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UNDERSTANDING WOMEN'S REPRODUCTIVE HEALTH NEEDS IN URBAN SLUMS IN INDIA: A RAPID ASSESSMENT

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An overview of women's health status presents a sobering picture. Deaths and illnesses from reproductive causes are highest among poor women the world over and among women in developing countries particularly. About one-third of the total disease burden among women aged 15 to 44 years in the developing countries is linked to health problems arising out of pregnancy, childbirth, abortion and reproductive tract infections (World Bank, 1993). Bang and Bang's (1989) study in Gadchiroli (Maharashtra) was one of the first community based studies on the prevalence of gynaecological morbidity among Indian women. Subsequently, several community based studies have reiterated and revealed the magnitude of reproductive morbidity among Indian women (Bang and Bang, 1994; Bhatia and Cleland, 1995; Gittlesohn et al., 1996; Latha et al., 1997; Koeing et al., 1998). An exhaustive review by Jejeebhoy (1997) reveals the grim side of obstetric morbidity. Not only are maternal mortality levels in India among the highest in the world (437 to 568 per 100,000 live births), but neonatal mortality was also high at 52.7 per 1000 live births, which is a direct consequence of women's poor health status prior to and during pregnancy. In addition to the suffering of women, yet another cause of concern is their almost apathetic attitude towards their own health and its management during illness. Women were found to seek treatment only when their health problem caused great physical discomfort or when it affected their work performance (Kapadia et al., 1997). Such a scenario therefore begs the attention of policymakers and programme managers to address women's health needs on an urgent basis.

The current focus on reproductive health in India is a result of the global recognition that these health needs have long been neglected and that the consequences of this neglect are devastating, particularly on the lives of women. Simultaneously, it is also acknowledged that the traditional population programmes which have focussed narrowly on contraceptive prevalence have not only failed to address women's reproductive health needs but are now not even able to lead to the achievement of the set demographic goals of the country. In order to address the twin goals of population stabilization as well as of reproductive health, several

*** Based on a project undertaken by the Population Research Centre, Baroda (Das, 1999)**

countries, including India, therefore have now restructured and reoriented their population policy and programmes to include reproductive health needs, particularly of women, and to provide services that are more responsive and sensitive to the socio-cultural milieu of individuals. The newly launched Reproductive and Child Health (RCH) programme of the Government of India in 1997 is indeed a long awaited move to integrate various earlier programmes of family planning and maternal and child health with those that aim to provide services for the management of sexually transmitted diseases, reproductive tract infection, HIV/AIDS and safe and voluntary childbearing and abortion. In other words, the RCH programme aims at integrating all interventions of fertility regulation and maternal and child health with reproductive health of both men and women. In addition, under the new programme, special attention will be paid to urban health. This has become crucial because of the rapid urbanisation and the resultant mass scale migration of the rural poor to urban areas. In the cities, they live in slums in unhygienic and unsanitary conditions with virtually no access to basic amenities like safe drinking water and toilets and which are the breeding grounds for diseases that endanger the health of its residents. In the absence of an adequate health care system, the urban poor of India, particularly the women, continue to suffer and remain in the vice like grip of poverty, powerlessness and disease. The special needs of this growing mass of population can, therefore, no longer be ignored since almost one third of the country's population resides in the slums of various cities. As a first step one needs to understand the health problems affecting this group of people and to know their treatment patterns for the same so as to design more appropriate and sensitive health services.

Objectives

A key feature of the present study is that it has aimed at understanding those aspects of women's health that are affected by their childbearing role (fertility and contraception) as well as because they are marginalized as women whose health per se is not accorded due importance. Such data need to be made available quickly and easily so as to feed back into the programme for immediate remedial measures. Keeping these aspects at the fore, the feasibility of employing a rapid community based survey was explored, the design of which approximates that of a large scale survey, but without the

luxury of time, to provide a "snapshot" of women's health in poverty settings.

The present research therefore aims at assessing the magnitude of reproductive (gynaecological and obstetric) morbidity among women residing in the slums of Baroda city, and their health seeking behaviour in the event of illness, through a rapid survey, so as to inform programme implementors. The specific objectives of the study are (i) to understand the socio-economic background, marriage and childbearing patterns of women in the slums of Baroda; (ii) to understand women's fertility and contraceptive behaviour and maternal health care practices including obstetric health and (iii) to assess the prevalence of various gynaecological health problems of women, their severity and treatment patterns for the same.

DATA & METHODOLOGY

To meet with the specific study objectives and to address the reproductive health needs of women living in urban slums, it was decided to study the slum population of Baroda, the third largest city of Gujarat state. About 11.4 lakhs people were counted in the city area in 1991 and the population was found growing at a fast rate. According to the recent statistics, the current population of the city is expected to be more than 16 lakhs and the city has approximately 2.8 lakhs population living in slum areas. Baroda city has approximately 55,000 slum households in 336 slum locations distributed in its ten wards. It was decided to select about 500-550 currently married women under the survey to elicit the necessary information on various aspects of reproductive health and fertility behaviour in the selected slum population. In order to take care of non-response at the household and individual levels, this sample was inflated by about 30 percent. Thus, it was decided to cover about 650-700 CMW under the survey for individual interview.

A multi-stage sampling design was adopted to draw the requisite sample from the selected slum areas. To select about 700 CMW from the slum areas of Baroda city, the entire urban slums of the city were taken to be the universe. A list of slum locations with their population size was prepared and 25 such slum locations were selected from the list by the method of

systematic sampling at the first stage. At the second stage, using the cluster sampling method 28 eligible women (CMW) from each of the 25 selected slum locations were selected to give rise to a total of 700 CMW required to be covered under the study. In the process of enumerating the required number of CMW for individual interview in a cluster, all the households covered were listed and necessary information of the households was obtained. To enumerate 700 currently married women about 749 households were covered from the 25 selected slum locations. However, out of these 700 CMW only 498 could be contacted for individual interview.

The data were collected through canvassing an interview schedule, an important component of which was to inquire about reproductive morbidity experienced by women through a checklist of symptoms and their treatment seeking behaviour for the reported morbidity. An attempt was also made to understand related influential aspects such as, socio-economic background, marriage and childbearing pattern, contraceptive behaviour, and abortion practices and maternal health care practices, among women in the study community.

The survey data were obtained by trained female workers under the close supervision of senior research staff of the Population Research Centre, Baroda. The survey in Baroda city was planned and accordingly undertaken during January 1999. The data were edited in the field as well as at the office before computer entry for suitable analysis. The results obtained are discussed in the following sections. A brief background of the study area is given before the presentation of the survey results.

Slum Population Scenario

Like the pattern in larger cities in the country, the slum population in Baroda city is also growing very fast. While no reliable recent estimate of slum population in the city is available, it is estimated that about one-fifth of the city's population lives in slums. The slum population lives in "*chawls*" (rows of single room tenement) and clusters of *zopadis* (huts), normally built on any vacant land (which is usually low lying and marshy and is prone to flooding in the monsoon) such as open spaces near the railway tracks or on the sides of major roads. The huts comprise an assortment of dwellings,

constructed with unconventional materials like untreated waste wooden planks, gunny bags, polythene sheets, bamboo, mats etc. used for walls as well as for roofs. Most of the huts do not have any sanitary facilities like bathroom or toilet within hut or tenement. A number of persons share one toilet, narrow pathways wind throughout the slums, with open drains on almost all sides of the huts. The people make use of common public taps or tube wells and wash their clothes and utensils near the open drains, increasing their chances of becoming a prey to bacterial and viral diseases. In recent years, however, efforts are underway in some localities, by the Municipal Corporation to better organise the slums and provide the residents with some basic amenities.

The growth of slum areas and concentration of the poor people in the slums is a rather depressing aspect of such urbanisation. Majority of the people who live there belong to lower socio-economic classes and have migrated to the city with the hope of better means of livelihood. Having basically no education, skill and work experience, they have no choice in the competitive job market and pick up lowly paid jobs such as construction labourer, domestic servants, casual factory workers and petty trading business. With their meager income, they are forced to live in slum areas in the most unsanitary and unhygienic conditions, and are carrying out their existence with the barest necessities of life. Even if people have some money, they do not invest it in house improvement, because of its temporary status or illegal occupation of the public lands and constant threat of eviction. Therefore, the housing of the slum dwellers is of lowest quality. Poor housing conditions, over crowded environment, poor sanitation, occupational hazards, group rivalries and clashes, stressful conditions together with lack of open space for children's recreation etc. are detrimental to the health of people in the slums.

The situation with respect to women's health in the urban slums is no different; rather their health is neglected the most. Insecurity related to regular income, food, shelter, access to health care and other essential services, along with poverty and difficult physical and social environments, such as exploitation and abuse in the treatment of women, have an adverse impact on the health of the urban poor women.

RESULTS & DISCUSSION

This section presents the results of the reproductive health survey, focussing on women's socio-economic background, marriage and childbearing pattern, maternal health care practices, contraceptive behaviour and the knowledge regarding safe abortion practices, Finally, the section attempts to understand the prevalence and severity of various reproductive morbidities among the slum women and their treatment seeking behaviour for the reported morbidity.

Socio-Economic Background

The socio-economic characteristics of the sample women, indicate that about 88 percent of women interviewed are Hindus, and 11 percent are Muslims, while less than one percent belongs to other religious groups. Among those women who are Hindus, majority (76 percent) belong to scheduled caste/scheduled tribe or to other lower caste communities. As regards their educational level, it is noted that about 45 percent of women are illiterate as against 23 percent of the husbands. This gap in education between men and women persists at all levels except at the primary levels where equal proportion of both men and women (33 percent) have attained the same level of education. It is further noted that about 3 percent of women have education up to higher secondary level, while this proportion increases to about 9 percent for their husbands. However, a very small proportion of both men and women (2 percent) has education beyond higher secondary schooling. The occupational structure of the population is also an important indicator of the socio-economic situation. The data reveal that more than three-fourths of the women (76percent) are housewives, indicating that most of these women have no independent income and depend on the limited resources of the family. About 16 percent of the women are class IV servants, non-agricultural labourers or domestic servants, while 3-4 percent each is either engaged in skilled job or petty business. Only a very small proportion (1 percent) is engaged in clerical and other related services. As regards their husbands' occupation, majority of them (63 percent) are class IV servants or non-agricultural labourers. Another 19 percent are petty traders and 13 percent skilled workers, while only 4 percent are engaged in white collar jobs. The remaining one percent is unemployed or are students.

The above data re-affirm that there is a concentration of the poor in the slums, as majority of them belong to socio-economically backward classes, are illiterate or poorly educated and are engaged in lowly paid jobs.

Marriage and Childbearing Patterns

In the Indian context, it is marriage which is associated with the start of exposure to childbearing via its relation to the onset of cohabitation with husband. The data on the age at effective marriage for the currently married women reveal that as high as 53 percent had married at ages less than 18 years, ignoring the legal age at marriage in India of 18 years for females. Apart from the question of ignorance of the legal minimum age at marriage, the awareness about risk of marrying at early adolescent ages appears to be very poor in urban slums. Nevertheless, another 38 percent of the slum women reported to have consummated their marriage at ages 18-20 years, while the remaining 8 percent had married and started living with their husband at ages 21 years and above. The mean age at effective marriage for the slum women appears to be about 17 years.

Similarly, when the initiation of childbearing among these slum women was examined, it is seen that more than half of the women (54 percent) had their first pregnancy at young ages (less 20 years). More than one-fifth of the women had became pregnant for the first time by the age of 17 years, while as low as 14 percent had had their first pregnancy at age 22 years or later. The mean age at first pregnancy was found to be about 19 years for slum women.

The distribution of the currently married women age 15-44 years by children ever born and living indicates that women have had an average of 2.8 live births (1.4 of each sex). The majority of the women (77 percent) have gone for 2 or more children in the childbearing years. In fact, about 56 percent of the women were found to have 3 or more children. The mean of live births was 2.8 (1.4 of each sex). The distribution of women by number of children surviving generally follows this pattern. About 51 percent of the women were found to have 3 or more surviving children. The mean number of children surviving was about 2.5 (1.3 males and 1.2 females).

The pace of childbearing is another important aspect to understand women's fertility behaviour. The study of closed and open birth intervals is important not only to understand the childbearing pattern, but it also helps to understand the likely influences on the health of the mother and the child. For example, many studies have shown that children born too close to previous births are at increased risk of dying especially if the interval between births is less than 24 months. Similarly, the chances of the mother suffering from maternal morbidity and related reproductive health problems increases if pregnancies occur in quick succession. The distribution of women by last closed birth interval (interval between last two live births) as well as by open birth interval (the time lapsed since last birth at the time of survey) reveals that about 24 percent of the women had less than two live births. The distribution of women who had two or more live births reveals that 12 percent of the women had a birth within 18 months of their previous birth and 9 percent of women had a birth interval of 18-23 months, while another 30 percent had a birth interval of 24-35 months. Only one-fourth of the women (25 percent) had a birth interval of 36 months or more between the last two children.

It is however encouraging to note that more than half of the women (57 percent) had had their last birth at least three years (36 months or more) prior to the date of survey, which increases to about 64 percent if one includes the women who postponed their next birth by 2-3 years (24-35 months). Such a pattern is indicative of favourable fertility behaviour in the study population, since women are doing something to limit or delay their subsequent births. The practice of contraception among these women, discussed later in the section, would throw more light on these aspects.

Maternal Health Care Status

The management of health problems during pregnancy and after delivery is important to maintain the health of the mother. The respondents were therefore asked to report about any health problems they had experienced during their last pregnancy. It is clearly evident from Table 1 that about 37 percent of the women had not experienced any health problem during their last pregnancy. About 20 percent reported about giddiness followed by excessive weakness and tiredness (17 percent), backache (16 percent), abdominal pain (10 percent),

bleeding and white discharge (8 percent) and oedema of the feet (7 percent). About 5-6 percent each reported about fever and general aches and pain while less than 1 percent each reported about night blindness and convulsions. Among the commonly experienced problem was that of nausea/vomiting, reported by 35 percent of the women. About 7 percent reported about other health problems such as blood pressure, urinary problems and breathlessness. If some of these problems are not medically treated, they can create complications during or after delivery.

Table 1: Status of Maternal Health Care, Urban Slums, Baroda City, 1999

Maternal Health Care	Percent distribution of currently married women*
1	2
Health problems experienced during the last pregnancy	
No problems experienced	36.7
Nausea and vomiting	34.5
Swelling of feet	7.4
Bleeding and white discharge	8.0
Excessive weakness/tiredness	16.9
Giddiness	19.5
Aches and pains	4.8
Backache	15.9
Fever	6.0
Convulsions	0.2
Abdominal pain	9.6
Night blindness	0.6
Others (B.P., Urinary problems, breathlessness etc.)	7.0
Never been pregnant	8.8
Total	100.0* (498)

Place of delivery for the last child	
Govt. hospital	22.5
Private hospital	28.9
PHC/CHC	0.2
Home	36.3
No live births	10.8
Not available	1.2
Total	100.0 (498)
Type of attendant at home delivery	
Doctor	2.2
ANM	3.3
Trained dai	9.4
Untrained dai	77.3
Relatives	9.9
Total	100.0*(181)++
Use of disposable delivery kit at home delivery	
Yes	6.6
No	48.1
Can't say	45.3
Total	100.0(181)++
Health problems experienced immediately after last delivery	
No problem experienced	65.7
Fever	5.8
Bleeding	0.6
Foul smelling discharge	0.4
Abdominal pain	7.2
Backache	6.4
Excessive tiredness/weakness/ anemic condition	6.2
Others	3.6
No live births	10.8
Total	100.0*(498)

Treatment sought for the health problems experienced after delivery	
No treatment taken	25.6
Treatment sought from:	
ANM	1.7
PHC	0.9
Govt. hospital	22.2
Private doctor	46.2
Others	4.2
Total	100.0*(117)**

++ Number of women who delivered their last child at home out of the total sample.
* Percentages add to more than 100 because of multiple responses.
** Number of women who experienced health problems are considered here for analysis.

The Table 1 further reveals that the place of delivery for the last child was noted to be "home" in case of 36 percent of the women. It is further interesting to note that out of those women who had an institutional delivery, the private facilities have a definite edge (29 percent) over government facilities (23 percent). A greater cause of concern is the fact that almost nine of the ten deliveries that took place at home (87 percent), were attended by untrained persons. Thus most of the deliveries that take place at home can pose a threat to the health of the mother and child if these deliveries at home remain unattended by medical and paramedical persons or at least by trained birth attendants. Yet another fact to ensure safe delivery at home is the use of sterile disposable delivery kit. These sterile kits were to have been provided to women who were in the third trimester of pregnancy so that the kit can be used by any birth attendant at the time of home delivery. The item on use of disposable kit was interpreted to include the use of sterile instruments (blade, knife) for conducting the delivery. Even this basic necessity of a safe delivery has been violated since only about 7 percent could recall about the use of such sterile equipments during home deliveries in the urban slums. Such a situation therefore requires remedial measures on the part of the health officials on a priority basis.

It is heartening to note that 66 percent of the women did not have any problems immediately after delivery (Table 1). Among the problems experienced were fever, bleeding, foul smelling discharge, backache, abdominal pain and weakness/anemic condition. It is further encouraging to note that of those who did have some health problem, the majority (74 percent) had sought treatment from various sources. The private services seem to be the preferred source of service (46 percent) followed by government hospital or PHC (23 percent) and ANM (2 percent).

Contraceptive Use, Unmet Need & Management of Side Effects

This section focusses on the fertility planning and related contraceptive practices among the surveyed population as well as assesses the unmet needs and quality of family planning counselling and the experience of method related side effects and their management.

It is evident from Table 2 that about 69 percent of women do not desire any more children (which includes 50 percent who have adopted terminal methods) while another 5 percent want to postpone their next birth for at least two years. Furthermore, another 14 percent of women appear undecided or non-committal regarding the timing of their next birth, while the remaining 12 percent of couples want their next child soon or within the next two years. This means that the last group of women would be rather reluctant to adopt some contraceptive at this

Table 2: Status of Family Planning Practices, Urban Slum, Baroda City, 1999

Family Planning Practices	Percent distribution of currently married women
1. Current contraceptive status	
Not using any method	39.2
Currently using:	

Male sterilisation	1.0
Female sterilisation	48.8
IUD	2.0
Oral pills	2.4
Condom	1.4
Natural methods	5.2
Any modern method	55.6
Total	100.0 (498)

2. Need for family planning services

Unmet need for FP[1]	
Total	15.6
For limiting[2]	12.4
For spacing[2]	3.2
Met need for FP[3]	60.8 (55.6)[4]
Total demand for FP	76.4 (71.2)[4]
Percentage of need satisfied	79.6 (78.1)[4]

3. Experience of side effects and treatment sought

No side effects experienced	80.2
Side effects experienced:	
Sought treatment	10.2
Did not seek treatment	9.6
Total	100.0 (303)

4. Source of treatment for side effects

Hospital	42.0
PHC/Urban Health Centre	-
Private doctor	58.1
Others	33.3
Total	100.0* (31)++

* Percentages add to more than 100 because of multiple responses.
\+ Based on current users of contraception.
++ Based on those who sought treatment for side effects.
1 Currently married women who say that they either do not want any more children or that they want to wait two or more years before having another child, but are not using contraception, are defined as having an unmet need for family planning.
2 Here women who do not want any more children, but are not using any method, are defined as having an unmet need for limiting the family size, while those who want to wait two or more years before having another child, but are not using any method, are defined as having an unmet need for spacing methods.
3 Current users of any family planning method are said to have a met need for family planning.
4 Indicates the corresponding figures based on the use of any modern method.

stage, whereas the groups comprising 74 percent of women who desire no more children or do not desire to have a child soon need to be provided adequate information and counselling on various available methods and helped to chose one method that

is most suitable and appropriate for them. Moreover, the remaining 14 percent of women who appear indecisive, need particular help in planning their family in the best possible way. In this regard, the data on counselling by health worker/ANM reveals that about 74 percent of the women (excluding
those who had already accepted a terminal method) were not given any advice on spacing methods by the ANM. Among those who did receive some advice, 21 percent were told about IUD, 10 percent were told about oral pills and 8 percent were advised about condom.

The actual practice of contraception among the sample women reveals that about 61 percent were found to be using some method of contraception (including natural methods) at the point of survey (Table 2). The use of modern methods was about 56 percent in the slum population of Baroda city. The method wise break-up reveals the strong preference for terminal methods among the slum community, their use being 50 percent. The use of spacing methods among the current users is about 11 percent. The greater reliance on terminal methods finds further support when women's ever use of contraception was assessed (Table 2). This reveals that 36 percent of them had never used any method, while 50 percent had accepted a terminal method. Among the modern spacing methods, IUD was the most popular (7 percent) followed by oral pills (6 percent) and condom (3 percent). Natural methods were used by 8 percent of the women.

It is satisfying to note that 80 percent of women did not have any side effects with their current contraceptive method (Table 2). Among the 20 percent who did have some side effects, 10 percent sought treatment while the remaining 10 percent did not do so. Among those who sought treatment, a little less than three-fifths (58 percent) had visited a private clinic for treatment, while a little over two-fifths (42 percent) went to a hospital. Another 6 percent relied on home remedies or sought treatment from traditional practitioners such as vaidya.

The extent of women's contraceptive needs met by the family planning programme can effectively be judged by the total demand for family planning services and the percentage of need which is being met. In this regard, it can be seen from Table 2 that the total demand for family planning services was 76 percent among the currently married women. Based on the

current use of contraception among the couples, it appears that in the case of 61 percent of the women, their need for family planning has been met while 15 percent of women still have an unmet need for contraception (12 percent for limiting and 3 percent for spacing), since they do not desire additional children (at all or in the near future), yet are not using any method of family planning. Thus, the programme has succeeded in satisfying the contraceptive needs of 80 percent of the women, which still leaves unfulfilled the needs of 20 percent of the currently married women.

Gynaecological Health Problems & Their Management

The Community Needs Assessment Approach, initially called target free approach, clearly articulates the need to move beyond family planning and MCH services to also include services that address the reproductive health needs of women (Govt. of India, 1998). In this regard, it is important to understand the varied gynaecological or reproductive health problems women generally experience and the nature of their treatment seeking behaviour for the same. Such information becomes useful for designing and delivering better women centered health services under the programme. In this regard, the present study has attempted to understand some of the commonly experienced reproductive health problems of women rather than all those, which often require clinical and pathological assessment. The details of the problems experienced by women during the one year prior to the survey as well as their management are summarized in Tables 3 and 4.

It is evident from Table 3 that as high as 85 percent of women had experienced one or the other health problem during the one year preceding the survey. The major problems reported by women were the symptoms that may be associated with pelvic inflammatory diseases (23-33 percent), feeling excessively weak or tired during normal household duties, backache (suggestive of anemic condition, 31-34 percent), menstrual disorders like irregular menstruation, excessive bleeding/painful menstruation/aches and pain during menstruation (21-32 percent) and white discharge with bad odour/itching, indicating lower reproductive tract infection (27 percent). With regard to the frequency of occurrence, it is noted that about 49 percent of the women reported that they suffer “Always” or “Often” with some health problem, indicating persistence of the problems

among a very large proportion of women in urban slums. Regarding this severity of various reproductive health problems, about 12-14 percent of women reported menstrual disorders (defined above) as a persisting health problem followed by the problems/symptoms related to PID (11-12 percent) and RTI (11 percent), while another 9 percent of women reported persisting health problems related to anemic condition. It may further be noted

Table 3: Experience of Gynaecological Health Problems (GHP) Among Currently Married Women during One Year Preceding the Survey, Urban Slums, Baroda City, 1999

Nature of GHP symptoms	Percent distribution of the women by the frequency of occurrence of symptoms of GHP during one year preceding the survey			
	Always/Often	Sometimes	Never	Total

A. Menstrual disorders				
Irregular menstruation	11.8	19.8	68.3	100.0
Excessive bleeding during menstruation/painful menstruation	14.0	7.0	78.9	100.0
B. Lower reproductive tract infection				
White discharge with bad odour/ itching	10.8	16.0	73.1	100.0
C. Pelvic inflammatory disease				
Lower abdominal pain/vaginal discharge with fever	12.4	20.5	67.1	100.0
Abdominal pain	11.0	12.0	76.9	100.0
D. Dyspareunia				
Pain during intercourse	2.8	7.0	90.2	100.0
E. Anemia				
Feeling excessively weak or tired during normal household duties	8.6	20.7	70.7	100.0
Backache	9.4	24.5	66.1	100.0
F. Urinary tract infection				
Pain/burning sensation while passing urine/abnormal frequency of urination	0.8	4.0	95.2	100.0
G. Prolapse				
Feeling of body mass coming out from vagina	-	1.4	98.6	100.0
H. Hemorrhoids				
Pain or bleeding while passing stools	-	0.8	99.2	100.0
I. Infertility[**]				
Difficulty in becoming pregnant	5.2	23.1	71.7	100.0
J. Fever	3.8	12.8	83.3	100.0
Experience of any symptom of GHP	48.6	78.9	14.9[+]	100.0 (498)

[+] The remaining 85.1 percent have reported the experience of a symptom of any reproductive health problem at least sometimes during the one year preceding the survey

[*] Percentages add to more than 100 because of varying degrees of severity reported for different health problems by each woman.

[**] Refers to life time experience of difficulty in conceiving.

from Table 3 that about 17 percent of women have reported about fever (with 4 percent indicating about its persistence) and 10 percent reported about the problem of dyspareunia (pain during intercourse), with 3 percent reporting about its persistence, while about 5 percent complained about the symptoms of urinary tract infection (such as pain/burning sensation during urination and abnormal frequency of urination) as another health problem, with less than one

percent indicating the persistence of these problems, during the one year preceding the survey. The other two symptom categories viz. hemorrhoids and prolapse were reported infrequently (one percent each). Finally, as high as 28 percent of the women reported about the problem of infertility. In other words, they had experienced difficulty in conceiving despite attempts, at some time or the other during their life time, while about 5 percent reported the experience of this problem more often.

The overall results seem to suggest that approximately eight to nine women out of ten in the urban slums reported the experience of at least one symptom of a health problem during the one year preceding the survey. Symptoms that may indicate acute PID, RTI, anemia and menstrual disorders, were commonly reported, but the symptoms that may be associated with the problem of dyspareunia and UTI were less common. All other symptom categories such as hemorrhoids and prolapse were reported infrequently. As regards the severity of these symptoms, about half of them reported that they always or often suffered with one or the other problem. The most common among them were again the symptoms that indicate PID, RTI, anemia and menstrual disorders. Another problem that causes concern is that of infertility, as a significant proportion of the women had experienced the difficulty of becoming pregnant quite often during their life time. This clearly indicates the magnitude of as well as severity of reproductive health problems among urban slum women and which therefore needs to form an important aspect in service provision under the programme. Furthermore, it also requires that the health workers, particularly the female health workers, be sensitized (through suitable training) to understand and elicit these problems among women, as well as be equipped to manage them in an effective manner.

The results thus appear consistent with those obtained from other similar community based studies (Koenig et al., 1998). In their review of six rural and urban studies, the authors found that menstrual disorders were in the range of 33 to 65 per cent, white discharge varied from 13 to 57 percent and lower abdominal pain ranged from 9 to 21 percent. Overall, the percent of women reporting one or more clinically diagnosed conditions varied from 26 percent to 70 percent or more. In fact the reporting of such morbidity conditions is found even higher in the present study, probably due to the characteristics of the

sample i.e. women residing in slum communities of Baroda. A similar study of rural Baroda by the authors (Das and Shah, 1998) noted a little lower prevalence rate with 81 percent of women reporting at least one symptom of a reproductive health problem, which once again reveals the greater vulnerability of urban slum women to such reproductive health problems.

Table 4: Treatment Seeking Behaviour Among Currently Married Women Who Reported Symptoms Associated with Gynaecological Morbidity During One Year Preceding the Survey, Urban Slums, Baroda City, 1999

Whether sought treatment/ source of treatment	Percent distribution of women who reported any reproductive problem during one year preceding the survey
No treatment taken	25.7
Treatment sought from:	
Government Hospital/Clinic	17.5
Private doctor	58.5
Others	5.0
Total	**100.0* (424)**[+]

[+] Excludes those women who did not report experience of any symptoms of reproductive health problem.

- Percentage add to more than 100 because of multiple responses.

The management of such health problems assumes great importance since still more than one-fourth of women had not sought any treatment for their problem (Table 4). It may further be noted from Table 4 that reliance on government sources for treatment is about 18 percent as against about 59 percent who relied on private doctors. About 5 percent relied on home remedies or sought treatment from traditional practitioners or brought medicines from drug stores. Therefore, understanding and managing these health problems of women and educating them on the need for seeking treatment and that too from the right source is all the more important in view of the fact that a very high proportion suffer from one or other health problem but do not consider them to be serious enough to seek treatment for it.

Knowledge and Practices about Safe Abortion

Ensuring women's access to safe abortion services is an essential component of ensuring women's right to safeguard

their health and is one of the components of Government of India's Reproductive and Child Health Programme. Women seek abortion for a variety of reasons viz. medical, social, failure of contraception, physical and economic reasons or a combination of many of these conditions. Unsafe abortion is one of the leading causes of maternal mortality and it also contributes significantly to maternal morbidity. Therefore, provision of safe and legal abortion is important for women's survival and reproductive health. India legalized medical termination of pregnancy on broad socio-medical grounds through the MTP Act, 1971. The aim of the Act was to reduce maternal mortality and morbidity due to illegal abortions. Under the RCH programme, women and adolescents are educated about the need for safe abortion practices and the facility for safe abortion is ensured by providing equipments, contractual doctors etc. at the government health centres. Special programmes are expected to be taken up for various vulnerable groups such as urban slums, tribal population and adolescents (Govt. of India, n.d.). In order to assess the knowledge and practices about safe abortion among urban slum women, the present survey also included a series of questions on these aspects. The responses to these questions are summarised in Table 5. When women's knowledge regarding sources of service for pregnancy termination was assessed, it was noted that about two-fifths of the slum women had no knowledge of any source of service they can avail to have the unwanted pregnancy terminated (Table 5). Nevertheless, slightly less than three-fifths of the women (58 percent) had the knowledge of a source of service for abortion. Among them, about 43 percent reported about government hospital for the service while 15 percent reported about private hospital or a specialised clinic for abortion. About 2 percent of the women from this community indicated that they would seek service from other sources or rely on home remedies.

When the abortion seeking behaviour of these women was assessed, it is noted that less than 4 percent had ever had an induced abortion (Table 5). About 39 percent of these women had sought pregnancy termination less than four years ago and 28 percent 4-7 years ago, while the remaining 33 percent had the last induced abortion at least 8 years ago. Majority of them had their pregnancy terminated by 3rd month (83 percent), while 11 percent had it terminated at 4th month and 6 percent at 5th month (Table 5). When the abortion seekers were asked about the place of service, it is evident from Table 5 that about 39

percent of the women had their pregnancy terminated at government hospital, another 50 percent at private hospital and the remaining 11 percent had gone to a specialised clinic. It is therefore satisfying to note that all the women who sought induced abortion, had always availed services from a safe health facility, although preference is more for private health facility than that of the government.

Table 5: Abortion Seeking Behaviour Among Currently Married Women Age 15-44 Years, Urban Slums, Baroda City, 1999

Knowledge and practices about safe abortion	Percent distribution
1	2
1. Knowledge of source of service to have pregnancy terminated:	
Government hospital	42.8
Private hospital	13.5
Clinic for abortion	1.4
Home remedies	0.2
Others	2.2
No knowledge of any source	40.0
Total	100.0 (498)*
2. Percent of women who ever had an induced abortion	3.6 (498)*
3. Number of years ago the induced abortion was done:	
Less than 4 years	38.9
4-7 years	27.8
8 or more years	33.3
Total	100.0(18)+
4. Months of pregnancy at which it was terminated:	
By 3rd month	83.3
4th month	11.1
5th month	5.6
Total	100.0(18)+
5. Type of health facility where	

abortion was done:	
Government hospital	38.9
Private hospital	50.0
Clinic for abortion	11.1
Total	100.0(18)
6. Experience of any health problem after the abortion:	
Experienced no health problem	72.2
Experience one or other problem (severe abdominal pain, bleeding, weakness, fever and discharge with pain)	27.8
Total	100.0(18)+

1	2
7.Whether sought treatment for their health problem	
No treatment taken	60.0
Treatment taken	40.0
Total	100.0(5)++
8.Reasons for the decision to have the pregnancy terminated:	
Did not want additional child/ Desired sex composition achieved	38.9
Did not want next child soon/ Previous child too young/ Difficult to take care of closely spaced births	33.3
Poor health of the mother/Growth of tumor/Bleeding during pregnancy/ Doctor advised on health ground of the mother	16.7
Poor growth of fetus/Doctor advised because there was no sign of life in fetus	11.1

Total	100.0

* Percentages are computed based on the total of currently married women interviewed.
\+ Percentages are computed based on those women who ever had an induced abortion.
\++ Percentages are based on those women who experienced any health problem after the induced abortion.

It is further satisfying to note that majority of the women (72 percent) who had sought an induced abortion, had not experienced any health problem after the abortion. The remaining 28 percent had experienced severe abdominal pain, bleeding, discharge with pain, fever, weakness or other related health problem after abortion. Among those who experienced a health problem after abortion, about 60 percent had sought treatment for the same.

Finally, when women who ever had an induced abortion were asked to state reasons for the decision to have the pregnancy terminated, their responses summarised in Table 5, reveal that majority had sought abortion for the reasons that reflect poor planning of pregnancies. In this context, it is noted that 39 percent had sought abortion because they did not want additional children or had achieved the desired sex composition (pregnancy unwanted), while another 33 percent had sought abortion because they did not want a next child at that time for one reason or other (pregnancy mistimed). On the other hand, the remaining 28 percent had sought abortion on health grounds. Among them, 17 percent reported that they had poor health or had developed a health problem (such as growth of tumor and bleeding during pregnancy) or followed doctor's advice. Another 11 percent reported about poor growth of the fetus or no sign of life in fetus as a reason for seeking abortion. The reported reasons for seeking abortion thus seem to suggest that there is an unmet need for family planning in the slum population. This aspect has already been noted in the earlier discussion. Therefore there is a need to strengthen the family planning component as well as safe motherhood programme, apart from improving MTP facilities and their utilisation, under the RCH programme.

EMERGING ISSUES

The main objectives of the present study were to assess the reproductive health status of the women and their health seeking behaviour in the urban slums of Baroda city. The study in particular has dealt with women's socio-economic background,

marriage and childbearing pattern, contraceptive behaviour, maternal health care practices and their knowledge regarding safe abortion practices. Finally, the study has dealt with the incidence and the severity of various reproductive health problems among urban slum women and their treatment seeking behaviour for the reported morbidity. The present study was undertaken in the urban slums of Baroda city during January, 1999. Data were obtained through individual interviews of 498 currently married women age 15-44 years, selected through cluster sampling method from 25 selected slum locations following a multistage sampling design. A household schedule along with the couple schedule was canvassed during the survey to collect information on various aspects of the study.

Like the pattern in larger cities in the country, majority of the people who live in the urban slums of Baroda city belong to lower socio-economic classes and have migrated to the city with the hope of better means of livelihood. With basically no education and meager income, they are forced to live in close and congested areas under the most unsanitary and unhygienic conditions, and are carrying out their existence with the barest necessities of life.

The situation with respect to women's health in the urban slums is no different, rather their health is neglected the most. Insecurity relating to regular income, food, shelter, access to health care and other essential services, along with poverty and difficult physical and social environments, such as exploitation and abuse in the treatment of women, have an adverse impact on the health of urban poor women.

As regards the marriage pattern of these women, about half of them had married at age less than 18 years, defying the legal age of 18 years for females in India as well as ignoring the risk of consummating the marriage at early adolescent ages. More than half the women had their first pregnancy at a young age (less than 20 years).

An examination of the birth history of these women further reveals that majority of them (77 percent) had given birth to 2 or more children in their childbearing years. About 56 percent of the women had given birth to three or more children. The mean number of live births was estimated to be 2.8 in the slum population. About 51 percent of the women were found to have

three or more surviving children, the mean being 2.5 living children. As regards the pace of childbearing, it is noted that only one fourth of the women who had a birth interval of 36 months or more between the last two children, appear to have provided adequate spacing between the children.

About 36 percent of the deliveries are still taking place at home. Most of these home deliveries (87 percent) are attended by untrained dais and relatives. Among the institutional deliveries, the preference is for a private clinic over the government facilities. The health of the mother and the child is further compromised as only 7 percent of home deliveries were conducted using a safe disposable delivery kit.

About 63 percent of the women had experienced one or the other health problem during their last pregnancy. The major problems reported are the symptoms related to anemia, oedema, night blindness RTI and other general illness. Majority of the women (66 percent) did not report any health problem after delivery. Among those who did have some problem, major problems reported were abdominal pain, backache, excessive tiredness/weakness and fever after delivery. About 76 percent of the women who had a health problem did seek treatment from one or the other source. However, among those who did seek treatment, the majority reported a preference for private services for treatment rather than government services. The provision of health care under the programme therefore needs to be geared up by improving the quality of services.

The focus on providing adequate information and counselling for the promotion of spacing methods is still missing under the revamped family welfare programme. About 74 percent of the women (excluding those who had already adopted terminal methods to limit their family size) had not been advised on spacing methods by the health worker. The rest did receive some advice on spacing methods particularly for the use of IUD, followed by oral pills and condom. As regards the practice of family planning, the data seem to indicate that about 61 percent of the currently married women in the district are using one or the other method of family planning. The use of modern methods among them reduces to about 56 percent, with a strong preference for terminal methods (50 percent). It is satisfying to note that about 80 percent of the women did not have any side effects with their current contraceptive method.

The analysis of the total demand for family planning services in the urban slum population reveals that the need for family planning has been met in the case of 61 percent of the women while another 15 percent of women still have an unmet need for contraception since they do not desire additional children at all or in the near future, yet are not using any method of family planning. In other words, the family welfare programme in the slum population has succeeded in satisfying the contraceptive needs of 80 percent of women, which still leaves unfulfilled the needs of 20 percent of the currently married women.

An analysis of self reported symptoms of gynaecological morbidity experienced by the urban slum women reveals that as high as 85 percent of the total women interviewed have had one or the other reproductive health problem during the one year preceding the survey. Symptoms that may indicate acute pelvic inflammatory disease (23-33 percent), reproductive tract infection (27 percent), anemic condition (31-34 percent) and menstrual disorders (21-32 percent), were commonly reported. But the symptoms that may be associated with the problem of dyspareunia (10 percent) and urinary tract infection (5 percent) were less common. The other symptom categories such as hemorrhoids and prolapse were reported infrequently (one percent each). As regards the severity of these health problems, almost half of the women (49 percent) reported that they always or often suffered with one or the other health problem during the one year preceding the survey. Among these health problems, the severe were again the symptoms that indicated PID, RTI, anemia and menstrual disorders. Another problem that causes concern is that of infertility, as about 5 percent of the currently married women had experienced the difficulty of becoming pregnant during their married life.

Further analysis of the treatment seeking pattern of these women reveals that more than one-fourth of them had not sought any treatment for their health problems. Among those who had sought treatment, the majority, (59 percent) relied on private doctors, rather than on government sources (18 percent) for treatment. The remaining 5 percent relied on home remedies or had sought treatment from traditional practitioners or brought medicines from drug stores. In view of the magnitude of reproductive health problems and poor treatment seeking

behaviour for these problems, there is an urgent need to incorporate this aspect in service provision under the family welfare programme. Furthermore, it also requires that female health workers be sensitized through suitable training, to understand and elicit these problems among women as well as be equipped to manage them in an effective manner.

About two-fifths of the slum women had no knowledge of a source of service they could access to have an unwanted pregnancy terminated. Less than 4 percent of the women interviewed had ever had an induced abortion. Majority of them had their pregnancy terminated by the third month (83 percent), while 11 percent at the fourth month and 6 percent at fifth month. All the women who had sought induced abortion had always availed services from a safe health facility, such as government or private hospital or specialised clinic, although preference was more for the private health facility than the government.

It is further satisfying to note that the majority of the women (72 percent) who had sought an induced abortion, had not experienced any health problem after the abortion. The remaining respondents (28 percent) did experience one or the other minor health problem after abortion, although three-fifths of them (60 percent) did seek treatment for their health problem. Finally, the analysis of the reasons for seeking abortion reveals that majority of the women (72 percent) had resorted to abortion for the reasons that reflect poor planning of the pregnancies, such as, they did not want any children or did not want their next child soon, while the remaining 28 percent had sought abortion on health grounds, such as poor health of the mother or complications during pregnancy. These results seem to suggest that there is an unmet need for family planning in the community which has also been noted in the analysis of contraceptive behaviour of these women. Therefore, there is an urgent need to strengthen the family planning component as well as safe motherhood programme, apart from improving MTP facilities and their utilization to minimise various health problems of the women.

To summarise the overall findings and conclude, it must be said that the quality of services under the new approach, are found deficient on three basic aspects, viz., the information and counselling on women's health, particularly maternal health and

family planning, the actual service provision (including treatment for reproductive health and FP problems), and follow-up. For example, simple measures that safeguard the health of the mother and child, in particular the use of safe delivery kit and availability of trained birth attendants (let alone paramedical staff), are found wanting to a great extent. The MCH programme is even devoid of the provision of adequate advice on safe motherhood and, in turn, on child survival. Regular visits of health workers to currently married women in urban slums is still missing (about 76 percent were not visited during three months preceding the survey) and more than half of the sample women were not advised on many maternal health care issues. On the family planning front, the provision of adequate information and counselling regarding various methods of contraception, particularly spacing methods, to the clients is not yet sufficient to meet individual family planning needs. Follow-up visit, which is another important component of the quality of services, is yet to improve. The reliance on private services by a large proportion of urban slum population raises doubts about the quality and credibility of the government health and family planning services provided in the slum areas.

With regard to women's health, the family welfare programme to date has restricted itself to maternal health care. The present survey has brought to light the heavy burden of reproductive morbidity among the majority of urban slum women. While such data from self reported symptoms (in the absence of clinical diagnoses) need to be interpreted with caution in accurately estimating the prevalence of gynaecological morbidity among women, they definitely bring to the fore women's perceived problems and therefore the need for gyaecological services, which need redressal under the reproductive and child health programme.

The family welfare performance in the slum areas has as such improved over the years. Family size has declined substantially and the level of contraceptive use among currently married women is not very low, particularly for the terminal methods in the slum areas. A further reduction in fertility and mortality in the population would largely depend on the greater use of spacing methods and improved MCH and other health services. These changes can only be brought about if the programme is directed to improve the three basic aspects of

quality, which were noted to be deficient in the urban slums as well as integrate the reproductive health component through suitable training of the grassroots level workers. Inspite of the Government of India's commitment under the nation's revamped family welfare programme to improve the out-reach of services particularly for the vulnerable groups of population, urban slum areas have still been left out of the planning process. Special programmes are yet to be taken up for urban slums, where the health delivery system is even more fragile than in rural areas, to address various issues raised above under the RCH programme.

REFERENCES

Bang, R.A., A.T. Bang, M. Baitule, Y. Chaudhury, S. Sarmukaddam and O. Tale. 1989. High Prevalence of Gynaecological Diseases in Rural Indian Women, **The Lancet**, 14: 58-88.

Bang,R.A. and A.T. Bang. 1991. Women's Perceptions of White Vaginal Discharge: Ethnographic Data from Rural Maharashtra. In : Gittlesohn et al., (Eds.). **Listening to Women Talk about their Health: Issues and Evidence from India**. Har Anand Publications, New Delhi.

Bhatia, J.C. and J. Cleland. 1995. Self Reported Symptoms of Gynaecological Morbidity and their Treatment in South India. **Studies in Family Planning**, 26(4): 103-216.

Das, N.P. and Urvi Shah. 1998. Understanding Women's Reproductive Health Needs in the Rural Areas of Gujarat. Paper presented at a workshop on **Reproductive Health Problems in Gujarat.**

Gittlesohn, J., M.E. Bentley, P. Pelto, M. Nag, S. Pachauri, A. Harrison and L. Landman (Eds.), 1994. **Listening to Women Talk about their Health: Issues and Evidence from India**, Har Anand Publications, New Delhi.

Govt. of India. n.d. Reproductive and Child Health Programme. Document of Ministry and Health and Family Welfare.

Jejeebhoy, S. 1997. Maternal Mortality and Morbidity in India: Priorities for Social Science Research. **The Journal of Family Welfare**: Special Issue on Safe Motherhood 43 (2): 31-52.

Kapadia, S., U. Shah and S. Sikri. 1997. Women's Reproductive Health: Understanding Explanatory Models of Illness Within a Socio-Psychological Context. Report of study funded by the Population Council, Department of Human Development and Family Studies, Faculty of Home Science, M.S. University of Baroda, Baroda.

Koeing, M., S. Jejeebhoy, S. Singh and S. Sridhar, 1998. Investigating Women's Gynaecological Morbidity in India: Not just Another KAP Survey. **Reproductive Health Matters** 6(11): 84-97

Latha, K., S.J. Kanani, N. Maitra, R.V. Bhatt, S.K. Senapati, S. Bhattacharya, S. Sridhar, G.B. Giri, P.P. Shah, S.P. Shah, L.A. Desai, I. Parikh, V. Taskar, N. Dharap and V. Mulgaonkar. 1997. Prevalence of Clinically Detectable Gynaecological Morbidity in India. Results of Four Community Based Studies, **The Journal of Family Welfare** 43(4): 8-16.