

Assessment of health status of women in urban slum

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Abstract

Women's health is increasingly recognized as an area that has emerged because of an increase in women's demand for unique health care services that consider gender, life circumstances, education, and religion, economic and socio-cultural environments. The three major constructs related to comprehensive women's health outcomes include personal factors, the health system factors, and social, economic and cultural factors. The present work is a cross-sectional study designed to examine the perceived and actual health status and health practices of women aged 18 to 64 years during the period December to March 2012. The health status survey a structured questionnaire was used. The results indicate that the perceived health condition by the women is good as a fact that in spite of many health effects they were not in medication and doesn't visit a doctor.

Key Words: Slum; Women Health; Living environment; Nutrition.

Introduction

When humans started to live in large numbers in close proximity to each other approximately 5,000 years ago, health challenges included the import of water, food and other essentials to the population and transport of excreta and other waste products away from the population. Many million people in low-income and informal settlements in cities of our own era face similar health challenges (UN Habitat, 2003; Garau *et al.*, 2005). As most of the urban slum dwellers live in tropical countries, their health is also threatened by a variety of tropical diseases influenced by social and environmental determinants (Utzinger *et al.*, 2006). Health equity can only be achieved by leveling up living conditions for the poor (Dahlgren and Whitehead, 2006) and by reducing differential exposure and vulnerabilities among different groups in society.

Like most cultures across the world, Indian society has deeply entrenched patriarchal norms and values. Patriarchy manifests itself in both the public and private spheres of women's lives in the country, determining their 'life chances' and resulting in their qualitatively inferior status in the various socio-economic spheres. It permeates

institutions and organizations and works in many insidious ways to undermine women's right to dignified lives. There are similarities in women's lived experiences due to such gendered existences. However, in a vast and socio-culturally heterogeneous country like India, women's multiple and often special needs are played out on a variegated terrain of age, caste, class and region resulting in a complexity of experiences. Traditional bases of social stratification such as caste and class reproduce themselves in women's lived experiences as also do rural-urban and regional disparities. New needs emerge as women progress through the life cycle. Talking about women's health and access to healthcare in such a complex setup thus poses a challenge (Manasee Mishra, 2006).

Women play a major role in determining the health of the community since women are often health caregivers and recipients at the same time. Therefore, women's health must place a higher priority on understanding a woman's health care needs (Hill & Mullett, 2005). The health of the population is influenced by the demographic characteristics and socioeconomic status of that community, types of health care services available,

quality and types of health care providers, medical technology, and health knowledge available (Abbasi, 1999; Kaplan *et al.*, 2005). Women’s health care services are an imperative global health need. However, providing comprehensive women’s health services across women’s life spans challenges health systems in both developed and developing countries (Raymond *et al.*, 2005). The World Health Organization (WHO, 2006) has determined women’s empowerment to be related to quality of life and human rights. One objective of the WHO and World Bank (Abbasi, 1999; WHO, 2007) is to improve women’s contributions to the local economy by ensuring adequate health care services. This descriptive study examined women’s health status in city of Visakhapatnam.

Methodology

We undertook a question survey, of a convenience sample of 100 heads of households living in the city of Visakhapatnam. The questionnaire consisted of two heads – a) demographic data and b) health effects perceived by the participants. A consent and confidentiality statement was read aloud, and the interview conducted with subject consent. Interviews took place from December - March 2012. Interviews

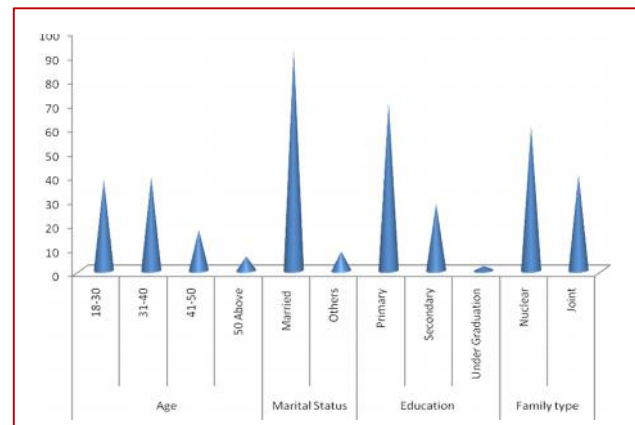


Fig. 1a. Demographic profiles of participants

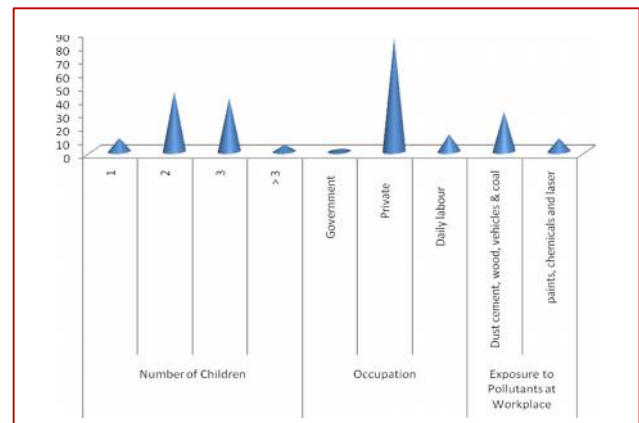


Fig. 1b. Demographic profiles of participants

Variable		%
Age	18-30	38
	31-40	39
	41-50	17
	50 Above	6
Marital Status	Married	92
	Others	8
Education	Primary	70
	Secondary	28
	Under Graduation	2
Family type	Nuclear	60
	Joint	40
Number of Children	1	10
	2	45
	3	40
	> 3	5
Occupation	Government	2
	Private	85
	Daily labour	13
Exposure to Pollutants at Workplace	Dust cement, wood, vehicles & coal	30
	paints, chemicals and laser	10

were conducted in one sitting for duration of 15–20 minutes.

Results

A sample of 100 participants agreed to participate in this study from the slums of Visakhapatnam. The participants were females ranging from 18–69 years of age with an average age of 43 years (Table 1). 92% of the participants were married, with only one 8% unmarried and remaining being divorced and widows. The majority (70%) had received only primary education while 28% of them had secondary education and only 2% being undergraduates. 60% of the women were from nuclear family and 40% of them hail from joint families (Fig.1a). 85% of the women had 2–3 children. 85% of the women work in private organizations, whereas 13% work as daily labors, 2% being government employees working in municipality. About 40% of the

participants expressed exposure to various pollutants at their workplace. Out of them 30% of them articulated regarding dust from cement, wood, vehicles and coal etc. Other 10% of the exposures, regarding paints, chemicals and laser (Fig.1b).

Living Conditions

All families lived in one to two room dwellings, in a kachha house (Table 2). An average of 5 people lived in each room. When asked regarding ventilation of the house 80% were only satisfied with their house ventilation and only 12% had excellent ventilation, remaining reported poor ventilation. Drinking water was from a tube well for few, the rest used city tap water, also sharing one tap among many. Electricity was available to all the families. 50% of the participants had a LPG stove for cooking whereas remaining 50% cooked their meals in or just outside their homes using kerosene and wood (Fig.2).

Table 2. Living conditions of the participants

Variable		%
No. of Rooms in House	1 - 2	100
	2 - 3	20
No. of People per room	4 - 5	80
	Excellent	12
Ventilation	Satisfied	80
	Poor	8
	Nuclear	60
Family type	Joint	40
	Tube Well	8
Drinking Water	Municipal Tap	92
	LPG	50
Type of Stove for Cooking	Kerosene and Wood	50

Nutrition

Rice and vegetables were consumed daily by all (Table 3) but foods with higher protein content were consumed daily by less than 20%. Meals were consumed three times per day in 89% of families. When asked: "Do you feel that your family eats a balanced diet and receives proper nutrition?" 70% responded negatively.

Health Effects

A total of 16 different health effects were reported by the respondents. Allergies, Anemia,

Asthma, backpain, bodypain, fatigue, gastritis, gynecological problem, hypertension, headache, joint pains, knee-pain, kidney problem, low blood pressure, urinary problem and thyroid. Most predominant beings are headache (31%), Anemia (28%), fatigue (24%) and backpain (17%). Few of them have also reported unexplained fevers (Table 3).

Table 3. Nutrition, Health Effects and Health Care trends of the participants

Variable		%
Daily food intake	Rice and Vegetables	100
	Protein Food	20
Health Effects	Headache	31
	Anemia	28
	Fatigue	24
	Back pain	17
Perception of their Health Condition	Excellent	2
	Good	80
	Poor	18

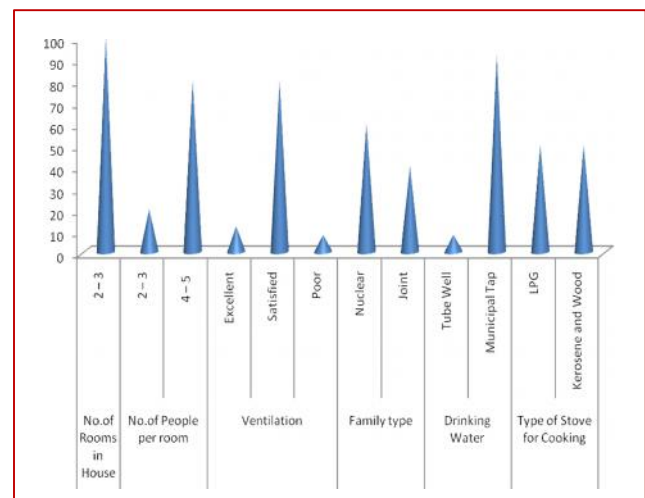


Fig.2. Living conditions of the participants

Health Care

Only 1% of the participants were under treatment and regular medication. When asked why not visiting a doctor with these health effects all they had to answer is that it will be expensive for them. When inquired regarding their perception of their health condition 80% of them agree that they have good health, 18% as poor health and only 2% as excellent health condition (Fig.3).

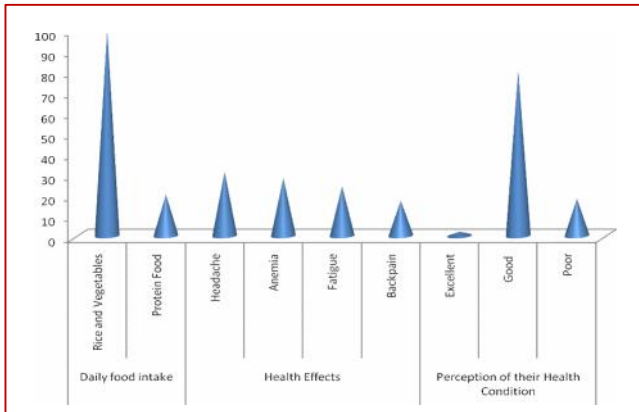


Fig.3. Nutrition, Health Effects and Health Care trends of the participants

Discussion

This study describes the subsistence of 100 participants living in the slums of Visakhapatnam. Participants are living in kachha houses with an average of 3 children per household. They were educated till primary and secondary levels, lived in unhygienic and difficult conditions, worked in the informal service sector and consumed a diet low in protein. Health concerns included a variety of acute and chronic conditions and difficulties accessing health was mainly due to poverty. The findings of this study are comparable to results of the 1995 Study of Urban Poverty in Bangladesh in which poverty was defined by monthly household income of 2264 BDT (\$66 1995 USD) and 2313 households were evaluated. Compared to the present study, living conditions, prevalence of illness, access to clean water and latrines, availability of health services, nutrition, education, employment and security were similar or slightly better for the 1995 cohort (Islam *et al.*, 1997). Other studies have also reported slum dwellers as comprising distressed migrants from rural areas, with poverty-driven urbanization due to unsustainable rural economy (Islam *et al.*, 1997; Barkat *et al.*, 1997; Rahman and Shahidullah, 2001). The urban poor have been noted to pay very high rent for dismal housing (Anam, 1993) and dwellings are often on government-owned land (Rahman and Shahidullah, 2001) moving within slums is common due to land re-appropriation (Islam *et al.*, 1997). As in other studies, pumped/tap

water is used for drinking while open/surface water is used for non-drinking purposes (Islam *et al.*, 1997; Ahmed *et al.*, 1998).

In this as in other studies, symptoms rather than diagnoses of diseases were reported, as in the literature (Hussain *et al.*, 1999). As in previous reports, most deaths occurred in the first year of life, and diarrhea was a frequent cause (Hussain *et al.*, 1999). At any given time, 30-45% of the urban poor have been reported ill (Anam, 1993). Barriers to care in the slums have been noted to be accessibility, long distances to travel, and family's unwillingness to spend money on female care, providers prejudiced against the poor, short clinic hours, and cost (Islam *et al.*, 1997; Hoque and Selwyn, 1996; Schuler, 2002). There were considerable limitations of this pilot study, including the small study size, a tiny fraction of the slums of Visakhapatnam. Slums are not uniform in their population or demographics. As language and health literacy limit reliability, symptoms rather than diagnoses may better investigate these participants.

Conclusions and Areas of Future Research

This study and others show that the people of slums are human capital greatly contributing to the economy and work force of the country. The majority here suffer unacceptable levels of malnutrition, hygiene and health, deprived of essential health services, financial stability, education and security. Slum living is an unavoidable reality of the future; efforts must be made to build the slums into sustainable communities.

Finally, numerous studies describe health and demographic data pointing to causes of poor health and livelihood in the slums. Conclusions generally identify the problem or risk factor and suggest that improvement of the variable in question will lead to improvements in outcomes e.g. improving nutrition is likely to reduce the incidence of diseases. These problems though important are numerous, and it is unlikely that piecemeal

solutions will be amply cost effective to achieve health in the slums; rather these problems require parallel attention. Funds are limited, and to alleviate poverty a detailed cost effectiveness analysis of comprehensive interventions is required, to create a strategy for sustainable improvements in the quality of life for those in the ever growing slums.

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