Design and Methodology

Evolution of Resettlement Colony in Delhi

According to 1981 census, India's urban population reflected a decennial growth rate of 46 percent over 1971 rising from 109 million to 156 million, thus an absolute increase by 47 million. The Sixth five Year Plan had stated that "of total urban population nearly a fifth is estimated to constitute the slum population" (sixth five year plan)\(^1\). It is further stated that "in 1985 the magnitude of such population needing attention was expected to rise to about 33.1 million."

In the light of overall slum development in India, Delhi's share is no less. Mr. Jagmohan Chairman, Delhi Development Authority wrote in 1979: "a recent study of the squatter settlements in Delhi by Town and Country Planning Organisation reveals that more than half a million people are living in 1373 clusters of Jhuggi Jhopri. It also indicates that whereas in 1951 there were only one "squatter" household over 20 non squatter households in urban Delhi, it was so in 1973 for less than 5 non-squatter households. Besides, this the squatter population has been growing at the annual rate of 12 per cent in comparison to the city's 4.5 percent. (Seminar; "summary", urbanisation,
growth of slums, Social Conflict and Environmental Hazards” P-28). 2

As Delhi is no exception to such growth and development of slum the state apparatus embarked upon clearance and prevention of such growths. The scheme of slum clearance was in operation in Delhi in the notified slum areas of walled city and its extensions since 1956. Under this programme, dangerous/dilapidated buildings and pockets notified as clearance areas under Slum areas (Improvement and Clearance) act 1956 were cleared and families affected by unavoidable clearance operations launched due to the fact that areas/building/properties becoming unfit for residential purposes, had been rehabilitated in flats constructed in slum resettlement in different parts of Delhi colonies. Under slum clearance scheme various changes were brought in from time to time since 1956 till 1975. 3

National emergency of 1975 had seen many changes on the face of Delhi along with the country under the operation of "clearance and beautification of Delhi", all the unauthorised slum, shanties and squatter colonies were cleared and bulldozed. These squatters were spread all over Delhi. As they had occupied Delhi Development Authorities (DDA) earmarked woodland plots, plots for private housing
and few of them encroached the road side pavements and huge sewage pipes. Moreover, those colonies which came up without any Delhi Development Authority permission; i.e. various post partition refuges hutments of Kingsway Camp, Vijay Nagar in North, Turkman Gate in Central Delhi, Krishna Nagar, Arjun Nagar of South Delhi. Some colonies of the West Delhi near Tilak Nagar. Although, these were developed long ago in 1947-48, over a period of time as the implementation of original master plan of Delhi became a necessity, Delhi Development Authority started demolishing these colonies and reallocated these at quite high price to housing societies or made flats and sold those at good price. And evicted people also became landless evacuees. It must be noted that two categories of displaced persons were made due to this cleaning operation.

- One who were shanty dwellers and evicted from their temporary dwellings (These are the people who are mostly labourers in unorganised sector, running their own petty shops or working as domestic servants.)
- The post partition refugees who were settled in various parts of Delhi in barracks and hutments also became homeless once again.

Then latter group could manage a better places of resettlement and good site in the colony by:
Encashing their contact, which they have built in all those years.

- By giving money as bribe wherever they could afford to give.
- By remaining united and representing to authorities and ultimately convincing them where as the former group could not do any such arrangement.

Resettlement: A Mode of Slum Rehabilitation:

With promulgation of national emergency in the year 1975 it was decided by Delhi Administration and other public bodies that all the squatter and slum colonies of the capital will be cleared and in turn resettlement colonies will be built. By 1976 almost all the resettlement colonies were allotted to the slum or jhuggi dwellers. Most of the resettlement colonies are agricultural or farm land of farmers in out skirts of the city. The resettlement colonies came up in North, East, West and South Delhi. Delhi Development Authority procured the lands at Rs 5 to Rs 8 per square yard. Each household has been given a cut out of 25 square yards. And all the colonies are 99 year lease hold one. The construction of resettlement have been done with certain specific objectives viz.
A decent living for the slum dwellers by providing them at least minimum provision of basic civic amenities i.e. clean water supply, sanitary tank or water sealed latrine, electricity, park and lawn for children to play, metalled roads, proper drainage system etc.

In later years it was thought that the resettlement of slum colonies should be a concept by which one should get "Shelter and Site" (Site to earn livelihood) together.

The provision of school, health facilities i.e. dispensaries or hospital run by government or corporation or allied bodies.

The houses were built with certain scientific understanding so that in small area with least cost input maximum facilities can be provide but in that process a lot of compromises have been made with ventilation facilities. And the shortage of space has forced the dwellers to avail community latrine facilities, of late the houses in some of the resettlement colonies been provided by domestic tap water supply.

The resettlement colonies were started in 1975-76 and were constructed till 1985. Thereafter the plan and construction of resettlement colonies have been abandoned. In the span of ten years the Delhi Development Authority
constructed forty-five resettlement colonies i.e.,

**Table-2**

**Distribution of Resettlement Colonies of Delhi**  
(source : D.D.A slum wing)

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>East</th>
<th>West</th>
<th>North</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Seelampuri Ph-I,II,III, IV</td>
<td>Najafgad Road Sector-A, D, E&amp;G, F</td>
<td>Mangolpuri Ph-I</td>
<td>Sunlight-Colony</td>
</tr>
<tr>
<td>2</td>
<td>Seelampuri Additional Plot</td>
<td>Hastasal</td>
<td>Mangolpuri Ph-II</td>
<td>Srinivas Puri</td>
</tr>
<tr>
<td>3</td>
<td>Seelampuri old</td>
<td>Madipur</td>
<td>Mangolpuri Ph-III</td>
<td>Garhi village</td>
</tr>
<tr>
<td>4</td>
<td>Seelampuri new Ph-I,II, III</td>
<td>Nangloi Ph-I,II,III, IV,V</td>
<td>Sultanpuri Additional plot</td>
<td>Kalkaji</td>
</tr>
<tr>
<td>5</td>
<td>Patparganj complex</td>
<td>Wazirpur</td>
<td>Sultanpuri Additional plot</td>
<td>Madangir</td>
</tr>
<tr>
<td>6</td>
<td>Trilokpuri</td>
<td>Shakurpur Ph-IV</td>
<td>Jahangirpuri Dakshinpuri</td>
<td>Dakshinpuri</td>
</tr>
<tr>
<td>7</td>
<td>Kalyanpuri</td>
<td>Shakurpur Ph-III</td>
<td>Dakshinpuri extn</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Kichripuri</td>
<td>Shakurpur Ph-I and II</td>
<td>Kondli</td>
<td>Tigri</td>
</tr>
<tr>
<td>9</td>
<td>Nand Nagri Ph-I</td>
<td>Khyala Ph-I,II,III</td>
<td>Nehru Vihar Moti Bagh</td>
<td></td>
</tr>
</tbody>
</table>

Table Contd.
The resettlement colonies house 1.4 million people. It has been reported by Delhi Development Authority that today 4.5 million or 53% of Delhi's population live in slums. According to above mentioned sources 1.3 million people live in Jhuggi jhompries, 1.8 million in slum designated area; Shajahanabad (ward 1 to ward 17) Chandrasekhar Azad Colony (near Gulabi bagh), parts of Pahar Ganj, Nabi Karim, Navjeewan camp (opposite to Kalkaji), Tigri near Khanpur depot, Zafrabad (Janta Mazdoor colony), Lal Bagh, Raghubir Nagar (near Najafgard). (Delhi Development Authority; Slum Wing Report 1989).

Although, for all official and administrative purpose since 1985 the resettlement colonies have been reconsidered as slum. The resettlement colonies were built in such a way that maximum number of people can be housed in minimum possible area. Most of the people in these colonies are engaged in unorganised sectors or they are self employed as
well as few of them are daily wage earner, wheeler dealer. Most of the migrant population of these colonies have come from adjoining sates of Delhi at different point of time in various phases. And settled here in Jhuggi, jhompries or resettlement colonies.

The inhabitants of resettlement colony of Delhi were found to be from different cultural background because they are hailing from different states i.e. Haryana, Rajasthan, Uttar Pradesh, Bihar and West Bengal. They have come in search of their livelihood in Delhi. During their stay in slums, they were exposed to various onslaughts, such onslaughts are the manifestations of rapid and indiscreet urbanization of this capital city. As a result of which a lot of changes were seen in their day to day life processes. These changes might have been adopted to cope up with urgent felt need faced by the dwellers of the slum along with other cultural groups.

In general the culture of community is a key component to understand the health culture and its dynamicity. In other words culture of the people and the community shape the health culture of a particular area. According to Banerji ....In order to understand the health culture of inhabitants of the resettlement colony of Delhi no systematic efforts have been made so far. Therefore, the
The present study is an effort to undertake a detailed systematic investigation into the rite-de-passage of the inhabitants.

That is to say, through the culture study an effort will be made to assess the health culture of the inhabitants of the resettlement colony and the people staying near the resettlement colony. As the preexisting health care institutions and their services shapes up the health culture of the community the emphasis will be also given to understand how far the available health care facilities have influenced the present health culture of the people turning in these resettlement colonies and in the close vicinity of it.

**Study Design**

The present study is designed to understand the role of hospital services in deriving the health culture of the resettlers of Delhi.

Before designing the present study the following objectives have been taken care of:

a) To understand the life process of the people of resettlement colony which is supposed to provide a better life chances to the slum dwellers of Delhi.

b) To study how far the inhabitants of resettlement
colony placed in the outskirt of the city have got the access to wide range of health care facilities which are available in different hospitals.

c) Finally an attempt was made to examine how the present health culture of the resettlers in Delhi has been evolved against the backdrop of the socio-economic life process of resettlement vis-a-vis the various hospital services.

**Study Design**

Jahangirpuri was found to be the oldest of forty five such resettlement established so far, the following points were considered for selecting study area.

- Jahangirpuri is one of the oldest resettlement colony
- It is connected by motor roads from all directions
- It is well connected by public transportation i.e. Delhi Transportation Corporation buses. The resettlers have easy accessibility to nearby four hospitals (Government and missionary run).
- It is interesting to study as it provides an ideal rural urban continuum because it is flanked by Bhalasawa village
- Moreover, this colony and the adjoining village was
easily accessible by the investigator. Besides, its greater density of population with high degree of heterogeneity which provides a wide range of issue to study the health culture of the people.

To understand present health culture of the resettlers it was necessary to undertake a detail study of the total life style of resettlers along with the villagers Bhalasawa. The village is much more older and stabler entity than the colony of Jahangirpuri. Moreover, the people of Jahangirpuri and the village Bhalasawa constitute a wider cultural kaleidoscope. Which would not only a deep insight into the health culture but also will give an opportunity for an indepth culture study in a dynamic urban cultural milieau.

Jahangirpuri resettlement colony's six blocks were selected (out of ten blocks) for the study from phases I & II, as earmarked by DDA slum wing. Following table shows the selected households of the colony and the village.
### Table - 3

Distribution of House Hold Covered in Different Blocks of Resettlement and Village Bhalasawa

<table>
<thead>
<tr>
<th>S.No</th>
<th>Village/Blocks</th>
<th>Number of Plots</th>
<th>Covered Blocks and Household for the Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A</td>
<td>1890</td>
<td>150</td>
</tr>
<tr>
<td>2.</td>
<td>B</td>
<td>1799</td>
<td>98</td>
</tr>
<tr>
<td>3.</td>
<td>C</td>
<td>1949</td>
<td>154</td>
</tr>
<tr>
<td>4.</td>
<td>D</td>
<td>1799</td>
<td>-</td>
</tr>
<tr>
<td>5.</td>
<td>E</td>
<td>2897</td>
<td>150</td>
</tr>
<tr>
<td>6.</td>
<td>G</td>
<td>2000</td>
<td>-</td>
</tr>
<tr>
<td>7.</td>
<td>H</td>
<td>2000</td>
<td>-</td>
</tr>
<tr>
<td>8.</td>
<td>I</td>
<td>2000</td>
<td>154</td>
</tr>
<tr>
<td>9.</td>
<td>J</td>
<td>2000</td>
<td>-</td>
</tr>
<tr>
<td>10.</td>
<td>K</td>
<td>2000</td>
<td>150</td>
</tr>
<tr>
<td>11.</td>
<td>Bhalasawa Village</td>
<td>300</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Grand Total 1006</td>
</tr>
</tbody>
</table>

In phase-I there are seven blocks in all, i.e. A.B.C.D.E.G & H out of which four blocks were selected viz. A.B.C. and E. And in phase-II there are three blocks. I. J and K. out of which two were selected viz, I and K. The
basis of selection of blocks were;

a) Giving proper representation to two phases of resettlement and the colony was divided into two phases by a road so the blocks of both the sides were taken.

b) A and B blocks were selected because the evacuees of Kingsway Camp hutments were resettled there.

c) C block was selected because most of the muslim migrants were resettled there.

d) E & EE blocks were selected because a missionary clinic along with T.B follow-up facilities were there.

e) I block was selected because the majority of trader migrants were resettled there.

f) K block was selected for the physical proximity with village.

The low lying landscape of the village with big ditches and open drains all around, has become prolific breeding ground of mosquitoes. There are no metalled road within the village. There is one panchayat house, which has been constructed by contribution. It was observed that the elderly use it as a meeting and gossip point during ordinary days. The hob-nob of political activities can be seen there during and after village election. It has no dispensary or hospital.
Study Population

A selection of the study population was made by considering the different characteristics of the total population with special emphasis on their economic parameters, besides representation was given to the factors like caste, religion and the linguistic groups. Out of nearly 16000 households in Jahangirpuri and 300 households of the village 1006 households have been selected, from the six study blocks as well as from the village Bhalasawa. These were selected on systematic random basis; i.e every tenth household was enlisted and surveyed in the resettlement colony and every alternative household was selected in the village for the study. The qualitative data were collected from these households. Further, the economic groupings of the poor, middle and the rich were done on the basis of the income of the family per month i.e., income upto Rs 700, between Rs. 701-1500 and Rs. 1501 and above. Different occupational groups were listed during the preliminary survey and subsequently average income of the family was calculated.

Selection of Health Institutions

Selection of the hospitals and health care institutions were made on the basis of physical proximity.
As per the definition of health culture it has been emphasised that in order to understand the health culture systematically of any community one has to take note of the available health institutions which belongs to the community in the form of indigenous institution (home remedy), folk and ethnic medicine etc.) and the institutions of the western medicines available to the community nearby to meet the unmet felt needs. In the present study it was essential to select the local health care institutions which forms an integral part of health practices of the community along with the hospital as key component available near by.

It was primarily the local health care institutions which were selected for the purpose of understanding the pattern of local institutional health care and the role of these institutions as referral body for the nearby M.C.D runned hospitals. The role of private practitioners were equally important to be studied, so, the private practitioners were also taken care of in the present study.

As the role of hospital is very essential to be known for understanding the health culture of the people, it became equally important to have a brief sketch of existing hospitals in Delhi along with the selected three; Hindu Rao, Kasturba and St. Stephens.
### Table-4
The list of Hospitals of Delhi

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Bed Strength</th>
<th>No. of Ward</th>
<th>Hospital Size</th>
<th>Agency</th>
<th>When Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>AIIMS</td>
<td>750</td>
<td>23</td>
<td>Large</td>
<td>Autonomous</td>
<td>1956</td>
</tr>
<tr>
<td>2.</td>
<td>Safdarjung</td>
<td>1207</td>
<td>32</td>
<td>Large</td>
<td>G.O.I.</td>
<td>1946</td>
</tr>
<tr>
<td>3.</td>
<td>Ram Manohar Lohia</td>
<td>730</td>
<td>10</td>
<td>Large</td>
<td>G.O.I.</td>
<td>1954</td>
</tr>
<tr>
<td>4.</td>
<td>LNJP</td>
<td>1107</td>
<td>27</td>
<td>Large</td>
<td>D.Adm.</td>
<td>1936</td>
</tr>
<tr>
<td>5.</td>
<td>Hindu Rao</td>
<td>345</td>
<td>13</td>
<td>Large</td>
<td>M.C.D</td>
<td>1911</td>
</tr>
<tr>
<td>6.</td>
<td>Lady Hardinge</td>
<td>580</td>
<td>13</td>
<td>Large</td>
<td>M.O.I.</td>
<td>-</td>
</tr>
<tr>
<td>7.</td>
<td>G.B. Pant</td>
<td>258</td>
<td>8</td>
<td>Large</td>
<td>Delhi</td>
<td>1964</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Admin.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Victoria Zanana/Kasturba</td>
<td>215</td>
<td>11</td>
<td>Medium</td>
<td>M.C.D</td>
<td>1905</td>
</tr>
<tr>
<td>9.</td>
<td>Tirath Ram Charitable</td>
<td>125</td>
<td>6</td>
<td>Medium</td>
<td>Charitable</td>
<td>1955</td>
</tr>
<tr>
<td>10.</td>
<td>Ganga Ram</td>
<td>190</td>
<td>5</td>
<td>Medium</td>
<td>Charitable</td>
<td>1954</td>
</tr>
<tr>
<td>11.</td>
<td>Holy Family</td>
<td>178</td>
<td>7</td>
<td>Medium</td>
<td>Mission</td>
<td>1956</td>
</tr>
<tr>
<td>12.</td>
<td>St.Stephens</td>
<td>170</td>
<td>-</td>
<td>Medium</td>
<td>Governing body</td>
<td>1834</td>
</tr>
<tr>
<td>13.</td>
<td>Kalkaji</td>
<td>31</td>
<td>4</td>
<td>Small</td>
<td>M.C.D</td>
<td>1952</td>
</tr>
</tbody>
</table>

contd....
14. Balak Ram 30 2 Small M.C.D Before 1900
15. Malavya Nagar 31 7 Small M.C.D 1952
16. Tilak Nagar 47 9 Small M.C.D 1954
17. Patel Nagar 15 5 Small M.C.D 1954
18. Lajpat Nagar 47 4 Small M.C.D 1948
19. Moti Nagar 31 3 Small M.C.D 1952
20. Civil Shadra 12 1 Small M.C.D 1939
21. General Hospital Shahdara 74 3 Small M.C.D 1963

The preliminary and the subsequent survey of the colony showed a definite trend of utilizing the services of hospital by the resettlement colony dwellers and the villagers. These trends helped the investigator in selecting the hospitals. Besides, the fact is that the local dispensaries are a part of overall referral system, so, a patient who goes to government dispensaries are referred to a particular hospital. It was found, that the independent choice of the hospital by the people and the referred cases happen to go in most of the occasion to the same hospital i.e. Hindu Rao, Kasturba etc.
It was also observed that majority go to Hindu Rao runnned by Municipal Corporation of Delhi (MCD). A few reasons for such great rush to Hindu Rao can be enlisted below.

a) It is the nearest general hospital
b) It is also a part of referral system.
c) No charges are made for treatment
d) It is sufficiently big enough with 800 regular beds besides, it provides various other make shift arrangement for indoor patients.
e) The hospital is well known for its mobile child care clinic which visits to the colony once or twice in a year.

So Hindu Rao Hospital was selectd as the first hospital for the present study.

Kasturba hospital was selected because it too comprises, the part of the referral unit. Moreover, no other female and children hospital of MCD exist within an easy reach of the resettlement colony and village dwellers of North Delhi. It was also found during the preliminary survey that 14% of the colony females and children visited to the above mentioned hospital. The female sterilization cases are also referred to this hospital from the colony. It was also found from the survey that the inception of
Copper-T is by and large carried out in the Kasturba hospital for the dwellers of North Delhi.

The Catholic missionary hospital called St. Stephen was also taken up for study purpose. The selection of this hospital was made on certain grounds, which were revealed during preliminary survey of the community.

a) 10% of the colony dwellers as well as villagers do visit St. Stephens.

b) It is easily accessible from the colony as well as the village.

c) A very nominal charge is made as consultation fees and a minimal charge is made for the cases who get admitted. In case the patient is too poor to afford any payment in that case he or she is not charged.

d) This hospital provided the investigator an opportunity to assess the performance of a missionary hospital.

The patients in above mentioned hospitals were interrogated by the investigator time and again. It was done in order to cross check the statement given by the ex-patients and the patient who were undergoing treatment in (O.P.D. and indoor both). In order to have comprehensive picture of the local health care system. All the health care facilities were looked into, the colony has various
government and private health care institutions. These are mainly run by Delhi Administration, Municipal Corporation, Christian Missionary and various other voluntary organisations. There is a plot earmarked for the purpose of hundred beded hospital but so far this has not come into existence.

Table-5
The Location of Dispensaries in Different Blocks of Resettlement

<table>
<thead>
<tr>
<th>Blocks</th>
<th>Types of local health care institution</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1. Employee State Insurance Dispensary</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2. M.C.D run Mother and Child Health (MCH) dispensary.</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Delhi Administration run general dispensary</td>
<td>1</td>
</tr>
<tr>
<td>C</td>
<td>Delhi Administration run Polyclinic (where specialists sit).</td>
<td>1</td>
</tr>
<tr>
<td>D</td>
<td>(MCD) Municipal Corporation of Delhi run MCH centre</td>
<td>1</td>
</tr>
<tr>
<td>E</td>
<td>Missionary (Catholic) run general dispensary and T.B. clinic</td>
<td>1</td>
</tr>
<tr>
<td>J</td>
<td>MCD run Ayurvedic clinic and Malaria detection and eradication centre</td>
<td>1</td>
</tr>
</tbody>
</table>

contd..
In every block private practitioners are there whose charges vary from Rs 5 to 15 per patient per visit.

One charitable Lions Club dispensary also exist in block A. They generally cater to patients suffering from minor ailments and medicines are given free of cost only for such cases.

Data to be Collected

The present study is comprised of two sections i.e. firstly, the culture of the people of Jahangirpuri and village Bhalasawa. And secondly, their respective health culture. In order to understand their culture in its totality, total way of the life styles of the study population along with other informations were collected. A systematic effort was made to collect the data on the following cultural parameters.

- Location, of colony physical feature, settlement pattern, housing, environmental sanitation, water supply, transport and communication system, trade and industries and various public institutions.

- Organization of the population of study area i.e.
historical background population and distribution of household, castes, scheduled castes.

Social structure and cultural background of resettlement dwelling, family, kinship and religion including beliefs, customs, rituals, fairs and festivals.

Economic structure of resettlers and villagers i.e. landholding, occupation and stratification

Place of resettlement and villagers power structure and the major social changes.

Health facilities inside and outside the resettlement and the village.

So far as the health culture is concerned the following parameters were considered

- Practices relating to pregnancy, childbirth, child rearing and various diseases associated with pregnancy, child birth and childhood care.
- Major communicable disease, i.e. T.B., Leprosy, typhoid, S.T.D., malaria
- Major chronic diseases i.e., asthma, rheumatism, heart disease
- Major accident i.e. burns, physical injuries, broken limbs.
- Psychosomatic problems.
- Alcohol related problem
- Minor ailment
- Response to problem of environmental sanitation
- Response to other preventive medical activities like malaria and other immunization programme.

Techniques and Tools of the Study

As the study was on culture and health culture so the investigator used anthropological and sociological techniques to collect data on the parameters mentioned earlier. To get acquainted in the resettlement setting, a preliminary survey was carried out in the area. A first hand information of the socioeconomic, cultural and health practices of the study population were gathered.

The preliminary survey continued for ten months starting in July 1985 and concluding in the month of May 1986. After the preliminary survey an analysis of the data were done and a detail study design was formulated.

The in-depth study was carried out from October 1986 to September 1987. In-depth qualitative data were gathered on socio-cultural and on parameters of health culture from the selected population of the colony and the village. This has been done on the basis of observation, formal and informal interviews and case studies. The cross checking of
the qualitative data has been done at various levels by means of conversation with the key informants. This has increased the reliability of the qualitative data immensely. In order to do proper stratification of the sample population economic grouping was done on the basis of the survey data. From this grouping qualitative data was collected. In order to strengthen the qualitative and quantitative data, a carefully designed interview schedule was administered in the resettlement colony as well as in the village. Thirty percent of the total selected 1006 households of (resettlement and village) 315 (poor - 95, middle-166 and rich 54) households were covered through this schedule. And the schedule comprised of total 73 parameters. Table 6A shows a detail characteristic of the study population.

Besides, the community level studies the investigator followed the patients in the selected hospitals to cross check the data on their health problem and health behaviour. The patients of Jahangirpuri and Bhalaswa were interrogated time and again while they were availing the O.P.D and the indoor services of the selected hospitals. The interview with the doctors, nurses and other staffs in the selected hospitals were carried out in order to cross check the statements given by patients of Jahangirpuri and Bhalaswa.
A set of checklists were designed carefully for different categories of functionaries to know the views of the staffs regarding various characters of patients within the hospital, their behaviour and conduct, the economic background of the patient. Attempt was also made to ascertain the duration for which he or she is serving the patients coming from Jahangirpuri resettlement colony. The status of communication between the staff and the patient as well as his attendant within the premises of the hospital. The perception of the performance of the doctors and other staffs of the hospital in the mind of resettlement colony people and subsequent reaction. The amount of cooperation expected by the doctors and other staffs from the patient, and the true cooperation availed. The reasons for Leaving Against Medical Advice (LAMA), what is the status of "Preferential treatment" in the hospital.

Suggestion of each category of staff was sought in order to know that what do they think about their level of performance, do they see any scope of further improvement in their performance.
Questions were put to know the level of personal attachment of the staffs with the patient of resettlement colony or the village.

The check-lists were introduced in April '87 and the survey was carried on till December '87 in the hospital. The check-lists were introduced in OPD, indoor, casualty, Emergency, Intensive Care Unit and Coronary Care Unit to all levels of employees including junior and senior doctors.

A Revisit to Jahangirpuri Bhalaswa:

The revisit to Jahangirpuri became an imperative after the devastating epidemic out break of Cholera and gastro enteritis in a group of trans-Yamuna resettlement colonies in the month of July, 1988. The target of such epidemic was the people of Nand Nagari in a single days span (24 and 25 July), two hundred and fifty people died and of which the majority of deaths were accounted to were that of children below five years of age.

So, the investigators apprehension prompted him to visit Jahangirpuri and find out if anything like that has happened or in the offing. As because the overall environmental situation was almost same like that of Nand.
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A revisit was made to the resettlement colony of
Jahangirpuri and the village in the month of July and August
88. The Municipal Corporation workers were actively engaged
in the month of July and August, 88 to do the clearance of
the colony drains, manholes, sanitary tanks and spray of
"gamaxine" powders on the street and near the gutters
running by the sides of the main road. The operation was
going on at a war footing as because the epidemic of gastro
enteritis- and cholera which killed many people in trans-
Yamuna resettlement colonies were anticipated in this colony
too. It was told to the investigator that as a preventive
measures to any such epidemic the operation was being
carried out. And the whole operation was a time bound,
target oriented exercise.

From 14th July, 1988 till 3rd
August, 1988 forty thousand inoculation of Cholera were made
and they were expecting by 13th August, 1988 a coverage of
nearly one lakh cases in their camp. Two mobile units
were inoculating in local schools to the children for
cholera and typhoid. But, it was also mentioned that they
are not covering the adjoining Bhalasawa village because it
was out of their target group. This kind of massive cleaning
and preventive operation provided a suitable situation to study
the people's reaction.

Rapport Building

The investigator used the anthropological techniques to build up the rapport with the various sections of community in the resettlement and village by identifying the key informants and local leaders on the basis of regular visit and inquiring about their well beings and various problems. Gradually the investigator could settle down to the community and got accepted as a member at the community level as well as at the level of various health institutions.

The rapport establishment in the hospital was problem for the investigator in the initial stage. But continuous visit to these hospitals and casual conversation with the inmates released lot of inhibition of the authorities thereby allowing the investigator to carry out the study.

Frequent talks with the resident doctors and General Duty Medical Officers (G.D.M.O) provided the investigator more and more insight into the working pattern, the organisational set up of the hospital. The doctor patient relationship particularly of those patients who come from resettlement colony or poor economic strata and when they are admitted how do they react. The intra and inter staff relationship were dealt in detail with the young doctors.
having the full confidence on the investigators the senior doctors informed in detail about the functioning of the hospital. So, it used to be a time taking process to collect data from the senior doctors in every hospital. This must be also mentioned that the Deputy Medical Superintendent of Hindu Rao considering the need of this study encouraged and allowed the investigator to do all most all sorts of queries. The Deputy Medical Superintendent of Kasturba hospital was equally helpful for carrying out the study in his hospital. It is also worth mentioning that the Administrator of St. Stephens hospital showed keen interest in the study.

Data Analysis:

The data collected from both the community and the village have been analysed manually. And thereafter the analysed data have been used to corroborate the qualitative facts by quantitative informations. The data collected from the hospital were also analysed and tabulated in order to find out a definite trend of health care pattern of the communities in resettlement colony and village.

On the whole the tabulated data also helped in comparison of similar variables in two different settings viz., The inter hospital performance, assessment of inter
community (the resettlement slum community versus the village) economic status, socio-cultural practices.

Intra block comparison within the resettlement colony of Jahangirpuri was also carried out. The tabulated data strengthened in qualitative assessment of the situation. Case studies were also incorporated in order to strengthen the qualitative and quantitative data which helped to reinforce the various assumption made in order to carry out the study.

Limitation of the Study

The study was kept confined within one resettlement colony as the time constrain was too much. The resettlement colony dwellers were not easily accessible as they had inhibitions to disclose facts to an outsider, initially so the investigator had to pursue directly and indirectly the people time again about the various types of data for this research study. Besides, the above mentioned difficulties the investigator faced also the following problems during data collection. interview i.e.

1. Heterogeneity of the urban migrant population

2. The women were mostly available at home but not the menfolk as mostly they were out for job. It used to be highly time consuming to contact head of the household. The investigator used to visit two to four
times in a day to interview the menfolk.

3. It was difficult to establish a close rapport with the study population because of urbanized population with variety of occupations and their reservation to divulge the relevant data in the initial stage.

4. As the study was partly institutionally based there were problems to get data because of non-availability of the officials during their duty hours.

5. Frequent entry to hospital and then to visit the inmates were difficult, moreover because the attendants of the patients were not able to give much time to the investigator in the hospital setting.

6. As the study has been carried out on the basis of recall method lapses of memory of the respondent created problem to gather data.
Notes


3. Delhi Development Authority (Slum wing) - D.D.A. (slum wing report, 1988, I.P Estate, New Delhi

4. Banerji, D - Poverty, Class and Health culture, Delhi, 1982.