CHAPTER I
CHAPTER 1

INTRODUCTION AND REVIEW OF LITERATURE

Over the last fifteen years, maternal mortality has been the reproductive health indicator that has proved to be the most resistant to validated improvement (Graham, 2002). The study of maternal morbidities has also revealed the extent of maternal ill health and its long term consequences in developing countries (Frotney and Smith, 1999).

Understanding maternal care-seeking is now recognized as an important step in tackling these problems. Studies are beginning to emerge that investigate the effect of male involvement in care seeking, the impact of perceived quality of care (Hulton et al, 2000) and women’s diverse understandings of potentially serious morbidities (Ganapathy et al, 1998). International attention on women’s status and autonomy has been wide spread but it has focused on the effect of autonomy on women’s fertility decision making, contraception and child health (eg Kishor, 2000, Hobcraft, 2000, Balk 1994, Govindasamy and Malhotra, 1996). Very few studies have been concern with autonomy and its effect on the reproductive health of women themselves. As maternity affects the majority of women in developing countries, maternal health can be seen as key to reproductive health in status in general, and investigating the effect of autonomy on maternal care seeking could
significantly increase our understanding of the pathways to reproductive health (Zoe et al. 2006).

The World Health Organization (1996a) estimated that 585000 maternal deaths occur globally every year, with the majority of this burden experienced in developing countries. Thaddeus and Maine (1994) suggested that 75 percent of these are due to direct obstetric causes and could be avoided with quality care at the appropriate time. Complications of pregnancy and childbirth also constitute the leading cause of death and disability among women 15 to 49 years of age, and 99 percent of these deaths occur in developing countries. The problem is particularly acute in Africa and South Asia, where women’s access to maternal health care and family planning is especially limited. It has also been reported that maternal mortality ratios are 15-20 times higher in developing countries and that life time risk of maternal death in developing countries is 1 in 51 as compared to 1 in 1967 in developed countries (Rochat 1981; Tinker et al 1993).

The maternal mortality can be reduced by making motherhood safer. Making Motherhood safer is fundamental to improving human welfare, reducing poverty and promoting economic development, which are the World Bank’s overarching goals. The World Bank was a co-founder of the Safe Motherhood Initiative, launched in 1987. The Initiative seeks to reduce illness and death related to pregnancy by ensuring that women have the best chance of having a safe pregnancy and delivery and a healthy baby. The ingredients necessary for making motherhood safer include prenatal care, safe delivery, postnatal care, family planning, and good nutrition. Also essential, is information to raise awareness among pregnant mothers and their families about the importance of
maternal health care and family planning services. The Bank's support for safe motherhood has increased substantially over the decade. In 1986, the Bank's overall lending program had less than 10 projects that included maternal health and family planning. Recognizing the magnitude of the problem, the Bank significantly expanded its efforts to make motherhood safer.

By improving maternal health and nutrition and immediate postnatal care could prevent about 75 percent of prenatal deaths, more than 50 percent of infant deaths, and 99 percent of maternal deaths.

Following facts highlights the seriousness of these problems:

- Each year almost 600,000 women die from complications of pregnancy and childbirth.
- At least 40 percent of women who become pregnant each year experience complications that require treatment from a trained provider, and one in 10 requires hospitalization.
- More than one-half of all pregnant women in developing countries are anemic.
- In many developing countries, maternal deaths account for 25 to 33 percent of all deaths of women of childbearing age.

This clearly indicates the alarming problems in the developing countries.

India, being a developing country, is not the exception for these problems. A substantial number of women die even in India each year during pregnancy or child birth. For every woman who die, many other suffer serious injuries at times permanent as a result of pregnancy the common
complications in pregnancy are obstructed labour, hemorrhage, eclampsia, infection and abortion (Brech 1969; bollough 1981; Alauddin 1986). Unsafe motherhood is still a reality in dream for much of India reported 78 percent of maternal death occurring in the study population could have been prevented by specific timely action (Bhatia, 1993).

The latest report released by the Registrar-General of India under the Ministry of Home affairs says that every seven minutes, one woman dies due to complications in pregnancy or child birth. That’s 77000 deaths every year. This further attributes the high percentage of deaths to rundown maternity services and mother-and-childcare centers and rural health facilities. The current survey also reports that there are 300 maternal per lakh live births and what is most worrying is that women in the 20-24 age group constitute one-third of the total deaths. The biggest cause seems to be haemorrhage, at 38 percent. Almost 11 percent deaths are due to infections and 8 percent due to abortions. The main causes for a majority of deaths are lack of education and awareness. Most women are anaemic because they don’t take good care of themselves. Inadequate health care and child birth in quick succession are the other issues. Abortions done by dais and quacks, which is widely prevalent in India, could also give rise to various infections. Utter Pradesh and Uttaranchal Pradesh leads the list with 70 percent maternal deaths. Kerala has the lowest mortality rate, 6.6 percent, while in Maharashtra there are less than 150 maternal deaths per one lakh live births. (Maharashtra Times, March 11, 2007).
The National Family Health Survey conducted by International Institute for Population Sciences (IIPS, 1992) reported that in Maharashtra, a state in India, 10 percent of women suffered at least one delivery related complications during delivery. Complications were most common for first birth and births preceding birth interval of less than 2 years. Premature births were more common for first births and for younger women than for older women. Births that were premature or low birth weight were more common among those who received antenatal care, no doubt because women with these conditions were more likely to seek medical health.

Promotion of maternal and child health has been one of the most important objective of the Family Welfare Programme in India. Antenatal care (ANC) refers to pregnancy-related health care provided by Doctors or a health worker in a medical facility or at home. The safe motherhood initiative proclaims that all pregnant women must receive a basic, professional antenatal care (Harrison, 1990). Ideally, antenatal care should monitor a pregnancy for signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counseling on preventive care, diet during pregnancy, delivery care, postnatal care and related issues. Antenatal care provides a preventive service that monitors women during pregnancy, with the potential to identify obvious complications and risk factors at an early stage in pregnancy, to arrange for appropriate maternal and child health care and to reduce maternal morbidity and mortality if delivered effectively. However, the success that it has in achieving this aim is related to the quality of service that is provided, the number of visits that a
women receives during pregnancy, the timing of those visits and the existence of and accessibility of professional delivery care when necessary (World Health Organization, 1996b).

In 1996, safe motherhood and child health services were incorporated in India into the Reproductive and Child Health (RCH) Programme. This program recommends that as part of antenatal care, women receive two doses of tetanus toxoid vaccine, adequate amounts of iron and folic acid tablets or syrup to prevent and treat anaemia, and at least three antenatal check-ups that include blood pressure checks and other procedures to detect pregnancy complications (Ministry of Health and Family Welfare, 1997; 1998b).

The accessibility of health services to the urban poor living in different cities of varying population sciences reveals that even slum people seek medical help from nearby private sources for minor ailments and for chronic, acute diseases, maternal and child health and family planning, they seek government services. It also gives an idea about how much health care accounts for the total expenditure at the household level in a month.

There are various factors that influence the individual’s health seeking behaviour towards their illness. The factors could be personal, environmental or social and in a way, reflect the health behavior utilization of people. Among slum women the morbidity and mortality due to reproductive tract infections/sexually transmitted infections are relatively very high compared to other health problems and many a time these are under reported. Similarly
diarrhoeal diseases contribute significantly to childhood morbidity and mortality in urban slums because of the delay in seeking appropriate treatment.

In general, women in slum remain unaware of their own reproductive health problems such as menstruation, sexuality, concept of menstrual hygiene and family planning methods. Further risk involved in repeated pregnancies and proper utilization of antenatal and postnatal care. Hence it is necessary to impart knowledge about these reproductive health problems. Women in the urban slums are unaware of the existing health facilities and even if available it has been adequately utilized. Thus to know the awareness of health care among study women and the infrastructure facilities available in the study areas, in detail, this study is undertaken.

1.1 Statement of the Problem under Study

Every society is divided in to haves and have-nots. The haves have all the facilities like good education, good accommodation, healthy food, and instant medical facilities where as, the have-nots do not have any of the aforementioned facilities. This has led to a number of social problems like illiteracy, early marriage and early birth at low age, high birth rate, low awareness of reproductive health problems and many more, especially to the women in a slum. They are forced to live in inhuman condition in the dirty pockets of the slums around the periphery of the big cities. Thus the purpose of this study is to find and evaluate the living conditions of the women in the
slums in Mumbai with respect to the awareness and the usage of antenatal care, postnatal care, child health care and awareness towards Reproductive Tract Infection, HIV/AIDS and its prevalence.

1.2 Rationale of Studying this Problem in the Case of Slum Women

There is a growing recognition that gynaecological morbidity is an important health problem among poor women in India. Yet, information on the levels and patterns of gynaecological problems experienced by women in India and even in the slums is sparse. There are few community-based studies in slums; since large proportions of women suffers reproductive morbidity silently, and are reluctant to seek care or to visit clinics and hospitals and even during pre and post natal periods, it is difficult to assess the true magnitude of the problem or the patterns of reproductive morbidity from which women suffer. Thus the rational of studying this problem is to know the utilization of health facilities towards antenatal care, postnatal care, child care, gynecological morbidity and awareness among the study women in the study areas, namely Ramabai Nagar in Bhandup and Rafi Nagar in Deonar area, focusing on both study women's perceptions and assessment of their gynecological health.

1.3 Review of literature

Maternal health care is poor in developing countries. Bad health services contribute significantly to maternal deaths. For example, a study of 152
maternal deaths in Dakar, Senegal, showed that the following major risk factors were associated with health system failures: medical equipment breakdown, late referral, lack of antenatal care and, most importantly, non-availability of health personnel at the time of admission (Garenne et al., 1997). Indeed the lack of a skilled attendant at the time of childbirth is the most serious risk factor for maternal death and yet the percentage of births attended by a trained person can be as low as 5% in some developing countries. Similarly family planning services can be poor and erratic, contributing to the lack of interest among potential clients. But behind this health system obstacle to the health of women in developing countries lies a plethora of other factors: social, cultural and political. The correlation between lack of education and high risk for maternal mortality has been demonstrated in several studies and reports (e.g. Harrison, 1996; World Bank, 1993). It applies equally to child health, which depends very much on parental schooling, especially the mother's (World Bank, 1993). It has also been shown to determine the level of use of contraception. Some cultural practices are detrimental to reproductive health. For example, in some societies pregnant women are prohibited from eating certain foods, thus contributing to poor nutritional status and anaemia. It is well known that anaemia is a risk factor for maternal morbidity and mortality (Bagnall, 1974). In other societies the practice of female genital mutilation (FGM) causes pain and difficulties in childbirth: this practice is common in South East Asia and Africa (Toubia, 1994). Political stability is essential to the sustainability of health programmes. Civil wars and the refugees resulting from them are not and cannot be conducive to the delivery of health care. Moreover, when you compare the
percentage of central government spending in such countries on defence, education and health, it is clear that defence is given priority (WHO, 1993). Ultimately poverty is the underlying determinant and common denominator for all these medical, social and political factors.

The gap between the rich and the poorest countries has increased from 8-fold to reach 30-fold. The relation between wealth and life expectancy is well known (World Bank, 1993). And that is not all. The debt burden and structural adjustment programmes (SAP) have made their mark on the access of the poor to health care. Developing countries have had a debt crisis since the seventies (Oxfam, 1986). Today there are developing countries which have a debt burden higher than their GNP. This means that imports such as medicines are outside their reach. Poverty is the root cause of the double tragedy of high maternal mortality rates and excessive fertility in developing countries. It exerts its influence through illiteracy, malnutrition and a low status of women. It weakens the health care system and reduces access to the little there is. It determines whether health services are utilised or not. Thus, reproductive health in developing countries is a complex issue, involving an interaction between demographic, socio-cultural and medical factors, all in turn determined by poverty. These factors may be summarised by paraphrasing the paradigm proposed by Griesgraber and Gunter (1996).

About one-third of the population of Dhaka city, Bangladesh lives in slums and squatter settlements. The urban slum population has a lower
immunization coverage and lower use of antenatal care, higher infant mortality and morbidity rates, and low contraceptive coverage compared to non-slum people. The health needs of this poor population are high, and it is likely that many of their needs are unmet. The urban population growth is much higher among the poor. The health situation in the slum areas will worsen if appropriate programmes are not implemented.

Research study to examine the effects of demographic and social factors on the positive trends in institution based use of antenatal and delivery care with medically trained professionals in Honduras and Guatemala from the late 1980's through the late 1990's was carried out (Stanton, 2004). The differential use of these maternal health services by urban/rural residence, parity, age, women’s education, women’s employment and Socio-economic status is similar across country and time period, and resembles patterns of use reported worldwide. The results show that all of these factors exert strong, unchanging and significant efforts on use of antenatal care.

Louise et al. (2005) have tried to assess the quality of maternal health services in urban India. The study was done in a slum area of Mumbai and data was collected from municipal and private hospitals. The various components in their framework were - Human and physical resources, Referral system, Maternity information system, use of appropriate technologies, Management of emergencies, Respect, dignity and equity and emotional support. All above components were measured in terms of certain percentages.
Most maternal deaths occur in the puerperium and most maternal morbidities probably also arise at that time. Maternal morbidities occur much more frequently than maternal deaths, but very little is known about their magnitude or causes. This study (Elizabeth, et al.1995) uses focus-group discussions to explore the experiences of childbirth and postpartum illness among rural Bangladeshi women. The women’s beliefs about disease causation, and their use of traditional health care, are explored. The significance of the findings for the training of traditional birth attendants and for programs of postpartum care is discussed.

One of the very few community-based studies conducted in a rural area of Maharashtra’s Gadchiroli district reports that of 650 women aged 13 and above, 55% reported gynaecological complaints, but as many as 92% were reported on clinical examination to have one or more gynaecological or sexually transmitted diseases. Yet only 8% had sought treatment (Bang et al., 1990).

Other studies from India and other developing countries-Karnataka, Bangladesh, Egypt, and Nigeria-corroborate significant though lower levels of reproductive morbidity among the general population (Younis et al., 1993 for Egypt; Brabin et al., 1995 for Nigeria; Bhatia et al., 1995 for Karnataka) or among specific sub-populations such as contraceptive users (Wasserheit et al., 1989).

This picture of high levels of morbidity, combined with a reluctance to seek treatment is corroborated by the working experiences of many non-
governmental organizations addressing health needs in both rural and urban India. Yet more rigorous information about levels and patterns of morbidity, their perceptions and correlates, is virtually non-existent. Community based studies of the prevalence and nature of gynecological morbidity in different settings that can provide information to health planners and policy makers regarding appropriate strategies to improve women's reproductive health are much needed.

Research study carried out in Delhi slums (Anita K. et al. 2003) revealed that the extent of utilization of health care services for RTIs/ STIs diseases found to be 32.9% among reproductive women and their health seeking behaviour found to be poor. Another study carried out in slums in Greater Mumbai (Yasudian 1990) revealed that most of the slum population was visiting private health facilities.

Study carried out in Dhaka slum (Rashid, 2004) regarding the reproductive health needs of married adolescent women reveals an insight into the situations in which adolescent women take decisions surrounding marriage, fertility, childbearing etc, within the socio-economic constraints that surround them and the larger structural conditions which govern their lives.

Numerous studies document the disadvantage in child health of the urban poor in African cities. This study (Magadi et al., 1990) uses Demographic and Health Survey data from 23 countries in sub-Saharan Africa to examine whether the urban poor experience comparable disadvantages in maternal
health care. The results show that, although on average the urban poor receive better antenatal and delivery care than rural residents, the care of the urban poor is worse than that of the urban non-poor. This suggests that the urban bias in the allocation of health services in Africa does not benefit the urban poor as much as the non-poor. Multilevel analyses reveal significant variations in maternal health in urban areas across countries of sub-Saharan Africa. The disadvantage of the urban poor is more pronounced in countries where maternal health care is relatively good. In these countries the urban poor tend to be even worse off than rural residents, suggesting that the urban poor have benefited least from improvements in maternal health care.

The study (Choudhry, 1997) was done on maternal and child care practices among women from India. As in all cultures, certain beliefs exist surrounding what facilitates a good pregnancy and its outcome, as well as negative sanctions. These practices continue to influence many immigrant women to whom western practices are either unknown or unacceptable. An understanding of the traditional belief system of such women can ease their adaptation into the Canadian and U.S. health care systems.

Another aim of study (Maimbolwa, et al., 2003) was to explore cultural childbirth practices and beliefs in Zambia as related by women accompanying labouring women to maternity units. These social support women were also interviewed about their views on providing companionship to labouring women. Thirty-six women accompanying labouring women to urban and rural maternity units in Zambia were interviewed. Eighteen of the women considered themselves to be mbusas, or traditional birth assistants and the rest said that
they followed labouring women to maternity units. Those who considered themselves traditional birth assistants advised childbearing women on appropriate cultural childbirth practices and assisted with deliveries at home. They also advised women on the use of traditional medicine, for example, to widen the birth canal and to precipitate labour. If something went wrong during labour, they relied on traditional beliefs and witchcraft to explain the mishap and expected the woman in labour to confess her purported 'bad' behaviour. Twelve of the women were in favour of providing support to labouring women in maternity units and learning about childbirth care from midwives. These social support women, including those who considered themselves as mbusas, lacked understanding of the causes of obstetric complications during childbirth, and had inadequate knowledge of the appropriate management of labour. Culturally-specific knowledge from this study should be used to guide policy-makers and health planners in the future development of safe motherhood initiatives in developing countries. Midwives have a unique opportunity to ensure that care given during childbirth is clinically safe and culturally sensitive.

The study was done (Khandekar et al, 1991) to examine the pattern and role of practices related to childbirth in some urban Integrated Child Development Scheme (ICDS) areas of Allahabad. Thirty-five centres out of 100 were chosen randomly. Each centre caters to an approximate population of 1,000. All the pregnant women registered at the selected Anganwadi centres during the course of one year formed the study population. In all, there were 661 women. A detailed history of past illnesses including obstetric problems,
family history of diseases, information about tetanus toxide immunization during the antenatal period, and childbirth practices including the type of instruments used at the time of delivery were obtained. This study finds that all the women were permanent residents of the area and were mostly from the lower socio-economic group. Women undergoing their second or third delivery utilised these services the least. More primiparas as compared to others had been immunised. Almost two-fifths of the women had delivered at home while the rest utilised public or private hospitals. Untrained personnel, irrespective of parity, conducted the majority of the births. Those who utilised trained persons for delivery were by and large primiparas. Awareness of the pregnant woman and the need for trained birth assistance were greater among women with educated husbands. Among the deliveries assisted by trained personnel, the perinatal mortality rate was 67.4 per 1,000 live births. It was 154.8 per 1,000 live births in the case of untrained assistance. The majority of the slum-dwellers surveyed had no faith in hospitals. They preferred to trust the untrained dai who belonged to the same socio-cultural milieu. The unhygienic practices of untrained persons were attributed to ignorance, illiteracy and lack of education of the dais and family members. The complications occurring during delivery clearly show the inability of untrained persons to identify 'high-risk mothers'. In conclusion it is stated that untrained ‘dais’ play an important role in the provision of natal care in urban slums. It is essential to train them to make these services acceptable and safe.
Another study was done (Nandraj et. al, 1994) to document and analyze perceived morbidity patterns; constraints of women in accessing health care facilities and their utilization; and patterns in expenditure on women's health. The study was conducted in the L ward of Greater Mumbai city, a congested pocket (slum) with residential units as well as small-scale factories and commercial establishments, poor sanitation, insufficient water supply, acute noise and air pollution. The majority of the population consisted of migrant labourers and entrepreneurs. The survey was conducted in five clusters - two slums, two chawls and one apartment block. The selection of the clusters was on the basis of their 'class character'. The predetermined sample size was 425. House listings were done in the identified clusters. Households were identified for survey through systematic sampling. In all, 430 households were covered in the study. The data were collected through interview schedules. Since women were the focus of the study, female investigators conducted the interviews, and the respondents were all women. A 'probe list' - a list of 14 symptoms - was used to probe the existence of specific symptoms among women which might otherwise go unreported. Each symptom reported after probing was recorded as an independent episode. During the survey a conducive environment was created which would encourage women to feel unhindered to speak about their health problems. The monthly prevalence rate for males was 169 per 1,000 as compared to 571 per 1,000 for females after probing. Reproductive illness accounted for 28.2 per cent of all episodes among females, the majority of them being related to menstruation and childbearing. The findings point to a strong relationship between women's work lives and their health. After probing, women had a higher morbidity rate than
men across all age-groups. Slum-dwellers suffered higher morbidity than non-slum-dwellers in each age-group, gender group and occupation group. Of the total illness episodes, 32.5 per cent were not treated. For 85 per cent of the illness episodes, private facilities were used. With regard to deliveries the public sector accounted for only 30 per cent, as compared to the private sector which accounted for 31.7 per cent. All the three abortions reported utilized private facilities. Only 38 per cent of the total contraception users utilized public facilities. There was a wide disparity in the utilization of public health facilities at different levels. In that, tertiary hospitals were overloaded, the first referral systems like health posts were underutilized. Utilization of the formal health sector was lower among women than men. Access to health care facilities in terms of distance and who provided health care were major factors which influenced utilization. In case of nearly two-thirds of the illness episodes, health facilities with less than 10 minutes distance from home were approached. Among women, fevers, respiratory and gastrointestinal illnesses were treated more than reproductive illnesses. Unwell men received equal treatment irrespective of age, whereas among women, those in the age-group of 0-11 years have a higher number of treated illnesses. The study doesn't show any direct impact of education on health-seeking behaviour. The most common reason given for non-treatment of an illness was that the illness was not serious enough to be attended to. Financial constraints were also an important reason for non-treatment, more so far women than for men.

About 47 percent of Indian children under 3 years are malnourished. 51.8 percent of Indian women in the age group of 15-49 are anaemic (UNICEF
Reports 1999-2002-Challenges & Opportunities). Concerned about these alarming statistics, in 1991 Nalamdana began a Communications Research project, Food for Thought, funded by the Earthwatch Institute, Boston, the project begin with a baseline research among the city slums and in village to determine the misconceptions and knowledge gaps about nutrition among young mothers and adolescents. This extensive research included information about regional dietary practices, food availability, and household economics. The information will allow Nalamdana to develop alternate solutions in the communications strategy and to explore interactive methods of reaching the target audience.

Expenditure on women's health care was lower than on males. For those illnesses that were reported only after probing, expenditure was generally lower than for the other illnesses. The findings of the study raise the issue of non-utilization of health services, especially by women, both for deliveries and other illnesses, even in a metropolitan city like Mumbai which has better public health facilities as compared to other parts of the country.

The 1994 International Conference on Population and Development (ICPD), held in Cairo, emphasized the need for delivering a broader range of integrated health and family-planning services. This need was echoed by the Health and Population Sector Programme (HPSP) 1998-2003 of the Govt of Bangladesh and the National Integrated Population and Health Programme (NIPHP) (1997-2002), supported by the United States Agency for International Development (USAID), to address the issues of missed opportunities and sustainability.
Results of several clinic-based studies in different countries, such as Latin America, Guatemala, Peru, and Mexico, indicated that the temporal and physical integration is not enough to ensure provision of more services to women for meeting their health needs and also ensure that the delivery of reproductive health services will become more efficient and less costly.

An assessment of the service-delivery system in a maternal child health and family planning (MCH-FP) clinic in Zone 3 of Dhaka city revealed that the rate of missed opportunities for providing immunizations were 44% among children coming to the MCH-FP clinics. For maternal TT immunization the rate of the missed opportunities were 87%.

Findings of a study conducted in a government Model ESP clinic in Dhaka city showed that 8-13 percent of clients had unmet needs for additional services Of these, over half had unmet needs for family planning and one-fifth for RTI, and one in 10 children aged less than 5 years visited the clinics, with the problem of acute respiratory infection.

Studies conducted in hospitals and clinics of Latin America and Guatemala found that clients, who visited a clinic for a particular service at a point of time, had additional needs for other services. But the existence of other services is little known by clients, resulting in the under-use of existing services. Similar findings were also observed in needs-assessment study
conducted in Zone 3 of Dhaka city. It was found that 25% and 20% of clients who visited the clinic for non-family-planning and non-EPI services were unaware of the availability of family-planning and EPI services in that facility. The above evidence from home and abroad has an obvious programmatic implication.

Results of the World Bank study showed that there were high burdens of reproductive morbidity among women of developing countries. About one-third of disease burden among women aged 15-44 years is linked to health problems relating to pregnancy, childbirth, abortion, and RTI. Available data for South Asia show that women have a huge unmet need for services relating to these conditions.

The study conducted in the 27 Urban Slums of Davangere City (Venkatesh et al., 2005) to know the extent of utilisation of health services by the mothers in the antenatal, intranatal and postnatal period and to see the factors influencing for the same, it was found that all the mothers who had delivery prior to 3 months from the initiation of the study, only 35.9% of the women had utilised all the three services i.e., antenatal, intranatal and postnatal completely. The percentage of deliveries conducted by the trained attendants was 70.4% and 64.7% of the women had received at least one postnatal visit. The socio-demographic factors like literacy status, occupation,
type of family, parity and an unwanted pregnancy were found to influence the pattern of utilization.

A recent review of the nine community-based studies of gynaecological morbidity in India showed a considerable burden of RTI/sexually transmitted infections (STIs). Results of studies in Bangladesh also show a significant burden of reproductive morbidity. A survey on nature of morbidity due to RTI among users and non-users of family planning showed that 22% of the 2,929 rural women of Bangladesh reported symptoms of infection. Of 472 symptomatic women examined, 68% had clinical or laboratory evidence of infection. This represents an important unmet need, because RTIs are frequently asymptomatic in women, are not recognized and treated, and may cause long-term problems, including infertility or neonatal sequelae, such as congenital syphilis and gonococcal eye disease.

Another study (Parikh et al) shows that almost three-quarters (73%) of all women reported one or more of the above gynaecological conditions. Almost one-third (30%) reported white discharge (pandhare pani)(5), a typical symptom of lower reproductive tract infection. Two in five (39%) reported lower back pain (kambar dukhi) and one in five (21%) reported abdominal pain (otipot dukhane). Almost two fifths (39%) report symptoms suggestive to the physician of one or more menstrual disorders, ranging from 23% who report symptoms suggestive of dysmenorrhoea (palitpot dukhate) to 13% who report oligomenorrhoea (scanty periods, angavar kami jane) and 5%-7% reporting irregular periods (aniyamit pali) or profuse bleeding (palit jast jane) (that is,
polymenorrhea, menorrhagia or metrorrhagia). Fewer women (3%-6%) report such conditions as 'something coming out' (anga bahar yete) or infertility (mool na hone) or dysuria (laghavila aff or garam laghavi). Low backache and lower abdominal pain are frequently, but not necessarily, symptoms relating to such gynaecological morbidities as pelvic inflammatory disease, cervicitis, vaginitis, cystocele, rectocele, polyp and fibroids. Hence, they are included among reported gynaecological complaints (although some studies have excluded both) (see, for example, Bang et al., 1989). As many as 39% and 2 1% of all respondents report low backache and lower abdominal pain respectively. Qualitative data from group discussions held with one hundred women also suggest the prevalence of these conditions(6). In a free listing of illnesses which women commonly suffer from, gynaecological conditions featured prominently. Among the 15 leading conditions listed, eight reflect gynaecological conditions: white discharge (61), low back pain (54), low abdominal pain (44), severe menstrual breeding (29), painful menstruation (21), burning micturition (11), uterine cancer (25), lump in the breast (22). Others included pain in the legs (36), general weakness (29), headache (22), pain in the joints (18) and tuberculosis (18), giddiness (17) and abdominal lump (11), some of which may also be manifestations of gynaecological conditions. In short, the results of this section suggest high levels of reported gynaecological morbidity including leucorrhoea, dysmenorrhoea and other menstrual complaints and low back pain.

A study done (Neha et,al.) in Kurla slum of Mumbai, it was revealed that there is a significantly higher burden of morbidity among women. It was not
possible to estimate the effect of any single factor on the reporting of women's morbidity. The objective of the study was to create an environment which encouraged women to feel unhindered to speak about their health problems even while a deliberate attempt was being made to elicit information about unreported illness through the probe list. There are no great variations in 'health awareness' among the different classes and among men and women due to the widespread exposure to media, the pervasive presence of health services and higher levels of education. In the context of analysis of reproductive labour, this study points to a strong relationship between women's work lives and their health. That all married women, (and those with children more so) reported significantly higher morbidity than other women is an indicator of the additional burden of morbidity that reproductive labour imposes. That this task becomes more demanding on their health within a degraded environment is very evident. This study points towards a need for more systematic study into women's health problems in relation to their work.

"Three and a half billion people, three quarters of all humanity, live in the developing countries of the South. These countries vary greatly in size, in levels of development, in economic, social and political structures. Yet they share a fundamental trait: they exist on the periphery of the developed countries of the North. Most of their people are poor; their economies are mostly weak and defenseless; they are generally powerless in the world arena (Joseph M. Kasonde1990)."
The prominent characteristics of reproductive health in developing countries are two: gross reproductive ill-health and excessive fertility. Ninety percent of the 585,000 women who die annually in the world from pregnancy related complications are in developing countries. Maternal mortality ratios range from 200 to over 1000 per 100,000 live births; the lifetime risk of dying from pregnancy related causes can be as high as 1 in 21 in those countries, compared to 1 in nearly 10,000 for industrialised countries (Fathalla, 1992). In most cases the causes - bleeding, infection, eclampsia and obstructed labour - are preventable or treatable, if only the necessary care were available. For every 1000 women of childbearing age (15-49 years) as many as 20 to 30 have an unsafe abortion; and most of these are in developing countries. Abortion related deaths are therefore common in developing countries, particularly in Asia and Africa. A pregnant woman in a poor developing country runs a risk of dying that is up to 500 times higher than her counterpart in an affluent developed country, and for every maternal death there are at least 20 women suffering from long-lasting pathological sequelae. This unfortunate status of ill-health has been described as "the obstetric pathology of poverty" (Abdel-Aleem et al., 1993). The pandemic of AIDS which has gripped the world has disproportionately affected the developing countries. HIV infection in these countries has been mainly transmitted through heterosexual contact. By the end of 1996 more than 22 million people were infected worldwide, of whom 14 million were in sub-Saharan Africa (UNAIDS, 1996). By the time of the last World HIV/AIDS conference in Geneva last year the figure had gone up to 29 million and had increased significantly in South and Southeast Asia (UNAIDS, 1998). But it is not only the feared AIDS. At least 333 million new cases of
curable sexually transmitted diseases (STDs) are estimated by WHO to have occurred globally in 1995 mostly in developing countries. In Cameroon, for example, reproductive tract infections (RTIs) are reported to be among the top five causes of consultation at medical institutions (Meheus, Schultz and Cates, 1990); while in Zimbabwe, up to 10% of the population were reported to have at least one RTI (Laga, 1994). Studies of women in India, Bangladesh and Egypt have shown RTI rates ranging from 52% to 92% (Younis et al., 1993). Syphilis in developing countries remains at levels comparable to those in Europe one hundred years ago. Pelvic infection may lead to infertility.

The accessibility of health services to the urban poor living in different cities of varying population sciences reveals that even slum people seek medical help from nearby private sources for minor ailments and for chronic, acute diseases, maternal and child health and family planning, they seek government services. It also gives an idea about how much health care accounts for the total expenditure at the household level in a month.

The community development program implemented (Demet Gural, 1996) since nine years, in the big cities' slums, executed in three different cities of Turkey, namely Istanbul (in the west) and, Gaziantep and Kilis (in the southeast) as well as in Nakhcevan autonomous region of Azerbaijan and Almaty city of Kazakstan where the migration rates are high shows that the women who receive their first information from the community workers continue to receive their services from the public health centers in their neighbourood or start seeking for more information and services.
Phanindra and Prakasham (1998) have tried to assess the quality of health care in rural Gujarat by using NFHS data. They have defined quality as utilization of services by different providers (Public and Private).

Research reviews by Nag (1983), Srinivasan (2002), Duggal and Amin (1989), Mumiandi (1997), Gandotra & Narayan Das (1983), Basu (1990) revealed that the studies have not focused on antenatal, post natal health awareness of women in slums in Greater Mumbai. Also, the limitation of these studies was the variation in scope as well as coverage of important aspects such as the type of health sources availed, physical distance to the source, expenditure incurred for treatment etc.

Reproductive morbidity refers to health problems related to reproductive organs and functions, including and outside of childbearing (Zurayk et al., 1993). Such morbidity can be classified as: obstetric morbidity, gynecological morbidity and contraceptive morbidity. Gynecological morbidity includes health problems outside pregnancy, like Reproductive Tract Infections (RTIs), menstrual problems, cervical entropy (erosion), infertility, cancers, prolepses and problems with intercourse.

In this study, reproductive morbidity has been considered as problems related to gynecological morbidity focusing on menstruation related problems. Gynecological morbidity is an important health problem especially among poor and adolescent women in India where health seeking behavior is at very low level. Yet no national level study has been conducted to provide the levels and
patterns of gynecological problems experienced by women in the country except a few community based studies. A review of literature on community based studies of gynecological morbidities conducted in India and other countries are discussed here and are as follows:

A few community based studies conducted in India on the gynecological morbidity showed that there exists a high prevalence of reproductive health problems (Bang and Bang, 1989; ZURAYK et al., 1993; BHATIA and CLELAND, 1995b; BHATIA et al., 1997; SRINIVASA et al., 1997; KOENIG et al., 1998; IIPS., 2000; SADHU et al., 2001).

Forty percent of currently married women in Maharashtra report some type of reproductive health problem, including abnormal vaginal discharge, symptoms of a urinary tract infection, and pain or bleeding associated with intercourse. Among these women, 53 percent have not sought any advice or treatment. These results suggest a need to expand reproductive health services, as well as information programmes that encourage women to discuss their problems with a health-care provider (NFHS-2, IIPS, 1998-99).

Differentials in the prevalence of reproductive health problems by age at first birth revealed that there exists strong association between two. Women who had their first birth in their teens tend to suffer more from reproductive health problems than women who had their first birth after 20 years of age. It was further showed that women belonging to other religion and rural women suffer from reproductive and sexual health problems more than
women belong to the Hindu religion and urban women. Among women who had their first birth before 19 years of age, a higher percent of other caste women suffer more from reproductive health problems, followed by SC/ST women. And other backward caste women, where as among women who had their first birth after 20 years of age, a higher percent of SC/ST women suffer more from reproductive health problems, followed by other cast women and backward caste women. Irrespective of their age group, increase in the number of child ever born increased the reporting of reproductive health problems.

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National Family Health Survey (1998-99) provided recent information on the prevalence of selected symptoms of RTI for the states of India. Few studies conducted in India provide information about the levels and patterns of gynecological problems focusing reproductive tract infections (RTI). An extensive review by Nandini Oomman (2000) reveals a decade’s research on reproductive tract infections and other gynecological morbidity studies in India brings out the limitation of the studies and non-availability of RTI data in India.

In a study on reproductive morbidity among currently married adolescent women with reference to gynecological morbidity reflecting RTI in two selected states i.e. Andhra Pradesh and Tamil Nadu regarding self reported symptoms of reproductive morbidity information was collected in relation to vaginal discharge accompanied by: itching/irritation, bad odour, abdominal pain, fever, pain/burning while urination and pain during intercourse, blood visible after sex. The data was collected from NFHS-2. The reproductive morbidity data for currently married adolescent women in these two states reveal that at least 31.4 percent women in the age group 15-19 suffer from one or more complications of reproductive health. Analysis shows that reproductive morbidity problems were found to be more for the study women in Andhra Pradesh than in Tamil Nadu. In Andhra Pradesh the percentage of study women who reported having one or more reproductive morbidity problems was found to be higher in private hospital deliveries than in home deliveries (Prakasam, 2004).
Further it has showed that the risk of reproductive morbidity in relation to the socio-economic and biological variable reveals that women who delivered within 14 years of age and got married over 14 years of age were found to have higher odds than reference category in reporting RTI problems. Tami Nadu shows a significant Phi-square value for these two variables. Also age at marriage and age at birth are the two socio-biological variables which emerged as influencing risk of reproductive morbidity (Prakasham, 2004).

Pregnancy-related complications, as well as congenital infections, can result from RTIs. Pelvic inflammatory disease (PID) can develop, and can cause infertility, ectopic pregnancy, and chronic pain. Recently, it has been shown that certain infections can increase the chances of HIV transmission. Unfortunately, symptoms and signs of many infections may not appear until it is too late to avoid such consequences and damage the reproductive organs. The morbidity associated with RTIs also affects the economic productivity and quality of life of many individual women and men and consequently, of whole communities. Even poverty is the root cause of the double tragedy of high maternal mortality rates and excessive fertility in developing countries. It exerts its influence through illiteracy, malnutrition and a low status of women. It weakens the health care system and reduces access to the little there is. It determines whether health services are utilized or not.

Pregnancy and childbearing characterize the experiences of a number of women in India. Adolescent fertility rates are high: roughly 107 births takes place per 1000 girls aged 15-19 and the fertility of this age group makes up 19%
of the total fertility rate. Over one in five give birth by age 17 and the median age at first birth is 19 years, suggesting that significant proportions of women undergo pregnancy at ages below which obstetric risks are particularly elevated. Early childbearing has resulted in adverse health consequences, including damage to the reproductive tract, maternal mortality, pregnancy complications, pre-natal and neonatal mortality and low birth weight. Even early childbearing infections and the infections in the reproductive tract and urinary tract are the leading causes for many chronic illness related to reproductive system like cervical problems, pelvic inflammatory disease etc. Pregnancy during adolescence poses a greater risk to reproductive health of women, compared to pregnancy later in life. It is also found that women who start childbearing at younger ages are prone to have more children at younger ages itself (Pradhan et al., 1996). This successive childbirth in the short span adversely affects the health of women.

In spite of these risks, pregnancy during adolescence occurs worldwide. However, the pattern and socio-cultural factors influencing adolescent pregnancy vary from country to country. In western societies, teenage pregnancy has been observed to be a major social problem, mainly due to premarital sexual relationship, whereas in the eastern societies, marriages take place during adolescence and women become mothers at very young ages. In developing country though age at marriage is on the rise in the recent period, still a major proportion of girls get married and give birth at early ages. Though NFHS (National Family Health Survey) - 1 and 2 showed a rise in median age at first birth of women, a considerable percent of women gave
their birth below the age 20. The prevalence of reproductive tract and urinary tract infections are also found to be high in developing countries like India. In a traditional country setting like India, extra marital relationship may not be the reason for high prevalence of these infections.

At least 333 million new cases of curable sexually transmitted diseases (STDs) are estimated by WHO to have occurred globally in 1995 mostly in developing countries. In Cameroon, for example, reproductive tract infections (RTIs) are reported to be among the top five causes of consultation at medical institutions (Meheus, et al., 1990); while in Zimbabwe, up to 10% of the population were reported to have at least one RTI (Laga, 1994). Studies of women in India, Bangladesh and Egypt have shown RTI rates ranging from 52% to 92% (Younis et al., 1993). Syphilis in developing countries remains at levels comparable to those in Europe one hundred years ago.

The International Conference on Population and Development (ICPD), held in Cairo 1994, went a long way towards recognizing women's reproductive health concerns. Several researchers have shown that women in India often bear the symptoms of Reproductive Tract infections (RTIs) silently without seeking health care due to lack of awareness and perception about the diseases. RTIs and their sequel are an important component of family planning, child survival, women's health, safe motherhood, and HIV prevention programmes. Thus, it is difficult to estimate the disease burden from hospital and clinic records. Health administrators, planners very much requires
information of prevalence studies on gynecological morbidity in different settings for framing the strategies to improve women's reproductive health.

Among these studies, few studies have examined the relationship between socioeconomic characteristics and prevalence of reproductive health problems. Many of the earlier studies examined the relationship between the current age of women and reproductive health problems, but menstruation related problems among adolescent women and their treatment seeking behavior and that to in slums remains neglected, which is an important component as far as the reproductive health problems are concerned.

Large percent adolescent women suffer from reproductive tract infections and menstruation related problems. Absence of reproductive tract infection is essential for the reproductive health of both men and women. Studying gynecological morbidity in different settings can provide information to health planners and administrators in formulating strategies to improve the reproductive health problem.

Keeping in view of above research work an attempt is made to evolve a suitable strategy for knowing the health seeking behavior of the study women, utilization of antenatal and delivery and child care services and the health facilities available to women in the reproductive age group in slum area of Greater Mumbai, this study have been initiated.
1.4 Objectives

The present study is an attempt to know:

i) The awareness of antenatal, postnatal and child care services among the reproductive women;

ii) The awareness of health facilities and their utilization in slums.

Specific Objectives:

i) To know the difference between the awareness of reproductive women towards antenatal, postnatal and child care services in two selected slums in Greater Mumbai;

ii) To know the difference in the proportion of slum dwellers contracting diseases like diarrhoeal, skin disease, fever etc. dependent on municipal water and on other sources of water supply;

iii) To test whether there is a difference in the awareness of health problems between age and sex groups of slum dwellers in the study area;

iv) To test whether there is a difference in the awareness of health problems between different income groups.
The first objective covers the respondent's attitude towards awareness of antenatal care, which covers the frequency of visiting urban health centers, govt. hospitals, or even private hospitals.

It shows how frequently study women have taken TT injections, consumed IFA tablets and undergone for regular checkups during the pregnancy, and other checkups such as measurement of height and weight and abdomen and blood pressure checkups, etc.

It also covers postnatal checkup visits.

The immunization program for child under child care is covered by this objective. It shows how many times Polio syrup was given to the child, and even BCG vaccine etc.

The second objective covers the awareness of health facilities and their utilization in both the slum areas among reproductive women.

The specific objective i) covers the hypothesis whether the difference in the proportion of slum dwellers contracting diseases likes diarrhoeal, skin disease, fever etc. dependent on municipal water and on other sources of water supply;
The specific objective ii) covers the hypothesis, whether there is a difference in the awareness of health problems between age and sex groups of slum dwellers in the study area;

The specific objective iii) covers the hypothesis, whether there is a difference in the awareness of health problems between different income groups.

1.5 Hypothesis

Our study is confined to the following aspects:

i) the awareness of antenatal care, postnatal and child care services among reproductive women exists;

ii) the awareness of health facilities and their utilization in slums exists;

iii) the difference in the proportion of slum dwellers contracting diseases like diarrhoeal, skin disease, fever etc. dependent on municipal water and on other sources of water supply exists;

iv) the awareness of health problems varies by age and sex;

v) the awareness of health problems between different income groups exists.
1.6 Conceptual Framework

The theoretical framework for the inter-relationship between reproductive health of mother, health of a child, availability of health facilities, utilization of Antenatal care, postnatal care and immunization and gynecological and obstetric problems of women is shown in Figure 1.1. Theoretically non utilization of ANC, PNC and immunization tends to affect on the health of mother and in turn child to a great extent. However reproductive health of women to a large extent would also be influenced by their background characteristics viz. household level factors such as place of residence, Religion, Caste, educational status, and work participation, family type and children ever born. More over reproductive health of mother and health of child would also be influenced by these background characteristics. Another influencing factor is availability of medical facilities in the study area where ANC, PNC and immunization and gynecology and obstetric problems of mother gets affected depending on availability of such facilities in the study area and therefore availability of medical facilities and utilization of ANC, PNC and immunization and Gynecology and Obstetric problems of mother can be placed as an intervening variables.
Figure 1.1

Conceptual Framework

Individual level Factors

Household level Factors

Community level Factors

Reproductive Health of Mother

Gynecology and Obstetric

Mother and Child Health

ANC
PNC
Immunization

Health of Child

Availability of Facilities
1.7 Organization of the Thesis

To understand the reproductive problem of study women an attempt has been made in this study and this study has been formulated under the following chapters.

Chapter 1, the present chapter discusses about the statement of the problem under study and rational of studying the problem in the case of slum women followed by introduction. It also discusses review of literature focusing on current research on the present topic namely, “Awareness of health care among women in slums in Greater Mumbai” and then objectives, hypothesis and conceptual framework.

Chapter 2 deals with study design and methodology of selection of study area. This part also describes the detailed procedure of selection of area i.e. study area and then selection of samples from this study area. If further highlights on data analysis and construction of index such as standard of living index and composite index.

Chapter 3 depicts the socio-economic and demographic profile of the study area households and the study women.

An attempt is made in Chapter number 4 to study the utilization of Antenatal, Postnatal and Child health care services in Rafi Nagar and Ramabai Nagar slum areas of Mumbai. Also findings on the basis of analyzed data are
made. Wherever possible, results are shown in terms of Tables, graphs, diagrams and also some statistical tests are applied.

In Chapter 5, availability and utilization of health facilities in the study area is discussed. Besides to these diseases in the slum and water borne diseases in Rafi Nagar and Ramabai Nagar slum areas of Mumbai are discussed. Also findings on the basis of analyzed data are made. Wherever possible, results are shown in terms of Tables, graphs, diagrams and also some statistical tests are applied.

In Chapter 6 reproductive health of study women are discussed in details. This chapter ends with knowing awareness of RTI and HIV/AIDS among study women.

In chapter 7, the conclusions of the study are stated. Also the policies to be adopted for the betterment of health of the women and the scope for further research in this area are discussed.

In the next chapter an attempt is made to explain the study design and methodology of selection of the study areas, Rafi nagar slum area and Ramabai nagar slum area.