CHAPTER SEVEN
FINDINGS AND CONCLUSION

7.0 Overview

This final chapter concludes the present thesis. The aim of this chapter is to summarize this study and to offer conclusions in the form of discussions. It begins with the discussion on the key findings and their interpretation (7.1). The discussions are grounded on the analysis of the primary data collected through both quantitative and qualitative methods. This thesis is brought to an end by proposing certain suggestions (7.2) for the policy makers, health professionals, and community workers.

7.1 Findings and Interpretation

In this section key findings of the study and systematic interpretation of those findings are offered. They are provided in the form of discussions on the basis of the data analysis of the indicators selected for this study.

7.1.1 Fertility

It was observed in this study that majority of the sampled women i.e. 40% had more than three children at the time of interview which is higher than the replacement level of fertility i.e. 2.1 children and higher than the national average of fertility i.e. 2.4. FGD 1 and 2 provides subjective understanding of desired fertility and desired sex composition of the children. From FGD 1 and 2 it was found that there exist age wise difference in perception of desired family size and the desired sex composition of children, for older women ideal number of children is four two boys and two girls and for younger women it is three two boys and a girl. Both younger and the older women have agreement on having at least two sons in the family.

It was observed in the study that in spite of strong son preference, daughters were valued too, and at least one daughter is considered essential in family. Daughters are considered

strong emotional support to old age parents. CSN 2 illustrated that how in spite of eight sons the women considered her family incomplete because she did not have a daughter. She still longs for a daughter and craves for emotional support a daughter provides to parents.

The study has also analyzed the relationship between fertility and education of women. It is seen in this study that fertility was higher among women who were uneducated than the women who were educated. The percentage of women with more than three children was found to be the same in women who were educated up to primary and secondary level and was found to be 10 points higher among the women who were educated up to senior secondary. There were only 12 women who were educated up to graduation and post graduation and none had more than three children, however with such scarce representation of women who were graduate and graduate in the sample size it is difficult to arrive at a clearly marked conclusion on relationship between fertility and women's education.

It is seen in this study that those who were self employed their share of having more than three children was exorbitantly higher i.e. 81% than any other occupational group. Mamdani (1972) and Nankarni (1976) also have similar observations in their studies they pointed out pointed out that the wage earners, small farmers, artisans employed in local industrial units prefer large families. Mamdani (1972) in his study illustrated that for them children are economic asset and an assurance against old age. The women whose husbands were casual laborers also had higher fertility than women whose husbands were regular salaried employed either in private sector or in government sector. FGD 1 and 2 also provided qualitative description of these differentials. The women whose husbands were employed in the government sector they were found to have lowest fertility level. One possible explanation of this trend could be that people employed in the government sector no matter what education they had and on what post they were they try to imitate the behavior of their colleagues and seniors. In this way the government's offices are the sites of 'melting pot' affecting each other's behavior even the intimate behavior like

fertility. The same cannot be said about the private sector and particularly the kind of private sector is there in Aligarh with limited job security which leaves the employees to have less interaction among themselves.

7.1.2 ANC

It was observed in this study that ANC utilization is quite high and majority of the women were seeking ANC services from the government sources anganwadi centers, urban primary health centers and health camps organized by the district hospitals and medical college. It was observed that all those women who sought ANC, majority of them had TT injection but 75% of the participants didn't have IFA tablets for 100 days. The findings of the study correspond with the findings of the other studies in slums of different cities (Godbole and Talwalkar, 1999). FGD 3 deliberated on consumption of IFA tablets and TT injection, it came out in the FGD 3 that government health facility are primary source of ANC services and majority however, women also complained under supply of IFA tablets for 100 days, they said they got only one strip of IFA tablets and there were advised to buy the rest of the tablets themselves which they never buy.

Women also opined that with consumption of IFA tablets they thought that it would make the baby so big that it would lead to have caesarean instead of normal delivery.

The study has observed that ANC utilization was the highest among SC and the least among OBC. This contradicts the findings of Navaneetham and Dharmalingam (2002) and Pallikadavath et al.(2004) where they noted that schedules caste women are less likely to utilize ANC. However, this trend needs to be analyzed keeping in mind the existing facilities in the slums. In this study it was observed that the slums with SC concentration had better healthcare facilities than the slums with OBC concentration for e.g Chuharpur with 90% SC population have 4 anganwadi centers, 2 urban primary health centers and a nearby district hospital. It was also observed that the awareness among women regarding the existing facilities was also high in SC than the women from OBC. However, in Maulanaazad Nagar there are two anganwadi center and an urban primary health centre. Whereas in Zakirnagar, the anganwadi centre is not functional and

the urban primary health centre had lack of staff, people also complained that the emphasis of the urban primary health centre was only immunization.

It was observed that women whose husbands were salaried class employed either in government sector or in private sector ANC utilization was substantially high in this category. The women whose husbands were employed in the government sector ANC utilization was found to be the highest among them.

It was observed in this study that with increase in education ANC utilization also increases. The women who were not educated ANC utilization is 42% while 80% women utilized ANC who were educated upto primary, 93% upto secondary and senior secondary and it became 100% in women who were graduate and above. Most of the literature available on ANC utilization pointed a strong association with women's education. In fact, women's education is the considered the most robust indicator associated with ANC. The more the woman is educated the more likely she is to utilize ANC services (Nielsen et al. 2001, Erci 2003). The present study also confirmed the strong association between women's education and ANC utilization.

FGD 3 provided an insight into what women thought of ANC and it emerged that there existed age wise difference in the opinion of women regarding ANC utilization.

It came out in the FGD 3 that majority of women who were more than 40 and were already mother-in-laws thought that ANC was something unwarranted, they elaborated that had it been that important they would not have delivered their babies successfully. However, they let their daughter-in-laws to seek ANC services even though they do not believe in it. Women confided that if they do not let their daughter-in-laws visit doctor, then daughter-in-law would feel bad about her mother-in-law and also this would spread in the community that mother-in-law did not let her daughter-in-law visit doctors during her pregnancy and her family would be labeled as primitive and traditional. Interestingly women considered ANC utilization as an embodiment of modernity and if they do not confirm to this they would be tagged as primitive and they did not want to be associated

with that tag as it would affect the future prospects of matrimonial alliance of their younger sons.

Women also thought that pregnancy and childbirth is innate to womanhood and which did not require any medical intervention. Women were also of this opinion that pregnancy is the period when women are at risk of witchcraft women should not go out. The risk of black magic and witchcraft increases if it is the first pregnancy and there is clear proscription of moving out after dark and in the afternoon time. CSN 3 illustrated also illustrated the existing belief system regarding child birth and pregnancy which is acting as a constraint towards ANC utilization.

7.1.3 Child Delivery: Institutional or Home

The study has noted that majority of the women in the studied population delivered their child at home and only 40% women had institutional delivery. Among women who had institutional delivery, majority of it occurred in public health facility. This raises two paradoxical points with more institutional delivery in government health facility than private health facility suggested increase in the utilization of public health facilities which is an optimistic indication of people's faith in government health facility but at the same time it is equally alarming as it raises serious concern of overburdening of the already overcrowded and overburdened public health system.

The study has also observed positive relationship between women's education and institutional delivery the more the women is educated, her chances of delivering child in an institutional also increases. With this conclusion the study also confirmed the findings of numerous studies like by Varma, Khan and Hazra (2010) where the authors have asserted that the likelihood of delivery in a health institution increases sharply with the increase in women's education. Similar findings were also seen in other studies outside India like Kebede , Gebeyehu and Andargie (2013) and Shiferaw, Spigt, Godefrooi, et al. study of Ethiopia. In fact NFHS 3 (2005-06) concluded that when the factors are controlled, education comes out to be as the single most important determinant of maternal health care utilization in India.

The study has observed that women whose husbands were casual labourers majority of them had home delivery, women whose husbands were salaried class and were employed in government sector, majority of them had institutional deliveries. Husbands who were salaried and employed in private sector, majority of their women had home deliveries and in self employed category majority had institutional delivery. Similar results were also reported in a study of South India () where it was found that women whose husbands were salaried were much more likely to institutional delivery or delivery attended by health professionals.

The study has seen that majority of the women from general caste category delivered in health institution while maximum women in OBC category had home deliveries and majority of the deliveries in SC they had home deliveries. Among all the caste categories the share of home delivery comparing institutional delivery is the highest among the SC in all the caste categories. One of the possible reasons for SC preference towards home delivery was the availability of '*dais'* and the caste affiliation of these *dais.* It was seen in this study that assistance in delivery was provided by the *dais* who were also from the same caste category and same caste affiliation was also considered as one of the important reasons for SC preference for home deliveries instead of institutional delivery**.** Navaneetham and Dharmalingam (2002) in their study of four southern states of India they observed that SC/ST women in were least expected to deliver in a health institution. Similarly, Kumar and Gupta (2015) also observed comparable trends and claimed that lesser number of SC had institutional deliveries as compared to other caste categories.

FGD 4 provided detailed account of the motivation behind the chosen place of delivery. FGD 4 women responded that it is convenient for them to deliver in an institution, but it was seen that the women who cited that institutional delivery is convenient for them, majority of them were the women whose relatives were employed either in Medical College or Malkhan Singh. Women also pointed that they had institutional delivery because they had certain complication and they did not want to have any risk so they thought it is better to deliver in hospitals where they would be under regular medical supervision.

On home delivery majority of the women questioned the medicalization of child birth they lamented that child birth is not a morbidity which requires medical intervention and supervision. They even reprimanded that child birth is turned into a medical condition which is in fact a crucial and joyous period of women's life which should happen at home in company of the near and dear ones.

Women of the studied population thought reproduction is innate to womanhood and it do not require any medical intervention. What the women described here is the pathologization of the normal by locating the child birth under the control of professional doctor. As it is observed that majority of the institutional deliveries occurred in public health facilities, it is the state regulated health facilities which are the dominant actor in this pathologization process.

Substantial number of women also responded that that it was primarily their family decision and they didn't have much say in that. Here it was observed that women who were even living in the nuclear household, the husbands were in continuous consultation with their elder female relatives on the issue of delivery. Another important aspect emerged in the FGD 4 was the logistic arrangement required in institutional delivery if they deliver in hospital who would take care of their other children at home and also they need someone in hospital as well so because of this delivering at home became common consensual choice of husband, wife and other female relatives in the family.

Women also thought that delivering in a hospital is an expensive elitist, middle class affair. They said we don't have enough resources to feed our families and delivering in hospital is an extra liability we have to think about. They also told the researcher that suppose we deliver in hospital we need somebody to accompany us that means loss of wage plus the money spend on fooding, transportation, etc. The person who would accompany the women in hospital they would go home also, so they would need money to travel. Middle class has hefty salaries they could afford to do so not us.

The study also observed that a significant number of women did not prefer institutional delivery because of apathetic attitude of doctors and other paramedical staff. Interestingly, what was disturbing for the women was the apathetic attitude of the paramedical staffs and not of the doctors. Women categorically pointed out that the indifference of paramedical staffs was extremely unsettling for them. They emphasized that the paramedical staffs humiliates them the most. This humiliation is aggravated because of the fact that many of the paramedical staffs are known to them and share with them the same socio-cultural, sometime the economic background, and many a time belong to the same caste category. But when the same people happen to be at medical spaces they boast of their institutional identity as a marker of power and domination. Women responded that they were slapped, scolded, shouted, called by names while delivering in an institution. Hollen (2003) in her study also had similar observation and she elaborated that ayahs have power because of being a part of the medical institution. Most of the ayah had similar caste and class background and to have a social distance from the patient they exhibit such unruly behavior.

The study has noticed that for women home delivery provided a comfortable environment where they were surrounded by their elder female relatives, neighbor and the dais. There are studies which have asserted that support and care women receive while delivering helps them to calm and also reduces the pain (Kitzinger, 1994). Patel (1994) in her study of Rajasthan village also pointed out that female relatives and the neighbors helped women to release their anxiety and tension which ultimately lessen the pain of child birth. The dais in the studied population enjoyed a celebrity status they were generally addressed by women as *mausi* or *khala* which illustrate the intimate relationship *dais* share with the women. The women were full of success stories of these *dais* in cases where even doctors and health facilities refuse to intervene, in those cases the *dais* help women to had successful vaginal delivery. Similarly a study of slums in Allahabad elaborated that the majority of the women favored home delivery taking the help of the untrained dais living in the same area (Khandekar, 1993). Ramana (2002) in her study pointed out the role of traditional *dais* behind this preference for home delivery. On this

issue Khandelkar (1993) pointed out women living in slums preferred home deliveries and women have immense trust on dais who belonged to the same socio-cultural milieu. Women also confided in FGD 4 that they were displeased at how the lure of institutional delivery turns out to be just a hoax for family planning. At health institutions, they are bombarded with doctors and health worker's questions who try to trick them into family planning. This could be an interesting area for further research.

7.1.4 Contraception

The study has found that majority of the women were using contraception and only 37% at the time of interview were not using any type of contraception. Those who were using contraception majority of them were using condoms followed by sterilization, IUCD and injectibles and very few women were using OCP. In FGD it was revealed women generally responded that they were condom users just to evade the regular visits of the health worker this raises important methodological issues in field of family planning. Among the sterilization there was only one case of male sterilization, rest were female sterilization. Study of Vishakhapatnam slum (Ramana, 2002) also reported similar trend and found out that around half of the women in slum use contraception and there also majority of them had sterilization and negligible percent of males have gone for sterilization.

The study has observed higher contraceptive usage in general caste category than that of OBC and SC. Shaw (1988) in his study of Calcutta slums also illustrated that caste is an important factor in contraception and SC had lowest contraceptive usage than any other caste category.

The study has noticed that sterilization was maximum among SC. Similar observations were also made by Shahid (2010) in his study of Lodha block in Aligarh observed that sterilization was maximum among SC. It is intriguing that in India unlike in other nations women of lower age group limit their fertility through sterilization. This is observed in this study also, among the women who were sterilized maximum were in the age group of

29-33. The possible explanation lies in the fact that the reproductive career of sampled population starts with an early age at marriage and early and frequent child birth, consequently the women achieve their desire family size at an early age and lead women to think about permanently limiting their fertility.

It was seen in this study that contraceptive usage was the least among women who were not educated. Mason (1984) elaborated in his study that with women education women's knowledge, attitudes and practice of family planning also increases. Chaudhury (1996) in his macro level study asserts the co-relationship between female education and the adoption of family planning. NFHS 3 also has pointed out significant relationship between women's education and contraception.

It is found in this study that the husbands who were casual laborers were less likely to use contraception than the one who were the salaried especially in government job, though this distinction diminished in salaried in private sector and in self employed category. Mamdani (1976) in his study discerned that the rationale for contraception usage cannot be uniform in all the class situations. Mamdani (1976) pointed out that the wage earners, small farmers, artisans employed in local industrial units prefer large families, for them children are economic assets and an assurance against old age.

In FGD 5 women narrated that how quite often health workers come and inquire about their contraceptive usage. This raises an important issue how women are treated as the reproductive beings by our policy makers whose fertility needs to be curtailed and they are the one who needs to be counseled. In this whole process men are the left out category and this does not seem to be mere coincidence. Women particularly the non users lambasted that if they say that they are not using anything it does not mean that they are not controlling their fertility. Women pointed out that there are certain social dos and donts in the society related to sexual and reproductive behavior. The study has observed that people have clear understanding of social norms related to fertility and they act accordingly, as it was also pointed out in various like Wyron and Gordon in Punjab(),

Kara and Sinha in Orissa() and Patel(1994) in Rajasthan. In this study also it was found that people conscientiously follow the social norms related to fertility. As it was pointed out that it was a social norm that after achieving the status of mother-in-law, women limit their sexual activity.

The study has observed that 37% women who are using any kind of modern contraception actually experienced problem associated with the chosen contraception. Among the OCP users except one all had experienced problems after using it and 43% of the DMPA users experienced problems after using it. Majority of the IUCD users i.e. 66% faced adversities after its usage and the women who had tubectomy 33% experienced problems after its adoption. Among all the users the problems associated with OCP users was found to be the maximum followed by IUCD users and sterilization and minimum with condom users. The problems women experienced after using contraception were menstrual problems, weight gain, white discharge, pain in lower back and lower abdominal, vaginal dryness, cramps in legs, stiffness around stomach and abdomen. In a study of slums of Baroda noted that 20% modern contraceptive users experienced some side effects related to the used contraception. Another study of urban area of Delhi noticed that higher reproductive morbidity among the contraceptive users (Bhatnagar, 2013).

FGD 6 provided women's experiences with contraception where women raised their opinion regarding contraception. The women who were injectible users they complained of irregular menstruation after DMPA use. They also complained of stiffness of lower abdomen and weight again around their waist after DMPA use. Despite the complaints to the use of injectibles experienced by the members in the focused group women were still curious about DMPA. Interestingly, DMPA which they called 'DIMPA' is a considered magic injection which could make women free for 5-7 years. DMPA is not part of government family planning program in India and is not available in public hospitals. It is unreachable for women living in slum areas who majorly rely on public health institution for family planning services and its inaccessibility and to become free from fear of

pregnancy for next few years makes it more desirable among women of the sampled population.

Many women in the focused group pointed that they used OCP in past but because of its side effects they have stopped using it. Women also expounded that the strict regimen of OCP use makes it difficult to use. Women also confided that they did not get OCP from urban primary health centers or any other public health facility and they have to buy it which again becomes a liability with their limited financial capacity.

Majority of the women complained of vaginal discharge with IUCD. It was observed in the study that very few IUCD users reported having pre-insertion screening and discussion with the doctors on its major side effects as discussed in CSN 5. Women also discussed that the insertion was actually done by the nurse and the doctor was frequently coming and going when the procedure was being conducted in the hospital. Majority of the IUCD users got it done at the district hospital who denied suffering from any complication as a result of their use of contraception. This is in stark contradiction to the findings of the FGDs and CSNs which clearly revealed many complications, majority of them face. This highlights the culture of silence related to reproductive morbidity. The complications range from menstrual problems (irregular or profuse bleeding), and white discharge to weight gain (particularly with IUCD and injectibles) and pain. Women who underwent sterilization complained of pain in lower abdomen and lower back, cramps in legs, excessive dryness around vagina etc. One of the women in CSN 6 complained of getting pregnant twice in spite of the sterilization, and at both the times, she underwent abortion. CSN 6 raises important question about how sterilization is being done in public health facilities and also the relentless zeal of the policy makers towards it. CSN 6 also reminds us of emergency period sterilization camps. Many women sought medical advice for their complications. Numerous studies on general health seeking behavior of women suggest that women seek medical advice when complications restrict their daily routine. The fact that majority of them sought medical intervention confirms that a large number of women suffer from complications. While the doctors, in majority of the cases,

refuse to acknowledge the cause of the complication in contraception use and diagnose their problem very unlike the way that those women face them as lived experiences.

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Women who sought medical advice for their condition, majority of the women responded that they were not satisfied with medical help provided by the doctor. Many of the women responded that their problems were overlooked and it was actually attributed to some other condition and women said they could not agree to it because it was their body they did understand their bodies and they were kind of sure that this problem arisen because of the particular contraceptive usage but the doctors failed to buy that argument. Many women also elaborated that after the medical help there is no substantial change in their situation, it required prolonged medication which they were unable to afford. It was observed in this study that women were not being counseled for the side effects of particular contraceptive method neither they were informed about all the available method of contraception. Women were being informed only about the one which the doctor or the health worker thought suitable for the women.

The study has pointed the women's self determination to choose the method of family planning she would like to choose for herself is seriously compromised and she is also not being informed about the side effects of the selected method on the contrary their problems associated with contraception is negated and overlooked. The concept of reproductive health which is viewed as synonymous with women's self determination, choice and has put an end to governments target oriented and method specific family planning program but in reality the idea of freedom and choice in matters related to

contraception with which reproductive health is synonymous with is bargained with the state's fixation to curb women's fertility.

At this juncture it is important to ask what features of hegemony and of biomedical perspectives, if any, do we find in this reading of the negation of women's subjective and lived experiences in the name of being objective and scientific. The findings of this study regarding the complications as a result of use of IUCD concur with numerous studies (Hoggart, 2013). What is the motivation and enthusiasm which make IUCD part of the government family planning programs in India is another valid question. Issues raised above are serious and should be topics of through future research. This study brings to the fore that women's freedom in choosing the method of family planning and informed decision making is seriously compromised and overlooked. The concept of reproductive health is synonymous with women's self determination and free choice and has put an end to governments target oriented and method specific family planning program. However, with the state's fixation to curb women's fertility, the idea of freedom and choice in matters related to contraception are compromised

7.2 Suggestions

The present study is a modest attempt to highlight the reproductive health issues of women in slums. It is evident from the study that substantial numbers of women utilize ANC services which is a positive trend towards favorable reproductive status. However, institutional delivery is still low and women prefer to deliver at home and *dais* are considered important in child delivery. The preference for home instead of a health facility is a serious impediment towards universal institutional delivery. A considerable number of women use contraception though only a single case of sterilization (vasectomy) was reported among males the rest were of female sterilization. This points to how women are treated as mere instruments to curb fertility.

Reproductive health of women can further be improved by making concerted efforts along with the following lines:

7.2.1 For Policy Makers

- There should be equal distribution of urban primary health centers and anganwadi centers in slums across the city. For instance it was observed that slums like Jangalgarhi with more than 5000 population there is no urban primary health center and there is only two anganwadi centers, similarly Maulanaazad Nagar with more than 8000 population too have only two anganwadi centers whereas there is provision of one anganwadi center per 1000 population.
- There should be delivery facility in all the urban primary health centers.
- Urban primary health centers should have facility for IUCD insertion and sterilization.
- There should be proper medical screening and follow up care should be provided in matters related to contraception as it is observed that often there is no medical screening prior to adoption of IUCD, and sterilization and women face post adoption complications.
- *Dais* should be mainstreamed into intuitional setting and trained to provide safe delivery in slum areas. *Dais* are considered the most trusted in matters related to child delivery. The mainstreaming of *dais* is pointed out by many studies like by Gulati, Tyagi, & Sharma (2003), Hollen, (2003)
- It should be ensured that women are provided with 100 days of IFA tablets.
- The emphasis should also be placed on safe delivery and not only on institutional delivery. *Dais* should be provided with training and certification to conduct safe deliveries at home.

7.2.2 For Health Professionals and Community Workers

- Women should be counseled about anemia and for 100 days IFA tablets consumption.

- Elderly women like mother-in-laws, sister in-laws and other important filial female relatives should also be counseled about ANC, IFA tablets, safe delivery and contraception.
- Women should have self determination in matters of contraception they should be informed about all the available methods of contraception and should be able to decide freely which suits them the best.
- Women should be informed about all possible side effects of particular contraceptive method in order to make informed consent a reality.
- The health professionals should shred away with their elitism and 'professional dominance' (1970) and treat people with dignity and respect. The doctors and the paramedical staffs in the health institution should be sensitive towards women's lived experiences. Stereotyping of a particular community should be avoided, there should be a code of conduct and there should be proper monitoring of the implementation of the code of conduct.
- Women should be provided with counseling on all aspect of safe motherhood not only on institutional delivery and family planning.
- Men should also be counseled about matters related to reproduction and particularly on family planning. The study observed that there is dearth of male social workers in public hospitals and absence of male social workers in urban primary health centers. Male social workers should be appointed to counsel men for contraception.
- Women of particular caste, class and religion should not be targeted for family planning owing to their higher fertility; this creates suspicion in the community. They should be counseled by taking the help of their informal leaders and influential community members.