ACCESS TO HEALTH CARE IN JAHANGIRPURI RESETTLEMENT COLONY, DELHI

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirement for the award of the degree of

MASTER OF PHILOSOPHY

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CERTIFICATE

This dissertation entitled **"Access to Health Care in Jahangirpuri Resettlement Colony, Delhi"** is submitted in partial fulfillment of six credits for the degree of Master of Philosophy of this university. This dissertation has not been submitted for any other degree of this university or any other university and is my original work.

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

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Dedicated

to my loving parents

& my Guru

CONTENTS

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INTRODUCTION

The health of the Urban population in India is in great jeopardy for various reasons. The significant adverse consequence of this likely to be witnessed by the end of this century, where about 40% of the total population would live in urban areas. The growing population and present process of urbanisation had been considered by many as prominent factors influencing health of the urban population. In addition to these two other factors such as formation of slums and settlements as by product of socio-economic process of urbanisation and industrialization has great affect on urban health. To deal with health as national priority the government of India in consonance with the World health Organization have announced the programme of Health for all by 2000 AD. According many policies and programmes have been devised to take care of health and well being of the all people in the country. unfortunately, these programmes and policies could not deal with health problem as desired, either in urban or rural areas. Slums and resettlement colonies in urban areas are the most vulnerable section ignored by the very design of urban health care system. It is observed that urban health care in India and other developing countries is a complex institute arising out of interaction between time honoured cultural values, socio-economic situation after the post independence due to rapid urbanisation and industrialization. Urban poor who live in urban resettlement or slums are deprived of adequate health care and basic amenities in Indian city, they live in sub-human condition of living in unhygienic environment. These problem are becoming more and more complicated due to population growth, acute paucity and

maldistribution of resources and further impoverished the large population which is already living below subsistence level. Increased population with poverty and socio-economic backwardness of the urban poor in urban settlement has no or lack of access to health and basic amenities. As observed that communicable disease are poverty related attributed by socio-economic condition of the urban poor. This pathetic scenario of health of the urban poor must not be ignored at any cost who contribute to urban economy directly contributing their labour in the process of urban economy directly contributing their labour in the process of urban economic activities. This inspired me to carry on this present study to identify some of the crucial aspect that consequences 'inaccess' or lack of access to health and basic amenities of the urban poor in Jahangirpuri resettlement colony.

This needs to be made clear about the study that it seeks to addressed and to understand the main issues and very purpose of the study. This study seeks to describe the health condition and their access to health seeks to describe the health condition and their access to health care in urban resettlement colony Jahangirpuri. In addition to access, it would emphasis partially access to basic amenities and their socio-economic condition in this colony. Here the 'accessibility' has been conceptualized as functional relationship between population and the health care resource, so population growth and other socio-economic variable have been given more importance. It will be helpful to the reader to understand the study if successive chapters are mentioned briefly. First chapter describes urbanisation in India, causes of migration, formation of slums and squatters and health problems of these colony.

Chapter second discusses, about the study area of Jahangirpuri resettlement colony of Delhi. This includes description of basic amenities including health problem and health care, water supply, sanitation, housing, drainage life style, socio-economic and demographic condition of this colony.

Chapter third explains issues of 'access' to health care and other basic amenities and socio-economic implications of accessibility. This chapter also describes briefly about condition of maternal and child health services. Here the socio-economic condition of the urban poor has been considered as characteristic of the urban poor population that seems to mismatch to the healthcare resource along with other basic amenities. It is observed that new health care technology does not suites socio-economic conditions existing in our society. To support the analysis quantitative data along with qualitative information have been used to show the realistic picture of accessibility and its factors influencing it.

In the fourth chapter efforts had been made to summarize the discussion, observation and issues emerged from the study.

Overall the study like to describe the issue of accessibility in terms of the population and the health care particular and basic amenities as a whole in urban settlement.

Scope of the Study

The urban health care delivery systems by its very design biased against urban poor. Present health care delivery system only favors public sector which is organized in terms of all kinds of social security. Upper middle class segment have access to adequate health care services in both private and public health hospitals. Hence urban health care is pro in favor of higher income group. On the other hand the urban poor and unorganized workers do not have even minimum level of access to health care along with basic amenities through public provisioning. The proposed study will strictly address the unorganized workers anybody who lives in resettlement colony. To be specific about the problem of accessibility as main issue of the study it would take account of aspects addressed by Salkever and Aday and Andersen. Two aspects of Accessibility as per Stalkers are physical and financial accessibility. Physical access indicates transportation, distances, time spend and financial accessibility indicates individual's ability to pay for health care. In addition to it loss of wages due to long waiting hours and in search of health care have been addressed in the study. This would make clear considering Aday and Andersons process indicator that accessibility is functional relationship between characteristics of population and health care resource.. Characteristic of health care resources implies the availability of hospital and nature of health service provided by hospital (both public and private) and the characteristics of the population that reflects differential existence either of obstacles and difficulties or factors responsible for meeting the health care needs..

Besides this crucial issue, study limit s to the characteristics variable linked with the population respondents those are family

size, caste affiliation, native place and occupation pattern. In addition to it, perception and attitudes towards public and private health, service available for the resettlement colonies had been discussed. Since these variables have significant correlation with the issue of accessibility which helped expressing accessibility is a broad domain.

Conceptualization

Rapid urbanization parallel with unprecedented population growth has been influencing development and changes. Desired goal of economic growth and social change through urbanization seems rudimentarily negative. Increased population due to pull factor associated with migration result in inappropriate distribution of growing population and the resources. These unprecedented growing population is lacking resources for survival tends to create maldistribution of resources such as shelter, water supply, sanitation, drainage etc and compels the urban poor to live in subhuman condition without basic amenities in urban poor settlement. Urban poor has low access or no access to adequate health care facilities along with basic amenities. Large family size must not be ignored in this regards as long as this relates with percapita household income and expenditure is concerned. Problem of access has been accrued due to population growth and the socio-economic aspect of the population Accessibility is not more availability of health care it beyond that, 'Accessibility is a functional relationship between population and resources. When we talk of population it means the characteristics of population and the nature of health care resources available. Country like India health care resources are there whatsoever exists but those do not qualify the need of the population. Accessibility is not more

availability of health services it goes beyond that. For example health care, in areas people have various kind of health service resource but this resources does not suits their socio-economic conditions that retreat them. By very design health care system is biased against the poor they are always deprived of health care resource in respect of public and private health care services. Urban poor still prefer to visit public hospital due to their socio-economic condition.

Purpose Of The Study

Since urban health care services has been observed biased against urban poor, who live in dilapidated housing without health care and basic amenities. Unhygienic living condition and lack of health care facilities resulted in major health problem. The purpose of this study is basically to see the level of access to health care and other basic amenities available in the colony. Besides these studies also seeks to assess the socio-economic aspects and its impact on access to health care and basic amenities in Jahangirpuri resettlement colony.

Design of Study

The area chosen for the study is Jahangirpuri resettlement colony, which is situated in North West Delhi.

Selection of Block

There are 13 blocks in the Jahangirpuri out of which 2 blocks name 'C' and 'G' were chosen for the study where interview and case study had been conducted. Every block consists of same number of household plot under 'plot scheme'. In Every block consists of same number of household plot under 'plot scheme'. In

every block there are 2000 household in the colony comprising population of these two block is that both the block has significant number of problem which is alike then any other block. Another criteria is both the block has different geographical location on block is at the Periphery of the colony and another one is middle of the colony.

Selection of Household

The selection of household is each block has been made by simple random sampling. In consultation of public work department and NGO's (Chatanalaya) and after preliminary fieldwork sample of 100 households has been arrived on. A further in-depth study of few household in every block has been conducted. After this the household list had been prepared for conducting interview. From each block 50 samples for two blocks had been selected for the study.

Data Collection

Tools for data collection:-

For collection of data from 100 household sample, a structured questions had been administrated among the key informant in each selected household under the study. The structured questionnaire we designed to collect information on following variables are:-

(i) **Socio Demographic Data:** This includes information related to family composition, household income, occupation, education, religion, caste etc.

(ii) **Physical Aspect:** This includes information related to characteristic of housing, sanitation, drainage and water supply.

(iii) **Aspect of Health Problem and Health Care:** This includes information pertaining to health problem of the people, illness occurred during last one year, birth and death and their utilization behaviour and view towards public and private hospital.

(iv) **Migration:** Information pertaining to reasons for migration as pull and push factors, state they originally belongs and no. of years of migration.

Research Techniques

Data required and information regarding the problem and other associated aspects had been collected through administration of questionnaire, interview, case study and observation method. Since, not all of the respondent are literate enough to response to the question put forth, so the researcher had to administered through interview among the respondent. In were conducted at their household with a brief introduction about the questions put forth. Clarification regarding their confusion in the process of interview. Then the questions are asked if no literate person is available and questionnaire was given to literate person it available in the family. To derive more in depth information than the schedule provided for, the researcher applied 'probes' after response given by them. Some times interviews was conducted in a group of neighbors and with family member or voluntary basis. This has given some more details about the problem. This involves basically quantitative data. To acquire qualitative data case study

was conduced. Case study was applied to gather information related to the one particular individuals exposure and non exposure to the health problem and treatment in regard to public and private hospital.

For case study 5 household was selected This was selected on the basis of list supported by NGO's personal. Case study provided qualitative data on historical back up of the problem of health and personal history. It was conduced at the household.

Non participant observation techniques was adopted to understand the process and field phenomena.

Process of Data Collection

The information collected for the study were basically primary sources, It was collected on earlier mentioned through interview, case study and observation. Questionnaire and case study consist of same variables. Questionnaire consists of close-ended questions and case study consists of open ended descriptive nature of questions.

Prior to holding an interview the respondent in each household were identified. Interviews were conducted with the prior information It was found a bit difficulty in conducting interviews, as most of the time the adult or the principal household heads are away for work. Thus the remained household respondent was interviewed in next visit.

It must be taken care of the sampling procedure that of few cases over repeated visit could not meet on that situation the household before or after the sample household was choosed.

For case study the researcher met NGO's personal who works and live in the colony and was taken with, To introduce the

researcher prior to case interview. Before conducting case interview for qualitative information researcher gave brief introduction about the problem without considering bias and value judgment, in addition to it conducive environment was brought up talking about general aspect of the colony. This practice was done to open up of the interviewee. Observation was done in both quantitative and qualitative interview. Facial expression was observed to understand better about the response given to the researcher, Observation about the problem was done.

During the process of interviews issues related to the problem and suggestion was asked to the interviewee.

CHAPTER - 1

URBANIZATION

Urbanization, in a demographic sense, is an increase in the proportion of the urban population (U) to the total population (T) over a period of time. As long as U/T increases there is urbanization. However, theoretically it is possible that this proportion remains constant over time where there is absolutely no rural urban migration or same population growth rate. But in so far absolute urban population increases in such a situation there will be problems of urbanization regardless of the fact that the rate of urbanization is zero. Expression of urbanization process, in a comprehensive sense and not in the statistical sense of an increase in (U/T). This is viewed, the process of urbanization is a continuing process which is not nearly a concomitant of industrialization but a concomitant of all gamut of factors underlying the process of economic growth and social change (Ashish Bose,).[1] In India the process of urbanization evolve the movement of rural workforce to urban centre contributing the process of economic growth. Urban centre are the place of traders which act as a pull factor of migration which opens up avenues for earning livelihood. On the other hand natural calamity such as drought, flood, famine also account for contributing migration from rural to urban. Population added to the urban places due to migration has been centered among the richer and poor people tends to stay poor (P. Prasad).[2]

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[1] Ashish Bose, (1980) "India's *Urbanization in* 1901-2000" Revised edition Tata McGraw Hill Publication.

[2] P.Prasad, (1995) *"Urban Slums – Health Education and Development" Delta Publication.*

In the third world countries the last phase of urban transition is taking place. Increase population has impact on magnitude of this transformation and poverty of the third world makes it a difficult transition. Unprecedented growing population has to find employment in labour market characterized by widespread unemployment and underemployment, adoption of new skills for earning, traditional abreast.

Urbanization in India

Urbanization in India in the present time is most rapid then any other developing countries. It had been relatively slow growth of urbanization over past 40 or 50 years. With the growth of urbanization population is also increasing due to lower rate of death against higher rate of birth. This has doubled by migration.

As per discussion done by Rakesh Mohan[3] since 1901 urbanization is taking place but after post independence and 1970 it has been rapid those are around 25.6 million population in 1901 in 1811 towns against 217 million of population in 3609 town in our country. The annual growth rate of urban population was 0.79% in 1921 has increased upto 3.15% in 1991. The most happening growth taking place in the enlargement of existing towns at every level rather than adding new towns to existing one. Very few number of new towns or urban settlements have been adding with the existing one. Urbanization is taking place on the periphery. Peripheral urbanization defines that a large number of villages at the borderline, but very number of them gradually get a town states. Basically this implies that majority of settlements are

[3] Rakesh Mohan (1996) A article on "Urbanization in India: Pattern and Emerging Policy Issues" in Josef Gugler edited "*The Urban Transformation of the Developing World.*", Oxford University Press.

in the towns and specially larger cities have exhibited urban characteristics for a very long time.

Over a period of ninety years, data don't reveal an obvious pattern of population growth. It was observed that annual growth of urban population was remark steady growth from 1921 to 1951. There was a slow down rate of urban population in1951-61. Annual growth of urban population was 2.34 in 1960's and it increased upto 3.15 at national level. Due to problem of declassification of urban the pattern of population growth was less marked from 1951 to 1981. This has been significant only after 80's while the urbanization is rapid.

According to Bose[4], the growth of urban population in India reveals level of urbanisation is increasing. According to census it was found that level of urbanisation was 11.0% in 1901 and 17.6% in 1951. After independence, the aspiration of the people, new national policy and programme and industrial growth influences significantly the level of urbanisation. It was observed that level of urbanisation was 23.7% and 26.1% in 1991.

As it was expected that over a time share of agriculture in the economy falls, the rate of rural population growth progressively slow down. But it was observed in 1971-81 the rate of population growth has increased.

It was observed from the Census of India 1991 that urban population in different class of towns the annual growth rate has observed slightly slow down in 1981-91. In 1961-71 annual growth of urban population was 4.32% increased upto 4.60 in 1971-81 in class I cities comprising (1,000000) population. In class II cities

[4] Bose, Ashish (1980) *"India's Urbanisation in 1901-200"* Tata McGraw Hill Publication.

comprising 50000-100000 population has been increasing 4.32% and 4.66% for the respective year. Class IV towns comprises a population of more than 5000 shows the growth rate of 3.27% and 3.86% in 1961-71, and 1971-81 respectively. There were around 145 class –I towns in 1971 comprising total population 60122 thousand that shows growth rate of 3.62 per year 1971-1981.

Level of urbanisation enumerated on the Census of India 1991 that urbanisation is rapid. It is observed that since 1951 level of urbanization was 17.6% in 1951, 20.2% in 1971 and 26.1% in 1991. Level of urbanisation has been exhibited lower than national level after a long decades since after independence in some states specially the BIMARU states are Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh. The level of urbanisation of these states just above 13%. Bihar 13.2% and Orissa 13.4% in1991 whereas national average of 26.1% level of urbanisation. Western industrialized states such as Gujarat, Maharashtra, Tamil Nadu has got upper end of above 30% level of urbanisation on this above national level of urbanisation.

Formation and growth process of slums and squatter settlement.

As mentioned in the introduction that slum and squatter settlement is the by product of socio-economic condition and interaction with mode of production in the process of urbanisation. Urban places being a place with enormous opportunity of employment that attracts people from rural and other urban areas for various reason. This influx of labour force stimulated by pull factor influence the population growth. This migrant population involve themselves in primary economic activities for earning their livelihood. They do not have ability to rent a house with basic

amenities so they take shelter in open space of the urban land illegally. Sometimes this land are privately owned also. This unprecedented growth of labour are encouraged due to patronization by political group and influential. This migrant labour force live without availability of basic amenities dilapidated house. The logic behind it is that they can save transportation cost and time on the part of workers and on the employer part they feel that they will have easy and cheaper access to this cheaper labour force.

This segment of population finds this places matching with their socio-economic condition. The proximity with the workplace is another factor encouraged by both employer and the worker to live in nearby factory or the workplace. Rapid urbanization industrialization and commercialization the agricultural land is turned into urban land use. For using the public land these squattering families are dislocate and resettled in other places with minimum basic facilities. These colonies are mix of both legal and illegal occupation of land.

A paper written by Ashish Bose shows that slums are not just because of urbanisation it has been contributed by the failure of family planning policy and urban policy. Failure of these especially in urban areas has influenced the natural increase in population. Migration is not alone responsible for formation and growth of slum.

One United Nations Conference on Human Settlement publication on "Survey of Slum and Squatter Settlement"[5] it emphasized on formation and growth of slum and squatter

[5] Development studies series, Vol. 1, *Survey of slum an squatter settlement* United Nations Conference on Human Settlement (Habitate) Publication (1982).

settlement was discussed. It identifies various types of formation process and to classify the factors influence those process. Process of formation has been classified from process of growth and change. Many factors effect the formation of settlement and slums and their growth and changes to a greater or lesser extent at different stages of development process of settlement formation comprise of invasion, accretion and entrepreneurial development.

Many of the squatter settlement and Slums are formed by invasion of public land, the urban poor illegally occupy public land where there is lesser chances of its requirement by development authority. In this process the family household of squatter organize planned invasion by large groups. They are always against the authority of the land used by them.

Some of squatter settlements form and grow by accretion with period of rapid growth reflecting particular historical circumstances. In this process occupation of land is illegal but in gradually individual household moves to vacant land expanding their horizon of living. Due to unauthorised nature of land occupation, they are eligible for removal in this process the squatters season a sites where the land owner has no immediate plan that require removal the squatters.

Entrepreneurial development denotes to employment opportunity. Development of enterprise attracts large population plays full factor of migration.

According to UN urban land policies slum is a "a building, group of area characterized by overcrowding deterioration, insanity condition or any of them, absence of facilities which endanger

health safety or morals of its inhabitants of the community. There is a marked variation in respect of physical conditions.

M. S. A. Rao, mentioned in their book[6] that study that slum relates to the conditions of poor in which slums are formed and causes the growth of slums. First, a slum develops as a result of squatting of poor migrants. A majority of migrants come to the cities are unskilled workers and poor. Due to their poverty they cannot rent a house and pay for urban infrastructure facilities. So they are not provided with adequate facilities by the city in terms of low rent houses with other settlement as illegal and does not provide any, Municipal land, this results with inevitable growth of slums with sub human living condition.

Second set of condition under which slum develop is the deterioration of a group of buildings in the old part in the absence of adequate municipal services slum condition increase. A variation in the city consists of people who work as sweeper in municipalities, hospital, and coolies and cobblers etc.

Third set of condition explains as the city expands, it increases population in the colonies of fisherman, washer man, safai, factory worker, Mazdoor etc. and the like, and village situated in periphery. In this process agricultural land of village is part to urban land use, whereas the inhabited are of the village is left intact without infrastructure facilities. Since rent and cost of this area would below, many poor unskilled worker come to live here. This increases population in these area lives without basic amenities and further sustains slum condition.

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[6] Rao M.S. A. (1991) "Urban Sociology". Orient Longman Publishing Company.

[7]Study done by Gore, 1970, Srinivas Rao 1966 and settlements of migrants show that immigration to cities follows, the networks of religion, caste, kinship, language and region. There is a tendency on the part of the people to sort themselves out and gather together on some of these lines. When a urban poor migrates in a large number they tend to build their hutment colonies to run their shelter nearby their place of work. This is crucial aspects which has not been considered in our plans and slum improvement programme. Distance from home to place of work plays significant role in formation of slums or squatting. It was observed that People of the resettlement colony leave their plot selling it to other due to many reasons and again they occupy open public space for shelter. Thus this process tend to continue. This is because of the advantage of prior do not have basic amenities for survival. Lack of basic amenities and poor unhygienic condition cause health problem or communicable disease. Hence the large numbers of the population live at risk with higher morbidity and mortality.

Development and formation of Jhughi Jhopdi resettlement colonies

Illegally occupying public land in metro-cities is a common phenomenon in India. The squattered family live in urban places near by their workspot where they can access to their workspot. These family does not qualify for urban basic facilities due to unauthorised shelter and habitation in public land. In Delhi there were 12749 squatter families in 1951, and is increased to 1956

[7] Gore M.S. (1970) *"Immigrants and Neighborhoods – Two aspects of life in a metropolitan city"* Tata Institute of Social Science Publication.

and 1,50,000 families in 1975. Those population live in a quite large section of urban land. There were only 57368 about half of them were resettled in 18 colonies developed by DDA and MCD as per Master plan. During 1975-77 about 1,48,000 more families were settled after developing plots in 16 resettlement colonies.

As per socio-economic survey[8] conducted by TCPO sometimes in 1973-74 it was estimated that prior to 1975 150,000 families were living in 1400 clusters spread out in parts of Delhi. These colonies covered an area of 598.4 hectors and had plots around 49019, the size of this is 21 sq. metre. After 1975 sixteen new colonies have been developed to resettle 149,000 population. In this period in 16 colonies covered in 968.0 hectares is relatively more than earlier colonies, with 1,48,262 plots. In India more than nine million people live in slums of which 12,50,000 are ion Bombay, 11,00,000 in Calcutta, 9,00,000 in Madras and 7,60,000.

Urban Slum and Unauthorised Colony

As mentioned that slums are created mainly because of poverty, social backwardness and unemployment of the people living in the countryside. Due to drought or other unfavourable condition in their villages, people without source of livelihood, find themselves in a difficult condition to maintain themselves and naturally drift towards the urban area to check out their livelihood. The rapid industrialization in these towns and cities provide more scope for employment opportunity and finally increase the intensive flow of poor labour class people to these areas from

[8] R.G.Gupta, "*Shelter for Poor in the Fourth World, Vol.2,1995*"

surrounding areas (P.V. Manohar Rao)[9]. Hence these have contributed by pull factor of migration. In such a condition, resided by poor are not taken care of such unprecedented growing population. They find difficulties for adequate housing, so they squatter where they get public and private space with close proximity of these areas. Lack of control on the prevention of the slums and increase in value of land, the land owner allows the population in unauthorized slums in his vacant land and collects the ground rent from the slum-dweller. Public places belonging to government municipalities trust board and other local body, in the process of occupation, these areas lack basic amenities for decent living creating multitude of like social, economic, psychological, health problem, etc.

To define a slum we usually emphasis on aspect of residential problems and overcrowded houses that are unfit for human occupation. According to the report of United Nations on the urban land policy explains that a slum is "a building, group of area characterized by overcrowdy deterioration, insanitary conditions or absence of facilities of amenities which because of these conditions or any of them endanger the health, safety or morals of its inhabitants or the community."

According to urban sociologist like Cist and Halbert slum is "an area of poor houses and poor people. It is an area of transition and decadence, a disorganized area, occupied by human derelicts, a catch of all of the criminal for the defective, the 'down and out'."

[9] P.V.Manohar Rao, "*Urban Slums in India*"

[10]Ashish Bose defines slum "as a deprived human settlement, a settlement which is demographically, economically and environmentally vulnerable".

Unauthorised Colony

The people of rural origin belong to low socio-economic status they take shelter in the capital and thus emerge unauthorised colony in the process of urbanisation. Delhi Development Authority who has been dealing with land trading has monopoly over land usage. These slums are sometimes regularized by the DDA and provides with basic services such as water supply, sanitation, electricity etc. to the residents of these colonies. These colonies got patronize sometimes through political pressure given sanction or identity. This easy access to land use of public open land the poor families take shelter in unauthorised land. For a long this colonies has been taking place. Many cases the labour force are brought to urban are from rural are by contractor, industrialist and then they illegally stay in the proximity of these traders and the urban elite group where these labour force at cheaper price.

[11]There were around 923 such colonies covering are of 5000 hectares accommodating 3 lakh families in 1990. Out of these colonies around 612 colonies have been regularized and recognized for regularization. Density of the population in all this colonies have been grouped into five zonal centres central, northern, southern, eastern and western. The highest number of squatter settlement and unauthorised colonies are in southern zone followed by eastern and western zones. The significant to note that

[10] Bose Ashish "*Urbanisation and Slums*"
[11] *Tale of Two Cities*, Published by VHAI, (1993) Voluntary Health Association of India.

the average settlement size in approximately 280 Jhuggis. About 75% cluster below the average size of 280 per cluster.

From official data, it was noted that the growth of the squatter families in those unauthorised colonies. It was in 1951 there were only 12,749 Jhuggis in 199 cluster all over Delhi and it rose upto 1.42 lakhs in 1373 cluster in 1973. This is very pertinent how the unauthorised colonies have been increasing in Delhi.

Urbanization is a continuous process of unplanned growth of cities due to high rate of migration and industrialization. This process in India is very rapid. Slums are created mainly because of poverty, social backwardness and unemployment of the people in the countryside. Since city is a place of available sources of employment and facilities people migrates from peripheral villages and countryside to city resulting unprecedented growth of population. Lack of economic resources among the poor household they take shelter in open land.

Characteristic features of Slum and Unauthorised Colony

Resettlement colonies have several characteristics which are:-

- **Low economic status:** Generally slums are the place where the poor and poverty stricken families live in. They are basically labour class people. The workforce has only occupation for survival are informal means of work. This is characterized by daily wages and lack of social security etc.

- **Over crowding:** The slums area are overcrowded. The population density is quite high in slums. Due to overcrowded, they are not in a position to access to basic amenities. The services of basic amenities are inappropriate.

This creates problem of availability and become unsafe for human habitation. In addition overcrowding, provided public utilities are often faces the problem of maintenance and sustenance of the public utility.

- **Heterogeneity:** Slums is seen as heterogeneous space in terms of religion, population origin, caste and class, language etc. One can find people from various religion – Hindu, Muslim, Sikh etc. People migrates from various states of the country. They are not all from same states and place, of course this is phenomena. They talk their own language where they belongs to as well as language of the place where they live.

- **Bad appearance:** Slums are the area where the people get both unauthorized or authorized land for shelter, they find difficulty in building adequate houses for living. Unorganized and distorted nature houses or shelter without proper planning earmark the bad condition. Hence it reflects the indifferent aesthetic nature may be called as bad appearance. Bad appearance is an inherent virtue of slum.

- **Social isolation:** The slum areas tend to be socially isolated from the other, partly by choice and partly by location. They are isolated from other social group. Their chief link with the labour market and with additional link through political organization. Slum is seen indifferent to other areas of a city.

- **High mobility:** The slum is usually an area of high mobility. Occupation and its place is a major factor for mobility of residence. Due to long distance of work place slum dwellers

earmark with high mobility. Horizontal mobility within the same occupational status is thus becoming increasingly possible for S.Cs. Vertical mobility in the sense of movement from one stratum to another is very restricted specially in Delhi but initial stages of social development process Schedule Caste group could be seen to gain vertical mobility. The same analysis is applied to Muslims, Buddhists and Lowly placed Sikh artisan groups.

Social Composition of Slum and Unauthorised Colony

The social composition of slums sometimes vary from slum to slum. Big cities have much differences between slums. Social ingredients of slums are – family, caste, tribe, occupational groups, associations, etc.

Family structure of the slum dweller usually has nuclear family consist of parents and children. They have large number of children (Manohar Rao)[12]: Due to adverse agricultural condition other relatives/caste fellows also migrate to city. Thus it can be seen that economic factor influences the decision to migrate for adequate occupation and kinship and caste and village exercise a strong influences on mapping the direction of migration (T.K. Majumdar).[13]

It was observed that various occupational groups tended to be dominated by heads of the households belonging to particular. A study in Delhi shows that a majority of hawkers and vendors are around 82% from Uttar Pradesh, Central and Western states.

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[12] P.V.Manohar Rao, "*Urban Slums in India*"

[13] T.K.Majumdar, (1978) "*The Urban Poor & Social Change; A Study of Squatter Settlement in Delhi*" in Alfred De Souza ed. "The Indian City – Poverty, Ecology and Urban Development", Manohar Publication.

Construction workers were dominated by Rajasthani accounted for 67.4%. Most of the unskilled manual occupation was shared by those from Uttar Pradesh (Post, telegraph, railways, electric supply, etc.). More than 60% of the workers in skilled manual occupation traditional skills and trades were from UP and Rajasthan. The tendency of the earners belonging to various regions to cluster around particular occupation emphasized the importance of social and cultural factors operating for the recruitment of urban workers and reflected a sort of division of labour based on regional basis. The various occupational groups are – Hawkers and vendors, Petty businessman and shopkeeper, unskilled/skilled construction workers, skilled and unskilled manual worker, traditional worker, industrial worker, semiprofessional, etc.

One study by Alfred de Souza said that occupational pattern of urban poor in slums and squatter settlement are to a great extent influenced by caste religion and regional factors, this is especially true of limited range of employment opportunities open to women. An early study of Delhi found that rural migrants to the city traded to be integrated into the economy of the city mainly through their recruitment in the service sector, transport and construction. A more recent study of Delhi squatter settlement by the TCPO (Town and Country Planning Organization) found that over 80% of the head household were involved in unskilled job in construction, manual and industrial labour (Alfred de Souza)[14].

The social network activated by rural migrants also function as mechanism of recruitment to the urban labour force and financial assistance to cope with the conditions of urban living.

[14] Alfred De Sonza (ed.) *"A Challenge of Urban Poverty"* in The Indian City Poverty, Ecology and Urban Development.

Studies undertaken in Bombay, Kanpur and Delhi by Majumdar and Menefee Sing and Calcutta by Lubell show kinship network or more generally a 'resource person' to be of crucial importance to migrate to the city. Though the family in urban areas nuclear but the linkages with family in rural areas are maintained by migrants.

A study in 1976 Menefee Sing[15] found that 90% of the Bastee family are nuclear, when interviewed more than half of the women considered the joint family as the ideal (Alfred de Souza).

Migration

Migration is an universally existing phenomena in urban as well as in rural areas. There are several factors that influence migration are – eco-demographic, technological, socio-cultural, geophysical and political institution. It was observed that almost in every metropolitan city speed of migration is taking rapidly after independence. The progressive development of metropolitan functions and diversification of socio-economic structure has resulted in a large expansion of employment opportunities has been playing as pull factor to attract the unemployed and underemployed unskilled and semi skilled workforce for better employment. The number of workforce in Delhi increased from 1.12 million in 1971, from a mere .70 million in 1941, Urban population of Delhi was 57.68 in 1981 rise to 84.72 lakh in 1991 and identified slum population was 84.72 lakh in 1981 and rise to 24.19 lakh. The major proportion of increase in population was contributed by a large influx of refugees due to partition of the country in 1947 and Punjab riots after 1970's. As many as .75 million of migrants came to Delhi 1970's, out of which .85%

[15] A. Manefee Singh, Alfred De Souza (ed), "*Women and the Family: coping with poverty in the Bastis of Delhi,* Ibid. *1978 p 8-9.s*"

belonged to the four adjoining states of UP, Haryana, Rajasthan and Punjab. The proportion of urban migrants among this is 56% (T.K. Majumdar, p. 19-20)[16].

A characteristic of Calcutta working force noted in all population and labour force survey of the city is its complex ever since its foundation, nevertheless the rate of immigration has been falling. From 1951 to 1961 the decade rate was 25% in Calcutta urban agglomeration and 32.8% for whole West Bengal, whereas from 1961 to 1971 the rate were 22.6% and 26.9% respectively. The migrated population are belongs to the flood of refugee and East Pakistan overwhelmed the problem of migration in mid 1960's. The West Bengal was the most recipient of net inter state migration in India. 2.2 million from other states and .6 million were born in West Bengal leaving net immigration of 1.6 million in 1961. Most of the immigrants from Bihar 60.6%, Orissa 8.4%, UP 15.6%. (Harold Lubell)[17].

A study by Biswaroop Das[18] highlights 80% of the respondent said that they had come to city from outside regions did not originally belongs to it. Section of them came from as far as northernmost and southernmost district of the country. The maximum proportion from Maharashtra, as high as 47% household belong to neighboring state, 18% from UP, 11% from Orissa, 13% Gujarat, 5% from Andhra Pradesh, less than 2% from state of Madhya Pradesh, Bihar and Rajasthan .

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[16] T.K. Mazumdar, (1978) "*The Urban Poor and Social Change; A Study of Squatter Settlement in Delhi.*" in Alfred De Souza ed. The Indian City. Poverty, Ecology and Urban Development.

[17] Harold Lubell (1978) *Migration and Employment; "The cause of Calcutta"* The case of Calcutta, Ibid.

[18] Das. Biswaroop, (1990) "*Socio-Economic Study of Slums in Surat City, 1994, Published by Center for Social Study*"

A study in Kanpur city reveals according to 1971 census 53.1% immigrants in the city the highest percentage, i.e. 65.88 was from within the state, other Indian states contributed 28.5%, immigrants from outside India was only 5.17% (Rajendra Kumar Awasthi, p. 18-19).[19]

Migration and Urbanisation

Problem of urbanization in India first thrashed out in considerable detail at an international seminar held at Barkeley (California) in 1960. This seminar contributed to the study of urbanization in India in the form of book published in 1962. The 1961 census figures betrayed by Kingly Davis in that urbanization has not moved rapidly since 1951. This census results big surprise to demographers, economist and planners, the most pessimistic projection of 1961 population made by demographer or government agency turned out to be an underestimates that time grown of population revealed unexpectedly high 21.5% for 1951-61 decade. The 1961 census revealed and unexpectedly low rate of urban growth around 26.4% for the 1951-61 decade without taking note of definitional change. The process of urbanization since 1901 till present the causes of migration and population was identified cause such as first world war and attempts to industrialization, Great depression of 1930 during 1921-31. In 1911 due to plague and great influenza as nature growth had impact on population growth.[20]

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[19] R.K. Aswathi, (1985) *"Urban Development and Metros in India"* Chaugh Publication, 1985, Allahabad

[20] Davis Kingsly (1972) "World Urbanization 1952-1970, vol. 2, Analysis of Trends Relationship and Development" Institute of International Studies, University of California.

Old Indian census reports contained a discussion on economic migration and marriage migration. But absence of any data in the census on this migration, so definite conclusion, could be revived at NSS report have picturise fairly of this type of migration. It focused that 57% males come to the big cities for economic reasons and 58% females for marriage or other earning member of household. Data on marriage as a factor can also be utilized to know their states particularity for other activities since the women who comes to Delhi due to marriage or after marriage may have influence in the process of social learning and socialization. In the present study data on marriage migration was not collected, in fact it was questionnaire was administered basically to the male only a few female have been interviewed. Male counterpart have responded economic reason at most it was little variation on the part of female part, they do give less importance to economic cause and their village exogamy.

The first major issues of migration and urbanization concern the problem as rural to urban primarily manifested in the process of urbanization of India and other third world countries. This present process of urbanization with unprecedented population growth is a symptom of backwardness of the economy, the stagnation of rural life, lack of advantages, stagnation of significant effort in improvement in agriculture and inability of the modern manufacturing sector to absorb the surplus labour force from rural areas to check out the economy of urban areas. Increase population growth of rural people in urban places becomes surplus workforce in productive sector. Hence it increases the gap and disparity pose a threat of urban elite. Again the same elite culture pervades continuously dominating urban poor (A. Bose).[21] This

[21] Bose Ashish, (1980) "*India's Urbanization in 1901-2000*" Tata McGraw Hill Publication.

urban workforce work to produce goods and services but the class stratification and purchasing power deprive them of consumption to fulfill there needs owing to origin of particular state and place and its cultural factors has also impact on occupation or recruitment process of urban workers follow the prototype of horizontal social mobility of the certain castes and class. But in urban places caste has little influence than class. Hence, it follow a kind of class struggle for survival among the labour class or power class people. In the process of urbanization in 3rd world countries migration an interplay of the forces of demand and supply in the labour market. Here the market and private initiatives play a significant role encouraging mass deprivation of the poor, exploitation of workers. Here in Indian cities supply of labour force is higher than demand giving comfortable path to market drive. There is inadequate working condition. All the cities always give shelter to many unidentified and unprecedented workforce, without any recognition. Poverty among the workforce compelled them to continue the culture of poverty. Urbanization in India is rapid but in negative side it is a protocol of elite culture, where the powerless will continue to be powerless, poor will continue to remain in poverty. Present scenario of urbanization has been negative impact on social development. Economic growth was grabbed by population growth and other socio-pathological factors such as poverty, discrimination, unemployment. This problem cannot be seen in isolated manner, as it is considered as vicious circle.

Population growth is a interrelated phenomena with urbanization. There are three component of population growth those are fertility mortality and migration. As this is natural process of population growth. It is discussed that India's

population is poised 76% during the periods 1996-2051. It was projected increase in age group 15-64. The population will double 541.6 millions in 1996 to 1089.5 millions in 2051, that means increase in 66.2% in 2051 from 58.0% in 1996. Most of this will be in labour market providing such a huge population will be the biggest challenge India will face in the first half of the 21st century. Thus if this process of urbanization with population growth will double the mass poverty, mass deprivation in coming decades in the urban areas (K.S. Natrajan, V. Jayachandren)[22].

Causes of Migration

All the major cities indicate that slum and squatter families are poor rural migrants basically from lower castes along with economic class. They migrate to the city through the existing nature of kinship, caste and village network in search of better income opportunities. Migration is usually defined as a geographical movement of people involving a change from their usual place of residence.

The major reason of migration is economic. In most of the developing countries low agricultural yield, agricultural unemployment and underemployment are the major factors pushing the rural migrants towards the areas with greater job opportunities. Rural people are compelled to migrate to urban areas due to unfavorable condition in the villages which is known as push factors and other one pull factor that considers the opportunity to absorb this labour force from rural areas. Former on express that adverse condition caused by poverty, low productivity,

[22] K.S. Natrajan, V. Jayachandren seminar papers on , "*Millenium Conference of Population Development and Environmental Nexus*" by Indian Association for the Study of Population, Population Foundation of India, United Nations Population Fund. Feb. 14-16th, 2000, Delhi.

draught and famine, exhaustion of natural resources people in rural areas are compelled to leave their native land in search of better economic opportunities. One study of four squatter settlements in Delhi 1975 formed that 81% of the respondents had left the village because they could no longer earn a living there. It was observed that most of the reason was adverse agricultural condition, fragmentation of land, declining demand for traditional skills.

The second factor is pull factors refers to those which attract the migrants from rural areas to urban area, for opportunities for better employments and higher wages, better working conditions and better amenities in these areas.

Migration Streams

Ashish Bose[23] has mentioned in his book about four migration streams are:

1.rural to rural

2.rural to urban

3.urban to urban and

4.urban to rural .

This classification had been done on the basis of place of birth and place of residence and considering the rural/urban breakdown. Territorial migration – short distance (intra-district) medium distance (inter district) and long distance (interstate). He has shows that rural to rural migration in case of male accounts for the largest number of migration in regard to short and medium distance migration and only in the case of long distance migration does rural to urban migration become most prominent form. He

[23] A.Bose,(1980) "*India's Urbanization in 1901-2000*" Tata McGraw Hill Publication.

viewed that this is not true in the case of female migration for which regardless of distance, rural to rural migration is the most important.

VLS Prakash Rao[24] in his book mentioned that it is urban full factor that operates over long and medium distances. In contrast the short distance migration – rural to rural is identified as essentially marriage and the 'marriage' unlike the employment is limited primarily to adjacent areas. Economic migration is low just over 3% in 1971. Here streams of migration is not clear cut.

Ashish Bose in his study focussed on the basis of 1961-82 census shows comparative picture of the four types of streams. Rural to rural and urban to rural migration influenced by social the economic factors characterized by "marriage migration" and return migration. It is notable that in many parts of India the customary practices of marriages places a taboo on finding spouse within village community.

Consequence of urbanisation

Urbanisation in India and any other third world countries is indispensable for economic growth and social change. But urbanisation in India is more rapid then other third world countries. Recent decades of urbanisation in India with present trend is considerably undesirable in terms of economic growth and social change. This changes can be seen in almost every aspect of human existence such as social structure, economy and employment, welfare environment, health and provision of health care services.

[24] V.L.S. Rao, (1983) "*Urbanization in India Spatial Dimension*", by Concept Publication,"

Rapid industrialization and development of commerce for economic growth and modernization stimulated urbanisation not only create a place of luxury on the other side it bring forth place of sorrow on the large majority of the population. As Delhi is considered as rich Delhi and poor Delhi. In the process of urbanisation and industrialization the villages are uprooted from their land and resettle them in other nearby. This made them to live in new social relationship and interaction with new environment which create a problem of coping up with the situation. In the process of urbanisation migration and population growth create problem of healthy subsistence. Poor and labour force new to the city starts sheltering on illegal spaces as they cannot afford the cost nor the government take care of. This leads to form slums and squatter settlement. The division labor is quite appear Since the urban population is constituted of rural migrants hence the same socio-culture is remarkable. The study likes to narrate the problems of urbanisation with particular reference to health care. Our present level of urbanisation and process of urbanization in terms of population growth among the poor is more crucial to reckon on. The rich becomes richer and poor tend to be poorer. This poverty compels the urban poor to adopt any kind of occupation such as manual labour. Vulnerable working environment result urbanization and development of trade and commerce hence creating post and modern settlement for the higher income group of people with all kinds of services at their doorstep.

Urbanization and Health

At the beginning of 19th century only 3%of the people in the world lived in the urban areas and this figure to 10% in twentieth

century, increased upto 40% in 1980 and it is projected about 48% by the year 2000 (J.P.Gupta).[25] The process urbanization is a continuous phenomena of unplanned growth of cities due to high rate of migration and industrialization. This process in India is very rapid creating slums for cheaper labour force from backward rural areas to provide them informal nature of source of employment. Slums, sqauttering, unauthorized colonies, etc. are created mainly because of poverty; social backwardness and unemployment of the people living in the countryside. Push factor like draught and other unfavourable condition; without source of livelihood find themselves in difficult condition to maintain themselves to survive, drift towards the urban areas. Hence the unprecedented growing population in urban areas create a condition of inadequate distribution of resources leading to inaccessibility of service provision in urban areas (P.V. Manohar Rao).[26] There is around 30% of the population in India living in urban areas. It was estimated that out of 2179.1 lakh urban population around 467.26 lakh live in slum areas in 1991 according to town and country Planning Organization.

Talking to the poverty, disease and misery of the people is often considered as an anti-national trait. Sophistication of medical technology in India is proponent of progress. Urban poor live in more congested and unhygienic condition plagued by malnutrition and other health hazards. This undermines the importance of medical facilities and their accessibility to the economically underprivileged in urban areas. As of today every fourth Indian lives in a town and 25.50% in urban slums. The

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[25] Gupta J.P. – (1993) *'Referral Services of Urban Health Care Delivery System"* in Uma Shankar, Girish K. Mishra ed. "Urban Health System".
[26] P.V.Manohar Rao, "*Urban Slums in India*"

urban population without basic amenities is increasing even faster than overall urban population.

Urban Health Problems

Increased deprivation and lack of adequate basic amenities and deteriorated living environment has been giving birth to plethora of health problem. Health problem are the reflection of the condition where people live in issue of health of this colony related with poverty and their socio-economic condition. Due to poverty they are more prone to poverty related diseases for example communicable disease, such as malnutrition, TB, including common illness. It was observed that most of the health problem occurs due to contaminated drinking water, unhygienic sanitation and vulnerable drains, Due to this quality of life is very critical. Due to stagnation and clogging drain water flies fly around the drains. This open drain creates a problem of waterborne disease like cholera, dengue diarrhea etc. Due to contaminated water people suffer from jaundice, Gastroentritis, Stomach pain etc were reported. Pollution caused disease like asthma, TB, Cancer, nausea, Cough, Fever, Viral fever, diabetes, eye problem etc. The more prevalent disease are respiratory illness among these are TB and asthma. It was the children who are the more vulnerable to diarrhea, inability to afford nutrition that leads to malnutrition of mothers and children is more apparent in this colony.

Urban Health Care

As per WHO estimates about 50% of the world population would be living in urban areas by the year 2000 AD. In 1981 Census urban population in India was 167 millions and by the year 2000 it was estimated 367 millions, around 45%of total

population. The urban population is growing faster 4.6% than the, national average 2.3 % To cater health care services to this growing population to a nation like India. Hence this growing population exist without adequate basic health care, living in dilapidated house and under serviced localities within the city. The of the is biased m regard to health. The situation in urban areas is far worst than rural area. Poverty considered by Mathus that is a natural condition of human existence. Poor has to accept misery. This is very about the health scenario in urban areas. Poverty is attached to the mortality and morbidity of large proportion in developing countries as a result of preventable disease. (Mohan Rao,)*. These diseases are poverty related and can be prevented by relatively simple intervention such as vaccination. But our national health programme for malaria, family planning has been seen failure due to socio-economic factors The vaccination or any other health service technology ignores socio economic futures. Health care services in India has been seen in the process of urbanization as much of curative and personal health care facility, the some part of the population go without accessing and utilizing the health services. Moreover the issue related with technology that needs the manpower which is used and has adverse impact or manpower development and organizational form within the health service system (lmrana Qadar). New technology would need new manpower or manpower development to be imparted to cater new skill to cope with the pattern of disease, this needs huge investment to our society.

In spite of concentration of health service facilities in the cities compared to the rural areas and relative proximity of hospital and other facilities, standard of health care seem to have fallen far

* Rao Mohan, "An Imagine Reality Malthusiasm, Neo-Malthusiasm and Population Myth".

below the reasonable minimum level for those who live in slums and jhuggi jhopdis. There is a phenomena of an "inverse care law" whereby those in greatest need of medical care have poorest access to it. While the principles of delivery of primary health care are equally applicable to urban health system as to rural health, the slum population remains ignored on this account to this date. There also exist a vast discrepancy between the quality of health care delivered by the private sector within the different sections of urban population (J.P. Gupta).[27]

Moreover new technology health care services considered more of curative and personal in nature. Thus curative health care services is not easily affordable to the poor segment in urban areas in slums and resettlement colonies. Promotive and preventive health care services have been ignored for the slum population. These services had been recommended by Krishnan Committee during 7th plan period. Seventh plan working group has recommended that there should be a health centre or health post for every 50000 population preferably located in slum areas or at least nearer to slum area. This centre should cater at least 40% of the slum population or poorer section of the community. This was meant for providing primary health care, maternity and child health care including Immunization and Family Welfare Services. They should give extensive health education to the community so that whatever facilities are provided are optimally used. But practically among all nothing has been done so far for the betterment of the poor part of community.

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[27] Gupta J.P. – (1993) *'Referral Services of Urban Health Care Delivery System"* in Uma Shankar, Girish K. Mishra ed. "Urban Health System"

Urban Health System

To cater with health care services the central ministry of health and family welfare is the ultimate authority responsible for setting standards of health facilities, implementing national level health programme and so on besides it own management of health service delivery system. Directorate General of Health Service (DGHS) serves as the technical wing advises minister of health and implementing programme in its behalf and coordinate other allied matters, policy along with technical information and assistance. Central government provide senses through hospital for public; hospital and dispensaries for government employees and their families; departmental hospitals for employees of the respective department; centre for medical education broadly the system has been categorized in 3 ways are (a) Hospital for general public run by DGHS such as Safdarjung Hospital, Ram Manohar Lohia Hospital, etc. Besides these central government also provides support in catering services to general public such as AIIMS, JIPMER, etc. and provide medical care at all three levels.[28]

The central govt. intervenes directly in providing health care facilities to is own employees and its family members through a network of dispensaries under contribution scheme known as Central Govt. Health Service (CGHS). These dispensaries locates in all fifteen national capitals to cater health services to its employee. These are specialized hospital to cater special care for mothers such as maternity hospital to public hospital.[29] But the

[28] Kundu Amitabh (1993) "Health Care Facilities in Urban India" in P.K. Uma Shankar and Girish K. Mishra Ed. Urban Health System. Reliance Publication and Indian Institute of Public Administration.

[29] Ibid.

characteristics of health resources such as infrastructure, drugs, manpower and services discourage them from visiting public hospital Thus they are encouraged by private hospital or health care provider by the-very nature of their hospitality and time consumed for treatment. In addition to it socio-economic condition of the patient that influence him to consult with private and public health care provider. Time spent for hospital has tremendous impact on utilization of particular health care provider.

Access to Health Service

Health Scenario in urban slums is more vulnerable than the rural areas. By very design of the urban Health System bias against the poor and weaker section without adequacy of services urban poor specially has no access to health services. Though they are provided with hospital polyclinic and dispensary by the state still they have been depriving of meeting health care needs. This is not just because there is no health care institution but due to many external factors like – social, cultural, economic and behavioural aspects play pivot role in maintaining access to health needs of the poor. These may be some other factors like organization behaviour and management. People attitudes and health practices also countable aspect influence access to health.

Urban poor in slums with distinct characteristics like – cultural, social, economic and practices influences perception toward health and health needs. They themselves perceive health as a State of Ability to work and feeling ease at work. And this has relationship with economic aspect such as loss of wages or leave from work. They don't perceive illness as problem for individual well-being. People think that if anybody go to hospital or health

centre means waste of time and wages, which has again link with present employment condition.

Urban resettlement has number of health care facilities run by state, private owned, NGO's, philanthropist RMPs. This plethora of health services still inadequate to cater health care services to the population adequately.

Concept of accessibility

In reviewing prior definition of 'accessibility', several issues and problem arise. The first involved the use of various terms as synonymous for accessibility very difficult to distinguish. For example, in a report on health care in rural areas no distinction is made between access to health services and availability of personnel and facilities.

Discursive Dictionary of Health Care[30] – in practice "Access, availability and acceptability are very difficult to differentiate. Widespread trend is to use access and accessibility inter-changeably. Salkever trents two aspects of accessibility:

Financial accessibility defined as the individual ability to pay for health care.

Physical accessibility defines as transportation, time and search cost implied in the process of obtaining care.

From the first definition financial accessibility seems refer to a characteristics of the patient rather then of health resources. For example – even if health services were inexpensive, a person may

[30] Julio a article "The Concept and Measurement of Accessibility-Health Service Research: An Anthology" Royal Commission on National Health Service.

not be able to afford them as other needs that compete his/her expenditure.

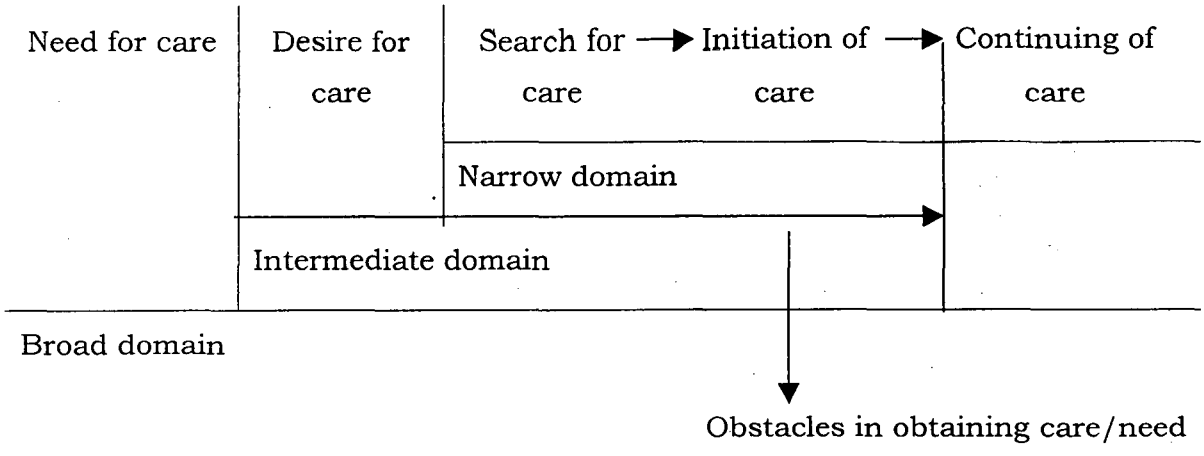
Adong and Anderson try to specify 'process indicators' of the accessibility that reflect characteristics of both the health system and the population at risk, or some type of relationship between two.

According to Penchansky and Thomas, they conceived accessibility as the functional relationship between the population and medical facilities and resources reflecting differential existence.

As per Chess 'Access index' Accessibility is functional relationship between 'resistance' and 'utilization of power'.

Possible domains for 'Accessibility' concept

SCHEMATIC FLOW CHART OF EVENTS



Broad definition of 'access' encompasses a wide array of concepts such as:

- Availability
- Affordability

- Ability
- Acceptability

Accessibility is tantamount saying that it is outside of the individual; who must want it, seek it and ultimately obtain it. It is solely interaction between individual's internal capabilities or exclusively on external resources.

Obstacles: Dimensions of obstacles

- Ecological: Arises from location of the sources of health care along with attendant repercussion of distance and loss of time.
- Financial obstacle: Price charged by provider
- Organizational: With a health establishment
    - Initial contact with Health Care System such as delay in getting appointment
    - Timely provision of health care within establishment.

In narrow domain obstacles in continuing care is not addressed.

CHAPTER - 2

DESCRIPTION OF JAHANGIRPURI RESETTLEMENT COLONY

Having arrived at the Jahangirpuri final list of every block have been collected and made up a visit around the colony for an overall understanding of the colony. The researcher cashier experience of working in the same locality was another back through of his knowledge about the locality choosed for study. At the same time the researcher met local people, MCD Offices, NGO's, Police Station and PWD and information was collected from all these agencies. There are 13 blocks in the colony with plotted housing scheme. The nature of this colony is of mix nature JJ Slum and refugee resettlement colony because this colony was earlier meant for those refugee from Punjab massacre who was supposed to resettle there. But as time passes these plots has been gone to the other in exchange of money. Plots allocated had been sold to other jhuggi dwellers from other slum thus the original plot owner disappears in majority of the cases. This colony not only comprised of plot housing in addition, there are jhuggi jhopri in between the blocks. Population growth rate due to birth, migration and reasons stand as a barrier in appropriate distribution of resources. Maldistribution of service continuing with population growth. The people living in this colony has peculiar requirement in terms of their life style and socio-cultural needs. Information regarding various aspect has been discussed in this chapter. It was argued that access of urban poor to infrastructural facilities and basic amenities has considered a major problem even before the launching of the liberalization. It was believed among

the liberal that it would make a change in the process of development. New technology unsuitable for the India socio-culturally and economically took a toll in privatizing the services.

Historical Aspects

Jahangir Puri Resettlement colony is one of the largest colony is a gross area of 400 hectares, in north zone of Delhi. It was developed after mid 70's. This colony was established to resettle families from Slums and unauthorised colony of Delhi. This colony was developed along with other fifteen-resettlement colony after 1975. This colony was occupied by victim of Punjab massacre and refugee from Bangladesh and Pakistan. Then Prime Minister Late Indira Gandhi has contributed in resettling the urban squatter families and family from unauthorised colony. Empirically soon after allocation people started living in 1976. There are both DDA built houses and self constructed houses in the colony. In 1976, people who are the original allotee of the plot was arranged for Rs. 2000/- from State Bank of India as a loan. The allotees took loan for development of their plots. But due to their poor socio-economic condition they spent the money get through loan for other purposes. When the interest of the loan increased unable to repay the amount accumulated over a time period. . This coupled with poverty compelled them to sell out the plots to relatively higher income group of families.

Demographic Aspect

There are about 2,60,704 families in 13 blocks of Jahangirpuri colony as per 1991 census. There are around 53,562 households in this colony. In the real sense this population is higher then the census data. There are about 2000 household plots

in every block allotted by DDA. The population of this colony consists of primarily Hindu, Muslim other religion such as Sikh, Christian etc. There are basically three categories of people live in are general, other backward caste and Schedule caste and no data about Scheduled tribe as per 1991 census. Basically the highest percentage of the population come from Uttar Pradesh followed by West Bengal, Bihar, Haryana, Punjab, and Rajasthan. It was reported that C-Block has got highest number of Muslim families then any other block, who are from West Bengal originated from Bangladesh. Average family size of the family consists of 6 members in the colony. This description strictly address only those live in plotted housing scheme of the colony.

Geographical Aspect

Jahangir Puri resettlement colony is situated in the northern part of Delhi at the near periphery of Delhi. This is one of the largest colony in a gross area of 400 hectares. This colony is situated at the lower level. The more problematic areas of the colony such as K block, EE and G block lower level of height that create a problem of water logging and lack of movement of water in drains. Owing to this condition during monsoon these particular blocks filled with water. Rainwater sometimes doe not get way to move on due blockage of drains and low-level area.

Socio-Economic Aspect

The majority of the household in this colony belongs to lower income group. Since this colony comprised of regulation from varied states from moral background. These people tend to maintain their rural culture. The people of this colony usually depends on labour or informal economic activities for their

livelihood. Due to poor income people are not in a position to afford basic minimum needs. Having migrated from rural background people has to take up new skilled job. Some of them involve in traditional work that need traditional skills. People in this colony involve in economic activities of both formal and informal. Among formal sector were government servant, Private job etc. besides these there are other economic activities such as sales, production, labour, self-employment, pithy business etc. These classified economic activities includes Business, Pithy shop, Sabji visdor, rickshaw puller, Mechanic, driver, safai, brush maker, Factory worker, construction worker, housemaid etc. It was observed that highest percentage of population adopted wage labour as Prime occupation for their survival.. This category includes Mazdoor, industry worker, rickshaw puller, construction worker, safai, driver etc. Majority of the schedule caste household engage in safai work. Woman in the colony involve in household activities tailoring, craft etc.

Basic Amenities

Present trend of deprivation of poor is not only a phenomena in rural but in urban area also. In urban areas the gap between the classes have been increasing. It is observed that basic services have reduced availability of basic amenities to poor in Jahangirpuri. In this colony comprised of 22000 plots primarily for 13 blocks, there are 2000 plotted houses in every block. This would be necessary to discuss that two block namely E and K been subdivided to E, EE and K1, K2 comprising equal number of household plots. This colonies was provided with bare minimum basic amenities are public latrine, urinates water supply, drainage

sewerage facility. The condition of there basic amenities is pathetic. There services are erratic and many of them is out of run.

Sanitation

Condition of sanitation is the colony is below accessible due to their vulnerable condition. In many places these facilities are out of working condition. There are 66 public latrines out of which 64 latrine were constructed in 7 blocks namely I, J, K, B, C, D and E blocks. Besides these there are 4 sulabh sauchalay in A, C, E and H blocks. The colony which planned to provide one latrine for 7 families but this facility substantially reduced. There are around 100 family use one latrine. But many of them got chocked on the basin. Very few latrine is on working condition. These facilities characterized by illmaintenance, dilapidation, bad smells and blocked due to erratic water supply in this facilities. Besides these the household in the colony has constructed their private latrine within their vicinity.

Water Supply

Supply of drinking water is very poor in the colony. People in the colony do not have separate drinking water supply. They use same source of water for differential use like washing cloths, washing utensil, bathing and sanitation and drinking. The quality of water is not suitable to have it for drinking. Water got contaminated with polluted water through leakages of pipeline. Sand and mud comes out from water tap. There are one water tap for 22 families but practically about 40-50 families use the same water tap. This facility is provided by MCD and Delhi Jal Board. Besides one hand pump was provided for 32 families. But during the incidence of dengue epidemic this facilities have been out of

use as Delhi Jal Board. Other sources of water are public post on the roadside and bus stand.

This colony was provided with one latrine for 7 families. But this facility has been substantially reduced. There are about 100 families use one latrine, but many of them are blocked in many parts of the colony. There are one water tap was provided for 22 families but practically about 40-50 families use same water tap. The quality and quality of water is more deplorable, contaminated water comes from MCD water supply. There was one hand pump for 32 families. All most every household connected with drainage system, but their working condition is more vulnerable. This open drainage filed with filk and mud creates a condition where disposed water is not moving condition. Sewerage on the roadside is also covered with polybags, and other household disposal. Besides these, surface drains was provided by constructing local and trunk drains, one bathroom for 6 families was planned but this facilities had been dropped.

Housing:

In the colony housing facility was provided through plotted housing scheme, there are 22000 plots comprises 1000 plots in Janta flats. There are 2000 plots in every block. Two block has been subdivided namely E and EE ; K1 and K2 comprises of 1000 plots in each block. The size of these plots varies from 21 square yards to 40 square yards. There were 50 houses in every raw of each block with open space in front of the one side of the houses. The houses were built on back to back without way for ventilation for fresh air in the houses. The characteristics of houses are pucca houses. Due to over population every individual household constructed additional rooms on the top of the ground floor to get a

grand rent through renting. Aside every block there were quite a large number of Jhugi Jhopdi cluster in C, J, G, H and K blocks.

Health Care Services

Health Care Service in this colony is dealt by two agencies are MCD and Delhi Administration, Directorate of Health Service. Dispensary run by DHS caters general health care and Dispensary run by MCD caters primarily for child and maternal care in the colony.

To deal with the health problem people of the colony depend on two types of health care system are public hospital and private hospital. Urban health care has been expected to provide with health care to its population. There are public dispensaries, with OPD Centre and one tertiary hospital with high concentration of services. Besides urban dispensaries there are maternal health centre, registered medical practitioner, private hospital to provide health care services in this colony. Urban dispensary to provide treatment for general diseases. This dispensary provides basically OPD services. Such as treatment for minor illness and child and maternal health. Since urban dispensary is considered basic unit at community level. Besides this there are hospital providing tertiary care at Babu Jagjeevan Ram hospital in the colony. There are Anganwadis at household level run by Integrated Child Development Scheme that provide immediate health and Nutrition, Immunization along with medicine specially for women and children. This way women and children are having little more access it seems. There are Registered Medical Practitioner (RMP) which is known as 'Quakes' providing treatment to these people at cheaper rate. But we are just giving small note on this. These RMPs

are poor in knowledge, turn into giving wrong treatment, this has havoc role in creating health status more deplorable in this colony.

There are again private hospital around the colony. Some medical Practitioner open up private clinic to provide medical care at their resident. Private health care service is more costlier then the cost recurred at RMPs. The nature of services are very different in this colony. This private clinic and hospitals services are most individualistic and clinical in nature. Besides there are some active NGO's Named Dipsikha, Jeevodaya (Christian Mission), Chetanalaya, Society for Social Service, Prayash, has been contributing health services in this colony. Public dispensaries and hospital basically provide treatment for general health problem and preventive health care. Thus Jahangir Puri Colony has little availability of health services of both private and public health care providers.

Health Problems

Health condition determined by environment condition in Indian cities is actively continuing to deteriorate, because of the active participation in the exclusion of large section from access to basic urban services. The consequences of such monopolization by upper and middle class population of state resources and benefit. Poor or lack of adequate basic amenities for survival tend to sustain suffering and disease among the poor population in the slum and resettlement colonies. Unhygienic housing condition, drinking water supply sanitation and drainage network influences slum people. Pathogenic living condition doubled with poverty has failed to keep up healthy communities in the resettlement colony and slums. (A.D. Khanna). Thus the basic amenities in the slums are ignored at large segment. This has got active correlation with

the phenomenal growth of population of "urban poor" in all major cities of India is quite evident from 1991 census estimation, about 1/3rd of Calcutta city and nearly 3/4th of residents of Bombay and ¥4 of urban Delhites are comprised of a mix of slum residents without any means of amenities. This is connected with the "recognition' as legal of that particular locality does not qualify the urban poor for urban Basic Services (UBS), Of course there are UBS Scheme had been on the resettlement colony of Delhi, as Jahangirpuri as study area. Still that could not adequately, and effectively deliver services due to maldistribution of population and resource allocated. Hence the services provided by UBS Scheme failed to meet the actual need of public health facilities geared the mortality and morbidity in the slum and resettlement colonies, (Indian Journal of Public Health).

The State of Health of a community can be considered as indicator for its quality of life. Besides state of amenities health is prerequisite aspects as this two has got causal relationship. The major health problems in this communities are - Fever, Polio side effect. Typhoid, Pneumonia, Stomach pain, Jaundice, TB, Gastric Asthma, Diarrhea etc. As it is observed that these health problems occurs at the productive age of individual's life in urban settlement. They continuously complain about the negative effect of lack of basic amenities. Of course the present study does not identify the age pattern of the ill person during the period of data collection. The present study identify out of 100 households sample 40% household reported illness during one year period since January 2000 to January 2001. As the ailment reported above are not always mutually exclusive, the percentage reported against these may overlap. The figure these for is suggestive rather than definite. If we analyze the situation for the whole Jahangirpuri the sample

size may not representative or satisfactory due to selection of sample as per population. Hence the sample may create problems in representing whole the settlement blocks. It is clear that more than 1/3 of the sample reported illness. The situation would appear to be worse if we observe the distribution of morbidity and death. Data collected from 98 sample reported death accounts higher among the male than female whose contribution to material good of their family is expected to be the greatest. Here age group have not been identified. Still roughly it was estimated that the age group of deaths are 0-10; 21-30 years; accounts around 22.1% each, and above 40 years accounts 33.3%. Hence it is pertinent that around 44.4% death occurred during productive age among the total deaths. 22% deaths among the youngest at around one year age that can be considered as child mortality. The cause of death reported are Typhoid, TB, Blood Pressure, Pregnancy related death. Jaundice, Polio-side effect, Stomach Pain and Asthma. TB has been reported higher than any other diseases during that period of one year. The factor associated with TB and other health problems are living environments, drinking water, housing condition drainage disposal. In resettlement colonies of Delhi Jahangirpuri has the same characteristics similar to other resettlement colonies. The plots allocated and houses constructed are back to back in congested way without facility of air ventilation inside the house is sanguine factor of spreading of TB infection in addition to other communicable disease. Here in the present problem dialectical materialism and reformist approach stresses the interrelationship seeing housing health and interconnections within the context of dynamic socio-economic system where the revolution of contradictions within the society is the source of change. It treats health and housing as two of host of interrelated variables. This implies the economic activities within the of

production, increased tension between social relation and process of production. Working environment and nature of occupation and living environment is better examples of this approach.

TABLE NO. 1

SEX WISE DEATH AMONG THE RESPONDENTS

SEX	NUMBER OF RESPONDENTS N = 9	PERCENTAGE (%)
Male	5	55.5
Female	4	44.5

TABLE NO. 2

AGE WISE DEATH AMONG THE RESPONDENTS

AGE GROUP	NUMBER OF DEATHS N=9	PERCENTAGE (%)
1-10	2	22.2
11-20	1	11.1
21-30	2	22.2
31-40	1	11.1
41 and above	3	33.3

Nature of Health Problem

Besides these there are plethora of health problem are such as diarrhea, headaches, respiratory disease, nausea, heart disease, etc. the disease occurred in the colony are result of poor basic amenities. Inadequate purification and leakage of water tube contaminate with polluted water heads to waterborne disease. For example, stomach pain jaundice, malaria, typhoid, diarrhea, water Overflowing drainage with water logging, lack of movement of disposal water construe conducive environment to lague, dengue, malaria, etc. It has been reported that mud and sand also comes out from water tap supplied by Jal Board. Overflow of drain water in nearby area attracts flies to grow to spread malaria.

SOCIO-ECONOMIC PROFILE OF RESPONDENTS

This would be helpful to explain about he socio-economic profile of the respondent in understanding the issues the study discuses in the succeeding chapter. Some of the important variables had been discussed below.

OCCUPATIONAL STRUCTURE:

TABLE NO. 3

OCCUPATIONAL DISTRIBUTION OF THE RESPONDENT

Category of Occupation	Number of Respondents N=100
Government Service	16
Private Job	2
Self-employed	22
Petty Shop (Business)	16
Labour	39
No work	4
No information	1

The Jahangirpuri resettlement colony with varied population from varying parts have adopted different occupation are Govt. Service, Pvt. Service, Sales, Production, Labour, Self-employed, Petty business are broadly categorized. Basically the population involve in informal and primary sector economic of activities for bare survival. The plethora of occupations some of them are traditional and new skilled are – Business, Petty shop, Sabji vendor, Driver, Mechanic, Safai, Brush-maker, Factory worker,

Rickshaw puller, Construction worker, Housemaid which have been identified from the respondent. From the interview, it was collected that the highest percentage of the respondent was found in labour category which accounts 39%, 22% for self-employed, 16% for petty shop (business), 16% in Govt. Service, 2% in Private job and 4% has no work. 1% has no information regarding it. Labour category includes – Mazdoor, industry worker, rickshaw puller, construction worker, safai, driver, attender. Petty shop (business) includes sabji vendor, paint vendor, agarbati vendor. Self-employment includes business, tailor, carpenter, bush maker, etc.

INCOME DISTRIBUTION:

TABLE NO. 4

INCOME DISTRIBUTION OF THE RESPONDENTS

Income Range (in Rs.)	**Number of Respondents N = 100**
Upto 1000	11
1001-2000	37
2001-3000	21
3001-4000	14
4001-5000	6
5001 and above	7
No income	4

From the quantitative data, few in-depth interview and qualitative data manifested that due to large number of informal sector occupational distribution among the resettlement dwellers there are great variation in level of income. Level of income as economic structure has been playing pivot role in determining the access to basic amenities and health care services. From the sample data it is observed that high segment respondent belongs to the income range of Rs. 1001-2000/- per month that accounted 37%, 21% belongs to range of Rs. 2001-3000, 14% belong to Rs. 3001-4000, 7% belongs to 5000 and 5001 and above accounted 7%, 11% belongs to upto Rs. 1000 a month. 4% has no income due to factory close. Level of income determines the purchasing power of the population.

RELIGION:

TABLE NO. 5

RELIGION WISE DISTRIBUTION OF THE RESPONDENTS

Religion	Number of Respondents
Hindu	88
Muslim	12

For the present study out of 13 blocks of Jahangirpuri only 2 blocks named G and C had been selected. After a rigorous visit around Jahangirpuri and discussion with other key person it was identified that some part of G and C block has quite a highest proportion of Muslims. From the interview 88% respondent identified as Hindu and rest 12% belongs to Muslim religion.

FAMILY SIZE:

TABLE NO. 6

FAMILY SIZE OF THE RESPONDENTS

Family Members	Number of Respondents
Less than 2	1
3 – 5	44
6 – 8	45
9 and above	10

From the collected data it is observed that 45% the highest percentage of family has family size of 6-8 number of family members, 44% family has family number 3-5, 10% family has family member of 9 and above, 1% less than 2 family member. Family size has strong relationship of the family with the economic status of the family. It has impact on the per capita expenditure of the family. Due to large number of family in the community people could not meet the bare necessities, education of children, cost of medical care, ability to pay for accessing basic services and health care services.

DURATION OF STAY:

TABLE NO. 7

DURATION OF STAY IN THE CITY OF RESPONDENTS

Years	Number of Respondents
`Less than 2 years	3
3 – 5	1
6 – 8	3
9 – 11	6
More than 12	86
No information	1

Since Jahangirpuri resettlement colony was allotted in 1976 for the people from Punjab to settle them in this colony. But incidentally the people who able to afford the plot since then. However it was observed that the duration of stay varies from family to family. Many people have shifted their residence selling their plot with ransom money. Still the present study manifested that 86% family have been staying in the colony more than 12 years, specially many of them have been living since 1976 soon

after establishment of the resettlement, 4% have been staying for 9-11 years, 3% 6-8 years, 3% in the range of below 2 years and the very least 1% have said stayed for 3-5 years. Duration of stay or place of residence with 0-9 years in place of enumeration was considered negligible to express the pattern of migration. In the present study residence more than 12 years accounts highest, i.e. 86%. Almost a hefty number of respondent said that they were residing within the city who have shifted to Jahangirpuri resettlement colony. It can be analyzed that many of them who were availed plots and building has sold it to others and started living in the same vicinity of slum, squatters, etc. This can be attributed by poverty of the household. If we combine all others .11% stayed for less than 12 years almost will equal percentage. This amplify the shift their residence and other related factor. Another is place of work plays active role in shifting their residence within the city.

NATIVE AND ORIGIN:

TABLE NO. – 8

STATE WISE DISTRIBUTION OF THE RESIDENTS

States	Number of Respondents
Madhya Pradesh	3
Bihar	3
Uttar Pradesh	58
West Bengal	9
Delhi	10
Haryana	6
Punjab	5
Others	5

Information collected regarding the state origin of the dwellers in the colony. There are population living from state MP, Rajasthan, UP, Bihar, West Bengal, Delhi, Haryana, Punjab and others. The major percentage of population belongs to UP, Bihar and West Bengal. Empirically it was found during interview and qualitative study that people reported West Bengal originally belongs to Bangladesh. Hence it may be cumbersome process in identifying these segment of population. From the study data collected from 100 household samples among the two block 'C' and

'G' identify the majority and other magnitude of the native distribution are – 58% from UP, Delhi 10%, West Bengal 9%, Haryana 6%, Punjab 5% with lowest Bihar 3% and 3% of MP and 5% others (Refer Table no. 1). The majority of the respondent belongs to UP. They migrated from UP are basically from nearer district to Delhi such as – Meerut, Azamgarh, Muradabad, etc.

Causes of Migration

The population of Jahangir puri colony migrated from different states basically they are rural origin. The causes of drift towards Delhi were many, such as unemployment, low agricultural yield, refugee from Pakistan during partition and victim of Punjab massacre.. The reason may be grouped as push factor played vital role in migration from rural areas towards Delhi. Besides these unfavourable condition such as unemployment due to overpopulation, low agricultural yield due to draught and flood and other natural condition played as push factor compelled majority of the respondent to migrate to Delhi. In the other hand these population were attracted by pull factor such as plethora of income avenues, and better quality of leaving and other services available in the Delhi. Migration streams observed in the colony were rural to urban; and urban to urban. Most of the people follows rural to urban, very few migrants follows urban to urban ,usually they came from small town in neighbouring states.

Caste Affiliation

Jahangir pun resettlement colony basically resided by large percentage of around more than 80% from other neighboring states. People in this colony except A, B and J block got higher sc population then other blocks. They are basically from Punjab and

Haryana. In other blocks other then A, B and J people belongs to Utter Pradesh, Bihar, Madhya Pradesh, West Bengal etc. The caste affiliation any the people population in these 10 blocks belongs to schedules caste groups' As a whole there are people from all four category had been identified.

In present study would give slumps on caste affiliation among the population. Out of the 100 sample 46% belongs to schedule caste the higher part 29% belongs to general categories and 18% come from backword caste and 3% belongs to ST and 4% did not have any response. It is observed that majority of them SC population come from Utter Pradesh followed by other states.

TABLE NO. 9

CATEGORYWISE DISTRIBUTION OF RESPONDENT

Category	No. of respondent N=100
SC	46
ST	3
OBC	18
General	29
No Information	4

Education and adoption:

Education has the effect of widening the mental horizons and awareness of a person. It prepares or predisposes him to be receptive to new idea. Even little limited education has positive impact on the people. An educated and capable man can read and write exposes an individual to influence of new ideas at least by enabling him to read newspapers and other periodicals. An educated individual is more responsive to change, supposed to be dynamic to exhibits or adopt new behaviour. Adaptability centers not only to a single aspect it is considered in every aspect of public amenities, housing, sanitation, health provider, etc. This may not be true for adoption of new ideas for the whole family members, due to replication of autocratic family pattern where the prime household will decide on what to adopt and what not. To express

this phenomena we can relate the education of the prime household who takes decision is not educated and if the children are more or less educated, still the adoption of new behaviour may not necessarily take place due to autocratic pattern of family and his capacity and ability to afford. Education is an important variable affecting awareness, attitude and perception, behaviour of an individual (Bindeswar Pathak, 1982, p. 33).

CHAPTER - 3

FACTORS OF ACCESSIBILITY

Health as a national priority for development. It is a contributory factor to development not merely a consequence of development. But the matter is whether population of a nation have provided health care services adequately. Health has been declared a fundamental human right. Article 246 and 46 of Indian Constitution covers the all health subject of the nation. Health is a state subject and state is responsible for health of the people. It has been criticized that health care services are predominantly urban oriented provide curative in to a large part of the urban population, is by very nature personal rather than public. Private practice and market drive with the process of urbanization has resulted economically least accessible to the poor population in the urban areas. This can be expressed in terms of availability of shopping for medical care. Curative care which has been considered more of a clinical and personal hence it does relate with the individual or personal aspect (Park and Park, Ghei).

Factors Responsible for Accessibility

As earlier mentioned in the previous chapters indicates the health condition and problems and its access to health services for the urban poor material. And urbanization with unprecedented population growth holds relationship with accessibility to basic amenities in urban slum localities. Health scenario in urban poor locality is more pathetic than rural area. Poor or lower income group people markedly have low access or no access to health service. Identity being economically poor and their occupation and

cost of medical treatment has been existing as barriers accessing heath care service. The present study would not stick to merely on economic factors it shall deal with social and physical factors. Besides, the study also give cursory views on institutional and behavioural factor. The issue 'accessibility' and 'availability" has been in use simultaneously. But accessibility and access should be restricted to phenomena that while to accessibility are not equivalent to it. As per Donabedian, "Accessibility is considered to be something beyond the mere presence or availability of resources at a given time and place. It includes the characteristics of the resource that facilitate or stand in the way of its use by potential client or user. Financial accessibility refer to the characteristics of the population and patient rather than health resource. Financial accessibility means individual capacity to the pay for care. It can be observed that accessibility is functional relationship between the population and health facilities and resources that reflect differential existence.

Economic Aspects

To explain the accessibility of health care services we have to consider the number of illness and their access to services in a given time. It is observed from qualitative and quantitative study lower income group and lower caste has lack of information that moulds their behaviour towards health care in Jahangirpuri resettlement colony. Out of 100 households have been interviewed of which 45 respondents reported fall illness on one or other disease. This quantify that 45% households sample suffer from illness. They reported that usually go for treatment in public and privately owned health care centre. It was observed that out of 45, 18 patients go to public hospital, 15 patients go to private and 10

patients go to both kind of hospital. Hence, it is pertinent that they have taken treatment in there itself 10 respondents reported visiting of both public and private hospital along with other source. It is observed that the pattern of treatment in health centre not similar. For minor ailment population goes to private health care provided or private hospital for treatment. For major illness or communicable diseases prefer to go to public hospital due to nature of treatment in private hospital and diagnostic procedure. Long duration of treatment like cancer, TB, malaria, etc. for communicable disease people prefer public health care provider. This has got relationship between income and of treatment of private health care provider. Due to poor income of the potential patient cannot afford the cost of treatment in private hospital. So for communicable disease has been considered national health priority. Due to nature of epidemic and endemic private health care provider shall not accept providing free or low cost health care services for the poor.

Usage Pattern of Health Care Provider

It is apparent, the relationship between income and usage pattern of health care provider in broader terms. Individual's ability to pay for health care determine access to utilize health care service. But the private health care provider do not emphasize the condition of the economically poor segment of population in the country. They believe and understand the public health care services are costly enough. For poverty related disease people depend on public health care provider such as MCD dispensary, Urban Health Centre, hospital, etc. There are other source of treatment such as Registered Medical Practitioner in urban areas in Jahangirpuri resettlement colonies. But this facility is generally

used by jhuggi dwellers. Condition along with quite significant participation of resettlement dwellers. Condition of Publicly owned health care services is pathetic where service delivery is deteriorating gradually.

People perceive that public health care institution are not effective and efficient enough to cater quality of care. Medicines and treatment they provide are not effective. Whenever they visit to this institution they are not behaved satisfactorily. Doctor does not checkup there health problems properly. It was reported that until and unless they know somebody among the hospital staff they are not treated adequately. So they consider that visiting a public health care institution is useless and waste of time. Staff always ignores them being a poor. It was reported that they are scolded by the staff and lack of responsibility among the staff discourage them from visiting this hospital.

Attitude and Perception towards Public Hospitals

View towards the public health care service majority of responded showed dissatisfaction than satisfaction those amounts 52% and 14% respectively. 3% reported irresponsibility and 17% reported both dissatisfied and irresponsible together - and 14% has no reply regarding this. While the preference for treatment was asked it was found 59% of the sample preferred public health and 35% for private health care services. Very negligible 1% goes to trust hospital and 5% has no information about there preference. Public health care is preferred by lower income group segment. On the other hand their visit to public hospital seems to have lesser than their preferences, but this not be the conclusion about their go on practice and preferences. It is observed that majority of the respondent shows dissatisfaction. Their perception towards public

health services is indifferent that the publicly owned hospital are not efficient enough to cater effective health services that depends more on proximity with hospital staff or doctor. However urban poor prefer to go publicly owned health care provider or hospital.

TABLE NO. 10

RESPONDENTS VIEW TOWARDS GOVERNMENT HOSPITAL

VIEWS	NUMBER OF RESPONDENTS N=100
Dissatisfied (a)	52
Satisfied (b)	14
Irresponsible (c)	3
Of the above (a& c)	17
No information (d)	14

Duration of Illness

Duration of illness is also contributory factor in accessing and utilization of health care services. This has not been covered in earlier studies among the literature survey covered by the researcher. Due to prolonged illness and long duration of illness they cannot afford the income for livelihood. This income has causal relationship in social practice of utilizing health care services. Poor or the lower class population has got indifferent attitudes towards the health needs and utilitarian behaviour. They

ignore their illness just because of loss of income for the days he/she spends on taking treatment or visiting a physician in public hospital. They would prefer income than giving a thought on health. These are all related to poverty. Hence we can say that poverty related to disease is not easy to eradicate from the land of India. Poverty compels them to go without treatment.

TABLE NO. 11

DURATION OF ILLNESS RESPONDENT

DURATION OF ILLNESS (IN DAYS)	NUMBER OF RESPONDENTS	PERCENTAGE (%)
Till one week	8	20
8-15 days	6	15
16-23 days	2	5
24-31 days	5	12.5
32 and above	13	32.5
No information	11	15

Present study shows that majority of the patient among the 45 patient, 45% reported went more than one month of duration of illness, 20% suffer for one week, 15% suffer for 8-15 days, 12.5 % upto 4th week and 5% suffer for 16-23 days 32.5% suffer from more than one month. From the quantitative and case study it was focused that the people they have indifferent attitudes towards health problem influence by their inability to pay and loss of

income. The rooted problem is that if the breadwinner of household fall sick who will bear income to survive the family. So there is always hasty in being defaulter from any kind of treatment among the poor. This is just because the circumstances of duration of illness in relation to loss of income stand as financial obstacle. One month long illness would definitely wasteful of man days labour and that has functional relationship between of illness duration and man days. In addition to it lack of monetary help or strength they are not successive in accessing health care services for such a long duration of illness.

COST OF TREATMENT

TABLE NO. 12

COST OF MEDICINE BORN BY RESPONDENTS

RUPEES/DAY	NUMBER OF RESPONDENTS
Upto Rs. 100	14
101-200	2
201 and above	17
Information	9

Family size is again related to another issue related to affordability of the cost of treatment and health care. Health care cannot be considered for one or two days phenomena it need to sustain. A household with large family member will not be in a

position to afford desired amount of money for treatment. Though it is possible that family may not be in position to invest on health care repeatedly. Due to large family size the income earned, to be spent on other aspects of life such as food, shelter, clothing, education and many more.

It was estimated that household expenditure per capita - Rs. 184 in rural and Rs. 258 in urban areas at national level. This shows though the present study do not make effort to explain the relationship between family size and cost of treatment. The study shows that upto Rs. 100 cost born by 17 respondent and above Rs. 201 by 17 respondents. Hence it is clear from the picture that per individual expenditure on health of the slum dweller is less than estimated national average. This is again problematic to show the co-relationship as information collected seems to be inadequate. It is remarkable that the people in slum has less economic access. Data presented here does not show not where they access to for which they had spent. From the qualitative study it is found that huge percentage of population go for private treatment even if simple illness and pay a huge amount.

Economic factors can be seen in terms of culture of poverty. Public health problems are related to poverty. Basically ability to pay that symbolize poverty that stand as barrier to afford adequate health care. Always economic factors alone do not influence access there are other factors have been discussed. Cost of health care and per capital cost.

Physical Aspects

Physical factors have been addressed by many scholar that influence access to health care services. Physical factors and

institutional factors have been observed together in present studies. Here we consider availability of drugs behaviour of staff, availability of doctor/staff, distance of hospital, long waiting hours, health infrastructure. Many studies observed that availability of drugs and its consumption that 75% urban and rural poor yet to get access to drugs. This huge part of the population belongs to low income group who cannot afford adequately in the time of need. Misuse of drugs by medical professional which victimized poor and gives drive to private market to flourish. It was reported that medicinal supplied to the hospitals are sold out by the staff to the medicine shop that create non availability of medicine. Only medicines they get from this institutions are basically for cough, fever, headache, dysentery etc. rest of the medicine required for treatment need to purchase from outside. Misuse of drugs and chances of medical shopping at their place plays pivot role to form consumerism behaviour among the patient. In this study through qualitative study it is found that medicines sometimes do not work effectively that leads to consult qualified physician. Among 100 respondent 30% reported visit to hospital another 30% never visit to hospital and other 40% has no adequate answers. 97% of respondent reported the distance of nearest hospital within three to five km, 2% reported distance of hospital less than 2 km., 6-8 another 6% reported respectively. Here in the case of Jahangirpuri resettlement colony the distance does not make differences; here the other factors like availability of doctor and time spend on queue for meeting doctor and treatment matters. 92% reported that to meet doctor they have to stand on queues almost 3-5 hours, 6% reported 6-8 hours. Time has been considered by majority that demotivates patient to go for public hospital. (See table No.11) even if a patient is in position to go for work in spite of illness, they do

not like to spend long hours on waiting line if they stand on line they have to loose their income for that particular day.

TABLE NO. 13

TIME SPENT FOR PUBLIC HOSPITAL BY HOUSEHOLD RESPONDENT

Time spent (in hours)	Number of Respondent N-100
Less than 2	2
3-5	92
6-8	6

Besides the distance, there is another issue related to access to health services. As mentioned earlier that many resettlement dweller do not prefer to visit Public hospital or health care due to very nature of long waiting hours in getting appointment with physician or doctor. This causes loss of wages for that particular day. It is observed in the present study that 92% of the respondent reported that they have to spend 3 – 5 hours for hospital that transportation and waiting hours. 6% reported that they have to spend 6- 8 hours and very ignorable 2% reported that they spend less than 2 hours for hospital. Hence the majority of the respondent spend 3-5 hours for hospital that de motivates them from visiting public hospital.

TABLE NO. 14

UTILISATION OF HEALTH INSTITUTION FOR TREATMENT BY RESPONDENT

HEALTH INSTITUTION	NUMBER OF RESPONDENTS N = 45	PERCENTAGE (%)
Public Hospital	18	40
Private Hospital	15	33
Both Public and Private	10	22.22
No information	2	4.44

PRIORITY FOR HEALTH CARE INSTITUTION

TABLE NO. 15

PRIORITY FOR HEALTH CARE INSTITUTION

Health Institution	Number of Respondents N = 100
Public Hospital	59
Private Hospital	35
Trust Hospital	1
No information	5

Priority for health care institution for treatment is apparently observed in many studies that people like to visit private health care institution than public hospital. But this may not be true for always. The present study shows the differences of priority of their treatment and health care institution in Jahangirpuri resettlement colony. Differences in priorities is not same for all strata of population though they visit to private health care. The upper stratum who can afford enough cost of treatment they prefer to visit private health care. On the other hand the poor and lower stratum of income the large segment of the poor resettlement colony prefer to visit public health care institution. From this study it is found that 59% of the respondent prefer to take treatment from public hospital, 35% respondent prefer to take treatment from private health care institutions responded adequately. Hence the majority of the respondent give priority to public hospital than private hospital. The reason behind this is very pertinent as earlier mentioned the cost of treatment. Of course for initial stage of diagnosis many of them go for private hospital but for prolong treatment they go for public hospital. (See table no. 13).

Reasons for Visiting Private Hospital:

There are many reasons for visiting private hospital. Private hospital considered to be efficient and effective in providing quality of care. It was reported that in private hospital people get immediate attention by the staff and doctor. Physician in private hospital check up their health problems properly. Private hospital is free from overcrowding hence they need not have to stand on waiting line for long hours. This is a crucial aspect for them as they can save their time and go for work. They can consult a physician and take proper diagnosis and treatment within limited time. They

are not misguided by the staff as it happened in public hospital. Availability of drugs within the premises also save their valuable time.

Maternal and Child Health Services

Among the sample interviewed 12 respondent reported birth taking place in their house hold. Place of birth are not allays same that varies. From table it is clear that home delivery is the major place of birth . home delivery is usually administrated by local traditional dais in the study blocks 41.6% delivery the highest number of delivery done by traditional dais. Very lowest around 16.6% delivery is administered by trained birth attendant (TBA). From the table it can be analyzed the availability of birth attendee and in maternal and child hospital in the locality. Involvement of dai is not just because of non-availability of dispensary or maternal health centre but to some extent non-availability of staff and doctors. Moreover in the time of need the dweller are not in a position to call ANM or trained personnel to administer delivery. The perception and general view of the resettlement dweller that even if they go for maternal health center they are not treated with human value.

Conditions of Maternal Child Health Services (MCH)

To cater maternal and child health services in urban health centers and dispensaries had been established. Unfortunately these services provided by government services are in-access to the people by very nature of service delivery, infrastructure and manpower. Not only curative health care is in-access but equally replicable into maternal health services .Non- availability of trained staff or absence of staff and inappropriate time schedule of visit of

physician have been influencing motivation among the people's initializing maternal health services.

STATUS OF CHILD BIRTH:

TABLE NO. 16

STATUS OF CHILD BIRTH

Status	No. of birth	Percentage %
Alive	11	91.6
Death	1	8.3

It is was observed in the study area in those particular block about status of childbirth where 91.6% birth was alive and 8.3% birth was dead among 12 births in the whole sample. It is obvious that infant mortality is quite a lower than Delhi average. But this data is not suggestive and do not represents as a whole block of the colony. There were 12 births among the 100 households sample. Out of which 91.6% alive and 8.3% child death during infancy.

SEX WISE DISTRIBUTION OF BIRTH:

TABLE NO. 17

SEX WISE BIRTH DISTRIBUTION

Sex	No. of Birth N = 12	Percentage %
Male	5	41.66
Female	7	58.33

Among 12 child birth of 100 samples female birth rate was observed higher than male birth. The majority of 58.33% female birth and 41.66% male birth were found. This is very much pertinent from the child rearing practices .Preferences for male child as heir of property and who will perform religious rituals of death of parents. Social practices of dowry during marriage is very much prevalent in the colony. All this results in ignorance and lower preferences towards female child and their health

Place of Delivery:

Out of 12 births 58.33% place of delivery was done at home, 8.33% at public Maternal health centre, 16.66% Nursing homes and 16.66% do not respond ad equality. Home delivery has been the highest which was seen in the colony. (See Table No.). Place of birth shows some influence the health care taken during infancy. Irresponsibility and ignorance in public maternal child health care centre stand as barrier in utilizing and availing the

services. Other way behavior of staff and non-availability of medicine discourage patient to visit this centre.

ADMINISTRATION OF DELIVERY

TABLE NO. 18

ADMINISTRATION OF DELIVERIES BY HEALTH PERSONNEL

Personnel	No. of Respondent N – 12	Percentage %
Dai	5	41.6
TBA	2	16.6
Mid-Wife	3	25.6
No information	2	16.6

Since time of delivery is in-appropriate with time schedule of the centre. Hence the population are compelled to do delivery at home taking help of Dai, Trained Birth Attender (TBA) and Midwife. 41.6% of delivery was administered by local dai, 16.6% delivery by TBA and 25% delivery by Midwife. 16.6% doesn't give any reply against this. When these personnel does home deliveries other healthy hygienic precautions are not taken at home. Dirty and un-hygienic hands of local dai who administered majority of deliveries causes health problems of the new born infants. The logic is very simple that these dais are easily and locally available in the moment of needs.

UTILIZATION OF MATERNAL AND CHILD HEALTH CENTERS:-

TABLE NO. 19

UTILIZATION OF MATERNITY SERVICES

Maternity Institutions	**No. of Pregnant Woman Responded**	**Percentage %**
Government Hospital	3	25.0
Private Nursing Home	2	16.6
Both Govt./ Private	1	8.3
No information	6	50.8

It was observed in the study that very few have been utilizing government maternal health services among the pregnant mother. Those 25% utilizing government maternal services, 16.6% utilizing private and nursing homes, 8.3% utilizes both government and private services and 50% has no response in this regard. Data shows that half of the women don't use any maternal health provider. Respondent who had not been utilizing any services do not have any information regarding maternal health care. Lack of awareness about women's health and facilities available in the

colony pervades non-utilization of these services. Level of utilization doesn't merely influenced by their willingness to use rather depends on knowledge of services available in the colony.

BASIC AMENITIES: Delivery and Access issue

Sanitation

Indian cities many of their postcolonial counterparts are beset by immense environmental problems at the end of the 20th century. As the urbanization process increasing these problems are accelerating. This is not just because of increase in urban settlement but the process of economic growth and social change and population growth in broadly. Urbanization process in India has been creating a mal distribution of resources and services among the rich and poor. Richer become rich and poor become poorer, Environmental problems such as air pollution and toxic wastes are occasionally addressed by governments when given publicity, the most profound of these environmental problems, the in sanitary living and working condition of large section of urban population are ignored - (Environment and Urbanisation and Bindewar Pathek). The most realistic problem of non-availability of service latrine to the large section of urban poor is not adequately addressed which is more fundamental for hygienic living and health. Next to Poverty the most depressing feature of India is its ability to ignore the surrounding filth and unhygienic conditions. Deprivation and in access due to replication of upper class domination culture dramatically results in poor coverage of sanitation in urban slums and resettlement colonies. One third of urban population does not have access to any type of latrines and one third is served by bucket latrine are hardly in sanitary. It is observed that incidence of shared latrine is extremely high at lower

level of consumption in slum and resettlement colony, around 56.62% shares with others. Poor sewerage coverage again inappropriate for flush system in urban slums. If we see flush system latrine in Delhi has declined 55.3% in 1988-89 to 49.2% in 1993 – (D.B.Ray).

TABLE NO. 20

UTILIZATION OF SANITATION FACILITIES

Category	**Number of Respondent N=100**
Public Latrine	71
Sulabh Souchalaya	8
Self constructed toilet	13
No particular place	4
No information	4

In the present study it has shown that sanitation problem in Jahangirpui resettlement colony does not differ from situation at-national level. The household among the sample size in the study area has significantly reveals the dire problem of sanitation. In Jahangirpuri resettlement colony people use three types of latrines facility are public latrine, private self-constructed and Sulabh Souchalaya broadly. Besides these people also go on defecation on open spaces near canal, which is grouped category

"no particular place". Among the 100 sample size 71% responded public latrine provided by municipalities, self constructed accounts 13%, Sulabh Chanchalay accounts 8%, 4% do not adopt any type of facility and 4% respondent did not response in this regard. It is clear from the data available that majority of the household utilize public latrine which is shared by other household.

There are one latrine complex comprising 10 latrines for every 50 household within their vicinity. Out of these more than half was without cleanliness and underserved due to sharing among the household. These unhygienic and dirty condition of latrines in the colony create inappropriate distribution hence leads to in access of latrine facility among the urban poor. Inaccess condition is doubled by ill maintenance and lack of repairing. This unfavorable condition of latrine in resettlement colony geared many to go for alternative facility such as Sulabh Souchalay and self constructed latrine but the last two types of facility is not easily affordable to everybody due to the purchasing capacity or their poor economic condition. While the type of latrine utilized by the household among the sample size, 81 % the majority use modern sanitary latrine without flush. Non-availability of adequate water supply or irregularity of water supply in the latrine create a problem of shading away of basins and bad smell tends individual away from using public latrines. These latrines are characterized by overflow and dilapidation. The majority of cases pits get chalked within short time due to lack of proper flush and shallow deep. Over pressure by the users and pressure of weathers often create unhygienic condition of latrines or public toilets in inaccess in terms maintenance and distribution among the household. This problem again mountained by the factor of education and awareness that form utilization behavior and perception regarding

safe and hygienic condition of public toilet. It has been observed that the colony comprises of labour class their poverty pervades the problem of illiteracy and lack of education do not create belongingness and healthy behaviour in utilization of public toilet. It is observed that quite a major part of the sample adopted self-constructed pit latrines within their household. For individual household purpose that accounts 13% which is quite significant.

TABLE NO. 21

TYPES OF TOILET USED BY RESPONDENTS

Type of Toilet	Number of Respondents
Modern without flush	81
Circular/Dug hole	3
No information	16

Modern sanitary latrine without flush. Non –availability of adequate water supply or irregularity of water supply in the latrine create a problem of shading away of basins and bad smell tends individual away from using public latrines. These latrines are characterized by overflow and dilapidation. The majority of cases pits get chalked within short time due to lack of proper flush and shallow deep. Over pressure by the users and pressure of weathers often create unhygienic condition of latrines in terms of maintenance and distribution among the household. This problem again accelerated by the factor of education and awareness that

form utilization behaviour and perception regarding safe and hygienic condition of public toilet. It has been observed that the colony comprises of labour class people their poverty pervades the problem of illiteracy and lack of education do not create belongingness and healthy behaviour in utilization of public toilet. It is observed that quite a major part of the sample adopted self constructed pit latrines within their household. For individual household purpose that accounts 13% which is quite significant.

Water Supply:

Urban poor are the whole gamut of inadequate supply of water supply. Household in slum and resettlement area has less access to safe drinking water supply. Here the issue is seen multi-factor that create access to water for urban poor in relation to the need of the population. Of course estimates of urban need are not easy to address. International norms tend to be too high to achieve at the level within foreseeable future. Whatever service exist their actual deliveries to the citizenry in both term quality and quantity are for less than the capacities in terms of machine and manpower. When private sector offer services these services are meant for the upper class the poor and lower and the lower class are not in position to avail it. Problem arises that services exist in poor settlement are not adequate but an actual delivery of these services are very pathetic. Under–repaired machine and inappropriately trained manpower is the issue to be considered for access. In many cases are not confined to one place it is replicated in other metros also. Leakages are widespread; water supply is wasted along with transmission line.

Household Utilization of Water Source

Supply of water is seen inadequate for drinking. Many reported that almost all the household have got private water supply connection in every plot. the only source they can use for drinking, cleaning and other use. No separate drinking water line is existing for the urban poor resettlement. Every plot owner constructed self water tap within their vicinity. It is observed that 52% of the respondent use private taps for single family, 28% by i.e. two household use same , 12% used by 3 household. More than 6% used by 4 families. Hence the household access is still lagging behind than Delhi average.

TABLE NO. 22

HOUSE HOLD UTILIZING SOME SOURCE OF WATER

No. of family	No. of respondent
One family	52
Two family	28
Three family	12
Above four	6
No information	2

Water requirement of Delhi prescribed by MPD –2001 based on a norm of 70 Gallon per capita per day, i.e. more then 50% than rural and JJ clusters. Water requirement for the growing population in rural and JJ cluster is calculated at lower norm of 30 Gallons per capita per day. This vast variation of normative needs

shows the disparity in association of water supply between poor and rich locality.

An average 75.72% have piped water supply but it does not express the number of family used the same water tap. In Janangirpuri resettlement colony almost 2/3rd of the respondent use self water tap. In this colony every plot got one or two rooms ahead the ground floor is on rent. So the rented family also use the same source of water. Hence the per capita consumption has been reduced duly to inappropriate population. This has got another side, i.e. family size 45% of the respondent have family size of six to eight member in their families. This again create problems in accessing water requirement. This has been doubled with low pressure of water inside the pipeline. Due to low pressure regularity of supply and quantity of flow of water from water tap are hampered. Out of 100 samples 53% reported regular supply of water, 5% reported irregular in supply and 42% sample did not have adequate reply regarding regularity of water supply. Inadequate supply of water for different purpose. (See table no. 20)

TABLE NO:- 23

REGULARITY OF SUPPLY OF WATER

Response	No. of respondent
Yes	53
No	5
No information	42

Source of Water supply:

Respondents living in the locality primarily depends on private water tap. Almost every household interviewed has got water connections for consumption of water. It is found that every private tap is utilized by many household living in rented house in the plot. there are other sources of water other than private tap are tube well, public stand post, water tap on the road side, water tanker, etc. for their use. But the problem is water supplied by MCD is very vulnerable which is not drinkable contaminated with drainage. It was reported that these pipelines usually carries mud and sand along with bad smell inappropriate to drink. There is no separate water supply for differential usage. They use the same source of water for drinking, washing clothes and utensils and bathing as well. Many of the public water tap have been existing as non-working condition. Water source getting from rube will is prohibited for drinking by Delhi Jal Board due to contaminated water in water level.

Cost of Water Supply:

It has been found that the household in the colony have their self water tap, hence the incidence of purchasing water from water tank is less pertinent owing to availability of water tap within their vicinity. Every household pays a minimum amount of water bill of 30/- a month for water supply. It was found that almost every household pay equal amount of money for the same, it varies when they pay late bill has to pay extra rupees 2/- as penalty. Still some of the responded replied some different amount that is not just pay the amount but the lack of information regarding out standing bill for 3 months together. This way household pay rupees 30/- for water charge to household responded rupees 96/- for three months. It is apparent that cost of civic water has been nominal, on the other hand quality of service is not satisfactory in the poor resettlement colony. Such a inhuman condition they have to sustain results in vulnerable condition of human resource or individual. This felt and faced water problem has been neglected by the government or any other institution. On the other side very nature of their income also restrict them from paying enough cost for satisfactory services. Government must not only consider it but there should be some practical intervention in this regard.

Housing

To own a house is the dream of every person that after remains elusive. Housing the poor in developing countries is one of the major challenges facing mankind in the last decades of twentieth century like India, Africa etc. The challenge is particularly in urban areas where population growth is faster along with urbanization. Housing is part and parcel of human living and that has significant affect on health of an individual, poor housing

condition in urban slum causes root of many public health problem of the inhabitants. Currently the major problem of housing for urban poor is their nature of employment in informal sector and their income. Due to poor income they cannot afford suitable houses for living. The major problem of this is the shortage of affordable accommodation for the urban poor, the low-income group. The urban poor is simply ignored for housing. Encouraged by the national and international agency which were stimulated by the United Nation General Assembly resolved to formulate global strategy for shelter to the year 2000 A.D. to encourage government to assist in meeting the needs of housing for all demand sector. Remarkable issue is that these resolution and programme formulated for could not address the need of the masses in urban areas were directly involved in production process. Government have been trying to settle and provide shelter to the urban poor through various programme and scheme like Sites and Service Scheme, Environmental Improvement of Slums (EIS), Slum Clearance policy etc. But these programme failed to meet the shelter requirement of the huge population.

Drainage Facility

As observed that almost every household has got pucca drainage connection in the locality, but its working condition is really remarkable. In front of every household on the rows has small drain that connect with further outlet. This drainage are not covered, mix with filth and water. This drain characterized with shallow deep, overflow and water logging. Due to shallow deep water flows outside the drains ,cause to spreading bad smells in front of the habitants and create conductive environment for communicable diseases to spread such as cholera, malaria, plague

etc. Prime outlet on roadside have been seen non working filled with polythene bags, waste disposals etc, that doubles the pathetic and deplorable conditions of drains. Among the samples 88% responded having drainage connection and 4% did not have drainage connection and 8% did not have any information regarding this.

CASE STUDY

Case No. 1

"Premvati (female) aged 45 years migrated from Meerut in Utter Pradesh. She got 5 daughters and 3 sons. The household of Premvati belongs to lower social strata of SC community. Her husband was a worker in factory since factory is closed and shifted Himachal Pradesh the family fails to earn regular income to run their livelihood. The family of Premvati has been living for 20 years in Gurmandi and after 1976 has been living in Jahangirpuri. The factor behind their migration to city was low yield of agriculture and unemployment. Premvati was brought along with her husband after two years of her marriage. She has been suffering from Gallbladder for last 3 years. She was suggested by her neighbour to assist to Babu Jag Jewan Ram hospital in the colony. Accordingly, she had been taking treatment from Babu Jag Jevan Ram (BJJR) hospital for two years then she was referred to Hindu Rao for operation more then one month. She used to get medicine from BJJR free of cost. She paid 800/- for blood; she has to get X-Ray outside from hospital. For injection she paid @15/- Rs. x 2 = 30/- Rs. for eleven days of her operation done. She spend 600/Rs. For transportation she doesn't get medicine regulatory, overcrowded made her to stand on ques where four lines per quo for around 2 hours and whole including diagnosis and treatment took five hours. Behaviour is not good of the staff, medicine provided by BJJR preferred by people these Hindu Rao. The hospital hardly ensure the facility of water supply and cleanliness of toilet.

Case No. 2

Mr. Chotelal aged 40 years, whose monthly income ranges from 2500-3000/- a month, its depends on his terms of business. Sometimes he could not meet adequate income due to fluctuation in his business. He had migrated from Buland Shahar in U.P. He got five children including 4 male and one female child. He was earlier living in Yamuna Pusta and in 1976 he started living in Jahangir Puri colony. He got two rooms in his plot. He is a semi literate individual he can just manage to read and write. The family do not have adequate basic amenities. He used to send his two children to MCD school Mr. Chotelal has been suffering form gastric and stomach pain for a quite longer period. He had visited at first Public hospital. Whenever gastric problem arises in the due time he used to go to health centre. This problem continued for 3 or 4 days that create a problem of earning livelihood and obtaining medical care. Due to unsatisfactory treatment he sited Hindu Rao to undergo treatment. It has got super speciality infrastructure in Hindu Rao. During his treatment he had to spend money due to availability of medicines and cost of transportation. He viewed that health centre and hospitals (Govt.) are always overcrowded and longer waiting hours. Doctor never treat properly diagnosis reported not effective. So he prefer sometimes, prefers private hospital, for minor illness. He believed that private hospital is caters quality of care. He was dissatisfied with public hospital. His family members also visit private hospital and clinic nearby the colony for treatment. As consultancy to doctor to be paid at 50/= to 80/- Rs. This again create problem for him to go all the time for private hospital.

Case – 3

Mr. Yakub aged 26 years educated upto second standard lives in the colony since 1992. He had migrated to Delhi from West Bengal due to unemployment and low agriculture production. He had came to Delhi with his parents. He got in total three children (3 female) along with his wife. Tailoring is his prime occupation to earn subsistence for livelihood. He gets fifty rupees a day and work for six days a week. He was owned one plot in the colony. He had to invest 80,000/- rupees for that plot can price of that plot. Before purchasing it, first two years living in the colony he took a room on rent room after his marriage.

For last 2 years he has been suffering from gastric severely. It was reported for long he felt stomach pain and feeling of burning. He has been postponing the days for visiting a doctor. He used to go for RMP's sometimes but the care is not sufficient and appropriate. He added that not only the but other family members also have been suffering from same problem. It was added that reason behind postponing his visit to doctor was the lack of time due to long waiting hours. Visiting a pubic hospital is a lose of wages. Moreover the way the procrastinate diagnosis and treatment. He was always refused to muscle shop to purchase medicine and to visit private hospital renew Dr. Khanna's Nursing home at Adorshangor. Doctor said that he has been suffering from Gastric and Stomach prior due to drinking water. Treatment after that he consulted with other private hospital Kingshway camp. For a minor illness also they visit to private doctor within their reach.

He viewed that public hospitals and dispensaries in the colony do not provide adequate services and quantify of care is very

low. Grievances against public hospital is long waiting hours, lack of medicine poor diagnosis etc. So he is not if favour of public hospital, rather have been utilizing private hospital. He complained that if doctor do not touch the patient and check up properly what is the need of visiting public hospital and private hospital he has to pay 80/- Rupees or charge of checkup and 100/- Rs for diagnosis Khanna's nursing home in addition to medicines. When he visited private clinic he has to spend 250/- including all consultancy, diagnosis and medicine.

Due to the higher cost of treatment he does not have financial strength to go for private hospital still he prefer to go for private hospital.

He said, he does not suffer from illness because they does not give much attention to health. If he does that he has to suffer lose of income.

Case-4:

Mr. Omprakash Aged 55 years old living with his family in his own house since 1976. He had migrated from Lahore in Pakistan. Earlier he used to work in factory as a worker. Since dislocation of polluting factory unit in the residential area where he is staying without any regular work for earning household income. He got four female and two males. He has to work in factory which is very dusty without any ventilation. To own a house he had to pay Rs. 2000/- as come though SBI. He has been suffering from work, TB and swelling of legs for last 2 years. He was not in a position to go for treatment of TB. He has been taking treatment from BJJR (Balan Jagyuva Ram) hospital for 1½ months. Medicine sometimes was irregular in collecting treatment regime due to his economic condition. Date of visiting hospital could not be followed by him as he had to go for work. He reported that a time schedule of public hospital is a problematic for him. He preferred BJJR hospital as he didn't have regular income source. For swelling of his legs he visited different hospital for 3 times spending around 1500/- Rupees for 34 days of required treatment including other public and private hospital. He has also been suffering from eye problem due to lack of vision. For this he has undergone treatment in Hindu Rao hospital. He was referred from BJJR to Hindu Rao hospital for test and treatment. According to him, he has to purchase medicine whichever not available in the drugs centre. After taking every treatment from different hospitals he was not satisfied the way they have to go through various obstacles since need for care. He viewed that public hospitals do not provide services as per his expiration. He had to stand on long waiting hours due to non-availability of medicines and distance of hospital which cater specialized medical care. They are not treated well by the staff. Still he prefers public hospital as he did not have financial ability to pay for".

Case-5:

Mr. Ziaul Mulcher aged 35 years have been staffing is the colony since 1976 taking a room on rent at 800/- Rs a month. prior coming to the colony he has been living at Yamuna Pusta. He had migrated to Delhi. He earns Rs. 2000/- a month livelihood for the family. He got 3 children out of which one child passed away after 2 months of delivery. His wife Mrs. Roshan aged 30 yrs. has been suffering from bone fracture on midrib for last 3 years. She has been taken to many hospital both public and private spending around one and half lakh of rupees for treatment. The condition of Mrs. Roshan is Very pathetic, she could not move properly. Till date he was taken to 4 hospital but in vain among these private hospital, Babu Jagjeevan Ram, Hindu Rao and Lok Nayak Narain Jai Prakash hospital, in spite of undergoing treatment in so many hospital she could not get recovered. She had been taking treatment in LNJP for 8 months. She used to get medicine from here and sometimes had to purchase from outside. For transportation she paid 150/- Rs per visit to LNJP at Delhi gate which is at far distance from Jahangir Puri. When treatment could not give effective cure she was taken to private hospital and taken treatment for 3 months. For this she had to spent 48/- Rs per day for 3 months for medicine and auto fare and public hospital she had to get X-ray and blood test, she got it done from outside. She complains that doctor in public hospital did not see her problem. Properly checkup is not satisfactory for her. Other subordinate staff procrastinates due to over crowding she was called after a week for blood test and X-ray, she complained that to get treatment in public hospital one must have proximity with staff or somebody known to patient. Sometimes she had to pay bribe to the staff to initiate the process of diagnosis and treatment. She usually had to

wait for 3-5 hours per visit to public hospital. She viewed that she is not satisfied with public hospital but no other option to go for private hospital due to lack of money.

CHAPTER - 4

CONCLUSION AND DISCUSSION

This chapter is aimed at bring together some of the important aspect derived from the study. This would help us to summarize the whole study on comprehensive manner. Some of the important aspect are-(1) major observation emerging from the description and analysis presented in the proceeding chapter (2) question and issued that derives as useful needed for further present mainly in the context of large section of urban poor and some aspects related to policy and programmes for the poor and poor urban colonies in the context of accessibility and urban health.

Jahangir resettlement colony established in 1976 to rehabilitate the Juggi dwellers and migrants from Punjab individual household plots had been allotted to Juggi dwellers in this colony. With the passage of time original allottee had sold out their plots due to their impoverished socio economic condition some of them gave their plot on rent. This colony was developed in the resign of Indira Gandhi primarily to rehabilitates victims of military problem in Punjab. In study blocks 'C' and 'G' majority people migrated from Utter Pradesh in addition to West Bengal, Bihar, Delhi and Haryana and Punjab. Whole Jahangirpuri had been divided primarily in 13 blocks as A,B,C,D,E,F,G,H,I,J,K, K2 almost jhuggi jhoppadi aside every blocks. Distribution of Jhuggis from the road side there are hardly Jhuggis in the colony, very few jhuggis are there which situated inside the colony.

The present study seeks to assess the accessibility to health services in private and public hospital so it limits to basically Public and Private health Care provider. Urban poor has low or no access to health services that symbolizes by the health of people in the colony.

Access' issues for health care and basic amenities in resettlement colony some of aspects such as economic, socio-cultural and behavioral aspects. Economic aspects' there are many factors such as economic strength, nature of occupation, family income and household expenditure per capita etc. It was observed that the lower classes tend to continue in-access to the health services and other basic amenities provided for 400/- among the household sample responded utilization of public hospital. Hence the majority of the respondent utilized public health care provider such as Jugjeeven Ram Hospital, Ram Manohar Lohia, Rajan Babu, Hiradu Rao, Kalwati Hospital and dispensaries run by Directorate Health Service. People in poor colonies still prefer to utilize public health care institution. 33% of the respondent use private health care institution. The figure should not be Ignored. This does not imply that they have to walk a long distance rather the very nature of the delivery of services and other administrative procedure of the hospital create problem of ocean. To receive desired service delivery along with satisfaction and other reason such as time consumed for to treatment also determine many to use private health provider. Cost recurred for treatment is most crucial reason for not visiting private hospital among majority of the respondent Due to nature of occupation and informal 'nature of work they cannot take of leave for treatment. He or she has to loose wages for that particular day of visiting public hospital. Majority reported that majority of the spend three to five hours for visiting

public hospital. Long waiting hours and long ques demotivates many of the respondent to visit public hospital. They feel that if they visit public hospital they have to loose wages. The more crucial is procrastinating of date of appointment and treatments.

Distance as a physical factor does not have influence in accessing health care services from public hospital in urban areas. As people of the locality visits Babu Jag Jeevan Ram Hospital for treatment which is situated at a distance of two kilometer. Majority i.e. 97% of the respondent replied that they have to walk down two kilometer for nearest public hospital. Besides this other public and private health care provider also there around the colony. To a majority people visit to government dispensaries located in the colony. People around 35% utilize private health care provider. The reason behind their low preference of private health care provider is economic or their purchasing power or lack of capacity to pay for services. Cost of treatment and diagnosis of private health care provider does not suits their socio- economic condition that compels them to go for public hospital though they have indifferent attitudes towards public hospitals.

Who were residing in sub human shanties and temporary shelter in various parts of Delhi. To shelter to these population 16 plotted housing aspects were developed. The plot size ranges from 21 to 40 square yards. Some of these got made one room, tone tenements also, the plots initially allotted for original allottee ad been sold but to relatively higher income group population due to various socio-economic reason such as marriage, disease, poverty, distance of work place etc. the aim to provide shelter for the poor not been achieved and it tends to become investment opportunity for relating higher income group.

It is observed from table no. that among the MCH. Services institution the majority 25% availed material health services from Government Hospital, other 16.6% from Private practitioner and nursing home and 8.3% goes for both private and public maternal health center. The rest 50% among the mothers who were pregnant did not give adequate responsed in this regard (see table no.). Availability of maternal health services have been providing by dispensary and maternal services is not adequately utilized due to non-availability of staff in the time of need . it is reported that non-availability of medicine and subhuman treatment in this center discouraged them from utilizing maternal health services. So they prefer to go for private hospital or nursing home for maternal health care. It is observed that for delivery they have to spend a huge amount of money for home delivery. The cost of delivery also varies according to the birth of male and child. If a mother gives birth to a male child the charges for birth attendee is higher than female child. Among the 12 birth, 41.6% spent Rs. 1000, 16.6% spent Rs. 1001-2000 and 25% spent more than Rs. 2001 for delivery. 16.6% have no information in this regard. Majority of the delivery spent up to Rs. 1000 (see table no.) Hence it is pertinent about the preference of male child and their value than female child and discrimination in child bearing in Indian Society.

Emerging Issues:

It would be meaningful to identify some of the major issues and questions arises out from the study. This would help us identifying issues related to resettlement and slum dwellers in other urban areas and help us to understand phenomenon and related aspects on more comprehensive fashion.

The most pertinent issues related to slum dwellers is legal identification and authorization of slum. Due to illegal occupation of public land the quite a large number of the slum had been authorized but still they are not provided with basic amenities. So this needs not to be ignored as they directly involve in the process of production in urban economy.

Issue of identification of slum, squatter settlement, unauthorized colony, which have been considered as same entity. This should not be seen as same rather to be dealt with differently. While talking to slum the government agency should emphasis separately.

Resettlement colonies by very nature constructed in such a way, which does not, suits for human living. Primarily the characteristics of the houses. Point to be noted while formulating policy on the structure of the plots which is indispensable to be considered. Pressure of over population on the public latrine and on other basic amenities has results in ill maintenance and dilapidation and under-repairement, and basic amenities have been used by more than it was planned for.

Existence of private and public health care services and their accessibility and utilization by the people in the slum and resettlement colony has been crucial issues to be reckoned. Factor such as economic, physical and institutional and behavioral aspects need to be considered which influence access and utility of health care services. Emergence of private health care is a result of inefficiency and non-availability of public health care services. Thus physical existence does not mean that there is access to health.

Moreover behavior of the patient has been developed such a way that they always believe and consider private hospital caters quality of care. The poor in this colony perceive health and illness untill and unless fall on bed and need bed rest they do not consider to go for treatment.

Lack of coordination among the various agency involving health care provision resulted in duplicacy and overlapping of services and possibility of medical shopping in private hospital has been the issues cause to in-access to certain group of population.

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APPENDIX

HINDI AND ENGLISH VERSION OF QUESTIONNAIRE

MAP OF JAHANGIRPURI RESETTLEMENT COLONY

QUESTIONNAIRE

1. Name of the main household:
   a. Occupation
   b. Family income
   c. Address
   d. Sex: Female/Male

2. Family Status

						Occupation			
Sl.No.	Name	Relationship with main household	Sex M/F	Age	Education of children are going to school	Prime	Additional	Income	Distance of work place

3. Do the every body staying in the house belongs to same caste Yes/No

4. Which state you belong to
   a. Rajasthan
   b. Andhra Pradesh
   c. Gujarat
   d. Madhya Pradesh
   e. Bihar
   f. Uttar Pradesh
   g. West Bengal
   h. Others, please mention

5. Religion of the family: Hindu/Muslim/Others

6. How long you have been staying in this city?
   a. Less than 2 years
   b. 3-5 years
   c. 6-8 years
   d. 9-11 years
   e. More than 12 years

7. Reason for migration
   a. Problem of unemployment
   b. Low agriculture yield
   c. Natural disaster
   d. Militancy problem
   e. Gathering property

f. Attracted by other sources of income
g. Marrige

8. Had any body been suffering from illness in last one year? Y/N

(a) If Yes

Name	Name of disease	Place of treatment	Duration of disease	Money spent on treatment	Test	Others	Remarks
							• Dissatificed treatment • more costly • time Consuming

(b) Is there any reason for not taking treatment in your family.

(i) Lack of money
(ii) No one in the family to look after
(iii) No one advised
(iv) Long distance

9. Was there any death in the family in last one year? Yes/No

Name of the person	Sex	Date of birth (Month)	Age	Reasons for death	Was there any death certificate (Yes/No)

10. Was there any birth in the family in last one year? Yes/No

If Yes

1	2	3	4	5	6	7
Name of the child	Month of birth	Is alive	Where delivery took place	Was she trained Birth Attendant	Cost of delivery	Place of availability of maternal and child health services

Code: General Hospital

(a) Public hospital
(b) Private hospital
(c) Maternal and child health centre
(d) Trust hospital
(e) Registered Medical practitioner

11. Where did you get necessary medicine from?
    (a) Public Hospital
    (b) Private Hospital
    (c) Medical Store
    (d) Registered Medical practitioner Doctor

12. Did anybody visited hospital in last one year, if yes for what purpose?
    (a) Immunization
    (b) Material Service
    (c) Contraceptive counseling
    (d) AIDS awareness
    (e) Women related disease
    (f) Health education

13. How long distance of hospital from your residence?
    (a) Less than 2 Km
    (b) 3-5 km
    (c) 6-8 km
    (d) 9-11 km
    (e) More than 12

14. Do you know what are the health facilities available in your community?
    Yes/No

15. Where do you give priority for treatment?
    (a) Public hospital
    (b) Private hospital
    (c) Trust hospital
    (d) Registered Medical Practitioner

16. What are the reasons for not visiting public hospital?
    (a) Long distance
    (b) Loss of wages
    (c) Non availability of doctor
    (d) Behaviour of the staff
    (e) Long queue
    (f) Non availability of medicine

17. How long hours do you spent for hospital?
    (a) Less then 2 hrs
    (b) 3-5 hrs
    (c) 6-8 hrs
    (d) 9-12 hrs
    (e) More than 12 hrs

18. Did any health personnel visited your family in last one year, if yes for what purpose?
    (a) Immunization
    (b) Maternal service
    (c) Contraceptive counseling
    (d) AIDS awareness
    (e) Women related disease

19. How do you view about public hospital?
    (a) Satisfied
    (b) Dissatisfied
    (c) Irresponsibility

20. Do you have own house?
    Yes/No

21. How many rooms are there in your house?
    (a) One Room
    (b) Two Room
    (c) Three Room
    (d) More than 4

22. To own a house how much money had you spent on?
    (a) Less than 5,000
    (b) 5,000 to 10,000
    (c) 10,000 to 15,000
    (d) 15,000 to 20,000
    (e) More than 20,000

23. Where do you get drinking water?
    (a) Private water tap
    (b) Private tap for several families
    (c) Public water tap
    (d) Water tap
    (e) Water pipe line on the roadside
    (f) MCD tankers

24. How much money do you spend for water

Uses	*MCD Tanker*	*Private Tap*	*MCD facilities (Rupees)*	*Rematks*
Bathing				*Irregular*
Washing Utensils				*Long queue*
Washing clothes				

25. Utilization of source of water for different purse

Uses	Drinking water	Public tap	Public place	Canal	MCD tanker
Bathing					
Washing Utensils					
Washing clothes					

26. Does all the facility available regularly? Yes/No

27. How many families use the same source of water?
    (a) One family
    (b) Two family
    (c) Three family
    (d) Four family
    (e) Five family
    (f) More than 5 family

28. Where do you go for toilet?
    (a) Public toilet
    (b) Road side
    (c) Open space
    (d) Near canal
    (e) Sulab sauchalay

29. What kind of toilet facilities do you have?
    (a) Modern with flush
    (b) Modern without flush
    (c) Dug hole
    (d) Round
    (e) Rectangular

30. How much money do you spend for toilet?
    (a) Rs. 0 to 5 per day/per month
    (b) Rs. 6 to 10 per day/per month
    (c) Rs. 11 to 15 per day/per month
    (d) Rs. 16 o 20 per day/per month
    (e) More than Rs. 21

31. Do you have bathing facilities in your house? Yes/No

32. What kind of place usually do your family use for bathing?
    (a) Public place
    (b) Well
    (c) Paying money
    (d) Hand pump
    (e) Canal or rivers
    (f) Others

33. Do you have any drainage facilities? Yes/No

प्रपत्र

1. परिवार के मुखिया का नाम :–
(क) व्यवसाय :
(ख) पारिवारिक आय :
(ग) पूरा पता :
(घ) लिंग : महिला / पुरूष

2. पारिवारिक स्थिति :–

क्र.स	नाम	मुखिया से संबंध	लिंग म/पु	आयु	शिक्षा (यदि बच्चे पढ़ रहे हैं)	व्यवसाय मुख्य	व्यवसाय अतिरिक्त	आय प्रतिदिन/ मासिक	कार्य के स्थान की दुरी

3. क्या सभी लोग जो घर में रहते हैं, एक ही जाति से संबंधित हैं ? हॉ / नहीं

4. आप किस राज्य से संबंधित हैं –
(क) राजस्थान
(ख) आंध्र प्रदेश
(ग) गुजरात
(घ) मध्य प्रदेश
(ड) विहार
(च) उत्तर प्रदेश
(छ) पश्चिम बंगाल

5. परिवार का धर्म : हिन्दु / मुसलिम / अन्य।

6. आप कबसे इस शहर में रह रहे हैं ?
(क) 2 वर्ष से कम
(ख) 3–5 वर्ष
(ग) 6–8 वर्ष
(घ) 9–11 वर्ष
(ड) 12 से अधिक

7. विस्थापित होने के कारण क्या हैं :–
(क) बेरोजगारी की समस्या,
(ख) निम्न कृषि उत्पादन,
(ग) प्राकृतिक आपदा,
(घ) उग्रवाद की समस्या,
(ड) धन इक्टठा कर लेना,

(च) अन्य आय [redacted] से आकर्षण,
(छ) विवाह होने का कारण।

8. पिछले एक वर्ष में परिवार में कोई बिमार रहा है क्या ? हाँ / ना

(क) अगर हाँ तो :–

नाम	बिमारी का नाम	इलाज कराने का स्थान	कितने दिन से वह बिमार था	कितना खर्च हुआ दवाई	जांच	अन्य	Remarks
							• शुश्रुत्ता सनलुस्त • महंगाई ज्यादा • समय ज्याद लगा

(ख) आपके परिवार में किसी–भी व्यक्ति का इलाज नहीं करने का कारण क्या है :
(i) धन का अभाव,
(ii) परिवार में देखभाल करनेवाले की अनुपस्थिति,
(iii) किसी ने सलाह नहीं दी,
(iv) दुरी अधिक थी,
(v) पर्ची / रसीद गुम हो गई थी,

9. पिछले एक वर्ष में परिवार में किसी व्यक्ति की मृत्यु हुई है ? हाँ / ना

व्यक्ति का नाम	~~लिंग~~	कब मृत्यु हुआ (महीना)	उम्र	मृत्यु का कारण	क्या मृत्यु का पंजीकरण हुआ (हाँ / नहीं)

10. क्या परिवार में पिछले एल साल में किसी बच्चे का जन्म हुआ ? हाँ / ना
अगर हाँ तो :–

1	2	3	4	5	6	7
बच्चे का नाम	जन्म का महीना	क्या जीवित है	बच्चे का जन्म कहां हुआ	क्या वह प्रशिक्षित जन्म परिचारिका थी -- हाँ / ना	जनन का खर्चा	मातृ एंव शिशु की स्वास्थ्य सुविधा कहा से मिलता था

CODE (क) सरकारी अस्पताल

(ग) 6–8 घंटे
(घ) 9–12 घंटे
(ड) 12 से अधिक

18. क्या आपके घर में कोई स्वास्थ्य कर्मचारी एक वर्ष में आया था ? तो किस उद्देश्य से :–
(क) टीकाकरण,
(ख) मातृसेवा,
(ग) गर्भनिरोधक परामर्श,
(घ) एडस् जागरुकता,
(ड) महिलाओं की बिमारी।

19. आप का सरकारी अस्पाताल की सेवा से क्या विचार है ?
(क) असंतुष्ट / संतुष्ट,
(ख) बिमारियों को सही से नहीं पहचानते,
(ग) उत्तदायीत्व नहीं है,
(घ) मरीज के प्रति असावधानी बरतना।

20. क्या आपका अपना मकान है ? हाँ / नहीं

21. आपके मकान में कितने कमरे हैं ?
(क) एक कमरा,
(ख) 2 कमरे,
(ग) 3 कमरे,
(घ) 4 से अधिक

22. घर प्राप्त करने के लिए आपको कितने रूप्ये खर्च करने पड़े ?
(क) 5000 से कम
(ख) 5000 से 10,000
(ग) 10,000 से 15,000
(घ) 15,000 से 20,000
(ड) 20,000 से अधिक

23. आप पीने का पानी कहां से लाते हैं ?
(क) निजी नल से,
(ख) कई परिवारों के लिए एक निजी नल से,
(ग) सार्वजनिक नल से,
(घ) नल–कुप से,
(ड) रास्ते के पास से जाते हुए पानी के पाइप से,
(च) पड़ोसियों के अहाते से,
(छ) नगरनिगम के टैकर से।

24. पानी के लिए आप कितने पैसे खर्च करते हैं ?

इस्तेमाल	नगरनिगम टैंकर (रुपेय में कर)	निजी नल लगने में	नगरनिगम सुविधाये (Rs.)	(Remarks)
स्नान / नहाने के लिये				• समय पे नही मिलता
बर्तन धोने के लिये				• लम्बी कतारें
कपडे धोने के लिये				

(ख) निजी चिकित्सालय
(ग) मातृ–शिशु स्वास्थ्य सेवा केन्द्र
(घ) द्रष्ट–अस्पताल
(ङ) आर.एम.पी.

11. आप की आवश्यक दवांए कहां से मिलती थीं :–
(क) सरकारी अस्पाताल से
(ख) निजी चिकित्सालय
(ग) दवाखाना
(घ) आर.एम.पी.

12. क्या कोई व्यक्ति एक वर्ष में अस्पताल गये थे ? हाँ / ना
यदि गये थे तो किस उद्देश्य से –
(क) टीकाकरण
(ख) मातृसेवा
(ग) गर्भनिरोधक परामर्श
(घ) एडस् जागरूकता
(ङ) महिलाओं की बिमारी
(च) स्वास्थ्य शिक्षा

13. आपके घर से अस्पाताल की दुरी कितनी है :–
(क) 2 कि.मि. से कम
(ख) 3–5 कि.मि.
(ग) 6–8 कि.मि.
(घ) 9–11 कि.मि.
(ङ) 12 से अधिक

14. क्या आप जानते हैं, स्वास्थ्य की क्या सुविधांए आप के समुदाय के लिए उपलब्ध हैं ?
हाँ / नहीं

15. आप बीमार का इलाज कराने कहाँ जाने की प्राथमिकता देते हैं ?
(क) सरकारी अस्पाताल
(ख) निजी चिकित्स्यालय
(ग) द्रष्ट अस्पाताल
(घ) आर.एम.पी.

16. सरकारी अस्पताल न जाने का क्या कारण है ?
(क) अधिक दुरी
(ख) श्रम का नुकसान
(ग) डाक्टरों की अनुपस्थिति
(घ) कर्मचारियों का व्यवहार
(ङ) लम्बी कतारें
(च) दवा नहीं मिलता

17. आप अस्पाताल के लिये कितना समय व्यय करते हैं ?
(क) 2 घंटे से कम
(ख) 3–5 घंटे

25. पानी स्रोत का इस्तेमाल किस प्रकार के कार्य के लिए करते हैं ?

इस्तेमाल	पीने वाले पानी से	सार्वजनिक नल से	सार्वजनिक जगह से	नहर से	नगर निगम टैंकर
स्नान / नहाने के लिये					
बर्तन धोने के लिये					
कपडे धोने के लिये					

26. क्या उपर्युक्त सभी सुविधायें नियमित उपलब्ध होती हैं ? हाँ / नही

27. एक ही स्रोत को कितने परिवार इस्तेमाल करते हैं ?
(क) 1 परिवार,
(ख) 2 परिवार,
(ग) 3 परिवार,
(घ) 4 परिवार,
(ङ) 5 परिवार,
(च) 5 से ज्यादा।

28. शौच के लिये आप कहां जाते हैं ?
(क) सार्वजनिक शौचालय,
(ख) सड़क के किनारे,
(ग) खुली जगह पर,
(घ) नहर के किनारे,
(ङ) सुलभ शौचालय में (पैसे देकर)।

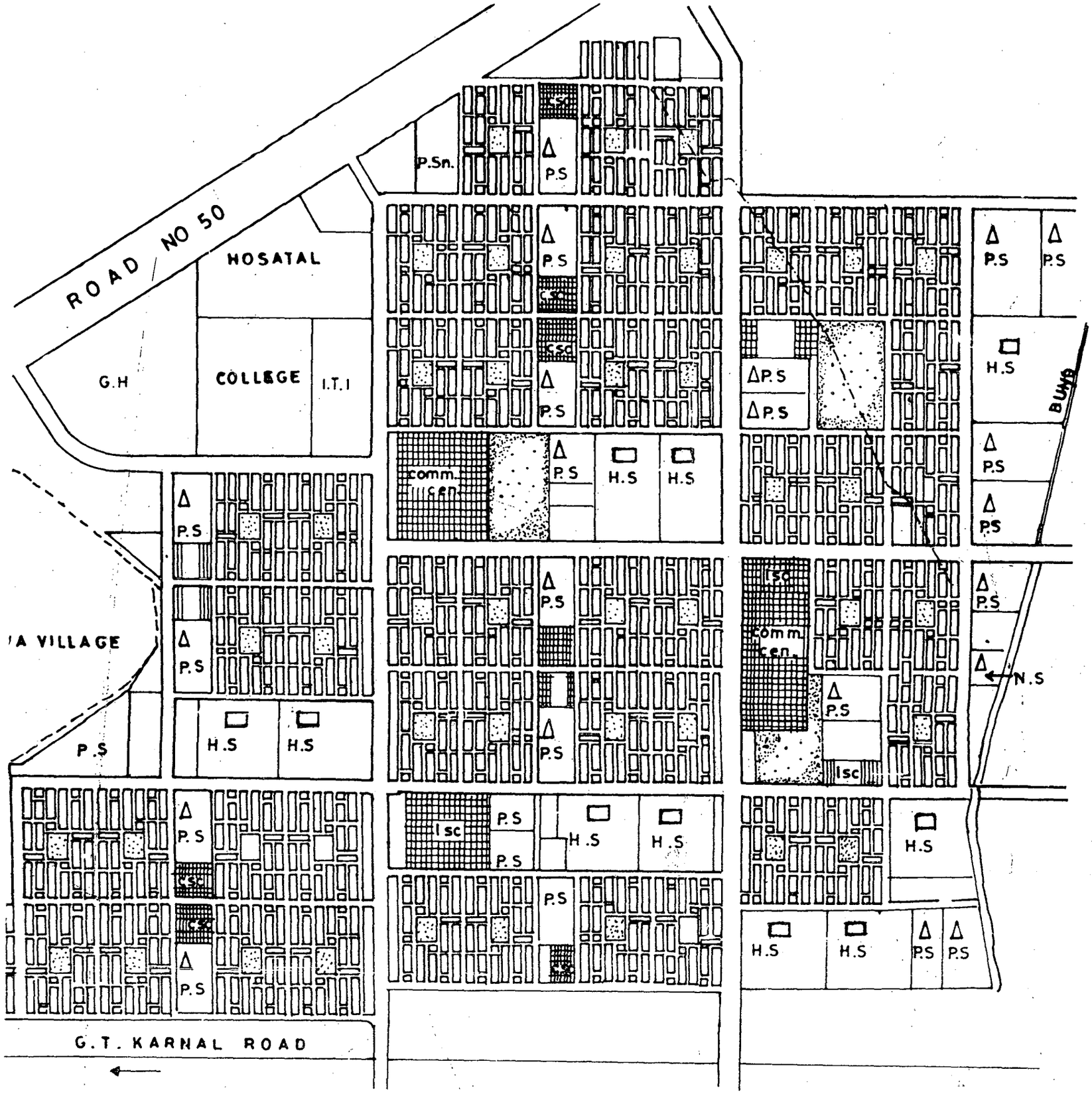
29. किस प्रकार के शौचालय की सुविधा आपके पास है ?
(क) आधुनिक बहाव वाला,
(ख) आधुनिक शैचालय (बिन बहाव),
(ग) गढ्ढे में,
(घ) गोलाकृति,
(ङ) आयताकार।

30. शौच के लिए आप कितना खर्च करते हैं ?
(क) 0 से 5 रू. प्रतिदिन / प्रतिमाह,
(ख) 6 से 10 रू. प्रतिदिन / प्रतिमाह,
(ग) 11 से 15 रू. प्रतिदिन / प्रतिमाह,
(घ) 16 से 20 रू. प्रतिदिन / प्रतिमाह,
(ङ) 21 रू. से अधिक।

31. क्या आपके घर में नहाने की सुविधायें हैं ? हाँ / नहीं

32. आपके परिवार वाले नहाने के लिये आमतौर पर किस प्रकार की जगहों का ईस्तेमाल करते हैं ?
(क) सावजनिक स्थान,
(ख) कुंआ,
(ग) पैसे खर्च करके,
(घ) चापा कल,
(ङ) नहर या नदी में,
(च) अन्य।

33. क्या आपके यहां नालियों की सुविधायें हैं ? हाँ / नहीं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HOSATAL
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