HEALTH SECURITY OF WOMEN LABOURERS LIVING IN SLUMS: A CASE STUDY OF DARJEELING TOWN

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
CHC	Community Health Centre
GoI	Government of India
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
JSSK	Janani Shishu Suraksha Karyakarm
JSY	Janani Suraksha Yojna
MDGs	Millennium Development Goals
MoHUPA	Ministry of Housing and Urban Poverty Alleviation
MMR	Maternal Mortality Ratio
MoUD	Ministry of Urban Development
NCD	Non Communicable Diseases
NFHS	National Family Health Survey
NHP	National Health Policy
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PHC	Primary Health Centres
PHW	Primary Health Workers

PNC	Post Natal Care
RTI	Reproductive Tract Infection
SARS	Severe Acute Respiratory Syndrome
SC	Sub Centre
SHP	Small Health Post
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
UNICEF	United Nations International Children Emergency Fund
UNICEF	United Nation International Child, Education Forum
WHO	World Health Organization
WMD	Weapon of Mass Destruction

CHAPTER- I

INTRODUCTION

Security discourses has been broadened to include human security in which the main focus is on individual as referent object. The non-traditional security threats affect socio, political, cultural, economic, and environmental of realms of human beings. One of the major challenges human security face today is the health issue. Health plays a very important role because it determines the well being of the family as well as the nation. Though there is tremendous advancement in the field of science and technology with especially on health infrastructure but people lack access to health care system due to various factors. The issues associated with health are ageing, obesity, underutilization and accessibility of health infrastructure, depletion of traditional methods of healing system, critical awareness regarding schemes and policies of health etc. All these aspects are debated within the gamut of human security cutting across the globe which demands a collective and interdisciplinary effort to find solutions.

The case of Darjeeling appear to be similar as Darjeeling being the healthy environment and sanatorium at one point of time but today the situation has drastically changed. The sewage system of Darjeeling town is very pathetic and water scarcity has become crucial concern. The sewage of the houses is dumped into the 'jhoras' and the safety tanks are in a deplorable conditions which complicate health and environmental problem. This is the condition of the people who are not residing in the slums, so let us imagine the situation of the people who reside in the slum areas. Women play a very important role in the household activities as well as they work as the bread earner of the households especially in the slums area. Women, as usual, have been treated as the secondary member in the family and almost half of the women are engage in both household activities as well as become an earner for their family. In India majority of the women are mostly confined to household activities where the improper sanitation, the water problem and the unhygienic environment put them in a vulnerable condition leading to diseases.

There is no doubt that health problem are increasing day by day but protection and prevention these diseases are been implemented very poorly. The primary health care

approach was developed with the recommendation of the Health Survey and Development Committee popularly known as the Bhore committee in 1946. There are 922 primary health care centres in West Bengal out of which 21 of them are in Darjeeling, but proper utilization are not made due to the lack of information, doctors and the medicines. The conditions of the hospitals are also bad and the infrastructures in the hospital are so poor and mostly patients have to go other places in search of good hospital facilities. There are number of occasions death happens due to the long travel and delay to reach hospital.

There is a provision of the pre-natal care and neo natal care of the mother but these facilities are not been utilized by them due to lack of awareness coupled with carelessness of the hospital authorities. In slums, there are many cases of delivery happening at home without the presence of professionals in an unhealthy precarious environment causing long lasting problem to both mother and new born babies. These all issues need be taken into consideration to understand the health security of women labourers in the slums of India with special focus on Darjeeling town. In this backdrop, there is an urgent need to securitize the health of women not only from biological angle but also from national security perspective.

RATIONALE AND SCOPE OF THE STUDY

With the increase of people living in Darjeeling, the impact on human health is now a growing concern. The rapid growth of slum populations in Darjeeling is an increasing challenge for local health authorities and deserves intensive investigations. There have been lots of funds sanctioned in the name of the development of the health infrastructure in Darjeeling from 2011 to 2013 but there is hardly any sign of the development and people's lack of awareness complicate the health problems. The improper health infrastructure have never become issue of concern for the people because political elites and wealthy can afford high standard treatment in a better hospitals but the poor people from the slums are left alone who sometimes could not survive due lack of health facilities. So along with the health administration, lack of awareness and political conscious of the people have become causes for the current situation. Based on the Bhore Committee report, primary health centres were made all over the state but still stand underutilized. The incompatibility between the health administration and the lack of

awareness of the people enable us to research into various factors such socio, economic and cultural factors that create health as security issues for women labourers living in slums.

Apart from this background the study tries to make connection between the health and human security and its relevance in the contemporary society. This study analyzes various security perspectives to examine health as human security issue. The study also helps us to understand the existing social hierarchy which is divided by class system that determines the health of the women of the slum area. The gender inequalities in the labour workforce participation and different policies and acts concern with the women, work and health are also analyzed. The drawbacks of the states and the government in their policies and their flawed implementation when it comes to health concerns of the slums area specially women labourers are examined.

Health as Human Security Issue

Human security is discussed at different scales and with reference to threats of varying scope moving through from broader to narrower definitions. The concept of human security redirects attention in discussions of security, from the national to state-level to human beings as the potential victims, beyond physical violence as the only relevant threat or vector and beyond physical harm as the only relevant damage. It is no longer from the holocaust of the war which was prevalent before but now it is more concerned with the safety of the human lives from the non-traditional threats like food, economy, health, class, caste, environment etc.

The frame work of human security was pioneered by the United Nations Development Program in 1994 and they have outlined seven areas of human security such as economic security, food security, health security, environmental security, personal security, community security and political security. Human security by contrast shifts the focus to individuals to people, as the referent object and it gives most attention to those people suffering from the insecurities (Kerr: 2010).

A consideration of basic components of human security must focuses on four of its essential characteristic human security is a universal concern, the components of human

security are interdependent, human security is easier to ensure through early prevention than later intervention, human security is people centred (Human Development Report: 1994). Human security is focused on complex and multidimensional threats that challenge the survival, livelihood and dignity of people. As a framework, it can be applied to a wide range of current and emerging challenges specially health and its related challenges.

Public health has been guided a broad vision of human needs. For example one of the pioneers of the public health, the 19th C, German pathologist Rudolf Virchow fought for the recognition of medicine as the social science. Virchow also called upon physician to be the apostles of peace and reconciliation (Gutlove and Thomson: 2003). Health is not only seen as the threats to the life of the individuals but it is also the concerns for the individual, society, state and even a concerns for the national security issues.

Health in the National Security Agenda

Earlier human beings were being used as weapons of war, and women and girls were the most vulnerable people who used to be the victims of it. It has been noted that during the Second World War, most of the people didn't die of bullets but due to the pandemic diseases, starvation etc. and the HIV affected women were used as weapons in spreading this dangerous diseases in war.

Throughout history infectious diseases have posed great challenge to national security. The epidemic of Black Death in Europe and smallpox among native populations of the Americas were so severe as to shape the political and demographic composition of the modern world. The HIV/AIDS pandemic had killed approximately 9 million people between 1990 and 2000 (Feldbaum: 2009). The major challenge that health security face is its borderless nature and the worst case is the HIV/AIDS. In South Africa, it was found the effects of HIV/AIDS was very negative and it generated the absenteeism with just 16 per cent of the health care workers in Mpumalanga, KwaZulu-Natal, and the North West province being HIV positive (Elbe: 2010). The relationship between health, sanitation and security is been fully explored and there has been great reluctance on the part of stakeholders to accept health and sanitation as a national security issue.

In both developing and industrial countries, the threats to health security are usually great for the poorest people in the rural areas and particularly women and children. While poor people in general have less health security, the situation for women is particularly difficult. Domestic violence is a global phenomenon and the medical community now recognizes domestic violence as a leading cause of morbidity and mortality among women. The women who have reported domestic violence had substantially infected with Sexually Transmitted diseases. The likelihood of getting STI is 2.5 times more for sexually abused women than non-abused women (Anithakumari: 2010).

Women are different from men; they experience different things while growing up and as adults, biological factors can influence their health. The factors related to gender can affect their treatment choices and role in society as they are the people who care and nurse both healthy and unhealthy in the society. The health security varies from region to region and society to society and the health issues also vary between male and female. Though they are biologically different and their roles in the society are also different, the women are more vulnerable to the health issues than men. The socio economic factors including education, income, inequality and occupation have been identified as the strongest and most consistent predicators of health and mortality in determining health status.

The Millennium Development Goals have adopted a fifth goal to improve maternal health to reduce it by three-quarters during 1990- 2015, but despite of the targeted goal pregnancy remain the major health concerns for the women especially in the developing countries (Millennium Development Goals : 2011).

The International Human Rights focuses to improve the women's health free from all forms of discrimination by improving right to survive, liberty, right to family and private life, education, right to health and care etc (Cook: 1999). But still women often suffer as a result of greater confinement and stricter gender roles. At the same time if the conflict escalates the women's workload and victimization also increases which affects her health (Sharpe: 2010). Watts and Zimmermann summarize research from various regions showing abnormal ratios of male to female caused by sex selective abortion, female infanticide and often fatal neglect of the health and nutritional needs of the girls.

There has been estimation that between 60 to 100 million women and girls who are missing from the normal population counts and refer specifically to the case of India (Roberts:2008).

These are the cases of the non-slums women and the conditions of women dwelling in the slums are much more vulnerable to diseases and health problem. They are exposed to disease, crime and natural disasters. There are many failures that add to the problem on people already burdened by poverty and other constrains. Lack of drinking water, clean, sanitary environment and adequate housing and garbage disposal pose series of threats to the health of slum dwellers. The women and children spend most of their time in and around the unhygienic environment and food they consume are not nutritional. Factors such as poor sanitation, improper disposal system, water scarcity etc contributes in spreading of diseases. Thus, women are more susceptible to the adverse health outcomes associated with inadequate housing conditions (Democracy Watch: 2010).

It is estimated that a sixth of the world's population lives in slum like conditions. South Asia has the largest share of slum dwellers and 56 percent of South Asia's population lives under slum conditions (United Nations Population Fund: 2007). Consequently, MDG-7 (Target 11) aims at improving the lives of at least 100 million slum dwellers by 2020. The harsh physical and social conditions life lead to chronic stress in slum dwellers. But this case is not only confined in the South Asian contest but everywhere the condition and the consequences which the slums women face, in terms of health, are more severe.

In 2010 it was identified that there were around 82 slums building in central Johannesburg where 50000 to 60000 people were living in a very worst condition with the problem of overcrowding, poor sanitation with little access to clean water and the miss management of the disposal of the waste. In Kibera, the Kenyan government classifies it as the informal settlement. There is no state sponsored development, sanitation or education and with a very limited access to health care facilities (Medicines Sans Frontieres: 2011). There were two dental diseases in Europe which was rare in the developed countries but was spread in the 19th century in the slums of Europe which are common in developing countries called Cancrum Oris a gangrene of the face and jaws

which caused by undernourishment of women and specially among the children which sometimes caused a fatal death (Madeley: 1984).

In India, the highest number of the slum dwellers is in Dharavi, Maharashtra where most of the primary healthcare are neglected. Despite underutilization of municipal services, women prefer to give birth at home where there is unsanitary and resource poor condition. Women's absence in the role of decision making affect her health during her pregnancy which leads to the ill health of both mother and the child (Matthews, Brooks, Stones et.all, at www.isst-india.org).

Estimates show health expenditure as a percentage of annual income varying from 3 percent in the richest 20% of the households to 12% in the bottom 20% of the households. A study in Rajasthan showed that health care purchased is often of poor quality, even harmful. The State has been gradually withdrawing from its role as a provider of basic services such as health and consequently poorer households have been left with the choice of forgoing treatment or falling prey to the essentially unregulated private sources of treatment (Chowdhary et.all: 2011).

Chennai district has 1230 slums in which 1.8 million people live in about 3 lakh households giving an average household size of 4.5 members (Census of India, 2001). Older slum dwellers and workers 'accumulate disadvantage' over their life-course due to a set of factors. Seriously inadequate old age support has a disproportionate impact on women because women outlive men. Life-course gender discrimination leaves older women relatively more deprived of resources than ageing men. Women retain a double burden of subsistence and household reproductive work. Almost half of the male slum dwellers aged 75-95 had working wives not much younger than them. As they grow older women tend to become the primary earner; their deprivation increases with age, they work until they are seized by death (Olsen et.all: 2010).

The reasons why health systems fail women are often complex and related to the biases they face in society. However, these shortfalls can be challenged and changed. For example, women face higher health costs than men due to their greater use of health care yet they are more prone to be poor, unemployed or else engaged in part time work or

work in the informal sector that offers no health benefits. Women are rarely represented in executive or management-level positions in the health system and they are tending to be concentrated in lower-paid jobs and exposed to greater occupational health risk (WHO: 2009).

Relative to the male peers, women residing in the slums have a greater incidence of chronic illness, high level of depression and earlier disability. Mother engaged in informal sectors may experience distinct health risks with non standard working hours, great job strain and less access to health insurance (Frech and Damaske: 2012). Depression is expected to be the second largest contributor to disease burden by 2020 and one in every three women worldwide being affected by common mental disorder including depression in the slums and non slums area (Basu: 2012).

Health of Women Labourers in the Slums

Slum dwellers are more likely to live in hazardous or toxic locations, which are more prone to natural disasters, such as floods and health risks, not just to slum dwellers but to city dwellers in general. Poor sanitation in some cities has led to large sections of the population defecating in the open. This contributes to the contamination of water and land resources within cities, and become a cause for the water borne diseases prevalent in slum. The women in Kolkata have to work both in house and even to the factories which create less time for her child in terms of nourishment. The other issues women face is that she falls into the victims of violence due to the consumption of alcohol by the male partner. Due to the long working hours she is not getting time to visit the health care centre or they are not bothered to visit the health care centre to take care of the health (Bandhyopadhya et.all: 2012).

The nutritional status of women in West Bengal is significantly worse than the national average. The incidence of anaemia among women is much higher than in many other parts of the country. Compared with the national average of 52 per cent, 63 per cent of married women in West Bengal were characterized as having iron-deficiency anaemia in 1998-99. The problem of excess arsenic drinking water exists in at least 75 blocks spread over 8 districts, accounting for an estimated population of over 13.5 million

people. This is an urgent problem requiring immediate public intervention (Westbengal Human Development Report: 2004).

Housing shortage and shortage of urban services finally lead to a situation when the settlements degenerate into slums. The total number of slums in Siliguri is 42 which hold 36.8% (56828) of the total population and 31.4% (9103) of the total households of the town. The numbers of families dwelling in these slum pockets are 13850 (Slums Statistical Report: 2011). Infiltration from neighbouring area and states are the major causes for the growth of slums in the town. But the rapid urbanization and allied improvement housing condition of slum dwellers remain in dilapidated condition. The over whelming majority children are kept away from school education for various reason. A considerable number of slum dweller suffers acutely from drinking water shortage and largely depend on solitary well. The slums are affected by diseases that spread epidemics which also affect the people residing nearby. Unhealthy sanitation system is highly detrimental to the environmental condition of the locality. Because of inadequate latrine facilities, the people residing in the periphery of the town use open fields for their latrine and ultimately lead to environmental pollution (Roy and Shah: 2011).

The case in Darjeeling is much similar as the rest of the country but in Darjeeling the women of the slum dwellers are working as daily labourers in construction, carrying goods, maids etc. The family burden rest to the women of the family which sometimes lead them to the hands of traffickers. In 1981 the reported slum pockets were confined to only 4 wards namely ward no 16,20, 13and 14 and in 2001 there were 8296 slum dwellers i.e. around 7.72 per cent of slums pockets in Darjeeling. These slums have emerged due to large influx of migrants from the surrounding areas of Nepal, Bihar, Tibet. These people live in such areas because they cannot afford to live in better residential areas (Chettri and Tamang: 2013). Today the slum population in Darjeeling has risen to 1, 20,414 around 22.5%, where 37 are the notified slum plus 51 new slums areas are found to be slums in Darjeeling. The condition of the women labourers in the slums of Darjeeling have the similar feature where the basic needs like water, sanitation, health facilities are neglected in the slum area. Under utilization of health facilities and the lack of information creates extra burden on the women's health in Darjeeling.

The above literature shows how the health of the women is deteriorating internationally, nationally and locally. It has become common phenomenon that numbers of slums are increasing and health conditions of these people living in slums have become least concern to authorities. In this backdrop, issues associated with health of women especially in the slums of Darjeeling need to be investigated to understand what factors that constitute current plight of slum dwellers and how to securitize them. The study tries to examine under utilization of health infrastructure by the slum dwellers especially by focusing on women. The socio economic condition of the women labourers in the slums are also analyzed to understand the lack of awareness of the people in health matters.

OBJECTIVES OF THE STUDY

- To securitize health of women from theoretical perspective.
- To understand how health of women has factored in the national security discourse.
- To analyze the policies, programmes and schemes for the women labourers in India.
- To examine the reasons for the low accessibility and underutilization of health infrastructure by women slums labourers in Darjeeling.
- To examine the health issues of women labourers in the slums of Darjeeling.

RESEARCH QUESTIONS

- Why does health of women especially slum labourers need to be securitized in the Indian context?
- How does women slum labourers health issues have been factored in the national security discourse?
- What are the schemes, funds, programmes available in India to improve the health of women in the slums?
- Why does health infrastructures are underutilized by women slums labourers?

HYPOTHESES

- The accessibility and availability of the health infrastructure is underutilized by women labourers in the Darjeeling town.
- Lack of critical awareness regarding health practices and programmes of women complicate the health issues in the slums of Darjeeling.

RESEARCH METHODOLOGY

LOCATION OF THE STUDY: As per Census Data 2011, the total recognized slum population in West Bengal is 37, 03,852, in 122 reported slums pockets which constitutes of 9.8 per cent population all over India. West Bengal has the third largest slum population in 2011 and fourth in 2001 indicating an increase in the population of slums in West Bengal. Darjeeling, one of the districts of West Bengal, has a total population of 1,84,6823 as per Census 2011 comprising 937259 male and 909564 female respectively. Darjeeling Town constitutes of 32 wards and 88 slums pockets.

STUDY AREA: The main study area is Darjeeling town where the maximum number of slum pockets is located. The study has been limited to Dhirdham area and Lowis Jubilee that come under ward no 17 below Railway Station where the condition is worse in comparison with the rest of the slums. Majority of the women labourers especially daily wage workers resides in this particular area.

RESEARCH METHODS: The study employs both qualitative as well as quantitative methods to collect primary and secondary data. The tools for primary data collection are questionnaires, interviews and the sample size is 100. Interviews have been conducted with various stakeholders from health departments, hospitals, health care centres.

CHAPTERISARTION

Chapter I is the introduction of the proposed research. It defines the basic concepts, objectives, research questions and methodology of the proposed research. The key concepts of the research include the concept of security and health security, the significance of women issues within health security paradigm and health security issues of women labourers of slums of the Darjeeling town.

Chapter II elaborates the theoretical background of security to securitize the health. Security in the wider level has been discussed with special reference to the emerging inclusion of health as a security issue. It conceptualizes the definition, nature and characteristic of security and health security. It highlights the major transition of security from traditional security to non-traditional security.

Chapter III deals with health issues at national level. The chapter is focusing on the importance of women in the health security agenda. Different issues of women health security along with governmental schemes for securitizing health security of women have been discussed and even the underutilization of health infrastructure has been validated in this chapter.

Chapter IV is a focused discussion on the health security scenario of the research field- the slums of Darjeeling district. It is a qualitative and quantitative discussion on the basis of the collected data and information from the field of the present research.

Chapter V gives the conclusion of entire dissertation which presents the brief outlook of the every chapter. It underlines the findings of the field work and focuses on the underutilization of the health care by the women living in the slums as well as by the non slum women. It delivers the fact that illiteracy has played the major role when it comes to the utilization of the health facilities and the one of the reasons for decline in the health of the women in the slums. With the summary of the dissertation it also underlines the policy prescription with future scope of study for research.

CHAPTER- II
SECURITIZATION OF HEALTH: AN OVERVIEW

INTRODUCTION

The question of security has usually been analyzed from military and power perspective. Traditional understanding of security with State as the main referent object has been broadened to non-traditional threats in the contemporary society. The realists see security as a derivative of power politics that reduces the complex concept of security from military and power. The broader framework of security incorporates regional, societal, environment, economic, as well as political aspects that play a major part in security analysis. The insecurity is not caused by one single factor instead it is caused by number of factors and there is no single solution to it. Most of the security threats have emerged recently like poverty, under development, infectious diseases, disasters etc. leading to the death of human beings especially the vulnerable sections of the society such as women, children and the poor. So, there is an urgent need to address those issues through the process of securitization.

This chapter analyzes the theoretical understanding of how security has broadened from traditional security to human security. Health of the women has been identified as a referent object that faces challenging threats in the contemporary times which needs to be securitized from women's perspective. The women living in slums are the most victimized in terms of economic and physical wellbeing. They are insecure inside their home especially when their health is concerned. This chapter brings upon the understanding the health issues to which the women in the slums are facing. It tries to analyze the theoretical understanding of how security has been broadened from traditional security perspective to human security. The process of securitization of health and global picture of the women living in the slums are discussed and explained in this chapter.

2.1: CONCEPTUALIZING SECURITY

The term security in general understanding means the situation where the essential factors concerning the individual are secured like employment, shelter, food, health, clothing etc. where the survival is the essential part of it and Ken Booth describes

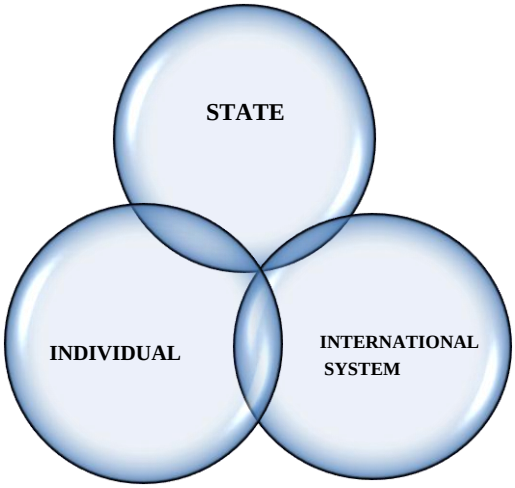
security as the 'survival- plus' where the plus indicates the freedom from all sorts of threats (Williams: 2008, 6). For Wolfers security refers to an absence of objective dangers, i.e. of security 'threats', 'challenges', 'vulnerabilities' and 'risks', and of subjective fears or concerns, and to the perception thereof (Baruch:2011,61). Conventionally the concept of security has been limited to military powers by the realists and the concept was routinely referred as national security. The Realists argue that the main responsibility of the state is to protect its citizens from external and internal threats using the military might and for them military power is the most important tool to secure all kind of security issues. But when it comes to the major security issue the national security is the foremost importance than other issues. Therefore military power is the political weapon to tackle the threats arising out of the different components.

Security has always been very crucial to all the countries because it decides the sovereignty of the country from the internal and external threats that directly and indirectly disturbs their security. In earlier years the major focus of the international relations was security of the State where the most important security issue was the national security or the defence of the State. These traditional views of national security derived from the realist paradigm that developed after the Second World War and during cold war period focused on State interests by promoting military defence. But it was very narrow understanding of security. Barry Buzan describes security as an 'underdeveloped concept', because the concept of security is a social construction which has no meaning in itself (Krause and William: 1996, 231).

The widening of the security studies was first made by Richard Ullman in the 80's where he had discussed that the problem with the military security is actually creating insecurities among the nation. Ullman contemplated that it is not the military security that should be given priority but priority should also be given to the non military issues. The framework of the widening of the security studies was made by Barry Buzan in 1983 in his work People, State and Fear where he drew a broader map and proposed five sectors where security could be threatened. These five sectors are economic, political, environment, societal and military. State, individual and the international system plays an equal and significant role in sustaining security. Each sector cannot address the issues

in isolation but all the sectors are overlapping and therefore have to rely on one another forming a web of knowledge to understand each concept individually. Therefore security is valorised by the threats which challenged it (Ullman: 1983, 133).

Figure 2.1 The relation among Individual, State and International system



Source: Self Compiled

The threats may come from the five sectors and even from other issues like the most vulnerable threats come from diseases. New security threats emerged after the end of the cold war like the new diseases like HIV/AIDs, pollution of environment which ended in climate change, societal issues which emerged due to the national and international migration especially from east to west. Thinking about securing the national integrity of a State, military issues are the major focus of the States but the real scene of the world is not confined within the walls of the national security but day to day challenges that people are facing from unemployment, poverty, hunger, diseases where people are directly and indirectly affected by it. The term threat plays the major role in the life of people because it has the tendency of giving the information about the insecure lives of the people. When security is discussed it is always about the insecurity towards the life of people and survival of the people. According to Ken Booth it is the heart and mind of the individual which begins with the experiences, imaginings, analysis

and fear that can be summoned up as the threat which creates insecurity among the people (Booth: 2007, 101).

The genesis of the word security creates priorities for the action and the use of the exceptional measures and which has the capacity to bring increased political attention to certain issues. Ole Waever argues that classical security was about survival and something is a security issue when it poses an existential threat to particular group or institution usually not the state. This life or death aspect of security threats in turn justifies the use of extraordinary measures to deal with them (Sheehan: 2006, 53). But security cannot be achieved at the expense of the other but it's a collective process which is based on sharing commitment or trust between all the state (Schafer: 2013, 6). The new understanding of the word security is concerned within the frame work of the human security paradigm where all the three levels given by Barry Buzan in his work "the State, Individual and the International System", are interdependent and interrelated with the concept of human security.

2.2: HUMAN SECURITY

The concept of human security redirects its attention from State centric to human as referent objects arising from the five as well as the other sectors. This human security thinking is perhaps best represented by Mahbub ul Haq who argued that the new concept of security must be based on the security of individuals not just security of the nation (Anthony: 2002, 23). The basic components of human security focus on four of essential characteristic according to the Human Development Report 1994:

1. Human security is a universal concern
2. The components of human security are interdependent
3. Human security is easier to ensure through early prevention than later intervention
4. Human security is people centred or can be portrayed as well being of the human.

The report elaborates seven dimension of human security that are; Personal, Environmental, Economic, Political, Community, Health and Food Security. Apart from this there are other scholars who have restated or revised the components of human

security like Jorge Nef, for example, Nef devises a fivefold classification scheme, arguing that human security comprises (1) environmental, personal, and physical security, (2) economic security, (3) social security, including freedom from discrimination based on age, gender, ethnicity, or social status, (4) political security, and (5) cultural security, or the set of psychological orientations of society geared to preserving and enhancing the ability to control uncertainty and fear (Paris: 2001, 91). The human security approach not only means to assess the vulnerability of the people and the issues that are threatening but it also means to assess the strategies in order to prevent, mitigate the problem that give rise to various insecurities or threats.

Table 2.1 Strategies and Capacities Needed for Addressing Human Insecurities

Human security Components	Strategies to enhance protection and empowerment	Capacities needed
Economic security	Assured access to basic income, Public and private sector employment, wage employment, self-employment, when necessary, government financed social safety nets.	Economic capital Human capital Public finance Financial reserves Diversified agriculture and economy
Food security	Entitlement to food ,by growing it themselves, having the ability to purchase it or through a public food distribution system	Diversified agriculture and economy, local and national distribution systems
Health security	Access to basic health care and health services, risk-sharing arrangements that pool membership funds and promote community-based insurance schemes.	universal basic education and knowledge on health related matters, indigenous/traditional health practices, Access to information and community-based knowledge creation
Environmental security	Sustainable practices that take into account natural resource and environmental degradation. Early warning and response mechanisms for natural and man-made disasters at all levels	Natural resource capital. Natural barriers to storm action. Natural environmental recovery processes. Biodiversity, indigenous/ traditional practices that respect the environment
Personal security	Rule of law, Explicit and enforced protection of human rights and civil liberties	Coping mechanisms, Adaptive strategies, Memory of past disasters
Community security	Explicit and enforced protection of ethnic groups and community identity. Protection from oppressive traditional practices, harsh treatment towards women, or discrimination again ethnic/ indigenous/refugee groups.	Social capital, Coping mechanisms, Adaptive strategies, Memory of past disasters, Local non-governmental organizations or traditional organisms
Political security	Protection of human rights, Protection from military dictatorships, abuse, political or state repression, torture, ill treatment, unlawful detention and imprisonment.	Good governance, Ethical standards, Local leadership, Accountability mechanisms.

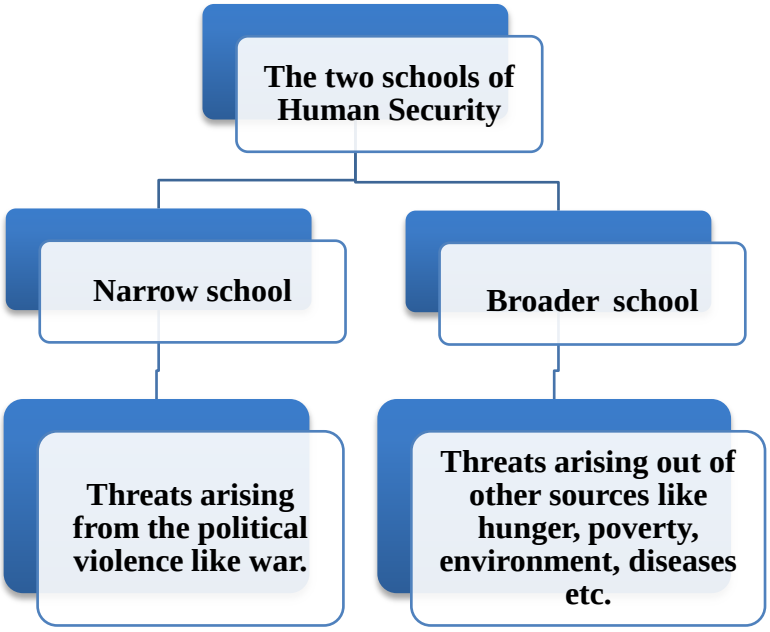
Source: United Nation Human Security Unit: 2009, 16 (http://ochaonline.un.org/humansecity) accessed 23/10/2014.

Whatever may be the components of human security, the focal point is the survival and well being of the people. It has been observed that some of the security threats were there from the earlier times but those were not considered as the security issues and people basically overlooked them and that is still happening in today's world which is creating extra burden or insecurity for the people as well as for the government in tackling the issues.

When dealing with human security it is not synonymous with human development as the latter is much of the broader definition while the former means freedom and safety with certain rules to be followed. Human security have two main aspects, it means first, safety from chronic threats as hunger, diseases and repression and second, it means protection from sudden and hurtful disruption in the pattern of daily life whether in home, jobs or communities (Human Development Report: 1994, 23). It is no longer about the threats from nuclear weapons or the holocaust of war but it's the aftermath of the war like economic depression, diseases, hunger, poverty, environment etc which has become the core worries for the people. It is about preventing violent conflict and reducing many deprivation and social inequalities. It is estimated that more than thousands of people die every year just because of the violence that people suffer from poverty, ill health, illiteracy and social deprivation and where human security acts as a way of addressing such social problems (Taylor: 2004, 66).

The question of survival is most important for human security. There are two notions in the understanding human security freedom of want and freedom of fear where the former refers to freedom from poverty, hunger, employment etc and the latter means freedom from violence where military power is important in terms from the freedom of fear. Which gives us the picture to understand security which is divided into two school Narrow and Broader School, where Mack is the proponent of the narrow school who argues the threats arising out of the political violence by the States or the other political organizations to the people is the main focus of human security, while the broader schools focus not on the threats from political violence but also threats from want (Kerr: 2010, 124).

Figure 2.2: Schools of Human Security



Source: Self Compiled

By this argument human security challenges the views of the Realist conception of International security because people are not concerned about the threats arising out of the war, interstate war or intra state war rather they are much concerned about the daily necessities like food, health, employment, hunger, elevation of poverty etc. This doesn't means that human security neglects the national security approaches that are of importance in dealing with the threats but realism is not sufficient in dealing with the other threats which hampers the lives of the people directly and indirectly.

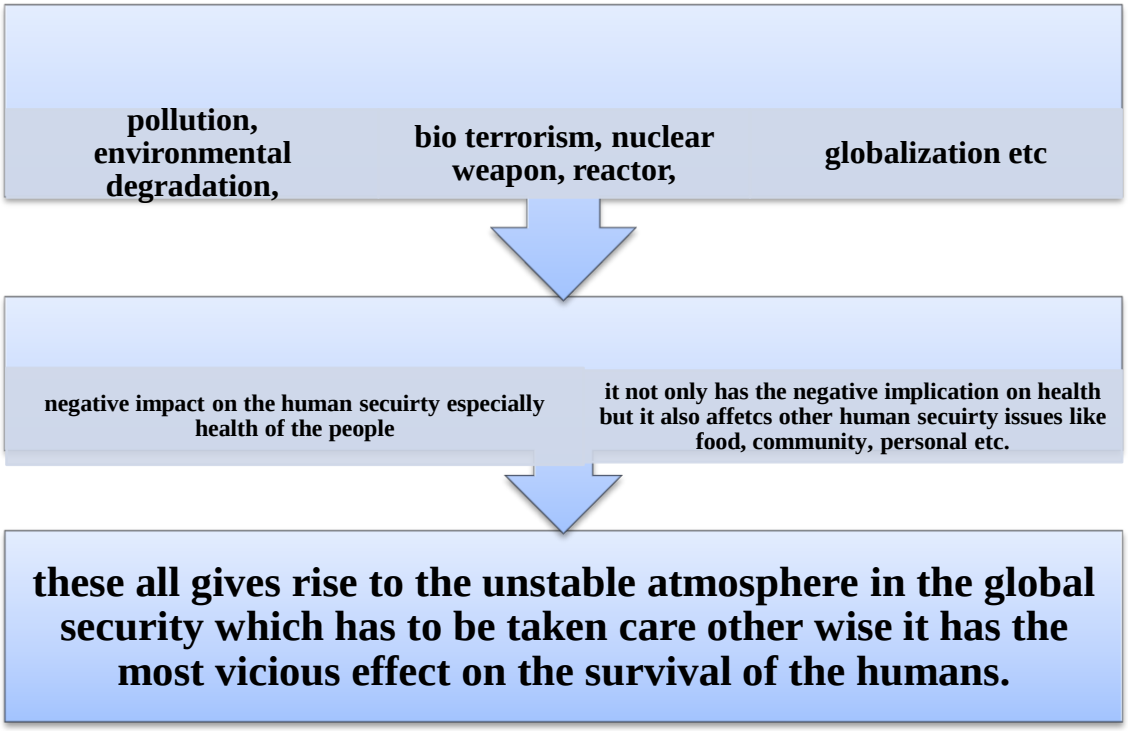
The security threats have now spread over all the domains of the human life causing very negative impact. But knowing the threats whom shall people approach for their security? As Barry Buzan has mentioned that it is the duty of the State to ensure security for it people and human security is the means to get it as human security is the idea that the individual is at the receiving end of all security concerns (Floyd: 2007, 40). It is the duty of the State to give protection and secure the life of its citizen and this gives us the idea that State and people are interconnected with each other like Buzan has

mentioned. So in order to secure the security of the people it is very important to include the three levels i.e. International, National and Individual into the core agenda to maintain security of people.

2.3: HEALTH AS A HUMAN SECURITY ISSUE

World Health Organization defines health as a well being of the human beings in terms of physical, mental and social and not just mere absence of disease, not only that it further states that it is the fundamental right of the human to attain sustainable health outcome and which helps in building peace and security across the world (Rockenschaub eds: 2007, 12). Health has always been the core of human security because its aim has always been the safety of human irrespective of the holocaust of war or from diseases. It is not just to safeguard the people from the war but also from the chronic diseases that slowly engulf the population if not checked properly. Poor health is like a slow poison that can take over the family, society and the state causing a serious implication. The evidence of keeping up the good health is linked to the one of the human security approaches. Throughout the history people have suffered number of health problems that caused unprecedented levels of deaths and threatened the lives of the people. The outbreak of severe acute respiratory syndrome (SARs) in 2003 shook the world creating huge chaos. This infectious disease continues to pose a threat in the lives of the people like the HIV/AIDs, tuberculosis, malaria, H1N1/ H5N1 swine flu, avian influenza, that remain endemic in many developing countries and cause millions of deaths per year (Elbe: 2010, 414). And the causes of these are not just confined to one issue like environmental pollution, globalization, nuclear reactor, bio-terrorism etc but it's a collective process that directly and indirectly gives birth to the new diseases.

Figure: 2.3: The process leading to Health disaster



Source: Self Compiled

It is not easy to believe that during the Second World War people died due to the war rather people died by disease , hunger, starvation and other forms of chronic infections. And after that people were affected not only by ethnic wars, environmental disasters etc but people were surrounded by new forms of infectious diseases. Human security is all about protecting the life of the people by putting the human at the centre but it is not possible to achieve complete security unless the health of the individual is achieved because health directly disturbs the security of the individual. The first aim of the human security is to overthrow the lethal disease out of the body of the individual and then subsequently out of the world. But it is not possible to achieve in isolation because health is not a national issues, it's an international issue that can only be eliminated if all the international system work together..

In 1994 the Human Development Report advocated health as individual's human right and public good that each and everyone should have access to and it is the duty of the State to provide the same. But this notion has been falsified in the developing

countries because they deny these rights. In some parts of the world even the most basic rights to people like food and shelter are violated and denied. The lack of food and shelter thus creates a direct implication on the health of the individual and further creates insecurity among the people due to the infectious disease which ultimately leads to the death of the individuals. Human security is comprehensive security where health has a very important role to play. It touches every core issues that threaten the survival of the human beings in general, health security promotes human security.

2.4: SECURITIZATION OF HEALTH

The term security is contested term because it varies from people to people, and place to place. The main agenda of the security has always been the human centric, maybe from the perspective of traditional to non-traditional because national security always consists of people which make them the core of the security subject. There are many issues that are of the major concerns like the environmental, health, poverty etc that have serious effects and where the main subject for concern is human. So the security's main agenda is to protect the human beings from all these threats and to secure its identity. In order to secure the security of the individual the process of securitization is very important. But before going on to the securitization of health, the definition of securitization is very important not only that, but its process and constituents should be discussed.

2.4.1: Securitization

According to the Copenhagen School as concern of security can be brought into the lines of security issues through the act of securitization which moves from the politicization to securitization. In very simple words securitization can be understood as the process of shifting certain issues into emergency mode from the normal priorities of the government. In securitization theory, security is treated not as an objective condition but as the outcome of a specific social process: the social construction of security issues is analyzed by examining the securitizing speech-acts through which threats become represented and recognized. Issues become securitized, treated as security issues, through these speech-acts which do not simply describe an existing security situation, but bring it into being as a security situation by successfully representing it as such (Williams: 2003,

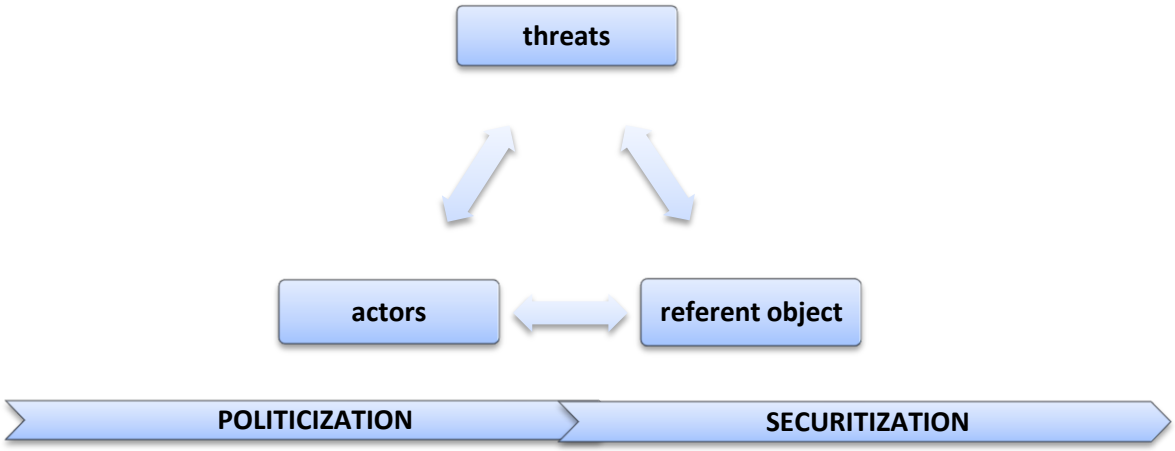
513). This speech act theory was pioneered by J.L. Austin at Harvard University in 1950's and which was developed by several other prominent philosophers. Language often encodes certain information; it has more than the literal meaning. According to Austin each speech act conveys three types of act which are;

1. Locutionary- a word of expression containing information and reference.
2. Illocutionary- it's the action after the expression of the information.
3. Prelocutionary- it's the effects after the two acts evoking a sense of feeling, beliefs, thought or action of the targeted audience (Balzacq: 2010, 56).

The Copenhagen School considers speech act to be the fore most point of the process of securitization. The securitization theory seeks to address the complex process and gives rise to the security concerns. The act of securitization can only be successful when there are three essential acts present which are actors, referent object and the most important the threats. According to Barry Buzan securitization will be successful where the issue must first constitute a threat to the state's core values as well as be incompatible with the peoples' core values. Moreover, the incompatibility between the threat and the core values of the people and the state can remain mutually exclusive. For example, the state regards terrorism as a threat to national unity, and the people regard terrorism to be incompatible with human rights or personal security. This dual incompatibility gives the state the legitimacy to conduct extraordinary measures due to its acceptance by the people, who regard such measures as being beneficial to their own existence. This dual relationship gives power to the individual thus promoting Human Security.

Where there is threat for the object like government, state, individual etc and which can only be securitized through the act of constructivism by speech act and then politicized and finally securitized. This connection can be understood clearly by this diagram:

Figure 2.4: The process of securitization



Source: Self Complied

The speech act alone doesn't make any security issues fully securitized or doesn't transfer the issues into the question of security rather it needs the audience to be convinced about the issues that the referent object is being under the security threat. In short securitization depends not only upon the speech acts but also depends upon the power of the actors in convincing the audience about the existential threats. And when threats are being discussed it doesn't meant threat to be always the physical but threats here means psychological or perceived or intangible too like the case of threats of identity issues, social etc. but sometimes the case of perceived threats gets transferred into physical threats. The complete security is never achieved as there exists the psychological threats or its security dilemma which gives rise to the notion of insecurity among the actors and state that prevents absolute security.

Securitization doesn't always mean the existence of threat or problem but it is also a political choice that is constructed accordingly. It also means the construction of danger that needs to be dealt with extraordinary measures and with this securitizing act an issue is raised from the realms of low politics to high politics. Thus securitization has an enormous power as an instrument of social and political mobilization.

2.4.2: Securitization of health issues

Health is one of the basic rights of human beings as stated by the World Health Organization but in some countries health has not been considered as an important issue. And as we can see throughout the history health has challenged the life of the people like the plague, cholera, small pox and the solution was not there. Since the 1970s, new diseases were identified at the unprecedented rate of one or more per year. The lessons of history are a good starting point for as they exemplify the huge challenges to health that have occurred repeatedly and relentlessly. Some infectious diseases that have persisted for thousands of years still pose threats on a global scale. Millions of the people around the world live in conditions of chronic insecurity, mostly because of the poverty which directly has its effects on the health. Serious infectious disease discoveries in the past decade have included Lassa and Marburg hemorrhagic fevers in Africa, variants of Creutzfeldt Jakob disease in Europe, meningococcal meningitis, Nipah virus in Malaysia and the West Nile virus in the America.

As the main component of poor health is poverty, as poverty has multiple dimensions, and many of them are inter-related, making a vicious cycle like poor health, disease and disability can prevent people from working full time, limiting their income and their ability to work to move out of poverty. Health problems for the breadwinner mean income problems, but an illness in the family can ruin an entire household. Not only is income lost, but expenses go up due to the need for medicines and health care and the need for family members to care for the sick person. Millions of people die due to the ill health and improper health facilities prevalent their. Respiratory infection, AIDS, diarrhea diseases, tuberculosis (TB) and malaria were the five leading causes of mortality from infectious disease between 2002 and 2006. Globally estimated 3.3 billion people were at risk of malaria in 2011 with the population living in the sub-Saharan Africa having the highest risk of malaria infection. Approximately half of countries with ongoing malaria transmission are on track to meet the World Health Assembly target to achieve a 75% reduction in malaria case incidence rates by 2015, compared to levels in 2000 (WHO: 2013). At the same time pandemic influenza which was at the rise and was considered as the most dangerous global health disease that took many lives.

It is pointed out that health problems are of security concerns where the public health has become an integral aspect of public health governance in the 21st century and also gives the idea of the most insecurity today is arising out of the health problem to which the whole world is facing today (Fidler: 2007, 41). HIV/AIDS has reached epidemic proportions; it destroys the very fabric of what constitutes a state: individuals, families, communities, economic and socio-political institutions, and the military and police forces which guarantee the protection of state institutions. AIDS and global insecurity coexist in a vicious cycle. AIDS contributes to national and international insecurity, from the instability of societies whose future has been thrown into doubt to the high levels of HIV infection experienced among military and peacekeeping personnel. HIV/AIDS is cause and effect, initiator and beneficiary, of instability and conflict in the world. In 2006 the UNAIDS estimated that 39.5 million people were living with HIV/AIDS, not only that between 2.5 million and 3.5 million died from AIDS related illness while 4.3 million of people were infected with these disease (Mclnnes:2012, 274). At the 54th World Health Assembly in May 2001 WHO urged the member state participate actively in improving epidemic alert and response measures to ensure global to health security.

Table 2.2 HIV/AIDs infected population during 2001-10

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
	M	I	L	L	I	O	N	S		
People living with AIDs	30.0	31.0	31.7	32.2	32.5	32.8	33.2	33.5	34.0	34.4
New HIV infection adults	2.8	2.7	2.6	2.4	2.3	2.3	2.2	2.2	2.2	2.2
New HIV infection children (thousand)	550000	560000	550000	540000	520000	480000	450000	400000	360000	310000
AIDs related deaths	1.9	2.1	2.2	2.3	2.3	2.3	2.2	2.1	2.0	1.9
People's treatment					1.3	2.0	2.9	4.1	5.3	6.6

Source:http://www.unaids.org/en/resources/campaigns/globalreport2013/factsheet , accessed 1/21/2015, 9.34pm

The above table reveals that in 2010 there were 34.4 million people living with AIDs but the positive picture of it is that the new HIV infected adults and children have fallen since 2005. Even the death rate due to this disease have fallen which was at the peak from 2004 to 2006 and then it declined. It is good to know that the number of infected HIV people is in a decline but it should be taken care that this disease is controlled and checked very carefully (UNAIDS: 2013). As the above table has given a picture that it is not hundreds or thousands of people who are infected but millions of people are infected by it which is of serious concern.

Table 2.3 Regional statistic for HIV/ AIDS affected population, 2011

Region	Adults and Children living with HIV/AIDS	Adults and children newly infected	AIDS related deaths in adults and children
Sub-Saharan Africa	23.5 million	1.8 million	1.2 million
North Africa and Middle East	300,000	37000	23000
South and South East Asia	4 million	280000	250000
East Asia	830000	890000	59000
Oceania	53000	2900	1300
Latin America	1.4 million	83000	54000
Caribbean	230000	13000	10000
Eastern Europe and Central Asia	1.4 million	140000	92000
North America	1.4 million	51000	21000
Western and Central Europe	900000	30000	7000

Source: www.avert.org/worldwide-HIV, accessed: /16/09/2014.

All these diseases like HIV/AIDS, SARS, H5N1 has a very negative impact because they have the tendency to be global in nature. The increased speed of the movement of goods and people and their interaction aggravates the concern. The outbreak of SARS in 2002-03 is an example showing that how diseases spread rapidly and this disease was originated from Guandong province of southern China in 2002 which soon spread to the whole world. With the improvement in the medicine the emergence of new kind of disease is also increasing causing much more damage. And due to the inflow and out flow of goods and people the chances of spreading and emergence of new kind of health problem are on the rise. The other disease that garbed the attention of the world is the Ebola virus the engulfed the West Africa in early

February 2014 and it is evolving in Guinea and Liberia. Infections with Ebola viruses originating from Africa cause a severe disease in humans, Ebola virus disease. Since the first documented Ebola virus disease (EVD) outbreak in Zaire (now: the Democratic Republic of Congo) in 1976, five species of the genus Ebola virus have been identified from samples collected from humans and non-human primates during outbreaks of the disease: Zaire Ebola virus (EBOV), Sudan Ebola virus, Reston Ebola virus, Tai Forest Ebola virus and Bundibugyo Ebola virus. Ebola viruses and Marburg virus, another member of the Filoviridae family, are classified as bio safety level 4 pathogens and require special containment measures and barrier protection, in particular for healthcare workers. The Ebola viruses are highly transmissible by direct contact with infected blood, secretions, tissues, organs or other bodily fluids of dead or living infected persons. Airborne transmission has not been documented and person-to-person transmission is considered the principal mode of transmission for human outbreaks regardless of how the index case was infected. Burial ceremonies are known to play a role in transmission (European Centre for Disease Prevention and Control: 2014, 2).

Figure 2.5 Ebola virus affected areas

Source:http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Ebola/Maps/accessed 23/10/2014

According to the report of the World Health Organization the total number of the deaths due to this virus is 1,013 and the number of people infected is 1,848 and 69 new Ebola virus disease (EVD) cases were registered in Guinea, Liberia and Sierra Leone with 52 of them reported lethal. Healthcare workers have frequently been infected while treating patients with suspected or confirmed EVD (European Centre for Disease Prevention and Control: 2014, 5).This occurred through close contact with patients when infection control precautions were not strictly practiced. Healthcare worker became infected through close contact with infected patients or contaminated hospital materials and medical waste. Apart from the above lethal disease other diseases also play a very important role like the disease caused by the improper water and sanitation system which are:

- Diarrhoea where 1.8 million people die every year mostly from the developing countries.
- Schistosomiasis which is estimated that 160 million people are infected with it, causing ten thousand deaths every year.
- Trachoma, 500 million of people are at risk from it.
- Intestinal helminths, 133 million people suffer from it causing 9400 death every year.
- Japanese Encephalitis, 20% of clinical cases of Japanese encephalitis die, and 35% suffer permanent brain damage.
- Hepatitis A, 1.5 million cases of clinical hepatitis A every year (WHO facts and figure: www.who.org)

Apart from this burden of disease, Tuberculosis is also seen as a global health problem. In 2012, an estimated 8.6 million people developed TB and 1.3 million died from the disease. The number of TB deaths is unacceptably large given that most are preventable. And it was estimated that the number of TB deaths among HIV-positive people in 2011 was 336,000. (www.who.org/TB). The most important in terms of global health issues is the interpersonal violence with special reference to women. The interpersonal violence i.e. domestic violence which has a long term effects towards the health of the women. It is considered as one of the factors for the death. In 2005, the

World Health Organization issued a landmark study on domestic violence that revealed that intimate partner violence is the most common form of violence that affects women. Domestic violence is known to affect women's sexual and reproductive health and may contribute the risk of sexually transmitted infections, including HIV. But the most important thing about the violence is that it is hidden and remains absent from the policy makers which complicate the health challenges. This not only results in death but sometimes it turns into depression which ultimately challenges the health of the people, women in particular. Depression is a significant contributor to the global burden of disease and effects people in all communities across the world. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life (WHO, 2012). Depression is the leading cause of the disability for both men and women. But it is observed that depression is higher in female than males which are the cause of the disease burden on women in both developed and developing countries. The effects of this depression while women are pregnant can affect the growth of the foetus and results in miscarriage or physical disability of the child.

2.4.3: Health problems of women living in slums

The problem of the slum is a global phenomenon for both the developing world and developed world. It is characterised by low sanitation facilities, water scarcity, overcrowded residential area, uncomfortable living area, poor infrastructure which leads to disaster in terms of health as well as environment. Many slum settlements are located close to or directly on top of former industrial sites, meaning that the residents are frequently exposed to toxic and chemical waste and the women are the most affected people in this condition. Not only do women have different physical needs than men, (for example, related to menstruation) but they also have greater need of privacy when using toilets and bathing. Inadequate and inaccessible toilets and bathrooms, as well as the lack of effective policing and insecurity, make women even more vulnerable to rape and other forms of gender based violence (Ganjiwale: 2012, 61).

Slums are prone to most of the disease that spread easily because of their scattered and very close surroundings, and the overcrowding itself creates health problems in the slums. The concentration of people living in small, poorly ventilated living areas increases the risk of disease transmission and other health problems. Infectious diseases thrive in overcrowded areas due to lack of ventilation, lack of hygiene and unhealthy environmental exposures. Overcrowding also contributes to stress and family violence, including child maltreatment, intimate partner violence and sexual violence, and elder abuse. In slums women tend to stay at home than compared to men not only that they are more towards the household chores like fetching water, securing food, nurturing the children etc. This makes women more vulnerable in terms of health, crime and violence. Low level of education results in the low health education, stigma and social exclusion must be cited as important intermediate determinants of health (WHO, Kobe Centre: 2005, 7).

According to UNDP the improper sanitation facilities poses a great security risk especially for women. One of the main reasons for the slum growth is the increase in the migration from rural to urban areas like the case of Nairobi in Kenya. The increase in the migration from the rural to urban the slums population is also increasing and which has a negative effect on the health of the people. Overpopulation in these areas leads to scarce water supplies and due to the lack of water supplies, garbage collection, excreta disposal, drainage, and electricity supply..?. The lack of proper sanitation system in Kenya is the biggest problem for the women in the slums. Most of the women are forced to take prostitution as their jobs because of the lack of the employment facilities create more disadvantages for the women. This kind of practices has led to the spread of sexually transmitted disease like the HIV/AIDS, gonorrhea, syphilis, herpes etc. especially among the women in Nairobi and Kibera slums. The presence of gender inequality present in the slums which leads to the insecurity of the women in terms of economic, social, health etc. Women feel insecure inside their settlement because of the rampant incidence of gender based violence prevalent in Nairobi (Amnesty International: 2010, 12).

The unhygienic condition of the area, improper sanitation system etc is not only the reasons behind the cause of health problem but other issues are also related to it like insufficient government services like the police and other government security personnel

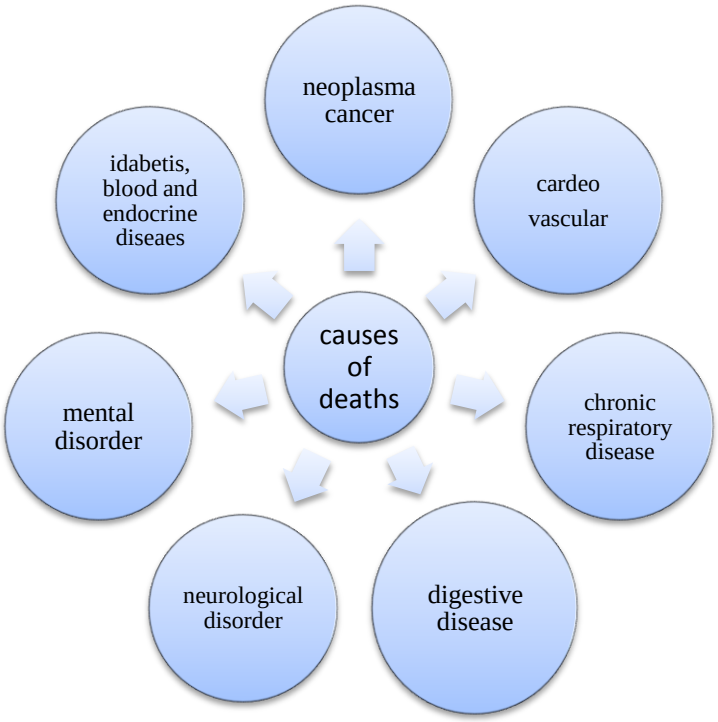
have intervened or carried out security operation; they have reportedly committed human rights violations. These include cases of sexual and other forms of gender-based violence committed by the police (Amnesty International: 2010, 14). Hygiene plays a very important role in one's life because it shapes the well being of the individual and if not taken care, it has the tendency to give birth to a new disease and creates health chaos in the world. And hygienic condition of the slums is so poor that in some cases it is the breeding ground of new diseases. The Ministry of Health and Family Welfare itself admits that the health indicators for the urban poor are worse than those of the rural poor due to the unavailability of urban Primary Health Care (PHC) and poor living conditions. Moreover, the sanitary system, hygiene practice and awareness of communicable or non-communicable diseases are very low among the slum dwellers. When availed, the poor population more often fails to use health services effectively for lack of knowledge and education. Their earnings are so low that the expenditures for healthcare are unaffordable for them (Jaishree: 2012, 62).

As the social structure present in the society also shapes the health of the women and even it's a disadvantage for her. In Bangladesh the health care facilities are provided according to the status of the individual in the household and due to the low status of the women and girls in the house, less money is spent for the medical treatment of females. This can be traced when the Bangladeshi cholera epidemics encircled Dhaka, the affected women were not taken into the hospital and this disease was more severe to women than men (Democracywatch: 2010, 4). The most important factor that guide the health of the individual is his surroundings or environment to which they dwell and most of the area to which the slums population resides is in very unhealthy place which directly hampers the health of the community. In some places of Johannesburg the slums are in the area of toxic waste land which is very dangerous, likewise the slums in Belo Horizonte and other Brazillian cities are prone to the slope failure and landslides. Rio de Janeiro's more famous slums are built on equally unstable soils atop denuded granite domes and hillsides which frequently give way with truly deadly results: 2000 killed in debris flows in 1966-67, 200 in 1988, and 70 at Christmas 2001. The worst natural disaster in the postwar United States, meanwhile, was the avalanche following heavy rains that killed some 500

people in the shantytown of Mamayes, built on a precarious hillside above Ponce, Puerto Rico (Davis: 2006, 122).

Disease are rising very rapidly like the population of the country even the Non Communicable Diseases are on the rise especially among the working women from the urban slums in low and middle countries where there is the rise of the Non Communicable Diseases. In developing countries, four Non Communicable Diseases dominate. Cardiovascular diseases, cancer, and chronic respiratory illnesses cause 80 percent of the deaths and two-thirds of the disability from NCDs in these countries. Death and disability from Non Communicable Diseases in low and middle income countries is increasing than the rate of decline from communicable diseases (Daniels and Donilons: 2014, 11).

Figure 2.6: Deaths due to NCDs



Source: Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2013

The reasons for the rise in the Non Communicable Diseases are due to the rise in the population with the rise in the slums pockets, globalization, pollution, new technologies, poor health regulation and protection. This all led to the global health challenges and causes of large number of premature death of the children and women.

CONCLUSION

It is a fact that international discourse on traditional security was dominated by realist perspective. But in the post cold war era traditional security has been broadened to non-traditional realms focusing majorly on human security. And the most important drawback of the security is that by making a security issues leaves nothing a security issues in the end which automatically making everything a priority by the process of securitization but here lies the major understanding that a issues can be securitized but without politicization nothing becomes an security. It's the politicization that creates the ground for the security and its emergency. It's the politic sensitivity that decides whether an issue is a security issue or not. And health is a matter of concern because of its negative effects on the globe and its flexibility. The survival of human is the most important target of the security which is also the sole aim of the human security too.

Though humans are threatened by different factors like the non-traditional threats but it should be kept in mind that traditional threats also can cause serious human security issues because the no traditional security has the tendency of creating chaos in the international security agenda which automatically leads to the securing the well being of the state. It's not that mere keeping the physical well being of the people as the agenda of human security but psychological well being as well in order to achieve full security. And when discussing the human security the health of the people is of importance as it has the capability of ruining the whole nation. The virus like SARs, HIV/AIDs, H5N1 influenza has created disorder in the world politics and there are many instances of using these viruses are the weapon of war by the terrorist groups which has serious effects on the health outcomes. Therefore health issues have become the most important and latest social, political, environmental and economical issues and where the securitization of health is up most important agenda at the national and international level. If we look into

the other side of the health implication on the world it's the one factor that brings the whole world into one umbrella. It creates a ground for co-operation and integration and helps in overcoming the issues together. It should not be dealt separately, it's a collaborative process.

But debate, discussion and implementation of health security has been focused primarily on masculine gender ignoring women that constitute half of the population. So health security could not be achieved in its appropriate sense in the militarized patriarchy system where women suffer from structural violence of the society and also become victims of physical abuse and explicit violence. In the end, the need to securitize health of women in the ambit of health security has become an inevitable and imperative in the contemporary society. In this regard, humanity as a whole has the core of the security agenda need to be studied and analyzed specifically focusing the health issues of women living in the slums who are the most vulnerable part of the society and also they are the main pillars of all society and family who look after well being of all.

CHAPTER- III

HEALTH SECURITY: A NATIONAL APPRAISAL

INTRODUCTION

Health is increasingly being recognized as the most crucial factor in national security discourse because it has the potential of engulfing whole world. In order to fight security issues government and institution at national and international level have launched and inaugurated many health schemes, policies, laws and programmes. In terms of availability and accessibility there are many health institutions for the masses but the system is not much accessible and approachable for the people. The socio economic factors play very negative role in the health of the women in the slums and though there are development in the health infrastructure and health care system but there is also decline in the utilization of these infrastructures by the people. There are many reasons for the underutilization of this infrastructure like the socio cultural aspects of the society, economic, education, gender bias which prevail in the slums of India as well at the international level. So in this chapter the underutilization, accessibility and availability of health infrastructure by the women living in the slums will be examined to understand health issues, laws of the women labourers in the slums. This chapter consists of six themes where it attempts to underline many issues in terms of health of the women labourers living in the slums of India not only that the schemes, policies and programmes concerning the health of the women labourers in the slums have been discussed.

3.1: Health as a National Security issue

Health cannot be treated separately and far away from the field of security because it has the long growing tendency to ruin the future of the nation by its dangerous effect on the world. When we talk about security, health is one of the important components that shouldn't be out of the focus from the policies makers and the government. Health security is the most essential part of the individual as well as the nation, in short health determines the well being of the nation and has an immense potential to create a chaos in the world. If we trace back to the history, health has always been the most prioritized issue in terms of the national security agenda. For example

during the Peloponnesian War, disease demoralized the Athenian people, undermined the political leadership, and weakened the army, preventing it from achieving key military objectives. 1918 influenza epidemic killed 25 million people, including 500,000 Americans. The Spanish flu struck 294,000 allied troops in the fall of 1918, alone. Nearly 23,000 died, and the disease caused significant, if short-lived problems on both the allied and German sides (Peterson: 2002, 45).

In the case of the HIV/AIDS which is one of the serious health bizarre that is shaking the security of the world and this pandemic disease not only led to wide spread of humanitarian concerns but it also led to the serious security issue most significantly by the United Nation Security Council. In 2000 the Security Council made a Resolution 1308 that set an agenda for the debate on HIV/AIDS as the, national security issue to which it has the tendency to affect the militaries and peacekeepers. The spread of HIV is the serious cause for the outburst of the violence in many places. It is a real security issue like in the case of the sub Saharan Africa where the highest rates of HIV/AIDS infected people were in the military especially in Malawi and Zimbabwe (McInnis: 2008, 280). The cause of the presence of the infection are the use of this virus as the weapons of war that damages the well being of the nation by weakening the militaries. In a little over two decades the spread of the disease is such that UNAIDS estimated up to 44 million people were infected and over 3 million of people died because of AIDS in 2004 alone of which most of them were children and women (www.unaids.org). This disease not only affects the peace of the nation but it also hampers the economic stabilities of the country because the presence of diseases disturbs the immunity which reflects on their working capabilities and gradually slows down the working value of the workers and disturbs the production of the company to they work. Health has the tendency to disturb economic, political, social and military stability. As the pandemic disease creates extra burden on the state in terms of financial matter and even the in social relation between the states which has a direct effects on the economics of the state. By causing severe economic, political, and social effects, epidemic diseases can produce domestic instability, civil war, or civil-military conflict, or it may lead a state to lash out against another State. In addition to the growing threat from resistant bacteria, previously unknown pathogens in humans are emerging and spreading primarily from animals like the SARS, which was

first came to the scene in the Guandong province of China in November 2002 which spread like wildfire. It was estimated that the number of the countries that were affected by these disease were 29 countries. Though the effects of the SARS was not so much but it showed that how a small diseases could get transferred from one place to another if not treated well before hand. It gave a serious check on the new emerging disease that had direct and indirect effects on the health of the people (Zhou and Yan: 2003, 34).

The most dangerous effects of the health are when it is use as the weapon of war. The use of these pathogens in the war can be traced back to the time of the cold war where the infected corps of the soldiers were used as the weapon of war so that the opposition team's army could be infected and lose the war. The other scenario can be looked in the time of the 9/11 attack of the mailing of the anthrax in United States. The effects of these infectious diseases are not the concern for one country it's the concerns for the entire world because it has the tendency of moving from one place to another. The Aum Shinrikyo, multinational terrorist group intend to develop a weapon of mass destruction in the Tokyo subway system in 1995 by using anthrax and botulism. The recent developments in medicine, hygiene, and public health have virtually eliminated widespread disease from industrialized countries like the U.S, making pandemics of new or emerging diseases as national security issue. The changes in agricultural practices have created new ecological niches for disease vast bovine, avian, and swine farms, in huge numbers and often in close proximity that can facilitate cross-species infection. Transportation of persons, animals, and food products around the world also presents a serious problem. New pathogens are emerging at an increasingly accelerated rate. A disease can change in several important ways: it can jump to a new species (swine to human), change transmission method (blood-borne to aerosol dispersion), become more lethal, or become drug-resistant. Emerging diseases or those thought to be wiped out are becoming more of an issue with globalization and changing societal practices (Evans: 2010, 102). The connection between the bio terrorism and the natural disease is the same as both of them has the same consequences which affect the health of the individual and the resolution for both of these should not be taken as a different subject.

In October 2009, the Centre for Bio Security of UPMC organized a conference that addressed many of the issues pertaining to the threat of biological weapons attacks. The Director of the Centre referenced a recent National Intelligence Estimate that identified bioterrorism as the intelligence community's most important WMD concern, because the knowledge, equipment, and pathogens required to construct a biological weapon are now globally dispersed, and there is no single technological methodology checkpoint or process that can be regulated to prevent the development of biological weapons (Gronvall: 2009, 433). The development of these weapons creates a huge burden on the government and this cannot be sort out so easily because of the presence of the illicit activities that helps in worsening the health of the individual. The trafficking of these weapons creates very negative health consequences which damages the well being of the world. The illicit activities have a very negative health outcome which is illustrated in this table:

Table 3.1 Illicit activities and Health problems

Illicit activities	Health implication
Trafficking of illicit drugs	Increases and sustains widespread addiction to illicit drugs, increase in morbidity and mortality from the use of illicit substances
Smuggling of people	Health risks to undocumented migrants when being smuggled increased risk of transmission of STDs from commercial sex workers.
Smuggling of goods	Increase supply of cheaper cigarettes, increase morbidity and mortality from tobacco related disease.
Illegal weapons sales	Increased risk of injury or death from weapons.

Source: McInnis and Lee: 2006, 19.

These illicit commercial activities of the world have a negative impact on the health. Every year millions of women and children are migrated from the world as

sometimes they fall into the prey of the sex workers and many of them become a slave or bonded labour. The commercial sex workers are transmitted from one place to another place where some are infected with the sexually transmitted disease which creates a high level of health disbalance. These trafficked women and children are used as the weapon of the war and plays a major role in the disturbing the peace of the world. Nigeria has been identified as the main centre for human trafficking where women and girls are the main victims. The result is that these women and girls are frequently recruited for sexual exploitation. Trafficking victims are forced to endure intercourse with multiple partners. They are also hired for pornography and bestiality. These conditions are experiences that make the women vulnerable to multiple abortions, STDs and other female reproductive health challenges that are increasingly responsible for the spread of HIV/AIDS (Burkhalter: 2003, 419). The most negative implication of theses pandemic disease is the rise and the use by the terrorist groups. Health and disease are the two main issues that should be taken care of because of its tendency to be used by the terrorism group which is of serious concerns for national and international communities.

3.2: Women's health and national security

Throughout the history disease has caused serious trouble in people's life and even to the national security. Disease has decimated militaries, altered or cancelled military operations and often caused more deaths in wartime than combat. The Black Death in Europe and smallpox among native populations of the Americas were so severe as to shape the political and demographic composition of the modern world (Feldbaum: 2009, 2). Threats to human security take different forms depending on upon the location and geography of people live and their socio-economic status. In addition, security threats for men and women differ, in particular in war and conflict. Throughout the history, when it comes to addressing the issues of national, state or even economic security, women have been effectively marginalized. If we look towards the social structure of the world it is dominated by the patriarchy system where the domination of men can be seen in the entire field like in economic, social, political and cultural settings. Many women in Jammu and Kashmir and Northeast India are afraid more of the sexual violence than of bombing or armed conflict. In certain matters the security need of the women and girls

are neglected and often their issues are not even considered as the security issues by the policies makers. When it comes to the war situation women and the girls are the most victimized people or can say as the easy prey. As women and girls are the main target during the war time they are not only sexually assaulted but they are also regularly killed and maimed. They are also sexually and physically assaulted and exploited by the people who are sent to protect them like the peacekeepers, aid workers, guards and police (Whitworth: 2008, 111). More insidiously humanitarian workers fuel markets for trafficked women in brothels and as domestic workers and labours. Women may enter into sexual relationship in exchange for food and shelter. The prostitute women are also prone to forceful arrest, physical assault and sexually harassed. In some cases police are the part of the human trafficking business and receive bribes for every transaction. Prostituted women have a high probability of acquiring sexually transmitted diseases, including HIV/AIDS. They commonly suffer unwanted pregnancies, infertility and miscarriage. Many experience serious post-traumatic stress disorder. Many slide into drug and alcohol abuse. Suicide rates are high among the women who are into the sex business. It's not about the protection of the women or girls from the physical violence which of the main issue but her core value should be securitized or should be the main aim of the government. And here the core value of the women means her identity as women, one of the most important members of the state which is often neglected by the state.

Domestic violence against women is often ignored by the militarized notion of state security. In fact commonalities between battered women and political prisoners and between rape survivors and combat soldiers traumatized by war can reveal the links between the private domain and state security (Herman: 1992, 2-3). Rape and other forms of other treatment of women have been employed as the tools of military strategy. The rape and deliberate impregnating of thousands of women like in the case of Muslims in Bosnia and Herzegovina used rape and violence of the women as the form of tools for ethnic cleansing which was conducted by the Serbs nationalists (Jeong:2000, 76). There are three major problems with the present international security system that prevent it from assuring the condition of comprehensive human security are:

1. It is dominantly masculine rather than fully human security
2. It is dominantly masculine rather than fully human in conception
3. It is designed to achieve the security of the state rather than that of the persons or human groups (Reardon: 2010, 16).

Women have the greatest stake in peace since they are often the involuntary victims of conflicts. Whether or not they actually participate in conflicts or not but the sufferer are always women. They lose their brothers, husbands and sons and, thereby often their very livelihoods; besides carrying permanent emotional scars because in the times of the conflictual situation they are the ones who lose their husband, brothers, son's and their loving ones. In many countries especially in India female are considered as the financial burden to the family and her gender role prevents her from getting all the basic things like the health facilities and often girls receive less food, making them much vulnerable to the disease which has the tendency for the genesis of new pandemic disease. The social inequalities that are presented in the societies are the main determinants for the rise of the new disease in the world threatening the state and the international order. The World Health Organization identified violence against women as epidemic throughout the world and a key public health concern. Interpersonal violence is the tenth leading cause of death for women between 15 and 44 years of age (Clark and Mon: 2003, 54).

The effects after the conflictual situation is very negative for the women especially for the pregnant women because they face stress which sometimes lands up in having depression or psychological disbalance which has a negative impact on the unborn child which ends up in having miscarriage or physical or mental defect for the newly born child. Women and adolescents have the highest rates of new HIV infection. Mother-to-child transmission of HIV, either during birth or breast feeding, contributes to increased infant and child mortality. At the same time, women and girls may have limited access to HIV/AIDS education and prevention, because of taboos around discussions of gender-based inequalities and sexuality, which limit their ability to make sexual and reproductive decisions free of discrimination, coercion and violence. The use of sexual violence as a strategic and tactical weapon of war contributes to the spread of STIs, including

HIV/AIDS. In Sierra Leone, it is estimated that 70 per cent to 90 per cent of rape survivors had contracted STIs. Abducted girls were at a particularly high risk due to the many episodes of sexual violence. Fear of stigma related to sexual or reproductive health may prevent women and girls from seeking testing for HIV or healthcare (UN Secretary General: 2002, 20).The health of the women is of concern for the government and in the international level. But health of the women is always neglected because of her gendered natures that follow her any where she goes. There is overwhelming evidence that HIV/AIDS infection is increasing among women than among men. A UNICEF document reports of 2001 that in 1998 around 43 per cent of all people over 15 years of age living with HIV/AIDS were women. The Indian National AIDS Control Organization in 2001 reports that the HIV epidemic in India continues to shift towards women and young people with an accompanying increase in vertical transmission and paediatrics HIV (UN Secretary General: 2002, 25).

In India the spread of HIV is very complex and it occurs through drug users by injecting themselves who affects their wives too. Prevalence levels also vary significantly by region. The southern states have a higher HIV prevalence level, with high risk groups consistently showing levels above five percent and rates in antenatal clinics exceeding one percent. These levels indicate that the epidemic is poised to spread to the general population. The states of Gujarat, Goa, Kerala, West Bengal and Nagaland have prevalence levels in excess of five percent in high risk groups, but less than one percent among women attending antenatal clinics. In these states the epidemic is still confined to the core transmitters. In the remaining states prevalence is below five percent even among high risk groups (Middleberg: 2003, 39). Apart from HIV/AIDS the other disease that threatens the health of the women is mental health that directly affects the health of the women. WHO estimated that with over 300 million people of the world is suffering from mental problems and depression itself is expected to be the second largest contributor of disease burden by 2020. The mental health is increasingly finding itself on the global radar of health hazards. Mental health and ill-health are largely determined by multiple and interacting social, psychological and biological factors. Evidence suggests that psychological disorders are more prevalent among people with relative social disadvantage (Desjarlais, Kleinman, Eisenberg and Good: 1995, 45). Risk factors for

poor mental health, including violence, childhood neglect, family breakdown, financial insecurity, and family history of psychiatric disorders, loss and bereavement, have always put women in a disadvantage position. Epidemiological and anthropological data reveal a consistently high prevalence of mental disorders among women, cutting across all barriers. As per WHO estimates, one in every three women worldwide is found to be afflicted by common mental disorders such as depression, anxiety and somatic complaints. While depressive disorders account for approximately 42 per cent of disability from neuropsychiatric disorders among women, their prevalence among men is only around 29 per cent. Some of the leading problems of the elderly depression, organic brain syndrome and dementia are reported to have a disproportionately high representation among women (Basu: 2012, 129). Disease should not be over looked because one small wound can become a big health issues today.

The violence against women whether physical and psychological violence is regarded as the violation of human rights by the International communities. The *Platform for Action* of the UN Fourth World Conference on Women in Beijing in 1995 further elaborated the nature and scope of gender-based violence, acknowledging that there can be no development without equality, and that as long as violence is tolerated, development becomes more elusive. The *Beijing Platform for Action* identifies twelve critical areas of concern which is shown in the following table:

Table 3.2 Critical Areas of concern listed by the Beijing Platform for Action

1.	**the increasing poverty of women**
2.	**education and training of women**
3.	**women and healthcare**
4.	**Violence against women**
5	**The effects of conflict upon women**
6	**Women and the economy**
7	**Women in power an decision making**
8	**Mechanism to promote the advancement of women**
9	**Promotion and protection of the human rights of women**
10	**Women and the media**
11	**Women and the environment**
12	**Girl child**

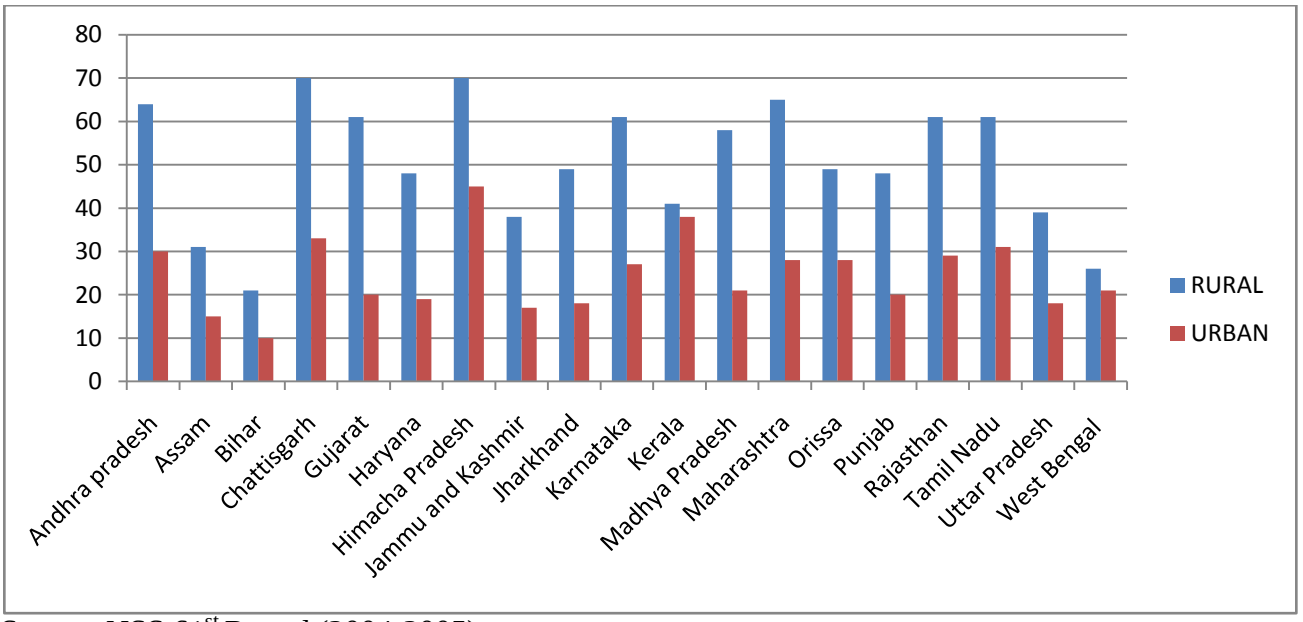
Source: Vlachoud and Biason (ed): 2005, 5.

Amartya Sen estimates that more than 60 million women are demographically missing from the world as a result of sex selective abortions and female infanticide in China, South Asia and North Africa. Infanticide has been practiced throughout human history in societies where boy children are valued, economically and socially, above girls. Advances in technology permit the modern horror of selectively aborting female foetuses. Medical testing for sex selection, although officially outlawed, has become a booming business in China, India and the Republic of Korea.

3.3: Women's health and work

In today's world women and men plays an equal role in the labour workforce participation. They have equal right in choosing their work and work accordingly to their comfort. Here the work is defined by the Census of India as participation in any economically productive activity with or without compensation, wages or profit. Work involves not only actual work but also includes effective supervision and direction of work. It even includes part time help or unpaid work on farm, family enterprise or in any other economic activities. In census a person is categorized as a worker if she/he had participated in any economically productive activity at any time during the reference period, which is normally one year preceding the date of enumeration (Census of India: 2001).Apart from working in the formal sector like in the corporate sectors, teaching, professional sectors etc, women tend to work more in the informal sector like domestic workers, vending, daily wage labour etc. and it is found that women from the rural areas has high rate in the labour work force participation than women from the urban areas.

Table 3.3 Female labour force across select Indian States



Source: NSS 61st Round (2004-2005).

Women tend to work more hours at home and fewer outside of the home, and they usually take primary responsibility for family well-being. Women have been highly satisfactory on routine, monotonous, repetitive, painstaking, intricate jobs. Most mass production jobs fit exactly into that description routine, monotonous, repetitive, painstaking, and intricate. (Anderson: 1943, 275). The women can work and do their task accordingly which is one of the plus points for them and also as their weak point because due to this nature they are always exploited by their boss or their male working partner in the working place. If we trace back to the history, during the industrial revolution women and children were the ones who used to get jobs very easily especially in the labour division because they are the one who used to work on a very low wage without any compensation or health facilities. This created a very negative effect on their health because most of the work was done inside air seal room without any ventilators and their work related with the chemical products which deteriorated their health (Rao: 2000, 236).

According to the International Labour Organization (ILO), each year an estimated 2.2 million men and women die from work related injuries and diseases and 160 million new cases of work-related disease arise. Women's work related injuries and disease are very less reported and the women's occupational health problems are under diagnosed. In developed countries, women are more often exposed to some physical risks, such as

highly repetitive movements, awkward postures, and biological agents in jobs where there is higher exposure. Women are exposed more often to some psychosocial risk factors such as psychological and sexual harassment and monotonous work. The most important health implication in working place is the sexual harassment which directly affects the psychology of the women which creates low working esteem for women. This may be one of the side but the other side of the working women is that when women is a working or taking part as the labour force participation where her income provides women with economic independence and increases their power in the household unit. And it also gives us the picture that employed women have much better physical and mental health than full-time homemakers (Sorensen: 1987, 30).The rates of depression are high among women rather than men, as this depression is caused by number of factors like violence, poverty, mental pressure etc, which creates a psychological disorder and disturbs the health of the women. Rape is a very much underreported crime that can have profound and prolonged impact. But workloads, socio cultural role of women are the main reasons for damaging her health. The family or household is most important, not only because it is the place where health behaviours are learned, practiced, and reinforced but also because it is where most short term acute and long term chronic diseases occurs.

3.4: Health issues in slums of India

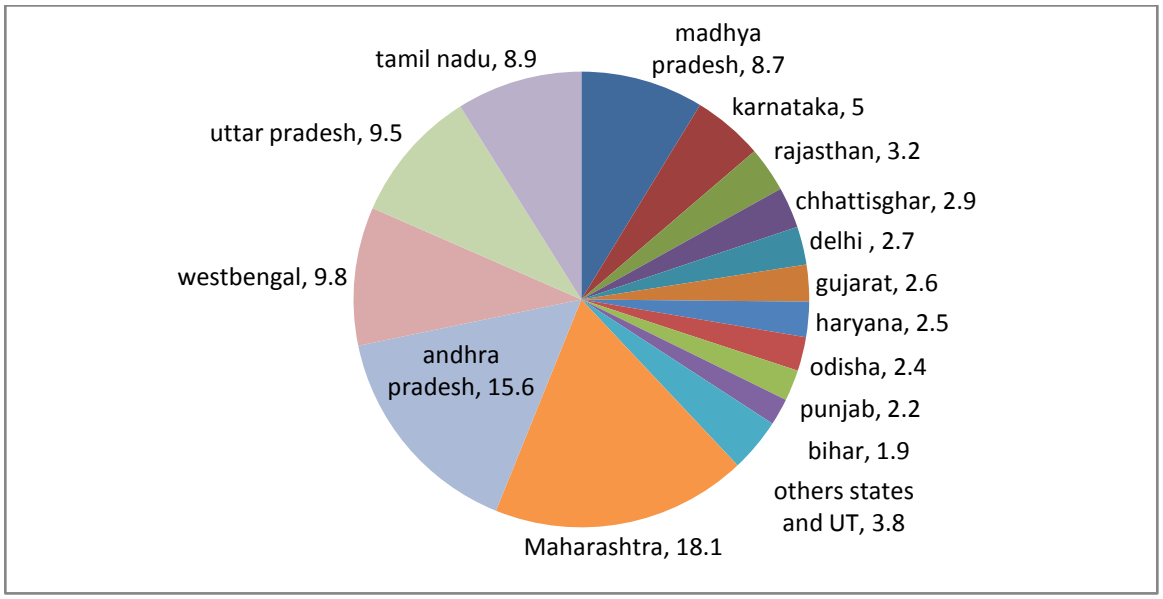
Health has always been the key indicator of well being of the State. Under Section-3 of the Slum Area Improvement and Clearance Act, 1956, slums have been defined as mainly those residential areas where dwellings are in any respect unfit for human habitation by reasons of dilapidation, overcrowding, faulty arrangements and designs of such buildings, narrowness or faulty arrangement of streets, lack of ventilation, light, sanitation facilities or any combination of these factors which are detrimental to safety, health and morals (Census of India: 2011). As per UN Habitat a slum is characterized by lack of durable housing, insufficient living area, and lack of access to clean water, inadequate sanitation and insecure tenure. And in 2011 three types of slums have been defined in census, namely, Notified slums, Recognized slums and Identified slums.

i. All notified areas in a town or city notified as ‘Slum’ by State, Union territories Administration or Local Government under any Act including a ‘Slum Act’ may be considered as Notified slums.

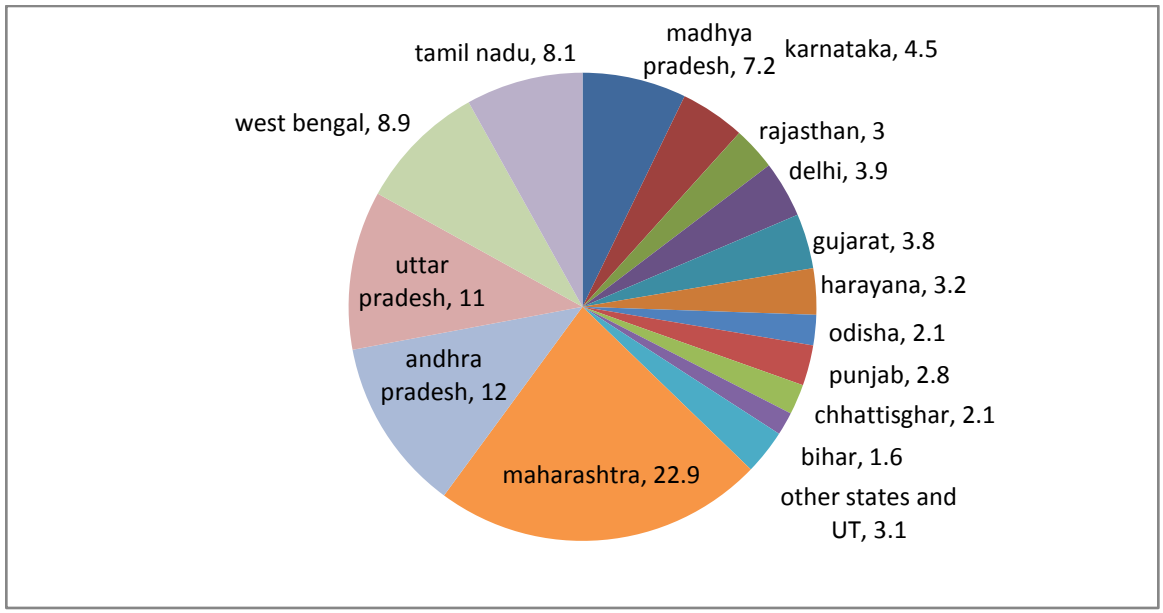
ii. All areas recognized as ‘Slum’ by State, Union territories Administration or Local Government, Housing and Slum Boards, which may have not been formally notified as slum under any act may be considered as Recognized slums.

iii. A compact area of at least 300 populations or about 60-70 households of poorly built congested tenements, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities. Such areas should be identified personally by the Charge Officer and also inspected by an officer nominated by Directorate of Census Operations. This fact must be duly recorded in the charge register. Such areas may be considered as Identified slums (Census of India: 2011).

Figure 3.1 Comparison of Slum population in India 2001 and 2011 (Census 2011)



2001



Source: Primary Census Abstract for Slums, 2011, Office of the Registrar General and Census Commissioner, India.

The slum population in India has increased from 2001 to 2011creating a very little space for improvement and not only that the condition of the women's health is also going from bad to worse in India. This health of the women is not just the physical well

or reproductive function but women's health connotes women's capacity to produce, rare, nurture children and to contribute to the society as the member of the state (Weisman: 1997, 179). Women's health is often referred as women's reproductive system namely wombs, breasts and vaginas. Women's health is all about health issues that affect women and recognizing the diversity of women's lives and the diversity that exists among women. Women's health is based on an all encompassing view of health whereby, "health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" and has as its starting point personally-defined needs (Brown et.all: 2001, 4). Women's health is an issue which has been taken up by many feminists, especially where reproductive health is concerned. Women's health is not confined with women only but it is concerned with the health of their children they bear, not only that she shapes her families, a productive member of the communities, contribute to the work force and builds a base for economic security of the nation. But it is seen that girls and women have lower level of mortality and burden of disease and the case of women in the slums are even much worse that the women in non slums areas (Nashid and Rashid: 2004, 120).

The most important determinant for the health of the family is the socio economic status. In India the growth in population and increase of the poverty is the major factors that are affecting the growth in the slums and the reasons for the ill health of the women in India. The increase of the slums population directly indicates poverty and other issues like improper sanitation facilities, drinking water facilities, health care facilities etc. They are exposed to violence, crime, and disease not only that they are vulnerable to natural disaster too. And most importantly lack of education and information further increases the problem in the slums. All these factors determine the health outcome of the individual.

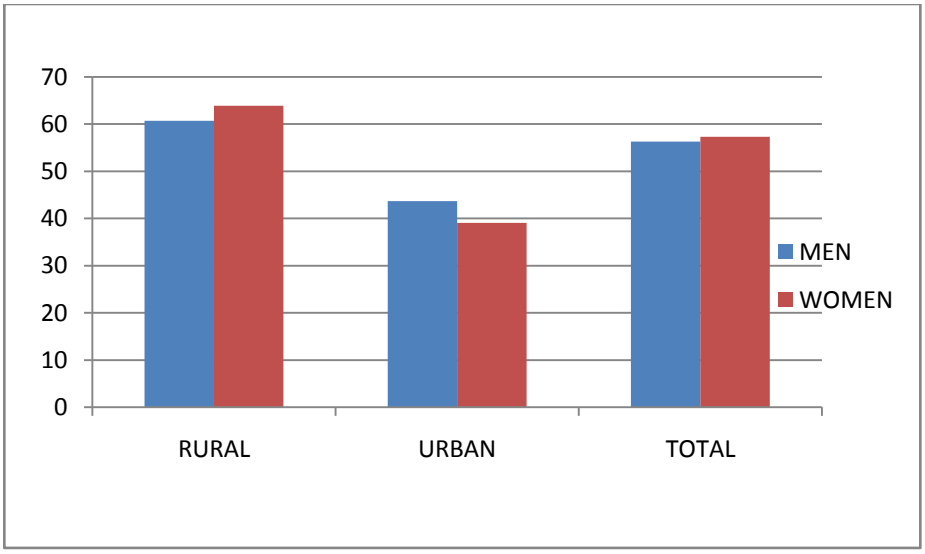
India is a patriarchal state where women are subordinate to men and the health of the women is intrinsically linked to their gender role and the prevailing patriarchy system in their society. The contribution of women to their families is often over looked in many cases and instead they are or considered as the economic burden for their family. There is a strong preference for sons in India, as sons are expected to take care of their parents as

they grow old. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. The preference of son leads to the so many female foeticide and infanticide. The girl child is killed without opening her eyes. Technologies like amniocentesis and ultrasound used in most parts of the world which are used largely for detecting foetal abnormalities, but lately it has been used in large parts of the Indian subcontinent for determining the sex of the foetus so that it can be aborted, if it happens to be a female. This system leads to the ill health of the women creating much big health consequences like uterus cancer, STDs, UTI, RTI etc. To prevent female foeticide and to restrict this misuse, the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act was passed on 20th September1994 (Saravana: 2000, 2). The Act forbids the communication of the sex of the foetus, but the enforcement of this act is not easy because of the silence of the women and mostly these issues are operated within the rural area and even in the slums in India. The information of the sex of the unborn was being extensively misused. Further, the majority of Indian women have low levels of both education and formal labour force participation. Women typically have very limited autonomy, firstly living under the control of their fathers, then their husbands, and finally their sons. All these are concerned with the health of the women and many of the health problems in India is related to high level of fertility. High levels of infant mortality combined with strong son preference, motivate women to bear large number of children which has very negatively effect on the health of a mother. Around 92 per cent of the women from slums and non slums area have gynaecological problem (www.swayam.info). And the health case of the women living in the slums is even worse. Slum dwellers were found to be disadvantaged in terms of maternal health services, compared with households residing in non-slum urban areas.

Poor health of the women in the slums is associated with the unhealthy living conditions, high fertility rates, inadequate hospitals, and low uptake of maternal health services. India contributes to 26 per cent of global burden of maternal deaths with nearly 136,000 women dying annually where the cases are related to pregnancy and childbirth. In Uttar Pradesh alone 21, 450 maternal deaths occurs every year because mostly the deliveries were done in the home itself which ended into the death of the mother. <www.unicef.org/india/health>. Pregnant and lactating mothers require additional

nutritional and physical care. In many slums area, the additional energy and micronutrient needs of pregnant mothers are not met. The result is high rate of low birth weight of a child which sometimes leads to death, impaired immune function, poor cognitive development, and chronic diseases later on in adulthood. Complications during pregnancy, childbirth, and breastfeeding are often untreated due to poverty and unhealthy living environment. Such complication can result in high maternal and infant mortality rates. Every year over 100,000 Indian women dies due to pregnancy related factors. India has a high maternal mortality ratio approximately 400 deaths per 100,000 births. This ratio is 56 times the ratio in the United States (World Health Organization).

Figure 3.2 Early Childhood Mortality Rates by Sex in India



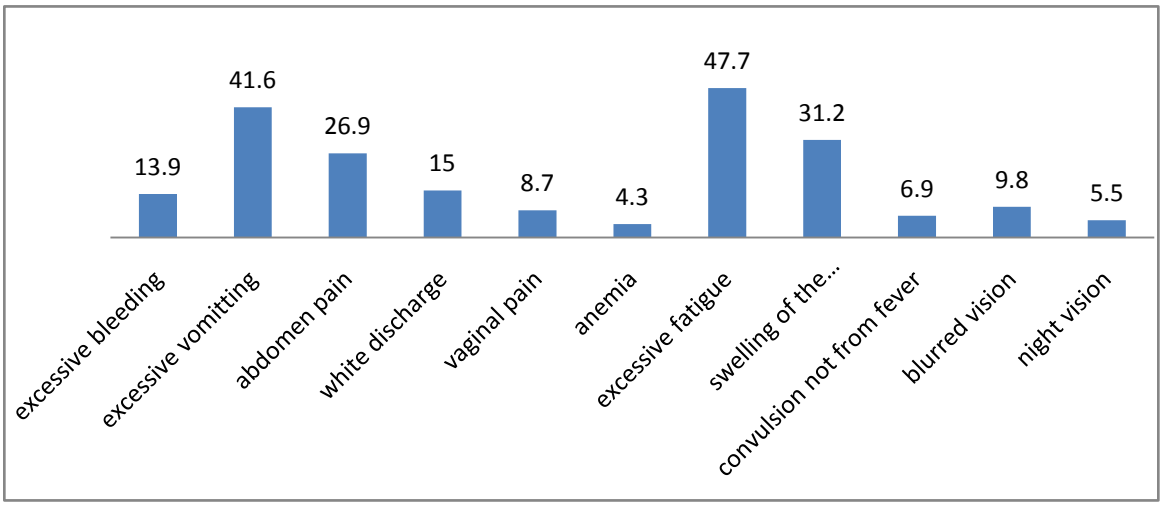
Source: NFHS, 2005-2006.

The rise of urbanization not only indicates the process of economic development of the country but it also cause for the rise in the slum population too. In order to have a better life and future people from the rural area migrates form their land to the urban areas for better opportunities which is in turn resulted in the development of squatter settlements and slums especially in metros and in large cities. And lack of many things and poverty creates different problems for them. In the slums of Meerut children is either not going to any schools or they are either dropout because of the low economic standard of the family which compel the children to search for work and to earn for their family living. They have the high number of children in a family, as they believe that more

members in the family mean more earning members. This creates maximum number of children trafficking especially girl child who fell into the prey of prostitution business, bonded child labour or slavery etc. Most of the children and the family are uneducated which creates health hazards among them and the female running houses have lots of problem because of the double work which has the tendency of mental disorder due to the excess stress and over load of work. And the lack of proper information the women in the slums of Meerut the antenatal care for the women is very low (Sajjad: 2014: 60).

Antenatal care provides a preventive service that monitors pregnancy for signs of complications, detects and treats pre-existing and concurrent problems of pregnancy, and provides advice and counselling on preventive care, diet during pregnancy, delivery care, postnatal care and related issues, thereby reducing maternal morbidity and mortality, if delivered effectively. In Ramabai Nagar slums in Mumbai the women in the slums remains remain unaware of their own reproductive health problems occurring during pregnancy such as danger sign for pregnancy, excessive bleeding, anaemia, diet care during pregnancy and blood pressure checks etc. and all these occurs because of the knowledge and also from the surrounding to which they dwells (Sarode: 2010, 86-87).

Figure 3.3 Antenatal Care Services during pregnancy in Ramabai Nagar Slum Hill, Bhandup, Mumbai, India.



Source: Sarode (2010) 86.

Access to water and sanitation services and the fulfilment of these fundamental human rights is experienced differently by men and women. The lack of access to sanitation and drinking water affects women and girls disproportionately, by impacting on their health and dignity. Women without water facilities and supplies and toilets within their homes have the tendency of sexual violence when travelling from the public facilities, open space to their home. Lack of access to water and sanitation services is a continuing problem in India. A study in 2010 conducted by the Water and Sanitation Programme of the World Bank estimated that inadequate sanitation costs India $US53.8 annually. The case of water and sanitation problem is similar case for all the slums in the world with particularly with that of women and in case of Delhi the multiple agencies are responsible for a variety of water and sanitation services for various parts of Delhi. The improper sewage system and the lack of latrine in the slum household are creating major health as well as environmental problem in India.

Table 3.6 Latrines and Sewage disposal in recognized and unrecognized slums in India

	Government recognized slums (%)	**Government unrecognized slums (%)**
Without latrines	17	51
Availability of individual septic tanks	66	35
Availability of underground sewage	30	15

Source: Indian census data, 2001.

It is not food which is the main determinants of life but also proper sanitation, water facilities, health facilities etc, are major issues that one must focus on because each of these factors has direct effects on the health of the individual. Water and sanitation creates extra burden on the working women in the slums because apart from the work load she has to manage for the water for her family and sometimes due to the lack to the access to water she has to go to fetch water which sometimes results in sexual violence

and even during the time of using the public latrines or open space as most of the slums lack public latrines.

India is considered as the worst country when the issues of sanitation are discussed and in Chennai the slums and non slums people have to depend on a few toilets especially in the market place, bus stops, informal work place, and pedestrian traffic and away from the slums area. Some of the toilets are not used because of it poor maintenance, the care taker is usually absent, locked at night, charges fee for the public toilets etc. Chennai has only 714 toilets for 46.81 lakh of people where 85 per cent of these toilets are used by the slums dwellers without water facilities and the lights (Census of India provision population totals: 2011).

Home is a place where WE feel secure and safe with the love of their parents and their family but the situation is not the same today maximum number of violence that occurs are inside the four wall of home. Rape is not often done by the unknown person but in reality most forced sex is committed by individuals known to the victim such as the intimate partner, male family members, acquaintances, and individuals in position of authority. For many girls and young women, their first sexual encounter is coerced, with younger girls more likely to experience sexual coercion at initiation than older ones. The worst form of the domestic violence is when a women is pregnant and in India one half of the women are reported to be abused during the time of pregnancy and not only that suicides and attempt to suicides are mostly associated with the inmate partner violence or family violence (Anithakumari: 2010, 300). One of the main originators of the inmate violence is the consumption of alcohol. Where sexual violence occurs in girls and young women, risk of transmission is also likely to be higher because girl's vaginal tracts are immature and tear easily during sexual intercourse. Evidence of direct transmission of STI and HIV following sexual violence is difficult to establish (WHO: UNAIDS Initiatives). And most of the inmate or inter-personal violence occurs in the slums where the sign of protection is invisible. The extent of problem of prevalence of violence against women in the slums globally is as follows:

- Globally, between 10 and 69 % of women report physical abuse by an intimate partner at least once in their lives.
- Between 6 and 47 % of adult women worldwide report being sexually assaulted by intimate partners in their lifetime.
- Between 7 and 48 % of girls and young women age 10-24 years report their first sexual encounter as coerced (WHO: 2002).

The problem with the working mother is that their young girl child falls into the hand of this kind sexual violence due to the absence of the adult in the house in the slums and non slums area. And this problem creates a mental stress for the women who ultimately lead to the mental illness which affects the physical well being of the women which hinders the work outcome and leads to poverty effecting whole family and her too. The anxiety and depression disorders are more likely to be found in women. The higher prevalence of anxiety and depressive disorders among women has been attributed to hormonal changes at certain times of their lives, psychological and social factors and domestic and sexual violence that they face (Mishra: 2006, 26). Such disorders are manifestations of the multiple burdens in women's lives and conflict that they experience.

Women labourers of the slums are usually not educated so their work is mostly confined with the informal sector which mainly concentrated in unskilled or a few semi skilled jobs where simple or traditional skills are required. The high rate of illiteracy among women, lack of skill and professional training, absence of on the job training facilities, social attitudes towards their employment are some of the impediments in the employment of women at the highest level of informal women labourers is their employment or unskilled jobs as they usually shift from one unskilled job to another. And some of the women are engaged in heavy manual work even till their time of delivery. Women's baby is delivered by neighbouring women or relatives or by traditional midwives. They only stay at home for a few days and after that they start continuing their manual work which is dangerous to their health and the new born child. In the case of slums in Jammu the home deliveries of the child is very often around 77.55 per cent and in slums of Delhi around 82 per cent of the deliveries are done in home and almost all the houses prefer traditional medicine for the new mother and child which sometimes

becomes the reasons of her ill health (Bhagat: 2013, 1662). The most of the maternal death are all because of home deliveries in India. India currently accounts for about a fifth of all maternal and new born deaths worldwide.

There are many reasons for their choice of giving birth at home as they fear and a sort of embarrassment giving birth in hospitals as the most important reasons for giving birth at home. There is fear of being alone in unfamiliar surroundings and fear of surgical intervention. In addition to fear, women felt it was embarrassing and uncomfortable for them to be in the presence of strangers during a very vulnerable time. Lack of privacy coupled with the absence of any family member by their side was in stark contrast to the safe and reassuring environment of their homes during the birth process. And the hospital care lack the homely environment and inadequate behaviour of the staffs. A house which is run by a women is very hard to be managed when she choose to give birth in hospital (Devasenapathy, George, Jerath et. all: 2014, 6). All these issues are the source for the ill health of the women in slums area and the condition of the women living in the urban slums is much more worse than the women living in the rural poor areas. Many are exposed to new types of risks associated with industrial pollution, road accidents, air pollution, poisonings, threat to child adolescent health, etc. Drainage system is poor in Mumbai which causes high incidence of infectious disease and epidemics. High densities of dwellings and lack of internal roads cause poor accessibility for emergency and life saving services. New squatter settlements come up on the periphery often on inhabitable lands because of their low values and cause environmental hazards. Malaria, tuberculosis, pneumonia, leprosy, meningitis, preventable infections in children such as measles, whooping cough and polio, diarrheal diseases and intestinal worm infections are some of the most common health problems apart from higher morbidity and mortality due to accidents.

3.5: Schemes, policies and programmes of women labourers in India

As per the WHO and the Government of India getting the health need is most important fundamental right of the people and in order to safeguard the health of its citizens the government of India had issued and incorporated many schemes, policies, laws and programmes. The constitution of India directs that state to regard the

improvement of the public health as the primary duties and even the accessibility and availability of the health care facilities as their prime object. There are many cases that the slum populations are denied of many rights may be in terms of the water facilities or sanitation which produces poor health outcomes. It's not that government has not been paying any active role in this matter but the Indian government has been active in initiating improvements in the living conditions of the slums, unsatisfactory living conditions continue to prevail in the bulk of slums. Non utilization or under utilization of maternal health care services, especially among urban slum population are high due to lack of awareness or access to health care and this calls for understanding the health seeking behaviour and utilization of services.

3.5.1: Women's health schemes and programmes : As most of the cases related to the high level of mortality rate in India is due to the system of home deliveries which not only affects the health of the mothers but also it affects the health of the child. The Reproductive and Child Health Programme emphasizes the need for mothers to deliver babies in very hygienic condition under the supervision of skilled health professionals but most of the deliveries are done at home without the any professional help. The government of India has launched a National Rural Health Mission and National Urban Health Mission in 2005. The mission covers the entire country with special focus on the challenges of strengthening weak public health system and improving key health indicators is highest. It also aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. India's National Health Policy, 2002 envisages the following goals for the year 2000-2015 as the main objective of the NHP is:

> *To achieve an acceptable standards of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in the deficient areas, and by upgrading the infrastructure in the existing institution*(NHP: 2002).

The important issue is to provide equitable access to health services without any distinction or division across the social and geographical expanse of the country. The National Rural Health Mission (NRHM) has the goals to be achieved by 2015:

Table 3.7 The NRHM have the goals to be achieved by 2015

2005	Eradicate polio and yaws, leprosy, Establish an integrated system of surveillance facilities, national health accountant and health statistic, increase state sector health.
2007	Achieve zero level of HIV/AIDS,
2010	Eliminate kala azar, reduce mortality rate by 50 %, blindness, increase public health facilities increase public health expenditure.
2015	Eliminate lymphatic filariasis.

Source: Ministry Of Health and Family Affairs, National Health Policy (2002).

The National Urban Health Mission has the focus on these following issues:

- Urban Poor Population living in listed and unlisted slums
- All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, and other temporary migrants.
- Public health thrust on sanitation, clean drinking water, vector control, etc.
- Strengthening public health capacity of urban local bodies(NUHM: 2012, 6).

The National Urban Health Mission will provide flexibility to the States to choose which model suits the needs and capacities of the states to best address the healthcare needs of the urban poor. All the services delivered under the urban health delivery system through the Urban-PHCs and Urban-Community Health Centres (CHC) will be universal

in nature, whereas the outreach services will be targeted to the target groups (slum dwellers and other vulnerable groups). Empowerment of community through awareness generation, whereby they are able to demand services from the health system will be an important area of emphasis in the NUHM. Health is very crucial issues that should be taken a good care as the magnitude of this can be proved by the fact that out of the eight MDGs three are directly related to the health of the people. The three goals are health issues namely child health, maternal health and combating HIV/AIDS. At the Millennium Summit held at the United Nation in September 2000, India along with 189 countries reaffirmed their commitment to working towards a better world.

India has achieved sizeable reductions in Maternal Mortality Ratio (MMR) and Neonatal Mortality Rate (NMR) in the last decade but there is still a lot of ground to cover in order to achieve the related Millennium Development Goals (MDG) by 2015.The major objectives of the National Rural Health Mission (NRHM) are to achieve an MMR of 212 and NMR of 35 per 1000 live births. Promotion of institutional deliveries is an important strategy for achieving these objectives. Under NRHM the federal government had launched several schemes such as the Janani Suraksha Yojna (JSY), Accredited Social Health Activist (ASHA) program, and Janani Shishu Suraksha Karyakarm (JSSK) to achieve this goal. The Accredited Social Health Activist (ASHA) program was launched to promote institutional delivery among pregnant women in rural areas of India (Silan and Kant et.all: 2014, 2). ASHAs are trained female community health volunteers selected from within the community and by the community leaders themselves. They receive performance based incentives for promoting immunization, institutional delivery, and other health related activities. In addition, several state governments have devised their own innovative schemes to increase institutional deliveries such as the delivery Hut Scheme launched by the Haryana government in 2008. Under this scheme all delivery related services were provided free of cost in government health facilities.

In India the main problem is the female foeticide as mention may be made in the above section and this issue is one of the extreme manifestations of violence against women and mostly this female foeticide take place in the slums and rural areas in India.

This action is done by the introduction of pre natal diagnostic test of sex determination before the birth of the child. So in order to eliminate this evil test the government had enacted an act in section 22 of the constitution the pre natal diagnostics techniques act which deals with the prohibition of the advertisements relating to preconception and pre natal sec determination of sex (Srivastava: 2010, 82). It is not the consent of the family whether to keep the child or not but the sole consent of the women is most important in this matter. According the India law abortion is not done by the family or even the husband consent but it's up to the woman's wish either to keep the child or not. The medical termination of pregnancy act of, 1971 under its section 3(2), give women right to privacy, decide about her own body, give space either to give birth or not, reproductive freedom.

3.5.2 Women labour Laws: Women constitute half of the population of the society and since the early ages women are engrossed with the domestic works. They are the sole rearer and care taker of the family in the house but today this tradition has been challenged by globalization and urbanization too. As the women are both the earner and rearer of the family. That creates health work over load leading to the mental disbalance creating health hazards. The most negative side is that they are mostly mistreated on the basis of social construction of gender which leads to the sexual assaults, rape, physical violence and even low wage. As in the case of slums in India, the main element that creates a ground for them to work are poverty, low education or illiteracy that compel them to engage in informal work.

The principle of equal pay for equal work is contained in clause (d) of Article of the Indian constitution which envisages that the State has to look upon that there should not be any distinction in the mode of payment irrespective of class, caste and gender. Equal pay for equal work finds it place in the directive principle of the state policy and it is an accompaniment of equality clause enshrined in Article 14 and 16 of the Constitution of India. With this view the president of India promulgated on 26th September, 1975 the Equal Remuneration Ordinance. The act ensures against the discrimination in recruitment and promotion of men and women. It provides for setting of Advisory Committees to promote employment opportunities for women (Constitution of India). Working women

have many problems especially during the time of the pregnancy and even with their family. In order to facilitate women's problem the government had enacted the Maternity Benefit Act, 1961 to regulate the employment of the women for certain period of time before or after child birth. This act tends to provide social justice to women workers and the section 5 of this Act provides that the maternity benefit to which every woman shall be entitled and liable for a payment for the period of her absence and after that too. The situation regarding enforcement of the provisions of this law is regularly monitored by the Central Ministry of Labour and the Central Advisory Committee. The Factories Act, 1948 has the following provisions of interest to women workers (Sections 19, 22(2), 27, 42(1)(b), 48, 66, 79(1) and 114)

- The Act prohibits women from being employed in cleaning; lubricating or adjusting certain machinery when it is in motion, if that would expose them to risk of injury. Women are also not allowed to work in the part of a factory where a cotton-opener is at work unless certain conditions are met.
- Suitable sanitation facilities must be provided.
- If more than 30 women workers are employed, the employer should provide a children care centre on the premise of child under six years of age and it is the duty of the state government should take the responsibilities for the requirement to provide clothes washing and changing facilities, child-feeding facilities and free milk and refreshments for the children.
- Women cannot be exempted from the requirement that the maximum working day for adults is 9 hours, and cannot work in factories between the hours of 6 am and 7 pm (Mishra: 2003, 600).

The working ambiance has to be very clean and fresh so that there will be least casualty in terms of health of the working people. So, in order to safeguard the health of the people working in the factories or any kind of institution or industry the government has enacted some health Acts for the worker under the Factory Act 1948, where the section 11 of the Act deals with the cleanliness which lays down the every factory or working place should be kept clean. The Section 12 (1)(2) lays down that the in every working place the factory should have the treatment of the affluent and it is the responsibility of

the state government for the arrangement of it. Section 18 deals with the provision of suitable and sufficient drinking water in every working place and Section 19 (1)(2) provides the provision of sufficient latrines and urinal accommodation and even that a separate accommodation shall be adequately provided for both male and female. In order to provide safety for the workers in the working place the government has employed a Act under the Factory Act, 1948 where Section 21 to Section 41 deals with the provision of safety for the workers. Women labourers are the integral part of the work force participant all over the globe and also a dispensable part of the social security schemes. A lot have been gone in the provision adequate benefit and security of the female workers both in the national and international level. In 1919 the International Labour Organization adopted child birth convention No.3 in its first session held in Washington. The convention provided for twelve weeks maternity leave for women employed in industrial and commercial undertakings. In 1929 the government of Bombay enacted the Maternity Benefit Acts and after the Madhya Pradesh also enacted the Act and so on it spread all over India (Mishra: 2003, 598).

In order to address the grievances and provide a social security for the working women the government of India has enacted rights and Acts for the safeguard of the women labourers. As the women workers, especially those in the informal sector are caught in the vicious circle of poverty, indebtedness, lack of economic assets and low income levels. The women workers live and work under many constraints and hence are vulnerable to exploitation and sometimes lead to health hazards. So, to provide a security in the working place the government has enacted sometimes Acts and provision for the working people and women in particular.

3.5.3 Programmes and schemes of slums: The growth of urbanization and population have always accompanied by the growth of the slums. They are the mass who are living in poverty and are the most insecure population who had to face many problems from living to health. The environment in the slums is very much affecting the health outcome of the people and lack of sanitation and water creates extra burden on the people. The most dangerous issues living in the slums are the physical violence of the women and children due to the inadequate facilities and infrastructure. So in order to facilitate the

slums population the Government had initiated many schemes and programmes for the slums population in India. The Ministry of Housing and Urban Poverty Alleviation has implemented various Plan and policies in the country to address the concerns of housing, infrastructure, slum development and basic civic amenities with special emphasis to the poor. The various programmes implemented by the MoHUPA is way in order to give a benefit to the poor living in poverty with special reference to the slums dwellers, here are some of the major programmes of the Ministry:

- Jawaharlal Nehru National Urban Renewal Mission
- Swarna JayantiShahari Rozgar Yojana
- Affordable Housing in Partnership
- Interest Subsidy Scheme for Housing the Urban Poor
- Urban Statistics for Human Resource and Assessments
- Integrated low cost sanitation Schemes
- Scheme of Slum free City Planning for Rajiv AwasYojana
- Projects and Schemes for the development for the development of North Eastern States, including Sikkim (MoHUPA: 2010).

The JNNURM launched on 3rdDecember 2005for reform linked, demand driven, fast track development of infrastructure and basic services to the poor in cities including housing and slum up gradation. The Mission comprises of two Sub- Missions, namely **Sub-Mission for Urban Infrastructure and Governance:** This will be administered by the Ministry of Urban Development through the Sub- Mission Directorate for Urban Infrastructure and Governance. The main thrust of the Sub-Mission will be on infrastructure projects relating to water supply and sanitation, sewerage, solid waste management, road network, urban transport and redevelopment of old city areas with a view to upgrading infrastructure therein, shifting industrial and commercial establishments to conforming areas, etc and the other is **Sub-Mission for Basic Services to the Urban Poor:** This will be administered by the Ministry of Urban Employment and Poverty Alleviation through the Sub-Mission Directorate for basic services to the urban poor. The main thrust of the Sub-Mission will be on integrated development of slums

through projects for providing shelter, basic services and other related civic amenities with a view to providing utilities to the urban poor (MoUEPA and MoUD, GoI).

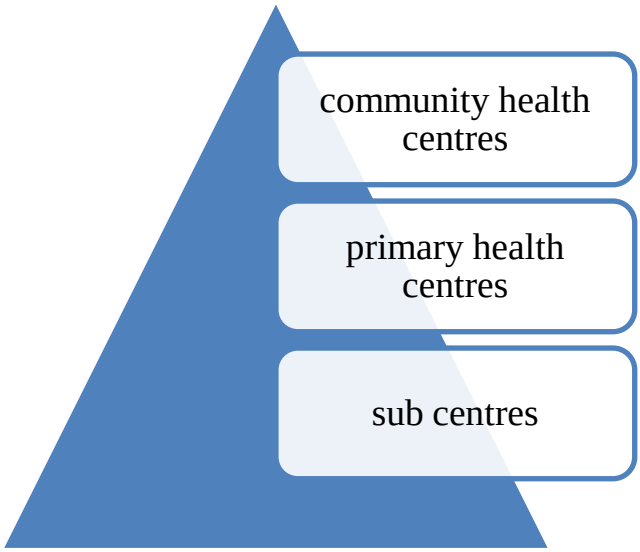
The most prominent problem in the slums is the sanitation facilities which have the serious impact of the health outcome of the population. The loss due to diseases caused by poor sanitation for children less than 14 years alone in urban areas amounts to Rs. 500 Crore at 2001 prices (Planning Commission- UNICEF, 2006). Inadequate discharge of untreated domestic and municipal wastewater has resulted in contamination of 75 percent of all surface water across India. The Millennium Development Goals (MDGs) enjoin upon the signatory nations to extend access to improved sanitation to at least of half the urban population by 2015, and 100% access by 2025. So in order to facilitate sanitation facilities to the poor the Ministry of Urban Development has employed National Urban Sanitation Policy for the improvement in the sanitation facility in India. The vision the this policy is to make all Indian cities and towns become totally sanitized, healthy and liveable and ensure and sustain good public health and environmental outcomes for all their citizens with a special focus on hygienic and affordable sanitation facilities for the urban poor and women. The overall goal of this policy is to transform Urban India into community-driven, totally sanitized, healthy and liveable cities and towns (MoUD, GoI). Government of India recognizes that sanitation is a state subject and on ground implementation and sustenance of public health and environmental outcomes requires strong city level institutions and stakeholders. It is not just the role of the government is important but the role of each sate and each individual is important in order make their country clean and health free country. Therefore each state and city needs to formulate its own sanitation strategy and their respective city sanitation plan respectively.

3.6 Utilization and underutilization of health care in India

The term accessibility and availability doesn't always means to get it but it also means to have easy access of it when it is needed without any difference or difficulty. As in India when it comes to utilization of health care facilities it is always disadvantage for women because in India caste and class plays a very major role. The health care system in India, at present, has a three-tier structure to provide health care services to its people.

The first tire, known as primary tire, has been developed to provide health care services to the vast majority of rural people. The primary tire comprises three types of health care institutions: Sub Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC). The top lies the district level like hospitals with the referral services is established at district head quarters.

Figure 3.4 Three types of health care services



Source: Self Compiled

The rural health care infrastructure has been developed to provide primary health care services through a network of integrated health and family welfare delivery system. There is urban bias in the healthcare infrastructure in India as the hospital and clinics are concentrated in the urban centres. The weakening of the public health care in country is further detoriating the health of the country by the process of privatization which is increasing and where the urban elites are gets timely and complete care. Apart from such dimensions of access, women's access to healthcare is mediated by gendered experiences. Since the recommendation of the Health Survey and Development Committee known as the Bhore Committee they established public health centre all over India in urban and rural areas.

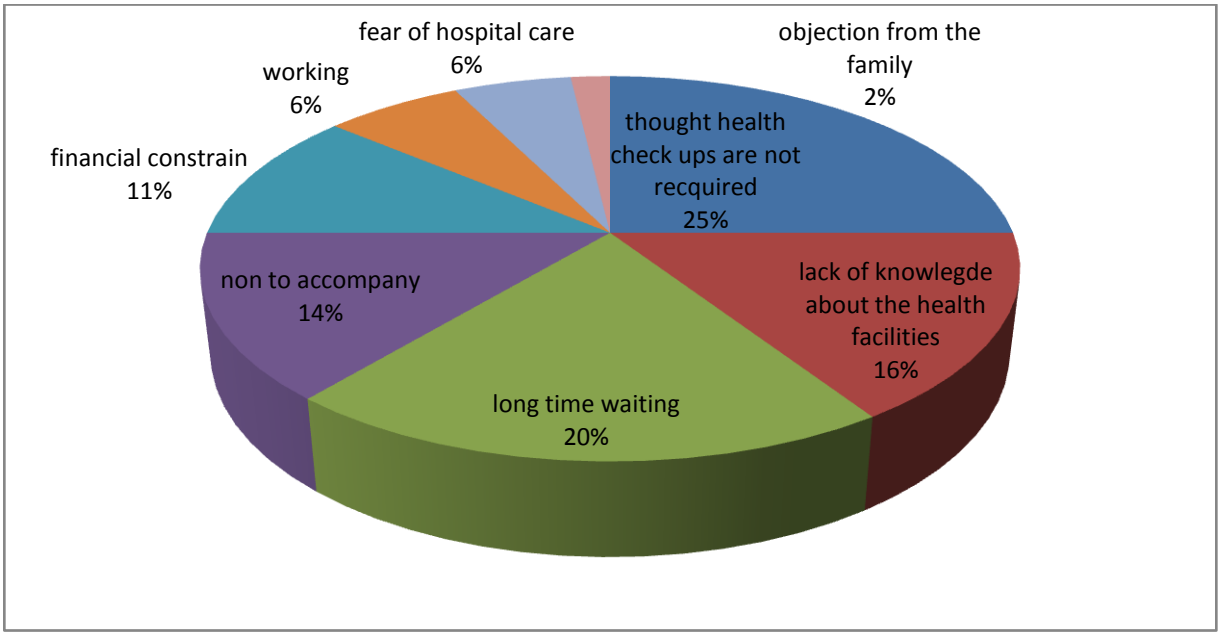
Table 3.8 Numbers of health care centres in India

Community Health Centres	Primary Health Centres	Sub Centers
3043	**22842**	**137311**

Source: Central Bureau of Health Intelligence: 2003

But the after having the accessibility of the health care centre people still lack health care due to many factor like education, traditional form of treatment, gendering, beliefs, customs etc. The most important reasons behind high levels of morbidity and mortality in women and girl children can often because of the patriarchal system which is very disadvantageous to the women in India. Poor maternal health is associated with unhealthy living conditions, high fertility rates, inadequate hospitals, and low uptake of maternal health services. Hundreds of millions of women and children have no access to health care and due to this 10.6 million children die before the age of five and half a million of women globally die at child birth (World Health Report 2005). The antenatal care is the most important right of a becoming mothers but this rights are not been used properly in India. In the slum region of Uttar Pradesh out of 340,000 pregnancies that occur every year among this population, only 2% receive complete ANC (Sarode: 2010, 87). The reasons for this underutilization of the ANC are due to following reasons:

Figure 3.5 Reasons for underutilization of ANC in Uttar Pradesh



Source: Sarode: 2010 and Agarwal et.all: 2007.

ANC is very essential when dealing with a safe motherhood. During antenatal period, women are likely to face health problems of reproductive nature and there will be a package of measures available for expectant mothers, which ensures safe motherhood. But due to the lack of knowledge and illiteracy the problem is created. Around 40 per cent of the birth is attended by the untrained attendants in the slums where complication happened (Khan et.all: 2009, 9). The NFHS survey found that nearly three quarters of all births took place at home and two-thirds of all births were not attended by trained medical personnel, where 39 per cent of birth took place in woman's own home and 9 per cent in their parents' house,72 percent of deliveries that took place at home, the mother reported that she did not feel that it was necessary to deliver in a health facility, and for more than a quarter, the mother said that delivery in a health facility is too expensive (NFHS: 2005-06). It is not the fact that family decision and the women's own perception was the main reasons for the underutilization of the health facilities but the governmental system is also has most significant role in the underutilization. Lack of quality care in government health facilities was the most frequent reason given for low utilization. The problems of hospitals in the rural area are the unhygienic condition of delivery rooms and less bed for the patients are common phenomena in government facilities. Improper cleaning of delivery instruments and delivery table also added to the bad experience of patients. Besides hygiene, concerns regarding patients' privacy were also emphasized as an important determinant of low utilization. Patients felt very embarrassed when they were examined in a room without privacy. Gender of the treating doctor was also an important issue for some patients. Gender role also played a major role because as most of the women felt uncomfortable when they were treated by the male doctors and even the family of the women objected in this matter. Lack of proper facilities for transporting pregnant women from their homes to government hospitals was considered to be an important factor for low utilization of services. In addition to non-availability of ambulance services in the immediate vicinity, dismal condition of village roads also caused the delay. There have been instances where the delivery occurred in the ambulance itself due to the various delays. The most important issues is that in India the public healthcare is of free of cost for the poor, but even having this facilities they lack this facilities due to the long distance. The distance between the health centres and the

affected household is far and due to this and non availability of the ambulance sometimes leads to the death of the sick (Agarwal and Kumar: 2009, 278).

There is an unprecedented economic growth in past two years in India but the investment in the health infrastructure but in the rural area their still lack the health infrastructure like about 75 per cent of the health infrastructure, medical personnel and other health resources are concentrated to the urban area where only 27 per cent of the people live there (John: 2009, 22). In India the public expenditure in health is very low related to the other countries which are give in the following table:

Table 3.9 Public expenditure on Health

Country	GDP in per cent
Argentina	4.0
Australia	5.5
Austria	6.0
Belgium	6.8
Canada	6.4
Denmark	6.7
Germany	8.3
India	**0.6**
Israel	7.0
Italy	5.3
Japan	5.9
Netherlands	6.1
Norway	6.2
Saudi Arabia	6.4
UK	5.9
UAS	6.5

Source: Srivastava: 2010, 12.

Success of the health centres lies in the working of the staffs but the case in the rural area there is the shortage of the working staff which creates health problem for the

poor. In many slums area there is no health care facilities available. There lies the unhygienic condition in slum where most of the family members suffer from one or two ailments. The physical environment in the slum is not congenial for good health, and because women have to devote longer duration in the unhygienic environment because of their family obligations, they along with the children, are the greater suffers of physical ailment. Malnutrition among children is another problem of urban slums. The major causes of childhood malnutrition in slums are inappropriate child feeding practices, infections, improper food security and suboptimal childcare besides poor availability and inadequate utilization of health care services. The case of early marriage leads to the ignorance of the health care facilities in India and small reproductive illness are regarded as the normal problem which sometimes go untreated. Utilization of healthcare services is poor in urban slums even though physical accessibility is present. Social and cultural barriers are more common in slums where healthcare services are not reachable. Home deliveries and unsafe deliveries are still widely prevalent in slums. Skilled birth attendants are not reaching to those who need them the most. Accessibility to healthcare services of slum population must be taken into account in the district health planning process. Healthcare services need to be scaled up so that ante-natal services and skilled birth attendants are available for all.

Most of the people in India prefer homemade remedies for certain ailment and even private health services because of the absence of major infrastructure in the governmental health services and even the people rely upon the traditional health practitioners like shaman who are more accessible to women and children. As the private health services are meted by the rich class people but the poor usually rely upon the traditional healers especially the poor women and children due to the expensive treatment.

CONCLUSION

Health should not be taken for granted as it's a national issue where the protection of the people from the harmful disease is the main agenda for the national as well as for international level. Health and disease consists of a global burden because of its borderless character and easily transferrable nature where one country is affected it

engulfs the whole globe. The case of HIV/AIDS is a matter of concerns for the entire nation because this disease has the tendency to ruins the security system of the international and national institutions. When we talk about women and disease it taken be said that, women has been used as the weapon of war since during the war time where the national security was the main agenda for the state. Through the history there are many instances of pandemic disease which has been used for the war by the states which caused serious health issues. Today the world is engraved with new disease and the most affected person is women because of her sex and gendering in the society and the worst affected in this matter is the women living in the slums. In slums they are already engaged with much health problems and poverty makes the situation even worse for her. In slums many of the women are working because of the economic constrain of the family they have to face many problems in their working place like sexual assault, violence, rape and due to the lack of sanitation facilities they are prone to rape and other sexual implication. At home also they not secure because of the prevalence of domestic violence. The most important things that put the women into jeopardy are because of the basic necessity like lack of sanitation in the slums to which she falls into the prey of victimization.

Though having much provision for the health and slums developmental schemes still there are many instance of violence against women further complicating her health and the rise in the slum population with many negative health outcomes. The one of the reasons for the under development of health of the women in the slums is the socio cultural structure and poverty in India and women tends that it's their fate and keep quite. This socio cultural constrains acts as the nature of the women which forces them to think in a very negative way when it comes to the health and poverty is like a vicious circle that keeps on engulfing the health of women and the slums population. This perception is very wrong because the constitution of India has give right to every women in choosing the right and wrong for her and she even has the will in her own reproductive system and it's not the family of the women can have a say in the matter of her body.

In the slums, women themselves deteriorate their health because of their strong belief in the socio cultural status of the society and their family. The under utilization of the health facilities are all concerned with this factor. It's not the government to be blame

for the misfortune of the health but the people should also be blamed for. Knowing every bit of the governmental policies and plan and even knowing the health care facilities and centres they do not go due to the social structure called patriarchal system strongly prevailing in the slums of India. As in the study it has shown that most of the women in slums don't wish to give birth in the health institution rather they choose home for delivery it's the environment that she is bought up and believe in. The social surrounding of the people is also of great concern in building up the mentality of the people which shapes the understanding of the people which gives the boost to the age old socio cultural norms of our society.

CHAPTER-IV

WOMEN LABOURERS HEALTH ISSUES IN SLUMS OF DARJEELING TOWN

Introduction

West Bengal covers the bottle neck of India in the east, which is bounded on the north by Sikkim and Bhutan, on the east by Assam and Bangladesh, on the south by the Bay of Bengal and on the west by Orissa, Bihar and Nepal. It therefore has three international frontiers to the north, east and west. West Bengal constitutes 9.8 per cent slums population which is third largest slum population as per 2011 census and 8.9 per cent as of 2001 census which holded fourth position in India. With the increasing of the population in West Bengal the slums population is also increasing with extra burden on health especially on women who face many health related problem like low nutritional level, underweight, anaemia, blood pressure, STI, UTI etc. Mental pressure is one of the most important health issues which are seen both in men and women due to many problems like poverty.

The case of Darjeeling is also much similar as the rest of the slums in India. They face many health problems arising out of improper sanitation system, drainage, water facilities, health facility etc. As Darjeeling used to be one of the health care sanatoriums for the Britishers and was considered as the main place to get healed from the diseases. But today the situation is not the same as before and at present Darjeeling in engulf with many kinds of health problems to which they are fighting and most importantly the people living in the slums of Darjeeling. So this chapter brings out different health problems and prospect of women living in the slums of Darjeeling which is based upon fieldwork. The chapter consists of eight themes where the accessibility, availability and underutilization of health institutions are examined. It also brings out different infrastructural needs and the areas that need proper focus for better health for the people living in the slums of Darjeeling town.

4.1: HEALTH INFRASTRUCTURE OF DARJEELING: AN OVER VIEW

Darjeeling is one of the districts of West Bengal having both tarai (plains) and pahar (hills). The district experienced high intensity of mortality during British period due to malaria and other deadly kala azar and black water fever. These types of fevers were common in Sukuna, Garidhura, Matighara and Naksalbari where there were no facilities for treatment (O'Malley: 1907, 20). Though the Britishers were familiar with these types of diseases as they do experience in their homeland, the natives were totally unaware of dealing with it. Some of the other diseases affected the people of the area were diphtheria, enteric and influenza. In 1905 a low intensity of plague affected Darjeeling and Kurseong which thankfully did not claim any human life, but the most important threat in the hills was from small pox.

In 1828 when General C.A. Lloyd along with J.W. Grant visited Darjeeling, struck with the idea of creating Darjeeling as the health sanatorium. He was very keen in building a sanatorium in Darjeeling which was strongly supported by Mr. Grant. In due course of time attention was also paid to the improvement of the general health of the people. Medical institutions were slowly established. By the late 19^{th} and early 20^{th} century, Darjeeling had three medical institutions; (a) the Eden Sanatorium which was opened in 1883 by Sir Ashley Eden, the then Lieutenant Governor General of West Bengal, who urged the necessity of providing healthy atmosphere and surrounding for the European patients from tea gardens of the district as well as the Europeans patients from the plains. (b) Lowis Jubilee Sanatorium which was opened in 1887 by the Mr. Lowis, the Commissioner of the Rajshahi Division, which was for the natives, this sanitarium had two sections; one for the orthodox Hindus and the other for the general masses and (c) Victoria Memorial Dispensary which was opened in 1888 for both natives and Europeans (O'Malley: 1907, 24).

In addition to this sanatorium, there were also other charitable health centres run by the government and the missionaries. During this period, though the Britishers introduced scientific treatment, people in Darjeeling side by side sought the help of the jhakris (shamans) and medicinal plants. This system is prevalent even today in some parts of the district.

4.2: PUBLIC HEALTH INFRASTRUCTURE: A CONTEMPORARY SCENARIO

With the passage of time and with the growth of the population, a drastic change was seen in the pattern of health care. Health care has become far more technical and far less personal. The basis for running a health organization in India is the primary health care approach which was developed with the recommendation of the Health Survey and Development Committee popularly known as the Bhore committee established in 1946. It emphasized on setting up primary health centres for making health services easy. With the pace of time and with more sophisticated life-style of the people, the health related problems also got diversified, the diseases becoming more prominent among others. According to the District Health Plan 2001, the major health problems faced by the people are water borne diseases like diarrhoea, worm infestation, hepatitis, typhoid, tuberculosis, skin diseases, fungal infections, acute respiratory infections, and addictions to alcohol and drugs. Along with these the incidence of systemic hypertension, coronary artery disease, cancer and diabetes are also on the increase.

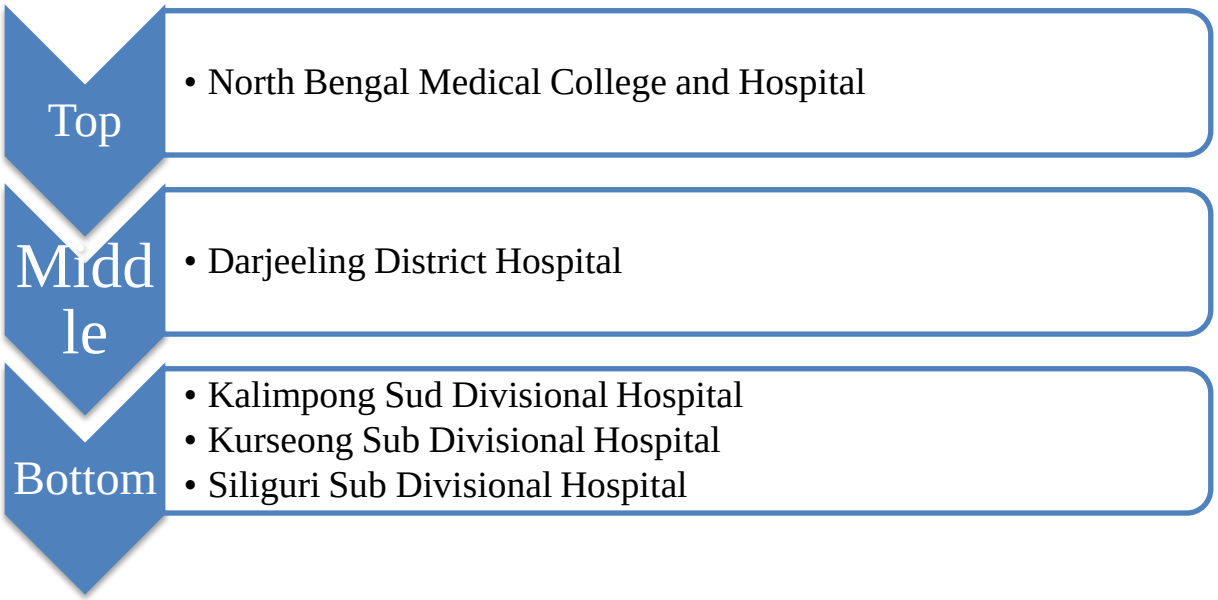
Table 4.1 Block wise Primary Health Centres in Darjeeling

BLOCK	Name of the PHC
Darjeeling- Pulbazaar	Lodhama
Jorebunglow- Sukhiapokheri	Sonada, Ghoom, pokhriabong
Rangli- Rangliot	Singritam, Takling
Kalimpong-1	Samthar, Teesta
Kalimpong-2	Gitdubling, Alghara
Gurobathan	Jaldhaka, Sherpagaon
Mirik	Soureni, Duptin
Kurseong (Sukuna)	Bagora, sittong, Ghayabari

Source: Chettri, Indu (2008-2009:72).

There are three Sub-Divisional Hospitals at Kalimpong, Siliguri and Kurseong and a District hospital which is in Darjeeling. The North Bengal Medical College and Hospital is located in Siliguri which comes at the top of the hierarchy system.

Figure 4.1 The names of the Sub Divisional and District Hospitals



Source: Self Compiled

The above mentioned hospitals are located in the three sub divisions. One is located in Darjeeling and Siliguri, the others are located in the sub divisions of Kalimpong and Kurseong. The Darjeeling district is composed of three sub divisions; Kalimpong, Kurseong and Darjeeling. Apart from having the major health centres in Darjeeling, it also has other health centres dealing with the problems of chest and leprosy which is shown in the table below:

Table 4.2 Chest Clinics and Leprosy units in Darjeeling

No. of chest clinics in Darjeeling	**No. of leprosy units in Darjeeling**
Names	Names
1. Deshbandhu Chest Clinic, Darjeelir	Leprosy Control Unit, Kalimpong
2. TB hospital Batasia, Darjeeling	
3. Chest Clinic, Kurseong,	Modified Leprosy Control Unit Kurseong
4. Chest Clinic Kalimpong	7 Set Centre, Darjeeling

Source: District Health Plan, 2001.

In order to raise the quality of the health care system and improve the infrastructure, government has set up number of health training centres and other medical institutions in Darjeeling which are shown below:

Table 4.3 Other Health Institutions and Services in Darjeeling

Name	Status	No. Of Centres
Nurses Training Schools Darjeeling	Under Govt Of West Bengal	_____
Nurses Training School Kalimpong	Under Govt Of West Bengal	_____
State Homoeopathy Dispensaries	_____	21 Dispensaries
Total No. Of Existing Sub Centres	_____	148 Sub Centres
Govt. Medical Plantation Hospital	Under Commerce Industries Dept Govt Of West Bengal	4 Hospitals
Tea Garden Hospital	Private	10 Hospital
Railway Hospital Tindharia	Railway Hospitals	_____

Source: District Health Plan 2001.

The main aim of health centre is to manage and provide infrastructure and other health facilities to the people, so that proper utilization of the facilities granted by the government is benefited by the people. The work of the health care system is not only to make sure of the utilization of the available facilities but also to make the public aware of the facilities available and provide knowledge about the health related problems and their solution to it. But in many cases the health care facilities are not utilized by the people as the National Family Health Survey NFHS-3, 2005-2006 found that the majority of the government facilities are underutilized especially by the women in the hills and the tribal regions.

4.3. SOCIO ECONOMIC CONDITIONS OF THE HOUSEHOLDS IN STUDY AREA

In Darjeeling there are around eighty eight notified slums where some areas are in very bad shape. The area of the study is one of the notified slums below the railway station in Dhirdham, Giri Dhara, Nava Jyoti and Amar Jyoti area. It comes under ward no 17, having 300 households with a number of health related problems. The below table will show the number of notified slums area in Darjeeling including the newly identified slums:

Table 4.4 Number of notified slums in Darjeeling with wards numbers

Name of the slum area	Ward no	No of household
Sunar Busty, Raja Hatta (Jorebunglow)	1	116
3 Pinnel Market, Dara Gaon (Ghoom)	2	109
Jarull Hatta, Beri Khan (Ghoom) and Municipal Gaon (Jorebunglow)	4	277
Nimki Dara	6	82
Lasha Villa	7	74
Bhaktey Busty	8	58
Cedder Cottage and Vineete	9	60
Nabin Gram (Gandhi Road)	11	184
Khola Gaon	12	47
Alubari Busty	13	96
Jawahar Busty I and II	14	115
Lower Rockhood	16	73
Mangal Puri, Sister Nevidita	17	167
Pragati Gram	18	42
Donavan Park	19	56
Bawney Busty	21	96
Lal Dehki	22	47
Shiva Gram, Jyoti Gram	23	176

Eden Coumpound	26	54
Bons Gram, Frymal Village A,B And C	27	226
Pinnel Market (Ghoom), Singtam Fatak, Mahakal Gram and Bhotey Busty	28	304
Navin Gram (Singamari)	29	60
Middle Bhotia Busty and Naya Gaon	31	197
Ging Naya Busty	32	79

Source: Field work: November 17th, 2014 and Darjeeling Municipal Corporation

The most important aspect of the slums in Darjeeling is that within one ward there are a number of slums and the non-slums fall under the ward numbers 3, 5, 10, 15, 20, 24, 25 and 30. The socio cultural surrounding of the slums are very heterogeneous in nature. They are composed of Nepalis from Nepal especially from Kathmandu, rural areas of Darjeeling, Kalimpong, Rajasthan, and Bihar etc. The women came to Darjeeling through marriage, for better job opportunities, transfer of their spouses, better education for their children etc. The government has again identified 51 more new slums in Darjeeling which is as follows:

Table 4.5 Newly notified slums in Darjeeling, 2014

List of new slums	**Ward no**
Garidhura, Jorebunglow	1
Batasia panchi pool, Dilmaya busty, Chota batasia	2
Upper side of Ghoom bhanjang	3
Pallo bari and Lourey dara, Jarrul hatta	4
Bokshi jhora, Nilan gram and Shanti gram	5
Limbu dara, Krishna villa, Lower bloomfield, Upper merry villa, West point	6
Shayam cottage and lower rose bank	7
Below railway station and RK Kushary road and Upper DB Road and Hill cart road	12

Ganesh gram	13
Hallay gaon, Dhara gaon, Pradhan cottage and Hitti gaon	14
South rockhood and Kopila sangh Victoria road	16
Amar jyoti, Nava jyoti and Giri dhara	17
Lower pragiti gram, Vher gaon, Jagrati gram, Jakir Husain busty and Tangli view, Harizan barrack	18
Donovan park and Jitin lane	19
Shankar gram and Bouddha gram	23
Eden hospital area	26
Triratna gram and Diocen gaun and Upper frymal	27
Mount hermon, Mount valley, St. josephs busty	29
Lower hermitage and Okden	30
Homden limbu busty	31
Chota ging busty	32
Limbu gaon and Makahal gaon	28

Source: Fieldwork on 16th, 2015 from Darjeeling

4.3.1: Women Respondents Age and Caste

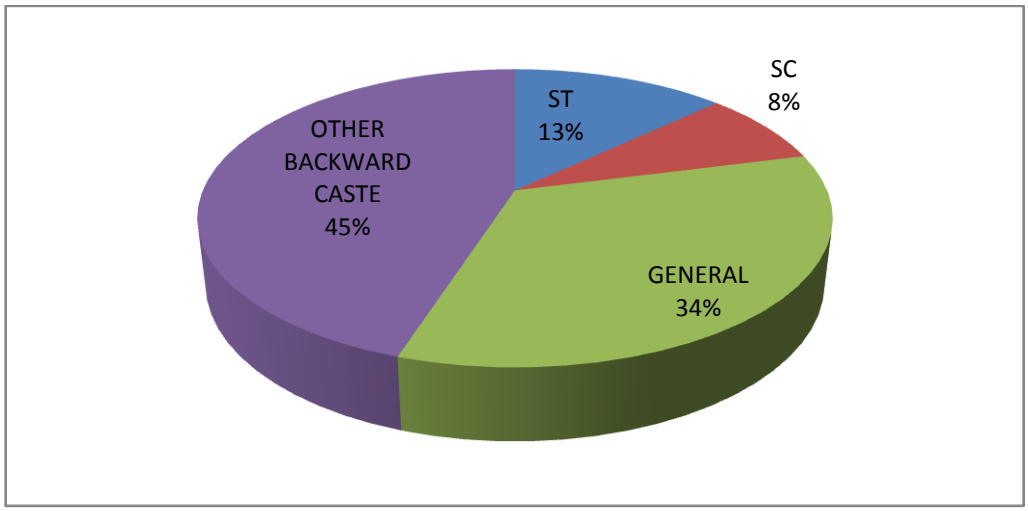
Most of the respondents are married and above eighteen years of age. The focus is given to the married women because they spend maximum time in their household surroundings taking care of the family members. Hence, they experience the day to day challenges in respect to their surroundings, especially with regard to health related issues.

Table 4.6 Age Composition of Married Women

Age group	Number
20-30	25
31-40	40
41-50	19
51-60	8
61 and above	8
Total	100

Source: Fieldwork: 14th November to 23rd November, 2014.

Figure 4.2 The Composition of the Respondents by Caste



Source: Fieldwork: 14th November to 23rd November, 2014.

The area of study is dominated by Nepali Hindus and Buddhist minority community. The area is inhabited by people belonging to different castes where inter-caste marriage is common. There is no domination of the one caste over the other and hence there is no distinction between higher caste and lower caste. The highest number of people residing are from other backward castes consisting of around 45 per cent like Rai, Thapa, Thami, Gurung, Sunuwar etc. Around 34 per cent of the respondents belong to the General category like Chettri, Karki, Tikhatri, Kharkha, Sharma, and Pandey. A total of 8 per cent falls under schedule caste like Barailey, Sunam, Balmiki, Sewa, Pariyar and 13 per cent falls under the schedule tribe especially Tamang. There is no sign of socio cultural difference and social hierarchy. Most of the people are from the upper Brahmins caste from Nepal and around 14 per cent of the households are from Nepal who came in search of jobs and settled here in Darjeeling. Most of the women are also from different parts of India, Nepal and from the rural areas of Darjeeling who either came either for better job opportunities or due to marriage. They live in peace and harmony with one another.

4.3.2: Literacy rate in Darjeeling

Darjeeling is considered to be the educational hub of West Bengal having the highest literacy rates among the other districts. According to 2011 census, the population

of Darjeeling is 18,46,823 out of which 9,37,259 were males and 9,09,564 were females. As per 2001 census, the population of Darjeeling was 16,09,172 out of which 8,30,644 were males and 7,78,528 were females. There is a growth in the population of 14.77 per cent from 2001 to 2011. And the literacy rate in 2001 was 80.05 for male and 62.94 for female while in 2011 the literacy rate was 85.61 and 73.33 for male and female respectively.

Table 4.7 Respondents Educational Qualifications

Education category	No. of female	Percent %
Class I - V	10	10
Class VI - X	21	21
Class XI - XII	1	1
Graduates	___	0
No formal education	68	68
total	100	100

Note: female indicates married women respondent

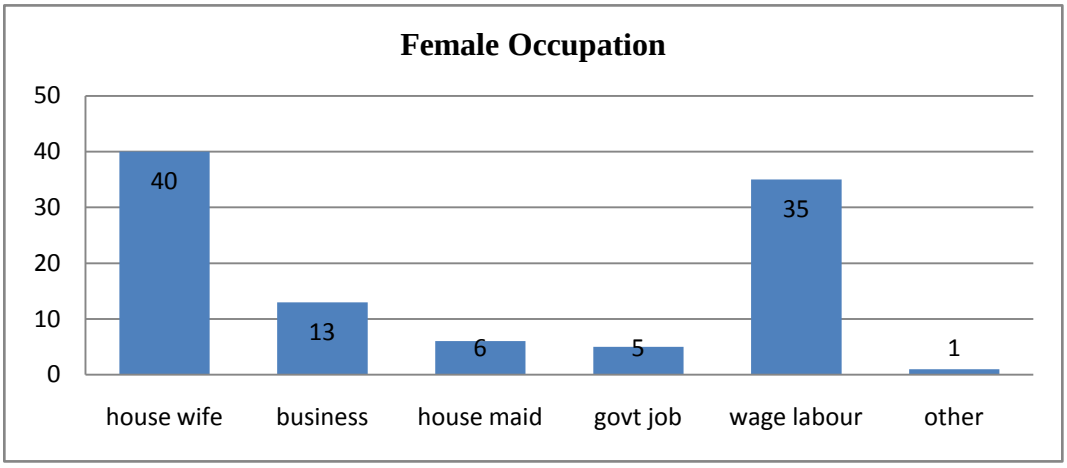
Source: Fieldwork, 14th November- 23rd November, 2014.

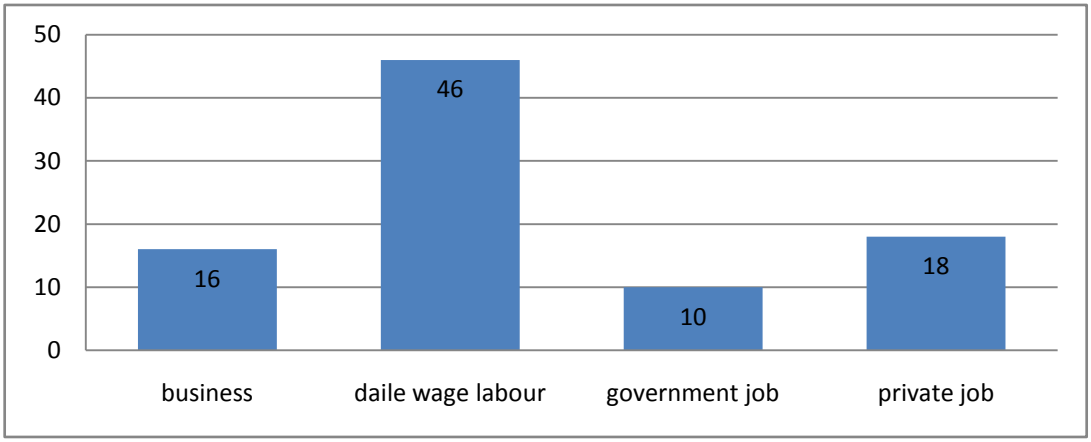
Most of the women respondents did not have formal schooling and some of them managed to attend till class VIII and IX. The maximum number of the respondents are dropouts due to financial problem, early marriage, poverty, engaging in household activities, migration etc. A few of the respondents can read and write in Nepali and some of them can manage only to sign. Many of the respondents expressed their view that education is the most important means for development. Though they couldn't attend school due to unfavourable circumstances, they prefer their children to get good education and occupation.

4.3.3: Work profile of Women respondents

Majority of the respondents both male and female were daily wage labourers. Mostly both husband and wife are earning members of the family. They are mostly engaged in unskilled and manual work as most of the jobs are occupied by the qualified and skilled persons.

Figure 4.3 Occupation and working status of the male and female





Note: male indicates the husbands of the women respondents

Source: Fieldwork: 15th November- 20th November, 2014.

Around 60 per cent of the women respondents are engaging in work as shopkeepers, private business, government jobs and household works while all the male members engage in some works. The percentage of women engaged as maids is 6 per cent where they are engaged in cleaning and cooking in others houses, but they not staying there. Around 13 per cent of the women are engaged in business like selling cloths door to door, women vendors, shopkeepers etc. Around 5 per cent of them are working in government sectors especially D-Group like cleaning in hospitals, municipality and ICDS. And 1 per cent of the women are engaged in other jobs like artist in the cultural shows and 40 per cent of the women are housewives. Around 10 per cent

of the women are single mothers who are divorced, separated or widows. 46 per cent of the male respondents engage as daily wage labourers like carrying loads, water supplies etc. 16 per cent of the males are engaged in business and 10 per cent as government employers like electricity department, army, and hospital. Around 18 per cent of the males are doing other works as cable operators, tailors, carpenters, working abroad etc.

4.4: LIVING CONDITION

The surrounding of the houses are also great indicators of the health of the people. The usage of water, sources of water, drainage system, sewage system all determine the health of the communities and family. Most of the respondents did not have the land of their own. The road condition is bad, congested and is not maintained properly. Since most of the houses are built very close to the drains and roads, it increases the risk of their health and life.

4.4.1: Types of accommodation: The houses can be divided into four types

Own house

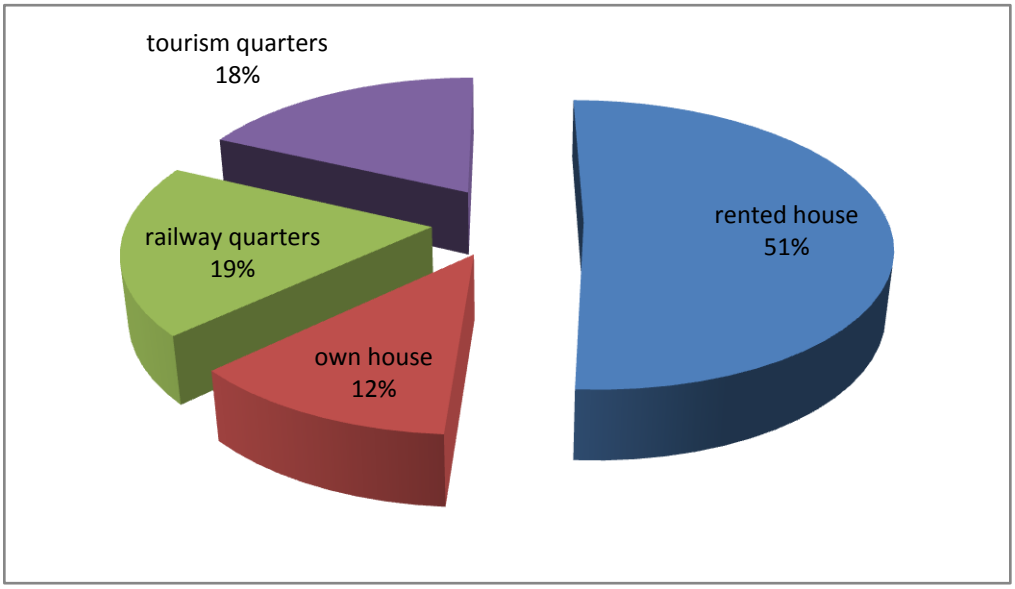
Railway quarters

Tourism quarters

Rented

As mentioned above the houses are divided into four house types. Though these quarters are allotted to government employees, in many cases original allottee doesn't stay in these quarters, but have rented the quarters for their personal benefit.

Figure 4.4 House holding Status



Note: rented house, own house, railway and tourism quarters comes under slum area

Source: Field work 15th November 2014- 13th January 2015.

This above figure 4.4 gives us the information that the majority of the house holding come under the arena of slums where maximum number of the respondents live in a rented house. Though they are staying in a rented government quarters they have to face many problems. The houses are semi pucca and kutcha where almost four to five households are staying. The rooms are very small and do not have any ventilators. Some houses have only one small congested room that is being used as kitchen, bed room, study room and parlour.

Figure 4.5 The type of houses found in the study area

Source: Fieldwork 15th November, 2014.

4.4.2: The sanitation system

Most of the respondents expressed that they did not have proper sanitation facilities which is a cause for serious health hazards.

Table 4.8 Sanitation Facilities

Sanitation facilities	No of toilets	Percentage %
Sharing	46	46%
Public toilets	9	9%
Own toilets	35	35%
Others	10	10%
Total	100	100

Source: Fieldwork 14th November- 23rd November, 2014.

The above table reveals that majority of the households have sharing toilets and rest have own toilets or use public toilets. Around four to five households use or have only one single toilet and the condition of the public toilets is miserable with filthy smell having no water, light and cleaning facilities. The quarters to which they give rent do not provide adequate basic facilities like water, light and latrines. There are also cases where there are no latrine facilities for some families. Around 10 per cent of the household do not have the basic toilet facilities; hence they depend on the jungle or in the railway public toilets. This can create moral and ethical issues leading to social disharmony and insecurity. The women respondents from this study also expressed the same view stating that they face lot of problems at night. Due to this the health of the women is adversely affected which is in the long run affecting the family and the society at large.

4.4.3: The source of drinking water

There is water crisis in the area of study though area comes under the government notified slums. They don't have private or government water facilities. The toilets are not sufficient and hygienic in this study area. Public toilets are not provided with water facilities and cleaner.

Table 4.9 Water Facilities

Source	Number
Spring water (giri dhara)	**63**
Municipality water	**13**
Own source	**9**
Buy water	**15**
Total	**100**

Source: Fieldwork 15th November 2014 - 13th January 2015.

Out of the total respondents only 13 households are privileged with government water facilities and rest of them have to rely on spring water. Since the spring water sometimes gets dried up in the months of December, January, March and April, the water crisis becomes severe and the people are compelled to buy water at a very high price.

Figure 4.6 Giri Dhara a source for water

Source: Fieldwork 19th November, 2014.

4.4.4: Sewage and Drainage

There is no proper drainage and sewage system in the study area that adds to the misery of the people living over there. They have one big jhora (drain) that drains their sewage and other waste products. The safety tanks are poorly checked, managed and maintained so much so that they have become breeding grounds of the insects and flies adding to the ill health of the people. The houses are constructed or people are residing just beside the drains and jhoras. The situation becomes worse during monsoon and summer season.

Figure 4.7 Sewage and Drain

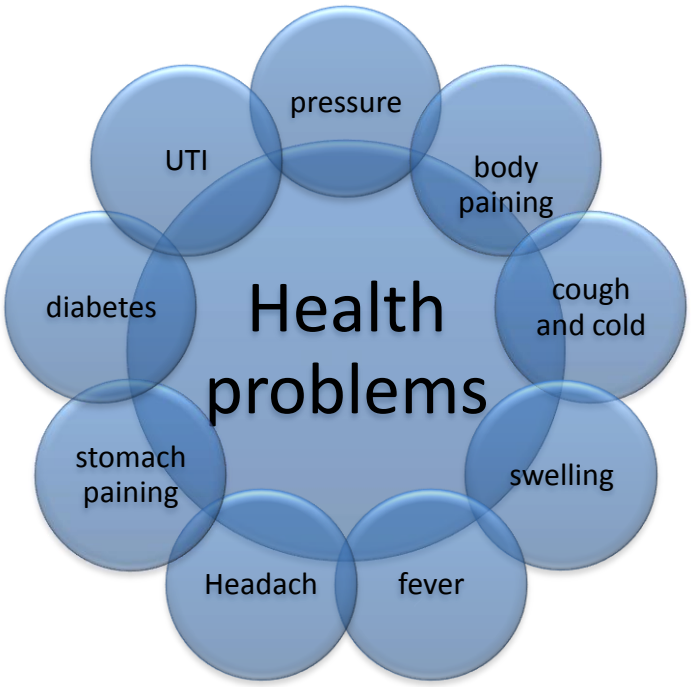
Source: Field work: 19th November, 2014.

The above image gives the information that people face many problems related to health and hygiene due to the filthy surroundings. Each and every house has their drains just beside their house which is filled with dirt and other filthy stuffs. There is also the case of dumping the sewage just in the neighbourhood that gets piled up with dirt and bad smell. This creates a negative health implication for them as well as their environment.

4.5: HEALTH OF WOMEN IN THE STUDY AREA

Most of the respondents believe that they have many negative health implications due to the improper drainage and sewage system. This has affected not just the health of the women but the children as well.

Figure 4.8 Diseases due to the Sewage and Drains

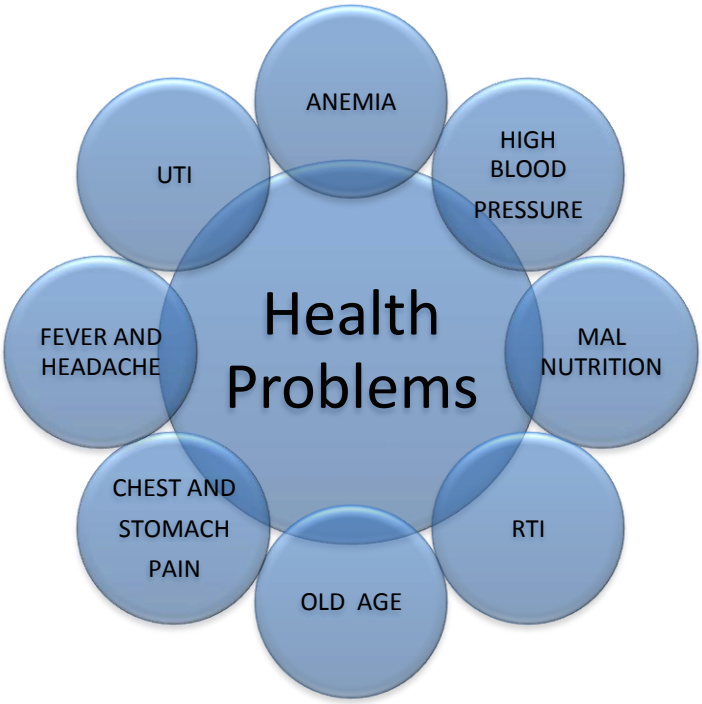


Source: Fieldwork, 15th November, 2014- 13th January 2014.

The above figure shows the health issues that the people face due to the unhygienic condition of surroundings which has direct impact on women and children. Some of the common health problems faced by the respondents are cough, cold, fever and swelling of the body. The problem of the high pressure is seen less among the housewives as compared to the working women. Only few cases of UTI are found among the women respondents and some of them are not aware of UTI and STI. Some of the women don't even think that these ailments are so important. They treat these issues as very normal for them.

There is one health care facility in ward no 17 of the study area i.e. Small Health Post 10, located in Mangalpuri that comes under municipality area where medical facilities are provided mainly for the BPL family. The staff of the SHP 10 handles the cases of ANC and PNC and the cases they handle related to the illness of women are:

Figure 4.9 Cases Reported at SHP 10



Source: Field work 13th January, 2015, interview with the nurse and the staffs of the SHP 10

In this SHP, the majority of the reported cases are ANC and new born baby's health case. This SHP does not have proper medical facilities and lack health infrastructures. Therefore the cases like blood pressure, chest pain etc are referred and treated at the district hospital.

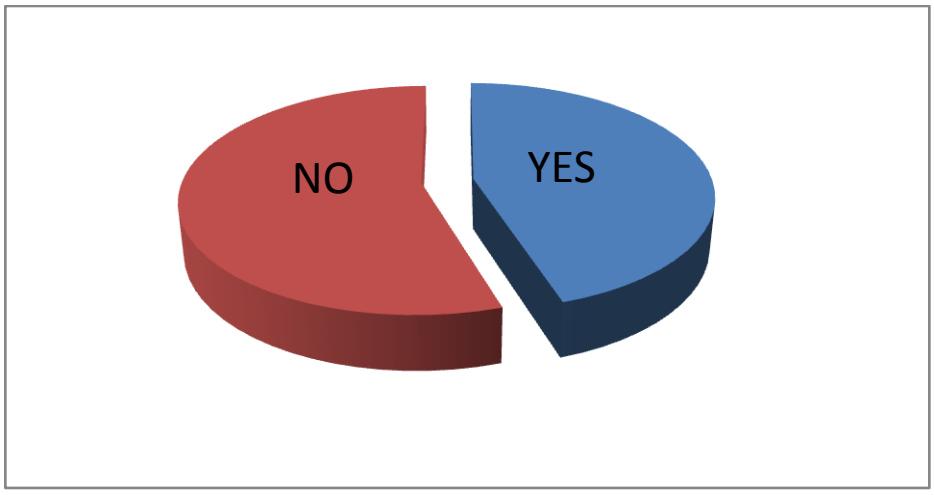
Table 4.10 No of Deaths of Women due to Health Problems from 2002-2008

year	No. of deaths (women)
2002	195
2003	204
2004	182
2005	171
2006	166
2007	165
2008	213
total	1296

Source: Fieldwork, 17th January 2015 and municipal records.

The table above reveals that the number of deaths due to the health hazards likes high blood pressure, cancer, death during delivery; accidents etc are more or less consistent. The maximum deaths toll is found in the year 2008 and the lowest is in the year 2007 where there is decrease in deaths.

Figure 4.10 Reply towards Ailments



Source: Fieldwork 15th November, 2014- 13th January 2015.

The above figure shows that around 55 per cent of women respondents feel that simple ailments are not an issue that should be taken care of and 45 percent of them feel that even minor health issues should be taken care of before it becomes vital and incurable. Most of the respondents felt that blood pressure is very dangerous and should be taken care of as much as possible. But they are not much concerned of sicknesses like headache, stomach pain, body pain, fever, cough and cold etc. Most of the respondents hold the view that maximum number of the health problems are due to the improper sewage and drainage system. So, in order to tackle the situation of the sewage and drains, the respondents from the study area entrusted a group to clean road and their surroundings. This particular initiative was taken to show their support towards the initiative taken by the Prime Minister Shri. Narendra Modi's Swatcha Bharat Abhiyan.

4.6:AVAILABILITY AND ACCESSIBILITY OF HEALTH INFRASTRUCTURES

Majority of the respondents do not utilize the health care facilities that are provided by the government. Most of the people prefer going to the private institutions for the medical needs and also follow shamanism for the healing of their illness. Most of them take their near and dear ones to the shamans for treatment. Though there is a SHP, they prefer going to government hospitals and private hospitals.

Table 4.11 Health institutions and Practitioners in Darjeeling

Health services	capability		
	Type of services	specialization	Total no. of doctors/paramedics
State government 1. Govt hospital 2. Bloomfield police hospital 3. New Victoria hospital 4. No govt nursing home 5. TB hospital	Inpatient department Inpatient department Inpatient department _____ OPD, indoor,OT	Gynaecologist, Maternity, Paediatrics, Medicines, Orthopaedics, Eyes. Do _____ TB	34 4
Municipality 1. SHP-16 2. Maternity Hospital, 3. Policlinic-1	Outdoor	Gynaecologist, Maternity, Paediatrics, Medicines, Orthopaedics, Eyes.	18
Private Hospitals 1. Nursing homes-3 2. Policlinic-1		Gynaecologist, Maternity, Paediatrics, Medicines, Orthopaedics, Eyes.	28

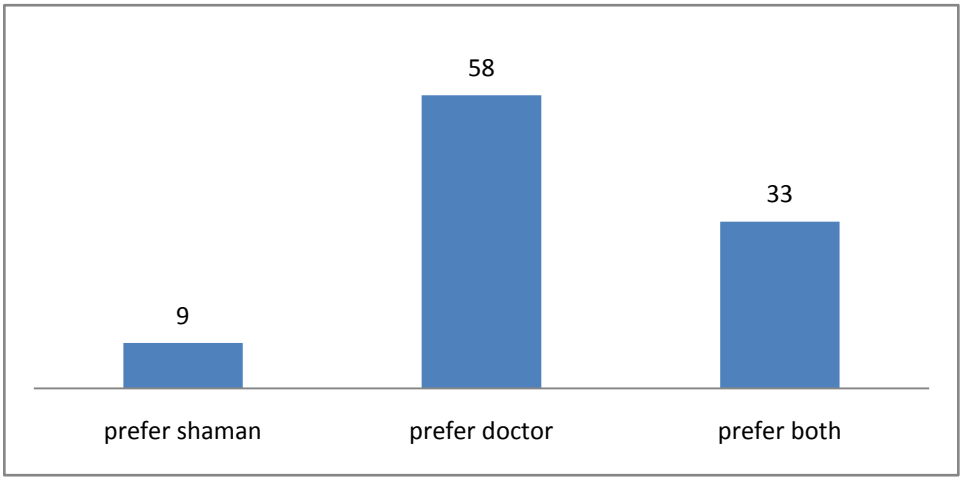
Source: Fieldwork 13th January, 2015 and Darjeeling Municipal Corporation health service delivery plan.

The Darjeeling sub division has six primary health centres in three blocks, viz; Lodhama, Sonada, Ghoom, Pokhriabong, Singritam and Takling. It has one district hospital and one maternity hospital located in Singamari which is 4.7 km away from the main study area. There are also other government institutions that cater to the needs of the people. There is one institution that particularly helps the pregnant women and new mothers. The institution is called 'Small Health Post' where maximum number of cases is related to ANC and PNC. This institution also takes care of the health of the old aged women and the BPL people. There are 16 Small Health Posts in 32 wards in Darjeeling block having the strength of 77 PHWs (Primary Health Workers) that are operational on Wednesdays and Fridays. This PHW has one visiting doctor and is supervised under one sister (nurse) with other staff. There is one Small Health Post in the study area i.e. in ward number 17. There are only 3 nursing homes, 34 doctor's chambers or dispensaries and 36 polyclinics run by individuals or private institutions that clearly indicate the deficiency of the health infrastructure in Darjeeling. There are 11 ambulances operating in the municipality which are sponsored by different health institutions under the jurisdiction of municipality, state and central and private organizations. However the quality of services is average and many times inadequate.

4.6.1: The utilization of health care facilities

Though there are various facilities and health infrastructure available in Darjeeling, these institutions are not much utilized. The most of the respondents approach the government hospital when they are in need of medical assistance and hardly know anything about these Primary Health Centres and Small Health Post. Some of them give preference to shaman than doctors.

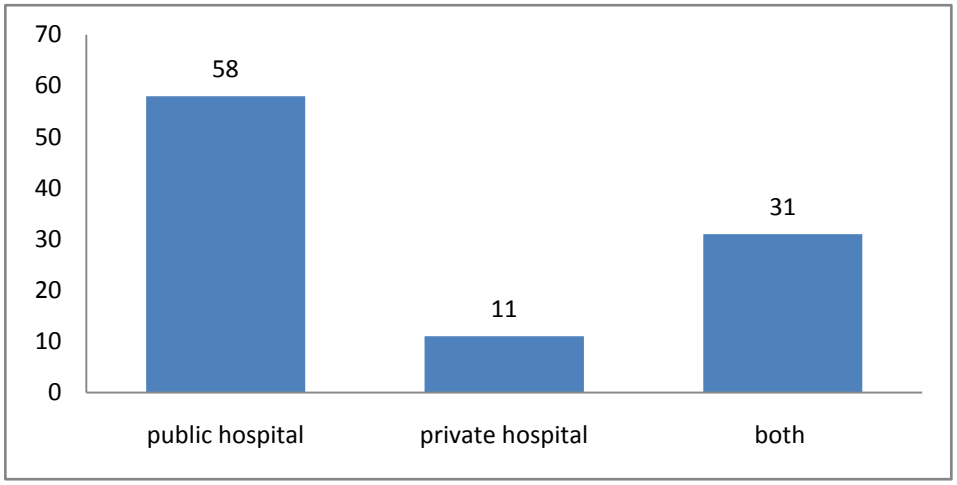
Figure 4.11 Preference to consult their problems



Fieldwork: 14th November, 2014- 13th January, 2015.

The above figure shows that most of the respondents prefer going to the doctors and shamans. Around 9% of the respondents prefer going to the shamans and 58% of the respondents prefer going to the doctors first. And 33% of the respondents prefer going to both doctors and shamans for the treatment. The majority people responded that they use shamans because shaman's treatment works when medicine fails. They prefer to consult doctors and side by side they take help from the shamans too. People are more open with the shamans than the doctors which make the job of the shamans easy and the job of the doctors difficult. When asked whether they visited doctors or consulted their health problems with the doctors, they answered on the affirmative. However most of the times they approached the doctor not for themselves but for their children. Most of them also responded that the reasons for the illness of their children are the improper sanitation, sewage and drainage problems in their surroundings.

Figure 4.12 Preference for consultation in terms private/public hospital



Source: Fieldwork 14th November-23rd November.2014.

As per the data 58% of the respondents prefer going to the public hospital i.e. the government hospital for their treatments, 11% goes to private hospitals and 31% prefer going to both government and private hospitals for treatment. The respondent's preferring public hospitals said that it is cheap and affordable. People preferring private hospitals and clinics say that they want better medical facilities and treatment and do not want to compromise on health. Though there are many instances of improper health management in the government hospitals, they are compelled to approach them since they cannot afford private treatment. There are also incidents of mismanagement of the hospital that had caused serious health hazards to women especially during pregnancy and delivery.

The case of Mrs.Thapa: *one of the 23 yrs old, respondent of the study area in August, 2014 has the case of misbehaviour and mismanagement from the staff of the govt hospital that almost killed the foetus. When she was in labour pain, she was taken to the government hospital for delivery. The mother of Mrs. Thapa approached the staff and sought for help. But instead of helping them they scolded her and said that the time has not come. Though she was in severe labour pain, no emergency aid was given to her. They said that the fetus had started eating the dirt of the womb of her mother. However when the doctors came to know about it, they did the operation and saved the baby and the mother because it almost crossed her time and the date of delivery. She said that doctors were very good and kind to them though the staff created chaos that saddened them.*

The case of Mrs. Rai: *Her case is not like the mismanagement of the hospital staffs but doctor in the private Yuma Hospital. Mrs.Rai who is 45 yrs old had terrible sinus problem since 12yrs. As a result she was not able to concentrate on her work and even had to abandon her job. In 2011 she went o the above mentioned hospital and the doctor did the operation on her nose which was not successful. Now she can hardly feel the sensation of smell and sometimes it leads to continuous bleeding of the nose for 5 to 10 minutes. Now she undergoes treatment both for sinus and for the consequences of her operation.*

Table 4.12 Knowledge of Primary Health Care and Small Health Post

Knowledge	Numbers
Know	**9**
Don't Know	**79**
Know but do not go	**12**

Source: Fieldwork 15th November, 2014-13 January, 2015.

The table above shows that 9% of the respondents have the knowledge about the health care centres, 12% have the knowledge but prefer going to the district hospital, and 79% do not know about such centres in their locality. The Government of India had initiated the schemes for the ANC and PNC facilities for the mother and the child until they reach the age of five. The immunization of child and the mother are free in these centres. This scheme is also available in Darjeeling and even the transportation facilities are freely provided to the needy.

Table 4.13 Reported Antenatal Care and Post natal checkups at SHP ward No. 17

Year	No of ANC and PNC checkups
2009	9
2010	12
2011	12
2012	7
2013	12
2014	9
Total	61

Source: Fieldwork 15th January, 2015, SHP 10 report 2009-14.

The above table shows that SHP is least utilized by the women. Over the last six years, only 61 cases of women came for the checkups and immunization. The lowest is in 2012 where only 7 women came for the treatment and checkups. One of the major reasons why women are not making use of SHP is that the district hospital is nearby where they have sufficient medicines and better infrastructure.

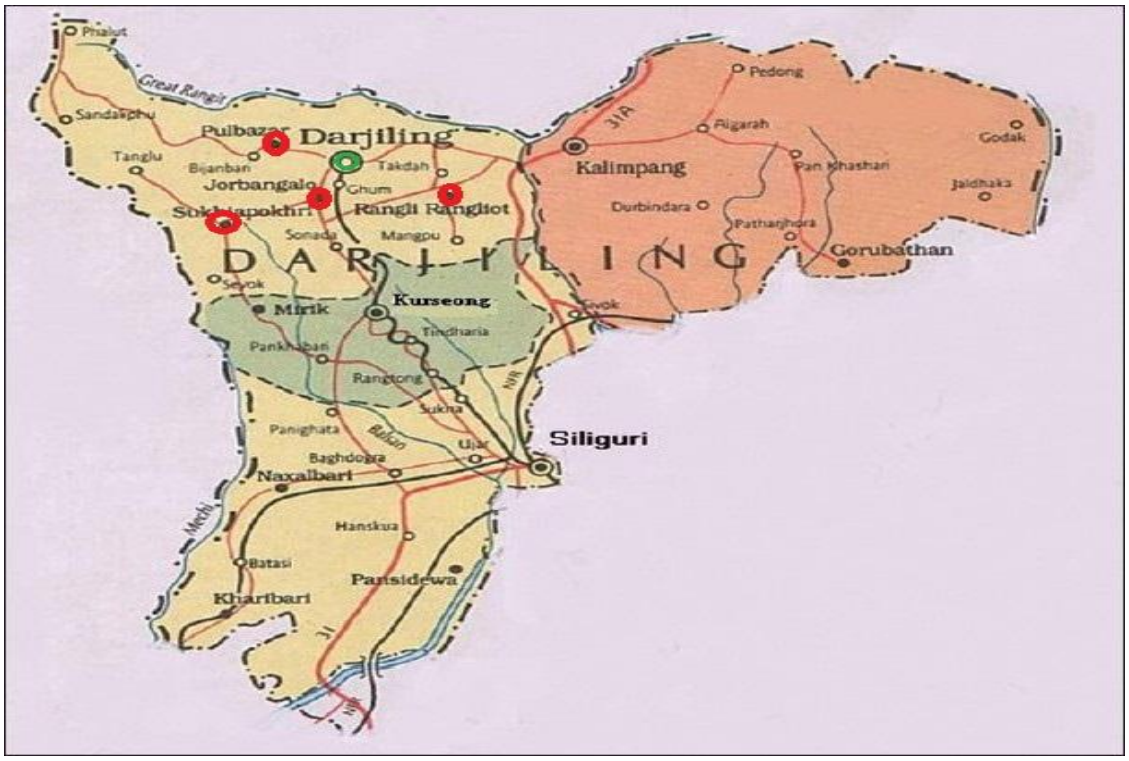
Table 4.14 Reported Children immunizations at SHP ward No. 17

year	March2007-april 2008		April2008-march 2009		March2009-april 2010		April 2010-march 2011		March2011-april2012		April2012-march 2013		April 2014-march 2015	
sex	M	F	M	F	M	F	M	F	M	F	M	F	M	F
age														
Less than 11 month	3	2	1	3	4	6	3	5	4	7	4	7	2	3
1 yr	4	2	6	6	5	2	0	0	1	3	1	0	1	3
2yr	1	4	2	1	0	2	1	0	0	0	0	0	0	0
3yr	3	1	1	0	1	0	1	1	0	0	0	0	0	0
4yr	0	0	0	0	0	0	0	1	0	0	0	1	3	2
5yr	0	0	0	0	2	1		1	0	0	0	0	0	0
total	11	9	10	10	10	11	5	8	5	10	5	8	6	8

Source: Fieldwork 15th January, 2015 and report of the SHP 10.

The above table shows that the maximum number of the child immunization is done in the SHP as it is most suitable and easy for them. The rush and long queue in the hospital makes the people to approach the SHP. There are 16 SHPs all over Darjeeling that is easily accessible to the people. Children below the age of five are immunized in this health centre. Since some medication is available in this centre it is indeed a boon for the women during pre and post pregnancy. Not only that guidance for the newly and expecting mothers are give here and even certain medication are also given which makes easier for the women to access medication during pre and post pregnancy. The most important advantage SHP is that it is just one and a half kms from the study area.

Figure 4.13 Map of Darjeeling



Notes: the red circles are the blocks where the primary health centres are located and their distance from the area of the study which is denoted by green.

Source: www.googlemaps.com, 16/12/14.

Health centres are far from the study area and most of the women do not wish to visit health centres as it is consuming time, money and energy. The distance from the study area to the PHC Blocks are 41.0 kms to Lodhama, 14 kms to Sonada, 8 kms to Ghoom, 18.5 kms to Pokheriabong, and 53.2 kms to Rangli Rangliot. So the respondents prefer going to the District Hospital which is very close to their area.

4.7:PROJECTS AND FUNDS OF THE SLUM DEVELOPMENT IN DARJEELING

In order to facilitate a good arena for the slum dwellers the government has allotted certain projects and funds for the development of the slums.

Table 4.15 Infrastructure Projects in Slums area

Project	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
	Total project Cost(lakhs)	Total project cost (lakhs)	Total project cost (lakhs)	Total project cost (lakhs)	Total project cost (lakhs)
Comprehensive Slum Development at Raja hatta	0	52.76	0	0	0
Comprehensive Slum Developmentat pinnel market	0	62.92	0	0	0
Comprehensive Slum Development at Dara Goan	0	49.19	0	0	0
Comprehensive Slum Development at Nimki dara	0	81.16	0	0	0
Comprehensive Slum Development at Lasha villa	0	89.06	0	0	0
Comprehensive Slum Development at Bhaktey busty	0	58.73	0	0	0
Comprehensive Slum Development at Alubari busty	0	97.44	0	0	0
Comprehensive Slum Development at Jawahar busty I	0	66.9	0	0	0
Comprehensive Slum Development at	0	77.7	0	0	0

Jawahar busty II					
Comprehensive Slum Development at Lower rockhood	**0**	**70.9**	**0**	**0**	**0**
Comprehensive Slum Development at mangalpuri	**0**	**119.52**	**0**	**0**	**0**
Comprehensive Slum Development at Sister Nividitya gram	**0**	**94.51**	**0**	**0**	**0**
Comprehensive Slum Development at Pragrati gram	**0**	**121.09**	**0**	**0**	**0**
Comprehensive Slum Development at Shiva gram	**0**	**70.05**	**0**	**0**	**0**
Comprehensive Slum Development at Eden compound	**0**	**55.74**	**0**	**0**	**0**
Comprehensive Slum Development at Burns gram	**0**	**108.51**	**0**	**0**	**0**
Comprehensive Slum Development at Frymal village	**0**	**89.24**	**0**	**0**	**0**
Comprehensive Slum Development at Bhanu gaon	**0**	**82.4**	**0**	**0**	**0**
Comprehensive Slum Development at Bhotey busty	**0**	**66.76**	**0**	**0**	**0**

Comprehensive Slum Development atNabin gram	**0**	**90.57**	**0**	**0**	**0**
Comprehensive Slum Development at Ging busty	**0**	**111.66**	**0**	**0**	**0**

Source: Fieldwork 13th January, 2015 and Municipal Corporation of Darjeeling Draft Development Plan.

The above table shows that only in the year 2009-2010 the projects were sanctioned in 21 slums in Darjeeling. The projects mostly comprise of water distribution lines, drainage, concrete roads, and street lights. Most of the slums lack these basic facilities and in some areas there are no street lights. The drainage is the most pathetic part of the slums because most of the houses are built right next to these drains. To worsen the situation in some places these drains are used as latrines which not only pollutes the environment but also has serious health hazards.

Table 4.16 Other development projects in Slum Areas

Name of the project	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**
	Total cost In lakhs	Total cost In lakhs	Total cost In lakhs	Total cost In lakhs	Total cost In lakhs
No. of sewer and kitchen based Bio gas plant And disposal system in slum Mangalpuri	0	34.44	0	0	0
No. of livelihood centre training for capacity building at the slum nimki dara	0	37.94	0	0	0
No .of community centre of 223.40 sq.m at the slum of Raja Hatta ward no 1 and Bhanu Gram ward no 28	0	40.49	0	0	0
No. of informal markets at lower Rockwood ward no 16	0	33.93	0	0	0

No. of animal pen of 704sq.m at the slum of Mangalpuri of ward no 17	0	11.45	0	0	0
Making provision for safe drinking water for all the slums area	5.00	0	0	0	0
Making provision for road connectivity Reference to all inhabitant specially for slums	6.87	0	0	0	0
Setting up street light in main roads of Darjeeling Municipality around slums area	0	11.10	0	0	0

Source: Slum Infrastructure Draft Development Plan, Darjeeling Municipal Corporation.

4.8: Solutions given by the Respondents to address the problems

As per the feedback given by the respondents they are deprived of proper health care in terms of medicine, infrastructure and live in an unhygienic environment vulnerable to diseases. If the health of women is affected, it adversely affects the entire family. Some of the suggestions given by the respondents to address the health related issues are;

- **Proper sanitation-** Proper sanitation facilities can overcome most of the health related issues faced by the slum dwellers**.** Sufficient Public toilets with water and light facilities under the supervision of a woman caretaker to manage and maintain them are required to address the issue.
- **Solid waste management-** Waste products should not be dumped into nearby drains or near the residential areas. It has to be either collected house to house or should be dumped in a place allotted for it. Authorities should take initiative in providing space for dumping the waste products and cleaning it from time to time.
- **Drainage system-** Drains should be made pucca and there should be people entrusted to oversee that it is functioning properly. It has to be covered so that people do not dump waste into the drains creating epidemics and diseases.

- **Water facilities-** At present there is only one water supply catering to the needs of the people of the area which is not sufficient. Therefore more water connections need to be provided by the authorities for the well being of the people.
- **Proper connections of the pipes-** The pipes that carry the waste products, especially the latrine pipes are not either connected properly or are broken. This not only pollutes the environment but affects the health of the people. Therefore periodical maintenance of these pipes is a priority.
- **Awareness camps in terms of the health and health infrastructure –** Since most of the people of the area of study are not aware of health and infrastructure facilities provided by the government, there should be occasional awareness camps or even a body of people to make known to them about the available facilities. This will also enable them to be aware of their health problems and the way to tackle them.
- **Proper infrastructure in the government and private hospitals-** The government and private hospitals do not have sufficient infrastructure that can meet the demands of the people. Therefore they want the government to provide adequate and necessary infrastructure to the hospitals and health centres so that they don't need to go for the treatment to other parts of India which is highly expensive and time consuming.
- **Free medicines-** At present government health institutions provide free medicines only for ordinary minor sicknesses. But when people are affected with severe major sicknesses they are asked to buy the medicines from outside hospital which is very expensive. Therefore there should be some provisions to get free medicines for major sicknesses in subsidised rate.

CHAPTER- V

CONCLUSION

Survival has been the core of every State since the ages and in order to secure its nation and its people, war was the only outcome for it. Military might was the weapon for the security of the nation. But as time passed on and this security agenda was challenged by other forms of issues like environment, health, economic, societal etc, where people became the centre of protection. The definition of security thus moved from the state to human. This present study shows how traditional concept of security has been broadened to include non-traditional threats where the role of the national and international system is very important and plays a very crucial role in sustenance of health of the world. The evolution of National Security to Human Security which today constitute a comprehensive security analysis with various factor such as environmental security, water security, energy security, health security etc. This study attempted to securitize the health of the women labourers living in the slums from international, national and regional perspective by examining the experiences of Darjeeling. The study tried to substantiate that the health of the women will definitely define the progress and prospects of the state in the present and future.

The security of the people mainly lies in the hands of the State to protect its people from various threats irrespective of caste, class, religion etc. In this regard the study has given a clear picture of human security which is of most challenging area to address widespread and cross-cutting threats facing both government and people. Once we recognize that human security varies considerably across countries, at different points in time, the application of human security calls for an assessment of human insecurities that is people centred, comprehensive, context-specific and preventive. The advancement of human security gives rise to more immediate and tangible results that comprehensively address the root causes behind the threats; identifies priorities based on the actual needs, vulnerabilities and capacities of Governments and people and reveals possible mismatches between domestic, regional and international policies and responses. The combinations of these elements help to strengthen actions taken by Governments and other actors in support of human security. The main agenda of the State is not only to secure its national boundaries and to safeguard from the external threats but the State should also secure its

people from the internal threats emerging from economic, political, societal, environmental and most specifically health security of the individual which is the one of the theme of human security. Unless the health of the people isn't secured there will always be insecurity towards the human life.

It is not the security of the State that should given priority but security of human in focus should be the main agenda of the security. Health is one of the most important areas which should be given more attention because it has the tendency of spreading, like the 1918 Influenza in America which almost killed thousands of people and the Spanish flu struck 294,000 allied troops in the fall of 1918 alone. The most terrorizing feature of disease is the outcome of bioterrorism where these diseases play very dangerous role creating further health hazards on the world. The most dangerous effects of the health are that use of virus as weapon of war like the biological agents in the war. For example, use of anthrax in United States. The effects of these infectious diseases are not the concern of one country it's the concerns for the entire world.

Threats to life may vary from time to time in different forms which may affect male and female differently especially during war. Women are more victimized than men because women are very easy prey during the war time not only that they fall into the pit of exploitation they are also assaulted by the people who they consider as their saviours like the peace keeping force. The humanitarian worker works as the suppliers of the trafficked women and girls. It may also happened that in order to save her family and children they often negotiate their body for the survival which sometimes leads to serious post-traumatic stress and disorder. In certain matters the security need of the women and girls are neglected and often their issues are not even considered as the security issues by the policy makers. Women are often considered as the secondary when security is concern which makes clear reasons for the rise in the number of sexual exploitation of women in India especially in the slums area.

There is a rise in the slums population in India further creating many negative health outcomes. The reasons for the negative health outcomes of women in slums are the improper sanitation facilities available in the slum house holdings, water facilities etc. In India the maximum number of the rape occurred due to the absence of the sanitation

system in the slums, far distance between houses to latrines. The maximum number of the people in the slums has latrines without water and the conditions of the latrines are disgusting further increasing high risk of UTI and RTI for women and girls. And plus they face inmate violence inside their own house which further help in decline of her health. In order to upgrade the health of women and slums the government have initiated many programmes, policies and even laws have been implemented like the government of India has launched a National Rural Health Mission and National Urban Health Mission in 2005, Jawaharlal Nehru National Urban Renewal Mission, Swarna Jayanti Shahari Rozgar Yojana, Scheme of Slum free City Planning for Rajiv Awas Yojana Janani Suraksha Yojna etc for slum upgrading programme and Janani Shishu Suraksha Karyakarm, Accredited Social Health Activist (ASHA) etc, to promote institutional delivery among pregnant women in rural areas of India. Though having these provisions there are cases of underutilization of health care institution because of the social and cultural structure present in the Indian society. The patriarchal system which is prevalent in India gives more power to men over women in social, economic, political and cultural setting. It has been discussed in this study that the most of the women's health needs are all guided by her husbands or her family and even she doesn't have any say in her physical need. Not only that the women themselves avoid the safe methods of institutional delivery because of the fear of embarrassment, surgical intervention, uncomfortable atmosphere of the hospital, inadequate behaviour of the hospital staff , expensive medical treatment etc.

Health institution is the one of India's largest sectors in terms of revenue and employment and this sector is constantly expanding since 1990's. Indian health care grew at the compound annual rate of 16 per cent, today the total value of the sector is 34 billion USD and India ranked as the world's 4^{th} largest pharmaceutical market in terms of volume. Though it's a leading pharmaceutical market but its accessibility is very complicated. Most of the people neglect the health system due to its expensive treatment and people still lacks health care. There are many reported cases where cases of death due to the displaced health care system, the unavailable and expensive medicines. Indian health care systems are more privatized which are too expensive for common people. The condition of the government hospitals are very pathetic and poor management compel

poor people to avoid government health infrastructure which further decline the health of women which may give one of the explanations for decline in her health.

When comparing the health status of different states in India it is found that most of the cases are similar, where the case of Darjeeling is also pretty much same. The study is conducted in the three area of ward no 17 which are Giri Dhara, Nava Jyoti and Amar Jyoti which are situated below railway station, Lowis Jubilee and Tourism quarters. The study reveals that most of the basic necessity in the slums of Darjeeling is missing like water facilities, sanitation, garbage disposal etc. which has been the sole reasons for the ill health of the women and their children. Apart of having health problems the people are dealing with other problems like they are illegally resided in this area. They are in a dilemma because at any point of time they can be vacated from this area. The most important problem they are facing is that being resided in the railway land the municipality is not considering them as municipal area and not only that the railway authority is also not considering them any facilities. This situation has given rise to number of problems as they are eliminated from all the facilities from both the municipality and railway authority. Poverty is the main reason behind the reason to which they are staying in this area. They don't have any option or cannot afford to have a proper house.

Unlike the other states of India, Darjeeling doesn't have the cases of HIVs in the slums area but it has the tendency of having it in future if not checked properly. But there are number of cases of RTIs and UTIs in the slum area due to the lack of proper sanitation facilities and water. The study draws and understanding that most of the health care centres in Darjeeling are underutilised where illiteracy and lack of knowledge among the women makes the situation even worse in terms of her health in Darjeeling. The lack of knowledge about the proper health care system creates extra burden on the health of a women and even her child.

Findings of the study

- Health security is emerging as the one of the most important issues in the National and International level.
- Health has multiple dimensions it's not about the physical well being but also psychological, social, economic etc; it is only after addressing all these phenomena a sustainable health of the nation will occur.
- The most important feature of the ill health, rape, sexual assaults of women living in the African regions is the lack of proper sanitation facilities and water scarcity.
- Poverty is the one of the major issue of women and girls trafficking in the International and National level.
- Socio cultural structure prevalent in India has given rise health problems for the women in the slums of India and not that women themselves avoided many health care facilities.
- Illiteracy is a major drawback in terms of underutilization of Health care in India and Darjeeling.
- Most of the people in the study area are feeling and living in insecurity because most of them are residing illegally in the Railway station's land. They fear of losing their home and becoming homeless. As the people are aloof of their basic necessity because the railway authority don't consider giving facilities to these people as they are staying illegally and neither Municipality because the Municipality considers that area as the railways area. So on both ways the people are not getting any benefits from either party.
- The people from the study area shares one latrine with four to five households without water and light. The most pathetic condition is the disposal system where the maximum numbers of the houses are built upon which are congested and which are without any ventilators.
- A large number of Health care institutions are situated in the urban area i.e. Darjeeling which creates a very difficult situation for the people from rural area to rich the hospitals.

- There is strong resentment towards the management of the hospital because of less investment in health infrastructure, mismanagement of the funds, less or no medicines, rude behaviour of the health staffs etc.

The study reveals that illiteracy is one of the reasons for the underutilization of the health institution which has created health problems in the slum of Darjeeling. So in order to improve the health of the women in slum of Darjeeling, education should be given most priority not only that the provision of night school should be developed as the most of the women are dropouts. In order to do so the political environment has to take up these issues very strongly and carefully. As securitization can only take place when there are the hands of political system so, the political environment has to be reformed and take up issues like the education for the drop outs, maximum numbers of investment in health infrastructure, sanitation and water facilities. Counselling and skill development programmes should be developed in the slum area so women can do something and earn for their family. As there are many Civil Societies in Darjeeling but none of them are working or taking the issues for the women labourers in the slums of Darjeeling so, more Civil Societies should come out to work for the cause of women labourers in slums of Darjeeling.

Further studies can be conducted in order to understand the different health problems in slums of Darjeeling. A study should be taken to know the health gap like the utilization, accessibility and availability between slums and non slums areas. Many studies should be initiated like the sanitation system, water facilities, and disposal system. As most of the governmental programmes, schemes policies are not properly implemented in Darjeeling so more studies can be carried out to find out the reasons and implementation so there will be reduction of health problem.

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APPENDIX

Questionnaire

1. Name of the respondent: _____
2. Age: _____
3. Educational qualification: _____
4. Occupation: _____
5. Where are you staying?
    a) Own house
    b) Rented house
    c) Quarters
    d) Others
6. Do you have any health problems: Yes/No
7. What kind of health problem do you face?
    a) Pressure
    b) Mal nutrition
    c) UTI/STI
    d) Others give details
8. Do you consider headache, fever, pressure, cough and cold etc. as an important factor in terms of health? Yes/No
9. If any member of the family gets sick where do you take them for medication?
    a) Government hospital
    b) Private hospital
    c) PHC
    d) Others, give details
10. When you are sick, where do you prefer to go for consultation?
    a) Doctor
    b) Traditional healer (shaman)
    c) Don't got
    d) Others give details
11. Have you ever consulted your health problem with a doctor? Yes/No

12. What is the house holding status of the slums people?
    a) Tourism quarters
    b) Railway quarters
    c) Own house
    d) rented
13. What kind of sanitation facilities are allotted to the people in slum area?
    a) Sharing
    b) Private
    c) Public
    d) own
14. What kind of health problems arises due to sanitation facilities?

    _____

    _____

    _____

15. Does the lack of clean and pure water have negative impact on your health? Yes/No
16. What is the source of water?
    a) Spring water
    b) Municipality water
    c) Buy
    d) Own source
17. Do you know about the government Primary Health Centres in Darjeeling? Yes/No
18. What is the distance between the health care centres from your place?

    _____

    _____

    _____

19. Do you face any problems in hospital? Yes/No
20. Do the health care centres have sufficient infrastructure and staffs? Yes/No
21. Do you have any suggestion and recommendation to improve the health infrastructure in Darjeeling?

    _____

    _____