Sustainable Health in the Times of SDGs- Voices from the Margins

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Abstract

The present chapter reflects on health care availability, utilization and pattern of morbidity in the slum. The first part deals with the general profile of the public health, proximate causes of the ill health, which provides the insight about the general profile of the infrastructure and basic amenities position vis a vis slum. The second part is related the health care utilization in slums namely services of medical institution, charges of the private medical institutions and clinics, source of treatment, reason for choosing the source of treatment, satisfaction with the treatment, user charge. This section also includes the access to the health care services in the slums and the mode of transport used for the utilization of the health care services. The third aspect of the study is related to the pattern of morbidity in slums includes illness in the last month, ailment on the survey date, hospitalisation in one year, average morbidity and hospitalisation rate in one year of three slums, type of ailment, ailment of the head of the household, ailment of the family members, no of days of inactivity and lastly analysis of the common problems and health status of slum dwellers, treatment sought and the proximate reasons for the ailments in slums been done.

Keywords: Index of wellbeing, Public Policy, Sustainable Health, Marginalisation.

Sustainability of the health

Sustainability of the health and care system depends on internal and external factors and public and political acceptability and support. The system's contribution to the economy through supporting a healthy workforce and providing a platform for health research and development is generally overlooked and should be maximized. Cross-sectoral partnerships of private and public organisations have crucial roles in building healthy and health creating communities, towns, and cities (Figure1).

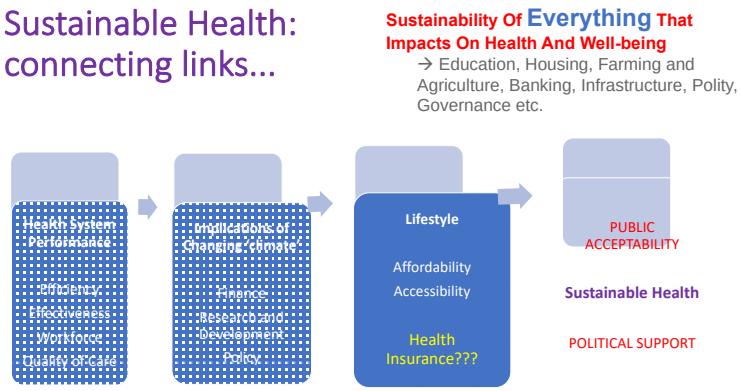

Figure 1-Connecting Sustainable Health

A new strategy and narrative are needed to embrace these wider issues. Sustainability is about finance and affordability, as well as about the efficiency and effectiveness of the system. It also depends on factors outside the control of the health and care sector. A sustainable health and care system functions within the limits of financial, social and environmental resources. However, in the changing scenario of economic growth and urban development, the current approach to delivering health and care cannot continue in the same way and stay within these limits.

Sustainable health needs to be fair. Therefore, services need to be **without discrimination or disparities, to all,** regardless of age, group identity, or place, and that the system is fair to the health professionals, institutions, and businesses supporting and delivering care (Fig 2).

India's public health system is grappling with low quality care, corruption, unhappiness with the system, poor accountability, unethical care, overcrowding of clinics, poor cooperation between public and private spheres, barriers of access to services and medicines, lack of public health knowledge, and low affordability. These drawbacks push wealthier Indians to use the private healthcare system, which is less accessible to low-income families, creating unequal medical treatment between classes.

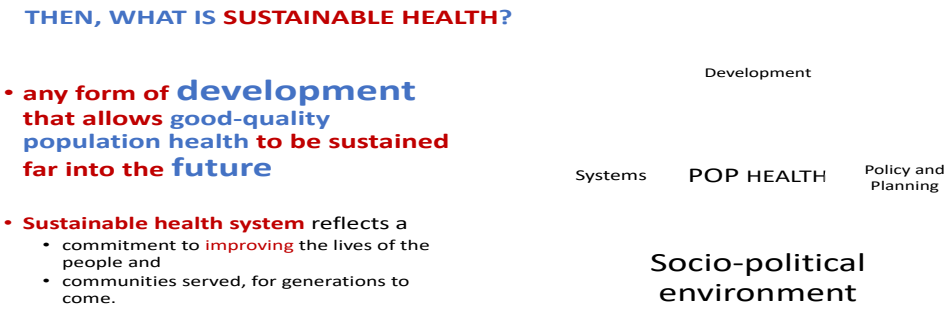

Figure 2 What is Sustainable Health?

Methods and Materials-

The present paper is extracted from a larger study located in Kusumpur Pahadi. The study was conducted in selected sites. Familiarity and feasibility were two important considerations. The methodology adopted was in three parts. The first dealts with defining sustainable health and vulnerability followed by urban context of sustainable health. Developing a concept and typology of discrimination with respect to health care has also been addressed in this part. The second part of the methodology deals with database and sample design; methods of measurements; and content analysis of the narratives obtained from the Consultative Meetings and discussions held during the fieldwork.

Issues of social discrimination in Universal access to health among urban poor

Urban poor are located over physical spaces which are deficient in the provisioning of safe drinking water and sanitation causing high incidence of diseases such as diarrhea and anemia. There is almost no sanitation facilities and no underground sewerage system. Availability of basic civic facilities, like potable water, water disposal and sanitation, are vital for healthy living of human populations. The approach road to the settlements of vulnerable populations is usually of a poor condition. Enabling environment for vulnerable populations can be created through the institutions by ways of policies and programmes and the sensitivity of the providers and co-users of the resources and services. Enhancing factors include the positive self-image consequent of propensity which allows access in contract to the negative self-image. Thus, a matrix of five factors juxtapose themselves to

transcend from access to utilization (Figure 3). Understanding of discrimination rests largely on how the concept of 'social exclusion' has been understood and evolved. Social exclusion, over last 30 years has referred to understanding the disadvantages experienced by some social groups and means to eliminate them. By early 1980s, 'social exclusion' became a concept to describe deprivation. It helped in recognizing poverty as an outcome of different processes leading to the experience of disadvantage which extended over years due to, and, leading to, poor educational opportunities, low wages and insecure employment. By 1990s social exclusion was distinguished in two broad ways- as an attribute of individuals; and as a property of societies. As an attribute of individuals social exclusion focuses directly on the nature of the lives people live and disadvantages they experience. Socially excluded people are isolated, lack social ties to family, local community, voluntary associations, trade unions or even nations. They are likely to be disadvantaged in the extent of their legal rights or their ability to use them effectively. It involves both consumption and work-related aspects of disadvantage.

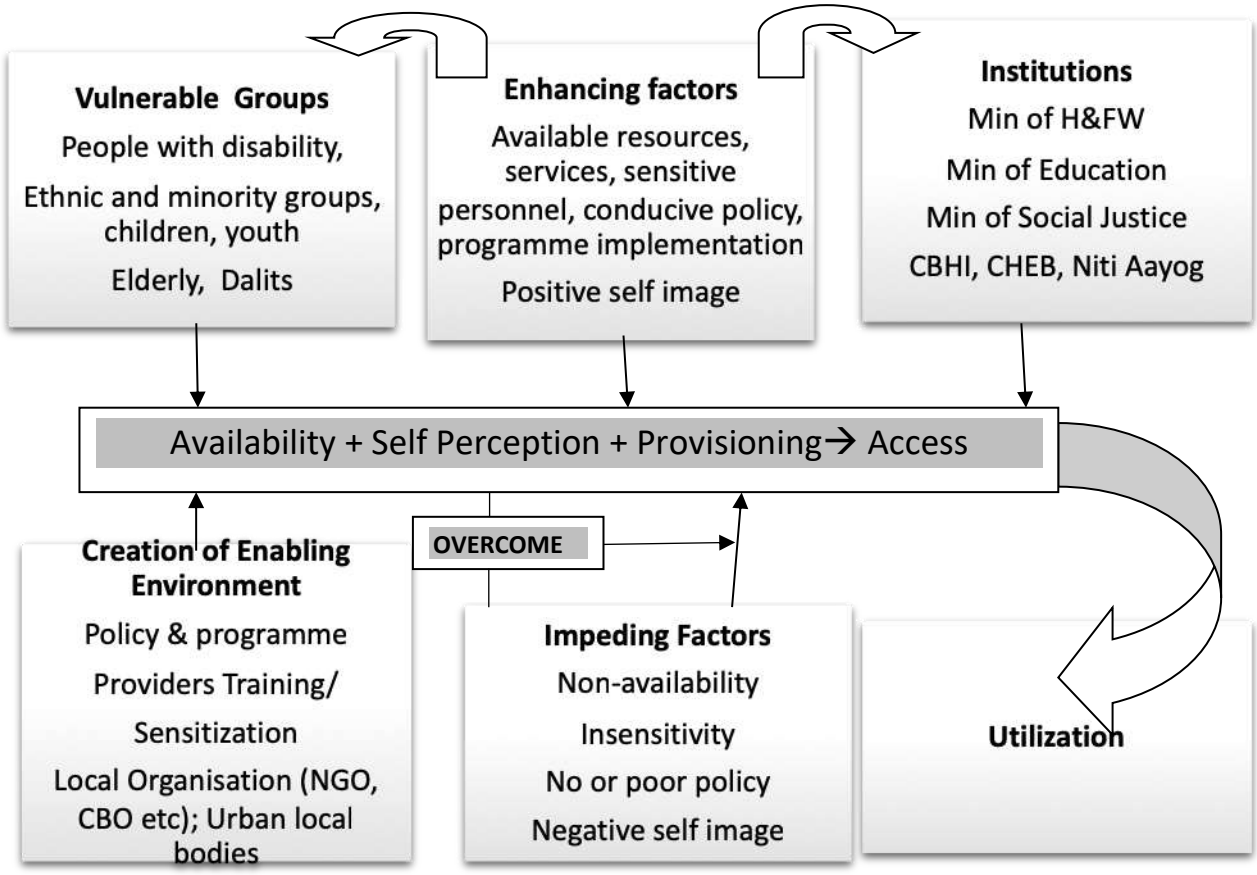

Figure 3- Dynamics of Factors Enhancing and Impeding Access to Resources
Source- Derived from Acharya, 2011

As property of societies, social exclusion is often a part of basic institutional framework and institutional arrangement within a nation. It refers to institutions and rules that enable and constraint human interaction. In this form of 'social exclusion' racial, sexual and other forms of discrimination are present. In the context of Indian sub-continent, caste-based social exclusion is unique and supersedes all other forms. Caste based social exclusion is linked with social deprivation as well as discrimination faced in the market where buying and selling of goods, particularly home based and through small units occurs. Market through which people can earn a livelihood is discriminatory. Public goods which should be available to all are limited to a few (Thorat, et al, 2006) Social determinant framework has also contributed in understanding the elements of social exclusion and has been useful in understanding health issues (Commission on Social Determinants; Nayar, 2007).

When extended to social exclusion in health care, causes of deprivation; and barriers in access to opportunities, services and resources which create and enhance enabling environment address-

- Exclusion of some groups
- Factors leading to their exclusion; and
- Means to end their exclusion

Due to differential access to resources, problems thus faced by vulnerable populations- women, children and youth, in these conditions are comparatively worse than others. Sanitation is important in maintaining environmental cleanliness and disease-free surrounding. The incidence of disease can be minimized if proper sanitation can be provided. Diseases are often caused by insanitation and unsafe disposal of various type of waste. Historically Chadwickian Sanitary Reforms[1] were set in motion because of existing poor sanitary conditions. Persons, particularly youth engaged in such works, without any safety gears, social security and legal protection, are additionally exposed to the risk of health hazards. Thus, sanitation coverage is as important as is the concern for persons providing the coverage. For majority of the poor the priority for health comes last because livelihood plays the pivotal role in their life, then shelter and finally health. Inside the slum are a mix of voluntary, government and private sector. Although the nearest government health facility is located within the distance of one km, the nearest government hospital is the Safdarjung hospital which is about 10 km away from Kusumpur Pahadi. There are two health centres run by the voluntary organisations. These centres mostly focus on immunization of children, and antenatal care of the mothers. There is a weekly mobile homeopathic clinic that comes to slum every Monday during 9.30 am to 4.40 pm.

Reported Illness Among Household members

Morbidity is one of the major experiences of the people in the study area, but the economic conditions and poor infrastructure restrict it from becoming a concern. As regards reported illness most of the household member have reported to have suffered from fever (57%) followed by cough and cold (23%). Other ailments like diarrhea and pneumonia, about 6% each; and conjunctivitis and fracture (1.9% each) have also been reported (Figure 4).

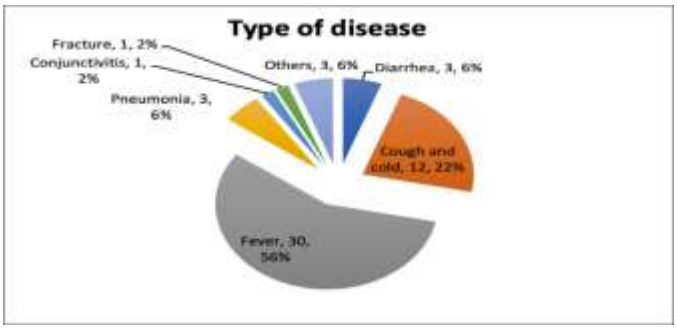

Figure 4 Different types of disease reported among Study participants

[1] After the influenza and typhoid epidemics in England 1837 and 1838, Edwin Chadwick Sanitation Commissioner, was asked by the government to carry out a new enquiry into sanitation. In the report, *The Sanitary Conditions of the Labouring Population,* published in 1842, Chadwick argued that disease was directly related to living conditions and that there was a desperate need for public health reform. A body was created to oversee street cleansing, refuse collection, water supply and sewerage systems. Chadwick suggested a constant supply of fresh clean water, water closets in every house, and a system of carrying sewage to outlying farms, where it would provide a cheap source of fertilizer for improving sanitary conditions.

Source- Fieldwork

However, if the illness episodes are disaggregated by social group, some observation are noteworthy and they reiterate the historical deprivation experienced by the SCs. Out of the total households (314) which reported no illness during the preceding one month of the fieldwork, less than 70 were SC. In contrast, 105 were OBC and 140 were 'Others'. The difference between the SC and the other two groups which are positioned higher on the social ladder ranges between 35-70 households (Table 1).

Table 1- Reported Illness Across Social Groups

Reported illness	SC	ST	OBC	Others	Total	% persons reporting illness
No Illness	**69**	**0**	**105**	**140**	**314**	**68.6**
All major Illness						
Respiratory	02	00	00	02	04	0.9
Digestive	07	01	03	02	13	2.6
CVD	00	00	02	02	04	0.4
Liver, Biliary system	03	0	0	0	03	0.5
All minor Illness						
Skin	03	00	01	00	04	0.9
Pregnancy and Childbirth	02	00	00	00	02	0.4
Cough, cold fever (viral)	53	00	04	12	69	15.1
Joint Pain	05	00	01	01	07	1.5
Injury	02	00	02	00	04	0.7
Jaundice	03	00	00	00	03	0.5
Cholera	05	00	01	01	07	1.2
Headache, backache	18	01	07	04	30	6.6
Total reported illness					**462**	**100**

Source -Fieldwork Note- Illness reported one month Preceding the Fieldwork

Private facilities as well as informal health services like grocery shops selling medicines for fever, headache and pain, are also present in the slum. Private facilities are present mostly in the form small doctors' clinics (Plate 6). Kusum Pur Pahari also has numerous chemist shops and informal local health care service providers often called as *Bengali* doctor. They are in demand mostly for providing health services at a very low rate. Health seeking behaviour was examined keeping in mind the issue of availability, accessibility and affordability. The residents of the slum approach the local health provider/informal health providers because of the following reasons: -

- People trust the local health provider.
- Proximity and access to local healers and health care service providers is playing an important role.
- They provide services on credit too.
- They talk nicely to patients and give them respect. They allow them to share their discomfort and illness
- Use of injection plays an important role for the residents. It is perceived as a 'qualification' and 'skill' of the doctor. *'A 'good' doctor is expected to give injections'* (FGDs 4, 7).

Maternal and child health in Kusumpud Pahadi

Reproductive and Child Health Programme (RCH) was launched in October 1997. Since then promotion of maternal and child health, particularly of the vulnerable population like the ones in the slum areas has been one of the most important objectives of the family welfare programme in Delhi[2]. The RCH programme incorporated the components covered under the child survival and safe motherhood (CSSM) programme and also included an additional component relating to reproductive tract infection and sexually transmitted infections. In order to improve maternal and child health in the urban slums, Government of Delhi established a Health Post or Family Welfare Centre for every 50,000-slum population[3]. However, the study participants interviewed, expressed their views about the importance of RCH services in the slum. They also expressed the discontent with the services provided.

Ante Natal Care (ANC):

There were some RCH services that were availed by the study participants. More than half of the women 58.02 per cent pregnant women had registered for ANC in Government Health Centre. A little over one-third (33.02) had registered in private hospital or a clinic. Nearly 97% received 3 ANC Check up with 100 IFA Tablets and two tetanus injections (TT). In this regard, the FGD discussions corroborated that almost all pregnant women were going for ANC registration with the help of ASHA (or USHA) and by ANMs in the Government facilities. As regards immunization all the eligible women got their children immunized. It was evident from the FGDs, that the purpose of child immunization was clear to all the women in the study slum areas. Mothers of small children came forward for immunizing their children whenever the ANM and AWWs scheduled to provide immunization in their locality. Mothers were very particular about the immunization cards; they also knew which doses were yet to be given.

Institutional Delivery: Nearly 98 per cent women participants had institutional delivery. Almost all the members in the FGDs were of the opinion that institutional delivery was the best for the mother and child because it takes care of any complication during the delivery. Despite this, some women went to their native place for home delivery as they considered the expertise of local dais and elder women at home more convenient than dealing with complex procedures of institutional delivery.

[2] RCH Phase II – National Programme Implementation Plan (2005-2012), Ministry of Health and Family Welfare, Government of India; Government of India (2006). National Guidelines on Prevention, Management, and Control of Reproductive Tract Infections including Sexually Transmitted Infections, Maternal Health Division and National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India; Government of India (2010). Operational Guidelines on Maternal and Newborn Health, GOI.

[3] Government of Delhi (2013). Annual Report of Health Post, Rotary Club, South Delhi.

Home Delivery: About 13 per cent women stated that their home delivery was assisted by trained health worker in the slum area. But trained dais with delivery kits were hardly available in the slum areas. It was the common belief that private clinics or nursing homes inclined to earn money for which normal delivery cases were deliberately made cesarean. The clients were not having any options in such cases.

Post Natal Care (PNC): About 62.14 per cent of the women availed the PNC services provided by health workers/ANM in the slum. However, the FGD findings indicated that PNC was important but most women in the slums could not use it because some women went back to their native home for delivery. PNC was neglected, consequently they faced complications which were detrimental for both the mother and newborn babies (Table.2).

Table 2- Reproductive and Child Health (RCH) Services Used

RCH Services ever Used in last five years	Total Cases accessing services	Total Cases	Percent accessing services to total cases
ANC registration in Government Health Centre	123	212	58.02
ANC registration in Private Hospital/clinic	70	212	33.02
Received 3 ANC Check up with IFA Tab 100 and 2 TT	205	212	96.69
Immunizations done for children	228	228	100
Institutional delivery	201	206	97.57
Home delivery assisted by trained health workers	27	206	13.12
PNC Services provided by health workers/ANM	128	206	62.14
Contraceptives used/using (women)	104	212	49.52

Source- Fieldwork

It was also important to understand the beneficiaries' satisfaction level for the RCH Services to understand the quality of the services provided in the study slum areas. The users' satisfaction is an important indicator to assess the quality of RCH. They are, more often than not, unaware whether any standards are followed by the health care providers for provisioning of care services. Therefore, their perception of 'good service' is reflected from their level of satisfaction for services they availed or want to avail (Table 3). About 25.54 per cent men and women in reproductive ages were fully satisfied with RCH services in the slum, while about 61 per cent of respondents were partially satisfied with these services. It implies that the quality of the RCH services is not perceived to be in a bad condition by the users in the study slums in Kusumpur Pahadi. It is noteworthy that among those fully satisfied, nearly half are SC and about one -fifth are HC Hindus (or Others). Perhaps the assertion to question the quality is more among the HC and therefore the consequent satisfaction is less. In contrast, the assertion to question the quality is less among the SC and therefore the consequent satisfaction is

more. Corroborating this is the distribution of those 'not satisfied', wherein lesser SCs as compared to OBC and Others are 'not satisfied'.

Table 3- Level Of Satisfaction On RCH Services Availed

Level of Satisfaction	Total Population (15-49 years)		Distribution across Social Groups (%)			
	Number	Percentage	SC	ST	OBC	Others
Fully Satisfied	58	25.54	12.61	4.10	3.64	5.19
Partially Satisfied	138	60.61	14.50	6.10	18.41	21.61
Not Satisfied	32	13.85	3.46	00	5.18	5.21
Total	228*	100	30.57	10.20	27.23	32.01

Source- Fieldwork Note- *Includes 117 men and 111 women

People resort to diverse source of health care for antenatal care, child delivery and post-natal care. Although this slum is located in the heart of the city, access to services is still a major concern and is evident in the number of women opting for home deliveries mostly with the help of dais with minimal and even no antenatal care or vaccination of the children under the age of five years. This is reflective not only of the structural constraints but also of the socio-cultural norms which influence utilization of certain services with variation across social groups (Ram, Pathak and Anamma, 1998; Kulkarni and Bariak, 2003, Acharya, 2011)

Reliance on government facility for delivery is prominent in the area as going to private facility will mean very high expenditure. Sometimes, though, women go to the private hospitals for child birth as they are not satisfied with the functioning of government services. Sometimes they felt they could afford 'better' services so they opted for the private, clearly indicating the misconception that government sector is 'poor' and the private sector is 'good'. Women mostly felt that the waiting time was very high if they went to Safdarjung Hospital. They were not happy with the kind of services they got there. They also pointed out at the language and derogatory words used by the hospital staff for them. One of the women (petty shop owner, widowed aged 32, Muslim) narrated her experience as follow: -

'These doctors get money from the government. They treat us as if we are coming from the streets. They give the same medicine for cold, cough, fever etc. I really wonder that how can they write the medicine for us without checking us properly, didi. It's all about the game of money and power. If we can look 'nice' (like other women) they will talk to us nicely.' (IDI, 14)

Health seeking behaviour for maternal and child health to a large extent was determined by the income and socio-cultural norms. But social identity based on caste, religion and ethnicity was also a strong propeller. Certain cultural norms also influenced the utilization of MCH services and it was evident in case of immunization of children, use of ICDS services and assistance during time of delivery.

Reproductive Health Care Services-

As regards Reproductive Health Care, 60% women of the study households did not use any assistance during birth. The share of those who used, however, increases with each income quintile. About 67% of those who used are from the fifth income quintile (Table 4).

Table 4 Income quintile and medical assistance during birth and Place of Birth

Income Quintile	Assistance during birth	Place of Birth				Total
		Home	PHC/State dispensary	Government hospital	Private Hospital	
1	5 (16.7%)	23 (76.7%)	5 (16.7%)	1 (3.3%)	1 (3.3%)	30
2	13 (40.6%)	20 (62.5%)	9 (28.1%)	3 (9.4%)	0 (0%)	32
3	12 (41.4%)	23 (79.3%)	5 (17.2%)	1 (3.4%)	0 (0%)	29
4	9 (39.1%)	16 (69.6%)	5 (21.7%)	2 (8.7%)	0 (0%)	23
5	18 (66.7%)	15 (55.6%)	11 (40.7%)	1 (3.7%)	0 (0%)	27
Total	57 (40.4%)	97 (68.8%)	35 (24.8%)	8 (5.7%)	1 (0.7%)	141

Source- Fieldwork

It is evident from the data that different sources are used for accessing health care. As regards place of delivery, of the total 141 reported during the study period, about 69% were at home, followed by 25% at the PHC or the dispensary. Most home (79%) and PHC/Dispensary (28%) deliveries were in the income quintile 3. Only one delivery was reported to have occurred in private hospital in lowest income quintile (Table 7.4). It is important to note that the use of medical assistance during delivery is directly related to income quintiles.

Access to Services for Maternal and Child Health by Social Group

When the access to services for maternal and child health is disaggregated by social groups, it is evident that access is better among OBC and the HC Hindu (Others) as compared to SC and ST. Even registration for ANC in public sector health facilities (which are free of cost with a minimal user fee, if at all) is two to three times less than that of OBC and 'Others'- socially advantaged groups. Similar differentials is evident in case of antenatal and post-natal care. Across social groups, more SCs resorted to home delivery as compared to other groups (Table 5).

Table 5 Distribution of RCH Services ever Used in Last five years Across Social Groups

RCH Services ever Used in last five years	Percent accessing services to total cases across Social Groups				
	Total	SC	ST	OBC	Others
ANC registration in Government Health Centre	58.02	32	50	65	85
ANC registration in Private Hospital/clinic	33.02	8	50	12	31
Received 3 ANC Check up with IFA Tab 100 and 2 TT	96.69	35	100	89	83

Immunizations done for children	100	100	100	100	100
Institutional delivery	97.57	73.5	100	85.1	96.3
Home delivery assisted by trained health workers	13.12	26.5	00	14.9	3.7
PNC Services provided by health workers/ANM	62.14	57.5	61.8.	87.5	95.8
Contraceptives used/using (women)	49.52	39.4	73.8	73.8	86.9

5Social Constraints in nutrition and breast-feeding

Nutritional status is an important indicator of development. Delhi with a population of more than 18 million, is one of the biggest metropolises. But nearly half its population lives in slums, unauthorized colonies, about 860 *jhuggi-jhopadi* cluster and 420,000 *jhuggis*[4]. Most vulnerable among them are the children, especially those aged 0-36 months because their health depends on maternal health and nutrition, breastfeeding, and quality of public health care services (Delhi Development Report, 2009). In comparison to Delhi's infant mortality rate (IMR) of 40, the IMR in the slums is higher at 54 for every 1,000 live births. The immunisation level in the slums covers a dismal 34 percent of the population and because of the negligence of civic authorities in providing safe drinking water and sanitation, there is a high incidence of diseases such as diarrhoea (75 percent) and anaemia (63 percent). Delhi has 35.4 percent stunted, 15.5 percent wasted and 33.1 percent underweight children under the age of three despite being a state with the second highest per capita income in India. About 67 percent children and 69 percent women construction workers living in the slums of Delhi are undernourished (Acharya and Reddy, 2016, 2017).

'The focus on quality health services has to be accompanied by a clear policy of land allocation for health services in Delhi's Master Plan. The current allocation shows a decreased allocation of space for primary health centres in urban poor settlements. More focus should be given to increasing the number of service providers… We need more skilled man power to handle our health services. That is key to proper implementation of the health services to the people'.[5]-In Kusumpur Pahadi socialization process has been such that the consciousness towards one's own health is absent. Gender discrimination becomes quite evident not only in terms of education but also in nutrition. Girls eat last or only after all the men and boys have eaten and their mothers are ready to serve them and their own self. The girls participating in the study reported in the FGDs that often they did not cook if alone or ate whatever was left over. Certain cultural practices prevalent in the study area need to be examined with reference to constraints leading to increased vulnerability of women and children particularly girls. A women belonging to the *Paasi* community (Scheduled Caste) stated-

> *"… after delivery the new mother can breast feed only when the Pandit (local Priest) proclaims an auspicious time which is usually after two days. After the day and time is fixed, the mother is bathed, the*

[4] Mahapatra, Dhananjay (2012) 'Half of Delhi's population lives in slums' http://timesofindia.indiatimes.com/city/delhi/Half-of-Delhis-population-lives-in-slums/articleshow/16664224.cms. Printed from The Times of India TNN | Oct 4, 2012, 08.07 AM IST. Accessed on21 March 2018

[5] Amod Kanth, chairman of the Delhi Commission for Protection of Child Rights (DCPCR) in his address during the release of the Forces Report "A situational analysis of the young child in India", at the India International Centre on 09 April 2018. The study was conducted in six slums in Delhi by Forces, a voluntary organisation working on child care services in India. 10/4/2018 The Hindu https://www.thehindu.com/news/52-per-cent-of-Delhi-lives-in-slums-without-basic-services/article16853844.ece 3/3

breasts cleaned with warm water, then sprinkled with rose water. Then some honey is applied to the nipples, prayers are offered in the form of chants recited by the priest and then the feeding begins" (IDI2).

This ritual is often followed by a feast given to the community members. It has been observed in the existing literature and the FGDs too that the ostentatious expenditure on this often cuts on the budget, time and energy which could be used for the health and hygiene of the mother and the newborn. A new mother in her interview to the researcher express her anguish as follows-

'I was supposed to take my child to the Health Centre for the immunization on the third day (after delivery). My husband had taken leave to accompany me. But the elders deiced that day to be the day of the initiation of breastfeeding ritual! Neither me nor my husband could convince the elders to change the day for the ritual and that vaccination more important. Our attempts to plea for the visit to the HC was ridiculed and the ritual given more importance. Although, I sensed that my mother-in-law was a little inclined to sending the newborn for vaccination, she could not overrule the 'orders' of the community leaders, one of them was her husband and my father-in-law'. (IDI 24)

This effectively means that the infant is missing out on the immunity producing colostrums. In some communities, the practice is to clean the breasts with the paste of the leaves plucked from the trees and then the colostrum is squeezed out near the tree close to the place of worship. While the rituals are ordained to be followed strictly, prioritizing religiosity, patriarchal and social norms are also evident. Non-observance of the rituals is likely to amount to the non-compliance of the norms laid down by the society. The denial of the 'right' of the community to get a feast from the family of the new born is interpreted as questioning the might of the community leaders. In this whole process, health of the mother and child are, for sure, affected, economic burden, which can be avoided, is also incurred.

Utilization of Services-

Utilization of care and counseling services depended on their availability and propensity to access. In the study area, availability was poor. Some of those available were used while others were not for reasons as varied as distance, time, availability of the provider and awareness regarding the availability of the service (s). The women considered the services at the nearest health facility as satisfactory despite the references made to the 'shortage of medicines' due to which they often had to buy the prescribed drugs. Some also preferred going to the private doctors since they were nearer to their residence as compared to the hospital.

There have been instances where the person could not be reached to the health facility because no means of transport was available when needed. They also pointed out that the doctors do not come to the center regularly and on time. A young adult said,

"… after coming so far to the Centre, when the doctor is not there then, we have no other option but to go to the private doctor" (IDI 10).

For pregnancy and child birth there is preference for the private practitioners. An important reason for this decision was lack of identity documents which obstructed the use public sector facilities. The household often took loans for meeting the health care expenditure. Generally, the very poor go to the government hospital and those who are a little well off, go to the private practitioners. Therefore, the registration of births is not being effectively covered. The Traditional Birth Attendant (TBA) and the private doctor ask for Rs. 1500 and the request to reduce the charges invites displeasure and demeaning attitude reflected as follows-

"…everybody becomes poor when it comes to giving money for 'safe' deliveries… 'enjoyment' during the act of procreation is forgotten"[6]. (IDI 12).

Quite often the women go for checkups only after four months of pregnancy when there is stomach ache or vomiting and the work starts getting affected-

"…Doctor told me I was in my fifth month …I was thinking it was just the beginning of the fourth month… so I registered for ANC" (IDI12).

Although the women seem to be fairly conscious about immunization of the children, they do not appear to be very regular in taking medicines, weight and Blood Pressure for themselves as expectant mother. So, most of them are contacting the health care service providers or visiting the facilities almost half way through the pregnancy. The economic factor is essentially impacting the health behavior of the vulnerable population. However, there is a marked difference between women across income quintiles as it is between SC and HC (others).

The study also reported that 49.8% women got married in age less than 18 years leading to early deliveries, multiple pregnancies and abortions. The prevalence of social health determinants as early marriage, multiple pregnancies and abortions, substance abuse, domestic violence indicated lower access to services available. As per WHO, about 5.7% of maternal deaths in Asia occur due to unsafe abortion. The present study also revealed a higher rate of abortions (13.2%) among women which may be largely due to lower awareness of birth control measures (as only 39.8% reported to be using them). This percentage of women using the birth control measures was similar to findings reported in "The state of Urban Health in Delhi" with about one-third (34.8%) of urban poor women practicing any modern contraceptive method in comparison to urban average of 64%.

Nutritional status of the Children

In Kusumpur Pahadi, the mean BMI of women in reproductive ages was found to be 21.51 ±1.5 Kg/m^2 (Zehra, 2012). BMI is being increasingly used as a measure of nutritional adequacy in adults, and is considered to be a better indicator of chronic energy deficiency. Though the normal mean BMI could be attributed to the representation of pooled data of pregnant, lactating and non-pregnant non- lactating women, however, within the population there are vulnerable groups who are more marginalized than the others. As per NFHS-4 data 36% of women are below the BMI cut off point of 18.5. In the study group of 2088 women 13.9% of women were found to be having BMI less than 18.5 As per NFHS 3 data for urban poor 44.7% of the infants were exclusively breastfed. The study data in the Kusumpur slums presented similar results with 47.2% of infants being exclusively breastfed for first six months. Also, the prevalence of infants being breastfed within an hour of birth was only 51% revealing a lower awareness level among the study group.44.3percent of lactating women were feeding their child some other food besides milk such as tea, saunf ka paani, sugar water and water to the child in the first 6 months.

Experience of discrimination

In the slums the issue of utmost importance for the unmarried males in the 15-24 year age group was of employment since most of them were either contracted manual labourers or hawkers; or were running small stalls. They found it difficult to take out time and money for their own health problems. They availed the health services (either public or private) only when the health problem becomes worse and seeking professional care becomes inevitable. Table 6 gives a picture of the problems faces by the users and the causes which they think can be attributed to them. The discussion has also brought to light some of the perceived solutions.

[6] This is a modest translation of the Hindi version of the narrative given during the interview. It had foul words and cannot be put verbatim. The closest attempt could be as follows- *'… sex karte waqt to bahut mazaa aata hain, par paise dete waqt dum nikal jata hai… gharib ho jate hai…'.*

Table 6-Problems Causes and Solutions- As perceived by the People

Problems	Causes	Solutions
Perceived as unclean, less informed/educated so need not be given same services	Lack of sensitivity; bias Poor socio-economic status often results in stereotyped image	Sensitization of the providers Alternate activities for income generation, specially in the view of dying traditional occupations such as weaving
Most camps are held in the dominant caste areas, so use is often restricted	Dominant castes wield power which providers often cannot overlook Dominant caste are more likely to provide the infrastructure for the service to be provided	Providers to be supported/ facilitated and encouraged for locating a service in non-dominant group locality
Most providers claim to be sensitive, yet evidence of discrimination	Understanding of 'sensitivity' depends on one's own historical biases	Mechanism for tacking historical biases -Leadership -Re-interpreting and questioning power relationships

Source- Consultative Meetings during the Fieldwork

Respondents in the study area have reported accounts of caste discrimination prevalent in the ICDS centers. One of the respondents said that children from the Dalit community are seated separately from those belonging to other castes for mid-day meal programme. The ANMs and other health workers often visit the dalit households. Dalits do not sit in the benches available in the care centre both public and private. In other provisions of public health like water and sanitation there is some evidence of caste discrimination, mostly in the form of subtle use of words.

Some spheres of discrimination such as dispensing of medicine, counseling, waiting, conduct of pathological tests; no evident experiences was reported. However, subtle references such as *' tumko toh sab kuch muft mein milta hai...'*[7] was reported by one of the users in reference to the caste status and affirmative action for education and job. Dispensing of medicine was perceived as the most discriminating sphere by most users. Consulting the care providers for referral and was the areas where least discrimination was perceived as well as experienced.

As regards the forms of discrimination, physical, immediate expressions of interaction- touch (tough roughly/ do not touch) and conversation (speak gently) appear to be the areas perceived as most discriminating. The providers of health care services are perceived as most discriminating by most users. The users suggest that public sector providers are more discriminating.

[7] When translated, literally means that the one being spoken to gets everything free of cost. The reference is being made to the perception of high caste of the reservation policy which enable the vulnerable population to access certain resources and services. This was evident from one of the in-depth interviews.

Key Challenges and Lessons-

Coordination between different agencies providing health services in the slums, like NGOs, urban health posts needs to be strengthened. Management and technical capacities of municipal health departments; alignment of health interventions with slum development and relocation programs needs to be given adequate attention. There are challenge of finding sites for new structures given the constricted space of the slum and within the slum. Frequent transfers of staff, and dependency on several agencies for provisioning of services are some of the key challenges faced during the study.

There are no simple solutions for addressing health care needs in the study areas, especially in the light of sustainability. Standardized service delivery models will work only when flexibility to infuse local needs is considered. Services need to be provided even if the facilities are yet to be built. Service delivery need to be started early on with outreach activities. There is need to focus on critical services and monitor their delivery. Limited curative care is important. To address the needs, fixed days for services, special clinics, providers' accountability and incentives for their activities are important. The opportunity to partner with community based organizations as well as private sector for provisioning of services need to be expended. It needs to be exploited through innovative partnerships. Large building structures should be avoided. Options to align with Slum Development Program of the municipal bodies for using existing facilities need to be explored. Interventions that actively engage local community, elected representatives and provisioning staff are more sustainable and therefore should be institutionalize. There is also need for continued engagement of development partners. The focus should be on improving service statistics through incentives. While planning the programs, long term sustainability – cost sharing, and institutional viability through -referral linkages need to be established.

Despite the available health care facilities and services in Delhi, there is a need to increase availability and accessibility of medical facilities in and around slums as the government facilities are poor in terms of provisioning of medical care services such as dispensary or mobile vans. In absence of this, the slum dwellers have to visit private doctors or unqualified quacks for consultation and medicines. MCD should provide adequate dispensaries in various slum pockets to increase its accessibility. Health authority should increase the intensity of immunization programme and health checkup camps for slums dwellers as the government run immunization programme and health checkup camps in slums are highly inadequate, except pulse-polio program. The governmental steps should be taken to increase the coverage as well as frequency of such activities in the slums for both preventive and curative care to improve the health status of the slum dwellers.

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