CHAPTER VI

DISCUSSION AND CONCLUSION:

Health and health behaviour of the slum population depend upon the basic and superstructure\textsuperscript{180,181} of their slum society. It has a historical dimension. In the process of change on the basic and super-structure, the social history of slum population provides empirical evidences in determining the facts of slum formation in Gwalior city. The growth and development of Muriya Pahar and Kampoo slum is of course, the product of urbanisation and industrialisation.

There were a number of complex determining factors such as local inhabitants, dark reaction or effects of the princely state abolition and zamindary system. These altogether were responsible to the formation of Gwalior slums. Endorsing it, such factors have also been observed in some cases of Calcutta slums.\textsuperscript{183,184} Anyhow, health beliefs and practices of dwellers have eventually been transformed along with the physical and structural developments of the slums. Physical structure of the slum is the turn of events of the actual facts.\textsuperscript{185,186} The housing conditions of both slums in Gwalior city are
viewed as much better than the bastis in Calcutta, Patna, Jhuggis in Delhi and Chawls in Bombay. It is observed that most of the houses (75.3%) of these two slums are pacca and they are mostly (87.3%) owned by the slum dwellers themselves, which is not a common feature in the context of the slums in metropolitan cities. Similarly, as far as the total coverage is concerned, water, electricity and latrine facilities are also much better in Gwalior. For example, most of the dwellers (89.6%) in Gwalior city have their own water taps. Thus, all these could make a clear distinction between the slums of Gwalior and the slums of other cities in India. They are considered to be good indicators with regard to positive health and health behaviour of the slum population.

Both the slums have a number of educational institutions specially middle level schools. They are mostly established by private ownership. As an important indicator, such establishment of education and its networking denote that the slum dwellers were quite aware of the benefits of education which in turn influenced their knowledge, attitude and practices of health care activities to a great extent as observed in other settings. For example there are water and latrine
facilities, about 34% families having graduates and above qualified persons.

Apart from historical, physical and educational dimensions, economic determinants of the slum life pattern are main instrumental means and ways in improving the quality of life and health care activities.\textsuperscript{199,200} In view, it is observed that more than half of the slum households are engaged in their settled occupational activities such as services (govt. and private), professionals (doctors, engineers and lawyers) and stable business. Though business people are slightly more in Kampoo slum than Muriya Pahar, most of the people have purchasing power as far as their expenditure pattern is concerned. Along with, some dwellers have also initiated small scale entrepreneurship such as making Carpet, Bidi, Shoe etc. at the local levels. Consequently economic status of slum dwellers has been classified by the established criteria\textsuperscript{120} as only 2.3% very poor, 34.0% poor, 40.3% not so poor and 23.3% well off in accordance with the slum conditions. Poor people are slightly less in Muriya Pahar than Kampoo slum, while other economic categories of the people are more or less same in both the slums.
In fact, such economic determinants in different forms have given the existing shape of health status and behavioural pattern of slum dwellers incorporating other socio-cultural and historical determinants which has also been observed in other studies.\textsuperscript{120,124,136} These forces are interrelated and interdependent which have altogether produced health status as a composite outcome of their network at the slum situation. In addition, such development has also been penetrated by some other social political actions undertaken by the slum dwellers over a period of time. They were basically social movements such as mass mobilisation, formal and informal organisations, and community involvement to the improvement of slum life pattern. In this context, slum residents formed a number of committees including Nagar Sudhar Samiti, Sarva Dharma Manab Kalyan Ashram, Asamta Nibaran Sangh, Slum Vikash Samiti, Pranti Jatav Sabha, Congress Sevadal, Mohalla Sudhar Samiti, Janakalyan Parisad, Bhahu Uddesh Vikash Samiti etc. Beside, they also developed strategies of preventive measures like Suraksha Samiti for controlling anti social elements. For all these the key and influential persons have played a major role as local decision makers within the slums.
Thus, the forces involved in the slum life pattern have formed the basis or state of health and dynamics of health culture affairs taking into account of the nature and extent of health problems and health care service facilities existing in and around the slum areas. Apart from these, the process and subdue contents of health culture are also influenced by the external forces such as watching television programmes, listening radio broadcasting, reading newspaper and getting into the information by their interpersonal communication and personal development etc. Commensurate with these forces, health culture as sub-cultural complex of the entire way of slum life, has been further conditioned by the availability and accessibility of different health care institutions.

Health Institutions and Slum People:

The existence of different health institutions became outcome of certain social changes including socio-economic and socio-political development. In the light of such health institutions and their different types of health care service provisions, the slum
residents have in turn, oriented themselves in fulfilling their required health care facilities. Depending upon the accessibility and availability of health services their adjustments and adaptions for healthy environment have basically been directed by economic conditions of the slum dwellers. Moreover, their knowledge, attitudes, perceptions beliefs and mode of actions regarding health and health problems are manifested as a particular behavioral pattern in their day to day life. Subsequently these have reflected as their state of minds and influenced in articulating and expressing their opinions that have been figured out for understanding their health culture at the slum situation.

Notwithstanding, the diffusion of health culture is perpetuated by some of the determinant factors as the forms of health institutions including qualified (medical) private practitioners, RMPs, vaids, traditional healers etc. that are constituted at the local set up and the government hospitals, corporation dispensary etc. which are comprised of wider network for health care services. Since most of them are of the use of modern allopathic medicine, the other systems of medicine including homeopathy, unani, and ayurved are not that much popular among the slum dwellers. But the poor residents, some
times, preferred to avail these alternatives as against modern system of medicine. Because there are non-availability and inaccessibility of their required health care services, their perception and meaning of health and health problems, and their affordability in terms of time, distance and wage factors.

As believed by the respondents (44.7%) the doctors of government hospitals have been exploiting people in the sense of advising patients to come over to their private clinics where they had to pay. While 27.3% confirmed that such doctors used to provide health care services to the people at hospital itself. In addition, 22.3% of the respondents perceived that doctors of government hospitals provide health services only to the rich and well off people in the society. After all these perception and practical experiences of the slum residents generated a common negative attitude towards the government hospitals and health establishment. The main reasons for such attitudes were, distance, time, lost wages, and private practice of the doctors. But it was not the same for modern system of medicine available in the private sector because they are locally available near to their door steps. This attitude was not influenced by any distinction of educational status of the residents.
Similarly all economic classes came to this attitude towards government hospitals. Thus, the corporation dispensary which is another form of public health care service provision was also viewed by the slum residents just as yet another government hospital. These factual determinants established the social particle of health culture over a period of time.

On the other hand, qualified (medical) private practitioners are quite popular at the slum areas. The behavioural pattern of such practitioners, their availability and accessibility were viewed by the residents in relation to their economic conditions and in the context of required health care services at the slum itself. Thus their perception and beliefs subsequently developed their attitude and behavioural action towards the locally available qualified medical practitioners. Consequently they positively internalised the utility of such practicing as their suitable health care activities at the slum situation. About 90% of the respondents hardened their positive attitudes towards locally available qualified medical private practitioners. Except very poor, all other economic classes seasoned their positive attitude as mentioned above. Most of the very poor people (71.42%) stated that local practitioners are
not so good for them because they don't provide free health care services.

In the light of their positive attitude, within a duration of one month about 20% of the residents made visits to local practitioners in relation to their required health care services. While it was only 0.33% in the case of government hospital. Despite the negative attitude towards corporation dispensary, about 48% of the respondents stated that they made their visits to corporation dispensary only once in the month. Not only this, about 63.15% of the total (228) residents who made their visits to different health institutions for different health problems, had been to the corporation dispensary.

This conflicting health behaviour in the form of visiting corporation dispensary against the culturally determined attitude of the slum people perceived in the context of economic reasons (less cost or free of cost) health care services, simple procedures of utilisation pattern, short time and distance factor and uniform class structure of service receivers clients. With reference to this, for slum dwellers health care services provided by corporation dispensary were cost effective than even locally available qualified medical private practitioners.
But hospital visits were more costly than private practitioners along with its negative attitude. None the less, despite the rigid attitudes towards the health institutions, the slum people modified their mode of health behaviour perpetuating the simple cost benefit required in their life pattern.

However, in the case of locally available registered medical practitioners (RMPs) about 70% of the residents thought that they were qualified medical private practitioners. Except very poor, all other economic classes regarded the same attitude. But within a duration of one month only 5% of the respondents made their visits to such RMPs in connection with the health problems. Despite positive attitude this type of health action taken for, considered to be very low profile in comparison with corporation dispensary and private practitioners. The reason for this health behaviour was confined with economic factors including high price of medicine and fees for services provided by RMPs.

Furthermore, about local quacks, most of the slum dwellers deliberated their negative views, not like what observed and perceived for other institutions. Only 29% considered that local quacks are good for some specific health problems like Pilia (Jaundice) and bone setting.
Anyhow, almost all of them did not make any visits to the quacks for any reason within a duration of one month. All these considerations made it clear that most of the slum people have culturally been conditioned for modern system of medicine and the institutions preferred depending upon their cost and benefit. Few people have their belief on traditional healing system of medicine for some specific health problems and economic constraints at the slum situation.

After all, those dwellers (about 25%) who took health actions made their visits to different health institutions - irrespective of the systems of medicine, specifically for minor ailments, heart/breathing problems, fever/malaria, stomach disorder/pain, and accident and injuries. Concerning the Kampoo slum, minor ailments and heart/breathing problems were not found during last one month period. For this, possible reason was non existence of qualified medical private practitioners who could be approached for such things in comparison with Muriya Pahar situation. According to table no. 62 & 63, these health problem were less prevalent among the poor people compared to the economically better off sections. Because, poor people are forced to suppress their pain and diseases due to economic reasons. Better economic condition led to
their greater health awareness and actions. In this regard, the role of health workers like malaria workers is important to cover up the poorer section. 93.3% of respondents pointed out that they have no idea about such worker visiting and educating slum population. This possibly created the scope for conditioning the present attitudes and behaviour of slum people in the context of health institution like govt. hospital and their health service system.

Socio-Cultural Perception, Meaning and Belief of Health:

According to availability and accessibility of health care services provided by different health institutions, certain attitude and action regarding health and health problems were developed in the mind of the slum dwellers. This frame of mind has furthermore extended their socio-cultural perception, meaning and belief systems at the slum environment. Thus, the concept of healthy person was perceived by the people as the fulfillment of certain basic requirements.

Most of the respondents (60.6%) perceived that the basic requirements of healthy person depend upon the better or good economic condition of the people. Their
educational status was perceived (by 58.3%) as an additional input for the same. However, the perception and meaning of healthy person were viewed in relation to the economic and educational determinants though the external forces including sanitation and hygienic environment are associated with it. As an wider connotation of the subject, it has also a sub-divisional significance in relation to different health institutions that are made available and accessible in a given situation.

Coextensive with the above perceived notion, most of the residents (65%) precisely internalised the necessity of food, clothing and shelter as prerequisite for healthy person. A sizable number of the considered that it could be maintained without medication. However, all these beliefs have thus, been deep rooted as community norms in relation to health culture of the slum population.

Cultural Habits, Norms and Customs and Health:

According to the respondents, people are the servants of their habits. Some of their habits and practices are transmitted from older people and passed on
to younger generation. In fact, these are the products of their subjective connotation generating from their objective or material environment. About 91.6% of the respondents viewed in such a way where some bad habits and practices like smoking and unhygienic or dirty dress pattern of older people cause ill-health of younger generation. Anyway, 59% of the respondents viewed that cultural norms on diet pattern condition the children, then pregnant mother and girl child.

Furthermore, majority of slum population (55%) distinguished that with regard to food eating custom male members are usually given first priority than female at the family level. The concept of purity and pollution of food stuff was viewed by the slum resident as due to dirty things (37.3%) and dirty insects (41%) get into, while only 16% considered it due to untouchable notion of cultural tradition. In the case of fasting practices, about 40.6% of the residents deliberated their views that older people do occasionally practice fasting for religious point of view which in turn relates their better health at slum situation. Consistent with this view, 56.6% expressed that there is nothing special for such practices while 42% of the respondents were of the opinion of regular worships.
In the day to day life activities of slum population all these including their habits and practices are regularised as part of their health culture. All these are the results of a long run perpetuation of such activities at the slum settings. Modification and change in these cultural traits are observed as very slow and gradual manner.

Child Health and Slum Population:

In the light of the common cultural beliefs system developed over a period of time, 73.3% of the respondents had viewed that education of the parents is most important for the positive health of the children. It was supplemented by the key respondents that educational status is a product of economic status, so that positive health of the children requires both the present economic condition of the parents and earlier economic status by which the parents were being educated. These in turn, developed a certain norms of aspirations among the parents in the forms of child care and proper attention to the child as was viewed by 73.6% of the respondents.

In consistent with economic power as mentioned above and the child development, about 96.3% of the
respondents considered nuclear family as the ideal type of family in the slum situation. In addition, these residents (66.6%) perceived and categorically pointed out on their multiple choices that poverty is the main reason of population growth. Consequently all these are manifested in the life pattern of slum people due to their economic condition.

Health Behaviour and Slum Population:

This part of discussion is basically dealt with the measures and actions adopted by the slum dwellers in the context of their health and health problems encountered in the day to day life. In other words, how and what extent the cultural perception meaning and attitudes about the different health problems or diseases are molded into action in the way of life of the slum residents.

According to the slum dwellers proper diet intake is practiced as the common care for one's own health. In addition they also maintain regular cleanliness for their good health. Apart from these, some people (41.3%) did not do anything special for their health. But in case of illness, slum dwellers usually watched common symptoms
that are locally known to them, and confirmed those consulting with the family member, then went for treatment. Thus, 83% consulted locally available private medical practitioners. Well off section of slum residents (89.99%) were the potential consumers than other economic groups in this regard.

On the other hand, almost all (97%) slum residents could not come across with any government health workers visiting slum population for health care activities. Therefore still, the residents (45.6%) consider the use of herbal plants as the treatment of some diseases including measles, chicken pox bone setting etc. In addition they also prepare some home remedies such as 'Kachha Haldi' (turmeric) juice for normal cough and could, some solution from 'tulshi' leaves for blood purification or antibiotic, raw potato juice application for burned cases etc. Anyhow all these are some of their local health care practices persisting/pertaining from generation to generation at the slum areas.

Health and Family Welfare Activities:

The cultural attitude towards girl child and the belief system over women's health, are boosted by the
socio-economic conditions and available and accessible health care services which have in turn, conditioned the health status of women at the slum areas. Some aspects including ante natal, postnatal delivery, contraceptives uses that are very much crucial for reproductive health are manifestations of their health status. For example the utilization and adaption of family planning contraceptives is an indication to understand the extent of women's health behavioural pattern.

Within their local knowledge and awareness about family planning, most of the resident (55.6%) didn't practice any contraceptives. Only 16.6% of women adopted the tubectomy as their permanent methods. While for family planning very few male member (2%) adopted vasectomy. Similarly the nirodh or condom users (9.3%) and terminal contraceptive users (5%) were very less at the slum area. The buyer of contraceptives such as nirodh are more than the people who have managed such things free of costs. The main reason of such practices is that there was almost no efforts made by health staff to motivate people about spacious and reproductive health. But the interesting finding is that lower economic groups are very much receptive in to the adaption of tubectomy and use of nirodhs than the higher income groups. This adoption of
contraceptives don't have significant relations with their educational backgrounds.

Since most of the deliveries are conducted at home, the child's birth registration is less (29.3%) at the slum area. The same is very less in the case of death registration also. However, most of the respondents preferred to have three child family (39.3%). One child in a family (17%) is also increasing at the slum area. Again most of the deliveries (41.3%) are conducted by local dais. But the deliveries conducted by the doctors in private clinic (37%) are increasing, while the preferential attitude of conducting delivery is higher in hospital (41.3%) than at home (30%) and in private clinics (22%). It was perceived because free of cost and safety measures in hospital. This attitude is more receptive among the higher education groups than lower educational levels, but no differences among their economic groups.

Regarding abortion, the slum dwellers have some cultural values - specially unmarried girls and newly married couples that they should not have any abortion. As a result, they (44.6%) didn't have any idea whether abortion is legal or illegal. Beside some people (23.5%) have understood abortion as illegal. As they believed, most of the residents (54.3%) didn't know where the
abortion services are available. While some people (45% in their multiple responses) could understand such services available at private clinics and nursing homes. Anyhow, very few persons (5.6%) conducted abortion only once by modern surgical methods. In fact, according to the key respondents, some of unmarried girls did their abortion hiding the facts because of social and cultural reason.

Health and Child Development:

Child's health is the first and foremost priority among the parents in the process of child rearing or socialisation. It begins with breast feeding. Majority of slum residents (73.3%) strongly believed that breast feeding is good for the children. Few residents (17.6%) considered it for both child and mother. But, still very few dwellers (9%) viewed that breast feeding is not good for mother. They thought it in terms of lack of lactation and physical beauty/attraction of the mothers.

Anyhow, half of the mothers population practiced their breast feeding to their children up to twelve months of age. Some mothers continued the same up to 18 months. Consistently most of them (60 %) started providing solid
food to their children at the age of six months. Some mothers (24.6%) started the same at eight month age of children.

For the immunisation of children, the slum dwellers were not much clear and need some more exposure. Because, the health workers did not make frequent visit to the slum people. However, some people came to know about immunisation on their own (43.3%) and could manage by ensuring immunisation for all of their children. While a sizable people could not be the proper beneficiaries of immunisation for their children either due to lack of knowledge or deliberateness. This was quite higher (54.5%) in Muriya Pahar than (31%) in Kampoo. The basic reason was lack of the visit of health workers interpersonal communications. Anyhow, most of the slum residents went to the hospital for immunisation despite their negative attitude. Dispensary was highly persisted in Muriya Pahar while the dwellers of Kampoo mostly went to hospital for the immunisation of their children. In view of their economic strata the higher economic income groups have availed immunisation facilities much more than the lower economic groups.
Culture and Woman Health:

Slum dwellers were aware of women's vulnerability. But, due to economic reasons the extent of such vulnerability was quite widened at the slum areas. As believed by the dwellers, adult girls of marriage age should get married as virgin, without illegitimate relations and social stigmas. Thinking about daughter's future, the poor parents drew attention to all the factors that are responsible for marriage. As a result some times early age at marriage of girls and their child bearing practices cause ill-health for women. However, 76.3% of respondent believed that age at marriage of a girl should not be less than 18 years. Besides, 60.6% considered their beliefs over exogenous marriage. In addition, due to lack of physical exercise and proper diet and nutrition, the old age problems have gradually been increasing in the slum areas.

Cultural Perception and Practices of Health Problems:

In the manner of the cultural habits, beliefs and customs, slum dwellers perceived their health problems and diseases in such a way where the external (subjective and
objective) environment of the organic system of human being becomes imbalance when its required inputs are not properly getting into the system itself. As believed by Madan Singh, key respondent, negligence and lack of awareness about health and hygiene are some of the causative factors for the prevalence of some diseases including 'haiza' (cholera), diarrhoea, malaria etc. On the other hand, shortage of water facilities, latrine, kachha drainage system etc. more responsible as the causative factors for such diseases at slum situation.

Nevertheless, for the perceived notion of different communicable diseases, majority (58.3%) considered physical environment which is made by man as the main causative factor in their multiple responses, while illiteracy of the people was contemplated (by 50%) as responsible for the same. Prevention of these diseases could be done and by improving socio-economic conditions of the people (30.6%) by increasing literacy rate (24%).

But the slum dwellers believed certain factors such as acute pain, excessive physical exhaustion exposed with to much heat and cold etc. as the normal causes of common fever. They also believed that when common fever does not go off, they suspect it as malaria and go for consultation with medical practitioners. In such a
situation, 98% of the respondents took action for malaria and consulted doctors (private practitioners). In the case of common pain and ache, key respondent, Mr. Dixit stated that about 90% of the slum people don't take any medication, only few (rest) go for medical treatment. Again, Dr. Jain, a private practitioner of the locality expressed his views that slum dwellers are not much aware of Jaundice disease, because, at the initial stage of this disease, patients used to undergo local healing treatment, but they are now coming forward for modern treatment as well.

Tuberculosis is one of the vulnerable diseases associated with a number of social and economic factors of slum people. It is quite value loaded disease, locally known as "Chut Ki Bimari". In this context, 26.3% of respondents perceived it as untouchable disease, 22.3% considered, it needs social isolation, while 15.3% perceived it as hereditary. On the other hand they (48.6%) believed that it is curable at TB clinic and some (29%) considered its proper treatment available at hospitals. However, 98.3% of the respondents deliberated their views that TB patients should consult doctors for treatment.
Leprosy is also viewed by the slum residents like tuberculosis. But its prevalence was very less at the slum areas. 62.6% of the respondents did not have any idea about leprosy disease. For the treatment 75% did not know what would be appropriate measures for this disease, while 25% considered, that in case of leprosy doctors should be consulted. Consequently such knowledge, attitude and belief regarding leprosy were confined among the slum dwellers due to its social isolation and non-existence of leprosy cases at the slum area.

On the report of the key respondents, diarrhoea was common health problem specially for the slum children. It is caused not only due to water contamination, but also due to food poisoning including eating food stuff here and there outside. Poor people are the vulnerable groups for this disease. Nevertheless, slum dweller have undertaken a number of measures for controlling diarrhoea problem. Of course, 41.6% believed that for diarrhoea problem, doctors should be consulted. But ORS or salt sugar solution was used by 22.6% in case of diarrhoea. Whereas 20% believed that banana should be given to the diarrhoea patients as control treatment.
In case of measles and chicken pox, some traditional belief systems are still existing at the slum situation. They are locally known as 'chechock' (measles) and 'chotimata' (chicken pox). According to the opinion given by Dr. Jain, earlier such disease prevalence were found during the hot (summer) season, but, now, it could be seen at any time. However, as believed by the slum residents, such patients are usually given very cold liquid stuff such as 'matta' (one kind of curd) to have. They are given bath with 'Neem Patti' boiled water, and usually kept in a isolated cool place. Anyhow, in addition to their belief and cultural practices, 29% of the respondents considered that measles and chicken pox cases should be given allopathic and hospital based treatment. It means they are coming forward to the modern system of medicine by changing their cultural traits.

Accidents and injuries are very common at the slum areas. Most of people in such situation usually consult private practitioners available at the locality, and proceed up to hospitals and nursing home for further treatment if necessary. For dog bite, they believe modern allopathic treatment, even for snake bite too which is very rare, most of the people deliberated their views towards the treatment of modern allopathic medicine. In
the case of leucorrhoea that are found among the hard working women, they know the reasons of the disease, but they don't have any other option such as complete rest and good food and clear dress, because they have to do hard work. In addition, for cough and cold, their common belief and attitude are confined towards home remedies such as mustered oil massage on the chest of the patient, 'haldi' juice with milk intake etc.

Furthermore, in the slum area, night blindness (eye disorder) is very common. For this, slum dwellers believed that the main reasons of this eye disorder are the shortage of vitamin 'A' and lack of nutrition in the diet. Anyway they used to consult the doctors in this regard, skin diseases are common among the poorer section. They can not take proper care about their hygiene and cleanliness of their children because they are always struggling for existence. Moreover, despite the polio immunisation about 25 polio cases were reported. The data were basically collected before the nation wide pulse polio programme for the mass started as polio eradication drive in the country. Beside, "few people (10-12%) are having heart problem" said Dr. Sharma. They are having treatment from the local private practitioners, and mostly belonged to well off sections.
Apart from all these health problems and diseases, 42.3% contemplated their opinion that they do not do any special cleaning for drinking water. But, in the case of consuming alcohol, about 70% of the slum adult male people use to consume alcohol frequently. Among them 5% are alcoholic and 15% are regular alcohol consumer but not alcoholic. In addition, about 47.3% of the families had smokers and 23.6% households had tobacco users. These bad habits persisted in all economic classes but the extent was higher towards the poor section at the slum areas.

Conclusion:

On the basis of facts and figures the slum situation of Gwalior city is understood as a typical by nature and slightly different from the slums of other metropolitan cities in India. But little similarity is observed in the context of growth and development that other slums pertain. The development of health culture of the Gwalior slums has been examined as sub-cultural complex of entire way of life of the people and has been attributed by a number of forces derived from its historical, social and political dimensions.
In fact, the determinants of health and health behaviour of people dwelling in the slums of Gwalior city are the products of their socio-economic forces such as expenditure and purchasing power of food, cloth, housing, education modern household necessities etc. In the process of individual and community initiation these have been inter linked with the purposive interventions such as health care service provision of public sector to improve the health status of the people and business interests of private sectors. In addition, some governmental inputs including electricity, water and sanitation road and communication etc. have been channelised through socio-political processes and active community participation for the better quality of life of the people.

Since the purchasing power of different economic groups of slum dwellers like well off, not so poor, poor and very poor are different at a point of time, their knowledge, beliefs, attitude, perceptions and meaning of health, health problems are not uniform in their health behaviour and health care practices at the slum situation. Their educational backgrounds that is higher and lower are not qualified by showing a significant variation in most of the determinant variables or indicators, for example,
bad opinion or negative attitude about government/public hospitals and dispensaries. While for some specific health needs like immunisation of the children and conducting delivery the dwellers have affirmative belief towards the action to be undertaken in the public or govt. hospitals and dispensaries because of their reliability of drugs, sophistication of equipments and safety measures.

As far as the findings of this study are concerned, over a period of time the slum dwellers of Gwalior city have developed a set of cultural perceptions, meanings and beliefs about their health and illness that has formed the basis for their health seeking and health promoting behaviour. Their health and other institutional arrangements within which their behaviour occurred and their socio-economic, political and physical context were responsible for those beliefs and institutions.

However, at the head of the lists of their possible health problems and human suffering in the urban slum development which can be reduced is a low level of public health and health care services, for example, lack of health worker's visits to the slum area.

There should not be the inevitability and continuation of adverse urban development. It can be stated categorically, that present technological knowledge
and administrative experience on decentralised or local level planning and management, fully applied is now adequate to meet the developing situation in the slum areas as far as health, hygiene, sanitation and housing are concerned.

Not all the difficulties of growing slums can be cured by a solution of the health problems, such matters as employment, transportation, education and other related social and economic problems are also involved. But few of these can be effectively managed, unless the slum environment is wholesome or integrated the felt-needs of the community and the people are endowed with health and vigour. Thus, modern health services and effective water and sanitation are indispensable. They are moreover, a basic human right.

This slum situation greatly accentuates the major problems of public or community health; these problems since of local primary concerns, can be dealt with in all their aspects effectively by encouraging community participation, needs based planning of local authorities of slum including Nagar Nigam or Municipal Committees. Health problems of slums are therefore, a national responsibility of higher priority specifically in terms of decentralised planning of resource allocation and
Furthermore, the problems of health and sanitation and unwholesome housing, which are an increasing urban scourge, are man made, are the direct result of neglect, ignorance and weak health administration what is required is a strong political will, and determination to take action in fulfilling felt-need by providing an integrated package of inputs into the determining factors of health culture of the slum dwellers.

The dimensions of health culture in the health programmes are not generally appreciated, and little efforts are made to build these components as well as into health service systems. If these are done the quality of life of the slum dwellers will be much better as an outcome of their health status and the effectiveness of the health programmes will be greater.