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REPRODUCTIVE HEALTH OF WOMEN IN INDIAN SLUMS: AN OVERVIEW

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Abstract: T*his paper attempts to present an overview of reproductive health of women living in slums in India, here the paper endeavours to investigate and analyse reproductive health of women living in Indian slums in terms of various indicators of reproductive health like total fertility rate, contraception, antenatal care and child delivery practices, etc. The paper analyzes how unhygienic, unsanitary, overcrowded living condition in slums adversely affects health of the inhabitants in general and reproductive health of women in particular. The paper has reviewed major studies conducted on reproductive health of women in slums in different Indian cities and also has taken into account various government surveys and reports. The paper also explores possible explanations of the major reproductive health issues of women living in slums. The paper also looks into reproductive health situation of different slums within a city and also investigates reproductive health situation of slums of different cities.*

Keywords: *Total fertility Rate, Contraception, Antenatal Care, Child delivery practices*

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INTRODUCTION

The slum dwellers experience widespread social isolation, are often illiterate and lack negotiation skills to demand improved public services. In particular, they are vulnerable to many health issues that occur as a consequence of poor living conditions. Their health indicators are much worse than urban averages and similar to or worse than those of rural populations (Health, 2010). It is generally perceived that the increasing number of health service providers in urban areas, would eventually cater to the needs and demands of urban population. However, rapid urbanization coupled with relentless growth of slum population created acute disparity within cities and made this supposition a distant dream (Rossi-Espagnet, 1984). Though it is true that the urban population has better availability and accessibility of health care services because of better-developed health infrastructure this is more evident in case of large cities. But it is equally true that the accessibility to these services and the quality of the services vary significantly between cities and within cities (Poel, O'Donnell.O, & Doorslae, 2007; Lalou & LeGrand, 1997)There exist considerable amount of literature to suggest that the slum population is more vulnerable in terms of their health than the rest of the urban population and is in fact no better than their rural counterparts (Islam, Montgomery, & Taneja., 2006); (Montgomery & Hewett, 2005); (Fotso, Ezeh, & Oronje, 2008).The situation becomes worse with women's health and more specifically with their reproductive health. Life in unhygienic, unsanitary condition in slums with low level of education, low social status attached to slum living adversely affect their health and when it comes to reproductive health problems there is shame and guilt associated with discussion on their reproductive health and gynaecological problems which result not only in higher actual morbidity, but also in lower treatment rates and therefore resulting in greater burden of ill health among women comparison to men (Nandraj, Madhiwalla, Sinha, & Jesani, 1998) (Parikh, Taskar, Dharap, & Mulgaonkar, Undated)

TOTAL FERTILITY RATE (TFR)

P.V.L Ramana (2002) in her study of slum women in Visakhapatnam found out that the total fertility rate in slum areas of Visakhapatnam is 3.2 which is quite high comparing the national average. Study of reproductive health of slums in New Delhi found that the fertility level of women in Delhi slum is significantly higher than the fertility level in non slum (Gulati, Tyagi, & Sharma, 2003). Later on NFHS 3 (Gupta, Fred, & Lhungdim, 2009) in its study of

slums in eight cities revealed that except Meerut, fertility levels in all the rest seven cities are already at the replacement level or below the replacement level. It is interesting to observe that the national average of TFR is 2.4 where urban TFR is 1.8 and rural TFR is 2.6 in such situation slum fertility level is not drastically different from urban fertility level. However, there exists variation in fertility level in slums of different cities. The TFR is higher by 0.2-0.5 children in slum areas than in non-slum areas in every city except Nagpur. Except for Hyderabad, the slum population has much higher fertility rates than the non slum population. The TFR for poor women in Delhi and Meerut is four children per woman. The TFR is lowest in Kolkata (1.4) and highest in Meerut.

CONTRACEPTION

Reddy (1984) in his study of Hyderabad city came across that contraception was significantly higher among the non-slum residents than the slum dwellers. He also found that among the current contraceptive users in both non slum and slum majority had undergone sterilization and there exists huge unmet demand for contraception for spacing. Base line survey conducted by Pune Municipal Corporation (2000) found out that there is huge difference in contraception in slum and non slum population This difference becomes acute particularly in spacing methods, the use of spacing methods in non-slum areas is about three times higher (31.8 per cent) compared to slum areas (Poona Municipal Corporation, 2000).

Study of Vishakhapatnam slum (Ramana, 2002) it was found out that around half of the women in slum use contraception and here also majority of them sterilization and negligible percent of males have gone for sterilization. On issue of higher female sterilization and male aversion towards sterilization, she has concluded that perhaps men prefer to be away from the burdens of the problems or at least do not take the risk or bear the possible pain of the operation. She also has mentioned that in some cases they are cautious about their virility.

(Gulati, Tyagi, & Sharma, 2003) in his study reported that use of contraception is only 34% whereas it is as high as 71% in non slum areas of Delhi. It is also found in the study that the 60% of contraceptive users in Delhi slums opted for sterilization that too female sterilization. Contraception is 11points higher in urban areas (64 %) than in rural areas (53 %) at the national level (IIPS and Macro International, 2007).Among the slum population NFHS 3 (Gupta, Fred, & Lhungdim, 2009) tells us that contraception among currently married women in slum is lower in slum areas than in non-slum areas except Chennai. The

method of contraception also differs from slum and non-slum areas of these cities. In every city, the use of modern spacing methods is lower in slum areas than in non-slum areas .Another study conducted in six cities of UP found that unmet need for family planning among women in the urban slums is much higher than those living in non-slum areas (Speizer I, 2012)

With these studies conclusion can be made that contraception is higher in non slum areas than slum areas, however female sterilization is higher in slum areas than in non-slum areas which is manifestation of how bodies of poor women are treated as instrument to curb numbers, to reduce birth rates. Sterilization as a matter of fact is much more complicated and risky operation than male sterilization.

ANTENATAL CARE (ANC)

Griffiths and Stephenson (Griffiths & Stephenson, 2001) found that women in slums of Mumbai would only avail antenatal care services if they experience problems during their pregnancies. However universal ANC is important for safe motherhood and to reduce mortality among mothers and infants. The idea to avail ANC only when having any problem is serious impediment towards realizing the dream of universal coverage of ANC and safe motherhood. The authors have concluded that the cultural environment in which people live significantly influence their attitude towards the utilisation of antenatal care services.

Study of women in Visakapatnam (Ramana, 2002) slums found that only 60% women in slums utilized antenatal care where the majority went for administering TT injection.

Study of Delhi slums (2003) found out that ANC utilization is 80% comparing ANC utilization in non slum areas of Delhi. It also brought that among those who are availing ANC the share of TT injection utilization is maximum. Even the annual health surveys (Government of India, 2012, 2013) also have given similar details and have cited the under consumption of iron folic acid tablets responsible for sluggish performance of ANC utilisation in 9 EAG states.

NFHS -3 (Gupta, Fred, & Lhungdim, 2009) concluded that in every city except Meerut, more than three-quarters of women had at least three antenatal care visits. All women in Chennai had at least three antenatal care visits, followed by Mumbai and Hyderabad (91 % each). The proportion of women who received three or more antenatal care visits is lower in slum areas than in non-slum areas, but the difference is only marginal (less than 3 %) in Meerut,

Chennai, Hyderabad, Indore, and Mumbai. Delhi has the largest difference in antenatal care visits between slum and non-slum areas (more than 20 %).

CHILDBIRTH PRACTICES

It is being observed that "child bearing in India, for majority of women, is more a health hazard than a natural function" (Government of India, 1974). In slum situation where the medical and the paramedical facilities are limited, poverty compels women to deliver at home in unhygienic condition with the help untrained personnel. A study of slums in Delhi concluded that women in slums preferred home delivery with the assistance of traditional birth attendants (TBAs) reason for such preference were cited that they were economical, accessible and the TBAs also helped women with household chores. (Sharma, Bali, & Bhargava, 1990). Another study conducted in slums of Allahabad to inquire about childbirth practices among women in slum areas brought that the majority of the women favored home delivery taking the help of the untrained dais living in the same area. (Khandekar, 1993). Study of slum Vishakhapatnam (Ramana, 2002) it was seen that 78% women in slum prefer home delivery and 22% go for institutional delivery where 15% deliver in government institution and 18% in private facility. The author has pointed out that slum women perceive delivery as a routine event and give no special significance for consulting a doctor. The author has provided two possible reason for home deliveries first is the economic reason the cost involved in delivering in hospitals and second the availability of dai in slum areas, in whom they have great trust. The author found that 76% deliveries in the slum are conducted by untrained dais. On this issue Khandelkar (1993) also pointed out in his study that the majority of slum dwellers have no faith on hospitals. They prefer and trust the untrained dais who belonged to the same socio-cultural milieu. Gulati, Tyagi and Sharma (2003) in their study of Delhi slums described that only 37% women in Delhi slums go for institutional delivery comparing 70% in non slum areas of Delhi. The authors were surprised to note that safe delivery in Delhi slum is 96% which is 74% in non slum population. The authors have pointed out the significance role of dais in slum areas who were trained. It is important to point here that institutional delivery is important to ensure safe delivery but at the same time needs and aspiration of people can't be overlooked. Hollen in her study of Tamil Nadu village also found that women delivering in an institution not necessarily have enriching experience rather they complain of doctors, nurse and other paramedical staff's

apathetic attitude towards their pain on the other hand these traditional dais who are from the same community have known them long consoles the delivering mothers, sympathises with them and that makes the process more soothing and easy. In all these studies it is seen that untrained dais play an important role in providing natal care in urban slums. It is important to tap the potential of this dais, train them to provide safe delivery and mainstream them in formal institutional setting. NFHS-3 (Gupta, Fred, & Lhungdim, 2009) in its study concluded that 60% of deliveries took place in health facilities and institutional delivery is nearly universal in Chennai, and as high (92 %) in Hyderabad. However in Meerut it is seen that only 46 % of deliveries were conducted in health facilities. However NFHS-3 (Gupta, Fred, & Lhungdim, 2009) concluded that all indicators of delivery and postnatal care were consistently better in non-slum areas than in slum areas in all cities except Indore, where institutional deliveries and deliveries by health personnel were more common in slum areas than in non-slum areas, and Chennai, where there was essentially no difference in the utilization of postnatal care. These individual cases need to be studied separately otherwise viewing the findings of the studies we could conclude that women in slum prefer home delivery than institutional delivery.

A recent study of slums in Aligarh reported that majority (67%) of the women in slums in preferred to deliver at their homes, the motivation behind home delivery is economic and normalcy in pregnancy (Khan, Khalique, Siddiqui, & Amir, 2013)

Slum dwellers also found to be disadvantaged in terms of maternal health services, compared with households residing in non-slum urban areas (Rutstein, Johnson, & Montana, 2005). The reach and utilization of primary health services is poor in urban slum communities in India. Primary health care facilities have not grown in proportion to the explosive growth of urban population, especially for the poor. Also, health facilities may not be in physical proximity to urban slum neighbourhoods. We have seen that there exist huge disparity among slum dwellers the slum dwellers in bigger metropolitan cities tend to perform better on these indicators taken for the present study whereas the slum of smaller cities like Merut doesn't have the similar statistics like that of Mumbai, Chennai or Delhi. Since these slums are better placed in terms of availability of services. However, the slum dwellers are more likely and in fact are more vulnerable to illness because of the general unhygienic conditions in which they live, and their low levels of awareness of preventive

care. In a study of cost of healthcare in Jalgaon district, (Duggal & Amin, 1989)observed that within urban areas, the slum population had a higher morbidity. Similarly, (Nandraj, Madhiwalla, Sinha, & Jesani, 1998)) contends that slum dwellers suffered higher morbidity than non-slum dwellers in each age group, gender group and occupation group.

CONCLUSION

With this discussion conclusion can be drawn that the fertility rate among slum dwellers is higher than their non slum counterpart however there exist wide variability in fertility trends in slums of different cities. It is seen that contraception is higher in non slum areas than slum areas and among the users female sterilization is maximum but it is not surprising keeping in view the national trend of female sterilization and its dominance in family planning dynamics. In child delivery practices the micro level study found a general preference for home delivery among the slum dwellers and these studies have also pointed out the role of traditional dais and the trust they have of the women there, in such situation it is immensely important to train these dais, mainstream them into formal sytem of service delivery to ensure safe motherhood. It is important to note that reproductive health in slums of different cities vary significantly. Reproductive health indicators of slums of bigger cities are far better than the slums of smaller towns and cities. Even slums of the same city vary significantly in terms of demographic distribution, accessibility of services and hence it also gets reflected in terms of its performance on various indicators. It would be misleading to draw inference and generalization from one slum or from slum of one city. There is need to have micro and detailed studies of slums bigger cities and small towns and of different slums of a city.

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