) (RCH 2002-04). The percent of unmet need for family planning varies from 6 percent in Davanagere to 25 percent in Gulbarga. The unmet need for limiting is highest in Dakshina Kannada (15.4 percent) and lowest in Mandya (3.7 percent). The unmet need for spacing is highest in Gulbarga (13.8 percent) and lowest in Davanagere (1 percent). It is also sizable in both Bangalore urban and Bangalore rural districts (17.8 and 14 percent). Unmet need is found to have differences by background characteristics. For the state as a whole unmet need is high in urban areas. It is also high among scheduled caste and other caste women and also among those who had 10 or more years of schooling. With regard to MCH services only 30 percent of women received full antenatal check-ups and 71 percent received full vaccination for children. An unmet need study of family planning and MCH can indicate the potential demand for Family Welfare services. With this background, the present study tries to analyse the operation of RCH programme and its utilisation in the slums of Bangalore city.

The three most important public agencies that are working in Bangalore city for the development of the slums are Bangalore Mahanagara

Palike, the Bangalore Development Authority and the Karnataka State Slum Clearance Board.

Objectives and Methodology

For purpose of study, the specific objectives framed are:

(i) to understand the reproductive health programmes operating in Bangalore city slums;

(ii) to analyse the utilisation of reproductive and child health services;

(iii) to assess the nature of unmet need related to the RCH programme; and

(iv) to identify the factors responsible for the unmet need related to RCH programme in the urban slums.

The study is based purely on the basis of primary data. Data collected from 5 randomly selected slums located in different corporation limits have been used. The sample size fixed for the study was 1,000 households, 200 households from each of the slums and these households were selected on random basis and a questionnaire was framed to collect information. In addition to the standard demographic and socio-economic characteristics of the family, the study obtained detailed information on health care accessibility, availability and utilisation from these selected households. In addition to this, focus group discussions were also held for married women in the age group of 15-44 years. From these one thousand households, 720 women were identified as currently married women eligible for the study. Forty women could not be interviewed for various reasons like being out of station, gone to work and refusal to answer etc. and thus 680 women were interviewed.

The socio-economic characteristics of the household and background characteristics of women and spouse play an important role in utilising RCH services. Hence, some of the background characteristics of the household such as religion, caste and education of the head of the household, housing characteristics like number of rooms in the house, drinking water facility, toilet facility, and consumer goods and information

on public distribution system etc., were collected. To analyse characteristics of eligible women and her spouse, indicators such as age, age at marriage, education, occupation, number of living children etc., were considered for both respondents and their husbands. The additional information sought include, (a) number of children ever born, living and desired, (b) knowledge, attitude and practice of maternal and child health services, (c) availability, accessibility and utilization of health services, (d) reasons for not availing the services and finally, (e) information related to contraceptive behaviour and need for family welfare services.

All the completed questionnaires were edited and analysis was done through simple percentage calculations.

Altogether 5 focus group discussions (FGD) were conducted in local language during the study. Analysis has been presented under broad headings, Housing profile, Characteristics of Head of the household, Socio-demographic characteristics of women, Maternal and Child Health services, Reproductive health problem and their health seeking behaviour, Knowledge, mode of transmission and curability of RTI/STI- HIV/AIDS and finally Contraceptive behaviour and unmet need for Family Welfare Services.

Study Area

The present study was conducted in Bangalore city. Bangalore, the capital of the state of Karnataka is one of the growing cities today, accounting approximately 6.5 million inhabitants comprising 30 percent of the urban poor, plus a floating population of one million (Times 2003). There were 159 declared slums in Bangalore as per the survey in 1973 by Prakash Rao and Tewari. While in the early 1990's the official figure was 401 and now approximately 500 slums exist in the city. The total slum population is approximately 1.12 million. About 20 percent of the population of the Bangalore urban agglomeration could be considered as being part of the slum population (Karnataka Slum Clearance Board 2001). A large proportion of slums fall under high population density category where 75 percent of the population estimated to be Hindus. On the

basis of language about 40 percent of the slums were identified as dominated by Tamilians, 31 percent by Kannadigas and 12 percent by Telugus. Only about 10 percent of the slums could be treated as linguistically diversified (Hans Schenk 2001).

Analysis

Profile of the Sampling Households

The profile of the sampling households by characteristics of the head of the household is presented in Table-1. As said earlier, the total number of households covered in the sample was 1,000. The religions represented in the sample were Hindus, Muslims and Christians. Hindus constituted the most dominant religious group (88 percent) followed by Muslims and Christians (6 percent each). Among Hindus, majority of them belonged to Scheduled Caste group. Seventy one percent of the head of households were residents and 29 percent were migrants. Among the households, a female-headed household was only 4 percent. With regard to literacy, 40 percent were illiterates and 20 percent of them completed 10 years of education. Majority of them spoke Kannada and Tamil as their mother tongue.

Table 1: Percentage Distribution of Households by Characteristics of the Head of the Household.

Variables	Categories	Percentage
Religion	Hindus	88
	Muslims	6
	Christians	6
	Others	-
Caste	Scheduled caste	54
	Scheduled tribe	17
	Other backward class	17
	Others	12
Place of Birth	Bangalore	71
	Within Karnataka	12
	Outside Karnataka	17
Head of household	Male	96
	Female	4
Literacy	Illiterate	40
	Primary 1 to 7th	30
	High School	10
	SSLC 10th Completed	17
	Above 10th	3
Mother Tongue	Kannada	48
	Tamil	36
	Telugu	4
	Others	12

The housing profile of the sample households is presented in Table-2. Based on the materials used for the construction of wall, roof and floor, houses were classified as kachcha, pucca, and semi-pucca. About 45 percent of the households were kachcha, 33 percent were semi-pucca and 22 percent were pucca. Space was always a constraint in the slum and the residents were compelled to live in cramped quarters where the rooms and kitchen were combined and thus 41 percent of the households in the slum resided in one-room houses where they shared the kitchen. Electricity was available for 91 percent

of the households. The source of drinking water and availability of sanitary facilities were important determinants of the health status of household members. Only 6 percent of the households had tap connection, while others depended on public taps and hand pumps. The availability of durable goods has been used as an indicator of socio-economic level. Majority of the people in these slums belong to lower middle socio-economic classes. On the whole 91 percent of the households availed public distribution system (PDS) facility in the area.

Table 2: Percentage Distribution of Households by Profile

Housing Characteristics		Percentage of Household
Type of House	Kachcha	45
	Semi pucca	33
	Pucca	22
No. of rooms	0	41
	1	52
	2	7
Electricity	yes	91
	No	9
Source of drinking water	Through-Pipe	6
	Hand Pump	67
	Others (Public Tap)	27
Separate kitchen	Yes	59
	No	41
Fuel used for cooking	Wood	49
	Kerosene	31
	Electricity	Nil
	Liquid petroleum gas	7
	Others (charcoal etc.,)	13
Durable goods	Radio	37
	TV	50
	Electric fan	26
	Telephone	4
	Bicycle	8
	Motor cycle	6
Availability of PDS card	Yes	91
	No	9

Social and Demographic Characteristics

The socio-demographic characteristics of the sample women who were currently married in the age group 15-44 (680 women) have been presented in Table 3. The age-distribution indicates that more than 70 percent of the women were below 30 years of age. It is also evident that a majority of the (as high as 75 percent) women got married at their younger ages (less than 18 years) and had more than 2 children. With regard to their educational level, 49 percent of the women were illiterate and 16 percent of women had 10 years of education.

Table 3: Socio - Demographic Characteristics of Currently Married Women and their spouse (in percentage)

Social and Demographic characteristics		
Age group	**Wife**	**Spouse**
15 – 19	9	1
20 – 24	21	6
25 – 29	41	23
30 – 34	17	39
35 – 39	10	19
40 & above	2	12
Education		
Illiterate	49	29
1 to 7th	13	14
8th to 10th	22	21
10th completed	14	29
Above 10th	2	7
Occupation		
House wife/not working	40	5
Corporation workers	39	66
Pvt. Factory	10	9
Govt. factory	1	3
Business	10	17
Age at marriage of women		
Below 15 years	7	-
15-18	68	-
Above 18	25	-
No. of Living children		
0	10	-
1	22	-
2	19	-
3	39	-
4	5	-
5	3	-
6+	2	-

Maternal and Child Health Services

The percentage of women who availed various maternal health services is presented in Table-4. Women receiving full ANC package was around 38 percent in the sample. It was also observed that 22 percent of total deliveries took place at home, and they were assisted by relatives and friends. Around eight percent of the institutional deliveries were attributed to private institutions. Complications during pregnancy, delivery and post-delivery period (Table-4a) were indicated by 40, 10 and 25 percentages of women respectively. The pregnancy complications were related to tiredness and swelling of hands and feet. The delivery complication was related to premature labour and breech presentation. The incidence of post-delivery complication included excessive bleeding and vaginal discharge. For most of these complications, nearby private clinics were used for further investigations.

Table 4: Percentage of Women Availing Maternal Health Services During the Last Pregnancy (January 2000 to December 2002)

Maternal Services	Percent Availing
Any ANC	
Yes	85
No	15
Place of ANC	
Government Health Centre	73
Private	27
Others	-
Stage of pregnancy at the time of first ANC	
First trimester	15
Second trimester	40
Services received	
Weight measured	72
Height measured	18
Blood pressure checked	71
Urine tested	54
Abdomen examined	77
Any X-ray	12
Ultra sound	12
Received IFA tablets	69
Received TT	78
Full ANC	38
Women who had	
Normal delivery	92
Caesarian delivery	8
Place of delivery	
Government institution/Corporation	70
Private institution	8
Home	22

Table 4a: Percentage of Women Reported Complications during Pregnancy, Delivery and Post-Delivery.

Women who had complications during	Percent
Pregnancy	40
Delivery	10
Post-delivery	25
Pregnancy related complications	
Tiredness	70
Swelling in hand & feet	35
Delivery related complications	
Premature labour	30
Prolong labour	55
Breech present	15
Post delivery complications	
Excessive bleeding	70
Vaginal discharge	30
Place of treatment	
Government	68
Private	32

Children's receiving the immunisation services is presented in Table-5. Most of the children received polio-0 and BCG and their percentages were 91 and 95 respectively. All the three doses of DPT were received by only 51 percent in the sample. About 54 percent of the children received vitamin A Vaccination and only 10 percent of the children received IFA liquid for iron supplement. Health workers were the most important sources of information for the immunization services. Diarrhea and pneumonia were the two important diseases, which affected most of the children (70 to 75 percent) during the past 3 months. Seventy percent of them visited nearby private clinics for the treatment.

Table 5: Percentage of Children Availed Child Health Care Services.

Child Health Services	Percentage
Polio-0	91
BCG	95
DPT Injection	
1	95
2	83
3	51
Polio doses	
1	92
2	70
3	40
Measles	56
Vitamin A	54
Source of Information	
HW	67
Doctor	9
Mass Media	8
Neighbours	5
Friends	4
NGO's	3
Others	2
No-response	2
Source of Vaccination	
Government Centre	92
Private Clinic	8
Children suffering from	
Diarrioea	72
Pneumonia	76
Place of treatment	
Government	28
Private	72

Reproductive Health Problems and Their Health Seeking Behaviour

RCH programme moves beyond MCH and Family Planning and it gives importance to reproductive health problems also. An assessment has been made to understand the commonly experienced reproductive health problems of women in the past one year prior to the Survey (Table-6). The study observed that as high as 57 percent of women had experienced one or the other problem. More than 50 percent of the women suffering from menstrual disorders, vaginal discharge problems or urinary tract infections did not seek treatment where as women with problems related to pregnancy and abortions took immediate treatment for their problems. It is also observed that only 15 percent of them visited governmental facilities, 60 percent visited private clinics and rest of them depend on home remedy for treatment.

Table 6: Percentage of Women (Aged 15-44) Reporting Reproductive Health Problems during the Past One Year

Problems	Percentage
Irregular menstruation	14
Excessive bleeding	12
Painful urination	10
White discharge	8
Pain during menstruation	8
Frequent urination	5

Knowledge, Transmission and Curability of RTI/STI and HIV/AIDS

RCH programme also gives importance to the healthy sexual life of the couples. Thus it gives importance in identifying and managing the reproductive tract infections, sexually transmitted infections and HIV/AIDS. Government and many NGO's are working to educate people about the knowledge, mode of transmission and curability of RTI/STI and AIDS. It is also observed (Table-7) that only 26 percent of women were aware of RTI/STI whereas 68 percent of them were aware of HIV/AIDS. For most of them, the source of information was either community or the NGO workers. Many of them were hesitant to

answer the mode of transmission and curability with regard to RTI/ STI. With regard to AIDS 45 percent of them expressed candidly that AIDS is not curable. About 25 percent of women reported one or more symptom of RTI/STI and 55 percent of them sought treatment for their problem. Most of them visited private clinics for treatment.

Table 7: Knowledge, Transmission and Curability of RTI/STI and HIV/ AIDS by Currently Married Women.

		In Percentage
Percent of Women Aware of	RTI/STI	26
	HIV/AIDS	68
Source of Information		
	Health Worker	5
	Doctor	7
	Community/NGO workers	45
	Newspaper/Magazine/Books	2
	Radio/TV	30
	Friend/Relatives	11
	Posters & Advertisement	12
Mode of Transmission RTI/STI		
	Sexual intercourse	12
	Lack of personal hygiene	5
	Do not know	83
Mode of Transmission HIV/AIDS		
	Sexual intercourse	5
	Needles	2
	Mother to Child	30
	Blood transfusion	43
	Do not know	20
Knowledge about Curability of RTI/STI		
	Curable	35
	Not Curable	5
	Do not Know	60
Knowledge about curability of HIV/AIDS		
	Curable	5
	Not Curable	40
	Do not know	55

Contraceptive Behaviour and Unmet Need for Family Welfare Services

The contraceptive behaviour among the currently married women (users and the non-users of family welfare) along with socio-demographic characteristics is presented in Tables 8 and 9. With regard to current use of contraception it is evident that 49 percent of the women were not using any method and 51percent were using family planning methods (42 percent Tubectomy, 5 percent Vasectomy and spacing method only 4 percent). About 60 percent of women did not have any side effects with their current use and 40 percent users reported some problem or the other. Among the women who had problems, only 50 percent of them sought medical treatment (mostly private clinic). The reported reasons for not going for treatment were, cannot afford to spend money, timings not convenient and doctors not available etc.

The reported reasons for not using contraception among non-users were:

(a) desire for more children - 11%

(b) lack of knowledge about the methods - 15%

(c) lack of knowledge about the sources - 20%

(d) husbands disapproval - 10%

(e) elders disapproval - 10%

(f) currently pregnant – like to go for sterilization after desired number.of sons and daughters - 10%

(g) already above age (7%) health reasons (8%) religious opposition (5%) and using contraception as injurious to health (4%).

Table 8: Contraceptive Behaviour Among the Married Women

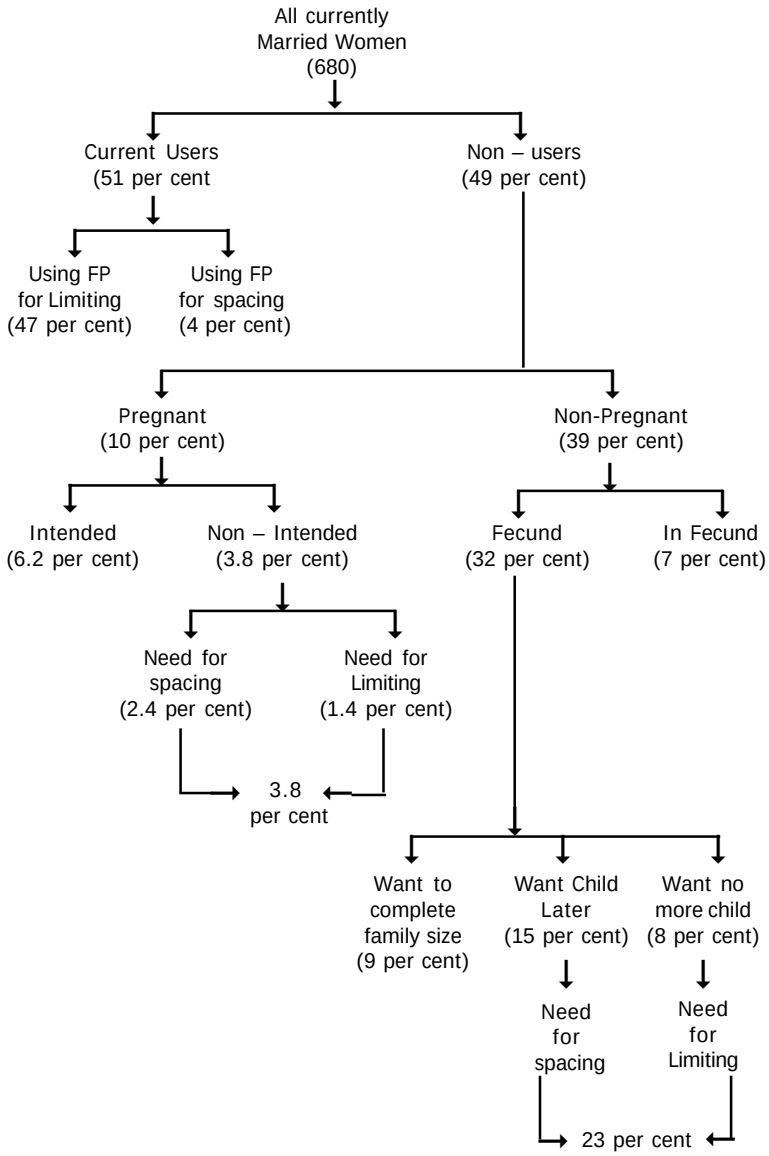
Contraceptive behaviour	In Percentage
Women using Family Planning methods	**51**
Permanent	47
Modern Spacing methods	4
Not using any contraceptives	**49**
Used contraceptives previously and discontinued	3.5
Never used any method	45.5

Table 9: Socio-Demographic Characteristics of Users and Non- Users of Family Planning (in percentage)

Details		Current users	Non-users
Women's Age			
	15-19	3	15
	20-24	12	30
	25-29	43	40
	30-34	26	9
	35-39	14	5
	40-44	2	1
	45 & above		
Type of family	Nuclear	65	31
	Non-nuclear	35	69
Number of Sons			
	Nil	7	53
	1	36	35
	2	29	7
	3	13	3
	4	13	1
	5 & above	2	1
Number of Daughters			
	Nil	16	45
	1	43	40
	2	23	13
	3	16	2
	4	2	
Education			
	Illiterate	44	55
	Primary	13	22
	Middle (Up to 7th)	23	10
	High School	18	12
	Completed SSLC	2	1
Generally go for treatment			
	Govt. /corporation	54	59
	Pvt. Clinic	40	37
	Home	3	2
	Others	3	2
	Satisfied with service	96	72
	Not satisfied	4	28

Among the current users (51 percent), 47 percent were using sterilization and only 4 per cent were using spacing, whereas among non-users, need for spacing methods was more (2.4+15= 17.4) compared to limiting (8+1.4 percent = 9.4 percent). Totally there was 26.8 percent of unmet need in the sample. Another 9 percent of non-users have decided to complete the family size by opting for female sterilization. This gives an impression that Family Welfare Programme is still giving more importance to the sterilization programme. The magnitude of the need for contraception varied substantially according to demographic and social characteristic of the women. The different socio-demographic characteristics like age, number of living children and education have been analysed with respect to current users and non-users to identify and provide valuable inputs to the formulation of strategies for meeting the demand of women for contraception with varying needs. The characteristics of users and non-users did not belong to any homogeneous group. The characteristics of non-users identified 85 percent of women were below 30 years of age, 69 percent belonged to non-nuclear families, 66 percent of them had one and two living children, 53 percent of them had no sons and 55 percent belonged to illiterate group etc.

Flow Diagram for the estimation of unmet needs for Family Planning



3.8 + 23.0 = 26.8 per cent
(Unmet Need)

The knowledge of antenatal, natal and postnatal check up was quite satisfactory. However many of them were not happy with timings and services of the near by urban family welfare centers.

The reasons attributed for not availing the complete dosage of MCH services were,

(a) lack of knowledge about the doses and
(b) long waiting time to receive the required service
(c) doctors not available and
(d) cannot afford to spend money in private clinic.

There was an unmet need of 26.8 percent for family planning that was mostly with women up to age 25 years. These mothers indicated the preference for spacing methods, which suggests that there is a greater demand for unmet need for spacing methods in the slums. With regard to immunization there was unmet need for 49 percent of children. Most of them did not have knowledge about complete dosage of immunization. With regard to reproductive health problem 57 percent had one or the other problem. Among them 50 percent did not go for treatment. Other 50 percent who visited, 15 percent visited government facility, 60 percent visited private facility and rest of them depended on home remedy for their treatment. The reported reasons for not visiting the health facility were, mainly lack of finance and, inconvenient timings.

FOCUS GROUP DISCUSSIONS (FGDs)

Focus Group Discussions are also an ideal tool to assess the outcome of a programme or intervention at the field level. Altogether 5 focus group discussions were conducted during the study. The group consisted women in the age of 15-44 years. Number of participants in each group consisted 30 to 40 members. Discussions were conducted at Anganwadi centres. Each discussion generally lasted between 30 to 45 minutes. Focus group participants were allowed to express what they knew about various aspects of the RCH programme and messages on health-related issues undertaken by IPP-VIII. The FGDs were conducted in the local language. The expression of the group on Family Welfare issues is presented in Table-10.

Table 10 Percentage of Women Expressing the Knowledge through Group Discussions:

Sl. No.	Knowledge	In Percent Yes	No
1	Heard any programme in radio about RCH issue	70	30
2	Seen any programme in TV about RCH	75	25
3	Media is useful in understanding women and child health problems	55	45
4	Any video/film show organized in your area regarding RCH	30	70
5	Any posters/hoarding on health issues exhibited in your locality	40	60
6	What is the ideal age for girls to get married? 18 years No response Others What is the ideal age for boys to get married? 21 years No response Others	 40 50 10 35 55 10	
7	How many TT injections to be given during pregnancy? One time Two time Three times No idea	 25 45 65 10	
8	Does the husband discuss with you about family planning matters? Yes No No response	 20 65 15	
9	Should the pregnant women take iron tablets? Yes No response	 75 25	
10	What types of examinations are conducted during programmes? Weight Blood count Blood pressure Abdominal check-up	 65 70 55 45	

11 What should the women do when they realise that they are pregnant?	
They must get registered with HW/hospital	20
They can inform elders	45
Just keep quiet thinking pregnancy is normal	35
12 Should a doctor examine her regularly?	
Yes	50
No	50
13 Which is the right place for delivery?	
Hospital	60
Nursing home	20
House	20
14 After how much time the breast-feeding to be started for the new born?	
Within one hour	25
After six hours	70
After 12 hours	5
15 Should the first milk be fed to the new born?	
Yes	45
Should not be fed	30
Throw it away	25

Regarding IEC programmes carried out through All India Radio and Doordarshan, 70 to 75 percent of people who possessed TV and Radio had heard about the programme. There were nearly 25 to 30 percent of the households despite owning TV/Radio expressed ignorance of the programme. However, those who watched the programme, by and large (55 per cent of them), expressed satisfaction about the programme. The programmes were able to convey the messages effectively. They felt that the language used in these programmes was very simple and conveyed the messages effectively. To find out the general exposure towards health messages, the respondents were asked to state whether they had seen any messages through film shows and through posters and hoardings. Thirty to forty per cent of them expressed that they had seen film shows and posters and hoardings. A considerable proportion of marriages took place before the boy or girl attained legally prescribed minimum age at marriage in the slums. It was

found that 40 percent of the respondents were aware of the legal age at marriage for girls whereas the knowledge with regard to boys' legal age at marriage was only 35 percent. The knowledge of ante-natal checkup, natal and post-natal checkup were quite satisfactory in the group, compared to breast feeding practices.

NGOs and their Involvement in Bangalore City Slums

In the recent period, Non-Governmental Organisations (NGOs) have taken up larger part in addressing socio-economic issues whose efforts are welcome because of their spontaneous efforts for attending to the due needs of the nation. Some of the prominent NGOs working in the study area and their activities have been presented in the following.

i) Paraspara Trust:

Paraspara Trust, an NGO was established in 1996, with the objective of eradicating child labour system. To achieve this goal, it started working with children, parents and the community. The Trust examined certain pertinent issues of child labour like lack of child care facility for working parents, lack of economic opportunities and started addressing them. The issues of child care for the working parent was addressed by non-formal education centres and crèches in the slums with the participation of the community. High dropout rate in the schools made the trust to look at the quality of education, need for special tuition and literacy classes for mothers who could support their children. To speed up this process, the trust also involves in other activities such as organising health camps for children and community in the slums, self-help groups for promoting savings and availing credit to improve the economic status of the poor, facilitate skill trainings through government schemes to improve the earning status etc. The Trust also works with street girl children to provide security, health and nutrition.

ii) Freedom Foundation:

Freedom Foundation is an NGO propagating, A healthy mother...a healthy child. Basically, they are working for the prevention of HIV and their main theme is the, 'prevention of mother to child transmission of HIV' (PMTCT). The activities related to the programme conducted by the Foundation are:

a. a simple blood test during pregnancy to know whether a person has HIV;
b. antiretroviral medication to the mother before delivery to protect the child from getting infected,
c. Prophylaxis to the infant to give added protection; and
d. to give guidance on infant feeding

The services of the PMTCT project are:

a. pre-test counselling, HIV testing and post test counseling;
b. training the health care staff of the hospitals regarding PMTCT;
c. antiretroviral medication for PMTCT given free of cost (for mother and infant);
d. guidance regarding infant feeding; and
e. testing the baby free of cost to know the health status.

iii) Asha Foundation:

Asha Foundation helpline was established in 1998. The projects cover a vast range of issues. They include imparting value based sexual education in the curricular of more than 120 schools; promotion of child welfare through counselling, free medical and nutritional care and the prevention of mother to child transmission of the HIV virus.

Some of their main projects are:

a. Life at the crossroads (LAC)
b. The Prevention of Mother to Child Transmission (PMTCT)
c. Empowering the forsaken and Asha's Training initiatives (Training).

Their activities in the project involve:

Changing the high-risk behaviour of families and individuals in the community;

Easing the financial burden on HIV positive families;

Improving nutrition and providing medical care for the children of HIV positive parents; and

Finally to improve the financial status of single mothers.

In addition to this, they hold workshops for doctors, nurses, counsellors, teachers, community health workers and other NGOs.

iv) Snehadaan:

Snehadaan is a care and support centre for people infected and affected with HIV/AIDS. Its vision is to provide quality health care to the sick, i.e., comprehensive and holistic, for the people infected and affected with HIV/AIDs. Further more it helps to prevent the occurrence and spread of HIV/AIDS through counseling and informational support.

Conclusion and Recommendations

The process of industrialisation and urbanisation has led to the migration of rural people into the cities in search of livelihood. The shift in population has led to the emergence of slums. The urban population living without the basic minimum social services is increasing at a faster rate than the overall urbanisation. Health issues in the urban areas are linked to variety of socio-economic factors, including education, housing, employment, environmental condition and communication.

In the new millennium, nations are judged by the well being of their people, i.e., by levels of health, nutrition and education; by civil and political liberties enjoyed by their citizens; by protection guaranteed to children and by provisions made for the vulnerable and the disadvantaged. The large population in India can be its greatest asset if they are provided with the means to lead healthy and economically productive lives. This necessitates co-ordination at all levels of the government and society like, increasing availability of affordable reproductive and child health

services, spread of literacy, convergence of service delivery for the urban poor, and participation of women in the paid work force etc.

A majority of the people in these slums belonged to lower middle socio-economic strata. With regard to MCH services, around 40 percent of currently married women availed maternal health services and 50 percent of the women availed child health services for their children. About 22 percent of the women had their deliveries at home and untrained dais and relatives attended most of them. Major problems associated with pregnancy and deliveries were anemic, abdominal pain, backache and tiredness. Ninety percent of the acceptors accepted terminal method of contraception.

Reproductive morbidity of various illness ranged from 10 to 40 percent among women and a large percentage of them did not seek health care at all. It is also observed that women suffering from menstrual disorders, vaginal discharge and urinary infection problems did not seek treatment, whereas women with problems related to pregnancy, delivery and post-delivery care underwent treatment. Most of the women visited nearby private clinics for emergency and serious health problems.

Only 26 percent of the women expressed awareness with regard to the knowledge of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs), whereas 68 percent of the women expressed awareness regarding HIV/AIDS. A majority of them acquired knowledge through mass media and NGO programmes.

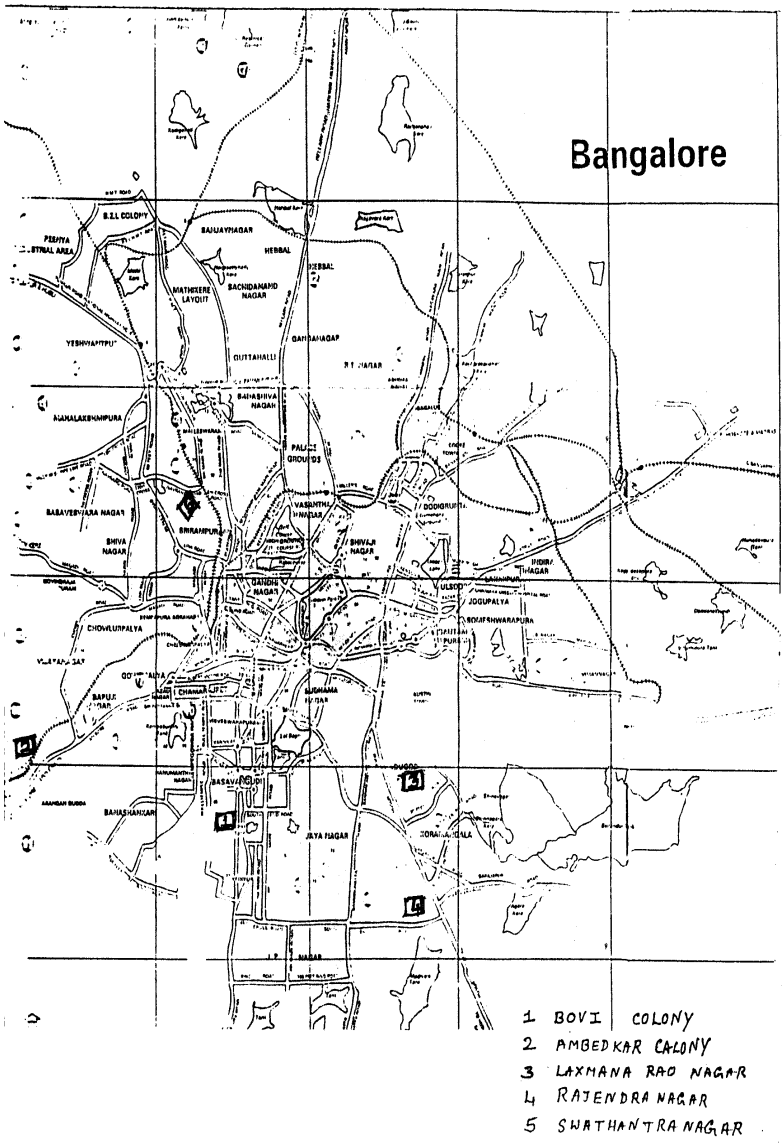
Fifty-one percent of the women of the sample size were using contraception, out of which 47 percent depended on permanent method. The main reasons for the 49 percent non-users of the contraception included desire for more children, disapproval of the family, lack of knowledge about methods and sources and other health reasons. There was an unmet need for 26.8 percent for family planning. Most of these women belong to below 30 years of age (85 percent) and preferred spacing methods, suggesting that there is a greater demand for unmet need relating to spacing-methods in the slums.

The study attempts to give reasons as to why even after becoming aware of contraceptive availability some women do not accept it or having accepted the need, others do not proceed to use contraception. Such reasons may be related to fertility problems or the method problems or may be due to opposition from the husband and family or due to lack of information and access. The study also shows that unmet need is a function of women's background such as degree of autonomy in functioning on their child bearing experiences, their level of education, exposure and also programme factors. Hence it must be realized that programme efficiency can be useful but not sufficient. Thus unmet need does not reflect just women who want contraceptives-a supply need, but also women who require motivation to what they are in need.

- The family planning programme should involve participation of the husbands since they are one of the major factors in influencing the contraceptive use.
- Should raise awareness among girls and communities about the Legislation of minimum age at marriage and the harmful health consequences of early pregnancy.
- Health workers must be trained to address the special needs of married adolescent girls with wider choice of contraceptive methods.
- More strategies like delivering health talk and educating the women with regard to RTI/STI and MTP are required.
- Trained birth attendant and safe delivery kit are required in the premises of the slum.
- Ensure regular follow up services for the modern spacing contraceptive users.
- IEC activities have to be strengthened.
- Quality of basic MCH and FP services should be strengthened on certain aspects like:

- Ensuring complete dosage of immunization for mothers and children,
- Information and counseling about women's health,
- Safe abortion services,
- Maximising the use of public health infrastructure and
- Providing 24-hour services for institutional deliveries in the Urban Family Welfare Centres.

Location of Slums under study
Bangalore City



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