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SOCIO-ECONOMIC AND POLITICAL DETERMINANTS OF PEOPLE'S RESPONSES TO THEIR HEALTH PROBLEMS

A case study of New Seemapuri–a resettlement colony in Delhi

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SNEHLATA GUPTA

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067

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CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY

New Delhi-110 067

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SUPERVISOR'S CERTIFICATE

Certified that the dissertation entitled "Socio-Economic and Political Determinants of People's Responses to Their Health Problems : A Case Study of New Seemapuri - A Resettlement Colony in Delhi" submitted by Ms Snehlata Gupta, is in partial fulfilment of six credits for the Degree of Master of Philosophy of this University. This dissertation has not been submitted for any degree of this University or to any other University, and is her own work.

I recommend that this dissertation be placed before the examiners for evaluation.

Prof. D. Banerji
Supervisor

Dr Imrana Qadeer
Chairperson

Gram : JAYENU Tel : 667676, 667557 Ext. 259, 262 Telex : 031-73167 JNU IN

This work is dedicated to the
rag pickers of New Seemapuri
for whatever they can make of(f) it.

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A C K N O W L E D G E M E N T

I wish to express my sincere gratitude for all the help I received from the Sabla Sangh members - Devi Kripa, Vidya, Vimla, Prem and Chhaya.

I am also grateful to the people of New Seemapuri who patiently answered all my questions and probings into their life.

I wish to acknowledge the help and guidance given to me by Dr. Banerjee and Dr, Imrana Qadeer.

I wish to acknowledge all my friends and family without whose help and support this dissertation would never have been completed.

5 Jan.1990

Snehlata Gupta

Chapter 1

INTRODUCTION

Cities today are a study in contrast. Projecting on the one hand an image of affluence progress and development through its well planned and beautifully laid out roads and residential areas, high rise buildings, shopping arcades stocked with the latest in consumer items and aids for a comfortable, luxurious lifestyle, sophisticated hospitals with the latest technology; on the other hand poor slum dwellers struggle to survive, in a hostile environment, without even basic amenities and minimum civic facilities.

The presence of these islands of filth, death, disease and disability, is a reflection of the inherent contradictions of city life. The price of the comforts and affluent lifestyle enjoyed by the elite of the city, paid by the sweat, tears and labour of those forced to live amidst slum conditions.

It is the dynamics of big city which use the needs of the poor migrants to force them into inhuman life situations and compell them to accept these situations as a price of the sustenance they get from the cities.

In India the origin and growth of slums could be traced to conditions of impoverishment of large sections of people. The pauperisation of the agricultural economy and migration

to cities had started under the British rule. It received a fresh impetus after independance with the thrust to industrialisation under the new government of 'free' India.[1] Capital intensive policies to develop agriculture or the desire for "Green revolution" in fact led to greater marginalisation and poverty in the countryside. The new economic policies meant to improve agricultural production worsened the situation further in terms of creation of 'man made' droughts, floods, land degradation, etc. Concentration of large populations in cities of well to do people also meant that better services were available in the cities than the country side. People who could no longer find any employment in their own or neighbouring villages moved to cities to search for a means of survival. They were no longer seasonal migrants looking for work in between agricultural cycles which till then had been the priority, rather, they now came to reside in the cities permanently.

In the cities the migrants sold their labour to eke out a living. The wages the poor migrants earned were not even adequate to meet nutritional needs leave alone those of shelter and other basic necessities. As a result the poor migrants started squatting on available, vacant land near their place of work, erecting hutments out of any available material such as card-board, old wood, straw, bamboo, packing cases, plastic sheets, old tins, mats, etc. A cluster of such dwellings soon acquired all the physical attributes of

a slum - substandard housing, high density and congestion unsanitary conditions, absence of basic amenities, like water supply, sewage, drainage and clearanel of garbage and faecal material.

Unlike Bombay and Calcutta which were established centres of trade and commerce[2] and industry as far back as the nineteenth century, Delhi has been the centre of political power and bureaucracy, the capital of the country. Thus the earliest migrants went to the industrial centres and relatively few people came to Delhi till after independance.[3] The first migrants were the refugees from Pakistan as the result of partition. Industry in Delhi grew around these people who were aided by the first government of independent India, to make a new beginning, having lost all they possessed while fleeing from Pakistan. As urbanisation caught pace Delhi became yet another centre attracting poor rural migrants.

Migration became a cause of concern for the authorities in Delhi in the 1960's.[4] There were several factors responsible for this migration. While 'green revolution' had deprived many of the poor agricultural workers of their source of livelihood in the states of Punjab, Haryana and Western U.P., it was the lack of any development programmes and recurrent floods and drought conditions in the states of Rajasthan, Bihar and eastern U.P., which saw thousands of people migrating to Delhi, which was simultaneously emerging as a new centre of industrial development.

On arrival migrants were soon absorbed in the mushrooming industrial units and other services sector the well off residents of the city required, such as, scavenging, clearance of garbage, sewage and waste disposal, transport, water and electric supply, etc. The industrialists were not interested in providing them with decent housing facilities and the well-off people wanted the 'eye-sore' slum settlements, which posed constant threat of disease and epidemics, removed from the immediate vicinity of their residential areas. The politicians too realised the value of the migrants as potential vote-banks. Caught in the conflict of needing the services, labour and votes of the poor slum dwellers and the threat they posed if they continued to live where they did it was decided to resettle them under the Jhuggi-Jhompri scheme in 18 sites, on the outskirts of the city, provided for under the Delhi Master Plan.[5]

The stream of migration begun in the sixties, received a fresh impetus in the seventies due to a boom in the construction industry and its ancilliary units (such as stone quarrying, brick kilns, etc.). The earlier factors for migration had also intensified, thus in 1974 there were another two lakh squatters apart from the 50,000 who had already been resettled. During the eighteen month period of internal emergency, from 1975-1977, another one and a half lakh of these squatters were, resettled in sixteen sites, mostly across the Yamuna and on the outskirts of the city.[6]

The resettlement schemes during their inception had promised to provide the city's squatter population with minimum amenities, necessary for a decent standard of living such as 80 sq. yards plots to each family, individual water and sewage facilities, schools, health centres, etc. But as costs of developing the land increased,[6a] the plot size was cut down to 25 sq. yards per family. Also once the objective of resettlement had been achieved the squatters and their living conditions were no longer of continued interest to the authorities. Only when elections were announced or through large scale epidemics[7] the resettlement colony dwellers managed to re-enter the consciousness of the powers that be.

The process of migration has by no means ended. Every year two lakh new migrants come to Delhi. Those who are overwhelmingly poor erect new slums near their place of work, living with absolutely no basic amenities. Those who are from slightly better off backgrounds or have some connections in the city manage to buy plots or ready made houses in the resettlement colonies, which are only marginally better in terms of amenities than the 'jhuggi-jhompri' clusters. Another new type of settler in resettlement colony comes from within the city itself, who may even have been born here and is forced to move to the colony due to increasing costs of living and exorbitant rents.

The arguement that wherever there are cities there will

be slums, has gathered force and momentum in the last two decades. It is also grudgingly accepted and acknowledged that the presence and growth of slums is an inevitable outcome of the process of urbanization.

The acceptance and acknowledgement of this aspect of 'urban reality' has drawn the attention of researchers, policy makers, reformers and experts from various fields and backgrounds, to the plight of the poor slum dweller (who has finally come of age!).

The sociological aspects of slums and lives of slum dwellers (such as migration patterns, caste, kinship and religious networks and links , demographic characteristics, level of basic amenities, social organization, etc.) are discussed by those interested in under-standing the impact of urbanization and industrialization. Growth of informal sector - a characteristic feature of slums is studied from the point of view of its relevance and contribution to the city's economy. Studies have also been undertaken from the specific point of view of formulating policies and programmes for slum dwellers, e.g. - for environmental improvement, income generation, improvement of health of slum dwellers, etc.[8]

While studies of the second variety are more specific in their dealing of the particular subject (health, environment, employment, occupation, houseing), studies of the first kind are broader and purport to provide a broad framework or perspective within which to study the 'reality' of slums and slum dwellers. The perspective developed by the first type of

studies is often used by the second type of studies.

The 'reality' of slum dwellers and their life situations emerging from a review of some of these studies and policy documents, places the responsibility of the poverty and its associated socio-economic features and culture, on the slum dwellers themselves. The authors believe that poverty generates its own culture of apathy, moral degeneration and decrepitude, lack of social, economic and political organisation, sense of personal inadequacy and inferiority complex. (Lewis, 1966; Stokes, 1962).

Policy documents sponsored by authorities such as the Delhi Development Authority (DDA, 1977; DDA, 1980) also promote and re-inforce myths and pre-conceptions about slum dwellers; such as - they are filthy, have 'anti-social' tendencies and have no desire or aspiration to better their lives.

A more charitable view (Singh and De'Souza, 1980) is that their poverty and way of life is a result of their ignorance and illiterate status and is aggravated by their uncontrolled fertility.

Two studies which attempt to go contrary to this dominant trend (Desai and Pillai, 1972; Rao and Rao, 1984) argue that "the basic ideology behind the problems of slums needs a careful examination. It needs to be recognized that the problem of slums is associated with the exploitative system of the capitalist society." "The city is for the rich and the middle classes, who can pay for the infra-

structure and other urban facilities and luxuries."

Basing ourselves on this essential approach we hypothesise that the slum dwellers are an uprooted people who find themselves in an alien social, economic and cultural milieu and whose only resource is their labour power. They have no option but to let it get exploited by the powerful in the city; which forces them not only to accept unfair economic conditions but also pushes them to the most uninhabitable parts of the peripheries of the city. Their meagre earnings and their unrecognised, half destroyed cultural traditions are their only assets through which they have to deal with the reality of their slum lives. In understanding their health situation and coping methods we have to understand their general socio-economic situation, the nature of the services provided, people's health needs and perception of the services and their responses. It is only a full grasp of all these dimensions which can provide an insight into the reasons of failures of interventive programmes.

The present study, uses this alternative perspective for viewing the problems of slum and slum dwellers. A perspective, which examines, the various social-political-economic and cultural factors and their inter-play responsible for keeping the slum dwellers in their present situation and prevents them from getting out of it or changing it.

Within this overall perspective the focus is the health situation of the slum dwellers, described here as - not a mere quantification in terms of various mortality and

morbidity rates. Rather it is a combination and interplay of different factors such as the load of illness and disease; the factors responsible for the creation of an environment leading to health problems; peoples experience and perception of what constitutes ill health; the services available to cope with problems and the experience and perception of the users of these services.

While there are numerous studies on various aspects of health in urban areas, the rural areas, the rural poor, there are few studies about the health of the urban poor.

Health problems of the urban poor, are more of an embarassment to the planners and policy makers, than, that of the rural poor. While health problems in rural areas can be ignored (by them) or put down to general underdevelopment of those areas, health problems of the poor in cities can not be similarly explained away, as cities are known to be affluent and house sophisticated hospitals stocked with the latest technologies.

The few studies, which do talk of health of the urban poor (Basu, 1988; D' Souza, 1987; Bhatnagar, 1986) seek to understand health and its various aspects within the same framework of false 'reality' - blaming the victims (or their behaviour) for their own misfortune - thus becoming tools for the further oppression of the people.

Studies 'appearing to be concerned' take the view that health behaviour and health status have to be 'modified' to

make family planning more acceptable because that is the primary cause for peoples poverty and ill health. (D'Souza 1987; Singh and D'Souza, 1980).

In contrast this study aims to understand the dynamics of socio-economic - cultural and political factors of a population in one resettlement colony in Delhi, and the resultant impact of these factors on the health situation of the people. In this study health incorporates an understanding of the following factors - the physical environment, work condition, availability and intake of food, health services and the perception and experience of illness. An attempt is also made to study the mechanism of coping evolved by the inhabitants of this 'basti' to deal with their health situation in order to understand the compulsions that make the people 'behave' in the way they do.

We believe that this study can contribute to the conceptualisation of alternative organisational forms of health services for the slum dwellers who have uptil now been held responsible for their misfortunes. While the existing approaches attempt to change the behaviour of people without attempting to change their situation; this study provides an understanding of why people behave in a certain way and thereby locates areas for intervention. Changes if introduced in the areas identified can make a big difference to the overall health situation and will also lead to changes in peoples responses towards services.

Footnotes

Chapter I

1 Bose, Ashish (1973), Studies in India's Urbanization, 1901-1971, Bombay: Tata McGraw Hill.

2 Singh and D. Souza (1980), The Urban Poor : Slum and Pavement Dwellers in the Major Cities of India, New Delhi, Manohar.

3 Op. cit.

4 Mishra and Gupta (1981), Resettlement Policies in Delhi, New Delhi, I.I.P.A.

5 Op. cit.

6 DDA (1980), Problems of Squatter Settlements in Delhi (mimeographed, Delhi).

6a In 1965 the cost of developing a 25 sq yard plot was Rs. 860/-, by 1980 this had gone up to Rs. 5,000/- for the same size of plot. Op. cit.

7 Reference here is to the cholera epidemic from May-August 1988.

8 e.g. Family Planning Foundation, Delhi Development Authority, Town and Country Planning Organisation.

Chapter II

METHODOLOGY

Given the objective of this dissertation which attempts to understand health situation of a specific group within their socio-economic, political and cultural milieu it was necessary to develop a methodology which helps explore all these with health as the main reference point.

2.1 The objective of this study, to focus on the determinants of the health situation of the people living in slums, needed to be further broken into the following specific objectives:

(i) To identify the socio-economic-political and cultural factors and their interplay which determine the environment and shape the health situation.

(ii) To assess the quality and quantity of basic amenities provided by the administration.

(iii) To assess the availability and quality of health services provided through private and government institutions.

(iv) To assess the effectiveness of health programmes offered by these institutions to meet the needs of the people in the 'bastis'.

(v) To understand people's assessment of patterns of diseases in the slum colony.

(vi) The mechanisms of coping devised by the people, to deal with their health problems.

(vii) Perceptions of the people of services and the various personnel associated with the delivery of services and implementation of health programmes.

(viii) Perception of the establishment or personnel responsible for intervening in the health situation and way of life of the slum dwellers.

To work towards these objectives our method essentially depended upon qualitative explorations of the different dimensions of peoples lives, after developing adequate rapport with the study population and then attempting to quantify certain specific aspects to be able to give weightage to some factors in the interplay of forces determining health situation.

2.2 Data Required

To bring out the subjective (as perceived by the people) and the objective (as assessed by the observer and technical personnel) dimensions of the health situation and to highlight the interplay of social, economic, cultural and political forces that determine health situation, in slums, a complex set of data was required. This covered:

(i) A historical background of the colony (being studied) from the time it came into existence, background of the migrant people who were resettled in this area, their place of origin, reasons for migration and the way of life in the village and in the city prior to resettlement.

(ii) Demographic characteristics of the population, educational levels, occupations, sources of income, household size and family structure.

(iii) Quality and adequacy of basic amenities such as water supply, toilet facilities, sewage and waste disposal, garbage clearance, electricity supply and housing.

(iv) Data on both the subjective feelings of people about these and the objective existence of the amenities was needed in order to evaluate their adequacy.

(v) Description of the daily existence within the colony and the work performed by different occupational groups.

(vi) Information on social and political organisations at the local level, the different power groups within the community, perceptions of local leaders, the state and its law and order machinery, voting patterns, views on social problems, e.g. unemployment, addictions of different kinds, illegal and "anti-social" activity such as prostitution, gambling, consumption of liquor, domestic violence.

(vii) Information on women's status, avenues for entertainment and leisure, peoples attempts and actions to change the situation in which they find themselves, their hopes and aspirations was also required.

(viii) Information on the availability and accessibility of different health services and institutions (both privately owned and government aided) was necessary. Along with this the health status and pattern of diseases in

the slum colony and people's perception of it was also studied; with special reference to women and children.

(ix) In the light of the above where people go for help and treatment of different ailments and what is their experience and perception of the different institutions and personnel was sought to be collected.

(x) Attitudes towards specific health programmes e.g., Family Planning, Maternal and Child Health, and their usefulness was gathered.

(xi) Data on dietary patterns and expenditure on food was also required as well as expenditure on health.

(xii) The attitude and perception of the service personnel which had direct and indirect impact on the health situation was also explored.

(xiii) Dispensary records and secondary data on the problems of slums and squatter settlements, the policies formulated and implemented to tackle these problems were also made use of.

2.3 Selection of Area

Given the nature of study and the time constraints it was possible to study only a small area intensively.[1]

New Seemapuri was selected for the study because of two major reasons: (a) The investigator had some contacts which helped in rapport building which was a necessary pre-requisite. (b) New Seemapuri is one of the resettlement colonies which dot the boundaries of Delhi city and which have a similar historical and socio-political background.

There are 44 resettlement colonies and 652 'jhuggi jhompri' clusters in Delhi housing approximately 35 lakh people. The total population of Delhi being approximately 68 lakhs this means about 52% of Delhi's population lives in slums of these kinds.[2]

New Seemapuri is one of 16 resettlement colonies created during the internal emergency from 1975-1977. The colony is spread over an area of 0.17 sq. kms.[3] and has a total population of about 30,000 people spread over 6 blocks - A, B,C, D, E and F, two 'jhuggi jhompri' clusters (of about 2,000 'jhuggies', housing, 10 thousand people) and one lot of Janata quarters near A Block (of about 300 plots housing approximately 1,800 people). The six blocks A,B,C,D,E and F have a total of 2,990 plots between them. Average number of plots in each block is 450 but some blocks have more plots than others. While A,B and F blocks are larger, C,D and E blocks are comparatively smaller. The average household size is 6 members per family.[4]

The F Block, chosen for the purpose of our intensive study, had 368 authorised plots and a total population of about 2,200 people.

2.4 Rapport Building

Studies of this kind are often viewed with suspicion by the people in disadvantaged communities because they see no outcome of those of direct use or benefit to them. Infact

this kind of information has often been used against them, e.g. the population control programme.

To be able to collect indepth data about an area and its people the major pre-requisites are a good rapport with the people, the familiarity of the researcher with the area and the people and vice-versa, and the ability to communicate to the people the use this data can be put to, if not to directly benefit the individual respondent or family, at least to understand the processes at work in their immediate environment.

New Seemapuri fulfilled all these pre-requisites because of the researcher's long standing association with a local women's organisation - the Sabla Sangh, comprising of women from within the 'basti'. Further incentive came from the fact that the Sabla Sangh felt, it could put to use the observations and findings of the study to gain insights and formulate better programmes and activities at the basti level. The presence of the Sabla Sangh not only facilitated in the collection of authentic data but also smoothened communication and rapport building between the researcher and the individual respondents. The Sabla Sangh was also able to provide valuable information regarding the qualitative aspects of peoples lives in the slums of which they themselves were a part.

2.5 Selection of Study Population

Given the time constraints covering even the whole of

New Seemapuri was not possible. Thus it was decided to study one block intensively both qualitatively and quantitatively. F Block was chosen for this purpose because of the features it exhibited of a typical slum environment. These were sub-standard housing, high density and congestion, over crowding, insanitary conditions, inadequate basic amenities like water supply, drainage, sewage and garbage clearance facilities.

In addition this particular block mostly comprised of unskilled daily wage earners, and self-employed people in petty business, trade and vending activities, fitting into the informal sector concept representative of slum colonies. Further only between 50-60% of all residents from F Block were originally squatters resettled from 'jhuggi jhompri' clusters within Delhi, whereas in the other blocks between 80-90% of the families were from among the original resettled squatters. This meant that, comparatively the composition of the population of F Block was more representative of the features exhibited by slum populations in general - caught somewhere in between their rural way of life and the constraints imposed by trying to adapt to the alien, urban life style - a population in transition from a rural background to an urban way of life.

2.6 Qualitative Data

Because of the varied nature of the data required the tools used for collection of data also had to be different.

For the information from people (a) from the 'basti' (b) the officials representing the administration the following tools were used:

(i) discussions in groups and individually

(ii) use of informants, such as : local leaders, community elders, panchayat leaders, Sabla Sangh members

(iii) Unstructured interviews with health personnel from the local dispensary and the sanitary inspector

(iv) detailed case reports and case studies of some families, and private practitioners

(v) non-participant observation. It was not possible to live in the 'basti' and participate in the daily life of the slum dwellers. However as much time as could possibly be spent, was spent in the colony, participating as a sympathiser in the programmes, campaigns and activities of the Sabla Sangh. A daily record was maintained in the field diary of the activities and observations made during the course of these

(vi) records maintained by the

(a) dispensary, of daily O.P.D. attendance,

(b) Sabla Sangh of its past activities, programmes and surveys

(c) sanitary inspector, were made use of

(vii) Secondary records consulted were review of literature, studies on slums and census data on Delhi.

2.7 Sampling

Questionnaire : From the qualitative data collected

key issues were identified for the purpose of quantification. The preliminary questionnaire was pretested and based on this experience suitable modifications were made. The interview schedule (in Hindi) was administered to the eldest male or female (who ever was available or contactable)in the sampled households. Where possible both were interviewed together.

Sampling:

It is generally believed that one occupational category such as rickshaw pullers, domestic workers and daily wage labour would come under one socio-economic category, our qualitative explorations revealed that this did not hold true for the occupational category of 'kabaad ka kaam' (or waste recyclers). While rag pickers and sorters mainly came under the lowest two socio-economic categories, the owners of 'kabaadi ki dukan' (the wholesalers in the business) came under the higher two socio-economic categories. Not only did their income levels and earnings differ but there were comparable differences in life styles and backgrounds as well. The qualitative data showed up this complex group, with a hierarchy of its own.[5] 43 households with 'kabaad ka kaam' as a regular source of income were identified in F-Block. To get an insight into their group dynamics it was decided to take all these households for quantitative analysis.[6] The rest of the households had to be sampled.

The unit of our study was a household. The population of 2,200 was distributed over 368 households in the F-Block.

Each plot was taken as one household and for the purpose of sampling a systematic random sample of every 5th household was taken.

Thus the sample consisted of 43 households of the waste recyclers and 54 households of the rest of the occupations. Our sample hence is purposive and biased to cover all the 'kabaad ka kaam' households. However due to the spread of these households over all economic categories, it still remains a representative sample of economic categories.

Out of the total of 97 households there were twelve non-respondents. Four plots, were being made use of as shops and no one lived on them; two families of policemen refused to answer any of the questions; two households of rag pickers and one Bengali migrant family involved in 'pankh ka kaam' refused to answer the questionnaire, essentially because the male members were away and the women did not like to take the responsibility of giving away information. Our enquiries into the families gave no reason to think that these three families were in anyway different from the rest of the group.

Of the remaining eighty-five interview schedules, while coding, 3 more had to be rejected due to incomplete answers.

Time Frame: Discussions with the Sabla Sangh were first held in July and August, 1988 to explain the objectives and to get feedback. This was followed by visits to New Seemapuri to get a feel of the place and initiate the process of informal discussions with some of the inhabitants. These visits were

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resumed in December 1988 to participate in some of the ongoing programmes and activities of the Sabla Sangh at the basti level.

Collection of qualitative data was started in earnest from January 1989 to March 1989. Visits to F-Block on a regular basis began in February 1989. The questionnaire was formulated and pre-tested between February 1989 and March 1989.

April and May were spent in administrating the pre-tested questionnaire to the sampled population. Data collection was completed by the 10th of June 1989. Quantitative data was also collected alongside.

2.9 Analysis

The notes of the daily diary were used to develop the qualitative descriptions of the life of people; (a) socio-economic, cultural and political and (b) their health situation. The main analytical effort was to see the relationships between the two. This was reinforced through quantitative analysis.

The sample population was divided into four categories using monthly income per consumption unit as the criteria. The four categories evolved with their economic ranges are as follows:

(i) Below subsistence level (BSL) - less than Rs. 150 per month per consumption unit

(ii) Subsistence level (SL) - between 150-300 rupees per month per consumption unit.

(iii) Above subsistence level (ASL) - between 300-450 rupees

per month per consumption unit.

(iv) Well off (WO) - above 450 rupees per month per consumption unit.

How the categories were evolved and their implications especially for food intake is discussed under foot note no. 25 of chapter three and in the section on availability and access in chapter four. Tables have been analysed in the light of these four categories, wherever relevant.

The division into four categories was made in order to study the impact of economic status on the variables that affect the health situation. Income levels taken as the criteria are reliable because unlike rural areas where seasonal availability of food and work often prevents people from eating throughout the year, in urban areas there are no comparable constraints. The major portion of the earnings is plenty even though underpaid throughout the year. In comparing income levels, contrary to the experiences of others, it was found that generally the people, especially from the lower categories did not show reluctance to reveal their earnings. Because of the close and continuous contact that was maintained during the survey it was obvious from from the lifestyle of the people that they could not be under reporting their earnings. Earnings in kind from other sources as in the case of domestic workers, households receiving leprosy dole, was freely admitted. Only in those cases where income was from dubious sources such as sale of illicit alcohol, gambling dens, drug peddling was there a tendency to

withhold this information. This applied to only 3 households from the sample population, however, from the living standards of the family it was obvious that income from such sources would not have been substantial enough since they all belonged to the lower-most categories. Even in these instances information about their "illegal earnings" could be gathered from neighbouring sources.

2.10 Limitations of the Study

The quantitative aspects of health status could not be adequately established because of the small sample, an inevitability given the time constraints.

While the study clearly brings out the differences of perceptions between men and women, the exact extent of that difference could not be estimated because mostly only one of the family heads could be interviewed.

Problem of recall affected the data with regard to health expenditure, the minor ailments for which medical help was sought, coverage of children by immunisation, etc.

Despite the rapport developed the element of suspicion and indifference could not be overcome completely for two major reasons : (i) the very negative image of the family planning programme; because of their experience of the programme in the past, 'basti' dwellers associate anyone (especially women) asking questions about health, family size, reproductive history etc., with family planning workers and

(ii) people were well aware that research of this kind are not being carried out with their interests in mind. Even studies of the present kind, despite their claim to the contrary, ultimately may not yield any immediate concrete results that benefit either the individual respondents or the slum community.

The questionnaire being in Hindi, many of the respondents speaking Bengali (a language the researcher does not know) and only a smatterring of Hindi and the study finally being written in English, many of the nuances particular to a language, were lost, during translations. Thus the data on attitudes and perceptions has sufferred somewhat.

Footnotes

Chapter II

1 Therefore in this study we are not speaking for all the slums in Delhi but only for a particular slum. However, some of the conditions of this slum are representative of at least a significant proportion of slums and therefore provide insights into a larger universe of slum population.

2 D.D.A. (1980), Problems of Squatter Settlements in Delhi (Mimeo - Delhi, 1980).

3 Mishra and Gupta (1981), Resettlement Policies in Delhi, New Delhi, IIPA.

4 From the records of Sabla Sangh and the Sanitary Inspector.

5 See Chapter III, Section 3.4.4 for a detailed discussion.

6 The other reason for choosing this group were -

(i) they provide a good insight into the unorganised sector

(ii) the occupation illustrates the phenomena of transition from a rural way of life and the mechanisms of survival adopted, to cope with city/urban life.

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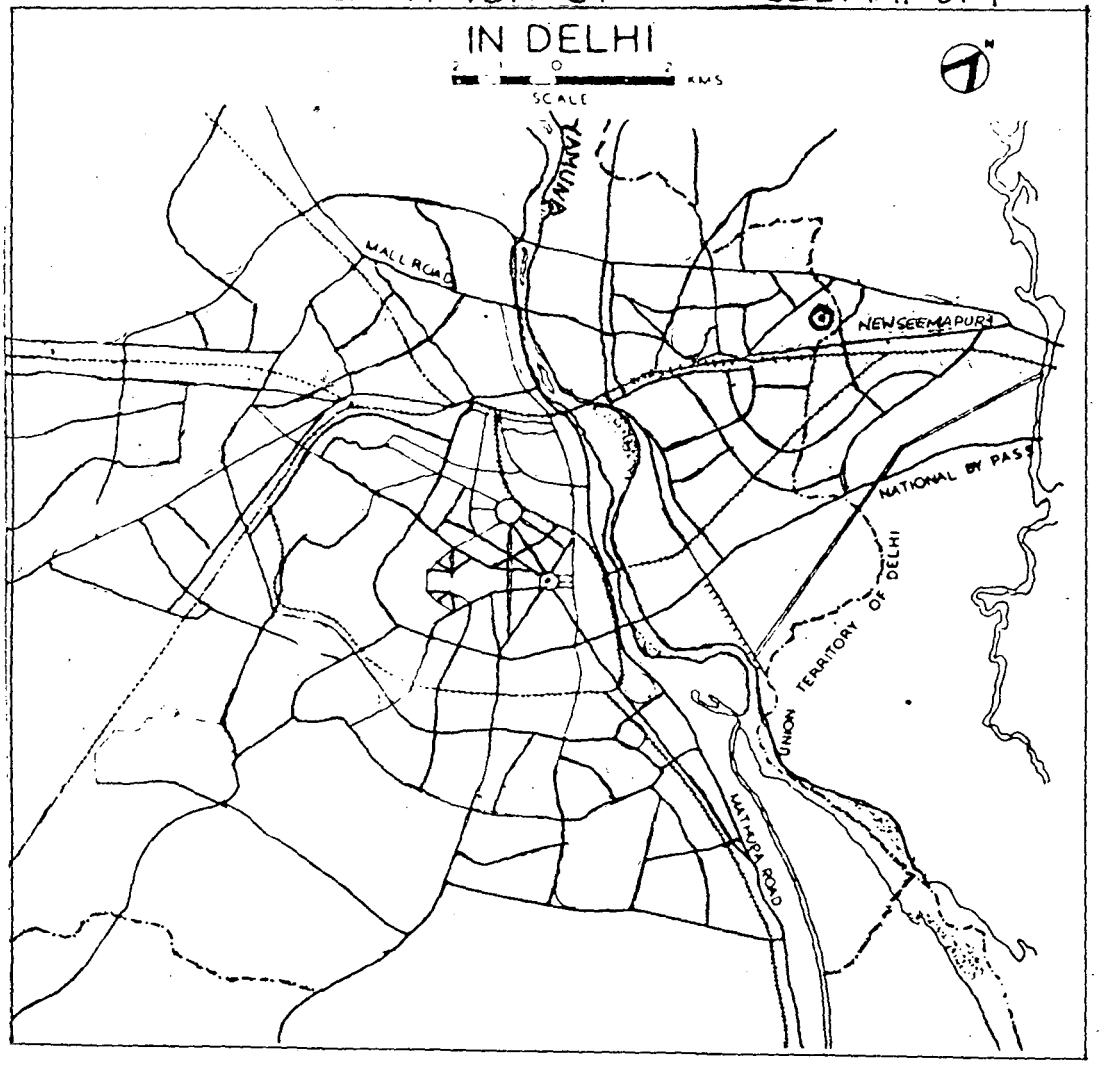
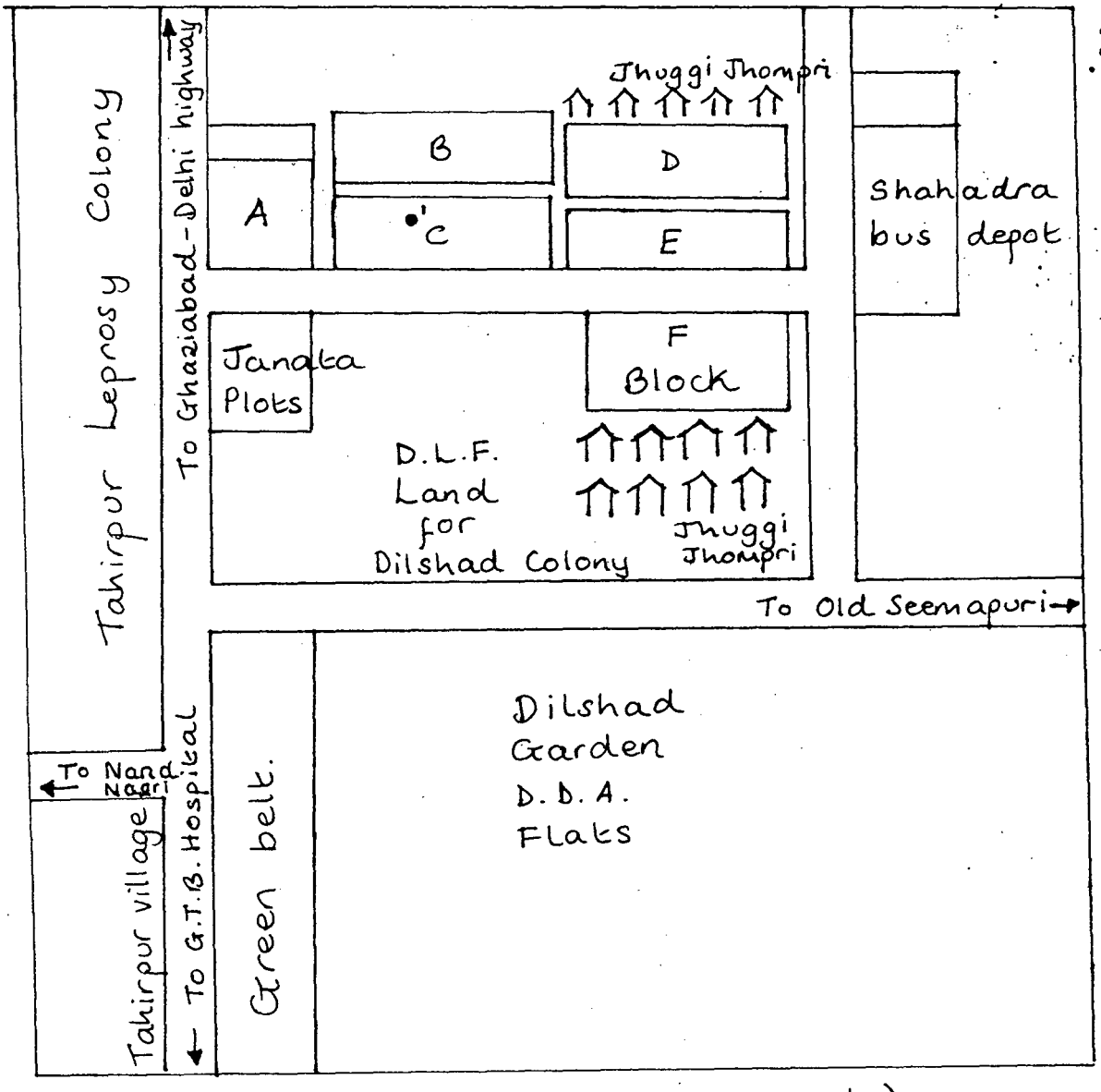
LOCATION OF NEW SEEMAPURI IN DELHI



MAP. NO. – 1

NEW SEEMAPURI



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MCH CENTRE

DELHI UNION TERRITORY

MAP NO. 2

Chapter III

SOCIAL, ECONOMIC, CULTURAL AND POLITICAL DIMENSIONS OF LIFE IN NEW SEEMAPURI

3.1.1 Origin of New Seemapuri

New Seemapuri is one of the resettlement colonies that traces its origin to the years of the Indian internal emergency 1975-77. The large scale migration that the city had been witnessing in the decade preceeding the "Emergency", had led to the mushrooming of clusters of hutments even in the middle class and upper class localities. Naturally, the makeshift dwellings with their accompanying filth and stench were beginning to mar the "beauty of these localities". It was not surprising then that during the "Emergency", which endowed the ruling elite with unlimited powers, as part of the scheme for making Delhi 'beautiful', people living in all such hutments were forcibly removed and "resettled" on the borders of Delhi.

Under the Jhuggi Jhompri resettlement scheme evolved to give Delhi a "face-lift", each 'squatter' family was allotted 25 sq. yard plots, along with community based basic amenities, in colonies especially created for them.

Thus "New Seemapuri" or the "new border colony" came into existence on the north-east border of the city.* This piece of what had been hitherto waste land was hastily developed through sanitary landfill programmes. The original master plan,[1] which had declared this area unfit for human habitation, (because its land level was lower than the Yamuna

*(see map no. 1, for location)

and was prone to floods and water logging,) was altered. Thus an area that had earlier been marked out for the development of a green belt[2] was readied to receive the first lot of settlers.

3.1.2 Important Characteristics of People Settled in New Seemapuri

The people resettled in New Seemapuri initially comprised of those brought from the Jhuggi Jhompri cluster, near the Indraprastha Thermal Power Station at I.T.O. Within a year, the colony received families from the Yamuna Bazaar hutment near the old Yamuna bridge as well.

The part of the colony where the power house squatters settled has developed into the A,B, C and D blocks and the area occupied by the Yamuna Bazaar squatters has come up as the E and F block. The differences amongst these blocks which started out by housing squatters from different areas have grown and sharpened over the years.

At the time of resettlement itself the squatters brought from near I.T.O. were in regular, salaried jobs,[3] whereas those brought from Yamuna Bazaar were daily wage earners or self-employed in petty vending business, trade, etc. Culturally and ethnically too, these two groups were different, those from I.T.O. were from the Hindi speaking belt e.g., U.P., Rajasthan, Punjab, Haryana and Bihar, whereas those at Yamuna Bazaar mainly belonged to West Bengal, Andhra Pradesh, Tamil Nadu, Karnataka or from across the

borders from Bangladesh, Nepal, etc. (See Table 3.1 for the statewise origin of respondents of F Block). The preconditions on which resettlement took place was also different. In the case of those from I.T.O., plot was exchanged for plot, whereas for the majority from Yamuna Bazaar plots were given only on the condition that an adult member from the family underwent a terminal method of contraception i.e., tubectomy/ vasectomy.

Being in regular salaried employment, those in the A, B and C blocks were able to withstand the trauma of resettlement better. Further, they were able to invest money to improve their situation in the forms of increasing basic amenities, constructing pucca houses on the plots allotted to them, etc. Today, the 'development' observed within blocks A,B and C is not matched by the E and F blocks, which in many respects lag behind. While the present residents of A, B and C blocks continue to be the original allottees from ITO, in E and F blocks many of the original allottees have been unable to withstand the economic and financial crises and have thus been forced to sell their allotted plots, to either move back to Yamuna Bazaar or as in some cases even back to the village.[4]

3.1.3 History of Migration of Current Residents in F Block, New Seemapuri

To understand why people migrate it is necessary to place it in the context of their socio-economic situation in the village that they have left behind.

Table 3.2 gives a breakup of the occupation of the people interviewed in F block, before migration. These occupations were either followed by the respondents themselves (if they are first generation migrants[5]) or by their parents or grandparents (if they are second or third generation migrants). Of the sample 40.2% of the respondents (or their families) were engaged in direct land based activity. Of these 42.4% did not own land; 42.4% were marginal or subsistence farmers (owning less than 5 acres of unirrigated land); 15.2% owned land for which wage labour had to be employed. Of those who did not own land a large majority 85.7% were agricultural wage labour whereas only 14.3% share cropped on others land.

Since agricultural activity is seasonal, during the days when no work was available on land most of the wage labour would try to supplement their income through other activities which ranged from unskilled work as in the construction industry, drive hired cycle rickshaws or engaged in petty vending. A large number of those not working directly in agricultural occupation, 26.8%, were employed usually in work that was also related to the cycle of agricultural production or depended on agricultural produce for payment. Thus there were boatmen, traditional craftsmen such as weavers, tailors, 'lohars' (blacksmiths) etc., 'mazdoors' or unskilled workers to cut earth, carry loads, potters etc.

3.1.4 The Reason for Migration

A look at Table 3.3 shows that a little more than sixty percent of the people migrated due to reasons related to the problem of unemployment or underemployment. This is not surprising considering that a large number were either poor agricultural landless labour or dependent on agricultural production for survival. The few who did own land had such small pieces of it that the produce was inadequate to meet the demands of the family. A poor harvest, floods or inadequate rains saw many people having to sell the little they owned, to join the ranks of the land-less and unskilled workers. If it was not natural calamities, it was other crises such as a sudden illness, someones death, a marriage, hospitalisation etc., which led to many having to sell their only resource - land.

In the case of migrants from the West Bengal especially Midnapore district, it was the building of the Haldia port project in the 1960's which resulted in the large scale displacement and eventual migration of the local inhabitants. For this project the government acquired large tracts of land. While compensation was paid to the land-owners, no thought was paid to the agricultural labour who had worked on this land and were to be further marginalised by this 'development project'.[6] The 1971 war with Bangladesh saw a lot of refugees cross into this district, as well, because its eastern boundary adjoins Bangladesh. An economy already in

shambles due to floods and a so called development project, was subjected to further strain by the incoming refugees, inevitably resulting in mass scale migration.

Amongst reasons given for migration it is also apparent that those who had migrated in the sixties and seventies and who formed the squatter population resettled in New Seemapuri, were doing so out of dire economic or social necessity. In contrast those who migrated in the eighties and are settlers by virtue of buying of plots have given betterment of opportunities as reason for their migration.[7]

Arrival in Delhi

Only few of the migrants who came to Delhi in the years between 1965 and 1975 had personal contacts in Delhi. Receiving information through village networks, most came along with their families to look for the work they had been told was available in abundance and at fair wages in the city. Without any contacts or material resources most of these people put up little 'jhuggies' in clusters, close to where work was available or where some of their village folk or kinsmen already lived. Thus the hutment colony at Yamuna Bazaar grew.

Among those who migrated after the emergency into this colony the majority belonged to a somewhat better socio-economic category. The people in this group were able to buy land directly in the resettlement colony or they had relatives who helped them tide over the initial years, till they were

ready to move on their own.[8] While the others from lower socio-economic backgrounds coming into the colony, being unable to buy plots for houses have put up 'jhuggies' either close to the resettlement colony itself or at the work place leading to the development of new clusters at the old sites. (See table 3.5 for a description of where the families interviewed in F Block came from, to New Seemapuri.)

3.1.5 Means of Survival During the Pre-Settlement Days

The people who migrated to Delhi and squatted in Yamuna Bazaar were unskilled. They were illiterate, did not know the language and were also culturally alienated from the city. With few possessions to call their own the only saleable commodity they had was their labour. So while men took up work as coolies, 'hamaals', handcart pushers and cycle rickshaw drivers, etc., women worked as domestic servants, took up petty vending, or in some cases even went in to prostitution. The old and infirm as well as few of the women in the family took to begging. The children supplemented the family earnings with work in tea stalls, hotels and way-side 'dhabas'. Petty thievery, trade in illicit goods and liquor, gambling was also resorted to when some people found themselves in desperate situations in the absence of 'work'. For these migrants material conditions had not altered considerably as had been hoped.

Following are some of the experiences, in people's own words of migration, and survival in Delhi, prior to resettlement.

(i)Mohd. Rafi (20 years): In 1968 our village came under floods. There was no food. People started dying, so my parents and brothers and sisters came to Delhi and started living in Yamuna Bazaar, earning a living out of working as load carriers.

(ii)Marjina (30 years): My father was a landless agricultural worker. He worked for as little as 20 paisa per day and 1 Re. a day, wages. My mother used to beg. I came with my parents to Delhi about 20 years ago, when we could no longer survive in the village, on our labour. There were already some people from our village in Delhi. So we made enquiries from them and came here. Initially we made a jhuggi in Yamuna Bazaar and lived there. My father and brother worked as load carriers (coolies) on daily wages.

(iii)Dilip is a young man aged 25, who is presently unemployed, and is from the lowest socio-economic category of the respondents - "when we first came here my father was the only wage earner, he used to carry loads and later started driving a cycle rickshaw. I started working when I was still very young, to supplement the income to feed our family of eight people. I worked in a hotel for Rs. 1.50 a day and quit the job ten years later when I reached 9.00 Rs. a day."

(iv)Shahjadi Bi came to Delhi with a sick husband and two young

children. They came from Bangalore to seek treatment for a heart ailment at All India Institute of Medical Sciences, for the husband - "I am from Bangalore in Karnataka. My father was a betel nut grower and trader. My husband supplied bamboo to mills and factories. I came to Delhi with my husband and children in the early sixties. I came for the treatment of my husband who was suffering from a heart problem. We were given the reference of a doctor in AIIMS who was from our town. We stayed on in Delhi out of economic compulsions to find work and earn a livelihood.

When we first arrived we stayed on the platform at the railway station. We could not locate the hospital. I had also lost the paper with the name and address of the doctor. So we trekked around to all the major hospitals of that time. - Irwin, Kasturba Gandhi, St. Stephen's hospital, etc. Finally someone suggested that we go to Medical Institute. There we recognised the doctor. For one year, while my husband was undergoing treatment there, we lived under a tree, on the pavement outside the hospital. The money I had brought from home had also finished and I had no job. The doctor then found me work as an ayah in the private wards of the hospital. I supplemented the earnings from this job by working as a domestic servant in the houses of some other doctors living on the campus. I used to put my children to sleep under the chowkidar's bench in the hospital while I worked. Finally when my husband was discharged we went to Yamuna Bazaar and put up a jhuggi there. My husband took up rag-picking while I set up a small tea-stall, and later also sold fire-wood."

(v) Jameela is now a grandmother and caters to the needs of fourteen family members who live together on 25 sq. yard plot. This is what she has to say about the struggle for survival - "Originally we come from Aligarh. My father-in-law was a landless agricultural worker. My husband came to Delhi as a young child, looking for work."

"He worked as a shop help for sometime selling lemon-soda bottles. Later on he started his own Lemon-soda stall, selling bottles for one anna each. He lived here and there with friends and distant relatives when I joined him in Delhi more than twenty-five years ago. We lived in Kucha Rehman for a while, in a rented tenement, later moving to Yamuna Bazaar from where we were brought here in 1976."

3.1.6 Trauma of Resettlement

Barely had they 'settled' down when the State apparatus under the guise of slum clearance programme moved in to rudely uproot them. In the week preceeding the 'clearance' of the slum the adult members from most of the families had already been forcibly taken to the sterilisation camps as part of the 'emergency' plan to control population.

On the appointed day families, along with their meagre belongings, were herded into trucks, taken to the resettlement colony. , New Seemapuri and unceremoniously dumped on the bare ground. This resettlement took place in the month of August 1976. Even today people recall the stark conditions of those

initial days. Surrounded by knee high grass and water logged ground, families struggled to put up some kind of make-shift shetters to keep out the rain, it being the middle of the rainy season. The only source of drinking water was a single hand-pump about half a kilometer away. There were no shops. So men walked to distant colonies to buy provisions.

Over the days the problems they had to counter kept increasing. Men left their wives and children for days on end in the new colony while they looked for work in the city. Women relate their horrific experiences of witnessing cremations and death even while having to deal with other emergencies single handedly. Being on the outskirts of the city, was to them for all intents and purposes, like being outside the city.[9] Because of the recent relocation, the surrounding areas were new and unfamiliar. Women felt helpless to cope with emergencies such as sudden illnesses and even birthing experiences. They did not know where to turn for help and intervention. All the places and people they had known or were familiar with for the time being seemed far away and out of reach.

For long they had to do without the minimum basic amenities. Since those initial days of desolation the colony however has been provided with some ,though inadequate, amenities. Whether these have made any difference to the immediate environment or quality of life of the people will be discussed in the subsequent sections.

The experience of resettlement and the struggle during

the days that followed is best expressed in peoples own words.

(i) - "They left us here, near the main road; the plots had not been marked out; three days after our arrival we were allotted plots. We used to bring food from Old Seemapuri (1 km. away). The piece of land on which F-Block now stands was a cremation ground. There were knee deep pot holes; there were no electric poles, or street lights, these came 6-8 months later; toilets were built 8-9 months later. We used to go to 'Delhi' to find work. Many people walked to 'Delhi'. There was one tap in D-Block from which we got our water."

(ii) - "It was just open ground, on which we lay for three days, covering ourselves with mats to keep out the rain. Toilets were built in 1977 and street lights came later."

(iii) - "The open ground was covered with knee high grass. We levelled the land and filled the pot holes. There were a couple of handpumps near the main road and one tap with potable water. There were no latrines and street lights even on the main road. It was difficult to go to and fro from 'Delhi'. There were few buses, making about 6 trips in the whole day. There must have been about 500 jhuggies then. Later many people left out of fear and some sold their plots and went back to Yamuna Bazaar".

(iv) - "As we got off the truck which had brought us here, we saw a young girl being cremated where F-Block is now situated. Hundreds of people camped on the open ground amidst waist high grass. There was one tap near the "Dudh Walla

school" (anganwadi) - 2-3 queues of people waited from morning to evening to get water. The hand-pump water contained worms and insects, many times we had to strain and use that water for drinking purposes. There were no shops around. Only the main road had been made 'pucca', all the others were left 'kutchcha'".

(v) - "The plot we were allotted was covered with water, so we camped on someone's else's plot for a while and only after 15-20 days claimed our own plot. There were no doctors here, nor any hospital or medical facility."

(vi) - "There was no facility to buy milk for children nor any arrangement for doctors or medicines. I used to go to distant colonies to buy old newspapers and bottles. Whatever I earned from selling those, would be used for meeting household expenditure. Food would be bought and cooked with the money I earned each day. Later my mother too started working as a domestic servant in the posh colonies situated, 10-15 kms. away.

(vii) - Since it was raining when we were brought here and there was no shelter of any kind my children and I used to cover ourselves with plastic sheets when we slept, to keep out the rain. We did not get any money or loan to build our houses (who listens to poor people). Water was avaible for only one hour a day. Many people used to bring water from Old Seemapuri or other parts of 'Delhi'."

(viii) - "Seven days after arrival, my son was born, on 'Janmasthami'. It was raining and the already water logged plot was

submerged under water. Quickly we erected a jhuggi of sorts and piled up bricks under the bed to raise it above the water level. I gave birth to my son on that."

(ix) - "During the emergency they started stirilising people and brought truck loads full from Yamuna Bazaar to New Seemapuri. This place resembled a jungle with waist high grass and huge pot holes (6-8 feet deep in places) filled with water. Only four houses had been built here till then. I was 8 months pregnant at the time and started having labour pains during relocation. My father and mother were in a panic, thinking I would die. Initially we just occupied this plot. Only after many requests and pleading, we got it registered in our name. My father had been allotted a plot in Jahangirpuri for having undergone vasectomy but he was scared to leave me here with my husband, so he tore his slip and stayed here."

3.2 New Seemapuri of Today

Depending on the side one enters from and depending on the time of the day one enters, New Seemapuri has a varying appearance. (See map no.2). The colony does not look uniformly good or bad. If one enters from the A block side, it looks fairly neat and tidy, with well paved and swept roads, drains mostly covered and 'pucca' houses arranged in neat rows. On the other hand if F-Block is the site of entry the view is more run down and depressing. Comparatively there are more 'kutcha' houses and 'jhuggies', with over flowing and broken

drains. The view is not improved by the fact that an unauthorised 'Jhuggi Jhompri' cluster of almost 1500 'jhuggies' adjoins it.

Behind F-Block, at first what appears to be large piles of garbage, turns out to be the collection of waste material, which forms the source of livelihood for several rag-picker families residing in F-Block.

The main road that runs through the colony is the centre of local commercial activity. Every kind of shop from pharmacies to those selling household items and provisions, consumer items, sweetmeats, electrical goods, footwear, clothing, barbers shops, blacksmiths, hardware stores, line the two sides of the main street. What strikes one about the colony is the complete absence of greenery. The spaces initially provided for parks have been appropriated for different purposes, one of them being the new "Sulabh Shauchalaya" complex.

A number of 'galis' or side streets branch of from the main road. There are 20-25 plots on each side of the 'gali'. 'Pucca' houses are interspersed with 'Jhuggies', at times leading to an incongruous sight of a 'jhuggi' res ting side by side to a garish two storeyed 'pucca' house.

In the F-Block although the immediate surrounding of the household may reflect the occupation followed by the members[10] of the family and the walls may be grimy and black with soot, the inside of the house is comparatively neat and clean, belying the commonly held notion that slum dwellers like to live in the midst of filth. Walking down the galis where the rag

pickers and "pankhwallahs" are concentrated one inevitably raises swarms of flies which have collected due to the piles of waste material, poultry refuse and open drains. .

A constant comparison to all these sights is a variety of smells that accompany one through the basti. The assorted smells of cooking, intermingle with a smell of decay, smoke from wood and kerosene fires, dust, human and animal excreta etc.

At any time of the day when one walks through the maze of lanes it appears as though a large chunk of the essential economic and household activities are being conducted either on the doorstep or on the streets, infront of the house. Whichever time of the day one goes there is a constant hum of activity. Early hours of the morning finds women looking on the street or doorstep, washing vessels, filling water, men bathing and getting ready for the days work. As the day advances mostly women, children and older people are to be seen. This is the time for washing clothes, bathing and getting ready for home based economic activity such as bindi sticking, making buttons, etc. Vendors come around selling vegetables, fruit, other eatables and household or consumer items. Late afternoon when the children have been scrubbed and fed, is the time for some relaxation before the evening work begins and men folk who go out of the colony to work start returning. Around 4-5 p.m. women start the evening meal by buying the vegetables and other ingredients. Rag-pickers

returning with the days booty sort it out in preparation to selling it to the local junk traders. As this activity comes to an end, the younger set of rag-pickers prepare to enjoy the remaining hours of the day. Freshly bathed and dressed in their best "disco" clothes the young men collect in groups around the local tea shops and street corners to chat or merely hang around. The evening programme may include a visit to the local cinema house or video parlour. As the evening wears on the air is filled with smoke from the fires, mosquitoes make their presence felt and dim pools of light vainly attempt to pierce the falling darkness. Men folk sit outside the house chatting, playingcards, smoking 'bidies'. The children run around, playing, screaming, yelling. Television sets are switched on and these add to the general background sounds. The winding up of the days activities begin by 10.00 p.m., as people prepare to retire for the night and cots line the street stray voices, shouts and screams rent the air as the frustrations of the day are taken out and expressed.

3.3 Way of Life in F-Block of Seemapuri

For most of the families Delhi has become the place of permanent residence. In the city the nuclear unit is economically more viable. 63.4% of the households interviewed live in nuclear units. Thus for economic and emotional sustenance the role of each member in the family becomes crucial.

3.3.1 Links With the Village

Of the households interviewed 23.2% continue to have a

very good social and economic link with the village from where they come. These people have come in the last 5-7 years and give economic betterment as the reason for migration. For them links with the village are on a reciprocal basis. They regularly visit the village - every five to six months - investing money on land in the village, sending money 'home' for the support of the other family members who continue to live there. They also receive in return agricultural and dairy produce such as wheat, rice, ghee, oil, pickles, fruits, etc., on a regular basis from their kin in the village. In times of emergency they can depend on financial assistance from the family in the village. Women will go home for deliveries and other occassions when they need rest or recuperation. They are here for purely economic reasons and the village continues to be the real home. For another 21.9% the link with the village is limited to the extent that they may visit it once in 2-3 years, for social occasions, such a marriages, deaths, etc. 54.9% have little or no contact and for them Delhi is the permanent home for better or worse. (See table 3.6).

3.4 Economic Survival

For most households resettlement has not considerably altered the means of survival, from the time they moved into Delhi.

3.4.1 Number of earners: Out of 82 households 214 members can be said to be working in activities with direct economic re-

turn. 39.2% of all households interviewed have only one earner; 26.83% have 2 earners; 12.19% have 3 earners; 7.32% have 4 earners; and 14.63% have 5 or more than 5 earners. (Table 3.7).

8.4% of all individual earners work with hired labour only;[11] 18.7% work with family plus hired labour; 34.6% work only with family labour and 38.3% work alone or individually.

3.4.2 Nature of Occupation - Can be divided into 4 broad categories : (i) those in jobs with regular salary/wages (ii) self-employed (iii) engaged in petty business, trade or usary and (iv) those on daily wages.[12] 12.6% come under the 1st category; 50.9% are self-employed, 28.5% fall under the third category and 7.9% on daily wages. (Table 3.8).

3.4.3 Number of occupations: All the working members in a household may follow either the same occupation, e.g., all may be engaged in rag-picking. Where there is more than one earner in a household they may each follow a different occupation e.g., in a house where two brothers are working one may be a rag-picker and the other may drive a cycle rickshaw. Table 3.9 gives a description of the number of occupations in a household. 70.73% of households follow a single occupation; 24.39% are engaged in 2 occupations; 3.66% have more than 3 occupations and only 1.22% follow more than 4 occupations.

3.4.4 The actual work:"Kabaadi Ka Kaam": The predominant occupation in F-Block is "Kabaadi Ka Kaam" (or dealing in junk/solid waste). Under this broad category come several kinds of

activities. (i) Rag picking, (ii) rag-sorting and (iii) whole sale buying and selling of the junk or waste material.
(i) Rag picking: This level of activity needs no investment and uses comparatively less physical labour than other physically demanding occupations such as construction work, 'hamaals', handcart pushers etc. Hence children, the old and the infirm and women are predominantly engaged in this activity. Rag pickers leave the colony early in the morning with a sack or cycle-cart. They walk or take a bus and go to different residential parts of the city and its colonies, collecting and picking any garbage that has some re-cycling potential. This waste material comprises of paper, plastic and polythene bags and sheets, broken plastic objects, glass pieces, bottles, cloth rags, scrap iron, tins, etc. Either this collection is brought home and sorted out or sorting is done near the place of collection itself and sold to a whole saler dealing in this junk. Waste material is differentially priced according to its recycling potential. Thus iron scrap (and tin) commands the highest value followed by different grades of plastic and paper.[13] Depending on how good a days' picking has been individual rag pickers are able to earn 15-40 rupees a day.

The second level of activity under 'kabaadi ka kaam' is that of the rag sorters and whole sale traders. The whole salers or 'kantewallahs'[14] as they are popularly referred to, need some amount of cash investment. Basically they buy and store the different waste products and sell it to individual factory owners who recycle particular products.[15] One factory

may recycle only glass or plastic or iron. "Kantewallahs" buy material from individual rag pickers and either employ or use family labour for sorting out the material in preparation to selling it. Rag sorters are mainly women and are paid a fixed daily wage of Rs. 15-17. Factory owners come to the 'basti' every seven to ten days and pick up the material they need from the whole salers. The "kantewallahs" can make upto 500-1000 rupees on every consignment they sell to the factory owners.

Amongst the 82 households, 16 are engaged in rag picking exclusively; 3 are engaged exclusively in sorting; 5 in picking and sorting and 19 are wholesalers.[16] "Kabaadi ka kaam" apart from being the main and regular source of income for many of the families is also resorted to in times of financial crises by individuals of some families, whose other sources of income are inadequate to meet the needs, for short periods.

Rag picking is a dirty job, wherein all kinds of garbage dumps, drains, by lanes and service lanes of colonies are scoured for rubbish. The work involves going through the refuse by hand. Initially when rag picking got defined as a specific occupation it was taken up only by those who were at the bottom of the social and economic rung in a society. Thus it was an occupation followed mostly by abjectly poor migrants. Today however rag picking is resorted to by those not so poor also. 15-40 rupees a day with very little investment and minimum expenditure of physical energy has made the occupation socially acceptable and economically viable.[17] Dealing

in whole sale of "kabaad" with a return of upto rupees hundred a day has made the job economically lucrative. In New Seemapuri, today approximately 20% of households are engaged in 'kabaadi ka kaam' of this 65-70% are from the Bengali migrant community and 30-35% are from the socially and culturally higher communities from the Hindi belt.[18] However even with the social acceptance of 'kabaadi ka kaam' the dirty job of physically going through the refuse and junk is still performed by the poorer Bengali migrant. But as stated earlier even this dirty job is resorted to by other communities at the time of dire economic straits. Considering the lucrative economic returns from wholesaleing of 'kabaad' many economically well off families (from the culturally and socially higher communities) have been entering this area of work, treating it as a kind of safe business investment.[19] This particular occupation is also taken seriously is evident from the fact that it is the only occupational group which has made attempts at unionising about which more will be followed in a later section.

"Pankhwallahs": Approximately about 10% of the households in F-Block are engaged in an activity broadly described as "pankh ka kaam". This activity is carried out only by the Bengali migrant community.

The adult male members leave in the morning for Jama Masjid where every morning thousands of poultry are slaughtered and dressed before being supplied to the various hotels and

eating places in the city. Around twelve in the afternoon, the men return with the skins and claws of the slaughtered poultry. These are then boiled by the women in huge cauldrons over open wood fires. The feathers are removed and the under lying skin is washed, in readiness to be sold in the local market by the men, as cheap or poor quality meat. This activity is mainly performed with the help of household labour, in which men, women and children participate. In a household where the number of women needed for de-feathering is not adequate women from other households are hired at the rate of six rupees a day. The entire activity brings in anything from rupees 40-80 a day. Business is usually slack during the monsoons and "navratri"[20] when meat eating is prohibited by the Hindu religion. Tuesdays is the weekly holiday because no slaughtering takes place on Tuesdays.

Another activity followed by a substantial number of adult males is that of driving cycle rickshaws. Few own the cycle rickshaws they drive. These are normally hired at the rate of Rs. 8/- per day. Men may drive these near the colony itself or go as far as Red Fort, Chandini Chowk or other trans-Yamuna colonies to drive the hired rickshaws. Depending, on the weather[21] and physical well-being of the man, earnings vary from Rs. 15-30 per day.

Tailoring, painting, whitewashing, petty vending of small household items and day to day necessities (such as vegetables, provisions, clothes, eatables, sweets, cigarettes, cooking fuel, consumer items, etc.), masonary, carpentary, pottery,

"mochi (cobbler) ka kaam", are some of the other occupations individual members of families are engaged in.

The salaried employment comprises of those in teaching, municipality workers and factory workers. The petty traders or business men deal in medicines, hardware, sweetmeat retailing, furniture making, cycle repairing and hiring, etc.

3.4.5 Earnings

The total income of a family depends upon the number of earners in the family and the renumeration that goes with the occupation that each follows. As in the unorganised sector in some cases the cash remuneration is augmented with income in kind. Thus there are instances of about five families (of the total who were interviewed) whose income is supplemented with leprosy dole[22] in the form of subsidised (or free) daily provisions, vegetable, fruit and other household necessities. In the case of those working as domestic servants left over food, old clothes, often add to the cash remuneration. Total income is also added to, in cash or kind, from sources such as: rent, produce from village land, or domestic animals such as: poultry, goats, pigeons, pigs, etc. Although income from "illegal" trade as in the sale of illicit liquor, banned drugs, narcoties, prostitution is not voluntarily disclosed, in some cases it adds to the family earnings. The ingenuity in raising money from almost any source is evident from the example of at least three families who sell their allotment of kerosene

oil from the fair price shop on the black market and use fire wood as cooking fuel for their own purpose.[23]

Of the households interviewed incomes vary from Rs. 300 to 6000/- per month. 18.3% have incomes ranging from 300-600 rupees per month. Incomes of 14.6% of the families range between 600-900 rupees per month. 32.9% have incomes between 900-1500 rupees per month; 17% have incomes between rupees 1500-2100 per month; 17% have incomes above 2100 rupees per month. (Table 3.10).

Overall income is not a sensitive indicator of the economic status of the family. It would be more accurate to measure income levels on the basis of the number of Consumption Units (C.U)[24] per family and the income available per C.U. Table 3.11 gives the distribution of the consumption units per family. 48.8% of all the households interviewed have between 4-6 consumption units; 22.9% have between 7-9 C.Us.; 19.5% families have between 1-3 C.Us., ; 10-12 consumption units are present in 8.54% of the families and 13-15 consumption units are found in 1.22% of the families.

24.4% of all families interviewed have incomes less than or equal to Rs. 150/- per month per consumption unit; 41.5% have an income between 150-300 rupees per month, per consumption unit; 22% of the families have incomes between 300-450 Rs. p.m., per consumption unit; and incomes above 450 Rs. p.m., per consumption unit is found in 12.2% of the families.

As per the I.C.M.R. recommendation the minimum amount

of money required to meet just nutritional needs is Rs. 200/- per consumption unit.[25] Considering this, of the households surveyed in 66% of the cases income available per consumption unit is less than 300 Rs. per month, which is barely adequate to survive.

3.4.6 Savings, Debts and Loans

At the time of the survey 47.6% of all families reported some savings. 69.5% of all families interviewed were under some debt or had taken a loan which they still had to pay off. (Table 3.12).

Money is borrowed from several sources hence one family could be in debt to several people at a given point in time. A family could have borrowed 50 rupees from a neighbour or relative to buy bulk ration or to pay the local doctor for a sudden illness. Larger loans for business, marriages, building of houses or severe illness, are taken from professional moneylenders on interest. The other source are the nationalised banks which advertise loan schems for the under privileged for employment generation.

Small amounts of money borrowed from neighbours or relatives are interest free, to tide over small and sudden financial needs. Being on daily wages the family may not have even a 'capital' of fifty rupees to buy ration that is available in bulk from the fair price shops, because the daily earnings are spent on daily consumption needs. In the words of one resident - "roj kamao, roj khaao" (earn every day - eat every day). Money borrowed from professional moneylenders

have a high interest rate which can go upto 360% per annum. And at times security in the form of jewellery, consumer items or even the house is asked to be pledged to obtain 'loans'.

Even under schemes offered by nationalised banks meant to offer low interest loans people inevitably have to pay high returns in the form of bribes - from the peon to the bank manager. Even then they may not succeed in obtaining the entire amount applied for.

Since the needs of a family are manifold,it is not unusual to find families borrowing from a new source while repaying another. Often money borrowed, may not necessarily be used for the same purpose it was borrowed for in the first place. Again it is not unusual to find that loan taken to set up some petty trade or vending activity has been consumed for a doctor's bill. (Table 3.13 gives reasons for debts and loans).

Some of these experiences are described in peoples own words:

Dilip who is unemployed and wanted to start a small business of his own (petty vending activity) - "I went to 11 banks, over a period of six months for a loan of just 2,500 rupees. I probably spent more than that amount during the 6 months, trying to secure the loan. Loans are only given to those who are able to give the bank manager a percentage of the sanctioned loan. One of my friends did that; he gave the Bank Manager 2,500 rupees and he was sanctioned a loan of 10,000 rupees. I too promised the manager, a percentage from

the loan, if I got it, but he wanted the money before sanctioning the loan still I had to give him 100 rupees as a price for even letting me into his office.

Mohd Rafi - "I took a loan of 400 rupees for Id. I have to repay it in 50 days. I am being charged 1 rupee interest on every 100 rupees every day. This is what is so terrible about being poor. If some one falls sick or has any other sudden need, its the easiest way of getting exploited."

Shubhra Tara is a widow, her husband having died in the summer of 1984 - "There was a scheme of 5,000 rupees from a bank for starting some home based petty vending kind of activity. I had applied, hoping if I got the money I would make my jhuggi into a pucca house and also open a small stall to sell fire wood. But eventually I got only a thousand rupees. At the same time my middle son fell ill with jaundice and I spent the money on his treatment and buying fruits and fish and other nourishing food for him. So far I have been able to repay five hundred rupees of that loan and another five hundred rupees is pending.

Savings do not necessarily fall under the traditional patterns of putting money into banks, post office saving schemes or buying insurance policies. Money is saved through locally organised chit fund schemes. Whereby each member of the chit fund pays a certain amount every month. During the monthly meetings bids are invited from members, the lowest bidder is given the priority and the amount asked for is given to him/

her. The remaining amount being shared between the others. The next time this bidder is not allowed to bid and the cycle goes on. Essentially, this also works as a free interest loan.

3.5 Social Status

F Block is predominantly Muslim (79.3%). Only 19.5% of all families interviewed are Hindus and 1.2% Sikhs.

47.5% of the households interviewed are from the Bengali community. 47.5% are from the Hindi speaking belt and 4.9% are from Tamil Nadu, Karnataka and Andhra Pradesh (Table 3.1).

15.9% of the families interviewed are headed by women and these households fall under the lowest economic categories.

3.5.1 Educational Status

Of the 158 adult members in the 82 households 59.5% are totally illiterate; 5.7% can sign their names; 10.8% can read and write Hindi, Bengali or Urdu; 7% are educated upto the primary level; 5.7% upto middle school; 1.3% upto secondary level, 3.8% are matric pass; 1.9% are intermediates and 4.4% are graduates. (Table 3.14).

The educational level according to gender shows a clear bias in favour of men. Whereas 78.5% of the women are illiterate; only 40.5% of the men are illiterate 15.2% of the men can read and write and only 6.3% of the women can read and write and while 6.3% of the men are graduates only 2.5% of the women are graduates.

Out of the 82 households surveyed 30 families send their

children to schools. All the families with children of school going age, in the highest economic category, send their children to school. While 41.7% of the families, with children of school going age, in the above subsistence level category send them to school, 34% of the families from the subsistence level and 25% of families from the below subsistence level category are able to send children to school.

While it may appear that giving formal education to children is not the top-most priority in families at and below subsistence level, there are very definite social and economic compulsions which prevent these families from sending their children to school, even if they wish to do so. As seen earlier being nuclear units at subsistence levels and below, the labour of each family member, irrespective of whether they are adults or children is crucial for the survival of family. Children if not engaged in direct economic activities relieve the adult earning members of daily chores like looking after younger siblings, cooking, washing, fetching water, etc. An additional problem is that education even if it is said to be "free" needs definite investments in terms of books, clothes, etc., which poor families can ill afford. Despite this when families try to send their children to school very often they could not secure admission for their children because they did not have a birth certificate.

3.5.2 Consumer Goods

The presence of the number of consumer and luxury items

is an indicator of the social status of a family, that it would like to project. Radio, Television sets and fans are the commonly available consumer items in the families, with 62.2% owning radios, 46.3% owning T.V. sets and 58.4% having electric fans. When compared to the fact that 66% of these same families have income per consumption unit of less than Rs. 300/- per month, it is obvious that consumerism has made great inroads into their scarce resources. Consumerism is also promoted by the possibility of hire purchase schemes which enable people to buy goods on instalment basis.

Items such as desert coolers, refrigerators, scooters, cooking gas, clearly luxury items are available with the top economic categories. (Table 3.15).

3.6.1 Quality of Housing

76.8% of all the families interviewed have 25 square yard plots; 13.4% have 50 sq. yards; 6.1% have 75 sq. yards; 2.4% have 100 sq. yards and 1.22% have 150 sq. yard plots. (Table 3.16). These plots may be contiguous to each other or spread over the block i.e. one family may have two separate 25 sq. yard plots in different parts of the block.

The plots have been acquired in different ways; one by one (if they are spread over the block), as one contiguous plot of say 50 sq. yards (if bought together); an empty plot may have been bought and a house built on it later, or a ready-made house may have been bought (especially in the case of the more recent settlers); plot may have been given for

undergoing tubectomy or vasectomy (in lieu of sterilisation), a relative may have gifted it, or as in the case of some people, they just occupied it. Table 3.17 describes how plots were obtained.

All the families of the two highest income groups who have 25 sq. yard plots have double or three storeyed houses. 81.8% of the families with 50 sq. yard plots also have double or three storeyed houses. In households with more than one plot of 25 sq. yards it has been observed that in many cases only part of the area of the plots is built for self-occupation. The rest of the area of the plot(s) is either left vacant or 'jhuggies' or 'kutcha' houses are built on them for the purpose of renting, carrying on income generation activities or houseing domestic animals.[26]

58.5% of the families interviewed lived in 'pucca' houses whereas 41.5% lived either in 'jhuggies' or 'kutchcha' houses.[27] Of these 88.2% of the families were from the lower two economic categories (see table 3.18). Even though 'lack of money' is the most often quoted reason for not building 'pucca' houses, it does not explain the whole picture. Building a 'pucca' house is a struggle in itself. Behind each unsuccessful attempt is a story - of severe illness leading to death of a male adult member, a fire which razed all the 'jhuggies', a petty trade which went bankrupt etc. The few who have managed to build 'pucca' houses (especially in the low income categories) have done so bit by bit over several years, by adding brick walls

one year a cement floor the following year and a 'pucca' roof the next year.

The struggle for creating a decent shelter is best expressed in people's own words:

(i) - "When we have money we will construct a pucca house - this "kutchcha" room that you see was also built by taking loans. The income in the house is inadequate to meet the costs of building a pucca house."

(ii) - "We live in a jhuggi because we don't have money to construct a pucca house. First we have to have adequate income to fell our stomachs (pehle pet bharne ka sadhan ho) then we'll construct a house."

(iii) - "How can I build a house? My expenditure on illnesses (in the family) exceeds my earnings."

(iv) - "We have no money to build a house. I am in heavy debt already due to my mother's illness and subsequent death."

(v) - "When there was a major fire about 8-9 years ago, our jhuggi got burnt along with everyone elses. We were given a few bricks then and with that we started the construction of this kutcha room."

(vi) - "I built this house bit by bit and in theprocess sold all the jewellery I had."

(vii) But by far the most poignant experience was recounted by Dharmender a rag-picker:

"We were brought here in trucks and left on this open ground. We were still young. My widowed mother started

levelling the land while we dug earth to fill the pot holes. She first erected a jhuggi, which had to be rebuilt several times; after every major fire, year after year when all the jhuggies used to get gutted. As I grew older I changed many jobs and finally set up a small stall for selling cigarettes, etc. We were the first family in this entire gali to build a pucca house. Then my brother fell ill. No one could diagnose what had happenned to him. He is paralysed from waist downwards. We took him to a number of government hospitals and private doctors. First I sold my stall. Over the years we sold everything of any value we possessed. Then we dismantled our pucca house and sold the bricks, the door frames, the doors, everything that could be sold. Now we are back once again living in a jhuggi. My mother has taken my brother to the village for treatment. I send them money every month; whatever I can spare from my earnings as a rag-picker. I have spent so much money on my brother's illness that with it I could have bought two more plots and built a three storeyed house."

The 25 sq. yard is barely adequate for the construction of one room not exceeding 10 feet by 10 feet. A little space is left over to be used as kitchen space and women use a corner of it to be able to bathe in privacy. Since houses are built contiguous to each other, the room at the back has no place for a window to let in air or light. Consequently these rooms

always wear a dark and gloomy look. There is no space to build any bathing or toilet facilities. But in some more orthodox Muslim households, especially, they have managed to squeeze in a dry latrine which empties on to the drain that flows outside the house.

3.6.2 Electricity

78% of households interviewed have electricity which is used for lighting the house and operate the few electricity run gadgets they may own (e.g., electric fans, T.V. sets etc.). In the rest of the households lighting is provided through small lamps using oil or kerosene. Of the households which have electricity, 75% have their own meters, the remaining 25% either pay for a line from the neighbours meter[27] or 'steal' electricity from the overhead high tension wires.[28] (Table 3.19).

One of the major reasons for not installing their own meters is the expense involved.[29] For the 'Jhuggi' dwellers the threat of fires also proves to be a deterrent. For a tiny spark from a faulty line can raze the 'jhuggies' made of highly inflammable material (plastic sheets, straw mats, thatch) in minutes. Sudden checks by the authorities leading to arrests deter those who would wish to steal electricity.

3.7 Social Environment

The people of F-Block have been residents of the re-settlement colony for the last 5-13 years. Although class and religious groupings exist what is more apparent is the

regional clusters that stand out. Bengalis intermingling with Bengalis and the north Indians or "Hindustanis" keeping to themselves. Among the Bengalis however sharp distinction is drawn between Bengalis from West Bengal and the immigrant Bengalis from Bangladesh.

Because of the haphazard allotment of plots during relocation no particular community is clustered on gali/area basis. Thus a south Indian family could very well be the next door neighbour of a Bengali from Bangladesh. In parts of the colony one observes that while one half of a lane houses migrants from Bengal the other part houses migrants from the different states of North India.

Although as stated earlier most of the day to day activity is carried out on the street in public view, inevitably leading to some social interaction with neighbouring households, in time of real need families seek help from their own relatives or people belonging to their community. This could vary from borrowing money, to keeping vigil over birthing, or taking care of children, accompanying sick people to hospitals and dispensary or intervening in family quarrels. Strikingly this network of neighbourly support is observed more among the lower social economic categories while those belonging to the upper categories more or less keep to themselves. Even amongst the lower categories because of cultural alienation especially with regard to language, the non-Hindi speaking communities tend to stick to each other more closely than the

Hindi speaking groups.

3.8 Status of Women

Households being predominantly Muslim, purdah system exists to some extent. But only women from the upper categories, belonging to Muslim families observe it. Women from lower categories whose contribution to the household economy is essential cannot "afford" to observe the purdah system. Women from the upper economic and social categories confine themselves to taking care of the house and children and do not contribute directly to the income of the families. Even for household work some may employ help. Generally they stay confined within the four walls of the house and make little or no attempt to come in contact with their neighbours from the poorer categories. When they do leave the house it is to visit relatives and friends in the other parts of the city on special occasions such as for marriages, festivals, etc. They are totally dependent on the male members of the family for all activities which entail going "outdoors", e.g., buying provisions, shopping for vegetables and other essentials, visiting the hospital or dispensary, etc.

Among the lower categories, which include, Bengali Muslims, women work both within the house and outside. In the case of direct economic activity participation is limited to the work they can find within the colony. If they go out of the colony for work it is mainly to work as domestic servants.

(See table 3.20 for a sex-wise distribution of earners in a household). Women from these categories have fewer constraints on their mobility within the colony. They have better exchange and contact with other families and are not entirely dependent on the male-members in their day to day transactions. 16% of the households, all of which belong to the lower categories, are headed by women. These women who had been "sheltered and protected" most of their lives learn to cope in a male world after the death of a male head or desertion by him. These women as well as those who are still under the protection of a male, irrespective of their economic categories express their dissatisfaction with their confinement and limited interactions with others. They also regret the fact that they are not educated, do not have skills that would enable them to work at better paid jobs, and enjoy the independence and social mobility that males enjoy. Women who are employed in income generating activity even if unskilled are more articulate, independent in bearing and confident about making their way if not around the world at least around the 'bastis'. Women who are dependant desire to change this state of affairs as there is a constant possibility of being left unprotected either through death or desertion. It is not uncommon that men desert their wives or make a bigamous marriage because the first wife has been unable to produce a child. Daughters are given away in marriage at a young age to get 'rid' of the social and economic liability. Women also resent the fact that all major and sometimes even minor decisions are made by the males

in the household. In households where women do not bring in cash incomes they have to wait for their husbands to give them a daily allowance for household expenditures as a 'dole'. In households where the daughter or sister is 'sent' back from her marital home frustrations and frictions often centre on this issue. In some cases a woman thus sent back has to face humiliation at the hands of her own family members or becomes the object of their and other neighbours pity.

Women perceive the lack of information about the world as an acute handicap. Constantly occupied with activities either within their households or outside they are left with little time and energy to listen to or share news of situations and events of the world outside their 'basti'. Bengali women feel especially handicapped not knowing Hindi and their opportunities of learning it are also limited compared to their menfolk, whose greater interaction with the outside world gives them greater opportunity to pick up, at least, the spoken language.

Contrary to the popularly held notion that in a "slum" all men drink and beat their wives regularly few women reported it as a regular occurrence. While it is true that women have experienced some form of physical violence, sometime or the other, in their marital life, it is the general overall oppression they perceive as a greater violence. About 10 women (from 82 households) disclosed that they were regularly beaten. The others said that there were occasional fights

and arguements over expenditure, use of contraception, and other issues, common and inevitable in every household.

(i) Shahjahan Bi is now a widow her husband having died two summers ago (1987) following T.B. of the brain was amongst one of the more vocal women about women's oppression including physical violence. She now works as a domestic servant - "My husband used to drink a lot. He also smoked 'hashish' and 'charas'. He used to buy liquor from across the border (1½ kms. away). There was always a lot of tension between me and my husband. He used to frequently beat me and abuse me. Once he even threw me out of the house. He used to give me ten rupees a day for household expenses out of which I had to feed ten children. I supplemented the money by selling my quota of kerosene from the ration shop on the black market, and cooked on a wood fire. Whatever he earned, repairing cycle rickshaws, he spent on gambling and drinking with his friends. Despite repeated requests he would not use a condom during intercourse. I tried using a CuT once but it did not suit me. He only knew how to produce children, not how to feed them or take care of them. After he died I had to move out of the house and find work. I wish I had some education and knew a little more about the world. It is so frightening sometimes and I have no one to turn to for help."

3.9 Festivals, Entertainment and Leisure

Being a predominantly Muslim area all Muslim festivals are celebrated with fanfare. "Meethi Id" and "Babri Id" especially so. Celebrations are mostly in keeping with the

families' economic status. While those who can afford them, wear new clothes on the occasion, the poor would try to wear at least well washed and clean clothes. Prayers are offered, sweets distributed and neighbours visit each other to spread good will and share good wishes on the festive occasions. 'Durga Puja' is the other community based celebration because of the presence of a sizeable Bengali community. All Hindu families contribute their bit, according to their economic status, towards this week long event.

For people who are engaged in daily wage labour every-day is a working day. For men it is only the few hours in the evening after the days work is finished that they can term the leisure hours. For young men with no family responsibility these hours are spent in their flashy attire at the video paralours or cinema halls in the vicinity or merely chatting around the local tea shops. For older men this time is spent either lying vacantly on a cot or playing cards with small stakes, drinking or chatting in groups. For women there is no defined leisure period. The only time they find to chat is late in the afternoon when one cycle of activity has ended during the day and the other has yet to begin. This too is restricted to only those women who are not involved in direct economic activity.

Playing cards or consuming alcohol is not confined to a leisure activity, sometimes these become a way of life specially for those who are unemployed. Thus under the patronage

of the local leaders and law keepers gambling and trade in illicit liquor from across the border[30] thrive. The last few years have been the emergence of drug addiction as a new menace. All these activities leave their impact on the impressionable minds of children who very often take to them from a very young age. It is this social milieu rather than the physical environment which concerns the parents, of growing children, the most.

(i) Visha Laxmi came to Delhi in the early seventies. Her husband was suffering from some form of a mental ailment and wandered off one day, never to return. She came from Madras with 5 young children and lived at Yamuna Bazaar. She is suffering from leprosy, and has been put on leprosy dole. One daughter studies in a boarding school in the 9th standard, two elder sons have moved out and gone back to Madras, the remaining one son (another daughter having died) works as a rag-picker. She is most worried about him - "My son is on drugs. He takes brown sugar. I took him for treatment (de-addiction) both to a private practitioner and the leprosy mission hospital. I spent 2,000 rupees on his treatment. Finally he was admitted at a de-addiction camp in Vivek Vihar. He is better now but drinks a lot. He is very restless. I live in constant fear of what is going to happen to him. I want to sendhim back to Madras but he refuses to go. He buys 'smack' (brown-sugar) from Old Seemapuri. There are some pushers here also. They persuaded and influenced him and got

him addicted. I don't like this place, but where can I go. I also have to consider my daughter's future. This is not a decent place to bring up a girl."

Nafisa has three young children. Her husband works on daily wages in a garment export factory. She moved to New Seemapuri about eight months ago. - "I have not been happy since we moved here. I am fed up with all the filth around, which the 'Bengalis' create. The children's socialization is being influenced by the environment around. If they sit in good company they pick up good manners and values. Here what can they learn. I do not allow them to go out much. The social environment is bad for young impressionable children."

Another woman who wanted to remain anonymous said - "Every kind of anti-social tendency is found here, gambling (by the young and old), drinking, petty thievery. It has a bad influence on children, but I am the last person entitled to make such remarks. My own husband who is a local leader with affiliations to a national political party is involved in these activities. He is protected by the police in all his nefarious deals - he runs gambling dens, sells illicit liquor and runs even a couple of prostitution rackets. I live in a constant state of fear, that is why I did not want to speak with you, or let you inside the house. I am fed up with this kind of life, with five young children where can I go?"

3.10 Unemployment

During conversations with people especially young adult males a wish is often expressed of finding regular, stable salaried employment that would relieve them of the uncertainty of daily wage labour. Although factory jobs may offer regular income the payment compares poorly with daily earnings from work such as rag picking.[31] Employment at factory also means travelling long distances and spending on transport. So the aspiration is to get salaried employment in one of the government run or government aided concerns. This opening is closed to many due to the lack of formal education. Those who do manage to acquire "degrees" find that educational qualifications by themselves are not sufficient and they require money to pay as bribes to apply for jobs or even to register on the employment exchange.

(i) Nawab Miyan (cycle rickshaw driver): "Only rag picking, sorting, unskilled work, construction work, is available here. No other type of regular salaried employment is possible within 5 kms of this basti. There are no industries or factories. One has to go to Delhi or Shahadara for that. They also demand a minimum level of education for factory work, even matric pass."

(ii) Mohd. Rafi (rag picker) - "We are told, you are not educated so what other work can you do."

(iii) Shahjahan Mallik (rag picker) - "When I first came here I applied for a job to the municipal corporation. I submit-

ted an application but didn't get a job, because they had asked for 2,500 rupees; but who had that kind of money then. I would like to do some other work rather than rag picking, but I have to find something first. There is a lot of unemployment here. Many who don't even earn enough to eat properly two times a day. Many are old, infirm, disabled or handicapped. What can they do? It is difficult to find work here. When educated people find it difficult to get jobs how can the illiterate get jobs. Then they also ask for certificates. I don't even have a birth certificate, having migrated to Delhi, with my parents, while I was still very young. So what to do?"

3.11 Social Organisations

The residents who were brought from Yamuna Bazaar remember and recount experiences of organisation around issues pertaining to the development and provision of basic amenities and health care services, and facilities such as ration cards etc.

When people are relatively new migrants it is but natural that they feel helpless at the way of the city. Under such conditions informal groups and networks form, for sharing information and resources. These help to cope with the various problems individuals and families may face in the course of their day to day lives. This support could range from dealing with the police, applying for loans and jobs, writing of appli-

cations and familiarising oneself with the city. The tradition of these informal networks has survived even after being re-settled in a new colony. Newer migrants are also inducted into these informal networks.

Today in New Seemapuri apart from these informal networks there is a trade union of the whole salers engaged in "Kabaadi ka Kaam". This trade union looks after the interests of the rag picking trade. It fixes the rates for the various kinds of material whole salers buy from individual rag pickers. It also helps individual members who may get into trouble for encroaching on vacant land (for storing and sorting out the waste material). An important ground rule laid down by the union is that no whole saler should buy stolen material.

Interestingly the leader of this union which has as many as 300 members is not a wholesaler or "kantaawala" himself. Rather he has been chosen for his ability to muster 10-15 "strongmen" at a call to settle matters that seem to require some strong arm tactics! The union also "intervenes" to settle disputes that arise amongst the other basti dwellers and the "kantewallahs".

Each community and caste group has its own panchayats with the elders of that community acting as its leaders. Disputes such as non-return of borrowed money; quarrels between husband and wife; marital discord, quarrels over property are usually settled through these forums. The panchayat may also take upon itself the task of arranging marriages, setting

limits on the amounts to be paid as dowry and setting norms of social behaviour.

Like slums and resettlement colonies all over the country, New Seemapuri also provides the means and cause for survival to voluntary organisations. These voluntary organisations may be funded by different departments of the state or international agencies claiming to work towards what is broadly considered 'development'; they offer services ranging from provision of basic health services, employment generation schemes, creche facilities, nutritional supplementation programmes, maternal and child welfare, educational inputs, pensions and schemes for the upliftment of widows, handicaped and the more radical ones claiming to work amongst the poorest of the poor for developing 'awareness' and 'raising consciousness'.

Units of all national political parties also function in the colony through their local cadre and community leaders. With an eye on potential vote banks, leaders try to cash in on and organise protests and demonstrations demanding better amenities and other local issues.

Apart from day to day activities, the different groups and organisations come forward to play an active role when there are major events needing relief work such as fires (which are a regular and periodic occurrence), outbreaks of epidemics (Cholera epidemic of 1988 being an example), riots, or to seek relief in individual cases such as when compensa-

tion was demanded from the DTC for the family of an accident victim.

Special mention needs to be made about the Sabla Sangh which is an organisation of local women. It seeks to empower women through providing critical insights about their daily lives, community and state politics and in organising them to demand for better services and facilities. This group has taken up issues of harassment, desertion, dowry, domestic violence etc. Workers of Sabla Sangh are all from within the community and are themselves women who have suffered greatly in their own lives in the past. They also run, centres for female literacy, childrens activity clubs and sewing classes.

3.12 Social Tensions

The different religious and regional communities co-exist in a fairly peaceful manner. In 1984 this colony experienced riots for the first time as part of the country wide riots following the assasination of the then Prime Minister.

There is, however, a constant under-current of tension between different regional groups which is manifest in statements of contempt on the means of livelihood, cultural habits, way of life etc. "Bengalis" are perceived to be "dirty" because they handle refuse and waste material and forage through garbage dumps. Bengalis look down upon the "Hindustanis" because they defecate in dry latrines built inside the house. The hindustanis accuse the "Bengalis" of bringing filth into

the colony through all the "kabaad" they collect and strongly believe that only by banning rag picking as an occupation can the physical environment of the colony be improved. Popular belief is also that it is migrants from West Bengal and immigrants from Bengladesh who are responsible for encouraging the spread of anti-social activities.

What ever be the truth behind all these statements, these perceptions may be coloured by a general distrust majority communities have towards minorities anywhere.

3.13 Local Leaders and Political Processes

The political climate[32] in which the resettlement colony was conceived is partly responsible for the emergence of certain political processes within the colony. The then ruling party (Cong.(I)) started by patronising some influential individuals who could help in pulling in the votes later on. They started by choosing people who already had some level of interaction with the local population, such as local R.M.Ps, quacks, panchayat elders etc. These people were already amongst the better off section and with their new connections and patronage became more powerful and influential, within the basti. Under the special police officer scheme[33] started by the Police Commissioner Ved Marwaha - some of these 'leaders' were appointed as Special Police Officers at the local police stations thus legitimising the nexus that already existed between them and the police force. An interesting

example was of "Dr Rana". Many people claimed him as their patron and leader. He was an original allottee who was re-settled in A Block of New Seemapuri from the power house jhuggies, near I.T.O. He claimed to be an R.M.P. He was made the first special police officer for New Seemapuri. He has since stopped practising, and in his own words is a "full time social worker." 'Dr Rana's' popularity base has suffered a setback with the emergence of another leader, Shabir Khan. They are the two rivals, for the post of chariman of the local Congress(I) committee. Shabir Khan is considered closer to the M.P. from the area H.K.L. Bhagat (of Cong.I). Shabir Khan is not locally resident, but lives in the neighbouring colony of Dilshad Garden (a middle class locality, where he has his own Bungalow). He runs a transport business and is now the special police officer for New Seemapuri.

The leaders are widely known to be linked with and providing protection to all kinds of nefarious activities in the 'basti' such as prostitution, sale of illicit liquor, narcotics and banned drugs. Their 'legitimate' activities include money lending, building-contracting, property development and dealing, etc. The Police are also in on the 'pay offs' and that is why they do not take any action against these activities, according to the people, it is not as though the police lack information or are ignorant about the goings on. The nexus between the local leaders and local police is well-established. In times of trouble the police are rarely contacted, they are popularly perceived as interested only in personal gain.

Inspite of these activities most people utilise these leaders some time, especially when the police harass them or for bureaucratic work like ration cards applications, registration at employment exchange, etc.

Problems regarding the lack of adequate and decent civic amenities in the colony are not usually the concern of local leaders, except when they feel some political gain can be achieved from it. The people are aware that such leaders participate in these activities for personal gain, and will only approach them if they are in a position to pay the price. The general perception of such leaders can be summed up in the words of one resident, "They would sell the shroud of a dead body to make money." "The leaders are also seen as perpetuating tensions between different communities, regional and religious. They are said to thrive on peoples insecurities and actively work to promote differences. Only this way can they maintain their hold over the general public. Thus the leader of one religious party raises the bogey of rising Muslim dominance, while another threatens the neighbouring illegal squatter settlement with eviction and a third holds the threat of deportation over the heads of illegal immigrants from Bangladesh.

Most residents showed considerable awareness about political party politics in the country. Those who do not read the newspaper[34] listen to the radio or watch the television and discuss amongst themselves such issues like the Babri-Masjid controversy, the Bofors deal etc. But the real issues

remain rising prices, unemployment, etc., which are closer to their reality. While a majority have voted Cong.(I) in the past and though somewhat dissatisfied with its proformance in the last few years still say that they will vote for Cong.(I) in the future either because its been the tradition of their families or they do not see a viable alternative to it. Those from West Bengal also show awareness of CPI(M)'s policies in West Bengal. Even though they do not consider it radically different from the generally anti-people stand of Cong.(I) they feel it is a good state level party and it has done something for the poor there, like raising minimum wages etc.

The residents of the colony were seen to be aware of the class inequality in society, and the 'state' as a representative of the ruling class. "The poor are victimised, but factory owners are never prosecuted for illegal practices. Schemes that are introduced by the government ostensibly to benefit the poor, usually benefit the well to do." — Hari Ram (factory worker, below subsistence level)

3.14 Aspirations

Most respondents were found to be fairly modest in their aspirations, for themselves and for their children. The poor hope for a future which is devoid of economic insecurity, and where adequate and decent civic amenities such as water, shelter, health and educational facilities can be obtained.

Some of the residents from the higher economic category or the 'majority' Hindi speaking community feel that the 'at-

mosphere' of the place has a bad influence on their children, and would, if they had the option, sell up and leave for a better locality.

Formal education is not widely felt to be desirable, because of the high rate of unemployment. Reading and writing are considered essential but beyond this they prefer their children to acquire a skill or trade. Those with some savings or resources would like to set up their children in business. Most others would like to find stable regular work, enabling them to improve their standard of living, make their house 'pucca', send their children to school.

In this chapter thus we have seen how the socio-economic situation seems to work as a triple bind on the people of New Seemapuri. A degraded living environment is about the only place that people who live a marginal economic existence are offered in Delhi. At the same time it is their deprived existence that perpetuates and worsens their living environment. The little that they do own, which is positive about their lives, their youth and the labour is also sucked by the city and its exploitative mechanisms.

Footnotes

CHAPTER III

1 DDA, Draft Master Plan for Delhi, 1961-1980.

2 NMJS, Crime Goes Unpunished, New Delhi, 1988, pp. 34-35.

3 These were class IV jobs in government run and government aided concerns such as the DESU, DDA, DTC, MCD, Government hospitals, nationalised banks etc.

4 According to estimates between 25-35% of original settlers have moved away.

5 First generation migrants are those who came to Delhi as adults - 52 of the respondents.

Second generation migrants - who were born in the city or came as very young children and grew up here - 28 respondents.

Third generation migrant - when the grand parents migrated and two generations have grown up in the city - 2 respondents.

6 From a conversation with Nazrul, an oustee and former community organiser in Yamuna Bazaar.

7 For year of migration by categories see table 3.4.

8 An example is Hashim Khan, who owns the National medical store. He tried a number of business enterprises - manufacture of footwear, suit cases, property dealing, all of which failed. During those times he stayed with relatives and close family friends. He is also known to have close links with the local level Congress (I) officials.

9 People kept referring to Delhi as "hame kaam ke liya dilli jana padta tha" (for work we had to go to Delhi). Even today people refer to Delhi as though they are not a part of it. "Doctor ne dawai likh di thi, woh main dilli se leaya tha" (the medicine the doctor had prescribed, I brought it from Delhi) or "hamare rishtedar dilli mein rahte hein" (our relatives live in Delhi).

10 Piles of garbage, around the house of a rag pickers or wholesaler dealing in kabad. Piles of feathers near the residence of "pankh wallahs".

11 Many "pankh wallahs" or whole salers of 'Kabad' hire people on daily wages to do the defeathering or sorting of the junk. The owner also works alongside, so it is not strictly an employer, employee relationship.

12 Term (i) and (iv) are self explanatory.

(iii) self-employed refers to all those involved in occupations such as rag picking, driving cycle rickshaw, cobbler etc. where no capital investment is made.

(iv) engaged in petty business, trade or usary describes those who own shops, or are whole salers of kabaad, or any business which needs some sort of capital investment.

13 Cost of different kinds of waste material collected -

(1) Plastic mixture (all kinds of plastic and polythene bags, polypacks) - 10.00 Rs/kg

(2) Plastic scrap (old chappals, broken plastic buckets etc.) - 4.00 Rs/kg

(3) Canvass - 1.50 Rs/kg

(4) Glass, rubber, jute - 0.40 Rs/kg

(5) Iron and tin scrap - 2.00 Rs/kg

(6) Card board, paper - 1.00/kg

(7) Copper, brass - 40.00 to 50.00 Rs/kg

The profit for the whole saler item-wise

(1) is 75 paisa per kg

(2) is 1 Re per kg.

(3) is 75 paisa per kg

(4) 25 paisa per kg.

(5) 50-75 paisa per kg

(6) 25 paisa per kg.

14 They are called "kante wallahs" because they own a pair of weigh scales, used for weighing the "kabaad" or assorted junk they buy.

15 Factory owners usually buy one product - just glass, or plastic mixture or iron and tin scrap. This is melted and goods for household use are made out of the recycled plastic, tin, etc. The items are usually bought and consumed by people in slums, resettlement colonies or other lower middle class areas of the city.

16 There are a total of 43 households in the colony with "kabaad ka kaam as a regular occupation. Of these 39 were interviewed.

17 Sometimes even young children go off on rag picking trips to earn some money to spend - this may be used to see a film at the local video parlour, buy some sweat meats or any other past time which needs a new rupees.

18 Of the 39 families interviewed in F Block with 'kabaad ka kaam" 11 were non-Bengalis (28.2%), 28 were Bengalis (71.8%).

19 Two examples of these were a family from UP where one adult male worked in the Pakistan embassy as a clerk in the visa section and his father had started his own "Kabaad ka dukaan" a few months ago.

- The other example was of a Punjabi migrant, who had originally come to Delhi during partition. He was employed in the Indian air force. After he retired a couple of years ago he bought two plots and built a kind of godown cum shop which he was using as a kabaad ki dukaan. He does not live in New Seemapuri and has a house in Durgapuri which is a better residential area.

20 On Tuesdays and during "Navratri" the 9 day period preceding Dushera, Hindus do not eat meat.

21 During the height of summer, the heat prevents most rickshaw drivers from working throughout the day. Earnings are therefore low during these months.

22 Leprosy dole is usually paid to those who are certified leprosy patients and their families. Usually a ration card is issued on which they can obtain free rations. But the facility is much misused. Most often leprosy patients themselves sell their 'free rations' to raise a bit of money on the side. Many people not afflicted with leprosy have also managed to procure these ration cards by paying some form of a bribe. This dole is obtained from Tahirpur a colony established by the government and several voluntary organisations for leprosy patients.

The dole comprises of the following items for one months:

100 gms - tea leaves; 2 match boxes, 10 gms turmeric, 100 gms red-chillies, 100 gms corriander, 10 gms cummin, 100 gms salt, toilet soap - 1 bar; soap for washing clothes - 2 bars.

mustard oil - 1 kilo, channa - 1 kg, dal - 2½ kg, roasted channa - 750 gms, sugar - 1 kg, 700 gms, powdered milk - 100 gms vegetables (daily) 250 gms.

Every year: 2 pairs of slipper, 4 sarees, blouce, patticoats, 4 bed sheets, 4 towels,
Once in three years - 1 blanket, 1 bed-spread, 1 dari.

Other items provided every month are - 100 gms of coconut oil, a tube of toothpaste - once in 3 months or 90 gm tin of tooth powder.

For fuel wood Rs. 13/- is given in cash every month.

Cereals are also provided free every month - up to 12 kgs for each adult.

23 Kerosene oil is sold at the rate of Rs. 2.25 per litre at the fair price shop. This is normally sold on the black market for Rs. 3.50 per litre. Fuel wood is available for between Rs 1.00- 1.25/kg.

For a 5 member family - 12 litres/month is sold
more than 5 members - 16 litres/month
more than 10 members - 22 litres/month (maximum)

24 If the age composition of the members of a household are taken into account when measuring living standards, consumption patterns etc., the concept of consumption unit is used by counting an adult person as one unit and the other members in relation to this. For the purposes of their study of Thaiyur Village, Djurfeldt and Lindkerg have defined C.U. as follows:

Age of individual	Counted as
1- 3 years	1/4 consumption unit
4 - 7 years	1/2 "
8 -14 years	3/4 "
15-59 years	1 "
60 years & above	3/4 "

25 "Recommended dietary intake for Indians", ICMR, 1981.

Amount of food required in grams per day for a poor labourer:

Adult male doing heavy work

Cereal - 670 gms
Pulse - 60 "
Green Veg - 40 "
Other Veg - 80 "
Roots & tubers - 80 gms
Milk - 250 "
Oil and fat - 65 gms
Sugar Jaggery - 55 gms

At current market prices the cost of this diet for one month works out Rs. 200/month.

Resettlement colony dwellers on an average day consumer the following:

Cereal (rice or wheat)
dal or vegetable or both
tea (with or without milk)
} twice a day (two full meals)

to even eat this food in the quantity recommended at market prices the cost works out to slightly above Rs. 150/-.

26 This is an attempt to divide the area of work from the residential part of the house, so that the filth and the garbage do not encroach on to the living space.

27 People who own meters charge Rs. 20/- a month for lighting one bulb, from line taken from their meter.

28 The overhead tension wires providing electricity to the street lamps are often tapped by attaching a wire from them to a meter in the house. No bill has to be paid for this 'illegal tapping' - people refer to it as 'taar dalna' (attaching a wire) or 'chori karna' (stealing).

29 The expense involved in installing a meter includes payment for the connection Rs.115 to the DESU as well as the private expenses of wiring and electrical work which varies from family to family. On an average people spend from between Rs.300-450 for installing their own meter.

30 The UP border is only at a distance of 1 km from New Seemapuri and liquor is more easily available there and regularly smuggled across. The reference to 'Border' is to this inter-state border.

31 Salary of an unskilled factory worker varies from between Rs.400-500 p.m. While earnings from rag pickings vary from Rs.700-900 p.m. of the salary from the factory Rs. 100 p.m. have to be spent on a monthly bus pass.

32 This is a reference to the Internal emergency from 1975-77, during which the people were forcibly resettled.

33 The special police officer scheme was introduced in 1985 to promote confidence in the police force of the people in the neighbourhood. One eminent person from within a basti; neighbourhood, college etc. was appointed a special police officer to liaison between the local police station and the citizens covered under it.

34 See Table 3.21 for newspaper reading by different categories.

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TABLE NO.- 3.1

STATE-WISE ORIGIN OF RESPONDENTS

by categories

Sl.no	categories / States	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
1	W. Bengal	10	50	17	50.0	9	50.0	1	10	37	45.1
2	Bangladesh	–	–	1	2.9	1	5.6	–	–	2	2.4
3	U.P.	6	30	10	29.4	7	38.9	4	40	27	32.9
4	Punjab	–	–	–	–	–	–	2	20	2	2.4
5	Haryana	1	5	1	2.9	–	–	–	–	2	2.4
6	Bihar	1	5	1	2.9	–	–	2	20	4	4.9
7	Delhi	1	5	2	5.9	1	5.6	–	–	4	4.9
8	Andhra.P.	–	–	1	2.9	–	–	1	10	2	2.4
9	Karnataka	1	5	–	–	–	–	–	–	1	1.2
10	Tamil Nadu	–	–	1	2.9	–	–	–	–	1	1.2
	TOTAL	20	100.0	34	99.8	18	100.1	10	100.0	82	99.8

BSL - BELOW SUBSISTENCE LEVEL

SL - SUBSISTENCE LEVEL

ASL - ABOVE SUBSISTENCE LEVEL

WO - WELL OFF

TABLE NO. 3·2

OCCUPATION IN VILLAGE BEFORE MIGRATION
by categories

occupations \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
on others' land	5	25·0	5	14·7	2	11·1	–	–	12	14·6
on own land	1	5·0	8	23·5	4	22·2	1	10·0	14	17·1
share cropping	1	5·0	–	–	1	5·6	–	–	2	2·4
Land owners (with hired labour)	–	–	–	–	2	11·1	3	30·0	5	6·1
skilled	2	10·0	3	8·8	1	5·6	–	–	6	7·3
unskilled	3	15·0	3	8·8	3	16·7	–	–	9	10·9
PETTY BUSINESS/ TRADE	3	15·0	3	8·8	3	16·7	–	–	9	10·9
SELF EMPLOYED	3	15·0	3	8·8	1	5·6	1	10·0	8	9·8
TRADITIONAL OCCUP. (dhobi, weaver etc.)	–	–	6	17·7	–	–	1	10·0	7	8·5
FACTORY EMPLOYEE	2	10·0	1	2·9	–	–	2	20·0	5	6·1
OTHERS	–	–	2	5·9	1	5·6	2	20·0	5	6·1
TOTAL	20	100·0	34	99·9	18	100·2	10	100·0	82	99·8

land based (agricultural)

daily wage (Mazdoori)

TABLE NO. - 3·3

REASONS FOR MIGRATION TO DELHI
by categories

categories / Reasons for migration	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
Unemployment/ underemployment and reasons leading to	15	75·0	23	67·6	12	66·7	2	20·0	52	63·4
illness	2	10·0	1	2·9	–	–	–	–	3	3·7
fights / running away from home	–	–	5	14·7	2	11·1	2	20·0	9	10·9
to better prospects : educ./buisness	–	–	–	–	1	5·6	5	50·0	6	7·3
others	2	10·0	3	8·8	1	5·6	–	–	6	7·3
N.A. (born here)	1	5·0	2	5·9	2	11·1	1	10·0	6	7·3
TOTAL	20	100·0	34	99·9	18	100·1	10	100·0	82	99·9

TABLE NO. - 3.4

YEAR OF ARRIVAL IN NEW SEEMAPURI

BSL + SL	No.	%	ASL + WO	No.	%	TOTAL	%
1976	33	61.1	1976	11	39.3	44	53.7
1977–1980	6	11.1	1977–1980	5	17.9	11	13.4
1981–1985	7	13.0	1981–1985	7	25.0	14	17.1
1986–1989	8	14.9	1986–1989	5	17.9	13	15.9
TOTAL	54	100		28	100	82	100

TABLE NO.-3·5

FROM WHERE ARRIVED IN NEW SEEMAPURI

SL.No.	Place from where arrived	No.	%
1	Yamuna Basti/bazaar	39	47·6
2	Evicted from elsewhere in Delhi	6	7·3
3	Other resettlement colonies	14	17·1
4	Other parts of Delhi	19	23·2
5	Straight from village	3	3·7
6	Non-respondent	1	1·2
		82	100

TABLE NO. - 3·6

TYPE OF LINKAGE OF HOUSEHOLDS WITH VILLAGE
by categories

Sl.no	Type of linkage \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
1	no links	8	40·0	9	26·5	6	33·3	1	10·0	24	29·3
2	occasional/ poor	7	35·0	9	26·5	3	16·7	2	20·0	21	25·6
3	good links	4	20·0	9	26·5	3	16·7	2	20·0	18	21·9
4	very good	1	5·0	7	20·6	6	33·3	5	50·0	19	23·2
	TOTAL	20	100·0	34	100·1	18	100·0	10	100·0	82	100·0

TABLE NO.-3·7

TOTAL NO. OF EARNERS PER HOUSEHOLD
by categories

No. of earners \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
1	7	35	12	35·29	9	50·00	4	40	32	39·02
2	9	45	9	26·47	1	5·56	3	30	22	26·83
3	4	20	3	8·82	2	11·11	1	10	10	12·19
4	–	–	3	8·82	2	11·11	1	10	6	7·32
⩾ 5	–	–	7	20·59	4	22·22	1	10	12	14·63
TOTAL	20	100	34	99·99	18	100·00	10	100·00	82	99·99

TABLE NO.-3.8

NATURE OF OCCUPATIONS OF INDIVIDUALS
by categories

Nature of occupations \ Categories	BSL	SL	ASL	WO	TOTAL
I With regular wages	3	10	3	11	27
II SELF EMPLOYED					
a. Individual	15	10	1	1	27
b. Family based	8	39	8	–	55
c. With hired labour	–	–	–	–	–
d. Mixed labour (family + hired)	–	19	8	–	27
III PETTY BUISNESS, TRADE, USURY					
a. Individual	4	4	2	1	11
b. Family based	–	–	10	9	19
c. With hired labour	–	1	7	10	18
d. Mixed labour (family + hired)	1	–	12	–	13
IV Daily wages	6	11	–	–	17
TOTAL	37	94	51	32	214

TABLE NO. - 3·9

NO. OF OCCUPATIONS IN A HOUSEHOLD
by categories

Categories / No. of occupations	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
1	16	80	23	67·65	15	83·33	4	40	58	70·73
2	4	20	8	23·53	2	11·11	6	60	20	24·39
3	–	–	2	5·88	1	5·56	–	–	3	3·66
4	–	–	1	2·94	–	–	–	–	1	1·22
TOTAL	20	100	34	100·00	18	100·00	10	100	82	100·00

TABLE NO. - 3·10

TOTAL INCOME OF EACH HOUSEHOLD

by categories

categories / Total income	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
≤ 300-600	8	40	7	20·59	-	-	-	-	15	18·29
601 - 900	8	40	3	8·82	1	5·56	-	-	12	14·63
901 - 1200	3	15	6	17·65	2	11·11	-	-	11	13·41
1201 - 1500	-	-	11	32·35	5	27·78	-	-	16	19·51
1501 - 1800	1	5	2	5·88	-	-	1	10	4	4·88
1801 - 2100	-	-	5	14·71	5	27·78	-	-	10	12·2
2101 - 2400	-	-	-	-	-	-	1	10	1	1·22
2401 - 2700	-	-	-	-	1	5·56	2	20	3	3·66
2701 - 3000	-	-	-	-	2	11·11	2	20	4	4·88
3001 - 4000	-	-	-	-	2	11·11	-	-	2	2·44
4001 - 5000	-	-	-	-	-	-	2	20	2	2·44
5001 - 6000	-	-	-	-	-	-	2	20	2	2·44
TOTAL	20	100·00	34	100·00	18	100·01	10	100·00	82	100·00

TABLE NO.-3.11

NO OF CONSUMPTION UNITS PER HOUSEHOLD by categories

No. of consumption units \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
1-3	1	5	10	29.41	4	22.22	1	10	16	19.51
4-6	13	65	11	32.35	10	55.56	6	60	40	48.78
7-9	5	25	8	23.53	3	16.67	2	20	18	21.95
10-12	-	-	5	14.71	1	5.56	1	10	7	8.54
13-15	1	5	-	-	-	-	-	-	1	1.22
TOTAL	20	100	34	100	18	100.01	10	100	82	100

TABLE NO.-3·12

HOUSEHOLDS WITH SAVINGS OR DEBTS/LOANS
by categories

categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
SAVINGS	3	15	15	44·1	11	61·1	10	100	39	47·6
DEBTS/LOANS	18	90	21	61·8	14	77·8	4	40	57	69·5
TOTAL HOUSEHOLDS	20		34		18		10		82	

TABLE NO.-3·13

REASONS FOR DEBTS/LOANS IN HOUSEHOLDS*
by categories

Reasons for Debts/Loans \ Categories	BSL	SL	ASL	WO	TOTAL
ILLNESS/ACCIDENTS	10	7	2	-	19
WORK/BUISNESS	3	6	11	4	24
FOOD/RATION	10	6	-	-	16
HOUSE/WATER/ELECTRICITY	8	10	2	2	22
MARRIAGE	2	3	2	-	7
FESTIVALS	3	4	1	-	8
OTHER	-	4	-	1	5
TOTAL	36	40	18	7	101

TOTAL HOUSEHOLDS WITH DEBTS
by categories

BSL	18
SL	21
ASL	14
WO	4

* A household may have more than one reason for being in debt

TABLE NO. - 3·14

RESPONDENTS' (male + female) EDUCATIONAL LEVEL IN HOUSEHOLDS by categories.

Level of Education \ categories	BSL		%		SL		%		ASL		%		WO		%		TOTAL		%	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
illiterate	9	18	50·0	90·0	16	27	48·5	79·4	7	12	38·9	75·0	-	5	-	55·6	32	62	40·5	7
sign	3	1	16·7	5·0	2	-	6·1	-	-	-	-	-	1	2	10·0	22·2	6	3	7·6	3
read + write	3	1	16·7	5·0	4	2	12·1	5·9	4	1	22·2	6·25	1	1	10·0	11·1	12	5	15·2	6
primary	1	-	5·5	-	3	3	9·1	8·8	2	-	11·1	-	1	1	10·0	11·1	7	4	8·9	5
middle	1	-	5·5	-	4	-	12·1	-	2	1	11·1	6·25	1	-	10·0	-	8	1	10·1	
secondary	-	-	-	-	-	1	-	2·9	-	-	-	-	1	-	10·0	-	1	1	1·3	
metric	1	-	5·5	-	1	-	3·0	-	3	-	16·7	-	1	-	10·0	-	6	-	7·6	
intermediate	-	-	-	-	1	-	3·0	-	-	1	-	6·25	1	-	10·0	-	2	1	2·5	
B.A.	-	-	-	-	2	1	6·1	2·9	-	1	-	6·25	3	-	30·0	-	5	2	6·3	
TOTAL NO. OF HOUSEHOLDS	18	20	99·9	100·0	33	34	100·0	99·9	18	16	100·0	100·0	10	9	100·0	100·0	79	79	100·0	

TABLE NO.-3.15

CONSUMER ITEMS PER HOUSEHOLD
by categories

categories / Consumer items	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
T.V.	4	20	11	32.4	15	83.3	8	80	38	46.3
RADIO	3	15	22	64.7	17	94.4	9	90	51	62.2
FAN	6	30	18	52.9	15	83.3	9	90	48	58.4
AIR COOLER	-	-	-	-	1	5.6	5	50	6	7.3
FRIDGE	-	-	-	-	-	-	2	20	2	2.4
GAS	-	-	-	-	1	5.6	2	20	3	3.7
SCOOTER	-	-	-	-	-	-	2	20	2	2.4
TOTAL	20		34		18		10		82	

TABLE NO.-3·16

SIZE OF PLOTS
by categories

Plot size in sq. yards \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
25	20	100	32	94·12	8	44·44	3	30	63	76·83
50	–	–	2	5·88	7	38·89	2	20	11	13·41
75	–	–	–	–	2	11·11	3	30	5	6·09
100	–	–	–	–	1	5·56	1	10	2	2·44
150	–	–	–	–	–	–	1	10	1	1·22
TOTAL	20	100	34	100·00	18	100·00	10	100·00	82	99·99

TABLE NO.-3·17

HOW PLOTS WERE OBTAINED
by categories

categories / means by which obtained	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
issued in lieu of sterilization	8	40	10	29·41	2	11·11	—	-	20	24·39
issued in lieu of earlier hutment	4	20	3	8·82	2	11·11	1	10	10	12·20
given by friend/relative	1	5	6	17·65	1	5·56	-	-	8	9·76
bought	4	20	13	38·24	8	44·44	8	80	33	40·24
in lieu of sterilization+ bought	-	-	-	-	3	16·67	-	-	3	3·66
in lieu of earlier hutment+ bought	-	-	-	-	2	11·11	-	-	2	2·44
living on rent	2	10	1	2·94	-	-	1	10	4	4·88
occupied	1	5	1	2·94	-	-	-	-	2	2·44
TOTAL	20	100·00	34	100·00	18	100·00	10	100·00	82	100·01

TABLE NO.-3.18

QUALITY OF HOUSING
by categories

categories / Quality of housing	BSL	%	SL	%	ASL	%	WO	%	TOTAL	
Jhuggi	8	40	7	20.59	2	11.11	–	–	17	20.73
Kutchcha	6	30	9	26.47	2	11.11	–	–	17	20.73
Pucca	6	30	18	52.94	9	50.00	8	80	41	50.00
Pucca+Kutchcha	–	–	–	–	2	11.11	–	–	2	2.44
Pucca+Jhuggi	–	–	–	–	1	5.56	–	–	1	1.22
Pucca+empty plot	–	–	–	–	2	11.11	2	20	4	4.88
TOTAL	20	100.00	34	100.00	18	100.00	10	100.00	82	100.00

TABLE NO.-3·19

SOURCE OF ELECTRICITY
by categories

Source of electricity \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
No electricity	7	35	8	23·53	2	11·11	1*	10	18	21·95
own meter	6	30	18	52·94	15	83·33	9	90	48	58·54
illegal connection	3	15	5	14·71	1	5·56	-	—	9	10·98
from neighbour's meter	4	20	3	8·82	-	-	-	—	7	8·54
TOTAL	20	100	34	100·00	18	100·00	10	100·00	82	100·01

*LIVES IN A RENTED HOUSE

TABLE NO.-3·20

SEX-WISE DISTRIBUTION OF EARNERS IN HOUSEHOLDS by categories

Sex of earners \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
only males	15	75	17	50·00	13	72·22	8	80	53	64·63
only females	1	5	1	2·94	–	–	–	–	2	2·44
males + females	4	20	16	47·06	5	27·78	2	20	27	32·93
TOTAL	20	100	34	100·00	18	100·00	10	100	82	100·00

TABLE NO.-3.21

NEWSPAPER READING IN HOUSEHOLDS
by categories

Categories / Reading	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
YES	3	15	10	29.4	13	72.2	8	80	34	41.5
NO	17	85	24	70.6	5	27.8	2	20	48	58.5
TOTAL	20	100.0	34	100.0	18	100.0	10	100.00	82	100.0

Chapter IV

HEALTH SITUATION AND ITS DETERMINANTS

Health situation of any population is a reflection of the socio-economic condition and the associated environment they live in. The previous chapter described this aspect of peoples lives in New Seemapuri with specific reference to F-Block. This chapter looks at the health situation of these residents and their mechanisms of coping with their health problems. Health situation as described here is not a mere quantification in terms of various mortality and morbidity rates. Rather, it is a combination and interplay of different factors, such as: the load of disease and illness,[1] the factors responsible for the creation of an environment leading to health problems, peoples experience and perception of what constitutes ill health, the services available to cope with problems and the experience and perception of the users of these services.

Our emphasis therefore is more on situational analysis rather than the health status, even so we will be commenting on the health status on the basis of our qualitative study and the records from the dispensary.

The load of disease producing organisms and pollutants a person is subjected to is determined by his/her physical environment, comprising of the immediate surroundings in which life is lived and work environment; and we propose to examine all these dimensions of health.

4.1 The Immediate Physical Environment

While health situation may be an indirect reflection of the socio-economic environment, the physical environment becomes a direct determinant of the health situation of a population.

4.1.1 Water

The availability or non-availability of/ prevalence of disease i.e. cholera, typhoid, gasteroentritis, infective hepatitis, parasitic infections etc.

When New Seemapuri was first created to accomodate squatters, the DDA provided the colony with shallow handpumps at the rate of three to four handpumps per block and there were only 3-4 taps with potable water in the entire colony. Later this was increased to two handpumps per 'gali' of about fifty families and two taps for each block housing between 300-350 families. The area being in the low lying environs of the Yamuna had a high water table in which the water was already polluted due to the presence of sewage matter and the sanitary land fill. This water was pumped up by the shallow handpumps while taps were supplied water from deep tubewells after being heavily treated with bleaching powder. In the light of this situation it was inevitable that a large part of the day's activities centered around the water tap or handpump. Members of families, from children to adult men and women spent between 5-8 hours per day to collect 2-3 buckets of water for essential activities such as cooking, washing and

A water is a crucial factor in the

bathing. Cooking and washing of vessels being a daily necessity, bathing and washing clothes was per force relegated to secondary importance, and only done once a week if at that.

Water from the taps was adequate for drinking but the supply was erratic with no sign of water, sometimes, for as long as four to five days. Under such circumstances handpump water, acceptable for washing and bathing activities, also had to be used for drinking and cooking. When the 'appearance'[2] of handpump water also deteriorated many families spent scarce resources on bringing drinking water from distant colonies and parts of the city.

This kind of water availability in the colony manifested in periodic occurrence of almost all water borne and water related diseases which ranged from gastero-entritis, skin problems, parasitic infections, dysentries (both amoebic and bacillus) etc.

Three years ago pipe lines were laid across the colony to facilitate provision of individual water connections. Although this had been a part of the original plan for provision of basic amenities,[3] the impetus was provided by the sudden need for the new Rajeev Gandhi's government[4] to project a pro-people image. After the pipe lines were laid the administrative indifference took over and no connection was made to provide water.

It needed an outbreak of cholera[5] to rudely awaken the administrative apathy to the problems people had been facing and had tried to draw attention to in the past.[6] Because of

the hue and cry created by the media and because of the fear that cholera may spread to the middle class and upper middle class colonies of the city, the administration was forced to swing into action. Contaminated water from the shallow hand pumps was located as the culprit, without going into how this water got contaminated in the first place. Attempts were then made to cover up the situation. Individual water connections were made available for a fixed amount.[7] This water in privately owned taps was supplied from the "Bhagirathi" scheme[8] which had originally been executed to supply water to the middle class and upper middle class colonies of Trans Yamuna.

However only those who could contribute between 350-450 rupees[9] could avail of this opportunity. Thus only 68% of all families interviewed in F-Block had installed taps in their houses. 90% of the families in the highest economic category[10] and only 55% of the families from the lowest economic category had installed taps (see table 4.1).

The scheme envisaged to upgrade the 'slum' colony of poor squatters has actually worked against the poorest of the poor. 32% of those interviewed who could not install taps were not only unable to afford individual water connections but were also deprived of the facility of public taps and handpumps which were removed in the wake of the cholera epidemic and the implementation of the new scheme. The poor were now at the mercy of their better off neighbours. While some neighbours were co-operative many others created problems

to the extent of rationing water![11] It had also created tensions amongst families in some 'galis', for instance - a Hindu family which owned a tap did not allow Muslim families to take water from it.

People have also tried to surmount problems of water shortage and costs of installation by pooling in resources. This was highlighted by two examples of community sharing of installation of handpumps wherein 5-6 families of the neighbourhood had pooled money to install and maintain one handpump.[12]

Water problems do not end at the provision of tap connections. The water supply in them is extremely erratic, when available, the pressure is low, and a flat rate of Rs. 9/- per month is charged regardless of the amount consumed. It is not surprising that most people despite being aware of the hazards of consuming handpump water still prefer installation of handpumps to taps, as at least the supplly in the former is assured.

Thus today despite the installation of taps and the water connections the drudgery and amount of time spent on collecting the water and the quality of water available has only marginally improved.

4.1.2 Toilets and Bathing Facilities

Most residents from village backgrounds are used to defecating in the open fields far from the sources of drinking water. But after coming to the city they have understood

the need to use latrines and have been trying to modify their behaviour accordingly. Contrary to the belief that people behave in an irrational manner the toilet and defecating situation in New Seemapuri bears out that the observed behaviour is the only possible, rational behaviour under the given circumstances.

Delhi Development Authority (DDA) had constructed one block of latrines with 72 seats for the use of all residents of F-Block. These are referred to as the 'old' or 'sarkari' latrines by the residents. The 'newones' are a block of latrines with 48 seats built by Sulabh International, a voluntary organisation. The old latrines are poorly maintained and are stinking pools of human excreta - and breeding grounds for all kinds of germs and diseases. The users are usually blamed for this. What is conveniently overlooked is the enormous load on each toilet seat - 40 people per seat if only the authorised residents use them and 105 people per seat if even half the unauthorised residents[13] (who have anyway not been provided with any alternative) use them as well.

The filth and the stench force many people to squat outside the latrines, worsening the situation further. Young children anyway find it difficult to use the seat designed for adults, and so they mostly squat on the 'nallis' outside the latrines or running adjacent to their houses. Women also cannot keep taking children to the toilet while in the midst of their household and other chores. This is another reason why children defecate in the open or on drains near their dwelling

places. The latrines are also poorly lit, most do not have doors, or if they do they do not close properly or are damaged, so women are scared to go in and usually squat outside at night. Instances of molestations are not uncommon either.[14]

The poor maintenance, design and inadequacy of the facility proves to be a deterrant against a proper and regular use of the facility. Many orthodox Muslims have built their own dry latrines inside their houses. These tiny 3 feet by 2 feet cubicles open directly to a tin container, placed over the 'nalli' outside the house and since there is no place to build a septic tank the night soil has to be taken away by a sweeper. Some of it finds its way into the drains and leads to fights and tensions with neighbours.

The building of the Sulabh Shauchalaya complex has somewhat eased the situation. It remains open from five o'clock in the morning to eleven o'clock at night. But once again it is only a limited number of people who can afford to pay 25 paisa per use of the toilets. While they are supposed to be free for women and children, it is not uncommon for the attendant to charge even ten year old boys. The attendant receives an incentive for every increase he can show in the attendance at the toilet, therefore he tries to charge as many men and children as possible everyday. Muslim women are often reluctant to go to these toilets because a male attendant sits at the entrance and is usually surrounded by four or five of his cronies, to help pass the time during

duty hours. The waiting time and queues also deter many people from using these toilets even though they are definitely cleaner. Bathrooms have also been built in the Sulabh complex but attendants discourage people from using these because they feel that the residents are too dirty! Men have to pay 75 paise for every bath.[15]

The better off people are waiting for the 'promised' opening up of the sewer lines so that they can build their own flush type toilets. The poor, however, will have to continue to depend on community facilities because they do not have the money or the space to construct their own latrines. It is also being said that after all the blocks have been provided with 'Sulabh' complexes the 'old' or 'sarkari' toilets will be demolished. When that happens the poorest of the poor will again be the worst sufferrers because neither are they in a position to build their own latrines (many can't even afford to build a 'pucca' room on their plot and continue to live in a jhuggi) nor are they in a position to pay for the use of the Sulabh facility. So they will be left with no option but to defecate in open areas.

Discussions with the Sanitary inspector and sweepers responsible to keep the civic amenities clean, reveal their helplessness. They are under staffed and ill-equipped[16] and further hampered by an inadequate supply of water and disinfectant. Many sweepers said that they have often had to use dirty drain water to clean the toilets. The load on the toilet complex is such that septic tanks need to be cleaned

at least once in three months, but till before the cholera epidemic of 1988, were cleaned once a year and after that once in six-months. No taps have been provided inside the toilets, people have to carry tins of water from the lone hand-pump outside the complex.

In March 1989 there was an incident where a man was burnt alive in a government ('sarkari') toilet in a resettlement colony, when he lit a 'bidi', and methane gas from decomposing excreta caught fire.[17]

The concerned authorities perpetuate the notion that people themselves are responsible for the state of their toilet facilities. And as long as people are blaming each other and the local staff, the authorities get away with providing grossly inadequate and poorly maintained facilities.

The usage of the different toilet facilities by men and women in the four economic categories is given in table 4.2.

4.1.3 State of Garbage Disposal, Drainage and Sewage Facilities

The colony is covered by a network of open, 'kutchcha', semi-'pucca' or 'pucca' drains, four feet deep and about one to one and a half feet wide. These converge onto a main drain or 'nullah' which is supposed to meet the main drains from other colonies in the area, finally emptying into the Yamuna after going through a sewage treatment plant. But this network stops at the level of the main drain or 'nullah' of the colony itself and water is pumped out and left in stagnant

pools on vacant land available near the colony. These pools are big enough to invite buffaloes, pigs and children to take a cool dip in, during the summer. The drains are generally poorly maintained and non-existent in certain parts of the colony. Their gradient is awry with water flowing backwards; standing stagnant in them; or overflowing into the 'gali'. Since these drains are open drains, garbage from heaps left lying around finds its way into them, blocking them further.

F-Block has been provided with one garbage dump which is situated approximately 200 metres away. There is no facility to throw garbage within close proximity to the households.

While attempts are made to keep the inside of the dwellings relatively clean, the garbage that collects as part of everyday living is disposed off in the most convenient way. Garbage from cooking activities (vegetable refuse, stale and left over food, wood ash) gets thrown into the 'nallis' running adjacent to the outer wall of the houses, on garbage heaps left behind by the sweepers or it is collected in tins and disposed off on the 'buggies'[18] brought around for the removal of the garbage heaps; dirty water from washing, bathing and cooking processes runsdirectly into the drains; excreta of young children who defecate inside the house also gets thrown into the drains or on the garbage heap.

Apart from household garbage an additional source of garbage in F-Block comes from the two most prevalent occupation followed, i.e. the 'kabaadi ka kaam" and the "pankh walon ka kaam". In the 'kabaadi ka kaam" many of the rag

pickers sort out their days collection outside the colony and sell it to 'kantewallahs' situated in other areas before returning to the colony. If about 25% of the rag pickers do this, the remaining 75% bring home the waste material and sort it within the colony itself. But the single largest amount of waste and refuse material is stored by the 'kantewallahs' in the block. This 'kabaad' is stored on the vacant land adjoining the colony, within enclosures on encroached public streets and thoroughfares, places meant for parks, outside the house, on vacant unbuilt plots within the block or within the house itself.[19] Sorting out and cleaning of the stored material is done everyday, prior to selling it. Most of what is left behind is piled up in small garbage heaps and left to accumulate. There is no place to throw it. Some finds its way into the drains or gets spread over the 'galis' and bylanes. Occassionally when the roads get swept, the sweeper piles it all up again and even more rarely may even cart it away.

The refuse from the "pankh walon ka kaam" is in the form of feathers and the ash from the wood fires on which the poultry skins are boiled prior to defeathering. This garbage is thrown onto the vacant land bordering the colony (which has been marked for the development of Dilshad Colony by the DLF group of developers and builders). When there is a strong gust of wind many of these feathers fly back into the colony.

According to people the drains are cleaned very-very

rarely. Sweepers come once in two or three weeks. They remove the silt and sullage from the drains and pile it up at intervals of 6-8 feet. The piles are left to dry and for the excess water to seep back into the drains. After 2-3 days another sweeper is supposed to come to wheel away the sullage in wheel barrows or on "buggies" and take it to the main garbage dump from where the municipal corporation is supposed to take away the garbage once a week. But the 'buggiwallah' does not always come and wheel barrows are in short supply and so the silt and sullage slips back into the drains, over course of time. The main garbage dump if it is cleaned at all, is done so once in about 3-6 months, by when most of the surrounding area is also covered by the overflowing garbage.

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The only time 'serious' cleaning activity has been observed by the people was (i) during the months of the cholera epidemic of 1988 (July-Sept.) (ii) the months leading upto this period in 1989 (April-June) (iii) when a V.I.P is to visit the area.

The provision and maintenance of civic amenities was in the hands of the DDA from the time of inception of the colony till the MCD was given charge after the cholera epidemic of 1989, even though this charge was reluctantly accepted by the MCD, who maintained that the task of development of the colonies had not been completed by the DDA and the MCD were only responsible for maintaining services not developing colonies, the DDA retained part of the responsibilities; resulting in

the division of the same amenity under two different administrative bodies. For instance while the maintenance of the network of drains at the 'basti' level was handed over to the MCD, the development and maintenance of the larger drains and main trunk connections still remained under the DDA.

According to the local staff and sanitary inspector responsible for sanitation and conservancy services, they are not adequately equipped to provide the extent of services these colonies need.[20] The design of the drains is not suited to efficient cleaning methods.[21] Nor have the administration provided them with a regular and efficient garbage and sewage disposable system.[22]

The residents feel that the change over has been successful in tightening up the system somewhat and has eliminated certain elements of corruption. Whereas earlier workers could easily avail of their salary and daily attendance without showing up for work, by bribing the concerned officer, the present sanitary inspector is respected for being strict and honest. So even if all the workers do not turn up for the entire eight hour duty stint they at least come around for four to five hours per day. The stagnating water in the drains seeps down to the water table and contaminates it with all kinds of faecal matter and toxic material. It is this contaminated water which when pulled up through shallow hand-pumps causes a host of diseases and infection of the aro-faecal variety.

The stagnating water in the drain also provides an ideal

environment for mosquitoes and flies to breed in. It is virtually impossible to sit outside during summer evenings because of the mosquitoes. Malaria, filaria, parasitic infection, boils, infected cuts and wounds, skin problems, gasteroentritis, etc. are common ailments which can be directly traced to deplorable sewage conditions. The open drains also pose a special hazard for young children, who have known to have fallen in them while playing and drowned.

4.2 Work and Health

The major occupations followed by people in F-Block are "kabaadi ka kaam", "pankh ka kaam" and unskilled jobs requiring hard physical labour such as construction work, driving cycle rickshaws, 'hamaals', pushing hand carts, etc.

Those who perform "kabaad ka kaam", handle garbage everyday. Therefore they are exposed to a host of oro-fecal infections because of handling dirt and often even standing knee deep in garbage piles, gives rise to skin diseases ranging from scabies to fungal infections. Apart from this they are also exposed to chemical toxins either through decomposing toxic material such as different kinds of plastics, chemicals in discarded bottles and the toxins from pesticides regularly sprayed on and around garbage dumps such as DDT and BHC powder. Quite often people engaged in this occupation sustain injuries from broken glass, scrap and rusted iron pieces, etc.

The women involved in "pankh ka kaam", sit around smoky

fires throughout the day, boiling poultry skins and removing the feathers. Any kind of easily combustible material such as leaves, twigs, fire-wood, straw, old rubber tyres, are used to make these fires. Constant direct exposure to the smoke results in chronic conjunctivitis (watering, burning, etching, foreign body sensations in the eye) and chronic upper respiratory diseases. Burns, from both, fire and scalding water are a common occurrence.

Unskilled physical labour results in various aches and pains. Chronic backaches is a major problem. Injuries, accidents at the work sites also form part of the hazards.

4.3 Strains of Household Work

All the women in the resettlement colony whether they work outside the home or not are engaged in household labour. Anything from 10-12 hours a day (which is half a day) is spent on housework. For women who in addition to housework, work outside the home, a full 'working' day could mean anything from 14-16 hours. Chronic conjunctivitis and upper respiratory problems due to sitting infront of a fire and chronic backaches, headaches, body aches, are constant problems. Because they handle water frequently in winter chilblains, arthritis etc. are common.

While the status of the immediate environment determines the load of disease producing organisms and pollutants, it is the individual's resistance to disease that determines who in

the group would fall sick and how often, which in turn is the reflection of the vulnurable status. The severity and the duration of the illness is then determined by the ability of the individual or the health system, to cope.

The following sections look at the food availability to the different groups, in the sample, the illness pattern and the mechanisms available to cope with it.

4.4 Food Availability and Access

4.4.1 Purchasing Power:

It is a truism to say that the amount of food available for a family is dependent on the income of the family, here taken to be the income per month, per consumption unit. As described in the chapter on socio-economic situation there are four categories in which the total families interviewed in the block, fall. These categories are i) Below subsistence level with income per month per consumption unit Rs. 150/-; 24.4% of all families come in this category (ii) Subsistence level with income between Rs. 150-300 per month per consumption unit; 41.5% of the families are in this category (iii) Above subsistence level with incomes between 300-450/- Rs. per month per consumption unit; 22% of the families are in this category and (iv) the well off category with incomes above Rs. 450/- per month per consumption unit; 12.2% of all the families surveyed are in this group.

Two hundred rupees was the minimum amount needed for purchasing food for one month for one consumption unit, where

this consumption unit was taken to be one adult male, if he ate according to the recommended intake of ICMR for a poor labourer.[23]

According to the above figures it is obvious that in the first category (BSL) even if all the money was spent on buying food, the families would still fall below the recommended dietary intake level while in the second category (SL) between 80-90% of the income of families would have to be spent on purchasing food alone. Only the upper two categories could come close to meeting the dietary requirements as well as have money to spend on other items.

4.4.2 Availability of Food : Ration Cards

Only cereals (rice and wheat) sugar and kerosene are regularly available at the ration (fair price) shop. Each family gets a fixed amount according to the number of adults and children enumerated on the card.[24] The items are available at rates slightly less than those at the open market and these have to be bought in bulk twice a month or when available at the appointed shops. Thus, not everyone can avail of the facility; daily wagers used to consuming the days income on the same day do not have enough put by to buy the fortnightly rations available in bulk at one go. Also only people who own a plot are entitled to a ration card.[25]

Of the families interviewed ten did not have ration cards as they were either tenants, had shifted from other area

and had not been able to transfer the card or had lost the temporary ration card and could not get a permanent replacement. There were instances of families with permanent ration cards all of whose members were not enumerated on it hence very often for these families the ration from the shop was not adequate to meet the needs of the family.[26] Apart from this the quantity of cereals allotted may not be adequate. For instance in families where rice is the only cereal consumed and the quota of wheat is not availed, rice is still not offered in lieu of wheat and the difference in requirements is made up by buying rice on the open market. Further even if a family owns a ration card they are forced to buy the items on the open market due to their non-availability in the ration shops when needed.

4.4.3 Food Intake

For 24.4% of the population surveyed who belong to the lower most economic category or are below subsistence level, food intake is generally monotonous. The bulk of the meal consists of a cereal (roti/boiled rice) which is consumed with a 'chutney' made of chillies, salts, onion or garlic. For people in this category both vegetables and dals are luxuries to be eaten only 2-3 times a week; either vegetable or dal is consumed at any one meal.

Only members who go outside the colony to work have anything in the morning, which could be considered break-fast and this could consist of the left overs from the previous night's dinner and a cup of black tea brewed at home or a cup

bought at the neighbouring tea stall. For the other members the first meal of the day is eaten around noon. The noon meal comprises of 2 or 3 'rotis' or approximately 100 gms. of rice (-boiled). The evening meal is the main meal of the day and consists of 4-5 'rotis' with 'dal' or vegetable if it is the dal or vegetable day.

For people in this category milk is a luxury, rarely consumed, be it for children or adults - or for making tea. Adults when desirous of having tea either have it black or buy it at the local corner tea shop for 50 paisa or Re. 1. It was observed while interviewing these families that whenever they wanted to offer us tea, a child would be sent out to buy tea leaves, milk and sugar or a 'ready made' tea would be ordered from a nearby shop.

Fruits, another luxury item was bought only when someone was ill.

For 41.5% of the families belonging to the subsistence level category, food intake was slightly better. Every major meal consumed consists of both a cereal and a vegetable. Occassionally a vegetable is substituted with a pulse. Once or twice a week some non-vegetarian food (fish or meat) is consumed in place of the vegetable. Milk, which for this category also is a luxury item is bought, only for infants or small children.

For the third economic category, above subsistence level, comprising of 22% of the surveyed population, the basic meal is much the same; however, two full meals are eaten in a day.

The quality of food is also somewhat better, for instance, when vegetables are bought, people from this category, would tend to buy the seasonal or green vegetables, even if slightly more expensive, rather than tubers like potatoes. Tea with milk is made on a regular basis. Non vegetarian food is also consumed more often.

The highest income group, 12.2% of all families surveyed, in the well off category, three meals a day are consumed. Breakfast consists of 'parathas', tea (with milk), bread, eggs, etc. The noon-meal and the evening meal consists of a cereal, a pulse and a vegetable. There is more variety in the vegetables consumed. Milk products such as ghee, curds are consumed regularly. Fruits are also bought regularly two or three times a week. Almost every other meal may also contain a non-vegetarian item like fish or meat. Once or twice a week a "sweet dish" like kheer, halwa, etc. compliment the meal.

From these observations it is clear probably, only those belonging to the upper most category have a balanced and an adequate calorie intake. Thus although all these people live in a city where food is available in plenty their personal intake is determined by their purchasing power.

4.5 Health Services

Health facilities are available for the people in New Seemapuri through the government run institutions, private sector institutions, charitable organizations and the indigenous and folk healers.

4.5.1 Government Health Care Institutions

Provision of medical services for the slum dwellers in resettlement colonies comes under the purview of Delhi Administration and the Municipal Corporation of Delhi (MCD).

The facilities are provided through a two tier system with the dispensary at the local basti level and referral to the nearest government hospital for serious ailments. Special programmes such as Maternal and Child Health (MCH), Family Planning, Malaria Eradication, Control of Communicable diseases (Tuberculosis, leprosy etc.) are run independently of the dispensary.

The Delhi Administration Dispensary, which is the first contact point for the slum people is meant to cover the entire population of a basti irrespective of the total number of people. Thus in New Seemapuri the dispensary caters to the needs of 30,000 people. This dispensary was established in 1979, three years after the creation of the resettlement colony. At that time the dispensary was meant to provide only curative services and a few preventive programmes such as immunisation and family planning.[27]

The MCD opened a centre for providing MCH services including Family Planning, in 1985.

The Delhi Administration dispensary was upgraded to a health centre in 1986-87.[28] The following additional services were to be provided in the newly opened health centres:

1) Out reach services:

i) Population education

ii) Information, Motivation about Family Planning methods and M.T.P.

iii) Health education

a) Environmental sanitation

b) Personal Hygiene

c) Communicable diseases

d) Nutrition

e) M.C.H. and E.P.I.

2) Preventive Services:

1. Immunization
2. Ante-Natal, Post-Natal and Infant Care.
3. Prophylaxis against Vit. 'A' deficiency
4. Prophylaxis against anaemia
5. Presumptive treatment against malaria
6. Identification of suspected cases of tuberculosis
7. Filariasis
8. Infant feeding

3) Family Planning Services:

1. Nirodh, other conventional contraceptive and pills
2. I.U.D. Insertion.
3. Sterilisation and M.T.P. Services either through referral Hospital or mobile vans provided under ROME Scheme or identified institutions, nearly existing or created.

4) Reports and Records:

Particularly in respect of the following:

1. Preventive Services
2. Family Planning Acceptors
3. Vital events
4. Morbidity and Mortality (particularly in respect of :

   a) Malaria, b) Tuberculosis, c) Leprosy d) Diarroheal diseases
5. Maintenance of Family Cards or register for population covered.

5) Curative Services:

1. First-aid during accidents and emergencies
2. Treatment of simple ailments
3. Follow up services to chronic cases.

The staffing pattern of the new health centres was to be as follows:

S.No.	Name of the Post	Staff for the Health Centre
1.	G.D.O. - I	1
2.	G.D.O. - II	2
3.	Pharmacist	3
4.	Lab. Asst.	1
5.	A.N.M.	3
6.	Dresser	1
7.	Nursing Orderly (1 male + 1 Female)	2
8.	S.C.C.	3
9.	Public Health Nurse	1

10.	Women Health Volunteer	3
11.	Family Welfare Worker	3
12.	Computor	1
		24

The M.C.H. Centre run under the M.C.D. is supposed to have an outreach programme which maintains records of all families in the 'basti', about eligible couples, couple protection rates, immunisation and nutritional status of children as well as nutritional status of women in the reproductive age group, and growth charts of children under 5. Identifying pregnant mothers for ante-natal care, 'at-risk cases' and ensuring all deliveries are conducted by trained dais, and motivating eligible couples to use contraception, insertion of I.U.D s and taking couples for terminal methods of Family Planning.

The staff at the MCH centre comprises of 2 A.N.Ms, Two L.H.V. one Lady Medical Officer, one Peon and one sweeper (part-time)

Under the 'Jhuggi Jhompri Swasthya Seva' (Slum health services), a mobile van visits the basti three times a week to provide curative services for simple ailments.

The referrals to government hospitals are made to the Guru Tegh Bahadur Hospital (GTB) and Swami Dayanand General Hospital (referred to simply as General Hospital). Both these hospitals are situated at a distance of 2½ kms. from New Semapuri.

For communicable diseases, e.g. T.B., patients are referred to investigations and treatment to the T.B. hospital in Shahdara (5 kms. away). Leprosy patients are sent to the leprosy mission hospital in Tahir Pur situated ½ a km. away. Patients are also referred to specialist hospitals, such as G.B. Pant, for heart and mental problems, Kasturba Gandhi for complicated delivery, Gynae and Ob. cases and Kalawati Saran for infections and children's diseases. These hospitals are at a distance of 15 to 20 kms. from the resettlement colonies.

Despite the notification about the upgradation of the dispensary into a health centre having been issued two years ago, the dispensary still continues to function at the same level of services and staff as before. Thus its staff of two medical officers, one laboratory assistant, three pharmacists, one A.N.M., one dresser, three security men, one nursing orderly (a total of 12 employees) continue to provide a minimum of curative services. The upgradation is only effective on paper.

The dispensary timings are from 8.00 a.m. to 3.00 p.m. with a short break of half an hour around 1.00 p.m. for lunch. Usually only one of the two doctor's on duty arrives around 9.00 a.m. and the work begins for the day. People seeking treatment start queuing up from 8.00 am. Mostly women accompanied by young children are seen. They first line up to register themselves at the registration counter. An O.P.D.

slip for a fee of 50 paise is given to them. This fee is not for the dispensary, the money is collected for the Red Cross sponsored - free cancer detection programme. Then the patients queue up to see the doctor. The doctor could spend anything between three minutes to 15 minutes examining a patient depending on whether it is a new case or an old case and the nature of ailment. Most people come with minor ailments such as cough and cold, headaches, diarrohea etc. Each doctor has his own style of functioning and communicating with the patients. A doctor who is particularly liked and has been serving at the dispensary since 1981, tries to put his patients at ease by asking them questions about areas of their interest or daily life. Stethescope, reflex hammer, tongue depressor and torch were the only instruments seen being used. Investigations are kept to a minimum. Being a non-medical person the researcher could not assess the quality of the examination. Occassionally a patient would be referred for further pathological tests of urine, stool and blood.

Patients requiring referring to hospitals are advised to go to the government hospitals but no follow up is done to see whether they have gone or not. No proper referral system is followed. People are just "told" that they should go to a hospital for further treatment. Once at the hospital people have to follow the hospital's procedure for treatment. Referral does not give them any advantage.

After examining the patient the doctor prescribes medi-

cines or dressing or injections as the case may be. If further tests are prescribed the patient has to queue up once again outside the pathology laboratories. If medicines are prescribed the patient has to queue up at the pharmacy. These dispensaries are poorly stocked hence almost 50% of all medicines prescribed have to be bought from a private chemist store. The cost is not refunded. Medicines for only 2 or 3 days are prescribed at a time after which the patients have to come back if the treatment has to be continued. This seems particularly wasteful in cases where antibiotics are prescribed or when nutritional deficiencies such as anaemia, vitamin deficiencies are being treated because they can not be treated by giving medicines for only 2 or 3 days. The drop out rate of such patients is high because they do not like to queue up again and again. Another striking feature about the treatment and diagnosis is that people are seldom explained what the disease is or the treatment being advised. All diagnosis and names of medicines if written are done so in English which very few people can read. Treatment for long term diseases such as T.B., leprosy, are not given at the dispensary. Especially in the case of T.B. if daily injections have to be taken people have to go to the T.B. hospital 5 kms. away everyday.

The dispensary has also discontinued immunization programmes and Family Planning services since the M.C.D.'s MCH centre operates from the first floor of the same building

(that houses this dispensary). For a while, services were being duplicated but once the stocks ran out no one was really interested in replenishing them.

No beds or in-patient facilities are available at the dispensary. If a serious or emergency case arrives the patients attendants have to make their own arrangements to take the patient to a hospital. Other than simple dressings for wounds or cuts no other treatment for injuries are possible including putting casts for fractures.

A leisurely lunch is taken by the staff from 1.00 to 2.00p.m. The ANMs, laboratory assistants wait upon the doctor at lunch serving chilled water from the dispensary refrigerator in summer. Dispensary opens to the public for an hour after that, after which the staff goes home. Among the staff only the security men are locally resident.

If any one needs immediate treatment or there is an emergency or someone falls ill after 3.00 p.m. when the dispensary closes, the only option they have is to go to a private practitioner or rush the patient in what ever conveyance available to the casua lity department of the nearest hospital.

The researcher was witness to several such 'emergencies' during the course of field work. It was 4.00 p.m. one day and Sheikh Abdul Rehman and his wife were being interviewed. Suddenly there was a commotion outside, and the Sheikh sahib's eldest son was brought in by his friends. He was limping and blood was flowing from his foot. It seemed that while sorting through a pile of garbage he had stepped on a glass

bottle/vial. The thin glass had shattered under the impact, lacerating his foot badly and though he had managed to pull out most of the pieces one had remained deeply embedded. The foot was washed and examined and it was found the glass had gone in too deep. The mother wanted to tie a 'poultice', while the father wanted to take him to a doctor. The dispensary had closed and the major hospitals were on strike, so the boy was taken to a private practitioner in the colony. When he came back he told us that the doctor had charged him twenty rupees for the consultation fee, dressing and an injection (it was assumed it was an anti-tetanus injection that the doctor gave, though he did not explain what was given). A week later when the researcher went to see the boy he was still having the wound dressed, there was some infection, and antibiotics had been given. He was paying the doctor five rupees per day for the dressing and the antibiotics from the chemist store had cost him fifteen rupees. He had also been unable to do any work in that week.

The MCH centre is visited by a lady doctor everyday for 2-3 hours. Family planning clinics are scheduled for Wednesdays, when Copper Ts are inserted and Fridays are reserved for immunization. Routine activities of the MCH programme such as providing iron, folic acid tablets to pregnant women, monitoring their progress, weighing babies is done on other days. The ANM's are supposed to go out on field visits everyday, visiting each family and maintaining records. But field

visits to families and 'anganwadis' are confined to the minimum. They do not have up to date records of all families in the area. For conducting deliveries the ANMs are only available during the daytime from 9 a.m. - 2.30 p.m. Since they are not locally resident they are not available for deliveries at any other time. Even when called to assist (which is rare) they seldom go. People when in need usually bypass the dispensary and go directly to the hospitals in the vicinity or the ones they are familiar with,[29] because they know that referral from dispensary does not give them any advantage.

4.5.2 Private Sector in Health Care

There are atleast 30 private practitioners in New Seemapuri which works out to one practitioner per 1000 population. Every block has 5-6 of these private practitioners. Except for one, none of them is a qualified allopathic practitioner.[30] They are unqualified persons who have picked up some amount of "medical knowledge" through their apprenticeship to doctors as compounders, dispensers of medicine and as ward boys[31] and have also developed certain "bedside manners". These practitioners dispense drugs from every system of medicine such as allopathic, ayurvedic, Unani and homeopathy. Their clinics referred to in local parlance as "doctor ki dukaan" (doctor's shop) remain open throughout the day. Since most of them are locally resident - their services are available even during the night. Apart from these the local chemist shop owners also prescribe medicines on the basis of symptoms.

These "doctors" charge a fee ranging from Rs. 5 to 20 depending on the ailment. Cost of simple medicines are also included in this fee. Expensive medicines such as 'tonics' are prescribed from outside. Most popularly prescribed drugs are antibiotics, pain-killers, anti-inflamatory drugs, vitamins and tonics. Injections are prescribed freely, often catering to the direct demands of the patients. Common instruments in medical practice, thermometer, stethoscope, tongue-depresser are utilized by them. However, once again the quality of examination could not be assertained. Where they score over the dispensary staff is in their "bedside manner" i.e. in their willingness to listen to the patient and in fitting their advice to the cultural belief of people about diseases. Thus, although the concept of 'hot' and 'cold' is not a part of modern medicine, these practitioners while prescribing even allopathic medicine advice on what should be eaten alongside and particularly 'hot' or 'cold' foods to be avoided. For investigations none of the local practitioners have any facility and the patients are referred to a laboratory in Old Seemapuri. In the last few years these private practitioners have graduated from giving injections as a routine remedy to intravenous drips. It is not an unusual sight to find patients lying in the clinic with intravenous drip on, to alleviate problems of dehydration, generalized weakness to regain strength and to restore vigour.

Patients prefer to go to these "doctors" because they give treatment on credit and in some really needy cases even

waive the fee entirely.

The experience of Mohd. Shaheed sums up why people prefer to go to private doctors: "About five years ago, three days after Indira Gandhi died, I took my wife to "Machchliwala Hospital" (Kasturba Gandhi Hospital). She had labour pains in her eighth month and delivered a baby girl. After the delivery her condition started deteriorating. 'Dr. Hoshiyar', from E-Block came to examine her and advised us to take her to the hospital. He accompanied us as well. In the hospital they did not explain what was wrong with her. I was asked to buy the drip and I.V. fluid. We waited from morning to evening, they did not use the drip on her, nor did they give her any other treatment. Finally we brought her back and Dr. Hoshiyar started treatment at home 'privately'. We owe her life to him."

4.5.3 Charitable Institutions

Red Cross hospital, leprosy mission hospital, St. Stephens dispensary and Help Age, are the charitable institutions providing health care to the residents of New Seemapuri. Although all of these are registered under the charitable institutions act, except for the leprosy mission hospital others charge a fee for services rendered.

The Red Cross hospital popularly referred to as the "border wala hospital" because of its location 1.5 kms. away near the Delhi-U.P. border, offers both O.P.D. and in-patient services. Rs. 2 is charged as registration fee. A whole

range of health services are offered here from cancer detection to operations for terminal methods of contraception and delivering babies. The leprosy mission hospital situated 0.5 km. away in Tahirpur is also a well equipped hospital, offering all health care facilities, but only registered leprosy patients and their family members can avail of these services. St. Stephens dispensary is situated in Nand Nagri 2 kms. away, it offers curative and preventive health services for a registration fee of Re. 1 which also includes the cost of some of the medicines prescribed, while others have to be bought from outside. Few people from New Seemapuri go to Nand Nagri to avail of these services. "Help Age India" sends a mobile van to the basti 3 times a week. Only people above 45 years of age are entitled to receive free medical aid from these vans.

Some of the factory workers and their family members in the colony are also covered by the ESI scheme.[32] The ESI hospital is situated 5 kms. away in Jhilmil colony. This is a fully equipped hospital for all kinds of treatment and investigations. If medicines prescribed are not available from the ESI store and have to be bought from outside, the costs are reimbursed.

4.5.4 Indigenous and Folk Healers:

This group comprises of mainly traditional 'dais' and faith healers. Each community has its own traditional 'dais' -

they are usually from families where this skill has been practised for two or three generations and the skill is handed down from mother to daughter or daughter-in-law. If the family from which the 'dai' comes, has some home based income generating activity they also participate in that. Since Muslims do not have a very clear caste system, it is not possible to say from which social strata the Muslim 'dais' come from. While amongst Hindus it is possible to say that they definitely come from the lower castes. It has been observed however that 'dais' from one community known to be very skilled are asked by women from other communities to come and help during deliveries. The 'dais' from the Bengali Muslim community do not ask for any cash payment but accept whatever is given to them by a family, as a symbol of their gratitude - it would be money, clothes or food items. 'Dais' from the Hindu community charge a minimum of 51 Rs. for delivering a female child and 101 Rs. for a male child. In addition they may also demand new clothes.

In these colonies 'Dais' often work in collaboration with the private practitioners and may call them to give injections during labour pains to dull the intensity of the pain, to induce labour or to facilitate the removal of the afterbirth.[33]

The 'dai' is usually first contacted when the labour pains start. The 'dai' assesses the position of the child and stays by the side of the mother, supporting and conforting her till the delivery is accomplished. In a normal delivery when the labour intensifies she massages the abdomen and prepares the

birth passage by lubricating it with oil or 'ghee'. She helps the woman decide on the most comfortable position for delivery, squatting, standing or lying on the back. As the head of the child emerges she coaxes the woman to push harder and guides the new born out with her hands. The umbilical chord is cut with a new razor blade and then clean cloth is used to cover the umbilicus. The 'dai' stays by the mother throughout the labour, however many hours (or days) it may take . Delivery is followed by post natal care for three to seven days - the duration varies from 'dai' to 'dai'. During this period the after birth and umbilical chord are buried and the woman is "cleansed". The mother and the new born are massaged daily and if there is any problem in breast feeding the 'dai' assists by expressing the milk from the breast. She also advises the woman and her family on the diet to be followed. This is culturally determined and varies from community to community. Food items considered to be 'hot' are advised while those considered 'cold' are to be avoided.

If there are emergencies during labour i.e. abnormal position of the baby, excessive bleeding during labour, retention of the placenta, prolapse of uterus, twins etc. the 'dai' calls in a private practitioner or advises the family to take the woman to a hospital. She also provides contraceptive advice and induces and performs abortions. She does not deal with gynaecological problems such as irregular cycles, menorrhagia, etc.[34]

Every community also has its own faith healers whose fee differs according to the ailment and treatment provided. Faith healers deal with problems which do not seem to have any apparent cause, problems where other treatments have been tried and not found beneficial and those which are believed to have supernatural causes. These problems range from children's ailments, headaches, undiagnosed fever, mental illness, repeated spontaneous abortions to heart problems and cancer. They provide charms and amulets to guard against the evil eye and spirits, oils which have been "blessed for massage", water and syrups likewise blessed and to be taken orally.

The fee charged by these healers may be in cash or kind: the cash varies from a few rupees to hundreds of rupees and they may demand clothes, food or sacrifice of animals in kind.

4.6 Health Status

Health statistics from the ministry of health and family welfare treat urban areas as one homogenous mass and rural areas as another. Differentiation in terms of mortality rates, birth rates, prevalence and incidence of disease etc. are made in terms of urban rural desparities and inter-state variations. No attempt is made to relate any of these parameters to socio-economic status. It is taken for granted that rural areas in general are poorer than urban areas and this is the only socio-economic variable adopted. In doing

this, what is glossed over is that health status is a direct reflection of the socio-economic status of a population. Thus health statistics of urban areas do not highlight the inherent disparities between an urban slum and the cities well off areas.

Even though this study does not add to the information on health status in terms of various rates of mortality and morbidity it gives some idea of the types of problems prevalent in slum areas and the broad extent and prevalence of these health problems. In order to get proper rates the total area and population covered would have to be much larger, which was beyond the scope of this study.

4.6.1 General Morbidity

The O.P.D. attendance records that could be of direct use to the study were available from the local Delhi Administration dispensary.

Visits to a private practitioner, dispensary, etc. could be one of the parameters to assess morbidity which is serious enough to merit seeking of some form of medical attention. This could be collected by either recording the visits from the respondents themselves or through the records maintained by the dispensary or private practitioner.

In New Seemapuri the private practitioner do not keep any records. The only approximation in terms of numbers of patients visiting them each day comes from the private practi-

tioners themselves. This could vary from 'doctor' to 'doctor' according to his popularity and the seasonal variation in occurrence of disease. Number of patients visiting each practitioner daily ranges from 10-50 (a safe average would be 15 patients during a full working day per practitioner).

The only records that could be used about daily O.P.D. attendance were from the local dispensary. It was possible to get records from 1 January 1989 - 30 June 1989. Table 4.3 describes the daily attendance at the dispensary during these months.[35]

Some form of prevalence rates of illness and disease can be arrived at from the combined attendance at private practitioner's clinic and O.P.D. of the dispensary.[36] Based on these calculations it was found that on an average one person pays at least 7 visits to the O.P.D. of the dispensary or private practitioners per year.

Expenditures on health could not be assessed although there was a specific question in the interview schedule about this, for two reasons - a) because of recall problems and b) it was not possible to compute costs due to the varied nature of ailments and source of treatment.

The diseases reported by the sample population were (i) communicable diseases - T.B., Leprosy[37] infective hepatitis, typhoid, filaria, malaria, chicken pox, measles, mumps.

(ii) Chest problems - Asthma, U.R.I., Bronchitis

(iii) Gynae and Ob. problems - infertility, repeated spontaneous abortions, excessive vaginal discharge.

(iv) E.N.T. problems

(v) Physical and mental retardation and handicaps

(vi) Epilepsy, mental disorders, depressions

(vii) Stomach ailments - worm infestation, dysentry diarrohea, chronic acidity, gasteroentritis

(viii) Cardio vascular problems - high or low B.P., angina.

(ix) Nutritional deficiencies -

(x) Skin disorders - boils, eczema[38]

4.6.2 Child Mortality

Data on deaths in children is available from qualitative sources. Table 4.4 gives a description of the total number of child deaths by total number of live births (of couples since the time they were married) in the four socio-economic categories. From this it is obvious that there is almost a fifty percent difference in the number of deaths in the lower two categories and the upper two categories.

Approximately 43% of the overall deaths in children has occurred before the age of one year. Of this fifty percent were in the first month of life. Another 40% of the deaths are in the one to six years of age group.

If the upper two and lower two categories are clubbed together the differences in the percentage of deaths below the age of one year does not seem to be gross ly different. Whereas in the one to six year age group, the percentage of

deaths in the categories of BSL and SL (11.34%) is more than double than ASL and WO (5.32%). The reasons for such a difference could only be speculated upon. It is possible that the percentage of deaths in children less than one year in the two major categories (BSL+SL and ASL+WO) is not different because all the children are subject to the same physical environment or it could be that the higher deaths in the lower categories are due to the poor socio-economic situation and this is counterbalanced by higher deaths in the upper categories due to feeding patterns (for instance bottle feeding). The sample is too small to draw definite conclusions and its an area that needs further investigations. The disparity in the deaths in age group one-six years between the two low categories and the two upper categories could be due to the kind of care the children receive in each of the categories, again it is not possible to come to definite conclusions because one needs to know the reasons for health and sex discrimination, nutritional level and medical attention at the time of illness.

It was found particularly difficult to collect data for this section. Even for simple questions such as "how many live children do you have?" Because these questions are associated with the family planning programme and family planning workers. Many women would just clam up after this question was asked. Thus it was not possible to get more comprehensive information on child births, deaths, immunization coverage,

total number of children under five etc.

The most common cause of death in children as reported by respondents were diarroheal diseases, premature births, neonatal tetanus, fevers, communicable diseases, typhoid, measles, chicken pox, jaundice, pneumonia, severe malnutrition and through accidents such as drowning in the 'nullahs' or being burnt in the jhuggi fires.

Treatment at the time of terminal illness reveals that of the total number of child deaths - in 23.5% of cases no form of treatment was taken. In these cases the child died suddenly in an accident, of no apparent cause, or without manifesting any symptoms of ill health, e.g. a new born child dying within a few hours or days of birth. For the remaining 76.5% both modern medicine through private and government institutions and faith healing was used. Modern medicine was used in combination with faith healers by 21% of those who went in for treatment. 71% used modern medicine either individually through private institutions (practitioners), government institutions or in combination of the two. 8.1% of people used faith healing alone for the treatment of terminal illness. Thus in 70.4% of all cases the child died despite seeking attention from modern medicine (see table 4.5). Also in 20 cases parents from the lower two categories not only took treatment for their children's illnesses and paid for it[39] (to private practitioners) gives lie to the fact that the poor are not concerned about child mortality and quickly

replace one child by having another.

4.7 Use Pattern of Health Services in Different Groups

The use of various health services depends upon various considerations, (a) the type of ailment, (b) who is the sick person, (c) at what time of the day is the person taken ill (d) how serious is the illness (e) how much money is available (f) how much time is available (g) what is the transport available. (h) previous experience of the facility (i) the levels of satisfaction gained in the past. A combination of these considerations come into play everytime someone falls ill and a decision has to be taken as to what kind of medical help to take and from whom.

Tables 4.6, 4.7 and 4.8 describe the ailments for which attention has been sought at the government hospital, government dispensary and private practitioners.

Home remedies were used exclusively for minor ailments such as colds, coughs, fever of a few days, minor injuries and wounds.

Faith healing was used in isolation or in combination with modern medicine for mostly children's ailments and all other illnesses except injuries and accidents. (See table 4.9, for use of faith healing for different ailments and whether in isolation of combination).

4.7.1 Use of Modern Medicine

Table 4.10 gives the use of modern medicine by respon-

dents families according to categories and the source e.g. - private practice, government hospital, government dispensary.

Private Practice: Almost all the people from the four categories have been to private practitioners sometime or the other. They are willing to spend cash for treatment. This specially for people from the lowest two categories means that the illness was serious enough for them to pay for medical help. The following interviews provide some insights:

i) Marjeena, her husband is a rag picker (below subsistence level) "A few months ago my husband had a big boil on one knee; he also had very high fever and was laid up for ten days. He could not go for work. I took a loan of 200 Rs. and started private treatment. I still have to pay back the loan. What use is money? When he feels well he can earn some more."

ii) Aashima, her husband is a painter works on daily wages, (below subsistence level) "My father had a kidney ailment. He was getting private treatment for it, then he had an accident and was admitted to 'General' hospital. He died there after 8 to 9 days because they did not take proper care. We fought a lot but it was no use. We spent all our money on his treatment. Also sold the little land we had in the village."

Government Dispensary: This is largely used by the lowest category (80%). This is becaue it is relatively cheaper, more easily accessible and local. Upper category use this service the least because they would prefer to use private practice

and pay cash rather than wait in long queues for the few medicines they can get more easily through the private practitioner.

i) Shahjahan Bi (below subsistence level, domestic servant): " When there is no money, we are forced to go to the dispensary. For minor ailments I go first to the dispensary, if the treatment does not help I go to a private practitioner. If I had the money I would go to a private doctor first."

ii) Savitri Devi (above subsistence level, wholesaler kabaad ka kaam) - "There are a lot of problems in going to the dispensary. I have small children. We have to queue up for long hours there, then they insist on tubectomy for limiting family size. That is why I prefer to go to a private practitioner. One also gets better faster and the treatment is faster."

iii) Ranjani (above subsistence level, owns hardware store): "The crowds at the dispensary are so overwhelming, that is why we go to a private practitioner. For minor ailments even though they charge upto fifteen rupees, one only has to visit him/her once, whatever the nature of ailment."

Government Hospital: The highest and lowest economic category use these services the most (85% and 80% respectively) however the reasons why they have used government hospitals are entirely different.

i) Ranjani continues - "For more serious ailments we go to Ram Manohar Lohia Hospital - because we know people there and we get good treatment."

ii) Hashim Khan (well off, owner of a chemist shop) - "My younger brother was involved in a fight. He was badly injured, had a large wound in the head and several fractures. He is known to Jagdish Tytler (a Cong.(I) M.P.), we got a letter of introduction from him and, took my brother to Ram Manohar Lohia Hospital. We got immediate attention and the doctors are looking after him very well."

iii) Jameela (below subsistence level husband is a daily wage earner, a mason): "We go to G.T.B. hospital or 'General' hospital when someone is seriously ill. Last year my grandson had diarrohea and got severely dehydrated - so we rushed him to G.T.B. hospital."

iv) Shubhratara (subsistence level, a widow, husband had a tea stall, one son is a cycle rickshaw driver and another works on daily wages at a factory): "My husband had a stomach ailment, later it turned out he had an ulcer. First we tried all kinds of private treatment. We sold the tea shop to meet his private treatment expenses. But when there was no cure, he went to hospital. He fought with me and went. I am scared of hospitals - but he was in so much pain. He died after 6 days."

The lowest category have more serious illnesses for which they cannot spend money on private practice and for which the hospitals offer the best possible help in the circumstances. In the case of upper categories it is more convenient to use hospitals because of their contacts and their

class background which ensures better treatment, for the least amount of expenditure; they can also spare the time needed to follow up hospital procedures.

The utilisation of charitable hospitals is low because they are viewed as hospitals for the treatment of serious illness. Anyhow when the illness is severe people prefer going to nearby government hospitals rather than charitable hospitals because they are definitely cheaper. Of the charitable hospitals Red Cross is most frequently used because it is nearer and more accessible.

i) Nawab Miyan (below subsistence level, cycle rickshaw driver) - "For treatment of all my family members I go to G.T.B. or 'General' hospital, which ever is more convenient for the moment. The "Red Cross" hospital they ask for a registration fee of two rupees. Today I took my son there, because he is having severe diarrohea and high fever. The other hospitals are on strike. Red Cross is more expensive, they also prescribed medicines from outside, but the treatment was good. It is closer and I could take the child in my cycle rickshaw."

4.7.2 Indigenous and Faith Healers:

Table 4.11 gives a description of respondents from different categories who have used these two varieties of services (home remedies and faith healing).

Faith Healing:

People from all categories have used faith healers,

however those from the lowest three categories have used them more (70%, 79%, 83%) than those from the upper categories (40%).

i) Shahjahan bi (below subsistence level, widow, domestic worker): "If a child has fever, or is in pain and even after giving him allopathic medicines he/she is not getting better we get some water or oil 'blessed' by a faith healer and use that. Or if a child keeps crying we either give him/her the 'blessed' water to drink or a massage with the 'blessed' oil. They get better after that. All mothers with young children do it. I had also taken my husband who had T.B. of the brain to a faith healer but he said nothing could be done because the ailment had no 'supernatural' (upar ka koi asar nahi hai) causes."

ii) Kamala (subsistence level, rag-sorter, husband drives an auto-rickshaw): "Suppose a child falls sick due to the 'evil eye' or 'supernatural causes', faith healing can cure him/her. The symptoms such a child exhibits are - vomitting, is scared at night, screams and yells, talks in his sleep, is listless and keepsleeping."

iii) Naseer-ud-din (above subsistence level, "pankh ka kaam"): "First we take a sick child to a Maulvi, if he/she gets better its fine, if not we take him either to a private doctor or a government doctor."

iv) Mohammed Shaheed (above subsistence level, clock maker and watch repairer): "A Maulvi (Muslim faith healer) can tell from the pulse, whether it is a regular illness or a result

of the influence of some supernatural causes). Usually we go to them for a child's illness. They charge for charms and amulets. The symptoms of these variety of illnesses are - a child waking up with a start, not eating properly, not playing, nor speaking, just keep on crying. The eyes bulge outwards. If faith healing does not help we take the child to a 'doctor'. Once my eight month old son was affected by the evil eye. He did not open his eyes for three days, nor would he drink any milk, only water. That time I tried a lot of faith healing and also spent a lot of money."

The belief in faith healing seems to be so strong because their understanding of the causation of disease is still in relation to the effect of supernatural forces. And this world view of disease and healing seems to have been retained despite their contact with the modern view of the causation of disease.

Home Remedies: Herbal teas, vegetables considered to have medicinal properties (e.g. onions, ginger, lime, garlic, mint) and spices (cummin, cardamom, turmeric, black pepper, cloves, etc.) form the basis of recipes used to treat ailments ranging from skin problems, fevers, heat stroke, diarrohea, minor wounds and injuries, coughs and colds. The use of these home remedies are dependent on two factors, the availability of specific herbs ('jadi - booti') and the presence of a person with the knowledge of how to use home remedies. The person with this knowledge is most likely to be an elder in the family.

Two families in the below subsistence level category had this to say about the use of home remedies - "In the

village people seldom go to the doctors. Here they go to the doctor even when they have a cold. In the village there is greater use of and dependance on home remedies, based on 'jadi-booti' (herbs). Here no one has the time and the herbs are not even available, while in the village you can get them from the fields or jungles. Every general store merchant in the village also stocks some essential dried herbs."

- "While my grandmother was still alive, she used home remedies. Now a days everyone straightaway goes to the doctor - only the elders knew the use of home remedies."

The experiences of families from the well off category is slightly different as is evident from this example: "My grandfather was the village hakim, my father learnt the skill from him and in turn passed on some of the knowledge to me. I use home remedies quite regularly. My father sends me essential herbs through parcels, from the village, whenever I run out.

The use pattern of home remedies described in Table 4.11 shows the highest use among the upper most category (60%). Although this data seems contradictory to popular belief that the poor use more home remedies, in the slum situation of New Seemapuri, it would seem that it is not just the fact of being poor that makes the use of home remedies more popular. Rather, as is evident from the above examples the use of these is very much a part of cultural integrity. Amongst the lower classes, not only has the family situation under gone a change (with the shift to the city) wherein more families are living in nuclear units and there are few elders around

for help and advice; the easy availability of special herbs from the fields and jungles near the villages has also been affected. While in the upper categories the family and kinship networks have suffered fewer setbacks, and the links with the village still being maintained on a regular basis the utilisation of traditional systems of healing have been maintained both in terms of knowledge and actual practice.

4.8 Why People do What They do e.g. Action Taken

Popular beliefs held by health functionaries responsible for the delivery of health care facilities and programmes for the slum dwellers have propagated certain myths about the behaviour and attitudes the poor hold about illness and disease. Some of these myths are that the poor do not approach medical help in time, they leave it too late for medical help to make a difference, they have irrational beliefs and use worthless traditional systems of healing and faith healing instead of scientific systems of modern medicine. What is ignored is that behaviour and attitudes reflect a set of experiences and knowledge of what is available, affordable, accessible and gives relief under the circumstances.

The preceeding section gives lie to the fact that the poor do not use modern systems of healing and are overwhelmingly in favour of traditional practices or faith healing. In fact it highlights that despite severe limitations of government services people still use them.

Action taken during an illness depends upon what is felt to be the causative factor in a particular illness and what is perceived to be an illness. Treatments from different sources are tried individually or in combination depending on what gives maximum relief in a situation or particular ailment. Other factors which influence action have already been discussed under the section on actual use. The only factor which needs to be further highlighted here is about the correlation between perception and experience of certain facilities which determine what facility is used.

4.8.1 What is Perceived to be an Illness

Illness is a subjective feeling. While a person may have a disease he/she may not experience it as an illness, till the symptoms of the disease start interfering with the daily activities, such as, pain, fever, etc. Once the disease is experienced a decision has to be made in terms of when and where treatment is sought.

(i) Shubhratara, speaks about her son who is a cycle rickshaw driver (subsistence level), "my son had jaundice a few months ago, all treatment was taken from private practitioners, hospital medicines react slowly while private medicines cure much faster". While in her own case she waited for a week before she went to seek treatment for pain in the throat. Then too she did not go to the private practitioner, she sought free treatment at the

leprosy mission hospital through a family friend of hers.

(ii) Sheikh Majid, a rag picker (below subsistence level), "I have not been feeling well for the last four to five days but I have not gone to see a doctor. He will take ten rupees that is all. I have been taking some ginger and 'tulsi' tea, I hope to get better soon". Three days later when the researcher met him when he was on his way back from the private doctor's 'shop'. He had high fever the previous two days he reported and had been unable to do any work.

(iii) Dilip, unemployed, while his two younger brothers are rag pickers (below subsistence level). "My wife is very weak, doctor's say that there is something 'wrong' with her blood. I showed her to a private doctor, he was charging between 25-30 rupees per day. For 4-5 days we took the treatment regularly, while I had some money. When the money got over I had to stop the treatment. I don't take her to a government hospital because she is needed at home to cook and feed my younger brothers on time. Hospitals take so long and the procedures are so cumbersome. She cannot be spared every day from household chores, if she has to follow up the treatment."

Examples quoted earlier also speak of how entire families have been rendered destitute to pay for the treatment of one adult male member.

In the light of the experiences quoted above and other explorations it is possible to abstract the factors which come into play to determine where and when treatment is sought

1. What is the position of the person in the family.
2. How crucial is the persons economic contribution perceived to be, for the survival of the family.
3. How crippling or disabling is the illness, e.g. loss of appetite is less worrying than weakness, giddiness, a fracture, etc.
4. How quickly treatment can be availed at a particular source, and how quick is the relief from a particular treatment.
5. How expensive does the overall treatment workout to be (taking into consideration the wages that will be lost, cost of transportation, doctor's fee, costs of medicines).
6. What is the persons world view of the causation of illness or disease.
7. The satisfaction gained by the interaction
   i) in terms of the 'bedside manner' of the faith healer, doctor;
   ii) in terms of relief from the particular ailment;
   iii) in terms of fitting in with the world view.

Thus in a family the health status of the adult male earning member is considered to be most important followed by the male children, the female children and finally the adult females irrespective of whether they are earning members or not. Accordingly medical relief is sought earlier for relatively less serious condition of the male member or male child. Women invariably delay treatment, till the illness becomes extremely 'disabling'.

4.8.2 Experiences of Different Facilities and Their Implication for Action

(i) Dilip, the unemployed young man continues, "I have to take my father 2-3 times in a month to the hospital. He has a heart problem. Twice we had to take him at night, once to G.T.B. and once to 'General'. At General hospital we reached at 1.30 a.m. The doctors were chatting with each other. I kept pleading with them to examine my father, but they kept sending me after one signature after another. After 45 minutes they touched him, kept him one night and put him on 'glucose' and sent him back the next day. At G.T.B. the night doctor was better. They kept him there for 2-3 days, medicines were prescribed from outside. After the experience at General hospital my father said to me that we should use private treatment as long as possible and go to hospitals only as a last resort. As it is my father is scared of hospitals because one of his sisters died in hospital, due to the staff's

carelessness. She had been hospitalised for some problem during pregnancy and the child too died. He is prepared to starve to pay the fees of the private doctors but he would not like to go to a hospital.

(ii) Nafisa's husband is a daily wage earner, he is a tailor at a garment factory (below subsistence level). My daughter had a lump behind the ear. About 9 or 10 months ago we took her to Kasturba Gandhi hospital, they gave some medicine and said if it does not get better go to Irwin, but we could not follow it up. A few days ago I took her to the dispensary, they too gave her some medicine, but it made no difference. Then they referred her to G.T.B. I took her to the Red Cross hospital after that, but they asked for money. Today my husband took her to G.T.B. since there was no money, even for the bus fare, both, father and daughter walked to hospital and back. They have asked them to come again for blood tests and X-ray. The hospitals are very crowded. That is the main problem.

(iii) Mohd Rafi, rag picker (below subsistence level), "Only big people go to government hospitals, when we people go they say 'you are dirty, don't come near, if you want to be examined stand apart'".

(iv) Mohd Yusuf, rag picker (below subsistence level), "I have been to the dispensary a few times for immunisation

for my child, but they behave very rudely with us. We are poor, our clothes too are dirty, we cannot speak Hindi very well. Private is better, he has to earn money, that is why he gives good medicines. In the government hospital they are only doing their duty, they are not concerned with the patient getting better.

(v) Jameela, husband is a daily wager, Mason (below subsistence level), "Earlier 'General' was a good hospital. Now they abuse us and push us away, outside a person may be very sick, inside the doctors are having fun. If a child has high fever, or there is no relief from hospitals, we go to private doctors. If the child is very sick and we cannot wait in long ques we go to private doctors. Private treatment is better. Medicines in hospitals are free so they do not give the correct medicines. They don't give the good medicines to poor people, they give them to the rich, or if a person is not getting better they give injections".

(vi) Sheikh Abdul Rehman, sells chicken meat, formerly drove a cycle rickshaw (subsistence level), "No attention is paid in government hospitals, they are only better in name. They are only for the rich, nothing is done for the poor. If a poor man goes he is asked to come another day, when a rich man goes he is attended immediately. In private hospitals they treat you properly".

(vii) Sheikh Dida, rag picker (subsistence level), "We only go to hospitals when someone is seriously ill, otherwise for all other kinds of illnesses we go to a private doctor. We go for private treatment because only when you have money (pay for treatment) do you get proper treatment".

(viii) Akbar, cycle rickshaw driver, immigrant from Bangladesh (subsistence level), "Last year my son fell ill - I took him to Tegh Bahadur, there I was asked a bribe of 250 rupees. I said I did not have the money. I told them if they were not going to admit my son they should give it to me in writing and if my child died, they would be responsible. I also threatened them that if they did not admit my child I would lodge a police complaint. Then a lady doctor came and took me aside and said "look we'll admit your child, if you fight with the doctor no one is going to listen to you, instead the police will arrest you, you are in a foreign country, so give us fifty rupees'. So I gave her fifty rupees, then they put him on a drip and gave him some medicine. After one day they discharged him, but he did not get better, then I took him to a private doctor, after which he got better".

(ix) Ayesha, 'pankh ka kaam' (subsistence level), "My daughter has polio, we took her to several hospitals, but our experience has been negative, no doctor ever explained

to us what was exactly wrong with her. My husband has a chronic back ache problem for which he is undergoing treatment at the Gupta Nursing home in Shahadara".

(x) Salauddin, rag picker (subsistence level), "Only when an illness is very severe, or when we have no money we go to the hospital, otherwise all treatment is taken from private. No one can be spared, my mother is very old and cannot read bus numbers, someone has to look after my old father also."

(xi) Kamala, rag sorter (subsistence level), "A piece of glass had got embedded in my hand. I went to the dispensary but it did not get better, the wound had got badly infected. Then I went to a private 'doctor'. I spent 300 rupees, after a while it got better. He told me if I had gone a week later he'd have had to amputate my hand".

(xii) Shahjahan begum (subsistence level), "In a bus accident my son broke his leg, then we had taken him to G.T.B. This was about a year ago. They put his leg in a plaster and prescribed medicines from outside. Our experience was good and the doctor was co-operative. May be we were just lucky. At night time or when government services are not available we go to private doctors. Once I had taken my son to the local dispensary. The doctor asked me what was wrong. As I kept describing

the child's condition, he kept looking elsewhere, did not even touch the child, finally wrote something on the OPD slip and said go upstairs. I asked him then to at least examine the child, instead of just writing something without examining him, and not even explaining to what needed to be done. So very irritably he told me to go upstairs for a blood test. When I reached there the lab. assistant wasn't there. He came back after a long time. Then when I went to get the injection, the injectionist was talking away blissfully unconcerned that someone was waiting outside. When I asked to give the injection, she just screamed at me".

(xiii) Mohd Shahid, watch maker (above subsistence level), "In government hospitals they do not give medicines, only give the cheap medicines. If it costs 15-20 rupees they prescribe it from outside. In government hospitals they prescribe according to whims".

(xiv) Momena, wholesaler, babaad ka kaam (above subsistence level), we don't go to hospitals because one has to stand in long queues, it takes the whole day. Fever, diarrohea, dysentry, cuts and wounds, in all instances we go to private doctors. Relief is only obtained after 2-3 visits and days of medication.

(xv) Rokiya Bewa, widow, son is a rag picker (below subsistence level), "When the dispensary is closed at

night and the condition is serious, what can we do, we go to private doctors. Sometimes the treatment gives relief, sometimes it does not. When the illness is due to super-natural effect, we also get charms and amulets."

(xvi) Anju, husband owns a 'kabaad ki dukan' (above subsistence level), "We don't go to hospitals. In all ailments/illnesses we go to private doctors. They may take up to 200 rupees, but the relief is quicker and one does not have to wait in long queues, in the crowds.

This data reflects that the first option for the adult male is generally the private practitioner because this service is most easily accessible, less time consuming and even though it is expensive, the relief through the treatment provided is perceived to be quicker.

The women and children usually end up taking treatment for their problems from the dispensary (as also evident from the O.P.D. figures of the dispensary records). Only in medical emergencies are they taken to private practitioners or the government hospital, or when the experience of the government dispensary has been particularly negative, e.g., refusal to give immunisation or medicines to children, when women with more than two live children, refuse to undergo tubectomy or accept I.U.Ds. This has led, in the past to open confrontation with the

staff at the centre and culminated in a demonstration against the dispensary personnel.[40]

People usually go to government hospitals first for medical emergencies, at night time. Although government hospitals are the next step for referral from the government dispensary, people prefer to go to private practitioners; only when the private practitioner 'gives up' and advices going to government hospitals do people always go to government hospitals. Thus private practitioners very often form the second tier between the government dispensary and government hospital.

From the examples quoted in section 4.7.2 under 'faith healing' the implications for actions are clear. Faith healing is used in specific ailments for which modern medicine does not seem to have definite diagnosis or when the treatment is not producing desired results. Faith healing is also used as a form of prevention to keep away the evil eye or other supernatural causes believed to influence disease and illness. Faith healing for most ailments is used in combination with modern medicine. Those who go in for faith healing for prevention purposes use modern medicine when it 'fails' and someone falls sick; those who use faith healing for its 'curative' aspect do so when modern medicine 'fails' to give relief from particular ailments.

Despite the fact that most people have used all the different kinds of services individually or in combination for different ailments, at some point of time or the other, the maximum amount of satisfaction is found in the case of private practice and faith healers and the least from government hospitals and dispensary.

Private practitioners and faith healers are locally resident and more familiar and conversant with the people's lives and cultural beliefs. Hence they are able to provide reassurance and explanations for illness which fits in with peoples world view about illnesses. It is also believed that because private practitioners charge money they give better services.

On the other hand the rude behaviour, often time consuming, confusing and bureaucratic procedures, discrimination and lack of information and explanation about illnesses affect the levels of satisfaction gained from interactions with the government hospital or dispensary.

The people also felt that in government hospitals the quality of medicines given is substandard or they are adulterated because it is popularly believed that the hospital staff sell the good medicines in the black market or reserve them for a higher class of people.

Correlating perception and experience: Tables 4.12, 4.13, 4.14 correlate peoples experience of a particular type of facility with their perception of the same facility. Some of the important implications of this are, positive experience is most likely to result in positive perception but in the case of government hospitals especially, despite a good experience people have a negative or mixed perception or despite no experience have a negative perception. In the case of government dispensary despite a mixed experience or no experience there is an overwhelmingly negative perception. In the case of private practice positive experience results in positive perception and mixed experience which may also contain some negative experience still yields positive perception. The single implication of this data is that in this prevailing atmosphere of distrust, especially vis-a-vis government services, it has to be doubly ensured that no mistake is being made because a single negative experience can further increase the damage already done. That perception is not a direct fall out of experience is also seen, the sources can be other peoples experiences or what has been seen happening in other instances. Private practitioners are perceived positively because of the atmosphere of trust which they have created.

4.8.3 Perception of Causality

The world view about causation of disease is certainly not purely magico religious. It depends on their perceived ability to make a difference to their health problems, as well as their understanding of the wider causes of poverty and the resultant ill health. Respondents in their reply included that they regarded inadequacy and poor quality of food, degraded environment to be additional causes.

(i) Hamida, rag sorter (below subsistence level), "We ourselves are dirty, the water supply is so unreliable. Only with adequate water can one remain clean. Only some people can remain clean, no wonder there are so many diseases."

(ii) Jameela (below subsistence level), "In the earlier days, home remedies would cure more illnesses/ailments. But then the quality of the food was so much better, these kinds of pesticides and fertilizers were not used on the land."

Dilip (below subsistence level) "both my father and wife fell sick only in the city. The air and water does not suit them here. In the village they were always healthy."

(iii) Sheikh Abdul Rehman (below subsistence level), "Look at the mosquitoes here - no wonder people keep getting malaria".

(iv) Hashim Khan, owner of a chemist store (well off), "Till the sewer lines are operationalised, the problem of ill health cannot be tackled here. The source of all problems is the contaminated ground water supply. The sewage seeps down and contaminates the ground water, this is pumped up by the land pumps. Since drinking water in the taps is available for only one or two hours a day and people do not have enough vessels to store water they are forced to drink the contaminated water from hand pumps. The other source contaminating the ground water are these government toilets. They are so filthy and badly maintained. Half the diseases in this area are because of oro-facial infections.

Most people as we can see from the above examples made a connection between ill health and their immediate environment. They complained about the filth, stagnation of water in the drains, the innumerable mosquitoes and flies and the lack of adequate sewage. Some even observed that the polluted air and water in the city were responsible for many of the health problems.

People were well aware, were they to get adequate amount of food, they would probably not require the help of medicines to stay healthy. This view is prevalent in almost all families at subsistence or below subsistence or below subsistence levels; almost anyone who retains memories of the village life or has good links with the

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village, felt that the food in the village, be it the quality of cereals, vegetables, fruits, milk, was superior to that obtainable in the city.

4.9 Family Welfare Programme

This programme, has been divided into two parts, one dealing with the family planning services and one dealing with the maternal and child health services.

The services provided by the government institution - the Delhi administration dispensary and the MCD's, MCH programme have been discussed under the section on health services.

What is of interest here is, however, the extent and quality of services provided, the coverage and people's utilisation of these services as well as people's experiences and perceptions of the programmes.

4.9.1 Family Planning Services

What has to be remembered is the condition under which people were resettled. During the emergency, when all over the country poor people were being coerced into undergoing tubectomy or vasectomy, these migrants were no exceptions. In many of the cases the pre-condition for being allotted a plot was 'accepting' a terminal method of contraception.

People's utilisation of the programme and their attitude to it has to be seen in the context of this.

Much of the information about use of conventional contraceptives could not be obtained due to people's understandable reluctance to talk about such personal choices. Their suspicion about these questions were also understandable because of their past experience when this information was used against them.

Table 4.15 describes by categories, the type of contraceptive used. What is significant is that 34% of the couples who do not use any contraceptive have a 'felt need' for some form of safe and effective contraception.

(i) Shahjadi bibi (below subsistence level). "I had a CuT inserted once for five years. Every year I was conceiving, my husband was ill and the earnings were not adequate to look after all the children, there was no one to take care of them either. But later I developed complications and had it removed."

(ii) Ayesha Begum, she is menopausal now, has five children (below subsistence level), "When I needed a contraceptive I had no information, today everyone is talking about them. My husband was very careless and un co-operative. Finally to avoid him I went to stay with my mother for four years."

(iii) Hamida (below subsistence level), "I have five children, I do not want any more. I had a Cu inserted 2-3 years ago but had it removed because of complications. These days also I am using a CuT but I feel giddy and have excessive white vaginal discharge. I cannot even go for a check up - where do I leave my little children. My husband is not at all understanding. The earlier CuT I had had to get removed privately because they refused to remove it at the hospital. I think I will go in for a tubectomy eventually. I hesitate only because my religion does not permit it, but the religion does not permit a lot of other things, which are being done."

(iv) Rajwati, a domestic servant (subsistence level), "My mother-in-law and I both requested my husband to use Nirodh, but he does not listen. Since the last one year I have been eating an ayurvedic pill. It brings on the menstruation on time every month. My husband bought it from the chemist store. I have only one daughter but I don't want to have any more children."

(v) Ramzaan (below subsistence level), "I have four children, and I don't want anymore. They say Islam does not sanction tubectomy or vasectomy. My husband thinks the same way. Let however many children be born. But I don't agree. I wonder why we should have so many children when we are so poor. I had even gone to get an MTP done

when I was pregnant with the third child then I changed my mind. I thought I would use a CuT instead."

(vi) Meena (subsistence level), "I had started using a CuT to space the second child. But due to the doctor's carelessness I conceived a second time despite the CuT. I am using it again now but my menstrual cycle has become very irregular and I have severe pain during each cycle."

(vii) Maya (subsistence level): out of five children only two are surviving, "After I have one more child, son or daughter, I'll get a tubectomy done. These days boys and girls are the same."

(viii) This lady did not want to reveal her name (below subsistence level): "My husband wants to have intercourse with me everynight. Why should he want to use Nirodh, he does not enjoy it then, on top of that he beats me. Tells me some way to stop having children. Pills and tubectomy are all harmful and unreliable. CuT leads to heavy bleeding, if you know of anyone who gives those 5 year injection (reference is to Net-En) then please get me one."

(ix) Rasheed, pankhwallah (subsistence level). "When one child is born, another child dies. Allah is giving and he also takes away. Sometimes I think we should not have more than two children but after getting sterilised suppose they die, only if there is a guarantee that they will survive."

(x) Nawab Miyan, cycle rickshaw driver (below subsistence level). "Of my six children four have died. What guarantee is there that these two will survive? How can we accept sterilisation when they coerce us in the dispensary."

Three more cases came to light of men who had been forcibly sterilised during the emergency, even before they were married or had any children. All their efforts to get re-canalisation done have born no fruit.

Several points about peoples family planning behaviour and attitudes become clear in the light of the above examples. There is a strong felt need for safe and effective contraception, especially among women. Contrary to popular belief people are not ignorant about the effects of large families on the well being of children. Children are a resource to them and people have arrived at what they feel is the optimum number of children they need to have - this is between three to five live children of whom at least two are sons before they go in for a terminal method of family planning.[41]

The experiences of many who have tried to use contraception have often been negative in terms of failure of contraceptive, no adequate care or treatment given when complications develop (see table 4.16 for sterilisation and complication figures). Thus people rightly feel that

health personnel are only interested in fulfilling their targets not actually interested in the people's or their family's welfare.

Women devise their own means to control their fertility, something planners and policy makers never consider, e.g., staying on at the natal home to keep away from husbands. The felt need is also most acute on women who have to bear the burden of not only giving birth but also of rearing the child. The fact that the illegal abortion rate is put as high as 15-20 abortions per month (by a local R.M.P) speaks for the absolute failure of the presently available contraceptives.

4.9.2 MCH Services

These are perceived by most women only as a ploy to get more women to accept family planning. This is obvious from the extent of coverage of these services. Only 12.9 per cent of all deliveries were conducted at hospitals (Table 4.17). The reasons vary. Women opt for hospital deliveries when the case is very complicated or when they have no one to help with deliveries at home. Hospital deliveries are not favoured because of the rude and abusive behaviour of the staff, the fear that children are exchanged, the fear of being forcibly sterilised. Some women have no one at home to look after the other children, so they do not want to go to hospital. A dai

is more used to the people's cultural beliefs and practices about deliveries so home deliveries by dais is preferred. An ANM is not contacted because she is not locally resident and when called she never comes. At home the presence of family members is also of great comfort and reassurance.

Immunisation

Almost 50 per cent of children have not been covered by any form of immunisation (Table 4.18). Many women who sought immunisation for children were refused these, either due to the unavailability of vaccines or because the woman refused to accept contraception. It is also difficult for women to keep track of the various vaccines and dosages and it is not uncommon for the same dose or vaccine to be repeated. This is so especially for those women who spend only part of the year in the city and make many visits to the village. The experiences and perceptions of government facilities also acts as a disincentive for more people to avail of this service.

Thus in conclusion, it is possible to say that by and large basti dwellers not only are aware of the services being offered but make an attempt to use them. It is their experience at government institutions and the quality of services offered which act as a greater disincentive rather than their own ignorance or illiterate status.

Cholera Epidemic

"Every year hundreds of people suffer from gasteroentritis and children die of diarrohea. Why was there such a hue and cry only last year".

"Only when a big epidemic sweeps the colonies the government comes here. Why don't they come and see at other times how we live".

The above two statements made by two respondents sum up the entire experience of the cholera epidemic. Every year from April-June the incidence of gastero intestinal diseases is very high - the only available data on this is from the O.P.D. attendance records of the local dispensary. Yet nothing had been done till the summer of 1988 when cholera struck several slum colonies in trans-Yamuna.

Though Nand Nagri which alone reported about 300 deaths is only 2 kms away, there was no comparable mortality or morbidity due to cholera in New Seemapuri. However, due to the Prime Minister's intervention they received individual water connections and roads were paved with bricks. The problem of sewage, contaminated hand pump water, daily clearance and removal of garbage and inadequacy of toilet facilities were temporarily affected through adhoc measures. But now, by and large things remain unchanged and the struggle for survival goes on.

FOOTNOTES

CHAPTER IV

1 "Disease" may be defined as the bio-physiological phenomenon which manifest themselves as changes in and malfunctions of the human body." (Corrad and Kern). Illness on the other hand, is the experience of being sick.
Sathyamala, et al. (1986), Taking Sides : The Choices before the Health Worker, Madras, Anitra Trust, p. 11.

2 'Appearance' in terms of the colour which was muddy and living organisms, visible to the naked eyes, such as worms etc.

3 Under the sites and services scheme of the DDA.

4 Rajeev Gandhi took over after the Sikh Riots when several of the resettlement colonies, New Seemapuri being one of them witnessed the most brutal carnage in the city. And H.K.L. Bhagat the Congress MP from this area was one of the chief accused.

5 Cholera epidemic in Delhi from April-July 1988.

6 Regular outbreaks of gasteroentrities and Diarroheal diseases in these colonies, lack of clean drinking water, poor drainage, lack of average facilities and over loaded toilet facilities.

Almost all the people the researcher spoke to said that they had given written applications to the DDA and even demonstrated outside the office in an effort to get them to improve the level and maintenance of civic amenities.

7 The amount that had to be paid for the connection was Rs. 115/-. The cost of installation varied for each family from between Rs. 250-350.

8 Under the Bhagirathi scheme water was piped from Ganganahar in UP to the middle class and upper middle class residential colonies developed by DDA. Trans Yamuna was not considered to have any safe drinking water supply of its own. The ground water was not considered safe for consumption and so this scheme was launched.

9 This includes the cost of connection and the cost of installation.

10 The only household without a tap is that of a bachelor, who has recently moved to the colony and is staying in a rented house and did not feel the need to invest in a tap connection for that house.

11 One respondent related that a neighbour allowed her only 2 buckets of water for drinking and working purposes, per day and for that she had to pay Rs.2 per month. The fixed rate for water being Rs.9 per month.

12 This sharing was observed amongst Bengali migrants families. The cost of installation of a handpump is about Rs. 4.50 p.m. This was divided between 6 families and they all used the handpump and also shared maintenance and repair costs.

13 The 'unauthorised' residents are from the jhuggi cluster adjoining F block where they are squatting on public land.

14 These constraints were reported by women during a campaign held for housing rights under the banner of National Campaign of Housing Rights.

15 Where women usually bathe has been mentioned under section 3.6.1 of Chapter III.

16 1 'Safai karam chari' and one water carrier (Bhiati) are supposed to clean 96 toilet seats twice a day.

17 The man was the husband of a Sabla Sangh member Jehangiripuri. Reports about this death appeared in the daily newspaper during March 1989.

18 Buggies are carts drawn by buffaloes or bullocks to transport garbage and sullage.

19 Part of a house, if it is a double storeyed house, or if its a double plot one plot may be used for storing 'kabad'.

20 & 22 The colony had three kinds of safai karamcharis i) for cleaning roads, ii) for cleaning oilets, and iii) for cleaning drains.

One karamchari was supposed to clean the drains of 3-4 'galis' everyday and one karamchari was supposed to clean 30,000 running feet of roads everyday. Each safai karam chari is given 1 broom every 3 months and 1 spade every 6 months. Each karamchari was supposed to be given one wheel barrow but not all of them had one. Vehicles were supposed to come daily to tow away the garbage containers but they did not show up for 15 days at a stretch. Only 8 'buggies' were available for the whole colony.

21 The drains were designed as open drains so that all kinds of filth accumulates in them. They adjoin houses so to prevent young children from falling in, people had covered them with slabs of stones or cemented them over, the gradient is awry

-/-

and there is no eventual outlet for the drains. All this creates impediments to an efficient cleaning of drains.

23 See footnote no. 25, Chapter III.

24 An adult is counted as one unit and a child as 1 unit. One unit was entitled to 20 kgs of cereal a month and 1,600 grams of sugar a month. Sugar was available at Rs. 5.35 per kg, rice for Rs. 3.35 per kg and wheat at Rs. 2.14 per kg. Palmollin cooking oil was also being provided @ Rs.36.00 for 2 kgs. Sometimes only 2 kgs was available a month while occasionally they were even given 4 kgs a month.

25 A permanent address has to be given to get a ration card. Landlord's usually do not wish to grant their tenants this privilege because they fear, then tenants may refuse to leave.

26 Families are only allowed to keep those members on the ration card who live in the house. Members who have gone away such as married daughters, have to have their names removed. But it was observed that once a name was removed and that person came back it was difficult to have him/her registered again.

27 From a personal conversation with the medical officer in charge.

28 Notification - Subject: Upgradation of health services, dated 13.4.87. Signed by Additional Director of Health Services. Issued from Directorate of Health Services, Delhi Administration, E Block, Saraswati Bhawan, Connaught Place, New Delhi. No. F.15/4/Msc/85-DHS/Estt/E2/4287. List of services quoted from notification no. E.12/20/86/DHS/P&S/Vol. III, undated.

29 The hospitals people were familiar with all the ones which were near their place of residence before eviction such as Hindu Rao, Irwin Hospital, Kasturba Gandhi, and Kalawati Saran.

30 There is one M.B.B.S. doctor in New Seemapuri and he started his practice there in the end of June 1989. Prior to his arrival there was no 'qualified' doctor in Seemapuri.

31 The RMP who was interviewed disclosed that he had picked up his 'medical' skills while working as an assistant to a doctor in Amritsar. Another respondent's son was working with Dr Hoshiyar to learn/acquire medical skills, by working as his assistant.

32 In the ESI Scheme - the money is contributed from 3 sources to ptovide health services to a factory worker. Part of the cost is deducted from the worker's salary, part is contributed by the employer and part by the state. All workers in factories, under the Factories Act and their family members are covered by the ESI scheme.

33 When asked the local RMP said the injection usually given during labour pain or after though assumed to be of Tetanus by the women was either of Baralgan, Oxytocin or Metturgin.

34 Information about the practices of Dai was also obtained from the report of a Sabla Sangh survey on deliveries conducted in the 'bastis'.

35 From the dispensary records:

Average monthly attendance of all patients	-	5,077
Average monthly attendance of all men	-	1,019
Average monthly attendance of all women	-	1,447
Average monthly attendance of all children	-	2,334

-/-

This data is from the daily OPD attendance register from January-June.

36 Average visits to the dispensary OPD per month = 5,000
In one year 5000x12 = 60,000.
Average visits to one pvt. practitioner in a day = 5
No. of pvt. practitioners (approx.) = 30

Total visits in a year 12 x 30 x 30 x 15 = 1,62,000.

Total OPD + Pvt. pract. visits = 2,22,000.

Thus the OPD attendance rates = $\frac{2,22,00 \times 100}{\text{Total population of New Seemapuri } 30,000}$

= 7400 per 100

Thus on an average one person makes 7 visits per year either to the OPD or pvt. practitioner.

37 The high incidence of leprosy is due to the close proximity of the leprosy patients colony in Tahir pur, 1/2 km away. Many of the leprosy patients who are not contagious or active agents stay within the colony too, with their families.

38 All these were reported, the research was not able to diagnose them.

39 Amounts spent on treating children's ailments varied from Rs. 100 to thousands of rupees.

40 Sabla Sangh, 1989: Family Planning Policy and People's Right to Health (mimeo), Delhi.

The Sabla Sangh also organised a demonstration against the dispensary around whom a lot of the anger was directed as it was seen as the representative of the state through whom the programme was implemented.

41 From OPD Records of the dispensary for the year 1989 :

	Amoebiasis	Dysentry and Diarrohea
January	76	200
February	62	258
March	79	187
April	88	192
May	96	190
June	135	205

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TABLE NO.-4·1

SOURCE OF WATER
by categories

Source of water \ categories	BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
own tap only	8	40	13	38·24	3	16·67	2	20	26	31·71
own H.P. only	4	20	8	23·53	2	11·11	-	-	14	17·07
own tap + H.P	3	15	7	20·59	13	72·22	7	70	30	36·59
Neither	5	25	6	17·65	—	—	1*	10	12	14·63
TOTAL	20	100	34	100·01	18	100	10	100	82	100

BACHELOR, LIVES ALONE IN A RENTED HOUSE.

TABLE NO.-4.2

TOILETS USED BY MALES AND FEMALES PER HOUSEHOLD by categories

Type of Toilet \ categories		BSL	%	SL	%	ASL	%	WO	%	TOTAL	%
Sarkari toilet	M	11	61.11	19	57.58	9	50.00	–	–	39	49.37
	F	11	55.00	14	41.18	7	43.75	–	–	32	40.51
Sulabh Shauchalaya	M	3	16.67	4	12.12	6	33.33	4	40.00	17	21.52
	F	5	25.00	10	29.41	4	25.00	2	22.22	21	26.58
Open Ground	M	2	11.11	4	12.12	–	–	1	10.00	7	8.86
	F	1	5.00	3	8.82	–	–	1	11.11	5	6.33
Private toilet	M	–	–	–	–	2	11.11	5	50.00	7	8.86
	F	1	5.00	–	–	2	12.50	6	66.67	9	11.39
Sarkari + Sulabh	M	1	5.56	6	18.18	1	5.56	–	–	8	10.13
	F	2	10.00	6	17.65	3	18.75	–	–	11	13.92
Sarkari + Open Ground	M	1	5.56	–	–	–	–	–	–	1	1.27
	F	–	–	1	2.94	–	–	–	–	1	1.27
TOTAL	M	18	100.01	33	100.00	18	100.00	10	100.00	79	100.01
	F	20	100.00	34	100.00	16	100.00	9	100.00	79	100.00

TABLE NO. 4.3

O.P.D ATTENDANCE AT THE DISPENSARY. JAN - JUNE 1989

MONTHS	MEN	WOMEN	CHILDREN	TOTAL
JAN	780	1470	2159	4409
FEB	1349	2508	3367	7224
MARCH	975	1796	2515	5236
APRIL	810	1446	1834	4090
MAY	947	1471	1945	4363
JUNE	1201	1758	2179	5138

TABLE NO. 4.4

AGE AT CHILD MORTALITY by categories.

Categories / AGE OF CHILD	BSL	SL	ASL	WO	TOTAL
≤ 1 MONTH NEONATAL	11	8	2	3	24
≤ 6 months – < 1yr	2	6	2	1	11
≥ 1yr – < 3yrs	6	12	1	2	21
≥ 3yrs – ≥ 6yrs	2	8	1	1	12
age not known	5	7	1	–	13
Total no. of deaths	26	41	7	7	81
Total no. of live births	109	165	60	42	376
% death by live births.	23.9	24.9	11.7	16.7	21.5

TABLE NO. 4.5

SOURCE OF TREATMENT BEFORE CHILD MORTALITY by categories.

CATEGORIES / SOURCE OF TREATMENT	BSL	SL	ASL	WO	TOTAL
GOVT HOSP.	7	6	2	1	16
PRIVATE	3	13	1	1	18
GOVT HOSP. + FAITH HEALER	-	5	-	-	5
PRIVATE + FAITH HEALER	-	3	2	3	8
GOVT. HOSP + PRIVATE	1	6	1	2	10
NO TREAT-MENT	10	8	1	-	18
ONLY FAITH HEALER.	5	-	-	-	5
TOTAL	26	41	7	7	81

TABLE NO. - 4·6

AILMENTS FOR WHICH VISITED GOVT. HOSPITAL

CATEGORIES / AILMENTS	BSL	SL	ASL	WO
FEVERS	2	1	2	1
DIARROHEAL DISEASES	4	3	1	1
GYNAE & Ob.	1	4	4	–
STOMACH	1	2	1	1
CARDIO-VASCULAR	2	1	–	1
COMMUNICABLE DISEASES: T. B. LEPROSY, FILARIA	5	4	–	1
PSYCHIARTIC	3	1	–	–
INJURIES & ACCIDENTS	1	4	2	1
UNSPECIFIED MAJOR	4	10	3	4
OTHERS	1	3	2	2

TABLE NO. 4.7.

AILMENTS FOR WHICH GOVERMENT DISPENSARY WAS USED.

Categories / SERVICES + AILMENTS	BSL	SL	ASL	WO
MCH Services	4	6	2	4
FEVER	12	24	2	—
U.R.I	17	8	5	1
INJURIES	8	9	3	2
GASTROENTRITIS & DIARRHEAL DISEASES	10	14	6	1
OTHERS	8	12	3	1
ALL GENERAL AILMENTS	11	16	7	2

TABLE NO. 4·8

List of Ailments For which Private Practitioners are visited.

	BSL	SL	ASL	WO
G.I. Tract and Diarrhoeal diseases	12	28	13	3
Fevers and U.R.I	16	22	16	4
Chest Problems	5	3	4	1
Injuries and accidents	8	7	4	2
Gynae and Ob.	3	6	3	2
Infectious diseases	6	6	3	1
Cardio Vascular Problems	2	2	1	2
others.	2	4	—	—.
Minor ailments.	14	9	6	5
all ailments.	8	11	9	—

TABLE NO. 4.9

Quality of
Use of Faith healing by Categories

Categories / USE OF FAITH HEALING	BSL	SL	ASL	WO	TOTAL
NO USE OF FAITH HEALING	4	5	3	6	18
ONLY FAITH HEALING	4	8	5	2	19
WITH MODERN MEDICNE*	10	14	10	2	36
NON RESPONDENT	2	7	–	–	9
TOTAL	20	34	18	10	82

*at Govt. & institutions or Pvt. Practice

TABLE NO 4.10

USAGE OF MODERN MEDICINE (SOURCES)
by categories

SOURCE / categories	GOVT HOSPITAL	GOVT DISP	PRIVATE PRACTICE	CHARITABLE INSTITUTIONS
BSL	17/20	16/20	19/20	3/20
SL	22/34	20/34	33/34	8/34
ASL	11/18	7/18	18/18	5/18
WO	8/10	4/10	10/10	1/10

TABLE NO. 4.11

USE OF FAITH HEALERS & HOME REMEDIES by categories.

SOURCE / categories	FAITH HEALERS	HOME REMEDIES
BSL	14/20	7/20
SL	22/34	13/34
ASL	15/18	4/18
WO	4/10	6/10

TABLE NO. 4.12

PERCEPTION / EXPERIENCE	POSITIVE					NEGATIVE					MIXED					NO ANSWER					TOTAL				
	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT
POSITIVE	1	1	1	1	4	-	2	2	2	6	5	1	2	-	8	-	-	-	-	-	6	4	5	3	18
NEGATIVE	-	1	-	-	1	-	4	2	1	7	-	1	-	-	1	-	-	-	-	-	-	6	2	1	9
MIXED	2	3	1	1	7	2	7	1	2	12	3	2	1	1	7	-	-	2	-	2	7	12	5	4	28
NO EXPERIENCE	-	1	-	-	1	5	5	4	2	16	-	-	-	-	-	2	6	2	-	10	7	12	6	2	27
TOTAL	3	6	2	2	13	7	18	9	7	41	8	4	3	1	16	2	6	4	-	12	20	34	18	10	82

CORRELATING TYPES OF EXPERIENCE WITH TYPES OF PERCEPTION OF GOVT. HOSPITALS

TABLE NO. 4.13

PERCEPTION / EXPERIENCE	POSITIVE					NEGATIVE					MIXED					NO ANSWER					TOTAL				
	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT
POSITIVE	4	3	-	-	7	1	-	-	-	1											5	3	-	-	8
NEGATIVE						4	8	1	2	15											4	8	1	2	15
MIXED						3	9	2	2	16	4	2	2	1	9	1	1	1	-	3	8	12	5	3	28
NO EXPERIENCE						1	5	6	4	16	-	-	1	-	1	2	6	5	1	14	3	11	12	5	31
TOTAL	4	3	-	-	7	9	22	9	8	48	4	2	3	1	10	3	7	6	1	17	20	34	18	10	82

CORRELATING TYPES OF EXPERIENCE WITH TYPES OF PERCEPTION OF GOVT. DISPENSARY.

TABLE NO. 4.14

PERCEPTION / EXPERIENCE	POSITIVE					NEGATIVE					MIXED					NO ANSWER					TOTAL				
	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT	BSL	SL	ASL	WO	TOT
POSITIVE	4	11	7	4	26																4	11	7	4	26
NEGATIVE																									
MIXED	5	7	3	2	17	1	1	-	1	3	8	13	6	3	30	1	-	2	-	3	15	21	11	6	53
NO EXP.																1	2	-	-	3	1	2	-	-	3
TOTAL	9	18	10	6	43	1	1	-	1	3	8	13	6	3	30	2	2	2	-	6	20	34	18	10	82

CORRELATING TYPES OF EXPERIENCE WITH TYPES OF PERCEPTION OF PVT. PRACTITIONERS.

TABLE NO. 4.15

USE OF CONTRACEPTION by categories

CATEGORIES / TYPE OF CONTRACEPTION	BSL	SL	ASL	WO	TOTAL
CONDOM	-	-	1	3	4
CUT (I.U.D)	2	3	-	1	6
ORAL CONTACEPTIVE PILL	-	-	1	-	1
AYURVEDIC PILL	-	2	-	-	2
TUBECTOMY/VASECTOMY	6	12	6	1	25
NO CONTRACEPTIVE BUT 'FELT NEED'	7	4	1	-	12
NO CONTRACEPTIVE	3	9	7	3	22
NO RESPONSE	2	4*	2**	2***	10
TOTAL	20	34	18	10	82

* 2 NON APPLICABLE

** 1 NON APPLICABLE

*** 1 NON APPLICABLE

TABLE NO. 4.16

Categories / METHOD ↓ COMPLICATIONS →	BSL	SL	ASL	WO
(i) VASECTOMY	4	6	5	1
(ii) TUBECTOMY	3	6	1	-
COMPLICATION OF (i)	1	2	1	-
COMPLICATION OF (ii)	-	6	1	-
RECEIVED INCENTIVE/ BENEFITS	7	10	4	-
TOTAL NO. OF STERILISATION.	7	12	6	1

TABLE NO. 4.17

HOME AND HOSPITAL DELIVERIES by categories.

	BSL	%	SL	%	ASL	%	WO	%	TOT	%
NUMBER OF DELIVERIES AT HOME	91	78·4	153	91·6	54	91·5	39	92·9	337	87·8
NUMBER OF DELIVERIES AT HOSPITAL	25	21·6	14	8·4	5	8·5	3.	7·1	47	12·9
TOTAL OF ALL DELIVERIES	116		167		59		42		384	
NO. OF WOMEN. IN EACH CATEGORY	24		36		21		9		90	

TABLE NO. 4.18

IMMUNISATION STATUS BY CATEGORIES.

	BSL	%	SL	%	ASL	%	WQ	%	TOT	%
ONLY PARTIAL POLIO+DPT	3		9		2		-		14	
ONLY BCG	19		21		4		3		47	
BCG + DPT PARTIAL POLIO	7		7		5		8		27	
ALL VACCINATIONS COMPLETED	7		13		15		12		47	
NO VACCINATION	42		70		22		11		145	
NO RESPONSE	6		16		7		2		31	
TOTAL NO. OF CHILDREN	84		138		55		36		313	
PERCENTAGE OF CHILDREN NOT VACCINATED OF THE TOTAL	50%		50.7%		40%		30.6		46.3%	

CHAPTER V

DISCUSSION

Chapter III provides enough insights into the quality of day to day life of people in New Seemapuri. In this section we highlight certain issues which we believe are critical in evolving any policy towards improving the situation of resettlement colonies.

The Changing Situation in New Seemapuri

The population of New Seemapuri constitutes the bottom in the hierarchy of the city of Delhi. They are labelled as the 'urban poor' or the 'slum dweller'. However within this broad category of urban poor, the resettlement population of New Seemapuri definitely constitutes the more secure amongst the destitutes. They are better off than the 'Jhuggi Jhompri' dwellers or squatters in temporary sites or pavement dwellers. They also have socio-economic disparities within them. Twelve per cent are economically better off in addition some are even relatively more powerful along with being economically better off.

The character of New Seemapuri has been changing over the years. It was created for the poor living in squatter settlements, near Yamuna Bazaar and I.P. Thermal power station. Initially these squatters had left their village in quest of a

better quality of life when their existence had been marginalized to the extent that their very survival was being threatened. In the cities the process of marginalization continued. While the labour they had to sell was used, they were paid very low wages for the most laborious and menial jobs. Their economic situation at the time left them with the only option of living in slum conditions with no basic amenities, where they had to struggle to survive under extremely hard conditions. Life in some ways was tougher because they had been even forced to surrender all their support systems of the village when they came to the city. The joint and extended family units had broken down. Only the nuclear units had migrated to the city. In many of the cases the men had come alone. Women had to not only look after the household and family but look for avenues to supplement the income by working outside the home. Thus many started working as domestic servants, or even resorted to begging.

When these poor squatters arrived in Delhi they tried to establish links either with caste, kin or village groups, that already lived here. Through these networks they found it easier to find jobs and adapt to the city's way of life. The migrants also tried to settle near groups of people, with whose way of life they were familiar, so that some form of a support system could develop.

The resettlement exercise of 1976 did not take these factors into considerations and groups were broken up and the people found themselves moved to different colonies on the periphery of the city. The way of life they had so carefully built up was again disrupted. They were moved far away from all they were familiar with, away from the people they knew and their work, which was integral to their very survival.

In the new situation, life had to be built up all over again, starting from constructing a new 'jhuggi', to finding alternative sources of work. Those who could not cope, either abandoned their allotted plots or sold them for a pittance to slum dwellers from other areas. This process continues to date. Whosoever amongst the poorest of the poor in New Seemapuri loses the battle for survival in the colony, through illness, death, loss of job, sells his plot or house and moves one step back, to a squatter settlement within Delhi or two steps back, to the marginalized existence in the village.

The people who have been buying those plots constitute the upper most or well off economic category. Four kinds of people comprise this economically well off category: (i) they come from other better off areas of the city and are forced to move to resettlement colonies due to the increasing cost of living and high rents; (ii) a section of the colony's original migrants have managed to better their economic conditions by

getting a permanent job (through contacts or recommendations) or by having more than one earner in the family; (iii) middle class or lower middle class people in small towns or villages working to invest some of their 'wealth' find only land in the resettlement colony within their range, and (iv) a section of the 'business class' who were original allottees to the colony or moved in prior to the 1980's are buying land as an investment in the colony. These are not only the economically well off and successful, they are also most often the most powerful or 'elite' of the colony due to their political connections and the patronage they receive from bigger power brokers within the city.

After the return of Congress (I) to power in 1980, the attitude of the administration towards the resettlement colony changed. Now they were viewed as vote banks and the people among them as a potential electorate which had to be wooed. A few environmental improvement schemes, slum development schemes and provision of basic amenities, were announced. These coincided with the entry of the better economic class of people to the colony. The 'elite' who were initially nurtured by the Congress further consolidated themselves with the return of their 'patrons' to power. It was these well off and "elite" who were also in a position to take advantage of the schemes and services provided - e.g. bank loans for setting up income

generating activity, electricity connection, applying for reserved jobs in government institutions, loans for constructing 'pucca' houses. In New Seemapuri this difference is strikingly obvious. The blocks where the majority of the well off and the politically powerful live, A, B and C are much better developed than say where the poorer and powerless live, the E and F blocks. Even amongst E and F blocks the 'pucca' 50 sq. yards or even 100 sq. yards double storeyed and three storeyed houses of the better off people stand out amongst the jhuggies and 'kutcha' houses of the majority of the poor.

Environmental Factors

Despite these economic and power differences the general environment for the colony as a whole is the same. This is primarily because the colony was initially conceived of for a certain class of people with little care taken about the quality of land. The only interest at the time was to get the slum dwellers out of sight but not so far away that their services could no longer be made use of. The land which was developed was in low lying and marshy area, where it was difficult to make a proper drainage system. Additionally it was developed through sanitary land fill programme, thus people were literally dumped on garbage. Inadequate drainage and seepage of sewage water down to the level of the groundwater has resulted in the

contamination of the source of water which is common to all resettlement colony dwellers. The frequency of cleaning efforts of public toilets, removal of garbage is also the same for all blocks. While the well off make efforts to achieve some level of hygiene, the poor are forced into acceptance, both express their discontent. This is because those who provide or plan services view the resettlement colony as a cluster of powerless people and do not make any distinction between the different categories of those who live there. The different economic levels are only obvious at the level of the colony.

While power and economic status does not and cannot make a drastic difference to the overall general environment which has an impact on health status of a population in terms of the kinds of infections and diseases that prevail, they can make a difference to other factors which have a bearing on ill health and disease. These factors are: (i) the kind of occupations people are forced to follow - thus ragpickers, who earn a living out of sorting through garbage are more prone to oro-faecal infections and toxic materials. Women from poor households involved in 'pankh ka kaam' are exposed to smoke throughout the day resulting in greater incidence of respiratory diseases and eye infections. Construction workers, coolies, 'hamaals,' hand cart pushers, and other unskilled workers are subject to great amounts of strain, chronic aches and pains. (ii) The food

intake of a person: Members of poor families usually end up doing the maximum labour for the poorest diet, both in terms of quantity and nutritional status. In their weakened and malnourished state they are less able to fight infection and disease than a better fed person exposed to the same infection. Thus it was observed that young children from poor families died more often of diarrohea due to contaminated water; coupled with their malnourished status than their counterparts from better off families. More children in the below subsistence and subsistence level families were reported to be suffering from 'sukha' or marasmus than those in the well off category. Almost double the number of children in the 1-6 year age group died in BSL and SL categories than in the corresponding age group in well off and ASL category. This shows that factors which are important for the survival of children in that age-group such as nutrition, quality of services are better for the ASL and well off categories.

Quality and Access of Health Services

Another thing which can make a difference to the health problems faced by different categories of people are the quality and quantity of services available to them. Money, power and contacts and the way of life that goes with them certainly make a difference to the availability and accessibility of health services. The well off and the powerful face fewer constraints in availing of health services; distances, costs, time, are of

much less concern to them than to the poorer class of people. Thus the well off equally use the government hospitals and private practitioners, whichever satisfies the needs and provides the maximum relief and satisfaction. They are in a position to pick and choose, the qualified private practitioner, the better hospital. For people in the poorer categories access to medical services is limited due to their resource constraints. Illness of one member not only affects the person who is suffering but it can upset the fine balance, achieved with difficulty, for the survival of the entire family. The health of every member of the family is crucial. And every decision to seek medical help has to be carefully made to maintain the balance so essential for survival. Thus, it has been observed that for general ailments adult male earners usually go to private practitioners. Since they cannot afford to go to qualified doctors they settle for the poor immitations of the local 'quacks.' Even though the service is more expressive when compared to the 'cost' of government hospitals it is perceived to be cheaper, in terms of not losing day's wages, no transport cost, quicker treatment etc. Women and children from these categories usually end up going to the government dispensary for general ailments and only visit private practitioners if the dispensary treatment is not giving relief or treatment itself is refused. Only in serious ailments do the poor go to government hospitals because then the costs of private treatment become prohibitive.

Quality of Services provided by Government Health Institutions

The services provided by the local government institutions such as the dispensary and the nearest general hospital are also the same for all classes of people of the resettlement colony. Because services were also planned and are being provided with the 'homogenous group' idea in mind. What has been observed in the context of the study population is that the well-off categories manage to avoid the negative effects of the programmes, because they can afford to go to other hospitals or to private practitioners, at the same time they are also able to take advantage of the few services they find useful. Thus their children can avail of the vaccine programme, the nutritional supplements, their women folk can go for pre-natal check ups, iron and folic acid tablets, etc.

The poor are less fortunate in this respect. They have little choice, but to go to the same dispensary and hospitals. When they go for specific services they either find that they are not available or they are refused treatment. It was seen that health services for control of communicable diseases, preventive programmes such as immunisation suffer because the emphasis of the health institutions is on family planning. Yet even when the poor people go for contraception

to the dispensary that is denied to them and they are only offered terminal methods. Those who have even accepted terminal methods find that no help or treatment is offered when they develop complications. During the cholera epidemic too when the need was for concrete treatment to be available locally and easily accessible, all that the people were really offered were useless health messages and a few ad hoc programmes such as removal of handpumps, clearance of garbage and cleaning up of toilet facilities. This did not do anything to solve the real problem of contaminated water and poor drainage and sewage.

The experential basis of response.

The rationality of those who plan or provide technical services is based on their knowledge, the information they have, their resources and experience. Similarly the rationality of the people who live in New Seemapuri is also based on their knowledge , the resources they have at their disposal, in terms of money, power, connection, time, people to spare , to take care of a sick person, information in terms of what is wrong, where to obtain the best possible help and their own experiences.

In the case of the former while experience is of one uniform kind and therefore reinforces their world views due to the numerous upheavels in the lives of the latter their experential base is also more hetergenous, varied

and at times contradictory. There is little reason for shifts in their original world views. In New Seema puri the experience of the Bengali residents clearly brought this out. The cultural assets rooted in the villages of Midnapur were rejected by the city of Delhi. By the time they became even familiar with the moves of the capital they were pushed into New Seemapuri amidst a heterogenous group with which they shared nothing. They were looked down upon by them for their forms of livelyhood and hence there was little support from any quarter and no help in crisis situation (case report no.9, Chapter III, page no. 42)It is not surprising then that some times people have to cling to all their resources including their belief systems for their survival.

Responses to health problems are also to a very large extent determined by where people stand in their present world view. World view is not determined by experience alone, but incorporates traditionally transferred and new knowledge, information and resources available. It is also not a stable framework - rather it undergoes a change as one or another of the determining factors is introduced. World view is important from the point of

understanding responses to health problems. Those who stand in a position of power, such as the well off and elite in New Seemapuri, and are able to make a perceptible difference to ill health by reaching and availing of modern scientific medicine, have a relatively modern concept of causality. Magico-religious belief is not so strong in them. On the other hand someone who feels relatively powerless, such as is common among the Bengali migrant community in the below subsistence level (who are culturally and economically the most alienated and vulnerable due to their minority status), the magico-religious belief is stronger because the quality of modern scientific medicine, their economic position and constraints allow has often not helped alleviate suffering from ill health. This experience does not promote shifts in the understanding of causality.

These different perceptions of causality however have not necessarily meant difference in their reaching out patterns. In fact as we have already argued 60 per cent of the well off retained their traditional health practices as against 35 per cent among the poor. This however was confined to illnesses like cold, U.R.I., pain, fever, diarrohea which are essentially self limiting.

This brings out an interesting relationship between practices and internal belief systems. The

well-off use more of allopathy though not government services - in serious illness and are inclined to newer ideas about causality but the poor who may use more of allopathic services specially government facilities, are in fact less inclined towards changing their beliefs regarding causality. This is essentially because of their poor experience with it.

This tendency to fall back upon one's traditional beliefs was highlighted by the specific category of Sabla Sangh's local women health workers. This is a group that can be said to have the maximum information. They are able to analyse the socio-political existence and identify factors for their exploitation and, powerlessness. Despite all these inputs from time to time they lapse into a magico-religious explanation for causality when either they do not really understand what went wrong or they feel to weak to be able to intervene. Prem, a health worker herself, had not been able to conceive till after 8 years of being married. When she did finally conceive in October 1988, her pregnancy ended in a miscarriage. She has not been able to conceive again. Every time faith healers talk of curing infertility, she gets interested and had at one point admitted that she believed that they had an explanation for her problem. In their work also they often reort to

"fate" and "god's will" while consoling a distraught family.

This vacillation in and out of the modern view of causality and into a magico-religious view of causality largely results in a set of actions wherein, amongst the powerless the dependence on faith healers who confirm the magico religious view of causality is quite high, while in the powerful it is much less. Nevertheless, it has to be acknowledged that people are learning to use modern scientific medicine. This is primarily because their own systems do not exist any more and secondly, among the existing choices, modern medicine despite all its negative dimensions still carries maximum hope of survival. The negative image of services is created by factors such as -

(a) rude behaviour of the staff
(b) lack of adequate services
(c) poor quality of medicine and skills
(d) misinformation
(e) withholding of information
(f) the expense involved
(g) time consuming procedures
(h) emphasis on family planning.

Our data provided sufficient evidence of those, especially in areas like family planning, cholera, etc. More people

from the poorer categories in Seemapuri have also been seen as turning to modern systems of medicine, in place of traditional systems of healing. This is because greater constraints are experienced by people in vailing the necessary ingredients. In nuclear units, a lot of knowledge has been lost and with the loss of traditional support systems traditional practices also cannot be observed. The well off people who have fewer constraints and can maintain their cultural and traditional integrity better still retain the use of traditional systems of healing more than the poor. The traditions and values of the well off have also suffered fewer upheavals and setbacks because they were the least likely to have experienced the trauma of marginalisation either in the village or that of resettlement in the city.

Table Nos. 4.12, 4.13 and 4.14 correlate types of experience with types of perception. What is significant here is that despite the quality of experience at government hospital and government dispensary, people from all categories have an overwhelmingly negative perception of these institutions. The possibility of a positive perception is highest when the experience has been positive. From the table, it is clear that in the case of mixed experience, which includes some positive experience the perceptions are mainly negative. This is not surprising considering the majority of people we

are talking about have lived constantly marginalized existence and the forces that have forced them into this life of deprivation are also reflected through the health service set up. Thus the sense of distrust, suspicion essentially controls all responses.

The implications of this are clear that if an improvement has to be made in people's overall way of life and quality of life, their experiential basis has to change. It is only when their experiential basis change that people's response also changes making them deal more effectively with their health problems.

While this is a general reality, itssignificance for the study population is extremely crucial. A people with very little confidence in their surroundings, a perpetual experience of exploitation and dehumanisation have a tendency to look at all interventions with suspicion.

It is for the planners and implementators to prove to them that their intentions are genuinely in the interest of the people. The experience of the cholera epidemic shows that massive campaigns however limited do elicit positive responses from the people.

It is important then to shift the approach of intervention from one which attempts to 'civilize' people

to one which creates a situation in which people's potentialities for a civilized existence can flower and enrich themselves through help and information provided by the services.

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CONCLUSIONS

1. The process of creation of slums is a dynamic, ongoing process. Resettlement colonies are among the better residential localities in this general category where entrance and eviction are constantly at work.

   The original allottees who were 'lucky' enough to get some plots but are amongst the most powerless of the residents, face constant threat to survival. This threat comes from a new class of people, who are comparatively well to do city dwellers. They generally have security of permanent jobs and at times also some social and political connections. They come into the colony either in search of cheap land deals, lower house rents or for specific purposes of business such as 'Kante Wallas'. These families come either from different parts of the city, from within the colony (such as those who earn enough to be able to but their own land and small business) or from other villages and small towns.

   Very often the pressures from this up coming class is so strong that the poorest are forced to sell out and move further away into the perpheral slums.

2. This creates divisions within the resettlement colonies

where, though all share an unhealthy dehumanising physical enviornment, the well of alone are able to circumvent some of it.

3. Depending upon their social situation, different categories live under different levels of socio-economic and political deprivation.

4. The implication of these for health are very significant as health is an outcome of the interaction of various socio-economic, cultural and political forces within the context of the resettlement colony.

5. The physical environment has direct implications for health. Firstly, the deprivation of people makes them more vulnerable (in terms of their nutrition status, physical protection through housing, clothing and services) and secondly, given the degredation of the enviornment, people always are at a higher level of risk of epedemics and endemics of a wide veriety of diseases.

6. The poor quality of health services is not due to scarcity so much as to the total approach of the health personnel in local dispensaries as well as the big hospitals.

7. The apathy, indifference and exploitative behaviour of the government insitutions pushes people into the hands of

private practitioners who exploit them but at least satisfy them to some extent.

8. The constant struggle for survival and their perpetually changing situation creates a panorama of world views dissolving into each other. This variety of beliefs a single individual is a means of coping with their contradictory existence where they are constantly chosing the least of the evil.

9. Often seen as their "fickle mindedness", unreliability and untrust worthiness, this fluidity of belief and response is the most critical aspect of the individuals in slum situations.

10. If handled correctly, this vacillation can be tackled by providing an experiential base which reinforces their trust and faith in the services. It is only through a constant reinforcement of this nature that their responses can become more predictable and acquire the rationality of those who plan. Without it, no amount of coercion or force will make people change their views or belief patterns.

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ANNEXURE

COPY OF THE INTERVIEW SCHEDULE

Socio-Economic Survey of F-Block, New Seemapuri

SURVEY FORM NO. PLOT NO. DATE:

NAME OF RESPONDENT: AGE:

PART ONE Village, migration and resettlement history

1. Name of the state, town, village or city, to which you belong.
2. What work did you (or your parents) do in the village.
3. Who was the first migrant to Delhi from your family.
   - When did you come.
   - Who did you come with
   - Where did you stay on arrival
   - Why did you come to Delhi
4. What work did you do in Delhi before resettlement.
5. When did you come to New Seemapuri, from where in Delhi did you come.
6. Describe the experience of resettlement and the conditions for survival in the first one or two years.
7. How many plots/houses do you own in New Seemapuri
   - How did you obtain them
   - If bought, for how much
   - If staying on rent, how much
8. Quality of housing - kutchcha, pucca, jhuggi
   - If not pucca - why not
   - If pucca - how many storeyes

9. What are your present links with the village
   - Who lives there
   - What do you own there (land, animals, house)
   - Do you send any money (or get anything from there)
10. How often do you visit the village, for what purpose.

PART TWO — Household information

11. Size of family:

    adults: (above 15 yrs.) male: female:

    children: (below 15 yrs.) male: female:

    Joint family or nuclear
    (any parents/grandparents in the house)

12. How many working members in the household (earners)
13. Description of work of each earner in terms of - occupation followed, income, place of work, hours of work (if household based activity, how many women from the family contribute; if labour is employed/hired - how many, wages paid).
14. Income from any other sources - describe.
15. Level of education
    adult males
    adult females
16. Religion: Caste:

Basic Amenities

17. Where do you get water from
    - for drinking
    - for washing and bathing

- If you do not own a tap or handpump, why not?
- Do you face any problem in getting water, elaborate.
- Any other information.

18. Which toilet facility do you use (old govt. toilets, Sulabh Shauchalaya, own toilet, open ground)

men- women- children-

- If you do not use Sulabh Shauchalaya, why not.
- What do you think of the old government toilets, in terms of adequacy, levels of cleanliness, and maintenance.
- Where do you bathe -

19. Do you have electricity in the house? If not what do you use.

- If yes, what is the source.
- If you do not have your own meter, why not
- Do you have any other problems with regard to electricity.

20. Where do you dispose your household garbage - (your occupation related garbage)

- How far is it from your house.

21. What is the state of the drains outside your house (broken, kutchcha, do not exist).

- How often are they cleaned.
- How often is the road/gali swept.

22. Do you have any complaints or any other comments about the drainage or levels of cleanliness.

23. What consumer items do you own (fan, radio, T.V., cycle,

scooter, etc.)

PART THREE — Household Expenditure

24. What do you cook on (wood fire, coal, kerosene, gas).
    - How much does it cost every month.
25. How much do you spend on food (each day/month).
26. Do you own a permanent ration card, if not why not.
    - Are all members of the household enumerated on it.
    - Is the allotted ration adequate.
27. What do you eat in a day, in terms of number of meals, cereals, dal, vegetable, fish, meat.
28. How often do you buy milk and fruits, for whom and how much.
29. Do you have any savings at present (how much).
30. Are you presently in debt? How much? For what purpose did you take the loan, from whom and what is the interest.
    - Any other information.

PART FOUR — Health Related Information (since living in New Seemapuri)

31. Have you ever been to a government hospital.
    - If no, why not
    - If yes, which one, for whom, what ailment, when, how much did you spend (transport, medicines, etc.)
    - Did you find the treatment useful/beneficial.
    - Describe your experience of the visit and the service you received.
32. Have you ever been to the local dispensary.

- If no , why not
- If yes, for whom, what ailment, when, did you find the treatment useful/beneficial.
- Describe your experience of the visit and the service you received.

33. Have you ever been to a private practitioner
- If no, why not
- If yes, which one, for whom, what ailment, when, how much did he charge.
- What was your experience of the private practitioner.

34. Have you ever tried faith healing.
- If no, why not
- If yes, for whom, what ailment, when, cost incurred. Did it prove helpful/beneficial.

35. Have you ever used home remedies.
- If no, why not
- If yes for whom, what ailment, what did you use, what did it cost, was it useful, helpful.

36. If any of the above treatment 'fails' what do you do next.

37. Which do you prefer, government hospital, government dispensary or private practitioner, why? (make a comparison of private practice and government services).
- Have you taken treatment from any other source, describe.
- Any other information.

38. How much do you spend on a month on health treatment (cost of medicines, transport, doctors fee, etc.)

Long Term Morbidity

39. Does anyone in your household have a long term illness/ problem (T.B., leprosy, cancer, long fever, asthma etc.)
- Who, since when.
- Is he/she taking treatment, from where
- How much have you spent on treatment so far
- What is the effect of this morbidity on the household.

Adult Mortality

40. Has any adult member of your family died since your coming to New Seemapuri? Who, when
- Of what ailment/illness
- For how long had he/she been ill before dying.
- Where did they go for treatment
- What was the cost incurred
- Impact of this on the household.

Health Education, Extension Services

41. Does anyone visit your area to give health related information or services, who?
- Do you recognise/have you ever seen/been visited by malaria worker, ANM, LHV.
- If yes, how often, what did they do.

42. Why do you think people fall ill.

- Any other information, complaints or suggestions.

PART FIVE — Information on children and reproductive history

43. Age groups of children

	male	female
< 1		
1 - 3		
4 - 7		
8 - 14		

44. How many male and female children go to school. If not, why not.

45. How many times did you conceive.

46. How many live births/still births

47. How many abortions did you have, were they induced or spontaneous.

- in which trimester
- if induced, why
- where did you get the abortion done, by whom, what did it cost.
- any problems after the abortion.

48. Of the children who died (in Delhi) how many male, how many female.

- at what age
- of what illness/ailment
- did you seek any treatment, what, where, cost incurred.
- if no, why not

Deliveries

49. How many before coming to Delhi -
How many in Delhi - home, hospital
- If home delivery, why, who attended.
- If hospital delivery, why.

50. Experience of delivery, elaborate, any problems.
- How much spent on each delivery.

51. Compare hospital and home delivery (if been to both) in future which will you prefer.
- Any other information.

Prenatal Care

52. In how many pregnancies were you covered by tetanus toxoid (how many shots did you take, from where and who gave you information.)
- Did you have any other checkups, where.
- Did you have any other problems, what.
- Did you take any special food, tonics, vitamins, etc. - who prescribed.
- Any other information.

Post Natal Period

53. Did you have any problems during post-natal period - what, where did you go for treatment.
- Did you receive any care, special diet, nutritional supplements during this period, what, who gave it.

Immunisation

54. How many of your children are covered by immunisation.
- What type, how many doses of each
- From where.
- Where did you get this information.

PART SIX Family Planning Programme.

55. Have you or your spouse been sterilised
- When, where, why, any incentive received
- Any problems after sterilisation, what, any treatment taken, where.

56. If not sterilised, any contraceptive method is followed? If yes, what, since when, why and where did you get it.
- Any problems with use of contraceptive, what, since when, any treatment taken, where.

57. If nothing is being used do you wish to use anything, to limit family size/space children.

58. What do you feel about family planning and the programme.

59. Any other information, comments, suggestions.

PART SEVEN Cholera Epidemic

60. Was anyone in your family affected during the epidemic of 1988?
- If yes, who, what happened, what did you do (in terms of treatment), where.

61. What was the impact/fall out of the epidemic in your

gali/block/colony.

PART EIGHT Environment

62. How do the safai karamcharis usually behave, are they co-operative.

63. What is the attitude of people in your gali/immediate neighbourhood about cleanliness (if Kabaadiwallah or pankhwallah, about your occupation).Do you face any problems. Have you ever had fights/tension over the issue of 'safai'.

64. Have you ever complained to the authorities about basic amenities, civic facilities (individually or collectively), what did you do, when, what happenned after that.

65. Who do you think is responsible for your filthy/degraded environment.

OTHER INFORMATION

Briefly comment on the following:

1. The family environment, domestic and marital violence and tensions.

2. Status of women in the family, attitude towards women in the family, in the basti, do they face any special problems.

3. Whom do you approach for help in times of need.

4. What is your relationship with your neighbours like, do you visit often, intervene on quarrels, help out during

times of need.

5. Any problem of alcoholism, drug addiction in the family or immediate neighbourhood (source of alcohol, drugs etc. - where obtained), impact of this on family, children, social environment.
6. Any gambling in the family, neighbourhood, its impact.
7. Comment on the problem of unemployment, why do you think there is unemployment, any suggestions.
8. What is the general attitude of the police, have you had any experience of them, comment.
9. What is the general attitude of local leaders, what do they do. What do you think about them.
10. Do you belong to any group, organisation, union or party? Who did you vote for last time, who will you vote for this time, why.
11. Have you ever participated in a demonstration or procession? When, where, for what issue, with whom.
12. Do you read the newspaper, listen to the radio, discuss topical issues, such as what and with whom.
13. What festivals do you celebrate, how.
14. How much free time do you get in a day, how do you spend it, do you watch T.V., go for films, or go out? How often.
15. Are you happy with your life as it is at present. Who do you think is responsible for your present situation/ condition.
16. What do you think you can do to change your present

situation.

17. What are your hopes/aspirations for the future.

18. Any other information, comments, researcher's observations.