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RESEARCH ARTICLE

PERSONAL HABITS AND MORBIDITIES OF WOMEN RESIDENTS OF SLUMS IN MYSURU CITY, INDIA

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ABSTRACT

Background: Women forms the vulnerable group in every community and specially more in economically weaker section of urban India represented by slums of urban India. The urban poor (slum dwellers) are at the interface between underdevelopment and industrialization as well as interface between rural and urban areas. Their disease pattern and personal habits also reflects the problems of both.
Objectives: To study personal habits and morbidities of Women residents of Slums in Mysore City.
Materials and Methods: A cross sectional study carried out on 653 women of slum dwellers of Mysore, between January 2014 and December 2015. Information was obtained by interviewing the study participants.
Results: Around 48% had any morbidities with 95% CI of 44-51.8, 5.7% have menstrual morbidities, and with 9.5% & 7% of smoking and alcohol use respectively.
Conclusions: Women centric focused health education among economically weaker section of communities should be encouraged. Women centric public health infrastructure should be made available for urban poor with focus on slum dwellers. The focus should be for communicable as well as non-communicable diseases as the group is vulnerable for both.

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INTRODUCTION

More than 50% of the world population was classified as urban for the first time in 2009 and is expected to reach around 69% in 2050 (World Urbanization Prospects, 2009). It has been estimated that slum populations would double before 2035 in the low- and middle-income countries (Slums of the World, 2003). One of the immediate consequences of population pressure in urban spaces is the growth of slums or urban communities that are characterized by poor access to civic services, inadequate housing, and overcrowding (The Challenge of Slums, 2003). The health status of women is a reflection of their social status. In order to get a clear picture of the health status of Indian women, we need to have reliable data on mortality, morbidity, nutritional status, problems related to reproduction, access to and utilization of services. Urbanization poses several socio-economic problems for cities in India and one among them is the rise of slums. The slum dwelling women are not only economically and socially backward but also a neglected section among the society. The environmental conditions of the slum area affect the health status of the slum dwellers automatically. Most of the houses in slum areas do not have any sanitary facilities like bathroom or toilet. A number of persons share one toilet, narrow pathways wind throughout the slums, with open drains on almost all sides. In recent years, however, efforts are underway in some localities, by the municipal corporation in organizing the slums & providing them with basic amenities. Rossy Espagnet (1984) redefines health in the context of the urban poor as follows: "The urban poor are at the interface between underdevelopment and industrialization. Moreover their disease pattern reflects the problems of both. From the first, they carry a heavy burden of infectious diseases and malnutrition, while from the second they suffer the typical spectrum of chronic and social diseases (Mulgaonkar and Veena, 1996). Besides, the urban poor are also at the interface between rural and urban residence, even the personal habits like smoking and alcohol reflects the pattern of both. In this context the present study was done to study the personal habits and morbidities of women residents of slums in Mysuru city.

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MATERIALS AND METHODS

Mysore is the fourth urbanized districts in Karnataka (65.26%, census 2011) with more than 50 percent of its residents living in urban area. The survey was conducted in notified slum areas of Mysore City. A cross sectional study carried out between January 2014 and December 2015 and a total of 653 individuals were interviewed using semi structured questionnaire. This sample size of 653 is calculated by using sample size calculator prepared by creative research system (CRS) (Ref.http.www.surveysystem.com). This gives the above sample size at 99% confidence level. Current study definition of morbidity is "any illness which requires medical treatment like consumption of any formulation of drugs over past six months" and menstrual morbidities included are mainly dysmenorrhea (painful menstrual cycles), menorrhagia (excessive bleeding during cycles), oligomenorrhea (intervals between menstruation exceeding 35 days) and polymenorrhea (interval between menstruation less than 21 days). Current tobacco use is use of any form of tobacco in last one week and current alcohol use is consumption of any form of alcohol in last one week. Confidentiality and autonomy of the respondent was given utmost importance also as per the institutional ethics committee certification, informed written consent was taken in Kannada language which was commonly spoken in these communities.

RESULTS

The collected data was analyzed using the SPSS package. The relevant frequencies and tables for the major variables were studied and interpreted in terms of the objectives of the study. Descriptive statistics and other suitable techniques of statistics used to interpret the data. There were 653 individuals who had responded in the study and out of the 653 individuals 313 (47.9%) with 95% CI of 44.0 -51.8 had any type of morbidities in last six months (Table 1) and 5.4 % of individuals had faced some or any menstrual morbidity (Table 2). With regards to individual habits almost 10% (95% CI of 7.21-11.79) of the respondents agreed that they consume tobacco in any form, and the most prevalent among any form of tobacco use was chewing (Table 3 and Fig 1). Also 7% (95% CI of 4.92-8.88) of individuals self-reported to be using Alcohol with varied frequency and quantity (Table 3).

Table 1. Morbidity Status of women slum dwellers in last six months

Morbidity in last 6 months	Frequency (n)	Percentage (%)	95% CI
Present	313	47.9	44.0 -51.8
Absent	340	52.1	
Total	653	100.0	

Table 2. Morbidity status during menstruation among women slum dwellers

Variable	Category	Frequency (n)	Percentage (%)
Menstrual problems	No response	26	4.0
	Yes	35	5.4
	No	592	90.7
	Total	653	100.0

Association between different habits and morbidities could not be found because of the poor variability of presence of different habits compared to morbidity status which is having equal variance in both the groups.

Table 3. Personal habits of the slum dwelling women

Variable	Category	Frequency (n)	Percentage (%)	95% CI
Current tobacco use in any form	Yes	62	9.5	7.21-11.79
	No	591	90.5	
	Total	653	100.0	
Form of tobacco consumption	Cigar/pipe	0	0	
	Pan masala	4	6.8	
	Ghutka	4	6.8	
	Chewing	33	55.9	
	Snuff	18	30.5	
	Total	59	100.0	
Alcohol	Yes	45	6.9	4.92-8.88
	No	608	93.1	
	Total	653	100.0	

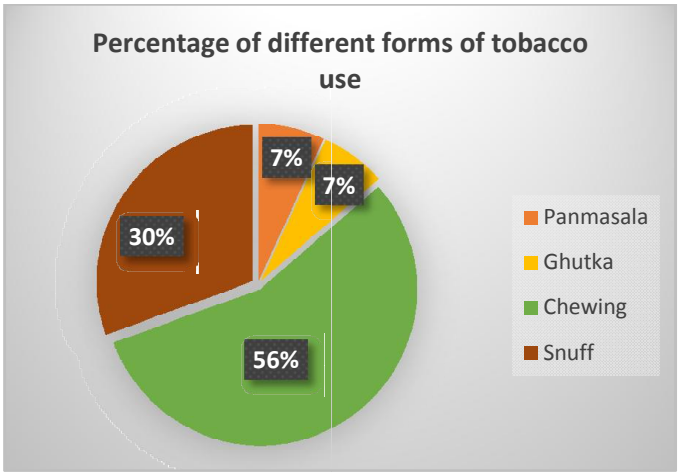

Fig. 1. Percentage distribution of different forms of tobacco use

DISCUSSION

Women's health has always been considered in terms of maternal and child health (MCH). The women's movement and the health movement in India have drawn the conclusion that the poor health of women is based on a broad concept presented by political, economic and social conditions in which women are treated as second class citizens. The lack of basic needs for survival such as clean water, nutritious food and adequate housing, affects everyone but more so for women because of their poor and economically backward status in the community. Current study with a definition of any illness which requires medical treatment like consumption of any formulation of drugs over past six months gives staggering figure of 48.5% as the prevalence of morbidity, even though this number is very large and duration of six months is too wide, it reflects the underlying conditions as conducted in other studies about women in India and world. A study conducted by sharma *et al* on assessment of morbidity and health issues in slum of Udaipur showed about 31.2% males and 34.6% females were either suffering from or have a history of one or more illness within previous two weeks (Sharma *et al*., 2013).

A study by T Puwar, B Kumpawat *et al* in slum area of Ahmedabad found that 67% of episodes of acute illness occurred among females and as compared to males this difference was statistically significant (Puwar and Kumpavat, 2008). Studies highlight the factual position that malnutrition is another serious health concern that Indian women face (Chatterjee, 1990). While malnutrition in India is found among all segments of the population, poor nutrition among women germinates in childhood and continues throughout their lifetimes (Chatterjee, 1990; Desai, 1994). Also due to differential treatment of men and women, if there is not enough food, women are the ones to suffer most (Horowitz and Kishwar, 1985) . These presentations are more for women from economically weaker sections of urban slum. Community based study conducted in a rural area of Maharashtra viz., Gadchiroli district, shows that, of 650 women aged 13 and above, 55% complained of gynecological problems, but on clinical examination and laboratory tests, as many as 92% were reported to have one or more gynecological morbidity. Community-based unpublished study on gynecological morbidity conducted at Streehitakarini - a women's welfare organization, located in urban slums of Bombay, showed that almost 73 % women reported one or more Gynecological complaints (Mulgaonkar and Veena, 1996). A study conducted in urban resettlement colony of Delhi showed 28% of women having problems in the last menstrual period, 44 percent reported excessive bleeding while 17 percent had severe abdominal pain (Baridalyne and Reddaiah, 2004). The present study shows that menstrual morbidity is about 6%. The great disparity between the results of current study and other studies are attributed to non-response of the study participants, inclusion of problems like dysmenorrhea, menorrhagia, oligomenorrhea and polymenorrhea as menstrual morbidities, but not any other gynecological studies that are included in other studies. Tobacco consumption was significantly higher in poor, less educated, scheduled castes and scheduled tribe populations (Rani *et al*., 2003). Also the current study finds higher prevalence of bad habits of smoking and Alcohol consumption which is more compared to general population especially among women and always the numbers with respect to personal habits are not the true picture due to reporting bias. The prevalence of alcohol use among the general adult female population in India is 5% (Park, 2015) which is compared to 7% in present study. The prevalence of tobacco use among the general adult female population is 20% (WHO fact sheet, 2009-2010) which is compared to 9% prevalence of this study group. A study by Gupta *et al*. had found self-reported tobacco smoking among females was 11.9% in 15 to 64 years age group at urban slums of Haryana in year 2003-2004 (Gupta *et al*., 2010). These findings also strengthen the hypothesis of high morbidity because of the direct risk behavior due to these personal habits which are proven as risk factors for non-communicable disease. Cost, social acceptability and non-stringent regulations pertaining to smokeless tobacco (SLT) product sales have made people choose and continue using SLT. Chewing tobacco is the commonest form with 55% among all forms of tobacco consumption in this study which is comparable to the study by Goswami et.al in Ahmedabad showing results where Tobacco chewing was significantly higher than tobacco smoking among females of 5 years and above ages, tobacco chewing was significantly higher than smoking (p=0000) (Goswami and Kedia, 2010). It is nothing but the reflection of social acceptance for this form of consumption among the women in the community. The facts of the study prove that the situation with respect to women's health in the urban slums is neglected the most. It is found that women were found to seek treatment only when their health problem caused great physical discomfort or when it affected their work performance. The problem is compounded by the absence of public health infrastructure like Primary health center in urban areas. Its absence also makes poor statistical record in urban areas especially for those in economically weaker section of urban areas where there is no formal public health infrastructure.

Conclusion

The situation with respect to women's health in the urban slums is neglected the most as discussed and also found that these women seek treatment only when their health problem caused great physical discomfort or when it affected their work performance, which implies their poor decision making and awareness of health. Such a scenario therefore solicits the attention of policy makers and program managers to address women's health needs on an urgent basis especially for those in economically weaker section of urban areas where there is no formal public health infrastructure. Following are the limitations of the present study

a) Study is limited / restricted only to the declared slums of Mysore city. Hence there is a less scope to generalize the data to other slums.
b) Association could not be proved between habits and morbidity.
c) Quantification of alcohol and smoking habits could not be done.

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