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Healthcare and Nutrition Amongst the Residents of Urban Slums Across India to Understand Inequalities in Urban for A Shift from Vulnerabilities to Resilience for a Sustainable Future

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Original Research Articles

Healthcare and Nutrition Amongst the Residents of Urban Slums Across India to Understand Inequalities in Urban for a Shift from Vulnerabilities to Resilience for a Sustainable Future

Dipti Mayee Sahoo[1], & Sneha Patnaik[2]*

Abstract

Urbanization, a defining feature of the twentieth and twenty-first centuries, has significantly transformed human settlement patterns, yet its impacts on health and well-being remain insufficiently understood. This study explores the relationship between urbanization and health, particularly in low-income urban areas of developing countries, where rapid urban expansion has led to complex social, environmental, and health challenges. The research aims to analyze the interplay between urban planning, health determinants, and social and environmental policies, highlighting the necessity for an integrated, multi-sectoral approach to urban health. Using a mixed-methods approach, the study incorporates both qualitative and quantitative research methods. The study population includes urban residents from selected low-income areas, with data collected through surveys, structured interviews, and secondary data analysis. The research tools include questionnaires assessing health conditions, environmental quality indicators, and policy evaluations. Statistical analysis, thematic coding, and policy impact assessments are employed to identify key trends and challenges associated with urban health.

The findings indicate that traditional sectoral approaches focused on remedial measures are insufficient to address contemporary urban health issues. While infectious diseases have declined in many urban areas, other health concerns, such as non-communicable diseases, environmental hazards, and socio-economic disparities, remain closely linked to urban living conditions. The study highlights the importance of shifting from conventional biomedical models to a holistic, ecological perspective that incorporates social determinants of health. In response to these challenges, the research advocates for coordinated interventions, such as the Healthy

Cities initiative, to promote health and social development at the local level. Key barriers to effective implementation, including policy fragmentation and governance challenges, are discussed. Finally, the study emphasizes the need to move beyond a vulnerability-focused framework and instead adopt resilience-based strategies to enhance urban health outcomes in an increasingly urbanized world.

Keywords: Urban Health; Social policy; Environmental; Vulnerability; Resilience

Introduction

Urban regions are home to more than a billion people worldwide; by 2030, more than half of the world's population is projected to reside there. Many rural residents relocate to urban regions in pursuit of employment, better living conditions, and access to healthcare facilities. The study's primary objective is to collate the findings related to perceptions, knowledge, attitude, and practices from studies across the urban slums in India related to healthcare and nutrition. Urbanization, a characteristic of the twentieth century, is a profound transformation of human settlement processes and their outcomes, which has not been well understood in terms of both positive and negative impacts. The world became mainly urban in 2007. It is thus timely to review the state of knowledge about urban health and the current priorities for research and action. This article considers both health determinants and outcomes in low-income urban areas of developing countries. This paper argues that the interrelations between urban planning, health, social, and environmental policies have been poorly articulated until now. Although sectoral approaches have often applied remedial and corrective measures to overcome unsatisfactory conditions in urban areas, today we know that infectious diseases stemming from insanitary conditions are not the leading cause of morbidity and mortality in Europe. Nonetheless diverse forms of ill health remain associated with place of work and residence. Therefore, in order to deal with the complexity and diversity of urban areas there is an urgent need to move from conventional, sectoral approaches based on biomedical models of health to coordinated action stemming from an ecological interpretation of health including its social determinants. This kind of approach is presented in order to promote health and social development at the local level. Thus, the need to study urban health in a multi-level and multi-sectoral way is highlighted and priorities for research are identified. Interventions such as the Healthy Cities project are considered and obstacles to the effective implementation of urban health programmes are discussed.

A systematic search of articles was conducted on the National Library of Medicine PubMed Portal Google Scholar, and J-Stor databases for published studies across the indexed journals. Academic social media sites like Academia.edu and Researchgate.org were also searched for grey literature. The inclusion criteria include studies conducted in Urban slums from 2010 to 2022, conducted amongst the Indian population within the Indian Geography, and focusing on documenting perceptions, knowledge, attitude, and practices. Exclusion criteria were cross-sectional surveys with quantitative questionnaires focusing on the prevalence of diseases and

the burden of risk factors, literature reviews, systematic reviews, frameworks for implementation of specific interventions, and experimental study designs.

A total of 18 qualitative observational studies were included in the review and the findings related to knowledge, attitudes, and practices identified from the literature were summarized. The literature indicated adequate knowledge about nutrition and healthcare, and the barriers towards transitioning knowledge to practice were related to lack of resources, priorities around employment and income, and the attitudes towards change-making were usually based on convenience to access cost of service and availability of the services.

While existing studies provide valuable insights into health-seeking behaviors, dietary patterns, and social determinants of health among the urban poor, the findings remain fragmented across different geographical and temporal contexts (Misra et al., 2017; Gaiha & Gillander Gådin, 2020; Gundewar & Chin, 2020). There is a critical need for an integrated approach to synthesize these insights and present a holistic understanding of healthcare perceptions and practices among India's urban poor. This study aims to consolidate evidence from diverse regions to identify common patterns and gaps, thereby informing future research and policy development (Das et al., 2018; Banerjee et al., 2021). The review recommends further investment in research to understand the perceptions, patterns of nutrition, and health-seeking behaviours. Also, there is a pressing need to use the evidence for developing policies in line with the expectations of poor urban communities.

Objective

To study the importance of shifting from conventional biomedical models to a holistic, ecological perspective that incorporates social determinants of health.

Literature Review

India is undergoing rapid urbanization, with nearly one-third of its population residing in cities. This urban shift is primarily driven by rural-to-urban migration, as individuals seek better employment opportunities, improved living conditions, and greater access to healthcare services. However, the rapid pace of urban expansion has led to a rise in urban poverty, particularly in informal settlements or slums. These areas often suffer from inadequate access to fundamental services such as clean water, sanitation, housing, and healthcare (Patra & Bandyopadhyay, 2020).

Urban Poverty and Its Dimensions

Urban poverty is a complex and multidimensional issue, extending beyond mere income deficiency. The Asian Development Bank (2014) defines urban poverty as encompassing vulnerabilities related to limited access to land, housing, infrastructure, economic opportunities, healthcare, and education. Urban poverty manifests in various forms, including health disparities,

lack of education, food insecurity, and economic instability. A key indicator of urban poverty is the proliferation of slums, where inadequate infrastructure forces residents to pay more for essential services such as water and electricity compared to those in better-serviced areas (ForumIAS, 2018).

Urban Poverty and Food Insecurity

Urban poverty significantly affects food security and nutritional well-being. A systematic review by Vilar-Compte et al. (2021) revealed that food insecurity among the urban poor leads to unhealthy dietary choices, increasing the risk of both chronic undernutrition and obesity. Psychosocial stress and social despair further contribute to obesity within these communities. Moreover, financial constraints often compel urban poor households to prioritize food over healthcare, exacerbating health risks (Joshi et al., 2019; Srivastava et al., 2009).

Healthcare Access and Health-Seeking Behavior

Several studies indicate a strong link between urban poverty, healthcare accessibility, and health outcomes. Research conducted by Joshi et al. (2019) in New Delhi found that food-insecure households were more likely to experience unmet healthcare needs due to financial barriers. Similarly, a study of urban slums in Lucknow highlighted how high out-of-pocket healthcare expenditures restrict medical access for the urban poor (Srivastava et al., 2009). A geospatial study in Dhaka, Bangladesh, found that 82% of healthcare providers in urban slums were private, 12% were public, and 6% were non-profit organizations (Adams et al., 2015). Many urban poor individuals opt for private healthcare despite its higher costs due to dissatisfaction with government healthcare services, a shortage of public healthcare facilities, and cultural affiliations with informal providers (E et al., 2021). Factors such as dignified treatment, home visit flexibility, and accessibility shape these preferences.

Theoretical Framework

This study is guided by two theoretical models: the Social Determinants of Health (SDH) framework and the Health Belief Model (HBM). These frameworks provide valuable insights into the socio-economic conditions that shape health-seeking behaviors and access to healthcare among the urban poor.

Social Determinants of Health (SDH) Framework

The SDH framework emphasizes that health outcomes are influenced by broader social, economic, and environmental factors. Key determinants in the context of urban poverty include: Economic stability: Income levels directly impact healthcare accessibility and food security.

Healthcare access and quality: The availability, affordability, and efficiency of healthcare services determine utilization patterns. Neighborhood and built environment: Living conditions in slums contribute to heightened health risks. Education: Literacy and health awareness influence healthcare decision-making (Thandassery & Duggal, 2004).

Health Belief Model (HBM)

The HBM explains health-seeking behaviors based on individual perceptions of risks and barriers to accessing care. This model consists of six core constructs: Perceived susceptibility: Individuals' assessment of their likelihood of falling ill. Perceived severity: Understanding the potential consequences of a health condition. Perceived benefits: Belief in the effectiveness of preventive measures. Perceived barriers: Economic, social, and logistical obstacles to healthcare access. Cues to action: External triggers prompting individuals to seek healthcare services. Self-efficacy: Confidence in one's ability to seek and adhere to medical treatment (Caswell & Zuckerman, 2018).

By integrating the SDH framework and the HBM, this study aims to explore how economic conditions, environmental factors, and individual perceptions influence healthcare-seeking behaviors among India's urban poor. These insights will inform policy recommendations aimed at improving healthcare accessibility and overall well-being for vulnerable populations.

Materials and Methods

This study employs a systematic review methodology to synthesize existing research on health perceptions, health-seeking behaviors, and nutritional practices among the urban poor residing in Indian slums. The study integrates qualitative and mixed-methods research to provide an in-depth understanding of community experiences and behaviors.

Study Population

The target population includes individuals living in urban slums across India. Studies that document perceptions, behaviors, and practices related to health and nutrition within this demographic are included in the review.

Sample Groups and Selection Techniques

A systematic selection process was followed to identify relevant studies. The study sample includes peer-reviewed journal articles, grey literature, and qualitative/mixed-methods studies that meet the inclusion criteria. Boolean operators ("AND" and "OR") were used to refine search results and ensure relevance.

Inclusion Criteria

Studies conducted in urban slums from 2010 to 2022. Research focused on the Indian population within Indian geography. Studies that document perceptions and practices related to health and nutrition.

Exclusion Criteria

Cross-sectional surveys that focus solely on quantitative measures of disease prevalence and risk factors. Literature reviews, systematic reviews, and implementation frameworks. Experimental study designs.

Research Tools and Data Collection

A systematic search of academic databases, including the National Library of Medicine PubMed Portal, Google Scholar, and J-STOR, was conducted to identify relevant published studies. Additionally, academic social media platforms such as Academia.edu and ResearchGate.org were explored for grey literature. Keywords Used: "Urban poor," "slum population," "slums," "preventive health," "health perception," "health-seeking behavior," "health-seeking patterns," "nutritional practices," "nutrition," and "healthy eating." A PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flowchart was used to document the screening and selection process of relevant studies.

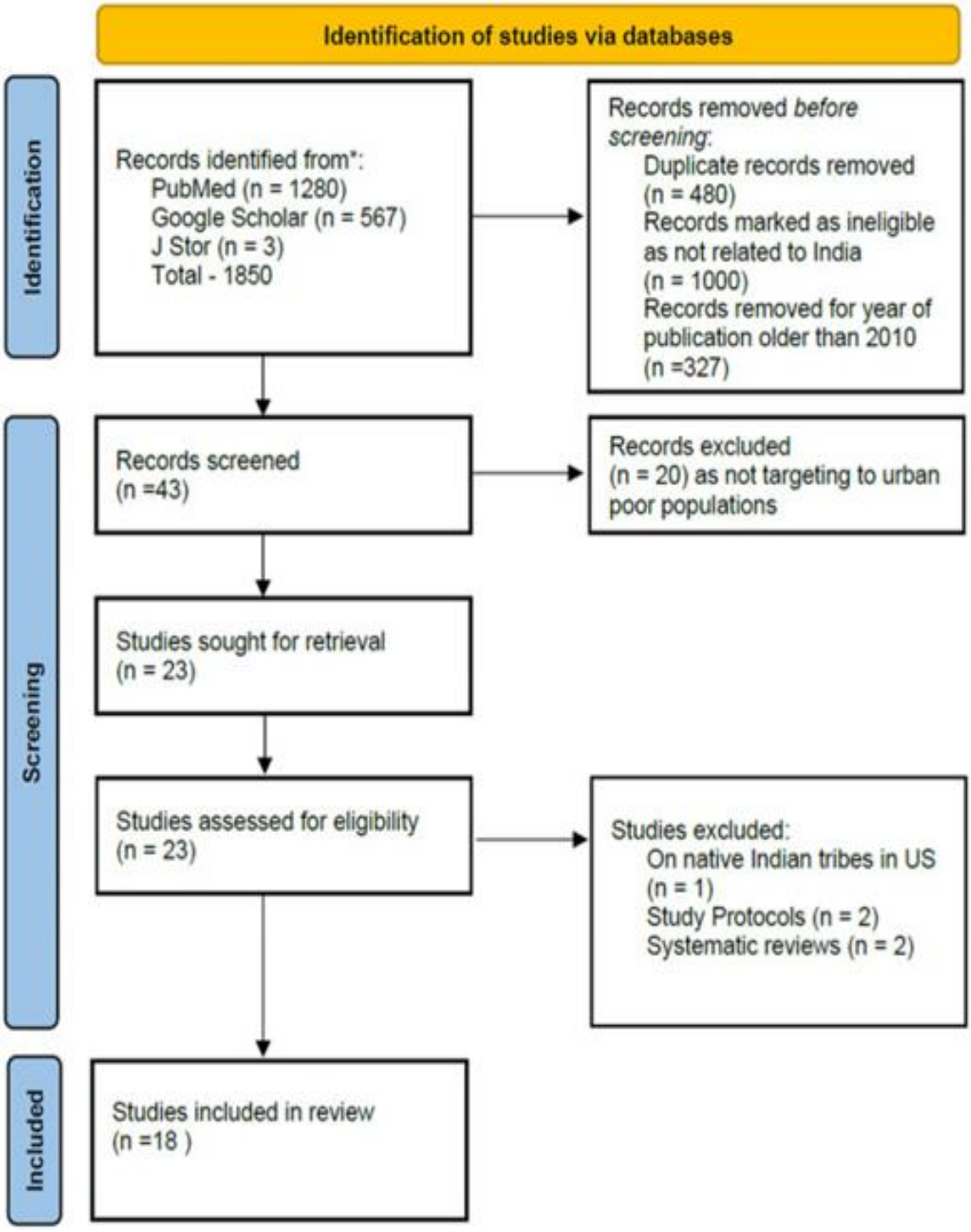

Figure 1 PRISMA flow chart of the literature review process

Research Procedures

1. Database Search & Screening

Initial search yielded 1,850 articles. Titles and abstracts were screened to exclude irrelevant studies, reducing the selection to 43 articles.

2. Full-Text Review

The 43 shortlisted articles were assessed in full by two independent researchers (AP and KP). 18 studies met the inclusion criteria and were included in the final review. Exclusions: Two studies were excluded for not being conducted within Indian geography, two were duplicates, and 26 did not meet the inclusion criteria (quantitative-only studies, studies outside urban slums, and a study protocol).

Data Analysis Methods

A thematic analysis approach was used to synthesize findings from the reviewed studies. The data were categorized into three main themes: Knowledge of good health and nutrition. Practices related to healthcare-seeking and eating habits. Attitudes toward change-making. Under each category, findings were further stratified based on the socio-ecological model: Personal level (individual knowledge, beliefs, and behaviors). Interpersonal level (family and peer influences). Community level (community norms and support structures). Policy level (government initiatives and public health policies). A summary of the reviewed 18 articles is presented in Table 1, categorizing insights based on the socio-ecological model framework.

Table 1 Description of the studies categorizing insights based on the socio-ecological model framework

Description of the studies included in the literature review

BPL: below poverty line; AWWs: Anganwadi Workers; NMs: nurse mentors; ASHA: Accredited Social Health Activist

Author	Geography Covered	Study Objective	Study Design	Target Population	Thematic Focus
Mahua Patra and Satarupa Bandyopadhyay [1]	Urban Slums of Kolkata	What are the determinants of the choice of type of hospital (Public or Private)? What are the determinants of seriousness about health care seeking (more or less)?	Cross-sectional study using a semi-structured interview	BPL and Non-BPL households	Quality of care, and competing priorities and health needs
Misra et al. [13]	Urban Slums of Delhi	Determine the awareness and health-seeking practices related to common eye conditions.	Cross-sectional study using a semi-structured interview	Individuals aged 18 to 60 years and residing in notified slums	Sustaining life and health
Gaiha and Gadin [14]	Urban Slums of Delhi	To explore barriers and opportunities to participate in	Cross-sectional study using a semi-structured	Heterosexual couples aged between 20 to 60	Sustaining life and health, and

This systematic review provides a comprehensive synthesis of the existing literature on health and nutrition perceptions among India's urban poor. By categorizing findings through a structured socio-ecological model, this study aims to inform policy interventions and community-based strategies for improving healthcare accessibility and nutritional outcomes in urban slum populations.

Results

The detailed characteristics of the studies included in presented in Table1.1. We classified the studies across the thematic areas. Three thematic areas were defined based on the broader themes that arise during the literature review.

Theme 1 was about sustaining life and health; focusing on personal and interpersonal levels of the socio-ecological model and concerning personal and family choices, answering why, how, and who makes the choices regarding health seeking. Theme 2 was about competing priorities and health needs; focused on the community level of the socio-ecological model and concerning how cultural norms shape health-seeking behaviour and nutritional behaviour. The third theme was on quality care; focused on the societal level of the socio-ecological model and concerning access, availability, and affordability of healthcare services.

Competing priorities and health needs were the most common themes 52% (n=9) indicating the literature was focused on health-seeking behaviour and nutritional practices of the target population. Sustaining life and health was the second common theme 41% (n=7) with a focus on choices related to health and nutrition. The theme of quality of care was least common with 29% (n=5) articles focusing on access, availability, and affordability of healthcare services. Geography-wise the studies were restricted to metro cities and major cities with Mumbai having covered by five studies, followed by Delhi, Kolkata, and Bengaluru each reporting four studies. Ahmedabad, Nagpur, and Kochi where other major towns wherein at least one study was conducted.

Knowledge of good health and nutrition

Knowledge of good health and nutrition referred to the knowledge of the respondents related to good practices like handwashing, use of toilets, clean drinking water, eating fresh fruits and green leafy vegetables, exercise, and physical activity and their impact on overall health status.

The study by Gaiha et al. focused on adolescents and their caregivers (parents) unfolded interesting insights into the knowledge related to a healthy diet [14]. All caregivers were having knowledge of high salt, high sugar, and high-fat food items were unhealthy. All the adolescents were also having the same knowledge that food containing high salt, and sugar fats increase weight, and causes acne. Another relevant finding was the caregivers were not having a clear understanding of a balanced diet or a nutritious diet. The general understanding amongst both adolescents and caregivers was food cooked at home is usually healthier than the one that is cooked outside.

A study conducted by Athavale et al. across the Mumbai slums amongst young mothers indicated clear knowledge of exclusive breastfeeding from healthcare providers, there was however conflicting information on family elders regarding exclusive breastfeeding (). The study also recorded the knowledge about hygiene and safe cooking practices which were found to be adequate as per national guidelines on young infant and child feeding practices.

Another study by Gaiha and Gadin (2020) explored the knowledge amongst young married couples on topics related to prevention, management, care, support, treatment, and rehabilitation: the questions were focused on food habits and nutrition; water, sanitation, and hygiene; physical activity; tobacco consumption, reproductive health (family planning methods); drug/alcohol abuse; Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS); mental illness; newborn health and heart disease. The source of knowledge for men was mass media, including radio, television, information, education, and communication (IEC) materials. For women, the source of knowledge was interpersonal communication (IPC) by elders, parents, relatives, school/children's school, peers, traditional healers, and employers. The most trusted source of information for the couples was the elder women in the house.

A study by Abdi et al. (2018) explored the knowledge of participants from slums to identify and rate common diseases based on health priorities. Diabetes followed by hypertension was the most common non-communicable disease recognised and stated to benefit from early screening. Dengue and diarrhoea were common infectious diseases with knowledge of risk factors, how to seek treatment, and disease course. Under the maternal and child diseases the knowledge on anaemia, and malnutrition was seen to be most comprehensive.

The study by Misra et al. (2017) amongst elderly participants living in urban slums indicated 50% of people were having knowledge about cataracts, related symptoms, and treatment options, and the knowledge was positively associated with years of schooling, and employment [18]. Males were more likely to present with knowledge about cataracts compared to women.

Overall, the studies reviewed were focused on a particular disease, age group, and knowledge of nutrition. The study by Kusuma et al. (2018) comparing the food choices among the non-slum and slum residents indicated similar levels of knowledge across the populations about the consumption of processed and packaged foods. The studies had limited exploration done to link health habits like exercise, hand washing, and boiling water before drinking, with health conditions.

Practices related to the healthcare-seeking and eating habits

The studies by Gaiha and Gadin, Gundewar and N. P. Chin, and Das, indicated that most respondents defined ill health as related to physical aspects (pain, swelling, uneasiness) and physical aspect was the most common reason for the visit to the health care provider. The study by Das reported that mental aspects of health were known to the participants, but was dismissed as something that can be managed with rest without the need to seek care from professionals. The Gaiha and Gadin study also cited the reason for dismissing mental health as being a lack of awareness about mental health conditions, the paucity of time to focus on something outside the physical health paradigm, and mental illness is highly stigmatized.

The series of studies by Das et al. across the urban slums of Kolkata, and Bengaluru indicated statistically significant differences related to health-seeking behaviours across the male and female respondents. The preferred choice of healthcare providers for males was pharmacists who would give tablets listening to their chief complaints and the transaction would not need any clinical examination or laboratory tests. Interestingly if the treatment sought from the pharmacist was not effective males preferred visiting private clinics and choose not to follow up with the pharmacist. The underlying reason for the behaviour cited is a preference for quick treatment, most studies reported males considered falling ill as a burden in terms of wage loss due to absenteeism, and thus preferred quick remedies. This was also reflected in the choice of therapy wherein men preferred modern medicine as its quick for gaining symptom relief. For serious health issues, the men preferred Government Hospitals.

The women had different practices with preferences for local traditional healers and herbalists for minor ailments. However, when the treatment would not yield desired results, the women would prefer the local traditional healer or herbalist to recommend the healthcare provider for further referral and would also follow up with the local traditional healer or herbalist regarding the treatment provided by a referred healthcare provider (Patra, & Bandyopadhyay, 2020). This was mainly because of the trust established between the local healthcare provider and the women seeking treatment. The women preferred healthcare providers who knew their language had similar cultural understanding, explained the cause of disease and the treatment plan in detail, and more importantly, were well-versed with the cultural practices of the community.

Both men and women, preferred government healthcare services for maternal and child health including immunization as they were able to seek the benefits of various government schemes. For the elderly group, the study by Misra et al. (2017) identified a preference for charitable trusts or NGOs for the treatment of cataracts as the trusts or NGOs organising camps would arrange for transportation and even provide free surgery for the residents. This was also strengthened by the good reviews shared by their friends and family members who had earlier sought treatment or surgery for cataracts from screening camps.

The study by Černauskas explored the likelihood of factors that determine the choice of healthcare providers, the factors examined were provider cost and type, distance to facility, the attitude of the doctor and staff, familiarity with the doctor, appropriateness of care, the results indicated for elderly patients nearness to healthcare facility was the key determinant for provide choice, for women and elderly women familiarity with the doctor and friendly attitude towards the patient. Young and formally educated participants had a strong preference for a friendly attitude of doctors and staff and appropriateness of care.

Attitude related to change-making

The attitude related to change-making explored the factors or the needs mentioned by the respondents to enable them to make positive changes related to diet and health. Most studies reviewed have not explored the attitude toward change-making directly. However, some of the responses documented in the publication hint towards factors like: for male residents of the slums, across Delhi and Mumbai (Das, et al, 2020), the quick service provisions were the key factor in shifting across various healthcare providers, they prefer shorter waiting times and medicines that can assure quicker recovery, thus the confidence of a healthcare provider also accounts to change making determinants. In the case of older residents' closeness to the healthcare provider was a key factor in change-making, they preferred to change to the closest healthcare provider while relaxing on cost and waiting time. For pregnant women and young mothers, clear instructions in written and explained by a nurse and/or Accredited Social Health Activist (ASHA) regarding young infant feeding practices was a clear change maker in terms of adopting WHO child feeding practices (Adams et al, 2015). In the case of breastfeeding mothers, the reassurances and encouragement from doctors or nurses regarding breastfeeding practices helped them to continue the change (Srivastava, et al, 2009).

Mind map

The mind map was constructed to summarise the findings of the review and contextualized in terms of the socio-ecological model, at the individual level the knowledge was about healthy diet, and nutritious food and its linkages to health were similar to contemporary populations across the non-slum residents, while practising the convenience of getting a food or healthcare service deviated from practising as per knowledge, and the same was seen across the change-making if the convenient availability of health food or healthcare service is provisioned individuals were willing to change.

Across the families, cultural practices did cloud the knowledge of good health and diet and also influenced practices, but most family members perceived convenience as a key determinant of practice. To sustain the change regarding diet and health positive reinforcement from providers like doctors, and nurses were a key criterion. At the community level, the knowledge remained good, the practices were dictated by personal preferences, and television was considered a key barrier that prevented change to healthy habits.

Discussion

The present review focuses on the perceptions of individuals residing in urban slums and how these perceptions shape their health and nutritional practices. A limited number of studies have explored the direct linkages between diet and health in these communities, highlighting a gap in research that needs further investigation.

A systematic review by Vilar-Compte et al. (2021) provides a global perspective on urban poverty, developing a conceptual framework where food security is central, branching out to issues such as employment and income at the personal level, housing conditions at the family level, and food pricing and neighborhood characteristics at the community level. Their findings indicate that populations lacking access to nutritious meals and consuming poor-quality diets are at greater health risk. The present review corroborates these findings, emphasizing similar connections between health and nutrition among the urban poor.

Further, Harpham et al. (2009) present a multidimensional overview of urban poverty, underscoring its association with nutrition and health. The paper advocates shifting the focus from disease treatment to preventive health measures. Slum residents face multiple barriers to maintaining good health, including inadequate access to healthcare services and limited health-related knowledge. Harpham et al. (2009) argue that research should address why some individuals and households cope better with these conditions, leading to improved health outcomes. Aligning with this perspective, the current review suggests that research should emphasize identifying protective factors among low-income urban populations and ways to strengthen these determinants to promote better health. Kusuma and Babu (2018) found that urban poor communities generally possess knowledge about diseases and nutritional facts and are aware of risk factors for both infectious and non-communicable diseases. However, their ability to translate this knowledge into practice is hindered by resource constraints, including financial limitations and a lack of accessible healthcare services. Similarly, this review highlights that urban poor populations struggle to implement health-promoting behaviors due to work priorities, financial instability, and inconvenient healthcare service delivery. The adoption of technological advancements in health education can play a critical role in bridging this gap and reaching a wider demographic.

A key strength of this study is its comprehensive approach to analyzing perceptions and practices at the individual, family, and community levels, thereby establishing linkages between healthcare and nutrition behaviors. This layered perspective offers valuable insights into how knowledge, attitudes, and practices are shaped across communities, providing a foundation for further research. However, a significant limitation is that most available literature is derived from metropolitan areas, with relatively little data from non-metro or tier II and III cities, leaving a research gap in understanding variations across different urban settings.

This review underscores the necessity of further research to explore how health and nutrition knowledge can be effectively converted into actionable steps. There is a need to

develop a clear framework outlining urban poor populations' perceptions of good health and well-being, potential enablers and barriers, and mechanisms to overcome these barriers. Additionally, policies should be better aligned with the actual needs of urban poor communities, necessitating robust evidence-based research to inform targeted interventions.

Conclusion

The knowledge among the residents of the urban poor communities was clearly represented across the literature. There was a clear indication that despite having clear knowledge of nutrition and health-seeking the practices were influenced by convenience, and availability of monetary resources. The factors affecting the practices have been similar across India. For example, the adult males preferring quicker turnaround time across the OPDs have been recorded from Mumbai and Delhi. There is limited literature on perceptions and patterns about the services delivered through public health systems. Although it is clearly evident that across the slums public healthcare providers like Accredited Social Health Activists (ASHAs), and Anganwadi Workers are important stakeholders. The role of community agencies in monitoring government service delivery is not explored in depth through literature. There is a pressing need to develop a separate category for residents of urban slums in terms of policy, research initiatives and developing interventions to promote preventive health behaviour and improve dietary practices through.

Suggestions

Suggestions and Implementations

Based on the findings of this study, several key suggestions and implementations are proposed to improve the quality of professional internships for tourism students at the Department of Linguistics and Literature (DLL), Ho Chi Minh City University of Education (HCMUE).

Recommendations for Public Health Initiatives

1. Enhanced Public Awareness Campaigns: Focus on nutrition, hygiene, and preventive healthcare, utilizing mass media and community-based approaches.
2. Integration of Traditional and Modern Healthcare: Leverage the trust in traditional healers by training them to provide accurate health information and referrals.
3. Tailored Health Communication Strategies: Develop gender-specific and age-appropriate messaging to address healthcare-seeking behaviors.
4. Strengthening Maternal and Child Health Services: Ensure clear, accessible guidance on infant and child nutrition for young mothers.

5. Improved Accessibility for the Elderly: Increase the availability of nearby healthcare facilities and community-based programs.

6. Regulating Media Influence on Nutrition: Promote healthy eating habits through responsible advertising and policy interventions.

Future Research Directions

1. Expanding Geographic Coverage: Conduct studies in rural and peri-urban areas to understand health-seeking behaviors beyond metro cities.

2. Longitudinal Studies on Behavior Change: Explore how knowledge influences long-term health habits and healthcare utilization.

3. Cultural Influences on Healthcare Choices: Investigate the role of cultural beliefs and traditions in shaping health-seeking behavior.

4. Intersection of Mental and Physical Health: Assess the barriers to mental healthcare awareness and treatment.

5. Impact of Digital Health Interventions: Evaluate the effectiveness of mobile health applications and telemedicine in improving health outcomes.

Declaration of Interests

The authors declare no competing interests.

Ethical Considerations

This study adhered to ethical research guidelines and obtained approval from the respective institutional ethics committees. Informed consent was secured from all participants prior to data collection, ensuring their rights, confidentiality, and voluntary participation. All procedures were conducted in accordance with ethical standards for research involving human subjects.

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Definition of Conflicts of Interest

No conflicts of interest to declare.

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