International Journal of Community Medicine and Public Health
Prabhu AV et al. Int J Community Med Public Health. 2021 Dec;8(12):5989-5992
http://www.ijcmph.com
pISSN2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20214602

Original Research Article

Health status of househelps living in the semi-urban area of Goa

Aadini V. Prabhu*, Hemangini K. Shah

Department of Preventive and Social Medicine, Goa Medical College and Hospital, Bambolim, Goa, India

Received: 26 September 2021
Accepted: 01 November 2021

***Correspondence:**
Dr. Aadini V. Prabhu,
E-mail: aadini.p@gmail.com

ABSTRACT

Background: The world's population is on the rise and so is the need for good housing and job opportunities. This has led to an increase in the number and overcrowding of existing slums which lack reliable sanitation and hygiene. People who work as househelps take on the responsibilities of the households where they work and their own families. The study was undertaken to determine the health status and quality of life of househelps residing in Goa.
Methods: A Community based cross sectional study was carried out among househelps living in the semi-urban area of Goa. Participants were selected via snowball sampling. Information was collected through a predetermined questionnaire and via medical examination, after initial briefing. The data was compiled; analyzed and appropriate statistical tests were applied.
Results: Marriage before 20 years of age was noted in majority (70.2%). Poor housing standards were noticed in 94%.64% had increased working hours. 80% of the househelps had health complaints of backache, menstrual problems, fever. Statistically significant difference was observed between daily working hours and morbidity, and between age of marriage and number of children. Number of children and morbidity also showed significant statistical relationship.
Conclusions: The study highlights the problems faced by the domestic helps which can be tackled by implementing laws which recognize them as a part of the organized sector, holding health camps in rural areas, increasing awareness about the diseases spread in an unhygienic environment.

Keywords: Househelp, Health, Semi-urban, India, Quality of life

INTRODUCTION

"You can tell the condition of the nation by looking at the status of its women." Said by Jawaharlal Nehru. The urbanization of different parts of the world constitutes a major demographic issue of the twenty-first century.[1] Over 55% of the world's population live in the urban areas, a proportion that is expected to increase to 68% by 2050.[2]Rapid urbanization first became manifest in the countries undergoing industrialization in the developed world, and today its prime locus is the poorer parts of Asia and Africa.[3] According to the 2011 census of India, the level of urbanization increased from 27.81% in 2001 census to 31.16% in 2011 census.[4] The rise in the urban population is contributed by the migration of the rural poor in search of a better standard of living which has led to the development of urban slums.

As per UN habitat, a "slum" is characterized by lack of durable housing, insufficient living area, lack of access to clean water, inadequate sanitation and insecure tenure.[3] Globally slums have been recognized as neglected communities. The poor health outcomes that slum residents exhibit are rooted in three key characteristics of slum settlements: poor environmental conditions and infrastructure; limited access to services due to lack of income to pay for treatment and preventive services; and reliance on poor quality and mostly informal and

unregulated health services that are not well suited to meeting the unique realities and health needs of slum dwellers.[5] The poor environmental condition coupled with high population density makes them a major reservoir for a wide spectrum of adverse health conditions such as under nutrition, delivery-related complications, postpartum morbidity, etc.[1] These conditions have an effect on the physical as well as the mental health status of the inhabitants.

The slums are usually overcrowded and house migrant workers, some of who work as domestic help. A domestic worker or domestic helper is a person who works within the employer's household. The data analysis of the National Sample Survey Office (61st round, 2004-2005) reveals an approximate figure of 4.2 million domestic workers in the society.[6]Women working as house helps or 'bais' in the houses of the upper socioeconomic class either work as part-time workers, full-time workers or as live-in workers.[7] Many of the helps who work part-time or full-time, go back home to take care of their own families.

In a cross-sectional study conducted in Sri Lankan women returning home as domestic maid complaints of physical violence directed mainly through their employers were made by 60% of women. Upon physical examination, two-thirds had evidence of injuries, with a third being subjected to repetitive/systematic violence. Eighty percent suffered some form of psychological trauma.[8] Taking into consideration that the domestic helps tend to overwork and ignore their health which could affect the quality of life led by them, the study was undertaken.

METHODS

A community based cross-sectional study was conducted to assess the health problems faced by househelps in the semi-urban area of Goa. Househelps in the age group of 18-65 years were included in the study. The study was conducted over a period of 2 months (August-September 2017). Sample size was calculated and 100 sample size was considered for the study. Snowball sampling technique was used. The study area was mapped and few study subjects were identified. The participants were then requested to recruit in more subjects for the study.

A written informed consent was taken from the participants prior to the study and a personal interview was conducted in the language comfortable to them. A self-designed questionnaire was used which included various subject matters like health problems, health seeking behavior, sanitation along with the demographic data of the househelps. Interviews were conducted face-to- face and the questionnaires were filled as per the answers given and a general medical examination was also conducted. Strict confidentiality was maintained.

The data was compiled on MS Excel and analyzed using appropriate statistical tests and chi square test. A p value of less than 0.05 was considered statistically significant.

Study design

Current study was a field operational research.

RESULTS

Majority, 89% of the participants were within the reproductive age group of 21-50 years. Out of the 100 study subjects, 6 were unmarried during the time the study was conducted and 94 were married. Amongst those married, a staggering 70.2% were married before the age of 20 years (Table 1).

Table 1: Age at which participants got married.

Age (years) of marriage	Frequency	Percentage
5-10	1	1.06
11-15	31	32.97
16-20	34	36.17
21-25	23	24.46
26-30	4	4.25
31-35	1	1.06
Total	94	100.00

46% of the women had 3 living children or more, while 32% had 2 living children (Figure 1). Overcrowding was noticed in the houses, with 35% having 5-8 members and 31% having more than 9 members in the house (Figure 2). 37% worked 4-6 hours a day, while almost half the study group worked more than 6 hours a day with 38% working 7-9 hours/day and 9%, 10-12 hours/day (Figure 3).

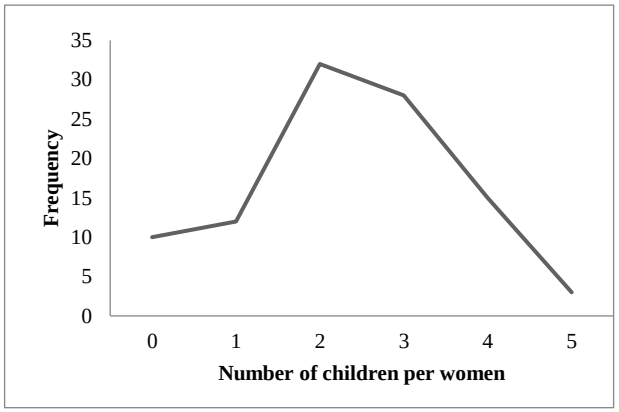

Figure 1: Number of children.

20% did not complain of any health issues while a substantial number of participants (80%) complained of health problems (Table 2). The most common complaints being fever (17.6%), headaches (15.1%), menstrual problems (13.4%) and syncopal episodes (11.7%).

Substance abuse was asked for in the study and while 78% did deny substance use 22% did give a history of paan or tobacco chewing. On general examination of the participants, they showed a mean pulse of 79.3 bpm and a mean systolic blood pressure of 115.46 mmHg and a mean diastolic blood pressure of 84.57 mmHg. Pallor was noticed in 36% of the domestic workers.

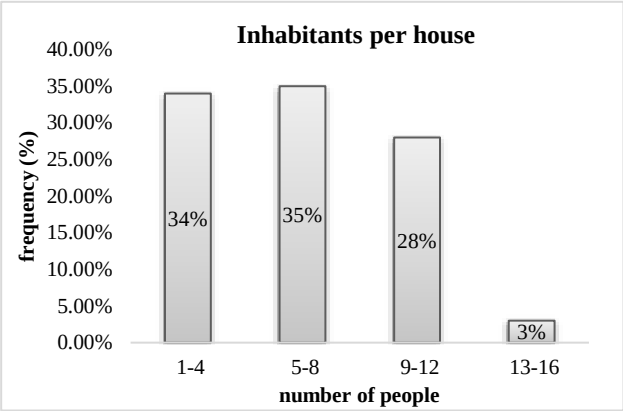

Figure 2: Standard of living.

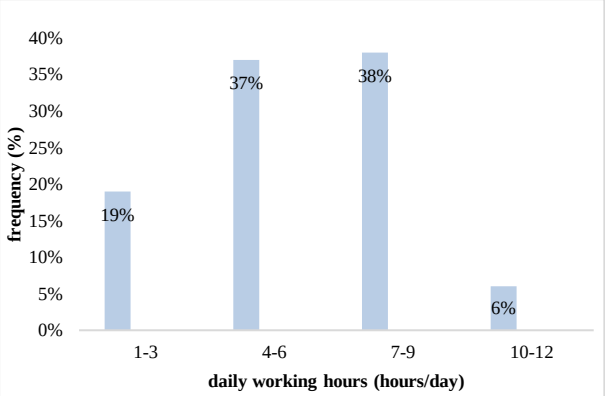

Figure 3: Daily working hours of the household.

Significant statistical difference was observed between morbidity and daily working hours (p=0.0003). Significant statistical difference was also detected between age of marriage and the number of children (p=0.03). Number of children and morbidity had significant statistical relationship (p=0.003).

DISCUSSION

In the present study 59% of women were married before the age of 18 years. According to the prohibition of child marriage act, in India a girl cannot marry before the age of 18. Early age of marriage predisposes women to an early age of child birth, increased chances of complications during childbirth and consequently to an increased number of children.[9] Housing standards were not met in more than 90% of the participants, with most having 2 rooms, one meant for cooking and the other for sleeping and recreational activities. Sharing of a common outdoor bathroom by 3-4 households was noted. Overcrowding, poor housing standards and unsanitary surroundings predispose the family members to communicable and infectious diseases.

Table 2: Morbidity in study population.

Morbidity	Frequency	Percentage
Joint ache	7	5.8
Menstrual problems	16	13.4
Syncope	14	11.7
Fever	21	17.6
Allergies	6	5.0
Malaria	6	5.0
Headache	18	15.1
Acidity	10	8.4
Body ache	11	9.2
Others	10	8.4
Total	119	100.00

As seen in the results, majority of the domestic helps had increased working hours with 64% working more than 7 hours/day. As per the factories act 1948, no adult can work for more than 48 hours in a week and not more than 9 hours in a day. It is a common practice for househelps to work in multiple homes in a day, as this usually guarantees a higher gross monthly income and this could be a driving reason for increased working hours/day. Health problems included menstrual issues (13.4%) like menorrhagia, dysmenorrhea, severe premenstrual syndrome. Joint ache (5.8%) and body ache (9.2%), fever (17.6%) and allergies (5.0%) were noted. Psychological stress was also reported by some house helps. In a community based cross sectional study conducted by M. Bhanderi et al wherein the reproductive morbidities among married women living in the slums of Rajkot, Gujarat were studied, 57% of women had at least one reproductive morbidity; of these, only one third sought health care. Providers' poor attitudes, poor quality of services, and long waiting times were found to be the reasons for not utilizing health facilities.[10] The findings of the present study correlate to a cross sectional study done by Pataro SM et al wherein the prevalence of back pain was noted in 37% urban cleaning workers. Among them, 62.8% of workers felt pain in the last 7 days. Lower back pain was associated with longer working hours, flexion and trunk rotation, psychosocial demands, working directly in collection and low schooling.[11] 5.0% of women suffered from vector borne diseases like malaria, conceivably owing to the unhygienic surrounding. According to the National family health survey (2005-06) 36.8% of the women in rural Goa suffered from anemia.[12]With pallor being noted in 36% of the women in the present study there has not been any change in the anemic status of the women over the past years. Regarding the health seeking behavior, a greater preponderance was seen towards private practitioners. When asked, various reasons were given with the common ones being, time lost on commute and long lines, OPD timings being inconvenient, need for multiple

follow ups and so on. This is different in comparison to a study conducted among rural population of south India by Chauhan et al wherein 54.6% of the study participants visited public health facilities.[13] However, in the study majority of the study population were males and therefore cannot be directly used as a comparison. While some of them did go to a tertiary care setting, it was noticed that they either did not follow up or followed up with a private practitioner. Use of Ayurvedic remedies and self-medication were practiced by the study population.

Limitations

This study was limited by its consideration of self-reported illnesses without any clinical diagnosis of morbidity; the estimation of morbidity could be inaccurate, and this may in turn affect the causal relationship.

CONCLUSION

India stands second, below China as the most populated country and is projected to overtake China by the year 2030. The urban and rural population is increasing tremendously. With this rise, the population of the slum dwellers might increase with a surge in the number of househelps who will thereby face problems in health care and sanitation. This study shows that there are statistical significant differences in daily working hours and morbidity, age of marriage and number of children, and number of children and morbidity. Health problems encountered by the house helps can be addressed by conducting free clinical checkups regularly. The government can play a pivotal role by implementing laws that recognize domestic workers as a part of the organized sector and in doing so providing them with job security, fixed working hours, standardized pay and health and insurance benefits. The findings of the study point towards the increasing needs of providing affordable housing and effective health care for domestic helps so that they can have a better quality of life.

ACKNOWLEDGEMENTS

Authors would like to thank the HoD of Preventive and Social Medicine, Dr. Jagdish Cacodkar, Ms. Aavani Prabhu and to all who supported the current study.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Prabhu AV, Shah HK. Health status of househelps living in the semi-urban area of Goa. Int J Community Med Public Health 2021;8:5989-92.