SOME ASPECTS OF UTILISATION OF HEALTH CARE SERVICES IN DELHI – A CASE STUDY OF DELHI SLUMS

Dissertation submitted to the Jawaharlal Nehru University
in partial fulfilment of the requirements
for the award of the Degree of

MASTER OF PHILOSOPHY

PARAMITA MOOKHERJEE

Centre for the Study of Regional Development
School of Social Sciences
Jawaharlal Nehru University
New Delhi – 110067

2002

जवाहरलाल नेहरू विश्वविद्यालय
JAWAHARLAL NEHRU UNIVERSITY
Centre for the Study of Regional Development
School of Social Sciences
New Delhi-110067

CERTIFICATE

I, Paramita Mookherjee, certify that the dissertation entitled " **SOME ASPECTS OF UTILISATION OF HEALTH CARE SERVICES – A CASE STUDY OF DELHI SLUMS**" degree of **MASTER OF PHILOSOPHY** is my bonafide work and may be placed before the examiners for evaluation.

Paramita Mookherjee

(PARAMITA MOOKHERJEE)

Forwarded by

(DR. SACHHIDANAND SINHA)
SUPERVISOR

(PROF S.K. THORAT)
CHAIRPERSON

29/7/2002

Tel. : 6107676, 6167557 Ext. 2466, 2463 Gram : JAYENU Fax : 91-011-6165886, 6198234

I dedicate this work to my

Respected Teacher,

Dr. Sachhidanand Sinha

Acknowledgements

With all humility I acknowledge the presence of the devine force in equipping me with the strength to finish my humble endeavour.

Immortality apart, mere gratitude and recognition of my debt to my supervisor, Dr. Sachhidanand Sinha, *seems a frivolity beyond forgiveness. But for Dr. Sinha, with his constant guidance and complete understanding it would have been an impossible task to finish this dissertation. As a matter of course, I cannot contain my gratitude to him in words.*

The deficiency of the English language is proving quite a deterrent in expressing my feeling for my parents whose presence at this moment of crisis in my life helped me tide over and write this work

My next vote of thanks goes to the Office staff at the Centre and at the School office whose sympathy and understanding made it possible to go through the formalities with all speed and smoothness.

My friends in the hostel and in the Center have given me constant encouragement to finish this work. All of them in their own way have tried to make me comfortable and provide me with all kinds of help so that I may recover fast and carry on with my work. My Thanks to them is a formality.

Contents

List of Tables

Chapter I

INTRODUCTION

The world Health Organisation has defined health as the state of complete physical and mental well-being and not merely an absence of any disease. The availability of health care services is a major factor in determining not only the level of well-being but also the question of ones survival. Health is an accepted fundamental entitlement of every human being. Now the question that arises is how far is the reality in accordance with the theory. This study seeks to understand the inequalities in the provision of health care facilities as far as the underpriviledged are concerned.

The question to be pondered over is that do the available facilities have a proper access to the population. One important factor is the physical ability to attend while the other is the financial ability to utilize it by paying. In what way can the provision of health care facilities be made accessible to the population? It is a fact that it is accessible to every body whoever stays nearby the facility or is it accessible only when one has the capacity to pay.

The next important question is of utilization. How are the facilities being provided and utilized by the population? This perspective includes the difference in the location of private and government institutes cum agencies, which, as a whole, goes a long way to affect the utilization pattern. This present study concentrates upon the aspect of accessibility and utilization pattern of the health care facilities, which, in

various way as an indispensable aspect takes the 'distance' criterion into consideration.

OBJECTIVES

(1) To examine the morbidity pattern of the slum segments of the urban population and how such needs are met by them, and
(2) To study the nature of differential use of health facilities in the context of curative and preventive health care.

DATABASE

The relevant data has been collected during the fieldwork conducted between 27th December 2001 and 8th January 2002.

METHODOLOGY

Field work has been done to collect the data from the seven of the slums.

The questionnaire was compiled keeping in mind that the main thrust was on health and the factors contributing directly or indirectly to the shaping of health status of the slums.

The sample household were chosen on the basis of location of the houses and the apparent economic condition i.e. good, bad and worst location then better off households, poor amenities etc. The idea behind this was that type of location and apparent economic condition could be expected to have an effect on the socio-economic condition and therefore

serve as a better reflection on the health status. In this manner, the information collected, have quite a good representation from all the different social and economic sections present in the slum.

Other than this percentage figures have been calculated showing the utilisation of the facilities and other characteristics.

Apart from this socio – economic status has been calculated for each of the 588 households. For this purpose indicators like education and occupation is utilised. For education, the total number of schooling years is considered. The average years of schooling of each household is calculated by dividing the total by the number people in each household. For occupation, ranks are assigned according to the type of occupation. Then an average of these ranks is taken. Next equal weightage is given to both these indicators as it is not known where one becomes more explanatory than the other i.e. Education - 0.50 and occupation – 0.50. This weightage is then multiplied by the figure got for each according to their ranks. Finally the socio – economic status is arrived at by adding the values for both these indicators.

The information regarding the ten diseases that have been clubbed together into four categories of degenerative, infectious, accidents and injuries and other diseases.

The seven slums have been divided into two sections of inner area and outer area. In the inner area slums like Kusumpur Pahari, Mayapuri and R.K Puram Sector are included while the outer area includes Yamuna Pushta, Mongolpuri, Narela and Samalkha. This is an attempt to understand the relationship existing between accessibility and utilization. Most of the studies have identified a negative relation ship

between distance and utilization pattern (Phillips, 1990)[1]. Although there have been instances where it is observed to vary according to illness. The analysis includes both the major and the minor ailments.

An Overview of the Slums Surveyed.

These slums were chosen keeping in mind that in Delhi they are spread all over. So an attempt has been made to bring some sort of a representation from each direction i.e. north south east west direction. Kusumpur Pahari, Ram Krishna Puram Sector– 2), and Samalkha are all located in the southern part of Delhi. Mongolpuri, Mayapuri are located in west Delhi. The resettlement colony of Narela is located in the north, practically adjacent to the Haryana border. Yamuna Pushta is situated on the banks of the Yamuna in the east of Delhi.

A summary of the slums are presented as follows :

Kusumpur Pahari

This slum is located in the posh locality of Vasant Vihar. It is completely hidden from the eye of a stranger walking in the area. It is quite an old one, slumming starting as early as 1972 approximately. About 75%, drawn from the neighbouring states –Rajasthan,Punjab and Haryana. This is a L-shaped settlement, with a cemented road going through it. The relatively richer and educated inhabitants are to be found settled on the sides of this cemented road. At the center of this slum, there is a playground and a closed community toilet. Almost half of the households have a pucca floor, with pucca or semi-pucca walls. The slum is divided into five blocks- A, B, C, D and E. Most of the houses

[1] Phillips, D. R. (1990), " *Health and Health Care in the Third World*". Longman Scientific and Technical, UK Ltd.

were pucca structures though somer had kutcha roofs. Electricity connection along with metres was found in nearly all the households. Those who did not have this resorted to hooking though none of them admitted to doing it. Those who had metered connection complained that they had to pay agents a fixed some of money every month other than paying the electricity bills. Garbage disposal was another problem. The residents had to lodge a complain every time to get it cleaned which happened to highly erratic; once a week to once a month depending upon the whims of the municipality and the local councillor. In some areas of the slum water posed a major problem. Serpentine queues were seen at the two local set of taps all throughout the day. Health care was provided by the PHC located in within the slum along ASHA (an NGO). Apollo group of hospitals had set up a charitable health centre called Mangaldeep. Other than these there were local RMPs.

Yamuna Pushta

The Yamuna Pushta slum (J.J. Camp, Thokar –8) is inhabited mainly by non-Bengali Muslims in the peripheries and by the Bengali Muslims at the core. The Bengalis have a community toilet. Water is uniformly distributed. But, in the Bengali-dominated areas, the roads are not properly cleaned and except for the locations along the main road, the lower and outer areas have a very bad drainage system. The inhabitants of this slum use building materials such as bricks, cement and stones for walls and floors; but for the roof they use kuchha materials. The main road is at a higher elevation than the lanes and some of the lanes cross the road at right angles. The houses are not properly cleaned and their toilets are very dirty, sometimes being built near the houses in the lane. The houses are not well ventilated. The lanes joining the roads are so narrow that one cannot walk easily. The

inhabitants take their bath and wash their clothes in these lanes, making them even dirtier. There is a teaching center in this part of the slum, where the small kids get education. The Muslim-dominated area is replete with dirty roads and a poor drainage system. Water keeps on flowing throughout the day on the roads and houseflies, mosquitoes and other insects are to be found everywhere. One important characteristic of this area is the high fertility rate of the inhabitants, with almost every household having at least 8-9 children. The other distinct feature of this area is the presence of Madrasahs (Muslim schools). Houses in this area are made of bamboo and are built every 2-3 years. Their houses are usually one-room tenements with one corner serving as the kitchen. Some rich people do have cemented houses, but they are very few.

Mayapuri

The Mayapuri slum (Keshavpuram, J.J. Camp) is inhabited predominantly by the industrial workers who work in the neighbouring industries. Delhi Nagar Nigam (Municipal Corporation) provides water and toilet facilities to the slum. It has a linear pattern of settlement along one side of the Rewari Railway track, the other side being a cantonment area. For drinking water, they tap the underground water source, but since the water table is very low, it is very difficult to obtain water. Pay-and-use toilets are found at a distance of every 20 to 30 metres, which are cleaned by the Municipal authority. Many houses have pucca houses. . Electricity is taken on illegal connections. House structures show an eclectic mix of pucca walls with kaccha floor and semi pucca roof. Deepalaya and the government PHC provide the health facility ofthe slum. Two Sulabh complexes are present and these were found to be relatively clean. Many people in the Delhi Cantonment Railway station area live near the nala (sewerage) in relatively dirty conditions, almost

bereft of the basic amenities. As the inhabitants are mostly industrial workers, they enjoy free health-care facilities by dint of their Employee State Insurance (E.S.I.) Cards. There are some coaching centres to give education to the young children. There is a J.J.camp near this slum, which has very narrow streets and only one tap. This slum is the largest among all those surveyed. The migrants in this slum are mainly Biharis in search of jobs.

Ram Krishna Puram Sector – 2

Located on either side of the sewage nala flowing behind St Thomas Church gets flooded with every heavy down pour. The R.K. Puram Sector-III slum is actually a cluster of two small slums—Dhapu colony and Hanuman camp. Dhapu colony is situated on the bank of a nala.. Hanuman colony had comparatively better – off households than those in the Dhapo colony. Majority of the households were one room tenements with dark and dingy interiors. Some of these were rented while others were owned. Pucca structures were more though some kachha structures do exist. Most of the people were essentially new migrants hailing from Uttar Pradesh. The older inhabitants were comparatively better off than the newer ones as they owned the structure and had both the ration card and the VP Singh card. A PHC provided the health care along with two local RMPs. Relatively better basic amenities viz, better drainage; water and toilet facilities are enjoyed by the residents. Almost everybody has the V.P.Singh card, ration card and photo identity card. Most of the residents are migrants either fom Bihar and U.P. or from South India. The lanes are dirty and the houses do not enjoy sunlight. The Hanuman-camp mainly houses the kabariwalas. In the Ranidas-camp slum, the roads are cemented and well–drained, there is electricity in some houses and water facility is available in the

Municipal toilet. There is a primary school and a handloom-weaving center run by an NGO, Ranidas.

Mongolpuri

Mongolpuri slum lies in two portions; one stands sandwiched between two factories, called tank no 1 and the other between a factory on one side and a flyover on the other, known as tank no 4. it is also known as the Udyog Nagar slum. The pollution level is very high because of the factories and the flyover. The population of this slum has migrated from different parts of Uttar Pradesh. Hindus and muslims live side by side without any problems ever. The lanes are also very polluted and dirty. In this slum, water is available from both public taps and handpumps. But, the water obtained from hand pumps is very polluted and so is used only for washing purposes, while the water obtained from public taps (supplied by the Municipality) is used for drinking purposes. Most of the inhabitants work in the surrounding industrial works, and their children go to the Pilgarhi School. Almost all houses use hooked electricity. There is a pay- and-use municipal toilet but it is closed between 11pm and 4 am. So, the people soil in the open places during this time.Majority of the male members are employed in the factories. The residents themselves own houses or one-room tenements, although some households were found to live in rented establishments. In tank no 4 a separate cordoned off area was found to be allotted to the leprosy affected families. Most of these families had come to this area from South India for teatment and have subsequently settled down there. These families get special help and treatment from the government. The dwellers living outside this area were found to harbour a mild feeling of resentment towards these sick people mainly because of the facilities given to them by the government. Water, electricity is available though

the voltage of the power remains low. Health facilities are provided by Deepalaya (an NGO) especially for the Leprosy patients.

Narela

Narela is a resettlement colony. During the clean up drive of Delhi a lot slums were torn down. Of these those slums in Minto Road and near Jawaharlal Nehru Stadium were resettled here. The government did not pay them any concessions for this movement on top of which these slum dwellers had to pay Rs 7000 for a tiny piece of land. There is only one set of taps for drinking and hooking purposes and were water is available only twice a day. There is no provision of electricity. Health centres are nonexistent. Since they were moved away from there pace of work they have to travel over a long distance paying high bus fares. Thus most of the people are unemployed; people who once used to earn enough for two sqare meals earn nohing today. Their savings have depleted in buing the plot and the in the move. The children who used to regularly go to school are siting idle as there are no schools to send the children. New born babies are not getting vaccinated as there are no local health centres. The whole area of Narela is in the process of being developed by the government. It is only after a minimum of 7 to 10 years that the new township will be developed enough to generate employment to these people.

Samalkha

Near the Samalkha-Gurgaon old highway, a dirty and very congested cluster of jhuggis is situated known as the Sonia Gandhi camp. There is the Samalkha village across the road. The people migrating from U.P. and Bihar inhabit this camp. There is a clear

division within the slum, with one side being full of garbage, having dirty roads, poor drainage facilities and not even one toilet; and the other side having bricked lanes and a pay-and use toilet run by the Sulabh International. The biggest problem of this slum seems to be the absence of drainage facilities. There are public hand pumps, but the people use the running water from the taps for drinking purposes.

Organisation of the Study

The whole study starts with the introduction of the idea behind the work. It contains the idea behind the research of the work. It also contains a small overview of the slums that have been surveyed

The first chapter is in two sections. The first part deals with the introduction to the idea behind the study,the objectives and the methodology. The second part takes into account the diffrerent studies and issues raised by the scholars who have worked in the context of health and slums. It is a survey of Literature and a discussion of certain concepts and issues, which have emerged from the different works on this topic.

The second Chapter Deals with the socio – economic differentials affecting the general health conditions of the slums. This has been done in the context of a demographic explanation at an inter slum level.

The third Chapter looks in to aspect of morbidity and utilisation of the available health care facilities. How socio economic differentials present affect the pattern of morbidity and health care utilisation. This has been looked at from the curative health care aspect only.

The fourth Chapter is all about preventive health care. Immunisation of children, pre and postnatal care and assistance during birth is the contents of this chapter.

Final aspect of the study is the conclusion where an attempt has been made at criticising the programmes and policies initiated by the government in the light of the findings.

SOME CONCEPTS AND ISSUES RELATED TO ACCESSIBILITY AND UTILISATION OF HEALTH FACILITIES

The present section discusses the literature on various issues associated with accessibility and utilization of health care facilities in the context of its overall organization and public policy. The study has been devided into two parts; the first, dealing with an overview of the literature while the second part advances some theoretical issues, concepts and perspective pertaining to accessibility and utilization of health care facilities in urban slum areas.

I) AN OVERVIEW OF LITERATURE

The studies on the relevant theme may broadly grouped into two categories:

a) Socio-Economic characteristic affecting utilisation of health –care facilities; and

b) Planning and Public Policy on Health Care.

World health Organisation has defined health as " state of complete physical, mental and social well being and not merely absence of disease[1]. The Slums per se has been regarded by most sociologists as

[1]WHO, (1983), *" Report on the Expert Committee on New Approaches to Health Education in Primary Health Care, Geneva*

reaping grounds of social pathology. According to Bergel (1955)[2]this condition involves large number of persons; secondly there is a wide recognition that it affects adversely the welfare of individuals, groups or communities; and thirdly, it is amenable to some form of collective action. The main problem that comes across is the problem of poverty coupled with lack of education. Crushing poverty and low standard of living prevail in these pockets of pervasive depression This really means that the level of production is so low that the share of each is meager. It is really true that the terms "rich" and the "poor" are relative, and no objective criteria divorced from normative constraints exists that could measure the extent of poverty and wealth. The per capita income of these slum dwellers is still quite small and quite inadequate for any decent standard of living. It is well known that nutrition is perhaps the most important factor in the maintenance of health and resistance to disease. Moreover, it has a direct bearing on the productive capacity of the individual. The Reports of the planning commission, which is based on diet surveys undertaken from time to time, admit that both under-nutrition and malnutrition exist widely[3]. The Problem of poverty is extremely complex, as it is tied up with the problem of unemployment, which is again related to the problem of economic development.

SOCIO - ECONOMIC ASPECTS

In the model developed by Suchman (1966)[4], a greater emphasis was placed on social group influences and less emphasis on the psychological, state of readiness. He hypothesized that very different

---

[2] Bergel F. E. (1955), *Urban Sociology,* Massachusetts, New Jersey, USA

[3] Reports of the *Health and Development Committee (1946), The health Survey and Planning Committee (1961).* Planning Commission, Government of India.

[4] Suchman, E.A. (1960) "*Health Orientation and Medical Care*" American Journal of Public Health 70, 319-33

levels of knowledge and attitudes to disease and illness would exist among ethnic and social groups. It was suggested that a cosmopolitan social structure is more likely to have scientific health orientation. Nolan (1967)[5] and his associates conducted a study to find whether the removal of economic barrier through prepayment of health services is feasible or not. It was found that majority of the upper classes paid visits for health supervision, but at majority of the lower classes visited clinics for acute condition. A model by Anderson6 (1968)[6], refined by Aday (1980) has emphasized family life cycle and bahavioural determinants of utilization. Factors what may predispose towards utilization are family size, composition and health beliefs, but certain enabling factors such as family or community's health resources may enhance utilization thereof.

Khandekar (1974)[7] restricted her study to maternity and child health services of Bombay. Though she found that middle-income group had better knowledge of health services, she did not come to the conclusion that income was the sole factor in determining such a pattern. She analyzed the role of age, family size, education and occupation. While studying the relationship of socioeconomic status with mortality pattern, data health attitudes and utilisation of health services, Tragler (1985)[8] found that poverty, unfavourable living environment are prime contributory factors towards the inhealthy conditionsof the slums. An individual as a component of society, influences as well as gets influenced by the social norms, values and intersectional patterns Mehta

---

[5] Nolan, R. (1996) "*Social Class Difference In Utilization of Pediatric services in a prepaid direct Service Medical Care Program*", American Journal of Public Health and Nations Health, vol. 57, January

[6] R.A. Anderson (1986), "*A Behavioural Model of Families use of Health Services*", Center of Health Administration Studies, 25, University of Chicago, Chicago.

[7] Khandekar, M. (1974), "*Utilization of Social Welfare Service in Greater Bombay*", Tata Institute of Social ~~Services~~ Sciences.

[8] Tragle, A. (1985): "*An Appraisal Health Care in Slums of Bombay*", Indian Journal of Social Work, Vol. 45. No. 4.

(1992)[9] The varying situations and the human complexities give rise to diverse patterns of health care, a need to strengthen the sociological aspects through appropriate leadership structure. Further social inequalities give rise to different educational achievements, which in turn produce differential knowledge of health services needs Yesudian(1988)[10]. The author suggests an integrated development programme for the poor to narrow down social inequality.

Baru (1993)[11] in her empirical study on inter-regional variation in health services in Andhra Pradesh recognized that health status of a population is shaped by a variety of factors like food, water, sanitation housing, income, availability and accessibility to health care facilities. Health services are one just input required improving health status of the population, which are shaped by socio-economic and political factors in society. George and Nandraj's[12] (1993) study on Maharashtra focuses on the socio-economic indicators to examine the relationship between health sector development and capitalist growth. The study reveals that the state presents a picture of moderate achievement in the field of health care against the context of remarkable economic development.

Khandekar[13] (1974) restricted her study to maternity and child health services of Bombay. Though she found that middle-income group had better knowledge of health services, she did not come to the conclusion that income was the sole factor in determining such a pattern. She analyzed the role of age, family, size, education and

[9] Mehta, S.P. (1992) Society and Health, Vikas Publishing House Pvt. Ltd
[10] Yesudian, C.A. K. (1988), Health Services Utilization in Urban India, Mittal Publications,Delhi
[11] Baru, R.V. (1993), "Inter-regional variations in Health Services in Andhra Pradesh", Economic and Political Weekly 28(20), 15 May 93, pp. 963-967.
[12] George, A, & Nandraj, S. (1993), "*State of Health Care in Maharashtra: A comparative Analysis*", Political Weekly 28 (32-33): 7-14 August.
[13] Khandekar, M. (1974), "*Utilization of Social Welfare Service in Greater Bombay*", Tata Institute of Social ~~Services~~ Sciences.

occupation. Ravindra, T.K. Sundari (1996)[14] study attempts to draw attention to the consequences of material and social deprivation on the health of a scheduled caste population through the examination of health status of the most vulnerable population subgroup, namely children under the age of five years. The study show that within the SC population in Chengalpattu, both infant morality rates and probability of dying before the age of five are higher than the comparable rates for rural Tamil Nadu.The study reveals that curative health services are actively sought, within the constraints imposed by the socio-economic situations. Neither 'ignorance' nor 'cultural' beliefs prevent people from seeking health care. The study observes that the poorest section of the population use private health facilities in preference to primary health centers is an indicator of the failure of public vicious circle is set in motion, which further widens health inequalities.

The important issues like landlessness, exclusive dependence on daily wage labour, illiteracy, poor housing condition, lack of safe drinking water and sanitary facilities cause avoidable morbidity such as respiratory problem, worm infection and skin diseases. Unless these issues are tackled "reservation" and "quotas" cannot narrow inequalities in health experienced by SC population down. Despite considerable differences in infrastructural and socio-economic developments, morbidity rates were not found to very between the study settlements as seen by the study undertaken by Asthana (1995)[15] in his paper which describes environmental and other health hazards in five slum settlement in Vishakhapatnam..

---

[14] Ravindra, T.K. "*Social Inequality and Child Health Status A Study of a Scheduled Caste population*".

[15] Asthana, S. (1995), "*Variations in Poverty And Health between Slum Settlements: Contradictory finding From Vishakhapatnam, India*" Social Science and Medicine, Vol. 40, No. 2, pp. 177-188.

Visaria and Gumbur (1996)[16] analyzed the utilization of health care facilities in Gujarat and Maharashtra both urban and rural areas. The household survey was mainly done keeping in mind the effectiveness of the universal immunization programme, which was launched in the country in 1985. They have attempted in differentiating the utilization of health services in terms of immunization against major vaccine preventable diseases and postnatal maternity care. These services play a vital role in influencing the level of infant, child and maternal morbidity and mortality.

These are many studies in which models have been used to describe, determine and predict utilization of health services. Various social and psychological variables are used in models to investigate and to attempt to explain the utilization of health services. Some studies have attempted to incorporate aspects of the "demand side" according to age, sex and social class while other studies have emphasized on the supply side.

Some other studies highlight one common phenomenon that health care system in India does not meet the large section of the population. The present model is based on the 'western technological institutional model" which is costly. It relies too heavily on expensively trained doctors, nurses etc. The system is closely linked to a rapidly growing medical industry of drugs, equipment, technology which in turn has given rise to an almost organized industry though the benefits of all these do not go to the people in an even way. Yesudians study pertaining to utilisation pattern also is a detailed study showing the social indicators. Kannan's study concentrates unto the morbidity with the

[16] Visaria Praisra, V, & Gumber, A. (1996), "*Socio-economic Differentials in Patterns of Health Care Access and Utilization*". Pp.50-84, (ed) by Monica Das Gupta, Lucia C. Chem. T.N. Krishna: Oxford University Press, Delhi, Bombay, Calcutta, and Madras.

socio-economic status and environment status separately and the picture emerges very clearly when compared with these two indicators.

Ranga Reddy, A (1995)[17] in his paper highlights certain pertinent issues of health care services in rural and urban India. He says that medical care is considered as price elastic. Un-organized urbanization is a source for generating diseases.

Guha's[18] (1996) study pertains to maternal and nutritional aspects of urban poor women and health specifities of the urban environment. The principal finding of the survey were the following: the significance of the traditional sector in health Care; the high cost of medical care and the high proportion of medical expenditure on medicines, the server caloric and fat deficits among younger women and expenditure on medicines, the severe caloric and fat deficits among younger women; and the penury of space and consequent exposure to pollutants. In the analyses of these findings, several areas have been identified as practical priority issues that need to be addressed by policy-markers. In Calcutta, primary health care is severely under developed. Almost all care to the slum populations is provided through hospitals and thus, entirely curative in nature. The primary health care standards, the structure and orientation of the system are clearly difficult to apply in urban settings without appropriate modifications. The effective use of health care by women in the Calcutta slums, as in India is closely related to her status and value in society. Urbanizations have done little to change traditional attitudes and roles towards women among the urban poor.

---

[17] Reddy, Ranga, A. (1995) "*Health Care System of Underprivileged moving From the State of Corporate Culture*", pp.11-19, (ed) Health Care Services Management Editor A. Ranga Reddy, Delta Publishing House, Delhi, Hyderabad.

[18] Guha, S.D (1996): "Health and Nutrition of the Urban Poor: the Case Study of the Calcutta Slums, pp. 172-201. Rama V Baru (1993) "*Mixed Economy In Medical Care Some Issues*", Madras Institute of Development Studies 23rd Inter Disciplinary research Methodology

Baru's[19] (1993) paper gives a historical account of the role played by the government and the private sector in India in the provision of health care. It indicates how the two have always co-existed and how government policies have either encouraged the private sector through investments in medical education, infrastructure and research, through loans, tax and import duty concessions on medical equipment or has left the sector alone.

Kethneni's[20] (1991) study seeks to put the debate on relative efficiency of the state and market in production and distribution of health care services in a large theoretical perspective by bringing in Keynesian and Marxian view on the nature of the state intervention in a capitalist economy, particularly in health care, and to se their relevance in understanding the role of the state in provision of health care. The second section deals with Keynesian and Marxian views on the roleof the state in a capitalist economy. The nature of the state intervention in the health care provision in India is analyzed in the final section.

PUBLIC POLICY AND PLANNING IN HEALTH CARE

A critical analysis presented by Banerjee (1993)[21] about the World Bank Report on the health sector in India observes, that the report has astonishingly overlooked aspects like socio-economic force and other critical inputs for health service development. The report missed the vertical programmes like target oriented time bound family planning programme of immunization, which cause damage to the health services.

---

[19] Baru, R.V. (1993) "Mixed Economy In Medical Care Some Issues", Madras Institute of Development Studies 23rd Inter Disciplinary research Methodology workshop, June 8-11,1993,at, RUSHA, Vellore, Madras Institute of Development Studies and ICSSR.

[20] Kethineni, V. (1991) "*Political Economy of State Intervention In Health Care*", Economic And Political Weekly, Oct. 19, 1991, pp 2427-2433

[21] D. Banerjee (1993) "*Simplistic Approach to Health Policy Analysis World Bank Team on Indian Health Sector*" Economic and Political Weakly, June 12, vol. XXVIII, no. 24

Banerjee says that the team calls for greater central action of health services at a time when the country has opted for a major programme of decentralized administration and the does not consider it as a policy alternative the country can look forward to.

Qadeer Imrana[22] (1994) tries to analyze World Bank's approach towards primary health care particularly with references to India. The first section looks at the evolution of PHC and its links with international interests. The second section examines what could be described as m(.-Uthe dualism in India's plans to build he health sector. The third section examines the World Bank's interventions in health and attempts to link it with India's receding commitment towards Health for All through Primary Health Care.

Shiva Kumar, A.K (1994)[23] examines the World Development Report 1993 in the light of the health status of Indian, their health seeking behaviour, the provisioning of health services both public and private sectors, and the effectiveness of government policy intervention.

Gupta[24] (1994) says that the World Development Report 1993 being the most comprehensive document of the World Bank regarding the health sector as a whole, and, in that sense, embodies the basic understanding of the bank towards this sector. He tried to critically analyze the essential formulations being made in this documents, as well as attempt to project the implications of these formulations on the future

---

[22] Qadeer, I (1994) "*The World Development Report 1993: The Brave New World of Primary Health Care*" Social Scientist, vol. 22, nos.12, Sep-Dec. pp.27-39.

[23] Shiva Kumar, A.K (1994) "Some Considerations in the Formulation of India's Health Policy: A note of equality". Social Scientist, vol. 22, no. 9-12, Sept-Dec., pp. 79-88

[24] SenGupta, A. (1993), World Development Report 1993 "*Implications for Infrastructure Development in Health Care and the Pharmaceutical Industries*" Social Scientist, vol. 22, no. 9-12, Sept.-Dec. 1994, pp. 112-128.

development of health infrastructure in developing countries. Antia[25] (1994) in an article says that World Development Report 1993 is an example of cleverly crafted display of concern for deteriorating health of the world's poor by the same institution which serves the vested interests of western government and multinational corporations, who, in their frantic search for the material resources of the entire planet, have reduced the majority of its human populace to a state of abject poverty. Prabhu[26] (1994) in his paper on the basis of World Development Report 1993 and India: Health sector financing Report 1993, seeks to highlight some of these issues as the characteristics of health financing in India. An analysis of the structural adjustment on the Union Government's health expenditure and it examines the health sector financing at the state level.

Kundu [27](1992) in his study on urban poor observes that the very system of health care has been designed to meet the minimum needs and affordability of the poor is vulnerable to manipulation by vested interests. He observes that programme and schemes are inadequate and superficial to meet the needs of the poor. His study provides a very useful exercise on the utilisation pattern on 42nd round of NSS data which successfully bring out the finer details of the prevailing health care system in urban areas and how 92% of the slum dwellers are forced is use private centers due to the lack of accessibility in government health centers.

---

[25] Antia, N.H. (1994), "*The World Development Report 1993: A Prescription for Health disaster*" Social Scientist, vol. 22, no. 9-12, pp. 147-151, Sept-Dec. 1994.

[26] Seeta Prabhu, K (1994) "*World Development Report 1993: Structural Adjustment and the Health Sector in India*", Social Scientist, vol. 22, nos. 9-12, Sept-Dec., 1994, pp. 89-97

[27] Kundu, A. (1993), In the Name of the Urban Poor: Access to Basic Amenities, Sage Publications

Tulasidhar[28](1993) in his empirical analysis tries to reflect upon the changes in the outlay in the health sector. The compression of public expenditure will result in cuts in the centers allocation to be states. Recent changes in the allocation of resources of the health care in the center and the states are reviewed and attempt is made to identify the threats of sustainability of present levels in expenditure on health care.

Muraleedharan[29] (1993) in his study raised certain fundamental questions regarding how health care services should be ethically perceived, what theoretical definitions would be appropriate and their user and implementation. He thinks that the purpose of public, both market and non -market economics has always been to reduce barriers in access to health care. The exercise is stimulating and useful but it fails to deal with a major question which is the nature of the society where the demand for quality in health care arises.

Donahue, John. M and Mcquire, Meredith B.[30](1995) in their article addresses the question to what extent do health care strategies in a given political economy, increase people's perceptions of responsibility to take change of their health, but do not structurally empower them to satisfy their health needs. In shaping health care policies, societies typically adopt one of the three strategies, linking their larger political economy and modes of exercising power, a market place strategy, a state-managerial strategy or a national participatory structural power, these strategies result in three very different approaches in creating a

[28] Tulasidhar, V.V. (1993) "*Expenditure Compression and Health Sector Outlays*" Economic and Political Weekly, vol. XXVIII, no. 45, Nov. 6, pp. 2473-2477.

[29] Muraleedharan, V.R, (1993) "*When is access to health care equal? Some public policy issues*" Economic and Political Weekly, 28 (250; 19 June, pp 1291-96

[30] Donahue J.M. & Meredith B. Mcguire, M.B. (1995) "*The Political Economy of Responsibility In Health and Illness*", Social Science and Medicine, Vol. 40, No. 1, pp. 47-53.

responsibility for health and illness. Changes in the political economy of health illustrate the changing field of choice within which care seekers must make their health care decisions.

Jeffery[31] (1996) while commenting on political economy of health care thinks that health planning in India has shifted resources toward preventive medicine, rural areas and paramedical workers. The notable features of Indian health policy are the extent to which it has shifted towards more appropriate models; and the role of factors internal of the government and political party structure. These have limited the implementation of even this relatively modest growth in a wide spread structure of public health care facilities. Inspite of which there is no certainty that these facilities will be effective or well managed. They function not to raise labour productivity but to head off social discontent and to expand a public sector to provide the jobs and contracts, which are the State Health Minister's stock-in-trade. The basis of the crisis in India is that health policy discussions still proceed on the assumption that the future is 'welfare static' in one form or another. The theme of the paper focuses on the fact that in policy was in tune with international ideas of how to deliver health services in poor countries and with the developing structure of the Indian State. The State is moving is one direction, international advice and funding is unable to seriously address the health policy issues which confront them.

Haddad and Fournier[32](1995) talked about the quality, cost and utilization of health serves in developing countries, taking a longitudinal case study in Zaire. The authors feel that the quality of

---

[31] Jeffery. (1996), "Toward a Political Economy of Health Care: Comparisons of India and Pakistan" pp. 270-194, (ed) Health, Poverty and Development in India, Monica Das Gupta, C. Chen and T.N.Krishanan, Oxford University Pres Delhi

[32] Haddad, S. & Forunier, P. (1995) "*Quality Cost and Utilization of Health Services in Developing countries: A Longitudinal Study In Zaire*", Social Science and Medicine, Vol. 40, No. 6, pp. 743-753.

public services has often been neglected in developing countries. While some attention is given to technical qualities, the interpersonal components of the quality of services are generally ignored or underestimated by planner and they are the very components, which are most resistant to change. It will be a major challenge for health systems to address this issue of quality of care in order to minimize the negative impact of the introduction of user payment schemes. Therefore, now is the time to place quality next to coverage in planner's agenda.

Purohit and Mohan[33] (1996) have come up with an article based on the report of a workshop on "Public Health Financing" held at Indian Institute of Health Management Research (IIHMR), Jaipur, on 3-4 March 1995. The World Bank publication suggested a need to streamline the expenditure on public health care. Against this backdrop, it was necessary to give the diverse mechanisms of catering to health services across the country, a boost by bringing forth experiences of various states and thereby evolve a broad consensus regarding the future means of public health financing. The four main themes are the extent of privatization of health services, the under prioritizing of primary health services vis-à-vis tertiary health institution, re-evaluation of financial allocation in public expenditure on health and seeking new means to mobilize resource for health services. It was opined that in fixing priorities in the primary health sector that preventive and primitive aspects need to be stressed more and pre-capita expenditure on drugs in rural areas has to be increased. The preventive aspect where water and sanitation should be taken care off, could prevent 50-70% of diseases. The expensive medical equipment should be avoided.

---

[33] Purohit, B.C. & Mohan, R. (1996), "*New Dimensions For Public Health Financing*". Economic and Political Weekly, Vol. XXXI, No. 8, Feb. 24, 1996, pp. 450-453.

Sanyal[34] (1996) in his study on household financing of Health Care uses the result of the survey conducted by (NIPEP) 199394, (NSSO) 1992 and (NCAR) 1992, for the purpose of ascertaining the use of the government and private sources of treatment by the households and the expenditure increased, changes in the utilization pattern, expenditure and the differentials across the rich and the poor. Revenue earnings of the hospitals are computed with the help of estimated payments made by the households to arrive at some plausible macro level estimates of the additional resources that could be generated by large and small hospitals.

Banerjee[35]1996) interprets that the inter play of tow types of socio-cultural and political forces have influenced the trends in public health practice in India. In he colonial period, while the interests of the colonial rulers were the dominant motivating factor, agitation for increasing the outreach of the health services to the masses of the people was a platform of the anti-colonial political struggle which led to the setting up Ofsokhey and Bhore committees after independence and the anti-colonial struggle took the form of struggle for democratization. There has been very rapid expansion of the health services since Independence but as pointed out in the National Health Policy document that there has been a strong privileged class, urban and curative bias in health service development. This reflects the class character of Indian society. Another series of setbacks came from a series of powerful backing from affluent western countries. The defects were even more damaging in social and economic philosophy of primary health care as enshrined India's

---

[34] S.K. Sanyal, (1996) "*Households Financing of Health Care*", Economic and Political Weekly, Vol. XXXI, No. 20, May 18 pp. 1216-1222

[35] Banerjee Debabar, (1996) "Political Economy of Public Health in India" pp. 295-314, (ed) Health Poverty and Development in India (ed) Monica dam Gupta, Lincoln C. Chen, T.N. Krishnan Delhi Oxford University Press, Bombay Calcutta, Madras.

National Health Policy. Kundu (1993)[36]probed into the delivery of health care services beginning from the intervention at center and state level to the contribution of local bodies he also described the role of public as well as private under takings and voluntary agencies. He examined the reimbursement scheme critically and finally did an assessment of health delivery system. In this part he critically examined the interplay of various factors responsible for the deterioration of public hospitals and then in difference of the health sector towards the poor.

Baru[37](1994) in her paper examined the available data to look into the structures of health care provision by public private and voluntary sectors across the states. The 42nd Round NSS data has been used to examine utilization patterns for both outpatients and in-patients care across the states. It has concluded with a discussion of the trends observed and the implications of the World Bank's recommendations for provision and utilization of health services.

Berman's[38](1996) paper reviews the size and composition of health expenditures in India and offers some comments and questions about what this information has to offer for the future development of health system. A recent estimate of national health expenditures is compared with earlier figures, which is followed by a comparison of India's expenditure level with other countries. The link between health spending and health impact is explored.

---

[36] Kundu Amitabh, (1993), "Health Care Facilities in Urban India: Sensitivity of the System to the Poor", pp. 45-60, Urban Health System (ed) P.K. Umashankar Grish K. Misra, Reliance Publishing House and the Indian Institute of Public Administration (Center for Urban studies) New Delhi.

[37] Baru R V. (1994), "*Structure and Utilization of Health Services: An Inter-State Analysis*", Social Scientist, Vol. 22, Nos. 9-12, Sept-Dec 1994, pp. 98-111.

[38] Berman, P. (1996), "Health Care Expenditure in India" (ed Health Poverty and Development in India (ed) Monica Dam Gupta, Lincoln C. Chen, T.N. Krishnan, Delhi, Oxford University Press Bombay, Calcutta, Madras 1996, pp.331-356.

Ghose[39] (1996) in his paper on Health Care and globalization says that a look at some indicators of health in the period 199093, after the enforcement of structural adjustment, contrasted those for the period 1987-90 field s a picture that should cause serous concern. He is not surprised since the public health centers are set up by the government over the years is now lying unused with practically no drugs available because of the sharp cut in public expenditure on health and the focus on privatization of health services.

Most of the studies were mainly on the public policy where important aspects were analysed. Banerjee and other authors succeeded in understanding the World Bank Report and the "essential clinical package" which is cloaked in a garment of concern for the poor remains to be a crucial hoax for them.

This study tries to examine the area wise utilization of facilities along the variation in the utilization pattern among the underprivileged segment of the population according to different location. The study tries to fulfill the research gap in the field of utilization and accessibility of the health services in the slums, as it has been a less researched area. The study also tries look into the aspects of distribution, accessibility and utilization in relation to various factors in a holistic way.

II) SOME ISSUES AND CONCEPTS IN HEALTH CARE

This section would make an attempt to discuss the theoretical perspectives about the aspects of availability, accessibility

[39] Ghose, A. (1996) "*Health care and Globalization Case for a Selective Approach*", Economic and Political Weekly, vol. XXXI, no. 8, Feb. 24, pp. 441-442

and utilization of health care facilities within the context of organisational structure in the urban areas.

The provision[40] of health care services is only example of a wide range of services, the availability of which is not only a major determinate in the level of well-being of quality of life enjoyed by households, but also on occasions, essential for their survival. Health care services are available both privately as well as publicly.

When it is the question of publicly provided goods and services, competition and conflicts largely take place in the political arena. The parliamentarians, politicians, ministers and bureaucrats compete with each other in furthering their political interest in total disregard to the needs of the larger section of the economically weaker section of the society.

As far as the question of resource allocation of private services is concerned, it follows the basic market principle of supply and demand and services are rendered according to one's ability to pay.

On the other hand the government procedures for the allocation of public resource are more complicated as their distribution invariably result form the interplay of many factors such as economies of scale, and the threshold requirement of the population, demand factor, and political pressure in terms of accessibility. Given the limited supply of resources, the problem is, how best to allocate the limited resources.

Resource's allocation is closely linked to the issue of provision and issues related to inequalities and inequities, while discussing provision

[40] Humphrays, J.S. (1985), "A political Economy Approach to the allocation of Health care Resource: The case of Remote Areas In Queensland", Australian Geographical studies, 23rd October, 1985, pp. 222-242

one cannot avoid the concept of equitable provision of services where actual location is as important as the amount of expenditure involved, while providing such services. Good medical care implies that it is accessible to people at the right time and place ie " where and when they need it".

Slum areas characterized by high density of population, high threshold requirement coupled with lack of purchasing power does not attract private entrepreneurs to operate services and thus the essential services is left to public sector.

Accessibility [41]lays a major role in determining the spatial inequity. A set of arguments stresses that some degree of spatial inequity is inevitable, and even acceptable but social inequity is not acceptable. Inequity implies that people may receive differential treatment if such a course of action is deemed fair and just. Hence an inequitable distribution may well be equitable. In other words, differentiation may be acceptable where as discrimination is unfair.

Dejong and Rutten[42] (1983) have outlined four basic principles of distribution, utilitarian, (and efficiency the goal minimising the surplus of benefits over cost equalitarianism (where health status is equalized by giving priority to those in most need); equal access (where everyone has equal access regardless of what or how much is provided); and libertarian (where distribution results from freely negotiated transfer in the market place)

---

[41] Humphrays, J.S. (1985), "A political Economy Approach to the allocation of Health care Resource: The case of Remote Areas In Queensland", Australian Geographical studies, 23rd October, 1985, pp. 222-242

[42] G.A. Dejong and F.F. Rutter (1983), "*Justice and Health for All*", Social science and Medicine 17, pp. 1085-1095

HEALTH CARE SYSTEM - A FRAMEWORK

The existing system of health care should be according to the varying needs of the recipients. The availability of services is, theoretically related to a population's need for them. Services vary over space according to the social and spatial variation. Some areas remain unserved by basic primary health care while some show over servicing in the public services. There is a general tendency of under servicing of primary level care in the private sector.

It is an implied fact the certain distributional principles are followed to determine the equitable distribution of resources. This distributive principle takes into consideration the persons needs and capacity to pay and accordingly sharing out costs and benefits proportionately.

Based on one assumption that all citizens require medical treatment equally, it follows that the services should be distributed with respect to population size. In evaluation the fact of distribution of medical services distance is one of the several factors of relevance, which is overlooked as greater priority is attached to other demographic, economic and social factors.

It becomes important to examine the ideology of those in power structure and their activity. It is also necessary to examine its role within a society's socio-economic and political system. Within the framework of political economy, health care represents one of the collective consumption goods and which they constitute to be public provision of socially necessary facilities and services, commodities that are not priced in market place.

Health care, depending on how the state conceives, can be regarded as a specific commodity, or part of broader societal good which is to be catered for the people relating to national development. Again there arises a set of conflicts on whether emphasis should be placed on curative or preventive programmes institutional or domiciliary services, centralised or community-based services. The implication of each policy is shown to differ significantly with respect to income distribution, public health and safety measure, and health education provision of health services and right to health.

HEALTH CARE PROBLEMS IN THE URBAN SLUMS

Slum dweller and urban poor who constitute a large section of the urban population have a poor level of health because they are under-nourished, suffer form infectious and parasitic infections, live in unhygienic conditions in unhealthy environment and are ignorant about health care and health related matter. They are not aware of various health hazards they are exposed to, and fail to utilized health services fully.

Houses crowded together, open sewerage system; open garbage, poor sanitation, and water logging are common phenomenon of a slum environment. Such an environment would encourage diseases like diarrhoea, gastro-enteritis and respiratory illness. Medical facilities are not available within the vicinity of slums, other than some municipalities providing dispensaries, which are obviously inadequate in terms of the requirement.

It has been observed[43]that in urban areas the poor section of the population goes for private doctors. Interestingly, the exorbitant

[43] Kundu, A. (1993), in the Name of the Urban Poor: Access to basic Amenities, Sage Publications.

charges of these doctors were not mentioned as a hindrance in availing themselves of these services. This may be due to immediate and personalised attention of the private doctors compensates for the higher charges. What the slum dwellers want is quick, and easy access to a doctor, proper attention and quick relief through medication so that the loss of the wages earned on a daily basis is the least. Due to ignorance they also land up with unqualified and untrained doctors for treatment who use antibiotics and other drugs indiscriminately. Urban poor like their rural counter parts, accept medical technology for cure of ailment but do not understand disease causative theories which are likely to motivate them to accept preventive measures such as nutrition, personal hygiene and sanitation and immunization.

Even the indigenous health system has institutionalised on modern lives with medical colleges, pharmaceutical industries and consulting chambers of medical practitioners. These traditional practitioners have become commercial healers, and health education and preventive aspects are neglected.

Most of the urban poor in India are still rooted in a rural way of life following occupation like animal husbandry, poultry, rope-making, basket weaving and numbers other cottage industries and handicrafts. A large chunk of scheduled caste population performs scavenging and other basic sanitary services.A sizeable number of people performs traditional jajmani services like that of washerman, barber and domestic servant. All the people may be territorially urban but their socio-cultural values are similar to that of their rural counterparts. Though they are a part of the urban community but regarding health care they still have a very careless attitude.

The health hazards of urban poor are therefore directly related to poverty, polluted and stressful urban environment and finally

a feeling of instability and insecurity. They are more vulnerable to communicable diseases and malnutrition and at the same time, they are exposed to great risks of accidents at work on the roads and in the dwelling places. Simultaneously health hazards associated with child labour, alcohol and drug abuse etc. increase their morbidity. Even in the most undeveloped rural areas, they do not experience such extremes of health hazards.

HEALTH CARE DELIVERY SYSTEM - AN ASSESSMENT

In an analysis of the organisational structure, Kundu[44](1993) found that the functioning of the institutions and the health sector reveal a bias expected in the form of subsidy in favour of the poor is almost non-existing. The urban poor who constitute a large sections of the populations are excluded from the special comprehensive health service developed for the employee of the organised sector comparison of central government and some public and private sector companies and corporations. They have a better access to qualified medical personnel and technical facilities of a high order with the help of a good referral system.

Employees working with state government and central government adopted some health care schemes for reimbursement of medical expenditure where benefits of such schemes are available by a small section of the employees in the highest income bracket.

The general population in which urban poor constitute a large number in entitled to a very small portion of health care facilities. There are only a few hospitals in Delhi and a few of them in other cities

[44] Kundu, A. (1993), in the Name of the Urban Poor: Access to basic Amenities, Sage Publications.

catering to the general public. That too, only a small fraction of the poor manages to reach these hospitals because of physical distance and various administrative difficulties. The poor who are only entitled to general hospitals have to compete with people having higher income levels engaged with the organised sector using those very same general hospitals. The very question of equality is contradicted. The public health care has a very complicated and long process of registration. Due to their ignorance, lack of knowledge and lack of self-confidence, run form one department to the other, bewildered and entangled. Thus they waste more time looking for the right place and by the time they land up to a proper place there is a long queue waiting in front of him/her. These waiting hours become prolonged for them as people with better contacts and higher education level get to persuade the doctor to avoid the huge queue and get an early check up. The poor people want quick relief, as prolonged illness would lead them to go without income, as they are daily wage earners. It is difficult for them to stay away from work for half a day. On the other hand the indifferent attitude of the medical personnel, low quality of service, non-availability of medicine and basic testing facilities and not functioning or a referral system discourage the poor to utilise the public health care facilities.

The rich or organised working class is aware of all facilities provided to them. They can pursue their situation by struggling with the complicated bureaucratic formalities. Their education, knowledge and the way they talk and present themselves help them to impress and highlight their problems and gather attention. Apart from that they would seek help of the contacts they have and use their power of influence.

Thus we can say that public health delivery system, in its very design is biased in favour of the rich organised working class and excludes the unorganised working poor.

It has been a general trend in that the demand in the intermediate and apex levels of services several time more than at the primary level. According to this demand the investment has been negligible for the strengthening of the middle and higher-level facilities excelling the research wing. The only task they perform is to provide consultation, a few routine tests, and then patients are often referred to non-governmental clinics. In such a situation of extreme scarcity, where private accessibility is determined by personal relationship, bureaucratic linkages and corruption it is out of question, for the poor to avail required facilities as they neither have connections nor can afford this privately.

Introduction of check and regulatory restrictions are required to protect the interest of the patients as well as the providers to establish an equitable and sustainable health care system, irrespective of the fact that health care system is market oriented or centrally controlled. Here lies the importance of Consumer Protection Act in delivering a better quality of health care.

Chapter II

Socio Economic Profile of the Sample Population Surveyed In the Slums

This chapter attempts to present a profile of the sample households surveyed in the 7 slums in various areas of Delhi. It is essentially a description of the demographic and socio – economic characteristics with reference to age, sex, education and occupation.

While analyzing the data on the educational level of the head of household, the data pertaining to the eldest member of the family who is not senile and in such cases, the next eldest, but earning member is considered. This has been done because not in all cases the respondent is the head and in some cases the head is a woman. An attempt has been made to calculate the socio economic status of the households in each slum. This will give a more accurate picture of the combined action of social and economic factors in each household. Moreover, taking some of the important indicators each has been ranked against the seven slums depending upon the status, from 7 – 1. This exercise was an attempt to give a clear idea of how each socio – economic factor does to shape the overall socio economic condition at slum level.

Table no. 2.1: Distribution of Sample Households according to the slums

	SLUM	Households	Male	Female	Total
1.	Kusumpur Pahari (South)	70	233 (59.4%)	159 (40.6%)	392
2.	Yamuna Pushta (East)	80	144 (52%)	133 (48%)	277
3.	Mayapuri (West)	79	222 (52.6%)	200 (47.4%)	422
4.	R.K.Puram Sector – 2 (South)	91	255 (54.9%)	218 (46.08%)	473
5.	Mongolpuri (North-West)	90	270 (54.6%)	224 (45.3%)	494
6.	Narela (North)	72	363 (55.9%)	286 (44.1%)	649
7.	Samalkha (South)	108	304 (53.1%)	268 (46.9%)	572
	TOTAL	590	1791	1488	3279

Table no. 2.1 represents area-wise distribution of the sample households and therein their population. The work covers 590 households with a population of 3279 persons. The female percentage, in none of the slums, crosses 48 while males are, obviously more. The highest female population is found in Yamuna Pushta (48%) while largest number of males resides in Kusumpur Pahari (59.4%).

Table no. 2.2: Sex Ratio existing in the Slums

	SLUM	Male	Female	Sex – Ratio (Females/1000males)
1.	Kusumpur Pahari (South)	232	160	690
2.	Yamuna Pushta (East)	144	132	917
3.	Mayapuri (West)	222	200	901
4.	R.K.Puram Sector – 2 (South)	256	216	844
5.	Mongolpuri (North-West)	270	224	830
6.	Narela (North)	363	286	787
7.	Samalkha (South)	300	269	891

The Sex – Ratio as seen in Table no. 2.2 shows the best value for the Yamuna Pushta and the lowest for Kusumpur Pahari. The Sex – Ratio for Delhi being 827 females/1000 males

Distribution of Population – The Age – Sex Structure

Table no. 2.3: Slum – wise Distribution of Population according to their Age – Sex Composition

SLUMS	Age groups											
	0 – 4 yrs		5 – 14 yrs		15 – 35 yrs		36 – 60 yrs		> 60 yrs		Tota;	
	M	F	M	F	M	F	M	F	M	F	M	F
Kusumpur Pahari	19.4%	14.4	30.2	25.0	34.1	43.2	15.9	16.7	.4%	.8%	23 100.0%	13 100.0%
Yamuna Pushta	14.6%	14.4	28.5	28.5	34.7	37.0	19.4	9.5	2.8	.5%	14 100.0%	20 100.0%
Mayapuri	12.2%	24.5	28.4	32.4	36.0	35.6	22.1	13.0	1.4	.5%	22 100.0%	21 100.0%
R.K.Puram Sec - 2	13.3%	18.5	28.9	31.3	37.9	32.6	19.1	15.6	.8%	1.3	25 100.0%	22 100.0%
Mongolpuri	17.8%	19.2	28.9	32.5	32.2	32.9	20.0	18.2	1.1	4.2	27 100.0%	28 100.0%
Narela	17.6%	12.2	30.6	33.5	27.0	33.1	22.3	13.8	2.5	1.9	36 100.0%	26 100.0%
Samalkha	19.4%	17.8	30.6	30.1	28.6	35.9	19.4	15.1	2.0	1.7	30 100.0%	1487 100.0%
Total	29 16.6%	25 17.3	53 29.6	86 30.47%	57 32.3	99 38.83%	35 19.9	41 16.22%	2 1.6	3 14.7 %	1791 100.0%	.257 100%

Table no. 2.3 shows the age sex structure of the sample population of the slums. The below 14 population is maximum for males in Narela with 48.2% of the total males of the slum lying in this age group. Females are maximum in Samalkha with 51.3% of them residing in that slum falling in this age bracket. The elderly population (65+) is maximum in Narela where both the males and the females show a good percentage when compared to the other slum's sample population of the same age group.

The slum having the maximum value of the working age group population is again Narela for both the males and the females. Though this slum has the maximum number of people who are able to work yet the living conditions show a rather dismal picture when compared to the other slums where the population in the working age group is not so favourable. This can be attributed to mainly two causes; one, being that the total number of dependants (<14yrs + 65yrs<) is also quite high, another being that Narela is a resettlement colony which has been uprooted and thrown far off from the normal areas of available work. Thus it is seen that maximum people are out of jobs as they cannot afford the commutation fare to reach their place of work.

Table no. 2.4: Slum-wise Family size of Households

SLUMS	Family Size					
	<2	3-5	6-8	9-11	>12	total
Kusumpur Pahari	(2.9%)	(52.9%)	(38.6%)	(2.9%)	(2.9%)	70 100.0
Yamuna Pushta	(1.3%)	(40.0%)	(48.8%)	(6.3%)	(3.8%)	8 100.0
Mayapuri	(2.6%)	(56.4%)	(35.9%)	(3.8%)	1.3%)	7 100.0
R.K. Puram Sec - 2	(3.3%)	(62.9%)	(32.6%)	(4.5%)	0	8 100.0
Mongolpuri	0	(51.1%)	(37.8%)	(7.8%)	(2.8%)	9 100.0
Narela	(2.8%)	(34.7%)	(52.8%)	(9.7%)	(2.8%)	7 100.0
Samalkha	0	(45.4%)	(43.5%)	(5.6%)	0	10 100.0
TOTAL	11 (1.9%)	289 (49.2%)	242 (41.2%)	34 (5.8%)	11 (1.9%)	58 100.0

Table no. 2.4 represents the slum-wise distribution of family size. Majority of the households in all the slums have a family of 3 to 5 members. In Narela 52.8% of the households have a family size ranging from 6 to 8.. While below 2 to 2 member households are absent in Samalkhan and Mongolpuri in the sample households.

SOCIO - ECONOMIC CHARACTERISTICS OF THE SAMPLE POPULATION

Socio – economic characteristics tend to differ from slum to slum. This in turn affects their health status leading to differential utilization of health facilities. The main aspects under consideration here are a) education b) occupation c) drinking water facility d) toilet facility and e) type of fuel used.

Table no.2.5: Distribution of Education among the sample population

	Educational level completed													
SLUM	Illiterate		Never enrolled		Not currently enrolled		Up to primary		Up to middle		Matric		Above Matric	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Kusumpur Pahari	11.88%	15.38%	13.98%	11.19%	3.5%	0.7%	8.39%	5.59%	13.29%	6.99%	5.59%	2.8%	0.7%	0
Yamuna Pushta	21.8%	17.29%	1.5%	4.5%	0	1.75%	23.31%	17.29%	6.01%	3.70%	1.5%	1.5%	1.75%	0
Mayapuri	16.81%	17.65%	13	20.17%		1.68%	12.61%	3.36%	7.56%	2.52%	5.88%	1.84%	0	0
R.K.Puram Sec - 2	18.12%	20.13%	8.05%	16.10%	2.68%	2.01%	8.72%	7.38%	10.06%	0	3.36%	1.36%	1.36%	0.67
Mongolpuri	18.99%	17.39%	14.53%	15.08%	1.12%	1.12%	13.41%	7.82%	5.59%	2.23%	2.23%	1.56%	0	0
Narela	22.07%	14.6%	3.57%	4.87%	3.24%	1.62%	16.23%	18.18%	5.52%	6.49%	1.95%	0.65%	0.65%	1.32
Samalkha	19.05%	12.12	20.78%	17.75%	3.03%	3.90%	5.19%	6.06%	6.49%	3.46%	1.29%	0.43	0.43%	
Total	239	206	132	153	28	23	157	130	93	50	35	13	7	2

Table no.2.5 shows the education already attained by the sample population in the 7 slums. The number of illiterates is the highest as is expected. Narela has the maximum number of illiterates be it male or female. The over-all picture show that as far as education of any level is

concerned women fare badly when compared to the males. Though Narela shows the maximum number of illiterates it also has the maximum people with education above higher secondary level along with R.K Puram Sec – 2.

Table no 2.6: Education level of the head of the household

SLUMS	*Level of education*																	
	Illiterate		Never enrolled		Upto primary		Upto middle		Matric		Higher secondary and above		*Total*	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Kusumpur Pahari	47.9%	68.2	6.3%	6.3%	14.6%	4.5%	18.8%	13.6%	8.3%		2.1%		4	
													100.0%	100.0
Yamuna Pushta	64.7%	78.6			17.6%	14.3%	11.8%	7.1%	5.9%				1	
													100.0%	100.0
Mayapuri	43.8%	71.4	6.3%	6.3%	22.9%	7.1%	16.7%	10.7%	4.2%		6.3%		4	
													100.0%	100.0
R.K.Puram Sec –2	52.2%	59.1	1.5%	1.5%	19.4%	27.3%	11.9%	9.1%	7.5%	4.5	7.5%		6	
													100.0%	100.0
Mongolpuri	50.0%	78.6			21.7%	14.3%	15.0%	3.6%	11.		1.7%		6	
									%				100.0%	100.0
Narela	62.3%	68.1	5.7%	5.7%	15.1%	21.3%	9.4%		3.8%	2.1	3.8%	4.3%	5	
													100.0%	100.0
Samalkha	65.1%	81.8			9.6%		13.3%	9.1%	4.8%	9.1	6.0%		8	
													100.0%	100.0
Tota;	20	12	1	10	63	25	52	11	2		1	2	37	1
	55.1%	70.9	2.7%	2.7%	16.8%	14.5%	13.8%	6.4%	6.6%	1.7	4.5%	1.2%	100.0%	100.0

The above table (2.6) shows there are a lot of households where the head of the household is a woman though the number of them is quite low but nevertheless they do exist. In Narela there are two women headed households who are educated above 12th standard.

DISTRIBUTION OF SAMPLE POPULATION AS PER OCCUPATION

Occupation decides the living standard of the population. The slum areas are most depressed sections of the society as they earn their livelihood through the least paying and the most menial of jobs involving long hours and most unhealthy of working conditions. This situation, as a result, affects their accessibility and utilization of the health services

in a rather negative manner such that they live in a vicious circle of ill being.

At the onset the population can be categorised into a) Worker b) Nonworker.

Non-Workers have been further categorized into

1. Student
2. Retired / elderly
3. Household work
4. Physically challenged
5. Seeking / available for work
6. Others (children too young to do work and the unemployed who are neither seeking nor are available for work).

Workers are also classified into

7. Working and studying
8. Self employed
9. Salaried
10. Wage Labourer.

The categories of workers categorized further to give a detailed picture of the kind of occupation the people are engaged in.

1. Construction unskilled
2. Construction skilled
3. Electric repair
4. Non electric repair
5. Manufacturing
6. Food processing
7. Trade (Retail / vending / hawking)

8. Transport skilled
9. Transport unskilled
10. Unskilled menial
11. Domestic help

12. Other services

Table no. 2.7: Distribution of population according Non Workers

Slums	Category of Non workers					
	Student	Retired /elderly	Household Work	Physically unable		others
Kusumpur Pahari	27.6%	2.8%	16.8%		2.6%	79 20.2%
Yamuna Pushta	18.4%	2.9%	20.6%	.4%	2.2%	73 26.4%
Mayapuri	26.3%	.9%	19.0%		4.7%	89 21.1%
R.K.Puram Sec- 2	34.7%	.4%	20.6%		2.7%	71 14.9%
Mongolpuri	25.6%	2.0%	17.9%	.4%	3.8%	121 24.4%
Narela	25.7%	4.2%	16.0%	.3%	5.4%	167 25.7%
Samalkhan	22.0%	2.1%	18.5%		2.4%	169 29.5%
Total	855 26.0%	74 2.3%	600 18.3%	5 .2%	117 3.6%	769 23.4%

* Percentages are calculated taking both workers + nonworkers

Table no.2.7 shows that Narela has the maximum number non-workers, which is quite expected, as it is a resettlement colony. The people have been pushed to such a place where there is no scope of employment. The number of persons who are studying is the maximum

in all the slums. Therefore it can be said that in the future the educational level of these slum dwellers is expected to rise.

Table no. 2.8: Distribution of population according to first category of Workers

SLUM	Category of Workers			
	Working /studying	Self employed	Salaried	Wage labourer
Kusumpur Pahari	.8%	7.1%	10.5%	11.7%
Yamuna Pushta	1.4%	15.5%	4.3%	7.9%
Mayapuri	.2%	8.5%	11.4%	7.8%
R.K Puram Sec - 2	.6%	11.6%	4.8%	9.7%
Mongolpuri	.2%	8.1%	7.1%	10.5%
Narela	.2%	4.6%	6.9%	10.9%
Samalkha	.7%	7.7%	3.8%	13.3%
TOTAL	17 .5%	276 8.4%	226 6.9%	346 10.5%

* Percentages are calculated taking both workers + nonworkers

In Table no 2.8 maximum number of workers are engaged as daily wage labourers. Samalkha has the largest number of people working as wage labourers.

In Table 2.9 maximum number of persons are engaged in working as unskilled menial. Kusumpur Pahari has the largest part of the worker population engaged in this work subcategory followed by Samalkha. This category is followed by other services. There is quite a large portion of the worker population who are studying along working.

Table no. 2.9: Dstribution of Workers by category of Occupation

	Const unskilled	Const Skilled	Eletric Repair	Non electric Repair	Manufa-cture	Food procrss-ing	Trade (Retail)	Transport Skiiled	Transport unskilled	Unskilled menial	Domest ic help	Others
Kusumpur Pahari	4.20%	2.50%	1.70%	0.80%	1.70%	-	10.80%	13.30%	2.50%	43.30%	10.00%	9.20%
Yamuna Pushta	4.90%	1.20%	1.20%	1.20%	8.50%	-	40.20%	3.70%	4.90%	7.30%	13.40%	13.40%
Mayapuri	11.10%	8.70%	4.00%	3.20%	27%	-	24.60%	0.80%	4.80%	5.60%	3.20%	7.10%
R.K.Puram Sec - 2	12.80%	5.30%	1.20%	2.30%	6.80%	3.00%	18.80%	6.80%	3.80%	18.80%	0.80%	18.00%
Mongolpuri	13.40%	6.30%	3.10%	0.80%	29.90%	1.60%	13.40%	1.60%	4.70%	10.20%	2.40%	12.60%
Narela	21.20%	3.80%		1.90%	7.70%	5.10%	8.30%	3.80%	3.20%	14.70%	3.20%	26.90%
Samalkha	9.20%	4.60%	3.30%	2.00%	5.30%	0.70%	10.50%	6.60%	3.30%	27.00%	3.90%	23.70%

Distribution of population having Access to Drinking Water

The position regarding safe drinking water supply in the country at the beginning of the **"Water and Sanitation Decade"** was brought out by the 1981 census. It considered only tap water and water drawn from hand pump / tube well to be safe drinking water. 38% of the households in the country had access to it while it was available to 75% of the urban households (1981 Census). The Sixth (6th) Plan (1980 – 85) estimated that 84% of the urban population and 33% of the rural population was covered by protected water supply (FRCH, 1987 – Supplement to the ICSSR / ICMR Report)[4]. The contribution of clean water is an important one in the lowering of mortality as well as an excellent check on epidemics.

Table no. 2.10 Drinking water facility

SLUMs	Source of Drinking Water			
	Public tap	Tanker	Pilferage	Others
Kusumpur Pahari	(60%)	(24.3%)	(13.8%)	(15.7%)
Yamuna Pushta	33 (41.3%)	(6.3%)	(5.2%)	(38.8%)
Mayapuri	(80.5%)	0	0	(13%)
R.K Puram Sec – 2	(74.2%)	(2.2%)	(16.9%)	(17.8%)
Mongolpuri	(75.6%)	(1.1%)	(5.6%)	(17.8%)
Narela	(73.6%)	(9.7%)	(2.8%)	(13.9%)
Samalkha	(41.7%)	0	0	(58.3%)

[4] Foundation for Research in Community Health (FRCH) (1987), *"Health Status of the Indian People* – A Supplement to the ICSSR / ICMR Report – Health for All: An Alternative Strategy, Bombay.

According to Table no. 2.10 majority of the sample households surveyed had access to drinking water supplied by tankers. Yamuna Pushta and Samalkha collected their water from other sources, which include the river Yamuna in the case of Samalkha. Pilferage from supply lines is maximum in the R.K Puram Sec – 2 slums as compared to the other slums.

Distribution of Sample Population according to the Use of the Type of Toilet Facility

The picture of sanitation given by **Environmental Hygiene Committee Report** in 1949 in not qualitatively different even today. Most of the human wastes continue to be discharged untreated into the water sources; sewers and drinking water main pipelines run side by side. Leakages are common and mixing is rampant. Programmes for protection of drinking water sources are complementary to the sanitation programmes.

Table no. 2.11: Toilet Facilities used by Sample Households (in Percentages)

SLUMs	Toilet facilities used			
	Open	Sulabh	Municipal	Pit
Kusumpur Pahari	90%	5.7%		4.3%
Yamuna Pushta	76.3%	16.3%	3.8%	3.8%
Mayapuri	19.0%	38.0%	17.7%	25.3%
R.K Puram Sec – 2	14.6%	36.0%	46.1%	1.1%
Mongolpuri	5.6%	55.6%	37.8%	1.1%
Narela	6.9%	43.1%	40.3%	4.2%
Samalkhan	69.4%	14.8%		

The use of toilet facilities in the slums have been classified into

1. Open
2. *Sulabh*
3. Municipal toilets
4. Pit
5. Open and Sulabh

Table no.2.11 shows the level of sanitation existing in the slums. *Sulabh* complexes are privately owned and the users have to pay a certain charge to the attendant. Though the slums are economically depressed yet most of the household opt for the use of the *Sulabh souchalalays.* This may be due to the fact that the *sulabh* complexes are kept relatively clean and there are water facilities. Alternatively the dwellers would have had to use open areas. Mongolpuri has the largest number of households opting to use the *Sulabh* complexes. Open spaces are the next most frequently used as toilets. With the Yamuna river flowing by the residents of Yamuna Pushta see no need for any other toilet facility; 76.3% of the residents of the slum use it. Pits are used majorly by the slum dwellers of Mayapuri when compared to the other slums; as such the majority of the household use the *Sulabh.*

The sanitation component of the UBS programme designed for the urban poor includes low cost pour flush latrines as per UNICEF / TAG design so as to do away with dry bucket type latrines, especially in the balwadis, anganwadis and the PHCs.

Garbage and sullage disposal system includes the construction of bathing cubicles, garbage pits and simple drains in the slums. The slums being illegal squats the government refuses to recognize the basic rights of the dwellers.

Distribution of Sample Population According to the Location of the Kitchen and the type of Fuel Used

The location of the kitchen in any household plays an important role in any household and even more so in a slum household where the entire family of 5 to 6 members huddle in one room. If the kitchen is located within the room the fumes of cooking and the heat thus generated makes the living conditions more horrific. On the other hand, if the kitchen is located outside the room then it means that the household is comparatively in a better position economically as they are able to afford the extra space and most importantly the health condition of the family could be expected to be in a not so bad condition given hat the other factors remains unchanged.

Table no. 2.12: Distribution of Sample Households according to the Location of the Kitchen

SLUMS	Location of the Kitchen		
	In the Room	Separate	Total
Kusumpur Pahari	(67.1%)	(32.9%)	70
Yamuna Pushta	(88.8%)	(11.3%)	80
Mayapuri	(94.8%)	(3.8%)	78
R.K. Puram Sec - 2	(82.0%)	(18.0%)	89
Mongolpuri	(94.4%)	(5.6%)	90
Narela	(87.5%)	(12.5%)	72
Samalkhan	(91.7%)	(8.3%)	108
Total	512 (87.1%)	74 (12.6%)	587

By the Table no 2.12 it is seen that the general idea that slums are depressed areas, the households will not have separate kitchen is true. Of the 587 households 512 households have no separate kitchen. Kusumpur Pahari, a relatively better off slum, have 33% of the households with separate kitchen.

Type of Fuel Used

1. Wood
2. Kerosene
3. Cooking gas
4. Wood and kerosene
5. All of the above three

Table no. 2.13: Distribution of Sample Households according to the Type of Fuel Used

Slums	Type of Fuel used			
	Wood	Kerosene	Cooking gas	Total
Kusumpur Pahari	(42.9%)	(20.0%)	(37.1%)	70
Yamuna Pushta	(33.8%)	(48.8%)	(16.3%)	80
Mayapuri	(14.1%)	(67.9%)	(8.9%)	78
R.K. Puram Sec - 2	(19.1%)	(57.3%)	(23.6%)	89
Mongolpuri	(8.9%)	(70.0%)	(5.6%)	90
Narela	(52.8%)	(31.9%)	(15.3%)	72
Samalkha	(58.3%)	(25.9%)	(6.5%)	108
TOTAL	194 (33.4%)	271 (46.16%)	108 (15.13%)	587

According to Table 2.13 the most common type of fuel used is kerosene followed by wood. Both these fuels give off highly poisonous fumes, which affect the health of the women and the child (who are

usually all the time at home) adversely. In Samalkha 58.3% of the households use wood as fuel followed by the resettlement colony of Narela. Kerosene use maximum in Mongolpuri with 70% of the households using it.

Table no.2.14: Distribution of Sample Households according to the Location of the kitchen and the Type of Fuel Used

SLUMS	Type of Fuel Used							
	Wood		Kerosene		Cooking gas		Total	
Location of Kitchen*	1	2	1	2	1	2	1	2
Kisumpur Pahari	27 (57.44)	3 (13.04)	11 (23.40)	3 (13.04)	9 (19.14)	17 (73.91)	47 (100)	23 (100)
Yamuna Pushta	21 (29.57)	6 (66.66)	38 (53.52)	1 (11.11)	11 (15.49)	2 (22.22)	71 (100)	9 (100)
Mayapuri	10 (13.51)	1 (33.33)	52 (70.27)	1 (33.3)	7 (94.5)	0 (0)	74 (100)	3 (100)
R.K.Puram Sec 2	14 (19.17)	3 (18.75)	42 (57.53)	9 (56.25)	17 (23.28)	4 (0.25)	73 (100)	16 (100)
Momgolpuri	7 (8.23)	1 (0.20)	62 (72.94)	1 (0.20)	4 (0.80)	1 (0.20)	85 (100)	5 (100)
Narela	34 (53.96)	4 (44.44)	21 (33.33)	2 (22.22)	8 (12.69)	3 (33.33)	63 (100)	9 (100)
Samalkha	56 (56.56)	7 (77.77)	27 (27.27)	1 (11.11)	6 (6.06)	1 (11.11)	99 (100)	9 (100)
Total	169	25	253	18	62	28	512	74

* 1. Inside the room, 2.separate

According to the Table no. 2.14 it is seen that a total 253 sample households have kitchen inside the room with kerosene as the cooking fuel followed by 169 households using wood. This means that among the

587 households surveyed 422 (71.89%) households are exposed to the poisonous fumes emitted by the cooking fuel.

Socio – Economic status

As the main focus of the chapter is on the general socio– economic condition of each of the slums surveyed an attempt has been made to give it a more concrete shape. The **socio –economic status** is calculated taking two indicators vis – a - vis education and occupation of the workers.

Taking education, the mean years of schooling has been calculated for each member and the average years of schooling of each household is found by dividing the total value by the number of members residing in a household.

The second indicator takes into account the worker population. Weights have been assigned according to the type of work performed by the worker. They are given on the basis of a)the duration of the work and b) approximate income earned. Subjective ranking has been done for these two ie for a) and b) on a scale of five and then averaged out to reach a composite rank. The weightages are taken and an average for each of the households is calculated.

Equal weights have been given to each of the indicators as a whole: education = 0.50 and Occupation = 0.50. This has been done because the extent of explanatory power of either of the indicators cannot be known accurately.

Then the corresponding figure for each of the indicators for each household is multiplied by their weightages. These two sets of figures are then added horizontally to find the socio – economic status of each household.

Finally the SES is grouped into quartiles from SES 1 to SES 4. The SES conditions worsen in descending order of the classes.

	Occupations	Weights
1.	Construction unskilled	2
2.	Construction skilled	5
3.	Electric repair	4
4.	Non electric repair	0.75
5.	Manufacturing	2.5
6.	Food processing	1.75
7.	Trade (Retail / vending / hawking)	2
8.	Transport skilled	3.75
9.	Transport unskilled	1.25
10.	Unskilled menial	0.5
11.	Domestic help	3.5
12.	Other services (Rickshaw puller, shop assistant)	2.25

Table no. 2.15: Socio – Economic Status of the slums

SLUMS	*SOCIO - ECONOMIC STATUS*						
	SES Class 1	*%*	*SES Class 2*	*%*	*SES Class 3*	*%*	*SES Class 4*
Kusumpur Pahari	16	22.86	21	30	19	27.14	15
Yamuna Pushta	17	10	18	15	20	25	25
Mayapuri	13	16.67	19	24.36	24	30.77	31
R.K.Puram	19	21.3	16	17.98	24	26.97	30
Mongolpuri	21	23.33	25	27.78	20	22.22	24
Narela	13	18.06	14	19.44	20	27.78	25
Samalkhan	22	20.4	27	25	23	21.3	36
	121	20.61	140	23.85	150	25.55	186

According to the table 2.15 it seen that all the slums have majority of the households falling under SES class 4 and the least in class 1. This can be explained by the fact that all the slums suffer from the chronic pathology of illiteracy and menial labour. Samalkhan shows the largest percentage of households under SES class 4 and also has the maximum households under SES class1 among all the other seven slums. It is seen that higher the SES class order greater the percentage of households falling in those classes

CONCLUSION

Ranking of the Slums according to some of the Characteristics

Table no.2.16: Ranks of the slums according to different aspects

SLUM	RANKS (According to different aspects)												
	Sex-Ratio	Edu- P	Edu- M	Edu-Ma	Illiterate	Non-W	Drink-W	Toilet-O	Toilet-S	Kitchen	Fuel (w+k)	Total	Rank-Final
Kusumpur Pahari	1	2	6	7	7	6	2	1	1	7	7	47	6
Yamuna Pushta	7	6	2	1.5	5	7	1	2	3	5	4	43.5	2
Mayapuri	6	1	1	5.5	6	5	5	4	5	3	5	46.5	3
R.K. Puram Sec – 2	4	3	4	4	4	4	6	5	4	4	3	45	4.5
Mongolpuri	3	5	3	3	3	3	7	7	7	2	2	45	4.5
Narela	2	7	7	5.5	1	1	4	6	6	6	6	51.5	7
Samalkhan	5	4	5	1.5	2	2	3	3	2	1	1	29.5	1

The table no.2.16 has been prepared taking into account some of the demographic and socio economic aspects of the slums. Aspects which are positive, that is, the increase in the value of which means better condition of the slum are ranked 7 to 1, highest to lowest. While negative aspects are ranked vice-versa. The slum with the largest number is regarded as having the best condition in regards to the aspects under consideration only. Kitchen means those households having kitchen within the room only. Fuel consists of wood and kerosene together. Edu-P is education primary, Edu-M is education upto middle level, Edu-Ma means education up to matriculation, Non-W is non worker, Toilet-O is use of open toilet, Toilet-S is use of Sulabh shouchalayas and Drink-w is availability of drinking water from pipe and tankers together.

In Kusumpur Pahari the sex ratio is the lowest so it is ranked 1; at the same time it has the largest number of people educated up to the matriculation level, so for this, it is ranked 7. This has been done for all the slums.

Finally it is found that the resettlement colony of Narela has the largest rank of 7, That is, based on these characters only Narela shows the best condition of all the slums. Kusumpur Pahari follows Narela. Samalkhan shows a value of 1 so it can be concluded that it has the worst of conditions according to the parameters taken for ranking.

All the slums have majority of the households falling under SES class 4 and the least in class 1. This can be explained by the fact that all the slums suffer from the chronic pathology of illiteracy and menial labour. Samalkhan shows the largest percentage of households under SES class 4 and also has the maximum households under SES class1 among all the other seven slums. It is seen that higher the SES class order greater the percentage of households falling in those classes.

Chapter III

Morbidity Pattern and Utilisation of Curative Health Care Facilities in the Slums

The measure of morbidity or the "state of ill health" as an indicator of the level of well being is being used increasingly in place of conventional indices like death and infant mortality rates to measure social development and personal well-being[5]. The role of morbidity in determining the standard and quality of life becomes imperative in a subcontinent like India with substantial rural – urban and social group differentials. Despite concentrated efforts, however India continues to be among the many developing countries of the world with high levels of morbidity especially among the infants, children, women and the elderly. Excessive vulnerability of the underpriviledged to their environment and their exposure to pathogenic agents means that infectious diseases and malnutrition are their severe health problems .

This Chapter examines the pattern of utilisation of the medical facilities in terms of curative health care in the seven slums surveyed. The objectives are

a) To look into the pattern of morbidity in relation to the demographic and socio- economic characteristics of the different slums surveyed

[5] Human Development Report, West and Central India, (2001). – NCAER, Oxford University Press Publication

b) The pattern of utilization of health care facilities in curative health care

Morbidity has been surveyed according major and minor illness, which is determined by the reference period of sickness i.e. two months and two weeks respectively. The data on diseases has some inherent problems associated with it. The main problem is that there is a large amount of under-reporting as the perception of householders was faulty in regards to the ailments they are suffering from. Secondly, wherever the respondents were women the nature and duration of illness were mainly assumptions or approximations as the general awareness about the various diseases among women in these slums is poor. This has, therefore, affected the true morbidity scenario.

The 10 diseases have been clubbed into four categories and they are:

a) Degenerative diseases

These are non-infective long-term illness and require regular check – ups and treatment. The occurrence of these diseases is seen more in the chronic form, as they tend to prolong for years. These diseases are related to the circulatory system, muscular and skeletal, nervous system and cardiovascular.

b) Infectious diseases.

This group includes diseases, which have a bacterial or viral cause. Many of these infectious diseases are today generally thought of as 'tropical' diseases[6] like digestive disorders and respiratory tract infections like whooping cough, pneumonia. The majority of these

[6] Phillips, D. R. (1990), " *Health and Health Care in the Third World*". Longman Scientific and Technical, UK Ltd

diseases are water borne such as diarrhoea, amoebic dysentery, cholera, and typhoid. Whether they be air borne or water borne the crux of the matter is that these are a result of inadequate basic environmental sanitation[7]

c) Accident and injuries

d) Others

Those diseases that do not fall under any of the above categories are clubbed under this head. They are ophthalmic, gynaecological, dermatological and other problems etc.

For the sake of further analysis the seven slums have been divided into two sections of inner area and outer area. In the inner area slums like Kusumpur Pahari, Mayapuri and R.K Puram Sector are included while the outer area includes Yamuna Pushta, Mongolpuri, Narela and Samalkha. This is an attempt to understand the relationship existing between accessibility and utilization. Most of the studies have identified a negative relation ship between distance and utilization pattern (Phillips, 1990)[8]. Although there have been instances where it is observed to vary according to illness. The analysis includes both the major and the minor ailments.

Minor Illness

The reference period for minor illness has been taken to be two weeks.. Minor illness generally tends to get neglected and proper care is not taken. These ailments later take a serious turn and often become either incurable or need highly expensive treatment.

---

[7] Wishwakarma, R.K. (1991), "*Health Status of the Underpriviledged*", Centre for Urban Studies, Indian Institiute of Public Administration.

[8] Phillips, D. R. (1990), " *Health and Health Care in the Third World*". Longman Scientific and Technical, UK Ltd.

Table no 3.1: Distribution of Minor Ailments and Morbidity level in the Sample Population

SLUMS	Morbidity					
	Degenerative	Infectious	Accidents/ injuries	Others	Total	Morbidity (rates / 1000)
Kusumpur Pahari	5	6	2	12	23	58.67
	21.7%	26.1%		52.2%	100.0%	
Yamuna Pushta	2	3		8	13	46.93
	15.4%	23.1%		61.5%	100.0%	
Mayapuri	1	9		5	15	35.54
	6.7%	60.0%		33.3%	100.0%	
R.K Puram Sec - 2	2	8	3	18	31	65.53
	6.5%	25.8%	9.7%	58.1%	100.0%	
Mongolpuri	6	16		7	29	58.94
	20.7%	55.2%		24.1%	100.0%	
Narela	7	13		18	38	58.55
	18.4%	34.2%		47.4%	100.0%	
Samalkha	7	18	2	9	36	62.93
	19.4%	50.0%	5.6%	25.0%	100.0%	
Total	30	73	5	77	185	56.41
	16.2%	39.5%	2.7%	41.6%	100.0%	

From table no 3.1 the morbidity rates are calculated. The aggregate morbidity rate for all the slums taken together is 56.41 /1000. Samalkha shows the highest level of morbidity at 63 /1000. The most healthy slum among the 7 is Mayapuri where the morbidity value is as low as 35.54. Infectious diseases are maximum among the slum population measuring 39.5% of the total sick population. In Samalkhan 70% of the people who are sick are suffering from this; followed by Narela and then Mongolpuri. Infectious diseases are followed by other diseases, which could include diseases like Gynaecological, ophthalmic and others. Narela suffers most from this group of disease, as there is no health center present there to check it or prevent new cases.

Table no.3.2: Minor Ailments and Morbidity levels according to area

Area	Degenerative	Infectious	Accidents/ injuries	Others	Total	Morbidity (rates / 1000)
Inner	(55%)	(45%)	(8%)	(10.89%)	59	53.24
outer	(96%)	(3.1%)	(2.5%)		16	63.53
TOTAL	(14%)	(47 %)	(57%)	(10.89%)	75	56.38

There is not much difference in the level of morbidity between the outer and the inner areas but if looked at it ailment wise it is found that the number of people affected by each disease are more.

Table no.3.3: Distribution of Minor ailments and Morbidity levels according to the sex of the population (clubbed)

SLUMS	*Morbidity*											
	Degenerative		Infectious		Accidents/ injuries		Others		Total		Morbidity (rates / 1000)	
	M	F	M	F	M	F	M	F	M	F	M	F
Kusumpur Pahari	33.3%	14.3%	22.2%	28.6%			44.4	57.1%	9 100.0%	14 100.0%	38.62	88.05
Yamuna Pushta	16.7%	14.3%	33.3%	14.3%			50.0	71.4%	6 100.0%	7 100.0%	41.66	52.63
Mayapuri		25.0%	72.7%	25.0%			27.3	50.0%	11 100.0%	4 100.0%	49.54	20
R.K Puram Sec - 2	11.1%		38.9%	7.7%	5.6	15.4%	44.4	76.9%	18 100.0%	13 100.0%	70.58	59.63
Mongolpuri	14.3%	26.7%	64.3%	46.7%			21.4	26.7%	14 100.0%	15 100.0%	51.85	66.96
Narela	14.3%	23.5%	38.1%	29.4%			47.6	47.1%	21 100.0%	17 100.0%	57.85	59.44
Samalkha	25.0%	15.0%	50.0%	50.0%	6.3	5.0%	18.8	30.0%	16 100.0%	20 100.0%	52.63	74.62
Total	15 15.8%	15 16.7%	4 46.3%	29 32.2%	2.1	3 3.3%	3 35.8	43 47.8%	95 100.0%	90 100.0%	51.04	60.48

Table 3.3 shows that at the overall level morbidity is the maximum among women. Slums like Mayapuri and R.K Puram show lesser morbidity for women than the men. It is very clear that the males suffer

maximum from infectious diseases more. Mongolpuri, situated between plastic factories, has the largest number of people suffering from this. It is no surprise as they work in these factories and inhale the poisonous smoke of the plastics. As observed in the field that women suffer from diseases mainly from the fact that no separate kitchen exists along with almost any ventilation. So inhalation of the fumes emitted from the burning kerosene or wood or whatever be the cooking medium is another culprit. So this can be a reason why In Samalkha where the air is already polluted from the dust particles floating in the air fresh air is almost non-existent. Therefore the air in the houses is not healthy making the women unhealthier. Samalkha has the maximum number of women suffering from infectious diseases. Narela has a worsening health situation, as the government pays no attention to these people. Thus the general health condition is sad.

Table no 3.4: Sex – Wise Distribution of minor ailments and Morbidity Levels according to Area.

Area	Degenerative		Infectious		Accidents/ Injuries		Others		Total		Morbidity (rates / 1000)	
	M	F	M	F	M	F	M	F	M	F	M	F
Inner	(78)	(0.03)	(44.71)	(19.35)	(2.6)	(0.06)	(42.01)	(65.51)	38	31	52.91	55.89
Outer	(22.72)	(20.33)	(59.09)	(38.98)	(.02)	(1.6)	19(43.18)	(38.98)	44	59	46.88	63.41
Total	(18.29)	(14.44)	(52.43)	(32.22)	(2.4)	3(3.3)	(42.68)	(47.77)	82	90	50.93	59.65

The above table (3.4) shows a peculiar phenomenon where the morbidity level is higher for the males in the inner area than those inthe outer area. One of the many reasons might be that the men in the inner areas are engaged in work, which are hazardous to their health. In fact, during the fieldwork it was found that men working in the factories around Mayapuri slum was constantly exposed to acrid fumes and on

top of it did not have the time to visit the PHC for treatment. Females as usual show a greater morbidity than the males for both the areas.

It is seen that the level of morbidity across age groups does not vary much. In the India: Human Development Report published by NCAER it is found that that they have neglected to take the 39 – 60 age group which has a large section of the working population involved in it. In the present work this portion of the population is included as less than 35 to 60 years. This is done mainly on the logic that in the among the slum dwellers who are engaged primarily in the unorganized informal sector there is no age of retirement. In most of the slums it was seen that people over 60 are working in some capacity or the other. Thus it would be a mistake to exclude this section of the population. This is more vulnerable to illness owing to the slowly advancing years. Highest morbidity is found among the children is in the 11 to 14 years group. This may be due to the fact that, in the field it was found, children in this age group, if not going to school are working either as rag pickers or other menial jobs in unhealthy atmospheres. Incidentally, occurrence of infectious diseases is also the highest in this group.

Table no. 3.5: Distribution of Minor ailments and Morbidity levels according to Age Group of the population and Area

Age- group	*Area*	*Morbidity*					
		Degenerative	Infectious	Accidents/ injuries	Others	Total	Morbidity (Rates / 1000)
< 4 yrs	Inner	(15.7)	(21.05)	(5.26)	(57.89)	19 (100)	71.82
	Outer	(13.04)	(56.52)	0	(30.43)	23(100)	52.42
	Total	6 (14.28)	17 (40.47)	1(23.80)	18 (42.85)	42 (100)	61.25
5 – 14	Inner	(28.57)	(38.09)	(95.23)	(47.61)	21(100)	74.64
	Outer	(13.33)	(45)	(1.66)	(31.66)	60 (100)	122.8
	Total	14(17.28)	35 (43.20)	3 (90.12)	29 (35.80)	81(100)	98.83
15 – 35	Inner	(5.26)	(52.63)	(5.26)	(42.10)	19 (100)	28.08
	Outer	(21.27)	(36.17)	0	(42.55)	47 (100)	50.98
	Total	11 (16.66)	27 (40.90)	1(15.15)	(42.42)	66 (100)	48.91
36 - 60	Inner	(50)	0	0	(50)	2 (100)	181.81
	Outer	0	(66.66)	0	(33.33)	6 (100)	61.111
	Total	1 (6.25)	4 (50)	0	3 (37.5)	8 (100)	121.46
> 61 yrs	Outer	(33.33)	0	0	(66.66)	3(100)	125
	Total	1(33.33)	0	0	2(66.66)	3(100)	31.25

By the above table (3.5) the level of morbidity is the maximum in the outer area belonging to the age – group of 5 - 14. But the maximum morbidity in the inner region is noticed in the 36 – 60 age group. This may be attributed to the fact they have no time to take care of themselves. The above 60 group shows no morbidity in the inner area which is quite surprising. This could be explained; as the slum population grows old they move back to their ancestral home than stay here than be a burden on their children in the slums.

Major Illness

Major illness is chronic by definition itself. All chronic illness are degenerative by nature and therefore not infectious. For the sake of analysis all the diseases have been clubbed under degenerative and Accidents / injuries. There is much difference in the disease pattern from the pattern emerging from the minor ailments. Here the most occurring disease is obviously the degenerative one. The slums having the largest number of people suffering from major problems happen to Samalkha with 25 people reporting to sick. The least diseased slum happen to be R.K Puram Sector 2 mainly by the dint of its location. It is situated bang in the middle with Safdarjung Enclave and R K Puram Colony on either side and is very near to both the AIIMs and Safdarjung hospital.

Table no 3.6: Symptoms of Major Illnesses and Level of Morbidity

SLUMS	*Symptoms*	
	Total	Morbidity (Rates/ 1000)
Kusumpur Pahari	23 (100)	56.12
Yamuna Pushta	15 (100)	50.54
Mayapuri	26 (100)	63.98
R.K Puram Sec - 2	18 (100)	38.05
Mongolpuri	33 (100)	69.76
Narela	34 (100)	72.87
Samalkha	35 (100)	62.92
Total	184 (100)	56.72

Morbidity as seen from table no 3.6 is found to be maximum in Narela mostly because there is no treatment facility. Due to lack of

treatment the diseases go on worsening and new diseases manifest due to lack of check. R K.Puram sector 2 has the lowest level of chronic morbidity is concerned.

Table no 3.7: Distribution of Major Illness and Morbidity according to Sex off the Sample population

SLUMS	Symptoms and Morbidity			
	Total		Morbidity (Rates / 1000)	
	M	F	M	F
Kusumpur Pahari	10 (100)	13 (100)	38.62	81.76
Yamuna Pushta	7 (100)	8 (100)	48.61	52.63
Mayapuri	18 (100)	8 (100)	81.08	45
R.K Puram Sec - 2	8 (100)	10 (100)	31.37	45.87
Mongolpuri	21 (100)	12 (100)	77.77	53.57
Narela	15 (100)	19 (100)	44.07	69.93
Samalkha	15 (1000	20 (100)	55.92	63.43
Total	94 (100)	90 (100)	49.98	58.73

From table no 3.7 it is clear that women are the worst suffers from chronic illnesses. Their aggregate morbidity level is at 58.73. Only in Mayapuri and Mongolpuri it is found that men are worse off than the women. It seems that that degenerative diseases are the most commonly occurring one. The population of Samalkha happens to bethe most susceptible one in this regard and the women are more so. This fact has been corroborated table no 3.10. Narela heads the list among all the slums with 8 males suffering from diseases. The over all picture shows that males are sicker than the females with 94 with only 90 females.

Table no.3.8: Distribution of Major Illness and Morbidity according to Sex (Area Wise)

Area	Total		Morbidity	
	Male	Female	Male	Female
Inner	24	32	43.38	57.58
Outer	61	58	56.59	59.89
Total	96	90	49.98	58.73

The table no.3.8 shows that even in the case for major illnesses the morbidity level of females exceed the morbidity of the males. The fact that the outer region is more susceptible to chronic diseases than the inner one is further reiterated. A strange phenomenon is noticed and that nobody suffers from senility even in the case of major illness. This might be due to the fact that the slum dwellers do not recognise senility, premature or otherwise to a kind of a disease and therefore do not report it.

The most noticeable phenomenon is that as the age groups are growing the incidence of disease is decreasing. Except for the working age group population. This can be explained in the fact that the slums constitute migrant population and migration takes place among the young and the fit while the old and the infirm mainly remain back in the villages.

Occurrence of chronic Illness (Table no 3.10) among the children between the age group 5 to 14 is the most, at around 22. Highest morbidity is noticed in the age group i.e. between 15 – 35. So it is seen that, even though morbidity in relation to minor illnesses, in this group is low, in the case of major ailments it is maximum. This may be attributed to the fact that exposure to factors causing illnesses is the most mainly due to the kind of work they do.

Table no. 3.9: Distribution of Major Illness and Morbidity level according to the Age (Area – Wise)

Age - group	*Area*	*Symptoms*	
		Total	Morbidity (rates / 1000)
< 5 yrs	inner	11 (100)	8.80
	outer	36(97.29%)	18.37
6 – 10 yrs	Inner	22(100)	10.13
	outer	40(97.6%)	13.52
15 – 55 yrs	inner	32(96.96)	25.82
	outer	24 (85.71%)	19.13
55 – 65 yrs	inner	1 (100)	0.7
	outer	1 (33.33%)	2.48

In the table 3.9 showing chronic morbidity, maximum is seen in the working age group of 15 – 55 years. In category the level of morbidity is more in the inner area than the outer. This may be due to the fact that the level of pollution and the state of working conditions are far worse in the inner city than the peripheral zone.

Effect of Education

Education plays a very important role in the perception and treatment of diseases. The general idea of hygiene, too, changes with education. Therefore in slums where the general level of education is low, if one member of the household has some kind of education then according to the NFHS - 2[9] it 'may affect ..... the health of children and proper hygiene practices.

It is found that with higher education the incidence of major illness lessens. It is primarily the illiterates and the people who have been never enrolled in any school are the ones suffering most from the major illnesses. Overall only 4 people are sick who have education up to the

[9] National Family Health Survey – 2, (1989 – 99),International Institute of population Sciences, Mumbai.

matriculation level. In comparison 27 illiterates and 27 people who have never enrolled in any school are reported to be suffering from the major diseases. According to the NCAER study[10] the level of morbidity should increase as better reporting takes place with increasing level of ecucation, but in this case that doesn't happen so it can be generally accepted that these people have a better awareness[11]

Table no.3.10 Incidence of major illness according to educational level

		SYMPTOMS		
Educational level		Degenerative	Accidents / injuries	Total
illiterates	Kusumpur Pahari	2 100.0%		2 100.0%
	Yamuna Pushta	1 100.0%		1 100.0%
	Mayapuri	4 100.0%		4 100.0%
	R.K Puram Sec - 2	5 100.0%		5 100.0%
	Mongolpuri	5 100.0%		5 100.0%
	Narela	6 100.0%		6 100.0%
	Samalkhan		2 50.0%	4 100.0%
	Total	25 92.59	2 7.4%	27 100.0%
Never enrolled	Kusumpur Pahari	3 100.0%		3 100.0%
	Yamuna Pushta	1 100.0%		1 100.0%
	Mayapuri	2 100.0%		2 100.0%
	R.K Puram Sec - 2	2 100.0%		2 100.0%
	Mongolpuri	6 100.0%		6 100.0%
	Narela	3 100.0%		3 100.0%
	Samalkhan	9 90.0%		1 10.0%

[10] India: Human Development Report,(1999), NCAER, Oxford university Press.
[11] Wishwakarma, R.K. (1991), "*Health Status of the Underpriviledged*", Centre for Urban Studies, Indian Institiute of Public Administration.

	Total	26 96.29%	27 100.0%
Not currently	R.K Puram Sec - 2	1 100.0%	1 100.0%
	Narela	1 100.0%	1 100.0%
	Samalkhan	3 100.0%	3 100.0%
	Total	5 100.0%	5 100.0%
Primary	Kusumpur Pahari	1 100.0%	1 100.0%
	Yamuna Pushta	2 100.0%	2 100.0%
	Mayapuri	1 100.0%	1 100.0%
	R.K Puram Sec - 2	1 100.0%	1 100.0%
	Mongolpuri	10 100.0%	10 100.0%
	Total	13 86.66%	15 100.0%
Middle	Kusumpur Pahari	2 100.0%	2 100.0%
	Yamuna Pushta	3 100.0%	3 100.0%
	Mayapuri	1 100.0%	1 100.0%
	R.K Puram Sec - 2	1 100.0%	1 100.0%
	Narela	1 100.0%	1 100.0%
	Total	8 100.0%	8 100.0%
Matric	Kusumpur Pahari	2 100.0%	2 100.0%
	Mayapuri	1 100.0%	1 100.0%
	Samalkhan	1 100.0%	1 100.0%
	TOTAL	4 100.0%	4 100.0%

Utilisation of Health Services

An attempt has been made to portray the utilisation of health services on all India bases as revealed by the NSS 42nd round. But the data on utilization of health services by socio – economc groups is not available.

Primary health care, as the source of first resort care, is an important constituent of the health care system. It is regarded as the key to attaining an acceptable level of health for all as means of removing widespread inequities in health services, more particularly in the backward areas be it rural or urban. Its organization and efficient operation are basic for implementing national health development actions[12].

In India, Primary health care is sough to be provided by primary health centers and sub centers. The concept of PHC was given to India by the Bhore Committee in 1946 to provide an integrated curative, preventive and promotive health care to rural population. The Committee suggested a norm of one PHC for population of 10,000 to 20,000 with 6 medical officers, 6 Nurses, and supporting staff. The population norms accepted for establishing PHCs are 30,000 and 20,000 for hilly and tribal areas and 5,000 for a sub center[13].

Utilisation by minor ailments

Minor illnesses tend to get neglected therefore reporting of there treatment might be faulty. In the slums where there is no money to spare for the treatment minor sicknesses are ignored. Depending on the information gathered type of treatment has been listed as follows:

---

[12] Basu, S (1990), "*Health Scenario and Health problems of Tribal Population in India*" Seminar on Continuity and change in Tribal Society, Indian Institute of Advanced Study, Shimla

[13] The Seventh Five Year Plan, Vol II, Planning Commission, Government of India

1.Home medication

2.Self-medication

3. RPM

4. Hakims /Vaid / Others

5.Homeopath

6. Allopathic

(This list is followed for the major illnesses as well)

Table no.3.11: Treatment availed by the people for Minor Illnesses.

SLUMS	*Treatment of minor Illnesses*					
	Home Medication	Self medication	RMP	Hakim/vaids	Allopathic	Total
Kusumpur Pahari	26.1%	60.9%		8.7%	4.3%	23 100.0%
Yamuna Pushta	61.5%	30.8%	7.7%			13 100.0%
Mayapuri	21.4%	42.9%		14.3%	21.4%	14 100.0%
R.K Puram Sec - 2	29.0%	51.6%		3.2%	16.1%	31 100.0%
Mongolpuri	10.3%	65.5%	17.2%		6.9%	29 100.0%
Narela	10.8%	62.2%	16.2%	8.1%	2.7%	37 100.0%
Samalkha	11.1%	52.8%	25.0%	2.8%	8.3%	36 100.0%
Total	37 20.2%	101 55.2%	21 11.5%	9 4.9%	15 8.2%	183 100.0%

As seen from Table no 3.11 in case minor ailments the slum dwellers do not go to homeopaths at all. It seen that most people prefer to go in for self-medication. In Mongolpuri 65.5% of the people treat themselves in case of short-term illness. Very few people visit the allopathic for treatment as these doctors charge a large fee. Even though the slums are an extension of the rural way of life yet it is found that hakims / vaids have lost their importance to these people as a total of nine people have returned to have visited these quacks out of the seven slums surveyed.

Table no. 3.12: Treatment availed by the people for Minor Illnesses Area–Wise.

Area	Home Medication	Self medication	RMP	Hakim/vaids	Allopathic	Total
Inner	18	36	0	5	9	68
Outer	19	65	20	4	6	115
Total	37	101	21	9	15	183

Even in table 3.12 as in table 3.9 it is clear that people prefer self-medication to any other treatment for minor illnesses. The outer area shows that maximum utilization of home medication.

As regards to the utilisation of the health facility by the sick there has been affirmative responses to zero utilization. The respondents regard health facility as only those provided by the government or private hospitals and RMPs. On further probing it was found that by zero utilization it does not mean that no treatment has been done. It was found that for all the cases with zero utilization responses the treatment availed is either self, home medication or resorting to the quacks.

Expenditure on health is a major source of concern for these slum dwellers therefore they tend to cut down on medical expenses whenever and however they can. Thus expenses are not much incurred for minor sicknesses.

Table no.3.13: Expenses incurred for treatment of Minor Illness

SLUMS	*EXPENDITURE (Rs)*						
	< 20	21-40	41 -80	81 - 160	161 - 320	>321	Total
Degenerative	8 25.0%		4 12.5%	8 25.0%	1 3.1%	11 34.4%	32 100.0%
Infectious	18 20.7%	12 13.8%	17 19.5%	11 12.6%	13 14.9%	16 18.4%	87 100.0%
Accidents / Injuries			1 16.7%	2 33.3%		3 50.0%	6 100.0%
Others	21 24.4%	7 8.1%	13 15.1%	15 17.4%	16 18.6%	14 16.3%	86 100.0%
Total	47 22.3%	19 9.0%	35 16.6%	36 17.1%	30 14.2%	44 20.9%	211 100.0%

The clubbed data shows (Table no. 3.13) that of the total expenditure on health majority is spent on Infectious diseases. In 20.9% of the total cases money spent is above Rs 321.

Utilisation by major ailments

It is seen that for major illnesses the slum dwellers prefer to visit the doctor. The incidence of using home and self-medication is very low and the allopathic mode of treatment has gained favour largely.

Table No. 3.14: Treatment Availed by the sample population for major Illnesses

Slums	*Treatment of Major Illnesses*						
	Home Medication	Self medication	RMP	Hakim/vaid	Homeopath	Allopathic I	Total
Kusumpur Pahari	1	2	4	1	1	13	22
	4.5%	9.1%	18.2%	4.5%	4.5%	59.1%	100.0%
Yamuna Pushta	2	2	1			10	15
	13.3%	13.3%	6.7%			66.7%	100.0%
Mayapuri	1	2	3	4	3	15	28
	3.6%	7.1%	10.7%	14.3%	10.7%	53.6%	100.0%
R.K Puram Sec - 2	1		2			15	18
	5.6%		11.1%			83.3%	100.0%
Mongolpuri	1	3	10		1	18	33
	3.0%	9.1%	30.3%		3.0%	54.5%	100.0%
Narela			4	3		29	36
			11.1%	8.3%		80.6%	100.0%
Samalkhan	1	3	9	2		23	38
	2.6%	7.9%	23.7%	5.3%		60.5%	100.0%
Total	7	12	33	10	5	123	190
	3.7%	6.3%	17.4%	5.3%	2.6%	64.7%	100.0%

For major Illness as is seen in the Table 3.14 very few people prefer home or self medication as opposed to in the case for minor illnesses. In this case 64.7% of the ill prefer to visit an allopathic. In all the slums none show below 50% preference for this type of treatment. In R.K Puram Sec – 2 slums it is 83.3%, which is the highest while Mayapuri shows the least with 53.2%. Homeopaths play absolutely no role in curing this illness, as they are not at all preferred by the slum dwellers. Even Hakims and Vaids have a better appreciation among the sample population.

Table no. 3.15: Type of Treatment availed by Area

Area	Home Medication	Self medication	RMP	Hakim/vaids	Homeopath	Allopathic	Total
inner	3	4	9	5	4	43	68
outer	4	8	24	5	1	70	122
total	7	12	33	10	5	123	90

The table no 3.15 shows that both the outer as well as the inner area prefer the services of an allopath. RMPs are next most popular type of treatment among the slum dwellers.

Table no. 3.16 Type of Treatment Availed by the people according to Ailments

SLUMS	*Treatment of major Illnesses*						
	Home Medication	Self medication	RMP	Hakim/vaid	Homeopath	Allopath	Total
Degenerative	4	3	4	3	1	30	45
Infectious	3	4	11	2		35	55
Accidents / Injuries		1	2			7	10
Others	6	4	23	5	4	69	111
Total	13	12	40	10	5	141	221

According to the table (3.16) Allopathic form of medicine is preferred to all other form of treatment. In all of the four types of diseases allopathic is the most resorted to one.

The range of expenditure for major illness is wide, from 0 to 40,000. If the patient has been shown to the PHC then almost everything is free. On the other hand if private medical attention is sought then the expenditure going up to 40,000 is probable.

Table no. 3.17: Expenditure incurred for treatment (Slum– wise)

SLUMS	*EXPENDITURE (Rs)*						
	< 100	101 – 200	201 – 400	401 – 800	801 - 1600	> 1601	Total
Kusumpur Pahari	2	3	5	6	3	4	23
	8.7%	13.0%	21.7%	26.1%	13.0%	17.4%	100.0%
Yamuna Pushta	5	1	1	5	4	3	19
	26.3%	5.3%	5.3%	26.3%	21.1%	15.8%	100.0%
Mayapuri	8	0	6	10	2	2	28
	28.6%	0	21.4%	35.7%	7.1%	7.1%	100.0%
R.K Puram Sec - 2	0	4	5	3	0	6	18
		22.2%	27.8%	16.7%	0	33.3%	100.0%
Mongolpuri	6	5	6	4	3	7	31
	19.4%	16.1%	19.4%	12.9%	9.7%	22.6%	100.0%
Narela	11	4	4	4	2	11	36
	30.6%	11.1%	11.1%	11.1%	5.6%	30.6%	100.0%
Samalkhan	12	6	5	6	2	7	38
	31.6%	15.8%	13.2%	15.8%	5.3%	18.4%	100.0%
Total	44	23	32	38	16	40	193
	22.8%	11.9%	16.6%	19.7%	8.3%	20.7%	100.0%

According to the table no 3.17 in around 22% of the total expenditure on health of the sample population has been below Rs 100. Around 20% the total health expenditure of the sample population is above Rs 1600. Majority of the population spend below Rs100or above Rs 1600. Samalkhan has the maximum health expenditure while R.K Purim has the least. Maximum expenditure is incurred while treating degenerative diseases (3.21) and the least for accidents and injuries.

Table no. 3.18: Expenditure on Treatment by Major Illnesses

SLUMS	*Expenditure (Rs)*						
	< 100	101 – 200	201 – 400	401 – 800	801 - 1600	> 1601	Total
Degenerative							43
	11.6%	9.3%	16.3%	23.3%	14.0%	25.6%	100.0%
Infectious							54
	38.9%	14.8%	13.0%	18.5%	1.9%	13.0%	100.0%
Accidents / Injuries							10
	10.0%		20.0%	40.0%	10.0%	20.0%	100.0%
Others							112
	24.1%	10.7%	14.3%	14.3%	13.4%	23.2%	100.0%
Total	54	24	32	40	23	46	219
	24.7%	11.0%	14.6%	18.3%	10.5%	21.0%	100.0%

The above table tries to show the expenditure incurred on treating each of the diseases. It is clearly seen that in the category of other diseases nearly 23.2% of the expenses are over Rs 1600.

CONCLUSION

A major support to the health care system is given by the environment. The conditions of living in these slums are so wretched that thinking of a healthy and steady life is almost impossible.

In the course of the analysis of the data it is seen that the morbidity rates are quite low. This is quite surprising as it contrary to the grain, which is that as these are areas of great depressions (economic, social and otherwise) the morbidity rate should naturally be high. This present situation should be looked at primarily from the point of location.

All the slums that were surveyed are located in the capital of the country i.e. Delhi. Here the conditions of life are a lot better than the rest of the country. Attention is paid more to almost every other thing as the country has a face to maintain to the rest of the world. Laws and bylaws are passed that are almost entirely meant and implemented here. Moreover these slums still have a better civic amenity situation when compared slums of Hyderabad[14] and Bombay[15]. The data on diseases has some inherent problems associated with it. The main problem is that there is a large amount of under-reporting as very few householders were able to identify that a small problem might actually be a disease. Secondly, wherever the respondents were women the nature and duration of illness were mainly assumptions or approximations as the general awareness about the various diseases among women in these slums is poor. This has, therefore, affected the true morbidity scenario.

While analyzing the data on morbidity, in terms of curative health care, it is found that infectious and Other disease are the most common occurring ones both among the short term (minor) and long term (major) ones. This can be partly put down to the polluted and unhygienic living conditions and has been borne out by the type of work that the sample population is engaged in. The women and the students and those workers who are self employed are the ones found to be suffer from these diseases. The slum people usually tend to neglect short duration or minor problems preferring to resort to home remedies or self-medication. It is only when these problems magnify to something serious that they tend to sit up and take notice. Allopathic form of medicine appeals most. Even among the people suffering from major diseases, expenses remain low. Though a significant number have spent thousands in treatment.

---

[14] Vaidyanathan, K.E. (1990), "*Health and Nutrition Survey in Slum Habitat*", Hyderabad Slum Improvement Project, in (ed) H.U Bijlani and Prodipto Roy, Council of Social Development, New Delhi

[15] Khandekar, M. (1974), "*Utilization of Social Welfare Service in Greater Bombay*", Tata Institute of Social Services

Education plays an important role in lowering the incidence of diseases. The education of even one member in the household increases the general level of awareness such that a lot of ailments that could have taken a serious turn are nipped in the bud. The type of occupation that one is involved in also has a bearing on the health status. Moreover the men are seen to suffer more than the females in terms of both the major and minor ailments may be because of the fact that they are exposed to both the outdoor and the indoor pollution.

Chapter IV

Utilisation Pattern of Health Facilities for Preventive Health Care across the Slums

Preventive health care addresses the issue of prevention of disease through immunization and other care. Understanding the processes through immunization comes to be institutionalized as a routine practice in public health care management. Immunization of the child and women is one of the most important of public health services as its objective is to bring down child mortality[16]. Promotion of maternal and child health has been one of the most important

This Chapter looks in to the utilisation of the medical facilities in terms of preventive health care in the seven slums surveyed.

The objective of this chapter is to analyse

a) the effect that socio-economic conditions have on preventive health care and
b) the pattern of utilisation of medical facilities across the slums.

The data on preventive health care has been looked at from three aspects i) immunization ii) prenatal care and iii) postnatal care. The information on pre and postnatal care has been collected for the past five years. Information is therefore for three births at the most. For the sake of analysis the data for these births have been clubbed together. For

[16] Wishwakarma, R.K. (1991), "*Health Styatus of the Underpriviledged*", Centre For Urban Studies, IIPA, WHO.

more than one birth, the place has been considered ie those births taken place in Delhi. This has been done, as in the course of the survey it was found that if the birth has taken place in the village, the mother had been unable to take the advantage of pre and post natal care, even in spite of being aware of it. Three major preventive care which has been discuss in this chapter are a) immunization b) Pre and post natal care and c) assistance during birth.

Immunisation of children

Immunisation of children against vaccine preventable diseases (VPD) had been in practice for along time since independence. An added impetus to the programme came with the adoption of the universal immunization programme (UIP) By the government of India in 1985. The programme included immunization of infants with BCG, DPT and oral polio vaccine to start with. In 1986 – 87, vaccination against measles was added to the programme. The facilities for vaccination were made available to the public in the PHCs in all states. The ministry of health and family welfare started targets for immunization and followed this by monitoring the coverage of the targeted children.

The standard immunization schedule developed for the child immunization programme specifies the age at which each vaccine is to be administered, the number of doses to be given and the route of vaccination.

In NFHS – 2, children who have received BCG, measles and three doses of each of DPT and Polio are considered to be fully vaccinated. Based on information obtained from the immunization card or reported by the mother, 70% of the children aged 12 – 23 months are fully

vaccinated and only 5% have not received any vaccination at all. Nearly 80% of the children have received three doses of DPT and polio vaccines.

Table no 4.1: Immunisation of children in the sample population

SLUMS	*Immunisation Vaccines*							
	BCG		DPT		Measles		Polio	
	No	Yes	No	Yes	No	Yes	No	Yes
Kusumpur Pahari	11.7%	88.3%	13.3%	86.7%	15.0%	85.0%	13.3%	86.7%
Yamuna Pushta	8.0%	92.0%	11.4%	88.6%	0	100.0%	25.7%	74.3%
Mayapuri	14.3%	85.7%	9.3%	90.7%	14.7%	85.3%	7.9%	92.1%
R.K Puram Sec - 2	17.1%	82.9%	19.8%	80.2%	22.2%	77.8%	4.9%	95.1%
Mongolpuri	8.4%	91.6%	22.9%	77.1%	26.5%	73.5%	4.8%	95.2%
Narela	12.3%	87.7%	21.3%	78.7%	27.0%	72.1%	7.4%	92.6%
Samalkhan	8.3%	91.7%	16.7%	82.1%	21.4%	78.6%	8.3%	91.7%
Total	58	440	94	445	111	428	47	494
	11.6%	88.4%	17.4%	82.4%	20.6%	79.3%	8.7%	91.3%

Immunisation pattern, according to the Table no 4.1, shows that the majority of the children who are aged below 6 years have been immunised. 100% of the children have received measles vaccine in Yamuna Pushta. The over all picture shows that none of the slums have a immunization level below 75 %. Narela shows a somewhat dismal picture in so far as child immunisation is considered. This slum before relocating to that area had a better condition of immunization (as reported by the dwellers). Currently with no PHC the children born after relocation have not been immunized.

The above findings are not different from those of NFHS– 2. There has been a considerable improvement in full vaccination coverage in Delhi since the NFHS – 1 when the proportion of children fully

vaccinated was 58%. The condition has bettered from the 42nd Round of the NSSO where the polio vaccination was pegged at 66 for Delhi[17].

One normally expects that a higher coverage would be reported for BCG which is given at the health care institution or by the ANM. Given the scheduling to be followed for vaccination it is also expected that DPT and polio should move together. On the other hand, measles vaccine being a late starter would mean that the shortfalls in the eligible populayion to be immunized may be longer than those for the for the other vaccines[18].

The education level of the mother has an important bearing on the perception and need of preventive care both for self and the children. It may be expected that the mothers with some amount of education will avail health services more than the ones who are illiterate.

According to Das, Das and Cotinho[19] the relation between female literacy or mother's education and child immunisation has though received much attention yet the exact mechanisms through which literacy functions to promote better health for children are still obscure. This picture is also seen in the slums surveyed. The coverage of measles is comparatively on the lower side than the other vaccinations

Prenatal care

Prenatal care of mothers is very necessary for safe childbirth and healthy babies. Ideally the Ante natal care should monitor a pregnancy

[17] NSSO, (1989), Child and Maternity Care (42nd Round, 1986 – 87)
[18] Das,R.R.Dasgupta,P.(2000), "*Child health and Immunisation: A Macro Perspective*" Economic and Political Weekly,Feb – 19,2000.
[19] Das,V.Das,R.K.Coutinho,L. (2000), "*Disease Control and Immunisation: A Sociological Enquiry*", Economic and Political Weekly, Feb 19, 2000.

for signs of cpmplications detect and treat persisting and concurrent problems of pregnancy and provide advice and councelling on preventive care, diet during pregnancy, delivery care, postnatal care and other issues[20]. According to Wishwakarma's[21] study a high percentage of mothers receive free food and medicine in urban areas during prenatal care. In these slums, being situated in the capital of the country, no such instance was found where free food is given out to the mother.

The educational level of the mothers utilising pre natal care along with the their educational level is given in Table no.4.2. Here it is seen that higher the educational level of the mothers greater is the utilisation of the health facility for prenatal care. Illiterate mothers show a greater tendency of not going for any prenatal care. Among the never enrolled mothers there is again a tendency of not taking advantage of any care but less than the previous category. Higher up the educational ladder the mothers are found to take complete care of themselves. The observation by Das, Das and Cotinho[22] does not hold true here as a positive relationship can be seen between mother's level of education and prenatal care utilization.

[20] NFHS – 2, Delhi, 1998 – 99, International Institute of Population Studies, Mumbai.
[21] Wishwakarma, R.K. (1991), "*Health Styatus of the Underpriviledged*", Centre For Urban Studies, IIPA, WHO
[22] Das,V.Das,R.K.Coutinho,L. (2000), "*Disease Control and Immunisation: A Sociological Enquiry*", Economic and Political Weekly, Feb 19, 2000.

Table no 4.2: Distribution of mothers according to Educational Level availing Prenatal cares in the sample population

Education Completed	*SLUMS*	*Type of Prenatal Care*					
		Not availing	Hospita (govt)	Hospital (pvt)	ANM	NGO	Total
Illiterates	Kusumpur Pahari	20.0%	40.0	20.0%	0	20.0%	100.0
	Yamuna Pushta	0	100.0	0	0		100.0
	Mayapuri	28.6%	71.4	0	0		100.0
	R.K Puram Sec - 2	80.0%		0	0	20.0%	100.0
	Mongolpuri	33.3%	16.7	16.7%	0	33.3%	100.0
	Narela	18.2%	54.5	18.2%	0	9.1	1 100.0
	Samalkhan	0	40.0	20.0%	0	40.0%	100.0
	Total	1 27.5%	1 42.5	5 12.5%		17.5%	4 100.0
Never enrolled	Kusumpur Pahari	0	33.3	66.7%	0		100.0
	Yamuna Pushta	0	100.0	0	0		100.0
	Mayapuri	0	25.0	25.0%	0	50.0%	100.0
	R.K Puram Sec - 2	0	75.0	25.0%	0		100.0
	Mongolpuri	0	62.5	12.5%	12.5%	12.5%	100.0
	Narela	0	66.7	33.3%	0		100.0
	Samalkhan	0	58.3	33.3%	8.3%		1 100.0
	Total	0	2 58.3	1 27.8%	2 5.6%	8.3	3 100.0
	Yamuna Pushta	16.7%	66.7	0	0	16.7%	100.0

upto Primary	R.K Puram Sec - 2	33.3%	33.3	33.3%	0		100.0
	Mongolpuri	0	50.0	0	0	50.0%	100.0
	Narela		64.3	14.3%	7.1%	14.3%	1 100.0
	Samalkhan	100.0%		0	0		100.0
	Total	3 11.5%	1 57.7	3 11.5%	1 3.8%	15.4%	2 100.0
Upto Middle	Kusumpur Pahari	0	50.0	0	50.0%		100.0
	Yamuna Pushta	0	100.0	0	0		100.0
	R.K Puram Sec - 2	100.0%		0	0		100.0
	Mongolpuri	0		0	0	100.0	100.0
	Narela	0	66.7	0	0	33.3%	100.0
	Samalkhan	0	100.0	0	0		100.0
	Total	1 7.1%	57.1		2 14.3%	21.4%	1 100.0
Matric	Mongolpuri	0		100.0%	0		100.0
	Narela	0		0	0	100.0	100.0
	Total	0		50.0%	0	50.0%	100.0
	Total	1 7.1%	57.1		2 14.3%	21.4%	1 100.0

. Here the role of education is not found to be important. The mothers who are availing the public care the most, happen to be those who have never enrolled for any kind of a formal education. This means that even though they themselves lack in education their family members are quite aware of the need. Pre and postnatal care type has been categorized into: 0 - Not availing care, 1 – Hospital / health center (public), 2- Hospital / health center (private), 3– Visiting ANM, 4. – VisitingNGO.

Table no.4.3: Utilisation of the type of prenatal facility

Facility	Frequenc	Percent
Not availing car	62	15.89
Hospital / health center (public)	203	52.51
Hospital / health center (private)	58	14.87
Visiting AN	19	4.87
Visiting NGO.	48	12.30
Tota	390	100

By table 4.3 it is found that private health care is the least availed as these people do not have the means of utilizing them. NFHS–2 results for Delhi show that 84 % of the mothers received prenatal care. The findings in the slums also reflect this figure amounting to 83.55%. The reasons behind why mothers did not go in for ante natal checks can be many. The main reason that was given for this during the fieldwork was that these mothers had gone to their place of domiciliary for child birth and consequently did not receive the care. According to Wiswakarma's study expectant mothers are better served in urban areas in the prenatal stages than their rural counterparts.

Spreading consciousness among the women regarding the immunization of self, before and after birth of baby is an important issue. It is the responsibility of the Auxiliary Nurse and Midwife (ANM) to spread awareness among the women. These people are the front line health workers who are entrusted with the duty of implementation of the health programmes of the primary health centers. Besides delivering health service to the community, they play a very important role in imparting health education[23]. In the slums that were surveyed the role of ANMs were minor. For all post and pre natal care and checkups the dwellers prefer to visit the nearest government hospital than visit the PHC.

[23] Coutinho,L. Bisht, S. Raje, G.(2000),"*Numerical Narratives and Documentary Practices: Vaccines, Targets and Reports of Immunisation Programme,*"

Table No. 4.4: Distribution of Population Availing Prenatal care according to Slums

Slums	*Pre natal care*					
	Not availing care	Hospitals (Public)	Hospitals (Private)	ANM	NGO	Total
Kusumpur Pahari	13.5%	48.6%	18.9%	8.1	10.8%	37 100.0%
Yamuna Pushta	17.9%	39.3%	17.9%	10.7%	14.3%	28 100.0%
Mayapuri	22.5%	60.0%	7.5	5.0	5.0	40 100.0%
R.K Puram Sec - 2	15.1%	52.8%	24.5%	1.9	5.7	53 100.0%
Mongolpuri	7.7	51.9%	9.6	3.8	26.9%	52 100.0%
Narela	5.5	65.8%	13.7%	2.7	12.3%	73 100.0%
Samalkha	10.3%	46.6%	20.7%	6.9	15.5%	58 100.0%
Total	4 12.0%	183 53.7%	5 16.1%	1 5.0	4 13.2%	341 100.0%

About 53% of the population visit the public hospitals for pre natal care (table no.4.4) while the role of the ANMs is limited to only 5%. ANMs have the maximum role to play in the Yamuna Pushta slum amounting to 10% only. Therefore it can be said that the ANMs have sadly failed in their duty by looking at the data, however during fieldwork several ANMs were seen to operate in the slums. Particularly in Kusumpur Pahari. This can be explained that though the people are aware of the presence of the ANM they are unwilling to trust her so do not take her advice.

Assistance at birth

Another important thrust of the Reproductive and Child Health Programme is to encourage deliveries under proper hygienic conditions under the supevision of trained health professionals.According to two the

NFHS surveys (NFHS – 1,2) the proportion of the deliveries attended by health professionals inceased from 54% in NFHS – 1 to 66% in NFHS –2.

In the case of the slums surveyed it was found (table 4.6) that health professionals mostly attended around 24 % of the births.

Table no.4.5: Assistance received during delivery

Assistance during birth	Frequency	Percent
Neighbours / Relatives	242	61.73
Dai	124	31.63
Trained Nurse	11	2.80
Doctors	9	22.59
Other	6	15.30
Total	392	1009

The NSSO data show that quite a high percentage of childbirths take place at home. In here an attempt has been made to draw some kind of a relationship between educational status of the mother andthe assistance received during birth of her baby. It is usually assumed that if the mother has some kind of a basic education she would prefer the help of a professionally trained person. But this idea is often constrained by the lack of money and the place where the mother is staying at the time of delivery. Moreover as is observed by Das, Das and Coutinho[24] the relationship between education of the mother and the health care availed is highly obscure.

[24] Das, V.Das,R.K.Coutinho,L. (2000), "*Disease Control and Immunisation: A Sociological Enquiry*", Economic and Political Weekly, Feb 19, 2000.

Table no. 4.6: Assistance received during Birth by the mothers according to their Educational Level in the Sample Population

Education Completed	*SLUMS*	*Assistance During Birth*					
		Neighbours	Dai	Tarined nurse	Doctors	others	Total
Illiterates	Kusumpur Pahari	4	1	0			5
		80.0%	20.0%	0			100.0%
	Yamuna Pushta	1		0			1
		100.0%		0			100.0%
	Mayapuri	7	1	0			8
		87.5%	12.5%	0			100.0%
	R.K Puram Sec - 2	2	2	1			5
		40.0%	40.0%	20.0%			100.0%
	Mongolpuri	5		0	1		6
		83.3%		0	16.7%		100.0%
	Narela	8	2	0	1		11
		72.7%	18.2%	0	9.1%		100.0%
	Samalkhan	4	1	0			5
		80.0%	20.0%	0			100.0%
	Total	31	7	1	2		41
		75.6%	17.1%	2.4%	4.9%		100.0%
Never enrolled	Kusumpur Pahari	2	2	0			4
		50.0%	50.0%	0			100.0%
	Yamuna Pushta	2		0			2
		100.0%		0			100.0%
	Mayapuri	3	1	0			4
		75.0%	25.0%	0			100.0%
	R.K Puram Sec - 2	4		0			4
		100.0%		0			100.0%
	Mongolpuri	3	5	0			8
		37.5%	62.5%	0			100.0%
	Narela	1	2	0			3
		33.3%	66.7%	0			100.0%
	Samalkhan	7	5	0			12
		58.3%	41.7%	0			100.0%
	Total	22	15	0			37
		59.5%	40.5%	0			100.0%
Upto Primary	Yamuna Pushta	5	1	0			6
		83.3%	16.7%	0			100.0%
	R.K Puram Sec - 2	2	1	0			3
		66.7%	33.3%	0			100.0%
		2		0			2
		100.0%		0			100.0%

	Narela			0		14
		78.6%				100.0%
				0		1
		0	21.4%		100.0%	100.0%
	Samalkhan					
	Total	2				26
		76.9%	19.2%		3.8%	100.0%
Upto Middle	Kusumpur Pahari					4
		100.0%		0		100.0%
	Yamuna Pushta					1
		100.0%		0		100.0%
	R.K Puram Sec - 2					1
		100.0%		0		100.0%
	Mongolpuri					1
		100.0%		0		100.0%
	Narela					6
		66.7%	33.3%	0		100.0%
	Samalkhan	1	33.3	0		1
		100.0%				100.0%
	Total					14
		85.7%	14.3%			100.0%
Matric	Mongolpuri					1
		100.0%		0		100.0%
	Narela					1
		100.%		0		100.0%
	Total	2				2
		100.0%		0		100.0%

Table no 4.6 shows that there is no effect of education where the type of assistance received during birth is considered. In all the slums over 75 % of the mothers have given birth without any trained help of some sort or the other. The relatives and neighbours have mostly assisted them. This may be due to one very important reason and that being; it costs nothing if helped by neighbours and relatives. Even where the mother is as educated as having read upto the matric level the preference is for non-professionals. The different types of assistance that is at the disposal of the mothers are–

1.Neighbours / relatives

2.Dai

3. Trained nurse

4.Doctor

5. Others

Postnatal care

Postnatal care is necessary for the mother for regaining health after the strains of childbirth. The health of the mother and her newborn baby depends not only on the health care she receives during her pregnancy and her delivery, but also on the care that she and her infant receive during the first few weeks after delivery. Postpartum checkups within two months are particularly important for births that take place in non institutional settings. Recognising the importance of postpartum check-ups, the Reproductive and Child Health Programme recommends three postpartum visits (Ministry of Health and Family Welfare,1998). The figure given by the NSSO (42nd round))for urban India was 24% , the corresponding figure for Delhi slums today is over 30%. The postnatal care utilization shows the same trend as the prenatal care. The most commonly used health facility, among those using it at all, is the public hospital or health center. A large portion of the mothers who are illiterate do not avail themselves of these facilities public or otherwise.

Table no.4.7: Type of facility used for post natal care

Facility	Frequency	Percentage
Not availing car	73	19.36
Hospital / health center (public)	196	51.17
Hospital / health center (private)	57	14.88
Visiting AN	14	36.55
Visiting NGO.	43	11.22
Tota	383	100

By the above table here, too, private health care is the least popular, keeping in mind the price factor.

Table no. 4.8: Distribution of Population Availing Postnatal care according to Slums

SLUMS	*POST-NATAL CARE*					
	Not availing care	Hospitals (Public)	Hospitals (Private)	ANM	NGO	Total
Kusumpur Pahari	6	17	7	3	5	38
	15.8%	44.7%	18.4%	7.9%	13.2%	100.0%
Yamuna Pushta	2	12	2	1	5	22
	9.1%	54.5%	9.1%	4.5%	22.7%	100.0%
Mayapuri	7	20	7	3	3	40
	17.5%	50.0%	17.5%	7.5%	7.5%	100.0%
R.K Puram Sec - 2	7	25	15	2	2	51
	13.7%	49.0%	29.4%	3.9%	3.9%	100.0%
Mongolpuri	6	25	7	2	12	52
	11.5%	48.1%	13.5%	3.8%	23.1%	100.0%
Narela	7	48	8	1	9	73
	9.6%	65.8%	11.0%	1.4%	12.3%	100.0%
Samalkha	10	31	9	2	6	58
	17.2%	53.4%	15.5%	3.4%	10.3%	100.0%
Total	45	178	55	14	42	334
	13.5%	53.3%	16.5%	4.2%	12.6%	100.0%

The above table 4.8 on postnatal care does not show much difference in the pattern of utilization than the prenatal care. In both the cases the role of ANM is quite limited.

CONCLUSION

In a study on the health utilization pattern of Madras city (Yesudian,1998)[25]it was found that when the poor sections of the society are found not to utilise the available free health services there can

[25] Yesudian, C.A.K.(1998), "Health Service Utilisation in Urban India : A Study, Mittal Publications. Delhi,1998

several reasons. The author found three reasons for this, one, that they are not aware of all the available free services. Two, their perception of the need and gravity of the situation is sadly low and third, they are constrained by their earnings. As far as the immunization of the slum children are concerned, over 75% of them were found to be immunized in nearly all the vaccines ie BCG, DPT, Polio and Measles. Thus utilisation of Immunisation services was not a problem among the poor of Delhi. The coverage of measles is still slightly lower as it was a late starter. The picture of preventive health care shows that education plays a very important role as far as pre and postnatal care is concerned.

In case of assistance during birth is found that the effect of education is nullified. Majority of the women prefer to be attended by their relatives or neighbours to seeking professional help however educated they may be. In this case the money matters. For pre and postnatal care education has a direct link. Illiterate or women who have had no schooling were found not to undertake any sort of preventive health care at all. Higher the level of education higher the awareness and better the utilization of pre and postnatal care. More than Health centers, public hospitals seem to find favour with these sample slum dwellers. The role of ANMS seems to be exaggerated by the literature, as their role is minimal here. The Private treatment was least favoured.

Chapter V

SUMMARY OF CONCLUSIONS

The health status of the people is much dependent on the control of environmental factors such as safe water and sanitation, garbage disposal, epidemiology of prevention and treatment of communicable diseases, prevention of polluting industries, air pollution, Occupational health, social medicine and health care. The relative importance of these factors vary from area to area for which reason in this study the slums have been chosen keeping locational direction in mind. Furthermore since the distribution of slums in Delhi is somewhat ubiquitous the sample slums have been chosen from all the four directions. Then they have been further grouped into inner and outer area. The basic problem in India is pollution, supply of safe drinking water and environmental sanitation including disposal of solid wastes. This control goes along way in the promotion of the health of the individual. The community water supply sanitation drainage and housing do not directly measure progress towards health but relate influence on that progress from outside the health sector. They have made considerable contribution to the improvement of health of the people during the past century.

This study concentrates on the factor of utilisation of health services in Delhi with particular reference to their use in seven of Delhi's slums.

In trying to analyse the above thrust two aspects of health care is looked into: the morbidity pattern existing among the dwellers in these slums and the how the existing health care facilities have been utilized by these people in terms of both curative and preventive health care.

In the first chapter, the study introduces the concept of health in the light of utilisation of health services. In here the literature pertaining to several issues and concepts have been discussed. The studies on the relevant themes have been grouped into two categories:

a) Socio economic characteristics affecting affecting utilization and

b) planning and policy on health care.

The second chapter attempts to provide a socio economic profile of the sample households. The main findings of this chapter are that Yamuna Pushta has the best sex ratio among all the slums whil Kusumpur Pahari have the lowest. The age – sex composition of the slums show that Samlkhan has the largest number of women in their population. Majority of the slums have a family size of 3 to 5 with the exception of Narela where the family size was between 6 – 8.

Illiteracy persists strongly in all the slums and as is expected the women are worse off than the males. There are a large portion of the population who are studying as well as working. The main occupations of the slum dwellers seem to be unskilled menial, where Kusumpur has the largest part of the workforce engaged in this category.

The level of sanitation of these slums is very low. The major part of the population uses open spaces. Water condition when available is bad

Finally in this chapter an attempt has been made to work out the socio economic status of the Sample households. By this it was fund that majority of the households fall under SES 4.

Again an attempt has been made to rank the slums according to the important socio economic indicators to form a slum level comparison. By this Nareala was found to be have the best possible situation.

The third chapter deals with the morbidity pattern and the utilization of the health care facilities in the context of curative health care.

The morbidity pattern prevailing in these slums were looked at under the broad groups of minor and chronic illnesses. In the minor illness infectious diseases were found to predominate. Morbidity rates were higher among the women in both the outer and inner areas with the outer area having a higher value than the inner area.

The inner area was found to have a better condition in terms of morbidity even in the case of major or chronic illness. Thus it can be said that the inner areas are better served in terms of medical and other attention.

Education was found to have an important role to play in lowering the morbidity in both major and Minor ailment cases.

As far as utilization of health facilities are concerned it was found that the people tend to neglect the minor illnesses. Majority resort to home medication and self madication. The main reason behind this was the constrains of the purse.

The picture completely changes when the problem happens to be a major or chronic illness. Then it was found that the people prefer th services of an allopath to any other.

The fourth chapter looks into the pattern of utilization of preventive health care. Under preventive health care the study looks into the immunization pattern of the children, pre and postnatal care andthe assistance received during delivery by the mother.

It was found that either the mothers were not availing any care and if they are then they use the services of the nearest hospital or the health center. Education was found to play an important role in here. Educated mothers were found to utilize these health facilities more than the illiterate mothers.

Over 75% of the children were immunised in nearly all the slums. It is seen that the immunisation programme is a success in the se slums of Delhi..

Most of the mothers did not receive any professional attention during the delivery of their babies. They preferred the help of the neighbours and relatives to the professional.

Keeping in mind the above conclusions it can be safely summarised to say that the present sad status of the slums would not have been true had the different programmes and policies been implemented to some extent in the slums. Though the drinking water situation is not as abject as the condition of the other facilities the pathetic ness does not improve. Coupled with the low socio – economic status i.e. prevalence of illiteracy, poverty, the slums go from bad to worse. Health conditions, as a result, too, take a downward plunge. The situation is now a little on the mend with the intervention of non-governmental organizations and charity trusts. Without serious governmental intervention this help is like a drop in the vast ocean of wretchedness.

REFERENCES

Anderson R.A (1986), "*A Behavioural Model of Families use of Health Services*", Center of Health Administration Studies, 25, University of Chicago, Chicago.

Antia, N.H. (1993), "*The World Development Report 1993: A Prescription for Health disaster*" Social Scientist, vol. 22, no. 9-12.

Asthana, S. (1995), "*Variations in Poverty And Health between Slum Settlements: Contradictory finding From Vishakhapatnam, India*" Social Science and Medicine

Banerjee D. (1993) "*Simplistic Approach to Health Policy Analysis World Bank Team on Indian Health Sector*" Economic and Political Weekly, June 12, vol. XXVIII, no. 24.

Banerjee D, (1996) "*Political Economy of Public Health in India*", in (ed) book, Health Poverty and Development in India (ed) Monica Dasgupta, Lincoln C. Chen, T.N. Krishnan Delhi Oxford University Press, Bombay Calcutta, Madras.

Baru, R.V. (1993) "*Mixed Economy In Medical Care Some Issues*", Madras Institute of Development Studies 23rd Inter Disciplinary research Methodology workshop, RUSHA, Vellore, Madras Institute of Development Studies and ICSSR.

Baru, R.V. (1993),"*Inter-regional variations in Health Services in Andhra Pradesh*", Economic and Political Weekly May 15 vol. XXVIII, no. 24.

Baru R V. (1994), "*Structure and Utilization of Health Services: An Inter-State Analysis*", Social Scientist, Vol. 22, Nos. 9-12.

Basu, S (1990), "*Health Scenario and Health problems of Tribal Population in India*" Seminar on Continuity and change in Tribal Society, Indian Institute of Advanced Study, Shimla

Bergel F. E. (1955), *Urban Sociology,* Massachusetts, New Jersey, USA

Berman, P. (1996), "Health Care Expenditure in India" (ed Health Poverty and Development in India (ed) Monica Dam Gupta, Lincoln C. Chen, T.N. Krishnan, Delhi, Oxford University Press Bombay.

Coutinho,L. Bisht, S. Raje, G.(2000),"*Numerical Narratives and Documentary Practices: Vaccines, Targets and Reports of Immunisation Programme,*"

Das,V.Das,R.K.Coutinho,L. (2000), "*Disease Control and Immunisation: A Sociological Enquiry*", Economic and Political Weekly, Feb 19, 2000.

Das,R.R.Dasgupta,P.(2000), "*Child health and Immunisation: A Macro Perspective*" Economic and Political Weekly,Feb – 19,2000.

Dejong, G.A and. Rutter, F.F (1983),"*Justice and Health for All*", Social science and Medicine. Vol 17

Donahue J.M.& Meredith B. Mcguire, M.B. (1995)"*The Political Economy of Responsibility In Health and Illness*", Social Science and Medicine, Vol. 40, No. 1.

George, A, & Nandraj, S. (1993), "*State of Health Care in Maharashtra: A Comparative Analysis*", Political Weekly 28 (32-33): 7-14 August.

Ghose, A. (1996) "*Health care and Globalization Case for a Selective Approach*", Economic and Political Weekly, Vol. XXXI, no. 8, Feb. 24.

Guha, S.D (1996): "*Health and Nutrition of the Urban Poor: the Case Study of the Calcutta Slums.* Rama V Baru (1993) "Mixed Economy In Medical Care Some Issues", Madras Institute of Development Studies 23rd Inter Disciplinary research Methodology workshop, RUSHA, Vellore, Madras Institute of Development Studies and ICSSR.

Haddad, S. & Fournier, P. (1995) "*Quality Cost and Utilization of Health Services in Developing countries: A Longitudinal Study In Zaire*", Social Science and Medicine, Vol. 40, No. 6.

Human Development Report, West and Central India, (2001). – NCAER, Oxford University Press Publication

Humphrays, J.S. (1985), "*A political Economy Approach to the allocation of Health care Resource: The case of Remote Areas In Queensland*", Australian Geographical studies, 23rd October.

ICSSR / ICMR (1981), Health for all an Alternative Strategy, Indian Institute of Education Pune.

Jeffery. (1996), "*Toward a Political Economy of Health Care: Comparisons of India and Pakistan*" pp. 270-194, (ed) Health, Poverty and Development in India, Monica Das Gupta, C. Chen and T.N.Krishnan, Oxford University Pres Delhi.

Kethineni, V. (1991) "*Political Economy of State Intervention In Health Care*", Economic And Political Weekly, Oct. 19.

Khandekar, M. (1974), "*Utilization of Social Welfare Service in Greater Bombay*", Tata Institute of Social Sciences.

Kundu, A. (1993), "*In the Name of the Urban Poor: Access to Basic Amenities*," Sage Publications.

Kundu Amitabh, (1993), *"Health Care Facilities in Urban India: Sensitivity of the System to the Poor"*, (ed) P.K. Umashankar Grish K. Misra, Reliance Publishing House and the Indian Institute of Public Administration (Center for Urban Studies) New Delhi.

Mankad, D. (1986), *"Environmental Pollution and Human Health – An Over view of the Indian situation"*, Medico Friends Circle: The case of pesticides, Bombay.

Mehta, S.P. (1992) *Society and Health*, Vikas Publishing House Pvt. Ltd

Muraleedharan, V.R, (1993) "*When is access to health care equal? Some public policy issues*" Economic and Political Weekly,, Vol 28. No 9, June19.

Murthy, N. et.al, (1990), *"How well do India's Social Service Programs Serve the poor?* World bank Working Paper

Nolan, R. (1996) "*Social Class Difference In Utilization of Pediatric services in a prepaid direct Service Medical Care Program*", American Journal of Public Health and Nations Health, Vol. 57.

Phillips, D. R. (1990), " *Health and Health Care in the Third World".* Longman Scientific and Technical, UK Ltd

Purohit, B.C. & Mohan, R. (1996), "*New Dimensions For Public Health Financing*". Economic and Political Weekly, Vol 31, No. 8, Feb. 24

Prabhu, S K (1994) "*World Development Report 1993: Structural Adjustment and the Health Sector in India*", Social Scientist, Vol. 22, nos. 9-12.

Qadeer, I (1994) "*The World Development Report 1993: The Brave New World of Primary Health Care*" Social Scientist, Vol. 22, nos.12.

Ranga Reddy,, A. (1995) *"Health Care System of Underprivileged moving From the State of Corporate Culture"*, in (ed) book, Health Care Services Management Editor A. Ranga Reddy, Delta Publishing House, Delhi.

Reports of the *Health and Development Committee (1946), The health Survey and Planning Committee (1961).* Planning Commission, Government of India.

Sanyal, S.K. (1996) *"Households Financing of Health Care"*, Economic and Political Weekly, Vol.31, No. 20, May 18.

SenGupta, A. (1993), World Development Report 1993 *"Implications for Infrastructure Development in Health Care and the Pharmaceutical Industries"* Social Scientist, Vol. 22, nos. 9-12.

The Seventh Five Year Plan, Vol II, Planning Commission, Government of India.

Shiva Kumar, A.K (1994) "Some Considerations in the Formulation of India's Health Policy: A note of equality". Social Scientist, Vol. 22, nos. 9-12.

Suchman, E.A. (1960) *"Health Orientation and Medical Care"* American Journal of Public Health Vol 70.

Tragle, A. (1985): *"An Appraisal Health Care in Slums of Bombay"*, Indian Journal of Social Work, Vol. 45. Nos. 4.

Tulasidhar, V.V. (1993) *"Expenditure Compression and Health Sector Outlays"* Economic and Political Weekly, Vol. 38, nos. 45.

Vaidyanathan, K.E. (1990), *"Health and Nutrition Survey in Slum Habitat"*, Hyderabad Slum Improvement Project, in (ed) H.U Bijlani and Prodipto Roy, Council of Social Development, New Delhi.

Visaria P.V, & Gumber, A. (1996), *"Socio-economic Differentials in Patterns of Health Care Access and Utilization"*. in, (ed) book by Monica Das Gupta, Lucia C. Chem. T.N. Krishna: Oxford University Press, Delhi.

WHO, (1983), *" Report on the Expert Committee on New Approaches to Health Education in Primary Health Care*, Geneva.

WHO, (1986), Health Aspects of Human Settlements, Paper– 66.

Wishwakarma, R.K. (1991), *"Health Status of the Underpriviledged"*, Centre for Urban Studies, Indian Institiute of Public Administration.

Yesudian, C.A. K. (1988), *Health Services Utilization in Urban India*, Mittal Publications, Delhi.