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Urban Health and Care-Seeking Behavior: A Case Study of Slums in India and the Philippines

Final Report

September 2006

Prepared by:

Mursaleena Islam
Abt Associates Inc.

Mark Montgomery
Consultant

Shivani Taneja
Consultant

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Abt Associates Inc.
4800 Montgomery Lane, Suite 600 ■ Bethesda, Maryland 20814
Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:

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Abstract

This report examines the health needs and care-seeking behavior of poor slum residents in two Asian cities – Indore, India and greater Manila, Philippines. The centerpiece of the study is a qualitative investigation set in four slums in Indore and two slums in greater Manila, where in-depth interviews of slum residents and health care providers were carried out. To supplement the qualitative analysis with quantitative background and context, we also conducted an analysis of the urban data from two recent Demographic and Health Surveys (DHS) for India and the Philippines and assembled a comprehensive portrait of poverty and health from these sources. The topics covered in the research include general health-seeking behavior and self-efficacy, family planning, maternal health, child health, tuberculosis, domestic violence and alcohol abuse, and environmental health and hygiene.

Findings from the DHS analysis show that the urban poor are particularly disadvantaged as compared to their non-poor counterparts (poverty is defined using a living standards index). For example, we find that in urban India, 30% of very poor women have an unmet need for contraception compared with 17% of non-poor women. In the urban Philippines, unmet needs for birth spacing and limiting are also more prevalent among the poor – more than 30% for the poor compared with 21% for the non-poor. Poor urban women are much more likely than the non-poor to give birth at home – in urban India 63% of the very poor give birth at home compared with 24% of the non-poor; in urban Philippines, 78% of the very poor give birth at home compared with 35% of the non-poor. Child mortality rates for the very poor are more than double those of the non-poor – 122 per 1000 children for the very poor compared with 50 per 1000 children for the non-poor in urban India; 47 per 1000 children for the very poor compared with 23 per 1000 children for the non-poor in urban Philippines.

Findings from the qualitative interviews shed light on the reasons for these dismal health conditions among the urban poor and help explain much about their health-seeking behavior. The dependence of the urban poor on cash is a key issue – in the highly monetized urban health system, the poor lack access to health care because they lack the means to pay for it. Health care providers understand this reality and have seen that it can result in delayed or no treatment and the inability of the poor to purchase medicines and adhere to treatment schedules. Providers also share their frustration about how to convey basic health information to poor patients. The poor have great difficulty in comprehending the nature of their illness and understanding their course of treatment. We find that outpatient care is primarily sought in the private sector in Indore and in the public sector in greater Manila. In Indore, quality of care and distance to a facility are among the reasons for seeking private care. In greater Manila, the cost of private care is the main reason given for seeking public care. Immunization and family planning services are sought in the public sector in both cities because they are provided free of money cost on scheduled and predictable days. Slum women express a strong preference for giving birth at home, in a comfortable and reassuring environment. In both cities, we were told of the impersonality of hospital settings and of the brusque and insensitive treatment women believe they will receive at the hands of the staff. Our interviews also suggest that arrangements for subsidies for urban poor are unsystematic and, depending on circumstance, might or might not succeed in providing the poor with subsidized services and medicines. The report includes a discussion of these and other findings, with many direct quotes from slum residents and providers. It concludes with several recommendations on interventions targeting the urban poor.

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Acronyms

ANM	Auxiliary Nurse-Midwives
ASHA	Accredited Social Health Worker
AWW	Anganwadi Worker
BHS	Barangay Health Station
BPL	Below-Poverty-Line
CBO	Community-Based Organization
DHS	Demographic Health Survey
DOH	Department of Health
DOTS	Directly Observed Treatment, Short-course
DPT	Diphtheria, Polio, Tetanus
EHP	Environmental Health Project
FP/RH	Family Planning and Reproductive Health
GNP	Gross National Product
GOI	Government of India
ICDS	Integrated Child Development Scheme
ILHZ	Inter-Local Health Zones
IUD	Intra-Uterine Device
LGU	Local Government Unit
MCH	Maternal and Child Health
MHC	Main Health Center
MIMIC	Multiple Indicator, Multiple Cause
MP	Madhya Pradesh
MWSS	Metropolitan Waterworks and Sewage System
M.Y. Hospital	Maharaja Yashwant Rao Holkar Hospital
NAWASA	National Waterworks and Sewage Authority
NCR	National Capital Region
NGO	Non-Governmental Organization
PHR_{plus}	Partners for Health Reform _{plus}

QMMC	Quezon Memorial Medical Centre
RCH II	Reproductive Child Health II
RHU	Rural Health Unit
TB	Tuberculosis
TBA	Traditional Birth Attendant
UHRC	Urban Health Resource Centre
UFWC	Urban Family Welfare Centre
USAID	United States Agency for International Development

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Executive Summary

Introduction

Over the next thirty years, the developing countries of Asia are likely to cross an historic threshold. They will become, for the first time, more urban than rural. As this transition takes place, it will inevitably bring closer attention to the problem of urban poverty in the region and its effects on public health. To date, urban poverty in developing countries has often gone unrecognized – and Asia has been no exception to the rule. Until recently, urban poverty has not been a central focus in the development strategies adopted by the region’s poorest countries, nor has it assumed a prominent position in the agendas of the agencies that assist these countries. The relative neglect of urban poverty has meant that the health needs of the urban poor are often overlooked.

This study examines the health needs and care-seeking behavior of poor slum residents in two Asian cities – Indore, in India’s state of Madhya Pradesh, and greater Manila in the Philippines. The four primary aims of the study are to: (1) gain a greater understanding of the existing needs for, and supply of, health services in slums; (2) document the health-seeking behavior of slum residents and examine their motivations for health-seeking; (3) analyze whether health needs are being met by the available supply of services, and explore why gaps exist between demand and supply; and (4) analyze the extent to which services with the potential for high impact are either not available to slum residents or not accessed by them.

The centerpiece of this study is a qualitative investigation set in four slum communities in Indore and two slums in greater Manila. The research team carried out in-depth qualitative interviews of slum residents and health care providers. To supplement the qualitative analysis with quantitative background and context, the research team also drew upon survey data from two recent Demographic and Health Surveys (DHS) for India and the Philippines, and assembled a comprehensive portrait of poverty and health from these sources.

Methodology

This study combines qualitative with quantitative research methods, using both primary and secondary data analysis. The fieldwork for the qualitative interviews took place in November and December of 2005. Semi-structured, in-depth interviews were conducted with slum residents and a range of health care providers identified by the residents. The provider interviews – covering both formal and informal public and private providers – were conducted to understand their perceptions of the health needs and behavior of the urban poor. Interviews with slum residents were designed to gain an understanding of health-seeking behavior and the nature of household decision-making from their own perspectives. In addition to gathering background social and demographic information, the interviews touched on seven topical areas:

- ▲ Health-seeking behavior and self-efficacy
- ▲ Family planning

- ▲ Maternal health
- ▲ Child health
- ▲ Tuberculosis (TB)
- ▲ Domestic violence and alcohol abuse
- ▲ Environmental health and hygiene

The qualitative data collection at the heart of this study is framed by an analysis of quantitative survey data drawn from two recent Demographic and Health Surveys: the 1998-99 National Family Health Survey for India and the 2003 National Demographic and Health Survey for the Philippines. The DHS survey interviews could not probe as deeply into the details of respondent beliefs and motivations as our qualitative explorations, but these survey data allow us to empirically document the strength of the relationships linking urban poverty to multiple measures of health. We constructed a living-standards index using a factor-analytic approach that classified urban households as “very poor” if they fell into the lowest 10% of urban households and “poor” if they fell between 11-25%; residents were labeled as “not poor” otherwise. A number of health indicators were analyzed for these three household groups. This study differs from much other research based on such indices of living standards, by restricting the index to urban households only. This allowed us to measure differences *within* the urban populations of the two countries.

Perspectives of Health Providers

A number of striking findings emerged from interviews with health care providers that warrant further attention. Beginning with the most important, we see that the providers are well aware that slum residents simply lack the cash needed to purchase medicines, assemble necessary supplies (as in the case of labor and delivery) and even pay for basic consultations where the formal private sector is concerned. The consequences are readily apparent: the urban poor endure illnesses until conditions worsen to the point that care can not be delayed any longer; they consult informal practitioners and traditional healers, in part because payments can be more flexible than in the formal sector; even if a course of medication is prescribed, the poor may abandon it to save on costs; and lacking the cash for check-ups, they may not return for necessary re-assessments.

In both Indore and greater Manila, arrangements have been set in place in the public sector that would enable the poor to gain access to health care at subsidized prices – at least in principle. However, even from the providers’ point of view these arrangements are a patchwork. The providers observed that medicines can be covered by subsidies, but this does not generally extend to supplies. A poor patient needing an injection could purchase the drug at a reduced rate, but would be required to pay full price for the syringe. Free medicines and supplies might be on hand if representatives of a pharmaceutical company happen to leave them. In the Philippines, the poor may also be referred to the barangay health clinic where a range of medicines is available at a subsidized price. The accounts given by the providers leave an impression that the arrangements for the poor are unsystematic and, depending on circumstance, might or might not succeed in providing them with subsidized medicines. The system is arranged in a way that requires poor patients and their families to spend time searching and negotiating with a variety of personnel at scattered sites. In effect, the poor are being asked to substitute the cost of their time for the prospect of reduced monetary cost. In a full-cost sense, this may result in no subsidy at all. A thorough review of this unsystematic set of arrangements for subsidized care, with a careful accounting of the time, money and informational costs imposed upon the poor, is essential.

The provider interviews also elicited a number of observations about the difficulties faced in communicating effectively with their poor patients. The literature on developing-country health care often emphasizes the social distance between providers and their patients, the formal language that providers can use to reinforce their own status, and the possibilities for rude or abusive behavior on the part of staff toward poor patients. But the literature does not stress the difficulty in getting basic information to poor, illiterate and possibly intimidated patients, even for the most well-intentioned and diplomatic health provider. We were struck by the providers' accounts of how even the most elementary information, delivered in what seemed to be layman's terms, had to be repeated (and sometimes repeated again) before the poor were able to comprehend the nature of their illness and understand the steps they would need to take in a course of treatment. We suspect that these difficulties in comprehension may extend to the area of family planning, where sustained efforts to inform potential users about contraceptive methods do not seem to have penetrated the thinking of poor women. Instead, it leaves them without a confident basis on which to make choices and keeping them vulnerable to rumors and ill-founded fears of side effects.

Some of the health providers spoke of the value of visual aids in communicating with the poor; others emphasized the need for sensitive one-on-one conversation. In the Philippines, the providers involved with the DOTS program offer instructive examples of the kinds of empathetic provider behavior, with close attention to how information is taken in by poor clients that could be used across the health system. Of course, such individualized care is doubtless in its demands on service providers. In this area as well, a systematic study is warranted.

We found little evidence of hostility on the part of formal sector providers towards the traditional healers operating in slum communities. There was some (perhaps grudging) tolerance and acceptance of the role the healers play among the urban poor. For their part, traditional healers spoke with pride of the central roles they perform in their communities. But at least in their representations to us, they took care to emphasize that some conditions (for example, persistent diarrheas) lie beyond their own competence and are best treated in formal medical settings.

Perspectives of Slum Residents: Urban Poverty

In many respects, the slums of Indore and greater Manila are similar in social organization and the daily difficulties that face the poor. In each setting, there are anxieties among the residents about how to find even the smallest amounts of cash needed to purchase each day's food and other necessities. Borrowing and lending of small amounts is very common in both settings, as is the borrowing or selling of assets when health and other emergencies arise.

The dependence on cash by the urban poor, and the difficulties they must endure in acquiring even the smallest amounts, is a key point where access to health is concerned. In Indore and Manila, as in many other urban settings, health care is available only to those with the means to pay. Even in the public sector, where consultation fees can be waived for the poor, important components of care such as medicines and supplies must be purchased from sources that require immediate cash. Formal private sector care is also accessible on a cash basis only. The simple and obvious point that has been given insufficient attention: is that the urban poor lack access to health care because they lack the means to pay for it.

In probing into the difficult areas of domestic violence and alcohol abuse, we touched on issues of women's self-esteem and self-efficacy that are likely to be very important in health-seeking behavior. Women have been handed the principal responsibility for maintaining the health of their children, their husbands and themselves. Yet the emotional and physical batterings of daily life may undermine their confidence and the sense of self that is needed to aggressively search for health information, learn what is

possible in health care, discover what they are entitled to and make the appropriate demands on the health care system. Women's mental health is not an isolated dimension of wellbeing – it provides the foundation supporting many other areas of health-seeking behavior in both preventive and curative care.

In other respects, the findings of this study challenge commonly held views of slum life. In contrast to what is often assumed, the slum-dwellers we interviewed in Indore and Manila regard their slums as communities to which they are likely to have a long-term attachment. Fears and insecurities about tenure and the prospects of eviction and relocation are common, but as the interviews in Kaingin have indicated, these fears can be tamped down when local NGOs and other groups are actively working to secure tenure and title to land. Especially in Indore, local rotating savings groups are an important informal source of economic support for women. But the interviews brought forward one significant limitation on their reach: the poorest women may lack the means to sustain participation in saving groups.

General Care-Seeking Behavior and Health Needs

DHS data show that in urban India all three household groups visit private providers more than public facilities, including the very poor. On the other hand, in urban Philippines, public facilities are visited more often. Slum residents in Indore and greater Manila also follow this pattern. In-depth interviews suggest the following patterns of behavior and health-related needs:

- ▲ Outpatient care is primarily sought in the private sector in Indore and in the public sector in greater Manila. Quality of care and distance to a facility are among the common reasons for seeking private care in Indore, while the cost of care (free service and medicines) is the main reason given for seeking public care in greater Manila. However, donations are commonly required in the barangay health centers in Manila and stock-outs of drugs in the health centers are commonly reported.
- ▲ Immunization and family planning services are sought in the public sector in both cities because these services are provided free, typically on scheduled and predictable days.
- ▲ Traditional healers are commonly visited in both cities, often as a first step before seeking formal medical care.
- ▲ Self-medication is common in both cities.
- ▲ Lack of cash to meet health expenses is a clear concern, particularly for meeting health needs of children and emergency medical care. Borrowing to meet health expenses is common in both cities.
- ▲ Slum residents in both Indore and greater Manila voiced the need for close-by and easily accessible health facilities. In Indore, there was a preference for female providers, while in greater Manila residents wanted regular visits by health workers. In both cities, female residents deplored men's the lack of involvement in family planning and health-related issues. Given the problem of water availability in Indore slums, residents specifically expressed the need for improved water and sanitation conditions.

Reproductive Health and Family Planning

The DHS analysis shows that the urban areas of India and the Philippines are marked by substantial unmet need for modern contraception, and these areas also exhibit substantial unwanted and mistimed

childbearing. Slum women are aware of abortion; some have undergone it themselves and others tell of neighbors who have had abortions. In the Indore and greater Manila slums, women fear the pain and bleeding of induced abortion. It is clearly an option of last resort.

In India the family planning program, has not yet succeeded in making it clear to women that contraceptive options exist other than sterilization and the oral pill. Women often feel obliged to take on the burden of contraception, and lack the detailed knowledge they need to assess injectable contraceptives, condoms and other methods. Men generally leave matters of contraception in the hands of women, typically little communication between spouses. In the study slums, women do not really understand how contraceptive drugs and devices act in the body (even in the most general terms) and it seems that service providers have not done enough to ensure that women achieve an understanding.

The interviews made clear that poor urban women in the Philippines slums lack adequate and detailed information about modern contraceptives, and thus lack the confidence to explore their use. Slum women have little understanding of how methods work and easily fall victim to rumors and misinformation about the side effects of contraceptive use. The interviews conducted with health providers may explain why the poor do not have a grasp of the information provided by the programs – as the providers told us, it is very difficult to convey medical information to the poor in terms they can understand. This is true even when (from the program’s point of view) information has been packaged in the simplest of terms.

In the study communities, antenatal care tends to be sought later in pregnancy than recommended, and relatively few women make the recommended number of visits. The care given is basic and we have the impression it is given rather mechanically, although the DHS reports do reflect the national emphasis in both countries on providing tetanus vaccinations and iron supplementation (in India, the slum women revealed they found the iron-folic acid tablets unpleasant and often failed to consume them). Notably missing from the standard package of antenatal care, especially for poor and very poor women (as shown in the DHS results) is any discussion of the risks women may confront in their pregnancies and what action should be taken if complications arise. Antenatal care, such as this, cannot be considered adequate.

Slum women continue to express a strong preference for giving birth at home. It is here that they believe they will find a comfortable and reassuring environment where their needs will be more quickly sensed and responded to by a birth attendant who is likely a trusted and long-standing member of the community. DHS analysis shows that in both countries, there are marked differences between the urban poor and non-poor with respect to home deliveries. In both Indore and greater Manila we were told of the impersonality of hospital settings, and the brusque and insensitive treatment women believe they will receive at the hands of the staff. Even so, and especially in the greater Manila sites, some women are now giving birth away from home – and the picture no doubt varies considerably from one slum community to the next. For the foreseeable future, however, programs aimed at improving conditions at childbirth must assume that most slum women will continue to prefer giving birth at home. In this dimension of health as in others, the thinking of the urban poor closely resembles that of rural villagers.

Child Health

Child health is of utmost concern for all women interviewed. Women worry about common illnesses such as diarrhea, fever, coughs and colds, which when left untreated may lead to death. Women worry about paying for their children’s health care – with the cost of medicines a particular concern. Women are aware that lack of clean water and proper sanitation are the cause of the common diseases but feel helpless in addressing these issues.

DHS data show that child mortality rates among very poor households are 122 (out of 1000) in urban India and 47 in urban Philippines. These rates are double those for not poor urban households in each country. In urban India, less than 70% of very poor households receive the common vaccines – in urban Philippines this is slightly higher, with rates approximately 90%. Women respondents in both India and the Philippines are aware of the need for immunizations, although many women did not know the names of the vaccines. This awareness appears to be recent, as younger children were immunized while older ones were not. Most men were vaguely aware of immunization and said their wives were responsible for their children's health and immunizations. In both countries, women respondents said they take their children to the public health center for immunizations or wait for an immunization camp to be staged in their slum –because the service is free. In the Philippines, some respondents said they could not afford fee for the hepatitis B vaccine. Women expressed a need for immunization services at the slums or given during home visits by health workers.

Tuberculosis and Other Health

In the Philippines, the Department of Health specifically requested that we address the topics of tuberculosis (TB) and dengue fever. Given the limited time allotted, these topics could not be addressed in Indore, India (although TB was discussed in several interviews where the respondents had experience with the disease). Slum residents in greater Manila were asked their awareness of TB and dengue fever, their understanding of the symptoms and causes of these diseases, and their knowledge of treatment options.

All respondents had heard about TB – and most were able to identify its symptoms as persistent cough with blood in the sputum. However, many did not know TB's causes and thought it was caused by too much drinking and smoking. All respondents said that TB could be treated, although they were not aware of the specifics – none knew of the DOTS program. Most said treatment was available at the health center.

Almost all respondents had heard about dengue fever, and were aware that it was a dangerous disease. Most were able to identify high fever as a symptom, and some also mentioned rashes, vomiting and nose bleeds. Most were aware it could be transmitted by mosquito bites. Most respondents had heard about dengue from TV, while others had heard from the health center or from neighbors.

Environmental Health

There can be little doubt of the urgent need for improved water supply and sanitation in these slums. These are basic human needs and fundamental in determining health risks, which are still far from being met in the study communities. In the poorest and least organized slum communities (such as Annapurna Thana in Indore), precarious social arrangements are made to sustain minimal access to drinking water. However, these arrangements tend to fray in periods of stress (such as the summer months when water supplies are limited). Although we could not directly measure water intake at the household level, it is likely it fails to meet basic health requirements. Even where the slum households have a theoretical awareness of the importance of washing and other water-related hygienic practices (as in the Philippines study sites), it is difficult to maintain these practices when water is scarce.

Access to sanitary human waste disposal is very poor, especially in the more disadvantaged slums of Indore. Relatively few households have or are able to share a flush toilet, and use of public toilets (where available) is mainly by men. Women must defecate in the open and are therefore subjected to humiliation

and harassment on a daily basis. Children seldom use public toilets or other sanitary measures for disposal of their waste. Consequently, they are likely to be exposed to elevated levels of health risk.

Quotes from Slum Residents

The report provides many direct quotes from slum residents on each of the above topics. The following will provide a flavor of the narratives.

Regarding use of public vs. private health facilities:

“I took my child to the health center. They asked me about the child's condition. They told me to take the patient to the hospital but I wasn't able to do so because I had no money then.” (Philippines)

“During emergencies, the health center wouldn't be the best place to go since there are just too many patients there. It's also on a first come first served basis. So if we have the money, we bring the child to a private clinic.” (Philippines)

“If somebody is quite unwell, who goes all that far [to the government dispensary]. This [private] doctor is right in front, so we go there only.” (India)

Regarding preference for home deliveries:

“They [other slum residents] usually go to the hospital while sometimes it [the delivery] is done at home with a midwife's assistance. Personally, I am apprehensive about going to the hospital because they say you will be stripped naked but will not fully assist you when the contractions become very painful. I did not have any complications. Lorna, my midwife, delivered my baby.” (Philippines)

“They don't keep you clean, wash and bathe you in the hospital [at delivery]. At home you can warm your water, have your bath and rest.” (India)

Regarding awareness about immunization and schedule:

“The vaccination takes place at the [health] center, Wednesdays are scheduled for children.” (Philippines)

“There is so much publicity about it [immunizations]. Nowadays in TV and in so many other places they are telling us about it. We get our child vaccinated in the Anganwadi, it is on second Tuesday of the month.” (India)

Recommendations

We organize our recommendations into three sets. The first pertains to concerns affecting the urban health system as a whole, which would need to be addressed in a system-wide manner. The second set is more “place-based”, leading to consideration of interventions that could be put into effect and evaluated community by community. The third set of recommendations is focused on the survey programs that gather much of the knowledge of urban and rural health conditions in poor countries.

Interventions at the urban health system level

- ▲ **Improve provider-patient communication.** The difficulties facing providers in conveying basic health information to the urban poor have not been fully appreciated. Interventions that should be considered entail training sessions for providers, the use of senior mentors to demonstrate how to communicate with the poor and other approaches. In the Philippines, the sensitive and empathetic communication strategies employed by treatment partners in the DOTS program might provide models of care relevant across the urban health system.
- ▲ **Assess use of health-care subsidies for the urban poor.** We have found the arrangements for subsidizing the money costs of health care for the urban poor to be unsystematic. It is doubtful that when all costs are taken into account, the poor receive any net subsidies. A careful accounting is needed of the full time, money and informational costs that such arrangements impose upon the poor.
- ▲ **Explore and pilot-test alternative health financing schemes.** For the urban poor, there is a fundamental constraint on access to health care. Embedded in a health system that is highly monetized by comparison with the rural system, the urban poor lack the cash to pay for care. More effective subsidies for the urban poor can include vouchers for specific drugs or treatment services, community-based health financing schemes and the development of partnerships with the private sector to provide reduced-price drugs.
- ▲ **Improve availability of medicines and supplies in public health centers in greater Manila.** Stock-outs of medicines and supplies afflict the public sector of the urban health care system. These serve to increase the time and money costs of health care for the urban poor, many of whom must rely on the public sector. As other researchers have done, we wish to draw attention to the importance of this systemic issue and stress its implications for the poor. In the Philippines, we recommend working closely with LGUs and public health providers in addressing this issue.

Community-level interventions

- ▲ **Improve health education and awareness among slum residents.** Education and behavioral change campaigns are common recommendations for health interventions with the poor. These are especially applicable in slum communities, whose residents often resemble rural villagers in their levels of health knowledge and attitudes. We recommend three areas of focus: (1) campaigns targeting and involving men; (2) campaigns addressing proper use of medications; and (3) creative campaigns to improve home management of common diseases.
- ▲ **Provide basic health training to traditional healers and slum leaders, and mobilize community health workers.** Much as in rural villages, traditional healers are important figures in urban slums. They would benefit from – and would appear to welcome – programs of training that would improve their medical knowledge, clarify the limits of traditional care and encourage positive interactions with the formal health care system. Likewise, slum community leaders – who serve as the interface between their poor constituents and the broader urban political, bureaucratic and health systems – would benefit from a focused health training program. This would allow them to give a more effective voice to the health concerns of their communities. In addition, slum residents expressed the need for more visits by health workers – slum women would prefer being served inside their community or through home visits. It would be important to design outreach or satellite-clinic interventions whereby staff is trained to work with the urban poor and learn how to give counsel and

communicate in ways that reach these populations.

- ▲ **Explore connections between urban poverty, alcoholism, domestic violence and self-efficacy in health.** The anxieties and stresses of daily life in the slums are heavy burdens for women and affect the social confidence and energy they bring to health-seeking behavior. Very little is yet known about how violence and alcoholism affect self-efficacy, which is a fundamental factor in health-seeking behavior. Interventions that reduce domestic violence or alcoholism may have wider-ranging health benefits. In addition, given the high rates of maternal mortality and the high rates of home deliveries among the very poor in both urban areas, we recommend specifically exploring the connections between urban poverty, self-efficacy and home deliveries. Understanding the range of factors, including cost, that encourage home deliveries, will allow a more effective design of interventions that support institutional deliveries or deliveries with skilled birth attendants.
- ▲ **Ensure access to clean drinking water and adequate sanitation.** This is an often-repeated recommendation for urban slum settings, but its importance must again be underscored. Sanitary conditions in the study slums are abysmal, as they are in many slum communities around the world. This presents particularly high levels of health risks to women and children. Still, when slum women are fully aware of the importance of maintaining good hygiene, they may be unable to follow these practices without access to an adequate supply of water.

Improve collection of urban and rural health data

We close our recommendations with a plea for improvements in the survey programs, such as the Demographic and Health Surveys, through which both rural and urban health conditions are documented and the determinants of health knowledge, attitudes, behavior and outcomes are studied. A central theme in this report is that city populations are highly diverse – they include communities of the poor that closely resemble rural villages in terms of the level of health risks, the quality of care available and the ways in which local residents understand health. To give unbiased guidance to health policy-makers, and to permit resources to be effectively targeted, health surveys must supply reliable portraits of health conditions in diverse urban populations as well as rural areas.

When new surveys are fielded, we would urge that appropriate consideration be given to over-sampling urban populations so the depth and nature of urban health needs can be compared with rural areas. In its 2003 report, *Cities Transformed: Demographic Change and Its Implications in the Developing World*, the National Research Council called for empirical documentation of health needs among four population groups: (1) rural dwellers; (2) residents of towns and smaller cities (in which health conditions were found to be similar to rural areas); (3) the urban poor who live in the slums of larger cities; and (4) the urban poor who live outside these slums. National sample surveys should be designed to make such comparisons possible. At present, these comparisons are not generally possible – small urban sample sizes and the lack of place identifiers (such as the name of the city in which a sample cluster is located) preclude them. As the developing world continues to urbanize, these deficiencies in data collection must be addressed.

1. Introduction

Over the next 30 years, the developing countries of Asia are likely to cross an historic threshold. They will become, for the first time, more urban than rural. As this transition takes place, it will inevitably bring closer attention to the problem of urban poverty and its effects on public health. It is curious, however, that to date the urban element in developing-country poverty has often gone unrecognized and the Asian literature has been no exception to this general rule. Until recently, urban poverty has not figured centrally in development strategies adopted by the region's poorest countries, nor has it assumed a prominent position in the agendas of the agencies that assist these countries. The relative neglect of urban poverty has meant that the health needs of the urban poor have often been overlooked.

The rationale seems to have been that since Asian cities are better supplied than rural villages with modern health facilities and providers, city residents must enjoy better access to these resources. When more closely inspected, however, this view is revealed to be too optimistic. The urban poor often face health threats that closely resemble the risks faced in rural areas. They can adopt patterns of health-seeking behavior that are hardly distinguishable from those of rural villagers, and the health services to which the urban poor have access can be little better in terms of quality than those located in rural areas. On average, health indicators in urban areas are generally better than in rural, but where health is concerned such averages are misleading. As the recent U.S. National Research Council report has shown (Montgomery, et al., 2003), urban areas are marked by substantial economic and health inequalities that can leave the urban poor no better off and, on occasion, in even worse health than rural villagers.

This study examines the health needs and health-seeking behavior of poor slum residents in two Asian cities—Indore, in India's state of Madhya Pradesh, and greater Manila, in the Philippines. The four primary aims of the study are to: (1) gain a greater understanding of the existing needs for, and supply of, health services in slums; (2) document the health-seeking behavior of slum residents and examine their motivations for health-seeking; (3) analyze whether health needs are being met by the available supply of services, and explore why gaps exist between demand and supply; and (4) analyze the extent to which services with the potential for high impact are either not available to slum residents or not accessed by them. The study results are intended for donors (including USAID) and other stakeholders to help in programming and targeting interventions for urban poor.

The centerpiece of this study is a qualitative investigation set in four slum communities in Indore and two slums in greater Manila. The research team carried out in-depth qualitative interviews of slum residents and health care providers, with the bulk of the fieldwork taking place in November and December 2005. To supplement the qualitative analysis with quantitative background and context, the research team also drew upon survey data from two recent Demographic and Health Surveys (DHS) for India and the Philippines, and assembled a comprehensive portrait of poverty and health from these sources.

The choice of India as one of the study sites was motivated, in part, by its government's recent recognition of urban poverty and health as issues that must be addressed. The urban poor have been singled out for special mention in India's 2000 National Population Program (NPP), and in the Reproductive and Child Health II (RCH-II) program and the Tenth Five-Year Plan (EHP, 2005a). In particular, RCH-II has identified several key states, Madhya Pradesh among them, in which reproductive

and child health services should have a focus on the urban poor. With little precedent to go on, state governments initially found it difficult to formulate their urban health proposals. To assist the states, the national government enlisted the USAID Environmental Health Project (now the Urban Health Resource Centre [UHRC]), designating it as the nodal agency for the design of the urban health component of RCH II. In this way, USAID-India has assumed a leading role in field-testing urban community mobilization, service provision and evaluation methods in connection with the RCH-II initiative. In view of the general neglect of urban poverty and health in much of developing Asia, these recent efforts on the part of India are a welcome innovation.

In the Philippines, nothing at the national and state governmental levels comparable to the Indian initiatives has emerged, but at the local government level (increasingly important in the decentralized governmental system of this country) there are a number of promising initiatives underway. Across the Philippines, active, well-organized networks of the urban poor are working closely with NGOs and local governments in upgrading homes and settlements and striving to ensure security of tenure for their members (D’Cruz and Satterthwaite, 2005). The Homeless People’s Federation, formed in 1997 as an alliance of geographically dispersed savings groups, now includes approximately 13,000 households in 22 cities across the country. This federation has been drawing special attention to the needs of slum residents living in dumpsites, along railway tracks, on land subject to flooding and in other high-risk environments. In four city governments (including Quezon City) the federation is conducting an enumeration of slum residents and identifying households living in such danger zones. In some cases, local governments and the federation have drawn up partnership agreements that give the federation a role in planning and facilitating the relocation of the slum households most at risk. Such productive partnerships between federations of the urban poor and local governments provide a model that may be worthy of emulation in other countries with rapidly decentralizing governmental systems (D’Cruz and Satterthwaite, 2005).

1.1 Organization of the Report

The chapters of this report are organized as follows: Chapter 2 describes the overall design of the study, and Chapter 3 provides background on urban India and the Philippines, as well as descriptions of the study sites (slum communities). Chapter 4 gives a sketch of the economic and social considerations that loom large in the lives of the urban poor, affecting health and many other aspects of their behavior. We detail our findings on the important issues of domestic violence and spousal alcohol abuse and their consequences for slum women’s autonomy, decision-making authority and sense of self-efficacy. These fundamental factors determining health-seeking behavior are too often overlooked.

With all of this as background, we continue to a series of chapters on key health topics. Chapter 5 summarizes the views of the health providers in our study communities, ranging from traditional healers to modern medical personnel in both private and public sectors. Chapter 6 presents the views of slum residents and describes their overall health-seeking behavior, health concerns and needs. Chapters 7 through 10, arranged according to health issues, provide a detailed account of health, as the slum residents themselves perceive its various dimensions. In these chapters we begin with quantitative results from the DHS surveys, using charts to depict the associations between urban poverty and health, and then discuss in more detail the findings that have emerged from the qualitative interviews with slum residents. Chapter 11 provides two profiles (or case studies) of slum residents from each city, which are developed from the qualitative interviews. Chapter 12 concludes with recommendations for future research and interventions based on our findings.

2. Study Design

As noted previously, this study combines qualitative and quantitative research methods, using both primary and secondary data analysis.

2.1 DHS Data Analysis

The qualitative data collection at the heart of this study is framed by an analysis of quantitative survey data drawn from two recent Demographic and Health Surveys: the 1998-99 National Family Health Survey for India (IIPS and ORC Macro, 2000) and the 2003 National Demographic and Health Survey for the Philippines (NSO, 2004). The DHS survey interviews could not probe as deeply into the details of respondent beliefs and motivations as our qualitative explorations, but these survey data allow us to empirically document the strength of the relationships linking urban poverty to multiple measures of health. The quantitative findings from the DHS also confer a measure of discipline on the conclusions we draw from the qualitative accounts, ensuring that the research gives appropriate weight to the local issues that are of demonstrably wider relevance.

The surveys in question are nationally representative surveys also designed to statistically represent the urban populations of the two countries. By the standards of surveys such as these the number of respondents is very large, but unfortunately neither DHS survey is large enough to provide a statistically reliable portrait of health at the city. To gain insight into the relationships between urban poverty and health, we extracted the urban sub-samples of the two DHS surveys and analyzed measures of health and living standards for the urban populations of India and the Philippines as a whole. Where sample sizes permitted, we have also tabulated the survey results for urban Madhya Pradesh (the state in which Indore is located) and the National Capital Region for the Philippines (where one of our Manila study sites is found, the other being in a neighboring municipality). Where the location-specific and all-urban results differ, we have taken note of these differences. If the differences are not statistically definitive, then they are at least suggestive about local conditions.

A methodological note may be in order here on how we estimate urban living standards. The DHS surveys gather detailed and reliable health data, but are not able to collect data on household incomes or consumption expenditures—to do that would require detailed and time-consuming efforts that would inevitably crowd out inquiries on health. As a result, health researchers working with DHS surveys have had little alternative but to construct measures of urban living standards from proxy variables. As with most other DHS surveys, those for India and the Philippines collect information on each household's ownership of a range of consumer durables, gathering simple indicators of the quality of housing as well as data on the age, sex and educational attainment of adult household members. From these disparate materials, a useful index of relative living standards can be fashioned. Although the index should not be seen as a substitute for data on incomes or consumption, and cannot be used to assess the proportion of poor or the depth of poverty as with monetized living standards measures, it has proven to be useful in identifying where households stand in relative terms.

We constructed the living-standards index using the factor-analytic MIMIC (multiple indicator, multiple cause) approach that Montgomery and Hewett (2005) applied to the urban samples of more than

60 Demographic and Health Surveys in all regions of the developing world. In pursuing this approach, we began by separating the DHS proxy measures for India and the Philippines into two sets: 1) a set of indicators of living standards, these being the ownership of consumer durables and the quality of housing which, when taken together, are loosely analogous to measures of household consumption; and 2) a set of determinants (“causes”) of household living standards, including the age and sex of the household head, the proportion of adults with various levels of schooling and the household’s access to electricity, as well as regional dummy variables. Most of the consumption indicators in the first set take the form of “yes/no” binary variables, which require special treatment when used in factor analysis. The statistical details are spelled out in Montgomery and Hewett (2005).

Using these living standards indicators and determinants, we estimated a factor score for each household in the urban DHS samples, carried out separately for India and the Philippines. After ranking the households in terms of this score, we then classified the households falling in the lowest 10% of the urban distribution as “very poor,” and those in the 11 – 25% range as “poor.” For brevity’s sake, we labeled the remaining urban households residing in the top three quartiles of the urban distribution as “not poor.” The “very poor,” “poor” and “not poor” labels refer to relative living standards only; the DHS datasets do not provide a means of constructing absolute measures that are strictly comparable to monetized incomes or consumption. Nevertheless, as Montgomery and Hewett (2005) have shown in their application to urban health, and as will be further demonstrated in this report, a relative classification of urban households yields sensible and useful results.

2.2 Qualitative Interviews of Slum Residents

As mentioned previously, the research team devoted much of its effort to gathering primary data on health and poverty as seen by the slum residents themselves. Semi-structured, in-depth interviews were conducted to understand their health-seeking behavior and the nature of household decision-making expressed in health care demand. In addition to the respondent’s background social and demographic information, the interviews touched on the following topical areas:

- ▲ Health-seeking behavior and self-efficacy
- ▲ Family planning
- ▲ Maternal health
- ▲ Child health
- ▲ Tuberculosis
- ▲ Domestic violence and alcohol abuse
- ▲ Environmental health and hygiene

It was not possible to enquire in-depth about each of these areas in any one interview; to do so would have required interviews of several hours’ duration. To ensure coverage of all topical areas in each slum community, the research team organized questions for each topical area into modules. They then administered a subset of these modules in each individual interview, rotating them across the interviews. This allowed the team to cover all of the topical areas in each community.

40 interviews were conducted in each of four slum neighborhoods in Indore, with approximately one-fourth conducted with men. 50 interviews were conducted in each of two slum communities in greater Manila, with men accounting for approximately one-fifth of the total.

2.3 Qualitative Interviews of Health Care Providers

Semi-structured, in-depth interviews were also conducted with public and private health care providers, including traditional healers. The topics included providers' perceptions of their slum clients, the health needs of the slum residents, and why residents tend to make use of only certain types of services. The health care providers were identified based on the interviews with slum residents; the team attempted to cover all providers mentioned by the slum residents in the course of their interviews. A total of 31 provider interviews were completed in Indore, and 27 in greater Manila.

2.4 Data Collection

Fieldwork was conducted over a two-month period in November - December 2005 in India and the Philippines. Tapes of the interviews were transcribed and then translated into English and reviewed by the authors. Notes and transcripts of interviews were handled as confidential documents throughout the study so that the anonymity of respondents could be maintained and their privacy respected. Annexes to Chapter 3 discuss the data collection process further for each country.

3. Background and Study Sites

This chapter provides an overview of the health systems of urban India and the Philippines, and presents profiles of the slum communities selected for the study.

3.1 India

The urban population of India currently accounts for 28% of the country's total, or 285 million people (Office of the Registrar General, 2001). India defines 'urban areas' as those having a population of at least 5,000, with a minimum of three-quarters of the male work force engaged in non-agricultural pursuits (other criteria also figure into the official definition). The country is on an increasing urbanization trajectory, with population growth over the 1991-2001 period estimated at 31% in India's urban areas, as compared with 18% in rural areas.¹ Approximately 35% of the urban population is estimated to be poor, and 15% extremely poor (Amis, 2002). However, the definitions of urban poverty in India are subject to debate and many believe that the official statistics under-report true poverty levels in cities and towns.

The extent to which urban poverty is spatially concentrated in "slums" is also open to debate, with at least two complicating factors. First, there is no consensus on how best to define slums, whether in India or in general. In India, the "notified" slums are probably over-represented in the official accounts and data— with notification referring to an official recognition of the slum community on the part of a municipality, a municipal corporation or another local body or development authority. Additionally, it implies that government bears some responsibility for the community's infrastructure and services.² Two large India-wide surveys of slum communities conducted in 1993 (GOI, 1997) and 2002 (GOI, 2003), uncovered more than 50,000 notified and non-notified slum communities across the country in each of these years. The 2001 census estimates cited in Chandrasekhar (2005) imply that as many as 41 million people live in these slums. (As Chandrasekhar [2005] points out, there are good reasons to think the total number of slum communities and the number of slum residents are likely to be under-estimated.) The National Sample Survey estimate for 2002 indicates that nearly half (49%) of the slum communities are not notified. Detailed on-the-ground investigations in Indore and elsewhere have confirmed large numbers of such slum communities, with substantial variation in the percent notified across locations (Agarwal and Taneja, 2005; GOI, 2003). Because notification means that government has accepted an obligation for maintenance and services in the community to some extent, the notified slums tend to be better equipped than non-notified slums with roads, electricity, provision for drainage, piped water, access

¹ This large urban increase is in spite of the change in the criteria used to define urban areas: in 1991 the minimum population required for an urban designation was 4,000, but this was raised to 5,000 in the 2001 census.

² As Chandrasekhar (2005) notes, these responsibilities are made plain in the Twelfth Schedule of India's constitution, which lists slum improvement and upgrading among the functions of urban local bodies. The Tenth Five Year Plan formulated for 2002-2007 specifies responsibilities at the state level, as follows (cited in Chandrasekhar, 2005) "...the thrust should be on the provision of all basic services such as potable water and sanitation services, including household taps, toilets with septic tanks, covered drains, waste collection services etc. to the slum settlements. Other activities for the socio-economic upliftment of the slum populations should also be taken up. Citywide master plans for slum improvement should be drawn up with the objective of removing the slum characteristics of the selected settlements. The annual programmes and projects, including those to be financed out of NSDP (National Slum Development Programme) funds, should be based on such master plans."

to flush latrines and removal of garbage. Still, there are great differences across Indian states in each of these aspects of service provision, even in the notified slums (Chandrasekhar, 2005; GOI, 2003). Moreover, as Chandrasekhar notes, from 1997-2002 there is evidence of greater improvement in service provision in the notified slums than in the non-notified slums during the same period. In short, no analysis of slum living conditions in India can be judged adequate unless it considers both non-notified and notified slums.

A further complication is that the urban poor are often considered synonymous with the population living in slums, a practice that ignores the poor who live outside slums and the non-poor who live within them. Chandrasekhar (2005, 2006) conducted an extensive investigation using the National Sample Survey data for 2002, and found considerable evidence of within-slum heterogeneity. His 2006 analysis of slum and non-slum communities in Mumbai (results are preliminary) indicates that of all slum residents surveyed, approximately one-third fall below the poverty line in terms of monthly per capita expenditures. An examination of per capita expenditure distributions shows that the residents of slum and squatter communities are poorer than residents of other areas as expected, but the expenditure distributions overlap to a surprising extent and there is clear evidence of substantial living standards heterogeneity within slums. (See Montgomery and Hewett, 2005, for similar findings based on DHS data from a range of developing countries.)

3.1.1 The Health System of Indore, Madhya Pradesh

As noted in EHP (2005a), the Reproductive and Child Health II program in India has put substantial emphasis on addressing the needs of the urban poor. But in the absence of specific guidelines on how to proceed, the government of India has been working with USAID-India to implement project field-tests to improve child health and nutrition among the slum dwellers of selected cities. USAID, in turn, tasked the Environmental Health Project with designing and implementing the efforts in Indore. Beginning in mid-2003, EHP-India took an innovative structural approach in this city, strengthening linkages between service providers and the slum communities by fostering partnerships among three groups: local government; NGOs; and community-based organizations.

As of the project's inception in 2003, Indore has long served as the economic hub of Madhya Pradesh and the wider region that includes Gujarat and Maharashtra. By comparison with other cities of its size, the residents of Indore have somewhat better access to employment opportunities. In 2001, the population of Indore had an estimated population of 1.6 million, with 40% thought to be residents of the city's slums. The total number of slum settlements ranges to about 500, if both recognized and unrecognized slums are included.

In Madhya Pradesh, the state government has been largely responsible for the delivery of public health services in urban areas. The government has formulated its own policies in relation to the national RCH-II program, expressing them in the state population policy documents and its nutrition and women's policies. But a marked gap has separated these policy pronouncements from their local implementation in the state's urban areas. EHP (2005a) notes that approximately 80% of all state health spending goes toward the maintenance of existing services, with little left over for an expansion of services to the urban poor or other under-served groups. Health spending per capita expenditure in the state was Rs. 227 in 1996, less than half of the World Bank (1993) recommended \$12 for a low-income country (Sharaef, 1999). Furthermore, of this rather low total, the public sector share is only 22%. A principal area of concern for the Environmental Health Project in Indore, therefore, was how to effectively mobilize slum and other local community resources given that public sector resources were exceedingly scarce and would very likely remain so for the foreseeable future.

The health system of Indore includes a great range of service providers. The public and private sectors include charitable and for-profit hospitals, medical professionals and many types of informal private providers. The public health system of Indore is a multi-tiered system that includes tertiary referral hospitals (a District Hospital, Medical College, Maternity Home and poly-clinics), as well as nursing homes, four small hospitals and 23 dispensaries. However, vacancies and lack of infrastructure have eroded the capabilities of some of these facilities, preventing them from functioning as intended.

Maharaja Yashwant Rao Holkar Hospital (M.Y. Hospital), the tertiary care hospital, is the government hospital with specialist facilities. This is the largest hospital in the state of Madhya Pradesh, and is the preferred option for a large urban and rural poor population based in Indore and elsewhere around the state. The maternity wing is housed in separate premises. The four small hospitals in the city were set up to function as Urban Family Welfare Centres (UFWC) – these are UFWC, Juni Indore; UFWC, Rajendra Nagar; UFWC, Mangilal Churiya; and UFWC, Harsiddhi. By design, each of these should have facilities for labor and delivery. However, inspection by the research team showed that none of the four hospitals had delivery facilities that were actually operative.

3.1.2 The Indore EHP Program

EHP-India began its urban health program activities in Indore by working in 75 slums located across the city. The four main objectives of the program were: (1) to increase coverage of services and adoption of key health behaviors in neo-natal survival, diarrhea control, and other child health priorities; (2) to improve the capacities of community-based organizations (CBOs), non-governmental organizations (NGOs), and both private and public sector health providers in health behavior promotion; (3) to ensure that health policies were better targeted and more total resources allocated to effect improvements in slum health; and, (4) to develop replicable models for urban child health programs.

The EHP-India approach attempted to organize its efforts according to the two concepts of social capital that have been prominent in the urban neighborhoods literature: that of “bonding” social capital, by which the links among community residents are strengthened; and that of “bridging” social capital, which involves linkages from poor communities to various groups and individuals located outside with the potential to make new resources available to the communities (whether in the form of funds, expertise or political clout). To implement the approach in Indore, EHP-India organized a series of partnerships drawing together NGOs, two levels of CBOs and local government (in the form of a municipal ward coordination committee). The NGO’s role was to cement connections with both public and private providers operating in the areas of maternal and child health and to provide overall supervision; the lead CBO was to support capacity-building and community linkage activities; and, at the level of slum communities themselves, the basti CBOs were to represent the residents of the community and ensure that services actually reached them.³ The ward coordination committee, in turn, was to meet each month to review progress and develop strategies to make best use of other local resources.

As the program unfolded, the NGOs and lead CBOs successfully coordinated with the Health Department and private institutions to field at least 50 maternal and child health (MCH) outreach camps each month. The project has yielded improvement in timely immunization coverage, increased trained attendance in home deliveries and better infant feeding behaviors. Additionally, some of the slums have also renovated their public toilet facilities. The strengthened social infrastructure is further evident in the

³ The five NGOs that have been involved in Indore are Bal Niketan Sangh (BNS), Pushpkunj Family Helper Project Trust (PFHPT), Bhartiya Grameen Mahila Sangh (BGMS), Centre for Development Economics and Development Consultants Society (CECOEDECON) and Indore Diocese Social Services Society (IDSSS). These NGOs implemented the program in collaboration with nine lead CBOs and 87 basti CBOs.

enhanced health promotion and negotiation capacities of approximately half of the basti CBOs, which are now better able to articulate and draw attention to the needs of their community residents.

3.1.3 Overview of Indore Study Sites

In 2002, 545 slum sites were identified within Indore in an in-depth vulnerability assessment of slums, with 438 being officially notified slums (Taneja and Agarwal, 2004). Approximately 157 of these slums were found to be extremely vulnerable in health needs. Our study selected four vulnerable slums in which to collect data. Although each slum was judged “vulnerable,” the selection of slums included communities with a range of socio-economic conditions. Brief profiles of the four slums follow. Table 3.1 presents summary indicators for the four slums. Annex A presents the data collection approach and highlights the challenges faced in the fieldwork to guide future researchers interested in similar topics.

Annapurna Thana: This is a very “urban” slum of approximately 350 households. It is built on a narrow, open stretch of land surrounded by respectable middle-class housing. There are three or four community water taps in the slum, but no other piped water connections. There are no toilet facilities -- and because houses and roads surround the slum, the residents have difficulty finding open space in which to relieve themselves. Heaps of trash and dirty pools of water are evident all around the community. Therefore, sanitation and hygiene are matters of serious concern in this community. Many women residents work as maids in nearby houses; when the men can find work (the unemployment rate is high), they are apt to take jobs as daily waged workers. Annapurna Thana thus gives every appearance of being a highly vulnerable slum, an impression strongly confirmed in the course of our fieldwork. The EHP program has been active here.

Chandra Prabhat Shekhar Nagar: This is an old slum located in the center of Indore with more than 1,200 households. It has been the site of repeated investments and program interventions, few of which have had any durable benefit. Many women work as rag pickers or domestic maids. Because the slum is located on a slope on the side of a ditch and is highly congested, hygiene and sanitation are major issues. The community is continually roiled by rumors that relocation is imminent. This, too, appeared from the outset of our work to be a very vulnerable slum. As the work proceeded, we found substantial evidence to support our initial impression. The EHP program does not cover this slum.

Rustam ka Bagicha: This is a very large slum of more than 4,000 households situated along an open, dirty ditch in a highly congested area. The majority of residents work on a piecemeal basis in the handmade leather toy industry. The slum appeared to be less vulnerable than some of the others we visited, but the community was quite heterogeneous. As part of the EHP program, the Indore Diocese Social Services Society (see previous footnote) works with approximately 1,000 households in the most vulnerable part of this slum.

Gotu ki Chawl: This slum adjoins Rustam ka Bagicha, but the two communities are predominantly differentiated by the community groups who live there. Gotu ki Chawl has more concrete houses than in Rustam ka Bagachi (or in other slums of Indore), and the community has maintained a basic standard of environmental cleanliness, suggesting that residents have been able to give more attention to hygiene and environmental conditions than in our other sites. Gotu ki Chawl seems to be a less vulnerable community than the others, and we were able to confirm this in our fieldwork. The EHP program does not cover this slum.

Table 3.1: Background characteristics of study slums in Indore, India

	Slum			
	Annapurna Thana ki basti	Chandra Prabhat Shekhar Nagar	Rustam Ka Bagicha	Gotu Ki Chawl
Age of slum	≤ 30 years	≥ 40 years	≥ 80 years	≥ 70 years
Number of households	350 hh	1,250 hh	4,400 hh	800 hh
Social groups	Scheduled Castes, Scheduled Tribes ⁴	Scheduled Castes	Scheduled Castes	Scheduled Castes
Origins of the residing population	Nimaad, Madhya Pradesh, Maharashtra	Maharashtra	Guna, Madhya Pradesh, Rajasthan, Maharashtra	Uttar Pradesh, Rajasthan, Maharashtra
Occupations of women	Domestic maid	Garbage collection, selling old clothes	Leather toy making	Domestic help; making incense sticks
Men	Daily wagers, construction workers	Daily wagers, band workers, construction workers	Daily wagers and leather toy making	Drivers, masons, clerical government jobs
Children	Garbage collection	Garbage collection	--	--
Land tenure	No legal papers	About half of households have lease papers	No registration papers, but people pay house tax	Majority have lease papers
Water source	Three common taps in the slum; many residents buy water from local temple and private houses	Supplied in slum through tanker (municipal); public watertaps on alternate days	Supplied through pipeline running outside houses	Supplied through pipeline running outside houses; boring available
Toilets	No public toilet; men use public toilets made in a nearby temple; women and children go by the roadside	Two public toilet complexes -total 13 seats used by about half the households on a monthly payment; other families use open spaces. Most children defecate in open	Small proportion have toilets at home; majority use four public toilet complexes	Majority have individual toilets within home; few use one public toilet complex
Roads	No roads; narrow muddy unpaved paths within slum	Very narrow paths within slum, not concrete	Narrow concrete roads or paths	Narrow concrete roads or paths
Government facilities inside the slum	None	One community hall; three Anganwadi centres; Primary school	One community hall; one Anganwadi centre; Primary school	One community hall; one Anganwadi centre

⁴ The Constitution of India has classified certain communities as Scheduled Tribes, Scheduled Castes and Other Backward Classes on the basis of their socio-economic status and ways of living. Reservations and schemes are proposed for bringing SCs and STs more into the mainstream and opening up options for development of these groups by taking on affirmative steps.

	Slum			
	Annapurna Thana ki basti	Chandra Prabhat Shekhar Nagar	Rustam Ka Bagicha	Gotu Ki Chawl
Nearest government health facility	U.F.W.C. Rajendra Nagar (about 2.5 k.m.)	U.F.W.C. Harsiddhi (across the road)	U.F.W.C. Mangilal Churiya (at about 1 km. distance)	

3.1.4 Respondent Characteristics in Indore

Tables 3.2 and 3.3 present background characteristics of the slum residents and health care providers interviewed in Indore. In-depth interviews with 156 slum residents, most of whom were women, were conducted in four slums – Table 3.2 presents some summary characteristics.

Table 3.2: Characteristics of slum resident interview respondents by slum site in Indore

	Name of Slum				Total
	AN	CH	RU	GO	
Age					
≤ 25 years	20	21	19	21	81
26 – 29 years	5	12	9	12	38
≥ 30 years	14	7	12	4	37
Sex					
Female	29	30	30	29	118
Male	10	10	10	8	38
Number of living children					
1 – 2	32	13	24	25	95
3 – 4	7	18	13	10	48
5 – 6	0	7	2	1	10
≥ 7	0	2	1	1	4
Number of living children < 5 years					
1	10	16	17	18	61
2	22	14	23	17	76
3 - 4	7	10	0	2	19
Education					
≤ 5 years	35	36	20	14	105
6 – 9 years	3	1	14	15	33
10 – 12 years (high schooling)	1	3	6	7	17
≥13 years (university)	0	0	0	1	1
Family Structure					
Joint	10	16	18	18	62
Nuclear	29	24	22	19	94

	Name of Slum								Total	
	AN		CH		RU		GO			
Nature of Work										
Organized/Formal Sector	0		0		0		0		0	
Informal unorganized sector	25		26		27		15		95	
Earning Pattern (by sex)										
	F	M	F	M	F	M	F	M	F	M
Full time employed	5	8	3	5	4	9	1	8	13	30
Part time employed	11	1	15	3	13	1	6	0	45	5
Not working	13	1	12	2	13	0	22	0	60	3
Specific Characteristics										
Pregnant Women	2		4		4		2		12	
Woman headed households	4		3		2		0		9	
Total number of participants	39		40		40		37		156	

Interviews were also conducted with 37 health service providers, identified through interviews with the slum residents. Many of these providers practiced near or within the slum. Some interviews were with providers, including hospitals, who were commonly mentioned in multiple slums. Most of the interviews were with private sector providers, as dictated by the care seeking behavior of slum residents (Table 3.3).

Table 3.3: Characteristics of health care provider interview respondents in Indore

	Total
Provider type	
Gynecologist or Specialist (MD)	5
General medicine (MBBS)	8
Government Nurse / ANM	7
Ayurvedic Doctor	1
Traditional Birth Attendants (dai)	4
Faith healers	3
Semi-quacks (registered medical practitioner or homeopathic diploma holders carrying out allopathic medicine)	6
Chemist / Compounder	3
Facility	
Part of larger hospital with in-patient facility	11
Functioning from clinic or health post with OPD only	17
Other	9
Sex	
Female	14
Male	23
Sector	
Private Sector	27
Public Sector	10
Total number of participants	37

3.2 The Philippines

The Philippines is home to approximately 80 million people, located across an archipelago of nearly 7,100 islands in the South Pacific (UNFPA, 2005). With high rates of literacy and an average life expectancy of 68 years, the Philippines enjoys a higher human development index (ranking 83rd out of 177 countries in 2002) than many other countries of the region (UNDP, 2005a). In 2005, per capita income (in 2002 international dollars) was \$5,231 (WHO, 2005). Between 1985 and 2000, substantial reductions were made in poverty rates in the Philippines, which fell from 44% to 28.4% (UNDP, 2005b). However, poverty remains the Philippines' single greatest development challenge, particularly as the income disparity widens across the population (UNDP, 2005b). In 2005, an estimated 2.3 million Filipino families were living below the poverty line, with 2 million of these also below the food subsistence threshold (UNDP, 2005b). The UNFPA views it as "unlikely" that the country will be able to achieve its targets specified in the UN Millennium Development Goals, as there remains substantial gaps and threats to the resources needed in improving reproductive health services, nutrition, primary education and the environment (UNFPA, 2005).

The Philippines continues to exhibit relatively rapid rates of population growth (1.8% annually) and increasing urbanization (UNFPA, 2005). The government has predicted that urbanization will continue to increase in the near future, possibly reaching 65% of the total population by 2020 (PCP, 2004). Demographic forces propelling urban growth include the high level of urban natural increase (the excess of urban births over urban deaths), continued migration from rural to urban areas, and the reclassification of certain regions from rural to urban (PCP, 2004).

For the urban poor, increasing rates of urbanization have translated into a high percentage of households living as informal settlers in slums or squatter areas. Although many of these urban households have higher incomes than rural villagers, the poverty associated with urban slums is characterized by poor-quality housing, overcrowding, insufficient access to basic services, illegal habitation, polluted environments and public health risks (ADB, 2004). Because of the informal and often illegal tenure of slum residents, local government can be unresponsive to the needs of residents, thus delaying the provision of basic human services and infrastructure.

The Philippines is subject to a wide spectrum of health care concerns, as the country is still battling endemic diseases such as dengue, malaria and leprosy, and an increased burden of non-communicable diseases such as diabetes and cancer. Table 3.4 shows the leading causes of mortality and morbidity in the Philippines (data from 2002).

Table 3.4: Leading causes of mortality and morbidity in the Philippines, 2002

10 Leading Causes of Mortality in the Philippines, 2002 by Number, Rate/100,000 of Population and Percentage			
Cause			
	Number	Rate	Percent*
1. Heart diseases	70,138	88.2	17.7
2. Vascular system diseases	49,519	62.3	12.5
3. Malignant neoplasm	38,821	48.8	9.8
4. Pneumonia	34,218	43.0	8.6
5. Accidents	33,617	42.3	8.5
6. Tuberculosis, all forms	28,507	35.9	7.2
7. Chronic obstructive pulmonary diseases	19,320	24.3	4.9
8. Certain conditions originating in the perinatal period	14,209	17.9	3.6
9. Diabetes mellitus	13,922	17.5	3.5
10. Nephritis, nephritic syndrome and nephrosis	9,192	11.6	2.3
* percent share from total deaths, all causes, Philippines Source: Philippine Health Statistics, 2002.			

10 Leading Causes of Morbidity in the Philippines, 2002 by Number, Rate/100,000 of Population and Percentage			
Cause			
	Number	Rate	Percent*
1. Pneumonia	734,581	924.0	NA
2. Diarrheas	726,310	913.6	NA
3. Bronchitis/ bronchiolitis	629,968	792.4	NA
4. Influenza	484,388	609.3	NA
5. Hypertension	304,690	383.2	NA
6. TB respiratory	114,221	143.7	NA
7. Heart diseases	52,237	65.7	NA
8. Malaria	39,994	50.3	NA
9. Chickenpox	28,600	36.0	NA
10. Measles	24,639	31.0	NA
* percent share from total morbidity Source: Philippine Health Statistics, 2002.			

Maternal Health and Family Planning. Although the 2003 DHS data shows a steady decline in the total fertility rate of Filipino women over the past 30 years (dropping from 6.0 children per women in 1970 to 3.5 in 2001), the country's fertility levels are still relatively high when compared with other countries in the region (NSO, 2004). This is a major factor in the country's high rate of population growth. Over two-thirds of all Filipino women rely on public providers for their family planning needs, although there is a discernible shift to private providers for modern contraceptives. In 2003, 29% of women used private providers for modern contraceptive methods (NSO, 2004).

Women in the Philippines still predominately deliver at home (61%) with the assistance of a birth attendant (hilot) (NSO, 2004). Although few women deliver in medical facilities, the majority of births are attended by a health professional of some type, either a doctor (34%), midwife (25% combined) or, less often, a nurse (1%) (NSO, 2004). Despite the attendance of medical professionals, maternal mortality rates are reported to be 170 deaths for every 100,000 live births for 2001 (UNICEF, 2005).

Child Health. In the Philippines, infant mortality is estimated at 28.7 deaths per 1,000 live births (NSO, 2004), higher than many other countries in the region. The common causes of childhood illness and death include acute respiratory infections, diarrhea and malaria, with nutritional problems and parasitism widespread (WHO/WPRO, 2005). In 2003, only approximately 60% of children had received immunization for the six preventable childhood diseases (tuberculosis, diphtheria, pertussis, tetanus, polio and measles) before one year of age (NSO, 2004).

Tuberculosis. Tuberculosis continues to present a threat to the health of many Filipinos. The Department of Health (DOH) identified 123,208 individuals who were TB-positive in 2002 (DOH, 2002). In 2003, less than 1% of women and approximately 1% of men reported a medical professional had informed them of their TB status in the previous 5 years (NSO, 2004).

3.2.1 The Health System in the Philippines

A range of private and government facilities provide health care services in the Philippines. DOH is responsible at the national level for formulating policy, setting quality standards and providing technical assistance to the local level. The DOH also delivers specialized services and operates many large hospitals that would not be feasible at the local level. In providing support and guidance for local health services, the DOH is responsible for deciding which health actions are safe and effective and most likely to be effective in the region (DOH, 2006).

Local government units (LGUs) are responsible for providing primary, secondary and some tertiary care. A brief description of the public health facilities follows:

- ▲ **DOH Hospitals:** National-level specialty hospitals (such as transplant centers and cancer care centers). Financed through DOH budget, user fees and PhilHealth insurance funds.
- ▲ **Provincial Hospitals:** Approximately 200 beds per hospital; has at least four specialty services; provides specialized care; financed through provincial governments, user fees and PhilHealth insurance funds.
- ▲ **District Hospitals:** Approximately 20-25 beds; point of referral for rural health units (RHUs) and barangay health stations (BHS) for complicated cases; has limited surgical capabilities; financed through provincial governments, user fees and PhilHealth insurance funds.
- ▲ **Rural Health Units (RHUs) or Urban Health Centers (UHCs):** Provides basic preventative and primary health care. Usually staffed by a doctor, nurse and midwives. Financed through municipal budgets and PhilHealth capitation fund.
- ▲ **Barangay Health Stations (BHS):** Primary health care facilities at the barangay or village level, staffed by a midwife. Barangay Health Workers are community volunteers who assist the BHS midwives. These centers provide preventative care, prenatal and postnatal care, FP methods, as well as nutritional supplements and other medications. Financed solely through municipal budgets.

LGUs may choose to provide health services either directly or by contracting to private providers (DOH, 2006). Many municipalities have joined to form Inter-Local Health Zones (ILHZ), a strategy that allows them to share resources for local health initiatives (DOH, 2006). The idea is that when resources are combined across municipalities in these zones, urban services can be provided more efficiently than by any one LGU (PCP, 2004).

In 1991, the government of the Philippines began the process of decentralizing the public health care system, resulting from the passage of Republic Act 7169, The Local Government Code of 1991 (Schneider and Racelis, 2004). Financial management and operations of health facilities were transferred from the national DOH to LGUs, which were to be financed by general block grants for a variety of public services (Schneider and Racelis, 2004). However, decentralization may have introduced gaps in service delivery, as a result of weak communication and collaboration between the central DOH and the LGUs (DOH, 2006).

The government continues to allocate limited funds for health care, with total expenditures on health dropping from 3.3% of GNP in 1999 to 2.9% of GNP in 2003 (DOH, 2006). Of the total spending on health in 2003, 33% was national DOH spending, 18% was local government spending and 10% was the

national health insurance program (PhilHealth). PhilHealth is mandated to provide health insurance coverage and affordable, acceptable, available and accessible health care services for all Filipinos (DOH, 2006). The government estimates that PhilHealth currently reaches 80% of the population, although low utilization rates continue due to lack of drugs, lack of awareness among cardholders of the program benefits and a lack of access to services (DOH, 2006). As shown in later chapters, despite official pronouncements suggesting otherwise, the urban poor of the Philippines are often not reached through PhilHealth.

Because of these gaps, out-of-pocket spending on health care remains high, at approximately 45% of total health expenditures in 2003 (DOH, 2006). Out-of-pocket expenses are mainly made to cover drugs and medicines (47% of out-of-pocket costs), hospital room charges (24%), and medical consultation fees (22%) (DOH, 2006). Although public local health units are not legally permitted to charge user fees for medical services or drugs, many patients are asked to provide “donations” to the facility. (As will be shown in Chapter 6, these “donations” are often a de facto requirement, and are therefore little different from formal fees.) Although drugs at local clinics are free to all patients, it is often the case that patients must purchase drugs from private pharmacies when public facility supplies run out (Schneider and Racelis, 2004). Hospitals charge inpatient fees for all uninsured patients, unless they are defined to be “charity patients” -- in which case the usual fees are waived (Schneider and Racelis, 2004). In some cities, LGUs provide medical assistance to indigents through their local social welfare offices. For example, in San Manuel, the hospitalization assistance program is part of the LGU's assistance package known as Aid to Individual in Crisis Situation, which covers costs of medicines, medical services and hospitalization of patients in critical situations – victims of natural calamities, accidents, epidemics, etc. An indigent client is entitled to financial assistance ranging from P500 to P5,000. The financial assistance is given on the basis of the patient's medical condition, based on the doctor's prescription and advice.⁵

Across the Philippines, lack of money for treatment was cited as the primary reason women do not seek medical treatment (67% of responses) according to the 2003 DHS data. Additional impediments are: not wanting to go to a facility alone (28%), distance from health facility (27%) and lack of transportation (26%). Among the population surveyed, those with the most difficulty in accessing health care for themselves are teenage girls, women with five or more children, widows, rural women, women with low education levels and poor women (NSO, 2004).

3.2.2 Greater Manila Study Sites

Metro Manila consists of 12 cities, five municipalities and 1,694 barangays governed by LGUs, which are increasingly autonomous as the country's process of decentralization unfolds. As UN-Habitat (2003: 216) observes, there is an increasing participation of NGOs and other local community-based organizations in the implementation and monitoring of LGU-led projects. A recent overview of slum communities in metro Manila (UN-Habitat, 2003:215) identified more than 500 communities scattered across the metropolitan area. There are some very large slums (such as Payatas), but many slum communities are relatively small. This review indicated that approximately three-quarters of slum households are long-term residents, having lived in their communities for at least five years. The majority had lived for a long time in either in their current locations or elsewhere in metro Manila.

The two slums sites selected for the study are located in Quezon City of the National Capital Region (NCR) and in the neighboring Cainta municipality of Rizal province. The extended metropolis that encompasses Manila city and its outlying urban region is officially called NCR. This area includes the

⁵ Communication with USAID/Philippines Mission, September 18, 2006.

populous areas of Manila city and Quezon City, and borders Rizal province (ADB, 2004). NCR is home to 54% of the country's urban population, nearly 11 million people (ADB, 2004). Among the urban population, an estimated 35% live in slum communities (Fry, et al 2002). Safe drinking water is inaccessible for 16% of households, and untreated wastewater is a conduit for disease-causing bacteria and viruses (PRB, 2006). Studies conducted on water safety between 1996-2001 found that four major rivers in NCR had such high levels of pollutants that they were categorized as "biologically dead" (PRB, 2006).

Although fertility is lower than the national level, women in the NCR have an average of 2.8 children (NSO, 2004). Contraceptive use among women living in NCR is 49% for any method and 32% for modern methods (NSO, 2004). The unmet need for family planning was estimated at 15% (NSO, 2004). The public health system in NCR is staffed by 658 doctors, 745 nurses, 1,165 midwives and 204 trained birth attendants (DOH, 2002). Additionally, the capital region is also highly populated with private health providers, including private hospitals, clinics and midwives. The accessibility of health facilities shows in statistics such as the percentage of women delivering in clinics or hospitals in NCR – 63.5% vs. the national average of 39% (NSO, 2004). Although residents in NCR have a greater number of public services in close proximity, there are large gaps in coverage and quality of these services.

Profiles of the two study slum sites in greater Manila are presented below. Table 3.5 presents some summary indicators for the two slums. Annex B describes the data collection process and highlights the challenges faced in the fieldwork to guide future researchers interested in similar topics.

3.2.2.1 San Buena

San Buena is considered the most economically depressed community in Barangay Santo Domingo, the third largest barangay in the Municipality of Cainta, located about 2.5 kilometers from Cainta proper.⁶ As of the 2005 census, San Buena had a total population of 1,753 persons residing in 250 households. San Buena lies 500 meters (or 10 minutes ride) from Sto. Domingo proper. According to local informants, the San Buena family privately owns the land of San Buena. Informal settlers started inhabiting the community in the late 1980s. These early settlers were mostly migrants from the nearby towns of Rizal, Antipolo and Binangonan, and were mostly Tagalogs with some Bisaya, Bikolano and Ilokano.

This slum community is comprised of: clusters of small shacks built on stilts along a canal, separated from the rest of the community by a dimly-lit lane; two-story shacks crowded about narrow walkways; and one-story shacks arrayed along a broader path that leads to a major road. Most of the houses are makeshifts constructed of temporary, flimsy materials such as "lawanit," coconut lumber, plastic and GI sheets for roofing. The narrow barangay road leading to San Buena is made of concrete; however, in the interior of San Buena, pathways are made of dirt. Even during the summer season, these paths are muddy and slippery due to lack of drainage. Only a few households have legal access to electricity from the Manila Electric Company (MERALCO). Most households, however, have illegal connections to neighbors with electricity, for which they pay the neighbor. Since the residents of San Buena are considered informal settlers who do not own the land on which their houses are built, there is a constant threat of eviction.

Most of the women in San Buena are housewives, taking care of their children and doing household chores. Others work as laundry women ("labandera") and food vendors ("tindera"), or as peddlers.

⁶ The barangay is bounded by Brgy. San Isidro on the north, Brgy. San Andres on the south, Brgy. San Juan on the northeast, and a portion of Sto. Nino and Sta. Rosa on the east. The Barangay is near the major thoroughfares of Ortigas Avenue, Felix Avenue and A. Bonifacio Avenue.

Relatively few of the men have jobs, although some are engaged part-time as construction workers outside the barangay. Some of the children do not attend school; even among school-goers, time after class is often spent fetching water and delivering it to the residents or collecting plastics and papers for sale to a local junk shop.

Potable water supply is regularly delivered by a private water service truck at a price of PhP 1.00 per gallon of water. The average water consumption per household is approximately 10-15 gallons per day. The water purchased from the delivery truck is mainly used for drinking and food preparation. For washing and bathing, a deep well is free of charge. However, the water from this well is murky and has an offensive smell.

The majority of the residents do not have their own toilets, but public toilet facilities are provided for the residents. These public toilets use a pail-flush toilet bowl, locally called “de buhos.” Some residents, especially women, use an “arinola” (chamber-pot) when urinating. Many still practice the “wrap and throw” method of feces disposal. Running alongside the San Buena slum is a polluted river that serves as the final outfall for domestic wastewater and storm water. Children relieve themselves in this river. (Although a concrete wall serves as the boundary between the community and the river, during strong typhoons the river overflows and floods the community.) There is no proper solid waste disposal and collection in San Buena. Solid wastes are thrown everywhere, particularly at the riverbank. Open canals are clogged and dirty. Due to unsanitary conditions, flies and mosquitoes proliferate.

San Buena does not have its own health center. The slum residents seek medical services in Barangay Sto. Domingo, which has four Health Centers and four Day Care Centers located in Guarr Subdivision, Marick Subdivision and St. Joseph Subdivision. The community health workers based in these facilities do not often visit San Buena. (A medical mission visited the slum once or twice, but according to the slum residents, these visits seem to have ceased.) Most of the residents go to the health center adjacent to the Barangay Hall in Sto. Domingo, about 500 meters from San Buena, or to another center near the Municipal Hall of Cainta. However, due to poverty, residents often rely on traditional healers like “hilots” (bone setters) in their community. There is no “Botika Binhi” in the area and at present, the community has no plans to establish one. (A Botika Binhi is a community-based, community-managed health-financing program that ensures the availability of affordable essential and herbal medicines in the community.) There is no local organization involved in the community welfare of San Buena. There are several youth organizations in the community, but these appear to be temporary and do not involve community service.

3.2.2.2 Kaingin

Barangay Pansol, in which our other Greater Manila study site is located, lies in the eastern part of Quezon City, about 17 kilometers from Manila. The barangay is regarded as relatively poor, although other affluent communities are near it.⁷ The area is mainly residential; there are no large commercial establishments or factories, but only small-scale businesses such as “sari-sari stores” (convenience stores). The residents are predominantly Roman Catholic, but with some followers of Iglesia ni Kristo, Protestant, Born-Again Christians, Moslems and other religions.⁸ Residents are mostly Tagalog migrants from the

⁷ The barangay is bounded on the north by its mother Barangay (now called “Barangay Matandang Balara”), on the east by the City of Marikina, on the southeast and southwest by Barangay Loyola Heights, and on the west and northwest by Barangay U.P. Campus.

⁸ Barangay Pansol has two public schools, the Balara Elementary School and the Balara High School. It also has three government-operated Day Care Centers, which provide kinder education and nutritional care for pre-school children. There are also four private pre-schools operating in the Barangay.

nearby communities of Montalban, Marikina and Quezon City. Others are from Bicol (Bikolana), the Visayan region (Bisaya) and Ilocano.

In the 1950s, Pansol proper was owned by the University of the Philippines, which exchanged it for property owned by the National Waterworks and Sewerage Authority (NAWASA), now renamed Metropolitan Waterworks and Sewerage System (MWSS). In 1964, Congress passed Republic Act No. 4640, authorizing the sale of the subdivision of Pansol to its bonafide residents. However, the law did not take effect due to lack of funds to purchase the whole area, and it was not until the Aquino presidency that the process began in earnest. The area now known as the Pansol Estate was bought from MWSS, administered by the National Housing Authority and sold to some of the residents. However, according to local accounts, other residents are still fighting for land ownership and, as we will discuss, a number of non-governmental organizations and associations are actively involved in the issue. The land and house lots have not yet been awarded to the local residents.

The barangay is divided into six smaller district areas, among which Kaingin 1 and Kaingin 2 are the sites for our research. These are considered the most depressed communities of Pansol, if not the whole of Quezon City. Located in the interior of Barangay Pansol, the Kaingin 1 and Kaingin 2 slums are accessible only by foot, jeepneys, pedicabs and tricycles. Kaingin 1 occupies an area of 18 hectares with an estimated population of 8,000 people in approximately 1,142 households. Kaingin 2 is smaller, with a total land area of four hectares and an estimated population of 5,000 in 668 households. The name of the community dates to the 1950s, when the area was full of cogon grasses, forcing the first settlers to weed out the grasses using the “kaingin” farming method.

A small creek traversing the barangay serves as a boundary between Kaingin 1 and Kaingin 2. The barangay road is made of concrete and asphalt. Some pathways going to the interior part of the community are also concrete, whereas others are muddy unpaved paths. Housing in Kaingin 1 is heavily congested with one to two meters separating one house from the next. The types of houses found here vary from more permanent, concrete structures in the upper part of the community to shacks built from pieces of wood and corrugated tin sheets in the low-lying areas. There are several households that have no electricity; they cook outside their homes using makeshift stoves fuelled by charcoal and wood. By contrast, most of the houses in Kaingin 2 are made of permanent concrete materials. Kaingin 2 is not as terribly congested and a small easement between each house is observed. The majority of the population living here has electricity powered by MERALCO (Manila Electric Company).

Potable water service for Kaingin 1 and Kaingin 2 is available from the MWSS. In Kaingin 1, approximately 60% of the total households have metered water connections, whereas in Kaingin 2 approximately 90% have connections. However, those households who lack the means to pay for water connections fetch water from their neighbors, paying about one peso (PhP 1.00) per pail (15 liters). Average household consumption for those who fetch water is about five pails per day. Fetched water is used mainly for drinking and washing, with water available continuously. Even so, water-borne diseases such as diarrhea and dysentery are common in the community, especially among children. This can be attributed to the contamination of water supply due to pipe leakages and the submerging of water pipes in open canals.

Approximately 60% of the households in Kaingin 1 and approximately 90% of those in Kaingin 2 have their own toilet rooms using “de buhos” or pail-flush type of toilet bowl. There are also public toilets available to residents who do not have their own toilets. However, many families residing near the creek still practice the “wrap and throw” method (wrapping feces in newspaper and throwing it away) or relieve themselves beside the creek.

There is no existing community drainage, although small open canals run through both Kaingin 1 and Kaingin 2. These open canals serve as the only outlet for domestic wastewater and storm water. During the summer season, the canal is stagnant and clogged by solid wastes. The canal's final outfall is the nearby creek. Flooding occurs during heavy rains. The barangay officials observe proper waste segregation and disposal through the "Tapat Ko, Linis Ko" community project. Also, barangay volunteers and street sweepers help to keep the community clean. Garbage is collected by the Quezon City Hall dump truck twice each week.

Most of the women in Kaingin 1 and Kaingin 2 are housewives. Others work as laundry women and food vendors or peddlers. Several women also work as salesladies in the department stores. Men are engaged in part-time jobs for MWSS, including digging, laying of pipes and repairing water lines; others work in construction or as pedicab or tricycle drivers. As in San Buena, children occupy their after-school hours earning small amounts of cash for their families by collecting plastics and papers to sell to the junk shop.

The Pansol Health Center, located in Pansol proper, is the only health center available and easily accessible to the residents of Kaingin. The health center is one tricycle or pedicab ride (500 meters to one kilometer) from Kaingin 1 and Kaingin 2. Residents complain that the health center often lacks medicines and does not provide for emergency needs. When there is a need for further medical attention, residents go to the nearest government hospitals, such as the Labor Hospital and Quirino Hospital. There are also several private health and dental clinics in the Barangay. There are two small pharmacies in Kaingin 1, however, residents prefer to buy medicines from Mercury Drug in Philcoa about ten kilometers from Pansol. Also, there are traditional healers and midwives in the community. The traditional healers include "hilots," or bonesetters, and "nagtatawas," or faith healers.

Unfortunately, there is no "Botika Binhi" in Kaingin 1 and 2, but there is a proposal under consideration to establish one in each community. Apart from the Barangay health nurse, midwives and traditional healers available in the community, there are no other health providers or community health workers who regularly visit the community. However, during rare occasions, the La Vista church brings a medical mission to Pansol.

The Barangay Pansol Council is composed of Barangay Captain and Councilors who manage community affairs.⁹ Aside from the Barangay Council, Pansol has several active local community organizations and non-government organizations providing various community services.¹⁰

⁹ Members of the Barangay Council head the following councils or committees: Barangay Anti-Drug Abuse Council; Peace and Order Council; Barangay Human Rights Action Center; Barangay Council for the Protection of Children; Solid Waste Management Committee; Barangay Disaster Coordinating Council; and Gender and Development (GAD).

¹⁰ These include: Pansol Bungad Association Inc, a non-governmental organization providing assistance on land ownership and other tenurial rights; Pansol Neighborhood Council Inc, a local organization which ensures peace and order in the community; Balara Filters Homeowners Association, a local-based organization providing assistance with home ownership; La Vista Homeowners Association Inc, a local-based organization which sees to peace and security of the neighborhoods; Pangkat Ugnayan sa Paninirahan, Inc (PUSP), a non-governmental organization involved in solving land ownership issues; Ugnayan ng mga Maninirahan sa Kaingin (UMASA KA- Inc), a local organization that provides assistance on land and home ownership; and Bukluran Magkakapitbahaya sa Kaingin, Inc. (BUMAKA , INC), a local organization involved in active protest to ensure land ownership and land rights.

Table 3.5: Background characteristics of study slums in greater Manila, Philippines

	KAINGIN 1	KAINGIN 2	CAINTA – SAN BUENA
Age of slum (estimated)	50 -60 years	50-60 years	15- 20 years
Number of households in slum	1,140	670 hh	250 hh
Social/ethnic groups of slum residents (most common)	Tagalog, Bisaya, Bicolano, Ilokano	Tagalog, Bisaya, Bicolano, Ilokano	Tagalog, Bicolano, Visaya
Origins of the residing population	Montalban, Marikina, Quezon City	Montalban, Marikina, Quezon City	Rizal, Binangonan, Antipolo
Common occupations of women in slum	Laundry women, food vendors or peddlers	Laundry women, food vendors or peddlers	Laundry women, food vendors or peddlers
Common occupations of men in slum	Part-time workers in MWSS (digging, changing of pipes, repairing water lines), construction workers, pedicab or tricycle drivers	Part-time workers in MWSS (digging, changing of pipes, repairing water lines), construction workers, pedicab or tricycle drivers	Construction workers or vendors
Common occupations of children in slum	Collecting plastics and selling	Collecting plastics and selling	Garbage collector and water delivery boys
Land tenure	Residents are still fighting for land ownership	Residents are still fighting for land ownership	Don't know the status; there's always a threat of eviction and demolition
Water source	MWSS – piped to community	MWSS – piped to community	Deep tubewell and water truck delivery
Toilets	“De buhos” pail flush type, inside or outside some homes; others practice wrap and throw	“De buhos” pail flush type, inside or outside some homes; others practice wrap and throw	“De buhos” outside some homes; public toilet; most practice wrap and throw
Roads within slum	90% are concrete and 10% of the paths are muddy, especially near the creek	90% are concrete and 10% p of the paths are muddy, especially near the creek	The main road to the slum is concrete, but inside the community paths are unpaved and muddy
Government facilities inside the slum	Multi-purpose hall, barangay post, Senior citizen's hall, one church	Multi-purpose hall, barangay post	None
Nearest government health facilities	Barangay Health Unit – 500 meters away from the community	Barangay Health Unit – 500 meters away from the community	Barangay Health Unit
Nearest private health facilities	Two private clinics; traditional practitioners	Two private clinics; traditional practitioners	Traditional practitioners

3.2.3 Respondent Characteristics in Greater Manila

Tables 3.6 and 3.7 present background characteristics of slum residents and health care providers interviewed for this study in Greater Manila. Here the research team carried out in-depth interviews with 100 slum residents, with most of these being women in the two slum communities (Table 3.6).

Interviews were also conducted with 27 health service providers, identified through the interviews with the slum residents. As in Indore, many of the providers operated nearby or in the slum. Some

interviews were with providers, including hospitals, who were commonly mentioned in both slums. In these communities, the public sector was mentioned more prominently than in Indore, and we therefore conducted most of the provider interviews with public sector providers (Table 3.7).

Table 3.6: Characteristics of slum resident interview respondents by slum site in greater Manila, Philippines

	Slum Name				Total
	Kaingin	San Buena			
Age					
≤ 25 years	10	7			17
26 – 29 years	6	10			16
≥ 30 years	36	30			66
NI					
Sex					
Female	43	37			80
Male	9	11			20
Number of children in household < 5 years					
0	2	0			2
1	13	11			24
2	17	30			47
3 or more	19	6			25
NI	1	1			2
Education					
≤ 5 years	5	11			16
6 – 9 years	4	4			8
10 – 12 years (high schooling)	34	31			65
≥13 years (university)	7	1			8
NI	2	1			3
Family Structure					
Joint / Extended	20	5			25
Nuclear	32	42			74
NI	0	1			1
Nature of Work					
Organized/Formal Sector	0	0			0
Informal unorganized sector	0	0			0
Earning Pattern (by sex)					
	Female	Male	Female	Male	
Full time employed	2	1	5	3	11
Part time employed	8	5	7	4	24
Not working	32	2	24	3	61
NI	1	1	1	1	4

	Slum Name		Total
	Kaingin	San Buena	
Specific Characteristics			
Pregnant Women	4	1	5
Woman headed households	0	2	2
Total number of participants	52	48	100

Table 3.7: Characteristics of health care provider interview respondents in greater Manila

	Total
Provider type	
Doctor – General Medicine	3
Doctor - Pediatrician	1
Doctor – OB/GYN	4
Licensed/Registered Nurse	7
Licensed/Registered Midwife	5
Traditional Birth Attendant	1
Traditional healer	3
Social Worker	1
Barangay/community health worker	4
Facility	
Part of larger hospital with in-patient facility	13
Functioning from clinic or health post with OPD only	10
Other	4
Sex	
Female	24
Male	3
Sector	
Private Sector	6
Public Sector	24
Total number of participants	27

4. Experiencing Urban Poverty

Before examining in detail the health-seeking behavior of slum-dwellers in the chapters that follow, we'll first describe some of the features of urban life as seen by slum residents. Their perceptions are expressed in residents' level of health and in the energies and social confidence they bring to their health-seeking behavior. We report on the views that the poor hold about their own slum communities, the economic insecurities they face in daily life—a pervasive theme in our conversations—and will describe how domestic violence, spousal alcohol abuse and a general lack of autonomy and decision-making power impose additional burdens on the lives of poor urban women.

Poverty and vulnerability are compounded by health concerns. Health shocks – one of many stresses faced by the poor – make them worse off (Narayan, et al, 2000). A multi-country study drawing on interviews with both urban and rural poor, found that sickness or injury of a family member was the most frequent trigger for a downward slide in wellbeing. It was the most frequent trigger for women and the second most frequent trigger for men after loss of employment or a decline in temporary and seasonal wages (Narayan, et al, 2000).

4.1 Interviews in Indore, India

4.1.1 Rural Opportunities Even More Limited Than in Urban Slums

In the communities studied in Indore, some residents had moved to the slum in the present generation, while other families had lived there for generations or believed that their ancestors had resided in the area since the founding of the kingdom.¹¹ No matter how recently arrived the resident, a common theme in their conversations -- and a rationale for remaining in the slums -- is the view that rural village life provides extremely limited economic opportunities. However difficult day-to-day life may be for the urban poor, they see more possibilities for eking out a living in their slum environments than in the countryside.

The following quotes are from interviews with Indore slum residents:

In our village, there is no labour work. Here women get a chance to work... sweeping, mopping.

There was no work [in the village] that would continue daily. Therefore we came here in search of work – had to come.

There is no water in our village [for agriculture]. That is why we came to Indore.

Whenever I need some money, I can go for picking and collecting garbage.

¹¹ The Holkars were an influential and strong royal family native to Indore. The city's history can be traced back to the 15th century.

We used to live in a village earlier. This is now our village. We have our livelihoods around this place only. We have worked a lot.

4.1.2 Insecurity of Tenure

Two of our slum sites, Goto Ki Chawl and Rustam Ka Bagicha, are quite old, dating back more than 70 years. The other two sites, Chandra Prabhat and Annapurna Thana, are more recently established, with the latter seeing its first generation of new residents. Residents of Goto Ki Chawl and Rustam Ka Bagicha told us that their families had lived there since the time of their grandparents or earlier, and they feel deeply rooted in their communities. In the newer slums of Annapurna Thana and Chandra Prabhat, a number of residents had moved to their current homes from another relocated slum site on the fringes of the present slum boundary. Some of these relocated participants were living in rental housing and viewed their situation as unsettled and precarious. Also, many long-term residents of Annapurna Thana and Chandra Prabhat, including some residents who had lived in their communities up to 40 years, do not yet feel “at home”.

This unsettled state of mind has much to do with the fundamental insecurity of living conditions. For the urban poor, the lack of secure tenure and the ever-present fear of eviction cast a cloud of uncertainty over many of their undertakings. Additionally, it undermines their incentives to invest in land or make any substantial improvements in housing, such as laying down a cement floor or putting up a new roof. The lack of investment incentive is clearly apparent in Annapurna Thana, an unregistered slum whose residents live in cardboard and mud structures that have the look of temporary shelters but function as long-term homes. Even the residents of Chandra Prabhat, a registered slum, realize that their present location is not necessarily permanent. There are persistent rumors that the authorities plan to move the residents to new high-rise structures and convert the land to other uses.¹²

Urban areas are sites where the politics of space play out, and the poor recognize that they may have limited political voice. Anxiety about relocation is common to many communities across Indore, whether these are unregistered slums, squatter settlements or informal settlements in areas not designated for residential purposes in the city’s master plan (e.g., land marked for future expansion of roads). Many residents are aware that even registered slums can be relocated, as has happened when major infrastructure investment programs (supported by bilateral funding) were carried out.¹³ Residents understand that relocations can take place with little notice— and those most directly affected could be the last to learn that such plans are afoot.

We are just staying here [for 30 years]. If some construction comes up, they will break our houses and ask us to go. We believe that big people can do certain things. We cannot say anything since we are small.

We can say this is our house, our land, we have always lived here. But the government will break this whenever they want to. That is why the government is called government.¹⁴

¹² About 175 families living on the riverside in Chandra Prabhat were relocated in the late 1990s. Some of these families have returned and re-established their houses in Chandra Prabhat.

¹³ A few slums in which investments were undertaken through the Indore Habitat Improvement Project have also been relocated.

¹⁴ The local word for government is ‘sarkar,’ meaning those in authority. It is used as a distant salute to the royal and/or the extremely powerful.

The need for assurance of secure tenure before undertaking investments in housing is seen in many developing countries (e.g., Neuwirth [2005] for Rio de Janeiro, Brazil and Mumbai, India).

When relocation is poorly planned and non-participatory in nature, it can paralyze the poor until they understand where they will be resettled and how they will make a living in the new site. Basic living conditions can change drastically, such as an increase in time spent getting water. Even when planning is adequate, relocation inevitably disrupts the social networks of the poor and complicates their access to public services (Lall, et al, 2006). A study of relocations shows that conditions often worsen for the poor, with women losing the work arrangements they had painstakingly constructed in their old neighbourhoods (YUVA, 1998). Moreover, as the poor are aware, it is quite possible for an indifferent government to move them to areas where they will face higher costs of living, higher work transportation costs and fewer economic opportunities. As one slum resident said:

We were earlier shifted to Aahirkhedi [a re-location slum site at urban edge of Indore]. But it becomes very far, and work is here. We came from the village for food, for this reason only. Otherwise why would we have come to Indore? If they throw us far, what will we do there? The fare itself is as high as our daily income.

4.1.3 Dependence on the Cash Economy

The lives of the urban poor are complicated by their dependence on the cash economy. Study participants spoke of their inability to meet daily needs for cash, which leaves them to manage on the very edge of subsistence. In contrast to rural life, where people can at least grow some of their daily food and nature provides other consumables (e.g., firewood), urban families have to earn cash every day to meet their basic needs. Few of the slum residents we interviewed could count on having any cash left over at the end of the day; every penny must be calculated. Some studies show that urban poor households spend 60–80% of their cash incomes on food (Ruel, et al, 1999).

He brings money in the evening, and in the morning it is all spent. Flour, wood etc. everything is expensive. Nothing can be done in 50 rupees.

I used to go to the wholesale grain market to clean the wheat. Then I started making toys, now that is very little. Will try and get stitching order now.

We just sit quietly and wait for the tea. And if we get money, then we make it and have it.

4.1.4 Urban Poor in the Informal Labor Market.

Even if slum residents rate the employment situation as being better than in rural areas, job opportunities for the urban poor are few and insecure. The market system exposes them to complex external forces whose effects are experienced by the urban poor as increased vulnerability. This is decidedly evident in the slums of Rustam Ka Bagicha and Goto Ki Chawl, particularly after the closing of the textile mills in which local men were regularly employed until 15-20 years ago. (The textile industry was the mainstay of Indore's economy until 1985.) Once this source of steady work for men disappeared, women and other family members had no choice but to seek out informal employment – offering uncertain income and low wages. In the informal sector it is unusual to hold a job that pays as much as the national minimum wage of Rs. 45 (approximately US \$1) for eight hours work, but the minimum wage is itself insufficient for city life.

Many participants in our study take whatever temporary work is available in their locations. Women usually work as domestic help, going to different houses for cleaning, washing or cooking. They work for one or two hours in each house and take on as many houses as they can manage. In the slums of Annapurna Thana and Chandra Prabhat, women also earn what they can by rag picking. In the better-off slum of Rustam Ka Bagicha, women are given work on a piece-rate basis in leather toy making. Workers in this handicraft complain of fluctuations in orders and an increase in the number of people doing such work. The result is that the very few orders must be shared over a larger labor force. If they leave work to bear and rear children, slum women can face difficulties in finding work again. Men's work is also highly uncertain in these slum communities, with manual cart-pushing, painting, playing in a band and different forms of manual labour being common temporary occupations. Jobs involving painting or playing in bands are seasonal, linked to festivals and marriages whose timing is influenced by the Hindu calendar. This is irregular, demand-driven employment. Slum residents striving to amass capital and build inventories for their businesses face harassment from the police, who threaten to cite them on suspicion of robbery in order to gain a cut of the business.

I work as a housemaid. Have to take care of 5 children. [Fire] wood [for one meal] is Rs.3. [This is about 5 - 10% of total daily earnings of husband and wife's combined earnings.] One kg of flour is expensive. One person's earnings are not enough. Not able to go now, because the child is young. Even he [husband] doesn't find work in the rains. One has to borrow and eat. That is all there is in life.

I would go for washing utensils and cleaning floors. But I was suffering from typhoid in November near Diwali. So only one house is left now [she was taken off work at other three houses].

4.1.5 Taking Loans and Selling Assets to Meet Expenses

People in the very poor slums of Annapurna Thana and Chandra Prabhat told of repeatedly borrowing small amounts of cash to buy food and meet other small needs, such as a one-time visit to doctor. When major needs arose, they told of having to sell assets. In contrast, residents of the better slums of Rustam Ka Bagicha and Goto Ki Chawl described borrowing for the purchase of a household asset, such as a refrigerator or air-cooler. Additionally, they borrowed in cases of serious health problems and for family occasions such as weddings. Such economic stresses are markedly worse in female-headed households and in households where the man is not working with any regularity.

Sold lots of things, lots of utensils...very often. I have even sold part of things I received from my parents at my wedding.

I would sell everything – all things, yesterday I sold the door, now if I don't have money to meet the needs, then what should I do. It was an iron door, so sold it for Rs. 90 [approximately USD 2].

Uncertainty about employment, the constant burden of debt and the limited reach of public services—all create a vicious cycle of conditions for Indore's poor. Although they hold aspirations regarding their children's education and future, and express their hopes that living conditions will improve, the lack of facilitating factors makes day-to-day survival a challenge. Even the most modest hopes for children's education can be frustrated. In Annapurna Thana, the poor say they cannot send children to school because there is no public school nearby and they lack money to pay school fees. (In other slums, most children are enrolled in the public schools inside or on the periphery of the community, which are basically free schools.) People who are marginally better off than the very poor are able to take

a few small steps in improving their lives. But, as they acknowledge, more substantial improvements depend on external factors that seem largely beyond their control.

A child born here learns to rag-pick when he is 7 months old when he goes with his mother on her rounds. What else will they do?

We make 1000 bidis [filter-less thin cigarette] a day, and get 38 rupees for them.

Even if money is not enough, you have to survive within it. There is nobody literate in our house to earn much.

[Borrow because] Can't let your children go hungry. Also have to pay for the girls' school fees.

Whether he [husband] keeps nicely or not, still I have to stay here only.

I am also a human being. I also get tired.

What should I say about myself? There is poverty?

There is limited food. There is illness. I feel weak, so these small kids have to work. Problems continue. We borrow from other women working here, and am repaying it. What else would life be?

4.1.6 Burdens Facing Poor Women

If adequate nutrition, the freedom to move about the community and an opportunity to rest and enjoy life's simple pleasures form the basis of good health, we find the women in our study slums deprived in each of these dimensions. Women are brought up to hold themselves in low esteem, and they live with an acceptance of their secondary status in relation to men. If a woman makes a decision or takes an initiative that departs from the norm for women, she may be looked upon as defiant or desperate, and she may even share that view herself.

What could she [my mother] do?

She too had to marry me off somehow, we were six sisters.

I have done the stitching work from my house itself. We do the work from inside the house only.

I talked to my husband [about wanting to get a tubal ligation done], and he said that when I become 30 years old then he will get my operation done. He will not get the operation done so fast.

Her husband is drinking only so others also feel she [must be] going out and earning.

If father drinks, then son also has to drink.

If he worries me a lot for sex, then I go to the neighbor's house, also I go to my relatives house and sleep there in the night and come back next morning.

No, I don't give any account, if I become stubborn about a certain thing that we have to have it, I go and buy it myself.

It was my decision that we should keep gap between the children. There is nobody in my house to look after them. I go to work in the factory also, and that is why I had to keep the gap in the children.

The in-depth interviews with women sometimes revealed a lack of attentiveness on the part of men to their daily household duties and larger responsibilities. There were accounts of men who effectively abandoned their homes, leaving it to their wives to look after the children. Married and with three or four children by their mid-twenties, men in these communities often resort to extra-marital relationships or remarry, leaving their wives with the burden of running the household.

We had to migrate as my mother-in-law said that your husband drinks so much, how will it carry on like this. Your husband also doesn't work and you too barely earn and you all eat...why should I look after your children also?

Four years back my husband left me and went away...now what can I do but earn for me and my three children. I am living with my sister and her children...

How can expenses suffice? It's all spent on liquor. And the kids needs medicines, he doesn't give, in fact asks for money and how much can I do? I have to keep running home for the kids. I earn 500-600. He gets Rs. 2000 in fact has just got a job 3-4 days back and he wants good food, not water like we manage. The kids are not able to go to school also, don't have sugar for tea etc.

Comparing interviews with men and women, we found that men are more reluctant to admit that their daily expenses are burdensome. Perhaps men do not wish to acknowledge their limited capacity to earn an income. They may also take it to be the wife's role to somehow keep the house running and see little point in inquiring into the daily difficulties of doing so. In addition, if a man admitted that funds are insufficient for the family's basic needs, this could raise the awkward question of how he is able to find the funds to support his drinking.

4.1.7 Domestic Violence

Discussions on domestic violence have been a particularly challenging aspect of this study. In some interviews, women have come forth and poured their hearts out; in others they have resisted the topic and striven to cover it up. To judge from the accounts provided and the awkwardness encountered in asking questions on the topic, it is apparent that domestic violence in the Indore slums is common.

So do you have a fight with your husband sometimes?

Now that we live together so there are fights often

So there's never been any slap or so?

Now if you are living together, and someone in the house hits you, what's in there? We fight usually over the children only.

Whatever comes in his hands, he hits with that only.

Did you get hurt seriously also anytime?

When I had this child in my stomach, he hit me with the broom, on my legs. He knew that I was pregnant, and still he hit me.

When he hits you, how do you feel then?

It pains me a lot. Sometimes, I feel like leaving him and going away, but then what about the children. They will just roam around the place and become like hooligans.

My father is very bad, he doesn't treat my mother well says she sleeps with other people. I just want to improve him; he says a lot of nasty things about my mother.

No one understands their wives. They treat wives like animals. They have no importance as human beings, are treated as animals.

In some interviews men have stated up-front that they hit or abuse their wives, sometimes taking credit for doing so less often than they might have or than was the norm in the past.

Do the two of you fight?

Sometimes, at the most I must have slapped her a couple of times.

She hasn't hit you?

How can she?

We are thakurs¹⁵, we eat everything...also drink.

Who drinks?

My father and I

Do you also have drunken fights?

Yes...sometimes with anybody. With my father, my brother, my wife.

When you beat your wife then somebody comes to help your wife?

My neighbour comes for my wife's help and they advice me on not to do like that.

When you beat your wife now, how does she react at that time?

She starts weeping at that time

Women described specific incidents of violence they had faced and the routine nature of violence at home. Domestic violence is common knowledge, yet talking about violence is a taboo. Several study participants who opened up, told of the brutality they had experienced.

¹⁵ Thakurs are a caste community. The community attaches great value to masculinity.

He used to kick me, slap me and sometimes he used to hit me with stick. Sometimes when he used to cross his limits I used to catch his shirt and throw him on the ground.

I just do not know why... Once he came drunk in the evening, and started beating me up, and took the gas cylinder and started to put fire in it. I stopped him, then he caught hold of my hand, and put it in the current wire, and my three fingers were burnt.

Hitting, beating and battering are just one distinct type of domestic violence. Women have also recounted their experiences of verbal abuse, sexual coercion and forced abortion, as well as severe restrictions on mobility that seem intended as a form of punishment or control.

Very dirty language he used to use. I also used to reply him back. But we cannot say those dirty words as a man says to us.

She had a girl, she had 4 girls and this would have become the fifth girl, but got her aborted.

How did she know it was a girl?

(After a gap) must have got a sonography done, and then seen. Had got it done one more time, then they said it was a boy in the stomach. In ours, there should be a boy, may it be only one.

Another kind of isolation arises in situations where the husband attempts to dominate his wife by resisting her associations with others. This is more likely when the woman is not working.

It is not our village that I should intervene and get involved (in any basti fight).

My husband says you should not bother about others or talk to anyone. I don't go out and just sit outside my house.

Injuries caused by battering—aching bodies, swellings, cuts and burns—are evident among the slum women. Women also attribute other ill health, including fever, constant nausea, acidity, disturbed menstrual cycles and reproductive tract infections, to the after-effects of domestic violence. In emotional terms, the effects take the form of a loss of self-esteem and are manifested in a sense of helplessness, depression and persistent feelings of a lack of control. These undermine the mental health of women and affect the children as well.

I feel tired, headache and tension is there.... I feel very angry.... I feel afraid, that when he will come after drinking that there will be a quarrel again.

I feel scared that I may get angry and say something that will make him hit me more.

How do the children manage when there is hitting at home?

When it is too much, then they call our parents, become quiet.

You feel agitated and tired?

Feel upset, and feel how this should end. When there is a fight, it has to be ended also.

I took all this to save the honor of the family. I feel so angry... It is all this that caused me so much tension.

Only when he hits me, do I get problems.

If he hits on the head it pains.

Injuries caused by battering—aching bodies, swellings, cuts and burns—are evident among the slum women. Women also attribute other ill health, including fever, constant nausea, acidity, disturbed menstrual cycles and reproductive tract infections, to the after-effects of domestic violence. In emotional terms, the effects take the form of a loss of self-esteem and are manifested in a sense of helplessness, depression and persistent feelings of a lack of control. These undermine the mental health of women and affect the children as well.

Once he beat me with an iron chair on my mouth and I got treatment for one month.

What did you tell the doctor?

I told him that my husband hit me with chair.

The doctor didn't say anything?

What would he say? He gave me treatment.

Did you ever report to police?

I reported many times, but due to small children they always let him go.

Did they take him to police station?

Yes they took him to the police station whenever he fights with me, I don't sleep with him.

He burns my clothes and increases my problems.

So what did you tell the doctor?

I told him that I fell down.

You did not tell him who hit you?

No, I did not.

Did you report it in the police station?

No, I did not.

Is this hitting justified?

If we do not listen to them [the husbands], they will hit us only.

What did you tell the doctor when your hand got burnt in the current?

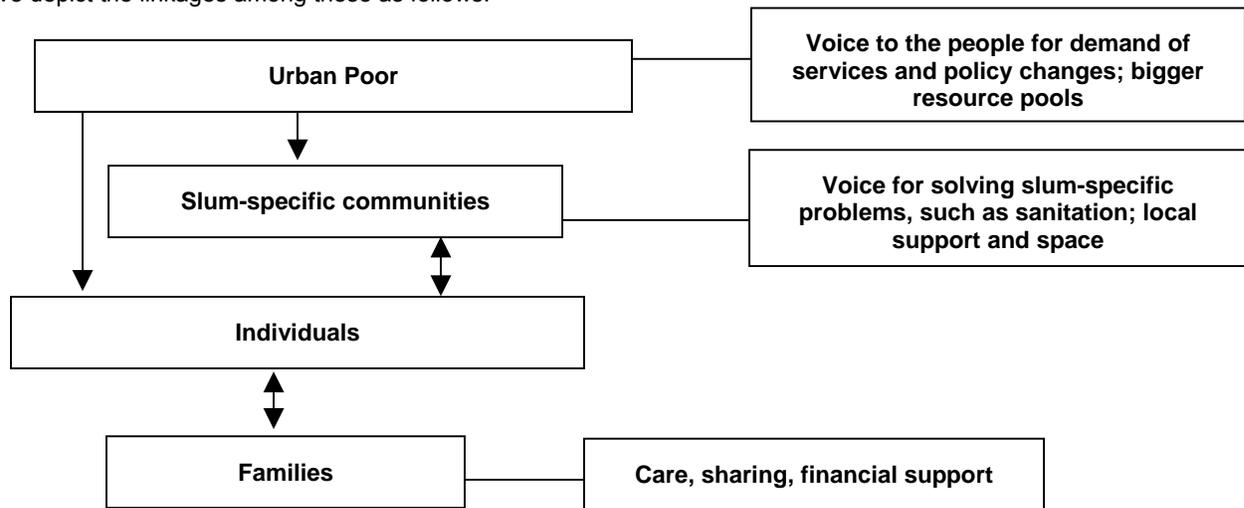
I told him that my hand got burnt while cooking food

Domestic violence is a complex issue, and a full examination of it is well beyond the scope of the present research. Among the complexities needing consideration are that, in most cases, the marital relationship in which violence occurs is also the context in which women seek support -- whether in

parenting, housekeeping or in health -- even within a relationship that has elements of abuse, degradation and coercion. Because violence is linked to depression, anxiety and low self-esteem, it may erode a woman's confidence and sense of competence in many social arenas. A positive sense of self-efficacy is needed to aggressively pursue health-seeking behavior in slum environments that already present many other obstacles. Although we cannot treat this theme in the depth it warrants, we would like to underscore the importance of the linkage from mental health (and the deleterious effects of domestic violence and alcohol abuse that often leads to it) to the health-seeking behavior of the urban poor.

4.1.8 Support Networks

The sense of efficacy that propels health-seeking behavior has both collective and individual components, with collective efficacy stemming from the actions and energies of local associations, social networks and other groups. We depict the linkages among these as follows:



In-depth interviews with different groups of slum residents reveal some of the strands of social networks through which individuals function, and give indications of the kinds of resources which individuals draw from participation in networks. Some of these networks are formalized, whereas others are less so. The benefits received can take both economic and social forms. Studies on social networks among the urban poor show that they can be viewed as a form of social capital, a type of durable asset that gives individuals and households an ability to secure resources such as time, information, money, in-kind gifts and other forms of help. They can therefore mitigate, at least to a degree, the effects of the harsh socioeconomic environment in which slum residents live (Schutte, 2006).

4.1.8.1 Support at the Family Level

Within marriage: The slum interviews depict a sharp division of roles between men and women. In Indore, it is the woman's responsibility for the daily preparation of food. It also appears to be her responsibility to arrange small loans from within the community or the extended family. Household chores, such as drawing water and finding wood for fuel, are also assigned to women. And, of course, ensuring that children remain healthy (especially in getting immunizations and, to the extent possible in this difficult environment, maintaining cleanliness of children's play-spaces) figures among a woman's most important responsibilities. By contrast, the responsibilities of Indore's men are mainly defined with respect to their earnings. But in these communities where men often work irregularly, women must also

play a key role in earning. It was only in the better-off slum of Goto Ki Chawl where some women had the luxury of observing that working was not permitted for women.

Within the marriages of slum residents, the space for discussion and support appears to be very limited. Most men are keenly conscious of their ‘masculinity’ and make use of this in their marital relationships. In-depth conversations with one’s spouse, even on issues as personal and central to the marriage as contraception, do not appear to occur often. In several interviews with slum women, it was clear that women took it as inevitable that men would drink, have affairs or even have additional marriages. Of course it bothered the women, but in their view, ‘men are like that.’ Even physical violence and verbal abuse were depicted as being part of life.

I can only scream and shout, what can I do? It hurts my soul to see what he is doing.

I have become habituated to it [his drinking and abusing].

It is the woman’s role to keep the house going. She cannot answer even when I am wrong.

Within extended families: Where extended families are living in the same slum or in adjoining slum areas in Indore, the sense of support and kinship among them appears to be very strong. This solidarity is seen across all the slum areas of our study. When family support is nearby, it confers upon both women and men a sense of security and builds confidence that they can meet crises as they arise. The support is both emotional and material in nature, the latter arising from the possibility of family resource pooling in times of need.

In contrast to the usual portrayal of a tense relationship between the woman and her in-laws, our in-depth interviews indicated that for the most part the relationship between mother-in-law and daughter-in-law is cordial and interdependent, with both women adding to the pool of household finances and supporting each other in difficult times. Interestingly, it was mainly in the better-off slums of Rustam Ka Bagicha and Goto Ki Chawl that an element of tension was seen in the relationship, apparently arising from disputes over dowry and family loans. Another relationship offering support across all slums is that among sisters-in-law.

When I fall sick, my mother-in-law comes with me. I am pregnant so my mother-in-law goes rag picking. I will have to work in the future, finally how long will she work for me.

If there is any need of money, we take from our parents, not from outside.

My mother-in-law did everything... I have my mother-in-law to help...in some houses there is nobody to help and then they are forced to get to work immediately (after the delivery).

4.1.8.2 Support at the Slum Level

Informally within community: Evident across all of the slums in our Indore study is a kinship, ease and sense of belonging among people of the same community. This sense of oneness, an air of community that is somehow distinctive in each slum but differs subtly across all of them, may have its roots in traditions of mutual support and assistance during religious and festive occasions and other times when customary practices and rituals come into play. To be sure, these slums are far from homogeneous. Indeed, where neighbours belong to different castes and thus different social communities, a certain distance marks their relationships that is evident even in conversation.

Small amounts of economic help for health or food needs are often managed within the community. When people face common socioeconomic problems, they readily understand the kinds of needs and emergencies that can arise and are more willing to lend small amounts to help each other. Many slum women told us of taking loans from other women for meeting household food expenses.

All the slums have had interventions aimed at promoting savings groups and furthering access to fair credit.¹⁶ These savings groups have been able to offer financial help at reasonable rates of interest. Although aware of the savings groups, many of our respondents were not themselves members. A certain rigidity of structure keeps the poorest slum residents from participating. Savings group membership is usually fixed (for instance, at ten women in total), and because it is expected that each member will make a monthly contribution (usually Rs. 50 or Rs. 100), those who lack the means to contribute are unable to join. Even savings group members did not spontaneously describe their group as either a structure they would first turn to or a place they could voice their concerns (unless the respondent was clearly a leader of the savings group).

People also join for political purposes, such as when they approach local authorities to press for attention to the community's infrastructure. In the accounts we heard, such mobilization seems directed toward maintaining the status quo rather than challenging with demands for new services. In other words, slum residents might band together to request repair of broken tap or water line (this effort usually brings results) or to argue against slum relocation, but would not demand new services or improvements. Even so, the energy generated in this collective action has potential which could be built upon.

Somebody's wedding, death, rally, fights... in these occasions, women have gotten together and explained things and helped each other. Women have gotten together on the issue of the demolition of the basti, and in reference to land matter, to say their things, they have made a rally and gone to the government official. The basti community leaders also get everyone together to go somewhere.

A sense of support and assistance from basti workers was observed in some of the slums, particularly in Annapurna Thana and Chandra Prabhat, where these workers accompany women having tubal ligations performed in government health facilities.

4.2 Interviews in Greater Manila, Philippines

In the Philippines, residents' concerns about insecurity of land tenure were not as marked as in the newer slum settlements of Indore. As in Indore, however, many of the slum residents in the Manila sites had lived in their communities for years, with many born there. Although most residents in our study do not hold titles to land and understand that they may face eviction, this concern is not as immediate as in the Annapurna slum of Indore. There do not appear to be any plans to relocate residents of these Manila slums and residents did not spontaneously voice fears of relocation. As we discussed in the community profile of Kaingin, there are proceedings underway that hold promise for residents to receive land titles, and a number of non-governmental organizations are active on this issue. Instead, most residents told of their concerns about meeting basic daily needs such as having sufficient food for their families.

¹⁶ Note that Indore has had extensive micro-finance interventions in its slum communities, initiated by the State Bank of Indore and the former Indore Habitat Improvement Project, and taken forward by Friends of World Women Banking. The government ICDS program has also initiated self-help groups. Some of these efforts are currently functioning but others are not, especially where the agency mounting the intervention had withdrawn before the savings groups developed adequate capacities and maturity.

4.2.1 Slums are Homes for Life

In our Manila sites, most residents moved to their current slum community from other parts of the city – very few had moved directly from rural areas. Most respondents had lived in the slum for many years with no plans to leave unless forced to do so. When asked how long they planned to live in the slum, most answered that they did not know. The slum was very much their home.

The following quotes are from interviews with greater Manila slum residents:

We are from here. My father was raised here. [Will live here] until we are old, perhaps until death. We have no other place to go.

I like it here because this is where we all grew up and where I found my husband...we are not the real squatters here because my father has lived here since he was child. This house is owned by my father. We do not pay rent.

I was born here...I have been here for a long time. My parents died here already.

We've been here for quite a while since we were already here when I gave birth to my second child. That was 23 years ago.

We would stay here until this place will be claimed by the owners.

I have not lived in another place since birth...I think it will be for a long time [that we live here].

I cannot tell [how long I'll live here]... until now we are fighting over this place.

[Lived here] A long time. I was born here...I cannot tell because they say this is not our land and we are not certain how long we can stay here.

My husband was born here. I've been here for ten or fifteen years already.

4.2.2 Insufficient Incomes and Inadequate Livelihoods

Most men in the slums we studied have temporary jobs in the informal sector, although very few have jobs that paid with any regularity. Most of the female respondents did not work outside the home, focusing instead on taking care of the children and other household duties. This is in sharp contrast to the slums in Indore, where most women had little alternative but to earn an income to help support the household. Most respondents in Manila clearly noted that their earnings were insufficient to meet household expenses, and emphasized that there was very little cash to pay for food, their most basic need. The lack of money for necessities was further exacerbated by alcohol abuse in the community, which drains away precious resources.

Only my husband works. He makes decorations. He receives his salary every Friday... His salary is not enough. Our expenses include the house rent and many others. We always have many expenses. Sometimes, it is not even enough to buy rice and viand.

My husband works as a vendor. He gets paid everyday... It's just enough for our food everyday. Sometimes it's not even enough. Also, my husband has vices, he drinks and smokes and sometimes he even goes to the beerhouse.

In my family, only two of us work... I sell some things, I collect garbage and used bottles... It's not enough, just for rice. Sometimes there wouldn't be enough for viand. We just buy salt.

My wife and I both work... We collect garbage, my wife and I help each other... It's just enough to buy food. When there's a little spare, we buy snacks.

Sometimes the money earned is just enough to pay for the credits. Prices are really high nowadays. Life is really hard that we have to borrow money again after paying previous debts.

As of now, it is only my husband who works. He operates a pedicab in Pansol... As of now the income is not enough, but we still get by through the day... I borrowed money from my elder sister when I gave birth since I did not have enough then.

As is the case in Indore, most residents of the Manila slums borrow money to meet household expenses – sometimes for food, other times for emergencies such as illnesses. Most prefer to borrow from family members (most commonly parents, in-laws or siblings), although some take loans from professional moneylenders. Some respondents have pawned household assets (such as a TV) to pay for medical expenses. Chapter 6 further discusses the concerns of meeting health expenditures.

I borrow money when I can no longer manage to afford the daily needs of my family like food and medicine. No, I haven't pawned anything.

[Borrowed money] sometimes to pay for the electric bills or for food.

I don't borrow money because it's hard to pay for it. I don't pawn as well.

We have some people whom we can borrow money from. Even if they place high interests on our loan, but during emergencies, there is nothing we can do but accept their conditions. I recall, when my husband had flu, we had no money to spend [for the medication].

With respect to medical expenses, residents stated:

I borrowed money from the factory when I was about to deliver my baby. It was to pay for the midwife and other expenses.

I borrowed money from my elder sister when I gave birth since I did not have enough then. I did not pawn anything because we didn't have anything to pawn.

I haven't borrowed money yet. I've pawned my TV and CD [player]. It was when my child was hospitalized and when I gave birth because the money needed was quite substantial. But we haven't yet redeemed the items.

I have borrowed money, when my child got diarrhea. His lips and mouth became sore. I borrowed money for his treatment. I have not pawned anything.

4.2.3 Domestic Violence

Respondents were asked about their awareness of domestic abuse in the community and its causes. Most respondents voiced an opinion on the issue, although most said it was not a common problem in their community. Our sense is that they underplayed the issue – after probing, multiple examples of recent cases of domestic violence emerged from their responses. Most women traced the main underlying cause of domestic violence to the lack of money, leading to squabbles over money and, less directly, alcohol abuse by the husband. Some say that the risk of abuse is heightened when women irritate their husbands, such as by nagging. Interestingly, many women expressed a view that husbands may be justified in beating their wives if they behave inappropriately, such as committing adultery. Others said that husbands should never beat their wives.

Regarding causes of domestic abuse, residents stated:

It usually happens. Couples here usually fight about household concerns. Most men do not have jobs, so they do not have money for expenses. As for me and my husband, it is not reasonable to fight over money since we only have each other. We avoid conflict.

Yes, I suffered a black eye and even miscarried. I did not even do anything to cause the beating.

There is, it's normal among couples. It often happens because of money matters.

Yes, some couples fight but it does not happen very often. They argue about drinking, when all the money is spent on drinking.

Sometimes, we quarrel because of money. Since money is difficult to earn, we argue where we will get the money for our daily expenses. Sometimes, my husband can still afford to have vices like playing tong-its [a card game]. We quarrel. We argue. Sometimes, if he hurts me, I fight back.

Usually, couples have misunderstandings. Most wives here are fond of gambling. Of course, their husbands get mad because instead of taking care of the children, their wives gamble... No. The man should not hurt the woman. He has no right even if she is his wife.

I can relate to that because I have hurt my wife. I lose my temper when she talks too much and so disturbs me during my rest... Sometimes my wife and I have misunderstandings about our dire financial situation. / Some couples here marry and eventually separate. Of course, you cannot control people's attitude. For me, the hard times is the number one cause... / Yes, it can be considered as an abuse especially now that we have laws against it. I agree with the laws for disciplinary reasons. But what about the men, and the causes of their action? It would be different if it is done everyday. That would be violence. They should know which fault caused you to hurt your wife. I agree with that law but I hope they will be fair in conducting an investigation.

Regarding when a husband may be justified in beating their wives, women said:

It depends, for example when the woman doesn't look after the house. Since the man works and when he gets home, the house is a mess. It depends on the situation.

None. They [the men] lose their wits/are mad when they get drunk.

When she is caught having an affair... but she should not be hit or battered.

If the woman does something wrong, has an affair with another man, she will surely get beaten up.

Perhaps when the wife cheats on her husband. But during an ordinary fight, no. For instance, if I am caught with another man, then I guess my husband has the right to hurt me.

In my opinion, regardless of the shortcoming a woman has done, she should not be harmed.

4.2.4 Support Networks

The strong sense of community and support networks found in the Indore slums is surprisingly absent in our study slums in greater Manila. Here, the interviews with slums residents do not reveal a closeness of community.

4.2.4.1 Support at the Family Level

Like in Indore, the interviews in greater Manila depict a sharp division of roles between men and women. It is women's responsibility to run the household. Household chores, including cooking and cleaning, are done by women. And, as in Indore, ensuring that children remain healthy (especially in getting immunizations and, to the extent possible in this difficult environment, maintaining cleanliness of children's play-spaces) figures among the most important responsibilities. By contrast, men consider earning their primary role in the family – even though many do not have regular or full-time jobs. Women seem to get very little support from their husbands in either daily chores, raising their children or being involved in health-related decisions. This increases the burden on women.

Our interviews also suggest that it is generally women's responsibility to arrange small loans for household needs. When women say they borrow, they generally borrow from close family members. The family is often mentioned as the only source of financial support that slum residents can turn to.

Sometimes I borrow money from my mother. Because once my husband's eye was hit by a nail and so we had to rush him to the hospital. I do not borrow money from others, I can always ask my mother and my sibling for a loan.

I borrow money from my siblings and my aunts.

We do borrow money but only from my in-laws.

I borrow money from my godfathers and godmothers. I borrow money because life is very difficult. Some people don't want to lend money because sometimes you cannot give it back. I borrow money from them because you won't hear anything from them.

4.2.4.2 Support at the Slum Level

Unlike in Indore, the interviews in greater Manila suggest that slum residents do not rely on the broader slum community for support. In response to a question on what types of activities people in the

area get together for, most respondents say none. Respondents mention few or no activities that involving other slum residents. This is more so in San Buena than in Kaingin – some residents in Kaingin report community activities and a few mention they participate in these activities. Some respondents mention borrowing money from neighbors.

I have borrowed money from my neighbor to buy rice, and foodstuffs. Yes, I pawned our VCD player for 1,000 pesos. I also borrowed money when my child almost died.

I don't have anyone I can ask for a loan. Also nothing to pawn.

Regarding what types of activities bring people in the area together, residents stated:

None.

I have no knowledge of that going on here.

The way we see it, our situation here calls for individual efforts because of the hardships of life especially with needs like the medicines. It is very difficult.

Plenty, like there's this homeowners' association that concerns itself with water access and works to give water access to all the households here. (Kaingin slum)

Among the projects here are basketball, volleyball. These help because they provide leisure and entertainment. (Kaingin slum)

4.3 Summary

In many respects, the slums of Manila and Indore are similar in social organization and the daily difficulties that face the poor. In each setting there are anxieties among the residents about how to find even the smallest amounts of cash needed to purchase each day's food and other necessities. Borrowing and lending of small amounts is very common in both settings, as is the borrowing or selling of assets when health and other emergencies arise.

The dependence on cash by the urban poor, and the difficulties they must endure in acquiring even the smallest amounts, is a key point where access to health is concerned. In Indore and Manila, as in many other urban settings, health care is available only to those with the means to pay. Even in the public sector, where consultation fees can be waived for the poor (as will be discussed in the following chapters), important components of care such as medicines and supplies must be purchased by the patient from sources that require immediate cash in exchange. Formal private sector care is also accessible on a cash basis only. This is a simple, obvious, and yet somehow neglected point---the urban poor lack access to health care because they lack the means to pay for it.

In probing into the difficult areas of domestic violence and alcohol abuse, we touched on issues of women's self-esteem and self-efficacy that are likely to be very important in health-seeking behavior. Women have been handed the principal responsibility for maintaining the health of their children, their husbands and themselves. Yet the emotional and physical batterings of daily life may undermine their confidence and erode the sense of self that is needed to aggressively search for health information, learn what is possible in health care, discover what they are entitled to and make the appropriate demands on the health care system. In our view, women's mental health is far from being an isolated dimension of wellbeing; good mental health supplies energies that can benefit a wide spectrum of health-seeking behavior.

In other respects, the findings of this chapter challenge commonly held views of slum life. In contrast to what is often assumed, the slum-dwellers we interviewed in Indore and Manila regard their slums as communities to which they are likely to have a long-term attachment. Fears and insecurities about tenure and the prospects of eviction and relocation are common, but as the interviews in Kaingin have indicated, these fears can be tamped down when local NGOs and other groups are actively working to secure tenure and title to land. Especially in Indore, local rotating savings groups are an important informal source of economic support for women. But the interviews brought out forward one significant limitation on their reach: the poorest women may lack the means to sustain participation in saving groups.

5. Views of Health Providers

Before delving into the detailed responses of slum residents about their own care-seeking behavior and needs, we first examine the views of the urban health providers. This chapter presents findings from our qualitative interviews with health providers in the study sites in India and the Philippines. These qualitative accounts are prefaced by a quantitative overview of the health facilities usually visited by urban residents, as reported in the country's Demographic and Health Survey.

5.1 India: Findings from the Demographic and Health Survey

Figure 5.1: Health facility generally visited when a household member falls ill, by poverty status in urban India. (Only one facility mentioned.)

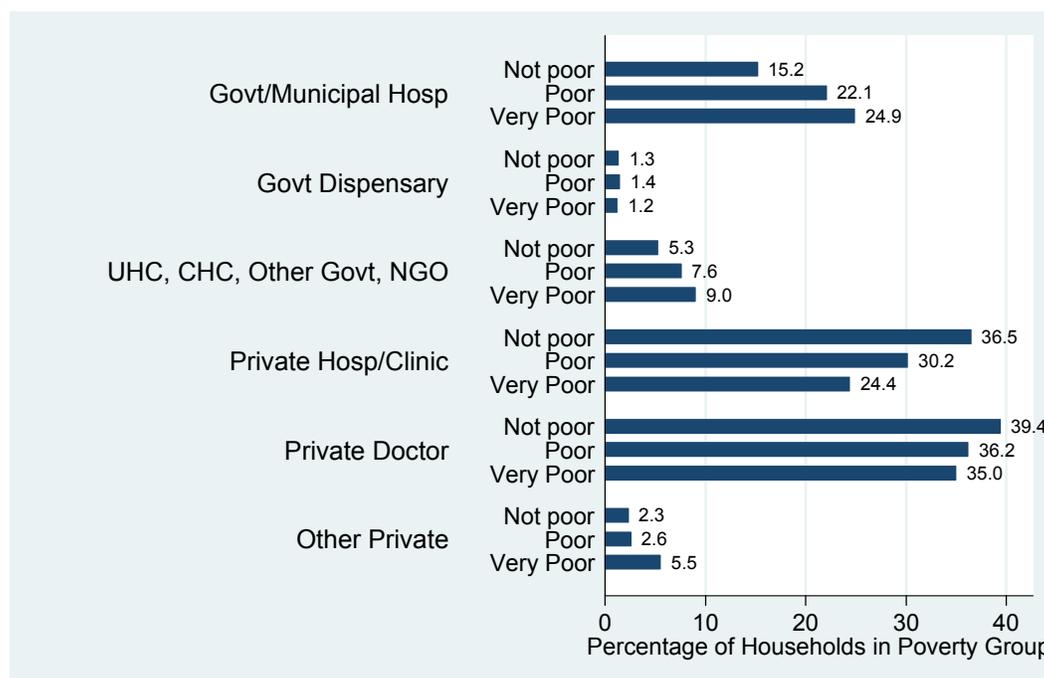


Figure 5.1 depicts the responses by urban residents to a broad question posed in the DHS about the use of health facilities: “When members of your household get sick, where do they generally go for treatment?” The answers refer to only one type of facility, and the time period of reference is left vague. As the figure shows, in urban India private sector providers are visited more often than public facilities. Substantial percentages of the urban poor also see private doctors.¹⁷ An Indore-specific study revealed similar conclusions, finding that 71% of slum residents approach the private sector for health care (George, et al, 1999; also see ADB, 2002). However, among poor and very poor urban households, a

¹⁷ In the figure, traditional healers are included in the “other private” category.

dependence on public health facilities is also clearly evident. For the public-sector facilities, the DHS results suggest relatively little usage of the government dispensaries as compared to government and municipal hospitals. To judge from the figure, sources of private care other than doctors and clinics/hospitals (such as medical stores, informal providers with some quasi-medical background and traditional healers) do not figure prominently in the urban health care scene. Our interviews with slum health providers and residents raise doubt on this point, suggesting much greater use of these varied sources than is evident in the DHS tabulations.

5.2 Interviews with Health Providers in Indore

Indore has better medical infrastructure than in many similar-sized places in Madhya Pradesh and across India. There are several locally established hospitals for those who can afford them, and residents may choose from some hospital chains that have national reputations. Additionally, there are several charitable and government hospitals that are specific to Indore, whose counterparts are not often found in other cities.

5.2.1 Private Health Care Providers

Formal Sector

The formal-sector private providers interviewed were mainly medical professionals (with the minimum qualification of an M.B.B.S.) whose clinics were located in the vicinity of the slums. They serve the low-income groups living in these slums as well as provide services to the financially better-off populations nearby. The private clinics are open morning and evening and remain open until late, closing during the afternoon hours. There was an equal rush in both the morning and evening. In these clinics, junior staff first interacts with the entering patients, checking for fever, taking blood pressure (if needed) and making notes of problems. The clinics we inspected have sufficient space for patients to sit and for examining patients who are lying down. At the busier clinics, two to four beds were arranged in a row so that the doctor could move down the row, examining patients one after the other.

In these clinics, poorer patients are charged lesser fees, although the total fee increases when an injection or medicine is provided. The doctors have many sample medicines available and give these to patients. Some medicines are bought in their generic form and distributed. Patients needing an intravenous drip can receive one at these small clinics if a professionally qualified doctor oversees the procedure. The majority of doctors give injections for all kinds of ailments.

While most doctors said they gave injections to children because kids did not take tablets easily, there was one very popular doctor who said he did not give injections at all since the children were small and could take the medicine in a syrup form. The preference for injectables is as much generated from the doctors' side as it is so often said to be a demand of the people. As one private doctor said, 'My hand is very quick with injections'.

Many of these doctors have established a working relationship with the slum-dwelling populations. Some said that they would occasionally permit their patients to pay on credit if the need arose.

Charitable Hospitals. There are two very large charitable hospitals in the city of Indore whose services are offered to patients at cost. Outpatient department charges are set at Rs. 15, and are generally affordable by the local slum population. However, even without mark-up, the fees for specialist treatments or surgeries are above what most slum-dwellers can afford.

Informal Sector

Informal health care providers are of varying types. They include traditional birth attendants who live in the slums, others with some claim to formal medical knowledge operating in clinics in the slums or make regular visits there, medical stores and different types of faith-healers.

Quacks. In the Indore slums, there are some informal health providers who, for lack of a better term, are called “quacks.” Quacks provide various treatments and medicines to slum residents, usually of an allopathic variety. Many operate small clinics but previously worked (or even continue to work) as assistants at established doctors’ clinics or hospitals, picking up a smattering of skills. They often seek to reinforce an image of professional competence by making use of stethoscopes and thermometers. While lacking much formal training or obvious technical competence, these providers do not operate in an entirely separate sphere from the formal-sector health providers. In defending their use of allopathic approaches (a departure from the more formal medical training some had acquired), the quacks described their approach as a response to demands for such treatments on the part of the slum residents themselves. In our interviews, the quacks took care not to suggest that they stepped into areas best left to the formal providers. For instance, if the patient’s family appeared capable of gathering sufficient financial resources, these providers insisted that they would advise the patient to seek care at a private or government hospital. A few of the informal providers said that they refrained from engaging in invasive procedures, such as putting in stitches or giving injections, and usually used only pills, syrups or other oral medicines in their treatments. One practitioner said that he gave an injection or put the patient on a drip only if a doctor with an MBBS had already prescribed it, but the patient could not afford it. A number of the quacks maintained referral links to senior doctors and private hospitals in the formal system. In addition, they recounted with some pride the formal training opportunities to which they had been invited and made it a point to mention that their clinic had achieved formal recognition by being designated as a DOTS center.

Medical Stores. Medical stores are found both within the slums (in the older established areas with concrete roads) and around them. These stores are often the first place slum residents go to obtain medicines to relieve distressing health symptoms. Our interviews showed that chemists are willing to sell drugs without seeing the patient; a drug could be offered on the basis of a description of the ailment by any family member, even a young child. Because medical stores allow drugs to be obtained without doctor’s fees, they are a relatively inexpensive way to obtain treatment. As one chemist put it:

A 23-year-old man serves as the main health service provider in Chandra Prabhat. His popularity stems in part from the regularity of his daily schedule over the past three years. During the day he works as a compounder in a private clinic but comes to the slum each evening. Walking around the slum, he gives medicines and injections where they are needed, and also puts a drip on patients inside their houses. He revisits ailing patients on a second and third day if needed.

People who are able to get little extra money prefer going to the doctor and then they usually buy full medicines on his prescription. But if they come to us directly, we give only one dose or maximum for a day. If the illness gets suppressed or is cured, then they don’t need to continue the dose. People cannot buy a full dose of medicines, even something as quinine that needs a full dose. We therefore don’t even tell the person that he needs to eat medicines further for three – five days because then he may not take even the first dose.

Faith healers. Popularly referred to as ‘Baba’, a term of respect, faith healers invoke the Gods through their chants and prayers, and present their abilities to cure as evidence of divine gifts. Healers are approached for all types of personal problems, including health issues. The treatment generally does not

involve medicines as such, but brings benefits through linkage to spirits or blessings. One faith healer said:

People come because of their faith in me. I don't do anything; everything is in God's hands. I am only serving as a conduit to God. There is no fee charged. People can put whatever they want in the donation box.

In their interactions with patients, a bond is clearly in evidence between healer and patient based on trust and faith. Over the centuries in India, as in many other parts of the world, inexplicable causes of illness and death have been explained as the consequence of upsetting local gods and spirits. Such systems of belief still persist.

A young man had some problem in his stomach for more than two months. The man's father explained that nobody could fully cure him and the problem kept coming back. The doctors in M.Y. Hospital also gave up. He came to 'Baba' and was given some rose petals and ash to eat; he took these to the hospital where his medication was continuing. He felt fine in three days. The father said, 'you have to do both treatments'.

Amidst very poor families, the faith-healing treatment predominates in circumstances where allopathic treatment is expensive and the formal service delivery system is alienating for the poor.

Traditional Birth Attendant (TBA). The local TBA is a critical source of emotional and medical support for women in the slums. Most TBAs are integral members of the slum community, with knowledge of pregnancy and childbirth often acquired while accompanying their own mothers or grandmothers in similar work. A number of the TBAs have obtained additional formal training, which typically reinforces the value of cleanliness, the importance of providing advice on antenatal care, the benefits of colostrum feeding and the need to make immediate referral to clinics or hospitals when complications arise during delivery. TBAs do not generally charge a standard fee, allowing the price of care to be determined by how much the family is willing or able to pay. The mode of payment is also informal and could be either cash or in kind.

In addition to overseeing deliveries, TBAs are also approached for other gynaecological problems, such as irregular periods, white discharge and infections. However, the lack of traditionally used herbal medicines in the community or the need for surgical intervention (as in cases of uterine prolapse) makes it difficult for the TBAs to provide care in these cases. One TBA in Annapurna slum said:

In some cases, the woman's entrails come out and then one has to push them in, then ask her to keep lying. Just do not stand. I told her, you have seven or eight kids; go for an operation now... otherwise you will die.

The following quotes convey a sense of the formal and informal private health-care system surrounding Indore's slums.

A private MBBS private doctor:

Mostly basti people bring their children with the complaints of fever, cold, irritations, diarrhea and cuts and scratches. Many times the same children come again and again.

Men normally come only when they are feeling very weak. They desire to spend money to have instant relief to be able to work the next day.

Women come less often, but on their own. They complain of backaches, fevers, hurts-swellings and weakness generally. The children are mostly brought by the women. The other common illnesses are malaria, jaundice, urinary problems, arthritis. Among small children 'cold fever', skin diseases and worm infestations are also common.

A provider at formal private clinic:

Our clinic is expensive and is normally accessed by basti persons for complications in childbirth. They also come where smaller clinics have stated complications relating to kidney, liver or heart. Usually they pay in installments. Sometimes we give them a discount.

A private MBBS doctor:

Whenever we organize a health camp in the slums, people always ask for medicines for strength. If any gynecological problems are identified during the camps and women are advised to come to the hospital for further check-ups, they don't come there.

A private informal provider, quack:

I carry medicines for fever, calcium, iron, antibiotics etc. I give an injection or a saline drip in needy situations. For anything serious I refer to the District hospital or a nearby private clinic.

A private informal TBA:

People call me for confirming pregnancy, sometimes in late evenings or day for problems like pain, bleeding during pregnancy. I do most of the deliveries in the slum. The household women help me. I do not abort children so they do not approach me for that. Some families also ask me to come and massage the child (and mother) for three days after delivery. Women keep consulting me for children's illnesses.

5.2.2 Public Health Care Providers

Government health services in Indore are supplied at several types of facilities. Civil dispensaries with limited outpatient services operate at several sites in the city. The dispensaries have an outreach staff, who are primarily auxiliary nurse-midwives (ANMs) serving designated areas in which they provide vaccinations, antenatal and postnatal care, along with family planning and other health awareness work. The decentralized facilities have at least one medical officer and run a common outpatient department open in the morning and usually late in the evenings, with minimal registration fees. The fee is waived and other subsidies for services are provided to patients who can supply identification showing that they fall below the poverty line (BPL). A spirit of camaraderie is evident among the ANMs and women clients at some of these dispensaries. This spirit owes much to the Medical Officer who is in charge of the facility. When this officer behaves toward patients in a sensitive and courteous manner, this sends a message that all staff must behave similarly. A civil dispensary provider states:

We offer vaccination and medicines for general illnesses that are in our stock. People keep falling ill here. They come for coughs and colds, fevers. We give whatever medicines we have in the stock. We also refer to the district hospitals.

Doctors at this level of the health care system complain of administrative problems and pressures associated with the vertical organization of health services and the need to show that “things are happening” in accordance with program objectives.

Field staff, health center:

We are indirectly told not to show any new detection cases of leprosy.

Doctor, health center:

If we are not able to meet the family planning targets, the senior level administration pulls us up. They don't see us catering to the needs of these many people here and only look at how many sterilizations.

Indore also has more centralized government facilities, among them a district hospital linked to the medical college and other district hospitals that specialize in systems of medicine such as ayurveda. These centralized government facilities maintain specialized outpatient departments open in the mornings and evenings. Along with admission, there is provision for emergency care on a 24-hour basis. When medicines are available in the government facilities, they are provided free of cost. In addition, there is a specialist and referral hospital (Chacha Nehru Children's Hospital, part of M.Y.H. Hospital) that treats children with very serious conditions (e.g., extreme dehydration or meningitis). There is a separate ward devoted to blood disorders.

In contrast to observations in the dispensaries, medical professionals in these large facilities appear to be alienated from their patients and are at times dismissive of them. A doctor at the Aryurvedic Government Hospital said:

People don't have any civic sense. They don't know what is good or what is bad for them.

A provider in Government Ayurveda Hospital:

Slum persons approach us for specific ailments like piles, asthma, arthritis and skin ailments. Women come with complaints of leucorrhoea, menstrual irregularity and constipation. Women also come and ask for medicines that could de-addict their husbands from alcohol.

Socio-economic conditions were also mentioned as taking a cumulative toll on health among the slum-dwellers. Among these, the staff identified:

Financial conditions limiting the ability to take a full course of medication. Some ailments, such as skin infections, generally go untreated.

Women's health problems and major illnesses also remain untreated.

People do not wait for the illness to abate or the treatment to take effect. They often resort to faith healers if they do not recover in two - three days. This change of treatment sometimes aggravates the condition.

Poor water and sanitation conditions continually introduce germs and spread infections.

Table 5.1: Common illnesses of poor in Indore, as described by health providers

General common illnesses/problems	Specific among women	Specific among men	Among children
Fevers	Fevers	Fevers	Fevers
Coughs/colds	Backache	Weakness	Coughs/colds
Diarrhea	Menstrual irregularity	Malaria, jaundice, typhoid,	Diarrhea
Skin infections, scabies	White discharge	Liver problems	Skin infections, scabies
Cuts/scratches	Arthritis		Cuts/scratches
Malaria	Weakness		Respiratory illnesses such as pneumonia and bronchitis
Jaundice	Pregnancy-related		Chicken pox
Typhoid	Stress/ anxiety		Malnutrition
Malnutrition			

5.3 The Philippines: Findings from the Demographic and Health Survey

The Demographic and Health Survey for the Philippines characterized the use of health facilities with more precision than the India DHS, focusing on the six months preceding the survey and allowing multiple responses. Figure 5.2 gives a sense of the range of health facilities of which urban households make use.¹⁸ (Note that a response indicating that no facility was visited in the preceding six months is allowed.) It is readily apparent from this figure that poor and very poor urban households in the Philippines are much less likely than non-poor households to make use of private clinics and hospitals, but are more likely to seek care at the barangay health station or another public urban health center. Usage of private clinics and hospitals is much lower in urban Philippines than in urban India, according to the DHS data.

¹⁸ Because the question is phrased in terms of facilities visited, reports of visits to traditional healers are not included here. Other questions in the Philippines DHS (not shown) included the traditional healer category.

Figure 5.2: Health facilities visited by any household member in the six months preceding the survey, by poverty status in urban Philippines. (All facilities mentioned.)

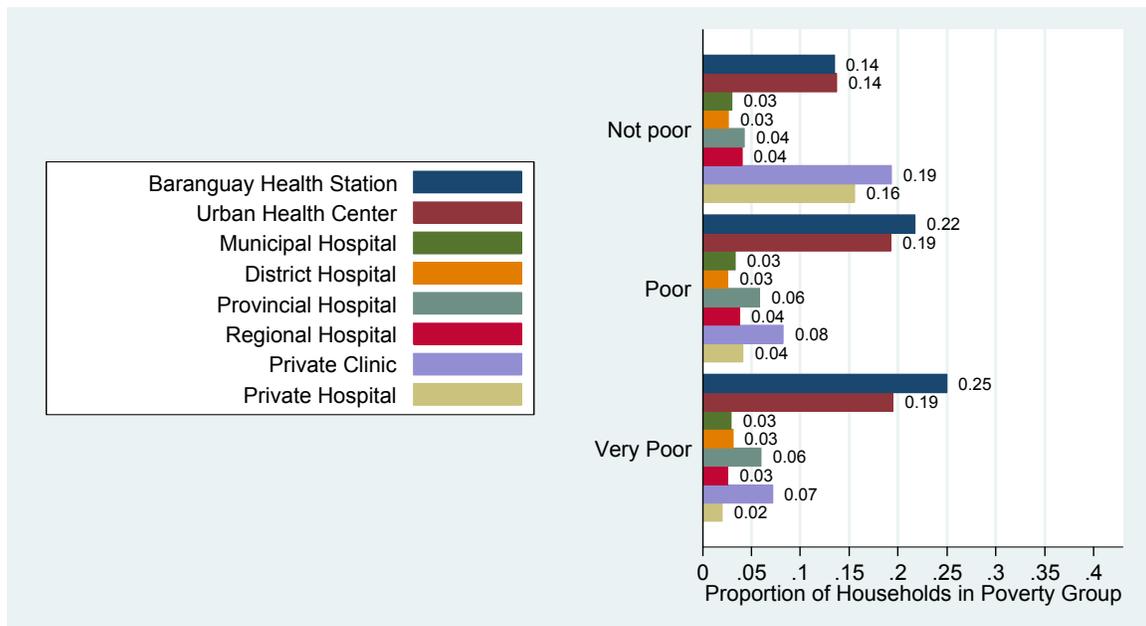
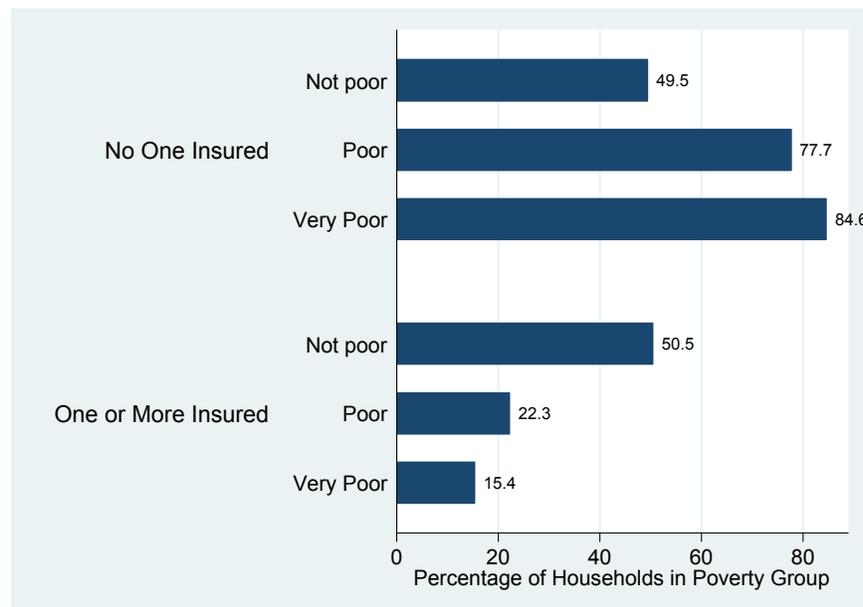


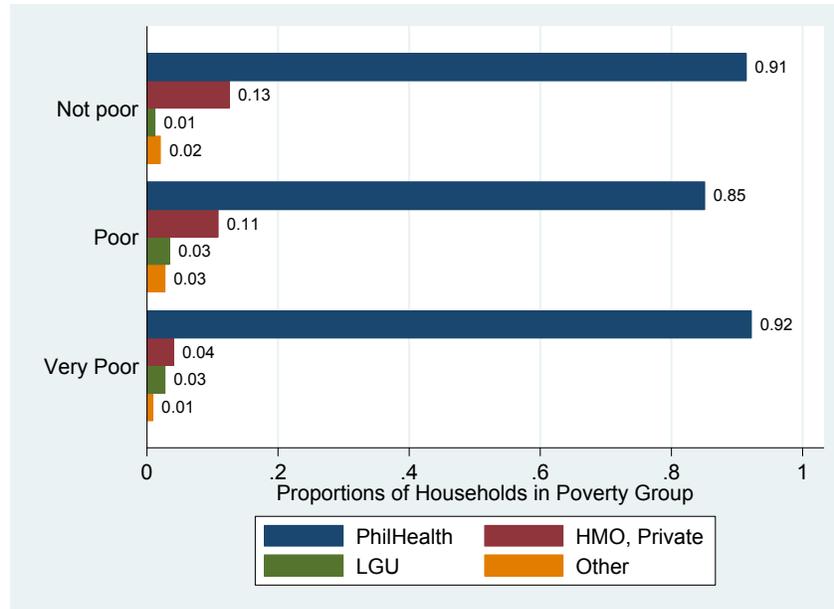
Figure 5.3: Coverage of any household member by health insurance, by poverty status in urban Philippines.



The 2003 DHS for the Philippines also included a health module that determined whether households were covered by any form of health insurance. Among these insurance types, the most important is the PhilHealth program (Schneider and Racelis, 2004). Figure 5.3 shows that to date, health

insurance coverage is markedly inequitable: the proportions of poor households with at least one member covered by insurance are less than half of the proportions for better-off households. And at 15.4%, the percentage of very poor households covered is less than a third of the coverage of the non-poor. Figure 5.4 shows that among families with any form of insurance coverage, PhilHealth is the dominant form by far. In respect to proportions and type of health insurance coverage, the National Capital Region is broadly similar to urban Philippines as a whole (NSO, 2004).

Figure 5.4: Type of insurance coverage, among families with at least one member covered by insurance, by poverty status in urban Philippines.



5.4 Interviews with Health Providers in Greater Manila

Against this background, we summarize the views of health service providers in Greater Manila, putting emphasis on the money costs of care, the difficulties of communicating with the poor, the importance of the barangay in the urban health care system and the role of traditional practitioners in relation to the formal healthcare sector.

5.4.1 The Money Costs of Health Care

The private for-profit formal health providers interviewed in the vicinity of San Buena and Kaingin do not make their services freely available to slum-dwellers, nor do they offer care to the poor at a subsidized price. Arrangements such as this are evidently infeasible in the private sector; our discussions gave no indication that full or partial subsidies for the poor are options under consideration. A doctor in a private clinic in Cainta put it bluntly:

150 pesos is the consultation fee. The tests and medicines are not included in that. They really have to pay the moment we finish checking them up.

In addition, only one provider (a general practitioner at Arnaiz Medical Hospital in Cainta) mentioned that patients could arrange to make payments on an instalment basis, but said that doing so would require an agreement with the patient's company. This would seem to exclude most, if not all, of the urban poor.

Government health providers, who are more likely to serve the urban poor, are regularly faced with patients who lack the ability to pay. The problem is not so much with respect to doctor's fees (in government facilities, there may be no fees for consultations as such, but some facilities charge for admission) but rather in the additional costs that patients must bear to purchase the medicines and supplies needed for treatment. These government providers described several ways the poor could obtain free or subsidized care. First, they noted that hospital pharmacies make medicines available at low prices. Second, if a pharmaceutical company has donated samples of medicines to the hospital, these samples are often distributed to the poor. Third, the providers refer poor patients to the hospital's "Social Service" unit where they may be eligible for discounts on admission fees and medicines. An obstetrics nurse at the Quezon Memorial Medical Centre (QMMC), stated:

We have social workers here who help the really poor patients. We have social workers who classify the capacity of the patient. If the patient is really poor, they are classified in the pharmacy under indigent.

If an NGO works with the hospital, patients may obtain free or discounted drugs from this source. Fourth, when prescribing medication, government providers often direct their poor patients to the barangay health centers where some common medicines can be obtained free of charge. A nurse in the Rural Health Unit in Cainta said that as in rural health units, some of which also serve the urban poor, vaccines and other medicines are given without charge if in stock. Finally, for selected medical services that are available through the public sector—notably, female sterilization (tubal ligation)—patients are eligible for substantial discounts. Said a female nurse at the family planning department of QMMC:

The hospital, as a way to encourage FP [family planning], provides incentives when the mother decides to avail of the free FP methods offered here. For example, the patient gets 50% discount from delivery expenses if she avails of ligation.

However, an obstetrician at QMMC identified an important inconsistency in the way many of the subsidy programs operate. Although subsidies are available for medicines, they do not cover necessary supplies:

Sometimes, they say they can ask for discounts or even free medicines, depending on the class. But in supplies, they cannot. So for instance, they get antibiotics for free [but] if you do not have syringe, how can you provide it? We still ask them to buy syringe to provide for the vaccines.

According to our interviews, stock-outs of medicines occur frequently, especially in the public-sector facilities, and stock-outs of supplies are also a regular occurrence. In these circumstances, it is the patient (or family) who must find the funds to purchase the prescribed medicines and necessary supplies. The availability of subsidies at the barangay or other facilities is quite important in determining the continuity and completion of treatment.

The lack of ready cash—given the low levels of coverage through PhilHealth and other insurance plans—has an effect on many dimensions of health-seeking behaviour of the urban poor. A female obstetrician at QMMC emphasized how a lack of funds prevents the poor from receiving timely care, by saying:

They endure their illness. They will not see a doctor if they can endure their illness. Of course, you'd understand also since their budget is only good enough for the more basic needs of their families. Sometimes I'd ask them why they did not seek treatment earlier, they'd tell me that it is only now that they were able to spare some money for check up.

An obstetrician at QMMC noted that poor women often arrive at the hospital in the very late stages of labor without having purchased the supplies they will need for delivery. The patient's family is then instructed to proceed immediately to the hospital pharmacy or an outside drugstore to purchase these supplies. In extreme cases when there is no time to spare, these basic supplies are taken from the hospital emergency room.

A private doctor in a Cainta clinic pointed out how an inability to pay causes poor patients to abandon treatment before they should:

The problem is they don't have the money so they stop the medication. Usually they just take the first few days then after that wala na. Money is their problem.

A pediatrician at QMMC noted that follow-up care is also hindered by the lack of funds:

Most of the patients come back because they are afraid [of the consequences for the child]. But usually, if there is a hospital charge, patients find reason out of this for not coming back. For example, after admission, we advise this patient of home medication and asked her to come back at a specific date. But she did not do so. After a month or several weeks, when she comes back, the baby's condition got worse again. Then when we traced the child and asked the parent for not coming back, she would just reason out that they do not have money then to pay for the visit, so they just decided not to come back.

Although it would seem obvious that allowing the poor to pay on an installment basis would ease some of these difficulties, a female obstetrician-gynaecologist at QMMC expressed doubt about whether the poor would really make use of any such arrangements, observing that:

You can't expect them to really come back here, just to pay, they don't even do that [return to the hospital] for follow-up check-up, how much more if it's to pay their dues?

5.4.2 Speaking so That the Poor Understand

The many difficulties of communicating with poor patients were underscored by nearly all of the formal-sector health providers interviewed. As one doctor in a private clinic/hospital in Cainta said:

Usually people from the slum areas belong to two general kinds or classes, either very very shy/timid that they are ashamed to tell what they feel or their sickness or the very aggressive [who] want a miracle right away and [in] an instant the patient become well. Usually, they have a companion when they come for consultation and usually the companion is the very aggressive kind and always ask all kinds of questions. The patient on the other hand does not usually tell you what is wrong or what they are feeling. Usually with the shy patients, they just listen, sometimes you are wondering if they really understand what you are talking about. On medications, you really have to explain the medications. How many times a day, coz usually some of them actually just nod when in fact they don't understand what I've been telling them so you really have to explain it

carefully especially the prescribed medicine. Educated people can already understand their medications in an instant.

A female midwife in the Cainta Municipal Health Center stated:

You see, when you are a health provider, you should also be talkative. For example, how can you make them aware of the importance of immunization? Most of the patients do not understand this so the motivation should come from us except when there are outbreaks such as measles within a community. This scares the residents. But most of the time, it is us who should do a lot of talking. That is why we are like chirping birds during immunizations - telling the mothers the names of the vaccines, what they are for and when to come back for the next shots.

The frustrations about knowing when information has been fully communicated to the poor were underlined by a female pediatrician at QMMC, who found that with non-Tagalog speakers, translators were sometimes needed:

Sometimes, they do not know already what is happening to their children. So you really have to explain everything to them. There are actually times when you have already explained everything to them but at the end of the day, you would know that they did not understand all that you have explained. So you have to repeat all over again. Sometimes, they are about to go home already but they have not yet fully understood the illness of their children. When you ask them why so, they would just tell you that the doctor has not explained that. But when you ask the doctor-in-charge, the doctor would say that he had already explained that to the patient. So when the doctor talk again with the patient, the patient would admit that the doctor had really explained everything to him but it is just that he did not understand/remember. You must not use technical terms. Actually, you do not just translate it in Tagalog but in very understandable or Layman's terms. When the patient is not Tagalog, like some who are from Quezon City but know Ilokano better, we will get someone here who knows Ilokano to talk to the patient.

As did a number of our formal-sector interviewees, this pediatrician often relied on sketches and other non-technical visual devices to convey information to her poor patients. She stressed the value of having such visual aids at hand. Her colleague at QMMC, an obstetrician-gynaecologist, joined her in expressing frustration at the effort needed to get information across, saying:

I guess for 90% of our patients, it is us who tell them things. Although there are some who are really inquisitive especially those who have had some education. [But among the urban poor?] They just accept everything we tell them. They rarely ask questions. And sometimes it is difficult to relate to them. They have a hard time understanding what we are saying, even if we use the most basic words or terms. Like for instance, sometimes, we tell them, this is the right way to take the medicine, to make sure that they understand us, we ask them to demonstrate. [Are they receptive to that?] Some, yes. But the others just don't care. They don't know anything, they don't even know when was their last period, family history, nothing. It's really frustrating.

The need for adequate communication is especially important in the DOTS program in which strict adherence to a demanding regimen of treatment is essential. As a female nurse in this program at QMMC said:

Because before they start and take on the medication, you have to inform them what the alarming signs are, and what will happen. Because we have four tablets all in all, and each tablet can cause some reactions. So we inform them what the common reactions were to each of the four tablets. So we advise them to monitor how they're feeling, observe their reactions, and take note of the duration and the times the reaction occur. So maybe that's good because once you tell them of these things early on you are able to gain their trust. They don't ask, what's this for? So in a way, I'm the one who opens up to them, inform them what will happen, what are the normal or common reactions, describe what the minor reactions are as against the alarming ones, things like that. Every time we meet, I ask them questions like 'How, what did you feel when you took this tablet?' And in return, they also sometimes ask us questions like, 'Is it normal if you feel numbness in some parts of my body?'

5.4.3 The Barangay Level of Health Care

The interviews underscored the importance of barangay health centers to the urban health system of the poor. As we discussed previously, these health centers serve as an important source for the poor to fill medical prescriptions free of charge. Doctors at higher-level centers and hospitals take referrals from barangay midwives for a range of problems, including those involving injectible contraceptives and IUDs. One doctor in the Cainta Health Center described a close working relationship between barangay health workers and his staff, whereby the health workers conduct initial screenings of patients, monitoring vital signs, taking blood pressure and temperature, and other routine tasks before referring a patient to the doctor.

In the view of our providers, the barangay is increasingly where the health outreach effort should be focused. A female pediatrician at QMMC stated:

I think there is no need for outreach anymore since there are already barangay health workers, doctors, municipal health officers, assigned per area. So in my opinion, the doctors in government hospitals should no longer be involved in outreach. We really lack manpower.

A female midwife at QMMC, who had herself been involved in outreach efforts in the Payatas slum (a huge dump site), said that many of the awareness-spreading activities she had been engaged in were now being effectively performed by the barangay.

5.4.4 Traditional Healers

A female traditional healer (hilot) in Kaingin described her methods in this way:

I massage the patient and I also have herbal medicines. For cough, I boil lagundi leaves. I also boil sambong leaves which I give my patients to drink. To those who are possessed by unseen entities, I provide them "tawas" healing. I burn alum crystals accompanied by praying. Through that, I can see the entity that possesses the patient's body. I have witnessed how my patients underwent delirium and worse, some even hit their companions with their fists. To cure that, I let my patients hold salt in their hands. For fever, after I administered "tawas," (a healing ritual) I pray over a basin of water. I use the water as I sponge bathe the patient. For sprains, I massage the painful area. Sprains cannot be detected by getting the pulse of the person. I really have to find where the sprained or fractured part is. I run my fingers over the suspected area. The bones are

usually straight and I can easily sense the sprained or fractured part if I feel some irregularities in shape.

My patients are laundry women, aircon repairmen, etc. Most of them complain about their headache and body pains. Those illnesses are brought about by too much work. They suffer from fatigue. Usually, cold air penetrates their back. I treat them by applying a cupping glass (or in Filipino terms, "binibentosahan") onto their back. The following day, the pain caused by the cold air is gone. They can already go back to work!

She said that she presses her patients to ensure that traditional care is really what they want:

When my patients come to me, I ask them why they did not consult a doctor first. I encourage them to seek professional help first since I am not a doctor. But they tell me that they want my service. Even if I tell them that I have no appropriate medicines to provide them, they still insist that they want my services.

Another female traditional healer in Kaingin spoke of the inattentiveness of formally-trained doctors, but also noted her own limits in complicated cases that require formal care, remarking:

Many doctors tend to neglect their patients. Even if the patient is already dying, if you won't push them, they will hardly attend to him.

[I don't provide care] in cases where professional treatment is required, like surgery or those illnesses in the internal organs. For example, I was able to treat one patient but his illness went back several weeks after the healing. I told him to seek professional help because he might have problems in his internal organs. After consulting with a doctor, it was diagnosed that there he had water retention in his lungs.

A female traditional healer in Cainta also made a point of underscoring her limitations, but noted that poor patients may not be able to afford the formal care that even she believes they need:

My resources are not enough. The one that can greatly help them is assistance provided by the hospital. I can only help them with what I can or what I have. The hospital has a lot of equipment, and has the medical professionals who are really knowledgeable about curing ailments.

There are also patients with diarrhea who come here but I advice them to seek professional help at the health center because I lack knowledge in that dangerous illness. However, they will tell me that they lack money. I have no choice but to attend to them. Thank God that sometimes, through my massage, they get well.

A doctor in the Cainta Health Center conceded that informal practitioners have a role to play in the health system, but also stressed the limits of that role, noting:

It's understandable since they are much cheaper than a doctor. But we also advise them that, should they encounter a difficult case, they should immediately refer the patient to a doctor.

A female doctor in obstetrics at QMMC agreed, saying:

Actually, they were called faith healers because they work by faith. I sometimes think that there is a psychological effect in terms of their work. But I disapprove when they start doing invasive procedures, such as, right after giving birth for example, recommending certain herbs for washing the perineum or the wounds. Because the doctor uses some medicines and sutures that could be affected by the methods that they are prescribing. Or they massage the womb of a pregnant woman to supposedly correct the position of the uterus but when the mother gets to the hospital, we'd find out that the baby was already aborted. This is a sad situation.

A female pediatrician at QMMC joined in taking this generally tolerant view:

Going to these traditional practitioners does not cost their patients much. I heard that there is this one traditional practitioner ('arbulario') who is giving medicine that can be bought from a drug store. For example, when somebody came to him and complained about cough, he prescribed one medicine that can be bought from a drug store. After that, the patient went well. From that moment on, whenever there is someone who has a cough comes to him, he just prescribes that particular medicine. In a way, such practice is not that harmful.

In the pediatrics ward of QMMC, a female nurse expressed similar views, observing:

I myself also go to 'hilot'. Perhaps because there are patients who do not have money to pay for hospital services. I just advice them to choose a good healer. The one who could give extra care when holding a child, without any unnecessary rituals. Or if such healer would ask you to drink an herbal medicine, you should be the one to prepare such drink. We have to do that because you cannot contradict all the patients' beliefs. You should be flexible and adjust for them. Otherwise, you will just end up fighting with them.

5.5 Summary of Interviews with Providers

A number of striking findings emerged from these interviews with health providers that warrant further attention. Beginning with the most important, we see that the providers are well aware that slum residents simply lack the cash needed to purchase medicines, assemble necessary complementary supplies (as in the case of labor and delivery) and even, where the formal private sector is concerned, pay for basic consultations. The consequences are readily apparent: the urban poor endure their illnesses until conditions worsen to the point that care cannot be put off any longer; they consult informal practitioners and traditional healers, in part because the arrangements for pay is more flexible than in the formal sector; even if a course of medication is prescribed, the poor may abandon it to save on the costs of the medicines; and lacking the cash for check-ups, they may fail to return for the necessary re-assessments of their conditions.

In both Indore and greater Manila, arrangements have been set in place in the public sector that, at least in principle, would enable the poor to gain access to health care at subsidized prices. However, from the providers' point of view these arrangements are a patchwork. Providers do not appear to get involved in deciding who qualifies for such subsidies—in the public hospitals near our Philippines study sites, patients in need of assistance are directed to a Social Service unit; in Indore, possession of a BPL (below-poverty-line) certification establishes some claims to subsidized care, but is determined outside the health system and it fails to cover many of the poor. The providers observed that medicines can be covered by

subsidies, but coverage does not generally extend to supplies. A poor patient needing an injection could purchase the drug at a reduced rate, but would be required to pay full price for the syringe. Free medicines and supplies might be on hand, if they happened to have been left by representatives of a pharmaceutical company. In the Philippines, the poor may also be referred to the barangay health clinic where a range of medicines is available at a subsidized price. The accounts given by the providers leave an impression of an unsystematic set of arrangements for the poor that, depending on circumstance, might or might not provide them with subsidized medicines. In any case, these arrangements require poor patients and their families to spend time searching and negotiating with what must be a bewildering variety of personnel at scattered sites. In effect, the poor are being asked to substitute the cost of their time for the prospect of reduced monetary cost. In a full-cost sense, this may result in no subsidy at all. A thorough review of this unsystematic set of arrangements for subsidized care, with a careful accounting of the full time, money and informational costs imposed upon the poor, is in our view very much in order.

The provider interviews also elicited a number of observations about the difficulties faced in communicating effectively with their poor patients. The literature on developing-country health care often emphasizes the social distance between providers and their patients, the formal language that providers can use to reinforce their own status, and the possibilities for rude or abusive behavior on the part of staff toward poor patients. But the literature has not much stressed how difficult it is, even for the most well-intentioned and diplomatic health provider, to get basic information across to poor, illiterate, and possibly intimidated patients. We were struck by the providers' accounts of how even the most basic information, delivered in what seemed to them to be elementary, layman's terms, nevertheless had to be repeated (and sometimes repeated again) before the poor were able to comprehend the nature of illness or the steps needed in a course of treatment. Some providers spoke of the value of visual aids in communicating with the poor; others emphasized the need for sensitive one-on-one conversation. In the Philippines, the providers involved with the DOTS program offer instructive examples of the kinds of provider behavior, with close attention to how information is taken in by the poor, that could be used across the health system. Of course, such individualized care is doubtless expensive in terms of its demands on service providers. In this area as well, a systematic study is in order.

6. Care-Seeking Behavior, Access and Perceived Quality of Care

6.1 Findings from the Demographic and Health Survey

In Chapter 5 we presented Figures 5.1 and 5.2, showing the health facilities visited by the three different poverty groups in urban India and urban Philippines. In urban India, all groups visit private sector facilities more than public facilities, although a third of the very poor visit public facilities. This is in contrast to urban Philippines, where use of private sector facilities is much less common, particularly by the very poor. The poor and very poor in urban Philippines more commonly visit public facilities such as the local health center. Interviews with slum residents in Indore, India and greater Manila, Philippines confirmed the findings from DHS and allowed further understanding of this care-seeking behavior. This chapter reports on these interviews and presents findings on general health seeking behavior, access to health care, perceived quality of health care services.

6.2 Interviews with Slum Residents in Indore

As discussed in Chapter 4, cash constraints and a lack of savings often deter poor residents from seeking health care. The interviews show that the financial situation is critical to the care-seeking behavior of slum residents. Additional issues were also noted, such as, distance to the health facility, the time schedule of the facility, views of family elders, and the gender of the caregiver. Access patterns and decisions regarding health care are critically influenced by a combination of these and many other factors. Ultimately, the core decisive factors appear to be those listed in the following table.

Conditions within the household	Conditions with respect to the health care provider
Financial situation on that day	Distance
Which family member is unwell	Costs: consultation fees, costs of medicines, cost of transport
Nature of the health problem/need	Ability to get relief from the ailment
Trust and faith in specific provider	Response and attitude
Traditional pattern of care	

6.2.1 Outpatient Care Commonly Sought in the Private Sector

Across the interviews in all slums in Indore, private practitioners are the primary choice for outpatient services. In fact, public hospitals are rarely used – whether one goes to a public facility is not an issue that is generally even deliberated. Primary reasons for not choosing a public facility is a poor perceived quality of care, complicated processes, and long waiting times. No specific factor appears dominant in influencing a household to choose a public facility over a private one -- including proximity to the facility or an existing relationship with the doctor. This is true even for the poorest families, where

cost factors tend to play a large role. Other studies have documented the preference for private providers. In India, more than 90% of children affected by diarrhea are taken to private health care providers (Bustreo, et al, 2003).

On opting for expensive private health care, slum residents note:

It is just that his treatment helps the children. Even if we have to go hungry, it is hard to bear your child suffering from pain.

You have to run around the first two days [in the government hospital] and then they start taking care regularly.

6.2.2 The First Health Care Option is the Nearest Physically and Financially Viable – It is Also Likely to be the Informal Sector

The determining factor in choosing among the private health care options (following the decision to actually seek care) is a familiar private practitioner in close proximity. Practitioners who are able to operate within or on the periphery of the slum reap the benefits. As slum residents state:

If somebody is quite unwell, who goes all that far [to the government dispensary]. This doctor is right in front, so we go there only.

The government hospital is far, and there is a big line, so I don't go there.

Although these practitioners are usually without a formal degree in allopathic medicine, they are generally the first choice in the slums of Chandra Prabhat, Goto Ki Chawl and Rustam Ka Bagicha. Such a practitioner is most likely male and may have a degree in homeopathy. Sometimes, he may also be a medical assistant with some experience working under a doctor or running a clinic as surrogate for the physician. These practitioners operate either through a small clinic within the slum or attend to people directly in their houses (as in Chandra Prabhat.) It is interesting to note that these informal practitioners are not necessarily available all hours of the day – a common complaint against the public health system. But they promise regularity and convenience by being available for predictable hours in the mornings and late evenings.

Slum residents also reported qualified doctors nearby. Interviews in Annapurna Thana slum showed access to a private qualified practitioner with a clinic near the slum but no semi-quacks in the slum. Because this slum is smaller than the other study slums and has no other poor groups living in the immediate proximity, it may not be worthwhile for a semi-quack to locate here (and poor infrastructure possibly makes it difficult to operate a practice in this slum). What usually drives residents to semi-quacks is physical availability and socially acceptable services at affordable prices. If the same were true for other types of private practitioners, slum residents would probably choose them as well.

Many small private clinics provide comparatively cheaper services to their poor clientele. The average fee is about a half dollar, which generally gets the patient a diagnosis, common medicines from the on-site stock and, possibly, a prescription for medicine from the store. The fee these clinics often charge slum-dwellers may be half of what they charge a wealthier patient. While even this amount is often a strain on limited resources, it is still something the poor can ultimately manage (from their own meager savings or from loans.) It should be noted that this amount is often equivalent to a poor slum resident's daily earnings.

6.2.3 There is a Friendly Relationship Between the Private Provider and the Family

Interviews with slum residents make it clear that a nearby private provider is much easier to approach than a doctor or nurse in an official public setting. This relationship with the local private provider often attains personal overtones, and cases of deferred payments are common. There is rarely a case where a woman, for instance, hesitates in meeting and talking to such a provider. Women often accompany their children to the doctor themselves, only occasionally waiting for adult male. On the issue of visiting government doctors, however, there is a palpable apprehension. This seems more common among men than women. The women still interact with public nurses as part of immunizations for children and meeting their contraception needs. There were no parallels in the private sector to the numerous cases where the respondents claim to have been rebuked by public health officials.

Slum residents state:

The doctor is good; he never insists that you have to pay him now... you can pay him whenever you have money... he gives you medicines, Speaks well to us.

The way of talking was good [of the private doctor], there was nothing to fear.

6.2.4 Relief for Pains and Fevers in Elders is Usually First Sought From Medical Stores

Across all slums, it was commonly stated that patients purchase some medicines directly from medical stores – particularly for health problems in adults. People stated they usually bought drugs from the store for fever, cough, cold, body aches, headaches and back pains. This kind of purchase for symptomatic treatment and relief is usually a maximum of one to two doses.

The interviews show that people choose to medicate on their own when they do not have enough money for the doctor's fees. However, this option is taken only when an ailment is not thought to be serious or have any associated risk. Additionally, residents will self-medicate if the ailment seems to be clearly linked with a previously felt symptom (such as head hurting from lack of sleep, catching a cold through getting wet).

Slum residents state:

When you don't have money, then take tablets (from the store).

If we don't have money, we do not go to the hospital. Just buy two rupees worth of medicines, have it and go to sleep.

Also observed were several respondents in Goto Ki Chawl and Rustam Ka Bagicha that bought medicines by name. More often, though, people go themselves or send their children to the store to ask for medicine with a simple description of the problem.

Slum residents state:

I take these tablets [combiflam] when I have pain in my arms and legs.

I tell him head is hurting and there is fever, and he gives the medicine.

This kind of practice is generally not followed for children. People clearly expressed that they thought it is not good practice to buy medicines for children without speaking directly to a doctor.

Slum residents state:

It can cause reaction in children [that is why they do not buy medicines for children without consultation]

Their body is small, it cannot take every medicine.

An interview with a medical storeowner across from a slum also revealed that over-the-counter drugs for inducing abortion were sold alongside contraceptives (birth control pills and condoms).

6.2.5 Preference for Specific Providers in the Marginally Better-Off Slums

Interviews in the Goto Ki Chawl and Rustam Ka Bagicha slums show that in some cases, respondents prefer visiting different providers for different family members. The decision to use different providers were mostly stated for children's illnesses and gynecologic problems. This pattern was observed only in these two (relatively) less vulnerable slums, possibly because residents in these slums have a greater understanding of different types of health providers (such as, specialists). This could also be linked to proximity, since these two slums have a lot more choices of medical facilities, compared to the two more vulnerable study slums.¹⁹

Slum residents say:

The child becomes okay only with his treatment only, so we take him there always.

For the children, we go to that doctor [a specialist close to the slum]. For ourselves, we go to this one [a semi-quack within the slum].

6.2.6 Preference for Specific Forms of Treatment is Mixed

People's choice of provider is guided by past experiences. They are fairly – though not always – loyal to their chosen provider, often quoting the phrase “only his medicines suit us.”

A common feature of most private clinic services is the higher use of injections and saline administration. This can only be explained as a complex combination of the clinics' interests and the clients' socio-economic and health conditions. Considering their fragile economic state, poor clients have little time to spare and expect immediate improvement, which injections and saline give the appearance of. For the provider, these types of additional services help augment their limited income.

Slum residents state:

Since the kids create a fuss over taking medicines, that's why [prefer injections for children].

¹⁹ While there was no physical count carried out, there are more than 50 outpatient facilities, and about ten inpatient hospitals at a walking distance of 10-15 minutes from the two slums.

This doctor's medicines work for the children. Fever comes down that very evening, he gives an injection.

It must be noted that there were specific practitioners who did not give injections at all and were still quite popular. Conversely, there were practitioners who said that they gave a shot for every ailment because people insisted on it and it had become a regular part of their practice. One interviewer observed that the doctor would listen to the patient standing on his door and put the injection that his assistant meanwhile had prepared for him

An MBBS qualified doctor in Chandra Prabhat states:

My hand moves very fast [with injections].

While it cannot be generalized in such a small sample, qualified doctors seemed to give shots more easily. Additionally, saline was also administered at home by the semi-quack in Chandra Prabhat.

6.2.7 Inability to Get Relief Usually Results in Shifting to More Expensive and Qualified Private Doctors and/or Traditional Healers

A pattern of visiting several providers was observed for long-drawn illnesses such as jaundice, typhoid, and fevers. More expensive doctors are sought out in addition to a faith healer for conception and other-pregnancy related issues, as well as the handling of a life-threatening illness.

Slum residents noted:

[On what treatments are followed] I take the God's name and bind a thread on her hand. That helps.

[On types of problems such treatment is done] If it is something external, a supernatural thing, when the doctor's medicines don't work, we realize that it is something else.

The children were ill - they would get fever every night and would be fine during the day. They were not becoming well here so we took them to the village and did as the village elders told us to do.

I had typhoid. I took medicines from the hospital and also from a person who had come from the village. When it was more than 12 days and I was not feeling better, I went to the village. They gave me a necklace with some herbs tied in it and put it around my neck. As one gets better, the necklace loosens up and becomes longer.

6.2.8 Immunization Services and Contraceptives are Sought From the Public Sector

Preventive medical care, such as immunizations of children and pregnant women, is sought from the public sector. These services are provided free and promoted through government programs. In addition, where the government programs have not been able to reach the Indore population, these programs are facilitated through NGOs and CBOs as part of the UHRC program.

As discussed in Chapter 7, tubal ligation, a common family planning method used by women, is carried out in public sector facilities. It was surprising to note that men insist on going to the public facility, since it requires a government institute certificate.

6.2.9 Interviews Showed Variations for Accessing Inpatient Health Care Within and Across Slums

Low-tier public sector health facilities were rarely mentioned in the interviews. Apart from deliveries, a centralized hospital is chosen if a public sector facility is needed. Many respondents of both genders said they had admitted their family member to a private hospital when necessary. Choosing the public sector was more common for deliveries (when people opt for an institutional delivery) and women in Rustam Ka Bagicha and Goto Ki Chawl reported deliveries in a nearby public maternity home. However, women with their first pregnancy were referred to the tertiary level hospital in the city, registering themselves prior to the pregnancy. If complications are identified during the pregnancy and the household decides to go for an institutional delivery, then the choice is usually a private hospital.

Slum residents say:

She was very weak, so we took her to the private hospital. A lot of money was spent.

In the check up at Nanda Nagar [the public sector maternity home], they said that the baby's head is not down and it will be a breach delivery, so we came back home and went to Ankur Hospital [a private facility] and got an operation done.

Inpatient health care for expensive illnesses that afflict family elders such as heart and lung ailments, were also mostly accessed in the public sector. It was often heard that once patients reach this main government hospital, doctors cannot refer them any further. In interviews with the private doctors, it was also heard that families were advised to take the patient to M.Y.H. Hospital if they cannot afford the health care.²⁰

A slum resident states:

We are not happy with the [M.Y.H.] Hospital. Nobody listens to us in government hospital. But surely you have to get cure there, they cannot refer us anywhere else. (In reference to an incident when respondent's child was admitted there for five days).

In regard to children, the interviews showed people generally opted for the private sector. There were some respondents (primarily men)²¹ who were confident of accessing health care at public sector facilities. But getting things done in the government health facilities requires a lot of maneuvering and skills that few people have -- thus resulting in a general hesitation in going there.

6.2.10 Need for Female Doctors Felt Across Slums

An issue that is not often studied is whether there is a stated preference for female providers. Some of the women in our interviews voiced the preference for a female provider. The private practitioners they

²⁰ M.Y.H. Hospital is the tertiary government institute in the city, and caters to a large population of this region (even beyond Indore). It has an independent children's unit within Chacha Nehru, which was also mentioned in several interviews.

²¹ Some of the male respondents were also among those most against visiting the public sector facilities.

normally visited are not female – only the gynecologists visited in the private sector and the nurses of the public dispensaries are female.

Slum residents state:

Female doctors can easily understand the problems of the female patient. We have no other option so we have to consult the [male] doctor.

We have problems explaining to a male doctor...can't repeat things to him.

[I feel comfortable explaining to the male doctor] when it is regarding the child, there is no problem, only when it is concerning myself.

Quantitative surveys conducted in India show a significant gender difference in the treatment of illnesses. The percentages of untreated illnesses are 17.7 for males and 20.3 (without probing) and 45.3 (with probing) for females (Madhiwala, et al, 2000). This has been attributed to low education levels, low social status of women, and stigma about gynecological illnesses (Nandraj, et al, 1998). In this context, the availability of a female doctor gains importance.

6.3 Health Expenditures in Indore

6.3.1 People are Unable to Save and Resort to Debt or Sale of Assets

As discussed in the earlier chapter on urban poverty (Chapter 4), slum residents struggle to meet their basic daily needs for food and shelter. Given the economic stresses of daily life in our slum sites, the notion of saving substantial amounts of money -- even just enough to carry the household past economic or health shocks -- is beyond most households. When shocks occur, we find that the only options are to take loans or sell assets. Slum residents prefer to take loans from workplaces, which is possible for women who work as domestic maids and for some men who work for contractors. Very small amounts are also borrowed from neighbors and family members. These loans, based on relatively long-term relationships, are generally given without interest. In other circumstances, loans are taken out at high rates of interest, usually 10-50% per month. Where people have assets such as utensils or jewelry, they sell or mortgage them. In the interviews, we were repeatedly told this was necessary to meet health expenses.

Slum residents remark:

You can cut back on money at home, but the child has to be okay.

Children had fallen sick... and had to borrow a thousand rupees. And then again the child fell sick, and I had to sell my cycle.

If someone falls ill, then we have to spend for that also. If none of us have [any money], then we have to take a loan. Keep taking loans...

We can't go to anyone when we need money. We have to sell something in time of illness or when we need it.

Serious adult illnesses can deplete a household's assets and cause a run-up of debt that mires the households in chronic poverty (Amis,

Mala's four-year-old son died in a private hospital. The doctors said that he eats a lot of mud and also said that he had jaundice. But actually she doesn't know the reason. She said, "Only God knows, we are not doctors, what can we say? He started vomiting everything that he would eat, very watery vomits. They gave him oxygen, I had also given blood. We took Rs. 5000 on loan, Rs. 2000 from my mother, and also spent all the money I had. He was admitted for three days, then they said he is in coma and he died."

2002). (In India, out-of-pocket expenditure amount to as much as 80% of all health care spending.) It has been estimated that in 1999-2000, 33 million people fell below the poverty line (known as BPL in India) due to health expenditures. This estimate is in addition to those who are already BPL -- and were pushed even deeper into acute poverty (Karan and Garg, 2005).

6.3.2 Outpatient Care Depends on the Availability of Funds

With daily cash earnings ranging from \$1-\$2.5, monetary costs of health care even as low as \$0.5-\$3 (the average range of fees of the health providers, without the medicines) can still present difficulties for poor households. The lack of cash causes some of the poor to forego or postpone care, or to engage in self-medication.

Slum residents state:

If they [people in the community] have money they will go [to the doctor], otherwise they stay at home. We are also like that, if we have money, we go, otherwise we just get medicines [from the store] and take them.

If you go to the doctor, have at least Rs. 100 in your pocket. Otherwise we'll pay the doctor's fees and not buy medicines.

6.3.3 Lack of Cash Also Compromises Inpatient Treatment

In our interviews, there were cases where the ill person was not admitted to a hospital or clinic because of lack of money. The patient was taken back and forth to the doctor's office for outpatient injections instead of inpatient care.

There are some health care discounts available to the poor, but these are earmarked for program-specific services (e.g., tubal ligation, contraceptive supplies, and institutional deliveries within the RCH program) rather than for the common ailments that afflict them almost daily. In addition, charges may be waived for the doctor's time but still payable for other services or medical supplies. These fees are often a cost the poor simply cannot afford.

Slum residents say:

They demanded Rs. 300-400. I did not have money at that time. I asked them to admit the child and I am going to go home for arranging the money, but they refused, so we came back.

Expenses are more than our earning. In case of illness of any family member, we face lack of money for their treatment. My son was suffering and he was admitted in the hospital. We took a loan of Rs. 1000, and now we have to pay Rs. 60 per day for 24 days. Whatever we earn, we have to first give him [the money-lender] and rest is for our livelihood.

6.4 Perceived Quality of Care in Indore

The quality of health care available to the urban slum residents is often perceived to be poor and unreliable. This section discusses the issues raised by the slums residents in Indore during the in-depth interviews.

6.4.1 The Formal Environment is Alienating

In the public sector's extremely formal and official environment, people in desperate need may find fulfilling the requirements intimidating and energy consuming. For an illiterate slum dweller, the formalities of registering, finding the correct doctor or department, not being able to read the signs, and finding where medicines are distributed is a daunting proposition. These factors should be taken into account in planning systems targeted to the poor.

Slum residents say:

If you go [to the public hospital], then they send you here and there. Make a slip here, make a slip there. The whole day goes blank and then it is closing time [working hours end], therefore we don't go to government hospitals.

We can't read which room is for what facility and the corridors are so long.

A woman described an incident where she was not able to get a blood test done. When she went to the laboratory (after the consultation with the doctor) the lab technician said he could not do it because the doctor had forgotten to sign while prescribing the test. It took her an hour to get the doctor to sign and the lady had to stand in the queue again. The laboratory had closed by then. The next day was not a day scheduled for pregnancy tests.

The men and women seeking care felt quite separated from the treatment they received. Medicine and disease still remain elusive for the slum residents. Neither education levels nor interactions with health care providers' offsets the lack of confidence in either the nature of the ailment or the treatment. This was observed across all in-depth interviews with slum respondents and health care providers.

However, the interviews revealed a sense of more confidence with alternate forms of health care, such as, "ayurveda" or faith healing. Respondents were more descriptive of these informal treatments, whereas for allopathic settings, the extent of their descriptions was limited to whether or not they received injections and medication. In cases where a family member was admitted to a health facility for a longer time, there was some rudimentary understanding of saline given for dehydration and blood transfusions. Outside of these simple situations, people did not know or understand the care given. It is interesting to note that many women respondents could specify by name children's vaccinations and the diseases they prevented. This is probably due to the intensive program interventions of NGOs, as well as constant media inputs on immunization schedules. In contrast, the interviews with women and observations at public sector health facilities indicate that discussions at the antenatal clinics are limited. For curative care at private or public places, poor slum residents are not involved in the treatment at all.

In designing interventions for the urban poor, it is important to design specific educational materials and strategies for drawing patients into conversations with providers so that they can understand the need for treatment, adherence to dosages and completing comprehensive care. Moreover, such strategies could also help develop a sense of control and confidence.

Slum residents say:

The doctor was good but they do not talk properly and tell things.

The medicines given by them [the government dispensary] are useless. They give the same medicines for everything. It does not affect me at all.

He gave some herbs, which are to be given after boiling in water. We have to go three times. But we got relief after two times, so we did not go the third time.

6.4.2 The Approach in Provision of Care and Attitude Toward Poor People is Often Insensitive

Interviews with slum residents suggest that public health care providers have a negative attitude toward the very poor. This affects the care provided and the interaction between the person seeking care (and accompanying family members) and the caregiver. Amid this perceived lack of sensitivity, patients feel a sense of distrust and doubt about the care provided.

Slum residents state:

Nobody listens to us in government hospitals.

They say in government hospitals, it will be like the government only.

The doctors and nurses shout.

The doctors [in a government hospital] do not attend properly... And one gets afraid of seeing the horrible scene there... I had gone once and I just ran back.

The doctor was just there and my brother ran to him saying do take a look at my father. The doctor scolded him off. When he came after a long time, he said there is nothing.

Table 6.1. Shows the results of a perceived quality of care study in government facilities in Indore, done through a government survey used as a planning tool within the urban health proposal of the Health Department. Given the low positive responses to any of the quality of care indicators, it is clear there is a poor perception of quality of the government facilities.

Table 6.1: Quality of care in government hospitals and dispensaries in Indore, India

Quality of care indicators	Positive response (%)
Timing of center convenient	23.0
Distance of center convenient	20.1
Availability of doctor/ANM	20.7
Privacy for examination	19.2
Availability of medicine	16.3
Explanation for taking medicine	21.6
Pay money for treatment	5.2
Long waiting period	17.2
Friendly staff	16.9
Effective treatment	20.2
Recommended center to relatives/friends	16.7

Source: Shuruat, 2001.

6.4.3 Public Health Care Has Not Been Adequately Decentralized

Public sector facilities are largely centralized. Referral and linkage patterns between communities, or establishing a strong first-tier and second-tier structure, have not been given sufficient focus in policy or implementation. As the National Health Policy document (2002) mentions, public health services in most urban areas are presently “meager” and “there is no uniform organizational structure” (GOI, 2002). The lack of a sound organizational structure implies there are hardly any referral procedures among the public hospitals. The National Rural Health Mission (NRHM) focuses on strengthening the infrastructure in rural areas. Thus far, this is not carried forward to urban areas of the country. Where there are provisions within specific (vertical) programs, there is a difficulty in accessing and using funds at the state level.

The resulting situation is that cities across the country have a varied health infrastructure. It is the metropolitans²² that have been largely able to attract funds through financed programs. But these sites do not have a strong community linkage, and the facilities are only operational with their specific program focus.

Slum residents observe:

The government hospital is very far. It is difficult to go there after he comes back from work.

No one comes here. They come only for giving immunizations to children.

Even within functional health units, the focus has become more program driven. Inadequate drug supplies and the unavailability of doctors make the treatment of common diseases very difficult. Across interviews, the respondents replied that they used public facilities for immunization services or for registration of their pregnancies. Visits to these health centers also showed provision of these services by nurses, the key functionaries of the RCH program.

A health dispensary visited as part of this study had the sanctioned staff of four doctors and supporting ANMs and compounders. The staff has separate program responsibilities, such as the leprosy program, immunizations and contraception. One doctor in the facility complained that she is unable to respond to people's ailments and has to prescribe medicines from outside since the quota for general medical supplies are extremely limited and finish within the first five months of the year.

6.5 Interviews with Slum Residents in Greater Manila

This section discusses overall care-seeking behavior, access to health care and quality issues as raised by slum residents in greater Manila.

6.5.1 Outpatient Care Commonly Sought in the Public Sector

Across the interviews in greater Manila, the public health center was clearly the choice for all outpatient services. Respondents say they go to the health center for common ailments such as fevers,

²² The World Bank-funded India Population Projects were implemented in the cities of Bangalore, Kolkata, Delhi, Hyderabad and Mumbai -- all large cities. It was expanded to smaller municipalities in the region of Kolkata and Hyderabad when a review showed an increase in funds available, primarily due to exchange rate adjustments.

coughs and colds, as well as for emergencies and severe illnesses. As discussed in the next section, traditional healers are sometimes approached first, although generally for minor sprains and not serious ailments. A few respondents mentioned going to private doctors, but this was not common. Respondents say the health center is chosen because services and medicines are provided free. However, respondents mention that health centers generally require (or ask for) donations and they feel obligated to pay. Respondents also mention a common concern that health centers often run out of medicines. The issue of medicine stock-outs is discussed in greater detail later in the chapter.

The public health center is also the source of much health information for slum residents. Their knowledge/awareness about a range of issues – immunization, family planning, application of medicines – comes from the health center. These are discussed in later sections.

Slum residents note:

We just go to the [public health] center. The center offers medicines for not so serious ailments here. Because of poverty, we just go to the center since we have no money for clinics and hospitals.

People usually go to Pansol Health Services. It's near here and it's free. However, there is a required donation, which costs 20 pesos.

At least, there is free check-up in the center unlike in the private clinic where you have to pay. You only give donations when you have consultation in the center.

I'll still go back to the center because there are no fees, only donation.

There are times when we bring the sick person to the health center. However, when there is no (free) medicine at the center, we just directly buy the medicine.

I go to the health center for consultation especially when I don't have money, because we just give donations. We go for check-up to get the prescription from the doctor. I go for consultation at the center when my child has fever, colds, cough, and diarrhea. I go to the traditional healer for sprain. But for other ailments such as fever, cough and colds, we go to the doctor for a check-up.

They [other slum residents] would really go to the health center first because they give free medicines there especially for those who really need check-up. Some of the people here would just go to a midwife maybe because of lack of money. Some go to the traditional healer. Others go to the hospital because they have the means.

People only go to the center because the service is free and you only give donations. Going to a doctor is expensive.

They [other slum residents] always go to the health center because it is just around the corner and medicines are sometimes given out for free.

I got the medicine here in the health center. I bought the paracetamol. The antibiotic was given to me.

[Goes to the health center] Because that's what we can afford and it is near. We were told that there was no doctor at the center so we were given a letter to proceed to Takano in Cainta, that is also a health center. But it would be expensive to go to a doctor.

I learned about it [use of medicines] in the health center. I went there for a medical check-up. The medicine was for free. They charged me only for the laboratory and the check-up was free.

6.5.2 Traditional Healers Visited by Many as the First Stop for Care

Many respondents noted that they first visit a local traditional healer before a formal provider (usually at the health center). Respondents made it clear that they (or their families) only go to the traditional healer for minor aches and sprains – the healer generally massages the affected area and often heals it. If the healer is able to help, then they have saved the trouble of going to a doctor. For ailments like diarrhea and fever, respondents generally prefer to go the health center directly. However, some of the interviews suggest that by first going to a traditional healer and thus delaying the visit to the health center, the health condition may be worsened and difficult to treat.

Slum residents state:

I take my children to the traditional healer for sprains or mild fever. The traditional healer knows what to do and any amount would suffice as payment.

A traditional healer is different from a doctor. Traditional healing can deal with, say, stomach gas. Hospitals just issue a prescription.

I go to the traditional healer if the medicine does not work like when the cough goes on and on which means that there might be a sprain. I believe that it is the traditional healer that cures sprain. But if the healer can no longer cure the ailment then we go to the doctor – that's for cough, fever, colds, skin problems, etc.

I go to the center when someone has fever but when someone in my family has a sprain then I go to the traditional healer for a massage.

I consult the traditional healer first for sprain but not for diarrhea, as he/she cannot treat that. The traditional healer applies some alum crystals for treatment. I go to the health center for check-up especially if someone in the family has colds or fever.

We usually go to the doctor and seldom to the traditional healer.

We go to the traditional healer for sprain. If it's more serious, like diarrhea, cough and colds, we go to the doctor.

My daughter was brought to a traditional healer for healing rites but the fever did not get any better so I brought her to a doctor. The doctor said that the child is anaemic and has iron deficiency.

We go to the health center and also to the healer. We have not yet gone to the (traditional) herbalist.... When there is only sprain I go to the healer. When the healer is not able to cure the fever, I go to the doctor. However, before I take the child to the doctor, I first see a healer. If the ailment is not cured within two to three days, I take the child to the doctor.

With a healer because you can just give the healer P5. We are given good care. We were not given any medicine, just massage. We were just told to give the sick child paracetamol.

Sometimes, we take the patient to a traditional healer before going to a doctor especially. When the sickness is cured, we no longer see a doctor. If not, we go the center, and if they are unable to treat there then we go to the hospital.

I went to the traditional healer when my child fell. The other time I went to a traditional healer was when I had flu, to have a massage. It was all right.

With the doctor, you'd need to have a proper check-up then you'd be given a prescription. But if the child is too sick to go, I just have the healer come over for a healing massage. Thank God, my children are able to recover the next day.

I consult the healer for sprains and then the doctor, when the ailment is not cured. For fever and coughs, I bring the children to the doctor. I did not have enough money at that time so I cannot afford a doctor. At the same time, the hospital is far from here.

6.5.3 Immunization and Family Planning Services Sought in the Public Sector

Most respondents noted going to the public health center for their children's vaccinations due to free immunizations (although concerns over requested donations were voiced, as discussed earlier). Some mentioned free medical missions held within the slum by different organizations, where immunizations are given on site. However, our sense is that these missions do not occur with any predictability for residents to rely on. The health center is also the main source of information for immunizations. A few residents also mentioned learning about immunizations from health workers who visit the slum or from TV ads. See Chapter 8 for further discussion of child health issues.

Those respondents using contraception generally go to the health center for consultations and products. Contraceptives are provided free in the health center – residents did not voice the same complaints for stock-outs of contraceptives as they did for medicines. Some women mentioned using the natural method for family planning and relying on the church for consultations. See Chapter 7 for further discussion of family planning issues.

Regarding source of information and services, slum residents state:

At the health center, they told us [about immunization].

They all go to the center. They conduct vaccinations every Wednesday afternoon.

At the health center. Sometimes, if somebody comes here in the barangay to administer vaccines, then I have my kids vaccinated.

Consultations are at the center [public health center] because they give contraceptives there.

The health center provides us information about it and told us that if we already have much knowledge we should have FP because life is very hard nowadays. The midwife also explains it to us. I also learned it from a friend.

[Got contraceptives at the] Health Center. It's easy to get there. It's near here.

I used to go to the center for the injectibles. But when I changed to the billing/bilang or natural method, I go to the church instead, that is where they teach us. Because it would be a risk to use injectibles when I am breastfeeding and the same way with the pills because it will affect my milk supply.

I've learned it [family planning] from the center and I've heard about it from my neighbors.

6.5.4 Self-medication is Common – Particularly for Pain and Fevers in Adults

Most respondents noted that they first self-medicate before seeking formal care. Self-medication for common ailments such as pains, fevers and colds is particularly widespread. Analgesics are primarily used and bought from drugstores or obtained from the health center. In some cases, residents noted the use of antibiotics – although it was not clear whether these are always bought with prescriptions and used after consultation with a doctor. If this is not always the case, there is reason for concern and may warrant health education about use of antibiotics. Respondents mentioned that they learn about use of medicines from family members, neighbors and the health center.

Slum residents say:

If the sickness is not that serious, we take our own initiative to treat it. If we can no longer treat it ourselves, we go to the doctor. In cases for example when a member of my family has diarrhea, high fever and convulsion.

For fever, I give paracetamol. Biogesic is paracetamol. For most of the sickness, I just give paracetamol. However, when the cough is really serious or when the fever and cough persists for three days, I give antibiotic - Amoxicillin.

I give paracetamol when my children have fever. When the ailment is serious, I bring them to the doctor to ask for prescriptions. But it's really really hard because we cannot afford to buy the medicines. Whenever the children are sick, there's that medicine that I usually let them take, that's Sipactor.

When my youngest gets sick, I give Tempra. The youngest is almost 2 months and April is turning three. I give paracetamol - Neo Aspilet. When I have body aches, I take Alaxan.

My husband takes it, too. For headaches, biogesic. Someone told me that. I buy from Mercury [Drugstore].

Me, I take Amoxicillin. That's what my mother takes when she has cough. When I had cough in the past, I take it on the second day. I didn't go for a check up.

We go to the center first for consultation before taking any medication.

Amoxicillin, Tempra with Calpo if the budget permits. The antibiotic with carbocistin is for the phlegm. I consult a doctor first before administering the medicine especially if the cough is with fever. For simple illness, I just give biogesic syrup. [Learnt from] my mother, from the drugstore.

I give paracetamol for fever and for the children, I give tempra. I learned this from the center and I buy the medicine at Mercury drug store. I go to the health center for consultations for serious ailments. I ask for help and treatment from the nurse as well.

6.5.5 No Particular Preference for Female Providers

Respondents in our slum communities in greater Manila were generally indifferent about the gender of their health care provider; with most saying it did not matter. What matters most is a provider who is available to attend to them and their children. Only a few women said they would prefer a female provider. This is in contrast to the responses in Indore, India where women commonly said that they would prefer a female provider.

Regarding the concern that the health provider may not be female, slum residents state:

It does not matter whether male or female.

I have no problem with that [not having a female provider].

No, not really. That's not a problem for me, so long as I get well.

I want a female health provider because I get embarrassed when it's a man.

It's also a problem. It's better to have a female provider because they tend to be more caring.

No, the important thing is for my child to be cured.

It's okay if there are not enough female health providers, as long as there's a doctor.

There is no problem whether its male or female doctor as long as I could understand him/her.

6.6 Health Expenditures in Greater Manila

6.6.1 Lack of Money and Concern for Meeting Health Needs, Particularly of Children

As in Indore, slum residents in greater Manila struggle to meet their basic needs for food and shelter. Earnings are not sufficient to cover daily expenses and any additional demands on their scarce resources, such as health care, is a serious burden. Lack of cash delays seeking care, getting appropriate follow-up to care and getting necessary medication. The interviews captured a recurring concern of all slum residents. Many women voiced concern over caring for their children and not able to attend to their health needs.

Slum residents note:

I went there [government hospital] recently to have my child checked up because of fever, cough, colds and allergy. I was not able to buy all the prescribed medicines after the consultation because of lack of money but I was able to buy the more important ones. Good thing the allergy was cured but not the cough and colds.

Yes, I will be worried especially if we don't have any money to buy the medicine and for the consultation fees. What I am most worried about if they get sick, I am concerned about my children's health. So I will do everything I can so that they will be given utmost care and they can get treatment in case of sickness so I would not have any regrets in the future.

I don't know anybody who could lend me money. Just like yesterday, my husband does not have money to buy medicine, so my child and I have to look for scrap metal and sell them to earn money. My child and I would keep a stock of scrap metal then we would sell it. Then we bought medicine for my husband. So we were able to buy then. / Also last Thursday, my husband went to his work place to ask if there is already available work to do, they said there is no vacancy yet. When he got home, he only had 40 pesos in his pocket, and used it to buy medicine for diarrhea, which is probably caused by the water he drank. / I had only 30 pesos with me – I really didn't have anything. I said to myself, I'll pray while walking since I only have 30 pesos. The medicine costs around 11 pesos and 65 centavos, my money is really not enough! As I passed by Dunkin Donuts, I saw a one-peso coin. I immediately bought Imodium! Life is really hard. It's really hard to be born in a poor family.

We really need other means. We scavenge for tins, cartons and we sell them. I applied for a job in company but was turned down. When my child got sick, I didn't even have money to buy medicine or consult a doctor. We have nobody to ask for help. / Only one of my four children has been vaccinated. When the children get sick, we go to the center but all they give us are prescriptions. My wife felt bad about getting only one child vaccinated so she never brought our children back to the center. My three children have not been vaccinated. We have not gone to anyone for help. We deal with our own problems. / The biggest problem is money. There have been many instances when we got sick, even collapsed but we could not go to the doctor because we didn't have money.

For instance, my second child is sick right now but we cannot go to the doctor because I have no money for transportation. My child has a kidney problem. Even if I want to get the child to the doctor, I cannot. We had been asked to go back to the Takano Health Center. / Andrea was having diarrhea and was vomiting. I brought her to E. Rodriguez. Takano referred us to that hospital. We weren't attended there, so we just went home because we were already hungry. We were supposed to go back the next day but we have no money for transportation anymore. We were not given medicines because it was supposed to be at Rodriguez, after the check-up.

6.6.2 Paying for Medicines is of Particular Concern

Almost all slum residents voiced the lack of cash for purchasing medicines. Even if free care is available at the health center, medicines are not always free.²³ Medicine stock-outs at the health center is common and the inability to pay for medicines at drug stores is a common concern.

Slum residents observe:

We were given some free medicines [at the health center] but for the others, we were just given a prescription. The price of medicines at Mercury was 63 pesos for Salvotamol, that's for his paracetamol. We weren't able to buy the other medicines since we did not have enough money.

²³ Care at the health center is usually not free, as residents mentioned having to provide donations. This issue of donations, or informal payments, should be explored further to understand their use and whether access to care for the poor at the center can be improved.

They will give free medicines [at the health center] if they are available. If there is none, we buy at the pharmacy at 79 pesos.

Of course I'm worried. Just like this time, my child is sick so we went to the center. I'll feel okay if we have the medicine. I'm also concerned about the fever if it gets worse and there will be complications. I am afraid we could not afford to buy medicines because they are expensive.

I ask for amoxicillin from the church if I have the prescription. There are available medicines at de la Strada [church]. I only buy medicines if I have the money. But if there are no resources, so be it. I won't buy anymore. When my husband had a job, I used to buy medicines according to what was prescribed since I had the money to buy them.

6.6.3 Earnings are Insufficient for Daily Needs – No Savings to Meet Health Expenses

Given that earnings are often insufficient to meet basic daily needs, it is no surprise that most slum residents cannot maintain savings. There is a clear concern that no money is left over after meeting daily needs. Thus, there are no savings on which to draw to meet health expenses.

Regarding whether earnings are sufficient for meeting needs, slum residents state:

No, it's not sufficient. There's a little left from our income though.

Sometimes it's not enough, sometimes it is but if you think about it, it is really not enough. We just try to make both ends meet.

The salary is not enough but we just live within our means. Nothing is left from his earnings.

Only my husband works, he is a fare collector/conductor of jeepneys. He gets a daily take. His salary is not enough. Sometimes it is barely enough. Nothing is left.

Only my husband works at Shakey's. He is a regular employee there and his salary is on the 5th and 20th of the month. He also receives an allowance every 20th of the month. The income is not enough. Nothing is actually left from his salary but the good thing is that my husband manages our finances well.

My husband and I plus my uncle works. We sell 'embotido' at the market. That is our main source of income. Sometimes, my uncle teaches dance lessons and he is being paid for that. Our income is okay, sometimes it is more than enough and sometimes not. This set up is okay because we do not have regular jobs so instead of just bumming around we have something to do as a source of income.

No, it's not enough. Sometimes there is something left but it is spent for transportation so the next day you would end up with nothing again. And then we borrow money again. That's the way it is. We borrow money after use to pay for our needs.

Only my husband works as a security guard. He receives his salary twice a month but I don't know when these pay dates are. His income is not enough. There are times when we can afford to pay and buy all our needs then next time, we will be in debt again.

I am the only one working in the family. / Sometimes there's extra. Somehow, there is something left for us – sometimes 20 or 30 pesos. I use it to buy food and use it for allowance of the children.

Quite enough. I also collect garbage, then I sell them to junk shops. The papers, sardines, opened cans of sardines, cardboard boxes, they can add to our income. Me, I don't think so much about what life could give or having a full life. I am not wishing for a life of bounty or comfort, I am content if we just have enough to feed ourselves. That's my only wish, to be able to eat at least three times a day. Just to be able to eat. Sometimes, there is much garbage to sell, those recyclables, they can be a source of income. Honestly, we can buy things out of it. But we have no savings at all. In fact, I also experienced a day with nothing to eat. Because if I eat, my kids won't be able to eat. But there are times that we are lucky enough and we have a little more.

6.6.4 Borrowing to Meet Health Expenses is Common

Given insufficient earnings and lack of savings, most slum residents noted that they borrow to meet health expenses in addition to their basic daily needs. Some noted that borrowing can be difficult and they worry about their ability to repay the loan. Respondents did not mention savings groups or other community groups.

Slum residents say:

I've borrowed many times for daily needs. Some of it was used to pay for the electric bill and school fees for my child who's in college.

Yes, I was able to borrow money because of desperation. I need it for expenses. I've also pawned some pieces of jewellery like earrings and a watch and also CDs. I use the money to buy food.

It's difficult to borrow money but one must look for means in case of an urgent need. I don't ask help from others... I don't mind money problems as much as I would worry about where to get food. I am embarrassed to borrow money so I don't borrow and I just wait in vain.

I borrow money from my godfathers and godmothers. I borrow money because life is very difficult. Some people don't want to lend money because sometimes you cannot give it back. I borrow money from them because you won't hear anything from them. The money that I borrow is spent for food, and health. Nothing is left from it.

Actually, I haven't paid it yet because I was confined in a hospital. I had a kidney stone then. Because of necessity, my wife had to borrow money from our neighbors, with interest. / We had nothing to pawn because we also don't have a lot of things. We had a lot of debts because of my hospitalization.

Yes, I have borrowed money from de la Strada, which is connected to the church. The payment is in installment basis. We've borrowed 2,000 pesos and we pay 460 pesos in installment. But because of difficulties, I wasn't able to pay the full amount. I planned to use the money to start a barbeque business. But of course, the money we loaned was first used to buy for our food and we were able to adjust the remaining amount for the business. But since we were dependent to the business, we got a lot from the profit of our business. / I haven't pawned any jewellery. / Most of our expenses are for our food and then I have one child to spend for schooling. My eldest child has asthma that continues to get worse and remain uncured even up to now that he is 13 years

old. And I can't buy the needed medicine for the asthma because even our expenses for food are limited.

Not yet. I have not tried borrowing from the neighbors because I have nothing to pay for it anyway. Even if I want to start a business, I could not because businesses here do not last. You start a retail business and then they couldn't pay immediately. A few days later, you'd have to pay for the amount you borrowed but you don't have money anymore. That's why after that time, I avoided borrowing even from the neighbors. I have not pawned since I don't have many things.

No, I haven't borrowed money for the past 6 months. No, I haven't pawned/mortgaged anything in exchange for money as well. Yes, I borrow money when someone in our family gets sick. At times, I borrow money to put up a small business; but on some occasions I do it because I have nothing at all.

I sold a drum. The money was used for my child's medicines. He was brought to the medical center because of infection from a cockroach [bite].

You see, when we run out of money, we ask help from my sibling. We ask for money, not borrow. I haven't pawned anything yet.

Yes, I do borrow money when needed. It would be for our food and for the fare of my child and husband. I haven't pawned anything because there is nothing to pawn.

Yes, I borrowed money during an emergency because my child fell and I had to rush him to the Labor [Hospital].

6.7 Perceived Quality of Care and Health Needs in Greater Manila

Respondents in Manila were not as vocal about the quality of health care as those in Indore. Respondents were asked if they received good treatment from their health provider, whether they would go back for care to the same provider and what they liked or did not like about the care. Most respondents said they were content with the service and had little else to say regarding quality of care. However, when probed further, some voiced concerns. The main concern is the stock-out of medicines. Residents are aware that health centers are supposed to provide medicines free of charge but most have experienced no availability.

Slum residents observe:

Yes, I'm content [with care at the public health center]. I'm okay with it since there's nowhere else to go that's the only place I know.

Yes, because we were not ignored/neglected there [the health center].

Yes, because that's where children are treated. I no longer worry when I bring my children there. The doctor really takes care of them.

Yes, since I am already used to going there for treatment.

I seldom go to the health center since the doctor is always out!

Never again would we go back there again. They have been negligent. And what we have experienced is enough, and it just had to happen to my son.

During emergencies, the health center wouldn't be the best place to go since there are just too many patients there. It's also on a first come first serve basis. So if we have the money, we bring the child to a private clinic.

We needed to have the child examined thoroughly but we were not attended to.

Sometimes, I have reservations because they do not have the medicines we need.

[What happens is] you get a number then wait for your turn to be called. If they have something to give, we are given (free) medicine but when there's none, we are only given a prescription. The difficult thing is, although you have the prescription, there's no money to buy. You have to go home and look for money. Of course, medicine is more expensive at the Mercury [Drugstore].

6.7.1 Medicine Stock-out at Health Centers

As mentioned earlier, medicine stock-outs at health centers is a primary concern of most respondents. Inability to pay for medicines out-of-pocket means that many slum residents must rely on the free medicines at health centers. However, stock-outs are quite common and most respondents have experienced this scarcity.

Slum residents state:

Sometimes it [medicine] is given at the center. When it's not available there, we buy it at Mercury [Drugstore].

Sometimes the health center ran out of stocks/medicines. Yes, it helps if you have free medicines.

The center was able to address the needs like for check-up although they don't give any medicine... It is not sufficient because when we brought our kids there [the health center], there were no vitamins. When there is cough, there is no medicine for it.

When you go for a check-up here, they don't give any medicine, just prescriptions. They tell us that we have to buy the medicine. If ever they give something, it would just be one capsule of Amoxicillin and they don't have Tempra and this and that. And I am not able to buy the prescribed medicines.

It's insufficient. Sometimes there's no medicine at the center. For example, there is not enough multivitamins our children really need. Sometimes the medicines are to expire soon although they never give expired drugs. That would be bad.

6.7.2 Health Needs

When respondents were asked what health services they need, most stressed the need for more doctors and medicines. Most respondents clearly stated the need for free medicines and consultation with doctors. Some voiced the need for food, nutrition and vitamins, particularly for children. A few voiced the need for a public hospital at a close distance. Approximately one-fifth of the respondents did not respond to this question or said they did not know.

Regarding health services they need, slum residents say:

It is necessary for the health center to have supplies of medicines whenever the people go there for consultation.

In our community, medicine supply is really a problem. Medicines that can cure cough and colds are needed since these are the most common ailments here. We also need a public hospital and not a private one; it shouldn't be far from the community and it should take care of our needs even if we don't have the money.

I need a medical check-up to relieve me of my health problems.

Maybe health check-up for the kids, vitamins and everyday food.

Nothing. They take good care of the patients.

They have good service, I am not complaining.

The main problem is the lack of a nearby hospital. The current hospital is far from here.

If there is someone who'll give free medicines in the area. The barangay captain gives away medicines but last Saturday the supply ran out so not everyone was able to avail.

I can only think of the medicines and food if possible and sterilized water as well.

I hope they'd offer a feeding program. Many children are in need of that.

Just provide continuous medication. I believe that the center has a role because it knows how to deal with it and maybe, they know the medicines needed, of course, they are from the center. The center can also provide free medicines.

We need vitamins to strengthen the lungs and to restore children's appetite.

We need vitamins for children. Nothing else. My concern is for my children, I want to make sure that their vaccinations are completed.

I hope they would send many doctors to attend more to those people who want have a check-up. Sometimes people would rather not go because they are not being attended to. How about those people who really need to be checked-up?

We need free medicine.

The medicines are not sufficient.

I think we need medicines and doctors. That's all.

What we need are medicines for children, that's all. We also have problems about money and resources for our daily needs.

6.8 Summary

DHS data show that in urban India, all three household groups visit private providers more than public facilities -- including the very poor. On the other hand, in urban Philippines, public facilities are visited more often. Slum residents in Indore and greater Manila also follow this pattern. In-depth interviews suggest the following patterns of behavior:

- ▲ Outpatient care is primarily sought in the private sector in Indore and in the public sector in greater Manila. Quality of care and distance to the facility are common reasons for seeking private care in Indore, while cost of care (free service and medicines) is the reason for seeking public care in greater Manila. However, donations are commonly required in the barangay health centers in Manila and stock-outs of drugs in the health centers are commonly reported.
- ▲ Immunization and family planning services are sought in the public sector in both cities because these services are provided free – typically on scheduled, predictable days.
- ▲ Traditional healers are commonly visited in both cities, often as a first stop before seeking formal medical care.
- ▲ Self-medication is common in both cities. However, ability to pay for drugs is a clear concern. Stock-outs in health centers in greater Manila is also commonly mentioned.
- ▲ Lack of cash to meet health expenses is a clear concern, particularly for meeting the health needs of children and emergency medical care. Borrowing to meet health expenses is common in both cities.
- ▲ Slum residents in both Indore and greater Manila voiced the need for close-by and easily accessible health facilities. In Indore, there was a preference for female providers, while in greater Manila residents wanted regular visits by health workers. In both cities, female residents deplored men's the lack of involvement in family planning and health-related issues. Given the problem of water availability in Indore slums, residents specifically expressed the need for improved water and sanitation conditions.

7. Family Planning and Reproductive Health

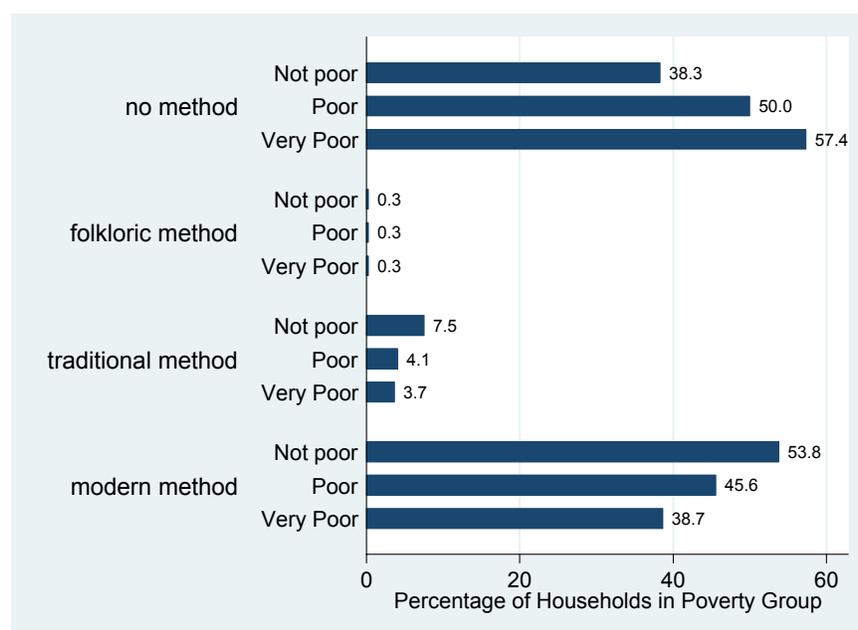
This section describes the demand for contraception used specifically for birth spacing and limiting in urban areas. It also explores how individuals deal with unwanted pregnancies and describes practices during pregnancy and delivery. Findings from DHS data are presented first, followed by responses from interviews with slums residents.

7.1 India: Findings from the Demographic and Health Survey

7.1.1 Contraceptive Use and Unintended Fertility

As Figure 7.1 shows, India's venerable and aggressive family planning program has yet to erase differentials in modern contraceptive method use even in urban populations. As can be seen, less than 40% of women from very poor households use modern contraceptive methods, well below the 54% for non-poor urban women.

Figure 7.1: Use of contraceptive methods by currently married women in urban India, by relative poverty status.

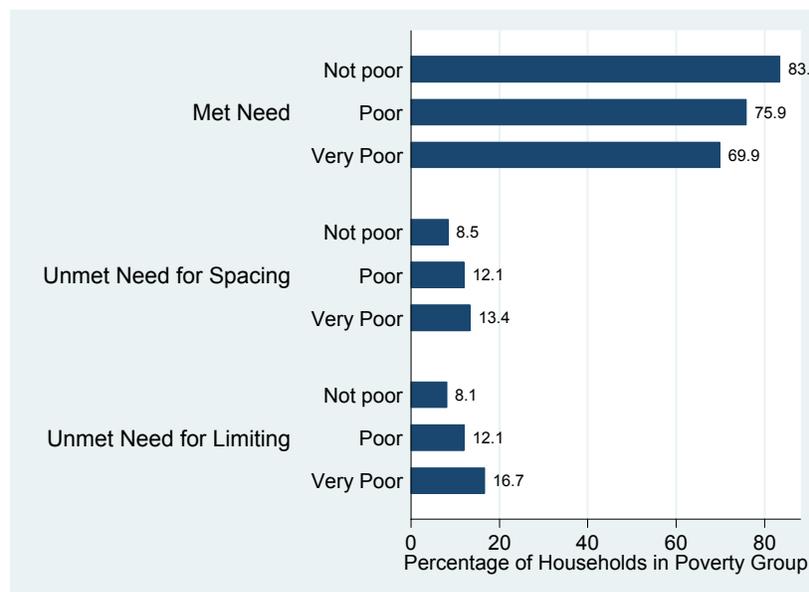


The baseline survey of slums in Indore found results similar to those seen in the figure, with current use of any contraceptive method being approximately 44% in the highly vulnerable and moderately vulnerable slums, and 48% in the less vulnerable slums (Agarwal and Taneja, 2005).

The measure known as “unmet need” is often considered to be a useful indicator of the potential demand for contraception beyond what is evident in current levels of contraceptive use. The measure summarizes the behavior of women in a reproductive union (formal or informal), who are neither pregnant nor postpartum amenorrheic, believe themselves to be capable of conceiving, and express a desire either to delay their next pregnancy or not to have another pregnancy at all. Some women in these circumstances make use of contraception (whether through modern or traditional methods and behavior) and are therefore said to have “met” their contraceptive needs. Other women do not use contraception despite their expressed desires to avoid pregnancy. These women are said to have an “unmet need” for contraception. Many concepts and potential ambiguities lie beneath the surface of the unmet need measure, but it is generally agreed that it identifies socioeconomic groups which might benefit from targeted program efforts. Thus, it may provide useful guidance for family planning programs and policies (Casterline and Sinding, 2000).

In urban India, levels of unmet need for contraception remain high (Figure 7.2). Adding unmet needs for limiting fertility to unmet needs for spacing, we find that 30% of very poor women have an unmet need for contraception, as do 24% of poor women and approximately 17% of non-poor women. The level of unmet need for contraception in urban Madhya Pradesh (not shown) is broadly similar to that of urban India as a whole.

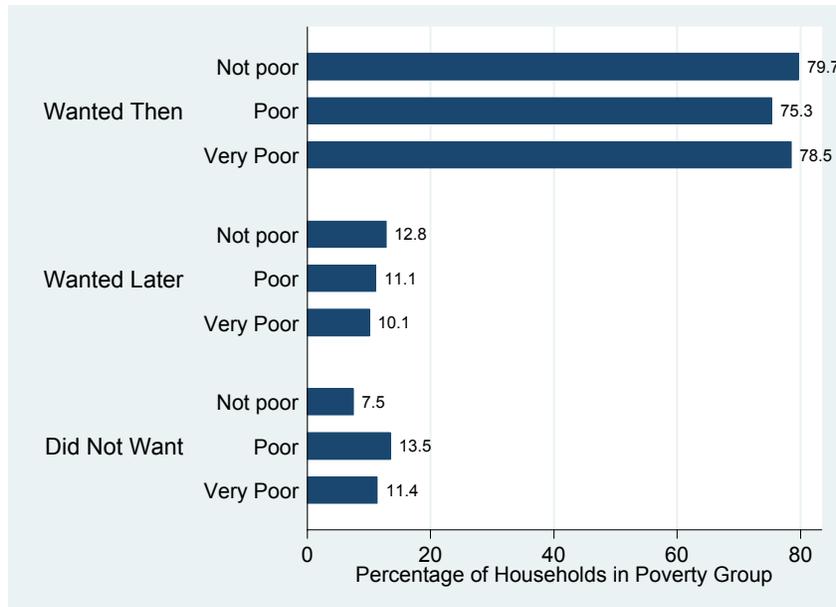
Figure 7.2: Unmet need for contraception among currently married women in urban India, by relative poverty status.



The levels of unmet need seen in Figure 7.2 are associated with a considerable incidence of unwanted and mistimed fertility, which are shown by poverty status in Figure 7.3. (Montgomery, et al, [1997] discuss the interpretive and analytical difficulties in retrospective measures of unwanted and mistimed fertility.) Unintended fertility is determined by questions that refer to the time when the woman became pregnant, and are phrased to elicit information on whether at that time the pregnancy was desired. Also, the DHS surveys do not attempt to gather information about induced abortion, and data on pregnancy generally refer only to pregnancies taken to term. By omitting pregnancies ending in abortion, the unintended pregnancy measures gathered in the DHS doubtless understate the true level of unintended pregnancy. In any case, the percentages of recent pregnancies that were intended—either wanted later or

not wanted at all— range from 20-25% depending on poverty status. Tabulations of the DHS survey showed that the situation is much the same in urban Madhya Pradesh as elsewhere in urban India.

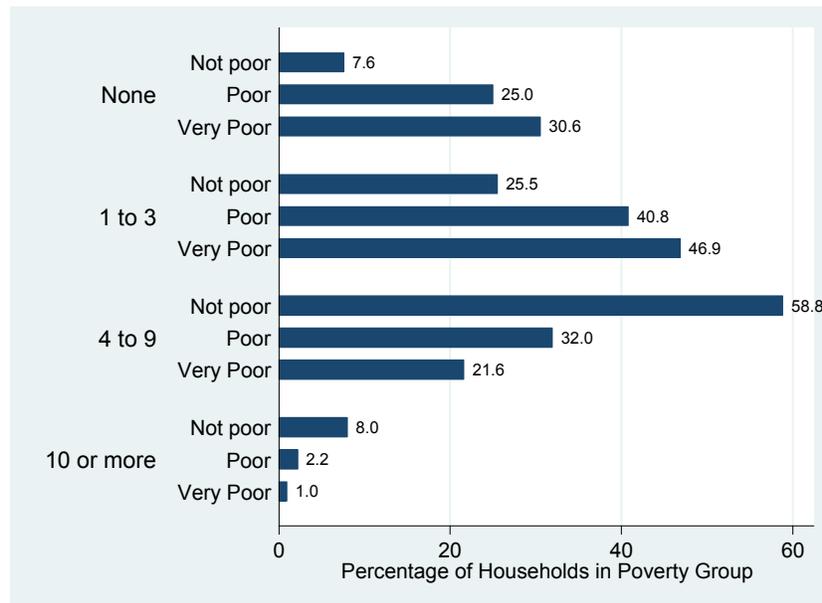
Figure 7.3: Whether most recent pregnancy was wanted, by relative poverty status in urban India.



7.1.2 Antenatal Care

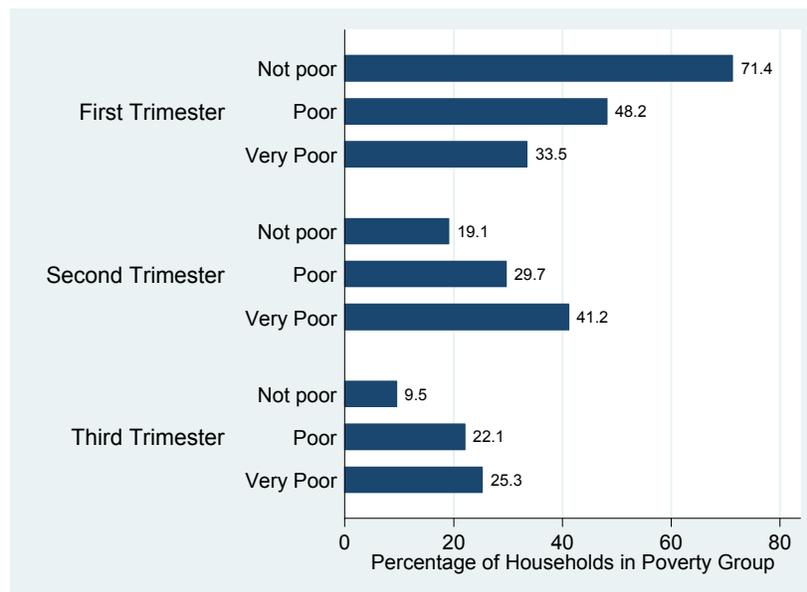
When they become pregnant, non-poor women in urban India generally make use of antenatal care; only about 8% of such women (Figure 4.4) made no antenatal care visit during their most recent pregnancy. But for poor and very poor women, the situation is quite different. 31% of very poor urban women made no antenatal visit and 25% of poor women also failed to seek care.

Figure 7.4: Number of antenatal visits, by relative poverty status in urban India.



In addition, poor and very poor urban women tend to make too few antenatal visits, with 41% and 47% respectively making only one to three visits. In urban Madhya Pradesh, the percentages of poor and very poor women who seek no antenatal care, or who make one to three visits, is even higher than in urban India in general.

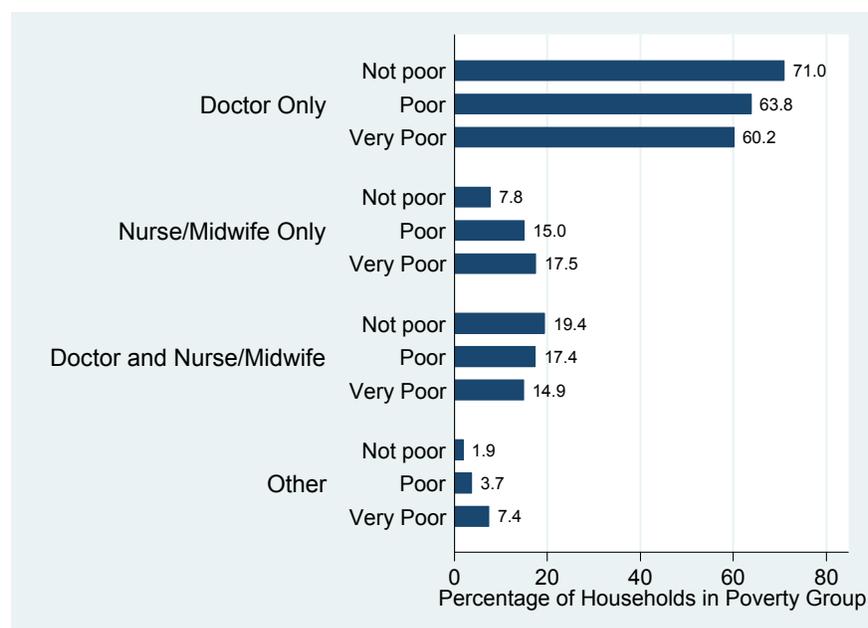
Figure 7.5: Trimester of first antenatal visit, among women making at least one visit, by relative poverty status in urban India.



Even when they do seek some antenatal care, poor urban women tend to do so later than the first trimester, when care is most recommended (Figure 7.5). In urban Madhya Pradesh the poor and very poor women who seek care also tend to do so late in their pregnancies. For instance, in this state 39% of very

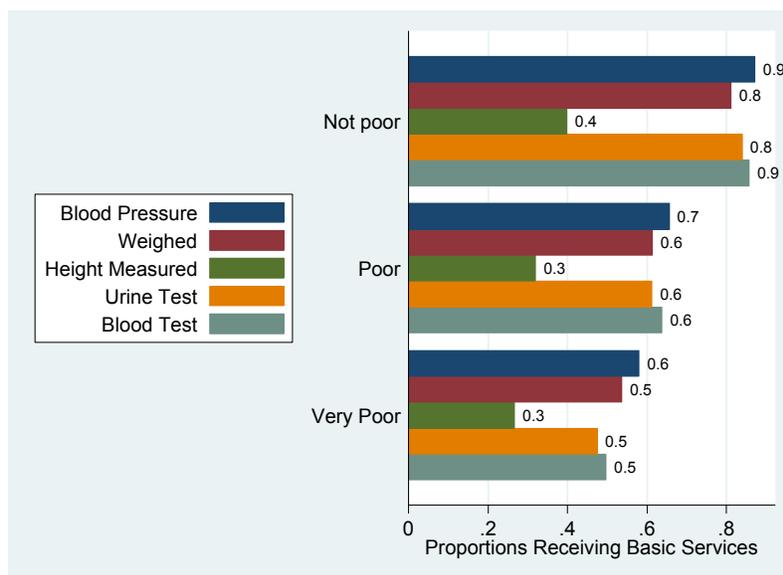
poor women wait until the third trimester to seek care, as do 28% of poor women. In Madhya Pradesh, only 13% of non-poor women wait until then. Most often in urban India the care provider is a doctor, although the poor are somewhat more likely to receive care from a combination of a doctor and nurse-midwife, or from a nurse-midwife alone (Figure 7.6). In urban Madhya Pradesh, women of poor and very poor households are substantially more likely than elsewhere in urban India to have their prenatal services given by a nurse-midwife only – 26% of poor women (compared with 15% in all urban India) and 21% of the very poor (compared with 17.5% in all urban India).

Figure 7.6: Providers of antenatal care, among women making at least one antenatal visit, by poverty status in urban India.



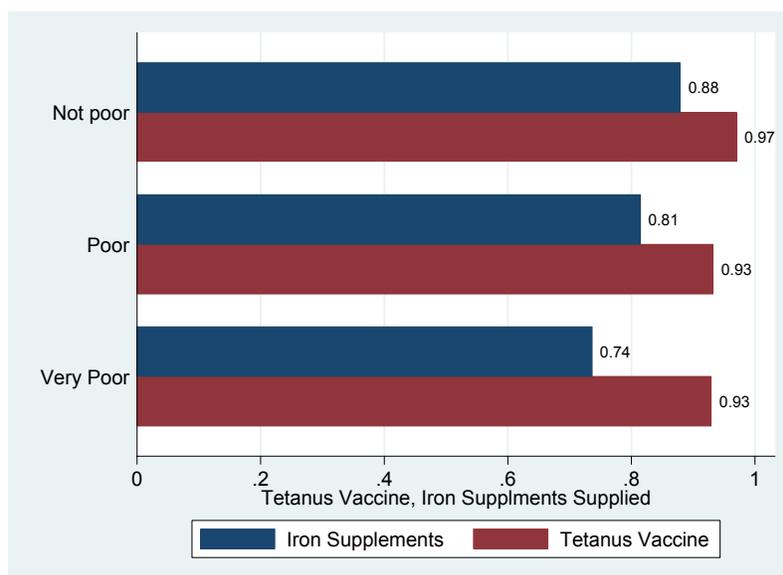
The services that women receive during antenatal visits include the taking of blood pressure, noting of weight and height, and urine and blood tests. In all these dimensions of care, the poor suffer from disadvantages (Figure 7.7). For instance, there is a gap of 30 percentage points in the likelihood of having blood pressure measured between very poor women (approximately 60% recall having received this basic service at some point in their antenatal care) and non-poor women (some 90% of whom recall it). Again, urban Madhya Pradesh distinguishes itself by its relatively low levels of care, especially for the poor and very poor women who are markedly less likely to receive services than in urban India as a whole.

Figure 7.7: Basic antenatal services received, among women making at least one antenatal visit, by relative poverty status in urban India.



In general, higher levels of antenatal care are reported where tetanus vaccinations and iron-folic acid supplements are concerned. Even among very poor women in urban India, more than 90% recall being given at least one tetanus vaccination over the course of antenatal care, and nearly three-quarters recall receiving supplements (Figure 7.8).

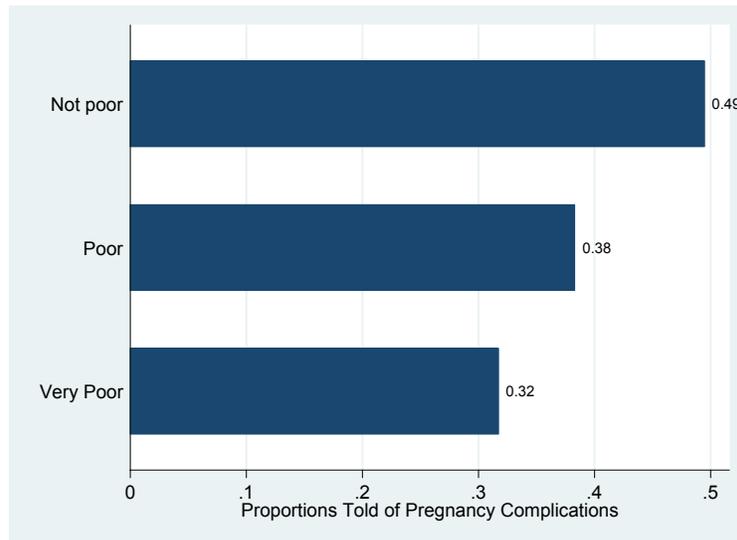
Figure 7.8: Women receiving tetanus vaccination and iron supplements during antenatal care, among those with at least one antenatal visit, by relative poverty status in urban India.



In other respects, the quality of antenatal care (insofar as quality can be judged from retrospective surveys) appears inadequate. Remarkably few urban women, especially among the very poor, recall hearing about the complications that can attend pregnancy and danger signs that would signal risk for the woman and her fetus (Figure 7.9). Less than one-third of the very poor women could remember the

caregiver providing any advice of this sort. And as would perhaps be expected, urban Madhya Pradesh is again on the low end of service quality relative to urban India, with only 38% of non-poor urban women in this state hearing of pregnancy complications during their prenatal care, as compared with 25% of poor women and 15% of the very poor.

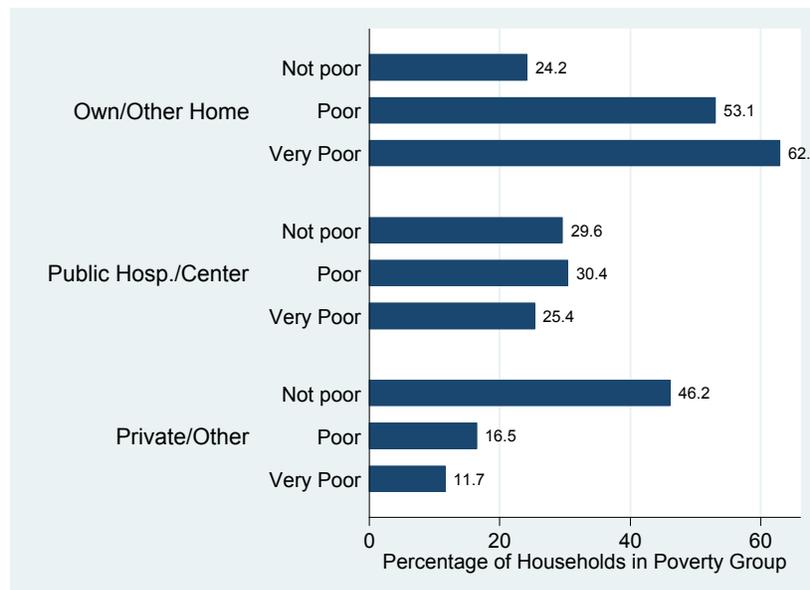
Figure 7.9: Women informed of complications and their danger signs during pregnancy, among those with at least one antenatal visit, by relative poverty status in urban India.



7.1.3 Delivery Care

Figure 7.10 clearly shows that nearly two out of three very poor women (63%) continue to give birth at home. This is in comparison with only one woman in four for the non-poor group.

Figure 7.10: Place of delivery, by relative poverty status in urban India



In urban Madhya Pradesh, giving birth at home is far more common than in the remainder of urban India. Here 36% of non-poor women deliver at home, as do 70% of poor women and 77% of the very poor. Likewise, the percentages of delivering in private birthing facilities are lower in Madhya Pradesh than elsewhere in urban India, with only 28% of the non-poor of Madhya Pradesh, 5% of the poor and 7% of the very poor giving birth in such facilities. The slums survey for Indore came to similar conclusions, finding that 69% of women in the most vulnerable of these slums gave birth at home, whereas 38% of women in the less vulnerable slums did so (Agarwal and Taneja, 2005).

7.2 Findings from the Indore Interviews

In all of the Indore slums visited, respondents expressed the need for small families of two to three children. This was in view of the earnings needed for the parents to adequately support more children than this, the childrearing time that would be involved and the educational and related aspirations parents hold for their children. Some women also mentioned the physical strain on their bodies that would come with repeated pregnancies. However, cutting across all of this is the strong preference to bear or bearing at least one or two sons. The pressure to have sons is felt within the family as well as the community at large.

A married 21-year-old woman with three daughters stated:

One girl and a son is ideal condition.

A married 23-year-old woman in Rustam Ka Bagicha said:

If a child comes in early, then the children can't be looked after nor us. That is why each woman should definitely have a gap of three years between the children.

A married 25-year-old woman from Annapurna Thana with two daughters and one son noted:

There should be two children, but there should be one boy also. Actually, boys are a must. There should be two boys.

The joy at the birth of a boy is expressed in different ways: the mother is given an extended postpartum rest and the family is willing to be more generous in its gifts of money to the birth assistant.

7.2.1 Contraception

In the descriptions given by women of conception and pregnancy, it is clear that the primary responsibility for anything having to do with contraception rests upon the individual woman or the community of women.

My husband doesn't talk [about contraception.] He doesn't realize that we have had three children and should not have more.

Social conditioning tends to inhibit communication between men and women on issues of contraception. Interestingly, in our interviews men appeared to be very much at ease in discussing contraception with their male and (in the few cases where they were matched) female interviewers. By contrast, women were clearly less comfortable than men in talking about contraception (with its attendant sexual implications) in our interviews, and told of being uneasy when the issue was raised in public.

A woman with Class 12 schooling in the Goto Ki Chawl slum, who has tried different methods of contraception, said:

Even if somebody is talking about all this, I walk out.

A CBO health-worker in Rustam Ka Bagicha, whose primary responsibility is to ensure full vaccination and safe deliveries, stated:

If we talk of this to the women, they will think that this is what we go and do in the meetings.

A woman in Annapurna Thana who has tried birth control pills and an IUD, but feels uncomfortable with these methods and is currently abstaining from sex to prevent pregnancy, said:

How shameful it is to talk to a doctor about such a thing. You are sitting that is why I am talking so much.

There were several interviews that revealed limited discussions between spouses on contraception. While men reported that ‘she doesn’t understand’, women felt hesitant to broach the issue. They also felt that talking to their husbands about contraception could raise the husbands’ suspicion that the wife has been discussing the topic with other women. Interviews with men show that they are aware of the communication gap, and feel they have to rely on their friends or workplace acquaintances for basic contraceptive information. The need for men to be given contraceptive information at younger ages was something many of them articulated:

Men start going out when they are very young. But there is no one to talk to them. The nurses and the anganwadi workers only talk to the women.

We use slang words to talk about the women’s menstrual cycle so that others don’t understand what we are talking about.

I work at the petrol pump so am lucky to be able to talk to the truck-drivers who come there. But other men don’t know who to talk to.

A predominantly female focus appears to be the norm among health service providers as well, in that their interventions focus solely on women even where condoms are being provided. With the majority of the field workers in the public health system being women, target interventions are also aimed at women. One of the recommendations provided in Chapter 12 focuses on delivering health education to men, including youth.

A number of factors enter women’s thinking about contraception; they can be organized as done in the following Table 7.1.

Table 7.1: Factors influencing women’s decisions regarding contraception.

Factor influencing contraception	Relevant quote from slum resident
Husband’s support	We both do not like to use anything. Operation, I will have to get it done, who else. I have not discussed it with anyone till now. We used condoms for two-three months, and then they [men] do what they want.
Role of extended family (in-laws)	I was afraid [during the delivery]... that if I have a girl, my mother-in-law would not be happy. Even I don’t want more children, he says I should get the operation done, but elders say no. Whatever they [elders] say, you have to agree.
Education and associated confidence	We don’t have so much intelligence [to understand contraception measures] See, I am illiterate [to talk of contraception].
Sense of own body’s fertility understood through earlier pregnancies	If we were conceiving year after year, then would have done something, but when it doesn’t happen like that, then why do something?
Number of children	Two children are enough. I have three girls. I expressed my feeling for doing an operation [for sterilization] but family members rejected it. Where my view is concerned, be it boy or girl, both are same.
Male children	There should be two children, the 2 should not become a 3, but in difficulties, you have to do, for the sake of a boy, these have become 3 Sons are never too many.
Health of children	I’ll get operation done when he is 2 -3 years old.

Across interviews with men and women in Indore, it was found that the permanent method of female tubal ligation is the contraceptive most often used. These sterilizations have mostly been conducted at government hospitals; often the local dispensary’s ANM accompanies the women to the procedure. Most women who decided on a ligation said they were satisfied; other women indicate they would also choose this method upon completing their families. Having grown up in communities shaped by patriarchy, the women themselves believe that they should be the ones to bear the pain of the operation. Often they do not expect their husbands to take any action of this kind. In the interviews, there were several instances in which both men and women said that the man should not undergo a vasectomy, most often because men must work and the operation could affect them. (It is not clear why this logic fails to apply to women’s work as well.) There was only one instance where the woman respondent said that her husband had gotten a vasectomy (in the better-off slum of Rustam Ka Bagicha.) In this particular case, the woman added that vasectomies were the practice in her extended family.

Husband doesn’t do, the wife has to do.

I [the woman] will go for the operation as men’s operation fails sometimes.

On why he will not choose a vasectomy, a man stated:

We are working people. What if something happens [after the vasectomy], some weakness develops. We can’t afford that. I have too much labour to do. Who will feed my six children?

Not having sex was also voiced as a measure for preventing pregnancies, but there is no fixed schedule to it. Several men and women were aware that a woman's body would be more fertile and likely to conceive on some days more than others, but the information is very thin and inaccurate.

A 22-year-old woman in Goto Ki Chawl with two children said:

I am down with periods for three days, and after that the next five to eight days, I don't speak to him. He uses condoms also. I don't eat pills, it has effects. I am scared that my daughter is two now, so now [I may conceive] any time.

A majority of respondents expressed discomfort with the available reversible contraceptive methods for birth spacing. The issues raised have less to do with the availability and money cost of these methods than with precisely how such methods should be used. Detailed knowledge of method use is clearly in short supply in our study communities. Although many people were aware that condoms, birth control pills, intra-uterine devices (copper-T) and injectables could all be employed to space or limit births, their only personal experiences were with condoms and pills.

We were using condom, but there was a problem, an itching sensation, now we are not using anything. I could take Mala D, but I am afraid. We'll have the operation later.

I used to get stomach ache and white discharge. The doctor told me it [birth control pill] doesn't suit everyone.

The contraception options for women are not fully comprehensible to them, and what the extraneous object (the drug or device) actually does inside the body does not appear to be explained to women by their service providers. This unfortunate practice leaves poor women without a clear understanding of contraception, and it gives them no avenue for the expression of doubts.

The doctor in the civil dispensary warmly told a woman who had come in with a wrapped-up week-old baby that she should take condoms for her husband, and also pills for herself if her husband did not use the condoms. There was no further discussion and she took these from the nurse. The doctor also scolded her for having had a home delivery, and told her not to come to this dispensary if she didn't have her next delivery at a hospital.

It is therefore not surprising that people are willing to believe in the alternatives offered by herbal methods or the blessings of a faith healer, which at least are accompanied by explanations of a sort. Some of the interviews with women and men in Goto Ki Chawl and Annapurna Thana showed their willingness to consider such alternative methods of contraception.

A 40-year-old male respondent in Annapurna Thana said:

[On what the couple used for contraception] It is a wild herb which once taken stops your period and she will not conceive. [On what if it doesn't work] We take the guarantee first from the person who gives it. It is available only in the village.

7.2.2 Unintended Pregnancy

To judge by the accounts given in our interviews, there is a high incidence of unintended pregnancy in these slum communities, where economic and health factors make pregnancy undesirable. Most

commonly, unwanted pregnancies occurred after the desired number of children had been born, among whom there was at least one male child. Already having small children in the house was another reason given for not wanting the pregnancy. Our sense is the reasons that such pregnancies occur have less to do with contraceptive failure as such than with the uneasiness and lack of knowledge of reversible contraceptives for birth limiting and spacing.

In many interviews we heard of abortions, or attempted abortions, of unwanted pregnancies. Most women took a medicine prescribed by a doctor to initiate bleeding, but the medicine did not always work. Women from Rustam Ka Bagicha and Goto Ki Chawl also told of undergoing a procedure in a hospital. Public facilities have not generally been used for abortion, unless it is accompanied by a tubal ligation.

I am afraid when the periods get disturbed. My husband says – it is up to me; he says go and get operated if you want. I told the doctor I don't want children, he said okay but it didn't work.

After the baby is two or three months in the stomach, don't feel like having it removed.

A 25-year-old woman in Annapurna Thana said:

I wondered why God is doing this to me, I didn't want six children. I said God should give it to someone else. We used to stay away from each other after the periods for 15 days, but still became pregnant, it didn't work. I earlier had birth control pills for a month and a half, but I used to get a burning feeling all over my body. So I went to the hospital and said to do the operation.

There were a few accounts of abortions being attempted without any medical supervision, which is quite risky and could prove life threatening.

I had some rich tea with pepper, jaggery and ginger and it led into the bleeding.

I had asked the doctor how much money she would take [to abort] and she said Rs. 2000. I didn't have so much money so I said I don't want it. I went to Ajmerwala Baba [a faith healer] and then came home and started bleeding. I spent Rs. 1000 there, and I aborted very easily... in about 10 days.

As for other reproductive health issues, a few women voiced problems of white discharge, continuous stomach pain, ulcers and some indirectly hinted of sexually transmitted illnesses. The issue needs further exploration, as it has clearly been an unheeded area of care.

It has been over a year. I get medicines from the store. Rs. 12 for 1 strip, it becomes okay for sometime, and then happens again.

Men normally don't stay with one woman. They go to anybody, so these days the woman gets diseases.

7.2.3 Antenatal Care

Identification of Pregnancy. The respondents said that their own pregnancy (or their spouse's in the case of male respondents) was usually recognized when the woman missed her period, and effectively confirmed after two missed periods in a row. In addition to amenorrhea, other confirmatory symptoms included vomiting (described by some as "water in the mouth"), nausea and unusual sensitivity to smells.

None of the participants took a medical test to confirm pregnancy; if further evidence were needed, a woman suspecting pregnancy would approach the local dai.

When you miss one or two periods, you come to know. We come to know that we are going to become a mother after five months; the baby roams around in the tummy.

Antenatal check-ups. Respondents from the better-off slum of Goto Ki Chawl reported that they generally presented themselves for antenatal check-ups at the Nanda Nagar maternity home, a public-sector health facility. Most reported they were happy with their care, but surprisingly few could describe much of what was done in the antenatal check-up other than the tetanus immunization. This method of providing antenatal care would seem to be little more than routine, dutifully carried out to meet program targets of full antenatal coverage. The women recalled very limited interactions with the doctor. In some cases as closing time approached, the research team observed women being shuttled to the vaccination counters without a full check-up. When we asked why this seemingly minimal care was considered satisfactory, the respondents replied that Nanda Nagar is a government place, and with so many people in the queue, extensive care is rarely possible. With the growing presence of NGOs in the slums and the urgings of trained TBAs that pregnant woman must be vaccinated, women have begun to take the tetanus vaccine. Whether they would do so without external encouragement is doubtful.

It was also noticed that in the government health facilities, particularly in M.Y. Hospital, there is a pattern of prescribing a sonography at least once during the pregnancy without any apparent need for it. This practice came up in the interviews with the staff at the hospital as well as interviews with women who had gone to a public hospital for antenatal care. In a society that is still marked by strong son preference, we suspect that the point of the sonogram was mainly to identify the sex of the fetus.

They had said that the baby is fine but getting the sonography done is very important.

In the other poorer slums, most respondents did not perceive antenatal care to have any substantial benefit and did not go to any medical facility during pregnancy. Some care tends to be sought from the caregivers who are available within the slum neighborhood, including the local dai as well as the government health functionary.

When there is no problem, then everything is okay, why show?

A woman in Chandra Prahabat with three children noted:

There is no pain so everything is fine [and don't need to go to the hospital]

Pregnant women feel assured that the fetus is fine if they can feel its movements (kicking in the uterus) or if the local traditional birth attendant confirms upon examination that the fetus is fine.

I had a pain downwards, and had called the dai. She comes and massages especially when you call her, and otherwise also asks.

Perceptions and practices pertaining to iron folate tablets. In contrast to the data from the DHS, pregnant women in our slum sites did not generally report consuming the iron-folic acid tablets made available for free in the public health system through the local ANM, AWW or community health volunteer. Most women understand that these tablets are meant to provide them with greater energy and benefit the baby, but many found the tablets unpleasant (they gave as examples their altered sense of taste, foul-smelling burps and burning in the stomach) and often did not continue them. A few women took note of the tablet's red color and surmised that taking it would likely cause heat in the body (heat, in

turn, is associated with bleeding). This simple and easily addressable point seems to have escaped government health providers.

Dietary practices and perspectives during pregnancy. Following what they had practiced in earlier pregnancies or the advice of elderly women in the family, women usually reported that during pregnancy they avoided foods such as fish and eggs, which are believed to generate heat inside the body and thus raise the risk of miscarriage or harm to the baby. Because papaya is a known purgative, it is also feared to induce miscarriage. Some respondents reported avoiding “sticky” substances such as custard apple, jackfruit and coconut, since these “stick” to the fetus rendering delivery difficult. Even when the pregnant woman was ill, such fears were reported as reasons for not taking medicines.

7.2.4 Delivery

Our respondents in the more vulnerable slums of Annapurna Thana and Chandra Prabhat repeatedly expressed their strong preference for home deliveries. This was underscored in almost all interviews conducted in these slums. It arises partly from the fact that the customary practice is so ingrained that it does not require much thought, and partly from a lack of trust in the care given in government facilities. In the other two slums, we encountered a mix of views about home births, although a preference for delivery at home was often stated. Marginally better socio-economic standing and the availability of a health facility specifically for deliveries in the vicinity of Rustam Ka Bagicha and Goto Ki Chawl have enabled a few families in these communities to deliver in private hospitals or government facilities. The influences of formal education, exposure and the customs in the neighborhood are probably the most critical determining factors.

In the more vulnerable slums, our respondents maintained that it is ‘the practice in their house’ to have the delivery assisted by the dai at home, and only if there is a complication would they go to a government or private hospital. A few examples arose in which a first or earlier child was delivered in a hospital, but subsequent deliveries were carried out at home. The advantages of delivering at home were described in various ways. A home birth is preferred for economic reasons, for the sense of support a woman feels in the presence of another woman to whom she is close (usually her mother or a sister-in-law) and women take comfort in the soothing attentions of the traditional birth attendant who lives among them as a well-known and trusted member of the community. This has been particularly noted in Chandra Prabhat where the dai is viewed with warmth and respect and referred to as our dai.

Dai people take very little [money], and do a lot of help, don't let little trouble also. They press the woman's back, get the child out soon, don't leave the woman alone and stay with her the full time; in the hospital, they don't handle things and the sisters [nurses] leave you.

She [dai] did everything. She reassured, pressed my back the whole night. That house was clean, well plastered, the baby was born in clean surroundings. It was a lot of problem at the hospital [during the first delivery]. No one reassured, mother-in-law sitting outside, husband sitting outside, nurse saying roam around, no one giving any moral support, so didn't like it at the hospital. That time I was just missing my parents and just wanted to die. They slap on your body over there, say to roam around, they don't reassure.

They don't keep you clean, wash and bathe you in the hospital. At home you can warm your water, have your bath and rest.

The money that will be spent there, it is better to eat food for that [money] at home.

We are honest people, so God is kind and we don't have complications that would force us to go to the hospital for the delivery.

All three children were born at home. I don't do bad for anyone, so God doesn't do bad for me [to force me to have deliveries in the hospital].

We have heard from a number of people, that they [in government hospitals] do not take proper care and the case gets spoiled. The lady doctor screams and shouts a lot during the delivery.

Details of the home deliveries received during in-depth interviews in Annapurna Thana reflected that TBAs were also practicing basic measures for safe deliveries. It was interesting that even the respondents were conscious of what the dai had done.

She washed her hands first. Wore gloves and cut the cord. And then it had to be cleaned. They said you shouldn't bathe the child for a few days because there are chances for pneumonia etc.

A focus on TBA training and their personal attributes have brought a positive situation in some slums by playing an active role in antenatal care, giving timely referrals to the hospital in case of emergencies during the delivery, and often accompanying the woman in labor.²⁴

In some interviews, women cited as a reason for hospital delivery that a tubal ligation could be carried out in the same admission period as the delivery. We believe that this is a common consideration in poor communities, since it avoids double hospitalization and extra time away from a woman's demanding household routines. The practice is being encouraged by a government scheme known as 'Janani Suraksha Yojana', whereby the woman is entitled to a financial payment if she delivers her third child in the hospital and adopts a permanent method of contraception while there.²⁵

A woman in Annapurna Thana who has had six home deliveries stated:

I will go to the Lal Hospital for the delivery. We will get medicines also and the operation will also be done. (On how do you know of this) some women come and she tells about where it should be done, where it would not cost. People are saying it will not cost at this government place.

Rest after delivery. There is a customary practice of rest after delivery, usually for a period of one to two months. The woman and the newborn child are considered untouchable during this period, especially in the first few days while residual bleeding continues and the baby's cord stump has not yet dried. Allowing the woman to rest helps her to recuperate as well as to care for the child when it is most

²⁴ Training of TBAs has been carried out through government agencies and also the EHP-Urban Health Program.

²⁵ The Janani Suraksha Yojana (Safe Motherhood Scheme) was introduced to encourage antenatal care and institutional deliveries. After being criticized for inhibiting choice, the program was modified to include home deliveries. However, at least in Madhya Pradesh, the program continues to promote institutional deliveries; local officials do not seem to have taken cognizance of the home delivery option. (Another criticism was that the program promoted institutional deliveries before the public health facilities were adequately strengthened.) Women in BPL families were eligible for delivering their first two children under this scheme. In Madhya Pradesh, the scheme has been extended to third deliveries on the condition that one of the spouses undergoes sterilization immediately after the delivery (although there may be continuing changes to these conditions).

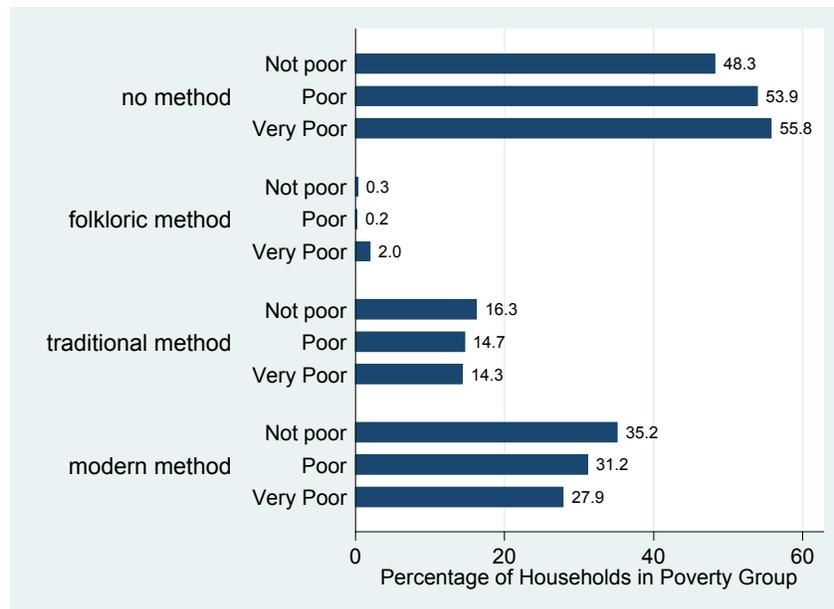
vulnerable. However, it soon becomes essential that women resume their work as soon as possible. Also, if the woman does not receive the full support of her family, especially her in-laws, her rest period can be cut short.

7.3 The Philippines: Findings from the Demographic and Health Survey

As in our analysis of urban India, we begin with a review of reproductive health conditions investigated in the Demographic and Health survey for the Philippines. Where differences between the National Capital Region (NCR) and the remainder of the urban Philippines appear to be of substantive interest, we will comment on these differences.

7.3.1 Contraception and Family Planning

Figure 7.11: Use of contraceptive methods by currently married women, by relative poverty status in urban Philippines.



As Figure 7.11 shows, household poverty is a significant determining factor in modern contraceptive use for married women. Considering all urban areas in the Philippines, only 28% of women in the very poor households make use of a modern method of contraception. Among the non-poor, 35% use these methods. There is little appreciable difference between the NCR and the remainder of the urban Philippines in levels of modern contraceptive use or in the patterns according to poverty status. In terms of overall levels of modern method use, the urban Philippines is well below urban India (Figure 7.1).

Figure 7.12: Unmet need for contraception among currently married women, by relative poverty status in urban Philippines.

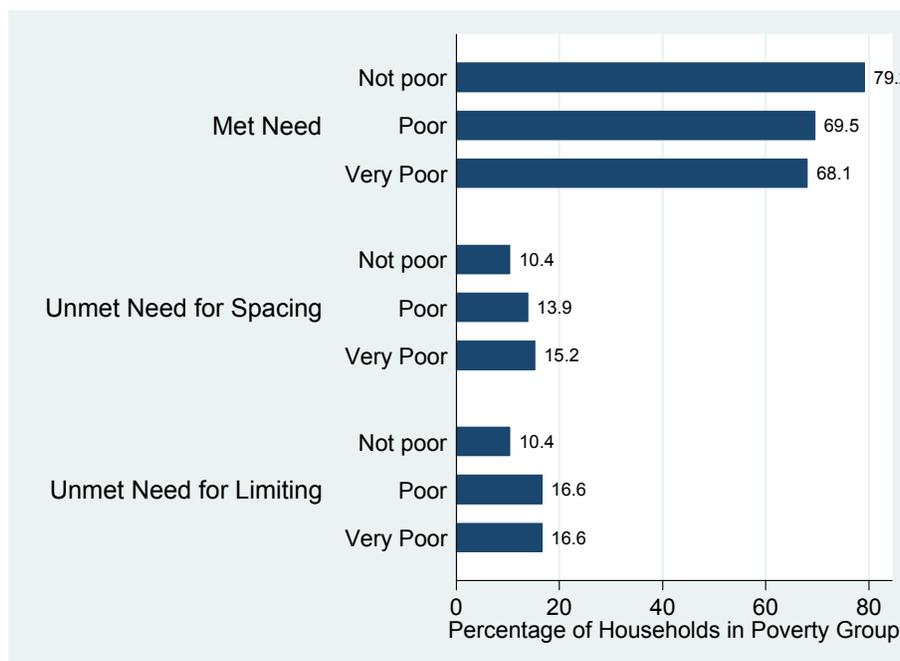
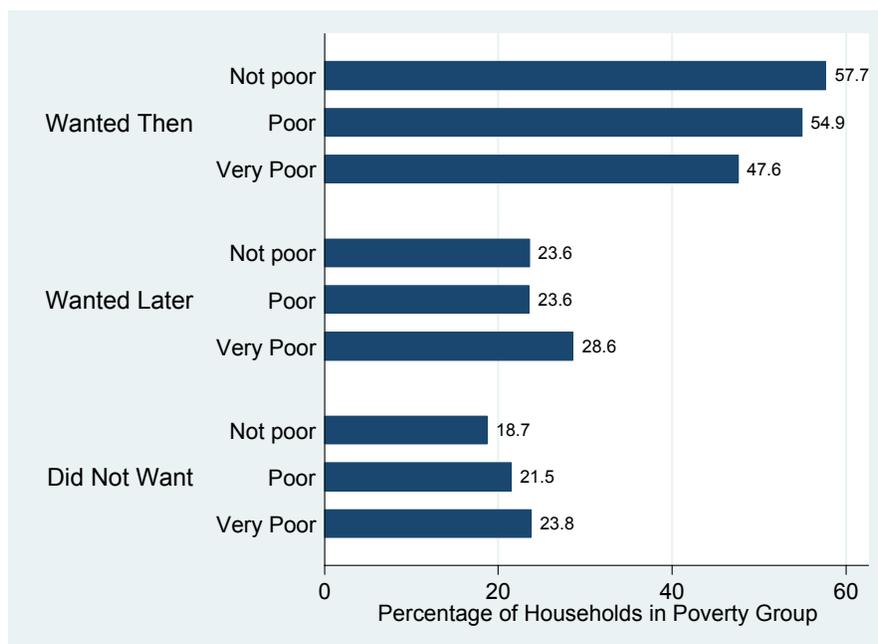


Figure 7.12 shows that in the urban Philippines, unmet needs for birth spacing and limiting are more prevalent among the urban poor – more than 30% for the poor and the very poor compared with 21% for the non-poor. The NCR broadly resembles the urban Philippines as a whole in levels of unmet need. Unmet needs for spacing and limiting are substantial across all groups. For example, among the married women in non-poor households in the NCR, approximately 10% have an unmet need for spacing, as do approximately 9% of women in poor households and 22% of married women in the very poor households. Unmet needs for limiting are estimated at 11% for non-poor women in the NCR, 21% for the poor women and 15% for the very poor. Taking the spacing and limiting categories of unmet need together, we find clear evidence of substantial unmet needs ranging from 21% of non-poor urban women in the national capital region to 30% of poor women and 37% of the very poor.

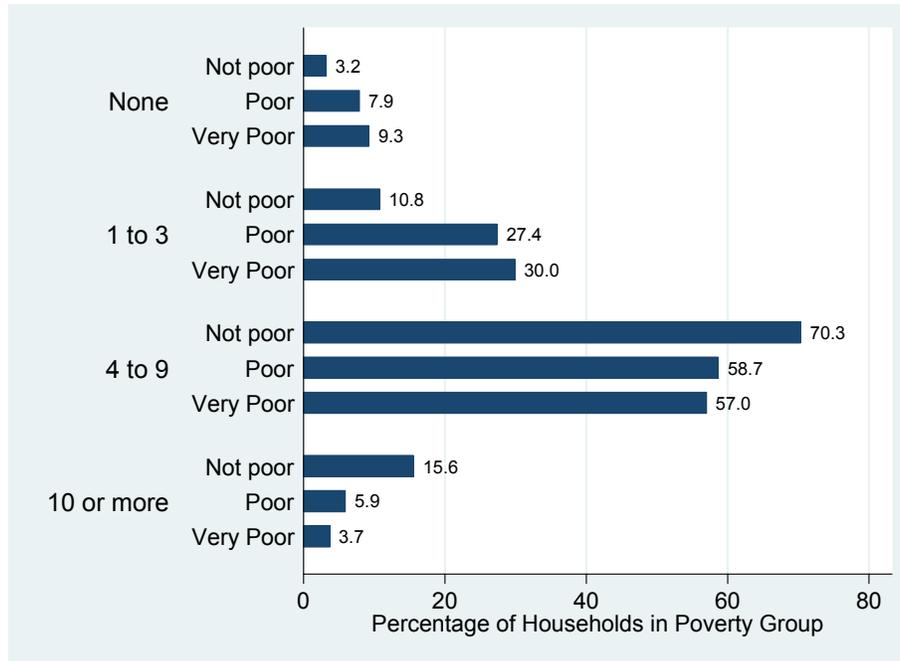
Figure 7.13: Whether most recent pregnancy was wanted at the time of conception, by relative poverty status in urban Philippines.



In view of these substantial levels of unmet need, it is not surprising that in the urban Philippines a considerable percentage of pregnancies occur when not wanted. Questions fielded in the 2003 DHS for the Philippines explored the woman’s views of her most recent pregnancy, asking her to recall her feelings at the time the pregnancy began. Figure 7.13 documents the extent of unwantedness and mistiming for these recent pregnancies for the urban Philippines. In the capital region (NCR), even greater differences by poverty status are evident in the “did not want” pregnancy category, perhaps because of the costs and difficulties of childrearing in this challenging urban environment. In the NCR, 18% of the non-poor women describe their most recent pregnancy as unwanted at the time, while approximately 25% of poor women characterize their pregnancies in this way as well as a remarkable 38% of very poor women. By comparison with urban India, these are quite high levels of unintended fertility.

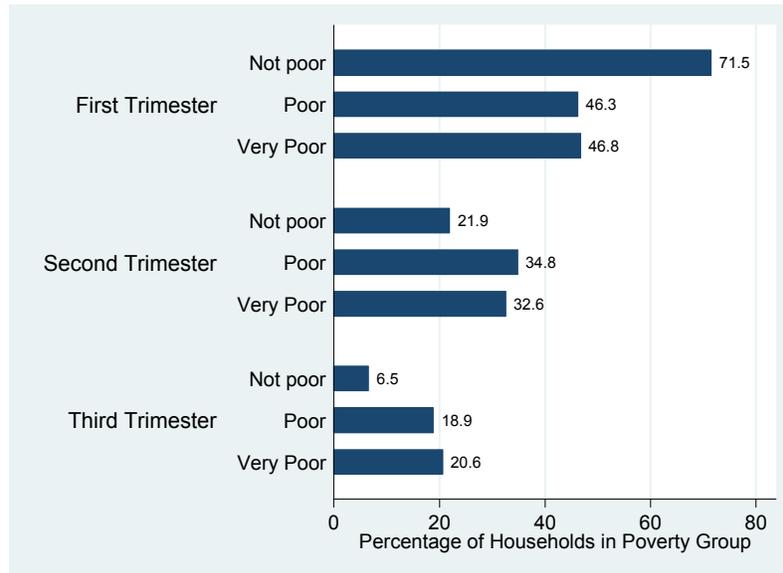
7.3.2 Antenatal Care

Figure 7.14: Number of antenatal visits, by relative poverty status in urban Philippines.



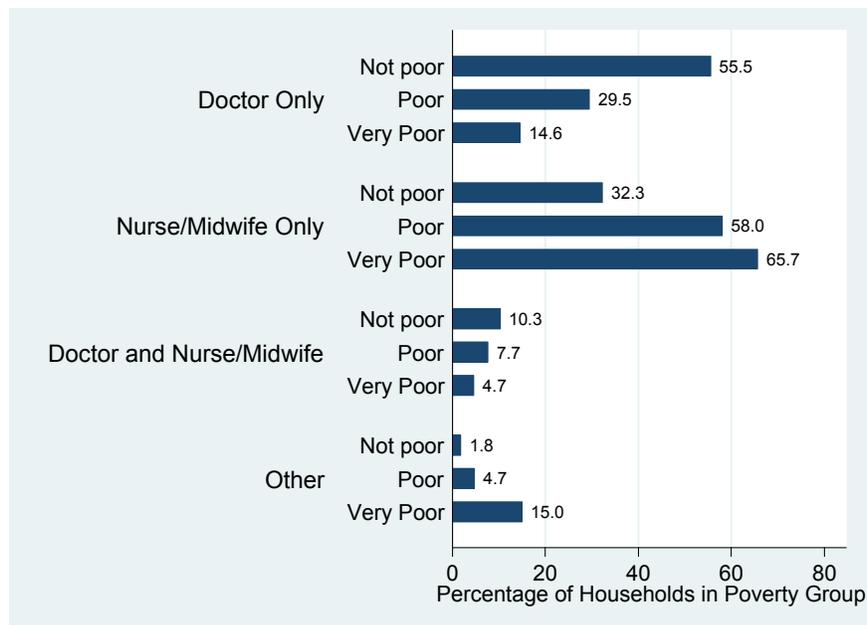
Most pregnant women in the urban Philippines make at least one antenatal visit and more than 60% of all women make four or more visits. Only 9% of very poor women fail to make even one antenatal visit, as Figure 7.14 shows. There is more use of antenatal care than seen in urban India. Even so, the same tendency is evident for poor and very poor women in the Philippines to make fewer antenatal visits; in the National Capital Region, for instance, 87% of non-poor women make at least four visits for antenatal care. Approximately 70% of poor women do so but only 55% of the very poor women undertake this many antenatal visits.

Figure 7.15: Trimester of first antenatal visit, among women making at least one visit, by relative poverty status in urban Philippines.



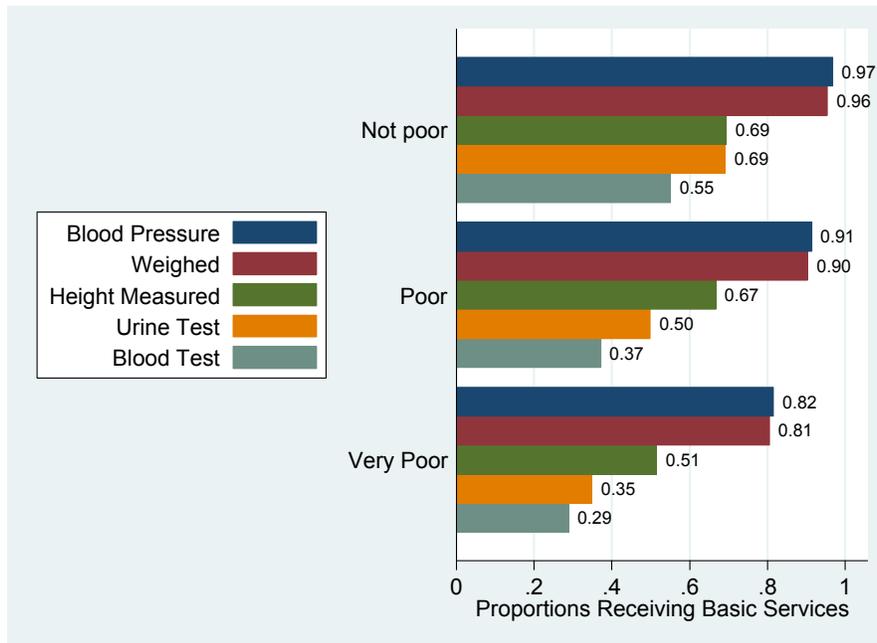
Poor/non-poor differences are also clearly evident in the timing of the first antenatal visit. Ideally, women would seek antenatal in the first trimester of their pregnancy and, as Figure 7.15 shows, this is the practice followed by 72% of non-poor women. Among poor women, however, less than half follow this recommended practice, and nearly one woman in five (18.9%) waits until the third trimester to seek antenatal care. The situation is much the same in the National Capital Region; here nearly 75% of non-poor women make antenatal visits in the first trimesters, whereas only 55% of poor women and 46% of very poor women do so.

Figure 7.16: Providers of antenatal care, among women making at least one antenatal visit, by relative poverty status in urban Philippines.



The women who seek antenatal care are mainly seen by doctors, nurse/midwives or a combination of the two. As Figure 7.16 shows, the poor and very poor are much less likely to be seen by doctors and much more likely to receive service from nurse/midwives. In the NCR, however, the situation is somewhat different from that of the urban Philippines as a whole. In the capital, even the very poor women are more likely to see doctors than nurse/midwives. 58% of the very poor receive care from doctors only (versus 14.6% in all urban Philippines), compared with 53% of poor women and nearly 72% of the non-poor.

Figure 7.17: Basic antenatal services received, among women making at least one antenatal visit, by relative poverty status in urban Philippines.



In the urban Philippines, it is standard practice for women to be weighed and their blood pressure taken during antenatal care examinations (Figure 7.17). Measurement of height is less common, as are blood and urine tests. Poor and very poor women, however, are markedly less likely than non-poor women to receive these basic services, as demonstrated in the figure. For example, more than half (55%) of non-poor women have a blood test during antenatal care, by comparison with only 29% of very poor women. In the NCR, levels of service are well above those seen elsewhere in the urban Philippines. Here, 56% of very poor women are given blood tests in the course of antenatal care, as are 59% of poor women. To be sure, some 69% of non-poor women in the NCR are given this service, but the differentials in care are not so marked in the NCR as they are in other urban areas. As Figure 7.18 shows, most women receive at least one tetanus vaccination and are given iron supplements during prenatal care (in these dimensions of service, the NCR is similar to other urban areas).

Figure 7.18: Women receiving tetanus vaccination and iron supplements during antenatal care, among those with at least one antenatal visit, by relative poverty status in urban Philippines.

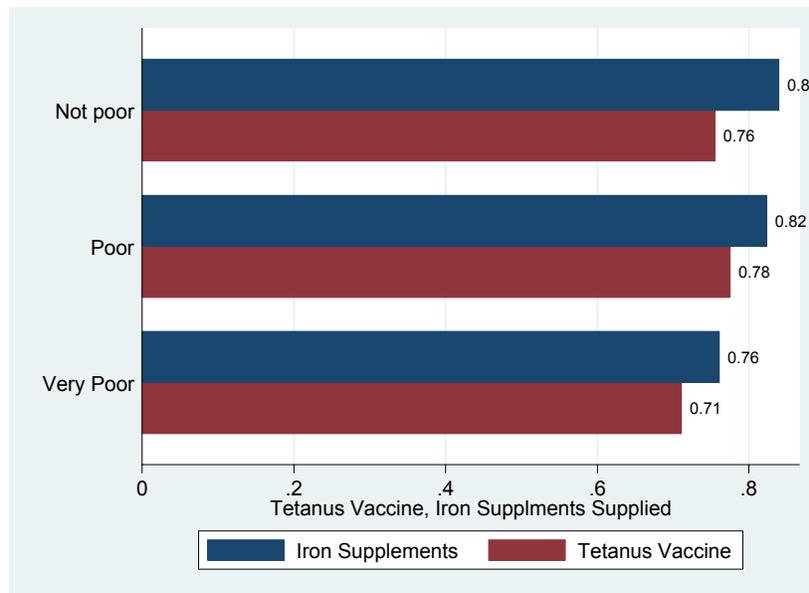
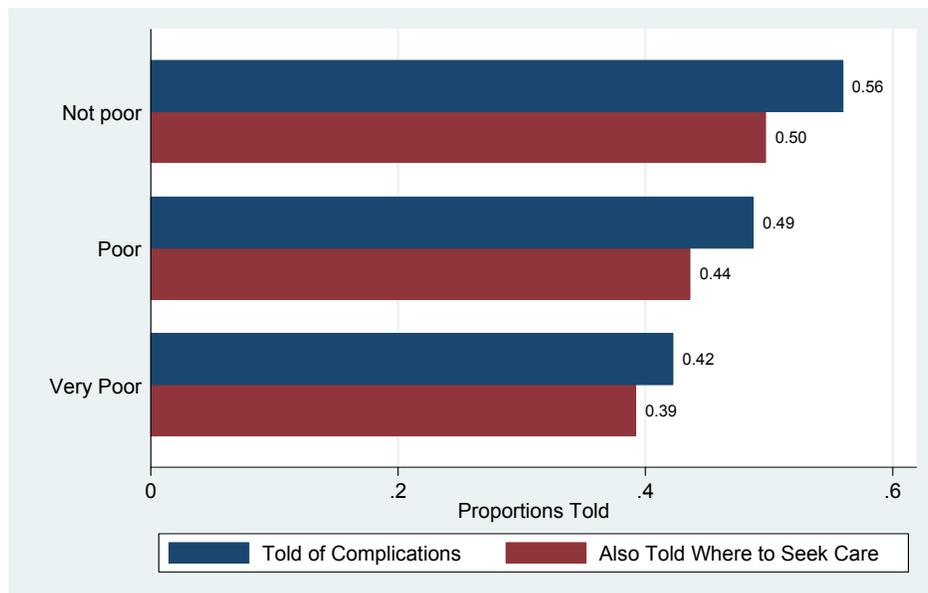


Figure 7.19. Women informed of complications and danger signs during pregnancy, and told where to seek care if these appear, among those with at least one antenatal visit, by relative poverty status in urban Philippines.

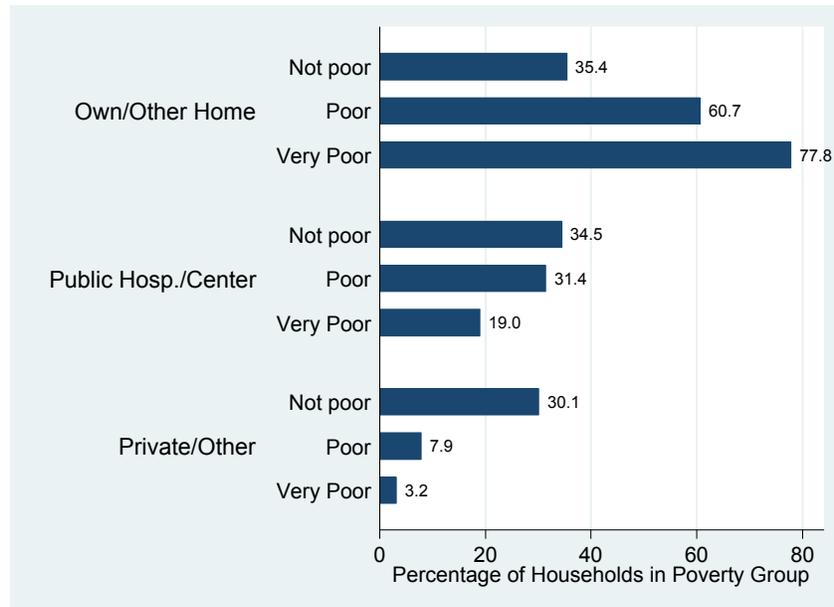


Apart from iron supplementation and tetanus vaccines, it is clear that the poor receive antenatal care that is inferior to the care given to the non-poor. Figure 7.19 summarizes the information supplied to women about what complications might arise during pregnancy and where care should be sought if such complications should occur. Less than 40% of very poor women are told about the complications and told

where they should go to seek care. By contrast, this basic information is made available to at least half of the non-poor women. Again, however, the NCR can be distinguished from other urban areas, as in this region over half of all women, whatever their poverty status, are given information about pregnancy complications and where to go should such complications occur.

7.3.3 Delivery Care

Figure 7.20: Place of delivery, by relative poverty status in urban Philippines.



As Figure 7.20 shows, poor urban women are much more likely than non-poor women to give birth at home. Among those not delivering at home, most poor women give birth in public hospitals or health centers and relatively few do so in private facilities. Although the differentials by relative poverty are also evident in the NCR, they are less pronounced than in the urban Philippines as a whole. Only 56% of very poor women in this urban area give birth at home, by comparison with nearly 80% in the urban Philippines. Approximately 49% of poor women in the NCR deliver at home, by comparison with 60% in all urban areas. In the NCR, about 40% of all three groups of women deliver in public facilities. As elsewhere, poor and very poor seldom give birth in private clinics, whereas approximately 35% of the non-poor women in the NCR do so.

7.4 Findings from the Greater Manila Interviews

7.4.1 Adequacy of Contraceptive Knowledge

Women often expressed the view that men need to know more about contraception than they do at present. Additionally, there was general agreement that the young are poorly informed.

More has to be done about information on family planning. The men know little about it, and more so the youth.

The knowledge is not enough. The men know little. Many of the youth try so many things and involve themselves with whatever until the time they suffer the consequences of their action. Some of them think that whatever happens will happen anyway.

One woman observed that a lack of information affects women as well as men and the young.

Yes because many women here do get pregnant. They don't care about the fact that they are poor and I am one of those who think the same way. Men don't know much about family planning either. They just care about happenings, drinking, basketball and hanging around. The youth, well, perhaps they don't know anything better. I heard of a young girl who already got pregnant. The youth also know about things related to sex. The youth should follow what their parents are telling them and not their peers. They should also choose their friends.

7.4.2 Method-Specific Knowledge

The amount of specific knowledge of methods varies. Tubal ligation is generally known among women, although some women recount scare stories of its purported side effects.

Yes, if you don't want to have any children anymore, you can have this. But if I have this, I should not move around the house too much like fetching water because carrying heavy loads is not advised and there should be a lot of rest. So I was afraid that it may cause my death.

Some have told me that ligation is good but I'm afraid of it. You see, I might have a relapse since I'm the only one who takes care of the house I have to carry heavy things and work at the dumpsites. When you have a relapse, there won't be any cure for that. My aunt was ligated and all her weight went down to her buttocks. She was never able to stand up thereafter.

Similar levels of general awareness and attendant fears of side effects emerge when the oral pill is discussed:

I had taken pills but not anymore since I experienced many aches such as headaches and toothache while I was on pills.

When you have varicose veins, heart ailments and anemia, you cannot take pills. I am anemic but I still tried the pill. I felt nauseous and dizzy every time I take it. My husband knew that I was on pill. I went to the center for a check up and asked for pills. They gave me some and told me to take it daily. I should also take some vitamins and when I feel something, I should stop taking them. And then, I got pregnant.

I used pills for more than a year then I stopped because I was getting irritable easily. I was prone to spanking my kids. Those were the side effects of the pills to me.

There is at least limited awareness of injectable contraceptives and IUDs, but little specific knowledge. Also, the respondents exhibited some confusion about what is meant by “natural family planning,” some thinking this was synonymous with the rhythm or withdrawal methods.

The health center was generally cited as the most prominent source of information about contraceptive methods, although midwives and neighbors were also mentioned. We did not hear that

women were discontented with the services offered at the center. Nor was there much concern expressed about travel or money costs of contraception, although some women resented having to provide “donations” in order to receive contraceptives.

The health center provides us information about it and told us that if we already have much knowledge we should have FP because life is very hard nowadays. The midwife also explains it to us. I also learned it from a friend.

I trust the center because the doctor has medicines coming from City Hall, which they give to us. Everything is okay. Sometimes, the medicines run out because it still comes from the City Hall. The service is good.

I go to Center for consultation because that's the place I know that offers information about family planning. The service is good and the place is near.

We give 20 pesos downstairs and there is also a donation box on the next floor. It's actually a forced donation. We should not pay anything, don't you think?

7.4.3 Dealing with Unplanned Pregnancy

In the interviews, respondents were asked about their perceptions of unwanted pregnancy in the community and their sense of whether (and how often) such pregnancies ended in abortions. There was some discomfort and uneasiness evident in the responses, as this is clearly a difficult topic to discuss. But there is awareness that unplanned pregnancies often occur, and many women could tell of neighbors or acquaintances who took medicines in an effort to abort.

I got pregnant and didn't plan on it. I took some herbs from a neighbor to discontinue it.

Yes, I had told myself I didn't want another one but there I was, pregnant again. I had wanted to abort it but I was afraid of taking the medicines. It's more difficult to have a miscarriage than to give birth.

I also thought about getting an abortion, but I could not do it. I was scared of the terrible consequences. I might bleed to death.

It's been really hard for me and I have thought of abortion, but I'm afraid to do it! I just tried that Cortal! But when I learned that nothing happened, I was afraid.

I told my husband that I'd rather die if I would get pregnant again. He said, we just let it be because it's already there. He told me that after I gave birth I would just have myself ligated because we don't want that in our conscience [if we had the baby aborted].

A number of women, speaking of their own lives, said that they had not had any unplanned pregnancies and that all of their children had been planned.

7.4.4 Antenatal Care and Delivery

Women in these slum communities have little knowledge of the risks they might face during pregnancy. Among women whose own pregnancies had been free of problems, only a few mentioned bleeding as a symptom needing attention. Women who had experienced bleeding in their own

pregnancies, however, were very clear that this condition demanded attention. Among the respondents, most said they had sought prenatal care, but by no means did all women report having done so. Among those who did not use prenatal care, most said that there was no need to go since they felt perfectly healthy during their pregnancy.

In San Buena, the health center is within walking distance and the fees (or donations) for antenatal care do not appear to be burdensome. The center evidently provides minimal services. Women tended to remember little of the care they received other than that they were given vitamins and were weighed or (if late in the pregnancy) had their “tummies” measured. Vaccinations are sometimes given, but clearly not all women receive them. Some women recalled being told of danger signs during pregnancy, but most did not.

At the center, they get your weight and that's it. They give us a prescription but I wasn't able to buy the medicines. On the other hand, at the health center in Pasig, they would measure the stomach. The services here are insufficient.

I was given an anti-tetanus. That's all. I would have preferred that she would carefully check my condition during my pregnancy and also the condition of the child. She did not do anything except ask a few questions about how many months have I been pregnant. I was required to go back for another check up until I will deliver. I would want a full check up during the prenatal.

Some women make use of health center antenatal services but also seek out traditional practitioners for some conditions:

I had my prenatal with the midwife at the center. Yes, I went to see a traditional healer. I had myself massaged because they told me that my baby is in a breach position, so I had the massage so it will be corrected. The traditional healer was able to fix the problem. I also went to the center for prenatal, it is nice there because you can hear the child's heartbeat, it is sort of a massage as well.

The health center in San Buena is often mentioned as the place where women give birth, if they do not do so at home. As mentioned previously, a number of women in San Buena go to the health center for antenatal care and some continue to delivery. But as in Indore, giving birth at home is preferable.

But most of the time, just in the house. For normal labor just in the house and we just call a midwife. Because we are poor, we cannot afford to go to the hospital. It saves us financially from paying the hospital.

I had my last pregnancy in our house because I wanted to and because my husband can take care of me unlike in the hospital where you will not be fully taken cared of.

At home, since my neighbors also do the same. I feel more comfortable at home. Unlike at the hospital, you're already in pain and they will still tell you to walk around.

The last was in our house because I prefer it here. I've heard stories about what happens when you deliver at the hospital. That you are left alone and you have no one to talk to, there's no one around you. I'm more comfortable of having my baby at home because my husband and mother are here beside me.

“They [other slum residents] usually go to the hospital while sometimes it [the delivery] is done at home with a midwife's assistance. Personally, I am apprehensive about going to the hospital because they say you will be stripped naked but will not fully assist you when the contractions become very painful. I did not have any complications. Lorna, my midwife, delivered my baby.”

Lorna [the local midwife] and my husband, that was good because they won't neglect you. Even when it was time for me to bathe, they were there. She would bathe/cleanse you, and give you massage.

Lorna. She is the best here. She won't abandon or neglect you. She would really attend and minister to you. She even takes good care of the baby

Some women make use of the health center for delivery:

At the health center. They usually go there for check-up and until they give birth.

They [other slum residents] go to the center because it is near and it is free.

They go to the Labor Hospital [This is QMMC], when they are having difficulty giving birth, but sometimes they just avail of the services of the traditional midwife here

Pregnant women usually go to the center [in San Buena] when it is time for them to deliver but others do it at home because it is cheaper. You only need about 500 Php. In the hospital you have to pay so much before you can be discharged.

Some of them just do it in their houses. There is also a midwife who comes here and who is a frequent service provider here. Some of them say that [when they got to a hospital] they are not well attended or being ignored even while in labor.

The delivery costs cited by women varied greatly, but usually fell in the 500-2000 peso range for women who delivered at home or, if away from home, had uncomplicated deliveries. One woman who delivered at home with the assistance of the local midwife said:

I didn't pay any prescribed amount. I just paid whatever amount I could afford for all the things used for the delivery.

7.5 Summary

The DHS analysis shows that the urban areas of India and the Philippines are marked by substantial unmet need for modern contraception, and these areas also exhibit substantial unwanted and mistimed childbearing. Where unmet need is concerned, the urban poor of both countries suffer from marked disadvantages compared with other non-poor urban residents. In the urban Philippines, similar disadvantages are also evident in unwanted and mistimed conception. Slum women are aware of abortion; some have undergone it themselves and others tell of neighbors who have had abortions. In the Indore and greater Manila slums, women fear the pain and bleeding of induced abortion. It is clearly an option of last resort.

In India the family planning program, which for many years put its emphasis on sterilization before expanding to incorporate the oral pill, has not yet succeeded in making it clear to poor women how the pill works or that other contraceptive options exist. Men generally leave matters of contraception in the

hands of women, with typically little communication between spouses. Women often feel obliged to take on the full burden of contraception, and lack the detailed knowledge they need to assess injectable contraceptives, condoms and other methods. In the study slums, women do not really understand how contraceptive drugs and devices act in the body (even in the most general terms) and it seems that service providers have not done enough to ensure that women achieve such an understanding.

The interviews made clear that poor urban women in the Philippines slums also lack adequate and detailed information about modern contraceptives, and thus lack the confidence they would need to explore their use. Women have little understanding of how methods work and easily fall victim to rumors and misinformation about the side effects of contraceptive use. In view of the substantial efforts made by the family planning programs of these countries to communicate information about contraceptive methods, this may seem baffling. However, the interviews conducted with health providers may explain why the poor do not have a grasp of the information provided by the programs—as the providers told us it is very difficult to convey medical information to the poor in terms they can understand. This is true even when (from the program’s point of view) information has been packaged in the simplest of terms.

In the study communities, antenatal care tends to be sought later in pregnancy than recommended, and relatively few women make the recommended number of visits. The care given is basic and we have the impression that it is given rather mechanically, although the DHS reports do reflect the national emphasis in both countries on providing tetanus vaccinations and iron supplementation. In both countries, there are few differences between the urban poor and non-poor receiving tetanus vaccinations and iron supplements (in India, interviews with slum women revealed that they found the iron-folic acid tablets unpleasant and often failed to consume them.) Notably missing from the standard package of antenatal care, especially for poor and very poor women (as shown in the DHS results) is any discussion of the risks women may confront in their pregnancies and what action should be taken if complications arise. Antenatal care such as this cannot be considered adequate.

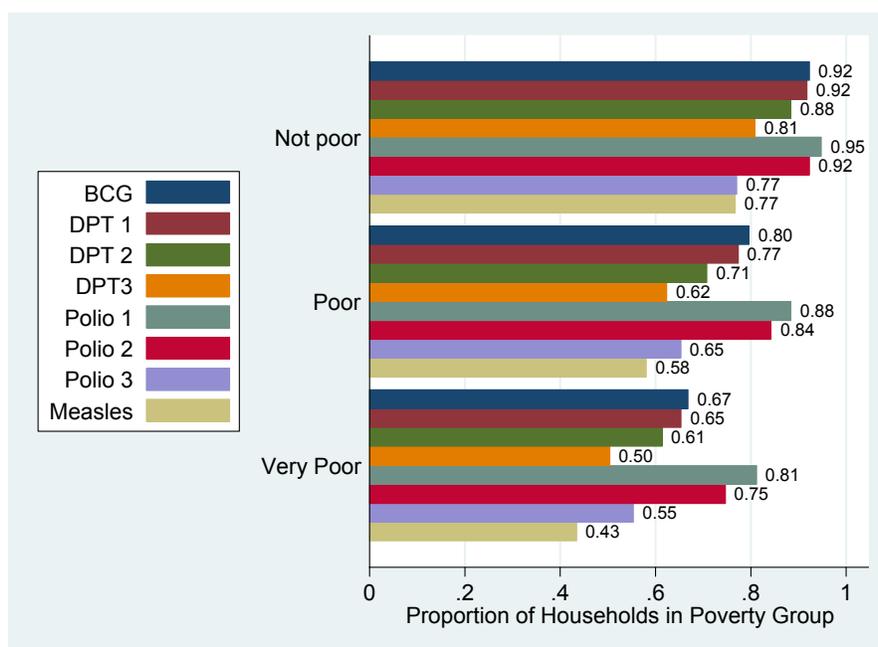
Slum women continue to express a strong preference for giving birth at home. It is here they believe they will find a comfortable and reassuring environment where their needs will be more quickly sensed and responded to by a birth attendant who herself is likely to be a trusted and long-standing member of the community. DHS analysis shows that in both countries, there are marked differences between the urban poor and non-poor with respect to home deliveries. In both Indore and greater Manila we were told of the impersonality of hospital settings and the brusque and insensitive treatment women believe they will receive at the hands of the staff. Even so, and especially in the greater Manila sites, some women are now giving birth away from home -- and the picture no doubt varies considerably from one slum community to the next. For the foreseeable future, however, programs aimed at improving conditions at childbirth must assume that many slum women will continue to prefer to give birth at home, much as women do in rural villages.

8. Children's Health

This section describes immunization patterns, feeding practices and common illnesses of urban children in India and the Philippines. Findings from DHS data are presented first, followed by responses from interviews with slums residents.

8.1 India: Findings from the Demographic and Health Survey

Figure 8.1: Vaccinations received by children 12-23 months of age at survey, by relative poverty status in urban India.



Although vaccination coverage is much better in India's urban areas than its rural villages, large differences by poverty status remain among urban residents. As Figure 8.1 shows, the poor and very poor households are markedly less likely to receive any of the vaccines listed than the non-poor across urban India – 65% of the very poor reported getting DPT1 vaccine for their children aged 12-23 months compared with 77% of the poor and 92% of the non-poor. 43% of the very poor reported getting the measles vaccine compared with 58% of the poor and 77% of the non-poor. In Indore, the slums survey showed that only one-third of children in the most vulnerable slums (33.8%) were fully immunized in infancy, while nearly half (49%) of children in the less vulnerable slums had been immunized by the end of infancy.

Figure 8.2: Child experiencing any persistent cough and cough with short breaths, in the two weeks before the survey, by relative poverty status in urban India.

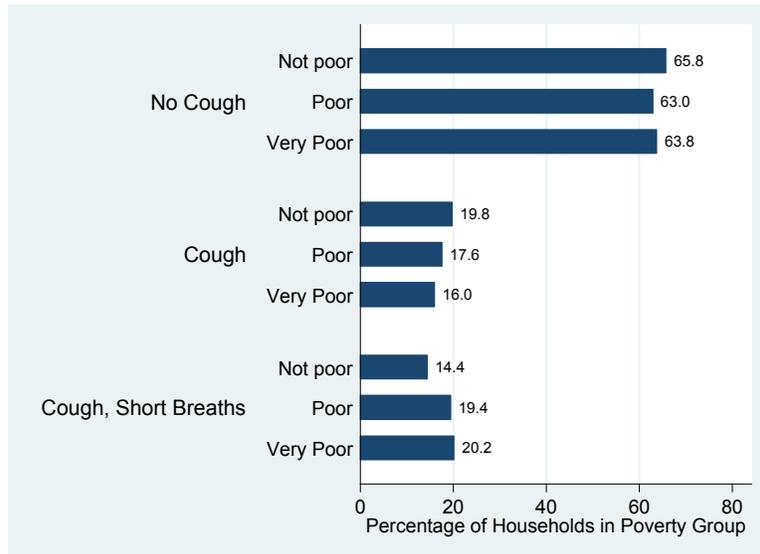


Figure 8.2 reports on another indicator of child health -- persistent cough and cough with short breaths. With respect to this indicator, the poor and very poor are not much worse off than the non-poor in all urban India. In fact, a slightly higher proportion of non-poor households (19.8%) reported persistent cough in the previous weeks compared with the very poor (16%). It is possible that the non-poor may be more attentive to and thus more likely to report even mild cases of cough than the very poor. Regardless, over 20% of the very poor report cough with short breath in addition to the 16% who reported persistent cough. There is some evidence of worse health in urban MP (compared with all urban India), with 28% of children in the very poor households experiencing cough with short breaths in the weeks preceding the survey (not shown in Figure 8.2).

Figure 8.3: Child experienced any diarrhea, and diarrhea with blood in the stool, in the two weeks before the survey, by poverty status in urban India.

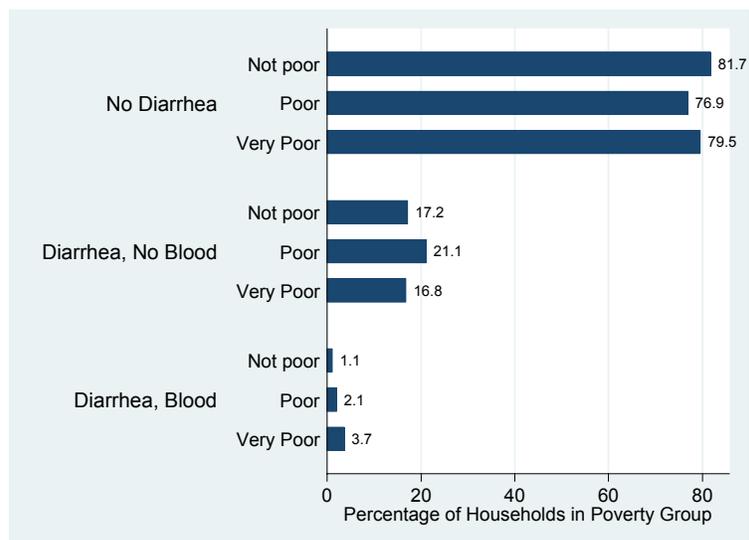
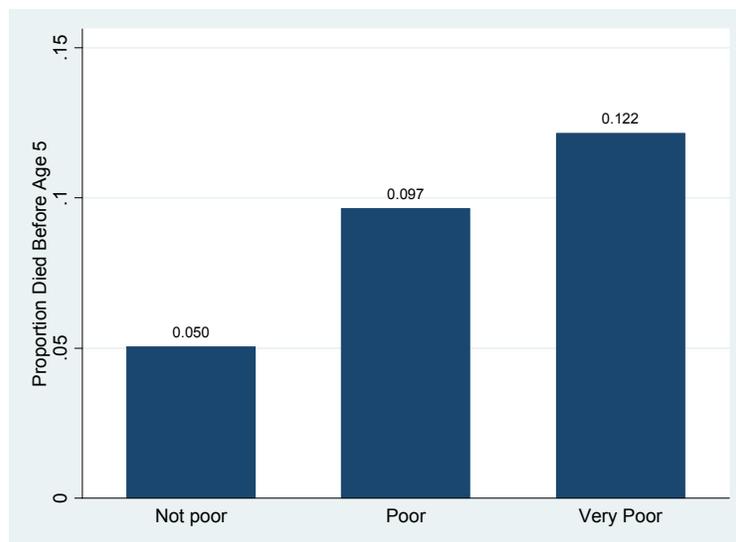


Figure 8.3 shows percentage of households reporting children with diarrhea and diarrhea with blood in the previous two weeks. As with cough, reporting of diarrhea by poor and non-poor households are quite similar – 16.8% of the very poor and 21.1% of the poor compared with 17.2% of the non-poor. However, twice the proportion of poor households report diarrhea with blood in the stool – 3.7% of the very poor and 2.1% of the poor compared with 1.1% of the non-poor.

Higher child morbidity among the poor is accompanied by much higher rates of child mortality. As Figure 8.4 shows, child mortality rates for very poor households are more than double those of the non-poor households – 122 per 1000 children for the very poor compared with 50 per 1000 children for the non-poor in urban India. The under-five mortality rate in India was reported to be 85.2 per 1000 in 2004 (World Bank, 2005).

Figure 8.4: Child mortality among children born five-ten years before the survey, by poverty status in urban India.



8.2 Findings from the Indore Interviews

Many of the in-depth interviews confirmed that morbidity is high among children. Few differences across slums emerged, most likely because poor children in these areas are exposed to the water-borne and communicable disease.

8.2.1 Colostrum Feeding Behavior

Our interviews with slum residents in Indore found that feeding colostrum to newborns has recently become an accepted practice. In the past, cultural beliefs had prohibited feeding colostrum. During interviews in Annapurna Thana, women explained why they believe that breastfeeding should be initiated immediately after birth and noted that they had not done this for their earlier children. The women said that they had been told of the importance of early breastfeeding from the slum-based health workers. It seems that the house-to-house follow-up of pregnant women in the UHRC program slums of Rustam Ka Bagicha and Annapurna Thana and the presence of a TBA in Chandra Prabhat have been critical to the adoption of this beneficial practice.

A woman in the Annapurna Thana slum with four children stated:

For this [1 ½ year old] child, I had [breast-] fed him immediately [after birth]. But at the time of the first child, mother-in-law had stopped – she was saying that the first milk is sour and spoilt, that is why had thrown it. But now they say that you should feed the first milk. Earlier they didn't explain so much, now hear this everywhere.

[Feeding the initial milk from birth] is good for the child...saves the child from diseases.

A few respondents, however, continued to follow the long-standing practice of giving the newborn jaggery water for the first three days.

8.2.2 Immunization

Attitudes to immunization are beginning to change in the study slums, and more often people are getting their children vaccinated. As in the practice of feeding colostrums, we found cases in which the older children had not been vaccinated but younger children were. All mothers knew that there was a course of vaccination to be followed. Several of the more literate mothers (in Rustam Ka Bagicha and Goto Ki Chawl) knew the names of the diseases that vaccinations prevent. Vaccination cards are also kept safely. In all slums, the AWW, ANM or the health worker of the basti reminds households that the vaccination is due and explains where the immunization camp will be held. In the slums where UHRC is working, the women knew the days on which the camp would be held. The same was true in Goto Ki Chawl, possibly because better-educated residents live here and the anganwadi centre is unusually active.

There is so much publicity about it [immunizations]. Nowadays in TV and in so many other places they are telling us about it. We get our child vaccinated in the Anganwadi, it is on second Tuesday of the month.

If we don't go, then she [slum-based health volunteers] goes to every house and calls, they spend the whole day here and call from every home.

8.2.3 Childhood Illnesses

Both parents and service providers reported that children often suffer from respiratory illnesses, water-borne diseases and other communicable illnesses. Mothers often diagnosed a child's illness through crankiness, fever or other visible symptoms, such as coughs or loose motions.

Infant deaths. Several participants had lost children in the first few days after delivery, although the causes of death could not be conclusively determined from the interview. The interviews showed that deaths were as commonly reported for institutional deliveries as for home deliveries. Slum residents are going to government nursing homes that are not equipped with adequate equipment for newborn care or to private nursing homes where intensive care treatment may be unavailable or not offered to the poor. This suggests that the quality of care in maternity homes must be examined, especially given the absence of pediatric specialists and equipment from most of these hospitals.

Diarrhea. Episodes of diarrhea are very common in the slums, occurring so often that residents sometimes do not describe them as illness. It is only when an episode of diarrhea worsens to the point of requiring hospitalization that people recognize the condition to be serious and identify it as a real threat to life.

This child [11 months old] often gets diarrhea. The stool is thin and green. I don't do any treatment at home. I go to the doctor when it becomes serious.

He was admitted for four days. Vomiting – diarrhea had happened, and used to cry a lot. Had him admitted, bottles [drip] were put. He got some benefit from the bottles. It was a private hospital. I used to stay in the hospital; his father would go to work and come in the evenings and then stay with me. Water used to go in the stools – at home also – the doctor said there was shortage of water.

The slum residents can identify different causes of diarrhea in their children, such as overeating, teething and playing in dirt. Some women clearly understood that there must be worms or germs in the mud (children play in mud and often put it in their mouths) that cause infections. These recognized links to diarrhea could be further elaborated in hygiene intervention programs.

A woman in the Chandra Prabhat slum said:

If the hands are dirty, then all germs in the dirt from the hand goes in the stomach. Dirt is in the nails also. They show in TV it is dirt which brings germs.

Many respondents said they gave children with diarrhea ORS, rice water and pulses-water while continuing to breastfeed. The slum women seemed to understand that when a child has more than two or three loose motions in one day or when its mouth is dry, there is cause for concern. However, it was not obvious that these symptoms necessarily spur any additional actions on the part of the parents. In the more vulnerable slums, the attitudes of women indicated that they felt a lack of control over the situation.

A woman in the Goto Ki Chawl slum who had completed class 8, noted:

We should maintain cleanliness, and not give stale food. When elders have a loose motion, we give curds, but in children we give salt and sugar mixture and rice water and other things.

A woman in Annapurna Thana, whose child was admitted to the hospital, says that her child had had continuous diarrhea for several weeks. She states:

We should give clean water, boiled water for small kids, clean food also. I do that but when I go for work, others give anything; we give attention when we are at home. Doctor says to take care that he eats and drinks and he will become okay

Water-borne illnesses. Many respondents mentioned jaundice and typhoid among children, and typhoid was also identified as one cause of children's deaths. The details of these episodes could not be completely recovered in our interviews; it was only explained that the children had fevers and mounting weakness. Parents faced with these serious illnesses have consulted faith healers. They also respect several restrictions on the child's diet, such as avoiding spicy and oily foods that are thought to stress the digestive system. Health information packets do not usually carry any information on diet, and its role in these illnesses is based on traditional knowledge.

Women clearly recognized the lack of hygiene as a major cause of illnesses. The women in our slum households tried to maintain the cleanliness of their family's drinking water. If they felt the precaution was necessary, they would collect water meant for drinking and for general use from separate sources. Additionally, they strained water to remove any obvious impurities, with some women using sterilizing chemicals when these were available. In the end, though, boiling water is simply impractical because it uses precious fuel resources.

If the children dirty the drinking water, we throw it and get fresh water.

The water is covered and kept.

Respiratory illnesses. Cough and colds were commonly reported. In some interviews, the children were also reported to have suffered from pneumonia. Inability to breathe or breathing heavily is clearly recognized as a dangerous condition in older children, but goes unnoticed in neonates and infants.

Wood is used as a cooking fuel in Chandra Prabhat and Annapurna Thana but homes are often built in a way that traps smoke inside. In addition, cooking stoves may be located too close to the women and other family members, thereby bring on congestive illnesses. Although the linkages are clearly important, the connections between cooking arrangements and respiratory illness could not be explored conclusively in this study.

Perceived causes of children's ill health. Health problems in infants are linked with the mother's food intake or other practices while the baby is still breastfeeding. For instance, the child's wellbeing is thought to be affected by the foods that create heat in the body or which are considered 'cold'. Other threats to health arise if the mother has worked in a cold place, such as on the floor or with water.

I had left her and was sitting outside when it was raining, she got a bad cough and cold after I breastfed her.

Loose motions happen because the mother is taking something wrong.

The remedies often take the form of prescriptions about what a person should eat or avoid eating so as not to aggravate the illness, and some foods are thought to have specific curative powers. For instance, ground cloves are views as good for curing cough and cold, and a mixture of sesame seeds and water is suggested for diarrhea.

8.2.4 Chronic Diseases

There were several situations of chronic disease in which parents took every means available to secure access to care, within the limits of financial ability and knowledge of what care should be sought. But modern treatment does not always prove effective as the process of exploring treatments draws out, people become increasingly unsure of what to do and may have no one knowledgeable to consult.

A man from Annapurna Thana slum said:

One of my daughters died. I didn't have the money so we couldn't save her. She was eight years old. She had these big boils on her body. We admitted her in the hospital but it didn't help. I went from one place to the other. People would say different things. Some would say, she has typhoid, don't give injection, show her to the baba [faith healer], don't give her oily things. I also got her water from the red temple, gave it to her, it didn't

help. I had gone to the village also to get (a holy) thread from the village also. But she died at the station.

There was one instance of a young girl being diagnosed with depression. Her mother felt helpless to intervene and was at a loss to know what she should do to restore her daughter to good health.

An Annapurna Thana woman with three daughters, referred to her nine-year-old by saying:

Who knows what illness had befallen her? She had some foamy things and closed her eyes and was completely numb. The doctor said that she is in depression, if you do tension, then again it will happen. If we make any sound, her mind just blows all around.

Surprisingly, epilepsy was mentioned in several interviews, particularly in Goto Ki Chawl. The study team could not find any reason for its evidently high incidence (reported in five interviews) in this particular slum. In other slums, at least one or two cases were identified among the respondents' children. Parents have tried various alternative medicines and cures in the face of this frightening illness; their desperation is at its peak just following an epileptic attack, but then subsides and is replaced by a hope that such episodes will not recur.

They have told me to go to Shegaon. There are many healers there. But I don't have the money to go so far.

Accidents. There was one death reported due to an accident. This was an instance when a young girl had gone to the toilet complex where she was bitten by a pig. The presence of pigs in the standing (not drained) waters in the Annapurna Thana settlement and near the toilet complexes in the other three slums was noticed, and several residents mentioned the constant threat from animals, especially with respect to dog bites. If a bite should occur, its treatment by rabies shots is a drawn out process and very expensive, even in government hospitals.

We showed her at many places, but she could not survive.

Other types of accidents mentioned including accounts of children hit by two-wheelers and a child drowning in a well. These incidents stem from the unsafe conditions in which the poor live.

8.3 The Philippines: Findings from the Demographic and Health Survey

As in our analysis of urban India, we begin with a review of child health conditions covered in the Demographic and Health survey for the Philippines. Where differences between the National Capital Region (NCR) and the remainder of the urban Philippines appear to be of substantive interest, we comment on these differences.

Figure 8.5: Vaccinations for children aged 12-23 months at survey, by relative poverty status in urban Philippines.

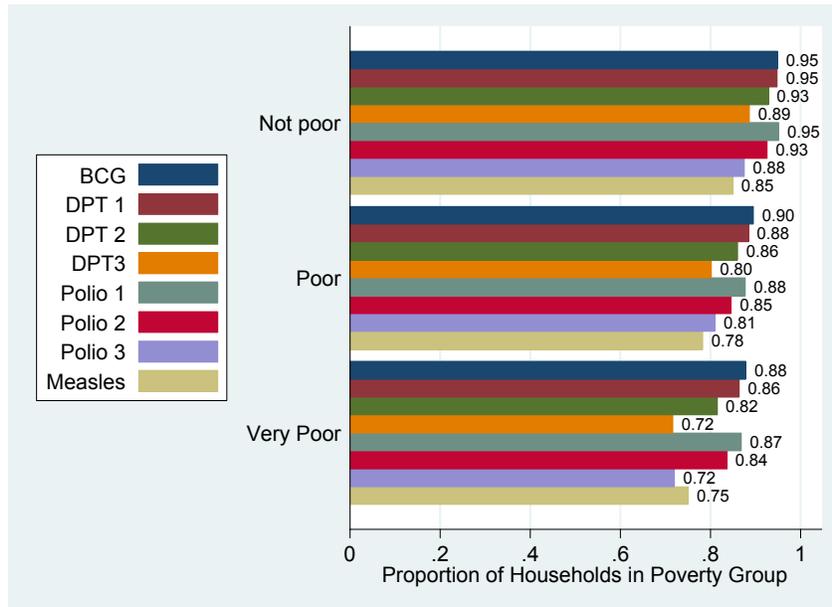


Figure 8.5 depicts vaccination coverage in the urban Philippines. Although the differences in vaccination coverage by poverty status are consistent across types of vaccine, they are not as large as those seen in urban India. Poor and very poor households are slightly less likely than the non-poor to receive any of the vaccines. Some 86% of the very poor reported getting DPT1 vaccine for children aged 12-23 months, compared with 88% of the poor and 95% of the non-poor. 75% of the very poor reported getting the measles vaccine compared with 78% of the poor and 85% of the non-poor.

Figure 8.6: Children experiencing any persistent cough, and cough with short breaths, in the two weeks prior to the survey, by relative poverty status in urban Philippines.

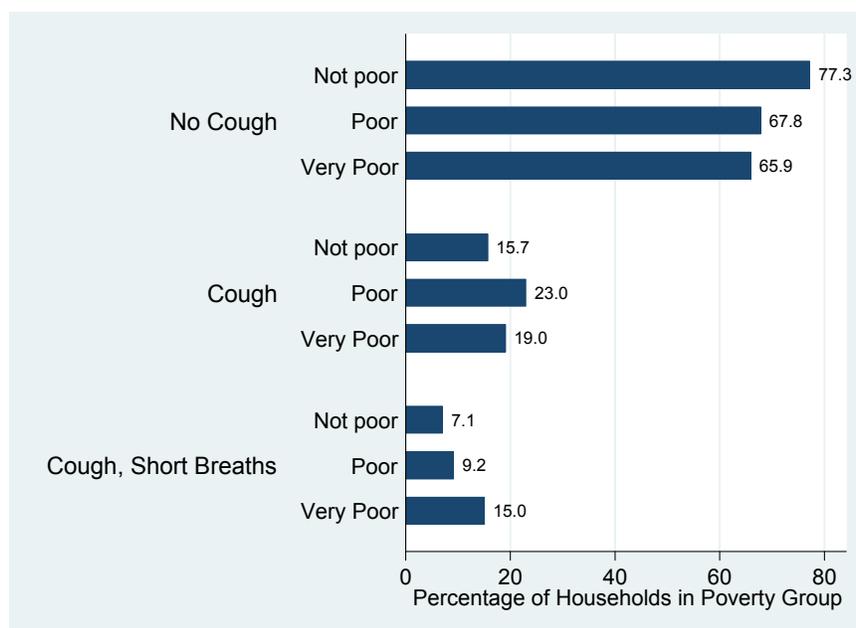


Figure 8.6 shows that rates of cough with short breath among children are twice as high among the very poor in urban Philippines than among the non-poor – 15% for the very poor compared with 7.1% for the non-poor. Some 34% of the very poor and 32% of the poor report either persistent cough or cough with short breath among children, compared with 23% of the non-poor. Conditions in the NCR are better than all urban Philippines with respect to this indicator. Across all urban areas about 11% of very poor women reported that in the preceding two weeks a child had suffered from cough with short, shallow breaths, but for the NCR the percentages for poor and non-poor women are 7% and 3% respectively.

Figure 8.7: Child experiencing any diarrhea in the two weeks before the survey, by relative poverty status in urban Philippines.

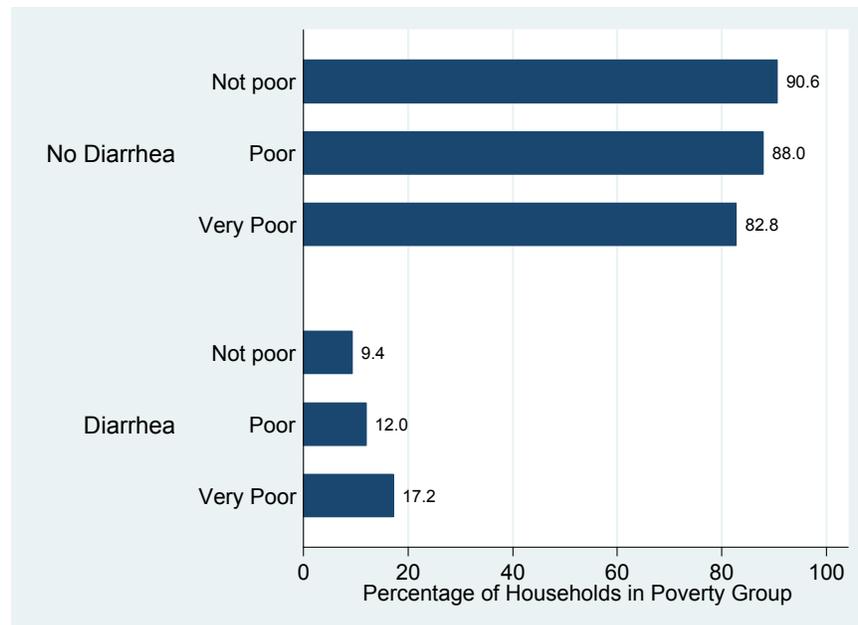
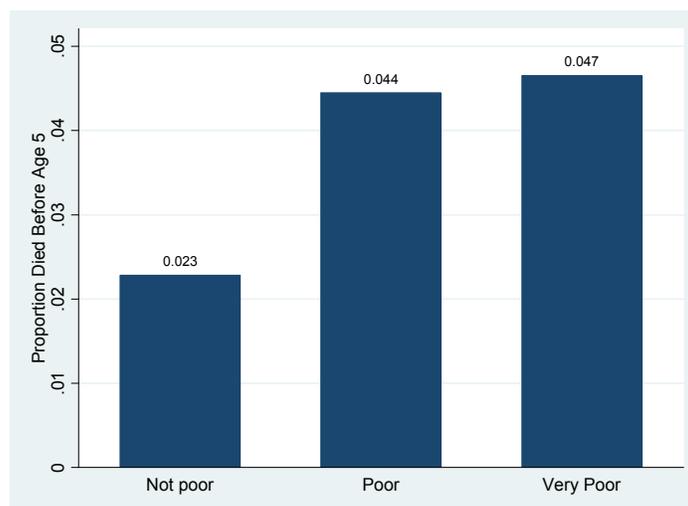


Figure 8.7 shows the percentage of households reporting children with diarrhea in the previous two weeks. Diarrheal rates for children in very poor households are almost twice as high as the rates for the non-poor – 17.2% for the very poor and 12% for the poor, compared with 9.4% for the non-poor. In the NCR as in the urban Philippines in general, diarrhea also strikes the children of poor and very poor women more often. Here 21% of very poor women reported diarrheal episodes in the two weeks preceding the survey, as compared with 11% of poor women and 9% of non-poor women.

High rates of child mortality are evident among the urban poor and very poor compared with the non-poor. As Figure 8.8 shows, child mortality rates for very poor households are more than double those of the non-poor households – 47 per 1000 children for the very poor and 44 per 1000 for the poor, compared with 23 per 1000 children for the non-poor in urban Philippines. Under-five mortality rate in the Philippines was reported to be 34.4 per 1000 in 2004 (World Bank, 2005).

Figure 8.8: Child mortality among those born at five-ten years before the survey, by relative poverty status in urban Philippines.



8.4 Findings from the Greater Manila Interviews

As in the case of Indore, many of the in-depth interviews suggested that morbidities are high among children. There were no clear differences across the two slums. When common illnesses were described in both slums, they were generally water-borne and communicable diseases, with symptoms of coughs, colds, fevers and diarrhea.

8.4.1 Immunization

As in Indore, respondents in greater Manila are aware of immunizations and get their children vaccinated. Specifically, the respondents were asked if the youngest child was immunized and most women answered ‘yes.’ Most men were aware of immunizations only in general terms but were not aware of the details. They said their wives understood these issues and kept track of them. Almost all mothers knew that there is a course of vaccination to be followed that saves children from diseases. Their source of information is usually the health center. A few women also mentioned that their information came from a class held in the slum by students. Most mothers did not know exactly which diseases each vaccine prevents, nor could they say exactly when each vaccine had to be administered.

Immunizations were given at the government health center and most mothers were aware of the specific days when the health center offers free immunizations. They also knew of the vaccination card provided by the health center, although most women did not know exactly what was written on the card. They did know that the card was important (some thought it would be needed when the child starts school) and they kept it in a safe place. Immunizations are officially free at the health center, although some respondents point out that “donations” must be paid at the health center to get them. Some also mentioned that the hepatitis B vaccine cost Peso 50, and since they could not afford the payment they did not get their children vaccinated.

Most women said the immunization service at the health center was fine. Others thought service at the center was too slow, and said that the staff did not pay sufficient attention to them and needed more training. A few of the respondents also expressed a need for more home visits for immunization.

Slum residents stated:

[Received vaccine] At the [health] center... however my child still has not been given the hepa vaccine because it's expensive. Immunization is every Wednesday.

They [health workers] should visit house to house. Others do not have the money to pay for the fare. You have to go to the Pansool Health Center for the injections. It means you have to pay for fare when you go to Pansol health Center and then you give a donation. I do not know if the one asking at the ground floor is a doctor. She told us that the donation is 20 pesos.

They provide good service since they are doctors.

For me it would be better if they are here near us. Also, it would be better if there is a clinic here.

They have a book where doctors write down the kind of injection they administer.

I learned from the center when the children were immunized.

Probably, the center needs to add more nurses, because the service is very slow.

8.4.2 Care for Common Illnesses

For children with common illnesses such as coughs, colds and fevers, most mothers first treat them at home with over-the-counter analgesics. If the child does not get better quickly, he or she is then taken to the health center -- which is generally preferred to private care because medicines are free. Other mothers described a mix of responses: some take a sick child to a private doctor while others go first to a traditional healer, and if the child is not healed they go subsequently to the health center. Many said they also try herbal remedies, such as cooked oregano leaves for coughs. Respondents were also asked about dengue fever. All were aware of it and knew it comes from mosquitoes. Most respondents learned about dengue fever from television.

Regarding care for a child sick with fever or common cold, slum residents said:

I give them medicine for fever then give them a sponge bath.

I let them take something herbal like oregano... my mother-in-law has some planted in her yard. I read it from a book.

I immediately take my child to the center if they are feeling ill. You would know that the child has an ailment if they are weak. They must be fully attended and taken cared of.

We go to the health center to ask for free medicines. If not, I go to the health center at Angono. Prescribed medicines are [available] there.

I go right away to the traditional healer even for a slight fever. They know about it. We only give donations.

We go to a traditional healer. But if he/she does not get well, we take him/her to the doctor.

Most respondents are concerned about diarrhea and know to monitor the diet of the sick child and get over-the-counter medicines. If the condition worsens, most respondents go to the health center. Most are aware that the causes of diarrhea are bad food or water.

Regarding care for child sick with diarrhea, slum residents said:

She had diarrhea twice. I just gave her something to drink at first however it was worse the second time so I had to bring her to the hospital. I cannot remember what medicine was given to her.

I would not go to a traditional healer for diarrhea. I only go to a doctor.

At the start of his diarrhea, our neighbor suggested that I give him oresol. I bought it from Mercury Drug.

Regarding diarrhea prevention, residents noted:

Yes, through cleanliness. Water and food have something to do with diarrhea.

Boil the water and avoid junk food.

It can be avoided if the child's things are clean.

Yes, it could be prevented. For example, if the food is no longer safe to eat, it should no longer be eaten. Wash hands first before eating.

8.5 Summary

Child health is of utmost concern for all women interviewed in both Indore and greater Manila. Women worry about common illnesses such as diarrhea, fever, coughs and colds, which when left untreated may lead to death. Women also worry about paying for their children's health care, and the cost of medicines is of concern. Women are aware that lack of clean water and proper sanitation are the cause of the common diseases but feel helpless to address these issues.

DHS data show that child mortality rates among very poor households are 122 (out of 1000) in urban India and 47 in urban Philippines. These rates are double those for non-poor urban households in each country. In urban India, less than 70% of very poor households receive the common vaccines – in urban Philippines this is slightly higher, with rates approximately 90%. Women respondents in both India and Philippines are aware of the need for immunizations, although many women did not know the names of the vaccines. The awareness appears to be recent, as younger children were immunized while older ones generally were not. Most men were only vaguely aware of the specifics of immunization and said their wives were responsible for their children's health and immunizations. In both countries, women respondents said they take their children to the public health center for immunizations or wait for an immunization camp at the slum site because the service is free. In the Philippines, some respondents said they could not afford the fee for the hepatitis B vaccine. Most women knew the schedule at the health center for immunization day and kept the vaccination card provided. Women expressed a need for immunization services at the slums or for home visits by health workers.

9. Environmental Health and Hygiene

In keeping with previous chapters, here we examine environment health and household behaviors linked to it, using a combination of quantitative data from the DHS and qualitative reports from individual interviews.

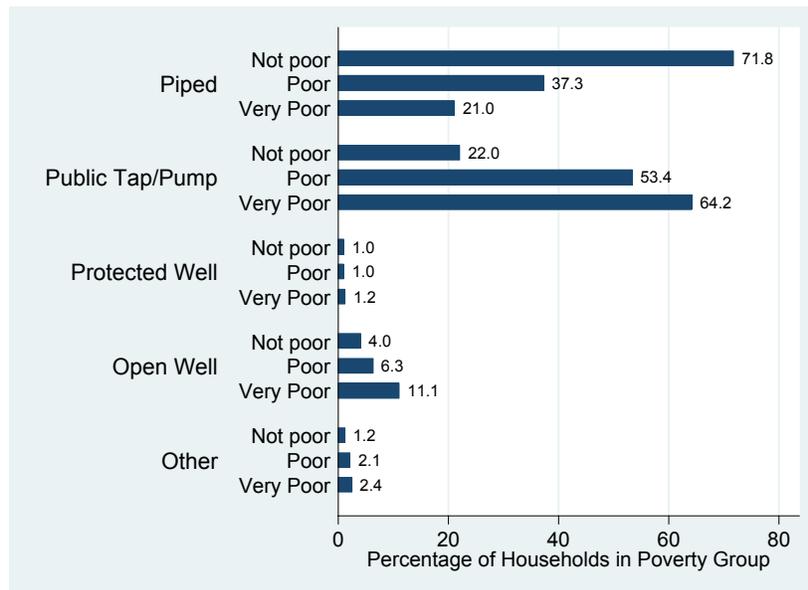
9.1 Water and Sanitation in India

In addition to the DHS data on urban India and the state of Madhya Pradesh, further quantitative findings are available for Indore from a 2002 baseline survey of the slum communities in this city (Agarwal and Taneja, 2005). The Indore survey distinguished among slums on the basis of a detailed index of vulnerability that characterizes each community as a whole, rather than at the level of households as we have done using the DHS data (see Table II of Agarwal and Taneja, 2005, for a description of the slum vulnerability index). The Indore results allow us to see how slum communities vary in levels of health and health services.

In urban India, the poor are much less likely to have access to piped water than the non-poor and are much more likely to take their drinking water from a public tap or pump (Figure 9.1). The differences by poverty status are enormous: only 21% of the very poor households have piped water, whereas nearly 72% of the non-poor households do -- a difference of over 50 percentage points. Note, however, that roughly one-fifth of non-poor households also draw their water from public taps, and one-fifth of the very poor have piped water. Evidently, there is considerable variation in access to water not only across poverty groups but also within them.

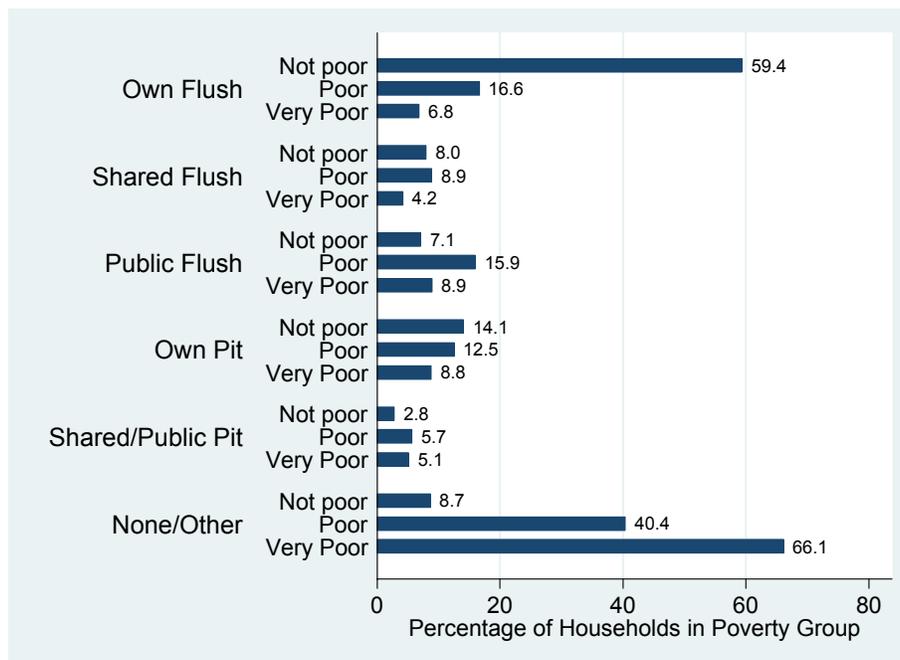
Where adequate access to drinking water is concerned, urban Madhya Pradesh is markedly less well served than urban India as a whole. Among the non-poor households of this state, only 65% have access to piped water (compared with 72% for such households across urban India); 22% of the poor households have piped water (compared with 37%); and only 7% of the very poor households do (compared with 21%). It seems that in the urban areas of this state, and especially among the poor, more drinking water is taken from public taps or pumps than elsewhere in urban India. Some 31% of the non-poor Madhya Pradesh households draw their drinking water from these public sources, as do 63% of poor households and 72% of the very poor. The Indore slums survey found that only 11% of households in the most vulnerable slums had access to piped water in the home; even among the least vulnerable slums in this study, only 32% had piped water (Agarwal and Taneja, 2005).

Figure 9.1: Access to drinking water, by poverty status in urban India.



Similar differentials are evident in access to sanitary means of disposal for human waste (Figure 9.2). Across urban India, only trivial percentages of very poor households have exclusive access to a flush toilet (6.8%) Even when shared access is considered, the total for this group is only 11%. Nearly two-thirds of very poor urban households in India rely on no sanitary method, while 40% of poor households are similarly disadvantaged.

Figure 9.2: Access to toilet, by poverty status in urban India.



In Madhya Pradesh, access to sanitary facilities is decidedly worse than in urban India as a whole. In this state, 91% of the very poor households have no access to flush or pit toilets and they must dispose of fecal matter in what is sure to be a highly unsanitary manner. 65% of the poor households also lack access to such toilets, whereas only 15% of the non-poor lack access. In the most vulnerable of the Indore slums, over half of the households had no toilet facility at all. This percentage dropped to 21% in the moderately vulnerable slums and to 16% in the least vulnerable of the slums in this study (Agarwal and Taneja, 2005).

9.2 Findings from the Indore Interviews

9.2.1 Unreliable Water Supply and Varying Conditions Across Slums

Access to water differs across the four slums of our study. The worst situation is seen in Annapurna Thana, where on a daily basis water must either be purchased or requested from the better-off residents of nearby houses --- a practice that requires making complicated arrangements with the owners of these households, and which depends on their tolerance.

If these people in the bungalows didn't pity us, we wouldn't even have had water.

During summer, the situation worsens because supplies are limited throughout the city and house-owners become reluctant to share their scarce rations with the slum-dwellers. When this occurs, the residents of Annapurna have little alternative but to walk considerable distances (up to a mile) for water from a public tap, with little possibility for water storage. The lack of storage reduces water consumption below acceptable levels and all but prevents hygienic practices from being followed in the home. In the other disadvantaged slum of Chandra Prabhat, the population is also dependent on public taps and pipelines. In the better-off slums of Rustam Ka Bagicha and Goto Ki Chawl, however, pipelines have been laid and there are small lines cut out from them from which households can draw their water. Water is stored in small underground tanks in front of houses – a storage option that is similar to having water piped to the home. Whenever water gives the appearance of being unclean, people strain it at the source but then use it for drinking without taking further precautions.

9.2.2 Poor Sanitation Conditions

Toilet conditions in Annapurna Thana and Chandra Prabhat are simply abysmal. Some men use the public toilet in Chandra Prabhat and men in Annapurna Thana make use of toilets in the nearby temple complex. Women, however, have no option but to defecate in the open. This unavoidable practice leads to numerous problems: women are acutely embarrassed; men leer at them, aggravating the situation; and the residents of the better-off neighboring homes raise objections. Moreover, during the rains a dry space to sit can be hard to find.

Slum residents state:

There is a lot of problem in going in the open. Sometimes there are men around. At times we go early in the morning and sometimes in the late evening. No chances to go there in the day.

We go for toilet early in the morning or at night.

We go to that empty plot for latrine, in rains we have to go to the other side. It is a big problem.

The bungalow people don't let you go, you have to go at night only.

In the slums of Rustam Ka Bagicha and Goto Ki Chawl, there are public toilets available, and some houses in Goto Ki Chawl have their own private toilets. Payment for usage of the public toilet is usually made monthly. In some interviews, the possibility of daily payments was also mentioned.

Children do not use the public toilets in any of the study slums, even when these are available. Children often defecate in the open a little distance from their house or go in the courtyard – which is not always cleaned up. Some women reported covering the child's stools with mud and then throwing it in the riverside or around the corner.

9.2.3 Trash Piles Up

Disposal of solid waste and garbage is an acute problem in the more vulnerable slums of Chandra Prabhat and Annapurna Thana. In Goto Ki Chawl and Rustam Ka Bagicha, accumulated garbage was kept aside for the trash collector, but there is no possibility of this in the two more impoverished communities. Slum residents strive to keep their houses clean, but the common spaces of the community inevitably become dumpyards and people often have fights over them.

Slum residents said:

We have a pot for collecting garbage then we cover it. The sweeper [trash collector] comes daily to pick up the garbage from our house.

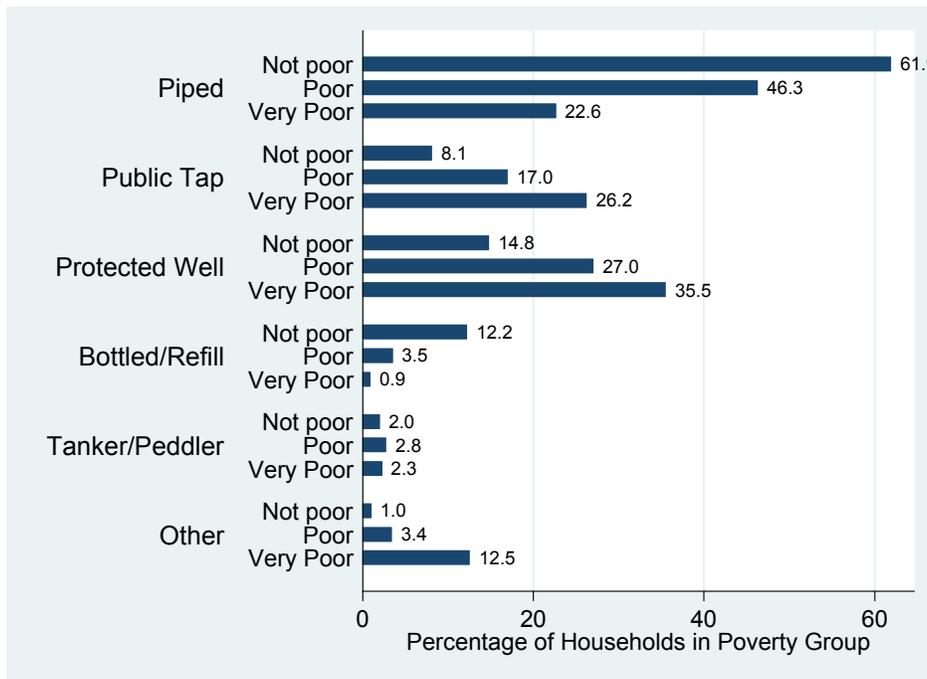
Home is clean, but surroundings are dirty.

9.3 Water and Sanitation in the Philippines

In the urban areas of the Philippines, nearly two-thirds (62%) of non-poor households have access to piped drinking water, compared with 46% of the poor households and only 23% of the very poor (Figure 9.3). As in urban India, the poor in the Philippines rely more heavily on public taps and protected wells as their sources of drinking water.

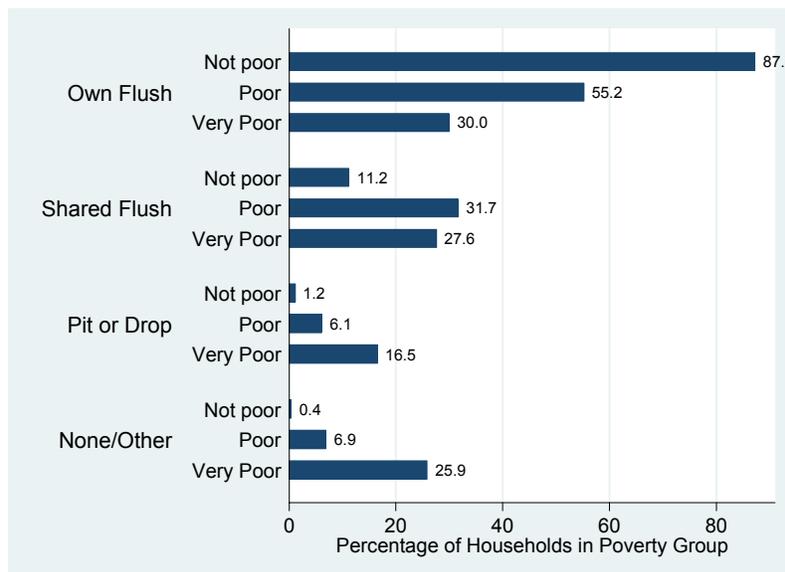
In the National Capital Region (NCR) poor and non-poor households are considerably more likely to have access to piped water than elsewhere in the urban Philippines. For example, 30% of very poor households in this region have access to piped water, as do 63% of poor households. The poor and very poor households of this region are less likely to take their drinking water from a protected well than other urban households, as are the NCR non-poor.

Figure 9.3: Access to drinking water, by poverty status in urban Philippines.



Regarding access to toilets and other sanitary means of human waste disposal, large differences in access by poverty status are in evidence -- although these differences are not nearly as large as in urban India. Across the Philippines, nearly nine in ten non-poor urban households have access to a private flush toilet, and almost all such households have access if shared toilets are considered (Figure 9.4). By contrast, only 30% of the very poor households have their own flush toilet, but with shared access taken into account this figure rises to 58%. The percentages of households without any sanitary means of waste disposal are much lower here than in urban India, although it should be noted that among the very poor about one household in four (or 26%) lacks all sanitary means of disposal.

Figure 9.4. Access to toilet, by poverty status in urban Philippines.



In the NCR, we see substantially more dependence among the poor on shared flush toilets than is evident for the urban Philippines as a whole. For example, among households that are very poor, 61% rely on shared toilets and among the poor, 45% rely on them (NSO, 2004). In the NCR, the poor are less reliant on the none/other methods of sanitation, which often involve defecation in the open or using the “wrap and throw” method for disposal of waste.

9.4 Findings from the Greater Manila Interviews

9.4.1 Water Availability Not a Concern

Interviews with slum residents suggested that water availability was not of concern in our study sites. In the better-off Kaingin slum, piped water is available to most households. There is a metering system and bills are paid monthly based on the metered charge. Respondents say that they have sufficient water. However, the quality of the water may be questionable in the slums with exposed pipes. In the more disadvantaged community of San Buena, water is purchased from water delivery trucks, which charge per container. The delivery truck is said to come most afternoons and our respondents believed that they have sufficient drinking water for their needs. (This is their perception, but whether consumption is adequate for health and hygienic needs is questionable.) There is also a deep tubewell to which some residents have access; water from this source is used for cleaning and laundry. Water service is provided by the Metropolitan Waterworks and Sewerage System (MWSS; also referred to as NAWASA from its earlier name.)

Most respondents said their water was clean for drinking, although some knew that the water had to be boiled to avoid exposing children to diarrheal diseases. Relatively few residents complained of the financial burden of paying for water.

Slum residents state:

From the faucet... from MWSS, it's the same for laundry, and also for bathing. Water does not run out, just so long as the MWSS keeps supplying water.

There is a water truck delivery service but we also run out of water. That is why we have containers to store water. The truck delivers water everyday.

We buy our water in containers... We have sufficient water supply.

We buy water... They say it's clean.

I think it's already clean because it's from NAWASA.

We get water from MWSS... We use a white t-shirt to filter the water.

We have our own water. We do not run out of water.

The water from the faucet is already clean.

It [the water] is clean. We boil the water for the young children.

9.4.2 Poor Sanitation Conditions

Toilet conditions vary across these slums. As the DHS analysis indicated for the urban Philippines and the NCR, many households have access to a toilet (although this is often shared by several households). These are traditional water-sealed toilet bowls that require manual water flushing, known locally as “de-buhos.” Such toilets are more common in the better-off areas of Kaingin than in San Buena. Other households use the “wrap and throw” method, with most children using the nearby canal in both of the study slums.

Slum residents said:

We have a toilet bowl. The others who don't have find other ways.

There is a hole which goes directly to the river.

Ours is water sealed. It is used by the four families renting here.

We just wrap our waste and throw it into the river

9.4.3 Trash Piles Up

Conditions within and across the two slums varied in terms of the visible piles of trash. Some residents simply threw their trash in the river; others claimed to burn it or pile it in one place for the trash truck to pick up. However, the trash truck did not seem to come with on any regular schedule or reasonable frequency.

Slum residents note:

A truck comes here but only once a month. We burn the garbage when the truck doesn't come.

A garbage truck comes here once a week. But when it doesn't come to collect, we throw the garbage aside and the garbage collectors would just get it.

We throw it [household trash] at the backyard. We have an area where garbage is burned.

The river is just near. Somewhere there.

I just throw it [household trash] into the river.

9.4.4 Hygiene Awareness and Behavior

Most respondents in the two slums have an awareness of the importance of hygiene in preventing disease. They seem to know that hands should be washed, especially before meals. But frequent hand washing does not seem to be generally advocated.

Regarding if and when children should wash their hands, residents said:

They should wash their hands whenever they touch or hold something. For the children, I, myself, wash their hands before and after eating.

Everyday. Before and after eating.

Before meals and sometimes when they play on the road.

Hands should always be washed, after eating. The children have to be reminded since they are still very young.

Probably every time they play. You need to wash them especially when they get dirty.

It must be done everyday. Sometimes they forget, I just see them eating already. Yes, it happens often.

Our children wash their hands before eating and before sleeping.

9.5 Summary

There can be little doubt of the continuing need for improved water supply and sanitation in the slums. These are basic human needs and fundamental factors in determining health risks, which are still very far from being met in the study communities as well as across urban India and the Philippines. In the poorest and least organized slum communities (such as Annapurna Thana in Indore), precarious social arrangements are made to sustain minimal access to drinking water, and these arrangements tend to fray in periods of stress (such as the summer months when water supplies are limited). Although we could not directly measure water intake at the household level, it is likely that it fails to meet basic health requirements. Even where the slum households have a theoretical awareness of the importance of washing and other water-related hygienic practices (as in the Philippines study sites), it is difficult to maintain these practices when water is scarce.

Access to sanitary means of human waste disposal is very poor, especially in the more disadvantaged slums of Indore. Relatively few households have or are able to share a flush toilet, and use of public toilets (where available) is mainly by men. Women must defecate in the open and are therefore subjected to humiliation and harassment on what seems to be a daily basis. Children seldom use public toilets or other sanitary measures for disposal of their waste. As a consequence, they are likely to be exposed to elevated levels of health risk.

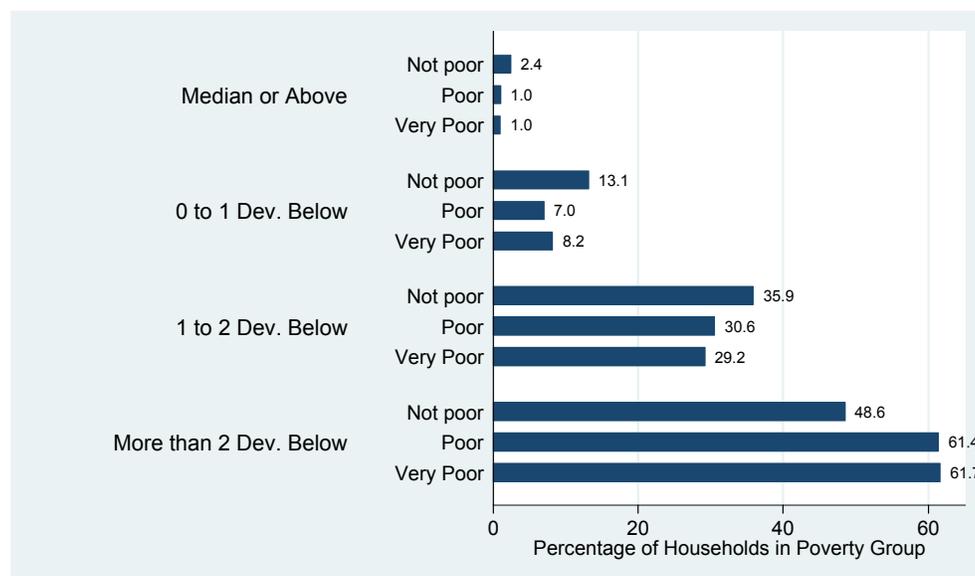
10. Other Health Issues

This chapter covers other health topics such as malnutrition, tuberculosis (TB) and dengue fever in greater detail. Our interviews addressed these topics, but not as fully as the health issues discussed earlier in this report. During the interviews in both Indore and greater Manila, malnutrition was mentioned as a cause of great concern. In the Philippines, the Department of Health specifically requested that we address TB and dengue fever with the slum residents. Residents in greater Manila were asked their awareness of TB and dengue fever, and we sought to determine their understanding of the symptoms and causes of these diseases, and their knowledge of treatment options. Given the limited time allotted, these topics were not specifically raised in the Indore interviews. However, TB was addressed here when respondents (or someone they knew) had TB.

10.1 Malnutrition

10.1.1 Malnutrition Among Indian Urban Women

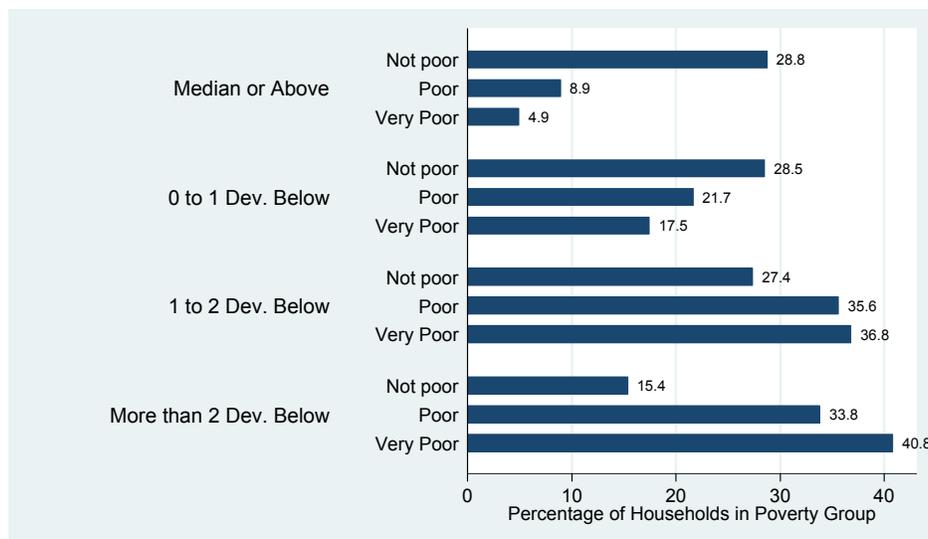
Figure 10.1: Women's height for age, by relative poverty status in urban India (expressed in standard deviations from the median of an international reference schedule).



The 1998-99 National Family Health Survey for India differed from other DHS surveys by collecting anthropometric information on adults. These data are summarized in terms of standard deviations from an international reference population that is generally well nourished. Depicting women's height (standardized for age), Figure 10.1 shows that urban Indian women are substantially shorter than the reference population. Among the three poverty groups we examined, over 60% of women from poor and very poor households are two or more standard deviations below the reference median. Additionally,

nearly half (49%) of the women from non-poor households fall below the median as well. Departures of this magnitude are indicative of severe stunting, and are the mark of nutritional deprivations women experienced in childhood and adolescence. Separate calculations for urban Madhya Pradesh (not shown) give similar results. Figure 10.2, which presents results on weight for height (also known as “wasting,” which can be influenced by more recent nutritional deprivations), provides strong evidence of the deprivations that continue to afflict poor and very poor women. These women are far more likely than the non-poor women to fall two or more standard deviations below the reference median.

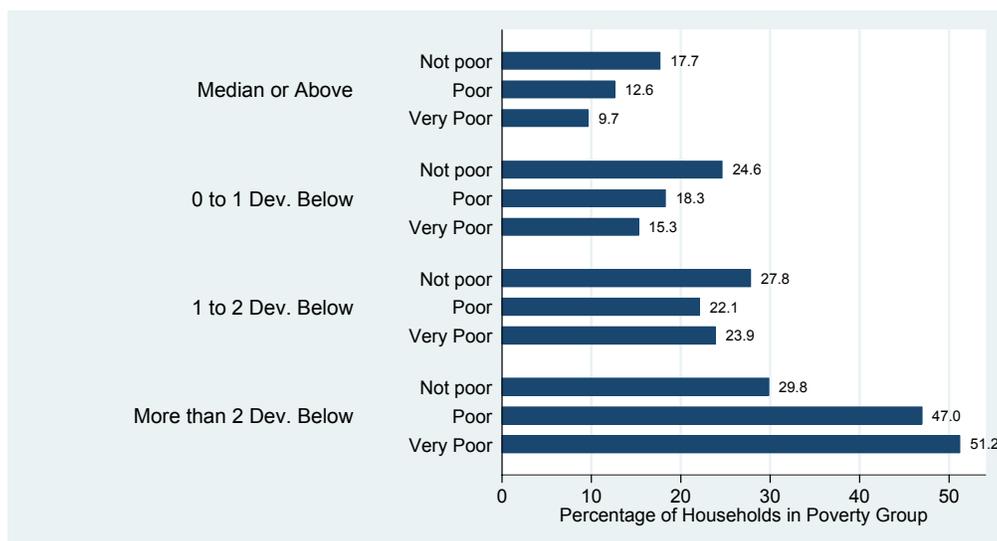
Figure 10.2: Women’s weight for height, by relative poverty status in urban India (expressed in standard deviations from the median of an international reference schedule).



10.1.2 Malnutrition Among Indian Children

High levels of malnutrition among urban children in India are recognized to be a contributing factor in child mortality. It is likely that malnutrition among mothers influences their children’s birth weight and in this way contributes substantially to neonatal mortality.

Figure 10.3: Children’s height for age, by relative poverty status in urban India (expressed in standard deviations from the median of an international reference schedule).



For over 75% of children in very poor households in urban India, height for age is more than one standard deviation below the international reference median. For 51% of these children, it is two or more standard deviations below (Figure 10.3). In comparison to all urban India, stunting is slightly more evident in urban Madhya Pradesh, with 64% of the children in very poor households falling two or more standard deviations from the reference line. This helps contextualize what we hear from the Indore slum residents regarding their food and nutrition.

10.1.3 Uncertainty of Adequate Food in Annapurna Thana and Chandra Prabhat

The inability to cook two square meals a day was noted in interviews with the residents of Indore’s Annapurna Thana and Chandra Prabhat slums. Food is generally cooked here only once a day, and its quantity and nutritional value vary with the day’s earnings. The other two study slums in Indore are far from optimal in many dimensions of economic wellbeing, but their families do generally appear to meet basic food needs. It is difficult to say precisely why things are closer to adequate in the communities of Rustam Ka Bagicha and Goto Ki Chawl. Among other reasons, some residents of these slums reported that they were able to buy certain food items in bulk. It has been seen in other settings (the urban centers of Tamil Nadu, for example), that households relying on daily earnings cook once a day with a daily purchase of approximately 100 grams of fresh vegetables (Rengaswamy, et al 2003). Households with regular weekly earnings could better plan their food expenditures and saved considerably through bulk purchases.

The participants in our study did not consciously link food intake to poor health (or at least they did not articulate the connection), and health seems to be understood by them within the limited context of disease. Recognition of weaknesses affecting the body was verbalized in some of the in-depth interviews.

But in very few interviews was there a clear link drawn between a child's death and either the mother's or the child's own nutritional intake.²⁶

A slum resident states:

No, he was too thin from the very beginning [in response to a question on if anything more could have been done to save an 18-month-old child who died, who was taken to several hospitals].

For most respondents, the food prepared is the same for all family members. Usually, no special provision is made for pregnant women or children. In the less vulnerable slums of Rustam Ka Bagicha and Goto Ki Chawl, the daily food habits are better. It should be noted, however, that attention to women's health throughout the life cycle -- not only during pregnancy, childbirth and lactation -- is essential to maintaining child health (U.N. Millennium Project, 2005).

10.1.4 Malnutrition in Greater Manila

Interviews in the greater Manila slums raised some of the same issues about the inadequacy of food and nutrition as in Indore. Common meals include rice *plus* one other dish, rice and salt, or instant noodles, depending on the household's cash situation is that day. Most respondents say they skip breakfast or drink only coffee. Many have just one meal because that's all they can afford. Most respondents say the same food is cooked for everyone, including children and pregnant women.

Regarding their means, slum residents say:

We have coffee for breakfast, rice and shrimp paste for lunch and for dinner, if there's none then there's no dinner. We have salt if there's no viand. / Vegetables, saluyot, as for canned goods we eat sardines, eggs, we rarely eat meat. We give priority to children's food.

They are the same even with the children. When I was pregnant I ate the same.

Fish, vegetables and milk for my children.

Bread and coffee for breakfast, for lunch, sometimes we have rice and vegetables, that's it. Life is hard nowadays, we cannot have two viands anymore. For dinner, the same although sometimes we have meat however, my husband has high blood.

We usually eat rice, sometimes noodles or other viand. We also eat sardines or dried fish.

We eat simple foods like vegetables, egg, noodles and dried fish. The pregnant have the same food as the others.

Sometimes we have sinigang (sour broth). If there is none, we would have sardines.

²⁶ Worth mentioning is a relationship between the mother's age and child survival. For a majority of our women respondents, age at marriage was between 13 and 16 years. Many of them reported having miscarriages and/or neonate deaths; see Tinker and Ransom (2002) for discussion.

Rice, dried fish, vegetables and if we can borrow money during Sundays, we have vegetables with meat.

Sometimes we eat rice porridge. We budget our meals. Our meals vary. When we were able to go to the market, then we would have vegetables, fruits, and sometimes sweet potatoes. That's all.

Noodles, sardines. If we have money we buy chicken feet or other delicious food. For the kids we have pork, chicken, fish. If we don't have the money, we only eat fish sauce.

We simply have rice, Lucky Me (noodles), and dried fish. Just those.

As of now, my husband has no work. We eat Lucky Me instant noodles, and the like. If there's money, we are able to buy fish.

Sometimes, we don't eat anything at all because my husband has no work, but most of the time, it's just rice and dried/salted fish for us

Regarding common illnesses and malnourishment, slum residents note:

[Common illnesses in the slum are] Cough, colds, nausea, diarrhea, malnourishment for kids; fever and flu for adults and older people.

Children usually suffer from cough, colds, vomiting, diarrhea, and malnourishment. Adults usually suffer from flu.

Malnutrition. The kids here lack vitamins. Most of the kids here seem to always have colds.

10.2 Tuberculosis

10.2.1 Findings from Indore

Several Indore respondents expressed concern about TB, noting that either they or a close relative had contracted the disease. This allowed the interviewer to further probe about the nature of TB and its treatment. Awareness about the illness was found to be mostly limited to its symptoms. Prolonged periods of coughing, weakness and sometimes blood in the sputum were mentioned as common symptoms. TV was often quoted as the source of information.

While many respondents had heard about TB, they did not express much interest in the topic if they had not been personally affected. Among those who have had a close encounter with the disease, however, discussion of the disease came easily. Yet even these respondents had limited information, mainly remarking on the long duration of treatment. The need for the continuation of treatment was well appreciated by those who had been diagnosed, as there is an element of fear associated with TB. (No one recognized the phrase 'DOTS' as such.)

The interviews also suggested that prior to diagnosis, respondents usually visited more than one private provider for treatment of the symptoms. When a TB diagnosis occurs, the treatment is then moved to a government facility. Delay in diagnosis also appeared to be common.

Following are excerpts from several Indore interviews covering TB. (I = interviewer, R = respondent)

I	How old is your sister who had TB?
R	She is younger to me.
I	Did anybody else also have it?
R	No.
I	Did people around know?
R	Yes.
I	Were people afraid of it?
R	No
I	How did you get to know it?
R	We did an x-ray and the doctor said, you better take her to the government hospital otherwise your bills are gong to increase.
I	What tests did he do?
R	Saliva test, x-rays.
I	What were the symptoms?
R	There was a lot of cough... the cough just did not stop.
I	Do people come to the basti and talk about TB, etc.?
R	No.
R	She was in the hospital for some 20-25 days. Later when we came home, we would take medicines for seven days, then 15 days, now one month stretches.
I	How much did it cost, the TB treatment?
R	The private doctors themselves must have cost Rs. 5000-6000. And about Rs. 2000 at the government hospital.
I	How did you get to know about this disease?
R	I had cough and ...
I	How did you get to know? (Is this meant to repeat?)
R	She had gone to the medical store to get medicines. The doctor hadn't told, but the medical store man did. Thus I got to know.
I	How did you first hear of TB?
R	From the TV.
I	How did the medical store man tell you?
R	I had asked him, what is this medicine for, brother? And he said, it is for TB.
I	The doctor didn't tell?
R	No. He thought he may get scared.
I	What else did the medical store man say?
R	He said have your medicines everyday... don't stop it in between.
I	When the store man told you, how did you feel?
R	Nothing much. The store fellow also explained to us well, saying, brother, this disease can be treated, just do not skip your medicines. The medicines cost Rs. 30 every day.
R	This is a common disease; do not be afraid, he said.

Excerpt from interview transcript covering TB (Indore, India)

I:	Has anyone been seriously sick during the last five-six months?
R:	Our grandmother was sick
I:	What happened to her?
R	: She had TB.
R:	They kept her on the third floor. They used to give her milk and fruit and she becomes okay. Everyday they used to give one liter milk.
I:	And how were the doctors?
R: .	They are very good and our grandmother's nature is so nice that they started saying that don't get discharged only. She stayed there for four months that she become very attached to the doctors
I:	How did you first discover that she had it?
R:	She used to get a lot of cough.
I:	And how did your neighbours react when they learnt she had it.
R: .	They were very good. They did not treat her differently
I:	And after four months she was completely okay?
R: .	Yes
I:	Have you heard in the basti anyone who has TB and is completely ostracized?
R:	We have never gone to anyone's house to see.
I:	So you liked the treatment there?
R:	Yes.
I:	How is regular cough different from TB?
R.	: You get blood also with TB when you cough
I.	So are you particular if someone gets a cough? What do you do?
R:	At our place if you have it for eight days or kids have it for three-four days, we take them to the hospitals and give them medicines.
I:	Children you take in three-four days, and what about elders?
R:	We tell them also to get the medicine anyways, at our place, everything is so sensible that they themselves get treated at our place. We use lot of medicines. When my father-in-law had a heart attack someone told him that if he does certain thing, has his medicines regularly. He won't get another attack so since then he has stopped having tea, he has only black tea since last five years, and used to have lot of garlic or garlic chutney
I:	So after how long was your grandmother diagnosed?
R:	After one month we had shown. There someone said that we should get her admitted in the government hospital, otherwise the doctors also said to get her admitted in the hospital. Otherwise it would spread to other members of the family at home. So we got her admitted and the doctors did not release her for four months.

10.2.2 Findings from Greater Manila

In these interviews, respondents were asked about their awareness of TB, their understanding of its symptoms and causes, and the treatment options. All respondents had heard about TB – and most were able to identify its symptoms as persistent cough with blood in the sputum. However, many did not know TB's causes and thought it was caused by too much drinking and smoking. All respondents knew that TB could be treated, although they were not aware of the specifics. Most said that treatment was available at

the health center. None of the respondents had heard of the DOTS program. Some respondents were not sure that there is stigma associated with TB, while others mentioned that TB patients were avoided because they were contagious. Some respondents knew of TB patients who had lost their jobs due to the illness. Respondents heard about TB from TV, neighbors, the health center or through a family member who contracted the disease. TV and other educational campaigns played a role in raising awareness among slum residents.

Regarding the awareness of TB, slum residents said:

I know the disease TB. I do not know where you get it, but I think if one smokes too much. They say that symptoms include back pains, recurrent difficulty in breathing, coughing and fever. The worse might be vomiting with blood.

Yes, at the health center. Cough that has gotten worse. If your sputum has blood in it. Then you lose weight. And you have cough for more than two weeks.

It scares me because people with TB vomit blood.

I think it is caused by drinking liquor and smoking.

It can be cured. If it's really bad, it's difficult to treat.

Yes, of course. You vomit blood, that's all I know.

They explain it at the health center. There are social workers that conduct door-to-door campaigns about it.

Yes, it's contagious. If someone who has TB coughs, you should stay away. In the past, we had a neighbor in Pasay who had TB. You shouldn't use plates/utensils used by a TB patient. It's like hepa.

They say it's contagious. But it can be cured if there is continuous medication.

The person has a hard/severe cough. It seems like the person has asthma attack. Breathing is difficult. Old and people who are working are prone to get TB. / We just heard it usually from the news. What we see on the news are the people who died.

Yes, I've heard of it already. They tell you about it at the center and you can read about it from the posters there. /, Others find them disgusting, and avoid them because they might be contagious.

Those who have TB lose a lot of weight and then have continuous coughing. Then there's blood and spotting. / They sympathize with them I don't think we have that in our community. We pity those who have TB.

My mother died of it. She already vomited blood. They say it is embarrassing. She was hurt because people seemed disgusted of her.

When one spits blood. Workers usually acquire TB most of the time. I would have had developed TB had not the cough been treated right away. I used to work in construction

and I usually laid down on uncovered floor when I got tired. That how I got it. I eventually coughed up blood. I didn't know it caused TB.

When I hear about the TB, I cringe, because I think this is a contagious disease. But the doctor explained that this is not easily transmitted, and that is not really a frightening disease. You cough all the time, have very low resistance. Those people who smoke are prone to TB. And you also get this when your back perspires and you dry this up with electric fan.

Yes, but I have not heard about that lately. I am afraid about that, because it is a difficult, serious illness. I have heard a person vomits blood if he/she has TB... It is curable, if it treated immediately or treated at an early stage... We just hear it usually from the news. What we see on the news are the people who died.

10.3 Dengue Fever

Only in greater Manila was dengue fever covered in interviews with slum residents. Respondents were asked if they had heard of dengue fever. If their answer was “yes,” they were then asked about their knowledge of the causes and symptoms of dengue. Almost all respondents had heard of dengue, and most were aware that it can be transmitted by mosquito bites. Most were also aware that high fever is a symptom. Some respondents knew of neighbors or family members who had died from dengue fever. Respondents heard about dengue from TV, neighbors and the health center. As with tuberculosis, it is clear that TV and other educational campaigns have raised awareness about this disease among slum residents.

Regarding awareness of dengue fever, slum residents stated:

Yes, I've heard of that. It's from mosquitoes coming from stagnant water.

Yes, from mosquitoes. Mosquito bites. That's all I know. I heard from the news on TV.

It is usually in the news and in the papers. There is a fever first then it worsens.

Yes, from mosquito bites. The health center conducts seminars about it.

Yes. It is caused by mosquito bites. It's so easy to catch dengue because there are mosquitoes everywhere, even here. I learned that from the doctor.

Yes, dengue is fatal. I learned on TV.

Yes, it can lead to death. We've heard a lot of stories of death because of that disease.

Someone once gave out pamphlets about dengue. It said that (the child has) dengue when there's nosebleed and when you give aspirin, rashes come out.

It can be avoided if people are responsible and clean up the surroundings.

Yes, I have heard about dengue. On TV, also my neighbor in Mindanao. I thought it was really dangerous because we're talking mosquitoes. They said with dengue, the mosquitoes come out at certain hours of the day, I think morning and afternoon. In a day, I think two hours? Is that 6 o'clock and 4 o'clock? We have a neighbor, a

teenager/adolescent. He was bitten by a mosquito, he said. He doesn't know what part of his body. Then he felt weak, and was trembling/shaking. He was brought to the hospital. The ultrasound results show it was dengue. He lost some blood. So they asked his friends for blood donation, but were not qualified because they always slept late.

I imagine that mosquitoes would come here. I also learned about dengue fever in the commercials and news on TV. Before, the houses were sprayed (to exterminate the mosquitoes). I hope it will be done every three months because I think mosquitoes would come back. They will not totally vanish anyway.

The common ailments here are bronchitis, diarrhea. For children, diarrhea, dengue fever is also common here these days. For the elderly, cough, influenza, that's the usual.

11. Profiles of Slum Residents

This chapter provides profiles of four slum residents – two in Indore, India and two in greater Manila, Philippines. These will provide a flavor of the types of discussions carried out during the in-depth qualitative interviews and act as an account of the lives of these slum residents. To protect their privacy and identity, respondents' real names are not used.

11.1 India

CASE 1 – PRIYA

Priya is a 25-year-old belonging to the Balai caste. She lives in the Annapurna Thana slum with her husband and three children. Her eldest son is seven years old, followed by another who is four. The youngest child is a girl just seven months old. She and her children live with her husband, who works as a rickshaw driver. His income is not stable, so to add to the family's income she has just begun working as domestic help. Her husband earns about Rs. 2000 a month, while Priya manages to earn about Rs. 500 or 600. However, this income is not sufficient. Most of it is spent by her husband on alcohol. In fact, he sometimes takes money from her specifically for this purpose.

They moved from Ratlam to Annapurna Thana about five or six months ago. Prior to that, they were living with Priya's in-laws in Ratlam. Her mother-in-law stated that Priya's husband drank too much and did not contribute to the family income; instead, he depended on them for feeding him and his family. Her in-laws asked them to set up a separate household and they moved to Indore. Since arriving, however, his drinking only increased and became worse without a job. In addition, their expenditures included rent for their hutment, food and medicines for their youngest child.

If Priya is unable to pay for food, she buys on credit and pays later. They have never taken a formal loan from anyone, though she sometimes borrows small amounts (Rs. 50 to Rs. 100) from her parents to tide her over in an immediate crisis. Recently, she has had to sell her toe rings and earrings. Her husband did not have work and she had just begun her new employment, so there was no way of getting enough money for food. They do not have a ration card since they have only recently moved here.

Their daily meals comprise of roti and daal or vegetables. Occasionally, if Priya is very tired, they have rice instead of roti because it is faster and easier to make. Water for drinking and other purposes is filled from the hand pump or from the community tap when there is running water every third day. They don't pay for the water. Priya uses the toilet complex within a nearby temple, while the children have no designated space. They simply find an empty spot and defecate there.

According to Priya, their move to this particular slum has been an advantage for two reasons. She is closer to her parents whom she can turn to for support. And secondly, there is no danger of anyone beating her children. Earlier, her mother-in-law was very strict with them and didn't hesitate to hit them. She also taunted Priya about her husband's drinking and his inability to earn.

Priya seems to enjoy the independence the move has given her. There are several small decisions she can make by herself, though for the bigger ones she has to consult her husband and get his consent. For example, she makes decisions with regard to cooking and food. She can also buy a sari for herself. But her husband makes all decisions involving a big purchase, selling jewelry or leaving the house for a visit to relatives. She also does not need to give him accounts of everything. In their previous home, Priya had to ask her mother-in-law about everything.

In this family, if someone falls ill they rest for a couple of days to see if they get better by themselves. During this time, pills from the local chemist store are procured by explaining the problem to him. If the illness persists, then the person is taken to a doctor. No particular home remedies are used, since no one in the family has any knowledge of them.

Since her child is small, Priya has made an arrangement with a private doctor who comes to their house if they call him. He charges Rs. 100 per visit, but she feels his treatment is very effective and he is always available. According to Priya, even if a telephone call is made late in the night, he comes. He may charge extra, but he would still come. Another reason for preferring his treatment was that his medicine works quickly. She told of an incident where her child had been very ill and she sent for the doctor. He put him on a drip and the child was fine by the next day. Since then, her faith in the doctor has greatly increased. There is another private doctor from Ratlam to whom people go, but he charges very high fees -- about Rs. 500. In cases of serious illness, people also go to the hospital.

If there is no one else to go with her to a doctor, Priya feels confident in going alone. The advantage of having another person is that they can also help to articulate the problem and listen to the doctor's instructions.

Priya feels that the main problem in the basti is men's liquor consumption. She sees this as both a health and a social problem. People drink and fight in the basti and create a ruckus in their homes. From seven in the evening to late in the night, the men drink and create havoc. Though her husband does not physically abuse her, he demands hot food at odd hours whenever he comes back drunk. She says that her father is worse. He verbally and physically abuses her mother and makes her massage his feet till he falls asleep, even if she is very tired. She firmly says that she will not allow her husband to make such demands of her and fervently wishes that her father would change.

The other problem she expresses is that men do not have respect for women in the basti. They treat them like animals, forcing them to work hard and making unfair demands of them.

Priya does not remember having any miscarriages or using temporary methods of contraception. The only time she used contraception was when she was sterilized. This was the last time she went to a hospital, about six months before the interview. It was the main district hospital. She was keen on having the operation since she was sure she did not want any more children. She already had two sons and a daughter, and her family members -- including her husband and in-laws -- agreed. She was referred to this hospital by a lady doctor at Rajinder Nagar who examined her. After giving her a couple of injections, she sent her to this hospital with a nurse. Priya was unconscious most of the time and was not able to remember the experience very clearly. The lady doctor had explained that after the operation she should take as much rest as possible, and avoid sexual relations and strenuous work. Additionally, she was advised to avoid eating sour things, especially brinjal, but to be sure to eat spinach and daal (pulses). Before she was discharged, they gave her a bottle of Revital (vitamin tonic) and Rs. 200, of which she spent Rs. 100 on travel in a rickshaw to and from the hospital. So far, she has not had any complications and carefully followed the doctor's advice of taking rest. It is only recently, after three months of rest that she began to work.

Priya's oldest son, who is now seven, was delivered at home in Ratlam by a dai, with the help of her mother-in-law. The dai massaged her back the entire night and had given her moral support as she spoke to her through the labor pains. She remembers that the house had been freshly plastered and it was very clean. In fact, she definitely prefers having children at home to going to the hospital.

For the delivery of her daughter, however, Priya had gone to a hospital – proving to be a complete contrast to her experience of having a delivery at home. Priya had regular check-ups during this pregnancy and taken injections (for tetanus, she recalls). She wanted her delivery to be carried out at home, but they insisted it was safer at the hospital. She recalled being alone in the hospital, as her mother-in-law and husband were made to wait outside. The hospital attendants were very rude and kept asking her to walk around if she felt uncomfortable. No one was there to reassure her or give moral support in her pain. She felt miserable and missed her parents and at the time wished she would die.

In the basti, some women went to the hospital while most others had their deliveries at home. Priya felt that due to the hard work women did, they were better able to bear the pain of childbirth. Also, a special concoction prepared for pregnant women helps soothe the muscles. *Plus*, when they have deliveries at home the dai is present throughout. There are three dais in the basti but sometimes all are busy and can not come. In this situation, the only option is to go to the hospital. This is more expensive and Priya believes that the money would be better spent on getting decent food for the mother.

After her deliveries, Priya has been able to rest for about 45 days without doing any work. She pointed out that this was a custom and women were not even supposed to cook in the postpartum period. It is believed that if the mother goes out of the house or works, the baby would get a bad stomach indicated by the color of its stool changing to yellow or green. Therefore, the mother was supposed to devote her time to caring for the baby and attending to its needs. Priya is not certain if other people of their community also follow this practice, but this was the routine she followed after each delivery.

Priya's work has also given her some mobility and confidence. Though she realizes her income will probably all go to feeding the family, she still hopes to put away some money for her children's education. She has decided not to tell her husband how many houses she is working in, so that he will not be able to seize the additional income she plans to save. She has had no formal education but is keen that her children go to school. However, at this point their economic condition does not allow for this. Priya also hopes she will have enough money later to make her own hut in front of her parent's house.

CASE 2 – MENA

Mena belongs to the Marathi Maang community and is the mother of five children – three girls and two boys. They live in Chandra Prabhat slum in a small jhuggi with walls made of cardboard and plastic sheets for a roof. Mena hopes to strengthen the walls by layering them with mud. The household gets water from one of the public taps in the slum or a borewell located some distance away. She uses the toilet in the complex where she pays Rs. 2 per visit, while the children simply use the river. This is what most women and children in the slum do. Garbage is disposed of in the river, as there is no other place to put it. Mena cleans the containers used for storing the family's drinking water. Food is cooked on the stove, though she hopes to get herself a gas stove. The initial investment is high but a gas stove is more convenient and economical.

Mena is not sure exactly how old she is. She was born in the slum and the only time she left the basti was when she married a musician in her family's village in Maharashtra. In that village, they had some land and her husband earned money by playing at weddings. For some time Mena's family prospered in the village. Mena recalls having everything she needed at that time. Eventually, though, the family had to move from Maharashtra to Indore because a food crisis hit the village. Her husband took to drinking, sold

their land and left his band, leaving the family with nothing to survive on. Others in the village also began to leave and the inhabitants are now scattered all over.

Mena's other four children were born after they moved to Indore. Mena is the sole earner and has five children, one of whom is under five years. She feels that if she had lived with her parents on her own, she might have been able to do better. Previously, Mena worked at a hostel as a cook. Her income was Rs. 1000 and regular, but she had to leave to look after her children who were very young at the time. She still hopes to find a similar job and has told her mother to look out for one. These days, her primary income is from rag picking. Since this does not earn enough, she supplements her income by working as domestic help. She earns about Rs. 50-100 a day. Her older son, who is around 12 or 13, works at a hotel and gets about Rs. 150 per week. Between the two, they only just manage to meet the household expenses. Almost all the income is spent on food for the family and it often falls short. There are several days with no money even for tea in the morning. On such days, small amounts of Rs. 20 to 50 are borrowed from neighbors and well-wishers. This is borrowed for two or three days to weather the crisis before the money is returned.

Mena likes her basti because she is familiar with it. Though people don't always come forward to help, they do support each other in times of grief or crisis. Though they do not intervene in domestic fights, they band together if there are disputes with someone from outside.

All Mena's children were delivered at home. Mena is thankful that she has never had to go to a hospital and feels it is divine reward for not harming anyone. While speaking about her delivery, Mena states she had gotten herself checked once when she first conceived but there was no time to go to the hospital for delivery. People spend a lot of money in hospitals, she believes. Mena knows of people who spent Rs. 15,000-20,000 on hospitals for delivery. She does not remember having any complications during her delivery or miscarriages.

Mena never really considered having fewer children than she does. Just after her marriage, she and her husband felt well off, with a constant income from farming and her husband's band, and they felt ready to build a family. (But now, even if she were to return to the village, it would be difficult because wages are low and the work is hard. There she would get about Rs. 30 a day in the field. Also, looking after the children would be difficult. Here, for the same amount of work, she can earn Rs. 100.) After her youngest daughter was born, Mena got sterilized. But she feels that the operation didn't suit her and had an adverse affect on her health and she has grown thinner.

Recently, Mena had to take a larger loan of Rs. 500 to pay her debt, buy food and purchase medicine for her younger son, whose medications cost Rs. 100. When there is not enough money even for food, Mena wonders where she can find the money for these medicines. The doctor has told her to take her son to a hospital, but without money how can she? She doesn't know what is wrong with her son. As soon as he gets a fever, he starts convulsing. His medicines cost Rs. 30 per tablet but she lost the prescription during the floods and then could not return to the doctor because there was no money. Several of her papers were lost in the floods. Mena simply hopes her son would not fall ill. But when he did become unwell, she had to spend more than Rs. 1000 on him. She sold several things in the house to raise the money. Most recently, only a week before the interview, she was forced to sell the iron door to the house. She had bought it for Rs. 200, she remembers, but could sell it only for Rs. 90 in the kalali, to the bhangarwala. A couple of weeks before that, Mena sold her fan – she saw no reason to keep it considering the condition of her house. She still has some steel utensils, but she says that one of these days it will be their turn to be sold.

Mena never had much jewelry. If she had come from a richer family, she might have had some. The two small gold beads she had in her mangalsutra were taken by her mother-in-law. She also took back the

anklets that Mena had worn in the wedding. Whatever else Mena may have had was sold to look after the household expenses. Now the only piece of jewelry she has is of brass, which she wears in her neck as a symbol of marriage.

Mena's husband left some time ago, but when the floods came, he made an appearance to claim flood relief compensation. She did not want to give him any money, but since the compensation came in his name, he took it. She may not have had to sell the household items if they had gotten the relief. When the husband comes, Mena looks after him because there is at least a chance that he may help with their situation. But the husband always takes to drink, and in that state there is nothing that can be done. She feels that he has probably found another woman and that's why he doesn't come here. She doesn't follow him nor does she ask him to stay; her only concern now are her children and she is determined to remain with them.

The only big fight Mena ever had was with her husband, when he drank and came back with no money. Soon she had to earn to feed herself and the children because he would not give them any money. He would come back drunk in the night and begin to verbally abuse her, cursing and swearing. This became a regular affair and they began to fight almost every day -- with physical abuse, such as hitting and beating, a part of these fights. Mena became sick and thin trying to run the household and bear these fights. She would climb onto the tin roof to escape. One day when he came back drunk and looking for her, she swore at him and threw stones and bricks from the roof. He went inside to hide and she challenged him to try and touch her again. One time, he got hurt and went to the police station. When they asked who hit him he told them it was his wife. If he had said anything else, she would have hit him more she says. What could the police say, asks Mena? Could anyone dare say anything when he hadn't even given the family food and spent all the money on alcohol? Once, when her husband had married a second time, Mena went to the police station and complained and eventually he had to leave her after giving her some money.

Now, however, Mena doesn't care what her husband does. She feels it is good he has left. Otherwise, every day there would be a fight with begging, crying and pleading. She told him several times to stop drinking, that they could go back to the village and start afresh. But he couldn't let go of the alcohol. She even offered to earn for the household if he felt burdened, as long as he gave up the alcohol. But he did not agree.

Alcohol is a big problem in Mena's basti. When men get drunk, they create so much noise and havoc, and fight outside and inside the house. Mena never goes near anyone who is drunk, even if she knows them. Speaking of one such neighbor, she says people become unreliable and unpredictable. Some women also drink, usually old women who work in cleaning drains and canals, but no "good" woman drinks. Women who are young and have husbands, don't drink. "Do you think that if they drank their husbands would keep them in the house?" Mena asks. "That is how it is in our society. No one would keep a drunken woman in the house." Once, Mena admits, she drank alcohol on her husband's insistence. Her stomach was hurting so he told her to have some. She got high and somehow burnt the house down. Her mother-in-law was very angry and scolded her husband, she even hit him for getting Mena drunk that day. But now her in-laws have become old and are in no position to say anything to their son.

When there is a fight in the house, nobody comes to help, Mena relates sadly. The neighbors think this is interference in a private matter. She feels that if there is a fight between husband and wife, people should intervene. If two or three people came and spoke sensibly, it would avoid a lot of trouble for the family, but that hardly ever happens. People feel that it is between the two of them. She had to mobilize people to keep her husband's abuse in check. Several times, she also went to the police station to complain and even got him arrested. But his relatives got him released.

Mena is happy that her husband is far away, but she does not wish him dead. A widow's life is something she is afraid of. Society does not view widows with much respect. People are very interested in whom a widow meets, how she dresses and what she does. If a woman without a husband lives well and remains beautiful, people say she has no remorse about losing a husband. She surely must be doing some bad things to be able to live like this. Therefore, it is better to look sad and dirty to avoid this talk. It does not take any money to be neat and clean like she did in her mother's house but to avoid unnecessary attention and talk she chooses not to. She takes care to wash her hands with detergent cake because she handles garbage and rags but does not pay much attention to her clothes.

Mena suffered from frequent headaches and when she went to a doctor, they realized there was a problem with her eyes. The treatment cost Rs. 200 but she could only spend Rs. 70. She hasn't returned to the doctor since. Her eyes water but her tears have dried. Nothing affects her anymore, she feels. If someone abuses her badly then maybe the tears would come, but even at a funeral she doesn't break down. She doesn't feel hungry the entire day or sleepy. Sometimes she works through the night and still doesn't feel sleepy. Her hands and feet tremble and she is sometimes not able to stand or work during the day. Thoughts about how, what and when she will be able to feed her children and what will become of them haunt her. She feels very tired and her waist, back, hands and legs hurt, but only during the day. She feels fine in the evenings so she works then. She says that the other women feel she has a witch and evil spirits inside her. They avoid going to her house and has become quite lonely.

According to Mena, health services in the basti are not very good. Even though there is a person who comes to the basti, the visits are not very regular. Children and women sometimes use these services when available. One of the children had an allergic reaction to a medicine and his eyes and face swelled up. Mena explains that the medicines had gotten soaked in the floods and were very old -- that was the reason for the reaction. Since then, however, people are very wary of the medicines given at the local public dispensary. She has also stopped giving medicines to her younger son who is seven, though she is very worried about him. Sometimes she takes the children to the charitable hospital, Choithram, but the expenses for treatment are over Rs. 2000. She borrowed Rs. 3000 from her mother so she could pay for the treatment. She admits that his ill health is a major cause of concern and stress for her. Less than six months ago, he had fever again, accompanied by convulsions and froth at the mouth. The doctor told her to take him Shegaon but she couldn't afford it. She feels that no one, including the doctors, is able to understand the reason for his convulsions. Since there is not enough money, Mena can't make any special food for her son – he doesn't even eat the daal, roti and occasional vegetables that are cooked. Sometimes, if she gives him a rupee or two, he buys and eats toast or cream roll. There is a clearly established linkage between good nutrition, health and illness in her mind. Because of his diet, he has lost weight and is more susceptible to illness, she explains. This constant worry has affected her more than her husband or money.

According to Mena, if someone falls ill people usually wait a couple of days to see if they get better or need medical attention. They usually procure medicines from the chemist during this time. The chemist gives tablets for fever, loose motions, etc. For children the medicine costs a rupee, for adults it costs three rupees. The cost obviously changes depending on the complaint. She doesn't know any home remedies and no one is treated at home. The chemist is the first resort in times of illness. If the problem persists, then a private doctor in Ranipura is approached. If there is still no relief, then people go to the private hospital, Arpan, in the vicinity. People feel the treatment given by the private doctor is effective. If he just examines the patient then he charges Rs. 20, if he administers an injection he charges Rs. 50-70. Even though this is expensive, people are willing to pay because they feel he is accessible and they get better with his medicines. Mena's parents usually take her son to the hospital when he falls ill. She doesn't understand what they say there and feels disoriented.

At this point, Mena's parents are the only social support she has. Since her husband left, she does not feel the need to run a separate kitchen. The food is cooked in her mother's kitchen along with that of the other family members. Every day about two kgs. of wheat is used for rotis. It costs Rs. 11 per kg. Since she doesn't have a ration card, everything is purchased at market prices. Though she tried to make her ration card once, she was unable to. Vegetables such as brinjal, spinach, etc. are cooked with the rotis. Fuel wood costs Rs. 8 and is used everyday. Tea and sugar add to this expense. All the food is bought with all the cash she earns in a day, thus leaving Mena unable to save for the future.

11.2 Philippines

CASE 1 – LINDA

"I don't want any pricking, just pills."

Linda is a 24-year-old homemaker and mother of four. She lives with her family and mother-in-law in Kaingin 1, a slum area in Quezon City. Their house, which consists of one room, is constructed from galvanized iron roofing, plywood walls and cement flooring. The whole house is approximately eight square meters.

At 24, Linda has already given birth five times, with four of the children still living. Her numerous pregnancies and responsibilities for taking care of her children, aged 0 to 5, have left her weak and fatigued. She knows she must work to feed her children – although at present she is jobless, as she wants to personally take care of her children.

Her husband has irregular work at best– and there are times when he does not work at all. He has work if someone hires him. But if there is no work, he bums around. On the other hand, even if Linda is at home she still earns. If someone comes over to their house for a haircut, she would charge ten pesos to those whom she personally knows. This becomes a source of income for her family.

"Salary is not enough, if I can only sell my husband."

The income they have now is not enough, especially since there are more mouths to feed. Even if there is an extra P20.00, this is not enough. At times, when she does not have any money, she borrows P10.00 from her neighbor to give to her children. She rationalizes that she would rather borrow money than see her children beg P1.00 to buy food. She laments that "I would be ashamed if my children ask for alms from other people, like asking for P1.00 or for coins." She usually borrows money from her husband's cousin. She would like to pawn things but, unfortunately, there is nothing to pawn. When she is unlucky and cannot find anybody to lend her money, she just sulks so she won't disturb others. Sometimes she thinks ridiculous thoughts like selling her husband, although she is quick to take that thought back. She believes that if this happens, nobody will take good care of them.

"Sometimes, I tell God if He can spare my child from sickness."

Linda resorts to the traditional healer when a family member has a sprain (pilay) or fever (lagnat). Sometimes, she would bring her children to the Health Center in Pansol proper (near Kaingin) to ask for a second opinion to make sure the doctor checks her children when they have fever. The mere thought of her children getting sick is not easy for her. She tells God to spare her child from sickness. She will not mind if she gets sick, although she feels uneasy or unstable. She feels like she also has a headache and body pains when her children are sick.

"My initial plan was to have only four children, but now they're five and one died."

According to Linda, she wanted to have only four children and her husband wanted only two, but they ended up with five. Unfortunately, one of her children died and that was a painful experience for her. She has already told her husband they should not have more children since life is hard nowadays. There are times when they do not have anything to eat, especially when her husband does not have any work. She pities her children because she knows they will suffer. She insisted to her husband the need to control the number of children.

Linda says that she does not want to get pregnant again but every time another child is born, she cannot deny the reality that her child is there. She pities herself and her children and is looking for any suggestion on contraceptives to use. She also thinks there are other women who know something about family planning, just like her. But she only knows about the pills. She has heard the IUD is a small object that is inserted in the woman's vagina. She thinks that either women are not taught about this or do not want to be taught about family planning. She also feels that men should be informed about family planning, too. She feels that it is unfair for women to just spread their legs all the time, as she is afraid of what might happen to the children when proper spacing is not observed. It is important that both she and her husband be concerned and decide on the issue.

"I don't want any pricking, just pills."

Linda does not like what she hears about tubal ligation and the IUD. She prefers to take the pills since she is afraid of ligation. As a woman, she worries about undergoing that kind of birth control procedure because she does the household chores. People have told her that when a woman undergoes ligation, she cannot lift heavy things nor can she freely move around. For Linda, this can not be since she has much to do in the house.

Food taboos and work prohibition

Linda has never given birth in the hospital, although all her check-ups and prenatal care were done at the Center. Unlike other mothers, she did not have a chance to see how a baby looked while inside the womb. When she was pregnant, she avoided lifting heavy objects because the baby might be aborted. She also believed that a woman who has just given birth must not move around much. She should rest in bed and the husband should take care of her. Right after giving birth, a woman should eat "tulingan," a kind of bloody fish, because it will cause bleeding. At the same time, she must also not eat "tambakol" because it has a foul smell. The woman should only take soup, so there will be enough milk for breastfeeding. Until now, according to Linda, many women share this belief.

Mefenamic for bleeding

Linda remembers that one time, after giving birth, she took mefenamic. She thought and believed that this mefenamic was for bleeding, although there is an alternative medicine that can be taken. These are the roots of certain plants that are boiled and drank for better blood circulation. This is called "pamughat" in their province.

"Abortion is not right, it's a sin."

Even though Linda has four children, and even if they do not have enough money to buy food and nice things, she does not think that abortion is the best alternative to control the number of children. She considers abortion a sin. She believes the woman must take responsibility for her actions because that child was given to her. She says women should not commit abortion in any way because it is the woman who suffers and is most affected in the end.

CASE 2 – NENE

Nene is a 30-year-old Tagalog speaker who lives in Kaingin, a slum area in Quezon City. She is a high school graduate and mother of five children. Her eldest child is in Grade 5. Of her five children, two are still below age five. There is a nuclear family. Their house, which is about nine square meters, has a galvanized iron roof and is constructed of hollow blocks and plywood walls with a cement floor. Their toilet is what is called the “de-buhos” or water sealed type.

Nene’s family has lived in Kaingin for the ten to fifteen years and will continue to stay as long as they can. They are concerned about an on-going dispute they are having with another claimant to the area. Nene is not sure what will happen because they are still fighting for their rights over the place. According to her, they cannot be evicted because most have been staying in Kaingin for a very long time.

Nene’s husband is the only one who is working, although his contract with the Metropolitan Waterworks and Sewerage System (MWSS) has just ended. He now works as a plumber.

“I have body pains, I think about how difficult life is.”

At present, their income is sufficient to buy food for everybody in the family and provide an allowance for the children who attend school. To make ends meet, though, Nene must budget tightly and juggle expenses. She sometimes borrows money from her aunt who understands if she cannot repay her debt on time. Nene says she could borrow money from many people but does not like to borrow unless they are relatives. She is afraid she cannot pay and might forever be indebted. There are times when they have to bear and suffer hunger when her husband does not leave money for food when he goes to work. Sometimes her mother-in-law gives them food. If Nene is not able to find money to buy food, she just cries because she feels there is nothing she can do. She laments, “ang hirap talaga ng buhay, ang sakit sa katawan” [Life is very difficult, it gives me a lot of body pains or head ache {euphemism)].

Mother’s class on family planning

Nene is very active in the neighborhood activities. She attends the Mother’s Class, a seminar for women (especially mothers), organized by the Parish of Dela Strada in the adjacent and somewhat more affluent barangay. This class has given her an awareness of family planning and nutrition. She is also a member of the neighborhood association that engages in livelihood activities such as sewing and embroidery. Nene’s knowledge of family planning and nutrition from the Mother’s Class was complemented by her own mother’s lessons. She learned from her mother how to take care of her nine siblings, as she was second born.

Sickness in children

In the past, it was quite easy if someone in her family was sick since her husband was working and they could consult the doctor with the help of PhilHealth (health insurance through MWSS). Nene cannot remember the name of the hospital but she is sure she has used PhilHealth to pay the hospital bills. After her husband’s contract with MWSS ended, though, they no longer enjoyed this privilege. She had to pawn her necklace when one of her children had amoebiasis. Another time, she went to her mother-in-law and asked for money to cover a health need. Since she discovered that the University of the Philippines (UP) has a health service that gives free medical check-ups and medicine, she and her children have gone there. They just need to go early and wait patiently. Nene has also stored some of the medicines she received from the UP Health Service and from the Health Center for emergency purposes; particularly the medicines for cough and fever.

“When my children are sick I usually consult the “hilot” (traditional healer) and to be sure the doctors.”

Sometimes Nene consults the traditional healer for a sprain and has it massaged. She is advised not to have her body exposed to the wind, because of the danger of “cold” or “nalamigan.” According to her, the traditional healer’s services are okay. She adds that if her child perspires after the massage, she is going to be okay. Usually the “hilot” advises her not to bathe the child, otherwise the child will have “body aches.” The traditional healer does not usually give medicine. Instead, for 20 pesos the traditional healer will use an ointment to massage the body.

Nene admits that she first goes to the traditional healer or “hilot” for treatment of a possible sprain, and then, just to be sure, she goes to the doctor. This also happens when her child has phlegm or high fever, as she fears that the child might have spasms or convulsion.

Prenatal in the health center but deliveries at home

Nene usually goes to the health center for prenatal care consultations. For giving birth, she consults the traditional birth attendant and the midwife. According to her, the midwife and the “hilot” (birth attendant) will take care of her and her child more than the people at the center will. The midwife and the “hilot” assisted in bathing her and her child, even after the delivery. They also administered the BCG vaccine to her child.

I am scared of dehydration

Nene is scared of diarrhea and dehydration. She was traumatized when her landlord’s child died in the hospital due to dehydration. According to her, when that incident happened she told them to remove the diaper so they can check the feces to see if it was watery. They did not do it, so the child died of dehydration. Nene is very conscious of this so at the onset of diarrhea in her own children, she gives the child Oresol or hydrite solution. She says that the hydrite solution is good because it will help replace the body’s fluids. It takes just one tablet and one liter of boiled water to make this solution. She also prohibits her children from eating oily foods, and “latondan” or bananas. “The child can eat bread or rice porridge but not oily foods,” she explains.

There are frequent quarrels if the husband has vices

In the slum, quarrels are frequent between husband and wife, especially when the husband has vices and beats up his wife. Nene’s advice to the wife would be to keep away from the husband, since women have no defense -- especially if the man is under the influence of alcohol. If the husband is an alcoholic, then the money for food is instead spent on alcohol. Nene believes there might be times when violence is inescapable, as when the husband cannot control himself and beats up his wife for nagging. Sometimes she thinks others should intervene and counsel the couple. They could even advise the couple to talk things over and refrain from violence. Her advice is for the wife to wait until the husband is no longer under the influence of alcohol before she addresses his violent behavior. If the couple cannot resolve things between them, Nene believes they should seek the help of the barangay officials. The couple should try to settle things first for the sake of their children. However, some couples, according to Nene, are not concerned about how their violent behavior may affect their family’s welfare.

All Nene’s children have complete immunization such as BCG and DPT. They also have had vaccinations against Hepatitis and Measles, as well as booster shots. Nene knows that DPT is for Diphtheria, which can kill if the pus spreads in the throat. This immunization was administered when her baby was just one or two weeks old.

Nene has an immunization card from the Health Center in Pansol proper. This card indicates the number of vaccines each child has received so far. It also contains the schedule for the next vaccination. The midwife or the nurse makes the entries. At the back of the card is information on proper care of the teeth, breastfeeding and proper diet for a pregnant mother. Nene said that they pay ten pesos for the card.

Nene gets her water supply from her husband's aunt who has a water connection from MWSS, the water provider in their area. They resort to this because they do not have their own water meter. She pays P100 to partly defray the cost of the monthly water bill. While Nene says that the water supply is clean, she boils the water just to be safe, especially for their drinking needs and for the children. There are times, though, when MWSS has to fix some water connections which results in no water at all. Usually, the company makes early announcements in the community so they can store water before the temporary disruption happens.

In cases when they are not able to store water and there is no water to wash their hands, they use alcohol instead. She also explained that children have to be constantly reminded to always wash their hands since they play a lot. Nobody knows what sorts of things they touch and what germs are on those things.

12. Recommendations

Through in-depth qualitative interviews with urban slum residents and health care providers, supplemented with material of a more quantitative nature from the DHS and other survey data, this study has sought to understand the health-seeking behavior and health needs of the urban poor in India and the Philippines. The findings that have emerged from this analysis provide the basis for a set of recommendations (presented below) to improve the health needs of slum residents. These recommendations are derived from our research on specific slums in Indore and greater Manila, but we believe they are likely to be of broader relevance.

Before presenting our recommendations, it is important to restate the obvious: poverty itself is a fundamental determinant of the health-seeking behavior of the urban poor, especially given that the urban health system is highly monetized. Targeted programs for poverty reduction – employment generation, workfare, education and secure land tenure – could do much to improve health. Such interventions lie beyond the scope of this report, but the health benefits that could stem from them must not be overlooked.

We organize our recommendations into three sets. The first of these has to do with concerns affecting the urban health system as a whole, which would need to be addressed in a system-wide manner. The second set is more “place-based” in nature, leading to consideration of interventions that could be put into effect and evaluated on a community-by-community basis. The third set of recommendations is focused on the survey programs that gather much of what is known about urban and rural health conditions in poor countries.

12.1 Interventions at the Urban Health System Level

- ▲ **Improve provider-patient communication.** The difficulties providers face in conveying basic health information to the urban poor patients have not been fully appreciated. Our interviews with providers revealed their serious concerns and frustrations in failing to effectively communicate with their poor patients. Interventions in this area could involve training sessions in which providers are taught how to apply creative communication strategies in working with the urban poor, and senior mentors demonstrate how such techniques can be applied. The training should also stress the use of non-technical visual aids in discussions with the urban--several providers we interviewed identified this as a need. It is important that materials being used be designed specifically for urban settings. In the Philippines, the sensitive and empathetic communication strategies employed by treatment partners in the DOTS program might provide models of care that are relevant across the urban health system.
- ▲ **Assess use of health-care subsidies for the urban poor.** We have found the arrangements for subsidizing the money costs of health care for the urban poor (through the current system of supply-side subsidies) to be unsystematic and it is doubtful that when all costs borne by the poor are taken into account, the poor in fact receive any net subsidies. A careful accounting of the full time, money and informational costs current subsidy arrangements impose upon the poor is much needed. In the Philippines, local government units (LGUs) are responsible for much provision of health services, and here we would recommend working

with the LGUs to understand how they allocate resources and implement subsidies for the urban poor.

- ▲ **Explore and pilot-test alternative health financing schemes.** Embedded in a health system that is highly monetized by comparison with the rural system, the urban poor lack the cash they need to pay for care, even in public-sector facilities. Poverty and the lack of ready cash often prevent the poor from completing treatment and receiving much-needed follow-up care. More effective subsidies for the urban poor can range from demand-side subsidies in the form of vouchers for specific medicines or treatment services; community-based health financing schemes might also be considered; and attention should be given to developing partnerships with the private sector to provide reduced-price medicines and services. There are many existing programs of this sort in India, the Philippines and elsewhere, although these are often aimed at rural rather than urban populations. For example, the Janani Suraksha Yojana scheme in India targets both rural and urban women in below-poverty-line (BPL) families and provides cash assistance/reimbursement tied to a safe motherhood package of services, including institutional deliveries. Community-based health financing schemes have also been gaining in popularity, with urban examples such as in the Payatas slum of Manila. We recommend assessing the extent to which such existing financing programs effectively address the health needs of the urban poor and, from this assessment, drawing lessons on best practice that can be used to design financing interventions to effectively target the urban poor.
- ▲ **Improve availability of medicines and supplies in public health centers in Greater Manila.** Frequent stock-outs of medicines and supplies afflict the public sector of the urban health care system, and increase the time and money costs of health care for the urban poor, many of whom must rely on the public sector. Our interviews with slum residents in greater Manila found stock-outs to be of particular concern there, where the poor rely heavily on the public health centers. The interviews revealed that the slum residents know that the health centers are meant to provide free medicines but they are aware that when the need for medicines and supplies arises, the centers will not necessarily have them on hand. An intervention in this area would have to address the broader systemic problem of drug and supply stock-outs in the health centers. In the Philippines particularly, we recommend working closely with LGUs and public health providers to address this issue.

12.2 Community-level Interventions

Improve health education and awareness among slum residents. Education and behavioral change campaigns are common recommendations for health interventions with the poor, and these are very much applicable in slum communities, whose residents often resemble rural villagers in terms of levels of health knowledge and behavior. We recommend three areas of focus: (1) campaigns targeted at and involving men; (2) campaigns addressing proper use of medications; and (3) creative campaigns to improve home management of common diseases. With respect to (1), women respondents in our study slums voiced the need for men to be more aware and involved in family planning and reproductive health (FP/RH) decisions. Some men seconded this concern, saying that FP/RH awareness campaigns are targeted at women and men have little opportunity to learn about these issues. Other campaigns could also raise issues of alcohol abuse and domestic violence on the part of men, which are daily concerns in the slums where we conducted our interviews. Regarding point (2), given the clear pattern of self-medication in both countries, education campaigns should be undertaken to encourage proper use of over-the-counter medicines, antibiotics and injectables. In the Philippines, the interviews suggested that the residents often respondents use old prescriptions, particularly for antibiotics – there is a clear need for education about

how such medicines function. In India, interviews suggest that the poor are overly concerned with injections and drips, even when these interventions would not be indicated by good medical practice. Again, education should allow more informed decisions by the urban poor. On point (3), creative approaches are needed to capture the attention of slum residents with respect to disease management. The Private Sector Partnerships for Better Health (PSP-One) project in India is working with celebrities and private sector partners on a diarrhea management program. The ‘Saathi Bachpan Ke’ or ‘Partners in Childhood’ program organizes creative road shows, house-to-house detailing and other approaches to reach the poor. These approaches should be explored further, pilot-tested and evaluated for effectiveness.

Provide basic health training to traditional healers and slum leaders, and mobilize community health workers. Our interviews find that traditional healers are important figures in urban slums, much as they are in rural villages. These health providers would benefit from—and on their part would appear to welcome—programs of training that improve their medical knowledge, clarify the limits of traditional care and encourage positive interactions with the formal health care system. Likewise, slum community leaders—who serve as the interface between their poor constituents and the broader urban political, bureaucratic, and health systems—would benefit from an appropriately focused health training program, so that they can more effectively give voice to the health concerns of their communities. The issues covered in such training could range from FP/RH and child health to TB and could address domestic violence and alcohol abuse. In addition, slum residents in our interviews expressed the need for more local attention on the part of health workers—slum women would clearly prefer to be served inside their community or through home visits. It would be important to design outreach or satellite-clinic interventions whereby staff is trained to work with the urban poor, and learn how to give counsel and communicate in ways that reach these poor populations. We can also learn from the program for Accredited Social Health Worker (ASHA) under RCH II in India – where ASHAs are meant to be community health activists and promoters of good health practices – and consider how to sustain such programs in the urban slums.

Explore connections between urban poverty, alcoholism, domestic violence and self-efficacy in health. The anxieties and stresses of daily life in the slums are heavy burdens for women to bear, and doubtless affect the social confidence and energy that they bring to health-seeking behavior. Very little is yet known about how violence and alcoholism affect self-efficacy, which is a fundamental factor in health-seeking behavior. Interventions that reduce domestic violence or alcoholism may have wider-ranging health benefits. In addition, given the high rates of maternal mortality and the high rates of home deliveries among the very poor in both urban areas, we recommend specifically exploring how urban poverty affects health seeking with respect to pregnancy and delivery. Understanding the range of factors, including cost, that encourage home deliveries will allow more effective design of interventions that support institutional deliveries or deliveries with skilled birth attendants.

Ensure access to clean drinking water and adequate sanitation. This is an often-repeated recommendation for urban slum settings, but its importance must again be underscored. Sanitary conditions in our study slums are abysmal, as they are in many slum communities around the world, presenting women and children, especially, with high levels of health risk. Even where slum women are fully aware of the importance of maintaining good hygiene, they may be unable to follow these practices without access to an adequate supply of water. And even when water supply may be considered adequate by the residents, as in our study slums in Manila, poor water quality and sanitary conditions may persist.

12.3 Improve Collection of Urban and Rural Health Data

We close our recommendations with a plea for improvements in the survey programs, such as the Demographic and Health Surveys, through which both rural and urban health conditions are documented

and the determinants of health knowledge, attitudes, behavior and outcomes are studied. A central theme in this report is that city populations are highly diverse—they include communities of the poor that closely resemble rural villages in terms of the level of health risks, the quality of care available and the ways in which health is understood by local residents. To give unbiased guidance to health policy-makers, and to permit resources to be effectively targeted, health surveys must supply reliable portraits of health conditions in diverse urban populations as well as in rural areas.

When new surveys are fielded, we would urge that appropriate consideration be given to over-sampling urban populations, so that the depth and nature of urban health needs can be compared with those of rural areas. In its 2003 report, *Cities Transformed: Demographic Change and Its Implications in the Developing World*, the National Research Council called for empirical documentation of health needs among four population groups: (1) rural dwellers; (2) residents of towns and smaller cities (in which health conditions were found to be similar to rural areas); (3) in larger cities, the urban poor who live in slums; and (4) the urban poor who live outside slums. National sample surveys should be designed to make such comparisons possible. But at present, these comparisons are not generally possible—small urban sample sizes and the lack of place identifiers (such as the name of the city in which a sample cluster is located) preclude them. As the developing world continues to urbanize, these deficiencies in data collection must be addressed.

Annex A: Data Collection in Indore, India

A team of five investigators carried out the in-depth interviews with slum residents and service providers. Each of the investigators had previous experience working with slum populations and health, whether in research or field activities. A four-day training session was held at Indore, covering health-seeking behaviors among slum residents, major morbidity conditions and health service delivery systems. Additionally, a goal was to review all of the modules of the interview protocol. The team met regularly during the data collection to exchange notes and discuss any challenges they were facing.

Before the start of each interview, oral informed consent was taken from the participant for conducting the interview and for tape-recording the conversation. The vast majority of the respondents who permitted interview-taking also agreed to have it recorded. The interviewer reported the details of each interview on a broad format based on memory and, when necessary, referred to the tape-recording. Verbatim transcripts of each of the tapes were prepared by a separate team.

In the majority of the interviews, the sex of the interviewer and the slum participant were matched. Interviews with men were managed more easily in the evenings. Flexible arrangements were needed to ensure privacy during interviews with women, as other family members were often nearby, particularly in joint families. Most women responded with warmth to the style and topics of these interviews. Almost all of them were curious about the purpose of the study. As the conversations matured, many women intimately shared and elaborated upon their experiences and understandings.

We attempted to cover all the health service providers mentioned in the interviews with the slum residents. There were 42 formal and informal service providers mentioned, of whom three could not be traced and four who did not consent to an interview. Many of the service providers would not agree to the tape-recording. The interviews with the formal service providers had to take place at times when their facilities were uncrowded, usually late evening or early morning when the clinic was just closing or opening. However, research team visits at other times helped us in observing interactions between the provider and the patients.

Pre-tested interview guides were used in the data collection with the slum respondents. Interviews with health service providers were based on a conceptual map covering the issues under study. The interviewers participated in the drafting of this conceptual map and were involved in the pre-testing of the guides. Because the interviewers were generally familiar with the data collection tools, these pre-tests were mainly used to guide the discussions and probe for additional details.

Annex B: Data Collection in Greater Manila, Philippines

The research team sought the Department of Health's approval and endorsement of the study. Their participation was engaged in several areas, such as identifying key health problems and issues in the squatter areas, the selection of the study sites, and in networking with local government units. The Department of Health endorsed the project in a letter to the local government units. The department's cooperation with the research team was requested in conducting the study and cooperation was also requested from the government hospital where the formal health providers were interviewed. Likewise, it was important to obtain the approval and endorsement of the city officials, the barangay officials and the slum community officials.

Sufficient time was allotted for study briefing meetings with the city officials to inform them what the study was about; who the donor and participating government agencies of the project were; the importance and potential uses for the findings; the specific study sites and subjects; what types of data were to be collected (e.g., family planning and reproductive care, environmental sanitation); and the protocols and ethics to be observed by the interview team in conducting the survey, including the time of the day when the interview was to be conducted and the duration (number of days) of the actual field survey. This was the first in an elaborate process of obtaining endorsements from a series of officials, which in the Philippines is necessary preliminary step to the fieldwork. The endorsement letter from the Department of Health proved to be important in gaining the approval of the local government officials. The city/municipality officials then gave their endorsement of the project to the barangay officials for the resident interviews and to barangay health officers for provider interviews. Another project briefing was undertaken with the barangay captains who, in turn, endorsed the project to the area 'tanods' or leaders with whom further briefings were made. In the final briefing with these local leaders, the intent and content of the survey was discussed in considerable detail. The barangay captain also endorsed the interview team to the barangay health officers to facilitate the interviews with health providers.

The next step was to properly introduce all the members of the interview team to the barangay and area officials. In this meeting, we also sought advice as to the best time of the day to conduct the interviews in the squatter community. Additionally, we discussed the possible dangers the interviewers were likely to encounter while conducting the survey. The squatter community is home to a number of drug addicts, criminals, alcoholics, and mentally unbalanced people. To ensure the safety of the interviewers, the officials advised that whenever possible the interviews be conducted in the morning of each day until the early afternoon. The barangay captain also directed the squatter community leaders to assist the interviewers in the conduct of the survey and to ensure their safety by escorting them to respondents' houses when that was required.

We also needed to engage the participation of the community leaders in the conduct of the survey. This was achieved by discussing the best strategy to select the sample, by obtaining the subject's cooperation and participation, and identifying the best location for the interviews. The community leaders made a sketch map of households which could be safely interviewed, and identified the danger zones (areas where most pot and boozing sessions are held) that the interview team should skirt. Given the number and type of respondents needed in the study, the community officials drew up a preliminary list of

potential households to achieve a balanced geographic representation. A visual inspection of the area was conducted by the community leaders with the whole interview team, who were also briefly introduced to some members of the community. A male community leader was identified as the point person and tasked to disseminate background information about the survey to potential male respondents and to schedule the interviews. In addition to providing information about the study, explaining its relevance to the community and conveying the endorsement of the study by the city and barangay officials, this man was tasked with contacting potential respondents to inform them that their answers will be kept confidential, that the right answer to the interview is an honest and truthful one, and that the interview would take about an hour and a half to be completed. A female barangay leader was instructed to do the same for the potential female respondents and, if possible, to accompany the interviewer to informal health providers identified by the community members. The designated slum community barangay officials were instructed to coordinate closely with the interviewer for contacting eligible respondents, noting changes in schedules and ensuring that the sample quota is attained. A specific place (community center and office of the community association in Cainta and the Barangay post in Kaingin) was also designated for the interviews. Because the community greatly respects the authority of the city and barangay leaders, close collaboration in the conduct of the survey proved to be critical in getting the cooperation of the community members and the success of the survey.

Issues

The study set a sample of 100 married respondents with children 0-5 years old. To achieve some gender representation, 20 of these were men. Achieving this quota and type of respondents posed a challenge. Although the slum mothers generally stay at home and can be interviewed at any time during working hours, there was concern about maintaining their focus and momentum for the hour and a half needed to complete an interview. By economic necessity, many of the men with very young children are working and could not be interviewed during work hours. The participation of the barangay and slum community leaders in identifying and contacting the eligible respondents and coordinating with the interview team was critical in ensuring that not only was the sample quota achieved, but also in obtaining the cooperation of community members.

One of the problems in conducting this research is finding the right setting in which to conduct the interviews privately. Because squatter areas are very poor and congested, it was not possible to find a place near the houses that was private and comfortable for both respondents and interviewers. Privacy and comfort are essential for a good interview -- but difficult to arrange in a slum area.

Since mothers take the primarily responsibility for care of their children, the presence of very young children prevents them from leaving home for very long. In Kaingin, the barangay leaders in charge of contacting the eligible respondents succeeded in bringing female respondents to the designated interview location by informing them of the schedule, thus enabling the respondents to arrange for childcare. This was difficult to do in Cainta, where mothers preferred to be interviewed at home while watching over their young. There are disadvantages in both cases. Because interviews are free flowing, they are not usually completed exactly as scheduled. In some cases, respondents in Kaingin arrived at the designated location while the previous interview was still being conducted, and had to wait. Because the interview location in Kaingin was a barangay post, interviewers had to make extra effort to ensure that privacy was maintained during the interview. In Cainta, the possibility of having other adults present during the interview was less where mothers were interviewed in their homes. But home interviews were also difficult because houses in this slum are too small to accommodate even one family. The at-home interviews in San Buena were disrupted by the noise of the children and the need for mothers to attend to their care from time to time. The male respondents in both areas were interviewed in the designated location and were subject to the same problems.

Because of the sensitivity of the topics covered in the survey, including reproductive issues, violent behavior towards spouses, and personal sanitation habits, it was critical that a male interviewer be assigned to conduct the male interviews and that female interviewers conducted interviews with female respondents. The need for matched interviews is underscored by the cultural conservatism of the population in the squatter community.

Clear understanding of the questions on the part of the respondent is obviously critical to response rates and the minimization of measurement error and bias. With these in mind, we hired seasoned interviewers holding graduate degrees in the social sciences, who were able to grasp the goals and objectives of the study and had a good understanding of how to conduct a household qualitative survey. Their skills were especially needed in pre-testing, when they were scrutinizing the English versions of the questions and finding ways to re-express them in terms suitable for the slum populations. The interviewers were required to pilot-test the two sets of modules in a minimum of two interviews. The interviewers also actively participated in identifying which of the main questions would be emphasized, and helped in rewording the questions in Tagalog. (As we designed the interview protocol, we identified a key question to be asked for each main topic, with the rest of the questions listed for follow-up and further probes.) In the pre-test, the supervising and interview team paid particular attention to the following issues: the wording of the questions in the local language and issues of equivalence of the meaning in English with the local language; identifying questions that were confusing and difficult to answer (at the end of the pre-test, respondents were asked which questions they found difficult to understand); determining which questions were redundant and would likely cause annoyance on the part of the respondents; and which questions could be interpreted in different ways by different respondents. The questionnaires were translated into the local language several times, taking into account the issues that surfaced during the pre-tests. The final set of questions were back-translated by a person not involved in the previous translations to refine the questionnaire.

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