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Maternal health and slums of India: issues and challenges

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ABSTRACT

Achieving equity in health care delivery is one the focus point in WHO's Ending Preventable Maternal Mortality Strategy. However, there is an indication of unequal access to and delivery of healthcare services. Nevertheless, the insufficient focus has been given to health equality in regards to the Millennium Development Goals. As a substitute, nations have concentrated on meeting national targets. Especially with regard of urban maternal health status slums is one of the vital areas as slums are generally characterized with poor health and slum's population is growing with a fast pace along with urban growth in most of the developing nations in the world. Therefore, to study factors associated with slums, poor health is essential. Studies shown there is a vast difference in slums with regards to socioeconomic and health status. Also, the legal definition of slums varies with region to region. India is facing many challenges with regards to slums low health status and to overcome these challenges is necessary to achieve equity and quality in health care regarding maternal health. This article tries to highlight the challenges and issue with regards to poor maternal health status in the slums of India.

Key words: Maternal health, slums, WHO, Millennium Development Goal, equity and quality

Introduction:

India has more than 20 % of all Maternal death in the world, and it is the most massive no of maternal death for any country in the world.(Lozano R et al. 2011; Mavalankar et al. 2008) While the downward trend in the last decade has been approximately 6 per cent, the current ratio of maternal mortality remains 187 per 100,000(Lozano R et al. 2011). Existing large variations among different populations sub-national level, in and within States. Socioeconomic status in India is closely correlated with access to and use of maternal health care (Kestertonet al. 2010; Bonu et al. 2009). India has initiated many flagship initiatives over the last two decades on enhanced Links to maternal health care and birth control, most recently National Urban Health Mission. Many programs seek a model change from individualized, upright approaches to a more systemic, interconnected approach to the life cycle. However, some states have slower growth. Increased access to antenatal care and professional attending at birth occurs primarily in the non-poor communities. However, access remains low amid the deprived and vulnerable section of the society. In 2006, 13 per cent of women in the lowest income group of wealth brought their babies in a facility relative to 84 per cent of women in the top income group of wealth (Vora et al., 2009). Women who

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belong to a Scheduled Caste or Scheduled Tribes, as well as individuals who live in city slums, often have limited access to then use of maternal health care service (UNICEF 2009; Hazarika, 2010).

Slums and health:

Excessive population in urban areas has resulted in an increase in informal metropolitan areas in many developing economies in the last few decades. More than half of the world's population lives in urban areas. By 2030, and over half of the lower - middle income countries-income population of the country will live in cities and towns (Montgomery 2008).

Approximately half of the population of Mumbai lives in the slum areas. Census 2011 recorded that there are 7933 declared cities or towns or urban settlements in India representing 31% of the country's total residents, of which 7933 slums are registered in 2453 cities representing 17.4% of the population residing in urban areas. Within these regions the north-eastern states and Chandigarh registered dramatically low slum presence. In 2001 Census, where the slum population represented 18.3 per cent of the total city population, the situation was added or less comparable. India's urban population accounted for approximately 10 per cent of the total slum population of the world's and 21 per cent of the entire slum population of Asia (Registrar General of India, 2011).

In India, "confirmation" or lawful registration as a slum settlement is fundamental to the government's acknowledgement of slums and is aimed to grant inhabitants access to municipal treated water and sanitation service. Nevertheless, several communities that show noticeably slum-like attributes were not reported (Subbaraman et al. 2012); for example, no new slum has notified since 1974 in Delhi (Bhan 2013). The UN definition includes occupation as one of its elements, which is expected to lead to discord concluded its distribution and the actual figure of Indian slum people. The difference in defining the slum in intergovernmental and country-level raise the question that does it mean something or does it affect theunderprivileged people living in the urban environment?

Studies have shown that slums in India are probably more genetic than is generally understood (Goli et al. 2011; Chandrasekhar and Mont Gomery 2009; Agarwal and Taneja 2005).Many slum inhabitants are very well traditional and may receive services either illegally or legally over time, on the contrary people pavement-dweller who are also imperfect but are not slum-habitants lack behind as they are not considered according to definitions (Agarwal 2011).Comparing and understanding the definition with regards to what constitutes a slum and what doesn't is very important for the evaluation of comprehensive works recording the health effects of area-level deprivation on healthiness, most of which grounded on the urban environment.

NFHS-3 (2005-06) found out that the intercity inequalities in the indicators concerning residential or economic status are much more significant than inequalities in intra-city. In certain cities in demographically and economically more advanced states, the well-being position of slum residents is not only higher than the health position of slum residents in cities in less developed states. However, it is even higher than the health of non-slum residents in those towns. NFHS 3 (2005-06) acknowledged the difference between urban slums but did not elaborate on the sole reasons for the low performance of reproductive health indicators and their association with other socio-economic indicators.

However, the process of how poverty in a community level associated with poor health is still under research but numerous studies in India has been documented poor health in slum areas (Gaur et al. 2013; Hazarika 2010; Gupta et al. 2009).Intimate living spaces, underprivileged sanitary conditions and nonexistence of access to safe drinking water (Sclar et al . 2005), all features of "slum-like" populations, seem to produce health issues above

besides beyond the possessions of merely living in an underprivileged home and other characteristics at the separate level (Rice and Rice 2009). For instance, crowding appears towards facilitate the spread of contagious infections such as pneumonia, diarrhea and tuberculosis (Unger and Riley 2007). There is plenty of evidence to say that the population of a slum is much more vulnerable compared to the rest of the municipal population as regards their health. For women's well-being and their reproductive wellbeing, in particular, the condition gets worse. The reproductive health of Indian slums represents a physical and economic condition where the availability of an ante-natal treatment (ANC) and other services is insufficient. They are often obsolete, geographically distant, too costly or culturally objectionable. Uttar Pradesh's baseline survey observed that there are differences in pregnancy and contraceptives between the slum and non-slum community of urban India. (Nanda, Achyut, Mishra, Calhoun, 2011). An analysis of slum people in Visakhapatnam (Ramana, 2002) showed that the overall fertility rate in Visakhapatnam slum areas is 3.2, which is identical tall compared to the national average. In their study of Mumbai slums, Griffiths and Stephenson (2001) have found out that ANC consumption among slum dwellers is low. Godbole and Talwalkar (1999) also stated that, particularly for three or even more ANC check-ups, the variation between slums and non-slums is quite significant. He argued that slums statement lesser attention frequently than non-slum regions. He similarly found out that the use of IFA tablets among women in slums is low.

Challenges:

Concerning maternal health, there are no of challenges especially in slums as slum characterizes poor socio-economic living conditions in general and studies indicate there is a link between health and socio-economic conditions as well as education which also an important variable affecting the health status and female literacy is much lower than male literacy in India. Many reasons contribute to the problem of education for girls and women in India. The utmost critical connection is the socio-economic position. Across town areas, girls greatest questionable to join school are those from slum area families in which associates of the household work in various low-paid and low-level jobs or non-organized or informal industries. This indicates that the household needs to be seen as a critical category affecting both girls ' education as well as women's health. The family is the "immediate health environment of its members who 'share (whether equitably or not) a common water source, sanitation facilities, breathing space, a hearth, and other facilities. This has important implications for the acquisition, transmission, prevention and treatment of disease" (Chatterjee 1989:16)

With its members, the household is often the central socializing unit, for example by formal or non-formal schooling, which may be available to all its members or not. Girls are even less likely to go to school for more extended periods than boys. Thus a lack of health-related information or awareness is assumed. This limits the practical use of this information by home health care or interaction with public health agencies. Apart from poor living condition of slums which affect the education and health status of the family in general and women’s health in particular studies also point out that cultural factor also plays a role in the difference between women’s health of different slums (Alaka Basu, 1992)

There are challenges related to education, socio-economic condition and cultural taboos. On the other hand, there are issues related to the health care system as well, which results in the low health status of women, especially in slums. The study suggests that one of the key tasks facing town, slum inhabitants about motherly health care were financial barriers and disrespectful care (Sudhinaraset et al. 2016). Women in the study proposed that insolent treatment took place in all kinds of public and private services in India. Women in the study indicated that cruel treatment took place in all forms of Indian hospitals, both governments as well as in private. This is an important issue. Since reports of disrespectful

treatment have been prevalent in this community, future interventions require to concentrate on patient-provider relationships amid urban, slum area women, especially who might experience discrimination due to their low position.

Health Expenditure:

"The weakest component of the public system is the first-level care services. Only 15 per cent of the public health budget is spent on dispensaries, health posts and maternity homes" (Gill et al.1999).According to Economic Survey by Ministry of Finance (2015-16, 2016-17) as a whole, India's spending on health care (amount of central and state spending) stood amid 1.2% and 1.6% of GDP around 2008-09. This spending is comparatively little compared to other nations like China (3.2%), the United States (8.5%) and Germany (9.4%).

Rural Health Statistics (2018) by the Ministry of Health and Family Welfare shows, at dissimilar levels of the healthcare scheme, a shortage has been reported. As of 2018, 2,188 CHC, 6,430 PHCs and 32,900 SCs have been deficient. Not only that, but it is also noted that the existing one is not working as expected with lack of infrastructure and facility. World Health Statistics shows that India is between the lowest with regards to the ratio of bed per 1000 people, it is only 0.7 per 1000 people compared to the global average, which is 3.4.

Rural Health Statistics (2018) Ministry of Health and Family Welfare also shows that despite the increase of registered doctors between 2014 and 2018 by 24 % which is 9,23,749 from 7,47,109 there is the increase in lack of health professionals. For example, 42% of doctors and also 82% of a specialist such as obstetricians, surgeons, physicians, gynecologists and pediatricians are lacking in Primary Health Centres of India as of 2018.

National Urban Health Mission

Government of India launched NRHM to deal with the health issues in rural areas under which new health infrastructure and facilities initiated, so far the results have shown improvement in health status. However, the gap is still to be filled as the studies shows. Health status of urban poor, particularly concerning maternal health is also very concerning as the population is growing in the cities as well as in the slums, to meet the challenges government introduced National Urban Health Mission. Thereby, the National Urban Health Mission tries to overcome urban poor health issues through rationalization and enhance of existing healthcare capacity in order to improve the health condition of urban poor through equal access to available health facilities. The NUHM will concentrate extensively on the following: (1) Identified and unregistered urban slum population (2) All other disadvantaged groups such as displaced persons, harrowers, road children, pullers, building staff, cement staff and lime workers, and sex workers and other transient migrants. (3) Improving the environmental capability of the urban municipal authorities in terms of public health to sanitation, clean drinking water, pest control etc.

Discussion

One of WHO's main goals is better maternal wellbeing. WHO aims to help minimize maternal mortality through research findings, delivering clinical and programming guidance based on evidence, developing national guidelines and delivering the Member States with the professional assistance in the development and execution of effective policies and programmes. The critical focus on equity in accessing the health care facilities, quality of health care, addressing maternal health causes and ensuring accountability. Developing countries of Africa and South-East Asia shows low maternal health status, and India with its sizeable poor population is one of them as studies shown that India has more than 20% of all global maternal deaths. Slums have a large population, and it is growing as the urban environment is growing, and the problem of poor health among urban poor's is also growing with it, especially maternal health issues. Suppose India wants to resolve the problem and achieve good maternal health status. In that case, new policies and guideline have to be

framed considering WHO's guidelines for maternal health. Although policies and programme like NHM under which NRHM and NUHM have been implemented to achieve better Public health system and for resolving maternal health issues and challenges, but still there are gaps which have to be filled. As the studies indicated that slums identification and consideration require a new approach. The population of the urban poor is growing. Lots of inadequate settlement has not been able to legally considered slum as per the definitions to describe slum. These definitions vary according to states and countries which raise the issue of evaluation of literature of slums health and it is necessary as one of the main points of WHO is to set guidelines and programmes based on evidence.

Studies suggest that maternal health is linked with socio-economic, cultural, educational factors, these vary according to various studies about slums shows that the slums generally lack behind which results into poor health in general and maternal health in particular. So in order to achieve better maternal health status, these factors should be considered and require to be worked on. Another important point that no of studies raise is the variation amongst the slums socio-economic and health status. Some slums of more developed states are better than the slums of less developed states and even better than the non-slum population of the region, which raises the question of equity in health care. WHO also led the focus on equity in accessing the health care facilities.

Expenditure on health care also lacks to cope with current health issues. Data revealed that despite the increase in the health care budget allocation, it is no way near the developed countries health expenditure in percentage. The need for new hospitals health personals is growing and but the availably is seriously lacking behind. New steps are taken like NUHM for urban health problems. However, the studies suggest that earlier steps, for example, NRHM which is focused on rural health issues needs improvement and a new approach for strategies and requires more fund allocation as the health infrastructure and facility such as PHC, CHC lacks in quality health care. Moreover, the quality of health care is one of the main focal points of WHO. Considering this, NUHM needs more fund allocation and better management to achieve equity in access to health care delivery and quality in service delivery.

In conclusion existing literature highlights problem of equity, quality, disrespectful care and also the link between the poor living condition with poor health status especially concerning slums and slums population growing with the fast pace with the growth of an urban environment in the country. A new strategy is required to achieve better maternal health status as all of these things are linked together if India wants to meet the challenges with regards of poor maternal health status than it is essential to consider what studies are revealing so that better health policy and programmes can be formulated and implemented.

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