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EXPERIENCE WITH FREE-OF-COST HEALTH CAMPS CONDUCTED IN URBAN SLUMS

Community Medicine

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ABSTRACT

This cross-sectional descriptive study, using the complete enumeration technique, was conducted during 13 health camps held between April 2018 and December 2018 in various slum areas. Out of the 4,747 patients who attended these camps, 2,168 (45.67%) were males and 2,579 (54.33%) were females. Though the number of female patients attending the camps exceeded that of males, the gender difference was not statistically significant. While 13.67% reported at the camp with ailments that could be examined and treated by a non-specialist doctor, 17.04% patients needed examination by ophthalmologists, 14.79% by orthopaedic specialists and 10.26% by dermatologists. 381 out of 2,579 (14.77%) women attended the health camps for gynaecological ailments. Out of 4,747 persons who attended the camps, only 149 (3.10%) were children. Periodic health camps, with provision for services of specialist doctors, can be an effective means of delivering specific community-based educational and health interventions in the underserved areas.

KEYWORDS

Free-of-cost, Health camps, Urban slums

INTRODUCTION

Health camps, when conducted periodically in slum areas, provide a constellation of free-of-cost services. Health camps can be an effective channel for delivery of the requisite health services to a population, [1, 2] but the utilization of services offered by these health camps is influenced by attitude of the intended beneficiaries in the target population. [3]

Under the National Urban Health Mission, which was launched in 2013, the existing urban health posts were upgraded as "urban primary health centres" in cities with population of 50,000 and above. Many daily-wage and self-employed workers are unable to avail of health services at these "urban primary health centres", which function only during the morning hours. This is the same time period when the workers are engaged in earning their wages. Transport costs also hinder healthcare seeking behaviour and therefore, health camps are, by and large, conducted within a slum area to obviate the need for transport. Since health camps are usually conducted from 9 AM to 5 PM, many daily-wage and self-employed workers may be able to attend these camps. Objective of health camps is to screen the patients in their localities, deliver medical care for minor common ailments, create health-related awareness and refer patients to higher centres for specialized care. These health camps were conducted during public holidays or weekends to ensure high number of beneficiaries. Any place in the locality, such as, local school or community recreation centre, which is accessible and convenient from the point of view of the intended beneficiaries and has sufficient area for waiting and patient examination, is selected as the venue for a camp. Outreach medical health camps are more convenient than outpatient clinics with high level of satisfaction among the beneficiaries. [4, 5]

Slums are socially heterogeneous human settlements, [6] where the inhabitants have inadequate housing and basic services, [7] no access to clean water, improper sanitation, and unsecured land tenure. [8] Urban slums are characterized by overcrowding, poor housing, choked drains, high density of insects and rodents, lack of garbage disposal facilities and poor hygiene. Though slum dwellers experience higher levels of socioeconomic disadvantage as compared to other urban residents, not all families living in slums are poverty-stricken or uneducated. [9] Depending on the prevailing socio-economic milieu and social perceptions, the concept of a slum manifests regional differences. [10] Pavement dwellers are usually not regarded as "slum dwellers". [11]

Migration from different areas, inherent social instability and diversity of cultures are among the factors that reduce enthusiasm and offer fewer opportunities to nurture the urban slum as a robust collective social unit. In India, a slum should be "notified" in order to be eligible for provision of potable water and sanitation, but, many settlements exhibiting slum-like features are never notified [12] The data from the Indian government and the UN on distribution and number of slum dwellers may not be comparable since the UN data would include all deprived areas, and not just the Government-notified "slums". [10]

MATERIAL AND METHODS

This cross-sectional descriptive study, using the complete enumeration technique, was conducted during 13 health camps held between April 2018 and December 2018 in various slum areas of Thane city, located about 30 km from the metropolis of Mumbai in Western India. The data were entered in Microsoft Excel spreadsheet (Microsoft Corporation, Redmond, WA, USA) and analyzed using SPSS statistical software Windows Version 25.0 (IBM Corporation, Armonk, NY, USA). For patients with multiple ailments that were examined by multiple specialists, the speciality where the patient was examined first was considered to prevent duplication of data. Categorical data were presented as frequencies. The statistical significance was determined at $p<0.05$.

RESULTS AND DISCUSSION

A total of 13 health camps were conducted between in collaboration with local non-governmental organizations. Out of the 4,747 patients who attended these camps, 2,168 (45.67%) were males and 2,579 (54.33%) were females. Though the number of female patients attending these camps exceeded that of males, the gender difference was not statistically significant (two-tailed independent t-test T value = -0.582; p=0.568). The gender-wise distribution of patients is depicted in Fig-1.

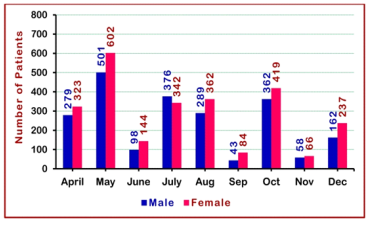

Fig-1: Gender-wise distribution of patients

While 649 (13.67%) reported at the camp with ailments that could be examined and treated by a non-specialist doctor, 809 (17.04%) patients needed examination by ophthalmologists, 702 (14.79%) by orthopaedic specialists and 487 (10.26%) by dermatologists. (Fig-2)
Self-perceived morbidity includes conditions that are perceived and reported by an individual in response to inquiries regarding illness or symptoms over a defined time period. [13] Since morbidity data may

be biased, measuring both self-reported and observed morbidity is recommended in order to depict a full range of morbidity. [14]

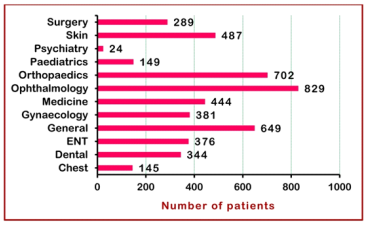

Fig-2: Speciality-wise distribution of patients

Women from lower socio-economic strata of society are weighed down by reproductive morbidity because social taboos attached to reproductive health problems create a "culture of silence" that can adversely affect women's health. [15]

In the present study, 381 out of 2,579 (14.77%) women attended the health camps for gynaecological ailments. A study conducted in a slum area in New Delhi reported that 88% had reproductive health problems. [16]

In an Ahmedabad-based study, 19% of females aged 15-44 years were clinically anaemic, [17] while in a Chennai-based study, 30% of slum-dwelling women aged 20 years and above were anaemic. [18] The sensitivity of clinical examinations for anaemia ranges from 19-70% while the specificity ranges from 70-100%. [19-22]

In the present study, there were only 149 children (3.10%) out of 4,747 persons who attended the camps. The frequency of respiratory illness was 17.2% in a Chennai slum, [18] 15% in a slum area of Ahmedabad [17] and about 4.5% in Delhi slums. [23] The causes of death in urban slum children include poor neonatal care, [24] diarrhoea, and respiratory infections. [24, 25] Malnutrition is part of a vicious cycle that includes poverty and disease. [26] This vicious cycle can be broken by specific nutrition and health interventions for under-five children.

CONCLUSION

Health camps can be used as a method for delivering specific community-based educational and health interventions in the unreached or underserved areas to achieve universal health coverage. It is necessary to include periodic health camps with provision for specialist services in the strategy for providing health care with optimum use of scarce resources.

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