Women and Health Care in Mumbai

A study of morbidity, utilisation and expenditure on health care by the households of the metropolis

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Introduction

The health of the general population as well as that of specific groups (infants, women, etc.) has for long been an important concern for development studies. When economic development is viewed in the context of human development, the success of countries in securing good health for their people assumes great significance. Morbidity, or physical and mental illness, is increasingly being recognised as a 'measurable indicator of well-being' (Shariff, 1995*).* Individuals in a society need to be regarded as critical agents in the development process rather than as beneficiaries. The role of women in this process assumes great significance, as they constitute a substantial portion of the population. They play a variety of roles both outside the household and within, most of which often go unacknowledged. The woman's ability to perform these roles, as also her quality of her life, is determined by the health status she enjoys. It is a well-established truth that women face a host of problems throughout their life cycle. These problems are related not only to physiological change, but also to the work they perform; their low status in the family and society; and gender discrimination due to social, cultural and economic factors operating inside and outside the home.

One of the major problems women face in relation to health is the lack of access to basic and good quality health care services. This can be traced to the structures of patriarchy that function in all sectors and in most of the communities. It is manifested in the pattern of health care provision ranging from the household to the government level. Women have little access to health care because their health is given very low priority in the household. The government health services and programs have also never accorded importance to women's overall health problems. Right from the first Five-Year Plan women's health has not progressed beyond care during maternity. One of the first programs that focussed specifically on women was in the Family Planning program. But this was mainly a population control program, targeted at women in the reproductive age. The Family Planning program was renamed the Family Welfare (FW) program, with the inclusion of the Maternal and Child Health (MCH) in its objectives. However, the emphasis remained the same, namely, carrying out sterlisations, inserting Intra Uterine Devices (IUDs), distributing condoms and mainly focussing on demographic targets of birth rate, total fertility rate, and couple protection rate, among others. These programs were given high priority in terms of foci, money, emphasis and importance as they were centrally funded, with a substantial allocation of resources. These programs were essentially sterilisation programs with incentives being provided and the functionaries spending a large amount of time chasing 'targets'. The FW program failed miserably, as the birth rate did not decline as expected. The program was reviewed again, especially when the MCH component under the Child Survival and Safe Motherhood (CSSM) program was launched in the 1980s. The emphasis was on prenatal, natal, and postnatal care, immunisations, vaccinations, etc. In the mid nineties, due to the criticism of the FW program and the international focus on reproductive health and reproductive rights, the government launched a new program from April 1996 called the Reproductive and Child Health (RCH) program. This program retains the major components of the earlier CSSM program adding on management of sexually transmitted diseases (STDs) and reproductive tract infections (RTIs) to its list of objectives. In most of the programs for women in India the underlying reason has

always been demographic. Even the latest RCH program narrows its concern to the reproductive role of women. Though there is a lot of rhetoric about the inter-relatedness of women's health problems, this does not get reflected in programs for women in a comprehensive manner. There is no examination of women's health needs in the broader perspective of their social role, the productive work that they perform both within the house and outside. Their mental health, the illnesses they suffer due to old age, or due to sexual abuse and violence, and the impact of new technologies, development processes and environmental factors on their health, etc. are not given due importance.

The problems have become more acute in the present economic context of the Structural Adjustment Program (SAP) being undertaken in the country. There is a further push for privatisation of the health sector. The private health sector is a dominant sector operating without any accountability or monitoring. Further, there is a cut back of funds for the health sector and intense targeting of health care services as against the provision of basic health care services to all. In the urban context, there are moves to cut down funds for health programs and to hand these over to the private sector. This is in spite of households already spending a substantial portion from their meager resources than what is being spent by the government on health care. The overall economic forces that are unleashed in the broader context determine to a large extent the various dynamics that operate within the household. In India, where the majority of the people live on a subsistence economy, the opportunities for women to access health care services are very little.

Women's health is accorded low priority not only in the private and public health sector but also within the households. This is due to the fact that women are not considered important except for their role as mothers. Access for women to health care services are very much determined by their age, education, earning and occupation status, and their role in the family, among a host of other factors.

The dynamics operating within the household with emphasis on women's health issues, especially with regard to the costs incurred on health care, have not been documented in great detail. A few small studies have highlighted the lack of concern for women's health and the neglect of their gynecological and other reproductive health problems. As per our knowledge no study has systematically and comprehensively looked at the cost aspect of women's health in its totality in India. In the recent past there have been studies documenting household level expenditure on health. But these have focussed on general expenditure on health care and have paid little attention to the cost of women's health *per se*. They have looked at the cost of maternity and abortion within the overall health expenditure (these studies are discussed in more detail in the subsequent chapters). Further, there has not been much focus on issues related to urban health, more specifically those affecting women especially from poor households. It is generally assumed that in urban areas health care is accessible just because it is available.

The present study makes an attempt to fill in these gaps. The major objectives of the study are to document and analytically understand the perceived morbidity patterns; the constraints women face in accessing health care facilities; their utilisation; and the expenditure incurred by households on women's health care with special reference to socio-economic differentials.

The conduct of the present study has been unique in many respects. In most of the household level studies conducted, the respondent was usually the head of the household, almost invariably a male. Due to this, issues with regard to women's health did not come out in great detail. As women constitute a major segment of society and suffer the most due to inaccessible health care and the male-dominated culture prevailing in Indian society, there was a need felt to examine and focus specifically on women's health. Some significant modifications were made in the methodology. Firstly, only women respondents in the household were administered the interview schedule and the investigators were also women. Secondly, we used a probe list (a list of 14 questions probing specific symptoms) to elicit more information as it has been generally found that many women do not perceive certain symptoms as 'illnesses' ***(Annexure 1)***. Thirdly, investigators were given intensive training to make them sensitive to women's health problems and the difficulties that women have in articulating these. Lastly, repeated contact was made with the women in the community before we commenced the survey so as to establish a good rapport with them.

The research design of the study was conceived using a mix of methodologies from both the quantitative and qualitative realm. As the objective was to document and analyse morbidity patterns and the extent of utilisation and expenditure incurred by households on women's health, various tools were employed for data collection from different levels and in various depths. In the quantitative methodology, the major tool used was the interview schedule administered to a large sample of households in the area selected. In the qualitative methodology in-depth interviews with respondents and key informants from the area selected were used in the study. In this report the analysis is restricted to the findings of the survey conducted.

Area for study

We had two criteria for selecting the area for our study in Mumbai city — firstly it had to be an area which had a Non-Government Organisation (NGO) working with women or in the field of health and which could benefit from our survey. Secondly, it had to be an area that would reflect the cosmopolitan nature of Mumbai, where people from different classes, linguistic and community backgrounds reside together.

After short-listing a few NGOs we selected the area where Jagruti Kendra, a church-based organisation was working in North Central Mumbai with a mixed population. The municipal corporation divides Mumbai city for administrative purposes into 26 wards. This area falls in 'L' Ward of Greater Mumbai. This ward has a population of over 5—6 lakhs people, a congested pocket with residential as well as factories, small-scale, and commercial units. It is reported to have poorly maintained water and sewerage systems, open drains, inadequate toilet and sanitation facilities, and acute noise and air pollution problems. In the same region is an open 'nallah', originally identified as 'Mithi' river, which is now used by industries for disposing of untreated effluents. For the purpose of our research survey, we limited ourselves to one section in 'L' ward, the area known as Bail Bazaar. Majority of the population consists of migrants from Uttar Pradesh, Tamil Nadu, Kerala and Karnataka, belonging to middle and lower income group. They are mainly mill workers, self-employed, skilled and unskilled labourers, and service sector workers. There are private hospitals, one fairly big charitable trust hospital, a Municipal Health Post, and two municipal

dispensaries at a walking distance of 15-30 minutes and three municipal hospitals at a distance of about half- to one-hour.

Selection of the households

Our targeted sample size was 425 households, taking into consideration an approximately 4 -5 per cent loss of sample. 60 per cent of the respondents in the sample were from the lower income group, 30 per cent from the middle-income group and 10 per cent from the higher income group. In the area under study the households were grouped into various clusters. The clusters were delineated using geographical boundaries such as walls, gutters and roads. The selection of the clusters was on the basis of their "class character", which was ascertained using indicators such as the occupation of residents, condition and size of their houses, the immediate environment outside houses, access to facilities like water, toilets, and electricity; and the visible presence of goods such as televisions, refrigerators and vehicles. We were able to short-list five clusters in the area for the purpose of our study. Each of these clusters had a very distinctive character. Of these, two clusters were slums located on land belonging to the airport authority; two were 'chawls' (1 or 2 room tenements built in rows alongside a narrow lane). The fifth cluster was a group of apartment blocks housed in multi-storied buildings.

Finally we covered 430 households from amongst the five clusters all located within an area of one square mile. Since we did not have lists of household units residing in these clusters we demarcated the area and counted the number of household units and excluded shops and establishments. We had decided on the sample size from each cluster, our random sample i.e., 'Nth' house, was decided accordingly. The houses with only male persons were excluded from the sample.

Conduct of the study

As we were dealing with sensitive issues like reproductive illness it was necessary and ethical to build a rapport with the women respondents in our study. This was carried out through a series of meetings in the clusters with the women, local organisations, and key individuals, among others. In addition to the meetings and individual contacts, we circulated leaflets in Marathi and Hindi with details about our organisation and particulars of our research study ***(Annexure 2)***. These leaflets were distributed widely among all members of the community, especially women. For those who could not read the leaflet, it was either read out or the gist of it was explained. In many cases our address and telephone numbers were important considerations in building trust and faith in the community.

The fact that they had a choice in the matter, to say no to the investigator, to refuse to share information fully, partially, or selectively, eased a number of fears. Another major 'obstacle remover' was our promise of maintaining secrecy, as regards identity and other individual information, as a matter of right of the participant. We promised that we would publish only collated data and share only final analysed data with the outsiders. Expectations about the outcome of the survey in the form of a health centre, drug dispensation or reimbursement of expenditure on reported illnesses, were dealt with honestly and without any false promises. The only outcome we stressed time and again was that this information would come back to them, given to

organisations and institutions that could utilise it for improving the situation, which was done subsequently.

Training of investigators

The employment of female investigators to interview women was one of the corner stones of our study. All the investigators involved in the study were from the 18--25 age group, and spoke and were able to interview and write in Marathi and Hindi. They were trained before the commencement of the survey. The training involved information about CEHAT and its projects. It also educated them on topics like the anatomy of a woman's body, menstruation, conception, pregnancy, delivery, contraception health problems, women's work and health problems, chronic illnesses like weakness, backache and pain during menstruation, etc. The use of questionnaire, method of eliciting the required information, assumptions and need for all questions, and necessity of recording them were explained to them. They were also trained to go beyond the interview schedule by building good rapport with the women in the clusters. The training stipulated the three tenets of field research - listen, probe and write. Good rapport building, rights of the informants and respect for ethical values even while conducting the survey with time and space limits, were emphasised all through the training.

Reference period

The reference period has been one of the important aspects of this study, as the information being elicited would depend on the respondents' ability to recall from the past and provide the required information. It was decided that **for information related to illness the reference period would be for the month of June (30-day period)**. Any illness, including chronic ones that became acute in the reference period for each of the family members was recorded (including hospitalisation) along with other details related to utilisation and expenditure. With regard to **pregnancy, delivery, abortion and contraception, the reference period was for the past one year**. This was done so as to get a sufficient sample to make estimations.

Tools for data collection

The study was conducted during the month of July in 1996. The method used was of one time data collection and only if the woman of the house was not present or she requested us to conduct the interview on another day, did the investigators visit again. The study considered the women in the house as proxy for all the members in the household. We appointed teams consisting of two investigators considering the sensitive nature of our study and to facilitate the smooth conduct of the interview. We went in for the survey method with an interview schedule to collect the major aspect of quantitative information as we were dealing with estimations related to perceived prevalence of illness, health-related events in the life cycle of a woman, and the utilisation of and expenditure on health care ***(Annexure 3)***.

The interview schedule

In the interview schedule, we divided the information sought into various sections on separate sheets of paper of different colours. First we elicited information with regard to the details of the respondent, head of household, language spoken and address. Then we asked for the names of all the family members in the household and

regarding their sex, age, relationship to the head of the household, education, occupation, martial status and number of children.

The woman respondent was asked about all the episodes of illness experienced by each of the family members in the month of June 1996. Following this, the investigator read out a list of 14 specific symptoms of illness to women above the age of 12 years. The investigators recorded the verbatim response of the women interviewed. This methodology of understanding women's illness proved very useful as we found that women when asked specifically with probes said that they had the problem but had never understood it as an illness. Further, they were asked whether any woman in the family was pregnant, had delivered, or had had an abortion in the past year. Information with regard to contraceptives being used including spacing and terminal methods was also elicited.

After this a separate illness card was filled up for each of the individuals who had fallen ill. In this, information like the number of illness episodes, symptoms, causes, period of illness, treatment taken, health facility utilised, the distance at which it was located, mode of transport, who accompanied the patient there, number of visits, number of days lost due to illness for both the person and family members and if treatment was not taken the reasons thereof, etc. was recorded. Then the expenditure incurred under each head such as doctors fees, expenditure on medicines, injections, tablets, tests, surgery, hospitalisation, transport, rituals performed, special diet, bribes, gifts paid, etc. was recorded. Where the information was not available separately it was recorded as a composite amount.

A separate card was filled for pregnancy related events. The information recorded in this section was with regard to the specific event, the date and place, complications if any, health facilities utilised, type of services received, etc. As with the illness card the expenditure was recorded separately under each of the heads, wherever applicable.

In the next step the interview sought information regarding sources of finances for the expenditure incurred. Reimbursement of expenditure for health care was also delved into but due to lack of sufficient data, no analysis could be made. After the recording of information related to illness / events we sought information with regard to the socio-economic condition of the household. The information sought in this section related to number of years of stay in the city, ownership of dwelling, physical aspects and structure of the house, and the economic condition of the household.

Problems encountered

The first dilemma we faced was with regard to the use of probes. Whereas it is a useful tool to counteract the problem of non-reporting of illness (especially those of reproductive nature and those not perceived to be illness such as weakness, vision problem, ear problem, mental illness, infertility, etc.), an inherent drawback of such a tool is the hint of 'suggestion'. The probe questions were asked with a lot of diffidence. The presence of outsiders, males or senior family member at the time of interview discouraged the responding woman as well as the investigators. Sometimes the probes on chest problems were reduced to only 'cough and cold probes' and skin problems to merely scabies, itches, etc. The significant probes on reproductive illnesses were difficult to handle even for our experienced investigators in the beginning but over a period of time women got over their diffidence and started

responding positively and with a lot of openness. However, we continued to face problems on some probes (like sexual health) for women in the age group of 50 years and above. In this section we were not able to differentiate between the 'no response' and 'no questions asked by the investigators'.

The nature of the household survey presented its own set of problems especially with regard to this kind of a study. Women were not accustomed to the survey format and generally were more comfortable while 'narrating'. Although the schedule was framed considering the flow of information that is logical in its questioning, the women did not always respond in that manner. It was especially difficult to get them to answer on each of the treatment and health facilities utilised and expenditure for each of the episodes. Problems also arose in seeking answers to questions on contraceptive use and illness probes. Regarding contraception, the investigators had difficulty in probing for contraceptive use, especially natural cycle method and multiple contraception utilised in the reference period. Similarly, we missed out on more than one event in an year especially regarding abortion.

There were problems in the selection of the households in the clusters as there were no reliable households' list containing family data available with any authority. We had to physically count the houses in the clusters to take a sample. As we had taken the sample from each of the clusters in terms of the Nth number by physically counting, we encountered households with only male members. We excluded these households from our sample and took the next house. This could be one of the explanations for lower male morbidity and a sex ratio in favour of females.

Another problem was the difficulty in demarcating households based on socio-economic criteria as, in Mumbai, due to its housing shortage, many households from a higher economic stratum would be living in the slums. Then again, the women respondents were unable to provide the income of the household members as they generally do not have access to information regarding income. Due to the inadequate data on income of the households we were not able to use this information in the analysis.

In our class-based strata for cluster and sample selection we had paid very little attention to religion and caste. But we later realised that the area had a majority of Muslim population and as it was difficult to change this, our study sample, as far as religion is concerned, may be slightly skewed.

One of the major problems faced by the investigators was in recording information in which the husband or another person had made payment at various facilities. As we had interviewed women in the household, and it is well-known that the head of the household or the main earner controls the purse strings (almost always a male member), in some cases the respondents were unable to provide the break-up of costs incurred.

Analysis

The quantitative data that was collected was analysed using Statistical Package for Social Sciences.

Mumbai is one of India's largest cities and an important commercial and industrial centre. According to the Census, Mumbai had a population of 99.26 lakhs in the year 1991. In the decade 1981-91, the population had grown at the rate of 1.8 per cent per

annum. Interestingly, the female population had grown by 27.15 per cent in the previous ten years, while the male population grew by only 17.34 per cent in the same period. The reason for this change in the gender composition of the population is very significant. Mumbai was historically regarded as a city of migrants. This is borne out by the fact that migration contributed 79.7 per cent to the increase in population between 1941 and 1951. These migrants were generally males, who came alone, searching for work. In 1951, there were 1659 males for every 1000 females. Since then, two processes have been underway. The sex ratio has become much more balanced (1222 males for 1000 females in 1991 can give 2001 sex ratio) and births contribute a large share to the growth of population. This is because there has been a significant increase in the proportion of females in the age group of 15 to 54 years in the total female population, i.e., women in the reproductive age. All these statistics indicate that Mumbai's population is becoming more settled, with families replacing the all-male households of earlier years. Another change that has taken place is that more and more women are entering the labour force. The female work force participation rate rose from 8.8 per cent in 1961 to 10.5 per cent in 1991. A large proportion of employed women find work in the unorganised service sector.

Area of study

Kurla's sex ratio was 767 females per 1000 males in 1991. The sex ratio of the Census Block No. 78, Bazargate -Church hall, within whose limits all the selected households are located, had an even lower sex ratio at 742 females per 1000 males. The sex ratio for the population above six years of age in the block was lowest at 712 females per 1000 males. This accounts for the large number of all-male households that were encountered and subsequently excluded from the survey. The female literacy rate for the census block stood at 69 per cent, 18 per cent less than the male literacy rate, while for Mumbai, the average difference between the male and female literacy rate is 12 per cent. The female work force participation rate for Census Block no. 78 was a low 6.72 per cent in comparison to the Mumbai figure of 10.5 per cent.

Kurla ward witnessed a sharp increase in population density in the 1981—91 decade. It increased from 17,161 persons per square kilometre to 45,775 persons. Kurla has traditionally been an industrial area. In spite of the unfavourable living conditions, industrial areas attract a working class population because, for them, the availability of employment close to home outweighs the disadvantage of living in a degraded environment. With the present government policy on land ownership and development, most of the 'unauthorised' houses of the working class are not served by any public amenities. Infrastructure for the disposal of waste and distribution of water as well as approach roads are not provided. Thus, due to the pressure of unregulated industrial activity and high density of population, working class neighbourhoods are generally associated with deteriorating infrastructure facilities and a highly congested and polluted environment.

CHARACTERISTICS OF HOUSEHOLDS

Language and Religion

In the overall distribution of households by language, the Hindi speaking population predominated to a very high degree. The Hindi speakers included both Hindus and Muslims. We found that there were same number of Hindu (45.6%) and Muslim (42.3%) households were nearly the same in number in the work sample. Christians

constituted 8.1 per cent of all households, while Buddhist households accounted for 3.5 per cent of all households.

Number of years of stay in Mumbai

One indicator on which we collected information was the number of years for which the family (usually the head of the household) had stayed in the city. 18 per cent of the heads of the households had been born in the city *(Table 3.1)*. Another 34 per cent of them had lived in the city for more than 15 years. Only 17 per cent of the households had been settled in the city for less than four years. Longer experience of life in the metropolitan city implies a stronger social support network, better employment opportunities, a greater understanding of systems such as large public hospitals, municipal corporation office etc. Though access to the above seems, logically, related to education and skill, it cannot be completely explained by these factors. Experience of life in a big city is in itself educative and thus, it is a significant determinant of the opportunities available to all persons, especially to women.

Housing

More than two-thirds of the households interviewed lived in one-room structures. Barely 7 per cent of the households had more than 2 rooms (including kitchen) for their use. However, considering that this locality is very old, we find that a large majority of the households are housed in permanent structures. More than 70 per cent of the houses have walls of cement and concrete. We found that the density of population in one of the slum pocket was 4.42 persons per room, while it was 2.14 persons per room in the apartment blocks.

Ownership of house

We found that 67 per cent of the households own the homes they live in. However, ownership of the house, in this case, is a very poor indicator of economic status. We found ownership to be highest at both the lower and upper end of the spectrum. The reason is that those living in unauthorised tenements are also owners of the houses, many self-constructed.

Facilities available within the house

In addition to the overcrowding, most of the houses were inadequately equipped. 60 per cent of the households relied on public toilets; another 27 per cent were dependent on the common toilets of the *chawl*. Only 13 per cent of the household had an independent toilet and 11 per cent of the households had a separate bathing facility. An overwhelming majority of the families made use of an open *mori* built inside the house, which naturally placed great restrictions on the women of the households. Households having water connection with a tap outlet inside the house was much more common with one-fourth of them enjoying this facility. 65 per cent of the households depended on the common tap in the chawl and 8.1 per cent were dependent on public taps *(Table 3.2).* So, it was not uncommon for women to be up at midnight or even later in order to fill water for the next day. Those who relied on common *chawl* taps were more privileged than users of public taps as they could restrict access to outsiders by locking the taps. Even among this group, there was a hierarchy among those who had applied and paid for the water connection and those who paid rent to use these taps. The former group had priority in the use of common chawl taps.

Environmental condition

As mentioned in the chapter on study design and methodology, a total of 430 households were covered from the five clusters *(Table 3.3).* As is evident from the table, the number of households interviewed in each cluster was not equal. The clusters themselves were very heterogeneous, in terms of both social and economic features. Although most of the households in the study suffered from the impact of the environmental problems the characteristic of an industrial area such as Kurla, the immediate environment of their houses varied considerably. Typically, in Mumbai, one finds that the physical condition of areas in close proximity to each other can vary dramatically. The 'cheek by jowl' presence of high, middle and low-income settlements is well-known. There are no attempts to prevent the deterioration of the few feet of common space between houses or to isolate the settlement from the influence of highly polluted surroundings as is evident in this area.

One categorisation we used to analyse the data was slum and non-slum so that we could better understand the impact of environment on the health of all individuals, and of women in particular. This classification has been done on the basis of our observation of the physical conditions of the settlements that were selected for the survey. 'Slum' was not as objective a category as we would have liked. We defined an entire cluster as a slum on the basis of the degradation of the immediate environment that we observed. Settlements where drains adjoining the houses were covered, common lanes between the rows of houses were paved, and where there was a demarcation of the areas used for garbage dumping and defecation were classified as non-slums.

Using this classification, we had 178 non-slum households comprising of 905 persons and 252 slum households having 1,244 persons *(Table 3.4).* The structure of only six of the non-slum households was not entirely constructed out of cement concrete. 119 slum households were not housed in permanent structures. There was a similar disparity in the amenities available. 59 per cent of the non-slum households had their own water connections, while only five households in the slum had the same facility. 82 per cent of the slum households used municipal toilets and only two had their own toilet. On the other hand, 30 per cent of the non-slum households had their own toilets and only 29 per cent used municipal toilets. Although 41 per cent of these households used toilets reserved for residents of the *chawl*, these were decidedly better-maintained than similar toilets used by 16 per cent of the slum households.

HOUSEHOLD CHARACTERISTICS

Respondents

This respondent was in most cases a married woman in the reproductive age group between 20 and 45 years of age. In practically all cases the respondent belonged to the immediate family of the head and thus, we find that all the respondents were well placed to answer questions on the household.

Heads of households

Males were the heads of an overwhelmingly large proportion of households. Only 10 per cent of the households had female heads *(Table 3.5).* We find that married men and single women are the most likely to be reported as heads of households. This indicates that marriage grants the status of head to men, while the break-up of

marriage through divorce or widowhood confers the same status on women. The age of the male heads of households is seen to be largely between 25 and 45 years. Female heads of households tend to be, on average, much older than male heads, and are mostly widows. Interestingly, 29 male heads and 24 female heads were not contributing to the household income. They were reported as housewives or non-earners. A deeper analysis of this reveals that wives and children of non-earning male heads and only children of non-earning female heads were the main breadwinners in such families. However, when the heads are employed, we find that the male heads of households tend to be in much more privileged and remunerative occupations. They are also invariably the main earners in their households. The female heads of the households are spread across the occupational range, but none higher than skilled or lower level service sector workers. None of the female heads were in professional jobs. This leads one to believe that, on the whole, female-headed households that are sustained by that woman's work may, in fact, be surviving with difficulty. It would be important to study the effect of this on the health condition of the woman, when she may have control of resources but may not have too many resources to control in the first place.

Size and Composition

We found that the size of the households varied considerably, the average size of the household is about five members, with nearly 43 per cent of the households having less than five members. There were a total of 2,149 individuals living in the 430 households interviewed. We found that the sex ratio (937 females per 1000 males) in our sample is markedly higher than that of the city as well as the ward and Census Block. This is on account of the exclusion of all-male households from the study. Also, the extremely small number of aged persons explains the predominantly young and largely nuclear families that we found. More than 90 per cent of the population was below 46 years *(Table 3.6).* Also, we found that the child population in our sample was not very large, similar to the pattern of the city. This may be on account of the relatively low birth rate prevalent in the city. There was not much significant difference in the age structure of the male and female population. Only, in the age group of 35 and above we found comparatively fewer women than men.

Employment

About 34 per cent of the individuals in the sample were employed *(Table 3.7).* The main group of persons who were employed in this sample was the adult men. The income of male workers was significantly the main source of income for the households. The maximum number of workers were found in the skilled workers category and employed in small units in the unorganised sector. We also found that unemployment among the men of different age groups varied considerably *(Table 3.8).* However, the pattern that we observed was very unusual. As expected, unemployment among men between 18 and 25 was high and it declined in the next age group, only to rise again among the older men. In terms of numbers, almost twice as many men in the 36—45 age group were unemployed as in the 26—35 age group, the unemployment being the highest in the old age group of above 45 years of age. Thus, one's assumption that the middle-aged male population would be most secure in terms of employment is belied. To complement this, we found that only half as many men in the older age group were working in unskilled and semi-skilled jobs as the younger age group, indicating that young men are entering the labour market

as low-paid workers. Analysis of work status in relation to educational level showed interesting trends. Non-workers were distributed all across the spectrum, although illiterates and those with only primary education were most likely to be unemployed. However, increasing education does not seem to diminish substantially the dangers of remaining unemployed. This seems to confirm a grim picture of increasingly constrained opportunities and subdued growth.

Sources of income

We found that 55 per cent of the households in the study reported salaries as their main source of income and a large proportion of them reported only one source of income *(Table 3.10).* Both these indicated a considerable measure of economic stability in the population. Of the few households who had a subsidiary source of income, those with salary as their main source of income supplemented it with income from self-employment (25 households) and casual labour (12 households).

Services and assets

In the absence of reliable information on income, data on assets is a valuable indicator of the level of resources that the households has access to. In the urban context, the source of procuring food is an important indicator of the presence of poverty or its absence. Nearly 78 per cent of the households had a ration card, but we found that 53 per cent of the households bought cereal food grains in the open market, although they had a ration card *(Table 3.9)*. Another 15 per cent of the households were compelled to buy grains from the market because they had no ration card. Only 25 per cent of the households used the public distribution system, either for buying all their cereals or part of it. About 13 per cent of the households reported facing scarcity of food at some point or the other. Of these, the largest number faced food shortage because money ran out before the end of the month (30 household); because they could not find work (6 households); because income was not sufficient (14 households); and because there was large seasonal variations in their income (4 households).

In terms of assets we found that most of the households (84 per cent) possessed no income generating assets. The most valuable asset that 30 households possessed was a fixed asset such as a house, go-down, shop or garage. 176 households owned some agricultural land in their native villages, but they generally did not derive any regular income from it. We found that reliance on kerosene stoves was the highest (75 per cent). However, ironically, far more households possessed televisions (42 per cent black and white and 16 per cent colour) than gas stoves. Admittedly, televisions are no longer considered a luxury, but the fact that they have priority over cooking gas creates interesting questions. Cooking gas eases the burden of cooking to a considerable extent. In spite of this, it is one of the last acquisitions in lower middle class households. Is this on account of the fire hazard that storing a cylinder poses (though stove-related accidents are much more common and pose a much greater danger to a woman's health and life); or is it because the gains from owning a television accrue to all family members, while the disadvantages and dangers of using a kerosene stove, and the time spent in acquiring kerosene from the Public Distribution System and other sources are borne only by the woman of the household? Though this question has marginal relevance to our study, it seems like a

very telling indicator of the marginalisation of women's concerns in the way resources are distributed in households who are well above the subsistence level.

CHARACTERISTICS OF WOMEN IN THE STUDY

Position in the household

There were 1,036 female individuals in the 430 households interviewed. Most women were immediate relatives of the head of the household, 45.5 per cent being daughters and 36.6 per cent wives of the head of the household *(Table 3.14)*.

Marital status

An analysis of the marital status of the women revealed that six married women were below 18 years of age, which is the legal age of marriage. However, by 26 years, nearly three-fourths (74.4 per cent) of the women were married *(Table 3.12).* By the age of 36, all the women had been married at some point in their life (referred into this report as ever-married respondents). The proportion of widows and single ever-married women increased with each older age group, till we found that among the oldest women (46 years and above) half the women were single. Marriage still seems to be an imperative event for all women, as can be seen from the fact that only four women above the age of 25 years are still unmarried. It also appears that remarriage, especially for older women, is still difficult or unacceptable, considering the fact that half the women above 45 years were single. This is in spite of the fact that there are fewer women in the older age groups than men. We may conclude that the wide gap between the ages of husbands and wives must be the reason why so many women outlive their husbands. We found the average difference in age between husbands and wives to be seven years. The consequences that this difference in age has for a woman's authority in the household are, therefore, predictable. Being younger, necessarily less-educated and skilled, means that she is disadvantaged not only on account of her sex, but also on account of her age.

Surprisingly, only six women were reported as separated or divorced from their husbands. However, it is likely that this category is much larger and many such women have been reported as married and cohabiting. Another category, which is likely to be larger than reported, is of those women whose husbands live away from home due to work. Understandably, there was reluctance on the part of these women to report the absence of their husbands to strangers. On the whole, however, we find that the group of married and cohabiting women, i.e. the group that is almost certainly sexually active, is the largest group.

Number of living children

In terms of the number of living children that the ever-married women have, we found considerable differences within different age groups. We found that on an average, women between 18 and 25 years had one child (mean = 1.25); for those in the older age groups, 26 to 35 years, the mean was 2.85 children per woman *(Table 3.13).* This average increased to 3.49 for women in the 36 - 45 age group and rose marginally to 3.77 for the oldest women (46 years and above). If we assume that child survival has improved considerably over the years, it means that the number of pregnancies and deliveries that the younger women had experienced would be even fewer than the data on living children suggests. Unfortunately, we did not have any direct information on the number of pregnancies or deliveries that women have had.

We found that around 3 per cent of the married women in the age group of beyond 25 years had no children, which is not very low.

Education

We found that the literacy rate for the women in the age group of 12 years and above was 70 per cent. However, the literacy rate for the female population above 7 years was 74 per cent in the sample. The female literacy rate for the city stood at 75.8 per cent in 1991. This means that illiteracy is fast declining among the women in our sample. We found a definite correlation between education and employment *(Table 3.15)*. 83 per cent of the illiterate and those with primary education were housewives. 65 per cent of those with secondary education were housewives. The employment rates for matriculates and those with higher education were progressively higher. More than half of these women were employed. Thus, we found that completing school and entering college vastly improves the chances of a woman being employed. While those with the least education were also employed, they were most likely to be unskilled and semi-skilled jobs, both laborious and less paying. With education, the opportunities for self-employment, a service sector or professional job increase greatly. Consequently, the gains to women from employment also increase greatly. Even without relating it to employment, education is an empowering experience.

Employment

We found that the large majority of the women in our sample had not even entered the labour market. The female work force participation rate for our sample was 10.71 per cent, which was marginally higher than work force participation rate for Kurla (7.1 per cent). An analysis of the type of employment indicated that women were not very favourably placed *(Table 3.14).* We found only 2 per cent (21 women) of the women employed in large units in the organised sector in secure government jobs. A large majority were employed in the completely insecure household sector, in casual labour or in small units in the unorganised sector (89 women). However, the number of women working was itself very small. We thus found that a large majority of the women earners were not protected by either social legislation (e.g., maternity benefits), or social welfare (e.g., health insurance). While for the rest of the women, there was not even direct access to income on account of being non-earners.

There were, however, indications that employment in poor households may not improve women's access to resources. There was no conclusive evidence to suggest that women would spend more on themselves if they had an independent income, in fact, their control on their own income may be practically non-existent. Analysis showed that women were mostly supplementary earners. Thus, neither was their income the most significant in the household nor were they in positions of authority in the family.

Table 3.1: Distribution of Households by Years of Stay in Mumbai

Years of Stay	Number of Households (%)
Less than four years	17.3
4 - 7 years	8.2
8 - 10 years	9.6
11 - 15 years	12.6
More than 16 years	34.1
Since birth	18.0
No response	0.8
Total (N)	**430**

Table 3.2: Infrastructure Facility

	Number of Households (%)
Ownership Pattern	
Owned by resident	67.4
Rented	19.5
Paghadi	7.7
Any other	5.1
No response	0.2
Type of Wall	
Tin sheet	18.4
Corrugated sheet	0.7
Cement or concrete	70.7
Half pucca, half kaccha	10.0
No response	0.2
Type of Toilet Facility	
Municipal toilet	60.0
Reserved for resident	26.5
Own toilet	12.8
Any other	0.2
No response	0.5
Type of Bathing Facility Available	
In the open	0.2
Mori	88.1
Bathroom	11.2
No response	0.5
Source of Drinking Water	
Public tap	8.1
Common tap for the *chawl*	65.6
Tap for personal use	25.6
No response	0.7
Total (N)	**430**

Table: 3.3 Households Interviewed in Each Cluster

Cluster	Number of Households (Actuals)
Cluster 1	87
Cluster 2	115
Cluster 3	45
Cluster 4	137
Apartments	46
Total	**430**

Table: 3.4 Living Environment of Households

Condition of the House	Households		
	Slum	Non-Slum	Total
Structure			
Pucca	133 (53)	172 (97)	305 (71)
Kutcha	119 (47)	06 (03)	125 (29)
Water Supply			
Own water connection	5 (02)	105 (59)	110 (26)
Public water supply	247 (98)	73 (41)	320 (74)
Toilet Facility			
Own toilet	2 (1)	53 (30)	55 (13)
Public/common toilet/open space	250 (99)	125 (70)	375 (87)
Total	**252 (58.6)**	**178 (41.4)**	**430**

Comment: Kaccha?

***Note**: Figures in parenthesis indicate percentages. Last row are row percentages*

Table: 3.5 Heads of Households

	Male	Female
Age Group in years		
18--25	33 (8.5)	1 (2.5)
26--35	155 (39.8)	6 (15.0)
36--45	112 (28.8)	12 (30.0)
46--97	87 (22.4)	21 (50.0)
Missing	2 (0.2)	1 (2.4)
Marital Status		
Never married	1 (0.3)	-
Currently married and cohabiting	382 (99.0)	6 (14.6)
Widow / widower	6 (0.8)	30 (73.2)
Husband away at work	-	1 (2.4)
Separated/divorced/ deserted	-	3 (7.3)
Any other (living in, etc.)	-	1 (2.4)
Earning Status in the Household		
Non-earner	30 (8.2)	2 (9.1)
Main earner	286 (80.8)	12 (29.5)

Supplementary earner	17 (4.8)	6 (13.6)
Equal earner	22 (6.2)	1 (2.3)
Housewife	-	20 (45.5)
Missing	34	-
Total (N)	**389 (90.4)**	**41 (9.6)**

Comment: %age?

***Note**: Figures in parenthesis indicate percentages. Last row are row percentages*

Table: 3.6 Distribution according to Age and Sex

Age Group (in years)	**Sex of Person**	
	Male	**Female**
0—4	133 (12.1)	138 (13.3)
5—11	193 (17.6)	198 (19.1)
12—17	133 (12.1)	124 (12.0)
18—25	207 (18.8)	207 (20.0)
26—35	209 (18.9)	194 (18.8)
36—45	128 (11.6)	103 (9.9)
46—97	100 (8.8)	69 (6.9)
Missing	10	3
Total	**1113**	**1036**

***Note**: Figures in parenthesis indicate percentages.*

Table: 3.7 Occupational Status of Individuals in the Sample by Education level

Type of Occupation	**Level of Education**											
	Illiterate/ Primary School		**Secondary / High School**		**Matriculate**		**College & Others**		**No Response**		**Total**	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Student	339	42.4	198	31.2	21	8.9	46	22.8	13	50	617	32.5
Unemployed	30	3.8	39	6.2	16	6.8	4	2.0	-	0	89	4.7
Housework	223	27.9	163	25.7	47	20.0	24	11.9	2	7.7	459	24.2
Non-workers	18	2.3	5	0.8	1	0.4	1	0.5	-	0		0.0
Unskilled workers/ Hawkers	64	8.0	28	4.4	12	5.1	5	2.5	7	26.9	116	6.1
Skilled workers/ Service sector	109	13.6	173	27.3	103	43.8	67	33.2	-	0	452	23.8
Professional/ Business	4	0.5	15	2.4	27	11.5	46	22.8	1	3.8	93	4.9
No response	13	1.6	13	2.1	8	3.4	9	4.5	3	11.5	46	2.4
Total	**800**	**42.1**	**634**	**33.4**	**12.3**	**100**	**10.6**	**100**	**1.3**	**100**	**1897***	**-**

Comment: ??

** 252 children below fourteen years were non-school/ non-working*
***Note:** Figures in parenthesis indicate percentages. Last row are row percentages*

Table: 3.8 Occupational Status of Adult Males by Age Group

Type of Occupation	**Age Group**				
	18--25 years	**26—35 years**	**36—45 years**	**46 years and above**	**Total**

	Number	%	Number	%	Number	%	Number	%	Number	%
Student	24	11.6	2	1.0		0	1	1	27	4.2
Unemployed	17	8.2	5	2.4	8	6.3	21	21	51	7.9
Non-worker	2	1.0	0	0.0		0	2	2	4	0.6
Unskilled worker/ Hawker	29	14.0	23	11.0	7	5.5	9	9	68	10.6
Skilled worker/ Service sector	116	56.0	138	66.0	82	64.1	43	43	379	58.9
Professional/ Business	13	6.3	29	13.9	24	18.8	9	9	75	11.6
No response	6	2.9	12	5.7	7	5.5	15	15	40	6.2

Table: 3.9 Characteristics of the Households

Characteristics	Number of Households (%)
Possession of Ration Card	
Yes	77.7
No	16.0
Any other response	0.2
No response	6.0
Source of Grain Procurement	
Open market (no ration card)	14.9
From ration shop	10.0
Open market (in spite of having ration card)	53.3
From ration shop (on another's card)	0.2
Any other	1.2
Both ration shop and open market	15.3
No response	5.1
Period and Reason for Scarcity of Food	
Never insufficient	86.7
At the end of the month	7.0
Due to expenses incurred on illness	0.2
Can not work, can not find work	1.4
Seasonal nature of work	0.9
Insufficient income	3.3
No response	0.5
Total (N)	**430**

Table: 3.10 Source of Income

Source of Income	No. of Households (%)
No income	3 (0.7)
Salary	235 (54.7)
Casual labour	73 (17.0)
Self-employment	100 (23.3)
Agriculture	1 (0.2)
Pension	4 (0.9)
Remuneration from members working outside Mumbai	1 (0.2)
Any other	4 (0.9)
No response	9 (2.1)
Total	**430 (100)**

Note: *Figure in parenthesis are in percentage*

Table: 3.11 Assets Owned by Households

	No. of Households
Income Generating Assets Owned	
No assets	364 (84.6)
Small machine, iron	17 (3.9)
Vehicle	14 (3.2)
Godown, shop, garage	20 (4.6)
House, attic	10 (2.3)
Any other	2 (0.4)
No response	3 (0.6)
Agricultural Land Owned	
No agricultural land	251 (58.3)
Yes, but no income	168 (39.0)
Yes, income in kind	8 (1.8)
No response	3 (0.6)
Type of Fuel Used	
Wood, straw, coal	2 (0.5)
Kerosene	322 (74.9)
Cooking gas	103 (24.0)
No response	3 (0.7)
Type of Vehicle	
Does not own vehicle	360 (83.7)
Bicycle	29 (6.7)
Scooter, motorbike	17 (4.0)
Tempo, truck	1 (0.2)
Any other	1 (0.2)
Autorickshaw	10 (2.3)
Private car, taxicab	10 (2.3)
No response	2 (0.5)
Television	
Do not possess	176 (40.9
Black and white	182 (42.3)
Colour	69 (16.0)
No response	3 (0.7)
Refrigerator	
Do not possess	360 (83.7)
Yes	67 (15.6)
No response	3 (0 .7)
Radio, Tape Recorder	
Do not possess	234 (54.4)
Yes	189 (44.0)
No response	7 (1.6)
Total	**430**

Comment: If clubbing with previous, %ages could be taken off.

Note: *Figures in parenthesis are percentages.*

Table: 3.12 Marital Status of Women According to Age

Comment: What are the figures within brackets?

Marital Status	Age Group in Years					
	0—11	12—17	18—25	26—35	36—45	46—97

Never married; engaged to be married; married but not yet cohabiting	336	118 (95.2)	52 (25.1)	4 (2.1)	-	-
Currently married and cohabiting; living in; husband away at work	-	6 (4.8)	153 (73.9)	182 (93.8)	91 (88.3)	35 (50.7)
Widowed; separated; divorced; deserted	-	-	1(0.5)	8 (4.1)	12 (11.7)	33 (47.8)
No response	-	-	1 (0.5)	-	-	1 (1.4)
Total	**138**	**124**	**207**	**194**	**103**	**69**

Note: *Figures in parenthesis are percentages.*

Comment: % of what?

Table: 3.13 Number of Living Children for Ever-Married Women by Age Group

Age Groups	Number of Living Children							
	Mean no. of Living Children	Nil	1—2 Children	3—4 Children	> 5 Children	NA	NR	Total
12—17	0.14	5 (4.0)	1 (0.8)	-	-	118 (95.2)	-	124
18—25	1.25	47 (22.7)	87 (42.0)	20 (9.7)	1 (0.5)	52 (25.1)	-	207
26—35	2.85	8 (4.1)	75 (38.7)	83 (42.8)	24 (12.4)	4 (2.1)	-	194
36—45	3.49	1 (1.0)	28 (27.2)	53 (51.5)	20 (19.4)	-	1 (1.0)	103
46—97	3.77	2 (2.9)	14 (20.3)	24 (34.8)	22 (31.9)	-	7 (10.1)	69

Comment: I don't understand this column.

Note: *Figures in parenthesis are percentages.*

Table: 3.14 Position in Household, Location of Workplace & Type of Work Done by Women

	% of Women
Relationship of Respondent to Head of Household	
Self	4.0
Parent	1.6
Sibling	0.9
Spouse	36.6
Child	45.5
Grandchild	4.4
Parent-in-law	0.5
Any other relative	1.7
Not related	0.3
Daughter-in-law	4.5
Location of Work Place	
In own home, housewife or retired, unemployed, student	49.1
On road, place to place	2.2
Small establishment	4.2
Large establishment, Govt. concern	2.0
Not applicable	42.3
No response	0.1

Type of Work Done	
Unskilled manual labour	1.9
Semi-skilled manual labour	1.1
Hawker	0.5
Small-scale manufacturer	1.3
Skilled worker	2.4
Small retailer	0.2
Peon, waiter, ward boy level	0.4
Secretarial level service	1.3
Nurse, teacher, compounder	1.6
Highly qualified professional	0 .1
Housewife	44.3
Student	29.1
Unemployed	2.3
Not applicable	13.2
No response	0.4
Total (N)	**1036**

Table: 3.15Occupational Level of Adult Women according to Level of Education

Educational Level of Individual	Occupational Level (%)				
	Non-workers and Housewives	Unskilled and Semi-skilled Workers	Skilled and Service Sector Workers	Lower Level Professionals	Professionals and Business Persons
Illiterate / Primary School	83.1	6.2	10.5	-	0.2
Secondary / High School	65.0	4.7	28.4	0.3	1.6
Matriculate	38.3	5.1	46.4	3.0	7.2
Higher Secondary	38.7	3.6	45.0	4.5	8.1
Undergraduate, Technical and Postgraduate	37.4	1.1	24.2	14.3	23.1

Total women (N= 573). Figures are in percentages.

Patterns of morbidity

The patterns of reporting of morbidity reveals not only important facets of the health status of various groups, but also points to inequalities in status and autonomy among various groups of individuals. Morbidity and mortality data have long been used to estimate the level of gender injustice in society. Greater gender justice in the distribution of food, health care and other resources help in ensuring the survival and health of women and female children. Although less clearly understood, women's work, autonomy in making reproductive choices and their relative status in the family and community also have an influence on their health. Morbidity among women is thus an important guide to understand their position in the household and the community. Health, defined broadly as a feeling of physical, mental and spiritual 'well-being' is often juxtaposed to its definition as absence of disease and infirmity. However, in actual reality, the relationship between 'well-being' and absence of disease is very complex. People's perception of their health, illness and causative factors is based on many factors — social, economic, cultural and environmental. From a strictly scientific point of view, one may assume that those who live in poverty, degraded living environment, and involved in occupations which are hazardous to health, etc. should necessarily have a lower feeling of well-being and thus complain more of ill-health and illness. However, studies have shown that this is not necessarily so the rich and well-placed strata complained of illness more often than the poorer strata (Duggal and Amin, 1989*)*. Also, people in the underdeveloped states in India reported less morbidity than those in the developed states (NSS, 1992).

There are no straightforward explanations as to how an individual's social position is reflected in his/her health status. Even our bodily experiences are coloured by our perception of our social role and the definition of that state in our culture. Thus, a state which can clinically be defined as 'illness' may not be experienced as such by the woman to whom it may seem a natural part of being a woman. Conversely, a clinician may refuse to accept a complaint made by her because it can not be medically established. However, unless we are prepared to accept and observe both these categories of problems, that part of women's morbidity will not emerge. It is a case of not seeing what we were not prepared to observe in the first place. Therefore, any investigation into health of people necessarily encounters the problem of understanding how health and illnesses are perceived and understood by people. A strictly medical approach to identify diseases among people, and a strictly sociological approach of accepting non-prompted answers given by people on their health and illness would not provide necessary answers. For instance, a number of studies done in the last ten years on women's reproductive health have found that while the number of reproductive illnesses reported by women in surveys is not high, on clinical examination a very large number of them were found to be suffering from diseases (BCC et al.).

Morbidity in health surveys

As knowledge from more studies accumulates, our understanding of the inter-linkages of socio-economic, political and environmental factors with health is deepened. Notably, in the past decade, three attempts have been made to conduct countrywide studies (National Sample Survey Organisation (NSSO) in 1986—87 and the National Council of Applied Economic Research (NCAER) in 1990 and 1993) to study morbidity, health care utilisation and expenditure through the use of household surveys. Apart from these, numerous small-scale studies have been conducted using the same methodology, the most significant among those including studies

conducted in Jalgaon (Duggal and Amin S, 1989), Madhya Pradesh (George, et al., 1994) and Kerala (Kannan, et al., 1991).

These health surveys recorded 'perceived morbidity'. They depend on the person's perception of his/her health status. Perceived morbidity refers to the reporting of episodes of illness occurring in the span of a specified time period (recall period) by the respondents themselves. There may be a criterion for identifying an illness episode, such as restriction of physical activity, confinement to bed, etc. A list of tracer conditions / probes (list of symptoms) may also be used to improve the reporting of minor ailments. Added to the heterogeneity of the studies conducted, there was no standardisation in the methodology of these studies. Thus, a brief review of their findings indicates certain consistent trends as well as striking differences. The most remarkable difference has been in the quantum of morbidity that these studies have been able to record. In 1990, the NCAER recorded a prevalence rate of 67.70 illness episodes (formally treated) per 1000 persons for a 15-day period in urban areas (NCAER, 1992). This was lower than the rural rate of 79.06. In 1993, a similar study **(**Sundari, 1995) recorded a prevalence rate of 103 episodes (including untreated illnesses) per month in urban areas. In the study Duggal and Amin, 1989 conducted in Jalgaon, which was one of the first studies of this kind, a total monthly prevalence rate of 149 episodes per thousand persons was recorded. The rates for males and females were 145 and 152 respectively. In the study of two districts in Madhya Pradesh conducted by the same organisation (George et al., 1994), the monthly morbidity rates was 323 for males and 296 for females. The total morbidity prevalence rate was 311. In the study conducted by Kerala Shastra Sahitya Parishad (KSSP) in rural Kerala (Kannan, et al., 1991) higher morbidity rates were recorded with male morbidity being 203 and female morbidity 206 per thousand for a reference period of two weeks.

Although the rates of morbidity themselves vary significantly, the gender difference in the reporting of morbidity in each case is very marginal. Female morbidity rates are higher by 1 to 5 percent than the total morbidity rates in the Jalgaon, KSSP and NCAER (1993) study. We find female morbidity lower than the total by 5 percent in Madhya Pradesh study and by 20 percent in the NCAER study of 1990. However, as the latter study took into consideration only formally treated illnesses, this finding is not surprising. It is very likely that a large percentage of women's illnesses go untreated. Both the NCAER studies as well as the Madhya Pradesh study which reported morbidity by age and sex showed that morbidity among adult women tended to be higher than morbidity among female children. This indicated that women faced a higher risk of illness after they reached the reproductive age. However, no study had attempted to systematically document the nature of additional illnesses suffered by women after they reached puberty through a household level survey**.** Evidently, an important aspect of women's health is the strain put on women's bodies by actual reproduction and the resultant short-term and lifelong health problems. However, studies on sexual or maternal health are not sufficient to understand how women's health condition changes after they enter into marriage and motherhood. These do not imply merely the responsibility of meeting the partner's sexual needs and the biological reproduction of children. Regardless of the other economic roles that they may perform, women in all societies undertake the responsibility of 'reproductive labour'. We must define it as a ‘'work relationship' (Harvey; 1990) into which women enter as wives and mothers. Women must undertake all the tasks that are necessary

for the sustenance of their households. How burdensome this role becomes depends on many factors, including the resources available to the household, the expected number of children she must bear and raise, the number of dependants and the sexual and age-wise division of work within the household. In general, as reproductive labour is seldom transferred to male members of the household, adult women in the household are often the sole members of the family to undertake this 'reproductive labour' (Chant; 1992). We attempted to use the household survey to explore the totality of women's health problems in relation to their lives and all aspects of their work.

Classification of illness

As explained earlier, we modified the morbidity survey methods hitherto used by researchers in order to capture a part of those illnesses suffered by women but normally not reported in the household surveys for various reasons. The investigators recorded verbatim response of the women interviewed and in the section covering morbidity, provided us with a list of symptoms suffered in the month of June 1996. Our investigators recorded each response to the probe as an independent episode of illness. So, on one hand more women reported morbidity than men in individual households, and on the other hand we had over-estimation of women's morbidity as some of the morbidity reported in response to probes were running concurrent and were a part of the symptom complex.

The resultant data on morbidity was then analysed and a maximum of three symptoms was coded for each episode from a list of 89 symptoms. The classification of the episodes into eight types of illness was then done taking into consideration all three symptoms. In case of doubt, the individual's gender and age as well as the stated reason for illness was taken into account. Although the types of illness were based broadly on the physiological systems (respiratory, gastrointestinal tract (GIT), reproductive system), we felt compelled to include categories such as 'aches, pain and injuries' and 'weakness' in the list. The final classification itself gives evidence to the distinctive character of women's health problems. The reporting of symptoms confirmed that women consider these health problems as important and as categories in themselves. Adhering to a strictly clinical classification of morbidity would have meant losing sight of this perception.

Prevalence

In the study, we recorded 780 episodes of illness among 2,149 individuals in the month of June. Thus, the monthly prevalence rate of illness is 363 per thousand *(Table 4.4).* However, we find very dramatic gender differences in this study. We find that when asked to report illness without any probing, women have reported nearly twice as many episodes of illness for themselves as for the male population. (Males recorded a monthly prevalence rate of 169 per thousand as compared to 297 for females). 47 per cent of the episodes recorded for women (including girls below 12 years) were reported after probing. When we add the episodes reported after probing, the female morbidity rate becomes three-and-a-half times higher than that of males (571 per thousand for females). No previous household study (where, usually, the gender of the respondent and the interviewer is not specified) has reported such a large difference in morbidity. This could be due to various factors namely, use of women investigators, use of a probe list and the way the study was conducted.

***(Note**: Morbidity rate in this study refers to the number of episodes reported for 1000 persons in the month of June '96. Monthly prevalence rate and rate of illness have been used alternatively for morbidity rate).*

Morbidity by type of illness

The high morbidity rates among women were characterised by the high prevalence of specific types of illnesses (*Table 4.1*). Reproductive illnesses formed the largest group of problems accounting for 28.2 per cent of all episodes among females. We found that 127 of the 167 reproductive episodes reported by women were related to menstruation and childbearing (menstrual problems, uterine prolapse, low backache and lower abdomen pain). Reproductive health problems of the above nature are often linked to nutritional deficiency problems, which are also manifested as weakness. Pain of the extremities which is indicative of poor nutrition accounted for 36 of the 74 episodes reported in the aches, pain and injuries category. Also, taken together, reproductive problems, aches, pains and injuries and weakness all of which are inter-related, formed 51.69 per cent of all illnesses reported among women. Thus, we see that these three types of illness form a complex of gender-related health problems.

When we considered the gender difference in the type of illness reported without probing, we found significant differences in the level of morbidity in every category among men and women *(Table 4.2).* Women have reported remarkably higher levels of almost all types of illness. In only one category, i.e., aches, pains and injuries, we found that the gender difference was not significant. When combined with the information received after probing the co-relation between gender and morbidity increased even further.

As anticipated, the high reporting of reproductive and related morbidity was achieved largely through the use of the probe list (*Table 4.3*). E.g., only 37 of the 167 episodes of reproductive health problems were reported without probing. For the three 'gender-related categories' that we have identified, 75 per cent of the episodes were reported with probing. In contrast, not surprisingly, for the categories of respiratory illness, gastro-intestinal problems and fevers, probing did not result in a significant increase in reporting. But we found that women reported significantly more episodes in these categories as well. Thus, the fact that women reported these types of illness much more frequently than men is very significant. This suggests that being female increases not merely the risk of reproductive and related morbidity, but also the likelihood of suffering from general health problems.

MORBIDITY BY SOCIO-ECONOMIC DIFFERENCES

Age

We found that in each and every age group, including children below 5 years, female morbidity was higher than male morbidity. In addition to this, we found that the gap between male and female morbidity increased with every age group. While female morbidity was 6 per cent higher in children below 5 years, it was 264 per cent higher among females above 45 years of age (excluding episodes recorded after probing). Likewise, we also found a wide variation in the distribution of illness among the different age groups in males and females. Among the males, predictably, we found morbidity to be highest among the under 5 population (361 per thousand). It steadily declined among the older males before rising among men between 36 and 45 years

(188 per thousand) *(Table 4.4).* Among the oldest age group, it declined marginally to 160 per thousand. As women were the main respondents in this study, it is very likely that child morbidity has been better recorded, while the illness of adult males has been under-reported. If we make allowance for these reporting errors, we are likely to see the characteristic “U” shape curve in male morbidity. This means that morbidity at both ends of the life span remains high.

For the female population, we saw an entirely different pattern emerging. We saw a steady rise in the morbidity rates with age. We found that the morbidity rates among female children were relatively much lower than those among adult women. It can also be observed that the rates continue to rise till the women reach the age of 45 years, after which they decline to a small extent. Excluding data gathered through the use of the probe list does not radically alter this pattern because we found that women in and beyond the reproductive age, who report the largest number of illnesses with probing had already reported very high morbidity initially. The high morbidity among women in the reproductive age, which was earlier only hinted at, is revealed very clearly in this study.

Marital status

To complement the evidence from the age-wise analysis of morbidity, we also saw the contribution of reproductive labour in the rates of morbidity reported by ever-married and never-married women. Cohabiting women reported a morbidity rate of 850 and other ever-married women a rate of 818 *(Table 4.4).* This was in sharp contrast to the rate of 290 for never-married women. Although we did not record the obstetric history of the women respondents, we recorded the number of living children for all ever-married women. We also found a link between the number of living children and female morbidity. The morbidity rate for married women with no children was 625, while for those with 3_4 living children it was 939.

Occupation and earning status

The effect of economic labour was also very apparent in the data on female morbidity. As the numbers of employed women were very small, it was not feasible to analyse morbidity in the context of the type of work done. However, even when we considered merely the work status of women, we found a strong co-relation between labour and morbidity. In the total female population, non-earners (students and girls below 12 years) had the lowest morbidity rates (230) *(Table 4.4)*. Housewives recorded a morbidity of 810, while those women who also earned an income had a morbidity rate of 774. Nuclear family with only one adult woman in the household is the most common family organisation to be observed in the city. As there is no distribution of housework between men and women, a woman must bear the entire responsibility for running the household. When such a woman seeks employment either by working at home or outside, the strain of paid work is merely added on to her existing workload.

The difference in the morbidity rates of women having the same work status living in a different environment is much more significant than the difference in the morbidity rates of housewives and earners in the same environment. Even as housewives, who, technically speaking, perform the same role in all households, women living in slums are put to a much greater risk of illness than employed women who live in a

better home environment. When these same women take up employment, our data suggests that their health deteriorates even further.

Morbidity by physical environment

The findings reveal (*Table: 4.4*) that living in a slum adversely affects the health of all individuals regardless of gender, age and work status. The morbidity rates of slum dwellers of all age groups are more than double those of their counterparts in non-slum households, the only exception being males in the age group of 12_17 and 26_35 years. We also found the same difference in the morbidity rates of males and females, non-workers and employed persons. The overall morbidity rates for slum dwellers were recorded as 429, as compared to 272 for non-slum dwellers. Remarkably, the effect of this variable (living environment) is to increase the quantum of morbidity for each group. The co-relation of morbidity with age, gender, marital status and work status is maintained within the same living environment. Thus, while the morbidity rates for housewives in the slum is as high as 971 (compared to 583 among non-slum housewives); it is even higher for earning women at 980. Likewise, earning women living in non-slum environment have a higher morbidity of 613, compared to housewives in the same living environment.

The analysis of morbidity in relation to the living environment showed the high degree of variation existing within groups defined according to work status, gender and marital status regardless of their living environment. Although the non-slum population comprised 42 per cent of the sample, their illness accounted for only 31.79 per cent of the total morbidity (*Table: 4.5*). Surprisingly, there is no significant variation in the morbidity pattern across the various categories of illness. In most cases the variation is very marginal. It would seem logical to assume that diseases, which have associations with pollution and lack of hygiene, would be more dominant in slum environment in comparison to other illnesses. On the contrary, we found that respiratory illnesses, GIT infections and fevers formed almost exactly the same proportion of total morbidity in both the slum and non-slum populations.

We found that slum dwellers suffered more frequently from all types of illnesses. Overall, morbidity among the slum population was 10 per cent higher than among the total population. However, this increase was uniformly distributed across all the types of illnesses. In all categories of illness, apart from ‘others’, the share of the morbidity of slum dwellers was higher by 10 to 16 per cent than their share in the total population. In the categories of ‘aches, pain and injuries’ the disparity was less significant (4 per cent). The category of ‘other’ problems, which included a wide range of non-infectious, chronic health problems, has been reported as often by slum dwellers as by non-slum dwellers. Overall, it is a relatively minor group of health problem. This finding suggests that living in a degraded environment contributes in a general increase ill health, rather than merely a rise in the incidence of specific diseases.

An analysis of the morbidity of women living in slums showed that the morbidity rates among married women was 1,026. This implies that every woman in this category reported an episode. Among the ever-married women, those with 1_4 children reported equally high rates. Housewives and earning women both reported similarly high morbidity. Similarly high rates could be observed, when we looked at the age-wise morbidity among women in the age group of 18_45 years. When taken together,

we found that married cohabiting women with children, in the reproductive age, who lived in a slum environment, were most vulnerable to ill health. One of the obvious explanations for this high morbidity in slums is the degraded physical environment and poor access to basic amenities. The overall condition of the air, water and land in this area is very poor, and the congestion and hygiene in the slums exacerbate the effects. Slum dwellers are brought more often into contact with toxins in the air, water and soil due to the open sewers, unpaved lanes, impermanent house structures and the use of common toilets and water taps.

Apart from the general hardships of living in an area with a degraded environment and the lack of space, light and fresh air, women in slum areas also suffered from many other disadvantages. As noted earlier, reproductive labour for women constitutes a crucial aspect of their work lives. The slum household as a workplace is understaffed, over-utilised and deprived of the most basic facilities. We found that among non-slum households, water from even common taps could be drawn directly through plastic pipes. In the slums, due to the longer distance and greater number of users of taps, water had to be carried home in large vessels. The open drains in the slums were invariably clogged with solid waste thrown into them and had to be frequently cleaned by the women themselves. Due to the long queues at the municipal toilets, small children were made to defecate outside the house and the women were naturally responsible for cleaning the place after that. In the absence of specified area for garbage disposal, women had to be vigilant against the dumping of waste near their houses by others. As the lanes were not paved, the house was surrounded entirely by dirt and sludge. The women fought a constant battle to keep these out of their houses. The environment of the slum makes it necessary for women to undertake a heavy burden of work merely to make the house livable.

Employed women in slums were either home-based workers or workers in the small industrial units close by. Thus, they were exposed to an additional degraded environment through their paid work. They also faced a heavier work burden because employment does not free women from the responsibility of housework. Thus, we found that they suffered from the highest level of morbidity.

This finding has a very important implication for the understanding of urban health problems. The high morbidity among slum dwellers, especially women, impresses on us the need to study ‘slum’ not merely as a physical environment, but also to examine the social, economic and even psychological pressures that these communities and their women, in particular, face. Our field experience made it very evident that destitution was not a widespread problem, even among the slum households. We found that, by and large, the households did not face any threats to survival. In the Indian context, the effect that relative poverty has on both the perception of illness and actual morbidity has never been explored.

Table: 4.1 Type of Illnesses Suffered

Type of Illness	Number of Episodes		
	Male	Female	Total
Reproductive problems	-	167 (28.2)	167 (21.4)
Aches, pains and injuries	24 (12.8)	74 (12.5)	98 (12.6)

Weakness	4 (2.1)	65 (11.0)	69 (8.9)
Fevers	40 (21.3)	67 (11.3)	107 (13.7)
Respiratory problems	85 (45.2)	115 (19.4)	200 (25.6)
Gastro-intestinal problems	23 (12.2)	44 (7.4)	67 (8.6)
Skin, eye, ear problems	5 (2.7)	31 (5.2)	36 (4.6)
Others*	7 (3.7)	29 (4.9)	36 (4.6)
Total	**188 (100)**	**592 (100)**	**780 (100)**

***Note:** "Others" include mental stress, anxiety, piles, bladder stone, kidney problems, involuntary urination, diabetes, hair loss, heart problems, blood pressure, paralysis, tumour and unspecified symptoms.*
Figures in parenthesis are percentages.

Table: 4.2 Number of Persons Reporting Various Types of Illness by Sex (Figures for women are with and without probing)

Type of Illness	**Males** (Number)	Without probe (Number)	**Females** Chi Square significance	Total (Number)	Chi Square significance
Reproductive problems	0	34	.00000	144	.00000
Aches, pain and injuries	23	27	.406	72	.00000
Weakness	2	13	.00278	62	.00000
Fever	39	60	.01148	66	.00207
Respiratory problems	84	105	.03429	114	.00563
G.I. tract problems	23	35	.06076	44	.00366
Skin, eye, ear problems	5	16	.00991	29	.00007
Others	7	15	.0594	29	.00009
Total reporting illness	**174**	**263**		**397**	
N	**1113**			**1036**	

** Total number of persons=2149*

Table: 4.3 Effect of Probe on Types of Illnesses Reported

Type of Illness	**Number of Episodes Reported by Women**			
	Without probing	**With probing**	**Not applicable**	**Total**
Reproductive problems	36 (21.6)	130 (77.8)	1	167
Ache, pain, injury	21 (28.4)	47 (63.5)	6	74
Weakness	12 (18.5)	52 (80.0)	1	65
Fevers	47 (70.2)	7 (10.5)	13	67

Respiratory problems	58	9 (7.8)	48	115
Gastro-Intestinal problems	22	9 (20.5)	13	44
Eye, ear, skin problems	16	13 (41.9)	2	31
Others	14	14 (48.3)	1	29
Total	**226 (38.2)**	**281 (47.5)**	**85 (14.3)**	**592 (100)**

Note: *Figures in parenthesis are percentages*.

Table: 4.4 Morbidity Prevalence Rates in Relation to Living Environment (Per Month Per 1000)

Characteristics	Females			Males			All Individuals
	All Females	Slum	Non-Slum	All Males	Slum	Non-Slum	
Age							
0--4 years	384	400	349	361	458	108	373
5--11 years	222	248	182	171	211	114	197
12--17 years	315	468	161	143	137	150	226
18--25 years	686	912	342	130	149	101	408
26--35 years	866	1052	595	101	95	110	469
36--45 years	874	956	810	188	200	175	494
> 45 years	783	1042	644	160	237	123	414
No response	667	2000	000	000	000	000	154
Education							
Illiterate	832	905	608	191	209	125	610
Primary school	418	526	239	172	204	111	297
Secondary/High-school	591	704	460	131	141	118	347
Matriculate	769	1313	629	102	73	125	323
College & others	357	1400	277	144	128	153	218
Not applicable	404	408	395	346	438	88	376
No response	500	000	1000	200	222	000	250
Household Size							
1--4 persons (3.3)	743	921	519	207	267	134	467
5--7 persons (5.7)	539	624	420	156	178	122	337
8--10 persons (8.6)	361	402	309	136	149	113	254
>10 persons (11.8)	556	1222	222	188	333	59	356
Marital Status							
Not married/cohabiting	290	337	227	195	251	116	238
Married/cohabiting	850	1026	621	127	129	123	481
Widowed/separated/ divorced	818	1000	593	625	600	667	794
Not applicable/No response	500	1000	000	500	500	-	500
Living Children							
Nil (0.0)	652	881	250	-	-	-	194
1--2 (1.5)	820	1000	589	-	-	-	791
3--4 (3.4)	939	1134	714	-	-	-	919
>4 (6.1)	882	886	875	-	-	-	775
Not applicable	285	333	223	-	-	-	236
No response	714	4000	167	-	-	-	556
Earning Status							
Housework	810	971	583	-			810
Non-earner	230	291	167	171	200	136	198
Earner	774	980	613	127	139	111	236
Not applicable/No response	404	418	368	291	362	127	341

Type of Occupation							
Student	223	266	179	171	194	144	196
Unemployed	417	529	143	169	229	100	236
Housework	811	974	579	-	-	-	811
Unskilled worker, hawker	750	818	643	96	122	41	312
Skilled worker, service sector	877	1120	688	144	142	148	235
Professional & Business	500	1000	438	67	133	50	151
Not applicable	402	406	389	335	416	128	368
No response	500	1000	000	143	154	125	174
Location of Work							
Own home	790	950	558	238	177	500	768
Place-to-place	1087	1188	857	85	85	83	366
Small establishment	705	765	667	140	152	121	200
Large establishment/Govt.	476	500	474	115	128	108	172
Not applicable	279	323	219	211	270	128	242
No response	2000	2000	0	53	90	0	150
ALL (N=2149)	**571**	**684**	**424**	**169**	**201**	**123**	**363**

Note: *Morbidity prevalence rate = (number of episodes / number of persons) x 1000*
For all figures underlined, the sample size (N) is less than 30.

Table: 4.5 Type of Morbidity and Living Environment

Type of Illness	**Living Environment**						
	Slum			**Non Slum**			**Total**
	No. of Episodes	**A**	**B**	**No. of Episodes**	**A**	**B**	**No. of Episodes**
Reproductive problems	124	108	97	43	82	70	167
Aches, pains	61	91	57	37	120	41	98
Weaknesses	48	102	40	21	97	29	69
Fevers	73	100	62	34	101	45	107
Respiratory problems	137	100	116	63	100	84	200
Gastro-intestinal problems	46	100	39	21	99	28	67
Problems of sense organs	27	110	21	9	79	15	36
Others *	18	73	21	18	159	15	36
Total	**534**		**453**	**246**		**328**	**780**

Note***: 1. Column A*** *indicates the variations in the pattern of morbidity for each living environment (mean=100). For example, 100 indicates that 'fevers' constitute the same proportion of morbidity in the slum population as in the total population.*

2. Column B *indicates expected frequencies for each type of morbidity.*

3. *Others* include mental stress, anxiety, piles, bladder stone, kidney problems, involuntary urination, diabetes, hair loss, heart problems, blood pressure, paralysis, tumour and unspecified symptoms.*

Utilisation of Health Services

Utilisation of health services is a complex phenomenon which is affected by various factors such as perception of illness; severity of illness; need for health care; knowledge about health services; physical, economic and social accessibility of health care services; quality of care; socio-economic and political structures; and the biases of the health care providers. Under-utilisation of health services is known to be more acute in the case of poor, disadvantaged sections of our society and is due to a wide and multifaceted socio-economic-cultural chasm that exists between the users and providers of health services.

There have been several studies conducted focusing on utilisation of health services in India. These studies have used different methodologies and settings to examine the aspect of health seeking behaviour. Some of the studies were conducted in the communities focussing on utilisation as part of larger studies that examined morbidity, event-related utilisation and expenditures incurred among other aspects. Some of them examined utilisation with regard to particular health facilities and in some of the studies the focus was on utilisation of health services related to specific illness. The studies which were conducted in the communities were (mentioned in the earlier chapters) by NSSO, FRCH, NCAER and KSSP (NSSO, 1992; Duggal and Amin, 1989; NCAER 1992; 1993; Kannan, et al., 1991; George et al., 1994). Aspects with regard to the general preference for formal / non-formal, indigenous, private / public type of health institutions and services have been studied at length. In addition to the above mentioned studies there have been many other studies conducted which focussed on certain aspects of the utilisation pattern. Some of the studies have examined factors such as socio- economic characteristics of respondents and looked into the gender differential. (Talwar et al., 1985; Das et al., 1982; Miller, 1982). The gender difference has been examined with regard to the timing of treatment more closely. (Kielmann, et al., 1983) Physical, economic, social and cultural inaccessibility of health services for Indian women has also been recorded by a number of other studies (Chatterjee, 1990; Khan et al., 1983; Das Gupta, 1987; and Ramalingaswami, 1987; and Jeffrey et al., 1989). There have been studies conducted on non-illness reproductive events, like pregnancy, delivery, post natal care, childcare, contraception and abortion. There is quite an extensive amount of research done on these aspects. Generally, the focus has been mainly on quality of care, program policy, demographic impact and the unmet needs of women, and only peripherally on utilisation. Khan et al., 1983 and Murthy, 1982 have conducted hospital-based studies. They show lower attendance at hospitals and high proportion of 'no treatment' among women. Those who do receive treatment, depend mostly on self-care, home remedies and a variety of "traditional" medical care. In contrast men are more likely to receive "modern" medical care, including institutional care, and higher quality care. (Das et al., 1982; Miller, 1981 cited by Chatterjee 1990, p.44)

There were studies that examined health-seeking behaviour with respect to certain illnesses, especially with regard on women's reproductive health, however, their focus has been on understanding gynecological morbidity and women's perception of the same. (Gittelsohn, 1994). Some qualitative studies (Visaria, 1992), have looked at men's perception of the unmet reproductive health needs of women. One finds a few specifically urban-based studies (ORG, 1990; Yesudian, 1988; Gill, 1996) focusing on how health services in urban settings are utilised.

Present study

Mumbai is privileged to have a well-developed infrastructure and a vast supply of public and private health care services. The services range from the super speciality tertiary level care hospital to general practitioners. The central government has its own dispensaries, which are available only for their employees. Further there are Employees State Insurance Scheme health care services which include hospitals and dispensaries and only cater to the organised sector employees. The various departments such as the ports, railways, defence, etc. have their own health care services and hospitals catering to their employees. For the general people the Bombay Municipal Corporation (BMC) provides the major care in the public sector along with the state government. There are six teaching hospitals (two state government owned), fifteen peripheral hospitals, 26 maternity homes, 159 dispensaries and 176 health posts run by the BMC. In the private sector, the CEHAT database records 1,082 private hospitals/nursing homes in Mumbai city run by individuals, co-operatives, corporate bodies, companies, religious bodies, trusts and NGOs. Apart from this there is a large segment consisting of private practitioners, polyclinics, and dispensaries.

In our study we have defined utilisation of health services in a manner that incorporates all health care services and facilities. 'Utilisation' is defined as all actions taken to access knowledge, facilities, items and services to ease, reduce, eliminate or prevent illness or specific symptoms or to cater to their health needs. 'Health facility' is taken to mean any institution inside / outside home, formal / informal, paid / unpaid / subsidised, belonging to any recognised / unrecognised system of medicine. 'Treatment of illness' includes advice (leading to action), examination, diagnosis of illness, cure and care of illness, symptoms reported and other health needs. 'Non–treatment' is when an illness is reported within the recall period, and where no action had been taken to alleviate the situation. In 'services' we have included also those received in the form of self-care / self-medication, home remedy from any local health service provider. Our intention was to include the entire gamut of utilisation of health care services in the community and to analyse the situation correctly, without a bias in favour of formal health care services.

Overall we find that in terms of treatment of illness, out of the 780 episodes reported, only 67 per cent were treated. In terms of gender difference we found that 91 per cent of the illness episodes of males were treated as compared to 60 per cent of females *(Table 5.1).* The average health facilities utilised per treated episodes worked out to 1.04 for males and 1.05 for females. The total number of visits during the recall period was 1,187 which worked out to 1.52 visit per illness episode and 2.2 per health facility (excluding home treatment where we have recorded no visits). There were only four cases of hospitalisation.

Type of health facility utilised

Private health facilities form more than 4/5ths of the total health facilities utilised (553). With private facilities covering 84 per cent, public facilities fare very poorly with only about 10 per cent utilisation. This is followed by about 6 per cent utilisation of home facilities and other health facilities. Even if we exclude pharmacists / chemists who are presently grouped under private facilities (about 1/10th), the difference in private and public health facility utilisation is vast. Utilisation of private sector facility is common for both men and women, but slightly lower for women (*Table 5.2*). Public

sector health facility is utilised in only about 9—10 per cent of the cases for males and females. The only other difference is that more female episodes get treated at home (around 6 per cent) than males (2 per cent).

When we categorised the health facilities broadly into private and non-private (public, home and other) health facility, we found that more number of women utilised non-private facilities than men. About 87 per cent male episodes were treated at private facilities and about 12 per cent were treated elsewhere, whereas in the case of females about 82 per cent of illness episodes were treated at private and 17 per cent were treated at non-private facilities.

Studies in urban areas show the same trend in greater utilisation of private facilities, about 73 per cent in Calcutta, 68 per cent in Indore and 51 per cent in Bharuch (ORG, 1990). All-India-based studies conducted by the NCAER also indicate that for all states except Himachal Pradesh, Assam, Orissa and Karnataka the utilisation of private facilities is high. Even in a state like Kerala, which has a well-developed public health infrastructure, there is a greater reliance on the private sector than public sector (NCAER, 1992). Public sector service utilisation in various studies, has ranged between 9 per cent (Duggal and Amin, 1989) to 36 per cent (NCAER, 1992).

Type of health facility utilised

It was found that only 10 per cent were being treated in hospitals / nursing homes. Apparently, the gender factor does not seem to be a deciding one in terms of utilisation of hospitals / nursing home facilities. Dispensaries / clinics constitute more than 3/4th of the health facilities used by men (79 per cent); and for women it is lower than that (74 per cent) *(Table 5.2).* Women's use of structures such as chemists / pharmacists, home and 'others' together, was close to double that of male utilisation. This could be because these structures are convenient to them in terms of time, their proximity to the place of residence, their easy accessibility even by someone else in lieu of the ill person and the fact that all this requires expenditure of less money. Most of all this practice is in keeping with their perception of what can be treated outside the formal structures. The other possibility could be that these are seen as stop gap arrangements till the time they can seek services from formal structures for their immediate health needs.

If we were to categorise the above in terms of private and public facilities, we would find that whereas people prefer dispensaries and clinics as opposed to hospitals and nursing homes in the private sector, the reverse holds true in the public sector. People prefer to use the public hospitals rather than the clinics and health posts *(Table 5.3).*

Location of the facilities

Distance to the health care facility, mode of transport taken to reach the facility, and waiting time are crucial in understanding utilisation. However, we have considered only physical distance of the health facility in terms of time taken to reach the health facility from one's place of residence. We found that about 2/3rd of the total facilities utilised were those in close proximity to the residence, requiring less than 10 minutes to reach. 78 per cent of these were private health facilities *(Table 5.4).* The public health facilities were generally spread out; less than 1/4th were at a distance of 10 minutes and another 36 per cent were at a half-hour distance, and 43 per cent more distant than that.

Type of treatment received

Out of the total treated episodes we found that more than half consisted of dispensed medicines (excluding injection). About one-fourth received medicines including injections and another five per cent took home remedies. 25 per cent episodes among women and 33 per cent among men were treated with an injection. Six per cent women and two per cent men took home remedies. *(Table 5.5).* The low percentage of injections reported may not entirely be true, as some respondents may not have reported them as separate from medicines dispensed.

Health provider

The provider of care would be an important deciding factor in choosing a particular health facility. The doctor was sought in more than three-fourths of the male and female illness episodes. The second most preferred provider was a paramedical person such as a chemist / compounder / nurse / multi-purpose worker *(Table 5.6).* The women treated their illness episodes in a varied manner although they too predominantly sought doctors. About 17 per cent of the female episodes were either self-treated or treated by paramedics, health workers, *mantriks*, *bhagats,* etc. in comparison to 10 per cent of the male episodes similarly treated. The recourse to self-medication (indigenous / folk medicine), though, was found to be low (four per cent) and the preference was to go in for easily available drugs at the chemist, continuing with old prescriptions, using what other people use as medicines for similar problems, etc.

Morbidity and Utilisation of health care services

Irrespective of the type of morbidity, private health facilities were generally preferred to public facilities. These findings were true for both men and women. Fevers and gastro-intestinal problems showed slightly higher utilisation of public health facilities than in other illness episodes in men. Health services at home were utilised to some extent in the case of aches, pains, injuries and respiratory problems. Episodes of weakness, eye/ear/skin and 'other' illnesses were very small to be analysed.

With regard to female episodes the trend was that fevers, respiratory and gastro-intestinal problems were most often treated, by more number of private health facilities. In case of reproductive illnesses, where only 39 per cent of the episodes were treated, about 70 per cent of health facilities utilised were private. Similarly, of the 35 per cent of treated weakness episodes, 82 per cent were privately treated. Home treatment was adopted for far more varied types of morbidity in women than for men.

While general illnesses are treated in ways that women thought were appropriate at the time, reproductive illnesses, due to their sensitive nature were either not treated or were preferred to be treated first in the most inconspicuous manner at home. Only later, if there was not much impact of these home remedies, did they take recourse to formal health facilities. Although we have not found large number of home treatment cases among women, we feel that there could be a process of seeking formal treatment which was not possible to be explored fully in the quantitative section but which is revealed in the qualitative data collected.

UTILISATION BY SOCIO-ECONOMIC DIFFERENTIALS

Age

The findings revealed that for males of all age groups the treated episodes were around 90 per cent but for females it showed a sharp fluctuation between 49 per cent and 97 per cent. The only equivalence in utilisation among males and females was in the high number of treated illness episodes for children in the age group of 0-1 years. Among females, it is during childhood that the most attention is received in terms of treated illness episodes. But this happy picture does not continue further in female adolescents. Unlike the male counterparts who had 89 per cent of their illness treated, the female adolescents had only 60 per cent of their illnesses treated. Thus a majority of the females in the age group of 12_45 years had only slightly more than half of their illness episodes treated *(Table 5.9).* Even among them, women in the 26_35 years age group have the lowest percentage of treated episodes (49 per cent). Older women, i.e., above 45 years, did not receive as much health care attention as the men in the same age group. The utilisation of home facilities among adult females was more or less in the 5_10 per cent range and was highest among the 18_25 years age group. Men are privileged in terms of utilisation irrespective of their age as compared to females who are not able to utilise health facilities, as they grow older.

Environment

Analysing utilisation of health facilities by respondents according to the environment they live in, we found that males in slums had a much higher percentage of treated episodes than the females. While males in non-slums had all their episodes treated, their female counterparts had only 69 per cent of the episodes treated. Men and women in slums used less private health facilities and more public health facilities than those in non-slums. This could be due to the lesser paying capacity of the people in slums for private health care facilities. Thus, as clearly brought out in other studies, it is the people from the slums who use public facilities more.

Marital status

Never-married males and females had a high percentage of treated episodes. The currently married men and women, on the other hand, were at the other end of the spectrum with less number of treated episodes. Among males, single men like widowers and men separated or divorced from their wives, and living-in partners had reported very few illness episodes *(Table 5.12).* Among the women, the widows and others fared as poorly as the currently married ones, if not more, indicating that there are similar pressures of household responsibilities dissuading them from getting their illnesses treated.

Earning status and occupation

The equal earners in both male and female categories had the least number of treated episodes followed by the main earners among females and non-earners among males. Housewives were the main group of people to resort to home remedies. *(Table 5.10).*

We found very few people belonging to the professional/ business/ enterprise category and have therefore deferred from analysing their health seeking behaviour. However, on the whole, men belonging to any of the occupation category had higher percentage of treated episodes than their counterparts among the women. The non-

workers among the males had 97 per cent of episodes treated while the female non-workers had only 57 per cent of the episodes treated. The unskilled male worker had 71 per cent of episodes treated as opposed to 44 per cent of the female unskilled worker. Among the skilled workers the percentage was 88 and 60 respectively. Thus utilisation of health facilities for the woman is not determined by her earning status and occupation.

Location of work

Hawking or working at different places does affect treatment-seeking behaviour for both the sexes. Such workers had the lowest percentage of treated illness episodes *(Table 5.11).* For women in this category as well as those working in small units / shops / establishments taking treatment for illness episodes seemed to be difficult thus leaving more than half of their illness episodes untreated. The few episodes that were treated were catered to by private facilities.

Education

Our study does not show any direct impact of education on health seeking behaviour. The important thing is that irrespective of the educational status all the males had about 86 to 94per cent of their episodes treated *(Table 5.12).* On the other hand, no matter how high the educational level of the women, not more than 65 per cent of their illness episodes were treated. (Except women who have technical/ professional education, who have very few reported episodes).

We reviewed treated episodes and utilisation by women, in the context of social accessibility. In more than one cluster we found that women did not go outside their houses, without the knowledge / permission of the rest of the family or the head of the family. Given this cultural backdrop, utilisation of formal health care facilities is bound to be inhibited and dependent on the head of the household. Even in households with nuclear family there are other pressures weighing down on the woman. Since mainly the woman of the household carries the burden of household chores, any time spent for health care means less time for household chores. Any friction with other demands of women's time for child care, fuel and water collection, or economically productive activities, affects women's use of formal health care. Thus, she can access health care only if she has a support system to fall back upon or when she feels confident of depending on those support systems. She is reluctant to go to a health facility because there is no one to take care of her household chores, children and husband in her absence (brief as it may be).

Non-utilisation

The finding that the number of illness episodes among females for which no treatment was sought, and so no health facility was utilised, was very high prompted us to examine this issue in depth. One finds that gender and age provide the most definite indication of differences in utilisation. The figure for no treatment among women is four times higher than that of men.

If we consider each socio-economic variable for analysis we find 11 per cent of the male illness episodes in slums were not treated, whereas males in non-slums did not leave any episode untreated. Women in both slum and non-slum environment had about 30_45 per cent of non-treated episodes. The males in the age group of 36_45 years and 45 years and more had the highest percentages of illness episodes not

treated (21 per cent and 25 per cent respectively) *(Table 5.14).* However, this figure looks inconsequential in comparison to women. The percentage of non-treated episodes for women above 12 years was around 45 per cent, with the women in the 26_35 years age group having the highest percentage of not-treated episodes. The difference between non-treated episodes of ever-married men and never-married men ranged between 5 per cent and 15 per cent. In the case of women, the difference between the corresponding categories was 18 and 47 per cent respectively.

The main earners in male and female populations suffered from higher percentage of non-treatment. However, the percentage was much higher for women (52 per cent) than men (15 per cent) in the same category. The women in the different earning status had between 46 and 52 per cent of their illness episodes not treated, while the percentage for men in different categories did not rise above 20 per cent. The non-working males had 3 per cent of illness episodes not treated as compared to 43 per cent among the non-working females. It is interesting to note that the percentage of untreated episodes of female skilled workers (40 per cent) was more or less the same as that of the female non-workers *(Table 5.14).* If we consider only those who reported substantial number of illness episodes, the highest percentage of non-treated episodes among males was 13 per cent which is found among the males working in small units and enterprises whereas for females it was nearly 50 per cent. Among housewives, who formed a large chunk of our respondents, no treatment was sought for 46 per cent of their illness episodes. Obviously, the hidden, unrecognised burden of housework takes its toll and added to that is the encumbrance of untreated illness or delayed treatment (not treated at the time of reporting of illness). At the same time we found that women who have independent incomes are not much better off than the housewives in this respect. The female skilled workers, the female earners (main, equal, and supplementary) all had 40_52 per cent of their illness episodes not treated *(Table 5.14).* Since we have not found any direct impact of education on health-seeking behaviour we note that no matter how high the educational level of the women in the household, it does not necessarily lead to greater health seeking behaviour. Excluding women who have technical / professional education (number of episodes are small) we found that whatever their educational status women did not treat about 35_48 per cent of their reported illnesses. Evidently, higher education or the ability to earn an independent income has not enabled them to have any real control over their own or their family's income, greater time and decision making in their hands *vis-à-vis* health.

The reasons for non-treatment of illness episodes was due to the fact that they did not consider the illness to be serious enough for treatment. Lack of financial resources available for seeking health care was also an important reason. We found that people do not seek treatment when the illness is considered to be seasonal / temporary / not very disturbing, or even when they have chronic, long-duration illnesses. Reasons for no treatment varied between the two sexes. Among men, about 59 per cent have stated that they did not seek treatment because the illness was seasonal, temporary or not very disturbing or when they were chronic episodes. Another 18 per cent have stated that they have not treated illnesses because of lack of support system, leave and other facilities *(Table 5.13).* Financial reasons are the cause for non-treatment in only 12 per cent of the illness episodes. On the other hand, 22 per cent of women's illnesses are not treated due to financial problems.

About 43 per cent of the women's 'non-treated episodes' are due to the perception that the illness is seasonal, temporary or long drawn and 12 per cent due to lack of social support system, etc.

The 'not treated illness episodes' bring out the real difference in utilisation by males and females. When they seek treatment for illness episodes, there is no apparent difference in the kind of health facilities utilised. However, the low status of women in household set-up and the society leads to a pattern of treatment that is subtly different from that of males. In the final analysis the prominent determining factor that emerges is the context in which men and women's role in the family and society is defined.

Table: 5.1 Utilisation of Health Facilities

Particulars	**Males**	**Females**	**Total**
No. of episodes treated	171 (91%)	355 (60%)	526 (68%)
No. of episodes not treated	17 (9%)	237 (40%)	254 (32.5%)
Total episodes reported	188	592	780
Total health facilities utilized	178	375	553
Average health facility utilised per treated episode	1.04	1.05	1.05

Note: *Figures in parenthesis are percentages.*

Table: 5.2 Type of Health Facility Utilised

	Males (%)	**Females (%)**	**Total (%)**
Type			
Private	154 (87)	309 (82.4)	463 (84)
Government	16 (9.0)	37 (10)	53 (10)
Home	4 (2.2)	22 (6)	26 (5)
Any Other	1 (0.6)	5 (1.3)	6 (1.1)
No Response / Not Applicable	3 (1.7)	2 (0.5)	5 (1)
Structure			
Dispensary / Health Post	141 (79.2)	276 (74)	417 (75.4)
Hospital / Nursing Home	18 (10.1)	36 (10)	54 (10)
Chemist / Pharmacy	12 (7)	38 (10.1)	50 (9.0)
Home	4 (2.2)	22 (6)	26 (5)
Any Other	0	1 (0.3)	1 (0.2)
No response/Not applicable	3 (2)	2 (0.5)	5 (1.2)
Total	**178 (100)**	**375 (100)**	**553 (100)**

Note: *Figures in parenthesis are percentages.*

Table: 5.3: Structure of Health Facilities Available

Type	**Structure of Health Facility**						
	Dispensary/ Health Post	**Hospital / Nursing home**	**Chemist**	**Home**	**Any Other**	**NR / NA**	**Total**
Private	405 (87)	9 (2)	49 (11)	0	0	-	463
Public	9 (17)	44 (83)	0	0	0	-	53

Home	0	0	0	26	0	-	26
Any other	3 (50)	1(16.7)	1(16.7)	0	1(16.7)	-	6
No response / Not applicable	-	-	-	-	-	5	5
Total	**417**	**54**	**50**	**26**	**1**	**5**	**553**

Note: *Figures in parenthesis are percentages.*

Table: 5.4 **Distance to Health Facility**

Type of Facility	Distance					Total	
	No Distance	< 10 min.	10 – 30 min.	30 min. -- <1 hour	1 hour & more	NR/NA	Total
Private	-	358 (77)	61 (13.2)	36 (7.7)	8 (1.7)	-	463
Govt.	-	13 (23)	19 (33.9)	16 (28.6)	8 (14.3)	-	56
Home	26 (100)	0	0	0	0	-	26
Other	-	2 (33.3)	2 (33.3)	1(17)	1(17)	-	6
No response / Not applicable	-	-	-	-	-	2	2
Total	**26**	**373**	**-**	**-**	**17**	**2**	**553**

Note: *Figures in parenthesis are percentages.*

Table: 5.5 **Type of Treatment Received (For Treated Episodes)**

Comment: Note missing.

Type of Treatment	Number		
	Males (%)	Females %	Total
Dispensed medicines	101 (59)	224 (63)	325 (61.7)
Dispensed medicines including injections	57 (33.3)	89 (25)	146 (27.7)
Special care including investigations	9 (5.2)	20 (5.6)	29 (5.5)
Home remedy	4 (2.3)	22 (6.1)	26 (4.9)
Total	171 (100)	355 (100)	526 (100)

Note: *Figures in parenthesis are percentages.*

Table: 5.6 **Provider of Health Care Services**

Type of Provider	Services Utilised		
	Males (%)	Females %	Total
Doctor (male and female)	157 (88.2)	309 (82.4)	466 (84.3)
Paramedic / Chemist / Nurse	11 (6.2)	39 (10.4)	50 (9)
Self	3 (1.6)	19 (5.1)	22 (4)
Any other (incl. More than 1 provider)	4 (2.2)	5 (1.3)	9 (2.4)
No response / Not applicable	3 (2)	3 (0.8)	6 (1.1)
Total	**178**	**375**	**553**

Note: *Figures in parenthesis are percentages.*

Table: 5.7 Utilisation of Health Facilities according to Morbidity

Type of Illness	Type of Facility Utilised							
	Private	Public	Home	Others	Total	No. of Treated Episodes (%)	Total no. of Episodes	No TreatmentTaken
Males								
Reproductive problems	0	0	0	0	0	0	0	0
Aches/Pains	18 (85.7)	2 (9.5)	1(4.7)	0	21 (100)	21 (87)	24	3 (12.5)
Weakness	1(100)	0	0	0	1 (100)	1 (25)	4	3 (75)
Fevers	37 (88.4)	4 (9.3)	0	1(2.3)	42 (100)	40 (100)	40	0
Respiratory problems	73 (92.4)	4 (5.1)	2 (2.5)	0	79 (100)	77 (90.5)	85	8 (11.7)
Gastro-intestinal problems	18 (86)	3 (14.3)	0	0	21(100)	21 (91)	23	2 (8.6)
Skin, eye, ear problems	2 (50)	1 (25)	1(25)	0	4	4 (80)	5	1 (20)
Others	5 (71)	2 (29)	0	0	7	7 (100)	7	0
No response/Not applicable							0	
Total	**154**	**16**	**4**	**1**	**175**	**171**	**188**	**17**
Females								
Reproductive problems	45 (69)	8 (12.3)	10 (15.4)	2 (3.1)	65	65 (38.9)	167	102 (61)
Aches/Pains	33 (77)	3 ((7)	5 (12)	2 (5)	43	41 (55.4)	74	33 (44.5)
Weakness	23(82)	4 (14.3)	1 (2.3)	0	28	23 (35)	65	42 (64.6)
Fevers	57 (96.6)	1((1.6)	1(1.6)	0	59	56 (83.5)	67	11 (16.4)
Respiratory problems	95(87.1)	13 (12)	1(1)	0	109	104 (90.4)	115	11 (9.5)
Gastro-intestinal problems	33 (82.5)	4 (10)	3 (7.5)	0	40	39 (88.6)	44	5 (11.3)
Skin, eye, ear problems	11 (69)	4 (25)	1 (6.3)	0	16	14 (45.1)	31	17 (54.8)
Others	12 (92.3)	0	0	1(8)	13	13 (44.8)	29	16 (55.1)
N o response/Not applicable					2			
Total	**309**	**37**	**22**	**5**	**375**	**355**	**592**	**237**
Combined (Male & Female)								

Reproductive problems	45(69)	8(12.3)	10(15)	2(3.1)	65 (100)	65 (39)	167	102 (61.1)
Aches/Pains	50(78)	5(7.8)	6(9.3)	2(3.1)	64 (100)	62 (63)	98	36 (37)
Weakness	24 (82.7)	4(13.7)	1(3.4)	0	29 (100)	24 (35)	69	45 (65)
Fevers	94 (93)	5 (4.9)	1 (0.9)	1(0.9)	101(100)	96- (90)	107	11 (10)
Respiratory problems	168 (89.3)	17(9.04)	3 (1.5)	0	188(100)	181 (90.5)	200	19 (9.5)
Gastro-intestinal problems	51(83.6)	7(11.4)	3(4.9)	0	61 (100)	60 (90)	67	7 (10.4)
Skin, eye, ear problems	13 (65)	5 (25)	2 (10)	0	20 (100)	18 (50)	36	18 (50)
Others	17 (85)	2 (10)	0	1 (5)	20 (100)	20 (56)	36	16 (44)
No response/Not applicable	-	-	-	-	5	-	-	-
Total	**463**	**53**	**26**	**6**	**553**	**526**	**780**	**254**

Note: *Figures in parenthesis are percentages.*

Table: 5.8 Utilisation of Health Facilities according to Age & Living environment

	Private	Public	Home	Others	Total Facilities Utilised	No. of Treated Episodes	Total no. of Episodes
Age (in years)							
Males							
0—11	69 (87.3)	8 (10.1)	1(1.2)	1 (1.2)	79	75 (93)	81
12—17	16 (94.1)	1 (5.8)	0	0	17	17 (89)	19
18—25	22 (88)	3 (12)	0	0	25	25 (93)	27
26—35	18 (94.7)	1 (5.2)	0	0	19	19 (90)	21
36—45	16 (80)	2 (10)	2 (10)	0	20	20 (83)	24
46—97	13 (86.6)	1 (6.6)	1 (6.6)	0	15	15 (94)	16
No response/Not applicable	-	-	-	-	3	-	-
Females							
0—11	79 (85.8)	10 (10.8)	2 (2.1)	1 (1.08)	92	87 (90)	97
12—17	24 (88.8)	3 (11.1)	0	0	27	24 (62)	39
18—25	64 (7.2)	9 (10.8)	9 (10.8)	1 (1.2)	83	81 (57)	142
26—35	66 (79.5)	11 (13.2)	6 (7.2)	0	83	82 (49	168
36—45	43 (86)	3 (6)	3 (6)	1 (2)	50	46 (51)	90
46—97	33 (86.8)	1 (2.6)	2 (5.2)	2 (5.2)	38	34 (63)	54
No response / Not applicable	-	-	-	-	2	1	2
Living Environment							
Males							
Slum	122 (87.1)	15 (10.7)	3 (2.1)	0	140 (100)	136 (88.8)	153
Non-slum	32 (91.4)	1 (2.8)	1 (2.8)	1 (2.8)	35 (100)	35 (100)	35
No response / Not applicable	-	-	-	-	3	-	-
Females							
Slum	239 (80.7)	34 (11.4)	19 (6.4)	4 (1.3)	296 (100)	280 (57.9)	483
Non-slum	70 (90.9)	3 (3.8)	3 (3.8)	1 (1.2)	77 (100)	75 (68.8)	109
No response / Not applicable	-	-	-	-	2	-	-
Total Males	**154**	**16**	**4**	**1**	**178**	**171**	**188**
Total Females	**309**	**37**	**22**	**5**	**375**	**355**	**592**

Note: *Figures in parenthesis are percentages.*

Table: 5.9 Utilisation of Health Facilities according to Earning Status & Occupation

	Private	Public	Home	Others	Total Facility Utilised	No. of treated Episodes	Total Number of Episodes
Earning Status							
Males							
Non-earner	19 (79.1)	3 (12.5)	1 (4.1)	1 (4.1)	24	24 (92)	26
Main earner	37 (90)	2 (5)	2 (5)	0	41	41 (83)	48
Supplementary earner	13 (76.4)	3 (17.6)	1 (5.8)	0	17	16 (94)	17
Equal earner	3 (100)	0	0	0	3	3 (100)	3
No response / Not applicable	82	8	0	0	93	87	94
Total	**154**	**16**	**4**	**1**	**178**	**171**	**188**
Females							
Non-earner	15 (83.3)	2 (11.1)	1 (5.5)	0	18	14 (52)	27
Main earner	7 (58.3)	2 (16.6)	2 (16.6)	1 (8.3)	12	11 (48)	23
Supplementary earner	20 (76.9)	4 (15.3)	2 (7.6)	0	26	26 (54)	48
Equal earner	7 (87.5)	0	1 (12.5)	0	8	7 (50)	14
Housewife	170 (82.5)	17 (8.2)	16 (7.7)	3 (1.4)	206	197 (54)	366
No response / Not applicable	90	12		1	105	100	114
Total	**309**	**37**	**22**	**5**	**375**	**355**	**592**
Occupation Category							
Males							
Non-worker & housewife	59 (88.05)	5 (7.4)	2 (2.9)	1 (1.4)	67	65 (97)	67
Unskilled / semi-skilled worker	5 (100)	0	0	0	5	5 (71)	7
Skilled worker	49 (89)	5 (9.09)	1 (1.8)	0	55	53 (88)	60
Professional / business	3 (75)	1 (25)	0	0	4	4 (100)	4
No response / Not applicable	39	5	0	0	47	44	50
Total	**154**	**16**	**4**	**1**	**178**	**171**	**188**
Females							
Non-worker/ housewife	229 (84.5)	22 (8.1)	17 (6.2)	3 (1.1)	271	258 (57.4)	449
Unskilled worker	9 (75)	0	3 (25)	0	12	12 (44)	27
Skilled worker	23 (76.6)	6 (20)	1 (3.3)	0	30	30 (60)	50
Professional /	4 (66.6)	0	1 (16.6)	1(16.	6	6 (67)	9

business				6)			
No response / Not applicable	44	9	0	1	56	49	54
Total	**309**	**37**	**22**	**5**	**375**	**355**	**592**

Note: *Figures in parenthesis are percentages.*

Table: 5.10 **Location of Work & Utilisation**

Location of Work	Private	Public	Home	Others	Facility Utilised	Episodes Treated (% of total Episodes)	Total Episodes
Males							
Retired/ unemployed	53 (86.8)	6 (9.8)	2 (3.2)	0	61	58 (97)	60
Own Home/ Housewife	4 (66.6)	1 (16.6)	0	1(16.6)	6	6 (100)	6
Hawker	2 (100)	0	0	0	2	2 (40)	5
Small unit/ Est./ shop	30 (88)	3 (8.8)	1 (2.9)	0	34	33 (87)	38
Large unit/ Shop/govt.	10 (76.9)	2 (15.3)	1 (7.6)	0	13	13 (100)	13
Others	12 (100)	0	0	0	12	12	14
No response / Not applicable	43	4	0	0	50	47	52
Total	**154**	**16**	**4**	**1**	**178**	**171**	**188**
Females							
Retired/ unemployed	52 (88)	5 (8.4)	2 (3.3)	0	59	55 (76.4)	72
Own home / housewife	183 (82.06)	19 (8.5)	18 (8.07)	3 (1.3)	223	213 (54.2)	393
Hawker/ place to place	8 (61.5)	3 (23.07)	1 (7.6)	1 (7.6)	13	13 (48.1)	27
Small unit/ Est./ shop	11 (91.6)	0	1 (8.3)	0	12	12 (48)	25

Comment: Omit?

Large unit/ Shop/govt.	8 (88.8)	1(11.1)	0	0	9	9 (75)	12
Others	1 (100)	0	0	0	1	1(25)	4
No response / Not applicable					58	52	59
Total	**309**	**37**	**22**	**5**	**375**	**355**	**592**

Note: *Figures in parenthesis are percentages.*

Table: 5.11 Utilisation of Health Facilities according to Marital Status & Educational Status

Marital Status	Private	Public	Home	Others	Facility Utilised	No. of episodes (% of total)	Total no. of episodes
Males							
Currently married	45 (86.5)	4 (7.6)	3 (5.7)	0	52	52 (85)	61
Never married	104 (88.8)	11(9.4)	1 (0.8)	1 (0.8)	117	113 (94.1)	120
Others	5 (83.3)	1 (16.6)	0	0	6	6 (100)	7
No response / Not applicable	-	-	-	-	3	-	-
Females							
Currently Married	179 (82.8)	20 (9.2)	16 (7.4)	1 (0.4)	216	208 (53)	394
Never married	107 (85.6)	14 (11.2)	2 (1.6)	2 (1.6)	125	120 (82)	147
Others	23 (71.8)	3 (9.3)	4 (12.5)	2 (6.2)	32	27 (52.9)	51
No response / Not applicable	-	-	-	-	2	3	-
Educational Status							
Males							
Illiterate	15 (78.9)	2 (10.5)	2 (10.5)	0	19	19 (86)	22
Primary school	28 (90.3)	3 (9.6)	0	0	31	30 (94)	32
Secondary / high school	41 (91.1)	3 (6.6)	0	1 (2.2)	45	41 (93.2)	44
Matriculation	14 (82.3)	3 (17.6)	0	0	17	15 (94)	16
Higher Secondary / College	15 (100)	0	0	0	15	15 (88)	17
Technical / Professional	1 (50)	0	1 (50)	0	2	2 (100)	2
Preschool / No response / Not applicable	40 (81.6)	5 (10.2)	1 (2.0)	0	49	49	55
Females							
Illiterate	78 (78.7)	9 (9.09)	9 (9.0)	3 (3.03)	99	92 (53.2)	173
Primary school	52 (83.8)	7 (11.2)	3 (4.8)	0	62	59 (65)	91
Secondary / high school	83 (86.4)	8 (8.3)	5 (5.2)	0	96	92 (52.3)	176
Matriculation	29 (80.5)	3 (8.3)	3 (8.3)	1 (2.7)	36	36 (60)	60
Higher Secondary / College	12 (92.3)	0	1 (7.6)	0	13	12 (57.1)	21
Technical / Professional	2 (66.6)	0	1 (33.3)	0	3	3 (75)	4
Preschool/ No response / Not applicable	53	10	0	1	66	61	67

Total	**154**	**16**	**4**	**1**	**178**	**171**	**188**
Total Females	**309**	**37**	**22**	**5**	**375**	**355**	**592**

Note: *Figures in parenthesis are percentages.*

Table: 5.12 Reasons For Not Treating Illness Episodes

Reason Stated	Number of Not Treated Episodes		
	Males	**Females**	**Total**
Financial reason	2 (12)	53 (22)	55 (22)
Illness seasonal / temporary / not very disturbing	9 (53)	54 (23)	63 (25)
Problem in access/ no leave/ no support system	3 (18)	24 (10)	27 (11)
Afraid / shy / painful treatment	2 (12)	36 (15)	38 (15)
Illness is chronic / long-term	1 (6)	48 (20)	49 (19)
Any other	0	5 (2.1)	5 (2)
No response / Not applicable	0	17 (7)	17 (7)
Total	**17**	**237**	**254**

Note : *Figures in parenthesis are percentages of total non-treated episodes.*

Table: 5.13 Non-Treatment of Illness Episodes According to Socio-Economic Differentials

	Males		**Females**	
	Non-treated Episodes (% of col. B)	**Total no. of Episodes**	**Non-treated Episodes (% of col. D)**	**Total no. of Episodes**
	A	B	C	D
Living Environment				
Slum	17 (11.1)	153	203 (42)	483
Non-slum	0	35	34 (31.1)	109
Age Group (In Years)				
0—11	6 (7.4)	81	10 (10)	97
12—17	2 (11)	19	15 (39)	39
18—25	2 (7.4)	27	61 (43)	142
26—35	2 (9.5)	21	86 (51)	168
36—45	4 (21)	24	44 (49)	90
46—97	1 (25)	16	20 (37)	54
No response / Not applicable	1	-	-	-
Marital Status				
Currently married	9 (15)	61	186 (47.2)	394
Never married	7 (5.8)	120	27 (18.4)	147
Others	1 (14.2)	7	24 (47.0)	51
Earner Status				
Non-earner	2 (8)	26	13 (48.1)	27
Main earner	7 (15)	48	12 (52)	23
Supplementary earner	1 (6)	17	22 (48)	48
Equal earner	0	3	7 (50)	14
Housewife	-	-	169 (46)	366

No response / Not applicable	7	94	14 (12)	114
Occupation Type				
Non-worker & housewife	2 (3)	67	191 (43)	499
Unskilled / semi-skilled worker	2 (29)	7	16 (59)	27
Skilled worker	7 (12)	60	20 (40)	50
Professional / business	0	4	3 (33.3)	9
No response / Not applicable	6	50	7	57
Location of Work				
Retired/ unemployed	2 (3.3)	60	17 (24)	72
Own home/ housewife	0	6	180 (46)	393
Hawker / place to place	3 (60)	5	14 (52)	27
Small unit / establishment / shop	5 (13.2)	38	13 (52)	25
Large unit / shop / govt.	0	13	3 (25)	12
Others	1 (7)	14	3 (75)	4
No response / Not applicable	6	52	7	59
Educational Status				
Illiterate	3 (18.2)	22	81 (47)	173
Primary school	2 (6.3)	32	32 (35.1)	91
Secondary / high school	3 (7)	44	84 (48)	176
Matriculation	1 (6.3)	16	24 (40)	60
Higher secondary	2 (12)	17	9 (43)	21
Technical / Professional	0	2	1 (25)	4
Preschool / No response / Not applicable	6	55	6	67
Total no. of episodes	**17 (9)**	**188**	**237 (40.0)**	**592**

Note: *Figures in parenthesis are percentages.*

Expenditure on Health

Expenditure on health care is incurred by various sectors of the health care system such as the government (central, state and local bodies (municipalities and zilla parishads). In addition to government expenditure, the various other departments such as defence, railways, etc. also spend on health care. In India, the households who spend on health care incur the major portions of health care costs.

In Mumbai city, public expenditure is incurred mainly by the state government and municipal corporation which range from health posts to the tertiary care teaching hospitals. Though the city is characterised by sharp contrasts, it has probably one of the best public health systems in the country. The total expenditure incurred by the Bombay Municipal Corporation (BMC) on public health in 1997 - 98 was Rs. 3,808 million. In addition, the state government spends another Rs. 1,050 million in Mumbai city, amounting to a total expenditure of around Rs. 4,858 million (Duggal and Nandraj, 1994). With a

population of 14 million persons (1996 estimates), the per capita expenditure is Rs. 347 per person per year.

Studies conducted in the recent past on household spending on health care which show that the expenditure incurred by households is nearly 4 to 5 times higher than what the government is spending on health care (NSSO 1992, NCAER 1992, Duggal and Amin, 1989, Kannan, et al., 1991, George, et al., 1994)

In this chapter we have analysed the expenditure incurred by the households on the treatment of illness affecting their members. We have documented expenditure incurred on individuals, for the treatment of each episode or event and for each facility utilised where costs were involved. We have also examined various components of the cost incurred, differentials in expenditure related to utilisation of the health facilities and other factors.

Expenditure on Illness

The total expenditure incurred for treating illness in the sample population was Rs. 74,455. The cost per episode (for 780 episodes) worked out to Rs. 95.45. The per capita expenditure for the one-month reference period amounted to Rs. 34.64 an annual per capita expenditure of Rs. 415.68 (which is about 20 per cent more than the health expenditure by public authorities). The high cost of per capita expenditure in the present study could be partially attributed to inflation and also to the fact that Bombay is a metropolitan city where the cost of living is generally higher.

As can be seen from *Table 6.1*, 62 per cent (Rs. 46,256) out of the total expenditure of Rs. 74,455 was spent on women. Analysing annual per capita expenditure, we found that the expenditure on women was higher – Rs. 538.90, as against Rs. 301.08 for males. This could be due to various factors. The number of illness episodes recorded for females was four times higher than that of males. However, the expenditure incurred per episode for females was lower at Rs. 78.59 than the average expenditure on the total episodes, which was Rs. 95.45. It was even lower in comparison with males (Rs. 148.56). The per capita expenditure obscures the actual cost of health care as many of those who fell ill did not necessarily seek treatment, more so females as shown in the earlier chapter. Out of the 592 illness episodes affecting women 40 per cent did not seek treatment as compared to 9 per cent untreated illness episodes for males. For 145 males illness episodes for which actual payment for treatment was made the average expenditure was Rs. 192.61 as compared to Rs. 154.57 for 301 paid illness episodes affecting women. Further when we analyse the expenditure of illness for those with probe and those illness reported without probe we find that the 281 female illness episodes reported after probing, only Rs. 59.58 per episode was spent, as against 271 illness episodes reported without probing where on an average Rs. 111.72 per episode were spent *(Table 6.1).* This clearly brings out the fact that many women who reported illness episodes after probing had been unable to utilise health care facilities.

Components of costs

Documentation of expenditure necessitates recording of expenditure items under various heads. Broadly, the expenditure incurred can be classified into two types - direct expenditure and indirect expenditure. The main components of direct expenditure are payment made to the health care provider, expenditure incurred on

medicines, diagnostic investigations, surgery, and charges for hospitalisation. Indirect costs would include expenditure on special diet for illness or events, travel to the facility, bribes and tips paid, costs on gifts given and rituals performed. Health care utilisation as defined in this study also included treatment taken at home using home remedies and rituals performed at home or elsewhere.

One of the major problems faced by the investigators was in recording information in which the husband or another person had made payments at the health facilities. In some cases the women respondents were unable to provide the breakup of costs incurred and could only provide information on the combined costs incurred. We recorded this expenditure as combined expenses. In the present study, the major part of the expenditure - around 40 per cent - were recorded as combined costs incurred. In 90 per cent of all such illness episodes, the combined expenditure was incurred on the fees paid to the doctor and the purchase of medicines.

The expenditure incurred on purchase of medicines accounted for 36.37 per cent of the total costs incurred by the sample population, with the major amount being spent by females. The expenditure on doctors' fees accounted for 6.49 per cent *(Table 6.2).* In the Madhya Pradesh (George et al., 1994) study also we find that three-fourths of the costs incurred are for doctors' fees and medicines. Similar findings are revealed in the NCAER study which revealed that 77.6 per cent of the expenditure in urban areas going in for fees and medicine. Gender differentiated analysis of the spending on components of health care did not reveal much difference in terms of proportion of expenditure incurred on each component.

Socio-economic differentials

Household expenditure on health care is determined by various factors, some of them existing within the family and some of them outside. The differentials in terms of spending when members in the household fall ill are based on factors such as the ill persons' importance in the family (their relationship, age, marital status, education, occupation and earning status), household income and most important of all, the gender of the person. In addition to these, other factors which influence the spending behaviour are the socio-economic class of the family, place of residence, type of illness, treatment taken, type of health facility utilised, distance of the health facility and so on.

Location of households

The location of the households and environment to a large extent determine the socio-economic condition of the households. Though the slum locality had a much higher morbidity rate of 436 episodes per 1000 persons, the total expenditure incurred for illness episodes in the slum area was just Rs.17,388 (23.35 per cent of the total expenditure of Rs. 74,455) *(Table 6.3).* We found that the per episode costs used among the slum households was as low as Rs. 39.88 as compared to the expenditure in the non-slum area was Rs. 509.52 per episode. In terms of utilisation, we found that for 68 per cent of the illness episodes in the slum households and 75 per cent in the non-slum households some health care facility had been utilised. Gender difference were evident both in slum and non-slum households were spending less on illness episodes affecting women compared to men. This is in spite of the fact that in both localities more women were ill than men. Further it is revealed

that the gender difference of spending between males and females is more pronounced in the non-slum area.

The people in slums who form a bulk of the population and suffer more from illnesses, are not able to spend on health care due to their low income and lower socio-economic status. Though the classification of the slum and non-slum areas cannot be used strictly in lieu of the class scale, some comparison can be done as it is the people from the lower socio-economic scale who reside in slums; those from the higher socio-economic scale reside in better-off houses. We find that higher the socio-economic scale, higher the spending on health care, if we take the slum and non-slum categories as a proxy indicator for class, the findings are quite closer to other studies where the class scale has been used.

Age group

A major factor that determines the expenditure incurred by the household on individuals is in relation to the age of the person falling ill. Those in the age group of above 45 years spent the highest in terms of per episode cost, which was Rs. 157.25. The major part of this expenditure was for illnesses affecting males. Expenditure on illness affecting children worked out to be Rs. 91.92, which is quite less as nearly 23 per cent of the children had reported ill. Further, the expenditure incurred on persons in the age group 0 - 11, 18-25 and 26-35 years was lower than the average expenditure of Rs. 95.45 per episode for all illness episodes. As the age increases the gap in expenditure on males and females is higher. Only in the age group of 12-17 years, the expenditure incurred on females was significantly higher at Rs. 260.79 than on males at Rs. 41.05. Expenditure on women was also slightly higher in the age group between 18-25 years *(Table 6.3)*. This could be due to the fact that during this period women are given importance due to the reproductive role they perform.

The expenditure incurred on women above the age of 36 years as compared to males in the same age group was very low – Rs. 50.90 for 36-45 years age group and Rs. 97.94 for above 46 years age group. This could be due to the fact that women in this age have already completed child bearing and are no longer considered vulnerable. There is significant neglect of elderly women although they are almost as prone to illness as younger women. The expenditure on female children was less than what is spent on male children. This clearly brings out that discrimination against females in provision of health care occurs at every stage of life.

Marital status

The major health expenditure incurred was made on persons who are currently married (Rs. 51,563 out of Rs. 74,455 or per episode cost of Rs. 113.32), followed by expenditure on those illnesses affecting the never married. The status of women in the family is determined by her relationship to others in the family. The expenditure incurred on currently married women was less than half (Rs. 90.26 per episode) as that of the males in the same category. Though the expenditure went up for those who had utilised some health facility in the same category, we found that there were only 126 female illness episodes where treatment was sought *(Table 6.3)*. The expenditure incurred on illness affecting widows and widowers was Rs. 35.80 (total Rs. 1647 out of Rs. 74,455). Individuals who have no spouses did not seem to be able to spend on health care. Only with regard to expenditure incurred on widows

and widowers, we find that expenditure on illness episodes of widows to be higher (Rs. 37.11) than that on widowers.

However, in comparison to the general population, the amount is very small. In sharp contrast, single women, who are divorced or separated or husbands are away at work, spent a negligible amount on illness when it affected them. The findings bring out clearly that the marital status of women in the households is a major factor in terms of access and expenditure on health care. Single women are most vulnerable when illness strikes because they are not able to utilise health facilities.

Education

Those with higher education spend more on their illness. Those who are illiterate had spent just Rs. 45.51 per illness episode, significantly less than the average. We further found that out of 173 episodes afflicting illiterate women, an expenditure of Rs. 40.65 per episode was incurred. While in only 99 episodes out of 173, women had utilised any health facility, out of 22 episodes among illiterate men, for 18 episodes health facility was used. Women who are more educated seem to spend more, especially those with secondary / higher school education and also qualified professionals.

Occupation and earning status

The occupation and earning status of the individuals in the household determine, to a substantial extent, the expenditure incurred by the households. Though the number of episodes affecting non-workers and housewives was high (516 episodes), the expenditure per episode for them was just Rs. 83.96. With specific reference to housewives, though they had the maximum number of episodes, the expenditure per episode was just Rs. 92.84. For the lower level professionals, in spite of having just 13 illness episodes, the episode per cost was Rs. 423.70, the gender difference being very vast *(Table 6.4).*

In relation to the earning status, the expenditure per episode was the highest among non-earners (Rs. 173.39) and the lowest among equal earners (Rs. 40.80). The expenditure on unskilled and semi-skilled categories was very low, at Rs. 28.47. Non-working children and adolescents accounted for 101 episodes, and spending on an average at Rs. 142.97 per episode *(Table 6.4).* Across all categories (except the unskilled and semi-skilled workers, where the difference was only marginal), the expenditure on male illness episodes was on the higher side than the females with the difference being vast among the lower level professionals. In terms of gender difference, we found that where the woman is an equal earner, the per episode cost (Rs. 41.83) was higher than the males (Rs. 35.00). The pattern of expenditure shows that those who are employed at a higher level and have an income spend more on illnesses affecting them.

Expenditure by type of morbidity

The type of illness affecting the person is another factor determining the spending on treatment. Majority of illness episodes (200) were reported as respiratory illnesses followed by reproductive illnesses afflicting women (167 episodes). In terms of expenditure incurred the major expenditure in terms of percentage (22.38 per cent) of the total expenditure and the cost per episode, went in treating gastro-enteric illness. In spite of reproductive illness accounting for 21.41 per cent of all episodes, the

expenditure incurred was only 19.31 per cent of the total expenditure and the per episode cost amounted to only Rs. 86.11 as not all illness episodes are treated *(Table 6.5).* Out of the total 167 reproductive illness episodes, for only 65 illness episodes of women had utilised some health facility incurring an average expenditure of Rs. 221.26. This clearly shows that on an average the expenditure incurred on reproductive illness for those who paid for treatment was very high and that the kind of reproductive illnesses they suffer needed greater or expensive care. The lowest expenditure incurred was on treating "weakness" (Rs. 35.15). On fevers, which affected a large proportion of the people, the expenditure incurred was very low and the gap in spending on the males and females was vast. For illnesses that were categorised as "others", the per capita expenditure was a high of Rs. 249.30.

In terms of gender difference, it was found that on illness episodes related to weakness and eye/nose/throat, males were spending more, but when viewed in terms of total expenditure, the quantum is quite small. The utilisation of facilities for illness episodes affecting females, especially those of weakness, aches and pains was very low as compared to the males in the same category. The above analysis of expenditure clearly shows that although many suffer from respiratory problems, the expenditure incurred is far too less than what the illness accounts for. The morbidity of women is very high, but the expenditure incurred on them is very low and in comparison with the males the difference is vast.

EXPENDITURE INCURRED BY UTILISATION OF HEALTH FACILITIES

Type of treatment taken

The major expenditure incurred by the people was on medicines dispensed (44.78 per cent), followed by expenditure incurred on special care which included investigations (30.64 per cent). Medicines dispensed and injections, together accounted for more than 60 per cent of the total expenditure, most of the amount was spent in private health facilities. The total expenditure incurred by type of treatment on women was more than that for males for all the categories except those related to special care and investigations, where the expenditure on male episodes was nearly double than that of females *(Table 6.6).* In terms of total expenditure incurred we found that the expenditure incurred on males was higher at Rs. 163.32 per treated episode than for females at Rs. 131.05.

Type of health facility

85.41 per cent of the expenditure was incurred on the private facilities, with insignificant gender difference. The expenditure on public facilities, which treated only 53 episodes, was Rs. 179.89 per episode, while expenditure on private facilities, which treated 473 episodes, was Rs. 134.46 per episode. Thus the expenditure incurred was higher in public than in private facilities. This is due to the fact that the number of episodes affecting females is higher in our study. We also find that more number of female illness episodes were being treated at private facilities and the male episodes at public health facilities. The expenditure on males was also higher when the illness episodes got treated by a relative or an NGO. Thus, the use of government facilities is actually not free as payment needs to be made for buying medicines not supplied by the government facility. And a study of the components of

expenditure clearly shows that the cost is dominated by the expense on purchase of medicines.

Expenditure incurred on female illness episodes was more than those of males when either a dispensary or health post were used. The expenditure incurred on treating illness in hospitals / nursing homes was much higher for males than females, both as a proportion of the total costs and per episode expenditure. The preference seemed to be to utilise the health post or dispensary in the private sector, as they were convenient location-wise as well as timings-wise. The women utilised chemists' shops more than the males, but the average expenditure incurred by them was less than that by males (Rs. 39.71 per episode for 38 illness episodes for females as compared to an average Rs. 98.25 per episode for 12 episodes for males). Home remedies were utilised mostly by women.

Table: 6.1 Characteristics of Expenditure on Illness

Characteristics	Males	Females	Total
Total number of persons in sample	1113	1036	2149
Total expenditure incurred (in Rs)	27,929	46,526	74,455
Total number of illness episodes	188	592	780
Average exp. per capita (monthly) (in Rs)	25.09	44.90	34.64
Average exp. per capita (yearly) (in Rs)	301.08	538.80	415.68
Average exp. per episode (in Rs)	148.56	78.59	95.45
Exp. on episodes without probing (in Rs)	-	111.72	-
Exp. on episodes with probing (in Rs)	-	59.58	-
Total number of episodes in which health facilities were utilised	178	375	553
Average exp. per health facility utilised (in Rs)	156.90	124.06	134.63
No. of not-treated episodes	17	237	254
No. of paying episodes *	145	301	446
Average expenditure (paying episodes) (in Rs)	192.61	154.57	166.93

***Note:** * Episodes for which treatment was paid for.*

Table: 6.2 Expenditure on Components of Health Care (In Rupees)

Health Care Costs	Mean Costs per episode where payment was made					
	Percentage to Total Expenditure			Mean Exp. on Paying Episode		
	Males	Females	Total	Males	Females	Total
Doctors' fees	6.10	6.69	6.49	81.90 (21)	64.85 (48)	50.34 (96)
Medicines	26.86	42.55	36.37	105.69 (71)	136.55 (145)	126.4 (216)

Investigations	5.44	3.16	4.01	152.00 (10)	113.30 (13)	130.1 (23)
Surgery	0	1.71	1.07	0 (0)	800.0 (1)	800.0 (1)
Hospitali-sation	4.94	4.86	4.53	690.0 (2)	1000.00 (2)	845.0 (4)
Travel	4.60	4.86	4.76	61.1 (21)	58.0 (39)	59.1 (60)
Rituals	0	0	0	0	0	0
Diet	3.74	1.70	2.47	87.25 (12)	46.7 (17)	63.4 (29)
Gifts / Bribes	0	30 0.06	30 0.04	0	30.0 (1)	30.0 (1)
Combined Costs	47.88	34.90	39.77	127.36 (105)	83.7 (194)	9.9 (299)
Any Other	0.35	0.03	0.15	100.00 (1)	15.0 (1)	57.5 (2)
Total Costs in Rs.	**27929**	**46526**	**74455**	**192.61 (145)**	**154.5 (301)**	**166.9 (446)**

***Note** : Figures in parenthesis are number of cases.*

Table: 6.3 Expenditure Incurred by Socio Economic Differentials

	Per Episode			Per Facility Utilised			Total Exp.
	Males	**Females**	**All**	**Males**	**Females**	**All**	**Total**
Locality							
Slum	103.05 (132)	74.24 (402)	32.56 (534)	97.13 (140)	100.82 (296)	39.88 (436)	17388
Non-slum	255.82 (56)	87.79 (190)	231.97 (246)	409.21 (35)	216.60 (77)	509.52 (112)	57067
No response / Not applicable	-	-	-	(3)	(2)	(5)	-
Age Group (in years)							
0—11	106.18 (81)	80.10 (97)	91.92 (178)	108.86 (79)	84.45 (92)	95.68 (171)	16362
12—17	41.05 (19)	260.79	188.81 (58)	45.87	376.69 (27)	248.88	10951

		(39)		(17)		(44)	
18—25	72.62 (27)	86.71 (142)	84.46 (169)	78.42 (25)	148.34 (83)	132.17 (108)	14275
26—35	183.00 (21)	37.91 (168)	54.03 (189)	202.25 (19)	76.73 (83)	100.12 (102)	10213
36—45	292.78 (24)	50.90 (90)	101.80 (114)	351.32 (20)	91.62 (50)	165.80 (70)	11606
46—97	357.43 (16)	97.94 (56)	157.25 (70)	381.25 (15)	139.17 (38)	207.69 (53)	11008
NR / NA	(0)	(2)	(2)	(3)	(2)	(5)	-
Marital Status							
Currently married	262.24 (61)	90.26 (394)	113.32 (455)	307.61(52)	164.64 (216)	192.39 (268)	51563
Never married	94.30 (120)	63.92 (147)	77.58 (267)	96.71 (117)	75.16 (125)	85.59 (242)	20714
Widow / widower	22.00 (4)	37.11 (42)	35.80 (46)	88.00 (1)	59.94 (26)	61.00 (27)	1647
Others *	175.66 (3)	0.44 (9)	44.25 (12)	105.39 (5)	0.66 (6)	48.27 (11)	531
NR / NA	-	-	-	(3)	(2)	(5)	-
Educational Level							
Illiterate	83.72 (22)	40.65 (173)	45.51 (195)	96.93 (19)	71.03 (99)	75.22 (118)	8876
Primary school	121.81 (32)	132.48 (91)	129.70 (123)	125.73 (31)	194.44 (62)	171.54 (93)	15954
Secondary / high school	70.90 (44)	80.67 (176)	78.72 (220)	69.32 (45)	147.88 (96)	122.82 (141)	17319
Matriculation	632.37 (16)	89.31 (60)	203.64 (76)	595.17 (17)	148.85 (36)	292.01 (53)	15477
Higher secondary / graduates / post graduates	115.47 (17)	36.09 (21)	71.60 (38)	130.85 (15)	58.29 (13)	97.17 (28)	2721
Technical / professional / others	73.00 (2)	127.49 (4)	34.66 (6)	73.00 (2)	169.98 (3)	41.60 (5)	208
Preschool & NA NR	124.39 (55)	119.62 (59)	113.93 (122)	139.62 (49)	106.92 (66)	120.86 (115)	13900
Total	**148.56 (188)**	**78.59 (592)**	**95.45 (780)**	**156.90 (178)**	**124.06 (375)**	**134.63 (553)**	**74455**

***Note:**. Figures in parenthesis are number of cases*

"Others" include women whose husbands were away at work or who were separated, divorced, engaged to be married,etc.

Table 6.4 Expenditure by Occupation and Earning Status

Occupation Category	All Episodes in Rs.			Facility Utilised in Rs.			
	Males	Females	All Persons	Males	Females	All Persons	**Total Exp.**
Non-worker & housewife	103.55 (67)	81.04 (449)	83.96 (516)	103.55 (67)	134.26 (271)	128.18 (338)	43327
Unskilled & semi-skilled worker	20.85 (7)	30.44 (27)	28.47 (34)	29.19 (5)	68.49 (12)	56.94 (17)	968
Skilled worker & service sector	127.50 (60)	43.26 (50)	89.20 (110)	139.09 (55)	72.10 (30)	115.44 (85)	9813
Lower level professional / business	1306.50 (4)	31.44 (9)	423.77 (13)	1306.50 (4)	47.16 (6)	550.90 (10)	5509
Non-working children & adolescents	167.31 (47)	121.74 (54)	142.95 (101)	167.31 (47)	121.74 (54)	142.95 (101)	14438
No response / Not applicable	35 (3)	98.33 (3)	66.66 (6)	-	200.00 (2)	200.00 (2)	400
Earning Status							
Non-earner	331.46 (26)	26.74 (27)	173.39 (53)	359.07 (24)	40.11 (18)	218.80 (42)	9190
Main earner	77.87 (48)	28.13 (23)	61.76 (71)	91.16 (41)	53.91 (12)	82.73 (53)	4385
Supplementary earner	83.94 (17)	41.83 (48)	52.85 (65)	83.94 (17)	125.84 (26)	79.88 (43)	3435
Equal earner	35.00 (3)	41.92 (14)	40.82 (17)	35.00 (3)	73.36 (8)	63.09 (11)	694
Houseworker	0 (0)	95.15 (366)	95.15 (366)	0 (0)	169.05 (206)	169.05 (206)	34825
Not Applicable	99.28 (90)	77.85 (107)	87.64 (197)	96.07 (93)	79.32 (105)	87.20 (198)	17266
No Response	1276.25 (4)	35.85 (7)	406.90 (11)	-	-	-	5356
Total	**148.56 (188)**	**78.59 (592)**	**95.45 (780)**	**156.9 (178)**	**124.06 (375)**	**134.63 (553)**	**74455**

Note : *Figures in parenthesis are number of cases*

Table: 6.5 Expenditure by Type of Morbidity (in Rs.)

Type of Morbidity	All Episodes			Facility Utilised			Total Exp.
	Males	**Females**	**All**	**Males**	**Females**	**All**	
Reproductive problems	0 (0)	86.11 (167)	86.11 (167)	0	221.23 (65)	221.26 (65)	14382
Aches, pains	82.95 (24)	43.91 (74)	53.47 (98)	94.80 (21)	75.56 (43)	81.89 (64)	5241
Weakness	9.50 (4)	36.73 (65)	35.15 (69)	38.00 (1)	85.26 (28)	83.65 (29)	2426
Fevers	142.25 (40)	57.40 (67)	89.12 (107)	135.47 (42)	65.18 (59)	94.41 (101)	9536
Respiratory	93.80 (85)	63.06	76.13	100.92 (79)	66.53 (109)	80.98 (188)	1522

problems		(115)	(200)				6
Gastro-intestinal problems	316.65 (23)	213.20 (44)	248.71 (67)	346.80 (21)	234.52 (40)	273.18(61)	16664
Eye, nose, ear problems	37.00 (5)	58.70 (31)	55.69 (36)	46.25 (4)	113.73 (16)	100.25 (20)	2005
Others	681.28 (7)	145.03 (29)	249.30 (36)	681.78 (7)	323.52 (13)	448.75 (20)	8975
No response / Not applicable	-	-	-	-	(2)	-	-
Total	**148.56 (188)**	**78.59 (592)**	**95.45 (780)**	**156.90 (178)**	**124.06 (375)**	**134.63 (553)**	**74455**

Note : *Figures in parenthesis are number of cases.*

Table: 6.6 **Expenditure by Type of Treatment Received**

Treatment Received	Episodes Treated			
	Males	**Females**	**Total**	**Total ***
Dispensed medicines	99.71 (101)	103.88 (224)	102.58 (325)	33341 (44.78%)
Dispensed medicines (incl. Injection)	106.00 (57)	123.68 (89)	116.78 (146)	17050 (22.89%)
Special care (incl. Investigations	1311.44 (9)	551.05 (20)	787.03 (29)	22824 (30.64%)
Home remedy	3.25 (4)	55.77 (22)	47.69 (26)	1240 (1.66%)
Total	**163.32 (171)**	**131.05 (355)**	**141.54 (526)**	**74455**

*Note: Figures in parenthesis are number of cases except last column * : As % of column total*

Comment: Which are the figures for expenditure and what are the figures in brackets?

Table: 6.7 **Expenditure by Utilisation**

	As % of Total Expenditure			Expenditure for Treated Episodes (Rs.)		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
Type of facility						
Private	84.27	86.10	85.41	154.83 (154)	125.59 (309)	134.46 (473)
Public	14.99	11.49	12.80	261.75 (16)	144.49 (37)	179.89 (53)
Home remedy	0.01	0.52	0.33	0.75 (4)	11.09 (22)	9.50 (26)
Family member / NGO	0.63	1.71	1.30	176.00 (1)	159.60 (5)	162.33 (6)
NR / NA	0.08	0.16	0.13	8.33 (3)	37.50 (2)	20.00 (5)
No treatment	-	-	-	0 (17)	0 (237)	0 (254)
Institution						
Dispensary / health post	62.53	79.15	72.92	123.86 (141)	133.43 (276)	130.20 (417)
Hospital / Nursing home	32.73	15.39	21.90	481.21 (18)	198.97 (36)	301.96 (54)
Chemist's shop	4.22	3.24	3.61	98.25 (12)	39.71 (38)	53.76 (50)
Home remedy	0.50	2.04	1.46	35.50 (4)	43.22 (22)	42.04 (26)
Any other / NR / NA	-	0.16	0.10	0 (3)	16.66 (3)	10.41 (6)
No treatment	-	-	-	0 (17)	0 (237)	0 (254)
Total	**100**	**100**	**100**	**156.90 (178)**	**124.06 (375)**	**134.63 (553)**

Note: Figures in brackets indicate number of treated episodes.

Comment: Family member?

Maternity and Contraception

In the earlier chapters we have examined various issues related to illness. Maternity events such as pregnancy, delivery, abortion, post natal care and use of contraceptives are not illnesses as such but important aspects which affect women's health to a very large extent.

Maternity events included pregnancies, deliveries and the abortions reported. Pregnancies included those, which had not been terminated or concluded in abortion or delivery in the reference period. In recording deliveries all pregnancies, which had concluded in the birth of a child for the reference, period was considered. Abortions included all induced and natural abortions in the same period. As this was a one-point study there was no overlapping of pregnancies as found in other studies, which had been done over different time periods. With regard to contraceptives used we recorded all the contraceptives used by women either as a spacing or terminal method in the reference period of one year. We took a reference period of one year (May 1995 to April 1996) to record information related to maternity events and use of contraceptives, among the sample population.

In the sample there were 1,036 women of whom 697 women were above the age of 12 years and out of them 466 were currently married women. There were a total of 112 maternity events recorded for 111 women in the sample. These included 49 pregnancies, 60 deliveries and 3 abortions. In one case a woman had two events, an abortion followed by a pregnancy *(Table 7.1).* With regard to contraceptive users there were 26 women who utilised 27 contraceptives (a woman had utilised Intra Uterine Device (IUD) twice) *(Table 7.2).* There were a total of 139 non-illness events (includes maternity and contraception) among women in the 18 to 45 years reproductive age group. Out of these events 35 per cent were pregnancies, 43 per cent deliveries, 2 per cent abortions and 19 per cent were contraception. Out of the 27 contraceptive users 10 were using Oral Pills (OPs), 13 were using IUDs and 4 had undergone sterilisation. Actually the total number of sterilisations recorded during the reference period were 7 but 3 of them were done immediately after delivery. Since it was difficult to divide utilisation of health facilities and expenditure for the two events, for the purpose of analysis we have taken the 3 cases primarily as delivery events. For the purpose of our analysis, we have considered only 4 cases of sterilisation.

More than four-fifths of all events, and every one of the abortions, were reported from the slums and less than one-sixth were from non-slum localities. The distribution of women according to age groups showed that the majority of women undergoing pregnancy, delivery, and abortions were in the 18 to 25 year age group *(Table 7.3).* There was a higher percentage of women in the 26 to 35 year age group who were using contraceptives. More than half of the total number of contraceptive users were above 25 years of age.

With regard to number of living children we found that about three-fourths of the total number of women have 3 or less children, 14 per cent have more than 3 children and 13 per cent have no children. About 35 per cent of the pregnant women had no living children, 58 per cent of them have 1 to 3 children and 6 per cent have more than 3 children *(Table 7.3).* Among the women who had delivered 38 per cent have only 1 child, around 55 per cent have 2 to 4 children and 7 per cent have more than 4 children and fall in the 'high risk' category. Among the contraceptive users, there were no childless women who used contraceptives and less than 20 per cent of the users had 1 child. Around 59 per cent of the contraceptive users had 2 to 3 children and 22 per cent had more than 3 children.

Utilisation of health facilities

No treatment / no health facility utilised in the case of pregnant women means no Ante Natal Care (ANC) including examination, immu-nisation, etc., and in the present study the percentage in this category was as high as 43 per cent. However, we must note that there were only four such cases, i.e., 19 per cent, from the non-slum areas. If we consider only women from the slum areas with no treatment, we find that about 70 per cent are in the first and second trimester and the rest are in their third trimester *(Table 7.3A).* Overall, more than a quarter of the pregnant women did not take any treatment during the first trimester, another 47 per cent did not use any health facility during their second trimester and 23 per cent had not sought any treatment even when they were in the third trimester. Of those pregnant women who did seek treatment or utilised health facilities, a higher percentage (57 per cent) utilised private facility and only 32 per cent utilised public facilities *(Table 7.4).*

20 per cent of deliveries took place at home, (own or natal home), without the assistance of a formally trained person. Deliveries in public facilities accounted for 30 per cent and those in private facilities accounted for 31.7 per cent *(Table 7.5).* In the slum areas 27 per cent of women utilised private facilities, 31 per cent public facilities, 23 per cent delivered at home and 16 per cent utilised other facilities. The preference for private facilities is not as much as that among non-slum women. In our study, all the women who have delivered at home belong to the slum area.

For the three abortions reported, private health facilities had been utilised. For contraceptions we found that the use of private health facilities is much higher than public ones. This could be because private facilities include chemists who dispense oral pills over the counter. If we exclude the ten cases of OP users, we find the dependence on private facilities is lowered to some extent. An important observation is that the public health facility was being utilised by only 38 per cent of the total contraceptive users.

In terms of providers of care for all the events it was found that the female doctor was preferred by 21.5 per cent, 14.3 per cent preferred the male doctor, 11 per cent the nurse, and 11.5 per cent the local chemist/ Community Health Volunteer/ Dai (Table 7.6). In the case of delivery about 38 per cent recalled receiving services from more than one provider. About three-fourths of the women utilised a health facility which was at a distance of not more than half an hour from their place of residence, the rest utilised health facilities which were further away. This situation is true for all events except contraception, where 37 per cent utilised a health facility that was more than half an hour's distance away. *(Table 7.6).* On the whole, we found that even for reproductive events, more women were utilising private rather than public health facilities. 18.6 per cent stated past experiences of self, relatives and other people as reasons for selecting providers and health facilities. A further 18.6 per cent reported easy physical access as a reason for choosing the facility *(Table 7.7).* Economic access in terms of free and subsidised services, or benefit under various schemes was also an important reason reported by 11.6 per cent of the women. Another 12 per cent reported that they did not have much choice left since that particular facility was the most appropriate at that time for whatever reason. About 7 per cent had stated good and appropriate services provided by the facility as being the reason. This included the presence of a lady doctor, one service being linked to other services, and referrals by another doctor.

Expenditure on maternity events and contraception

The total expenditure incurred on all maternity events was Rs. 1,59,052, working out to a mean expenditure of Rs. 1433.71 per event with 91 per cent of the expenditure incurred on delivery and PNC, pregnancy accounting for 6.56 per cent of the total costs incurred *(Table 7.1).* The expenditure on abortions was very small as the number of cases recorded was just three. The average expenditure on pregnancy was Rs. 213.08, delivery Rs. 2428.90 and abortion Rs. 989.00. Of those 28 pregnant women who utilised a health facility the average paying event cost was Rs. 372.89. A point to be noted is that the expenditure could not be bifurcated separately for delivery and post natal care as the respondents were unable to report the break-up of expenditure in terms of amount spent separately on the women and their infants. It is quite understandable as post natal care is generally done on combined visits, of both mother and child, to the doctor. Therefore we have taken the total expenditure incurred on delivery and PNC combined. The same is true for cases of abortions.

The total expenditure incurred by those who utilised contraceptive was Rs. 7,283, out of which more than 50 per cent of the expenditure was on those who utilised IUDs and 45 per cent was spent on the four cases of sterilisation (Table 7.2). The average expenditure incurred on oral pills per user was Rs. 13.20, for IUCD user Rs. 297.77 and for sterilisation Rs. 820, and for all users combined it was Rs. 769.74. The expenditure incurred on the use of contraceptives was closer to the total per capita expenditure incurred on the sample population of Rs. 415.95. There was a high amount of expenditure incurred by the households in spite of the massive funding of the family planning program.

Components of expenditure

Doctors' fees and medicine accounted for 20 per cent of the total costs incurred on events. Only medicines accounted for 13.98 per cent of the total costs. As a proportion of the costs on medicines we found that a substantial amount, Rs. 19,457 out of a total of Rs. 22,253, was spent on deliveries. It accounted for 25 per cent of the costs incurred on total expenditure on pregnancy. A higher sum was spent on doctors' fees by those who were pregnant and in comparison the amount spent on doctors' fees for those who had deli-vered was just 6.04 per cent of the total costs incurred on deliveries *(Table 7.8)*. It has to be noted that for deliveries the major expenditure was incurred on hospitalisation, which included doctors' fees and medicines. Out of a total expenditure of Rs. 10,135, ninety per cent was spent by those who had delivered. Six women who had deli-vered had been hospitalised and had paid an ave-rage amount of Rs. 1,533.33. Those who underwent abortion paid an even higher amount for hospitalisation, as for the two cases the average expenditure was Rs. 467.50. So, the major expenditure in institutional deliveries and abortions are hospitalisation costs. This includes fees charged by the doctor for conducting delivery/abortion and for the labour room charges, specialists' charges, if applicable, plus a whole lot of other charges.

Pregnant women were advised many investigations and sonography with nearly 24 per cent of the total costs incurred on pregnancy going into them. Out of this, sonographic examinations alone accounted for nearly 13 per cent costs. As health care facilities were not utilised in many pregnancy cases, the average expenditure

per pregnancy event worked out to only Rs. 24.12. But for those who had utilised the facilities, it worked out to Rs. 197.00. For those who had delivered, the costs shot up to 10 times. The women who were pregnant were paying, on an average, Rs. 466.67 for sonography. Hence we see that more than 75 per cent of the health care costs go in direct expenditure; in pregnancies doctors' fees and medicines account for the major share, and in deliveries and abortions the major share goes in hospitalisation, followed by doctors' fees and medicines.

Travel expenditure, incurred in majority of the events, showed an average of Rs. 15.35 for pregnant women, Rs. 43.55 for those who had delivered, and Rs. 52.33 for abortion events. But it accounted for 2.21 per cent of the total costs incurred on all events. Only those who had delivered gave gifts and bribes and it accounted for 2.23 per cent of the total costs, the average cost working out to Rs. 59.21.

In terms of diet we found that pregnant women generally did not spend on any special diet (except in one case where Rs. 500 was spent), whereas women who had delivered spent an average of Rs. 191.08. *(Table 7.8).* The women who had undergone abortions were not spending on diet at all. Expenditure on rituals also followed the same pattern as that of diet. We found that pregnant women were not spending much as compared to those who had delivered. This is probably because of the many customs and traditions that have to be followed and spent on when a child is born.

All the contraceptive users had made some form of payment either as direct expenditure or indirect expenditure. All the users had spent on travel, average expenditure working out to Rs. 12.55. The expenditure on device was mainly that spent on purchase of oral pills *(Table 7.9).* The expenditure on medicines was incurred by nearly all the IUD users and those who had undergone sterilisation, where the average expenditure was Rs. 35.12. The expenditure on diet was incurred by all those who had undergone sterilisation.

Socio-economic differentials by expenditure

The differentials in expenditure on maternity events and contraception have been analysed examining the age of the women, number of living children, education, occupation, earning status and locality of the household.

Age

In terms of expenditure incurred on maternity events age of the woman becomes an important factor with regard to expenditure incurred by the household. For all the events in the sample the highest expenditure was incurred by those in the age group of 26-35 years, Rs. 1816.29. This included 22 deliveries, average expenditure working out to Rs. 3227.04 per delivery. But pregnant women in this age group spent only a measly amount of Rs. 49.88, much less than Rs. 213.08, the average expenditure incurred on pregnancy *(Table 7.10).* The amount spent is very low considering the fact that this amount would not even cover the basic ANC that needs to be provided in terms of TT injections and iron and folic acid tablets, leave alone other tests, diet, etc. The expenditure incurred by women in the age group of 18-25 years was Rs. 318.10. Further analysis reveals that as the age increases the expenditure on pregnancy reduces drastically. This is also true for deliveries. In contrast, the expenditure incurred on contraception increases as the age increases *(Table 7.11).*

Number of living children

Expenditure on maternity events was inversely proportional to the number of living children. For pregnant women having no children the average expenditure incurred was Rs. 376.24 (17 events), for women with one child Rs. 142.94 (16 events), with two children Rs. 140.44 (9 events) and those having three children just Rs. 7.50 *(Table 7.10).* But for women having more than four children we found that the expenditure incurred per event was higher in both kinds of events. But this is due to the fact that in one case the expenditure was as high as Rs. 15000, which skews the entire average expenditure. This brings out the fact that women are important only for their childbearing role, and her importance reduces with the number of children she bears.

Education

Educational status is a major determining factor in terms of expenditure incurred. Higher the educational level, higher the expenditure. Women who were illiterate were spending only Rs. 1624.50 for 28 deliveries as compared to Rs. 3225.83 spent for 18 deliveries by women who had had secondary school education. *(Table7.10).* And during pregnancy, women who were educated were spending Rs. 473.33 per event as compared to the 21 pregnant women who were illiterate and were spending only Rs. 290.19.

With regard to contraception the differentials in terms of education revealed that illiterate users were spending Rs. 252.00 on an average mainly on oral pills, and those having a secondary school education were spending Rs. 443.44, mainly on sterilisation. The lowest expenditure was for those with a primary school education, who were just spending Rs. 55.57 *(Table 7.11).*

Location of households

Taking location of the households as the variable, we found that for all the events, the expenditure incurred by the households living in the non-slum area was Rs.. 1741.16, as compared to those in the slum area where it was Rs.. 1303.25, which is less than the average expenditure for all the events. In slum areas the expenditure incurred on pregnancy was more than that spent in the non-slum area but for delivery and PNC the non-slum households were spending more than the slum households, in spite of the fact that the number of deliveries in the slum households was much higher that in the non slum-area *(Table 7.10).* All 3 cases of abortions were from the slum areas.

Though the number of contraceptive users was more in the slum area, the expenditure incurred by them was very less as compared to those from the non-slum area. The expenditure of seven contraceptive users in the non-slum area was 61.33 per cent of the total costs. In terms of per user costs, the non-slum users were spending five times more (Rs. 638.14) as compared to slum users who were spending Rs. 140.80 *(Table 7.11)*. The difference was quite vast with regard to expenditure for all the types of contraceptive users, more so with those who underwent sterilisation.

Occupation and earning status

Unskilled and semi-skilled women workers and other professionals were spending more than the housewives on maternity-related events. There were 55 delivery

events and 44 pregnancy events among housewives (non-earning women), and they spent just Rs. 2404.07 per delivery event and Rs.. 217.75 per pregnancy. In one case, where the woman was an equal earner, expenditure on delivery was as high as Rs. 8075.00 *(Table 7.10).* Status of women in the household in terms of occupation and earning status determines the amount of money that is spent on them for maternity events. The same is true for abortions. It transpires that pregnant women spend most during the second trimester of their pregnancy (Rs. 264.38 on an average) followed by the third trimester during which they spend Rs. 225.81 on an average. Working women, especially those in professions like teaching and nursing spent more on contraceptives than housewives, of whom 22 users were spending just Rs. 266.28 *(Table 7.11).*

Utilisation by expenditure

It is clear that the major amount goes in the utilisation of private facilities. Women who had their deliveries outside Mumbai had also spent a significant amount. The private sector seems to be preferred for care during pregnancy whereas for delivery both private and public facilities are being utilised *(Table 7.12).* Even in home deliveries (8 cases) there was expenditure incurred because after delivery the women visited the doctor. All the abortion events utilised private health facilities. The mean expenditure incurred per abortion worked out to Rs. 989 per abortion. This is a very high amount when we compare it with per capita expenditure of Rs. 415 incurred on health care.

In terms of the type of health facility utilised and the expenditure incurred thereof, we found that for pregnancies an equal amount of expenditure was being incurred on both dispensary / health post and the OPD of the hospital / nursing home *(Table 7.12).* The women preferred to go to a woman provider, and to avail of the services of a female doctor or nurse or an Auxiliary Nurse Midwife, they were paying a higher price, especially for delivery events. In spite of the govern-ment's emphasis on Maternal and Child Health services we found that the amount spent by households was very high and that there was a major expenditure incurred on utilisation of public health facilities.

Majority of the contraceptive users were utilising private facilities. Out of the total expenditure of Rs. 7,283 incurred, 94.17 per cent was spent in the private facilities, the per user costs working out to Rs. 428.68 as compared to public facilities of Rs. 39.40 *(Table 7.13).* The major expenditure incurred in the private facilities was by those who had undergone sterilisation, which accounted for a substantial amount. We also found that for IUD users the expenditure incurred in private facilities was quite high, Rs. 755.80. Those who were utilising public facilities were going mainly to the health posts for IUDs.

Table: 7.1 Maternity Events (Overall Characteristics)

	Pregnancy	Delivery & PNC	Abortion & PNC	Total
Total number of events	49	60	3	112
Total expenditure incurred	10441.00	145734.00	2967.00	159052
Average expenditure per event	213.08	2428.90	989.00	1433.71

No. of events for which health facility was utilised	28	60	3	91
No. of events not treated	21	0	0	21
Number of paying events	28	60	3	91
Average exp. per paying event	372.89	2428.90	989.00	1747.82

Note : *Total number of women in sample : 1036*

Total number of women above the age of 12 years : 697 (3 no responses included)

Total number of women currently married in sample population: 466.

Table: 7.2 Contraception (Overall Characteristics)

Use of Contraceptives	Oral Pill Users	IUCD Users	Sterlisation	Total
Number of women using contraceptives	10	12	4	26
Contraceptives used	10	13	4	27 *
Total exp. incurred the sample (in Rs)	132.00	3871.00	3280.00	7283.00
Average exp. per contraceptive (in Rs)	13.20	297.77	820.00	269.74
Average cost per females user (in Rs)	13.20	322.58	820.00	280.11

** One user had two IUCD insertions during the period in question.*

Table: 7.3 Record of Non-Illness Events

	Pregnancy	Delivery	Abortion	Contraception	Total
Locality					
Slum	44 (87.7)	51 (85)	1 (33.3)	24 (88.8)	120 (86.3)
Non-slum	5 (10.2)	9 (15)	2 (66.7)	3 (11.1)	19 (13.7)
Age (in years)					
18--25	30 (61.2)	36 (60)	2 (66.7)	11 (40.7)	79 (56.8)
26--35	18 (36.7)	22 (36.7)	1 (33.3)	15 (55.5)	56 (40.2)
36--45	1 (2.0)	2 (3.3)	0	1 (3.7)	4 (2.8)
No. of Living Children					
None	17 (34.6)	0	1 (33.3)	0	18 (12.9)
One child	16 (32.6)	23 (38.3)	0	5 (18.5)	44 (31.6)
Two children	9 (18.3)	19 (31.7)	1 (33.3)	9 (33.3)	38 (7.3)
Three children	4 (8.1)	7 (11.7)	1 (33.3)	7 (25.9)	19 (13.7)
> than 3 children	3 (6.1)	11 (18.3)	0	6 (22.2)	20 (14.4)
Total	**49 (100)**	**60 (100)**	**3 (100)**	**27 (100)**	**139 (100)**

Table: 7.3A Stages of Pregnancy for which No Treatment was Taken

Locality	Ist trimester	Iind trimester	IIIrd trimester	Total
Slum	3 (17.6)	9 (52.9)	5 (29.4)	17 (100)
Non- slum	3 (75)	1 (25)	0	4 (100)

Total	**6 (28.5)**	**10 (47.6)**	**5 (23.8)**	**21 (100)**

Table: 7.4 **Utilisation of Health Facility for Delivery**

Cluster	Private	Public	Home	Others	NA / NR	Total
Slum	14 (27.4)	16 (31.3)	12 (23.5)	8 (15.6)	1 (1.9)	51 (100)
Non-slum	5 (55.5)	2 (22.2)	0	2 (22.2)	-	9 (100)
Total	19 (31.7)	18 (30)	12 (20)	10 (16.7)	1 (1.7)	60

Table: 7.5 **Type of Health Facility Utilised for Events**

Type of Health Facility	Pregnancy	Delivery	Abortion	Contra cep-tion	Total
Private	16 (57.1)	19 (1.7)	3 (100)	16 (59.2)	54 (45.7)
Public	9 (32.1)	18 (30)	0	10 (37.03)	37 (31.3)
Home	0	12 (20)	0	0	12 (10.2)
Others	3 (10.7)	10 (16.7)	0	1 (3.7)	14 (11.9)
No response	0	1 (1.7)	0	0	1 (0.8)
Total	**28**	**60**	**3**	**27**	**118**

***Note**: "Others" include women who went out of Mumbai for delivery.*

Table: 7.6 Health Service Provider & Distance of Health Facility from Residence

	Pregnancy	Delivery	Abortion	Contracep-tion	Total
Provider of Care					
Self / relative / neighbour	0	4 (6.7)	0	0	4 (3)
Doctor (male / unspecified)	7 (14.2)	4 (6.7)	2 (66.7)	7 (25.9)	20 (14.3)
Doctor (female)	13 (26.5)	8 (13.3)	0	9 (33.3)	30 (21.5)
Nurse	0	10 (16.7)	0	5 (18.5)	15 (10.7)
Dai / CHV / chemist	3 (6.1)	8 (13.3)	0	5 (18.5)	16 (11.5)
> than 1 provider	3 (6.1)	23 (38.3)	1 (33.3)	1 (3.7)	28 (20.1)
Not applicable / No response	23 (46.9)	3 (5)	0	0	26 (18.7)
Total	49 (100)	60 (100)	3 (100)	27 (100)	139 (100)
Distance Of Health Facility from Residence					
< 10 minutes	9 (36)	9 (20.9)	0	9 (33.3)	27 (27.5)
10 minutes -- < ½ hour	11 (44)	23 (53.5)	3 (100)	8 (29.6)	47 (47.9)
> ½ hour	5 (20)	11(25)	0	10 (37)	26 (26.5)
Total	**25 (100)**	**43 (100)**	**3 (100)**	**27 (100)**	**98 (100)**

Table: 7.7 Reason for Selecting Health Facility (Excl. Contraception & Include. Post Natal Care Services)

Comment: This table can be omitted.

Reasons	No. of households (%)
Past experience	32 (18.6)
Easy physical access	32 (18.6)
Economic Access	20 (11.6)
Emergency	21 (12.2)

Table: 7.8 Components Of Costs For Maternity Events (In Rupees)

Health Care Costs	Costs as per cent of total				Average Expenditure			Paying Events		
	Preg n-ancy (49)	Delive ry & PNC (60)	Aborti on & PNC (3)	Total	Pregn-ancy (49)	Delivery & PNC (60)	Abortio n & PNC (3)	Pregna ncy	Deliv ery & PNC	Abort ions & PNC
Doctors' fees	33.9 6	6.04	0	7.76	72.37	146.76	0	253.28 (14)	733.8 3 (12)	0
Medicin e	25.7 2	13.35	3.70	13.9 8	54.82	326.20	36.67	179.07 (15)	748.3 5 (26)	110.0 0 (1)
Investig a-tions	11.3 2	0.96	0	1.62	24.12	23.50	0	197.00 (6)	235.0 0 (6)	0
Sono-graphy	13.4 0	0.38	11.12	1.43	28.57	8.75	110.00	466.67 (3)	187.0 0 (3)	115.0 0 (2)
Surgery	0	0	0	0	0	0	0	0	0	0
Hospita-lisation	0	6.31	31.51	6.36	0	153.33	311.67	0	533.3 3 (6)	467.5 0 (2)
Travel	7.18	1.79	5.29	2.21	15.35	43.55	52.33	57.85 (13)	90.10 (29)	78.50 (2)
Gifts / bribes	0	2.43	0	2.23	0	59.21	0	0	104.5 0 (34)	0
Diet	4.78	7.86	0	7.51	10.20	191.08	0	500 (1)	545.9 5 (21)	0
Rituals	1.62	10.31	0	9.55	3.47	250.50	0	170 (1)	878.7 5 (8)	0
Any other	0.04	0.46	6.74	0.55	0.10	11.38	66.67	250 (2)	85.37 (8)	100.0 0 (2)
Combin ed exp.	1.91	50.06	41.62	46.7 4	4.08	1215.93	411.67	200 (1)	3316. 18 (22)	617.5 0 (2)
Total	**1044 1**	**14573 4**	**2967**	**1591 42**	**213.08**	**2428.90**	**989.00**	**372.89 (28)**	**2428. 90 (60)**	**989 (3)**

Table: 7.9 Components of Costs for Contraception

Comment: In rupees?

Components of Costs	Oral Pill Users	IUCD Users	Sterilisation	Total
Device	12.20 (10)	-	-	12.20 (10)
Medicines	-	9.33 (12)	112.50 (4)	35.12 (16)
Travel	1.00 (10)	8.38 (13)	55.00 (4)	12.55 (27)
Diet	-	-	27.50 (4)	27.50 (4)
Gifts / bribes	-	-	12.50 (4)	2.50 (4)
Combined expenses	-	331.81 (13)	612.50 (4)	358.82 (17)

Note: *Figures in brackets are the no. of users*

Table: 7.10 Differentials in Maternity Costs

	Pregnancy	Delivery & PNC	Abortion & PNC	All Events
Locality				
Slum	234.89 (37)	2267.83 (42)	989.00 (3)	1303.25 (82)
Non-slum	146.33 (12)	2804.72 (18)		1741.16 (30)
Age Group (in years)				
18 – 25	318.10 (30)	1991.08 (36)	195.00 (2)	1200.16 (68)
26 – 35	49.88 (18)	3227.04 (22)	2577.00 (1)	1816.29 (41)
36 – 45	0 (1)	1530.00 (2)		1530 (2)
Number of Children				
None children	376.24 (17)	-	280.00 (1)	370.88 (18)
1 child	142.94 (16)	3339.91 (23)	-	2028.33 (39)
2 children	140.44 (9)	1774.05 (19)	2577.00 (1)	1294.75 (29)
3 children	7.50 (4)	1276.57 (7)	110.00 (1)	756.33 (12)
> 4 children	154.67 (3)	2388.45 (11)	-	1909.78 (14)
Educational Level				
Illiterate	290.19 (21)	1624.50 (28)	110.00 (1)	1033.80 (50)
Primary school	0 (1)	817.50 (4)	280.00 (1)	591.66 (6)
Secondary / high school	152.76 (17)	3225.83 (18)	2577.00 (1)	1756.63 (36)
Matriculation	57.50 (4)	2736.00 (8)	-	1843.16 (12)
Higher secondary / Graduate / Technical	473.33 (3)	17005.00 (1)	-	4606.25 (4)
Tailoring/Diploma in Education	33.33 (3)	20.00 (1)	-	30.00 (4)
Type of Occupation				

Comment: What is this?

Unskilled / semi-skilled worker	30.00 (1)	1715.00 (2)	-	1153.33 (3)
Skilled worker / small-scale manufacturer	276.67 (3)	-	-	276.66 (3)
Nurse / teacher	-	4852.50 (2)	1476.00 (2)	3164.25 (4)
Housewife	217.75 (44)	2404.07 (55)	390.00 (1)	1421.95 (100)
Student	-	0 (1)	-	(1)
Missing cases	(1)	-	-	(1)
Earning Status				
Non-earner	-	150.00 (1)	-	150.00 (1)
Main earner	0 (1)	-	-	731.75 (4)
Supplementary earner	15.00 (2)	370.00 (1)	2577.00 (1)	8075.00 (1)
Equal earner	0 (1)	8075.00 (1)	-	1420.29 (100)
Housewife	222.44 (43)	2401.34 (55)	195.00 (2)	1477.75 (4)
No response / Missing cases	423.00 (2)	2532.50 (2)	-	-
Total	**(49)**	**(60)**	**(3)**	**(112)**

Table: 7.11 Differentials in Costs on Contraception

Cluster	Oral Pill Users	IUCD Users	Sterlisation	Total
Slum	6.75 (8)	277.44 (9)	238.33 (3)	140.80 (20)
Non-slum	39.00 (2)	456.00 (4)	2565.00 (1)	638.14 (7)
Age (in years)				
20—25	7.00 (5)	180.60 (6)	300.00 (1)	118.25 (12)
26—30	23.50 (4)	398.14 (7)	315.00 (2)	270.07 (13)
31—36	3.00 (1)		2350.00 (1)	1176.50 (2)
Educational Level				
Illiterate	2.66 (3)	1000 (1)		252.00 (4)
3rd to 5th standard	13.50 (2)	10.66 (3)	315.00 (2)	55.57 (7)
7th to 8th standard	8.50 (2)	203.00 (5)	1475.00 (2)	443.44 (9)
10th to 12th standard	26.66 (3)	453.75 (4)		270.71 (7)
Type of Occupation				
Semi-skilled / skilled worker	2 (1)	-	600.00 (1)	301.00 (2)
Secretary/Nurse/Teacher/ Service	75 (1)	507 (2)	-	363.00 (3)
Housewife	6.87 (8)	259.72 (11)	893.33 (3)	266.28 (22)

Table: 7.12 Expenditure on Maternity by Utilisation

	Pregnancy	Delivery & PNC	Abortion & PNC	All Events
Type of Institution				
Private	541.50 (16)	4669.11 (19)	989.00 (3)	2640.63 (38)
Govt	103.67 (9)	1141.22 (18)	-	795.37 (27
Outside Mumbai	407.00 (2)	3592.00 (7)	-	2884.22 (9)
At own home	-	315.83 (12)	-	315.83 (12)
Any other	30.00 (1)	3692.50 (2)	-	2471.66 (3)
Missing cases / NR	-	80.00 (2)	-	80.00 (2)

Comment: Are this table necessary? Th just collation of data preceding tables.

No treatment (Males)	0 (21)	-	-	-
Institution				
Dispensary/ Health Post	340.00 (11)	2529.00 (1)	110.00 (1)	490.69 (13)
Hosp/Nursing home	392.47 (15)	2868.9 (45)	1428.50 (2)	2223.33 (62)
Outside Mumbai	407.00 (2)	-	-	407.00 (2)
At Home	-	714.42 (12)	-	714.08 (12)
Any other	-	2765.00 (2)	-	2765.00 (2)
No Treatment	0 (21)	-	-	-
Provider				
Male doc. / unspecified gender	298.43 (7)	3233.75 (4)	1363.50 (2)	-
Female Doc.	398.62 (13)	3005.13 (8)	-	-
Doc/Nurse/ANM	1585.00 (2)	3141.46 (26)	240.00 (1)	
Dai	0 (3)	866.50 (8)	-	-
Any other *	0 (1)	1438.28 (14)	-	-
NR	0 (2)	-	-	-
No TreatMalest	0 (21)	-	-	-
Distance				
Less than 1 k.m	179.11 (9)	4097.44 (9)	-	-
1 k.m to less than 2 .m	607.27 (11)	2508.56 (23)	959.00 (3)	-
2 k.m to less than 3 .m	146.50 (6)	2491.11 (9)	-	-
More than 3 k.m	635 (2)	7655.00 (2)	-	-
Home	-	701.08 (12)	-	-
No treatment	(21)	-	-	-
Number of Visits				
1 Visit	64.71 (7)	3074.88 (34)	280 (1)	2506.64 (42)
2 Visits	225.25 (4)	757.50 (4)	110 (1)	449.00 (9)
3 Visits	121.75 (4)	3094.50 (4)	-	1608.12 (8)
4 & more than 4 visits	874.22 (9)	4435.50 (4)	2577 (1)	2013.35 (14)

No response	183.00 (4)	574.14 (14)	-	487.11 (18)
No treatment taken / Not applicable	0 (21)	-	-	-
Total	**(49)**	**(60)**	**(3)**	**112**

*Note : * Other: Self, relative, nurse & Ayah ,more than 2 provider*

Conclusions

The findings of this study need to be placed in the context of the methodology adopted in the present study and the issues it throws up on the gender differentials in relation to morbidity, utilisation and expenditure on health care services.

Methodology

This study highlighted certain very interesting aspects in the methodology of health surveys and in the larger study of women's health. The unique methodology adopted in the conduct of this study, effectively did away the gender blindness prevalent in the previous household level studies. When no importance is attached to the gender of the respondent and interviewer, the levels of morbidity reported for both males and females are almost similar. Due to the modifications that we made in the methodology, we were able to record a significantly higher burden of morbidity among women. This impressed on us the need to be sensitive to women's perceptions about their health problems. Purely medical or even sociological categories of illness would prove inadequate to record the complexity of illness perceived by women. Although this fact has been stressed in almost all qualitative micro-studies on women's health, an attempt was made to integrate these insights into a quantitative study.

Morbidity

The objective of the study was to create an environment, which encouraged women to feel unhindered to speak about their health problems even while a deliberate attempt was being made to elicit information about unreported illness through the probe list. Out of a total of 780 episodes reported, the monthly prevalence rate of illness worked out to 363 per thousand, with the gender difference being vast. The monthly prevalence rate for males was 169 per thousand as compared to 297 for females. When we add the episodes reported after probing, the rate for females goes up three-and-a-half times, to 571 per thousand. No previous household study has reported such a high morbidity. The high morbidity reported by women in our sample was complemented by the high prevalence rate of specific types of illness. Reproductive illness accounted for 28.2 per cent of all episodes among females, the majority of them related to menstruation and child bearing. A very high percentage of women reported morbidity due to aches, pains, injuries and weaknesses. Taken together with reproductive problems they form 51.69 per cent of all illnesses reported among women. In terms of gender difference there was marked difference in the type of illnesses reported in every category. Women have reported remarkably higher levels of almost all types of illnesses especially after probing.

Further, the findings point to a strong relationship between women's work life and their health. No study of work and health among women can afford to avoid an exploration of the household as a workplace. For 90 per cent of the women (in this case), the household is their workplace. That all married women, (and those with children, more so) reported significantly higher morbidity than other women is an indicator of the additional burden of morbidity that reproductive labour imposes. It is very evident that this task becomes more demanding on their health within a degraded environment. All this points towards a need for more systematic studies into women's health problems in relation to their work. Just as we observe the changes affecting other areas of work, in terms of technological changes, changes in labour organisation, etc.; it would be incorrect to understand 'housework' as an unchanging routine of tasks. We must understand how the nature of reproductive labour is transformed by changes in the larger world that surrounds the household where it is undertaken. This would give valuable insight into the study of the health problems of women, who labour both inside and outside the home. The findings also throw more light on the pressures of urban living, and in a marginalised community such as a slum, and these are reflected sharply in the reporting of morbidity. This also prompts us to explore further into the health consequences of poverty for those who live on the social margins of the city. We find a population who is reporting an increasingly lower sense of 'well being'.

Utilisation of health services

Our sample shows high non-utilisation of health care, with 32.5 per cent of the illness episodes not being treated. Non-utilisation was also high during pregnancy and delivery. Twenty per cent of the deliveries were conducted at home. Thus, in Mumbai, in spite of having some of the best health facilities in the country, people residing within the city were not able to access them. This is a shame and if this is the case in Mumbai the situation in rural areas can well be imagined.

Wherever health care facilities have been utilised, it is apparent that there is a high preference for private health services. Private facilities were approached for nearly 85 per cent of the illness episodes, with only 10 per cent seeking public facilities. Though the percentages vary, the fact holds true for pregnancies, deliveries, abortions, and even contraception.

The types of private facilities utilised were mainly clinics and dispensaries located near the place of residence. When it was a question of a public facility people generally chose a hospital rather than a dispensary. Public facilities were utilised mainly by the people from the slums. As mentioned earlier Mumbai has a vast network of public facilities provided mainly by the municipal corporation complemented by the state government. Though these facilities exist there is a disparity in terms of their utilisation. At one end the tertiary care hospitals are overloaded, with insufficient number of beds and high out-patient care utilisation and at the other end of the scale are maternity homes, dispensaries and health posts not being utilised. People prefer to go directly to hospitals than to the first level unit as most of the time they do not have medicines, or the doctor is not available, the timings are inconvenient, etc. The solution seems to be in strengthening the first referral care backed by a good referral system.

As far as preference for the health provider was concerned, 80 per cent seemed to prefer to consult a doctor. Self-medication was sought by only four per cent and this percentage mainly purchased drugs directly from the chemists' shops or general stores. For maternity events the female doctor was preferred most followed by the male doctor, the nurse and the local

chemist / CHV / Dai .One of the factors why 39 per cent of the reproductive illnesses were not treated could be due to the non-availability of female doctors, and another could be related to access of health care services.

Another reason for the majority preferring the private health sector may be their convenient location and timings. For nearly two-thirds of the illness episodes health facilities which were less than 10 minutes distance from home were approached, 78 per cent of them being private health facilities. In case of maternity events about three-fourths of the women utilised a health facility which was at a distance of not more than half an hour.

A strong gender bias towards males is very much evident right across the findings of the whole study. Women, according to our study, have got a raw deal both in terms of utilisation and the expenditure incurred on their illness and non-illness events. One finds that irrespective of the age, education, occupation, earning status, location of the households there was a wide difference among men and women in terms of utilisation. Out of the total of 271 not treated illness episodes, male episodes accounted for only 17 and female episodes accounted for 254. On the whole, about 67 per cent of the illness episodes were treated at one or the other health facilities. Home remedies were used by more number of women than men. Women's use of chemists/ pharmacists / home was close to double that of male utilisation, indicating their accessibility in terms of time, resources, and in keeping with their perception of what can be treated outside of the formal structures and as a stop gap arrangement.

For women in all age groups formal health facility utilisation (public and private) is lower than men. Girls in the age group of 0-11 years have a high number of treated illnesses but as age increases, utilisation decreases. Women in the 26_35 years age group have the lowest percentage of treated episodes. Older women, i.e., above 45 years of age, do not receive as much health care attention as the men in the same age group. Men are privileged in terms of utilization, irrespective of their age.

In terms of location of the households, we find that males in slums have a higher percentage of treated episodes than females. The gender bias continues with men belonging to any of the occupation category having higher percentage of treated episodes than their counterparts among the women. Housewives formed a large section of our respondents. We find that 46 per cent of them who had fallen ill did not take any treatment. Those women who had independent income did not fare very differently from the housewives with regard to utilisation of health services. Our study does not show any direct impact of education on health seeking behaviour. The important thing is that irrespective of the educational status, all the males had about 86-94 per cent of their episodes treated. On the other hand, no matter how high the educational level of the women, not more than 65 per cent of their illness episodes are treated. This clearly brings out the fact that utilisation of health facilities for women are not determined by their earning status, occupation and education. What becomes evident is that the low status of women in the household set-up and the society leads to a very different pattern of treatment and non-treatment for men and women.

Expenditure on health care

The study threw up various major issues with regard to the expenditure patterns. The total expenditure on health care (including maternity and contraception) worked out to Rs. 2,40,790. In terms of proportion of expenditure we find that 84.30 per cent went for treating illness and 15 per cent went for maternity, leaving less than 1 per cent for contraception. On an average, the per capita expenditure worked out to Rs. 41.09 for the entire population of 2,149 persons and for a household having a

family size of four, it worked out to Rs. 164.45 per month. Taking the figures on a per annum basis we find that the expenditure per capita works out to Rs. 493.08 and per household works out to Rs. 1,973.51. The expenditure incurred is much higher that what is spent by the government, which is just Rs. 250 per person in Mumbai city, and very much higher than the national per capita expenditure of Rs. 90.

Analysing expenditure incurred only on illness (as apart from total expenditure and that for maternity events) we find that out of a total expenditure incurred of Rs. 74,455 by the sample population, the per capita expenditure works out to Rs. 34.64 per month, i.e., Rs. 415.68 per annum; with average cost for the 780 reported episodes working out to Rs. 95.45. Since health facilities had not been utilised for all episodes, and since some of those who had utilised some facility had not paid for it, the expenditure per paying episode worked out to Rs. 166.93. Ninety per cent of this went into doctors' fees and medicines. Majority of the expenditure, nearly 85.41 per cent, was spent on private health facilities. In terms of per episode costs we find that the expenditure on public facilities was much higher than what was incurred on the private facilities. Three-fourths of the expenditure was incurred by illness episodes in the non-slum area, though the morbidity was much higher in the slum area. The people in slums, who form the bulk of the population and whom illness seems to strike more often, are not able to spend due to their low income and lower socio-economic status.

Gender bias is very much evident in terms of expenditure on illness also. Expenditure incurred on female illness episodes was much lower than what was spent on males. In terms of per episode cost, the expenditure incurred on women was just Rs. 78.59 as compared to expenditure on males which was Rs. 148.56. With regard to those that had utilised health facility we find the same pattern emerging. In both the slum and non-slum areas, households were spending less on illness episodes affecting women than what was spent on men. Reproductive illness, which accounted for 21.41 per cent of the total episodes, accounted for only 19.31 per cent of the total expenditure incurred. But the cost per episode for those who had utilised facilities worked out to a high of Rs. 221.26 per episode. The lowest expenditure incurred was on weakness, Rs. 35.15, and this affected 95 per cent of the women who reported ill. Examining the expenditure incurred by age we find that as the age increases the difference in expenditure become sharper between males and females with less expenditure incurred on female illness episodes. Only during the ages of 12 to 17 years is the expenditure incurred on females higher (Rs. 260.79) than on males (Rs. 41.05). In the age group of 18—25 years also the expenditure is higher than males in the same group, but only slightly. The expenditure incurred on currently married women was less than half (Rs. 90.26) per episode as that of the males in the same category. Across all categories (except the unskilled and semi-skilled workers where the difference was only marginal) the expenditure on male illness episodes was on the higher side than the females with difference being vast among the lower level professionals.

Analysis of expenditure incurred on non-illness events reveals that 91 per cent of the expenditure incurred was on delivery, with pregnancy accounting for 6.56 per cent of the total costs incurred on maternity events. The mean expenditure on all maternity events works out to Rs. 1,433.71 per event, and the average expenditure on pregnancy Rs. 213.08, on delivery Rs. 2,428.90 and on abortion to Rs.. 989.00. Of those 28 pregnant women who utilised health facilities the average paying event cost was Rs. 372.89. With regard to expenditure incurred on contraceptives, we find that out of the total expenditure incurred of Rs. 7,283, half was on those who used IUDs and 45 per cent was spent on the four sterilisations. The average expenditure

incurred on oral pills per user was Rs. 13.20, for IUCD user Rs. 297.77 and for sterilisation Rs. 820, and for all the users, it was Rs. 769.74.

It needs to be stressed that the methodology employed for studies of this nature needs to be more sensitive to women's health in terms of emphasis on eliciting information from women with regard to illness that are not perceived as illnesses as such and illnesses which relate to reproductive and sexual aspects. Further, the issue of non-utilisation of health services especially by women who suffer from various illness and for deliveries even in a premier city such as Mumbai which has better public health facilities as compared to other parts of the country, needs to be addressed. Though the services are available, the access to them is determined by factors operating within the household and outside. The factors related to issues within the household need to be dealt at a societal level. The forces that operate at the broader level need to be examined in a more gender sensitive manner so that more women can avail of the services.

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Annexure 1

List of questions for probing

(To be probed for all women of 12 years and above in the household)

1. Pain in any part of the body
2. Trouble with eating and digestion
3. Problems with chest and breathing
4. Trouble with seeing, hearing and moving
5. Weakness and related problems
6. Mental stress
7. Any skin problems
8. Problems with passing urine
9. Problems with the genital organs
10. Problems related to menstruation
11. Problems with having children or during childbirth
12. Problems during intercourse
13. Problems while using contraception
14. Any injury or accident or bite, any other long term illness

Annexure 2

Centre For Enquiry into Health and Allied Themes
519, Prabhu Darshan, 31, S.S. Nagar, Amboli, Andheri (W) 400 068
Phone: 625 0363

HOUSEHOLD EXPENDITURE ON WOMEN'S HEALTH

Dear Sister,

We are conducting a study on women's health.

Our organisation has a special interest in health issues. It is a secular, non governmental organisation. It is five years old and is run by its staff. It is governed by Anusandhan Trust (Reg. No. E 13480). We have conducted many research studies in different parts of Maharashtra. People from different sectors and disciplines work in this organisation.

This study aims to understand those aspects of health which you understand very well. We want know what illnesses people, and especially women, suffer from, where do they go for help and how much is spent on seeking care. By conducting such a

study, the experiences of many people can be brought together and we can gain a better understanding of the condition of the entire city or tehsil.

For this reason, we want to know from women about themselves and their family members' health. We also want information about events – deliveries, pregnancies, abortion and deaths which have occurred in the past year in the household. Without the consent of the respondent, this information will not be shared with anybody. At the end of the study, a detailed report will be written on the basis of all the information collected. No individual's name will be printed in this report. This report will be available for all to read. You will also be given a small summarised report. We hope that this study will give the people in the community more information about the status of health in their area. We will also be able to answer some questions that we have in our minds.

We have selected the households purely by counting the number of houses, and not with any other objective. By sampling, all kinds of people can be included in the study. However, you have a right to refuse to give the interview and also to refuse to answer specific questions. CEHAT and the individuals who have signed this letter promise you that this information will not be divulged to anyone else.

If you have any doubts, questions or suggestions, please call us, meet us or write to us.

Name of the investigator:_____

Researchers

Roopashri Sinha
Neha Madhiwalla
Sunil Nandraj
Amar Jesani *(Co-ordinator)*
*(**Note:** This pamphlet has been translated from Marathi.)*

Annexure 3

SCHEDULE NO : _____

HOUSEHOLD EXPENDITURE ON WOMEN'S HEALTH IN MUMBAI CITY

Centre for Enquiry into Health & Allied Themes (CEHAT)

519 Prabhu Darshan 31 SS Nagar, Amboli Andheri, (W) Mumbai 400 068

The objective of the study is to document and analytically understand the extent of perceived morbidity, patterns of health care service utilization and expenditures incurred by households on women's health.

All Information provided and recorded in this schedule would be kept confidential & used for research purposes o names and identity of respondents will not be disclosed under any circumstances.

==========

NUMBER OF VISITS : _____ DATE/S : _____
_____
INVESTIGATORS NAME : _____ CHECKED
_____
REMARKS
_____
_____

==========

1) Respondents Name : _____ 1a) Relationship to the head of the hou
_____
1b) Religion : _____ 1c) Caste/Tr
_____
1d) Mother tongue : _____
1e) Address : House/ Bldg. No : _____ Street : _____
_____
Village / City : _____ District : _____ Pin
_____

SCHEDULE NO. : ____

FAMILY PROFILE

Sl. No	Name	Sex	Age	Relation with the head of the household	Education	Occupation	Marital Status	No of living children	Delivery / Abortion / Pregnancy (Day/Month)	Method of Family Planning used	Illness in the last month	Il t (

SCHEDULE NO : _____

ILLNESS CARD

Person's Name : _____
Household No : _____

Illness No	Symptom of Illness & causes	Duration of illness (write dates)	If illness is chronic since when	Type of health facility utilized and reasons for that	Type of treatment	Treatment taken after how many days	Reasons for non-treatment	Distance from the house b> type of vehicle used c> Who accompanied	No of visits	Number of days normal life affected (individual)	Num of d nor lif affe (Fan

Expenditure incurred

Illness No	Doctor's Fees	Medicine / Injection / Tonic / Tablets	Expenditure on examination	Expenditure on operation	Expendi-ture on hospitali-zation	Expen di-ture on Travel	Expendi-ture on rituals / Prayers	Expen di-ture on special diet	Expendi-ture on bribes / gifts / tips	Expenditure borne by family members	C (d

SCHEDULE NO : _____

PREGNANCY (ANC) / DELIVERY / ABORTION / POST NATAL CARE (PNC) CARD

Women's Name : _____ **Household No** : _____

1) EVENT ***(circle whichever applicable)*** **: PREGNANCY / DELIVERY / ABORTION / POST NATAL CARE**
2) Any problems / complications :

_____

3) Any problems:

_____

Event & Place	Health Center	Reasons for choice of health facility	Type of treatment given and by whom	Treat-ment given by	Distance from the house b> type of vehicle used c> Who accompanied	Duration of stay in the health centre hrs/days	No of visits	Number of days normal life affected (individual)	Number of days normal life affected (Family)
ANC									
DELIVERY / ABORTION									
PNC									

Expenditure incurred

Events	Doctors	Medicine/Injecti	Expen di-ture on	Expendi -ture on operati	Expen di-ture on	Expen di-ture on	Expen di-ture on	Expen di-ture on	Expen di-ture on	Expen di-ture borne	Other expend i-ture

	Fees	on/ tonic/ Tablets	exami- nation	on	Hospit a- lisation	travel	rituals / prayer s	special diet	gifts / bribes / tips	by family membe rs	
ANC											
DELIVERY / ABORTIO N											
PNC											

SCHEDULE NO : _____

CONTRACEPTIVE CARD

Name :

_____

_____ **Household No**. _____

Contraceptive used :

_____

_____ **Date** : _____

Health Facility utilised	Person provided the service	What kind of services provided	Any problems while receiving service	No. of hrs / days stay in health facility	Distance from the house b> type of vehicle used c> who accompanied	No of days normal routine affected (person)	

Expenditure incurred

Doctor's fees	Medicine / Injection / tonic / Tablets	Expenditure on examination	Operation	Hospitalisation	Expenditure on travel	Expen di-ture on rituals / prayer	Ex di- c spe d		

SCHEDULE NO. : _____

PHYSICAL INFRASTRUCTURE, ASSETS & INCOME

1) No of years of stay in the city: _____**2) Ownership of House** : _____

2a) Number of rooms (Including kitchen) : _____ **2b) Area of the house** : (in Sq.ft) _____

2c) Type of House : Roof _____ Wall _____ Floor _____

3) Drinking water sources : _____ _____

4) Toilet : Present within the House / Public Toilet / Open / Any other (specify) _____

4a) If open : _____ _____

5) Bathroom : In the House / Mori / Open / Any other (specify) : _____

6) Nutrition: Were do you purchase your food grains from ? a) **Wheat**: ration shop / open market b) **Rice**: ration shop / open market

c) Jowar: ration shop / open market d) **Bazara**: ration shop / open market

6b) Do you eat sufficient food ? Yes / No

6c) When do you have problems procuring food ? Yes / No (give details):

_____

7) Assets in the household

7a) Productive assets : _____ _____

7b) Agricultural land : _____ _____

7c) Details of agricultural land : _____ _____

7d) Any other property : _____ _____

7e) Other Assets : Vehicle Television Fridge Fuel Radio

8) Sources of Income / Earnings :

Name	Salaries	Wage Income	Self employme	Income from	Rent	Interest / Profit	Pension	Any otl incom	

			nt	**Land**					

9) Total monthly income of the household:

_____

_____

SCHEDULE NO : _____

SOURCE OF FINANCE

This has to be administered to those household who have spent money either on illness / ANC / pregnancy / abortion / delivery / contraception of the members in the household.

How did your household meet the expenditure incurred on health?

	Total expenditure						
		Self earning	**From schemes**	**From recoveries**	**Borrowing**	**Sale of asset / pawning assets**	
Illness							
Pregnancy							
Abortion							
Delivery							
Contraception							
Death							

Is it possible to recover the amount spent:
_____
_____

Loss of earnings *(No. of days & amount) (* Only for daily wage earners)* :
_____

Compensation received from various sources *(in case if contraceptive used)*:
_____

++

SCHEDULE NO : _____

DEATH CARD

Name : _____
Household No._____
1) Date of death :
_____
_____
2) Cause of death :
_____
_____
2a) If cause of death due to illness *(give details)* :
_____
_____
2b) If cause of death due to abortion *(give details)* :_____
_____

2c) If cause of death due to maternity related *(give details)* : _____

2d) If cause of death due to contraceptive used *(give details)* :_____

3) Whether registered : _____

_____

4) Expenditure incurred: _____

_____

4a) Total expenditure incurred prior to death on treatment *(if applicable)* : _____

4b) Total expenditure incurred on ceremony, rites etc. : _____

_____