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Reproductive Health of Women in Urban Slums of Bombay

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In the last decade, several international and national movements have focused their attention, on the long neglected areas of women's reproductive health. Community based research in India has made it evident that the reproductive morbidity is not confined to special clinic based population but it is instead widespread within the community at large. This paper addresses the nature and prevalence of gynecological and related morbidity's in the urban slums of Mumbai India. It also outlines multifactorial determinants that affect the prevalence of the disease conditions and presents policy recommendations passed upon the experience of the author of working in the field of community health which can better meet the needs of women and their families in the developing world.

Introduction

It is, indeed heartening to see that in recent years, several international and national movements have focused their attention on the long-neglected areas of women's reproductive health as evidenced by the safe motherhood initiatives and by the adoption of women's comprehensive health perspectives in the strategies addressing the child survival, the family planning and the development of women. The past decade has witnessed a significant shift on the subject of human reproduction from a mainly 'demographic issue' to a broader women's health and development issue, that is viewed as a key determinant of both individual well-being and societal prosperity. An Indian woman's health is no longer considered merely a state of physical well-being, but an expression of the many roles she performs as wife, mother, health care provider and wage-earner, and their interaction with the socioeconomic and cultural factors which influence her daily life. Several research studies in the developing countries have documented the relationships and the important linkages between reproductive health of women and the socioeconomic development, especially relating to enhancement of economic opportunities and education of women, fertility reduction and child survival (Cleland, 1988). Reproductive health is thus inextricably linked to the subject of reproductive rights and freedom, and to women's status and empowerment. Several community studies in the Third

World countries and in India have culminated in a general recognition of the magnitude of the women's reproductive health problems and there is some evidence of commitment to redress this grievous neglect as stated above, while making the policy at the national level. Moreover concerted efforts supplemented with multidisciplinary research by epidemiologists and social scientists are required to redress these complex problems of women. There is also an imperative need to understand gaps in knowledge regarding the levels, the determinants and the consequences, of the women's reproductive health problems and translate the concepts arrived at, into policies and programs, so as to design appropriate and locally relevant interventions, for improving the women's reproductive health.

In the context of the above situation, this paper seeks to review the health, including its related problems and the needs of underprivileged population in the urban areas. The purpose of this paper is:

• To understand the impact of population explosion and urbanization, and to provide an analysis of the risks to the poor women's health in urban slums;

• To describe the existing situation of women's reproductive morbidity, focusing on the reproductive tract infections including the sexually transmitted diseases;

• To identify the socio-cultural and economic determinants and their consequences on reproductive health of women, and

• To suggest actions in the areas of policies, programs and researches to minimize these risks in order to improve the reproductive health of women.

Before going, further into discussion on the various points, it is felt necessary to understand the concepts and the definitions of reproductive health.

Women's Reproductive Health: Concepts and Definitions

Reproductive health is defined as "the ability of women to live through the reproductive years and beyond, with reproductive choice, dignity and successful child bearing, and to be free from gynecological diseases and risks" (Evans et al. 1987) and reproductive health approach is described as "the ability of a woman and her partner to reproduce and regulate their fertility, with the full knowledge

of the personal and social consequences of their decisions and with the access to the means of implementing them". A reproductive health approach also means that, couples are able to have sexual relationship, free from the fear of unwanted pregnancy and from contracting any of the diseases, people have the ability to reproduce and regulate their fertility, women are then able to go through pregnancy and child birth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and their well-being, (Fathalla, 1988).

Within the framework of WHO's definition of health as 'a state of complete physical mental and social well-being and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying, and safe sex life, and that they, have the capacity to reproduce and the freedom to decide if, when and how often, to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective affordable and acceptable method of fertility regulation, of their choice, and the right of access to appropriate health services, that will enable women to go safely through their pregnancy and child birth, and to provide couples with the best chance of having, a healthy infant (WH0, 1994a).

One cannot fail to notice that the concept of reproductive health has also been explained by a term reproductive morbidity. Various conceptualizations of reproductive health (Evans et al. 1987; Germaine, 1987; Fathalla 1988; Zurayk, 1988) consider reproductive morbidity as inclusive of conditions of physical ill-health relating to 'successful child bearing and freedom from gynecological diseases and risks'. WHO defines reproductive morbidity as "any morbidity due to dysfunction of reproductive tract which is a consequence of reproductive behavior including pregnancy, abortion, child birth or sexual behavior, arising due to physical, social and mental problems, or are aggravated by these functions". Zurayk et al. 1993 also defined reproductive morbidity to include obstetric morbidity and gynecological morbidity, which include conditions during pregnancy, delivery and the postpartum period, as well as conditions of reproductive tract related infections, cervical cell changes, infertility and such other conditions respectively.

Thus the reproductive health approach extends beyond the narrow confines of family planning, besides, encompassing all aspects of human sexuality and reproductive health needs during the various stages of the life cycle.

Impact of population explosion and urbanization on the health of poor urban women

It is but natural that the current trends in world urbanization have generated a great deal of concern. Worldwide, there has been a substantial increase in the size of urban population from 50 million in 1970 to 1.6 billion in 1988, and the United Nations (UN) predicts a figure reaching, 3.1 billion by the Year 2000. India's urban population of about 217 million (in 1994) one of the largest in the world, is estimated to grow to 290-350 million by 2000 AD. Around 39 to 43% of India's slum population is distributed in the metropolitan cities of Calcutta, Bombay, Delhi and Madras. In India like in other less developed countries, the average percentage of the population living in urban areas is expected to rise from, 28 to 44. It may probably climb to 65 to 70% in some areas. Fifty percents of these city dwellers will be struggling for survival in slums and shanty, towns. The two principal hypotheses of this urban growth explained by Kelly and Williamson are:

- The unusually rapid rate's of population growth compels the landless labor to migrate to the cities due to twin problems of poverty and unemployment.

- Economic forces push migrants to cities. Recent events such as economic recession, droughts, storms, floods and communal strifes have contributed to a further push from rural to urban areas. The rapid growth of cities has been accompanied by a rapid growth in the slum population, where people are forced to live in grossly substandard, overcrowded conditions, in a state of abject poverty and inadequate access to basic health and social infrastructure and services.

Urban Economy

Almost two-thirds of the people employed in manufacturing trade, transportation and commerce sector are concentrated in the urban areas but because of the disparity between the size of the population and the available facilities and the resources, the expected economic progress is very slow. Moreover, the benefits of this urban growth are not shared equally by all. In larger cities, one-third to one-half of the population lives in slums and about 15 % of the male work-force and 25 % of the female work-force have no regular employment (Mathur, 1993). It is estimated that the present average of 50% of the urban population living in extreme poverty might go up to 79 % in some cities.

Assuming that, in 2000 AD, one-half of the urban population will still be subsisting on low income and over one billion people will be counted among the urban poor, these figures, translated into; human terms, forecast very critical time ahead for most of the women and children living in the cities and towns of the developing countries of the world. Most of them will not benefit from the amenities that urban areas may offer. They, will be literally struggling for survival (Donohue, 1982).

Bombay Population - A Profile

The urban agglomeration of Greater Bombay is a unique entity in the physical and cultural setting, of not only, Maharashtra, but also of the whole of India. Bombay has a population of 12.57 million (1991 census). In the first four decades of this century, the phenomenal growth in the population of Bombay was due to Bombay being a natural harbour, the earliest railway network and the development and expansion of cotton industry. After the Indian Independence, this pace of growth gathered further momentum. About 500 new persons enter this city every day in search of livelihood.

During the last 50 years, Bombay has degenerated into a city of slums. The slums consist of chawls (with single room tenements) and clusters of zopadis (huts), dispersed over a large area of the city of Bombay. Each chawl is a two or three storeyed building of cement concrete, having about 20 single-room tenements on either side of the corridor with amenities, such as electricity supply, common water supply and lavatories. The huts consist of a motley assortment of dwellings, constructed with unconventional materials like the untreated waste wooden planks, roofing material, gunny bags, polythene sheets, bamboos, mats, etc. used for walling as well as for roofing. The hut is normally a single room enclosure, but in recent years, two storeyed structures of wooden planks have also come up due to increase in density of population and family size. Most of the huts do not have any sanitary facilities like bathroom or latrine within the huts. There is, approximately, one latrine per 250 persons in the slums, while in the chawls, 15-20 persons share one latrine. Narrow pathways wind throughout the slums, with open drains on all sides of the huts. Most of the huts have hardly any drainage facility. People wash their clothes and utensils near the open drains, increasing the chances of becoming a prey to bacterial and viral diseases. It is a general observation that new slums come up on lands which are not suitable for development of conventional shelters viz. low-lying marshy lands prone to flooding in the monsoon, hill slopes, open spaces next to railway tracks, major roadways, etc.

Economic Conditions

A very depressing aspect of such urbanization is the concentration of the poor people in, the slums. Majority of them belong to socio-economically backward classes and have migrated to Bombay city with the hope of better means of livelihood. Considering the per capita urban income of Rs. 210/- month as a demarcation line for defusing "poverty?", as described in the Eighth Five Year Plan estimates show, that at present, an average of 50 % of the urban population lives at the level of extreme poverty, with the result that, slum dwellers are forced to live in the most insanitary and unhygienic conditions and are carrying out their daily existence with the barest necessities of life. Women have the least access to income earning activities. Domestic duties, childcare and household responsibilities, together with the discrimination in the job market, greatly limits women's possibilities of finding a secure and reasonably paid job. A major part of women's earning is spent on food and other essential commodities consumed by her family members, and the remainder is spent on children's education and illness. So women's health is not regarded as a priority.

The Urban Environment

The urban slum is characterized by over crowded environment. Poor sanitation, occupational hazards caused by small industries, group rivalries and clashes, stressful conditions together with lack of open space for children's recreation etc., are detrimental to the health of people in the slums. Moreover, exploitation, abuse in the treatment of women are also the additional factors of the said ill-health. The illegal occupation of the public unproductive lands implies greater proliferation of squatter settlement. Even if people have some money, they do not invest it in house improvements, because of its temporary status and constant threat of eviction by antisocial elements. Therefore the housing of the slum dwellers is of the lowest quality.

Existing Situation of Women's Reproductive Morbidity

Rossy Espagnet (1984) redefines health in the context of the urban poor as follows: "The urban poor are at the interface between underdevelopment and industrialization. Moreover their disease pattern reflects the problems of both. From the first, they carry a heavy burden of infectious diseases and malnutrition, while from the second they suffer the typical spectrum of chronic and social diseases." Heterogeneity of the urban population and insecurity relating to regular income, food, shelter, access to health care and other essential services,

along with the poverty and difficult physical and social environments, have adverse impact on the health of the urban poor women and on the urban families.

Status of reproductive health in India cannot be measured adequately due to lack of information available on this subject. Most studies are clinic-based or hospital based. Inappropriate outcome indicators and limited measurement-techniques make that task even more difficult. The available information on the obstetric morbidity shows that there are areas of concern as far as health care delivery is concerned. Antenatal care is limited to distribution of iron/ folic acid tablets and tetanus immunization. The Family Planning programs are focused more on female sterilization than on spacing methods. The programs are target oriented, with the result that there is a tendency to compromise on quality care. Measures beyond contraception are neglected. Moreover, services like counseling and health education are not adequately provided. Access to MTP services is also limited. Besides these factors, management of side effects and of complications of contraceptive measures are inadequate.

The adolescent girls in the urban areas face the problems of unwanted pregnancy, illegal and unsafe abortion, early marriage, early and frequent child bearing, malnutrition, sexually transmitted diseases, psychological disturbances, drug dependence, violence and accidents. Women in reproductive ages face multiple pregnancies, malnourishment mental stress and strain, low literacy, lack of access to health care system, inadequate medical facilities such as high risk screening, poor referral etc., which add to obstetric morbidity. Since health is not a priority, these women tend to neglect their health. The elderly women suffer health problems of oldage. Many of them are widows. Due to low public expenditure on the social welfare and decreased family support, these women become more vulnerable to the health hazards.

Prevalence of Reproductive Tract Infections Including Sexually Transmitted Diseases

Reproductive tract infections, especially among the females, are recognized by health professionals and researchers to be a major health problem in India. This is evident from some of the community studies carried out in the country, in the recent years. However, the majority of these studies have small sample size, besides having methodical limitations. Hence their findings cannot be considered as conclusive. In spite of these inadequacies, they attempt to impart useful information on the patterns, magnitude and types of infections prevailing in

different locations. Community based study conducted in a rural area of Maharashtra viz., Gadchiroli district, shows that, of 650 women aged 13 and above, 55% complained of gynecological problems, but on clinical examination and laboratory tests, as many as 92% were reported to have one or more gynecological morbidity.

Community-based unpublished study on gynecological morbidity conducted at Streehitakarini - a women s welfare organization, located in urban slums of Bombay, showed that almost 73 % women reported one or more Gynecological complaints. Common complaints given by these women were: white discharge (30 %), lower-backache (39 %), and abdominal pain (21 %). Almost 39 % of these women reported one or more menstrual disorders. Other less common complaints were: something coming out per vaginum, dysuria and infertility. The study showed gynecological morbidity, of 73 % on clinical examination. The leading gynecological problems included cervicitis (39 %), with or without erosion, uterine prolapse (19 %), including cystocoel, rectocoel and pelvic inflammatory disease (16 %). Common sexually transmitted diseases noticed in this study were Trichomoniasis, Gonorrhea, Syphilis and Chlamydial infections. In addition to sexually transmitted diseases, high rates of endogenous infections were also commonly observed. Candidiasis was observed among 17% and bacterial vaginosis was found among 15 % of women.

Health Seeking Behavior

There is a considerable ethnographic evidence of women's reluctance to seek care, especially, gynecological health care in India. Slum women perceive gynecological problems as a normal aspect of womanhood unless these problems reach severity. The most frequently reported illnesses by these slum women are, white vaginal discharge followed by low backache, pain in the abdomen, irregular menstrual bleeding, leg pain, and general weakness. Besides, local health practitioners of various, alternative medical systems, faith healers, quacks, pharmacists and shopkeepers also play a role in health care delivery. Home remedies for treatment of gynecological problems are widely known and are used in the slums. A variety of remedies like paste of "cress seeds", "dates eaten with water or milk", jageery, mutton, pigeon and several other things which produce 'heat' in the body, are used in the treatment of irregular periods, while boiled coriander seeds, banana, yogurt and fresh fruits are consumed for the problem of excessive menstruation. Women associate leucorrhoea with their husbands' promiscuity, alcoholism, multiple pregnancies, lifting heavy weight or with having sexual relations during menstruation or within 10- 12 days of delivery. Leucorrhoea is perceived as a hot condition and cooling foods include

rice, green vegetables, fruits. Other remedies include hibiscus flowers and roots, various spices (cumin, coriander) tulsi (basil leaves) and roots of banyan and of neem tree.

Reluctance to Seek Gynecological Care

Community based qualitative research study on reluctance to seek gynecological care conducted in the urban slums of Bombay show that slum women are generally reluctant to seek care for their gynecological problems. Socio-cultural and economic factors complicate their access to health services. The Indian women are conditioned to suffer in silence, and are therefore slow to respond to their own medical needs. The economic status affects women's ability and their decisions to seek care. It is difficult for a woman to forgo daily wages and normal household responsibilities. Poverty is a major factor leading to poor utilization of services. Moreover, overwork, lack of time, fatigue and the multifarious duties attached to Indian womanhood are other inhibiting factors. Bombay's slum women share income earning or productive tasks with men, while single-handedly performing domestic chores and child care responsibilities. The joint family system with too many mouths to feed has made it difficult for women to make both ends meet. Due to traditional beliefs, a woman is conditioned to think of her family first and to suffer in silence on all personal matters, particularly relating to her health. Most health services, run by the government, are rendered free of charge and are thus seen as being less qualitative or effective than the services offered at high cost in the private sector. The connection between the quality and the cost of services is so ingrained in the mind of the lay public that costly treatment becomes synonymous with quality treatment and free treatment is tantamount to poor and negligent treatment. Apart from socioeconomic factors, other inhibitions consist of cultural and attitudinal factors. Health largely depends on people's environment, their life style and behavior. The obstacles to women's development also include traditional beliefs, religious misconceptions and the tendency of some women to attribute health problems to destiny, due to lack of scientific knowledge and approach. A high frequency of alcoholism and unemployment among men also leads to unrelieved drudgery. Women's inferior status and their role in the society, pose difficulties in making decisions for themselves. Family and social customs dictate the extent to which a woman is permitted to seek health care. Mothers-in law or husbands are the main decision-makers as far as health care is concerned. This sex-differentiation appears to affect health of women. Women themselves are conditioned to accept their reproductive role and do not have control on their bodies. Women are forced to fulfill the obligations imposed on them as wives, daughters-in-law and mothers. Men consider women to be objects of sexual pleasure and their health is not of prime importance. Men are reluctant to help women seek gynecological health

care because they fear diminishing of sexual pleasure following use of instruments during gynecological check up. There is a constant pressure on the medical profession to fulfill population control targets set by the government. As a result women have a fear of intrauterine devices being inserted without their knowledge or consent. Mothers-in-law and husbands often consider women's health needs to be limited to care during pregnancy, child birth and post delivery. Even in Government policy, maternal and child health services have been organized as vertical health programs but women's gynecological and general health have not received adequate attention.

Thus it is obvious that seeking health care is a multifaceted problem and women's health is influenced by the socioeconomic, cultural, environmental, biological and behavioral factors.

Determinants and Consequences of Reproductive Tract Infections

Health problems in the urban poor are determined by different interacting factors which act synergistically and affect their disease conditions. These factor pertain to women's socioeconomic status, prevailing sexual practices and behaviors, their biological constitution, the nature and quality of health care services available to them, socio-cultural attitudes and values which render RTIs and other gynecological health problems as issue with social taboo and stigma.

Biological Risk Factors

Women's vulnerability to HIV/AIDS and RTIs including STDs is linked inextricably to Women's biological and social roles. Early marriage and early initiation of sexual activity in adolescent girls makes them more prone to such infections. Young girls are victims of rape, incest or child molestation. Early and forced coitus exposes them to STDs and damage the vagina. Less developed genital tract of adolescents acts as a poor barrier to HIV, STD infections and causes genital ulcers. Male supremacy coexisting with restrictive social structures limit women's economic, social and legal independence. With the result, men often maintain strong control over females' sexuality. Due to double standards of sexual behavior, sexual coercion and gender discrimination in schooling, employment and property and legal rights. women are frequently made powerless either to refuse intercourse with an infected man, or to insist that he use a condom or remain monogamous. Reluctance of men to use condoms during intercourse and deposition of potentially infectious semen into the vagina increases the female's likelihood of acquiring STDs. When women acquire these diseases, they are much more likely to be asymptomatic than men and so they

are less likely to seek health care than men. Women are also more likely to suffer from serious long term consequences of STDs including pelvic inflammatory disease, tubal pregnancy and infertility.

Socio-cultural and Behavioral Factors

Specific sexual, marital and reproductive customs relating to sexual behavior pose women to higher risk of STD transmission. High risk behaviors transcend social or geographical boundaries to affect broad spectrum of the population. Various behaviors observed by Judith Wasserheit are also observed in slums of Bombay and they are as following:

- Initiation of young males into sexual intercourse with experienced females.

- Arranged marriages, seduction or sexual abuse of young women of young girls by older sexually active men.

- Early sexual debut of young men or women combined with multiple sexual partners.
- Divorce and remarriage resulting from STD induced infertility of either partner.

- Prolonged sexual abstinence following childbirth when accompanied by a husband's casual extramarital sexual activity.

- Frequent or prolonged separation of spouses due to labor migration especially when mates patronize prostitutes or have casual sexual encounters.

- The availability of significant populations of single, separated or divorced women seeking sexual contacts in exchange for money, gifts, favors or pleasure.

- Infrequent use of condoms or spermicides in sexual intercourse.

- Sexual Practices such as forced intercourse or anal intercourse in homosexual and heterosexual intercourse.

Women's social status and gender disparities between men and women also influence the prevalence of RTIs. Women's economic insecurity and their dependence on male partners decrease their ability to protect themselves from RTIs. Women suffer RTIs and STDs in silence due to the guilt shame and stigma associated with these illnesses. Often the socio-cultural emphasis of premarital chastity, sexual fidelity and monogamy makes women reluctant to bring RTIs and STDs to the attention of family members and medical practitioners.

Latrogenic Risk Factors

Among RTIs which are not sexually acquired, the major risk factors appear to be unhygienic practices and the nonobservance of aseptic procedures in hospitals and community, settings. Women are exposed to infection in activities related to childbearing and contraception. Some of the women in slums give birth to the child at home often in unhygienic conditions and are consequently at higher risk of RTIs. Medical terminations of pregnancy or dilatation of cervix performed in unhygienic conditions, unsafe abortions [characterized by the lack of inadequacy of skill of the provider, hazardous techniques and unsanitary facilities [WHO 1992b] are a potential source of RTIs for women. Poor quality care during transcervical procedures including IUD insertions could lead to such infections. Inadequate or nonexistent screening and follow up can lead to or exacerbate reproductive health problems resulting from women's efforts to regulate their fertility.

Health Care Delivery Factors

Despite having good health infrastructure in the government hospitals of Bombay, people in the slums of Bombay prefer to go to the private doctors. Long distances and waiting hours as well as the attitudes of medical professionals have been found to discourage them from using public hospitals. Sometimes the cultural divisions between health service providers and women creates barriers in communications.

Recommended Services for Prevention and Management of Reproductive Health Problems

Rapid urbanization with the present degradation in environmental conditions has had far reaching consequences for poor women with regard to their ability to safeguard their own health and that of their families. It has been well accepted that the high burden of reproductive morbidity among urban poor women is due to interaction in between biomedical, socioeconomic, cultural and behavioral factors. Amongst these, major factors which have adverse impact on women's reproductive health are poverty, powerlessness, low social status, malnutrition, infection, high fertility and lack of access to health care. The future challenge in developing effective urban health program lies in understanding reproductive health needs and priorities of women, increasing self reliance among communities especially the poorer sections of slums, developing simplistic and multi-sectoral interventions and in improving greater accessibility to better quality health services. Thus there is a continuing need to strengthen the health infrastructure with utilization and application of comprehensive reproductive health services package. It is also recommended that operations research be undertaken to concurrently assess the feasibility and effectiveness of the various health interventions in the services package in order to document lessons learnt for planning new programs. The following services are recommended in a comprehensive reproductive health service package to be advocated at community and district level.

Prevention and Management of Unwanted Pregnancy

This can be achieved by following steps:

- Ensure contraceptive safety in the family planning program with greater attention to all clinical procedures especially to aseptic techniques and to screening clients for contraindications and preexisting health problems.

- Increase method choice by including reversible contraceptive methods with attention to improving the quality of services and addressing clients reproductive health needs.

- Promote barrier methods and spermicides to meet needs of younger, lower parity couples.

- Develop effective outreach programs with high priority to strengthening sexuality and gender information, education, supportive counseling and follow up services.

- Develop effective referral systems.

- Encourage men to take responsibility for family planning, reproduction and child care.

- Involve men in the health care program to bring about changes in their sexual behavior for fertility control and prevention of infections.

- Work with communication systems to provide information and to change images of the role of men as husbands and fathers and to bring about legal and political reforms.

Services For Safe Abortions

These services can be improved by following measures:

- Strengthen public sector programs to provide safe abortion services.

- Improve quality of services both in public as well as private sectors by proper monitoring of MTP services and training of health care providers at various levels.

Services To Promote Safe Motherhood

- Strengthen maternity care services by ensuring timely detection, management and referral of complications during pregnancy, delivery and postpartam period, with interventions for the management of sexually transmitted infections and reproductive tract infections, especially screening for syphilis during the antenatal period and to prevent maternal and neonatal morbidity and mortality. Strengthen outreach services to ensure proper antenatal care, postpartam services, which include early detection and management of infection and

hemorrhage, support for breast feeding, nutrition counseling and family planning services.

- Ensure safe delivery services at community and hospital level.

- Improve nutritional status of adolescents and women with greater emphasis on nutrition education and food supplementation programs and on reaching and targeting vulnerable groups such as pregnant lactating women and adolescent girls.

- Strengthen neonatal, perinatal care systems and child survival programs.

Prevention and Treatment of Reproductive Tract Infections Including Sexually Transmitted Diseases.

The essential elements of a control of reproductive tract infections including sexually transmitted infections are:

- Information, education, and communication for the promotion of safer sexual behavior including consistent condom use and the promotion of appropriate health care seeking behavior especially for individuals with sexually transmitted infections related symptoms and those at increased risk of infection.

- Provision of clinical services for the diagnosis and treatment of symptomatic and asymptomatic patients and their partners and

- Provision of condoms of good quality at affordable prices. (Van Dam 1994).

The following are the further measures to be adopted :

- Ensure routine prophylaxis for gonococcal infection of the new born and routine testing of syphilis in antenatal women.

- Promote social marketing, and distribution of condoms.

- Provide sexuality and gender information, education, counseling for adolescents, youth, men and women.

- Integrate services for the prevention and treatment of RTIs into existing health programs such as MCH and family planning, programs.

- Ensure early, detection of RTIs including STDs by clinical and laboratory procedures, treatment of cases by syndromic approach and management of sexual contacts.

- Ensure partner notification and referral.

- Ensure management of referred cases at community or hospital level and feed back to referral source.

- Develop safe, effective female controlled methods for protection against STDs. Develop and make available simple, inexpensive, rapid diagnostic tests for RTIs and STDs.

- Ensure services for the prevention and treatment of various gynecological problems in different age groups of women and provide counseling and referral services for gynecological problems related to menstrual hygiene, safe abortion, safe delivery, and the prevention of RTIs and STDs.

- Promote down stage screening for the early detection of cervical cancer.

- Provide services for prevention and treatment of infertility.

- Ensure involvement of adolescents in reproductive health programs by following steps.

(i) Involve parents of adolescents and community leaders in providing information to them taking into account gender differences, wide variations in their social situations and sexual behavior due to conflicting pressures and confounding information available to them.

(ii) Provide nutritional supplementation and health and nutrition education to the adolescents.

Some of the general points to be taken into consideration in policy formulation, program development and research are as follows:

- Promote integrated development services to the women in urban areas which will address their multiple needs in all aspects of lives throughout their life cycle.

- Ensure affordable, accessible and comprehensive health services with sufficient allocation of resources for health and health related services.

- Ensure active participation of women in decision making, determining health needs, developing health programs and in deciding priorities for health research.

- Provide basic infrastructure which will improve the quality of women's lives and health such as adequate water supply and sanitation to enable women to maintain hygiene and reduce risks of infections.

- Support gender sensitive community based research.

(i) To enable and empower women to better understand and articulate their health needs.

(ii) To better understand sexual and health seeking behavior of men and women in the urban slums.

(iii) To monitor trends in the prevalence of RTIs/STDs. their microbiological spectrum, clinical findings and antibiotic sensitivity.

(iv) To develop and validate low cost diagnostic tests and to validate syndromic management of RTIs including STDs.

It is thus important that while aiming at improving the standards of the urban poor policy makers should address factors which are responsible for the manifest of diseases as well as the psychosocial dimensions. More innovative and systematic interventions and qualitative approaches actively involving slum communities are needed to meet this challenge. Strengthening of the community workers movement and establishing viable partnership between NGOs and local Government networks will add to the success of reproductive health programs.

Abbreviations

1.	F.P.	Family Planning
2.	HIV	Human Immunodeficiency Virus
3.	IUD	Intrauterine Device.
4.	MTPs	Medical Termination of Pregnancies
5.	PID	Pelvic Inflammatory Disease.
6.	RTIs	Reproductive Tract Infections.
7.	STDs	Sexually Transmitted Diseases.
8.	MCH	Maternal and Child Health Services.
9.	NGO	Non-governmental Organization.
Footnotes		
10.	Zopadi	A Hut.

11.	Chawl	Single room tenements.

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