Discussion

On the basis of the study of the culture of the resettlers and villagers of Bhalasawa it can be safely asserted that there is no cultural difference between the two settlements but both the subcultural groupings are more pronounced in their manifestation of core culture. These subcultures determine the differential health culture of the resettlers and villagers.

In fact, there is considerable concern among the social scientists about the approach to the study of the culture of slum dwellers or resettlers or the sub-urban villagers. Culture of these people are pray of various intervention of complex urbanization process. Various sub-cultural groupings of resettlement colony and village Bhalasaw provided a very good opportunity to study the dynamics of changes in the health cultures of resettlers in context of hospital net work system.

Compared to urban living, living in sub-urban villages or resettlement colonies has major disadvantages. A big city enjoys many social, economic and political benefits that are not available to a population of corresponding size in sub-urban villages or resettlement colonies. The dependence of the resettlers and sub-urban villages on cities makes them
more vulnerable to exploitation and control by city-based political leaders, industrialists, traders, bureaucrats, and intellectuals. When for instance, a person living in a resettlement colony on sub-urban village becomes seriously ill, at most he has very limited access to the hospital services. The hospital facilities being complex and complicated often he may have to visit to a near by private practitioner for easier and less complicated investigation and treatment. Even when physicians at the hospital are able to handle the problem with more reasonable confidence, the relatives might have to rush to get special medicines that might be prescribed by the physicians. For relatives of the patients, this means their wastage of their time, effort, and money needed to undertake the journey to bring medicine besides he is more prone to be cheated by the medicine sellers in terms of price and for quality of medicine.

In contrast, a well-off city dweller in Delhi has relatively easier access to sophisticated medical institutions and good quality medicines with less expense and effort. On the contrary a rickshaw-puller staying in the resettlement colony or sub-urban village in the same city, may not be able to derive the same degree of benefits, but faces distinct disadvantages to achieve less meaningful
health services at the time of his need. This is not only applicable to acquire the health services but also in every manner in leading day-to-day life process of meeting the basic needs.

The health culture of a population includes cultural perception and cultural meaning of various health problems, the various cultural mechanisms that are adopted by the community to deal with such problems, the various purposive interventions by the government in the field of health and the behaviour of individuals in response to the various health problems. The pre-existing health culture of a population is also to be understood in the context of the cultural dynamics.

The people who have been resettled in various resettlement colonies of Delhi have experienced the various life process while staying earlier in authorised and unauthorised slums after migrating from various rural pockets of different states, while migrating to Delhi they have carried their cultural traits and their the then health culture. During their stay in the slum and getting battering of slum life they lost some of their earlier cultural traits as well as health culture. They started adopting slowly to the new forms of health practices under compulsion, in an alien
culture. Subsequently their pre-existing health culture vis-
-a-vis their culture moulds into a new form. The new form of
health culture of these resettlers in the resettlement
colony is the core of the present study which has been
designed around the dynamics of cultural change viz., village
life to slum living and finally slum to resettlement.

To understand this change the present way of life of these
resettlers has to be understood which has been affected
heavily by contaminated source of drinking water, dust, dirt
and infestations by various kinds of insects and other pests
and parasites, extensive poverty, grossly substandard
housing, poor drainage and fecal contamination of the soil
and extremely poor personal hygiene. They create an
ecological condition highly conducive to widespread
prevalence of various kinds of communicable diseases,
undernutrition and malnutrition and high rate of morbidity
and mortality among children and mothers, combined with
the health hazards in these localities and thnings have
worsened as these problems are more here than in the cities.
Also, unlike city where the more privileged classes acquire
more hygienic living conditions and civic amenities,

The abject dependence of resettlement on city and the
hazardous conditions of village life have had a profound influence on the culture, including the health culture, of inhabitants of Jahangirpuri. This influence is more pronounced amongst the poorer sections. They have to additionally suffer deprivations because they are poor, because they have lower rates of literacy, lower educational level and because they are abjectly dependent on the richer section of the colony and the city. This denial of social justice and political rights restricts opportunities and facilities needed to bring about cultural changes and to cope more effectively with various problems. Often this sheer weight of prevailing adverse conditions of the poor make them cling to ideas and practices which are patently obscurantist. It must be noted that these determinants of culture are quite different from what are generally included under "culture of poverty". (Valentine)¹. For a proper understanding of the cultural practices of a community including its health practice it is, therefore, necessary to relate its culture to the social, economic and political forces which maintain the ecological settings. Out of the most striking findings of this study was the extensive prevalence of poverty. Even when it is defined in terms of the basic biological need of hunger satisfaction there is a very high prevalence of poverty and there are wide
variations. Poverty also leads to further disintegration and deterioration of the environment and of living condition - of sanitation, of the quality of drinking water, of shelter, of clothing, and being forced eat all kinds of substandard food stuff to satisfy the pangs of hunger.

This unequal settlement pattern and living conditions, making the inhabitants of Jahangirpuri and Bhalasawa villagers depend on the unfavourable ecological conditions, leading to exploitation and social injustice and extensive poverty, which has far reaching influence on the entire way of life of the affected people, all such consideration mould these cultural perception and cultural meaning of health problems and people's response to health services provided by the hospitals. Furthermore, it would be simplistic to consider the cultural traits as static entities. Though in their efforts, or struggle - people seek out new ways of perceiving their health problems and their cultural meaning, along with such changes they also develop better ways of coping with their health problems, by formulating or searching out new health institutions(private practitioners) and changing their health behaviour. This understanding is central to this study's analysis of health practices of population of Jahangirpuri resettlement colony and villagers of Bhalasawa.
It was observed in the present study that system of institutional health care in operation was complex rather than a simple one. It has been noted that the ex-practitioner of Hindu Rao is a leading (private) practitioner of the resettlement colony, who conceals his incapability by finding an alibi by sending the patients to Hindu Rao which not only gets him high esteem in the eyes of the patient but also gives him good reputation by making the patients admission easier in Hindu Rao.

Such kind of referral is doubly beneficial i.e. the patient can get preferential treatment in terms of jumping the queue, taking more and more time of the doctor for consultation, getting better and effective medicine prescribed and at times patient gets all or most of those prescribed medicine free of cost from the O.P.D.

These kinds of favours to the patient in turn gets beneficial for carrying out the private practice of the doctor in the resettlement.

This kind of smooth relation do not exist between the patient who approaches straight to the doctor in the hospital and gets treated in O.P.D. or tries to get admission. Even, if the patient is admitted he faces a lot of humiliation during his stay both in the hands of doctors
and other staff. Such humiliation is mostly the outcome of highly bureaucratized and technocratic, non humanistic health care system of various government institutions covered in this study.

It was found that direct communication by cheaper and easier mode of transportation helped the people to go to Hindu Rao, Kasturba and to St. Stephens. Ninety percent of such visits are non-referral (as per preliminary survey) on the contrary the patients directly go to such health care institution. The massive load of unguided patients not only create a huge rush in the O.P.D. but also most of the time remain inadequately served.

This type of chaos can be avoided by proper referral and by imparting adequate knowledge about the function and meaning of the hospital. Moreover, it also needs a thorough guidance and instruction for the people and patient to make these institutions purposefully effective.

It was also reported by the nurses that less than five percent of the patients visiting from Jahangirpuri belong to richer section of the population, even that five percent is comprised of patients from the village of Bhalasawa (approx. 3%, belong to village). On the contrary it was reported by the nurses of St. Stephens that the patients
coming from the village or the resettlement are mainly the richer section of the people.

It was noted by the investigator that the delivery cases of the resettlement colony only visit to Kasturba hospital, on querying from the nurses and doctors as well it was found that the villagers of Bhalasawa did not visit the M.C.D. because of its low standard of hygiene and over crowded bed situation (inspite of the references made by the local level doctors to Kasturba Hospital). The fact of untidiness was also endorsed by some of the nurses in a very technical manner.

In other words they said the chances of cross-infection was high because of duplication and triplication of patients on a single bed. Moreover, the investigator found that the patients were lying on the floors and in the corridor for days together. The uncleanliness became more glaring when the investigator observed that the cats were loitering right within each and every ward and fiddling with the medicine or the food of the patient in absence or when the patient was sleeping. On asking about the menace of cat in the wards by the investigator one of the nurses told that, "these cats mainly survived on the thrown away placenta of the patient and once they got the taste of it
they are not likely to leave the ward of the hospital."

About the standard of treatment the nurses showed a mix reaction. Ten out of thirteen nurses told that Kasturba was good for handling the gynecological and obstetrics cases besides, for the children as well. Rest of the nurses were of the view that they lacked in modern gadgets of treatment if not in the expertise. One of the nurses was quite unhappy with the type of misutilization of the talent of the nurses i.e. she had a special training in public health nursing where as she was not able to utilise her expertise any where.

As per the doctors, seven out of seventeen agreed that there is scope for improvement in the indoor wards in terms of behaviour of the staff and the gadgetry. The patients and the personnel of hospitals praised for the Intensive Care Unit and the Cardiac Care Unit of the hospital. The level of efficiency was high in these two divisions i.e. the patients admitted in these departments were terminal one, secondly they were less in number and above all the best of man power and gadgets were furnished in these two units. The care and efficiency of treatment did not vary largely in regard to the above mentioned units of M.C.D. hospitals or St. Stephens.
So far as the availability of food for indoor cases were concerned, all the patients injured had full satisfaction in terms of quantity but so far as the quality of food was concerned the patients had one or the other grudge. Mainly the inmates complained of the taste of the food was not good and according to some the amount of milk they got was not sufficient. Almost every attendant had problem of not getting adequate food so they mainly relied on the food brought from their home.

Health institutions exist but the meaning of these institutions does not justify its existence within the overall social system. The people to be served are not at ease when they visit the hospital! The doctors and other paramedics make the patient follow what they want them to follow without trying to understand the real need of the patient.

The meaning of the health institution will not find its total expression as long as all the factors as availability, accessibility, affordability and acceptability are not fulfilled. The faith, reliance and anti-prejudicial gesture on both the sides is an imperative towards making a sound health culture of the people.

According of the doctors of the Emergency and the Casualty...
said to the investigator that the complaints had been received in the above mentioned departments as well. According to the doctors and nurses of the indoor the number of complaints in admitted cases were as low as ten percent. Most probable being the lack of confidence to complain or the lack of knowledge regarding the right of an indoor patient.

So far as the nutritive value of the food given was concerned much care was given only in case of heart and diabetic patients. Although, a dietician is there in each of these government hospital but in no case the patients were given adequate food.

It was not applicable in case of St. Stephens as the food given in that hospital was as per the affordability of the patient, so it was found that the poor patients would not get all food brought from their house but the type of food they are supposed to bring for the patient were well determined by the doctor in advance.

Quite contrary to such arguments the investigator found that as and when the ward aya or ward boy bring milk for the patients some amount was taken out and kept for the tea or coffee. The same view was endorsed by the patient when the investigator asked them whether they got adequate
milk to drink or not. The reply was negative. The patients also complained that the nurses were party to such things at times. The patients always wanted some extra food for their attendant and ward boy refused and that always created certain amount of row between the two. The patient said that they requested kitchen staff to bring extra food from the kitchen. Such situation occurs only in M.C.D. hospitals. Out Patient Department is the gateway to any hospital. All round performance of O.P.D. either promotes or tarnishes the image of the hospital. In order to gauge the performance level and efficacy of the O.P.D., exhaustive queries and investigations at all levels were conducted.

The supply of medicine in O.P.D. was adequate the patients in O.P.D. said unequivocally that for all the prescriptions at least one or two medicines were never to be found in the dispensary of the O.P.D. And the same they had to be purchase from the private market. No patient of the O.P.D. were happy with the efficacy of the medicine given in O.P.D. Those who could afford to purchase from market they preferred to have medicine of better quality from the market only. In case of St. Stephens only abjectly poor patients were given medicine from the hospital whereas the relatively richer patients purchase the medicine from within the
hospital shop.

So far as the behaviour of the hospital staff is concerned the doctors of the M.C.D. hospitals fully endorsed that the standard of the OPD had lot more scope for improvement. But according to them much could not be achieved due to lack of streamlining of the local referral system. Doctors and nurses (interviewed) said that there was hardly any scope of improvement in the Emergency and the Casualty. Whereas the doctors agreed that there was scope of improvement in indoor facilities and staff behaviour.

Much talked of ambulatory services for the community was in jeopardy, as the investigator asked about the community base services which they were supposed to render, was being carried out or not. It was found that less than five percent only visited Jahangirpuri schools in connection with Universal Immunisation Programme, the school children were asked to bring their younger brothers and sisters below five years of age to the school, where they were vaccinated. The team comprised of one doctor, one nurse and one class IV employee. It became conspicuous from the fact (mentioned above) that no one of the staffs were either interested in door to door service or in doing a true community base health care treatment.

Ineffective O.P.D. combined with perfunctory
ambulatory services & inadequate referral led to a system of inevitable intervention of the private practitioners in the colony and in the village. In other words the unmet felt need of the people were in the rage.

Subsequently, this had given rise to a new dimension of institutional health care approach where a myriad of quackery to allopathic medicare were thriving simultaneously even without serving the purpose. The availability of the local institute of health and accessibility to those were of very stereotypic nature. In other words, those were much symbolic in existence than being pragmatic. In health culture chapter it was noted that the people of the colony approached to these places under distress condition or those who could afford to exploit the direct or indirect relation with the doctors had only gone there. The general apathy in behaviour and mechanical approach of treatment with built in prejudice of the doctors and other staffs indirectly encouraged the private practitioner to grow rapidly.

Resettlement colonies added a new dimension in private sector health care approach.

It was worth to mention of the study carried out by
Sahu of tribal community of an industrial set up, he also noted the same type of bottleneck of the state run health institution. He found, the unskilled, ill-equipped, ill informed, uneducated, ill motivated quacks were having larger vista of operation in Rourkela and in hinterland the steel plant or government doctors were equally good in treating the Oraons. So far as open market of health care was concerned, it was found by Madan that various reasons can be assigned for the liking and opting the private doctors and treatment of open market system.

- Effectiveness of treatment
- Cheapness of drug
- Lastly, the frequent availability of the doctor.

It was found that eighty percent irrespective of caste, creed, religion, economic capability rated the efficiency of the medicine on top and according the respondents it is high in allopathic private practitioners. The factor of cheapness of drug also plays role but on an average five percent opted for cheap drug. Followed by other factors.

In order to know the various loopholes of the system in our institutional health care, a systematic series of observations specially designed questionnaire and purposive conversation were carried out with various echelon of health
care staffs.

The responses of the queries are given below:

Forty Eight out of fifty doctors either had visited or seen Jahangirpuri and heard about the village Bhalasawa. According to them, the people of the above mentioned resettlement were socio-economically poor and lead a life in the unhygienic surroundings. Same number of doctors said that the patients abided by the instructions given to them only when they were admitted and they tend to forget the same instruction when they are discharged. This kind of situation had been attributed to the carelessness of the patient by the doctor.

But it had been verified and this happens when the patient is illiterate or instructions have not been given clearly. Eighteen admitted the fact of communication gap between them and the patient and nearly same amount of the nurses and para-medicos endorsed the fact of communicational gap. In case of O.P.D. twenty doctors were ready to admit the fact of patients disenchantedment was due to unaccounted loss of time. But in case of emergency both the patient and the doctor were of the view that the services in the emergency is effective and better than that of the O.P.D. The patient did admit that they did not understand
what they were told in O.P.D. or when they were admitted. It was admitted by some of the junior doctors that for them to make the patient understand each and every thing was not essential. As they inherited such kind of behaviour from their seniors who by and large did not tell the patient what the ailment is, how much time it will take to get cured, how long one has to stay and why. This behaviour continued as the patient became a mechanical entity for the doctor rather than being a living social being. This kind of behaviour is not only confined within the doctors but also deeply rooted in nurses and the para-medics. And this kind of situation is essentially responsible for creating a good deal of misunderstanding between the patient and the hospital staffs.

It was also noticed very commonly that the senior doctors did find fault with the patient at the first instance rather than with their own juniors. The investigator could find only one to two doctors during the study in the hospital, who admitted the fact that the level of treatment had deteriorated substantially over a period of time. It was told by the doctors of the hospitals to the investigators that seventy percent of the patients revealed their ailment after a great of enquiry by the doctor. The same impression could not be had in case of the O.P.D as
both the doctors and the patients admitted that with the

given condition of chaos in the O.P.D. it was not possible
to give or take better treatment.

It was unanimously reported by the doctors that the
patients coming from Jahangirpuri for treatment were poor
and some were extremely poor as well. The hygienic condition
of these patients were too bad and reasons attributed to
such condition was abject poverty of these people. The
study showed that those who were extremely poor were not
able to utilise the hospitals in the true sense of the term
because for them it was available but not accessible or
affordable. The prime reason of such paradox was the lesser
amount of contact besides their economic deprivation made
this cadre of patient as passive recipient of mercy and
sympathy. On the contrary the economically better off were
able to cash their connections and could afford to spend as
and when required.

So far as the richer section of the resettler are
concerned, it was said by the doctor that they did not
prefer to visit to the MCD run hospitals. It was also one
of the reasons that the investigator had chosen to study
patients

a handful few in St. Stephens as this cadre of patient
visit to the above mentioned hospital rather than the MCD
one. Around eighty percent of the cases admitted from the poor section of the people were severe or terminal cases. The above mentioned fact was admitted by all the staffs of the hospital. Such a situation was attributed to two distinct type of thought, the doctors attributed such situation to a) The ignorance of the patient regarding their ailment b) The fear of the alien institution as well as culture where the patient gets lost and feels absolutely helpless. However paradoxical may it seem but such views were only mentioned by the doctors doing house job or fresh or young General Duty Medical Officer (G.D.M.O) but not by the specialists.

This kind of situation compells one to think that such situation is essentially an out come of an alien system which was grafted on this soil to serve a particular section of the society in British India and even today after forty years of independence the situation did not change in spirit but has changed in form. The doctors also admitted the fact that such system of hospital health care leads to more and more complication of treatment as the case does not come in the first instance but after getting dissatisfied from the quack or the private doctor. And any further mistake to diagnose the case leads to more complication and wastage of time and at times it also prove fatalistic. So, thirty six
of fifty seven of the doctors were of the view that there should be a proper referral at the beginning followed by a systematic and thorough O.P.D. system. This would not only enhance chances of the patients’ survival more but also bring the hospital more and more close to the patients.

The same number of doctors confirmed the fact that disease aetiology based treatment of today had always taken up the ailment per-se, it does not go beyond that as it has not been imbibed in today’s doctor. The social perception of the disease is less meaningful than that of the cause and effect relationship of the disease in the present context of diagnosis.

The doctors were of the view that the chronic cases were Leaving Against Medical Advise (LAMA) from the hospital, besides a small section who were scared of blood donation or any kind of operation. The cases of LAMA were not so high in case of St. Stephens hospital. The reason was their tender care given to the patient in comparison to that of M.C.D. hospitals. The LAMA cases also symbolise the lost faith in the doctor and the institutional health care system. On deep probing it was found that eleven out of fifteen of the doctors felt such a situation is not exclusively the fallacy of the hospital doctors alone. It was equally an onus to be shared by the local doctors. This
kind of allegations and counter allegations did not solve the situation, rather it made the whole system more complex (at the cost of patients health).

On querying about the patients view regarding the opinion of the performance of nurses and paramedics in the hospital it was found that the patients complained about these staff to the doctors about their negligence and misbehaviour. A section of the patients could not say anything as either they were scared or did not know about their rights (when they go to hospital or get admitted in it). The fear psychosis of the patients were so pronounced that even the investigator got the feel of it at the very first instance in the hospital. The patients did not tell the problems to the investigator easily. But the patients after getting convinced, disclose all information to the investigator but requested not to disclose it because if, such information leaks to the nurse or to the doctor then he may have to leave the hospital even before getting treated properly (as per the belief of the patient).

Regarding the preferential treatment, forty eight doctors agree that it was a common practice, some senior doctors said that it was unavoidable because they were bound to help bureaucrats and politicians first in comparison to
those who were poor and helpless one so as to retain their position. Nurses also endorsed the same view. Quite contrary to the doctors and nurses the class-IV staff unanimously said that they help to those poor and destitute who did not have any one to look after.

Twenty eight out of fifty seven of the doctors said that their performance was not upto the mark in O.P.D. but they had no solution to such confusion and irregularities.

The management of the missionary hospital was in the hand of a professional manager who looks after each and every aspect of the hospital. During the conversation of the investigator with the manager of the hospital it was found that he was supposed to inculcate the work culture and the professionalism in the doctors of the hospital. In contradiction to such attitude the corporation doctors were of the view that the decline of clinical ethics and humanism was mainly due to the cut throat professionalism. Besides, the sense of acute insecurity combined with a lust for more and more earnings led to such carelessness in treatment of the patient.

The preferential treatment was evident in both types of the hospitals but manifested in different ways. In case of the M.C.D. the doctors give extra care to the well known
personalities like political figures, bureaucrats and to their own relatives while in the missionary run it was either religion or status bound. In other words, the poor in both the cases found it difficult to have a sympathetic care.

The menace of bribe was common in the municipal corporation run hospital, according to the doctors they were helpless to stop check such activities. But on the contrary such practices were totally forbidden in St. Stephens hospital.

In St. Stephens Hospital any deviation to the guideline meant invitation punitive action. This type of measure invariably checks malpractices at the lower level.

The nurses were also interviewed to know the type of feeling they had regarding the patients of Jahangirpuri and about the villagers of Bhalasawa. To know the nurse-patient interaction in the wards, constant observations were made by the investigator in all the three hospitals. It was found that thirty eight out of forty seven of nurses had heard about the resettlement of Jahangirpuri. Nineteen had seen or visited the colony. Forty two nurses were of the view that the personal hygiene was very bad of the people of study area. Those who visited the colony said
that the locality by no means was hygienic to live in. All the nurses were of the opinion that their main obstacles was the poor economic standard. According to nurses the patients when admitted try to cooperate in their own manner so it becomes difficult at times for them to interact with the patient.

Regarding the loss of time and wage of the poor patient, almost thirty nurses were not happy because according to them it was harrasment to patient due to mismanagement of numbering system, ill kept medical records of the cases, improper referral and streamlining of the cases.

On asking about the overall performance level and the scope to improve the treatment and raise the popularity of the hospital the nurses replied that there is a strong need in the change of behaviour of the class IV employees, followed by improvement in the quality and quantity of the gadgets in different wards. Four nurses were of the view that they should be imparted with newer training and knowledges. Such training would help them to give better treatment and care of patients. Only two nurses said that to improve the quality of performance of the hospital there is a need of screening at the very entry point and that is only possible by charging some amount at the O.P.D. itself.
The paramedicals were also interviewed by the investigator to know about the views of the performance standard of the hospital as well as to know that how they view their own hospital in terms of its efficacy. It was also very important to know from these people about the performance because majority of these people belonged to poorer section of the society. Moreover most of the class IV staff of the hospital even stayed in one of the resettlement colonies. They were engaged in hospital as sweeper, ward-aya or as ward boy. On asking about the acquaintance of these people with Jahangirpuri and their people, cent percent said that they know the place and the people. And seventeen out of thirty four of these staff said that they regularly visited the colony. According to these people the hygiene was not really bad but the people of Jahangirpuri were economically poor. But almost all agreed that how they can ignore these people as they are also part of patients.

According to class IV staffs of these hospitals it was clear that these patients were so scared or shy in nature that they did not talk much when they were admitted. The class IV or the paramedics gave them help many a time i.e. they are at times admitted but no attendant come due to one or the other problem of domestic or financial nature.
The patient need to be taken to latrine or bathroom or sometimes some medicine has to be brought from outside the hospital then no one else can be approached by these patients except for these class-IV.

The investigator asked from the class-IV employees that whether they expect some bribe for these helps rendered to the patients. Although, the reply came in emphatic "no" but while the same question was put to the patient or even to the doctor in the absence of these people they said that in cases of child birth no excuse can be given by any means they will take tips and the amount will be high if the child is a boy.

On quality of services given to the patients the paramedics and the class IV rated their hospital at high esteem. But according to elderly staff it was said that the quality of the services have deteriorated than what it was earlier. The reason given to such decadency were primarily two, firstly, the increasing pressure of patient and lack of beds at the same time and secondly, the lack of sincerity in the present day doctors to serve patient sincerely.

On the question of interpersonal behaviour the class-IV and the paramedics told that they always kept amicable relation with the poor and the resettlement colony
dwellers. They lose temper with the patients only when they spoil the ward with dirt and filth or in other words when they are forced to sweep more than twice a day. There is a large scale mismanagement in the attendance of the regular class-IV employees. The sanitary inspectors of the hospital are getting bribe from the regular employees and letting them remain missing in duty hours and in those hours of the day these employees are doing extra work and earning extra money. Whereas the adhoc or the daily wage employees are forced to do extra job to compensate the undone work of the regular employees. So, it is obvious that the quality of service given by these people are really below standard many a times. This was found to be common complaint in both the MCD run hospitals. This type of irregularities were not reported in St. Stephens.

The shortage of drugs seem to be one of the most common phenomena of MCD hospitals. One of the senior ward aya in Hindu Rao told the investigator that she of her own had caught personnels of dispensary who was involved in misappropriation of the medicine from the dispensary and the same was reported by her to the Deputy Medical Superintendent. Although various threats were given to her by the gang of people who were involved in it. But the Deputy Medical Superintendent did not take any action
against those staffs. As the union came to rescue. In Kasturba it was told that the paramedical staffs do sell out even the cotton bundle, common drugs as well as at times contraceptives are also sold out in bulk to out side shopkeepers.

Regarding the O.P.D. of the hospital the paramedics and the class IV said the rush and the time taken there was too much. They also admitted that in cases of acquaintance whoever has approached to them for getting their turn jumped been helped Particularly, if the patient belongs to their own colony or resettlement. The class-IV and the paramedics opined that the emergency and the casualty of their hospital is quite prompt and is comparable to the St. Stephens. To maintain the indoor more cleaner and nicer they commented that there is need of more staffs and as long as the manpower will remain low it will be difficult to give better service than that of present day.

According to many of the doctors who are enthusiastic to work for the patient found the management of the MCD run hospitals do not give much liberty to work, moreover, they are also bound by certain bureaucratic red tapism. On the contrary the work culture of missionary run hospitals vary to a large extent. It was admitted by two or three house
officers of the missionary hospital that they serve more on a contract basis rather than with so called missionary zeal. St. Stephens plays the game of hire and fire more so with those who are not Christians.

The study showed the medical social workers is a notional figure for the MCD hospitals rather than being a true functionary. The medical social worker in the MCD hospitals are primarily doing the work of promoter of family welfare and counseling for the maintainence of the small family. To help the authorities to detect the real needy people. Government aid during rehabilitation, The medical social workers along with the O.P.D. doctors are supposed to disseminate the health education to the patients. But it was unfortunate to find that the medical social workers in both the hospitals were not carrying out these duties. In case of St. Stephens hospital it was found by the investigator that the medical social worker was carrying out all those duties which she is supposed to carry out. Moreover, she is also counseling the patients who are discharged and are undergoing follow up treatment or trying to get rehabilitated at their home, as the colony of Nand Nagari has been adopted by St. Stephens, so the medical social worker of the above said hospital visit the area in person and do help to a large extent to those discharged and
those who are trying to get rehabilitated. On the whole it was realised that even if the patient of Jahangirpuri and like need attention when they approach the hospital they are not able to get adequate attention. But unfortunately no one is really ready to admit that the fault lies in the institution. On the contrary,

The lack of space, manpower, gadgets, medicine, laundry items etc. or in other words the problem of logistics and management, besides the manpower management problem and secondly the socio-cultural barrier between the doctor, nurse and the class-IV or paramedics on one side and the patient on the other (the schism between the two levels were quite clearly visible when the patient belongs to Jahangirpuri or in similar colony with poor socio-economic strata). Given such type of hospital infrastructure and the institutional health care besides the type of privilege class based patient care system it becomes necessary to go into the overall existing system of health care approach of today against the back drop of our socio-cultural milieu.

According to Banerji, hospital should be defined in the following manner ...... "a hospital is required to become a community institution. This calls for a basic change in the culture of the hospital. It may be emphasised that such
a change does not imply that a hospital will cease to offer high technology, services or that there would be any decline in the status of those who provide high technology. A basic change in the culture of a hospital implies essentially a change in the relationship between a technology and community. From inward or westward looking, market dominated, technology oriented institution, the hospital opens itself to its requirements by bringing about the necessary reorientation in its technology and in the reorganization and management.

Hospital thus becomes closely integrated with the entire health services system even while they may be at the apex".....(Banerji 1981). Further more in the same light Banerji has said ...."an epidemiological approach to define the role of hospital as a community institution. In other words activities of hospital becomes an integral part of an overall health strategy involving the use of an "optimised" package of technology promotive, preventive curative and rehabilitative component".....

...."Having defined the entire range of community health problems, one has to define the health culture of the community, including the felt needs that are generated by various health problems.".....(Banerji).
In the light of above arguments of Banerji, the present study finds its appropriate place and position. Moreover the study deems fit for understanding the role of hospitals in understanding the health culture of Delhi resettlement along with its adjoining areas. This study also gives lot of insight into the validity of contemporary hospital as a pedastal of rural-urban health care system. The study also raises the issue to modify the institutional health care in Indian cities and to make it more meaningful for the needy masses. The role of absolutely passive recipients patient has become a legitimised fact of the day. The trauma of hospitalisation for the poor patient is even greater than physical and psychological pains or suffering. The reason for such condition has been explained in the case of the boy with broken leg called Mohan (vide chapter-v).

The indicator of development and health care has remained confined within the bed-patient ratio, super specialisation super specialist, advanced technique, combined with advanced mechanical and technocratic support often governed by bureaucrats who make the institute run in a time bound target oriented manner.

Today the system of institutional health care has become a dehumanised highly technocratised and contractual
state apparatus which has been explained in the case of Goddi (vide chapter-v)

There is a lack of understanding on the part of the doctors of patients; health culture" where he tries to put and mould the patients culture as per the culture of the institution and when the patient do not confirm to this they are blamed, neglected and ignored. This has resulted in frequent visit of this patient to privat institutions and those are increasing day by day in these localities.

All these together have led to a status of confusion and confrontation within and without the system of health care.

As Antia puts .... "We are informed that the large urban public hospitals are for the care of the poor and needy who cannot afford private medical care and that the affiliated medical colleges are there to produce the doctors who will look after the health of our people. The plethora of reports about the rank inefficiency, callousness and inhuman conditions that prevail in these institutions....demonstrates that the poor are only there to justify the construction and running of such hospitals.

The only time any attempt is made to provide effective service is when a politician, bureaucrat, doctor or their
relations and friends, require free service, for, these hospitals have become free private nursing homes for the rich and influentials: ...

...."The facilities and training provided is therefore in keeping with the requirement of private practice among the affluent section of our society and their pattern of diseases, rather than with the requirement of the vast majority which lives in rural India or even in the urban slums.

Antia has also raised the issue of medical teaching and training of the doctors in hospitals. ...."There is not a single general practitioner in the large hospital who can teach the student the care of common illness and demonstrate how to sort out the few cases requiring more specialised care. This duty is left to the sweet will of the clerk who issues the O.P.D. papers. Even the staff of such institution finds difficulty in locating the myriad departments and one can imagine the plight of the poor without any to advise or guide them in the medical maze"....

In this same connection he also mentioned that,...."The large urban hospital with its affiliated medical colleges are therefore institutions designed more for the benefit of medical profession, the politician and
the medical industry rather than for the poor. Besides, large institutions by their very nature are impersonal and not keeping with our very personalised culture"....

While suggesting an alternative to such a system of health care, he said

...."What the vast majority of our people require are small thirty to sixty bed hospitals situated within easy reach of the community and where the majority of the basic as well as referral problems of local population can be attended to, in a human atmosphere, leaving only a very few difficult problems for the urban apex hospital"....(Antia,)

Of late with various committee recommendations and plethora of small and big reports, decisions have been taken to go for small bedded hospitals in various resettlement colonies. Along with the inception of the colony of Jahangirpuri it was also decided by the authorities of Delhi Administration that they would build one hundred bedded hospital for the colony as well as for the adjoining village residents. But it is unfortunate to see that the plot of hospital is harbouring plenty of unauthorised slum dwellers. The people of the colony although needs the hospital in their locality very badly but by now they have given up all
hopes of getting the plot for the purpose of hospital.

Such a situation reflects a lack of political will to make the hospital within the needy peoples community and in turn to develop a true community oriented, health culture conscious, institutional health care system.

Any early action for construction would have made the hospital well versed with the felt need of the people. The orientation of staffs would have moulded the staff for peoples need. As, Banerji, has said that the health status of the people is always maintaining a kind of dynamic equilibrium and to keep the equilibrium in proper order there is a need of purposive intervention by the state, and these are only possible when the steps taken are well timed and well accepted as well. Todays, lackadaisical hospital health care system of Delhi and other big cities are outcome of an alien system grafted in toto with no major concern of its being accepted by the masses. The situation is getting more and more exacerbated by building a superstructure of highly dehumanised, technocratic professional, parochial and commercial cadre of specialists.

The present study has found ample examples of above mentioned facts and so it warrants a serious thinking on the part of our policy planners and administrators for making
the hospital an integral part of peoples health culture which in turn would be an inevitable part of the resettlers and rural peoples society and culture.
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