STUDY OF HEALTH PROBLEMS AND PRACTICES OF UNDERPRIVILEGED WOMEN AND CHILDREN IN "BHUMIHEEN CAMP" - A SLUM OF DELHI

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CERTIFICATE

Certified that the dissertation entitled **STUDY OF HEALTH PROBLEMS AND PRACTICES OF UNDERPRIVILEGED WOMEN AND CHILDREN IN 'BHUMIHEEN CAMP' - A SLUM OF DELHI**, submitted by **MISS KOUSHAMBHI BASU** is in partial fulfillment of six credits out of the total requirements of twenty four credits for the award of **MASTER OF PHILOSOPHY (M.PHIL)** of this university. This dissertation has not been previously submitted for any other degree of this or any other university and is her own work.

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

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LIST OF ABBREVIATIONS

1.	AIIMS	-	All India Institute of Medical Sciences.
2.	ANC	-	Antenatal Care
3.	i.e.	-	That is
4.	MCH	-	Maternal and Child Health.
5.	MCD	-	Municipal Corporation of Delhi
6.	DDA	-	Delhi Development Authority
7.	NGO	-	Non Governmental Organisation

CHAPTER -I

INTRODUCTION

INTRODUCTION:

VULNERABLE GROUP - MOTHER AND CHILD

Bearing children is the unique privilege and function of women. In India, women of the child bearing age (15-44 yrs.) constitute 22 percent and children under five year of age 17 percent of the total population (Kapil, 1980).Pregnancy and child birth which are although normal biological functions of women, expose them to certain special risks and dangers. Women in the reproductive age groups, especially among the lower socio-economic groups, are often found to be either pregnant or nursing the infant. Pregnancies take place too early, too often, too close, leaving behind exhausted anemic and crippled mothers (Ramalingaswami, 1986). For infants, the risk of dying is very closely related to the environment in which they live, because they are ill-equipped to deal with infection, inadequate food and lack of elementary hygiene. While the baby is in his mother's womb, the health and nutrition of the mother, her age and the number of children she has and the interval between them, care during pregnancy, all have profound influence on his survival and optimum growth (Ghosh, 1987). Thus infants and expectant mothers constitute the most vulnerable sections of the population, especially among the lower socio-economic groups.

Good health, good nutrition, adequate medical care and bearing children during optimum age, help to reduce maternal risks. On the other hand, bearing many children at short intervals and pregnancy at very young age or late in life increase the risks of maternal mortality. The other important

factors which are responsible for high maternal and infant mortality rates are poverty, low socio-economic status of women, especially the low female literacy. Under nutrition, over crowding, lack of protected water supply, poor environmental sanitation, low levels of education, the attitudes and perceptions of mothers, the traditions and taboos observed during pregnancy and with regard to infant feeding practices, all act to produce the backdrop to the high infant mortality often associated with high maternal mortality (Ramalingaswami, 1986). WHO has recommended a risk approach (WHO, 1978) to health care which would reduce infant and maternal mortality by timely identification of risks, appropriate training of the health workers and adequate referral facilities. In India, it is important to include the social and economic criteria among the risk factors (Ghosh, 1987). One cannot do anything to prevent this risk, but certainly one can give the vulnerable group priority care.

While it is true that child's health is dependent on the mother's, there is no justification for concentrating on women's health only during motherhood. In taking such a view the medical profession seems to be totally unconcerned with what happens to the woman before, between and after her pregnancies. Apart from maternity care, the health services have contributed little to overall health of women. The causes that lead to the unnecessary deaths of so many women, most in the prime of their lives, originate long before their pregnancies and extend far beyond the realm of medical care. They are the result of a complex

interaction of factors rooted in the social and economic contexts in which Indian women are placed (Shiva, 1992). The high rate of maternal mortality in India does not merely reflect the abysmal conditions of services which are supposed to ensure safe child birth and care during pregnancy, but also indicate the chronic neglect of women since childhood and pressures on them. It is linked as much to nutritional status as to literacy, age at marriage and birth spacing. In a social environment, where decisions regarding their health are not taken by women, where they are the main victims of scarcity and neglect within their own families, health strategies for women should be formulated only by fully integrating women's role as a mother with other aspects of her life (Qadeer, 1991). The cummulative effect of poverty, undernutrition and the neglect of the girl child in all spheres is reflected in poor body size during pregnancy and child birth, and high maternal and infant mortality (Shiva, 1992).

It is increasingly recognized that urbanization leads to special medical problems which have been emphasized by WHO in 1963. "Malnutrition, poor housing, over crowded living conditions and insanitary surroundings exert their harmful effects particularly with health of the mothers and children, who constitute a highly vulnerable group among the slum population in urban areas of developing countries". The health problems of infants and mothers are to be seen not in isolation but as part of the major problems of poverty and poor environmental sanitaiton. Respiratory infection and diarrhoeal diseases are more frequent in children living in over crowded dwellings with

poor light, ventilation and sanitation. In fection and undernutrition play a synergistic role in progressively undermining the health of mothers and children in slum population.

SLUMS:

Slums have been the corollaries of urbanisation in nearly all societies going through the transition from an agrarian civilizatoin to an industrial one (Roy and Bijlani, 1991). Bose (Dube, 1977) has pointed out, the process of urbanisation has been essentially a process of migration to the city. When migrants reach the city they invariably find themselves pushed into the slums or squatter settlements. Majumdar and Singh have pointed out that the primary reason for rural urban migration is economic, and the rural people migrate to the cities in search of employment rather than better employment opportunities (Desouza, 1978).

There is no general agreement on the definition of a slum. Slum is defined by the United Nations (1952) as a "building a group of buildings or areas characterized by overcrowding, deterioration, insanitary conditions or absence of facilities or amenities, which because of these conditions or any of them endanger the health safety or morals of its inhabitants or the community". Local conditions are, however, taken into account while defining the "Slums", as it needs to be viewed in the context of general and economic and housing conditions in the area.

An estimated 30 percent of the urban population in 12 major cities in India live in slums (National Building Organisation, 1981). With the country's present urban population standing at 217.18 million (1991 census) slum dwellers form 50 percent of the population in Delhi, 38 percent in Bombay and 42 percent in Calcutta. Thus, around one fifth of India's urban population lives in slums (State of India's urbanisation, 1988). Slums manifest themselves in a variety of forms and take on different names like the multi storeyed concrete Chawls of Bombay, the dilapidated katras of Delhi, the Cheris of Madras, bustees of Calcutta and Jhuggis in Northern India.

After independence, Delhi has become the main gravitational point for migrants from different states. With concentration of the administrative machinery in Delhi as the pull factor and rural impoverishment as the push factor, slums have emerged as an essential component of this major metropolis (Chakraborty et. al, 1993). Delhi has more than half of its population living in slums (State of India's Urbanisation 1988). It is estimated that out of Delhi's total population at present about 75 percent live in substandard areas with break up of 1.4 million in unauthorized colonies, 1.0 million in jhuggi clusters, 1.0 million in resettlement colonies, 0.3 million in urban villages, 0.5 million in rural areas and 1.8 million in slum areas (Basu, 1988). The slum areas of Delhi are classified into a) planned developed resettlement colonies b) notified slum areas c) unauthorised colonies and jhuggi jhompri clusters. There are 47 resettlement colonies, 33 notified slum areas and more than a

thousand unauthorised jhuggi jhompri clusters spread all over Delhi (DDA). More over there are instances of encroachment of unauthorised dwellings into resettlemnt colonies, thus evolving case of slums within slums (Sabir Ali, 1990).

In his study of squatter settlements in Delhi, Majumdar (1975) identifies the social characterisitics of urban poor as being largely migrants from villages (93 percent), a disproportionately large percentage belonging to scheduled and lower castes (65 percent), majority of them (43 percent of males) being illiterate and working in informal sectors where entry is easy, requiring less skills, less education, and less capital. Hence Majumdar argues that "the urban poor are the same as those in the rural areas - both lying at the bottom of social structure and suffering from cumulative inequalities". However, in contrast to villages, the urban complex offers scope to urban poor for overcoming limitations of caste to acquire new skills and find employment on the basis of skill, although it is doubtful how far they succeed in this endeavour.

HEALTH SCENARIO IN SLUMS:

Slum areas are characterised by overcrowding, poor environmental sanitation, inadequate infrastructural amenities like sewerage lines, protected water supply etc. and proliferation of socio-economic maladies. The inadequate public facilities and services, and the unhygienic conditions of the slum environment obviously have severe consequences on the overall health of the community. Urban slum population, a heterogenous floating group of people, economically and socially

deprived do not have their own health care systems (Desai and Pillai, 1972). Amidst medical institutions of excellence which may provide intensive and sophisticated medical care, there is almost total lack of basic health care facilities for the poor, especially the slum dwellers. The responsibility of providing basic health care services to the urban poor and slum dwellers lies on the local municipal bodies which do not have adequate resources, facilities and infrastructure to discharge their responsibilities towards the health of the people.

The Town and Country Planning Organisation (TCPO) survey of four squatter settlements of Delhi in 1975 (Singh and DeSouza, 1980) found that slum dwellers themselves complained mostly of stomach disorders, fever and measles, while doctors cited dysentry, diarrhoea, hookworms, round worms, malaria, typhoid and tuberculosis as the most common health problems in the slums. Other studies on health situation in Delhi slums (Gupta, 1990; Bhatnagar et al, 1986) also found high prevalence of respiratory disorders, TB, digestive disorders, rheumatic diseases and unqualified fever among the slum population. From the study conducted by institute of urban affairs, New Delhi (1988), it has been seen that the health problems of urban slum dwellers are directly related to their poverty, the polluted and stressful urban environment and their social instability.

There are no accurate statistics regarding general mortality rates among the slum dwellers in major cities. Wiebe (1975) cites the 1961 study of slums in Madras which found that although slum areas have a birth rate which is 43 percent higher

than non-slum areas, they have a death rate which is 50 percent higher. Infant mortality rate has been regarded as the most sensitive index of the health status of a community. The National Institute of Health and Family Welfare (NIHFW) study among 4 slums of Delhi reported an infant mortality rate (IMR) of 86 per 1000 live births over the year 1983-84 (Bhatnagar et al, 1986). An important finding of TCPO's study (1975) in Delhi was that child mortality rates (220 or 204 for males and 237 for females) varied considerably among the various castes and regional groups included in the study. Income, child rearing practices, and mother's employment appeared to be important factors contributing to this variation (Singh and DeSouza, 1980).

Although modern urban health facilities are awaited of by the poor, they are often far away from the slum, and too expensive. The study of Prasad (1974) revealed that maximum people were not utilizing the curative health services till they become seriously ill because they could not afford to loose their gainful employed time in the early stages of the disease in attending to the clinic or hospital and their economic state was not allowing them to go to the private practitioners. However, when they are forced to seek treatment, the slum dwellers prefer to go to private health services rather than government. The general view of the slum dwellers is that going to a government dispensary is more time consuming which they cannot afford.

The survey done by Bharat Sevak Samaj (1959) showed that 65 percent of slum dwellers received treatment for illness from

private practitioner and only 29 percent from government hospital or municipal dispensaries. Studies of Bhatnagar et al (1986), Bijlani and Roy (1991) have also revealed similar percentages regarding the preference of slum dwellers for private health services than government. A study conducted in a slum of South Delhi (Kumar et al, 1991) has highlighted the role of mobile health services in provision of medical relief to slum dwellers. The average time spent in mobile clinic was upto 30 minutes (as reported by majority) and of the 52.5 percent of slum dwellers availing mobile health services, 62.6 percent felt "satisfied" with the kind of services provided by the mobile health clinic (run by AIIMS). Thus, it seems that poor voice an almost universal priority for better health facilities nearby, at costs which they can afford (Singh & DeSouza, 1980).

STUDIES ON MATERNAL AND CHILD HEALTH IN SLUMS:

Most of the studies on urban slums have depended on data collected from the household head who in a large majority of cases, is male and thus such studies ignore almost entirely the needs and priorities of women and family. There have been only few studies specifically on slum women bringing into light the slum women's status, their basic needs and priorities, the strategies women employ to cope with conditions of absolute poverty and insecurity resulting from migration (Fernandes, 1991; Singh, 1980). The low caste urban poor women are victims of cummulative inequalities, i.e. they accumulate in themselves all the disadvantages of the division of society into urban rural, upper lower class, high low caste and male female

categories (Fernandes, 1991). Even after migration to the city, the urban poor women continue to be denied access to education, health and other services more than urban poor men are deprived of them.

The study by Singh (1980) among 4 bastis of Delhi found that the harsh physical environment of the basties (especially the gross inadequacy of public utilities and service) created special problems for the well being of the family, particularly for women who carry out most of the domestic work of the family, and children whose vulnerability can be demonstrated by their high rates of mortality. A large majority of those included in this study lived in nuclear families, but they maintained extensive kinship and caste networks within the slum which provided valuable friendship and psychological support to women and the family in addition to more tangible benefits like small loans, finding a job, and a place to stay. Fernandes's study of 10 slums in Delhi also showed that women's caste or ethnic group in the slum acted as coping mechanism to deal with the problems that slum women had to face as a result of staying in the slum.

An important finding of Singh's study (1980) is that women in slums are more prone to illness than men. The most frequently cited ailments in the slums were fever, cough, malaria, and diarrhoea and females suffered from all of these symptoms and diseases more than males. Gupta's study (1990) points out that slum women are engaged for long hours in household chores. Chronic conjunctivities and upper respiratory problems due to

sitting in front of a fire and chronic backaches, headaches are constant health problems of slum women. But unless they are very sick, they do not pay attention for existing social reality the health of women is not a priority at all.

Pregnancy and child birth are major health risks for urban poor women living in slums. A study in slums of Maharashtra and Gujarat (UGC-DRS Project, 1989) looked into the effects of micro environmental conditions like poor housing and sanitation and macro environmental influences of social, economic and cultural variables on health of pregnant women, nursing mothers and children below five. The study revealed that a higher pregnancy wastage was associated with maternal age less than 15 years at first conception, short birth spacing (less than 2 yrs.) working women and deliveries conducted by "unskilled dais." In the underprivileged women studies, weight gain during pregnancy was found to be inadequate and this was mainly attributed to poor dietary intake, consumption of less food during pregnancy for fear of complicated delivery and other food taboos observed during pregnancy. Only 9.2 percent in Maharashtra and 33 percent in Gujarat women took nutrient supplements during pregnancy. Satpathy's study (1987) showed that even imparting knowledge about need for extra nutrients and special diet during pregnancy to women does not help the situation since they either consider it unnecessary (based on their past experience) or are unable to take the extra food due to the existing socio-economic reality.

Number of studies have been done in urban slums on health of pregnant mothers, their utilization of health services during pregnancy and the factors associated with it. Kapil's study (1980) in a semi urban locality of Delhi showed that around 27 percent of pregnant women had "high risk" factors (as laid down by WHO, 1978), while Dutta's study (1990) in a semi-urban community in Pune found the prevalence rate of high risk pregnant women as 44.65 percent. These findings prove that pregnancy and child birth are major health risks for urban poor women. The study done by Grover and Roy (1988) in Kalkaji (Delhi) slum revealed that only 19 percent of the pregnant mothers were aware of the importance of medical care during pregnancy and got themselves registered at maternity centre, although 43 percent of pregnant mothers were found to be anaemic. Murthy's study (1990) further shows that only 11.7 percent of pregnant mothers (utilizing antenatal care services) registered in the first trimester and only 25 percent paid three or more visits in pregnancy. This indicates lack of motivation of women with regard to not only the ante natal care services but to the general health services also. They seek treatment for their health problems only when it is in acute stage, otherwise giving no priority to their health.

Both Kapil's (1980) and Dutta's (1990) studies have linked utilization of ante-natal services with literacy, maternal age, income and socio-economic class. The studies show that utilization of health services during pregnancy increases with

increase in educational status of both wife and husband (more in case of wife), increase in per capita income and socio-economic class but that there is an inverse relationship between maternal age and utilization of antenatal care services. Further the studies reveal that ignorance about existing health facilities and unawareness of the need for medical care during pregnancy are the main reasons for non-utilization of health services. Moreover in a study conducted in Delhi slum, Sapru (1974) observed that distance from the health centre beyond 3.5 KMs was found to be strongly associated with lowered utilisation of maternal and child health services. Grover's study (1988) explain non-utilization of ante-natal services by heavy domestic work that slum women are required to do, difficulty of leaving small children alone at home, and lack of regular service provided by para-medical staff. The findings of these various studies thus indicate the important influence of social and economic factors on utilisation of health services by slum women during pregnancy.

Further, a number of studies have reported that most slum women are still delivering at home and that too by untrained "dais". According to NIHFW study of slums in Delhi (Bhatnagar et al, 1986), 74 percent of all deliveries were conducted by untrained "dais" while Grover's study (1988) showed that only 18 percent of slum women had their last delivery in the maternity centre or hospital. Thus although slum women are living in very proximity of available health services of all systems and categories, yet they are unable to avail health and

medical care due to the interplay of various social, cultural and economic factors.

Children are most vulnerable group to diseases, disability and death. The health and nutritional status of the children is likely to be influenced by the quality of the environment in which they live. The TCPO (1975) study in Delhi slums found the major causes of child mortality as airborne or virus infection (29.5 percent) and water borne diseases (16 percent) which clearly shows that the unhygienic environment and crowded conditions of slums are directly responsible for high rates of child mortality and morbidity in slums. A study of Agarwal and Katiyar (1981) compared the morbidity rates of under five children in urban areas, urban slum and rural areas of Varanasi. It was observed by them that the incidence of morbidity was higher in urban slum and rural children as compared to urban group and that it was significantly higher in those children who lived in 'Kachcha'/mixed houses, having inadequate ventilation consumed water from open wells or handpumps and had the habit of open field defecation as compared to those living in pucca houses with adequate ventilation utilised tap water and were using service latrines. Another study in urban slum and rural areas of Maharashtra and Gujarat (UGC-DRS Project, 1989) found that peak age for morbidity was 10-35 months and that nuclear family system, large family size, low income groups, illiterate mothers and 'Kuccha' housing were some of the factors positively related with morbidity in children.

Nutritional status of children in low socio-economic groups depends on several factors and the causal relationship between malnutrition, ecological factors, socio-economic status and health are complex. There has been some studies on nutritional status of infants and children in urban slums and the factors responsible for it. A study conducted in urban slum of Bhopal (Dwivedi et al, 1992) showed that prevalence rate of malnutrition among children under five years of age was 63.4 percent, while Singh's study (1980) in Delhi slums estimated that at least 40 percent, and possibly as many as 60 percent of the children between the ages of one and five suffered from various degrees of malnutrition. Dwivedi's study reveals that malnutrtion among children increases with family size, birth order, infections and worm infestation whereas this decreases with socio-economic status, father's literacy status, birth interval and immunization status. He argues that malnutrition is a man made disease and is totally preventable through due course of care.

Another study (Khanna et al,1984) compared the effects of socio-economic status and mother's education on child care and feeding practices in normal and malnourished children in urban slums of Bombay. The study revealed that in the normal group illiteracy rate was 20 percent and only 16 percent had monthly income less than Rs.50 per head, whereas in malnourished group illiteracy rate was 40 percent and 46 percent had income less than Rs.50 per head. Their study further showed that 65.6 percent mothers of normal group fed colostrum as compared to 20

percent in malnourished group and about 64 percent of normal children received their first feed 4-6 hours after birth as compared to 10 percent in malnourished group. Thus poverty, low literacy status, poor environmental sanitation, which are inherent in the slum dweller's life lead to improper modes of infant care resulting in high risk of malnutrition. Further in a majority of malnourished children in this study, poor growth and development was due to prolonged breast feeding beyond 6 months of age along with faulty weaning practices, which resulted in inadequate intake of protein and calories and poor hygienic conditions and faulty sterilization led to frequent diarrhoeal attacks.

Prolonged breast feeding (mean duration of 22.7 months) leading to high risk of malnutrition was also found in urban slums of Maharashtra and Gujarat (UGC-DRS project, 1989). However, Chijkara and Gupta's study (1986) in a Delhi slum showed a tendency towards early discontinuation of breast feeding among slum women and they observed that the main reason for this was the nuclear family set up, where the traditional teaching by elders at home to initiate and continue breast feeding was no longer available. Further, it was found (UGC-DRS Project, 1989) that the transition from breast milk to adult food in children was abrupt, with semi solids never being introduced in case of 85 percent children and the meals prepared were the same as for adults and were mostly cereal based (thus deficient in protein and vitamins). The introduction of supplementary feeding under poor environmental conditions poses additional hazards of infection.

Dutta's study (1984) in a slum area of Pune highlights that utilisation of child health facilities is conditioned by a number of interacting factors, among which type of family, social class and literacy status is of vital importance. The study showed that utilisation of health facilities increased to a large extent with the rise in educational and occupational status of father and mother (but to a lesser extent in case of mother). Utilisation was significantly higher in case of children from joint families which probably indicates that more members in the joint family could help in utilizing existing health facilities for children. The reasons for non-utilisation were ignorance about need for immunisation, time constraint, and lack of regular visits by para medical staff (Dutta 1984, Kapil 1980). TCPO's study (1975) in Delhi slum further provided some evidence that females child received less medical attention when ill. The findings of the study showed that 29.3 percent of female children died from unknown causes compared to only 22 percent of male children. This has important implication regarding child's right to life, and the fact that discrimination against girl child begins right from birth.

RATIONALE OF STUDY:

The term 'underprivileged' denotes those segments of population who do not have a normal standard of living or rights in a community and thus include the economically weaker sections, socially weaker sections and geographically inaccessible groups, as also the victims of social, political and religious turmoil (Basu, 1992). Urban slums are comprised of fairly heterogenous

floating groups of population, which are economically and socially deprived andd faces multifarious problems on health front. Apart from slum population in general being an underprivileged group, slum women in particular suffer from far more inequalities than slum men. They accumulate in themselves all the disadvantages of the division of society into urban rural, upper lower class, high low caste, and male female categories. Further, among slum women, expectant mothers are particularly more vulnerable since pregnancy and childbirth, which are normal biological functions, become associated with many grave risks (especially in slum conditions) which can endanger their lives. Similarly infancy is a period of time when risk of dying is very closely related to the physical and social environment in which infants live. Thus, given the urban slum environment, children (particularly below one year group) and pregnant women are the most vulnerable sections of underprivileged slum population. The health problems of the underprivileged require special attention because of their special placement in difficult areas, and the difficult circumstances in which they live. Although a number of studies are available on health of slum dwellers in different major cities of India, most of the data in such studies have been collected from the household head who, in a large majority of cases, is male. Thus there is paucity of comprehensive information on women's perception and felt needs in the slum and the impact of slum environment on their health and well-being. Few studies have been carried out on maternal and child health in

urban slums, but most of them are regarding the utilisation of health services. Health facilities are only one of the factors that influence the health of population in general and pregnant mothers and infants in particular. Hardly any systematic attempts have been made to study the kinds of health problem faced by slum women (especially during pregnancy) and children, as well as the various health practices followed by them in urban slum environment. The health problems and practices of any community are profoundly influenced by an interplay of social, economic, cultural and political factors. There is, thus, a paucity of information regarding how the various socio-economic and cultural factors interact to determine the health situationof pregnant slum women and infants.

GENERAL OBJECTIVE OF THE STUDY:

Keeping these factors into consideration, the present study brings into light the health problems and practices of slum women (especially expectant and lactating mothers) and children (below one year), as well as how the socio-economic and physical environment influence them. An effort has thus been made in this study to highlight the role of various factors (environmental, social, economic, cultural) in determining the health of pregnant women, lactating mothers and infants, the strategies that they employ in coping with their health problems in slum conditions.

CHAPTER -II

DESIGN OF THE STUDY

DESIGN OF THE STUDY

As stated earlier the general objective of the present study is to identify the various socio-economic and culture factors whose interplay determine the health of pregnant women, lactating mothers and children below one year in slum conditions. It is necessary to break this down into the following Specific Objectives.

1. To ascertain the socio-economic condition under which the slum women are forced to live.
2. To assess the quality and quantity of basic amenities provided to the slum dwellers.
3. To identify the problems faced in the day to day life processes of pregnant women and lactating mothers in slum conditions.
4. To understand the status and role of slum women, their perception of health and disease treatment their socio-cultural practices and their coping mechanisms.
5. To identify the health problems prevailing among pregnant women, lactating mothers and children below one year.
6. To assess the availability and quality of maternal and child health services provided to the slum dwellers.

STUDY AREA AND STUDY POPULATION:

The study was conducted in Bhumiheen camp, one of the few slums of Govindpuri in South Delhi. It came up in 1977 as a jhuggi jhompri colony due to resettlement of migrated people from different states like Uttar Pradesh, West Bengal, Bihar,Madhya Pradesh etc. The colony is spread over an area of about 2 acres

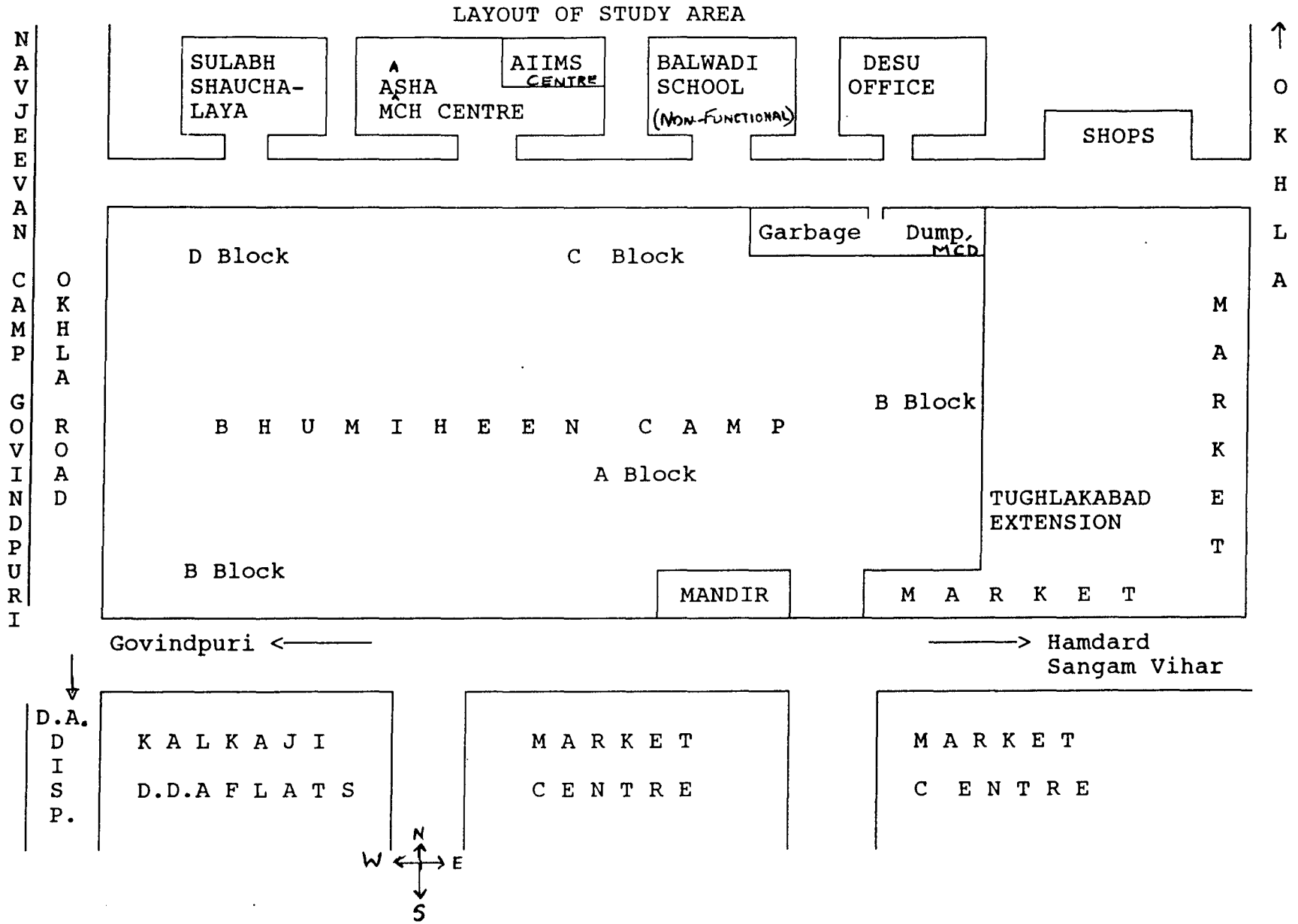
LAYOUT OF STUDY AREA
NAVJEEVAN CAMP
GOVINDPURI
OKHLA ROAD
SULABH SHAUCHA-LAYA
AIIMS CENTRE
ASHA MCH CENTRE
BALWADI SCHOOL (NON-FUNCTIONAL)
DESU OFFICE
SHOPS
OKHLA
Garbage
Dump, MCD
D Block
C Block
B Block
BHUMIHEEN CAMP
A Block
B Block
TUGHLAKABAD EXTENSION
MARKET
MANDIR
MARKET
Govindpuri
Hamdard
Sangam Vihar
D.A. DISP.
KALKAJI D.D.A FLATS
MARKET CENTRE
MARKET CENTRE
N
W
E
S

Fig 1

of land and is situated between busy market areas of Kalkaji DDA flats and Govindpuri. Okhla industrial area, which is a source of livelihood of many residents of Bhumiheen camp, is just about 3-4 Kms. away from the slum. It was ascertained from the headman that the study area has an approximately population of 10,800. There are about 2060 houses distributed in fur blocks-ABC and D.

A preliminary study was conducted in Bhumiheen camp which revealed the following characteristics of the area and population and because of which this slum was taken as the study area.

a) It exhibited features of a typical slum environment. The living condition in this slum was found to be grossly inadequate, with high population density, overcrowding, substandard housing, inadequate basic amenities like water supply, drainage, sewage and garbage clearance facilities. In addition, the population 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.

b) From the preliminary study of Bhumiheen camp, it was found that the particular area was having people of different states (like West Bengal, Uttar Pradesh, Bihar) and of religions, with different cultural views, belief and attitude which determine their health related practices and utilisation of maternal and child health services. Moreover, many different type of Maternal and child health infrastrucutres (private, government, Non-governmental

organisation) are available around the area, which makes one curious regarding how far they are promoting the well-being of the slum women.

c) The investigator had some contacts in this slum which helped in rapport building, a necessary prerequisite in studies of this kind.

STUDY SAMPLE:

A survey was first carried out to identify the target study households of lactating mothers with children below one year and pregnant women of all trimester. The survey was conducted over a period of two months with the help of local women, untrained dais staying in the slum, and female health workers of a MCH centre run by a Non-governmental Organisation (Aasha). The researcher also went through the records maintained by the two nearby government dispensary (Kalkaji DDA flats) in order to identify the targeted group (pregnant women and lactating mothers with children below one year). The result of the survey showed that over the period of two months, there were 45 pregnant women (of all trimester) and 86 lactating mothers with children below one year in the four blocks of Bhumiheen camp. It was decided to take all the pregnant women as found by the survey, but to sample the population of lactating mothers with children below one year. For the purpose of sampling a systematic random sample of every second lactating mother with a child below one year (as listed by the survey) was taken.

Thus the study sample consisted of: a) all 45 pregnant women of all trimester. b) 43 sampled lactating mothers with children below one year (out of a total of 86 lactating mothers).

TABLE 1
DISTRIBUTION OF WOMEN ACCORDING TO REPRODUCTIVE STATUS:

S.NO.	STATUS	NO.OF WOMEN BLOCKS A	B	C	D	TOTAL
1.	Pregnant Women	13	18	9	5	45
2.	Lactating Mothers with children below one year	11	18	7	7	43
		24	36	16	12	88

DATA REQUIRED:

To bring out the subjective (as perceived by the slum women) and the objective (as assessed by the observer and technical personnel) dimensions of the health situation of pregnant women, lactating mothers and children below one year and to highlight the interplay of social, cultural and economic forces that determine their health situation in slum, a complex set of data was required. This covered:-

1. A historical background of the colony (being studied) from the time it came into existence, background of the migrant people settled in the slum, their place of origin, and reasons for migration.
2. Demographic characteristics of the study population, educational levels, occupations, sources of income, household size and family structure.

3. Quality and adequacy of basic amenities such as water supply, toilet facilities, sewage and waste disposal, garbage clearance electricity supply and housing.
4. Information on the availability and accessibility of different health services (especially MCH) and institutions (Private, Government, NGO).
5. Data regarding the kind of health problems faced by pregnant women, lactating mothers and children below one year.
6. In the light of the above,where women go for help and treatment of different ailments and what is their experience and perception of the different institutions and personnel.
7. The attitude and perception of the service personnel which had direct and indirect impact on the health situation.
8. Data regarding the socio-cultural practices and beliefs of slum women which directly or indirectly affects their health as well as their utilisaton of MCH services.
9. Information on women's status, their attempts and action to deal with the situation in which they find themselves.

METHODS OF DATA COLLECTION:

As per objectives of the study, different tools need to be developed for collecting different types of data. Three different schedules namely, area profile, household schedule and case study schedules were designed for collecting in depth data from the study population. Household schedule and case study schedules were pretested in ten households of the selected slum, before being finally accepted as a tool for collection of data.

AREA PROFILE SCHEDULE:

The schedule was designed to collect general information about the study area, nature of population, distribution of households, location of roadways, industries etc. existing facilities for drinking water, drainage, latrines, garbage disposal, available health facilities inside and outside the slum area. The idea was to collect information regarding availability/non-availability of basic amenities and access to various maternal and child health services. The area profile schedule was administered to Pradhan (headman) of the slum area and to the elderly residents of every block in order to obtain detailed information about Bhumiheen camp. The area profile schedule is shown in appendix-I.

HOUSEHOLD SCHEDULE:

The household schedule was used for interviewing lactating mothers (with children below one year) and pregnant women to get information regarding demographic characteristics of the study population, their health problems and their socio-cultural practices which have a direct or indirect impact on their health It was a semi-structured schedule with both closed and open end questions. The schedule covered various household particulars i.e. Name, age, sex, caste, religion, occupation, income, education, place and reason of migration, family size, and questions pertaining to their health problems,their experience with health personnel, their reasons for utilization/ non-utilization of MCH services, their child rearing practices and cultural practices observed during pregnancy and after child

birth. This schedule was administered to all 45 pregnant women and 43 sampled lactating mothers and detailed information was elicited from them. The household schedule is shown in Appendix.II.

CASE STUDIES:

Case study approach was adopted for eliciting in depth information on women's status and role, their perception of health and disease treatment, and their mechanisms of coping with their health problems in slum conditions. Out of the 45 pregnant women and 43 sampled lactating mothers interviewed, ten (six pregnant and four lactating mothers) were identified for case studies. The criteria for identification were those women who had faced (or are facing) acute health problems during pregnancy. These women, being either beneficiary or non-beneficiary of maternal and child health services were interviewed with the help of detailed check lists (as shown in Appendix-III). Case study schedules were thus developed on:

1. Status and role of slum women
2. Their perception of health and disease treatment
3. The manner in which they deal with their health problems in slum environment.

Apart from making use of these three schedules, informations were also collected through discussions in groups and individually and by spending some time in the colony, observing the day to day activities of people. A daily record was maintained in the field diary of the activities and observations made during the course of these. The researcher also held

unstructured interviews with untrained dais (staying in the slum) and female health workers of maternal and child health centre (run by a NGO, AASHA), in order to understand their attitude and perception regarding the service they provide to the slum dwellers.

RAPPORT BUILDING:

To be able to collect in depth data about an area and its people, the major prerequisites are a good rapport with the people, the familiarity of the researcher with the area and the people and vice versa. Before launching the survey for data collection, a good rapport was established with the slum dwellers. Help of local leaders (formal and informal) and influential persons of the community were sought for conducting the field work. The researcher had long standing association with few local women and influential persons of the slum, who made the researcher familiar with the area and residents of Bhumiheen camp. Help was also sought from the untrained dais (staying in the slum) and female health workers of MCH centre (run by a NGO). They introduced the researcher to the respondents of the study, explained the purpose of the study to them, and removed their suspicions and fear. At least two or three visits were made to each of the respondents, involving them in informal discussions, before conducting in depth interviews.

TIME FRAME:

Visits were made to Bhumiheen camp first in end of September, 1993, to get a feel of the place and initiate the process of informal discussions with some of the inhabitants.

After some interaction with the residents and explaining them the purpose of the study, the area profile schedule was administered to the Pradhan (Headman) and senior residents of every block.

In November and December, a survey was conducted to identify the number of pregnant women (of all trimester) and lactating mothers with children below one year in the slum, over that period of time. The household schedule was formulated and pretested in early January, 1994. From mid January to early March, the sampled population were interviewed with household schedule. Case study schedules were introduced after that and data collection was completed by the 30th March, 1994.

ANALYSIS OF DATA:

The collected data has been analysed and broadly classified into the following:

1. Socio-economic and cultural profile of study population.
2. Health profile of study population.

The socio-economic and cultural profile gives the total picture of Bhumiheen camp. It describes the characteristics of the population, distribution of hutments, the various social and economic groupings found in the slum, the basic services available for slum dwellers and their quality of life. Data regarding literacy levels, family structure and size, household income and occupation, have been classified in tables to provide a complete socio-economic description of study population in the study area.

The Health Profile deals with health related information obtained by administering household and case study schedules to the study sample. After interviewing 45 pregnant women and 43 sampled lactating mothers with household schedule, information regarding the health problems of pregnant, lactating mothers, and infants, their health practices, their utilisation/non-utilisation of maternal and child health services the reasons for it, and other such health related data have been tabulated to give a picture of the health situation of the study sample.

LIMITATIONS OF STUDY:

This study had the expected limitations of a single investigator as research work for a M.Phil dissertation. Time was a major constraint in this study and thus collecting in-depth information from the study population in a short period of time, proved difficult. The present study involved collecting some sensitive information concerning the health of pregnant women and therefore required considerable care to develop adequate rapport with the study population. However, 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. It was found that in the study area (a slum of south Delhi), various types of surveys had been conducted in the past and therefore people were fed up answering personal questions, for they felt that it did not yield any immediate concrete result. People alleged that research of this kind are not being carriedout with their interest in mind. Thus, despite attempts to develop adequate rapport with the study population,

the element of suspicion and indifference could not be overcome completely and hence collection of data to that extent may have suffered. Finally, the study was conducted in a slum of south Delhi (though having a typical slum environment), it is doubtful how far the findings of the study are equally applicable in case of other slums of Delhi and other metropolitan cities of India.

CHAPTER -III

SOCIO-ECONOMIC AND CULTURAL PROFILE OF STUDY POPULATION

SOCIO-ECONOMIC AND CULTURAL PROFILE OF STUDY POPULATION:

The study was conducted in Bhumiheen Camp, a jhuggi - jhompri colony of Govindpuri. The slum has grown since 1977 and covers an area of approximately two acres of land, the original purpose of which was to construct a bus terminal. But the area turned into a jhuggi-jhompri colony with the incoming of migrant people, in search of jobs, from different states. The initial clustering was formed by small gorups consisting of kinsmen, relatives, fellow-villagers or those intimately known to each other. With time, however, other groups arrived and occupied the vacant areas. Since 1980 some of the slum dwellers even had their own ration cards. But it was in 1989, during V.P. Singh's government, that the dwelling units were arranged in four blocks, given a specific house number, and every household was given a ration card.

Bhumiheen camp comprises of clusters of jhuggis numbering approximately 2,060 households, with a population of about 10,800 persons. They are migrant population in search of jobs from different states like West Bengal, Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh and Haryana. Majority of them are Hindus, with Muslims accounting for only 5 percent of total population. The slum population is distributed in four blocks - A,B,C, and D. It was found that A block has 374 households, while B and C blocks have 686 and 688 households respectively and D block comprises of only 230 households. However, one does not find a neat arrangement of houses in the four block, but often

one comes across haphazard numbering of houses and their placement in different blocks.

HOUSING PATTERN:

Around half of the slum population resides in dwelling units with brick and mud walls and roofs of asbestos or iron sheets (that is, semi-pucca houses), while about 25 percent of slum dwellers are privileged enough to live in pucca houses, that is houses with walls of burnt bricks, plastered with cement and roofs of stone or concrete. The rest of the population are, however, forced to live in huts with walls of mud, mortar and broken bricks and with thatch roofs, or roofs made of tarpaulin, used tin sheets and other sundry materials. Before 1991 most of the dwelling units were of the hut type, that is "Kuchha" houses. But in 1991, residents of Bhumiheen camp suffered from a major outbreak of fire, when most of the jhuggis were gutted. Following this, majority of the slum dwellers, with government assistance, build semi-pucca houses for themselves. Few of them could even construct pucca houses to protect themselves from future similar incidents. However, a certain section of the population could manage only "Kuchha" houses since government assistance failed to reach them. It has been alleged by this section that most of the financial assistance given by the government was cornered by the local powerful men and distributed among their own groups.

In the "Kuchha" houses there is no separate ventilation other then the door. This may have been done to shut out strong hot winds in the summer and the cold in the winter, and to

prevent rainwater getting into the jhuggis. Even in the semi-pucca and some of the pucca houses, there is no provision for chimney or windows. This sometimes turns out to be the cause of health problems of the inmates of the house. Most of the houses have only one tiny room where the whole family has to eat, sleep and live together. One can notice few pucca double storey houses, having two or three small rooms in the ground floor. These houses are owned by relatively well off big families, often by local headman and his relatives. However, there are some double storey houses, with only one tiny room in the ground floor and these houses are generally given on rent, while the owner occupies one-two rooms.

The four blocks can be differentiated in terms of their housing pattern. One finds that A and B blocks are highly congested, with the houses being quite close to each other and the lanes being very narrow and dirty. Some of the houses of C block, which are actually located on the border of B block, also exhibit similar pattern. In contrast, most of the houses of C and D blocks are relatively neatly arranged with some distance between the houses and the lanes being brick-paved, broad and quite clean. Here one can observe groups of women sitting on "charpoys" (Cots) in the lanes and doing their work. There are even few houses with some enclosed area and a gate in front of it. (this was mostly in case of Muslim households, which are in dominant number in D block). It has also been observed that most of the double storey houses are located in A and B blocks, with few in C block.

In almost all of the households, there is electricity and many families own some type of consumer durable goods like radio, television, electrical heaters etc.

BASIC SERVICES:

The physical environment of the slum is harsh and presents many obstacles to growth and development, especially when compared to the planned areas of the city. The most obvious disparity is in the gross inadequacy of public utilities and services.

Water:

Municipal taps are the main sources of drinking water for the residents of Bhumiheen camp. There are fifteen municipality taps but out of these only ten are in working condition. There are also six handpumps in the slum, out of which two are not working. The handpumps are mostly made available by the slum dwellers themselves. Municipal corporation has laid down water lines for the slum dwellers but mostly there are no taps. In the majority of the cases people take water directly from the line itself which is at or below the ground level (by digging a sort of a cubicle hole). Often one could find a garbage heap next to the water source, thereby increasing the possibility of water contamination.

The few handpumps and water lines found in the slum had to supply water to all of the households for their basic domestic chores such as cooking, washing, cleaning and bathing and were clearly inadequate for meeting the needs of the pupulation they were meant to support. Some household chores could be carried

out at the water source itself, but several gallons of water a day still had to be carried back to the jhuggi and stored. This was normally done by woman of the household (sometimes assisted by her children) and generally required to wait in long queues for considerable amount of time. The struggle to get some water often led to heated arguments and even to fights (causing sometimes injury to women folk).

Each block has three - four municipal water taps and one or two handpumps located in it. However, A block has only two water lines and no handpumps. It could be observed that water problem was acute in A block. The residents of A block reported that the pressure of water supply was very low throughout the year. Water timing observed during the period of study were three hours in the morning and another three hours in the evening. The non-availability of water in A block forced its residents to fetch water from the adjoining blocks, which was resented by the residents of those blocks. The water si tuation is much better in C and D blocks, where one can find water taps and handpumps working to meet the demands of households. Further, the residents of these blocks could also get water from the taps on the roadside.

However during summer, the entire slum population faces water crisis, with often no water supply for two-three days. It was reported that during summer, most of the handpumps went dry. The slum dwellers then have to face extreme difficulty in collecting water from far off places. But there was no complain regarding the purity of water suppy. Some of the slum dwellers

stated that often health officials came and gave them water purifying tablets to put in their water containers.

Drainage System and Garbage Disposal:

There is no proper drainage system existing in the Bhumiheen camp area. There are open "Kuchha" drains made by residents and most of the time they are cleaned by locally hired sweepers. The slum dwellers usually throw their refuse here and there, inside and outside the slum. But most of the residents dispose their garbage in front of their hutments or at the corners of their "gali" (lanes). The road across the D block has an enclosed area for garbage disposal. Some of the slum dwellers throw their refuse directly there. Once or twice a week the sweepers too, remove the garbage from the slum locality itself.

However, the common complaint of slum dwellers is that the sweepers are highly irregular and as a result refuse and children's excreta would collect in the uncovered drains, attracting flies and becoming a natural source of infection and disease. But quite often each "gali" pooled in some amount of money to ensure regular service by the sweeper. This system seemed more operative in C and D blocks, where the drains looked relatively clean, since they were also sometimes cleaned by the people themselves. But in A and B blocks, one could witness heaps of garbage lying at various corners and dirty drains becoming breeding ground for mosquitoes. There seemed a tendency among the residents of these blocks to wholly depend on the municipal sweepers to clean the drains and collect garbage from the various corners of the blocks. Only sometimes people

from National Malaria Eradication Programmee would come for spraying chemicals in the drains.

Toilet and Bathing Facilities:

Outside the slum, there is a "Sulabh Shauchalaya" being manned by a caretaker, which provides six latrines (three each for males and females) and bathing facilities for slum dwellers. It is more frequently used by women and chldren and a charge of 25 paise is levied on their every visit (or rupees three on a monthly basis), while 75 paise is demanded from men. Due to inadequate number of latrines, they were inevitably overloaded and poorly maintained, thus becoming health hazards themselves rather than promoting a hygienic environment. Some of the slum dwellers then resort to going to open field and nearby parks for defecation. Children are found to defecate anywhere they like, very often in front of the jhuggis itself. It was observed that sewer lines in the public latines sometimes get defective, with sewer water flowing into the slum and very often near the source of drinking water, creating serious health hazards.

Market Facilities:

The slum area is surrounded by pucca roads and well connected to various important places. Okhla industrial area is approximately three-four kilometers away from the slum, where many slum dwellers are getting their employment. Market places surround the slum area from both the sides. On the one side is the Kalkaji DDA flats market and on the other side is the Govindpuri market area. These markets have different shops,

selling all possible goods. A few small grocery shops of daily needs are also present inside the slum locality.

Educational Institutes:

There is one government school in Kalkaji DDA flats area, near the slum, where many children of the slum dwellers are studying. There are two "Balwadis" being run by CUS PLAN (a non-governmental organisation) and these accomodate around 30 chidren daily in one shift. They take children aged between four-seven years, teach them few basics and at lunch break given them some food like banana, dalia, channa etc. to eat. Once a year children are provided with uniforms.

The Balwadis employ twenty women who are paid around Rs.200 monthly. These employees are mostly slum women, with few trained teachers from outside. It is mostly women of some influence, who are likely to get employed by the Balwadi. A fee of rupees twenty per month is charged from each student, which the slum dwellers often find quite difficult to pay. They complain that the fee has been gradually increased over a period of time, which has compelled many of them to withdraw their children. The parents of these children reported that quite frequently they did not receive the free uniform meant for their children, since they were taken by the employees of Balwadi. They further complained that sometimes even the food meant for their children, were eaten partly by the slum women employed by the Balwadi. Hence it could be observed that quite a few parents were not satisfied with the functioning of the Balwadis.

CHARACTERISTICS OF STUDY SAMPLE:

The study area being cosmopolitan in nature, the study sample consists of women of different **RELIGION** and of different states and these have been presented in table 2 and 3 respectively.

TABLE - 2

DISTRIBUTION OF WOMEN ACCORDING TO RELIGION

S.No.	Religion	No.of Women in four Blocks				Total	Percentage
		A	B	C	D		
1.	HINDU	23	28	9	6	66	75.00
2.	MUSLIM	-	8	7	5	20	22.73
3.	SIKH	1	-	-	1	2	2.27
		24	36	16	12	88	100.00

The distribution of women, over the 4 blocks, according to their religion can be seen from the above table. The study sample thus comprises of 75 percent Hindu and 22 percent Muslim women (being quite a fair representative of Muslim population in the slum itself). Only two Sikh women were found to be pregnant at the time of the study and hence were included in the study sample.

Table 3 shows the distribution of 88 study group population on the basis of their **STATE-WISE ORIGIN**, that is, the state from where they have migrated.

TABLE - 3

DISTRIBUTION OF STUDY SAMPLE ACCORDING TO STATE OF ORIGIN

S.No.	State of Origin	No.of Women in four Blocks				Total	%PERCENT
		A	B	C	D		
1.	UTTAR PRADESH	6	18	5	10	39	44.32
2.	WEST BENGAL	11	9	5	-	25	28.41
3.	BIHAR	2	7	3	1	13	14.77
4.	OTHERS(MP,RAJAS-THAN,HARYANA)	5	2	3	1	11	12.50
		24	36	16	12	88	100.00

It can be observed from table-3 that majority (44 percent) were from Uttar Pradesh, followed by West Bengal (i.e. Bengalees) accounting for 28 percent of the study population, and the remaining 12.5 percent were from different states like Madhya Pradesh, Rajasthan and Haryana. Further, out of the 20 Muslim households under study, 70 percent belong to UP and rest hail from Bihar and Rajasthan. It was observed that people belonging to same linguistic and religious community were living close to each other in the same or adjoining block. Thus, it was noted that more than half of Muslim households (under study) were located in C and D blocks (but not in A block), whereas A block had a high concentration of Bengali Hindus. This can be attributed to a large extent, to the tendency of each small group of settlers to occupy some extra space to accomodate future additions to the group.

Reason of Migration:

People who take up residence in slums are generally people of rural origin and low socio-economic status who have been forced by economic factors to look beyond the village for a

STUDY POPULATION
BHUMIHEEN CAMP, DELHI

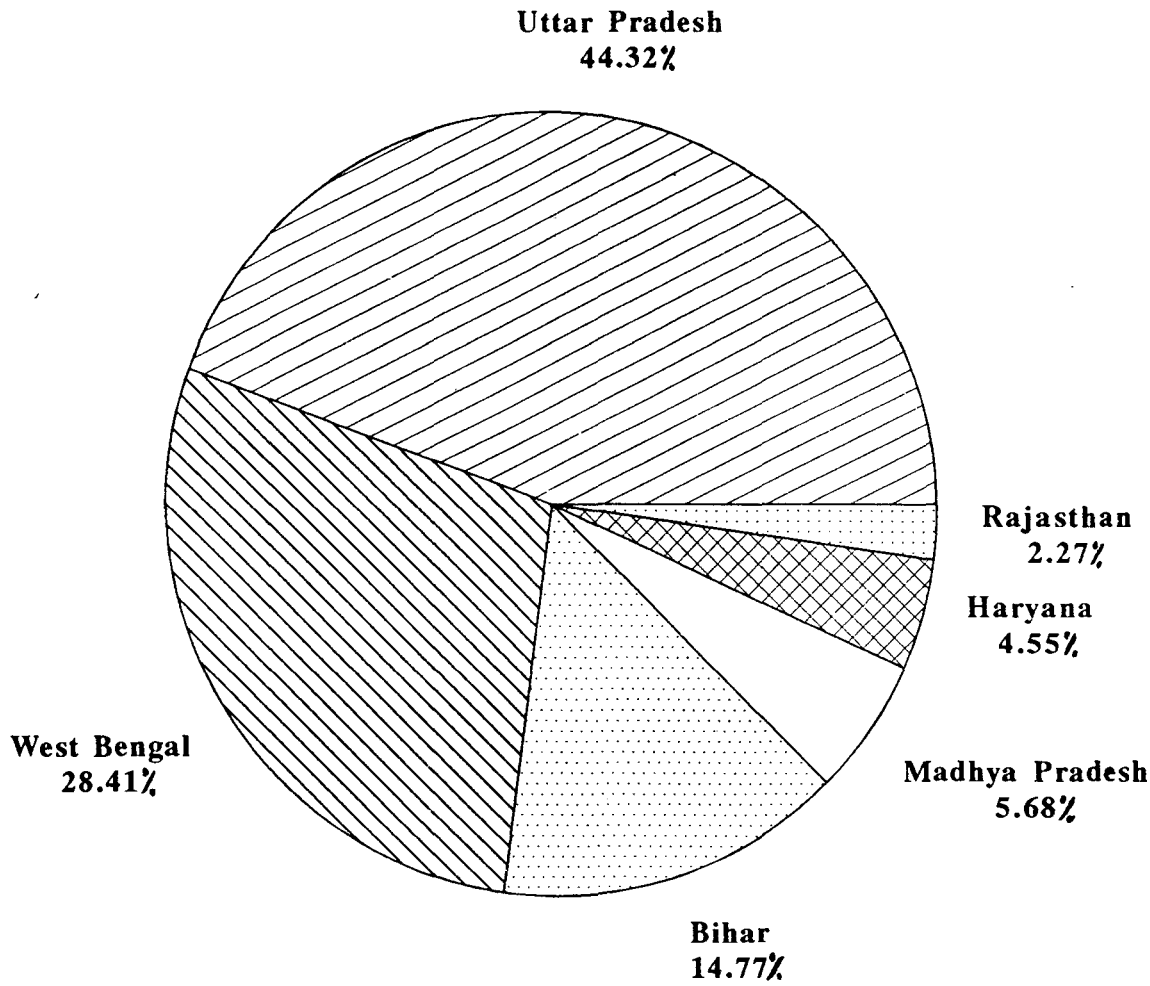

Fig. 2

means to support their family. When the slum women in the study sample were asked why they had left the village, 90 percent replied that they had left because they could not support themselves in the village. The majority said that this was because of adverse agricultural conditions (e.g. drought) or that there was simply no work available in the village.

However, there were two respndents who reported the availability of better health facilities in Delhi as the reason for migration. In the words of Parmilla, a Bihari illiterate women ....."She came to Delhi to bear sons and she has been successful. In her village she experienced twice pregnancy loss in first trimester, which was followed by a long period (7 years) of no conception. She had tried all means (traditional healers) in her village and after 9 years of marriage, she finally came to Delhi (Govindpuri) to seek help from the "good" doctors available here. Within one year, before she could settle down and seek doctor's advice, she conceived and gave birth to a son without having any complication. She is thus grateful to her brother who had suggested her to migrate to Delhi and found her a place in Bhumiheen Camp, where he was staying." In a similar search for better doctors and health services Gita, mother of two children (below 5 yrs.) came to this slum two yrs back, where her relatives were also staying. "She had lost two of her children because of lack of health facilities in her village. In case of first child, she had consulted traditional healer but the treatment didn't work out and the child died. In the second case, she tried to rush the sick child to a doctor but

by the time she reached the health centre (which was very faraway from her village), it was too late. This when her third son was born, she came to Delhi to be near the big ;hospitals and the 'good' doctors. Hence, these two slum women came with their family to Delhi primarily to avail better health facilities and so far they do not feel let down.

The remaining respondents came to Delhi only after their marriage, while their husbands had already migrated and for reasons which they were not aware of. More than half of the study population chose Delhi as their destination because they had relatives, friends or caste fellows who were also migrating or who already lived in Delhi. Thus, it can be seen that while economic factors primarily influence the decision to migrate, the ties of kinship, caste and village exercise a strong influence in shaping the direction of migration streams from the village to the city.

Duration of Stay in the Study Area:

The numb.er of years for which the respondents have been staying in Bhumiheen camp was ascertained and the same has been presented in table-4.

TABLE - 4

DISTRIBUTION OF HOUSEHOLDS ACCORDING TO NUMBER OF YEARS OF STAY IN THE STUDY AREA

S.No.	Duration of Stay (in years)	No.of Households	Percentage
1.	Less than 3	12	13.64
2.	3-6	16	18.18
3.	6-9	17	19.32
4.	9-12	16	18.18
5.	12-15	10	11.36
6.	15 and above	17	19.32
		88	100.00

It can be observed from the above table that the study sample covers evenly respondents staying for varying number of years in the slum i.e. right from less than a year to more than 15 years.This seems necessary since the number of years for which a migrant family is exposed to city life has an important influence on their potential job opportunities, their awareness of availability of various basic services (including health services) and their attitude towards life.

Age Distribution of Women in Study Sample:

Table 5 shows the distribution of women in the study according to their age.

TABLE - 5

DISTRIBUTION OF RESPONDENTS ACCORDING TO AGE

S.No.	AGE	NO.OF WOMEN	PERCENTAGE
1.	15-20	5	5.68
2.	20-25	20	22.73
3.	25-30	25	28.41
4.	30-35	31	35.23
5.	35-40	7	7.95
6.	40-45	-	-
		88	100.00

As can be seen from the above table that maximum respondents (35.2 percent) were in age group of 30-35 years, few women (7) even in age group 35-40, but none over 40 years. It can be observed from the table that 63 percent of women were found to be pregnant or nursing (and sometimes both) in the age group 25-35 years indicating this as the peak period for increasing family size, although women start building their family before

they are even 20 years and continue till they are 40 years. Thus, women spend more than twenty years of their life in being repeatedly pregnant and nursing children.

Family Structure:

In the slum, joint families are rare. In fact, 84 percent of the families studied in Bhumiheen camp were basically nuclear in structure and this can be seen from table 6 which gives the distribution of study households according to type of family. In this study, nuclear family is defined as married couple living with their unmarried children and often a single kin staying too (Kolenda, P.,)

TABLE - 6

DISTRIBUTION OF STUDY HOUSEHOLDS ACCAORDING TO TYPE OF FAMILY

S.No.	TYPE OF FAMILY	NO.OF HOUSEHOLDS	PERCENTAGE
1.	NUCLEAR	74	84.09
2.	JOINT	14	15.91
		88	100.00

It could be argued that one reason for the predominance of nuclear families could be lack of space. Another factor is that in-laws often stay back in the village, and thus the basis for a full fledged joint family is not always present, even if money and space would allow. The trend observed is that of a single kin (generally husband's brother) living with couple and their children. Out of 74 families classified as nuclear, 31 percent had a single kin staying with the couple and their children. In quite a few cases, husband's mother stays with the couple while

the father manages whatever property is left in the village. Further, it should be noted that out of the 14 families classified as joint, some of them actually occupied two or more jhuggis (and these were not always contiguous) although they shared expenses and ate together. The remaining joint families lived together in one house having two or three rooms and with more than one earning member.

Family Size:

Most of the slum studies (Grover, 1983) found that the slum family size was smaller, reflecting the fact that majority of the slum dwellers lived in nuclear families as they belonged to active working force mostly immigrant and young. The distribution of study households by family size is given in table.7

TABLE - 7

DISTRIBUTION OF STUDY HOUSEHOLDS ACCORDING TO NO.OF FAMILY MEMBERS

S.No.	NO.OF FAMILY MEMBERS	NO.OF HOUSEHOLDS	PERCENTAGE
1.	2	-	-
2.	3	11	12.50
3	4	16	18.18
4.	5	17	19.32
5.	6	19	21.59
6.	7	11	12.50
7.	8	9	10.23
8.	9	5	5.68
9.	10	-	-
		88	100.00

The above table shows that 59 percent of households were having between 4-6 family members. Since nuclear family structure (i.e. couple with their children, and often a single

kin staying together) is found to be predominant in the study area, this indicates that maximum women of this slum were mother of 2-3 children at the time of the study. An interesting observaton that can be made from table 7 is that 25 families had more than 6 members although only 14 joint families (all of them having 7-9 members) were found in the present study. Thus. this indicates that around 12.5 percent women were mother of at least 4-6 children at the time when they were found to be pregnant again or nursing an infant. Such incidence of large households may mean the need for extra hands to earn for the family and also lack of awareness and motivation to adopt family planning methods. This implies that women of lower socio-economic group spend a considerable span of their life in pregnancy and nursing infants.

Educational Status:

The literacy rate has been found to be poor among the slum dwellers. This can be seen from table-8 which gives the distribution of men (husband in case of present study) and women according to their educational status.

TABLE - 8

DISTRIBUTION OF MEN (HUSBAND) AND WOMEN ACCORDING TO THEIR EDUCATIONAL STATUS

S.NO.	EDUCATIONAL STATUS	NO.OF MEN	%AGE	NO.OF WOMEN	%AGE
1.	ILLITERATE	35	40.23	59	67.05
2.	LITERATE	13	14.94	7	7.95
3.	PRIMARY SCHOOL	14	16.09	6	18.18
4.	MIDDLE SCHOOL	14	16.09	5	5.68
5.	HIGH SCHOOL	8	9.20	1	1.14
6.	HIGHER SECONDARY	3	3.45	-	-
		88	100.00	88	100.00

It is evident from the table that majority of slum dwellers are illiterates with only 3 men having passed school. The table indicates not only prevalence of high rates of illiteracy among the slum dwellers but also a sharp difference in the educational levels of males and females. This can be seen from the fact that whereas only 40 percent men are illiterates, the percentage is much higher in case of women (67 percent). Similarly while 14 percent men could at least read and write their name etc. (that is, they were literates), only 7 percent women were having this advantage. The difference is more apparent in higher levels of education, with 9 percent of men having passed high school, while only one woman being so fortunate. Thus, it seems that people of lower socio-economic group (especially from rural areas) cannot afford nor do they see any benefit in educating girls. The girls are at best given only primary education and made to drop out by middle and higher levels of education. Besides poor literacy rates of slum women, there seems to be a variation in their educational status on the basis of their state of origin. This can be seen from table 9 which shows the distribution of women according to their educational level and the state from where they have migrated.

DISTRIBUTION OF WOMEN ACCORDING TO EDUCATIONAL STATUS

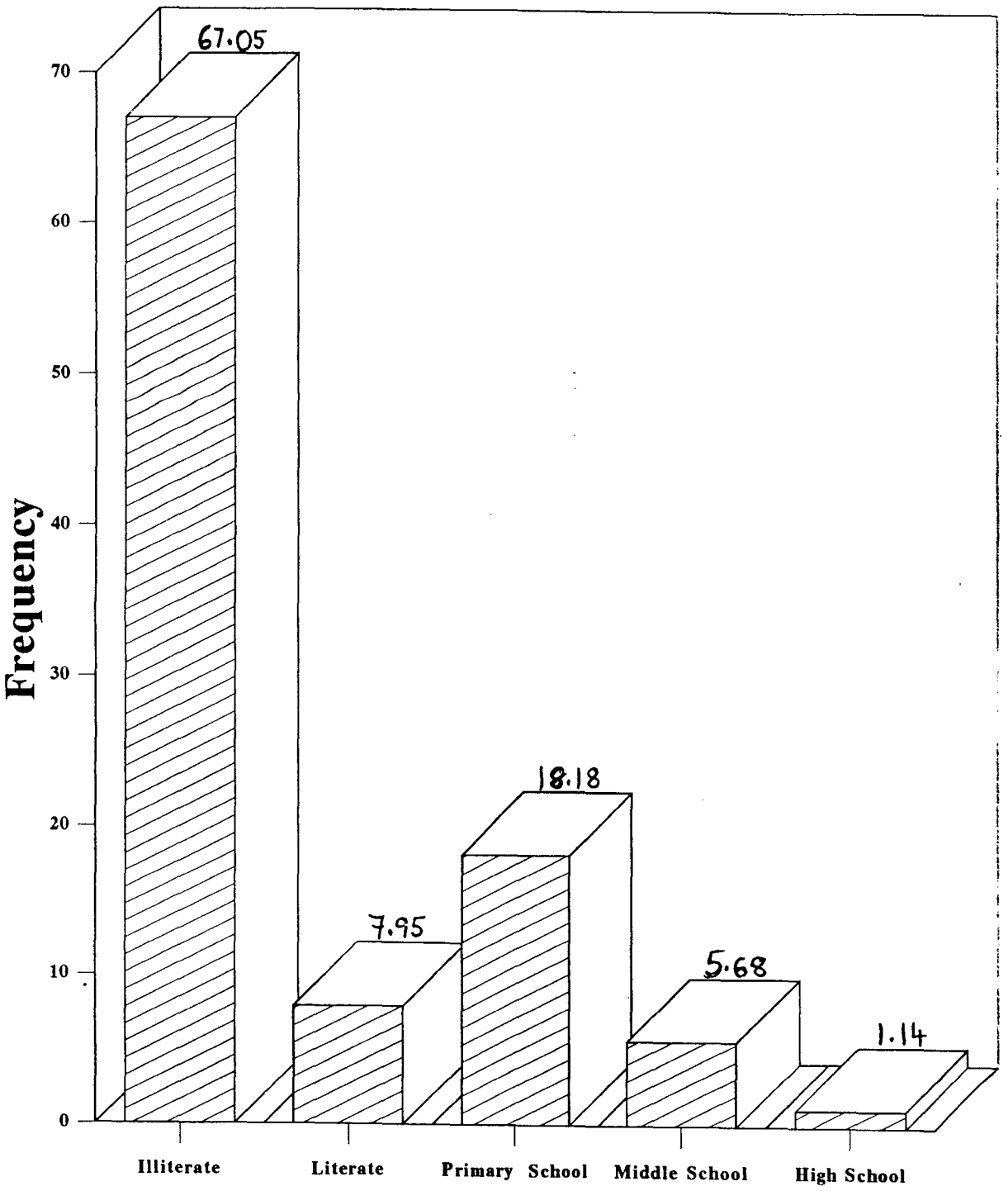

Fig. 3

TABLE - 9

DISTRIBUTION OF WOMEN ACCORDING TO EDUCATIONAL STATUS AND STATE-WISE ORIGIN

S. NO	EDUCATIONAL STATUS	UTTAR PRADESH NO.OF WOMEN	%AGE	WEST BENGAL NO.OF WOMEN	%AGE	BIHAR NO.OF WOMEN	%AGE	OTHERS NO.OF WOMEN	% AGE
1.	ILLITERATES	32	82.05	12	46.15	11	84.62	4	40
2.	LITERATES	2	5.13	3	11.54	1	7.69	1	10
3.	PRIMARY	2	5.13	8	30.77	1	7.69	5	50
4.	MIDDLE SCHOOL	2	5.13	3	11.54	-	-	-	-
5.	HIGH SCHOOL	1	2.56	-	-	-	-	-	-
		39	100.00	26	100.00	13	100.00	10	100

It can be observed from the table that whereas illiteracy rates are as high as 84 percent and 82 percent among women belonging to Bihar and U.P. respective, only 46 percent Bengalee women are found to be illiterate. Further although women hailing from Uttar Pradesh and Bihar constitute 59 percent of the study population, they together contribute as high as 72 percent to the female illiteracy (67 percent) prevailing in the slum. This variation in literacy levels among women in terms of state-wise origin, is more apparent at the level of primary education. Out of 16 slum women (under study) who have attained primary levels of education, 50 percent are Bengalees and only 18 percent belong to Uttar Pradesh and Bihar. Regarding variation among religious communities, it was found that whereas 65 percent of Hindu women were

illiterates, among Muslim women (constituting 22 percent) of study population. The illiteracy rate was a little higher i.e. 70 percent. Further, out of 70 percent illiterate Muslim women, 78.6 percent belong to Uttar Pradesh and Bihar, whether Hindu or Muslim, had poor literacy levels in comparison to Bengali Hindu women. This indicates that the decision to educate girls (even till the primary level) is determined by vairous socio-economic factors and cultural beliefs prevailing among people of a certain community.

OCCUPATIONAL STATUS

It was observed that all males of present study (ie husband of women under study) are engaged in some income-generating activities and that some females (in the study) are also helping in sharing the economy of the family. Rural migrants with limited knowledge, skills, and capital resources are engaged in economic activities where the incomes are low. The slum women in the study sample were asked about the occupation of their husband and the same has been presented in Table 10.

TABLE 10

DISTRIBUTION OF OCCUPATIONS AMONG HUSBAND OF RESPONDENTS

S.NO.	OCCUPATIONAL STATUS	NUMBER OF MEN	PERCENTAGE
1.	Factory Worker	26	29.55
2.	Self Employed (running small shops, tailoring at home)	12	13.64
3.	Employee in shops	7	7.95
4.	Painter	9	10.23
5.	Street hawker	12	13.64
6.	Rikshaw puller/ Auto drivers	9	10.23
7.	Skilled workers (Electricians, Motor Mechanic, Plumber Carpenter)	7	7.95
8.	Labourers	6	6.82
		88	100.00

As it can be seen from the table, the menfolk are engaged in different types of job, but a significant percentage (29 percent) employed in factories, though on a temporary basis. The Okhla industrial area, which is around 3-4 kilometers away from the study area, thus is a source of livelihood for a large number of families staying in Bhumiheen camp. These rural men, with their limited skills and capital resources, engage themselves in any economic activity (for however short period of time) which provides them with some income for the subsistence of their families.

It was observed that majority of the slum women were housewives which eventually help them to look after their children properly. Some women were however found to be working to share the economic burden of their families, and most of these women were unskilled workers either manual labourers or more commonly, they were domestic maid servants. In the study sample, with the exception of two women, none of them were found to be working outside their home. This was to a large extent due to the fact that the study sample comprises of pregnant and lactating women, who are unable to leave their home for pregnancy related problems and child care responsibilities. Only two women, who are mother of 10-11 months old child and have young daughter to look after the infants, were employed in domestic service and factory work. In both the cases, the husbands were not currently employed, one being sick and other having gone to village for last two months, which forced these women to go out and earn cash income for the family.

Further, only 10 women (mostly Bengalees) out of the 88 study population reported that they were previously engaged in paid jobs (domestic services) but had given up in their advanced stage of pregnancy and that they intend to take it up again after their child grows up. But the majority of women never stepped out of their home for any income generating job, since their husband do not alllow. These women do value the possible increase in household income but argue that with the burden of household work, frequent pregnancy and child care responsibilities as well as social restrictions on their movement, it is nearly impossible for them to contribute to household income by doing some job. This seemed more the case among women hailing from Uttar Pradesh and less among Bengalees.

Hence in most of the households, one finds only a single earner of cash income. There were, however, very few households (mostly Muslim) where women were engaged in home based economic activity like tailoring, embroidery, and making buttons, and thus were also an earning members. In those households, where a single kin is also staying with the couple, one does often find two income earners but not always there is the system of pooling in of income. It was also seen that women in slum were more likely to take up employment in middle age than when they were young and newly married. Thus, in those households where mother or mother-in-law were found to be staying with the couple, they were often found to be working as domestic maids.

Households Income

Rural migrants with limited knowledge, skills, and lack of exposure to city life are engaged in economic activities where the incomes are low. No matter how poor they are most households try to earn income not simply to survive but improve their position. An attempt has been made to get an idea about the monthly household income of the different households under study and the same has been presented in table 11. The household income has been calculated by adding the income of the head of the household and other full time workers.

TABLE 11

DISTRIBUTION OF MONTHLY HOUSEHOLD INCOME AMONG THE STUDY HOUSEHOLDS

S. NO.	MONTHLY HOUSEHOLD INCOME (IN RS.)	NO OF HOUSEHOLDS	PERCENTAGE
1.	Less than 500	11	12.50
2.	500-1000	35	39.77
3.	1000-1500	30	34.09
4.	1500-2000	12	13.64
5.	2000 and above	-	-
		88	100.00

It can be seen from the table that maximum slum households earn between rupees 500-1000 per month, followed by a large percentage earning between 1000 to 1500 rupees. Only few households earned less than Rs. 500 per month and these were found to be new migrants, being currently unable to find suitable jobs, and subsisting on miscellaneous jobs and borrowed money from relatives staying in the slum. It is necessary to say a word about the reliability of income data. It was not so much difficult to ascertain the income of the daily wage earners and salaried workers, though there was a tendency among them to report the income on the lower side. However in case of those engaged in petty business retail trade and hawking, it was quite difficult to estimate their earnings since they themselves were not sure about the exact amount of monthly income and also they were reluctant to reveal the exact figures (and a tendency for under reporting was observed). To avoid such difficulties to maximum possible extent, the monthly household income was calculated keeping into account such factors as the quality of housing, ownership of consumer durables etc, and further the monthly income of the study households were classified in broad income categories. The aim of this exercise was to simply get an idea about the monthly income of the households under study.

Unemployment

Most of the women interviewed expressed that the main problem arises out of the temporary nature of employment. They aspired for regular, stable, salaried employment for their husband which would relieve them of the uncertainty of daily wage

earnings. It was observed that as long as there is work, the income is more or less adequate to cover their expenses. But long periods of unemployment makes it difficult for them to survive and forces them to subsist on borrowed money. Those who are rikshaw pullers and auto drivers, complain about the high rent that they have to pay to the owners of the vehicle, leaving them with little money to subsist. Even if a part of rikshaw get broken, they often find it impossible to repair it (having no extra money) resulting in long periods of no work, which further reduces the household income to zero.

The seasonal nature of employment was also pointed out by some of the slum women. Wives of rikshaw pullers and auto-drivers, and painters preferred winter when their husband could do (and get) more work, while wife of a plumber preferred summer months when her husband was likely to get more work. Thus, it was observed that the slum dwellers were able to get themselves employed only for short periods of time.

Savings, Debts And Loans

Information on the actual amount of savings was not available as very few of the households had any cash savings. The study sample households although living in the impersonal urban environment of the metropolis, were basically dependent on the informal social security provided by extensive social networks (such as those involving kindship and caste) around 70 percent of the slum households borrowed money. It was observed the most of the households borrowed money for meeting social obligations and living costs. Another important reason for

borrowing is sudden illness, which results in loss of wages, high cost of medicines and doctors bill.

Informal credit mechanisms served the financial need of the sample households. The main sources of taking loans were friends, relatives, informal chit fund society, and money lenders living nearby. 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. Being on daily wages, the family may not have even a `capital' of 50 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 everyday -eat everyday). Generally, the loans involving large sums of money were taken from relatives and friends. The usual interest rate prevalent in the slum is 10 percent per month.

In quite a few cases, loans (of considerable amount) had been taken when one of the family member was seriously ill and because of which the family is still under heavy debts. 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 be 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 doctors bill.

Links With Village

Out of the households interviewed, 40 percent continue to have very good social and economic link with the village from where they come. These families have come in the last 5-7 years and gave economic betterment as the reason for migration. They regularly visit the village (every year) and send money `home' for the support of the other family members, who continue to link there. In times of emergency, they can depend on financial assistance from the village or can go back to them. This was clearly seen in case of Anju's family, wife of a plumber, who suffers from the problems of seasonal nature of her husband`s occupation. "Her family has to bear acute economic crisis in the winter season because her husband does nt get much work during winter months. Hence her father-in-law who manages their small ancestral land in the village sends them money regularly during those months and sometimes they go and spend those months in the village itself.

During pregnancy (especially in case of first pregnancy) and child birth, women go to home and also on special occasions, when they need rest or recuperation. These families are here for purely economic reasons and the village continues to be their real home. For another 35 percent of the study population, the link with the village is limited to the extent that they may visit it once in 2-3 years, for social occasions, such as marriages, deaths etc. For the rest 25 percent they have little or no contact with their village and for them Delhi is the permanent home for better or worse.

Status Of Women

Differing values and customs derived from the rural society tend to persist in the urban environment, as was observed in the present study. Women from UP, for example, whether Hindu or Muslim,are often left behind in the village to assume the major social, and often economic, responsibility for their families when their menfolk migrate to the city. When these women come to Delhi, they are reluctant to move beyond their homes or the `basti' and tend to have a low work force participation rate. This seemed the case for most of the Uttar Pradesh Women under study. Although number of women expressed their willingness to do jobs to earn cash income badly needed for subsistence of their families, they were reluctant to step out of the slum area for fear of ridicule by caste fellows and extended kinship group. These women agreed that this was the major reason why their husbands also did not allow their going out for work. Their mobility seemed mostly restricted within the slum and nearby health centres. Among other regional and caste groups, however, families nearly always migrate as a unit, and in some groups (especially Bengalees) women participate in the work force as actively as men. Work at least draws these women out into contact with the outside society, even if these contacts are limited in scope and content. It was observed that women who are (or previously were) 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 `basti'. Moreover, most of those women who are

totally dependent and under the protection of male members, expressed dissatisfaction with their confinement and limited interactions with others. Only few women seemed satisfied with their limited mobility and other social restrictions and it was observed that they belonged to economically better off families, with most of their necessities satisfied.

In very few Muslim households (3-4) purdah system was found to exist and these were mostly joint family households. In the words of Kaneja, a young daughter-in-law of a Muslim family, "She hardly steps out of her house, not even to come in contact with her neighbours, but remains confined within the four walls of her house. When she does leave the house, it is to visit her relatives and friends in the other parts of Delhi on special occasions such as for marriages, festivals etc. Domestic chores like fetching water from distant taps, buying provisions, washing clothes at the common tap, as well as taking the sick child to the health centre, are done by her mother-in-law and sister-in-law. When she is forced to step out by some urgent need, she goes out heavily veiled and accompanied by her husband or an elderly female relative". This holds good for other young married Muslim women in `purdah' (and living in joint families). They seem to be totally dependent on the male and elderly female members of the family for all activities which entail going "outdoors" eg shopping vegetables and other essentials, fetching water from distant taps, visiting the hospital or dispensary etc. Some of these women are, however, engaged in home based economic activity

like tailoring, embroidery etc. These women, nevertheless, expressed no dissatisfaction with the state of affairs since they argued they were `used to' this system right from childhood.

But rest of the Muslim women in the study sample reported that they could not "afford" to observe the "purdah" system in the slum environment. Badrunisa, mother of four children, felt that it was nearly impossible to maintain such customs in a strict sense, in this environment. "She argues that under the circumstances in which they are forced to live in the study area, i.e., living in only one tiny room, very close to the neighbour`s house and where more than half of the household work has to be done on the lanes (outside the house) it is unthinkable for them to observe purdah from males who are found in groups at each and every corner of the slum. However, when she leaves for her native village, she goes well covered and never steps out of her village house without a veil".

Badrunisa's opinion is also held by other Muslim women under study, and they point out that the domestic chores demanded their movement within the slum and they have no relatives (or other family members) here to help them out with these chores. Thus, these women have fewer constraints on their mobility within the study area, have better exchange and contact with other families, and are not entirely dependent on the male members in their day-to-day transactions. Further it was reported since most of the muslim women do not follow this custom in a strict sense in the slum environment, their husbands too do not expect them to cover

their faces while moving around in the slum area, but demand strict observance only in their village.

Within every family, there are numerous domestic chores and responsibilities which must be carried out on a regular basis. In order to arrive at an understanding of how these roles are allocated within the family, the women, (in the study) were asked to specify the person in the family who had the primary responsibility for performing common domestic chores, and also the person (if any) who helped the most in a secondary capacity. It was revealed by these women that there were certain chores which were performed almost exclusively by them such as cooking, washing utensils, washing clothes, cleaning the house etc and thus these tasks could be labelled as `female tasks'.

About 20 percent of the respondents, who had young daughters,admitted that these tasks were shared between them and their daughters and when they were sick, it was done exclusively by their daughters but not by their sons or husband. It was also found that most of the slum women were highly dependent on their neighbours/relatives, for helping them with domestic chores at the time of their sickness, child birth etc. Only in those cases where there were no young daughters and no neighbourly support, the husbands were found to help in domestic chores when their wives were seriously ill or after delivery. Further it was pointed out by some of the women that their husband had the primary responsibility for certain household work like shopping for cereals (only in few cases), buying clothes for the family, taking care of home repairs etc. Child care was a critical

domestic task for which, it was observed, that the males were ready to assume more responsibility than for other kinds of household work that are considered basically a women's responsibility. Thus, the findings indicated that the husband's major domestic responsibilities relate directly to economic aspects of running a household and very little else.

Dhanpati a new migrant from Uttar Pradesh, revealed that "at the time of delivery (in the slum), her husband refused to help her out with the household work since he considered it below his dignity to do such 'female tasks'. Being a newcomer to the slum, she couldn't even expect help from the neighbours and having no daughter, she was forced to get up and do domestic chores from the very next day of child birth. She pointed out that if she had been in her village home, she would have got at least one month of rest and such a period of rest could also be enjoyed here in this slum, if she had a daughter. Thus, she felt that daughters were an invaluable domestic resource for women living in slum conditions."

However, a certain section of women (in the study) reported that they experienced extreme uneasiness whenever their husband helped them (during their sickness) with household work, since according to them, "one cannot expect men to do those tasks which women were born to perform". It could be clearly observed that these women had been socialised in an environment where women are considered to be the 'second' or 'lesser sex'. Thus women seemed to carry an especially heavy responsibility for the domestic work of the family among the urban poor and this burden was most often

shared by their daughters (but not by their sons) from very early in life.

While women are assigned the greatest responsibility for carrying out domestic chores, they do not exercise the major authority in making decisions in family affairs. Few items like planning the daily menu etc, women themselves make the decision, but husband were said to exercise sole authority far more than the wife with regard to financial decisions (i.e. purchase or sale of property or jewelry, money spent on festivals or weddings). It was reported by the women in the study that when their husband go to village, while they stay in Delhi, only then they exercise sole authority in making decisions for those matters demanding immediate attention. However, more women said that the husband and wife makes the decision jointly than that either the husband or wife make the decision unilaterally.

It was also observed that women felt inadept to make many decisions since they perceived their lack of information about the world as an acute handicap, and therefore, willingly let their husband have the sole authority in many affairs, being more knowledgeable than themselves. This feelings of men knowing more than women because they had seen the world relatively more as well as the notion that a women's capacity to understand a particular situation and take important decision is much less than a man's, seemed prevalent among a significant number of slum women in the study. These women argued that a wife should not even try interfering in important (outside) matters but rather restrict her authority to taking decisions concerning the family

since "she was born competent only in that field". Thus, there seemed to be a considerable amount of sharing in the decision making process of slum households, with men and women both exercising an influence in many of the critical decisions within the family, but men generally holding the upper hand with regard to financial affairs.

It was also found that a woman very rarely disagreed with the decision of her husband, even though she may strongly feel against it. She knows that even if she shows disagreement, her husband will not change his ideas and decision, so she thinks it is better to adjust herself with the situation. Further it was pointed out by the slum women in the study that in case they voiced their protests, they are likely to be beaten up by their husband and hence they preferred keeping silent. Kaushalaya,a Bihari illiterate woman who is staying in the study area for last 15 years, narrated her experience in the early years of her marriage, in the following words..... "In the years following her marriage she was in the habit of voicing her opinion to her husband, but she used to get severely beaten whenever that meant going against his decision. Sometimes the bruises were so serious that she had to take a doctor's help. Very soon she realized that she was only supposed to carry out his decisions quietly, without a single voice of dissent. Since then she has been able to reduce considerably her share of daily injuries".

The case of Shabnam, a young independent thinking Muslim mother of two children, was quite different. "Though she also gets regularly beaten by her husband whenever she argues her

point of view with him, she doesn't give up voicing her opinion for fear of bruises, since she is just unable to quietly follow his decisions even if she strongly disagreed with it. She, moreover, feels that she is right in arguing with her husband since according to her, a wife should not get totally subdued by her husband. But she admitted that most often she had to carry out his decisions, willingly or unwillingly, when she gets fed up with daily beatings".

Alcoholic consumption was also found to be a major reason for torture of wives. Majority of women reported that any struggle to avoid a beating would be useless and that it is better to be quiet and bear it, because rebuff and protest by wife only results in infuriating the intoxicated man still further. Thus, wife beating seemed quite a frequent occurrence in this slum and most women had accepted it as a part of their life. However, it needs to be added that it is poverty that leads men to take their frustrations and helplessness out on an accessible and vulnerable victim-woman. Thus the slum woman suffers much more than the man does.

As stated earlier women (in the study sample) do not work outside their home because small children and frequent pregnancy prevent them from doing so. They are, therefore, deprived of the little income they could earn. It was expressed by majority of the slum women that if they too earned cash income, they would spend most of their earnings in meetings the basic needs of the family and not divert any money for their personal use, which was allegedly done by their husband. Many of the women did not feel

confident about the exact earnings of their husband and were quite sure that their husband under reported their income in order to keep a share for their personal use. This can be clearly observed in the experience of the following slum woman Kusum, wife of a rikshaw puller reported that "most often her husband would stay out the whole day and come back very late in night to say that he earned nothing that day since nobody hired his rikshaw. She was very sure that her husband had strayed on the wrong path and was spending his earnings on gambling, liquor, and other women, while giving out a very small household allowance to her on which she (and her four children) had to subsist for many days together. She was earning few rupees by tailoring clothes at home, but she longed to step out of her home for some work and earn cash income, with which she could buy adequate food and clothes for her children, as well as pay the doctor's bill".

Thus, in most of the households where women did not bring in cash incomes they have to wait for their husband to give them a daily allowance for household expenditures as a `dole' which was resented by them. Some of them said that when their children fall sick or they themselves are ill, they have to wait till their husband decide to give them money to take the ailing member to the health centre. Majority of them reported that men were more willing to spend money on the children's health and in case of wife to wait till she is just unable to do household work. However, delaying treatment of health problem till it meant stoppage of work, seemed the case for most women as well as men

in the slum. Husband in most cases did not accompany wife and children to the hospital/health centre primarily because of work load. As one of the respondent observed that if everytime she expects her husband to accompany her to the health centre, then 'who will earn food for them?'. However in addition to their work load, they were simply not willing to assume this responsibility rather they feel that their duty was over by giving money for medicines and doctor's bill to their wives. In such cases, neigbours and relatives were a source of great support and it was found that mostly women went in small groups to the hospital.

It was reported by only few women that the attitude of their husband and other members of the family was caring at the time of delivery and they were sent to their parent's home for delivery. However, most of them said that this was only for the first delivery and the caring attitude was maintained only if the issue was male. Some of the women revealed that they were even abused and beaten up by their husband and in-laws for delivering a female child. But they maintained that they themselves did not discriminate against their daughters, and some women even said that they took greater care of their daughters since they were `paraya dhan' (ie, somebody else's property). Some of them did admit that their husband very often adopted discriminatory practices like scolding their daughters for small reasons, not playing with them but taking more care of their sons, and most importantly, not sending them to school. Very often the reason for not sending young girls to school were economic ones, ie, not

having enough money to send both children to school. However besides economic reasons, it was observed that both men and women did not value girls educations highly since they see little benefits of it. These women argued that the job which are open to them have no so such requirements; it is the men, they reason, who need education since all jobs are potentially open to them. Jobs which are considered appropriate for women of the middle and upper classes to pursue such as teaching, nursing, and clerical work obviously require a far higher level of education and training than is within the reach of women in the bastis. They did not realize the importance of education in improving social status of women since they said that women were born with such a `fate'.

Regarding food intake it was maintained by all of the women in the study, that no discrimination was made against girls, since food distribution was in their power and they did not believe in differential treatment between sons and daughters. But it was observed that the with young girls being denied the privilege to go to school they were also deprived of the mid day meal given at the school and thus had a lesser intake of food than their brothers.

It was admitted by most of the women that daughters carry far more responsibility for household tasks from very early in life than sons and that they appear to be an especially invaluable domestic resource for women who live in predominantly nuclear families. But these women did not feel that the relatively more burden of domestic chores on young girls was a

discrimination against them since the society demanded that girls should be well versed in household work and therefore, they were training their daughters to assume this responsibility well when they get married. Thus it was observed that while young girls were required to cook, clean, and take care of their younger siblings, the young boys were either found to be playing around the corners of the slum or else they were seen going to school.

SOCIAL ENVIRONMENT OF BHUMIHEEN CAMP

At any t ime of the day when one walks through the maze of lanes it appears as though a large chunk of the essential domestic activities are being conducted either on the door step or on the lanes in front of the house. Which ever time of the day one goes there is a constant hum of activity which gave a feeling of being alive throughout this time. Early hours of the morning finds women washing vessels, cooking food, filling water, men bathing and getting ready for day's work. Some of the women who work as domestic servants leave the house in early hours. As the day advances mostly women children and older people are to be seen. This is the time for washing clothes, bathing and cleaning the house. One can witness a lot of gossiping among women while doing their domestic chores like fetching water and washing clothes near the water taps.

Some of the women who are engaged in home based economic activity such as tailoring, embroidery, making buttoms etc get ready for it. Vendors come around selling vegetables, fish, clothes and other household items and one can see groups of women bargaining with them at different corners of the slum. Late

afternoon, when the children have been scrubbed and fed, is the time for some relaxation before evening work begins and men folk who go out of the colony to work start returning. Women working as domestic servants come back home at noon, cook food, feed the family, and by late afternoon again go out for work. They thus have a very hectic and exhausting day trying to balance both household chores and outside work.

The occupational life of the majorit y of the slum dwellers is such that they go out to work in the morning and come back home in late evenings. The feel exhausted after long hours of work and go to sleep after eating food and attending to some household duties. There is not much time available for leisure in the daily routine of their life.

This is more in case of women who spent their entire day in doing household work. These women just have the opport unity of greeting their neighbours or friends at common water taps, while spending most of their time in coping with difficulties posed by slum conditions. Men still enjoy some leisure time on holidays but for slum women there are no holidays as such except on occasions when they visit their relatives or friends in other part of Delhi. There is no organised recreational activity for women and children. One can notice quite frequently men sitting in groups, chatting and often p lying cards etc. But one hardly comes across any group of women sitting and chatting since domestic chores occupied most of their time. In fact a need for an active women's organisation dealing with the problems faced by slum women, was expressed by most of the women in the study.

Further, with no playground facilities, young children were found to be loitering around aimlessly or playing some local games in small groups in the lanes.

Although class and religious groupings exist what is more apparent is the regional clusters that stand out. Bengalis (all Hindu) intermingling with Bengalis and the north Indians or Hindustanis keeping too themselves. This tendency is reinforced by the arrangement of the four blocks wherein people of the same region are residing close to each other. However there did not seem to be any social tensions between the different religious and regional communities. In terms of the normal everyday activities of women it was found that the caste and kinship groups provide the most common basis for organising community activity. Weddings and festivals are the most frequent occasions for community action and participation in these events is largely limited to the caste and kinship group. Caste endogamy restricts marital arrangements across these boundaries, and rural caste traditions often dictate the form of expression of festivals and ceremonies effectively precluding the participation of neighbours of differing religion, castes or regions in these important events.

Although as stated earlier most of the day to day activity is carried out on the lanes 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. In many of the cases, the neighbours too belong to the same caste and kinship group,

because of the tendency of slum dwellers to settle down together. Caste and kinship (who are most often neighbours), thus give the needed social support to an individual (especially woman) varying from giving loans, helping in child birth and child care, accompanying sick people to hospitals/dispensaries or intervening in family quarrels. Strikingly, this network of neighbourly support is observed more among the lower socio-economic categories while those belonging to the relatively upper categories more or less keep to themselves.

CHAPTER - IV

HEALTH PROBLEMS AND PRACTICES OF STUDY POPULATION

HEALTH PROBLEMS AND PRACTICES OF STUDY POPULATION

Health is a function, not only of medical care, but of the overall integrated development of society - cultural, economic, social and political. The health problems and practices of any community are profoundly influenced by an interplay of social, ecoromic, cultural and political factors. Each of these aspects have a deep influence on health, which in turn influences all the aspects. Hence, it is not possible to raise the health status and quality of life of people unless such efforts are integrated with the wider effort to bring about the overall transformation of a society (ICSSR-ICMR, 1981). Health situation of any population is a reflection of the socio-economic condition and the associated environment in which they live in. The socio-economic and cultural aspects of people's live in Bhumiheen camp, with specific reference to mothers and children has been dealt in the previous chapter. This chapter looks at the health situation of pregnant women, nursing mothers and children below one year, that is, their health problems, their health practices, their utilisation of health services and mechanisms of coping with their health problems.

HEALTH SERVICES:

Health facilities are available for the people in Bhumiheen camp through the government run institutions, private sector institutions, non-governmental institutions and the indigenous and folk healers.

MCH Infrastructure Available For The Slum:

1. Government Dispensaries - 1 (in Kalkaji DDA flats area)
2. MCH Centre (by MCD) - 1 (Kalkaji hospital)
3. Private allopatic doctors/clinics - 5 (most popular among the slum dwellers)
4. Non-Governmental Organisation (AASHA) MCH Centre - 1
5. Private Hospital - 1 (Hamdard Institute)
6. Drug Stores - 2
7. Private clinic (run by quacks) within the slum - 6
7. Traditional healers (within the slum) - 4
8. Untrained traditional birth attendants (within the slum) - 5
9. Trained dai (trained by Aasha, staying within the slum) - 2

Provision of medical services for the slum dwellers comes under the purview of Delhi Administration and 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. There is one Delhi Administration dispensary near Bhumiheen camp and where the slum dwellers regularly go for treatment of their health problems. In case of serious ailments, the patients are generally referred to safdarjung hospital and sometimes All India Institute of Medical Sciences. Under Maternal and Child Health programme, these dispensary provide ante-natal care to pregnant women and on a fixed day (once a week) provide immunisation facilities. The dispensary timings are from 8.00 a.m. to 3.00 p.m. with a short break of half an how around 1.00 p.m. for lunch. People seeking

treatment start queuing up from morning and mostly women accompanied by young children are seen. In caseof complicated deliveries, slum women are referred to Kalkaji hospital.

Majority of the slum dwellers however approach private allopathic doctors, who are available within quarter to two kilometre distance from the study area. Slum women in the study argued that they get immediate relief by taking medicines from private practitioners and therefore, whenever they have some money they prefer going to a private allopathic doctor than to a government dispensary. It was pointed out that the private practitioners most frequented by them, were retired doctors from Safdarjung hospital and AIIMS. Further, it was revealed by some slum women that few private doctors gave small loans to them for payment of medicines and fees. These doctors generally belong to their own community (regional) and therefore these women trusted them more and could communicate well with them. For serious illness, they were referred to government hospitals, mostly Safdarjung. It was observed that if a person recovers and comes back home from a particular hospital, the others are also motivated to go there for treatment of their health problems. This seems the case for Safdarjung.

Aasha, a Non-governmental organisation, runs a MCH Centre just across the slum, where pregnant mothers go for ante-natal care, and immunisation of their children. The organisation has employed women from each slum (in the Govindpuri area) and trained them as 'health workers'. These female health workers are supposed to provide health education to the slum dwellers

(specifically relating to hygiene, sanitation etc.), motivate slum women to adopt family planning methods and are trained to do the work of traditional birth attendants. There are three such female health workers for Bhumiheen camp, each taking care of around 200 households. They also give iron and folic acid tablets to pregnant women, teach the slum dwellers how to prepare ORT solution and frequently accompany them to hospitals for X-rays, blood tests etc. An important responsibility of these health workers is to identify pregnant mothers for ante-natal care, ensure that deliveries are conducted properly and motivate the mother to immunise the new-born. These health workers are paid around Rs.300 per month and are expected to be committed to their work. They are supposed to regularly report to Aasha office every morning, where they are informed about their daily duties. However, it was observed that these health workers were not very committed to their work. This could be seen from the fact that very few slum dwellers were aware of such female health workers and they were those who lived in their neighbourhood. Moreover, some slum women reported that these health workers charged for iron and folic acid tablets, which were supposed to be distributed free among pregnant women. It was also found that almost all deliveries (in the present study) were conducted by untrained dai's and only two were conducted by these female health workers.

At the Aasha MCH Centre, every Wednesday a lady doctor sits and treats the health problems of women of Bhumiheen camp and of other nearby slums. The pregnant women and lactating mothers

first make a registration card for a charge of rupees seven. On this card, their health problems, dosage of tetanus toxoid injections and immunisation dates of their children are noted down. For serious complications, the doctor refers the patient to a government hospital. Some medicines and tonics are given free to the women, while others are prescribed and they have to buy from the market. No charge is made for doctor's services, slum women have to pay only for registration.

Next to the Aasha, MCH Centre, there is a health centre run by AIIMS provide treatment for children below six months. Doctors from AIIMS look into the health problems of infants and immunisation facilities. They also visit children (below 6 months) in their homes and give them medicines for fever, diarrhoea etc It was reported by the slum dwellers that a mobile health van from AIIMS used to come once a month, which they found very useful. However for the last 2-3 months, it has stopped coming causing some inconvenience to the slum dwellers.

Within the slum area only quack doctors are available. They are those who have in the past worked with private doctors and now they have opened their own clinic. In emergency they provide the 'necessary help'. There are five untrained dais staying in the slum, who have learnt the delivery practice by day to day experience. Maximum slum dwellers approach these untrained dais for delivery help. These dais often work in collaboration with the quacks and may call them to give injections during labour pains to dull the intensity of the pain or to induce labour.

TRADITIONAL HEALTH PRACTICES OF STUDY POPULATION:

It was found that majority of the slum women in the study continued, in the urban slum environment, some of the health practices which they followed in their village. Consulting traditional healers for different health problems is one such practice continued by some of the slum women in the urban environment.

Traditional Healers:

Traditional healers deal with problems where other treatments have been tried and not found beneficial and those which are believed to have supernatural causes. These problems range from child's ailment (like fear of 'evil eye'), undiagnosed fever, mental illness, repeated abortions, infertility etc. These healers 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 range from few rupees to few hundred rupees and often payment is made partly in kind like clothes etc. Many of the respondents reported that often the fees charged by these healers are much higher than those taken by doctors. There were however few traditional healers who charged no fee as such, but accepted any payment willingly given by the patient.

It was observed that women in the study consulted traditional healers first (than medical doctors) when not much payment of fees were involved. But in other cases, the doctors were first consulted and if medicines didn't work, then the traditional healers were consulted. It was reported by most of

the slum women in the study that in their village, they consulted only traditional healers for their family's health problems, since doctors and health facilities were not easily available and accessible. Only when the case become too serious, that the patient would be taken to the nearest town and admitted in the public hospital. In urban slum environment, however, these women experience great difficulty in finding a 'trusted' traditional healer, to whom they can seek treatment for the health problems of their family. In fact quite a few cases were reported where slum mothers had suffered at the hands of 'dishonest' traditional healers "Savitri, mother of two young children, narated her experience in the initial years of stay in Bhumiheen camp. She came to this slum after her marriage and was advised by her mother not to consult any doctor for health problems but to find a traditional healer and consult him for the purpose. Thus when her six months old daughter had very high fever, she consulted a traditional healer within the study area (the only one she was aware of). But her daughter did not recover and by the time she admitted her daughter in Safdarjung hospital, it was too late. Since then she get her children treated only by medical doctors, while when she goes to her village, she consults traditional healer".

The difficulty in finding 'good' traditional healers in urban environment and hence giving up the practice of consulting such healers, has been narrated by many slum women in the study. However, there were quite a few cases where women had benefitted immensely from the traditional healing system. These were

generally for such health problems like infertility, repeated abortions, warding off evil spirits etc. Moreover, it was found that the absence of elderly females, because of predominance of nuclear family structure in the slum, created problems for young in experienced women in slum conditions. These women then cope with their health problems by taking help from their kin and caste group. Thus it was found in the present study that women consulted traditional healers for certain health problems but utilised medical facilities too, as a result of staying in urban environment.

Post Natal Practices:

There are certain other cultural practices which are observed by women in the study, but only to some extent, because of living in slum conditions. It was found that almost all of the slum mothers (in the study sample) remained confined to their bed with the newborn child for at least 8-10 days after delivery. After the stipulated period of time, the mother takes her first bath (after childbirth) which signifies her 'purity'. In some cases, it was reported that on the day of first bath, a puja is also performed to make the mother and the newborn child ritually 'pure'. However, it was observed by most of the slum women that a number of rituals associated with pregnancy and child birth, had to be given up in slum conditions because of their limited spaced homes and nuclear family structure (no elderly ladies to perform the rituals). A practice which is however maintained by most of these women is that of not allowing the mother to do cooking (that is, touching utencils) for about 7-10 days after

delivery. Slum women generally seek help from caste and kin group women for doing household work in post natal period, since predominance of nuclear family structure in the study area implies that women have to cope with their problems alone. Thus some women had to do cooking from the very next day of childbirth, since there was no one to help around. The actual practice is however for the mother to remain confined to bed and not to cook for one and half month, which was unthinkable for these women in slum conditions, with no female relatives to do household work and with only one room for the whole family to live. However, this custom was strictly observed when these women went to their maternal home in village for delivery. Thus, most of the mothers in the study complained that they were forced to give up many of their cultural practices associated with motherhood because of their stay in the slum and being away from their kin group.

Dietary Taboos:

It was revealed by majority of women in the study sample that they observed certain dietary taboos during pregnancy and post-natal period, as they have been advised to do so by elderly ladies of village home. Some women reported that they ate less food during pregnancy for fear of increasing the size of unborn baby and thus having difficulty during childbirth. Many women tried to avoid certain foods like egg, papaya, leafy vegetables, etc. during pregnancy with the belief that these were abortive in nature and might cause developmental defects to babies or gastric upset to mothers.

It was observed that more food taboos were maintained in the post natal period. Majority of the respondents reported that after delivery, for 1-2 days the mother has to remain on liquid diet mainly honey water, tea milk etc. After that less than full meal should be taken and most important the mother should not consume large quantities of water. It was perceived by these women that "since our body has lot of water inside, additional water will create problem in quick healing of the mother". Moreover, the water should be warm and the mother was forbidden to take cold water and cold food. Among these women, it was found that the concept of 'heat producing' foods and 'cold producing' foods was highly prevalent. Thus the nursing mother was forbidden to take rice, leafy vegetables, certain kinds of fish, channa dal, even roti (wheat), since these were supposed to produce cold and cause gastric upset to the mother, which in turn causes ill health of the baby through the breast milk. The mothers was advised to take large quantities of ghee, milk, dry fruits etc. which were supposed to be good for both mother and child. However, these foods could not be afforded by the poor slum mother.

It was found that although majority of the slum families in the present study were non-vegetarian, only some included non-vegetarian food occasionally in thier diet. Generally the daily meals comprised of wheat (roti), rice, dal, and vegetables. Few slum women in the study reported that they could not regularly take vegetables in their diet and often had to satisfy themselves with only potatoes. It was observed that one major meal was

cooked in early morning, which men ate and went out for day's work while the leftovers were eaten by women and children. Thus, very often the major share of non-vegetarian food (like egg and sometimes fish) or even vegetables were eaten by male members of the household, while women had to subsist on leftover dal, roti or rice. Milk and fruits were rarely taken and when bought were mostly consumed by men and children. Women in the study revealed that this was because of following the traditional custom of feeding one's husband first and then eating his left overs. More over, in the existing economic reality, the slum women were unable to supplement the left over food with other food items. Thus, slum women's intake of food was relatively less adequate than slum men's.

Place of Delivery and Birth Attendant:

Another practice that was found to be continued from village to urban slum environment is that of delivering at home and by traditional birth attendants. Table 12 shows the place of delivery of respondents in the present study.

TABLE - 12

DISTRIBUTION OF WOMEN ACCORDING TO PLACE OF LAST DELIVERY:

S.No.	PLACE OF DELIVERY	NO.OF WOMEN	PERCENTAGE
1.	HOME (IN SLUM)	56	65.12
2.	VILLAGE HOME	11	12.79
3.	GOVERNMENT HOSPITAL (SAFDARJUNG,LADY HARDINGE)	19	22.09
		86	100.00

DISTRIBUTION OF WOMEN ACCORDING TO PLACE OF LAST DELIVERY

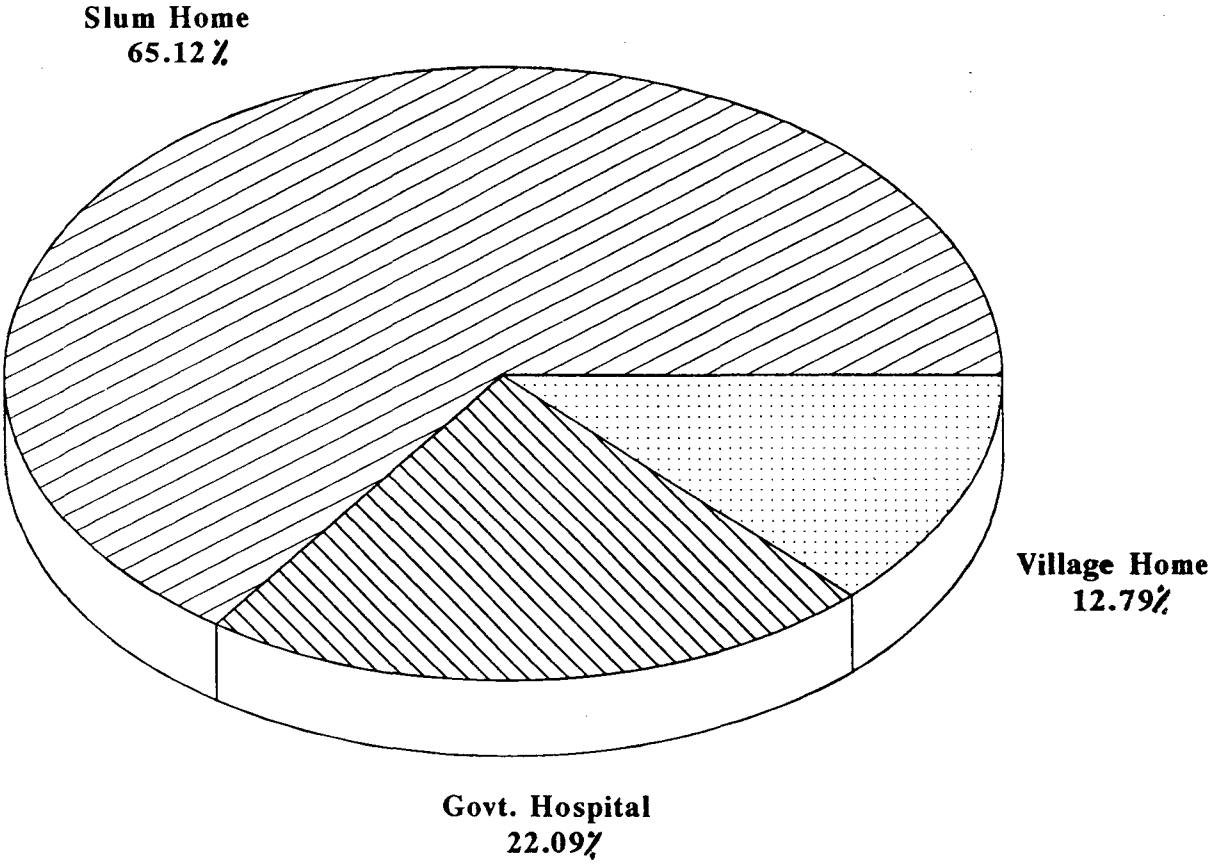

Fig.4

Out of 88 women under study, there were two cases of first pregnancy. Thus, out of 86 women, 65.1 percent series took place at home in the study area. 12 percent women went to their maternal home in village for the purpose of child birth and therefore it can be seen that around 77 percent of women in the study sample maintained the tradition of delivering child in home environment (whether in slum or in village). Only 22 percent of women staying in the slum had their deliveries in government hospitals. It was found that the reasons for hospital deliveries were when the case was complicated (an the woman has been advised by a doctor to do so for safe delivery) or when a pregnant woman was not aware of a trusted dai to help her during delivery. It was reported by most of the women in the study that it was more comfortable at home to have deliveries, in their own cultural and traditional way and in the same way as their mothers had delivered in the past (and have remained 'healthy' for long). These women were found to be ignorant about how delivery were conducted in hospital and scared of rude behaviour and neglect by hospital staff. Some respondents revealed that they had gone to a hospital, in the initial years of stay in the slum, for purpose of safe delivery but either the child died after few days in the hospital or it was a case of still birth and since then they continued with the traditional practice of delivering at home.

Further it was observed that apart from being a traditional practice, slum conditions also forced these women to deliver at home, instead of going to a hospital. An important factor reported by the women was the timing of the delivery. These slum

women cannot afford to get admitted in hospital before the delivery date, but have to work till the delivery nearly takes place and hence if it is night (which was the case for a significant number), they were unable to reach the hospital, even if they wanted to. Moreover it was reported by majority of the respondents that if there was no one at home to look after the other children and do household work, they could not afford to go to hospital for delivery. Thus absence of joint family structure proved to be a major difficulty for women during pregnancy and child birth in slum environment and this problem was overcome to a certain extent with support from caste group. However, having deliveries in slum home also is not very easy and comfortable. In one small room, where the whole family eats, sleeps, and lives together, it becomes extremely difficult for the delivery to take place, as there is no extra space available essential for child birth. Because of these difficulties and also due to cultural practice, some women go to their parent's home in village for delivery. This practice is more strictly observed in case of first pregnancy.

In the present study, majority of the home deliveries (95 percent) had been conducted by untrained traditional birth attendants. Only in two cases, it was done by female health workers of Aasha, who were given specific training for the purpose. It was found however,that most of the women in the study sample were unaware of the concept of 'trained' birth attendants. It was indicated by a large number of slum women that they preferred "dai" from their own socio-cultural

environment and those dais who were known to conduct safe deliveries in neighbourhood or in the family. They were found to be very much apprehensive to approach other health personnel who were unknown to them. Majority of the respondents reported that in their village almost all deliveries are conducted safely by dais and hence they continue the same practice in urban slum environment too. Some of them did not feel the need for 'trained' birth attendants since they argued that these dais have many years of experience in this work and are therefore quite trained for the purpose. Others, however, were unaware of any trained dai and expressed their preference for these trained dais, if safe delivery was ensured. In only two cases, the delivery was conducted by an elderly lady of the house, since majority of the families in the slum are nuclear in composition.

The fees charged by dais ranged from rupees 150 to 200 (and often a saree in addition) with 30-40 rupees difference being maintained (by most of them) between a male and female child. With more fees charged for male delivery by dais, the attitude towards girl child is reflected, right from birth. Only few women could afford to have massage after delivery, since the dais charged an extra rupees ten for every massage. Very few dais visited after delivery to inquire about the health of both the mother and the newborn child. Most of the dais delivered the child, cleaned the baby and the mother and left until called again for help, for which they charged an extra amount. It was felt by some women in the study that dais of the study area were more greedy of money than their village dais. But the others

argued that since cost of living in urban environment was so high, these dais were justified in charging high fees for their services. Moreover, slum women reported that inspite of high fees charged by dais, home deliveries were preferred over hospital ones, since the dais could be paid anytime, while the hospital bills had to be cleared immediately. Thus, most of the mothers in the slum preferred home deliveries conducted by untrained traditional birth attendants because she was accessible, the delivery was economical, and the house was not neglected.

It was observed in the present study that very often these dais worked in collaboration with the 'doctors' (quacks) available within the slum. Dais would call these quacks to give injections during labour pain to dull the intensity of the pain or to induce labour. These injections, as reported by the respondents costs around rupees 100 to 150 and sometimes they are even given after delivery to both the mother and the child. The women in the study sample were not knowledgeable about the name and need for such injections, but complained about their high cost and the fact that the dais insisted upon them to take the injection. 23 percent of home deliveries were attended by dais and quacks. Some of the women were more assured after taking the injection, since they felt that it was probably the proper thing to do. Thus, it was observed that the slum women in the study sample (because of staying in urban environment) while following the traditional practice of delivering at home by dais, were also

willing to avail the services of a doctor (even if quacks) if it ensured safe delivery.

Breastfeeding Practices:

The dai not only delivers the child but also gives dietary advice to the new mother. After the delivery of the child, the dai would advise the mother to feed the baby `gur', honey and water for two to three days, as well as forbid her to give the first breast milk (that is, colostrum) to the baby. In the present study it was found that although breastfeeding was universal it was most often not initiated on the day of the birth of the child but sometimes delayed till the third day of the delivery. This was because of customary taboos, socio-cultural systems and norms learnt by the new mother from the elderly ladies of her village home and neighbourhood (including the dai). Thus it was observed that 77.9 percent mothers did not give colostrum to their babies and out of these 91 percent had home deliveries. 22 percent however, gave their first milk to the baby, which is very essential for the good health of the child. Out of these 22 percent women, who did not discard colostrum, 68 percent had hospital deliveries, and they reported that hospital nurse educated them about the high nutritional quality of colostrum and it's necessity for baby's well-being. Thus, health education seems necessary for slum mothers.

It was further found that breastfeeding was continued for as long as possible, very often till the child was of two to three years of age. The problem reported by most of the mothers in the study sample, was insufficiency of breast milk, and hence babies

had to be fed on milk bought from the market. This often was the major cause of diarrhoeal infections in infants since sterilising feeding bottles (or spoon and bowl) is an infrequent practice among slum mothers. These women had learnt the practice of feeding infants from their mothers and continued it in urban slum environment. Semi-solids were generally introduced after 4-6 months, and the babies were usually given banana, dalia, half of an egg, liquid extract of pulses etc. Some, however, were found to give a portion of the meal cooked for the whole family, instead of preparing a special meal for the child. Very few mothers were also found to be giving commercial tin food to their children.

Reproductive Status of Women in Study Sample:

As stated earlier, the study sample consists of 45 pregnant women (of all trimester), and 43 lactating mothers with children below one year. Out of the 45 pregnant women, it was found that there are 8 women who are pregnant as well as nursing children above one year (mostly between 1½ and 2 years). This indicates that prolonged breastfeeding practices are prevalent among slum dwellers and that inter-pregnancy gap is very less.

Health Problems of Women and Children in Study Sample and Their Perception of it:

All the women in Bhumiheen camp whether they work outside the home or not are engaged in household labour. Of the 88 women interviewed, most of them (with exception of two) do not work outside their home because of pregnancy or child-care responsibilities, but they are engaged for long hours in

DISTRIBUTION OF WOMEN ACCORDING TO REPRODUCTIVE STATUS

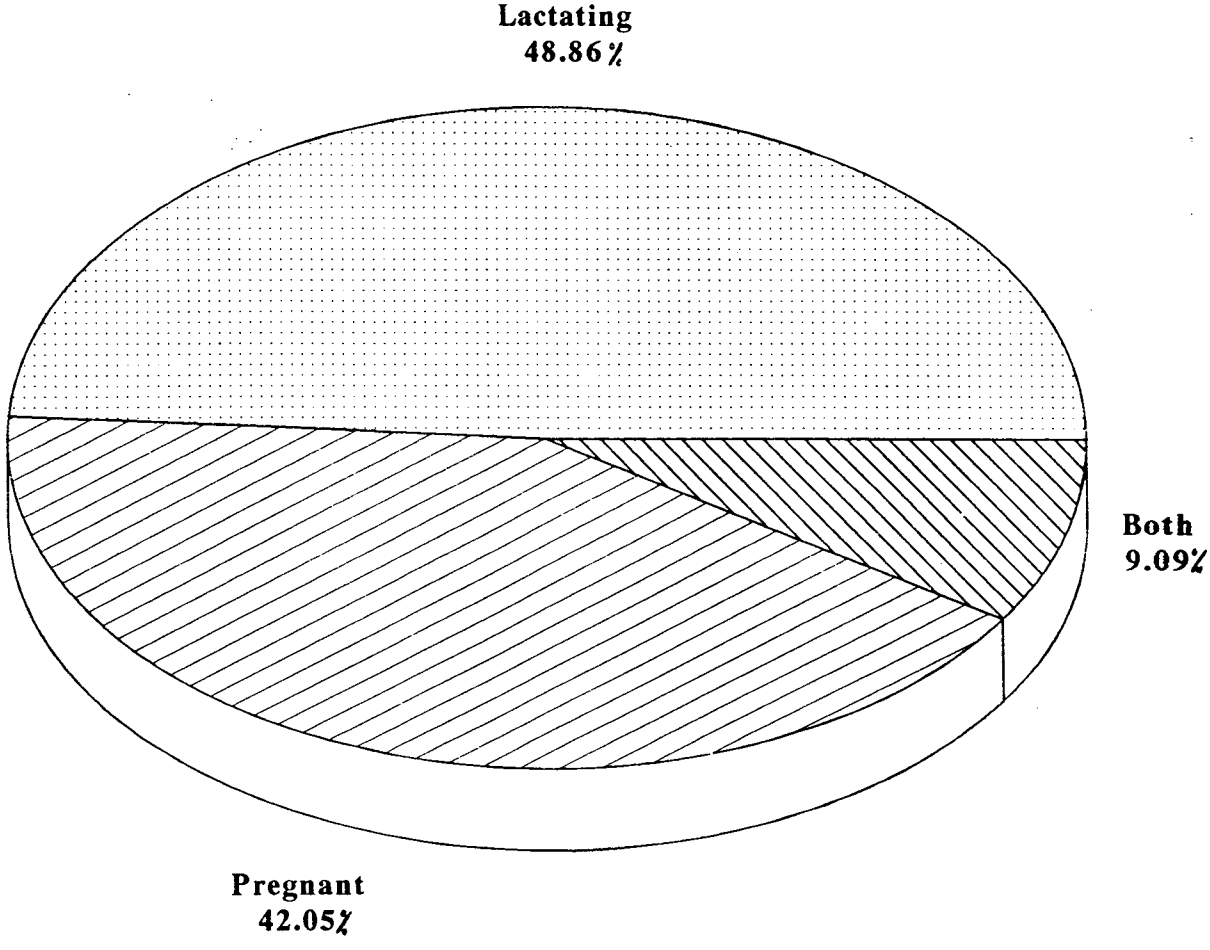

Fig. 5

household work. The common health problems reported by them were fever, chronic backaches, headaches, joint aches, skin diseases, chest pain, Tuberculosis, and respiratory problems. Infants were found to be suffering mostly from cold and fever, pneumonia, and diarrhoeal diseases. Acute diarrhoeal disease is the leading cause of death of children under one year of age and this has been found in the present study too.

A perceived relation between under-nutrition, over-crowding, lack of protected water supply, poor environmental sanitation and their own as well as their children's health problems exists among slum women. It was remarked by few respondents that given the dirty slum environment, with garbage heaps, filthy drains and flies hovering on them, diarrhoeal diseases and skin problems were inevitable. Pranoti, Bengali nursing mother, observes that "although they had to suffer from lack of food in their village yet there they had access to fresh vegetables and fish (from nearby ponds), but here they were forced to subsist on stale foods bought from the market, which in her opinion was the cause of her own and her baby's sickness, since she was breastfeeding. "Majority of women who suffered from constant problem of bodyaches felt that this was due to their long hours of household work in their limited spaced homes, with no separate kitchen and cooking on `chullah'(stove), with no proper ventilation.

Kusum, a pregnant and nursing mother suffering from acute problem of jointaches and also a tuberculosis patient, when asked about the likely cause of her health problems replied that ..... So far as she thinks living in overcrowded conditions

with inadequate public services, heavy burden of household chores including carrying heavy buckets of water from distant taps, and very less inter-pregnancy gap, acts as an energy drain on women and causes health problems. She felt that she had a much better health in her village but was constantly suffering from ailments since her stay in this slum.

Another respondent reported that her neighbours were suffering from Tuberculosis and that they keep spitting around, which she fears could infect her family, especially her children as they play around the neighbourhood.

Thus, it was observed that according to slum women in the study poverty, inadequate and poor quality of food fumes, polluted air, use of contaminated hand pump water, open and stagnant filthy drains, lack of proper disposal of garbage, prevalence of flies and mosquitoes, over-crowded conditions, and excess work load were the main factors responsible for their ill health and disease.

Complications During Pregnancy:

An attempt has been made to find out the various health problems being faced by pregnant women during pregnancy and those faced by lactating mothers in their last pregnancy, and the same has been presented in Table 13.

TABLE 13.

DISTRIBUTION OF WOMEN ACCORDING TO PROBLEMS FACED DURING PREGNANCY

SL. NO.	PROBLEMS	NUMBER OF WOMEN	PERCENTAGE
1.	Swelling of feet	4	4.5
2.	Stomach pains (of unknown etiology)	8	9.1
3.	Anaemia	8	9.1
4.	Weakness	11	12.5
5.	No specific health problem	57	64.8
		88	100.00

It can be seen from the table that 35.2 percent faced complications during pregnancy, the most common being extreme weakness resulting in inability to do household work. Anaemia was reported by those who visited doctor and got there haemoglobin tests done. Moreover table reveals that 64.8 percent of women in the study sample did not face any problem, despite low socio-economic status and ignorance prevailing among slum women. It was however, found that out of 57 women who did not report any complication during pregnancy, 35 answered that they had experienced some health problems during pregnancy but they felt that it was normal to undergo such complications during pregnancy (and hence was not worth reporting). This fact of women not giving priority to their health but being conditioned right from childhood to bear sickness, can also be seen from the finding that out of the 31 women who reported having faced complications during pregnancy, 13 women did not consult any

doctor or health centre to seek treatment for the problem.

Health Practices Adopted by Study Population in Urban Environment:

It was found that slum women in the study, as a result of staying in urban environment, although continued many of their traditional health practices, but they also adopted some new practices with time. The number of years for which a migrant rural family is exposed to city life (and hence to urban health structure) was found to be an important determinant of the extent to which the family was aware as well as utilised health services for their health problems.

Awareness and Utilisation of Antenatal Care:

Data were collected to get an idea about the awareness of need for antenatal care and of its sources available around the slum area, among the slum women. It was seen that as many as 80.6 percent of the respondents were aware of both the need for antenatal care and of nearly free sources of maternal and child health services near the study area. Around 19.4 percent women in the study sample were, therefore, found to be unaware of the importance of medical care during pregnancy as well as of any such source of antenatal services. Out of these 19.4 percent, 5 percent had recently migrated from their village and thus their ignorance could be partly attributed to their lack of exposure to urban health services.

Regarding the utilisation of antenatal services, it was found that 61.36 percent of respondents had currently registered or had registered in their last pregnancy, as the case may be, for antenatal check-up.

Thus, high degree of awareness as well as utilisation of antenatal care was found in the present study. This indicates that rural women after migrating to urban slum areas are willing to utilise urban health facilities if it is easily accessible and economical.

`AASHA' which runs a MCH centre across the study area and whose staff regularly (once a week) visit Bhumiheen Camp for immunisation and health education, were to a large extent responsible for high degree of awareness and utilisation of antenatal services among Bhumiheen Camp women. Many of the respondents reported that when they take their children for treatment and immunisation to the MCH, they too are motivated by the health workers there to take Tetanus Toxoid injection. Thus, it was observed that out of 61.36 percent registered for antenatal check up, 80 percent had received only Tetanus Toxoid injection, followed by 65 percent receiving both the injection as well as iron/folic acid tablets, while the concern of respondents for blood/urine examination and record of weight/blood pressure, was very less.

Source of ANC

The role played by Aasha can also be observed from the table (14) showing the source from where the respondents received antenatal case.

TABLE-14

DISTRIBUTION OF WOMEN ACCORDING TO SOURCE OF ANC

SL. NO.	SOURCE OF ANC	NUMBER OF WOMEN	PERCENTAGE
1.	Government Dispensary (Kalkaji DDA Flats)	10	18.52
2.	Government Hospital (Safdarjung)	8	14.82
3.	Private Clinic	6	11.11
4.	Aasha MCH Centre	30	55.55
		54	100.00

The findings reveal that majority of the respondents (55.5 percent) used the Aasha MCH centre as major source of antenatal care. Further only 33 percent used government source of ANC care as it was reported by them that it was time consuming and often there was insufficient medicines/injections available, which meant that they had to come again. The fact that 88 percent used nearly free sources of ANC (since Aasha charges a nominal registration fee) and only 11.11 percent went for paid ANC services (that is, private clinics), implies that slum women can only afford to utilise antenatal facilities if it is nearly free, given their low economic status.

Distance Travelled For Antenatal Care

Not only is there need for free sources of antenatal care, but also such health facilities should be available near the homes of slum women.

In the present study, data was collected to find out the distance travelled by slum women for antenatal check-up. It was

found that 55.5 percent women travelled less than a kilometre (that is, to Aasha, maternal and child health centre) for antenatal care, while around 29.6 percent travelled less than two kilometres (that is, to government dispensaries) for the purpose. Interestingly, while 85 percent travelled less than two kilometres for antenatal services, 14.8 percent travelled more than 8 kilometres (that is, to Safdarjung hospital) to avail antenatal care. However, it was found that these women had registered primarily for the purpose of delivering in Safdarjung hospital and in hope that in case of emergency they will be taken care of. Thus, an inverse relationship between distance to be travelled for antenatal care and its utilisation can be observed in this study.

Time of First Visit for Antenatal Check-up:

The degree of motivation of women with regard to antenatal services (and hence for general health services too) is also revealed by the gestational age at which a pregnant woman registers her pregnancy. Data regarding the time of first visit for ANC (as presented in table 15) has been collected only for currently pregnant women, since lactating mothers were having problem in recalling the exact time of registration for ANC.

TABLE 15
DISTRIBUTION OF WOMEN ACCORDING TO TIME OF FIRST VISIT FOR ANC

SL. NO.	SOURCE OF ANC	NUMBER OF WOMEN	PERCENTAGE
1.	FIRST TRIMESTER	3	13.63
2.	SECOND "	12	54.55
3.	THIRD "	7	31.82
		22	100.00

Out of 45 currently pregnant women under study, only 22 had registered for ANC, and as can be seen from table 15,only 13.6 percent registered in the first trimester. It can be observed that majority of women (54.5 percent) registered only in IInd trimester, while a significant percentage (31.8 percent) had registered as late as in IIIrd trimester. This implies that these women are not well aware of the fact that the earlier the pregnancy is registered, the better it is for both the mother and foetus. Thus, although 48.8 percent of pregnant women had utilised antenatal services, only 13 percent were fully motivated and aware of benefits of early registration of pregnancy.

Motivating Factors in Utilising ANC:

An attempt has been made to find out the various factors that motivated the women of study sample to utilise ANC, and the same has been presented in table .

TABLE 16

DISTRIBUTION OF WOMEN ACCORDING TO MOTIVATING FACTORS IN UTILISING ANC

SL. NO.	MOTIVATING FACTORS	NUMBER OF WOMEN	PERCENTAGE
1.	Complications in last pregnancy	5	9.26
2.	Complications in current pregnancy	14	25.93
3.	Self motivated	12	22.22
4.	Health Worker (Aasha MCH Centre)	7	12.96
5.	Family	6	11.11
6.	Neighbour or Friend	10	18.52
		54	100.00

It can be observed from Table 16 that out of the total women who registered for antenatal care, one-fourth of them had taken it as a treatment for the health problems that they were facing during pregnancy like swelling of feet, anaemia, weakness, and body pains. It was only after they faced complications that they registered for antenatal check-up (and this can also be observed from table 15 which shows that most women registered in late pregnancy). However, 22 percent utilised ANC on self motivation. This is a happy sign that slum dwellers are slowly realizing themselves that maternal and child health care is essential for mother's and children's well-being. It was found that majority of these women (22 percent) were actually motivated when they visited a health centre (mostly Aasha) for their children's health problems.

An important factor motivating a pregnant mother to utilise ANC are her neighbours or friends, who are well aware of the importance of medical care during pregnancy as well as the source of such care (mostly because of their longer stay in urban environment), and often accompany her to the health centre. This has been the case for 18 percent women in the present study. Similar role is also often played by family member (s) who is relatively educated (mostly husband).

Female health workers of Aasha have also motivated pregnant slum women to go for antenatal check-up (as in case of 7 women) by regularly going to their homes. A small percentage (9.26 percent) of women were motivated by the previous problems like prolonged labour, difficulty in child birth often resulting in

infant's death etc, which were not tackled well at home during last pregnancy. Thus, different factor or factors operate in isolation or in combination to motivate pregnant slum women to seek medical care.

Reasons for Non-utilisation of ANC

An attempt has also been made to look into the various reasons for which 38 percent women did not register for antenatal check-up. This has been presented in table 17.

TABLE SHOWING THE REASONS FOR NOT GETTING REGISTERED FOR ANC

SL. NO.	REASONS	NUMBER OF WOMEN	PERCENTAGE
1.	No knowledge	11	32.35
2.	Do not feel the necessity	7	20.58
3.	Scared of hospitals/injections	5	14.71
4.	Gone to village	5	14.71
5.	Intending to register for	6	11.11
	ANC in future	-	-
		34	100.00

It can be seen from table 17 that majority of women (32.35 percent) were not aware of the need for medical care during pregnancy as well as the source of such health services. Around 20 percenty women did not feel the necessity for antenatal services. According to them, pregnancy is very much a natural physiological phenomena and other elderly women of their family never faced any problem during their pregnancy and delivery time, even without utilising health services. In other words, these

respondents did not see any benefits in antenatal registration. Out of the 6 women who had not yet registered for antenatal check-up but were intending to do so in future, most of them were in fifth or sixth months of pregnancy. This again points out the lack of motivation on the part of slum women to get themselves registered in early pregnancy as well as their unawareness of the benefits of such early registration.

Immunisation

Regarding utilisation of immunisation facilities by mothers for their children, it was found that out of 43 children below one year, 32 had been given at least one dosage of the vaccine. But around 11 children were deprived of immunisation services. The reasons for non-immunisation, by questioning the respective mothers, were found to be unawareness of need for immunisation, lack of time, and more importantly, an inherit fear of giving injections to their child or to take their child to a hospital/health centre. It was observed that most of these mothers did not feel the necessity of immunising their children. These women tried to follow their old traditions and beliefs. According to them, in the village many children and even their other children were not immunised, but they were quite healthy. Hence they did not understand the importance of immunisation. On the other hand, there were few cases where the older children had been immunised but had fallen sick immediately and hence the mothers were scared to immunise their new born. Taking the new born to a hospital or health centre was also considered in auspicious by some of them and thus keeping the child deprived

from immunisation services. In some of the cases, the mothers were willing to get their children vaccinated but were delaying it, although their children were of 6-8 months old. They were thus unaware of the importance of early immunisation and the possible diseases that a child may get because of the delay. However the fact that in the present study, 74 percent mothers got their children registered for immunisation indicates that they are willing to accept new practices if it can ensure their well-being. It was observed in the present study that both mother and father were more willing to utilise modern health services for the betterment of their children's heath than their own.

Sources of Immunisation

It was observed that most of the mothers (40 percent) utilised government dispensaries (Kalkaji, DDA Flats) and NGO. Aasha (53 percent) as the major source for immunisation of their children. It was noticed that services provided by Aasha was quite regular and was based to a large extent on the need of the slum community regarding utilisation of immunisation services. A record of the vaccines given to a child and the date for next vaccination was maintained by the staff of Aasha on the registration card of the nursing mother and this proves to be very helpful to the mother who would otherwise feel confused. Out of the 32 mothers, only two were utilising private sources of immunisation. Thus, most mothers utilised immunisation facilities if it was easily available near the study area.

Perception Regarding Government and Private Health Services:

It was found by detailed interviewing of the mothers that a large percentage (74.5 percent) were dissatisfied with the government health services. It was reported by most of the respondents that going to a government dispensary meant losing a lot of one's time standing in long queues. Moreover, it was pointed out that most often the medicines prescribed did not work immediately and the patient had to be taken again and again to the doctor before relief could be expected. This was a very important factor which motivated the respondents to go to private doctors, since there they were assured of quick relief. Many of them said that though the fees charged by the private doctors were quite high but repeated visits were not required, one visit was very often enough. On the other hand, government dispensaries demanded repeated visits from them since for most of the time, the medicines did not provide immediate relief. It was observed that most of the slum dwellers never took the full dosage of medicine prescribed by the doctor, but gave it up as soon as they felt better. Hence, immediate relief was a major criteria for them in selecting between government and private sources of health services.

Moreover, it was pointed out that most of the doctors at the government dispensary asked the patient itself as to what was wrong with her/him, which was not approved by the slum dwellers who felt that the doctor should be knowing their health problems as well as the cause of it. It was also argued by quite a few of the respondents that only cheap medicines (mostly tonics) were

given free by these dispensaries and the rest of the medicines they had to buy from the market. Hence use of government health services did not prove to be very cheap in comparison to private. Some even remarked that the same medicines were prescribed by Government dispensaries for different diseases. Thus, it seemed that people did not trust government health services for their general health problems, but went mostly for routine immunisation etc. Majority of them said that since private sources were expensive, they first went to government doctors and in case of no immediate relief, they went to private doctors, where quick relief was granted.

CHAPTER -V

DISCUSSION

DISCUSSION

The health problems and practices of any community are profoundly influenced by an interplay of social, economic, and cultural factors. Health situation of any population is a reflection of the socio-economic condition and the associated environment in which they live in. It is therefore necessary to study in depth the various social, economic, and cultural factors as well as the physical environment in which the people live in, to understand how these factors determine the health of the people. While the third chapter discussed the social, economic, and cultural dimensions of life in Bhumiheen camp, the previous chapter highlighted the health situation of pregnant women, nursing mother, and children below one year. This chapter tries to highlight how the various social, economic and cultural aspects as well as the physical environment in which the study population live, determines their health situation.

THE 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. In Delhi, inspite of the disproportionately high expenditure on services, there is marked shortage of clean drinking water and environment hygiene, while there is a high level of air pollution. It is the urban poor who do not avail of basic services and who have to contend with pollution. The health problems of slum dwellers within a deteriorating environment cannot be viewed in isolation from the environment.As has been

noted in other slum studies(Aggarwal and Katiyan, 1981; Singh, 1980) and in the present study, open drains, poorly maintained public latrines, inadequate water supply no street lighting, few paved lanes, and `Kuccha' housing are the typical of the deteriorating environment of the slums.

In the present study most of the house were found to have only one room which was accomodating 3-5 persons. This problem of limited living space was seen to affect particularly women and children. It is women who spend most of their time in their homes because of burden of household work and social restrictions on mobility. They work for long hours at a stretch in their limited spaced homes, often in uncomfortable postures, which creates many problem for them, especially if they are in late stage of pregnancy. It was found that most women in the study were suffering from chronic backaches and jointaches. Gupta`s study (1990) also found similar health problems among slum women, which resulted because of their work environment. Further many slum women are engaged in home based economic activity like tailoring, making buttons etc and therefore precious space of their homes get used for storing raw materials and work machines. Since the high cost of even minimal housing relative to the income of the slum dwellers force the families to live in the smallest possible space, a portion of the daily chores and activities of the family has to be carried out doors. This style of living, involving as it does frequent and extensive face to face interaction (especially among women) and little privacy obviously requires a considerable amount of cooperation and

social control. Thus it could be particularly straining for those minority groups whose customs, beliefs and values differ from those of their neighbours.

Because of excessive work load, slum mothers cannot always carry their children around and are forced to leave them on their own. Infants begin to crawl at the age of 9-11 months and often on the contaminated dirt floor of their house. Since hand to mouth activity is a primary method of exploring the world at this age, as well as a technique for self-feeding, the frequency of touching and injecting animal feces and other contaminated detritus is quite high. This tendency sometimes lead to diarrhoeal infections which is a frequent and dangerous health problem for infants below one year. It has also been reported by mothers in the study that their babies most often suffer from diarrhoeal problems. They felt that it was nearly impossible for them to keep the house totally clean since flies, mosquitoes and other insects which breed on the open drains in front of their house, very easily find their way in.

Another problem relating to housing and health are the materials that are used in construction. As poor generally build their own homes without any government subsidies, they are forced to use inexpensive and hazardous materials. It was noted that in the study area, asbestos was a material commonly used for roofing, when it is known to have a carcinogenic effect. Several homes had brick walls with black polythene that is believed to be associated with high incidence of coughs, colds, pneumonia and tuberculosis, as polythene forms are inadequate cover against the

cold and damp. It was found that some women in the study were suffering from tuberculosis and majority of the infants at least once had pneumonia since their birth. Further some houses had tin roofs which are in appropriate for in door cooking. It was observed that the effect of use of hazardous housing materials was more on women and children who spend most of their time inside their homes. These findings have been corroborated in other studies on Delhi`s urban poor (JILL CARR-Haris, 1992). Further majority of the slum houses lack proper ventilation, particularly in winter when food is also cooked indoors. A major source of air pollution is the cooking of food in houses with inadequate ventilation. The burning of cooking fuel indoors causes heavy smoke in the atmosphere, exposing the women and infants to these toxic fumes. Since many households use wood and dung as a fuel, the scale of the problem is immense. A significant number of women in the study reported respiratory disorders which could be clearly linked to air pollution. Any condition which results in reducing the blood's capability to carry oxygen to the tissues, like anaemia, will make a person more susceptible to carbon monoxide toxicity. Around 9 percent pregnant women in the study (table 13) were found to be anaemic and their exposure to carbon monoxied could likely affect the unborn child, leading to reduced birth weight and increased perinatal death rates.

Inadequate water supply characterises most of the slums of Delhi (as well as all over India) and Bhumiheen Camp is no different. Scarcity of water affects slum population in general and women in particular. Since the primary responsibility for doing domestic chores such as cooking, washing, cleaning and bathing children lies with women, they are required to wait in long queues at common water taps and carry several gallons of water a day back to the jhuggis to store them. With few water lines made available to the slum dwellers and with handpumps often not working, one can witness a lot of fighting and pushing among womenfolk for water sometimes causing serious injuries, especially to pregnant women. Health complications, because of injuries from fightings at water source, was reported by at least five pregnant women in the study. Accident can also occur when (as was observed) a pregnant women balances a heavy bucket of water in one hand and an infant in the other and walks through narrow slippery lanes of the slum. Many a times half of their day is spend on fetching water from distant taps and storing them. Lack of water also meant irregular bathings which lead to skin diseases, found to be very common among the slum women in the study. Quite frequently mothers having skin disease infact their nursing infant, causing serious health problems in them. It was also observed that slum dwellers often use shallow hand pumps as a source of water supply and therefore one has doubts how far they are able to drink clean water.

Further lack of proper toilet and bathing facilities causes immense problems to women. While menfolk can ease themselves anywhere in the open, women are forced to go to public latrines which are over loaded and poorly maintained, often a health hazard themsleves. Moreover, during pregnancy women experience extreme difficulty in using faraway public latrines, which are often water logged. Children are generally forced to defecate in open drains. Uncovered filthy drains and garbage heaps attract flies, mosquitoes etc and become a natural source of infection and disease. Very often garbage has been found to be dumped near a water source and hence there is a high possibility of water getting contaminated, Diarrhoeal infections, skin diseases, and malaria are thus common health problems reported by the residents of Bhumiheen Camp. Urban malaria has to be linked with the general level of sanitation (i.e. open sewers, location of solid waste disposal, pollution of bodies of water, etc) as well as flooding during the monsoon. Especially vulnerable to urban malaria are the slum dwellers living in low-lying areas. That are apt to remain flood-affected long after the monsoons recede. Frequent malarial fevers weakens the already weak body of urban poor pregnant women.

SOCIO-ECONOMIC DIMENSIONS

Many physical ailments are the direct result of adjusting to a new social environment. In urban slum areas migrants find the patterns of behaviour in cities conflicting with what they know from their traditions. Individuals who have been raised in farms

and in small towns, according to local customs, get suddenly uprooted and exposed to dehumanised conditions of the urban slum areas. When migrants settle down in slums, their settlement (as was observed) is not a haphazard process but involves a good deal of social manipulation of physical space, which many strengthen or limit soical interaction. This has been also found in four bastis of Delhi in Singh's study (1980). Families of dominant castes generally cluster together in such a way that in times of need, they provide social support to each other. This social support is essential for slum women who play a major role in the family's efforts to cope with conditions of absolute poverty. The fact that caste and kin group are used as coping mechanism by slum women for dealing with problems posed by slum environment has also been highlighted by other studies on slums (Ferandes, 1991; Singh, 1980).

Women interviewed in the study area observed that after leaving joint family set up in village and being exposed to harsh slum conditions, kinship ties provide valuable friendship and psychological support to them and the family in addition to other more tangible benefits (like finding a job, giving small loans in times of emergency etc). Husbands are generally unable to help them (the women in the study) in dealing with the problems since most of their time is spend in earning income for the family. In times of need such as during sickness, delivery, and after child birth women sometimes are solely dependent on their caste group for help. Very often new migrant women are informed by kin group women who have been staying in the slum for many years(thus is

exposed to city life for long period of time) about the need for medical care during pregnancy, the need for immunising infants, and the place where such health facilities are available. Hence it was found in the present study that around 18 percent pregnant women were motivated by their kin group to register for ante-natal care (Table 16).

Since women need special support during delivery and rest after childbirth, they frequently go to their village home before delivery and return only after some period of time. This custom was found to be more strictly observed in case of first delivery, when a young women is less competent to deal with probelms associated with pregnancy and child birth alone in slum conditions. By the time of third or fourth child women generally prefer to deliver in their slum home since by then they have enough support from their own caste and kin group (who are very often their neighbours too). Sometimes an elderly female member would come from village to help during childbirth and enable the mother to take rest for some time. In many cases, in the present study, home remedies for childs health came from their village home (as per the advice of elderly female members of the family), which are not available in the city or young women are ignorant about them. In times of financial emergency too the slum dwellers were found to depend on their village home. Frequently, during periods of financial crisis women and children were sent back to the village home. Caste and kin group in the slum also helped in tiding over such periods of crisis by giving out small loans. Thus, majority of migrant families in the study

area were found to be maintaining good social and economic links with thier village, which helped them to live in urban slum environment.

Despite the fact that food production has increased over the decades, malnourishment is a major problem in India and it has been pointed out by urban slum studies (Dwivedi, 1992; Singh and DeSouza, 1980) that it's prevalence is very high among people belonging to lower socio-economic strata. Majority of the slum dwellers included in the study were non-vegetarian, yet meat and eggs (both high protein animal foods) were only rarely included regularly in the diet of the poor. Animal protein was simply too expensive for regular consumption. The most common items in the poor person's diet turn out to be wheat, dal (lentils), rice and vegetables respectively. Recent research has shown that if wheat and dal are consumed in sufficient quantities, the basic protein and calorie needs of an individual can be met as well as most of the vitamin requirements. However, it was found in the present study that within households, the available food is distributed according to the status of the individual rather than according to nutritional requirements. Women and female children usually receive what is left over. Studies on health of slum women thus have found that majority of women belonging to the lower socio-economic status are undernourished (Kapil, 1980; Dutta et al, 1990).

Women in general and pregnant women in particular, have special nutritional needs. Women in the study reported that they could buy milk, fruits occasionally that is, only when they had

enough money (left after buying cereals, vegetables, pulses) and most of it was consumed by children (as they cannot eat properly from the family meal) and their husband (as they work hard the whole day to earn food for the family and their well-being is essential). Although majority of the women were aware that their body needs milk and fruits during pregnancy (as they generally experience severe weakness), they feel that it is nearly impossible to consume such food since they can never hope to buy these nutritious (and expensive) foods in large quantities (that will suffice for the whole family) and by social norm they cannot eat without giving first to their husband. Thus, pregnant and lactating women who specially need a balanced diet are not only deprived of nutritious foods like milk, fruits and sometimes even vegetables, but quite often they are even unable to consume wheat, dal, and rice in sufficient quantities since they eat what is left over, after the male members have been fed properly (as per traditional practice). Such an improper diet frequently leads to complications during pregnancy (as has been reported by 35.2 percent of women in the study) and also endangers the life of the unborn child since an underweight, undernourished mother gives birth to a small underweight child who has 3-4 times risk of dying, compared to a better birth w eight baby. But it was found that unless these women had serious complication they did not seek medical care (as was the case with 42 percent women who had complications during pregnancy) since due to societal norms, they are conditioned to tolerate suffering. Moreover, lactating mothers when they eat less, do not have enough breast milk and as

a result are deprived of essential, highly nutritous breast milk.

Undernutrition does not merely make a person tired and weak (as most of the women in the study felt during pregnancy and lactation), it predisposes one to innumerable infections, worsening an already fatigued state. Add to this, women have to bear the heavy burden of work within the home and sometimes outside too. It was found women continue hard physical labour (especially those employed in domestic services) in addition to their household chores. Doing domestic chores itself in harsh slum conditions demands a lot of energy from women, who have the primary responsibility for household work (as found in Singh's study, 1980, as well as in the present study). It was observed that even fetching water from distant taps consumed nearly 4 to 5 hours of a woman's day, leaving her totally exhausted. Sharing of household chores is not possible (as was revealed by most of the women) since their husbands are busy earning food for the family and also are not willing to do such 'female tasks'. Because of nuclear family structure in the slum, these women do not have any other female members to help them out and thus the entire burden of household work (an sometimes outside work too) fall on them, very often shared only by their young daughters. Working beyond the limits of physical tolerance, their bodies are depleted of essential resources (moreover not replaced by intake of nutritious meal), thus resulting in foetal wastage and low birth weight babies.

The prevalence of very low female literacy rates in the study area (an also corrobated by other slum studies like Singh, 1980; Fernandes, 1989) provides another indicator of slum women's social position. The slum women mainly come from rural environment where girl's education is very often considered of no benefit. Unlike women in middle and upper classes, hence women in bastis have little chance of getting educated. Thus the slum women are deprived of the means by which they could learn about the world and thereby become more confident to deal with any situation, instead of being totally dependent on males for dealing with the world outside their homes. It was reported by most of the women that while they had greater responsibility for household work, they had relatively much lesser authority than their husband in decision making process, since they were considered less knowledgeable or even ignorant about varous affairs. Even decisions concerning when a woman should consult doctor for her health problems (or register for antenatal care) and when she should take her sick child to the health centre, are often taken by the husband. The woman has to wait till her husband decides to give her the money needed for medicine and doctor's fee. It was revealed by women in the study that generally their husbands were more willing to spend on their children's health than on their wives. However, both mother and father were found to give first preference to children's health than on their own. They delayed treatment of their health problems till they were just unable to work, since they couldn't afford the luxury of going to a doctor at slightest illness.

It was observed that those women who were engaged in economic activity (or were previously engaged but had left because of pregnancy and child care responsibility) exercised relatively greater authority in decision making process than those women who although work hard the whole day in their homes but do not earn cash income for the family. Women thus expressed the desire to be engaged in home based economic activity by which they could earn some money for their family as well take care of their young children. It was revealed by most of the women that their husbands often diverted a part of the family income on their personal uses, thus deprive the family of precious cash earnings. These women felt that if they were able to earn some money, they would spend the entire amount on good food, clothes, and proper medical care for their children and husband.

Educating slum women thus seemed a must not only for improving their social (as well as economic) position, but also for improving their health conditions. It was found in the present study that whereas 61 percent of women who registered for antenatal care were illiterates, 76 percent of women who did not utilise antenatal care, were illiterates. Similarly, 90 percent of those women who did not utilise immunisation facilities were illiterates. Thus it seems that a woman who has at least a primary level of education, is more likely to be aware of need for medical care during pregnancy and for infants, as well as to utilise the existing health facilities. This finding has been corroborated by Kapil (1980) and Dutta's Study (1990). Moreover it was felt that a woman who has passed at least primary school,

was more likely to accept health educations than an illiterate woman. The need for imparting health education among these slum women can be seen from the fact that only 13 percent of pregnant women had registered in the first trimester (table 15), although 61 percent of women (in the study) had registered for antenatal care, implying that very few were really aware of the benefits of early registeration (to both mother and foeetus). Further it was found that mostly women utilised antenatal services, when they were having complications or that they wanted to take precautions since in previous pregnancy they had experienced acute health problems (as can be observed from table 16). Hence these slum women should be informed clearly about the reason why they need medical care during pregnancy, so that they are able to utilise these facilities properly. Moreover, the fact that out of the 22 percent of women in the study who had given colostrum (the first breast milk) to the baby, 68 percent were informed about the high nutritional quality of colostrum by hospital nurse (since they had delivered in hospitals), further emphasized the need for imparting health education to these slum women. Thus, it could be observed that rural women after migration to urban slum areas were willing to accept new health practices, provided they are made aware and health facilities are easily available.

Many women in the study especially those from Uttar Pradesh were found to have social restriction on their mobility outside the slum and hence have very low work force participation rate. On the other hand, out of the ten women reported to have been working (as domestic maids) before pregnancy, eight were

Bengalees and it seemed in their case the restriction was less in operation. These women (who previously worked as well as those who were found to be currently engaged in economic activity) were found to be more confident in doing out door activities than those who had not moved beyond their homes and the study area. This was the case since work brought these women out into contact with the wider society, even if these contacts were limited in scope and content and thereby made them self confident. It was observed that most of the women belonging to Uttar Pradesh utilised antenatal services and immunisation facilitiess from the nearby Aasha MCH centre (which is less than a kilometre from the slum) while quite a few Bengalee women who were used to moving beyond their homes for doing various activities, went as far as Safdarjung hospital (which is 8-9 kilometres away from the slum) to avail these health services. Further it was reported by some of the women hailing from Uttar Pradesh that because Aasha maternal and child health centre was so nearby they were availing antenatal services as well as immunising their babies since they couldn't go far away from the slum to seek medical care without their husband accompanying them (which is very rare since men bear the economic burden of their families). This kind of inverse relationship between distance travelled for availing antenatal care and utilisation of antenatal services has been found in other studies too (Sapru, 1974).

Utilisation of health services was seen to be dependent not only on the distance to be travelled for availing it, but also on how slum women perceived the health services rendered by health

centres, whether government or private. It was reported by most of the women in the study that lack of money forced them to go to government health centre. However they did not feel satisfied with the services rendered by the health personnel in the government health centre or hospital. Thus, those women who could afford private health services preferred going to a private doctor/clinic, while those who could afford only government health services went to a government health centre for curative services only. Even then they were not satisfied since they did not get immediate relief by taking medicines from a government health centre. It was further observed that they ignored going for preventive health services like utilising antenatal care and immunisation facilities, since it involved spending their whole day in long queues or being required to go more than once to the health centre because of non-availability of medicines/injections etc.

CULTURAL FACTORS:

Differing values and customs dervied from the rural society, were seen to persist in the urban environment too. It was found that majority of the slum dwellers (both Hindu and Muslim) depended on traditional healers for the treatment of many of their physical ailments. These traditional healers deal with problems where other treatments have been tried and not found beneficial and those which are believed to have supernatural causes. Some traditional healders charge quite a high fee (sometimes higher than medical doctor) while others accept any payment (without formally fixing a rate), whether in cash or

kind. It was observed that most women preferred those healers who did not extort a high fee from them but accept what was willingly given. This was not only due to economic reason, but also because according to their belief these healers get healing power as a gift from God, and therefore they should not cash upon it. Further, it was observed that depending upon the kind and intensity of health problems, these women first consulted a medical doctor (when sickness was severe) or a traditional healer. However some women reported that they had lost faith in traditional healers since their children had died in consulting a traditional healer first and delaying treatment by a doctor. On the other hand, few women revealed that they had benefitted immensely from the traditional healing system.

Thus, it was observed that for certain types of health problems like infertility, repeated pregnancy loss, fear of evil eye, spirits etc. these slum women consulted traditional healers and most often felt benefitted. On the other hand, for high fevers, diarrhoeal infections etc. in young children, they preferred consulting doctor since whenever respondents had delayed treatment because of going to a traditonal healer, it had often proved fatal. An important difficulty faced by slum women was of not getting a 'good' traditional healer in urban environment. Hence many women reported having faith in the system of traditional healing (as they reglarly consulted such healers in their village) but that they had given up because of staying in slum environment.

Maintenance of dietary taboos during pregnancy and post-natal period has been reported by few studies on rural and urban slum women (Satpathy, 1987; Shiva, 1992). In this study too, majority of women reported the necessity for observance of food taboos during pregnancy and especially in post-natal period. Eating less food and water, avoiding certain 'cold producing' food (like rice) and those which are likely to cause gastric upset, were in most cases strictly observed by pregnant and nursing mothers. It was however observed that such cultural taboos were less in case of Muslim women and majority of them revealed that they do not maintain any such taboos or follow them less strictly. It could be seen that strict observance of such taboos by slum women (as has been found in the present study) deprive their body of essential nutrients during pregnancy and post-natal period (that is, over a period of time when they need a specially nutritious diet). This is because while according to their cultural belief they should avoid certain foods, they are also required to consume other foods in sufficient quantities like milk, fruits, ghee, dry fruits etc. But in the existing economic reality, for most of the slum women it is unthinkable to buy such expensive foods, let alone consume them in large quantities. Thus slum women avoid the tabooed foods, while being unable to eat the culturally prescribed foods during pregnancy and post-natal period.

Another culturally tabooed food is colostrum, that is the first breast milk of the mother and this was observed to be strictly maintained by slum women in urban environment (77.9

percent mothers did not give colostrum to their babies in the present study). Thus, it was observed that although breast feeding was universal, because of certain socio-cultural beliefs, most often it was not initiated on the day of the birth of the child but sometimes delayed till the third day of the delivery. Infants were hence deprived of essential highly nutritious colostrum because of the existing socio-cultural system and norms. Moreover weak body of lactating slum mothers very often resulted in insufficient breast milk, which meant feeding the infant with milk bought from the market, and if inhygienically given causing various kinds of infections to the infant.

As has been found in the present study and in other slum studies (Bhatnagar etal, 1986) slum women maintain the traditional practice of delivering their house itself (table 12). The care of new borns in the home is governed by traditional practices and customes. While some traditional practices are harmful (eating less food during pregnancy, use of an unsterile knife or blade for cutting the umbilical cord, discarding of colostrum and delaying breast feeding)., many are not and some may indeed be superior to the "modern" system (isolation of the mother-infant for 40 days ideally, oil massage to the new born confinement at the woman's maternal home). Elderly persons in the family (whether in village or in slum itself) as well as traditional birth attendants, have tremendous control on what should be done or not done during pregnancy, labour, post partum and new born care.

It was observed that very often proper hygien e was not maintained by the traditional birth attendants who conducted most of the deliveries in the slum. Proper hand washing by the "dais" remained a problem, especially in water scarce areas and sterilization of cord ties and blades continued to be an infrequent practice in slum environment. Moreover, the dais very often in collaboration with the quacks in the slum gave injections to pregnant mothers for easy delivery, which could possibly lead to complications since the patient is not under the observation of an experienced qualified doctor. Thus, the cultural practice of deliverying by the hands of a dai, could sometimes lead to complication resulting in death of infant or mother. However, the cultural practice of keeping the mother and the newborn together for some period of time, proves beneficial for both mother's and child's health. The mother's body get the much needed rest after delivery and the baby gets warmth from the mother's body in an otherwise cold slum home. Many mothers reported that they regularly massaged their babies with specific oil, since that was the practice observed in their village home by elderly females in their families. Hence it could be observed that while some of the socio-cultural beliefs held by slum women had an adverse impact on their child's health as well as on their own, quite a few had a postive impact.

The trend of delivering at home instead of in a hospital among slum women, was not only due to observance of traditional practice but also in many cases because of previous bad experience in government hospital. Slum women were scared of

rude behaviour and neglect by hospital staff during delivery time. Some women reported that the doctors came after delivery was over and that they delay in handing over the infant to the mother. Few women were of the opinion that hospital meant a lot of running around from one counter to the next and in late stage of pregnancy, this proves difficult. Thus majority preferred slum home (where they get support from their own caste group), over the cold, uncooperative, and indifferent environment of public hospitals. Moreover, even for their health problems, many women are reluctant to go to hospital since they feel that proper medical care is not provided there, instead they are left at the mercy of doctors and nurses who are least cooperative and often hostile in their attitude towards them.

Even for Aasha MCH centre, which is otherwise relatively more acceptable to the slum women than the government dispensary, the slum women in the study feel that their health workers often adopt a superior attitude and scold them for every small reasons. Many women reported that very often when their children suffer from diarrhoeal infections, the health staff at Aasha accuse them of neglecting the baby, without specifying the cause of the health problem and the remedy for it. Further, it was alleged by some women that the free medicine given by Aasha are old and hence do not work, while the medicines prescribed and to be bought from the market, prove too costly for them. Thus there seemed to be a gap between what is expected by slum women from the health institutions (both government and non-governmental ones) and what is given by health providers in these

institutions. This often discourages slum women from utilising urban health services, while at the same time not being able to seek treatment of their (and their children's) health problem in their own traditional way, because of staying in urban environment.

CHAPTER - VI

SUMMARY

SUMMARY

Slum areas are characterized by overcrowding, poor environmental sanitation, inadequate infrastructural amenities like sewerage lines, protected water supply etc. and proliferation of socio-economic maladies. Urban slums are comprised of fairly heterogeneous floating groups of population, which are economically and socially deprived and faces multifarious problems on health front. Slum women suffer from far more inequalities than slum men, since they accumulate in themselves all the disadvantages of the division of society into urban rural, upper lower class, high low caste and male female categories. Further, pregnant women and infants in particular are the most vulnerable sections of slum population since pregnancy and infancy in slum conditions are associated with many grave risks, which endanger their lives. The health problems of underprivileged slum women and children require special attention because of their special placement in difficult areas and the difficult circumstances in which they live. There is paucity of information on health problems and practices of slum women (especially during pregnancy) and infants, as well as the various factors influencing them. Thus, the present study aims to highlight the health problems and practices of pregnant and lactating slum mothers as well as children below one year, and the role played by various factors (physical environment, social, economic, cultural) in influencing it.

The study was conducted in Bhumiheen camp, which came up in 1977 as a jhuggi jhompri colony in Govindpui, South Delhi. The study area has an approximately population of about 10,800 migrated persons from different states like Uttar Pradesh, West Bengal, Bihar, Madhya Pradesh etc. living in 2060 houses distributed in four blocks (A,B,C and D). The study area is situated between busy market area of Kalkaji DDA flats and Govindpuri, with Okhla industrial area (major source of livelihood of residents of Bhumiheen camp) only 3-4 Kms away. The slum population of Bhumiheen camp is predominantly Hindu with Muslims accounting for only 5 percent of total population.

A survey was carried out first to identify the target study hoseholds of lactating mothers with children below one year and pregnant women of all trimester. It was found that over the period of two months there were 45 pregnant women and 86 lactating mothers with children below one year in Bhumiheen camp. While all pregnant women were included in the study, a systematic random sampling of every second lactating mother having a child less than a year, was done. Thus the study sample consisted of a) all 45 pregnant women (of all trimester) and b) 43 sampled lactating mothers with children below one year. For collecting in-depth data from the study sample three diffrent schedules namely area profile, household schedule, case study schedule were used. Before collection of data, an effort was made to establish good rapport with residents of Bhumiheen camp.

It was found in the present study that health problems and practices of slum women were profoundly influenced by an interplay of environmental, social, economic, and cultural factors. The common health problems reported by slum women (in the study) were fever, chronic backaches and jointaches, skin diseases, chest pain, tuberculosis, and respiratory problems. While infants were found to be suffering mostly from cold, fever, pneumonia, and diarrhoeal infections. These health problems of women and children could be directly related to their physical environment, that is, over crowded conditions, use of hazardous housing materials, lack of ventilation, lack of protected water supply, open and stagnant filthy drains, inadequate garbage disposal faciliies, prevalence of flies and mosquitoes,lack of proper toilet and bathing faciliies and heavy domestic work load in harsh slum conditions. Further, it was found that 35.2 percent of women in the study faced complications during pregnancy such as swelling of feet, stomach pains, anaemia, and weakness. This could be directly related to the socio-economic condition under which slum women are forced to live. It was observed that women and children ate leftovers from meals (generally comprising of only wheat, lentils and sometimes vegetables) cooked for male members of the household. Thus pregnant and lactating slum women who have special nutritional needs, were deprived of adequate and nutritious diet because of their economic status and social norm of feeding husbands first.

A very low female literacy rate was fond in the study population, which deprived these women of decision- making authority, the opportunity to earn cash income for the family (and thus raise its standard of living) and to be independent. All these were observed to have an adverse impact on health situation of women and their children. Educating slum women seemed also necessary since it was found to have a positive impact on utilisation of antenatal health services and immunisation facilities. Some educated slum women were found to have given up harmful traditional practices like eating less food during pregnancy, discarding of colostrum and delaying breastfeeding, as well as unhygienic way of delivering in their homes.

However, most of the slum women in the study area were found to be continuing at least some of their traditional health practices (though to a much lesser extent) associated with pregnancy and child rearing in urban slum environment. These women were found to be consulting traditional healers for their (and their childen's) health problems, observing dietary taboos and rituals during pregnancy and post natal period, delivering at home by traditional birth attenants, discarding colostrum, and delaying breast feeding. Strict observance of traditional practices was not possible in urban environment because of predominance of nuclear family structure (in the study area), greater awareness and acceptance of urban health facilities. Many problems associated with pregnancy, childbirth and child rearing in slum conditions, were coped by study population with

support from caste and kin group women. Although there was greater awareness and utilisation of health faciliies by study population, there was also high level of dissatisfaction with urban health services (especially government). Thus, slum women, while being unable to continue many of their traditional health practices in urban environment, are also unable to adopt new ways of dealing with their health problems since urban health infrastructure is not oriented to meet their needs.

REFERENCES

REFERENCES

Agarwal, D.K., Katiyan, G.P., Influence of environmental factors of under five morbidity, Indian Pediatrics, Aug 18(9), 1981.

Basu, A.R., Urban squatter housing in Third World, Mittal Publications, 1988.

Basu, S., 'Health and culture among the underprivileged groups of India'. State of India's Health, VHAI 1992.

Bharat Sevak Samaj Delhi Pradesh 'Slums of old Delhi' Almaram & Sons, 1959.

Bhatnagar, S., et al, 'Health Care Delivery model in urban slums of Delhi (Report) NIHFW, 1986.

Bijlani, H.U., Roy P. (ed) 'Slum Habitat Hyderabad Slum Improvement project, CSD, 1991.

Bose, A. 'India: The urban context: in Dube, S.C. (eds) India since Independence, 1977.

Chakraborty, S., Rana, G. - Violence in urban slums; A case study of Delhi; Social Action Vol.43, No.2, 1993.

Chijkara, A.J. Gupta, S. 'Growing up in an urban slum; Indian Pediatrics, Vol.23, 1986.

Desai, A.R., Pillai, D., (ed.) Slums and urbanization, Bombay Popular Prakashan, 1970.

DeSouza,A. 'The challenge of urban poverty in Desouza (eds) The Indian City, 1978.

Dutta, P.K., et.al, 'Utilisation of health services by 'High Risk' pregnant women in a semi-urban community of Pune. Indian Journal of Maternal and Child Health, 1990(1):15-19.

Dutta, P.K., et al, 'Utilisation of health services by 'high risk' children under five in a slum of Pune, Health and Population-Perspectives and Issues. Vol7(2):148-58, 1984.

Dwivedi, S.N., et.al 'Malnutrition among children in an urban Indian slum and its associations; Ind.Jr.of Maternal and child health, Vol.3, No.3, 1992

Fernandes, W., 'Urbanisation, coping Mechanisms, and slum women's status' Social action, Vol.41, Oct-Dec.1991.

Ghosh,S., 'Infant and childhood mortality' Ind. Pediatrics Vol.24, 1987.

Grover, V.L., Roy,S., 'Pattern of services utilized by slum dwellers for maternal care', Proceedings international conference in primary health care, 1988.

Gupta,S., Socio-Economic and political determinants of people's responses to their health problems - A case study of New Seemapuri - a resettlement colony of Delhi, M.Phil Thesis, J.N.U. 1990.

ICSSR-ICMR - Health for all. An alternative Strategy, 1981.

Jill Carr-Harris - Environment and health State of India's Health, VHAI, 1992.

Kapil, U. - A study of High risk mothers and children under five in a semi urban community. Thesis for M.D. preventive and social Medicine, Delhi University, 1980.

Khanna, S., et.al - A comparative study of effects of socio-economic and mothers education on child care and feeding practices in normal and malnourished children in urban slums of Bombay, Souvenir Nepas Jou.3(1), 1984.

Kolenda, P.M., Regional differences in Indian family structure, in Crane, R.I (eds) Regions and Regionalism in South Asian Studies.

Kumar, R. et.al., Health Seeking Behaviour of Urban slum dwwellers Health and Population - Perspectives & Issues, Vol.14, No.1 and 2, 1992.

Majumdar, T.K., Urbanising poor - 'A sociological study of low income migrants communities in Delhi, 1975.

Murthy, G.V. et al. 'Utilisation paterns of Antenatal services in an urban slum 'The Jr.of Obst. & Gynea. Vol.1, Feb.1990.

National Building Organisation - Handbook of Housing Statistics, New Delhi, 1981.

National Institute of Urban Affairs - State of India's Urbanisation (1988).

Pal, M., Study of factors affecting the utilization of maternal and child health and family planning services among the urban slum dwellers. M.D. Thesis, Delhi University, 1993.

Qadeer, I. 'Integrally women; 'Health for the Millions, VHAI, Vol.XVII, No.5, Dec.1991.

Ramalingaswami, P., The child as a focus for Health promotion in the developing World' Soc.Sci. & Med., Vol.22, 1986.

Report of UGC - DRS project A integrated study on MCH problems of socially disadvantaged group in rural and urban areas of Maharashtra and Gujarat - Deptt. of Science & Nutriton, Bombay Univ. 1989.

Sabir Ali, Slums within slums, A study of resettlement colonies, CSO, 1990.

Sapru, R., Appraisal of MCH/FW services rendered through an urban MCH/FW centre and urban maternity homes. Thesis for M.D.(CHA), 1974.

Satpathy, S.K., et al, 'Dietetic Behaviour of Antenatal Mother in an Urban slum community of Pondicherry Ind. Jou. of Commu. Medi. Vol.XI, No.3, 1987.

Shiva, M., 'Women and Health' State of India's Health VHAI, 1992.

Singh, A.M. 'Women and the family Coping with poverty in the Bastis of Delhi' in DeSouza(ed) The Indian City, 1980.

Singh, A.M., Desouza, A. 'The urban poor slum and pavement dwellers in the major cities of India' (New Delhi, Manohar, 1980).

Siva Rama Prasad ' The slum Health, An exploratory study of prevalence of illness in an urban slum' M.D. thesis (1974).

United Nations Secretariat - Urban land policies, Doc. ST/SCA/9 Apr, 1952.

WHO - Risk Approach for MCH Care, WHO offset publication, No.39, 1978.

Wiebe, P., 'Social life in an Indian Slum' 1975.

Zurbrigg, Sheila, Rakku's Story: Structure of ill-health and the Source of Change (Madras; Sidma offset press, 1984).

APPENDICES

APPENDIX - I

STUDY AREA PROFILE:

1. Name of the slum area
2. Total number of households
3. Total Population
4. Break up of households by communities
5. place of origin of the main inhabiting communities
6. Drinking Water Source:

Type	Number	In working condition (Yes/No)
Tap		
Tubewell		
Handpump		
Others		

7. Washing Facilities:

Utencils	A.	In kitchen/bathroom
Clothes	B.	Outside house
Bathing	C.	Near tap/handpump

8. Drainage:

a) What kind of drain? Closed/open/stagnant pond/nallah

b) Is there any ditch containing water near house in the community? Y/N

c) Do you/official spray chemicals on open drains?

Y/N if yes, how often?

9) Latrines:

a) Are you using latrines? Y/N

Community or private

b) If no, how near to locality are the functions being performed? (in feet)

c) Location of toilets - in house/behind/close to house

d) Are the latrines from - DDA/Sulabh

e) Who use toilets/latrines most frequently?

Adult Male Women & children

f) Any charges levied for using toilets?

g) How far are latrines from water source?

10-20 feet

20-25 feet

50 or more feet

II. Garbage:

a) Where is the household waste dropped?

nearby and in same locality

far but in same locality

in different locality

in Govt. dump

b) Do the municipality peple visit lyour locality regularly to remove garbage? Y/N

c) If no, do you take action to keep your locality ;clean? Y/N

Collective effort Y/N

12) Location:

Identyfy in area, number of

a) Roadways Major Minor

b) Industries Major Minor

c) Market centres large Small vendors

d) Educational Institute

e) Medical services Nos.

Govt. Hosp/clinic

pvt. Hosp/clinic

Drug store/Pharmacist

Pvt. allopathic doctor (RMP)

Ayurvedic dispensary

Traditional Healers

ICDS/Special nutrition programme

Voluntary Health Organisation

14) Incidence of Epidemic during last one year

Epidemic	Yes	No
Malaria		
Cholera		
Chicken pox		
Conjuctivitis		
Dengue fever		

APPENDIX - II

HOUSEHOLD SCHEDULE

HOUSEHOLD PARTICULARS:

1. Name of: a) Head of household _____

   b) Respondent _____

2. Status of women: Pregnant and or lactating mother

   No.of children: One two three four

3. Religion _____ Caste _____

4. Educational Status: Wife_____ Husband_____

5. Occupational Status: Wife_____ Husband _____

6. Family size/history:

   a) No.of family members_____

   b) Any case of death in the family/still birth etc.

7. No.of earning members

8. Total family income (Approx.)

9. Name of place from where migrated

   Reason of migration
   Duration of stay in the slum area

HEALTH RELATED PARTICULARS:

10. Do you have any health problem?
    What are those and since when?

11. Did you face any specific health problem during pregnancy or after delivery?

12. Do you know any health institution/MCH centres available near your area?

13. Did you visit any of the institutions during pregnancy?
    If yes, where and what did they do?

    If No, why not?

14. Do you know any health worker who visits your slum area? What does/he/she do?

15. Are you stisfied with the treatment/behaviour of health staff (or the health worker) at the health centre you visit?

16. Do you consult private doctors? Where?
What is your preference between Govt. dispensary and Private doctors? Why?

17. Where was the last delivery conducted?
by whom?

18. Was there any complication at the time of delivery or later on because of delivery?

In mother
In new born

19. Whom would you prefer for conducting delivery in future? Why?

20. Did you get your child vaccinated?
If yes, where and how regularly?
If no, why not?

21. When a child has severe diarrhoea or dysentry, cough and cold with fever, what do you do ?

22. Have you ever used home remediess?

If yes, state the type

23. Do you consult any traditional healer?
Did it prove beneficial?

24. Do you get the encouragement of your family members in taking your child yourself to the health centre?

25. Do you have any customs to follow during pregnancy or in the post-natal period?

26. Did you give colostrum to your child? Why?

27. How long do you breast feed the baby? when are semi solids introduced?

28. What are the major problems you face in day to day life in the slum?

29. What factors do you think are responsiblee for your (and your family's) health problem?

APPENDIX-III

CASE STUDY SCHEDULES

STATUS & ROLE OF WOMEN

1) Role in decision making

a) Take independent decisions without consulting husband.

b) Her opinion always taken by the family while taking any decision.

c) In which matters your opinion is not considered?

2) How does your husband react when you are not well?

i) Takes you immediately to the hospital.

ii) Helps in household work.

3) How is a woman treated by male members of the family before child birth?

4) Is there any difference in treatment if the first issue is female/male?

5) Is there any change in attitude of other family members towards her after the first delivery?

6) Do you feel uneasy when your husband cooperates with you in domestic activities? Yes/No

7) Which activities of thee children are looked after by

a) Father
b) Mother
c) Both

8) How is your husband's behaviour towards you?

i) Good behaviour

ii) Beating

iii) Capital harassment

9) How often do you disagree with your husband's decisions regarding your family?

Do you always express your disagreement?

10) Is there any role of social worker, Mahila Mandal, Voluntary organisation or Govt. organisation in your locality for women?

11) Do you participate in any activity of female organisation?

WOMEN'S PERCEPTION OF HEALTH & DISEASE TREATMENT

1) Meals per day

2) Vegetarian/Non vegetarian diet

If non-veg., state the frequency of intake

3) How often do you take milk?

a) Once a day

b) Once a week

c) Not regularly

4) Do you think the food your family is consuming is adequate? or would you like something more?

5) How long can you work at a stretch?

6) Do you face any problem while working?

If yes, state the source of discomfort

7) What are the common illnesses among women?

8) When do you decide to consult for sickness?

Immediately
After a few days

9) Where do you go to take the treatment for sickness?

10) In case of sickness generally who takes the decision for consulting doctor?

11) Do you take medicines regularly as prescribed by the doctor and also go for follow up?

12) Have you ever shied away from medical help?

If yes, specify with reasons?

13) Any perceived relation between excreta and gastroenteritis?

14) Any perceived relation between exposure to garbage and skin problem?

15) What is your opinion regarding the following?

a) Respiratory disease related to air quality

b) Gastroenteritis related to water quality

c) Skin problems (scabies etc.) related to environmental sanitation.

d) Fever due to malnutrition.

16) Any relation between social environment and ill health of community?