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The present study shows that the Slum dwellers suffer from poor health due to many factors which are show above. As been reported earlier, the poor sanitation, housing, lifestyle, gender discrimination in health care, and socio-economic status are the contributing factors to poor health.

There is a need of community awareness and educating women about consequences of reproductive health and its effect of general health. This needs immediate attention and adequate community awareness, education and infrastructure strengthening for health services delivery relevant to reproductive health problems.

The policies in regard to providing door to door services, and strong counseling to community in regard to family planning, reproductive health, strengthening the public hospitals, government hospital can improve the health status.

We describe the challenges to good health and health care presented by the physical and legal characteristics of slums. It will take time to address underlying political, economic, and social forces that create and perpetuate slums. Yet many interventions and services can be implemented immediately with life-saving effect. Our approach to slum health is neither comprehensive nor exclusive. It is our simple goal to direct the attention and efforts of health professionals to the characteristics of slum life that profoundly affect health. Together we can move from understanding to action, and improve the lives of people who live in slums right now.

The slum dwellers do not lag behind the others in general and reproductive health. In fact, in the incidence of morbidity the slums While there is not much difference in the causes of illness and its duration, the cause of death shows a difference.
In the slum areas among the selected population, there are 53.83% cases of communicable diseases, 46.05% cases of non-communicable and 0.07 injuries. Women suffer more from diseases in the Group I, as those include maternal and reproductive morbidity. Men suffer from non-communicable diseases and injuries.

The high morbidity rates among women are complemented by the high prevalence of specific types of illnesses. Reproductive illnesses form the largest group of problems accounting for 28.2 per cent of all episodes among females. We find that 100 episodes of gynecological health problems reported by women were related to menstruation and child bearing (Menstrual problems, uterine prolapse, low backache and lower abdomen pain.)

In general, sickness reported in children surveyed was 558 (93%) of short duration sickness and 42(7%) of the sickness were of long duration sickness. Specific information related to diarrhea, high fever and acute respiratory infections was collected as these morbid conditions are the most common conditions in children and major causes of childhood mortality. It is a period prevalence of diarrhoea based on a two week recalls of the child’s primary caretaker- in most cases the mother. 19.8% children were found to be suffering with diarrhoea in past 24 hours and 19.7% children suffered with diarrhoea proceeding two weeks of survey. The most common cause of diarrhoea is eating in excess, contaminated food and water, problem with the digestive system, eating spicy and hot food. In addition to this, the group mentioned that malnourished children suffer more frequently with diarrhoea as compared to normal children because of their poor digestive system. Very few mothers have the understanding that diarrhoea occurs frequently among children due to lack of proper sanitation and hygiene.

Thirteen percent of the elderly respondents reported chronic problems and seven percent bed-ridden. joint pains and eye problems were again the two most important ones. A higher percentage of women reported cataract/loss of vision than men. This was also true of joint pains, for the first stated condition. The data
reveals that heart disease and diabetes do not seem to afflict the majority of the elderly population in Slum.

Life style indicators like chewing tobacco, smoking and alcoholism which have detrimental effect on health, slum dwellers are more prone to these habits.

Occupational health hazards were common among the beedi rollers and agrbathi makers.

The health problems of any community are influenced by interplay of various factors including social, economic and political ones. The common beliefs, customs, practice analysis of health indices of the community. The ethno medicinal beliefs of these slum dwellers of Mysore city are characterized by both natural and supernatural elements. They attribute that the climate, exposure to rain, sun, cold weather and food can cause illnesses. The supernatural belief includes the wrath of spirits, invasion of spirits, default in conducting ancestral worship, breech in taboos and some practices warding evil eyes.

Environmental factors affecting health of the slum population include crowding and congestion, unsanitary surroundings, lack of proper sunshine and fresh air. The health is also affected by communicable diseases of digestive system such as diarrhoea as also of respiratory system like bronchitis and pneumonia. Information on health problems of the slum residents during one year are recorded by asking them what did they suffer from during this period.

The sanitation hygiene behaviour indicators chosen were as follows: access to clean drinking; using piped water always for drinking; covering their drinking water storage containers; storing water scoops off the floor; burial or burning of solid waste; disposing of waste water in pits, keeping domestic animals out of the house; home infested with flies; latrine in use by household; and latrine used by all household members, infant's excreta disposed of in latrine. All the households involved in the study have access to toilet facilities although the quality differs. Some of the toilets that the people use are unsafe and even illegal for human use.
Conclusion

The unsafe structures do not have proper ventilation; doors, roofs and even the seats are not stable and dangerous for young children. In places where there are no toilets people tend to use bushes and dongas to relieve themselves. In some cases the shortage of the facility is evidenced by human waste along the paths. The toilets were not properly cleaned.

The reasons for this and other differences we highlight elsewhere are to be sought in the education level, the housing condition, the income and standard of living of the slums. But when it comes to housing this difference is more telling. Majority of respondents 76% has been found having one room space in their houses. 19% of the respondent houses have two rooms accommodation. The story of flooring also tells the poverty of the slums. It is not only in the nature of housing but also in the amenities that slum houses lag behind. Only less of them have running water at home. But it is in the toilet facilities that the difference is appalling. Though slum households do have toilet facilities driving them to open grounds or public toilets that are very ill kept.

Thus the slum dwellers have to put up with poor and unhygienic housing conditions. They cannot afford anything better. While we did not rely on their statement of income because of the tendency for understatement, the expenditure data revealed that about 60 per cent of the slums and suburbs spend less than Rs.1500 a month.

Illness strikes them as a catastrophe. Those who were unlucky enough to be stricken had to spend money out of their meager income, as there are no insurance schemes worth the name. Persons in the slums who went for treatment, most of them borrowing and some pledging or even selling assets.

Large Urban Poor Population and Unmet RCH Needs Growing urban poverty- According to the census of 2001, Mysore city had a total population of 799,228 with 406,363 males and 392,865 females, making it the second largest city in Karnataka. 19% of the population in Mysore live below the poverty line and 8.95% of the population live in slums. The exponential growth in population
is driven mainly by influx of migrants to the city and most of whom settle down in urban poor habitations. Further, about half (10 per cent) of Mysore resides in urban poor habitations like resettlement and unauthorized colonies including slums. Poor Health Conditions- Commonly reported averages of the health status of the urban population mask the worrying health conditions of the urban poor. This report which disaggregates data by economic groups indicates the poor state of health of the urban poor in Mysore. Weak Policy Implementation- Over the years, a large number of policies and programs have been initiated with the objective of improving the conditions of the slum community. These include policies aimed at improvement of housing and basic services, environmental improvement in slums, generation of employment and community empowerment focusing on women, improvement of the status of women and children and ensuring food security. However, this has not been translated into effective programs which could have a significant impact on the health of the urban poor. Multiplicity of Service Provides and Weak Coordination and Convergence Health Services to the slum dwellers in Mysore are provided by a multitude of departments such as the Departments of Health, Social Welfare, Slum Development from different authorities such as MCD and GONCTD. There is weak coordination between these agencies. There is a lack of well defined catchment areas of the health facilities, instances of overlap in the catchment areas of two health facilities managed by different authorities and several health facilities operate from the same premises. Thus, there is considerable scope for synergy and the complementary use of skills and resources of the various departments for improving the health and well being of the slum dwellers in Mysore. Inadequate primary health infrastructure- The urban poor in Mysore are underserved by primary health care facilities. The rapid growth of population has also overburdened the existing health facilities rendering them ineffective to serve the needs of the urban poor. Some slum settlements are entirely uncovered by health services and the quality of services in others is seriously compromised. In urban poor habitations like Shanthinagar, urban public health infrastructure on
which the poor are most dependent caters only to 50% of the population in the area.

The health vulnerability of the slum dwellers is further accentuated by the poor environmental conditions. The situation analysis of slums in Shanthinagar in Mysore city revealed that most of the slums are located next to drains, lack access to safe drinking water and toilet facilities exposing the residents to increased risk of contracting a host of diseases. Increasing coordination and convergence of departments in-charge of water supply, sanitation and slum improvements with the health department is a pre-requisite for improving the health conditions of slum dwellers.

A multitude of factors like inadequate health services, lack of functional convergence among different departments and programs and inadequate capacity of urban local bodies result in poor health outcomes among the urban poor.

When we come to the reproductive health of women we notice the same trend as in general health the standard quite high, but lower than the non-slums. The survey found the menstrual health of both married women and adolescent girls to be good. But one interesting piece of information that came out is that nearly 19 percent of the women in the city get married before the legal age of 18, the proportion being nearly 20 per cent in the slums. One would not have expected this, given the comparatively high status of education in the city.

Perhaps it is poverty that drives the parents to lighten the burden earlier. Most of the married women have conceived at least once, but about 14 per cent in the overall sample had abortions. The fact that more of them in the slums and suburbs had more than one abortion than in the non-slums is a matter of concern. Nearly all of them had antenatal check up in the previous or current pregnancy, mostly starting in the third month. The number of antenatal visits is about 7, the slums showing no let up. Even in the components of the check up neither the overall sample nor the slums showed any shortfall. No wonder, the vast majority of them did not have any problems during pregnancy. As one would expect from a literate population living in a city with good health infrastructure, most of the
deliveries took place in institutions, slums falling slightly behind the other two areas. Again, the majority of them had normal deliveries without any problems resulting in live births, in the slums.

The next issue probed was the prevalence of contraception among married women. As the capital of the state well known for bringing down the growth of population in a relatively short period, one would have expected most of the women to use some form of contraception. But only about 59 per cent in the overall sample use them, slightly higher in the slums. This is even lower than the contraceptive prevalence rate of 66 per cent in the urban areas of the state as revealed in the National Family Health Survey conducted in 1998. The reason for this lower prevalence was the desire to have children and not lack of knowledge. But surprisingly, the desire for male child was not a great reason and was evenly matched by the desire for female child unlike in the other states. But why 41 per cent of the women do not use contraception in spite of knowing about it remains a mystery.

The awareness of AIDS, Sexually Transmitted Diseases (STI) and Reproductive Tract Infections (RTI) is an important aspect of reproductive health of women, adolescent girls and men. Our study revealed that among all these groups awareness is quite high, with some differences in degree. The awareness about HIV/AIDS is the highest among girls, followed by men and married women. But while about 77 per cent of the married women in the slums are aware of HIV/AIDS only 55 per cent are aware of RTI and 52 per cent of STI. This gap is noticed in the suburbs and non-slums as well as in the slums and is true about men and adolescent girls also. Government of India has special programme for increasing the awareness of HIV/AIDS through the National AIDS Control Organization, which seemed to have had its impact. But the same vehicle could have been easily adapted to spread the message about the other two important groups of conditions. Alas, this was not to be! AIDS is handled by the Department of Health while the other two are by the Department of Family Welfare, though both constitute the Ministry of Health and Family Welfare headed by one Minister of Government of India. The health activists who were interviewed were very critical of this lack of coordination.
Though a higher proportion of men are aware of STI and HIV than married women, when it comes to the preventive measures they woefully lag behind.

The population under the study being from the lower and lower middle class and their disposable incomes being very limited, it is natural that they have overwhelmingly indicated that, given the choice, they would prefer using public health services. This is so, because that is clearly the less costly option, while it also does not give rise to unnecessary medication, diagnostics and procedures. This would be true at the larger level across the country given the overall context of poverty. In today’s scenario, with accounting public investments and expenditure in healthcare and the introduction of user charges, the expectations of people, especially the poor, are being belied. The people have great faith in the public system and expect social support fro the state for services like health, education and housing – the three critical elements of social security.

The study brings out how a largely poor urban community in the biggest upcoming IT city in India is lacking access to public health-care services. The non-availability of a public hospital within or in close proximity to their locality and an inadequate number of public dispensaries makes life difficult, especially for the poor who too are forced to seek care from the private sector. The findings of the study clearly indicate that the potential demand for public health services is very high provided they are conveniently located and affordable. In fact, given the choice, a large proportion of users of private health services would prefer making use of public health services.

Given the responses on the unmet need expressed by respondents, it is evident that if public health care services were in easy access range and well provided, then 88 percent and percent of the population would use public health services for hospitalization and ambulatory care, respectively. This is in sharp contrast to the actual utilization pattern within the same community. This gap reflects the inadequacies within the public health care system, both with respect to numbers of physical access and in terms of adequacy of resources and quality of
care. By contrast, the private health sector fulfills those expectations yet at a tremendous cost to the patient.

Therefore, the state must assume a more proactive role in strengthening access and quality of care of its health services for its citizens. That would mean not only more resources to be allocated for health care in its budgets but also increased efforts into improving allocative efficiencies so that resources are better and more effectively utilized. For instance, even from the existing budgets, if more resources are allocated to dispensaries, if dispensaries and health posts are integrated, if a referral system for hospitals is put in place and graduate passing out of public medical schools compulsorily put in three to five years of public service as return for the virtually free medical education they have received, and other similar measures, then effectiveness of the public heath-care system will improve tremendously and it will regain the esteem and respect it enjoyed until recently.

We end by considering the significance of these findings. Ill health was a major shock in the slum households with 22% of households causing deterioration in financial status. The impact off illness shocks includes reduction of income, increased earner: dependency ratios and increased expenditure.
**Recommendations**

1) More effective education about hygienic menstrual practices could be a major contribution to improving women’s reproductive health, including reduction of reproductive tract infections.

2) The problems that beset the public health system and suggestions for improvement are listed below:

   a) Shortage of drugs and consumables in the hospitals- Allocate more funds in the State budget for health. Its share has come down from over 16 per cent in 1974-75 to under 12 in 2000-01. At least retain the old proportion. Also improve logistics of supplies.

   b) Shortage of manpower- Stop the practice of granting long leave to medical personnel for taking up employment abroad.

   c) Environment hazard in the slums - Drainage and waste removal must be attended to as priority. If the City cannot maintain public toilets, which many in the slums depend on, pay-and-use toilets may be introduced and the upkeep entrusted with private agencies.

   d) Heavy rush in the hospitals, especially in the secondary and tertiary units - The services being virtually free, all tend to rush to the secondary and tertiary units, while the primary ones lie unutilized. Attempts at making the former referral units have failed. No government can provide all services to all at all times. Providing free services to the rich is only depriving the poor of opportunities of better service. Introduction of user fee collection from those who can afford will fetch the much-needed revenue to the system and reduce the overcrowding. A small experiment is already in place where the Hospital Development Committees are allowed to charge user fees and utilise them for the development of the hospital. This should be expanded. Another suggestion is to develop a partnership with the private sector, which is well developed in the State.
3. Poor facilities for the aged - With the demographic transition and increased longevity, the proportion of the aged has increased in the State as per census report of 2001. Geriatric care should be introduced in the medical curriculum and NGOs encouraged and assisted to set up old age homes and provide home nursing.

4. Poor health awareness of the people - Better health education is called for. Community based organizations and NGOs should be roped in for this.

5. Financial burden of illness - This is the gravest problem and can be addressed only by an appropriate health insurance scheme that protects the poor against the financial risks from catastrophic illness. The city and the State with near 100 per cent literacy are ideally suited for introducing such a scheme. It can be thrown open to the private sector, but the need for regulating their practices and protecting the poor cannot be overemphasized.

Thus we found the slums and suburbs to have nearly the same general health and reproductive health status with some notable exceptions explained by poverty, lower education level and housing and environmental conditions. Our in-depth interviews revealed that the situation is remediable if there is political will.