FINDINGS, SUMMARY AND CONCLUSIONS

Reproductive health in India is largely influenced by poverty-related and socio-culture factors on the one hand, and programme interventions on the other. Socio-cultural factors which impinge reproductive health include women’s lack of awareness of health practices, strong seclusion norms which inhibit health-seeking, adolescent marriage, large family size norms which encourage frequent and closely spaced pregnancies, and a general devaluation of women which makes them the last to obtain food or health care and which requires of them long periods of physical activity.

Decades of research have shown impacts health and is aggravated by health status (World Health Organization, 2005)

To overcome in the area of health, India adopted the development approach. In the development approach, improvement in health status is viewed primarily as a product of socio-economic development. By definition, development implies improved nutrition, hygienic living and working conditions, greater awareness of health problems and wider accessibility to health care services which have a favorable effect on the health status of the people. Improvements in health status as well as health care are treated as integrated components of the development process, in which medical care is just one of the many inputs; the impact
of state intervention on health status depends on its overall socio-economic policies.

Accordingly, India during the past few years made a bold and impressive, determined and planned effort to empower health status of its populace. Over the years it has adopted a two faced strategy. On one hand it strived to achieve overall socio-economic development with equity to influence and enhance the health status; and on the other it has attempted to raise the health status independent of socio-economic development through State intervention by extending health care with equity. RCH was one such programme which was launched in the year 1997.

**Statement of the Problems:**

Gender, health and poverty are strongly interconnected and there is a strong dimension but according to WHO, the appropriate detailed studies and data collection of slums women's health circumstances have not been undertaken. Maternal health care and infant mortality statistics need to be collected and examined in relation to the level of infrastructural services present. Accessibility in respect of women's special health needs associated with their reproductive function needs to be undertaken: identification of the gender and household resource constraints, such as taboos and cultural customs, which prevent women accessing health facilities or place women in specific health danger in
any particular location needs to be undertaken and a comprehensive data mapping of such patterns needs to be developed. As women have particular health needs examining the proportion of access to reproductive health will provide an early indicator as to whether women have been adequately included or participate in health services.

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health care with equity. RCH was one such programme which was launched in the year 1997.

While poor quality of care can inhibit women from seeking health care, women’s lack of autonomy in decision-making or movement is also an important constraint on women’s health seeking. Women are, by and large, taught self-denial and modesty from an early age and are hence unlikely to acknowledge a health problem, and particularly a gynaecology problem, unless it is very advanced (SEWA- Rural 1994). For example, large number of women experience white discharge but consider it as part of their life and rarely seek medical care for such problem.

Lack of decision-making, freedom of movement and time can restrict visits to health centres, even where a health problem has been recognized. Moreover, pelvic examinations are strongly resisted by women. And even if a problem has been diagnosed, treatment is frequently not followed through because it is seen as an unnecessary expense or too demanding.

The available literature is inadequate when it comes to assessing reproductive health and its underlying causes. Rigorous indirect estimates of maternal mortality, at the state and district level are essential. Micro-level analyses of the links between reproductive health outcomes and their socio-economic and cultural antecedents in different setting would go a long way in tailoring services in locally relevant way.
On the impact of interventions designed to redress reproductive health deficiencies.

The present study is focused on slums women and is understand in the context of selected indigenous communities. These selected communities are spread in slums of the remote and pockets of a backward District namely Anantapuramu Municipal Corporation, Andhra Pradesh. The habitation is border to the Karnataka state.

**OBJECTIVES**

The present study aims at understand the “Reproductive Health care and hygiene practices of the women living in slums areas”

The specific **objectives** of the study are:

1. To portray the socio-economic and demographic profile of respondents.
2. To study the psychological changes and cultural practices followed during puberty and menstruation among the women in slum areas.
3. To assess the antenatal, intra-natal and post-natal care availed by adolescent mothers in slum areas.
4. To study the social status of women in the slums in India.
5. To examine the reproductive health status of the respondents.
6. To analyze the reproductive health hygienic practices of the selected communities in the slums areas in Anantapuramu Municipal Corporation.

The study is carried out in the context of Anantapuramu Municipal Corporation of Andhra Pradesh. The study sample comprises 240 households drawn from 6 Slumsdweller by adopting stratified random sampling technique. Interview schedule and focus group discussions were employed for the data collection.

**Major Findings**

The study slums represent remotely located Anantapuramu Municipal Corporation of the District which is itself a chronically drought prone and backward district.

**Socio-Economic Status**

Our study reveals that the respondents under reference were found to be relatively young women of below thirty five years, married, illiterate, involved in manual work and poor.

The respondents represent OC, BC, SC, ST communities in slums dwellers of Anantapuramu Municipal Corporation. OC are Economically Poor, BC Communities belong to Backward Castes, SC Communities Mala and Madiga belong to Scheduled Castes, and ST Communities belong to Tribal castes.
The average age of the respondents was found to be 35 years. However, 52.9 per cent of the respondents were found to be in the age group of 26 to 25 years; and 28.8 were aged above 47 years.

The respondents are found to have small sized families. The average size of the family was found to be 4.76 members, which is smaller than the district’s average size of five members.

Majority of the respondents belong to nuclear families (96.3 per cent) and only 3.8 per cent belong to joint families.

The respondents are illiterates (39.2 per cent). The female illiteracy is found to be higher than the district’s female illiteracy (59.1 per cent). Illiteracy was found to be highest among SC’s (40.4 percent) and ST’s (50.0 per cent) community members. It is found that majority 60.9 per cent had degree and intermediate above years of school education.

The average annual income of the respondents was found to be only rupees 8,439. OC’s, BC’s, SC’s and ST’s community women were found to earn the least incomes (Rs.7,440).

**Access to Health facility and services**

Our analysis reveals that the health services of health professional and Medical facilities are accessible at a reasonable distance for the majority of the respondents and communities under reference.
The only exception however is that of SC's and ST's members. The gratifying feature is that a prepondering majority of OC's and BC's members under reference have access to these facilities either within slums areas. It is found that Doctor birth attendant is accessible within for 55.4 per cent of respondents. The services of ANM/Nurse can be availed by 36.2 per cent of respondents within the slums. Only 8.4 per cent respondents can have access to midwife and elder women within the Slums.

A large percentage of OC's, BC's, SC's, ST's members do not have access to both government and private health facilities.

Reproductive Health Status

Marital Status: The proportion of women who are married and their age structure has implications for policy making and programme implementation.

In our study, it is found that marriage and marital status is universal among the Other Castes, Backward Castes, Scheduled Castes and Scheduled Tribes under study as against one-fifth women aged 15-49 years who were never married at all India level.

Considerable percentage (28.81 per cent) of women are found to be young and married (less than 25 years)

Age at Marriage: The legal age for girls marriage in India is 18 years. It is found that 40.17 per cent of women aged 15-49 years were married
below the legal age; but among the younger population (15-25 years) it was found to be only 27.27 per cent.

The mean age at marriage however, was found to be 18.21 years for women aged 15-49 years and 18.63 years for women aged 15-25 years. The mean age at marriage was found to be lower than the legal age at marriage among the SC's and BC's community, which was 17.58 years.

The percentages of marriages below the legal age were found to more among Scheduled Castes community (46.9 per cent) and Backward Class community (35.6).

**Age at first birth:** First birth at adolescent age (< 18 years) is hazardous for women’s reproductive health. Our study reveals an encouraging trend in this regard.

It is found that the mean age at first birth was 20.85 years and it is slightly lower (20.60 years) for the women aged 15-25 years. The mean age at first birth was found to be consistently above 20 years among all the caste groups under study.

**Reproductive Health Practices**

- Our study reveals an encouraging trend of progressive decline in the birth deliveries at home.
• It is observed that while the importance of institutional deliveries is gaining greater acceptance, the credibility of government run health facilities is poor.

• Birth deliveries at hospital, it is found continue to be more among backward castes.

• The modern trained ANM, it is found is fast replacing the traditional midwife in assisting deliveries.

• Majority of the respondents (72.9 per cent) have received full IFA supplementation. But it is found this practice diminishes as the age and pregnancy order increases.

• Differential IFA acceptance levels among the castes under reference are observed. The supplementation of IFA is at low level among the SC' and ST's than the other castes communities.

• Age and pregnancy order, caste differentials are found to be associated in the coverage of ANC services.

• It is found that younger mothers (15.25) of pregnancy have received greater attention with regard to ANC. As the age, pregnancy order increases, the ANC services and acceptance had to as low as less than 30 per cent.

• The Scheduled castes have been paid greater attention in the coverage of ANC services than the backward castes.

• Among the backward castes are found to at a disadvantage in availing ANC service.
• The reach of ANC checkups and Services during the third trimester is found to be poor, particularly during second and third pregnancy and thus escape the identification of risk factors.

• Adolescent aged given should be taught about hygiene especially by mother used for perineal care. They should be taught above growth spread menstrual cycles. What care should be taken large number of respondents’ 86.4 per cent hot water and 3.8 per cent use of plain water. only 10.0 per cent Antiseptic Solutions used for perineal care.

• Hygiene for Perineal pad use women in slums area now a days it is better to education them use 38.3 per cent clean cotton clothes. OC's, BC's ,SC's, and ST's communities in slums area 59.2 per cent use old clothes. Only 2.5 per cent of the respondents can use to women silk cloth.
Conclusions

India has been making a bold attempt to provide reproductive health with equity to its massive populace independent of poverty and other socio-economic constraints. It has pursued a development approach after adopting a strategy of reproductive child health programme in 1997.

Based on the analysis and findings in the study an attempt is made to draw a few broad conclusions on the issues addressed.

Our first conclusion is that the strategy of RCH programme and the concept of reproductive health are facilitating greater for the achievement of reproductive health with equity independent of socio-cultural constraints like poverty.

Higher age at marriage and first child birth, greater percentage of institutional births (deliveries), coverage of antenatal care services, access to grass-root health professionals, and health facility, to younger mothers (age 15-25 years) in particular and others (25>) in general among the poverty ridden Forward Castes, Backward Castes, Scheduled Caste and Scheduled Tribe members under study suggests social inclusion and provision of reproductive health with equity.

Notwithstanding the efforts and achievements in the area of reproductive health equity, our second conclusion is that practices are more in such reproductive health care areas as immunization, reduction
of anemia, antenatal checkup services, identification of risk factors particularly during the third trimester of pregnancy, pregnancy complication, knowledge/awareness of reproductive track infections, and such social groups as older mothers (25+ years age) with second and third pregnancies, women belonging to such occupational groups which are involved in urban occupation structure.

Our third conclusion is that the persistence is more due to the lapses of monitoring and involvement of middle level/senior professionals/officers rather than access to health facility and grass-root health professionals; and due to the failure of emphasis on advocacy and information education and communication (IEC) to sensitize these groups.

Women in general and women of the social groups mentioned above in particular are socialized in self-denial and modesty and hence are unlikely to acknowledge a health problem. Moreover, these groups consider child bearing and the related events normal process and part of a woman’s life which do not deserve any special efforts and care. This is compounded by women’s lack of autonomy and decision making. Hence, the need for stress on advocacy and IEC.

Our fourth conclusion is that practices observed in the reproductive health care area are of social relational and are passive. These are relational deprivations which can lead to very bad results. The
deprivations come about through a social process in which there is no deliberate attempt to exclude.

In the recent years the reproductive health problems of women in slums have attracted the attention of a number of institutions are being made highlighting different aspects.

This study will hopefully bring to light the existing deficiencies and provide valuable information that would be of great operational significance for future actions and policy formulations.