Ethnographic Perspectives on Slum-dwelling Women's Access to Primary Care: The Case of Pune, India[1]

Neha Verma Madan
(College of Engineering, Pune and School of Planning and Architecture, New Delhi, India)
nmv.civil@coep.ac.in

This article describes the methodology and results of a two-month empirical study based on a focused ethnography (FE) approach and aimed at exploring the Primary Health Care (PHC) experiences of women who live in slums in Pune, India. I look at the current scenario regarding accessibility to primary health care facilities by women in Indian slums, explain the need for the present study and discuss the methodology adopted for ethnographic research and the challenges, tensions and dilemmas that arise when working with women living in slums. I consider issues concerning access to health care facilities in the case-study area and the attendant difficulties. I examine the reasons why people rely more on the private sector. These issues will be the object of analysis leading to conclusions.
Keywords: Public health, slums, women, ethnography, accessibility.

Introduction

Urbanisation is one of the leading global trends of the 21st century that has a significant impact on health. By 2050, over 70% of the world's population will live in cities. Currently, Indian cities are facing a triple health threat: infectious diseases like HIV/AIDS, tuberculosis and pneumonia; diarrheal diseases; non-communicable diseases like asthma, heart disease, cancer, and diabetes. They also face violence and injuries, including road traffic injuries (World Health Organization 2019). According to the Census of 2011, the population of India has crossed 1.21 billion with an urban population of 377 million, which is 31.16% of the total population. Urban areas provide great opportunities for people to prosper and can provide a healthy living environment through enhanced access to services. These positive aspects of city life attract people to migrate to urban areas (Chandrasekhar and Sharma 2015). In India, the employment-driven migration is mainly from the less developed states to large metropolitan areas, wherein the migrants become employed in low-paid jobs in unorganised sectors (Mukherji 2001) and are often settled in slums that lack basic public services, thus becoming exposed to health risks and the related problems.

The slum population in Indian cities is rapidly expanding, with a 25.1% decadal growth rate (Office of the Registrar General & Census Commissioner 2013). This population offers complex challenges in terms of health services for disadvantaged groups, like women and children (Ministry of Health & Family Welfare 2006). The access and use of Primary Health Care[2] facilities are severely limited and this is more so for the disadvantaged section of the

[1] I am thankful to anonymous peer reviewers and the Board of *Urbanities* for giving valuable suggestions on my research article that helped me in finalizing this paper for publication

[2] Types of healthcare according to World Health Organization (WHO) are: (i) Primary Healthcare, which denotes the first level of contact between individuals and families with the health system. It provides care for mother and child, which includes family planning, immunization, prevention of locally endemic diseases, treatment of common diseases or injuries, provision of essential facilities, health education, provision of food and nutrition and adequate supply of safe drinking water. (ii) Secondary Healthcare, which includes treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes childbirth, intensive care, and

population in urban areas. Barriers are identified at both provider and beneficiary levels. Many approaches such as free or subsidised medical care, patient health card, and incentive schemes have been tried to prevent diseases and promote health among urban poor. However, the goal of 'Health for All' remains unachieved in developing countries like India. In many urban areas, the primary health care facilities are not available and some that are remain underutilised, while there is overcrowding in secondary and tertiary care services. The situation remains nevertheless complex because, with no referral and screening system, most of the equipment and machinery in secondary and tertiary care centres is underutilised. Furthermore, while the local government (municipalities) must provide both preventive and curative services to the urban population, the existing infrastructure is inadequate to cater to the growing urban population.

Public health care provisioning for women and children in urban slums is mostly unstructured, fragile and with an almost non-existent outreach (Madhiwalla 2007). The use of health service facilities is compromised due to limited capacity for decision making, negligent and delayed care-seeking, issues of access and (Hazarika 2010) affordability and the large number of unorganised private providers. This is compounded by socio-behavioural, spatial and economic inequities that define the context of disempowerment and constraint for this population. The National Urban Health Mission (NUHM) launched in 2013 advises on improving the health of the urban slum populations through a need-based city-specific urban health care system that includes a refurbished primary care system, targeted outreach, equitable access and involvement of the community and Urban Local Bodies (ULBs) (Ministry of Health & Family Welfare 2013). The lack of formative information and disaggregated data impedes efficient urban health policy-making and programming (Save the Children 2016).

Women Health in Urban India

Among the urban population, the maternity services also show a disparity between the urban poor and the rest of the urban population. The proportion of urban poor women receiving full antenatal care is very low compared to other urban women. Although urban India has a relatively very sound and strong healthcare infrastructure both in the public and private sectors, there is a marked disparity between rich and poor in terms of availability of the service and use of the resources.

According to the Sample Registration System (SRS),[3] in 2014-16 the Maternal Mortality Rate (MMR) was 130/100,000 live birth, while in developed countries such as Australia and Canada the MMR is less than 10/100,000 live births. Figure 1 shows that in India 44.4% of urban poor women have access to institutional deliveries against 78.5% of non-poor women. The use of healthcare services is minimal among urban poor women as compared to urban non-

medical imaging services. (iii) Tertiary Healthcare; this refers to a third level of health system, in which specialized consultative care is provided usually on referral from primary and secondary medical care. The main provider of tertiary care is the National Health system, which consists of Regional Hospitals and National Hospitals.

[3] Data released by the office of Registrar General of India.

poor women. The primary health facilities have not increased in proportion to the growth of the urban poor population. Figure 2 shows that only 54.3% of urban poor mothers undergo a minimum of 3 antenatal care check-ups during pregnancy, while this percentage rises to 83.1% among urban non-poor women and drops to 43.7% among rural mothers. According to the National Family Health Survey (NFHS),[4] among urban poor families 3.56 % are home deliveries, against 21.5% among non-poor families.

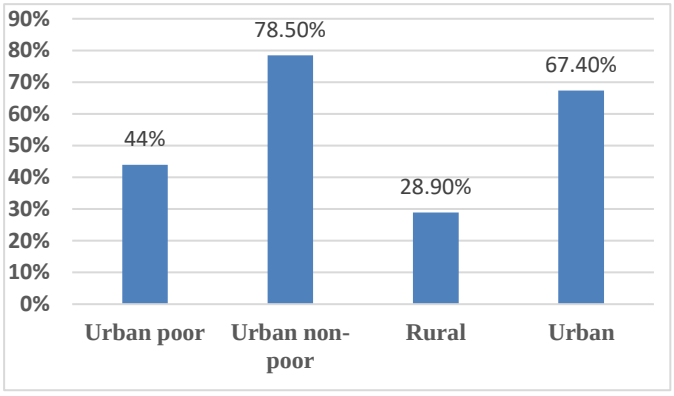


Figure 1. Birth in public health facilities in urban and rural areas- 2005-06 (NFHS 3 Data)

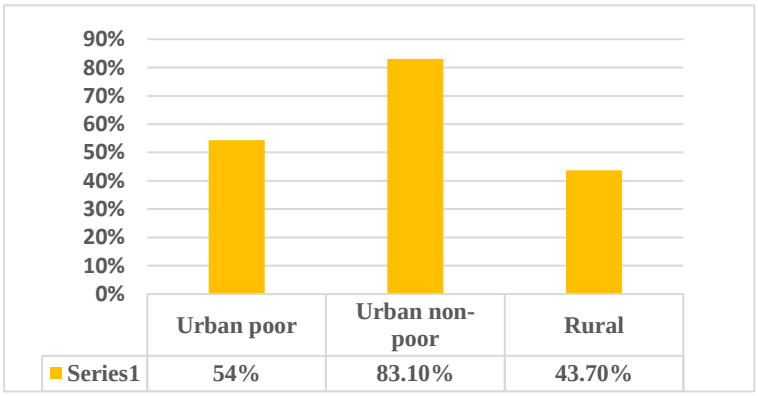


Figure 2. Mothers who had at least 3 antenatal visits- 2005-06 (NFHS 3 Data).

Issues of Accessibility to Health Care Services for Women

Access includes affordability and availability as well as quality. Affordability and availability imply that irrespective of economic status or geographical location every individual should be able to afford effective healthcare services. In terms of quality, the more government spends on improving healthcare infrastructure, training the healthcare providers, getting the latest technology and expanding the network of hospitals and dispensaries and primary health centres the better the quality of the healthcare services people will receive. The on-the-ground situation

[4] The NFHS is a large-scale, multi-round survey conducted in a representative sample of households throughout India. The survey provides state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilization and quality of health and family planning services.

is different on all these aspects, as indicated by the National Health Profile (NHP).[5] The data for the year 2017 show that there is only one government allopathic doctor for every 10,189 individuals, one government hospital bed for every 2,046 people and one state-run hospital for every 90,343 people. The study stated that India has a little over 1 million allopathic doctors for 1.3 billion people, just about 10% of whom work in the public health sector.

Many quantitative studies have been published which identify reasons for lack of access to PHCs by slum-dwelling women in India. However, a qualitative approach is needed to understand the attitude, perceptions and thinking processes of women who use PHC facilities. Qualitative research needs to look at how much information women have on the available medical facilities and how they view availability and should look at the issues concerning public medical facilities. Such kind of research can also help us to understand why women make certain choices, how thoughts and ideas vary among different women or how well certain ideas are understood. Qualitative research may follow a quantitative study in order to dig deeper into trends.

Qualitative research is a general term for exploratory methodologies described as ethnographic, naturalistic, anthropological, field or participant observer research. It gives importance to considering variables in their natural setting. The interaction between variables and their analysis is important. The material is collected through open-ended questionnaires that provide direct testimonies (Krase 2018). This is different from quantitative research which attempts to gather data by objective methods to provide information about relations, comparisons and predictions and tends to remove the investigator from the investigation.

Here I present an ethnographic study on slum-dwelling women's access to public health care facilities focusing on their experiences in the primary health care centre. I adopt the investigation method known in anthropology as ethnography (Hammersley and Atkinson 2009) because it provides the most basic form of social investigation that works with several information sources. Given an interest in understanding dynamics among varied urban cultures, social strata and traditions, Pardo and Prato (2018) argue that urban anthropology is more than anthropology *of* the city; significantly, it should be intended as anthropological research carried out *in* urban areas. By ethnographic method, I mean a ground-level research activity carried out for prolonged periods in direct contact with the object of study, followed by the systematisation of the experience in a text format (Caprara and Landim 2008). Based on a long period of on-the-ground, ethnographic research involves the construction of theoretical knowledge alongside data collection (Caprara and Landim 2008). It is, therefore, not only a research method but a process conducted by sensitive reflection, taking into account the field experience itself together with observation and information derived from the people with whom the anthropologist is working (Caprara and Landim 2008). As shown by Pardo and Prato in their recent publication on comparative urban ethnography and theory (2018), field research carried out applying traditional methodology in specific urban areas offers an empirical understanding of the broader

[5] National Health Profile (NHP) is an annual publication of the Central Bureau of Health Intelligence (CBHI). It covers all the major information on Demography, Socio-Economic Status, Disease Morbidity & Mortality, Healthcare Finance, Human Resources in Health and Healthcare Infrastructure.

context and the attendant sociological connections through the ethnographic study of local people's links to the rest of the city and beyond. Pardo and Prato stress that 'while there is no need to fetishize fieldwork — certainly not as an end — its unique value cannot be overstated' (2018: 2). They demonstrate that ethnographically-based research can produce 'up-to-date readable contributions that avoid abstract generalities while engaging with the analytical complexity of ethnographic evidence' (2018: 2).

Over the last decade, research on health has been accompanied by a growing interest in the use of qualitative methods and the research techniques applied throughout the 20th century in the social sciences and particularly in anthropology. This interest is explained by the importance currently given to national healthcare policies and to the qualitative dimension of the healthcare services offered to citizens. A growing emphasis has therefore been put on research and evaluation instruments focused on the users' perception (Caprara and Landim 2008). Within this theoretical-methodological framework, several scholars have used the ethnographic method to study a variety of themes in the health area, from the functioning of the health system to the evaluation of the quality of healthcare services from the users' perspective (Caprara and Landim 2008).

In pages that follow, I will present results from the ethnographic study that I conducted in June-July 2018 in five slums of Pune, Maharashtra state, India.

Why this Study

In the literature outlined above, the emphasis on lack of use of primary health care facilities in slums is seen as mainly due to socio-economic and cultural factors as well to the location of health care facilities, accessibility and the experiences of women in public medical facilities. All these factors play the deciding role in the use of primary health care facilities. Also, there is a strong tendency to use private health care facilities as compared to government facilities. In Pune, this is evident from the primary survey carried out by Save the Childre's Saving Newborn Lives (SNL) Program in collaboration with the Pune Municipal Corporation (PMC) and the National Health Mission of the Government of Maharashtra in 2016. Thirty-seven percent of women cited the comfort level in government facilities as the main factor for not using them. The discussion that follows will draw on a focused ethnography to understand these issues. I shall address the following research questions:

1. How the experiences of women using Public Health Service facilities are deciding factor in utilizing public health care services in the slum area?
2. Why women are more inclined towards using private health care facilities as compared to public health care services?
3. How accessibility to public health care facilities can be improved in slums using issues that will be identified using current ethnographic study?

I did fieldwork among women living in slums in Pune in order to investigate their experiences in using existing public health care facilities. As I have mentioned, the ethnographic method in health services research has slowly gained recognition although it is argued that it is still underused (Bunce et al. 2014). The ethnographic approach mainly involves

interviews, observational fieldwork and document reviews (Savage 2000). The researcher is immersed in a social setting to understand the subjects' behaviour and views on the topic under study. Arguably, there can be multiple and diverse interpretations of the meaning of the empirical observations (Atkinson and Hammersley 1994). In the current study, we have used the focused ethnography (FE) approach, which has a focused field of inquiry. The background of the problem is studied and, based on the literature, a problem-focused research question is formulated before going into the field. This approach involves short term visits in the field and targeted data collection during customised visits to the field in a specific timeframe or during events. The interviews with subjects are normally structured around the study topic (Higginbottom et al. 2013, Knoblauch 2005). While in traditional ethnographic research[6] the researcher does not enter the field with formerly specified questions (Roper and Shapira 2000), in focused ethnography, a researcher with insider or background knowledge of the cultural group will employ intensive methods of data collection and recording, such as video or audio-taping (Higginbottom et al. 2013) to address a specific research question. For the current study, the method of focused ethnography was chosen because it allowed data generation on our pre-defined topic in the context and cultural landscape of the general practice of poor women's accessing primary health care facilities.

While there have been arguments in the literature about the use of focused ethnography there are very few publications on the conduct of a focused ethnography in health services research. Here, I report on our experience and on the challenges of conducting a team-based FE. Our study explored issues of inaccessibility of primary health care facilities among women living in slums of Pune. I use this study as an example to illustrate the benefits and challenges associated with a team FE approach. The next section will explore the case study area and the issues arising around sampling and the methods of data collection used, including individual interviews, small-group interviews and semi-participant observation along with writing field notes.

The Case Study — Pune

Pune is the second-largest city in Maharashtra after Mumbai, with a population of 3.1 million and, according to the Census of India 2011 is the ninth-largest in India. The Pune Region of Maharashtra comprises five districts; Pune is the largest. Pune District accounts for 33% of the total population of the Maharashtra State and has an urbanisation rate of 60.89% (GOI 2010). The population growth rate in the Pune district is 30.34%; that is, twice the state growth rate of 15.99% (Butsh et al. 2017). The data on demography and medical facilities are given in Table 1 below.

[6] Traditionally ethnography is characterised by in-depth observation of groups of individuals, taking into account the influences of the historical and cultural contexts on social interactions. This process of immersion in the real-world context and detailed analysis enables the researcher to investigate and describe the complexities and cultural nuances of the specific setting and of the phenomenon under investigation (Streubert and Carpenter 2011).

Demography (Census 2011)	**Medical Units with PMC**
Population: 3.1 m (9th most populous in India)	1 General Hospital
Area: 479 km (2nd in Maharashtra)	1 Infections Disease Hospital
Population Density: 6500 per sq km	15 Maternity Homes
Sex Ratio: 948	44 Dispensaries
Literacy: 89.6%	2 Mobile Dispensary
Slums in Pune 564 Slums (357 Notified)	2 Polyclinics
Population: 33% of Pune	1 Central Immunisation Centre
Density: 6 times of non-slum area	7 ICDS Projects
Population Growth Rate: 1.5 times of Pune City	21 Urban Family Welfare Centres
	531 Regd. Private Facilities

Table 1: Demographic and medical facilities data in Pune city.

The Situation in the Slums

This Situation Analysis carried out in 2016 by Save the Children's Saving Newborn Lives (SNL) Program in collaboration with the Pune Municipal Corporation (PMC) and the National Health Mission–Government of Maharashtra presented the accessibility status of primary health care facilities to women and children living in slums of Pune. A total of 601 recently delivered women were selected from 30 slum clusters using a house-to-house survey. Of the 601 women, 43% was primiparous[7]. Pregnancy at a young age was commonly seen with 25% women in the teenage years who have already experienced more than one pregnancy. The majority of the women (57%) had not been visited by any FLW (Front Line Workers) at home in the last 6 months prior to the survey leaving MNH (Maternal and Child Health) care-seeking choices mostly self-driven and conditioned by prevalent socio-behavioural beliefs and preferences (Figure 3; see also Figure 4).

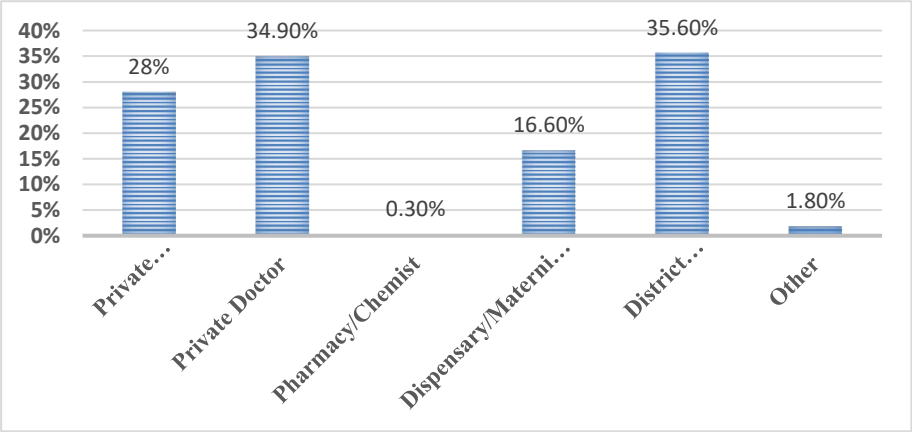


Figure 3. Preferred Site of Care Seeking for Pregnancy and Childbirth Related Conditions.

[7] Giving or having given birth for the first time.

Public Health Service Delivery and Access[8]

In the surveyed slums, the *Anganwadi* Workers (AWW)[9] provided pregnancy registration services and nutrition counselling for pregnant women. The women in slums were unable to differentiate between AWWs and Auxiliary Nurse Midwives (ANMs). There was minimal outreach by ANMs and Medical Officers (MOs) in the slums. For women, the primary and secondary level public health facilities provided ANC (Ante Natal Care) services but they lacked infrastructure for investigations (for example, ultrasonography, X-rays), C-sections and specialist care (for example, paediatric); these services were available only at the tertiary care facility. Public health facilities had a bad reputation for the unavailability of a regular and comprehensive quality service under one roof, the unfriendliness of staff, almost universal high referral rates, unforeseen out-of-pocket expenses, inconvenience (distance, transport, Out-Patient Department waiting time). Consequently, private facilities were preferred (Figure 4). Among women who reported visiting a private provider, 37% felt more comfortable with private providers while 29% said that they were available at all times (Figure 4).

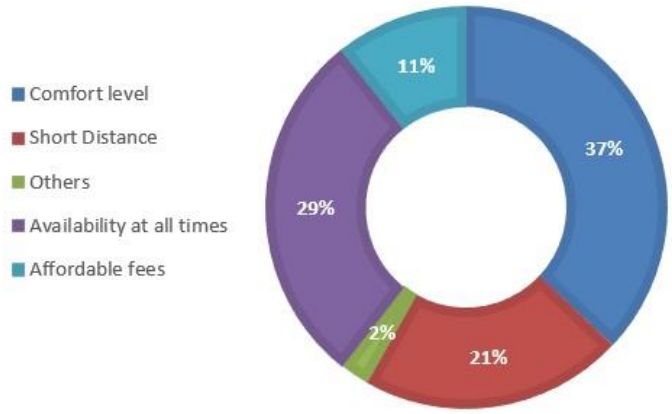


Figure 4. Tertiary level public health facilities were more preferred by women for health care.

The Ethnographic Study: Methodology and Issues

In line with the focused-ethnography approach, our data collection began with observations conducted at given times, meaning that the researchers did not fully immerse themselves in the subjects' lives. Observations were performed while living with women in their house and

[8] Source: City Health Plan, Pune 2016-2020. Pune Municipal Corporation (PMC) in collaboration with Save the Children, India prepared City Health Plan Pune (2016-2020) to provide the broad framework ensuring availability, accessibility and affordability of healthcare services that is to be administered by PMC.

[9] An *Anganwadi* is the focal point for the delivery of ICDS (The Integrated Child Development Service Scheme). ICDS is one of the initiatives taken up by the Central Government, which provides a package of six services viz., supplementary nutrition, immunization, health check-ups, referral services, nutrition and health education for mothers/pregnant women, nursing mothers and to adolescent girls. An *Anganwadi* normally covers a population of 1000 in both rural and urban areas and 700 in tribal areas. Services at *Anganwadi* centre (AWC) are delivered by an *Anganwadi* Worker (AWW) who is a part-time honorary worker. She is a woman of the same locality, chosen by the people, having educational qualification of middle school or higher.

accompanying them at public health care facilities. The duration of these observations varied in each case, but the researchers usually followed the woman through her workday and her interactions with nurses and other staff in primary health care; these encounters usually lasted between 10 to 20 min to over an hour (See Table 2 for the frequency of data collection). Observational data were recorded between visits to homes as hand-written field notes, focusing on the ways in which women and primary health care staff related to and dealt with organisational systems. Field notes included information about observations, verbal exchanges and the researcher's understanding and interpretations of events. Throughout, the researcher was discreet and did not interfere when observing the subjects and their interaction with PHC staff. Informal conversations were limited to when participants were on their own, allowing the researcher to compare interpretations of meanings of observed behaviour with participants' understanding.

Observations	
Time range PHC (hours)	8–45
Approx. no. of different patients observed, not invited to interviews	20
Women interviews	
Number of women included for interviews	8
Time range of interview duration (minutes)	20–40

Table 2. Frequency of data collection methods.

All subjects were observed before starting the interviews. The goal of the semi-structured interviews was to talk about issues that were important to women, while allowing the researcher to ask explanations about specific topics and observed events, and clarification on any doubts. Thus, the interviews provided insights into background meanings, values, concepts and the thought patterns (often shared on a cultural level) behind observed practices and expressed beliefs (Guest et al. 2013).

For this survey a sampling method was adopted in order to identify the slums to be researched and the women living there. We chose slums where we had acquaintances. In most cases, there was no objection to us conducting a primary survey but slums dwellers were uncomfortable about us carrying out ethnographic research (more on this in the next section). When we started the survey, the target population was 20 women but had to revise this in view of this resistance.

We conducted this survey in the 5 slums of Pune. The interview guidelines were developed specifically for the women. Some of the topics discussed in the interviews were particularly relevant to the present article, including women's experiences of doctor-patient interactions, everyday home care practices, priorities and time management. Semi-structured interviews allow for flexibility to explore emerging topics (Guest et al. 2013) and, as the focus of this discussion arose from observations done while collecting data for the previously published study, many of the questions asked revolved around observed practices of subjects to uncover, as I have mentioned, the meanings behind the practices. The interviewees were encouraged to talk about situations that they had experienced and that stood out in a positive

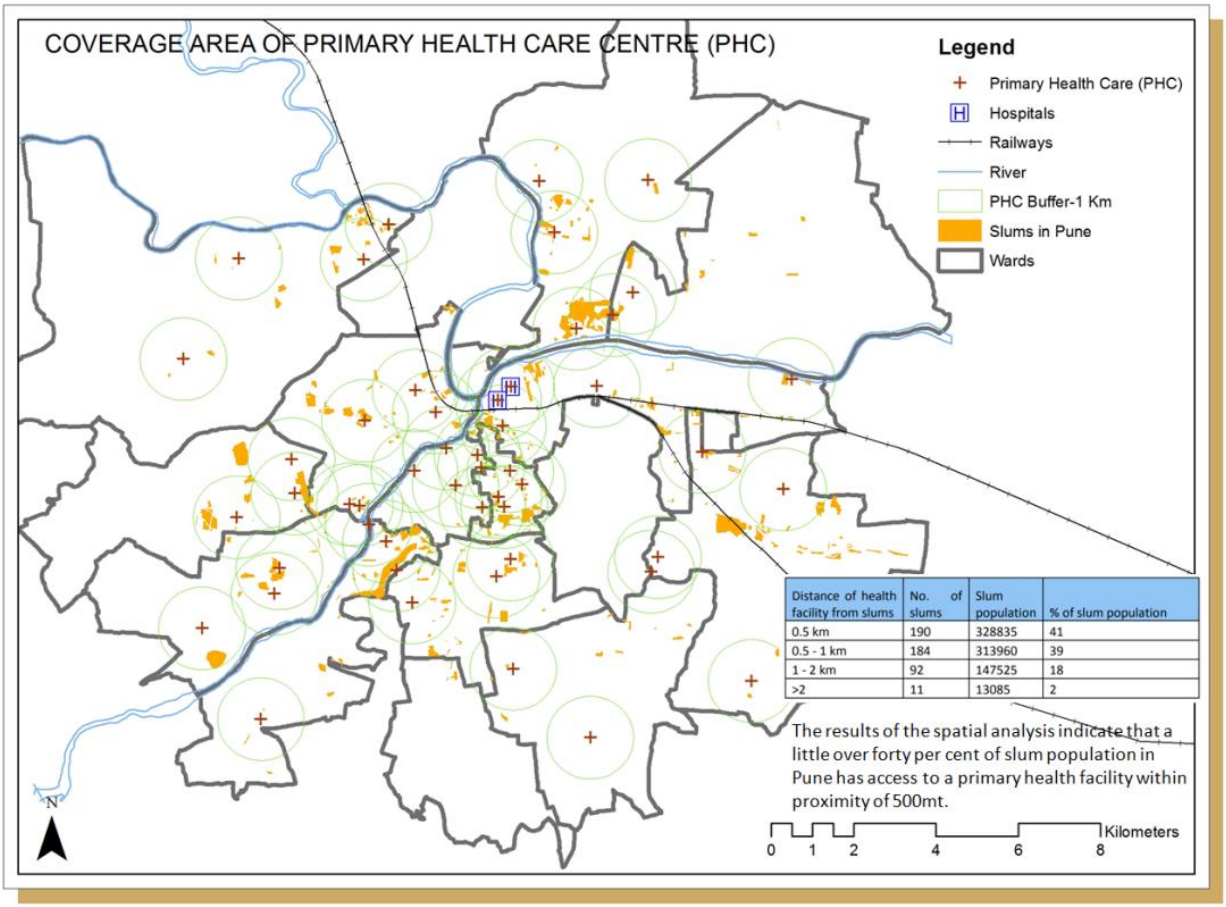
and negative sense. Meeting the respondents' preferences, interviews were performed in their homes. They lasted 30-60 minutes and were videotaped and transcribed word for word by the researcher.

The Interviews

During the survey, we noticed that some women were outspoken when discussing issues of proper access to primary health care services, while others were reluctant to talk about these issues as they were not clear about how we would use the interviews. Dandekar Vasti was the first slum that we surveyed. This is an old slum located in Navi Peth area of Pune (Ward number 29). My first interviewee was Sushma who has lived Dandekar Vasti for the last 14 years as a homemaker. She has two daughters and her husband is a rickshaw driver. I first met her during my visit in May 2018, when I conducted a primary survey for a quantitative analysis. In June 2019, I approached her again for the ethnographic survey. For this survey, I enquired about her health problems and asked where she was getting medical treatment. I found that she had menstrual problems for which she saw doctors regularly. On 4th June, I visited her again and carried out observation from morning to noon, noticing that she was unable to perform her daily chores properly due to stomach ache and discomfort. When I asked if she was taking medication, she said that she was on home remedies like unripe papaya and ginger. At noon she decided to visit a PHC facility, which was located approximately 2 Kilometres from her house. Having obtained her permission, I went along. We hired an auto-rickshaw, which charged 30 Rupees (Rs) to take us to the PHC. We reached PHC in 15 minutes, to find long queue of people waiting to see a doctor. Before meeting the doctor, every patient was required to make a case paper to be shown later to the doctor; the case paper cost 10 Rs. It took Sushma 10 minutes to get her case paper and then she had to wait her turn to be visited. After 45 minutes to 1 hr, she was allowed to see the doctor. She went in alone and within 3-4 minutes came out with a prescription. In this PHC the medicines are free, so all Sushma had to do was to show the prescription to chemist. We went back to her home again by auto-rickshaw, which also cost her 30 Rs. Once at home I asked her a few questions about on her experiences in PHC. She said:

> 'There was a long queue with no proper arrangements for handling patients. The doctor had no extra chair where a patient could sit. She asked questions about my problems while I was standing. She did not touch me or examine me properly. The interaction lasted only a few minutes and she prescribed the medicines. The PHC is open from 10am to 1pm and then from 2pm to 5 pm. Women who work have difficulty in using this facility compared to women who are homemakers. The behaviour of the PHC staff was average. I am not satisfied with treatments provided in PHC. The interaction with the doctor in private care facilities is very different. There, the doctor has a proper chair where patients can sit there are proper beds where doctors examine patients properly.'

In Pune, around 41% of slums are covered by Primary Health Care (PHC) within a range of 500m; still, only 9% of women are using the local PHC.[10] Most of the women surveyed for our ethnographic research have raised issues similar to Sushma's. Kamal is an *Anganwadi* worker who has lived in the Gurudutt Vasti slum (Ward number 29) for the last 30 years. Having enquired about her health problems and where she was getting her medical treatment, I found that she had had diarrhoea for the last two days and expected to see a doctor soon. After obtaining her permission, I accompanied her to the PHC when she next went there. Initially, she was hesitant to let me go with her because she was an *Anganwadi* worker and was concerned that the interview could to be used to criticise government facilities. I assured her that the sole purpose of this interview was to understand the issues, not to criticise anyone.



Map 1. Coverage of PHC in Pune city (Source: Secondary Survey conducted for PhD study in PMC (Pune Municipal Corporation) office in the month of May 2018.

On 6th June I visited her again from morning to noon and noticed that while working as an *Anganwad*i worker she was unable to concentrate fully on her work due to stomach cramps

[10] These data are from a Primary Survey done as part of a doctoral study in May 2018. At that time, 80 slums were selected from Pune to assess the accessibility of PHC (Primary Health Care) facility to women. The results indicated that only 9% of total sample of 600 women out of 80 slums were using PHC facility.

and weakness. At noon we decided to visit PHC facility which was approximately 0.5 Kilometres from her house. We hired an auto-rickshaw for 20 Rs and reached the PHC in 10 minutes. There, she experienced the same kind of long wait as Sushma to see a doctor for 3 or 4 minutes, obtain a prescription and get free medicines. She, too, needed to make a case paper costing 10 Rs before meeting the doctor. We went back to her home by auto-rickshaw, which again cost 20 Rs. Once there, I asked her to comment on her experience in the PHC. She said:

> 'Anandbai Gadgil is the medical facility that I visited. This is a government facility. Usually, I also go private. In a government facility, we have to wait in lines before meeting the doctor. In a government facility, doctors don't examine patients properly as compared to the private clinic but medicines are as good and fees are less. On some days the waiting time is 1 hr. There were no X-ray and Sonography facilities. Given a chance I would prefer a private facility as compared to a government facility.'

So, Kamal, too, is not satisfied with government facilities. She was also concerned with the check-up provided by doctors and facilities in the government centre. Most women living in the slum are comfortable taking home remedies before consulting doctors for treatment. Like Sushma, Kamla was also taking some home remedies before visiting a PHC.

Manisha, a resident of DandekarVasti slum has the same story to tell. She suffered from arthritis and had difficulty walking. She was using an oil prescribed by her neighbour, which for the last week had on her knees and hands. On 8th June we persuaded her to visit the medical facility near her place. She was prescribed medicines, which she obtained free of charge from the chemist at the PHC. Back at home. I asked her comments. She said:

> 'The facilities in the government centre are good but there are long queues and waiting hours. The waiting time in the private facility is quite less. In a government hospital, we only have to pay 10 Rs as a fee and medicines are free. In a private hospital, the expense goes up to 500 Rs. In case of hospitalisation, we use a government facility but for OPD we prefer private facilities.'

While the PHCs are normally used for OPD (Outpatient Department), women are mostly dependent on government-run hospitals for their deliveries but their experiences are not good. Namita's husband and father-in-law living in the Shankarmath slum, Hadapsar-Pune, borrowed money and she delivered her baby boy in the relative comfort of a private health clinic which charged her 6,000 Rs. While Namita's delivery was normal and her family was able to repay the debt, her neighbour Parvati's case took an unfortunate turn. She had a complex pregnancy and was admitted to the government-run hospital. Not only was she scared by the hospital staff's rude behaviour, but was also disturbed by the deaths of a mother and her new-born baby that she witnessed in the nearby room. She recalled,

> 'I was very scared listening to the cries of all the women in the ward in the process of labour pain and listening to nurses talking to them so rudely. The woman with whom I was sharing my room had just delivered a baby girl — both the woman and

> the child died before my eyes. My head started spinning after this and I told my husband that I could not stand being there. So, we just walked out of the hospital.'

Her husband, who runs a *paav-bhaji* (Indian bread snack) stall to earn a living, took Parvati to a private hospital where her baby was delivered through a Caesarean section. But it entailed a four-day stay in hospital and a debt of 35,000 Rs.

While some families borrow money to pay for private health care, others opt for home births. According to Kalyani, an *Anganwad*i worker based in the Jehangir Nagar slum, Hadapsar Pune, sending patients to the hospital is sometimes counterproductive. 'It is so difficult to convince women to go to hospitals for their check-ups and many are so discouraged by their experiences in these facilities that they end up delivering at home'.

According to a large number of *Anganwadi* workers to whom we have spoken, rude behaviour and physical abuse are major factors that deter women from seeking institutional deliveries.

Kamla, an *Anganwadi* worker, narrates an incident that happened when she took a patient to the hospital for her first delivery, 'When I went to see her on the occasion of her second pregnancy, she firmly refused to go to the hospital, saying that she was treated extremely badly on the earlier occasion and had decided to opt for a home delivery'. According to Kamla, women refuse to go to government hospital because the behaviour of doctors is consistently bad in all government facilities. She says, 'They speak to their patients in such an abusive way, sometimes hit them and turn them away even when the patient is in labour'.

Deliveries in institutional facilities have been regarded as an answer to address India's high levels of infant and maternal mortality but, unless something is done to make the experience a happier one for ordinary women, nothing will change. The whole system is designed to lure women into institutional delivery but it is not equipped for it, thus creating barriers to the programme.

Challenges in Conducting Ethnography

As an ethnographer, it was challenging to conduct this kind of research in the slums. Out of all the total 80 slums that were surveyed for quantitative analysis, the women of 8 slums allowed us to conduct our ethnographic study. For this study, I and one of my students decided to stay with these women the whole day and decided to understand more about the problem and issues they are currently having concerning accessing health care services.

The primary requirement of the ethnography survey is gaining the trust and confidence (Prato and Pardo 2013: 96) of the women who are willing to be interviewed. These women have been living in these slums for many years and have been using the primary health care facilities. When we first met for the survey, they were apprehensive about our study and motives. We were not invited to survey or even talk to them because many times agencies come, ask questions, assess the facilities and if they spot problems they use them for their ulterior motives. It took us a long time to make local women accept our study and reassure them that we would not use their remarks without their consent.

Along with the women whom we considered for our ethnography, other slum dwellers were continuously asking questions concerning our project and the place we come from. Being an outsider, it was difficult for me to handle people as their questions were in the Marathi language (the local language in the study area) and I was no so well-versed in this language but this problem was solved as most of the time my student helped me to understanding people's concerns.

Discussion

Health is a fundamental right, and it is the right of patients to receive respectful and dignified treatment and the services they need. Unfortunately, a majority of the people in developing countries, particularly the urban poor, cannot use health services. In India, the primary health care services are greatly underutilised because they offer a low-quality treatment and are marred by lack of responsibility and proper management, and by insufficient resources. It is also apparent that private hospitals are successful at providing better healthcare facilities and contributing to lessen pressure on public hospitals. Private medical facilities are characterised by a clean and healthy environment, sterilised equipment, efficient handling of patient grievances, availability of medical tests and pharmacy facilities located in the hospital, the polite attitude of doctors, nurses and supporting staff. However, although urban slum dwellers are well motivated to use private medical facilities, the high cost often forces them to resort to public medical facilities. The ethnographic study conducted in selected Pune slums has brought out these problems and the discomfort among women who use the public medical facilities. Free medicine was for them only encouraging factor when using these facilities.

While conducting ethnographic research, I observed understaffed medical facilities with obsolete tools, limited beds and lack of proper infrastructure. Moreover, many women complained about the repeated use of surgical equipment and syringes on several patients with unsatisfactory sterilisation, thus raising the risk of spreading infections and diseases. We often noted absenteeism among hospital staff such as sweepers, health technicians, nurses and even physicians. There is also a rising concern that patients in public hospitals, especially in the tertiary care facilities, are often treated by junior doctors, who are not yet well-experienced in the field.

In outpatient departments and emergency wards, we observed patients being advised, on occasion, to seek admission to private wards. Patients waiting their turn to get a bed were seated two to three on a single bed. Also, we noticed doctors in public hospitals spending very little time visiting. In short, in government hospitals, the doctors, nurses and supporting staff are not providing sufficient individual care to patients. Lack of staff interest in duty, absenteeism, inclination to work in private clinics, lack of feedback and accountability are the key factors that lead to patients' dissatisfaction with public hospitals.

Conclusions

As we have seen, the interviews show that women living in the slum areas of Pune have primary health care facilities that are spatially accessible to them. However, our findings tallied with

those of the primary survey conducted in May 2018 among approximately 600 women living in Pune slums, which showed that, despite better spatial accessibility to PHCs, only 9% of the surveyed women were using a PHC facility. The rest were dependent on private hospitals or clinics for their medical treatments. The ethnography brought out clearly that there are no obvious socio-economic reasons that are make public health care facilities non-accessible to women. The reasons in favour of private facilities given by the women whom we met included behaviour of the administrative and nursing staff and doctors; long waiting times and the opening times of the PHC. The doctors stationed in PHC spend little time discussing medical issues with women in OPD, they do not examine patients properly and prescribe medicines just looking at the patients once they have described their symptoms. In many PHCs that I visited there were no chairs for patients in OPD, women discussed their medical issues with doctors while standing and in many cases within 2 minutes doctors prescribed medicines and moved on to the next patient. As such incidents make women believe that their treatment is not done properly, they turn to private medical facilities for treatment. There, the cost of treatment is high but women feel satisfied as doctors listen to them, examine them properly and give them proper treatment. Moreover, while conducting an ethnographic survey, I found that many women who live in slums work as housemaids, or do private jobs. The PHCs are open is between 10 am and 1 pm and between 2pm and 5 pm, which does not suit working women.

The bad behaviour of those who staff government facilities is a common problem across the country. It is important to note that, as many reports point out, government facilities are understaffed and the personnel work under difficult conditions; not only they are not trained adequately, but are also overburdened and work long hours without proper support; there is clearly a need for a better working environment. It is equally important to stress that there is a need to sensitise doctors and other staff to behave better when giving treatment; they should be properly trained before they start working in a PHC. On the basis of my ethnographic experience, I believe that if these conditions were satisfied the accessibility to government PHC services would surely increase.

References

Atkinson, P. and Hammersley, M. 1994. Ethnography and participant observation. In N. K. Denzin and Y. S. Lincoln (eds), *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Bunce, A., Gold, R., Davis, J., McMullen, C., Jaworski, V., Mercer, M. and Nelson, C. 2014. Ethnographic process evaluation in primary care: explaining the complexity of implementation. *BMC Health Services Research*, 14 (1); available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265455/.

Caprara, A. and Landim, L. 2008. Ethnography: use, potentialities and limits in health research. *Interface (Botucatu)*, 4. Available at: http://socialsciences.scielo.org/scielo.php?script=sci_arttext&pid=S1414-32832008000100010 [Accessed 28 Jun. 2019] .

Chandrasekhar, S. and Sharma, A. 2015. Urbanization and Spatial Patterns of Internal Migration in India. *Spatial Demography*, 3 (2): 63-89. Available at: http://www.igidr.ac.in/pdf/publication/WP-2014-016.pdf [Accessed 3 June 2019].

Guest, G., Namey, E., and Mitchell, M. 2013. *Collecting qualitative data: a field manual for applied research*, SAGE Publications, Ltd, 55 City Road, London, doi: 10.4135/9781506374680; Accessed 3 July 2019.

Higginbottom, G., Pillay, J. and Boadu, N. 2013. *Guidance on Performing Focused Ethnographies with an Emphasis on Healthcare Research*. Nova South Eastern University. Available at: https://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1550&context=tqr; Accessed 28 Jun. 2019.

Hammersley, M. and Atkinson, P. 2009. *Etnografía*. Barcelona: Paidós Ibérica.

Hazarika, I. 2010. Women's Reproductive Health in Slum Populations in India: Evidence From NFHS-3. *Journal of Urban Health*, 87 (2): 264-277. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845837/; Accessed 5 June 2019.

Krase, J. 2018. The Multitude of Approaches to Urban Ethnography: Blessing or Curse?. In I. Pardo and G. B. Prato (eds), *The Palgrave Handbook on Urban Ethnography*. New York: Palgrave-Macmillan.

Knoblauch, H. 2005. Focused Ethnography [30 paragraphs]. Forum Qualitative Sozialforschung/Forum: *Qualitative Social Research*, 6 (3) Art. 44, http://nbn-resolving.de/urn:nbn:de:0114-fqs0503440.

Madhiwalla, N. 2007. Healthcare in Urban Slums in India. *The National Medical Journal of India*, 2 (3): 113-114. Available at: http://archive.nmji.in/archives/Volume_20_3_May_June/editorial/Editorial_2.pdf; Accessed 21 June 2019.

Ministry of Health & Family Welfare (MoHFW). 2013. *National urban health mission-framework for implementation*. New Delhi: Government of India.

Ministry of Health and Family Welfare, Government of India -MoHFW. 2006. *National Family Health Survey (NFHS-3), Volume 1*. Mumbai: International Institute for Population Sciences Deonar.

Mukherji, S. 2001. Low quality migration in India: the phenomena of distressed migration and acute urban decay. In: *24th IUSSP Conference*. Session 80: Internal migration – Social process and National patterns. Available at: http://archive.iussp.org/Brazil2001/s80/S80_04_Mukherji.pdf; Accessed 25 June 2019.

Office of the Registrar General & Census Commissioner, India-ORGI. 2013. *Primary Census Abstract for Slum*. New Delhi: Census of India 2011.

Pardo, I. and Prato, G. B. 2018. Introduction: Urban Ethnography Matters — Analytical Strength, Theoretical Value and Significance to Society. In I. Pardo and G. B. Prato (eds), *The Palgrave Handbook on Urban Ethnography*. New York: Palgrave-Macmillan.

Prato, G. B. and Pardo, I. 2013. Urban Anthropology. *Urbanities–Journal of Urban Ethnography*, 3 (2): 80-110.

Roper, J.M. and Shapira, J. 2000. *Ethnography in nursing research*, Thousand Oaks, CA: Sage.

Savage, J. 2000. Ethnography and health care. *The BMJ*, 321 (7273): 1400-1402.

Save the Children. 2016. *Situation of Maternal and Newborn Health in Urban Slums of Pune*. Summary Report. Pune: Saving Newborn Lives, Save the Children. Available at: https://www.healthynewbornnetwork.org/hnn-content/uploads/summary-report-Pune-1.pdf [Accessed 20 June 2019].

Streubert, H. J. and Carpenter, D. R .2011. *Qualitative Research in Nursing: Advancing the Humanistic Imperative.* Philadelphia: Lippincott, Williams & Wilkins.

World Health Organization. 2019). *Urban Health*. Available at: https://www.who.int/topics/urban_health/en/;Accessed 19 June 2019.