THE STATUS OF REPRODUCTIVE HEALTH OF WOMEN IN THE SLUMS OF INDORE

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ABSTRACT

The reproductive health status of women residing in slums in Indore city of Madhya Pradesh were studied through the administration of an interview schedule to get the views of the respondents regarding this and then reproductive health camps were conducted to clinically diagnose and treat these women. The results were analysed and it was found that the status of reproductive health is not up to the mark and policy measures are required to improve matters.

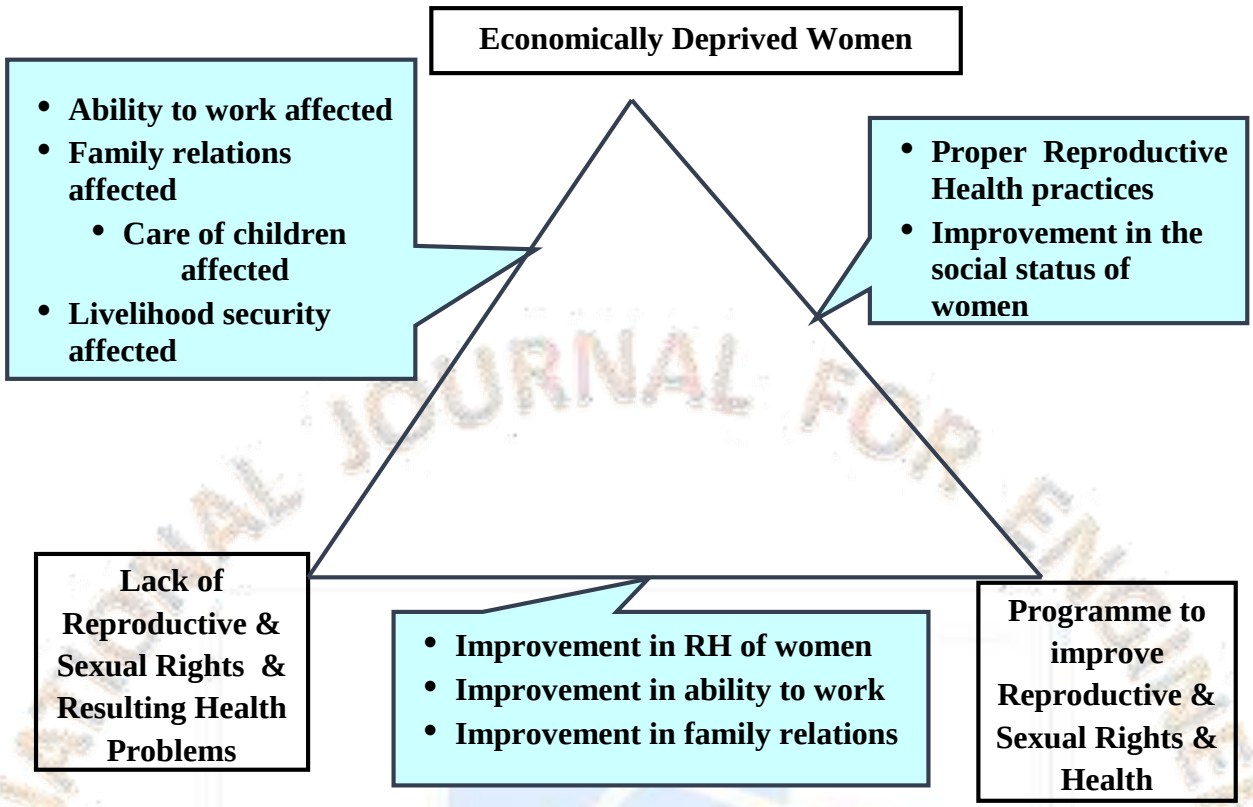
1. Introduction

The research is of an exploratory nature to study the various aspects of the reproductive health of economically deprived women residing in the slums of Indore city through a survey. This was followed by a clinical remedial programme to address the health problems that were revealed by the survey. The city of Indore was chosen as it is a fairly large city and has a substantial slum population.

2. Reproductive Health Framework for Research

The slums and the women respondents of the city were chosen at random as they are all more or less similar across the city with very little stratification within them except for religion. The data was collected from primary and secondary sources. Primary sources were the urban poor women and other associated stake holders and the tools included the administering of an interview schedule, observation, key person interviews and case studies. Action research through the conduct of reproductive health and rights workshops followed by reproductive health clinics were done to intervene through clinical diagnosis and treatment. The secondary research involved a review of literature and study of the documents of the Government and NGOs.The framework of this study focuses on the reproductive and sexual rights and health problems of economically deprived urban women, the factors that cause them, how they adversely affect them and how ameliorative programmes can improve the situation. This is illustrated in Fig 1 below.

Fig. 1 Reproductive Health and Rights Framework for Research



3. The Sampling Framework

The demographic details of the slums of Indore are given in Table 1 below.

Table 1: Details of Slum Population in Indore (2021)

Sl. No.	Zone	Ward No.	No. Notified Slums	Slum Population				Literacy Rate (%)
				Total	Female	Schedule Caste	Schedule Tribe	
1		4	8	7148	3424	114	57	72.6
2		7	11	3138	1507	131	25	79.3
3		9	14	2817	1253	228	28	84.7
4	Kila Maidan	16	13	15082	7300	30	15	75.1
5		6	5	20564	9995	781	370	73.8
6		67	16	15771	7681	315	157	80.1
7		68	6	4841	2358	135	116	82.1
8		69	3	6492	3130	279	129	75.9
9	Raj Mohalla	70	10	22695	11121	363	295	82.2
10	Nagar	56	4	3116	1518	96	49	77.2
11	Nigam	58	1	261	129	7	3	83.1
12		10	5	5334	2598	21	10	73.8
13		12	1	1585	761	22	9	72.5
14	Maharana	13	1	204	93	5	1	77.5
15	Pratap	17	1	6994	4224	173	72	78.1
16		21	11	9122	822	81	37	71.3
17		22	1	1774	3693	84	38	65.2
18	Sukhliya	28	7	7709	4631	59	29	80.7

Sl. No.	Zone	Ward No.	No. Notified Slums	Slum Population				Literacy Rate (%)
				Total	Female	Schedule Caste	Schedule Tribe	
19		33	8	9896	8790	313	147	77.9
20		24	19	18466	8296	242	104	73.5
21	Subhash	26	8	17355	2405	37	5	71.4
22	Nagar	27	1	4704	6618	150	68	83.6
23		31	6	13673	851	16	7	79.9
24	Scheme No.	32	2	1782	471	26	12	83.6
25	54	34	1	981	6847	155	70	80.4
26		30	11	14175	6270	246	103	78.8
27		35	11	12980	381	14	6	83.6
28		36	1	785	13076	775	360	86.1
29	Vijay Nagar	37	22	27702	13076	775	360	80.5
30		44	10	20221	10091	100	40	85.2
31		45	4	4551	2230	59	27	78.5
32	Pancham Ki	46	11	10754	6723	530	251	86.6
33	Phel	47	7	7562	10489	866	410	86.1
34		38	17	13948	19260	1431	654	66.2
35		39	24	22802	10489	866	410	76.9
36		40	26	40891	19260	1431	645	68.1
37	Saket Nagar	43	2	4432	2141	75	35	83.1
38		48	3	4479	2159	101	76	70.4
39		49	4	4184	1967	828	401	65.1
40		54	9	5485	2672	27	11	84.1
41		55	4	564	278	11	5	78.3
42	Stadium	60	7	7827	3812	180	86	85.1
43		59	6	2892	1397	147	69	71.1
44		61	14	15642	7665	406	203	82.1
45		62	13	13814	6797	262	124	80.2
46		65	7	6962	3377	63	35	75
47	Harsiddhi	66	5	5071	2460	519	10	79
48		74	6	6757	3197	40	87	65.8
49		77	3	9329	4656	111	223	71.5
50		78	13	15614	7370	936	202	75.3
51		80	1	770	378	9	10	80.9
52	Bilavali	81	4	8364	4032	100	200	82.7
53		79	3	2627	1261	23	13	78.8
54		82	1	207	100	41	2	85.1
55	Hawa	84	3	7132	3495	7	14	79.6
56	Bangla	85	7	14395	6809	86	187	72.4
57		2	3	2154	1045	23	10	60.4
58		71	3	5039	2379	25	55	79.5
59	Dravid	72	2	1563	740	12	37	81.2
60	Nagar	73	4	3367	1633	60	37	78.5
61		1	9	5965	2840	298	137	66.6
62		5	6	9702	4619	116	48	72.6
63		14	4	2923	1439	116	52	82.7
64	Aerodrome	15	3	5612	2694	117	56	78.7

Sl. No.	Zone	Ward No.	No. Notified Slums	Slum Population				Literacy Rate (%)
				Total	Female	Schedule Caste	Schedule Tribe	
65		18	12	13844	6646	207	110	84.4
66		19	16	25388	11958	431	203	70.1
67		20	8	8542	4058	179	76	74.6
68	Narval	23	8	4079	1926	77	36	71.4
69		51	9	8805	3309	80	35	67.1
70		52	11	9325	4467	456	195	72.2
71		53	9	4140	2037	62	28	82.3
72		63	8	9414	4727	105	84	88.1
73	Krishi Vihar	64	8	5852	2874	70	29	65.2
74		41	9	6006	2841	78	36	71.1
75		50	8	4397	2063	312	145	67.5
76	Scheme No.	75	19	41560	20074	249	540	81.6
77	94	76	10	4905	2306	470	480	77.2
	Total (% in brackets)	**77**	**591**	**697004**	**364559 (52.3)**	**18471 (2.7)**	**9541 (1.4)**	**77.0**

Source: Indore Municipal Corporation (IMC, 2022)

The map of the slum locations in Indore is shown in Fig 2 below.

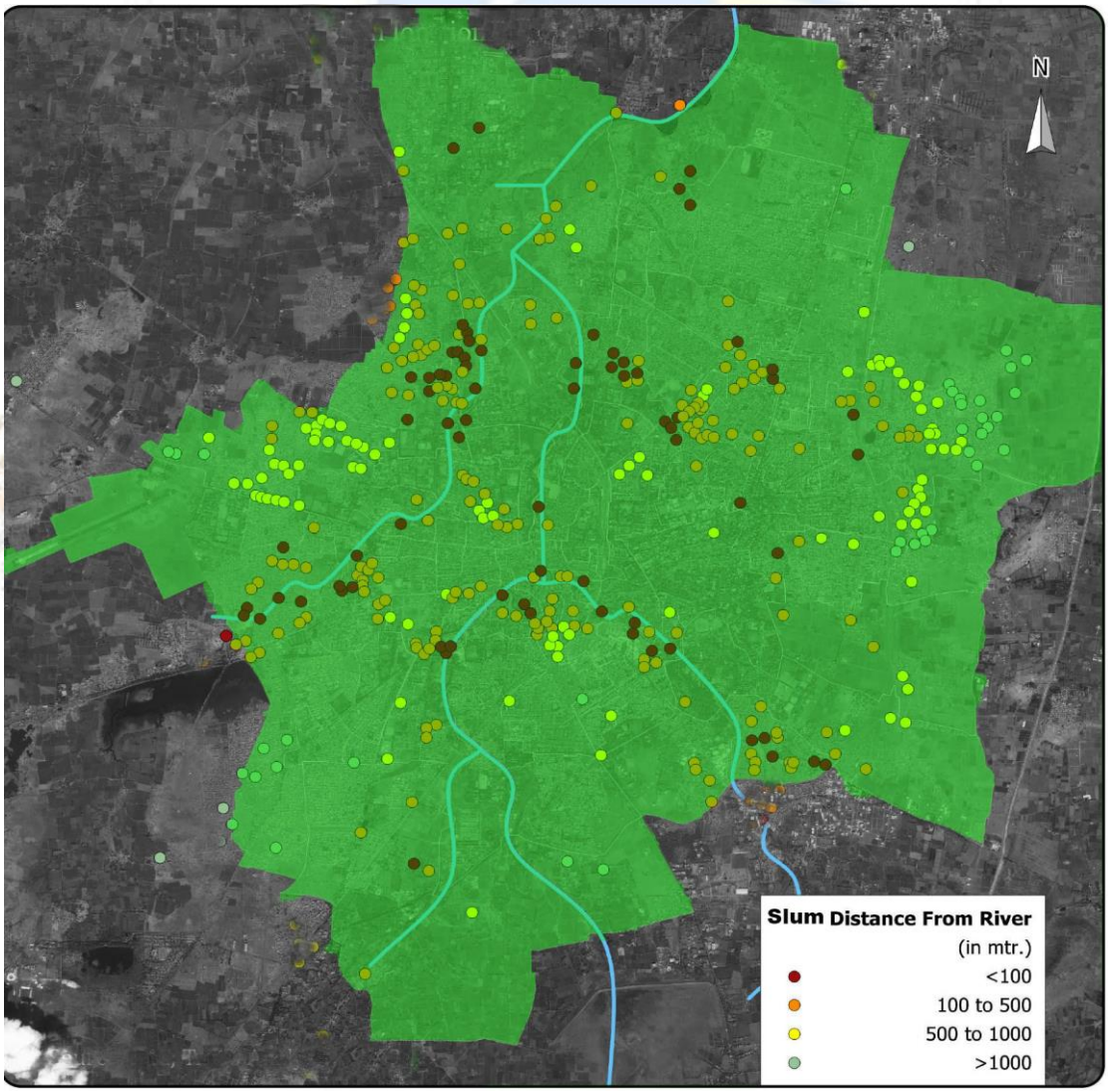


Fig. 2 Slum Locations in Indore City (IMC, 2022)

There are 85 wards in Indore city distributed over 19 zones. There are 591 notified slums in the city in 77 wards distributed over all these zones as per the records of the Indore Municipal Corporation.

The proportion of women is notably higher than that of men in the slum population. The proportion of Scheduled Castes and Scheduled Tribes is very low. Even though there is no data on the proportion of Muslims in the slum population, their proportion in the city population is 14 percent. Similarly, the proportion of the Other Backward Classes in the population is 48 percent.

Broadly, we can assume that the universe of the study is a normal distribution considering that the slums in Indore have a large population of around 3,64,559 women. Therefore, after estimating the prevalence of reproductive health problems among these women from the NFHS 5 reports for Indore district, we used the theory of normal distributions to estimate the sample size.

Therefore, to ensure that there are Scheduled Castes, Scheduled Tribes, Other Backward Classes and Muslims in the study sample in proportion to their proportion in the population **stratified random cluster sampling** was adopted for selection of the respondents.

The World Health Organisation has developed a tried and tested sampling methodology for researching the socio-economic characteristics associated with any epidemiological phenomenon (Lwanga & Lemeshow, 1991). According to this the appropriate simple random sample size for a survey in which the universe population is large enough for it to be possible to assume that it is a normal distribution is determined by three factors -

a. the estimated prevalence of the variable of interest – which is reproductive health morbidity of women residing in urban slums in this case.
b. the desired level of confidence and
c. the acceptable margin of error.

Then the simple random sample size required can be estimated by the following formula -

n= $\mathbf{t^2}$ x $\mathbf{p(1-p)/m^2}$**,** where

n = required sample size

t = confidence level at 95% (standard value of 1.96 for a normal distribution)

p = prevalence of reproductive health morbidity in the population. If we take the proportion of women in the age group 15 -49 who are suffering from anaemia to be a proxy indicator of reproductive health morbidity in the absence of secondary data on such morbidity in Indore, then the value is 48% (standard value 0.48) for the city (IIPS, op cit).

m = margin of error which is assumed to be 5% (standard value of 0.05)

Thus, for the present research **n**= 1.96^2 x 0.48(1- 0.48)/0.05^2

or **n** = 384

The survey in this study is designed with a stratified random cluster sample, that is a representative selection of slums to ensure the appropriate proportions of of Scheduled Castes, Scheduled Tribes and Muslims in the sample similar to that in the population. The nineteen zones which are of different sizes and demographic characteristics were first made into twelve clusters in such a way that they had the requisite socio-economic and religious characteristics. One slum was then selected randomly from each cluster. Finally, 50 eligible women who are married and in the age group of 15 – 49 years were administered the survey from each of 7 selected slums and 51 women from the rest of the 5 selected slums.

Thus, the sample is not a simple random one for which the formula has been developed. To correct for this difference in design, the sample size is multiplied by the design effect **D** which is generally assumed to be 1.5 for such surveys. The corrected sample **n** x **D** = 384 x 1.5 = 576

Finally, the sample was further increased by about 5% to account for contingencies such as non-response or recording error to give a final value of 605. Thirty is the standard number of clusters established for such surveys. So, the 605 married women in the age group 15 - 49 years have been selected from 12 different slums in a stratified random way in proportion of the different communities in the universe population. The slums selected for the survey are as follows –

1. Nayapura
2. Kabitkheri
3. Gulabbai Ka Bageecha
4. Yashoda Nagar

5. Roshan Nagar
6. Khatipura
7. Jabran Colony
8. Sonia Gandhi Nagar
9. Hukmakheri
10. Naya Basera
11. Chitawad Kakar
12. Palda

4. The Fertility Characteristics of the Respondents

The fertility by age group of the respondents is given in Table 2 below. The total fertility rate of the sample defined as the total number of successful pregnancies divided by the total number of respondents is 2.3 which is slightly higher than the replacement rate of 2.1. However, since the fertility rate in the age group of thirty and below, which is more likely to bear children, is 1.72, the chances are that the fertility rate will converge to the replacement rate for this sample with time. In fact, the women in the younger age groups are delaying their first pregnancies and also spacing their second pregnancies. The fertility rate is higher among the older women but they are not only fewer in number but have also completed their child bearing.

Therefore, it can be concluded that planning is being done consciously by the respondents to limit the family size with help from their menfolk. Thus, most of the younger women have at least got control of their bodies to the extent that they can now limit the number of children they bear to one or two. This is good for, their families and for the society as a whole.

Table 2: Fertility by Age of Respondents

Age	No. of Pregnancies (Includes those that have been aborted)								Total
	0	1	2	3	4	5	6	7	
< 20	10	0	1	0	0	0	0	0	11
21 - 25	28	61	50	14	3	0	0	0	156
26 - 30	12	17	67	41	13	1	0	0	151

Age	No. of Pregnancies (Includes those that have been aborted)								Total
	0	1	2	3	4	5	6	7	
31 - 35	5	4	50	47	14	4	2	1	127
36 - 40	3	5	24	16	22	8	0	2	80
41 - 45	2	3	11	28	24	8	3	1	80
Total	**60**	**90**	**203**	**146**	**76**	**21**	**5**	**4**	**605**

The infertility rates for the sample are given in Table 3 below. The overall infertility rate at 5.3 percent is a matter of concern as it is a bit high, especially as the highest number reporting infertility are from the below 25 years age group. Since these women are poor, they have not got themselves and their husbands tested to diagnose their infertility.

Table 3: Infertility by Age of Respondents

Age in Years	Infertility (%age in brackets)
< 20	0
21 - 25	13
26 - 30	9
31 - 35	5
36 - 40	3
41 - 45	2
Total	**32 (5.3)**

5. Pregnancy Characteristics of the Respondents

The pregnancy characteristics of the respondents have been detailed in this section. The place of pregnancy is given in Table 4 below. The first pregnancies were carried out mostly in the parental home (88.8 %), whereas from the second pregnancies (89.7 %) onwards and especially from the third pregnancies, the marital home was preferred. This is due to the greater provision of safe motherhood services by the state through the Janani Suraksha Yojana which

has made ante-natal and post-natal care and institutional delivery compulsory to cut down on maternal mortality.

Table 4: Place of Pregnancy of Respondents

Place of Pregnancy	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
Marital Home	61	408	252	106	30	9	4	870
Parental Home	484	47	0	0	0	0	0	531
Total	545	455	252	106	30	9	4	1401

The place of delivery is given in Table 5 below. The concentration of the government health system in ensuring safe motherhood is reflected in the fact that most of the deliveries (83.4 percent) have been carried out in government health institutions, mainly hospitals and also primary and community health centres. Home deliveries are limited in number and mostly gone through by the older women for their earlier pregnancies. Given the economic weakness of the respondents very few deliveries have taken place in private hospitals or nursing homes (3.7 %). **The number of abortions was eleven**. This is a fairly low number which again testifies to the provision of better safe motherhood services by the government to bring down abortions and mortalities and bring pregnancies safely to term.

Table 5: Place of Delivery of Respondents

Place of Delivery	**Sequence of Pregnancies**							**Total**
	Ist	**2nd**	**3rd**	**4th**	**5th**	**6th**	**7th**	
Marital Home	51	19	7	4	0	0	0	81
Parental Home	82	9	6	0	0	0	0	97
Primary Health Centre	24	24	18	9	2	2	1	80
Community Health Centre	12	9	15	4	3	2	1	46
Government Hospital	349	369	199	86	24	5	2	1034

Place of Delivery	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
Private Nursing Home	16	15	3	2	0	0	0	36
Private Hospital	7	7	2	0	0	0	0	16
Total	**541**	**452**	**250**	**105**	**29**	**9**	**4**	**1390**

The age wise distribution of deliveries is given in Table 6. The proportion of deliveries at age less than eighteen is 38.3 percent which is quite high and a matter of concern. These have mostly been for the older women but this is still prevalent among the younger women due to early marriage. As mentioned earlier, this has adverse physical and mental health consequences for the women.

Table 6: Age at Time of Delivery of Respondents

Age in Years at Time of Delivery	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
<15	87	57						144
15-17	198	188	2					388
18-25	224	179	123	21	4			551
26 -35	32	28	125	62	11	4	3	265
36-45	0	0	0	22	14	5	1	42
Total	**541**	**452**	**250**	**105**	**29**	**9**	**4**	**1390**

The type of delivery is detailed in Table 7. Most of the pregnancies were carried to term with only eleven abortions. Only five were delivered by caesarian section and the overwhelming numbers are through normal delivery. This too is evidence of the improvement that has taken place in obstetric services and ante-natal care provided to pregnant women.

Table 7: Type of Delivery of Respondents

Type of Delivery	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
Normal	540	450	248	105	29	9	4	1385
Caesarian	1	2	2					5
Abortion/ Miscarriage	4	3	2	1	1			11
Total	**545**	**455**	**252**	**106**	**30**	**9**	**4**	**1401**

The cost of delivery is given in Table 8 below. The average cost associated with normal delivery is very reasonable at Rs 526 while that for caesarian sections is almost ten times higher at Rs 4670. The abortion cost is also not very high at Rs 750.

Table 8: Average Cost (Rs) of Delivery of Respondents

Type of Delivery	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
Normal	550	450	530	520	560	535	540	526
Caesarian	4000	4500	5500					4670
Abortion / Miscarriage	700	800	750	700	800			750

The details of the benefits received under the Janani Surakha Yojana are given in Table 9 below. The Janani Suraksha Yojana is running quite well currently even if the older women in the sample did not get its benefits in their earlier pregnancies. Consequently, in 86.4 percent of the deliveries the scheme benefits have been received by the respondents and this combined with ante-natal care has eased their pregnancies.

Table 9: Janani Suraksha Benefits Received by Respondents

Receipt of JSY Benefit	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
Yes	463	389	219	94	26	7	3	1201
No	78	63	31	11	3	2	1	189
Total	**541**	**452**	**250**	**105**	**29**	**9**	**4**	**1390**

The pre-natal care details are given in Table 10. Prenatal Vaccination and Checkup Status is good for the sample as 92.5 percent have received the service from the Government Health system. Some of the respondents have incurred costs in sonography and private checkups and special diets.

Table 10: Pre-natal Vaccination and Checkup and Average Costs (Rs)

Vaccination Status	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
Yes	488	420	239	98	27	9	4	1285
No	53	32	11	7	2			105
Costs	650	720	750	760	790	810	830	760
Total	**541**	**452**	**250**	**105**	**29**	**9**	**4**	**1390**

The post-natal care details are given in Table 11 below. Post-natal Vaccination and Checkup Status is also good for the sample as 86.0 percent have received the service from the Government Health system. Some of the respondents have incurred costs in private checkups and special diets.

Table 11: Post-natal Vaccination and Checkup and Average Costs (Rs)

Vaccination Status	Sequence of Pregnancies							Total
	Ist	2nd	3rd	4th	5th	6th	7th	
Yes	464	399	219	86	18	6	3	1195
No	77	53	31	19	11	3	1	195
Costs	570	600	620	640	660	690	710	642
Total	**541**	**452**	**250**	**105**	**29**	**9**	**4**	**1390**

The public health system is focused on reducing total fertility and maternal mortality rates and so this has resulted in both the rates coming down and despite their poverty, the respondents have done well on both counts. The pre-natal and post-natal care too has been of fairly good quality.

6. Menstrual Hygiene, Contraception and Sterilisation

The details of the menstrual hygiene methods used by the respondents are given in Table 12 below. A considerable proportion of women, 66.3 percent, use cloth for menstrual hygiene. This is substantially more than the national average of 50 percent as estimated in the National Family Health Survey Five (IIPS, 2021).

Table 12: Menstrual Hygiene Methods

Menstrual Hygiene Method	Frequency	Percent
Cloth	401	66.3
Napkin	204	33.7
Total	**605**	**100.0**

Management of menstrual hygiene is a problem area mainly because of the patriarchal taboos surrounding it. Women in India, mostly use cloth during the menstrual period and then wash and dry the cloth in the shade for reuse. They have to dry it in the shade because it cannot be dried in the open under the sun because it is against the patriarchal norm that anything to do with menstruation is dirty and should be kept private. For poor women in urban areas this has become a serious problem because of lack of space which results in lack of privacy. Matters have been further compounded by the unavailability of cotton cloth for use during the periods. Earlier women used to tear old sarees to use as menstrual cloth. However, cotton clothing has become expensive and so in most cases poor urban women wear only clothes made from synthetic materials which cannot be used for menstrual purposes because they do not absorb the menstrual blood.

There is a school of opinion that favours the use of sanitary napkins by poor women and they ran a campaign for the Government to reduce the taxes on these and this has led to the tax on sale of napkins being scrapped in 2018 (Drishti, 2020). There are also many innovations for making sanitary pads which are much cheaper. In fact under the Integrated Child Development Programme, subsidised sanitary napkins are being supplied to adolescent girls and women from

the Anganwaris or child care centres. However, the problem of disposal of the used napkins still remains for poor urban women due to the patriarchal taboo. The subsidised napkins are few and far between because they are supplied only to a few women and most others have to buy the expensive ones from the market which is difficult given their poverty.

So even today, cloth washed, dried and reused remains the most favoured option for poor women. Given this fact a solution has emerged in Indore. In the slums in which these poor women reside, the small shops sell red pieces of thick felt cloth as shown below which are used by the women during their periods.

Fig. 3: Red Cloth Used By Respondents for Menstrual Hygiene

These cloth pieces have good absorbent qualities and are cheap to buy. Three pieces of cloth are sold for Rs 30 and they last for six months. A larger piece of cloth with strings at the end also is available at Rs 50 for three pieces for use by those women who do not wear panties and have to tie the cloth. They can be washed and hung out to dry outside also because of their deep red colour which camouflages the blood stains. Though most women still dry them in the shade, there are some who dry them in the sun.

What is most intriguing is that a demand from poor women for a suitable solution to their menstrual hygiene management problems has been provided by the market in a very cost effective manner and not by the government or NGOs which are pushing them to use sanitary napkins. There are some NGOs which help women in the slums to form self help groups and

provide them with sanitary napkin making machines so that cheap sanitary napkins could be made available to them (Sukhtankar & Shenoy, 2022). The NGO Goonj also prepares sanitary napkins from the used cloth that it collects for distribution to poor women. However, in both these cases a lot of management is involved whereas in the market solution of providing red felt cloth the problem has been solved at the individual level.

The contraceptive methods used are detailed in Table 13 below. The number of women in the sample who have not been sterilized is 284. Among this a large proportion of 66.5 percent of women are not using any contraception. The rest are using condoms, copper Ts and contraceptive pills. Most women are still in the process of completing their family and so are not using contraception. Only a few who want to space their child bearing are doing so. There is resistance to the use of condoms among the men and so pills and copper Ts are used by the women to practice spacing.

Table 13: Contraceptive Methods

Contraceptive Methods	**Frequency**	**Percent**
Condom	39	13.7
Copper T	32	11.3
Mala D	24	8.5
Injection	0	0
None	189	66.5
Total	**284**	**100.0**

The details of the sterilization methods used by the respondents is given in Table 14. Most of the 321 sterilised women, 70.7 percent, have been operated on with the laparoscopic method. Only the older women who were sterilized earlier have been manually operated on.

Table 14: Sterilisation Methods

Sterilisation Methods	**Frequency**	**Percent**
Laparoscopy	227	70.7
Manual	94	29.3
Total	321	100.0

7. Respondent's Power Equation with their Husbands

The gender division of domestic work is detailed in Table 15. There is a clear adverse gender division of labour with none of the males doing domestic and care work alone and only 8.6 percent doing it along with their wives. Otherwise, it is mostly the women who have to bear the brunt of this work on their own. This puts a double work load on those women who also work to earn money.

Table 15: Gender Division of Domestic Work

Who Does Domestic Care Work	Frequency	Percent
Male alone	0	0
Female alone	553	91.4
Both	52	8.6
Total	**605**	**100.0**

The addictions of the respondents' husbands are given in Table 16 below. Most of the men are addicted as only 5.6 percent have no addictions whatsoever. The most are addicted to liquor (42.3 %) followed by tobacco derivatives (36.7 %) and as high as 13.1 percent are addicted to more than one substance.

Table 16: Husband's Addictions

Addictions	Frequency	Percent
Liquor	256	42.3
Gutkha	121	20.0
Tobacco	12	2.0
Ganja	14	2.3
Beedi	76	12.6
Cigarette	13	2.1
Combination of Above	79	13.1
None	34	5.6
Total	**605**	**100.0**

The details of domestic violence suffered by the respondents is given in Table 17. The domestic violence scenario is very difficult for women as only 1.3 percent have reported that they do not suffer any form of violence. Physical beating is the most prevalent form of violence at 35.7 percent closely followed by verbal abuse at 34.4 percent. Violence is the most potent weapon in the hands of the men to subjugate their women and its high prevalence shows that the respondents are oppressed by their men. Especially, when the men are under the influence

of alcohol then they beat and abuse the women the most. Therefore, this is a serious problem that also negatively affects the health of the women.

Table 17: Domestic Violence by Husband

Form of Violence	Frequency	Percent
Physical Beating	216	35.7
Verbal Abuse	208	34.4
Mental Torture	69	11.4
Combination of Above	104	17.2
None	8	1.3
Total	**605**	**100.0**

The status of sexual rights of the respondents is given in Table 18 below. Women have little control over their bodies as far as decision to have sex is concerned. None of the respondents said that they had any decision making power in this matter and only three women said that they decided along with the men. The combination of alcohol addiction, physical violence and forced sex leads to women suffering from various gynaecological problems as a result of having excessive sex to fulfill the demands of their husbands.

Table 18: Status of Sexual Rights

Who Decides When and How many times to have sex	Frequency	Percent
Male	602	99.5
Female	0	0
Both	3	0.5
Total	**605**	**100.0**

Thus, most women are oppressed by their husbands and their sexual empowerment status is very low. The control over their bodies, which is a basic condition for sexual and reproductive health, is lacking. Consequently, as revealed in the clinical examinations that were conducted in the reproductive health clinics, their gynaecological health is adversely affected. Overall , patriarchal control of the respondents by their husbands and society is of a high order.

8. Respondents' Perceptions about their Reproductive Health

The reproductive health problems as reported by the respondents are detailed below in Table 19 below. The women reported waist pain as the most frequent problem with 71.5 percent suffering from it. This is a symptom resulting from various infections of the vagina and uterus which cumulatively affected 53.4 percent of the women. A high proportion of women, 65.5 percent, also complained of dizziness which is the result of weakness arising from a combination of malnutrition and anaemia. Menstruation related problems cumulatively affected 50.3 percent of women and this too is a serious problem area that manifests itself through waist pain and lower abdomen pain at the time of the periods. Many women were reluctant to reveal their problems and had to be coaxed to speak about them. In most cases they said that they were suffering these problems in silence as they did not know how to get treatment for them.

Table 19: Type of Health Problem

Health Problem	Frequency	Percent*
Hazy Eyesight	53	8.8
Nightblindness	29	4.8
Dizziness	396	65.5
Waist Pain	435	71.5
Lower Abdomen Pain	169	27.9
White Discharge	175	28.9
Stinking Discharge	29	4.8
Itching in Vagina	73	12.1
Swelling in Vagina	28	4.6
Burning in Urine	76	12.6
Uncontrolled Urine	37	6.1
Continuous Cough	17	2.8
Prolapsed Uterus	18	3.0
Swelling of Body	21	3.5
Less Menstruation	61	10.1
Irregular Menstruation	100	16.5
Excessive Menstruation	94	15.5
Painful Menstruation	49	8.1
Breast Pain	20	3.3
Total	**1880**	

*The proportion of those who reported being afflicted with this problem from among the total respondents.

The morbidity levels of the respondents based on their responses is given in Table 20 below. The proportion of women who did not report any problem is quite low at 7.3 percent but this was contradicted by actual clinical examination later. On an average each woman suffered from three problems with some suffering from as many as ten. Thus, the reported morbidity levels are quite high and indicative of the lack of access to proper clinical services

for treating them. In many cases women had become accustomed to living with pain as they thought that there was no solution for mitigating it.

Table 20: Number of Health Problems Suffered by Respondents

No. of Health Problems	Frequency	Percent
0	44	7.3
1	68	11.2
2	165	27.3
3	100	16.5
4	102	16.9
5	61	10.1
6	28	4.6
7	17	2.8
8	4	.7
9	8	1.3
10	8	1.3
Total	**605**	**100.0**

9. Results of Clinical Diagnosis in Reproductive Health Camps

The results of the clinical examination done in the reproductive health camps show higher levels of morbidity as detailed below. These camps were conducted in collaboration with the NGO, Mahila Jagat Lihaaz Samiti (https://mahilajagatlihazsamiti.in/), wherein their network among the slum women was used to good effect to get the women to agree to being surveyed and then clinically examined and treated for their problems. The nutritional status of the respondent women is given in Table 21 below. The nutritional status of women as measured by the Body Mass Index (BMI = Weight in Kilograms/(Height in Meters)^2) is a matter of concern as 26 percent are malnourished with BMI less than 18.5 and 20 percent are obese with BMI more than 25. This contradicts the answers that the respondents gave earlier that they had adequate nutrition during pregnancy and after child birth.

Table 21: Nutritional Status of Respondents

Nutrition Status	Frequency	Percent
Malnourished (BMI*,<18.5)	157	26.0
Normal (BMI 18.5-25)	327	54.0
Obese (BMI>25)	121	20.0
Total	**605**	**100.0**

*BMI = Weight in Kilograms/(Height in Meters)^2

The haemoglobin levels of the respondents are given in Table 22 below. These results are even more worrying as 6.3 percent of the women are severely anaemic while another 69.7 percent are anaemic. This indicates that there is severe malnutrition.

Table 22: Blood Haemoglobin Levels of Respondents

Haemoglobin gms/decilitre	Frequency	Percent
≤9.0 (Severe Anaemia)	38	6.3
<12 (Anaemia)	422	69.7
≥12.0 (Normal)	145	24.0
Total	**605**	**100.0**

The blood pressure levels of the respondents are given in Table 23 below. These are high for 18 percent of the women and low for 8.6 percent of the women and so overall there is a problem here.

Table 23: Blood Pressure Levels of Respondents

Blood Pressure	Frequency	Percent
Normal	444	73.4
High	109	18.0
Low	52	8.6
Total	**605**	**100.0**

The details of Menstrual problems being suffered by the respondents is given in Table 24 below. Clinical examination revealed that 19.7 percent of the women were suffering from some menstrual disorder or other which is less than what the respondents have themselves reported in the survey interviews. This is because these problems occur from time to time and they were not there at the time of clinical examination. Nevertheless, the proportion is high enough to be a matter of concern that needs to be addressed.

Table 24: Menstrual Problems of Respondents

Type of Problem	Frequency	Percent
Amenorrhea (No Menstruation)	6	1.0
Dysmenorrhea (Cramps with Menstruation)	19	3.1
Menorrhagea (Excessive Bleeding)	22	3.6
Frequent	19	3.1
Irregular	28	4.6
Premenstrual Syndrome	7	1.2
Scanty Menstruation	18	3.0
No Menstrual Problems	486	80.3
Total	**605**	**100.0**

The gynaecological problems of the respondents as diagnosed in the reproductive health camps are detailed below in Table 25 below. Clinical diagnosis revealed severe gynaecological problems among the women. Cervical erosion, hypertrophy, cysts etc, which affect the cervix at the mouth of the uterus affected cumulatively 81.1 percent of the women. Similarly, 75.7 percent of the women cumulatively suffered from various vaginal disorders like discharges, itches etc. This is much higher than what the women themselves reported during the survey and is an indication of the extent to which the respondents lack awareness regarding these problems. In many cases even though the women reported no problems, clinical examination revealed that they had problems.

Table 25: Gynaecological Problems of Respondents

Type of Problem	Frequency	Percent*
Infertility	29	4.8
HIV	1	0.2
Mild Erosion of Cervix	188	31.1
Heavy Erosion of Cervix	87	14.4
Prolapse of Uterus	18	3
Cystocele	30	5
Rectocele	7	1.2
Nabothion Cyst	28	4.6
Hypertrophy	140	23.1
Endocervical Polyp	10	1.7
Cervicitis	7	1.2
Pregnancy	50	8.3
White Discharge	276	45.6
Mixed Discharge	73	12.1
Fungal Infection	51	8.4
Itch in Vagina	58	9.6
Incontinence in Urine	27	4.5
Burning in Urine	34	5.6
Hysterectomy	3	0.5
Polycystic Ovarian Disease	4	0.7
Dizziness	211	34.9
Backache	234	38.7
Headache	47	7.8
Bodyache	94	15.5
Abdominal Pain	130	21.5
Joint Pain	43	7.1
Weakness	143	23.6
Thyroid	3	0.5
Diabetes	6	1

Type of Problem	Frequency	Percent*
Piles	20	3.3
Gastritis	24	4

*The proportion of those who reported being afflicted with this problem from among the total respondents.

These problems are not very serious in most cases and were easily treated in the clinical camps. However, neither the government hospitals and health centres nor the private quacks have solutions for these problems which in most cases the women themselves are not aware of and are revealed only after clinical examination. Especially, in the case of cervical degeneration, if these problems are neglected over a long period of time, then they lead to complications which require surgery.

Another area of concern is that the examination revealed an almost similar proportion of women, 4.8 percent with infertility as in the survey where it was 5.3 percent. This problem could be due to a combination of other problems requiring further investigation. Unfortunately, treatment for infertility is quite costly and is out of reach of these poor women.

Overall, lack of awareness among the women about their gynaecological problems and their inability to get them treated due to lack of gynaecological diagnosis and treatment services in Government health centres combined with the high price of such treatment from qualified medical practitioners has resulted in these women suffering in silence.

10. Conclusions

Thus, we can conclude as follows –

1. The surveyed women lead a marginal existence and this is further reinforced by the patriarchal nature of society which results in their suffering from domestic violence and being unable to control their bodies compounded by adverse impact on menstrual hygiene. The proportion of respondents who have not suffered any form of domestic violence is a low 1.3 percent while none of them are able to decide when to have sex or babies. Domestic violence and coercion are the main complaints of the women as revealed in the case studies.
2. The respondents, consequently, suffer from reproductive and gynaecological health problems which they are unable to treat on their own with on an average each respondent suffering from three reproductive health problems.

3. The government health services are inadequate and especially so in the case of gynaecological problems. The respondents have to access private health services as a result adding to their costs of living. Since private qualified gynaecological health services are very costly, the women cannot access them at all and have to suffer in silence from various problems of the reproductive tract.
4. The clinical camps that were conducted established that the respondents were more mal-nourished than they were aware of and also suffered from anaemia and blood pressure problems. The proportion of women who are malnourished is 27 percent and those who are anaemic is 76 percent.
5. The clinical camps also established the severe adverse gynaecological health situation of the respondents which is much worse than what they had reported in the survey. Clinical testing revealed that 19.7 percent of the women were suffering from some menstrual disorder or other which is a very high proportion and cervical erosion, hypertrophy, cysts etc affected cumulatively 81.1 percent of the women. Similarly, 75.7 percent of the women cumulatively suffered from various vaginal disorders like discharges, itches etc.
6. The clinical camps through diagnosis, testing and medication were able to successfully treat the gynaecological problems being faced by the respondents over a period of two weeks to three months.

We can conclude that due to patriarchy, the respondents, who are economically deprived women, are suffering from gynaecological problems which can be solved through a well-designed combination of empowerment training and clinical diagnosis and treatment. This does not require a very big allocation of resources but only a policy decision on the part of the government to provide gynaecological services to economically deprived women and a proper implementation of the existing laws and schemes that are already there for the empowerment of women. The problem spans the realms of public health and gender equity and the solution too, has to come through a multi-disciplinary approach as follows.

The efficacy of public health systems are analysed by a parameter based framework developed by the Indian Institute of Public Health (Kadam & Panda, 2023) and it has been detailed for the present case of reproductive health of the women in the slums of Indore in Table 26 –

Table 26 : Framework for Analysis of Efficacy of the Reproductive Health System

Parameter	Provision Status	Suggested Remedy
Distance	The Hospitals and health centres are situated at a Distance from the slums and so are difficult to access by the women who are either unpaid homemakers or low paid daily wage workers.	Clinics should be organised in the slums themselves. Doctors, nurses, lab technicians and pharmacists must go in a team to examine and treat the women.
Staff	The primary and community health centres do not have gynaecologists and adequate nurses and lab technicians. The bigger hospitals have less staff for the population.	Adequate numbers of well trained doctors, nurses and lab technicians need to be posted in health centres and hospitals
Services	Only obstetric services for safe motherhood are available in most health centres and even the bigger hospitals deficient in the provision of gynaecological services	Gynaecological services must be provided in addition to obstetric services.
Drugs	Drugs for gynaecological problems are unavailable.	Drugs provided free of cost for gynaecological problems
Social Appropriateness	There is lack of appreciation among medical staff of the huge cultural barriers that prevent women from expressing their gynaecological problems freely.	Awareness building both among medical staff and the women in slums regarding the inappropriateness of these cultural taboos and the need for articulating and understanding the

Parameter	Provision Status	Suggested Remedy
		gynaecological problems of women.
Affordability	Medicines and procedures for treating gynaecological problems are not available and so they have to be accessed from the open market at high prices	Medicines and procedures for gynaecological examination and treatment must be made available either free of cost or at subsidised rates.

Source: Kadam & Panda, 2023

The United Nations has developed a parameter based framework for gender equity and it is detailed for the present case in Table 27 below

Table 27 : Framework for Analysis of Gender Equity for Reproductive Health

Parameter	Provision Status	Suggested Remedy
Non-Discrimination in Allocation of Resources	There is a paucity of resources allocated for reproductive health and what is there is for ensuring safe motherhood to the almost total exclusion of gynaecological health.	Increase resources allocated for gynaecological examination and treatment for women.
The Right to Livelihood	Women's livelihood issues are not being addressed and they are mostly either homemakers or domestic workers. Without economic empowerment and independence, the women are subservient to their men.	Training and funding must be provided to facilitate women to find work either in jobs or in self employment and so become economically empowered.
Sexual and Reproductive	Women have no say in when to have sex, get pregnant or	Awareness camps must be organised to make women

Parameter	Provision Status	Suggested Remedy
Choice and Informed Consent	sterilised. These decisions are all taken by men. There is very little awareness about their rights and so in most cases there is no informed consent.	aware of their rights and also sensitise the men to the problems created by patriarchal oppression for both men and women.
Women friendly laws and policies	There are substantial legal and policy protection for women but implementation is extremely poor.	Improved implementation of laws and policies for women's protection must be done.
Gender Based Violence	There is rampant gender based violence both physical and verbal. Women are mostly scared of their husbands and also of social taboos and so cannot live as free and fearless individuals	Better implementation of laws against gender based violence and the operation of shelter homes is needed to prevent gender based violence.

Source: United Nations, 2023

The implementation of this combined strategy of improved reproductive health services delivery and effective gender equity measures by the government will go a long way in alleviating the dismal state of affairs with regard to reproductive health and rights of women living in the slums of Indore that has been revealed by this study. The study has also shown that these measures do not require great outlays of financial resources and all that are required are a few policy tweaks to ensure that existing laws, rules and schemes are properly implemented through a gender equity lens.

References

Drishti (2020): *India Needs Free Menstrual Products, Not a Tax Cut,* Youth ki Awaaz accessed at url https://www.youthkiawaaz.com/2020/04/a-movement-for-a-tax-free-sanitary-napkin-or-free-availability-of-pads-for-all-what-does/ on 14.06.2020

IIPS (2021): *National Family Health Survey V*, International Institute of Population Sciences, Mumbai.

Kadam, S & Panda, B (2023): *Introduction to Public Health, Health Systems and Policy,* Indian Institute of Public Health, Bhubaneswar.

Lwanga, S.K. and Lemeshow, S. *Sample Size Determination in Health Studies: A Practical Manual,* World Health Organisation, Geneva.

Sukhtankar, V & Shenoy, P (2022): *Entrepreneurial Empowerment Support For My Pad My Right Initiative In Goa,* National Bank for Agriculture and Rural Development accessed at url https://www.nabard.org/hindi/auth/writereaddata/tender/0112225033nrs-29.pdf on 14.06.2023

United Nations (2023): *Right to Sexual and Reproductive Health,* accessed at url https://www.un.org/womenwatch/daw/csw/shalev.htm on 15.06.2023