The International Conference of Population and Development (ICPD) held at Cairo in 1994, tried to draw the attention for ‘Reproductive Health’ of the masses, both men and women. The ‘Reproductive Health’ program launched worldwide is a sequel to this concern. This program which had emerged from the initial ‘Mother and Child Health Program’ gave due importance to health of adolescents too. The adolescents are usually at the threshold of adulthood where usually a score of reproductive health problems may be encountered by them, especially the females, who undergo enormous changes due to unique function of bearing of children.

The prognosis of reproductive health problems depends on the health-seeking behaviour of the women. If she considers it as a problem, she may seek help of a treatment-seeking agency and on the other hand if she perceives it a normal routine affair she may neglect the particular reproductive health problem, which may deteriorate her health, especially the reproductive health, further. How did the slum women perceive these reproductive health problems and what was their treatment seeking behaviour in relation to these problems was the main research inquiry for the present study. To frame the conceptual model for the study, an attempt has been made to develop an integrated conceptual model, by using three models of Rosenstock (1966), Mechanic (1978) and Jejeebhoy (1997). This integrated model depicts that reproductive health seeking behaviour of a woman would be influenced by host of factors in a complex way. There are two types of determinants, which may effect the reproductive health status and subsequent reproductive health-seeking behaviour. These are background determinants (woman’s autonomy, economic status, accessibility of services, quality of services) and intermediate determinants (health status, nutritional status, reproductive status, health care behaviour). Thus rather than a simple medical problem, poor reproductive health should be considered a series of social, cultural and economic circumstances. Moreover a ‘culture of silence’ prevails among the Indian women themselves. Even the daughters are unable
to discuss the reproductive health problems with their mothers, especially when unmarried. Therefore, everything happening in regard to such matters is taken for granted and the suffering continues. In short, women’s position in the society has consequences for their health as well as for their experiences as consumers of health care. Since women wield less economic and political power than men, they are also more likely to be socially and psychologically dependent. The matriarchal subordination of women affects their lives in several aspects of reproductive health behaviour. Keeping this in mind the reproductive health seeking behaviour of the young females (10 – 24 years) living in the slums of Chandigarh, U.T. was planned, which was partly exploratory and partly descriptive in nature with the following objectives:

1. To enumerate the prevalence of reproductive health morbidities among young females of slums in Chandigarh.
2. To study the perceptions of these young females about their reproductive health needs.
3. To gain in-depth insight into their attitude, beliefs and knowledge relating to reproductive health problems, and to examine their consistency and inconsistency with prevailing practices.
4. To correlate the factors influencing the perceptions, practices and reproductive health treatment seeking behaviour of the respondents.
5. To identify issues pertaining to improvement in reproductive health services.

The initial phases of literature review and other resources helped the researcher to get acquainted with the various reproductive health terminologies and operational definitions. It provided an insight, to develop an interview schedule used for collecting data for this study. Several studies were identified for comparison for prevalence of reproductive morbidities among the respondents, patterns and preferences for seeking treatment for particular morbidities. Studies reviewed in literature provided not only the guidance to assess the perception of respondents regarding their general and reproductive health needs, but also their knowledge, attitude and practices relating to these needs.
A total of 386 respondents were selected from the four slum locations of Chandigarh. A multi-stage sampling technique was used for selection of the respondents. Data was collected, by personal observation and using semi-structural interview schedule. Qualitative information was generated by a dialogue process with the respondents. In a few cases, where the respondent was unmarried, interviews were conducted in the presence of mothers. However, in all cases only the respondents were interviewed in total privacy.

MAIN FINDINGS:

The main findings of the study are as follows:

Background Profile –

Background profile of the respondents helps in understanding the socio-economic framework of the slums and the ways in which the rights and obligations of the individuals are socially defined. The analysis revealed that:

- The larger population (62%) of the study population had migrated from other states with low health indices (OBIMARU), as per national index. Majority (73.1%) had their own houses and 48.4 percent of total respondents were staying in kutchha houses. Almost 62 percent lived in single room dwellings, with 40 percent of the respondents having a density of 3-4 persons per room.

- Only 59 percent had access to safe water supply from the municipal tap, while 67 percent had no toilets and had to go for open-air defecation. Thus water supply and sanitation of these slums are at a lower ebb. Almost 90 percent had electricity connection (either legal or illegal) and almost one-fifth used LPG as fuel for cooking.

- Majority (77%) had a cycle and 16.6 percent owned a scooter as a conveyance. Almost 64 percent had a television, with 41 percent having a cable connection, making them accessible to media and communication. Eighty-five percent respondents also owned a radio or stereo.

- Educational status of the respondents was quiet low. Forty three percent of them were illiterate and another 24.6 percent were educated up till primary level. Only 4.2 percent had education of more than class tenth.
The mean age of the respondents was 17.97 years; 89 percent of them belonged to Hindu religion and 82.6 percent were either scheduled castes or lower castes. Almost 51 percent were ever married. About 74 percent were living in nuclear families, with a mean household size of 5.38 persons. Majority of the families comprised of 5-8 persons.

A majority (three-fourth) of the respondents were non-working. The rest 25 percent of working respondents comprised mainly maidservants (20%), rag pickers (1.6%) and petty jobs (3%), etc. The average income of these respondents was Rs.153.1 per month. The heads of the families of almost 45 percent were engaged as sweepers, maidservants, labourers, etc. Per capita income of the respondent’s families ranged from as low as Rs.167 to as high as Rs.5333, with a mean per capita income of Rs.891. Thus overall it indicates that the study population belongs to lower socio-economic status.

**Nutritional and Reproductive Health Profile -**

The respondents were assessed for their nutritional status, before proceeding to reproductive health profile, since nutrition has an effect on almost every aspect of health. The main findings of this chapter were:

- Seventy percent of the respondents were undernourished as per WHO classification of Body Mass Index (BMI). While only 2 percent were found to be obese, the mean BMI was 16.77, which is almost 8.3 percent less than the normal BMI of 18.5.

- An inverse relationship was found between BMI and age, marital status, type of family, migration status and per capita income of the family, though the caste, religion, household size and educational status of the respondent had no obvious effect on BMI status.

- About 86 percent of the respondents had attained menarche at the time of study. Out of these only 32 percent respondents knew about the menstrual process before its initiation, where the main source of knowledge was friends (50%) and sister / sister-in-law (30%).
• Among the non-menstruating respondents only 33 percent had heard or knew something about menstruation and among them 44 percent came to know about it from sister / sister-in-law. None of them could tell exactly about the menstruation process.

• More than 57 percent of the menstruating respondents observed one or more restrictions during menstruating days and 99 percent of them observed these on all the days of menstruation. Majority (71%) avoided going to holy places, taking prasad, keeping fast, etc, because the body is considered impure during these days. The main reason for these restrictions observance was that elders asked them to do so, though they themselves did not know the rationale behind it.

• The mean age at menarche was 13.74 years and the mean age at marriage was 15.37 years.

• Interestingly, a mean difference of 1.63 years had been found between menarche and marriage and a mean difference of 2.09 years between marriage and age at first delivery, which is 17.46 years.

• By the age of 24 years, almost 40 percent had three or more conceptions and 7 percent had 5 – 6 conceptions.

• Out of 331 respondents, who had started menstruating 61 percent reported one or more reproductive health problems. Menstrual problem was the most common among 39 percent respondents, followed by antenatal problems in 20 percent and lower backache in 15 percent of the respondents.

• A total of 364 problems were found in 203 respondents with a mean of 1.79 reproductive health problems per woman. The number of problems ranged from 1 to 8 among them.

The present study has shown a slightly lower percentage of women reporting reproductive health problems than those found in literature review. But since there was no provision for investigation and referral follow-up, a much higher prevalence can be expected than as reported by 61.3 percent respondents.
Prevalence of Reproductive Health Problems and Treatment Seeking Behaviour-

Nowadays more and more facts are being observed wherein it is found, that reproductive morbidity issue is deeply rooted in the marginal status of women in the Indian society. Due to ‘culture of silence’ that envelops women, most of them do not seek health care till it becomes an emergency. Most of these reproductive health problems are associated with complications, which are both physiological and psychological as well. Therefore, to assess the nature and burden of reproductive morbidity among slum women, the most likely nine reproductive health problems, which could be found among females of 10 – 24 years, were enlisted and data collected and analyzed. These reproductive health problems are:

B] Excessive vaginal discharge.
C] Lower backache.
D] Prolapse of uterus.
E] Urinary problems.
F] Antenatal problems.
G] Postnatal problems.
H] Conception problems.
I] Contraception problems.

Some major findings regarding prevalence of the above reproductive health problems and treatment seeking behaviour for these problems are given below:

A] Menstrual problems

About 39 percent of the respondents reported menstrual problems, and dysmenorrhea, was the most common complaint reported by 61 percent respondents. Almost 90 percent had discussed the menstrual problems with their social contacts, among which a majority (63.8%) preferred mother and sister, while medical personnel were preferred by the least (3.4%). Out of a total of 129 respondents reporting menstrual problems only 36 percent took treatment for these problems. Two-third (67.4%) had taken the treatment on the same day (for dysmenorrhea), while 4.3 percent took treatment after one
year of commencement of problem. Almost 64 percent had consulted only one treatment-seeking agency while self-medication was the most common mode of treatment. Among the respondents who did not seek treatment, 41 percent considered it normal to have the menstrual problems, while 18 percent respondent’s family did not allow them to go for any treatment. The money spent for taking treatment for menstrual problems ranged from Rs.2 to Rs.2000.

B) Excessive Vaginal Discharge

Excessive vaginal discharge was reported by 13.9 percent respondents, for a duration ranging from 1 month to 8 years. About one-fourth (26.1%) never discussed this problem with others. Less than one-fourth (23.9%) of the respondents, who had this problem, had at some time taken treatment over a period of 1 month to 3 years, while rest three-fourth never took treatment since they considered it a normal phenomenon. The money spent for this problem ranged from Rs.50 to Rs.2000. Since it recurred most of the time, many respondents either tried various agencies, or left the treatment in between.

C) Lower Backache

About one-sixth (15.1%) respondents reported having lower backache for a period ranging from 1 month to 4 years. Eighty-six percent of them complained having backache for fifteen or more days every month. Though the problem has been discussed by almost three-fourth (74%) of the respondents, but only 44 percent of them ever sought some treatment. Here too self-medication was the most common mode of getting relief from the symptom among 81.9 percent of the respondents. The money spent for this problem ranged from Rs.2 to Rs.200.

D) Prolapsed Uterus

The uterine prolapse was reported by only 3.3 percent of the respondents, but since respondents were young, even this percentage is of concern. About 54.5 percent had talked about this problem while only 18.2 percent sought some treatment. Rest 81.8 percent again considered this
normal. The treatment costed about Rs.50 to Rs.500 among various respondents. The duration of problem ranged from 1 month to 8 years.

**E] Urinary Problem**

A total of six respondents, which comprised 1.2 percent, had reported problems related to urinary tract, which included frequent urge to pass urine, difficulty while micturation and incontinence of urine. Almost 80 percent of them related it to their delivery conducted at home by a traditional birth attendant. Only one respondent had sought treatment, others considering it normal did not seek any help-seeking agency.

**F] Problems Related to Pregnancy**

Among the respondents, who were pregnant at the time of study, almost 38.6 percent had some problem, while for the last pregnancy this figure stood at 42.4 percent. In contrast to other problems, more than 90 percent for current pregnancy and more than 98 percent for the last pregnancy had discussed their complications with their social network. For both pregnancies husband had been the most prominent person to be told about their problems. The non-consultation was very high at 58.2 percent, and 86.4 percent respectively for the respondents who did not seek any treatment for the past and current pregnancy problems. Majority of the respondents had consulted only one agency. Regarding the antenatal check-up (ANC) less than one-fourth (22.3%) and more than three-fourth (80.2%) had gone for it during current and last pregnancy respectively. Majority of them had gone for ANC in the second trimester. Government dispensaries and hospitals had been preferred by more than 80 percent in both the pregnancies. Only 36 percent and 35 percent had tetanus toxoid, while 27 percent and 56 percent took iron supplementation during the current and last pregnancies respectively, though not a single respondent had consumed all 200 prescribed iron tablets, due to various reasons. A little less than half (48%) for the current pregnancy and more than half (67%) for the previous pregnancy had either planned or had delivered at home by a traditional birth attendant. Though majority had gone
for ANC in the government hospitals but in case of any problems during the pregnancy they preferred to consult private practitioners. The money spent ranged from Rs.0 to Rs.1000.

G] Postnatal Complications

The respondents were also asked retrospectively to report for any illness during their last post-delivery period. About 14 percent respondents reported some sort of illness. A large proportion (64%) did consult some treatment-seeking agency for this postpartum complication and private practitioners again were the most preferred agency. The respondents had spent money in the range of Rs.25 to Rs.1000 for treatment of postpartum complications. Among 36 percent of the respondents who did not consult any help seeking agency, majority (75%) respondent’s family did not allow them to seek any treatment for these problems.

H] Problems Related to Conception

As per the findings of this study, 22 (11.2%) respondents did not conceive till the time of study. Out of these 22, six respondents comprising 27.3 percent had been married for less than a year and thus had been excluded. The rest 8.1 percent respondents out of the total respondents were termed as infertile, since they did not conceive inspite of continuous cohabitation with their husband. About 62.5 percent respondents had taken the treatment for their conception problem. The number of agencies consulted had been considerably more for infertility in comparison to other problems discussed so far. The money spent for this problem ranged from Rs.50 to as high as Rs.20000, which suggested that these people want a child at any cost, even if it means spending more than their economic capacity. Out of them, 44 percent had at one time consulted a magicotherapist for their non-conception problem.

I] Problems Related to Contraception Use

Only 32 percent of the respondents reported using a contraceptive, which is much lower than the national figure of 41 percent. Out of the 32 percent who were using some contraceptive, almost (one-third (31.6%) had
female sterilization, while 22.8 percent used condoms. Less than one-fifth
(17.5%) had an Intra-Uterine Device insertion i.e. CUT. The main source of
adoption of a contraceptive was a government dispensary/hospital and the
main source of knowledge, was the husband among 33.3 percent respondents.
The media did not play much role in disseminating the knowledge which was
reported by only 5.3 percent respondents. Six respondents (10.5%) reported
experiencing some problem due to the contraceptive use and all of them were
IUD users. Thus almost 30 percent of the total IUD users among the study
respondents had reported a problem. Only two respondents sought treatment,
while the rest considered it normal. Both of these respondents went for free
treatment to a government agency. About 27.2 percent of the respondents,
who did not adopt any contraceptive, wanted more children, 12.4 percent
wanted another male child and 11.6 percent had lactational ammenorrhoea.
Interestingly, none of the respondent’s husband had undergone sterilization i.e.
Vasectomy.

**Respondent’s Perception of Reproductive Health**
Perception is the meaning given by an individual to a particular event,
which is usually the result of a variety of experiences both social and cultural norms
and values that are expected from the individual by self and the society at large. That
is why different people tend to respond to different symptoms of health and illness
differently. The respondents were enquired about their attitude and perception
towards health and reproductive health in the present study. The salient findings of
this chapter were as follows:

- Only less than one-tenth (9.7%) perceived themselves to be on the highest Likert
  Type rating scale of 10. Almost three-fourth (77.5%) rated themselves on 5 or
  below this scale. Approximately one-fourth (24.1%) perceived to have full
  control on their health, while another 22.3 percent had either some or good
  control. Rest 53.6 percent either did not know or had no control at all.
- Only one-third (35.9%) of the respondents emphasized on consuming good diet
  especially milk and milk products to keep healthy, whereas rest 64 percent said
that they did nothing to care for their health. Doing exercises, yoga and going for
walk was the activity to keep healthy as perceived by almost 77.7 percent, though
they did not perform them due to time constraints, shyness, etc.

- The respondents were not very well aware of what constitutes good reproductive
health. Majority (83%) said that having regular menstrual periods means good
reproductive health, while many (80%) said that absence of any illness of the
reproductive organs constitutes good reproductive health. More than three-fourth
(77.3%) perceived ability to reproduce children as a sign of good reproductive
health.

- For a majority of the respondents, the decision of treatment seeking agency in case
of sickness rested mostly with either their mother (55.4%) or husband (22.5%) and
similar was the case with buying ration for the house. The respondents had
maximum say in buying clothes for themselves (43%), which indicates the
importance given to outwardly appearance. Many of them were allowed to go
alone to buy clothes, but not to a doctor in case of sickness.

**Treatment Seeking Behaviour with Selected Variables**

The treatment seeking behaviour invariably depends on many factors
viz. their own perception, society’s view, social context reference, decisive ability of
the individual, their socio-demographic variables (education, caste, economic status,
family type), etc. That is the reason why different people react to the same situation
or same health problem in a different way. With context to this, six hypothesis
relating to educational status, migration status, economic status, working status, type
of family and caste of the respondents were put to test and the following results were
observed:

1. Hypothesis stating that reproductive health seeking behaviour would vary
among literate and illiterates is partially accepted. A mixed trend for reproductive
health problems among the respondents was observed. For only one problem (i.e.
menstrual problem) out of a total ten, the more literate women reported higher
prevalence, while for six problems, it was the opposite. For three problems of
antenatal complications (both present and past) and postnatal complications the
results were inconsistent. There was no statistical difference in discussing their problems with their kith and kin among various categories of literates, except in case of excessive vaginal discharge and present antenatal complications where illiterates and lesser-educated discussed more than the literate. The postnatal complications had been discussed by all, whosoever had reported, irrespective of their educational status.

Regarding the treatment taken, the indicative trends observed were that a higher number of literates used available reproductive health services, but the results were statistically insignificant. For menstrual problems and lower backache, the modal treatment preferred was self-medication, since analgesics were well known to almost all the respondents. The educated knew by name and the illiterates preserved the empty cartons of the medicine, which they could procure on their own over the counter from the chemists. Again for contraception problems, all the groups preferred government agency. The reason for this could be that, the agency for procurement for most of the contraceptives had been the government dispensary or government hospital. Therefore it can be said that education does not have much influence on the health-seeking pattern for reproductive health problems. Irrespective of their educational status all the females observe ‘culture of silence’ and most of them are exposed to the same type of environment in these slums and thus acquire the same culture from each other, thus it seems education has very limited role to play.

2. Hypothesis stating that migrants are likely to avail lesser health facilities than the non-migrants, who may have more orientation to these facilities stands rejected. Migrants had reported more number of problems, than the non-migrants. The mean reproductive health problems per women were also higher among the migrants, which was statistically significant too. But when specific reproductive health problems were analyzed in relation to migration status, two problems of excessive vaginal discharge and contraception were found to be more prevalent among the non-migrants. Overall results observed had been statistically significant results for only four types of reproductive health problems viz.
menstrual problems, lower backache, urinary problems and postnatal complications.

There was no obvious difference in pattern of seeking treatment for these reproductive health problems, though the agencies preferred varied for antenatal complications, prolapse of uterus and contraception problems. Migrants preferred the private allopathic doctors than the non-migrants. As already discussed, migrants may face challenges, due to financial, social and cultural differences in their places of migration. It was assumed that they might not be aware of the health facilities available in and around their residences. Contrary to this, the results of this study show that there was not much difference in the treatment-seeking behaviour among the two groups for reproductive health problems. The reason for this could be the pattern of migration, in this part of the country. It has been generally observed that the people who had long ago migrated, tend to bring in their kith and kin here. The newly migrated, most of the times either shares the dwellings of their relatives who have brought them or they tend to build their own hutment near by. Therefore, they are usually not at a disadvantage in case of their surroundings. They are made aware of all the facilities available by their relatives, neighbours, etc. Another fact, which had been observed, is that even if the new migrants do not have any relatives of their own, they tend to have fictitious kinship. Therefore the people from the same village or same district or even same state, who try to build up some relations, some common sharing, thus becoming a part of a ‘fictitious kinship’. A very well defined cohesiveness has been found to occur between such groups. Therefore, it is assumed that their behaviour regarding morbidity also would not differ much. Another factor for these diminished differences between migrants and non-migrants may be that migrants tend to be innovative and flexible as suggested by Armstrong (1995). Thus it may not take them long to learn about hospitals, clinics and other reproductive health care services and this is what the results of present study had shown.

3. Hypothesis stating that economic status of the family would make the difference in seeking reproductive health services stands rejected. Although it was observed
that more women suffering from single reproductive health problem belonged to lower socio-economic status group, but no consistent pattern was observed for higher number of morbidities among the respondents. The probable reason could be their cultural context in which they are staying. It is usually seen, that people of different cultures start adopting each other’s cultural and social views, while staying together e.g. festival of Diwali is celebrated by most people in India, irrespective of their religion, caste and creed. Similarly, it is assumed that when these slum dwellers are staying together, they too start behaving in the same way as their neighbours do. Like their diets, jobs and interests, people’s fertility preferences and other reproductive behaviour too change as they become integrated into their surroundings. Another probable reason could be that respondents from lower socio-economic status group have probably not reported about these reproductive health problems, since they accept it as a normal phenomenon. In almost six reproductive health problems i.e. in case of lower backache, vaginal discharge, prolapse of uterus, urinary problem, postnatal complications and conception problems, or the higher socio-economic status group respondents might have exaggerated their problems in order to attract more attention. On the other hand, the treatment-seeking behaviour for most of the problems had been the same within three socio-economic status groups wherein any socio-economic status group had not preferred government services.

4. Hypothesis stating that since working women are usually self dependent, and are more likely to decide for themselves, while the non-working will have to ask for approval of her husband if married or father if unmarried. The analysis partially accepts this hypothesis. Though there was statistical significance in occurrence of reproductive health problems among the two groups, but treatment-seeking pattern was not very different. Both the groups had same agencies as their modal agency for 50 percent of the reproductive health problems (menstruation, vaginal discharge, lower backache, postnatal complications and contraception problems), but still it could be seen that working women had consulted more number of help seeking agencies (five) than the non-working, who had consulted only three types of agencies. Another salient difference observed was in case of problems relating
to conception, where the working respondents preferred either government setting or magicotherapist, while the non-working respondents preferred the costlier allopathic private practitioners.

5. Hypothesis stating that the reproductive treatment-seeking behaviour of the females will vary according to the type of family in which they live stands partially accepted. There was no significant difference in the reported prevalence of various reproductive health problems among the two groups. The respondents living in joint families refrained from discussing their reproductive health problems with other people, except in case of menstrual and antenatal problems, which is contrary to the belief that the joint families may give females a wider social context for discussing their reproductive health needs and the senior females may help the respondents to decide for the treatment. Out of a total of ten reproductive health problems, seven problems have been discussed by larger percentage of respondents among those living in nuclear families. But the treatment-seeking agency was different in four of the reported reproductive health problems. The respondents staying in joint families contacted more types of agencies, which tend to suggest that more females in a joint family means giving more suggestions regarding types of treatment to be taken, while respondents in nuclear families approached only either the government agencies or private doctors, around their colonies.

6. Hypothesis stating that reproductive health seeking behaviour would differ among different castes, in the society stands partially accepted. Though there was no statistical difference either in reported occurrence of these problems among the two scheduled and non-scheduled caste groups, or regarding discussion with their social contacts, but treatment-seeking agency had varied among the two groups. While the non-scheduled castes preferred only private (allopathic) doctors and self-medication (only for lower backache), the scheduled castes experimented with varied help seeking agencies, which included government agencies and traditional birth attendants too. Thus, it can be seen that the behaviour of both scheduled and non-scheduled caste respondents do not differ much. Caste
disparities are not significantly reflected in their behaviour for seeking treatment for reproductive health problems, which may be because they belong to the same ‘culture of poverty’ and thereby compete for the same level of resources. The social interaction in these slums is not usually restricted by casteism. People from different origins get together and as already discussed earlier, start accepting each other’s norms and behaviours, thereby giving a picture of uniqueness to these slums. Caste disparities may reflect in certain spheres like eating, social gatherings, etc. but as far as treatment-seeking behaviour for reproductive health problems is concerned, it is not very clearly differentiated.

Therefore it can be seen that the present study does not totally support the typical findings, of other studies which have examined the general health-seeking behaviour and have been reviewed earlier. In the theoretical framework constructed for the present study, we stated that the reproductive health status would be influenced by background determinants (women’s autonomy, economic status, accessibility and quality of services) and intermediate determinants (health status, nutritional status, reproductive status and health care behaviour). Moreover morbidity related to reproductive health is also directly influenced by the bio-social, bio-physical and bio-psychological aspects of an individual. However this study has only partially supported these assumptions.

There could be various reasons for this partial acceptance, of some of the hypothesis proposed in this study. The foremost reason seems to be the typical nature of the population studied i.e. the slums. Though few studies had reflected on prevalence of reproductive health problems and their treatment-seeking behaviour among the slum populations, but they have not examined the relationship between reproductive health problems by any background variables. In all these studies, slums have been assumed to have a homogenous population. However in the present study the slums have been treated as having heterogeneous population and as such the social, economical and demographic background has been taken into consideration while analyzing reproductive health seeking behaviour. The differential background of the respondents reflected on their belief systems, norms and values particularly
when they come from different cultural areas and settle in such urban locations. At
the same time their proximity to the urban living, exposure to urban environment and
mass media may influence their behaviour in a great deal and induce some changes in
their normative and behavioural patterns. As a matter of fact many of the residents
particularly in the slums, though belonging to socio-economic and cultural
heterogeneity tend to homogenize on certain aspects of their behavioural responses.
Treatment seeking behaviour appears to be one of these aspects and as such, is not
very strongly influenced by their socio-economic and cultural heterogeneity.

It may be emphasized that deep-rooted cultural values and normative
behaviour usually does not dissipate in the short run. People cling to these values and
perhaps celebrate these more eloquently when placed in a new environment in order
to preserve their cultural identities. But they are given space for adjustments and new
expressions in few locations in order to maximize the benefits, and adopt a pragmatic
approach for social and economic adjustments. Therefore, in spite of the fact that
there are internal differences among the respondents in this study, with respect to their
education, socio-economic, migration, occupation, caste and family status, there is an
integrating force of urban living which tends to overwrite such differences in having
access to service sectors e.g. health, education, housing and so on. The
homogenization process sometimes is gradual while at other times spontaneous of
making use of the social sector services. Thus a new blend of socio-cultural values
emerge among these groups living in urban settlements, slums in this case, through
their physical, social and environmental proximity with the urban society. Thus the
people living in such locations show an emergence of a society, which is
contemporaneous with the modern society and incorporate those mechanisms that
may be functional and pragmatic for their existence of the people living in such
places. Therefore, people living in slum areas may have dualism of traditional value
systems, of their place of origin and a new blend of modern value systems, which they
derive and adopt in the urban setting. The former tend to stress on retention of
individual or group identities in socio-cultural spheres while the latter is responsible
for their socio-economic adjustments and lead to their homogenization process. This
homogenization process can be attributed to the impact of either the media (85%
owned a radio / stereo, 64% had T.V. and 41% had cable connection), or their interaction at informal levels with their employers, peers, neighbours, etc., who are more likely to influence them and thus create homogenization tendencies in seeking reproductive health care. It has been observed that people, who have settled together after migrating from the same origin, usually help each other. Rather at the first instance, a majority of them came to these slums at a known address where a relative, co-villager or a person from the same caste, religion or region lived. Most of the times these older residents act as agents for the newer residents and over the years, this process results in the formation of well-defined settlements inhabited with stable population that develops its own local community. Though superficially these slums manifest heterogeneity of several castes, regional or religious groups, however when grouped together in these sub-urban settlements, they exhibit a kind of homogenization process, with a well-defined cohesiveness. Therefore it may be assumed that their behaviour regarding the said reproductive health morbidity also would not differ much. Hence, the findings of the present study are somewhat different than the already known findings in the existing literature on health seeking behaviour. This study is a step forward in analyzing in detail the reproductive health-seeking behaviour among adolescents living in the marginalized areas of urban settings. Further detailed and in-depth studies are needed in the area, for comparative purposes and to generate systematic knowledge for policy and program support and interventions.

RECOMMENDATIONS

In the post Cairo era, which had created a euphoria on reproductive health, many glaring changes have taken place worldwide. Therefore nowadays, instead of just the mother and child health, the reproductive health strategy of health development programs of all countries promote essential health care packages with priority to reproductive health interventions such as (i) safe motherhood; including care of newborn, (ii) family planning / spacing, (iii) prevention and management of complications of abortion, (iv) reproductive tract infection and other sexually transmitted diseases including HIV infection and fertility and (v) adolescent reproductive health.
On the basis of experience and the results obtained in the present study, the following recommendations are being made:

- In-depth prospective research, both quantitative and qualitative is needed to study the links between the socio-economic status and culture on the woman’s reproductive health, especially in the marginalized communities such as slums. The prospective studies may provide vital clues to the type of behaviour people exhibit while they experience reproductive health problems over a period of time.

- A different kind of methodology is needed to access more accurately the true cost of reproductive morbidity and mortality to the society as a whole.

- The period of migration may have some influence on the reproductive health-seeking behaviour. Thus, an in-depth study may be carried out by comparing the period of stay of migrants in these slums.

- Both prospective and retrospective studies need to be carried out in various settings and then compared, in order to observe the effect of the social, demographic, economic and cultural contexts on their reproductive health.

- Discrepancies have been found between women’s perception and expression of their needs and biomedical assessments of their health, thus limiting their seeking of appropriate health services. Therefore, indicators which are based on women’s own reporting may not be sufficiently accurate, thereby resulting in under-reporting of prevalence of reproductive morbidities.

- Innovative strategies for education in reproductive health need to be initiated in schools, as well as in adult literacy programs. An appropriate package of information needs to be developed for special groups like young women in these slums. The approach should empower women to take decisions regarding their reproductive lives, involving young people in the development and implementation of programs and services, making greater efforts to reach the poorest of the poor, the marginalized and the excluded, and also invoking men to
assume greater responsibility for reproductive health of their own as well as their better halves.

- Adults need to be sensitized in providing a more supportive environment for young people. Many young people, especially the educated expressed that they could discuss sexual and reproductive health matters more openly with their parents, teachers and others. For this, these adults need to develop skill to understand the adolescents’ development and perspectives keeping in view the changing modern times.

- Women’s empowerment, which includes both social and economic alleviation, can play an important role in better utilization of reproductive health package. These may include measures such as nutritional support, health care support, better vocational training and employment opportunities for women and more stringent actions for mitigating the suppression of fairer sex, etc.

- Efforts should be made to make available the services of female gynecologists or female general practitioners in these colonies and slum dispensaries, which are operated by the government. It has been observed that, usually these poor women who are orthodox, shun from visiting these government agencies, if male doctors are present. Moreover, sometimes the patients have to follow cumbersome procedures, for getting investigation, since these are not available in these dispensaries. On the other hand private practitioners have most of the facilities available for diagnosis either within their clinics or they tie up with laboratories in and around in these very slums, so people prefer going to them. Another major setback why people prefer private practitioners to the governmental settings is the availability of the doctors, all seven days and till late hours in the evenings, while government dispensaries are open only on working days and that too till about 2.00 p.m. So the government needs to take some stringent steps in order to achieve the goals set by the government itself, otherwise the ‘Reproductive Health’ euphoria will also gradually diminish as has other mother related programs, floated from time to time.