CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

1. Urbanization:

Urbanisation is one of the major social changes sweeping all over the world, especially in developing countries, where urban growth rates are rapidly increasing. Urbanisation brings fundamental changes in the ways people live — in the number of people they see, in the places they work, and often in the quality of water they drink, the air they breathe, and the housing in which they live. Such changes have profound implications — both positive and negative — for the health of city residents.¹

In considering the three main aspects of urbanization — geographic, administrative and demographic — the United Nations Expert Committee was of the opinion that consideration of health problems should not necessarily be confined within the geographical limits of a town or city. Problems of water supply and sewage disposal, for example may involve extension of urban influences to areas beyond its physical boundaries.²
Similarly the need for health services often extends beyond the administrative limits of the municipalities.\(^3\) The demographic aspect of urbanization, however, appears to be the overriding factor in considering problems of urbanization.\(^4\)

In fact, urbanization as understood by the Expert Committee of World Health Organization on Public Health Administration, 1963\(^5\) is the process whereby an increasing proportion of a country's population lives in urban localities, is a natural process which has characterised the last century over the whole world. One of the main, but not the only, causes of this process has been the increasing industrialization of urban areas with the attendant immigration, both permanent and temporary, of people from rural areas for economic and social reasons.\(^6\)

Urbanization has been characterised by a phenomenal growth of large cities. Rural to urban migration has been the major component of this rapid growth.\(^7\) At present, it has been estimated that nearly one-third of the world population lives in sub-standard conditions.\(^8\) This is equally true in urban slums. This process of urbanization has not only been affecting ecological equilibrium (i.e., the population density at the given locality and the state of carping capacity of a
given area), but has also been pushing the people who have migrated from rural area into precarious socio-economic conditions which impede the attainment of good health. 9

In fact, urbanization has been emerging as an important issue for the developing countries for quite some time. 10 And the health status of the people who have been congregating in the cities to earn their livelihood are staying in the sub-human conditions like basties, jhumpadis jhuggis etc. and this health status is declining more than before.

As the world population has been estimated to increase from 4.4 billion in 1988 to 6.2 billion by the year 2000, the urban population will also increase from 1.8 billion to 3.2 billion during the same period. Over 2 billion of which will be in the developing countries. 11 In the same manner, India's urban population will increase from 231.60 million in 1990 to 330.02 million by the year 2000 as shown in table 1.
Table 1:

<table>
<thead>
<tr>
<th>Year</th>
<th>%age of population residing in urban areas</th>
<th>percentage of urban population residing in Urban Agglomeration (out of total 24 cities)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bombay</td>
</tr>
<tr>
<td>1950</td>
<td>17.3</td>
<td>4.70</td>
</tr>
<tr>
<td>1955</td>
<td>17.6</td>
<td>4.94</td>
</tr>
<tr>
<td>1960</td>
<td>18.0</td>
<td>5.11</td>
</tr>
<tr>
<td>1965</td>
<td>18.8</td>
<td>5.21</td>
</tr>
<tr>
<td>1970</td>
<td>19.8</td>
<td>5.30</td>
</tr>
<tr>
<td>1975</td>
<td>21.3</td>
<td>5.18</td>
</tr>
<tr>
<td>1980</td>
<td>23.1</td>
<td>5.08</td>
</tr>
<tr>
<td>1985</td>
<td>24.3</td>
<td>5.31</td>
</tr>
<tr>
<td>1990</td>
<td>25.5</td>
<td>5.66</td>
</tr>
<tr>
<td>1995</td>
<td>26.8</td>
<td>6.05</td>
</tr>
<tr>
<td>2000</td>
<td>28.6</td>
<td>6.24</td>
</tr>
</tbody>
</table>


However, according to World Population Perspectives it was found that in India 17.3 % of the total population resided in urban areas in 1950. This percentage of population gradually increased in the urban areas as 18.0 % in 1960, 19.8 % in 1970, 23.1% in 1980 and 25.5 % in 1990. It is estimated that 1995 it will be 26.5% and 28.6% in 2000.
Similarly, there are 24 cities that have been considered as Urban Agglomeration in India. The percentage of urban population residing in urban Agglomeration particularly in Bombay, Calcutta, Delhi and Madras has indicated as different by nature. In 1950 there were 4.70 % of urban population residing in Bombay, 7.21 % in Calcutta, 2.25 % in Delhi and 2.27 % in Madras city. These percentages have been increased over a period of time. The trend of increase in urban population in these cities has been projected in table no. 1. It has a lot of developmental implication - particularly health in the cities.

Again there are 24 cities out of 102 major cities with more than 2 lakh population have been listed in the chart of United Nations Urban Agglomeration by the year 1990. Among those cities Bombay, Calcutta, Delhi and Madras have already been declared as megapolises.

According to the Seventh Five Year Plan document it is stated that including four megapolises there are number of cities and towns in India including 216 class-I (100,000 and above population), 270 class-II (50,000 to 99,000 population), 1048 class-IV (10,000 to 19,999 population), 742 class-V (5,000 to 9,999 population), and 230 class-VI (less than 5,000 population).
2. Slums and Urbanization:

One-third of India's urban population lives in slums of the cities. According to an official estimate it was placed at 57 million or about 28% of urban population, as of 1987-88. The slum population, with the current rate of urban growth could be placed somewhere between 75-80 million, as of 1991.

In fact, during 1981 census there was a decision taken by the Government of India to prepare an inventory document of slums in class-I and II cities and towns. It was basically a decision to help the planners to prepare plans of action for improvement of slum dwellers vis-a-vis making provisions of basic civic services. From the calculation of the census data, it could be stated that in the 12 states of India 269 out of the 489 class-I and II cities and towns have notified slums as shown in table 2.
Table 2:

Distribution of Slum Population of Notified Slums, Their Area, Density Pattern by Class of Cities and Towns.

<table>
<thead>
<tr>
<th>Class-size</th>
<th>No. of Towns having notified cities and towns</th>
<th>No. of notified slums</th>
<th>Slum population (%</th>
<th>Slum area (sq.km.) in slums</th>
<th>Density (per sq.km.) in slums</th>
<th>Density (%) having slums</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDIA</td>
<td>489</td>
<td>269</td>
<td>6741</td>
<td>15.10</td>
<td>4.76</td>
<td>5.641</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>200</td>
<td>138</td>
<td>5787</td>
<td>15.01</td>
<td>3.69</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>289</td>
<td>131</td>
<td>954</td>
<td>15.36</td>
<td>8.80</td>
</tr>
<tr>
<td>1. Andhra</td>
<td>Total</td>
<td>52</td>
<td>44</td>
<td>850</td>
<td>12.43</td>
<td>2.93</td>
</tr>
<tr>
<td>Pradesh</td>
<td>I</td>
<td>21</td>
<td>18</td>
<td>659</td>
<td>11.75</td>
<td>2.95</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>33</td>
<td>26</td>
<td>191</td>
<td>14.60</td>
<td>2.95</td>
</tr>
<tr>
<td>2. Bihar</td>
<td>Total</td>
<td>39</td>
<td>15</td>
<td>295</td>
<td>25.92</td>
<td>4.69</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>14</td>
<td>11</td>
<td>258</td>
<td>26.03</td>
<td>4.98</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>25</td>
<td>4</td>
<td>37</td>
<td>24.93</td>
<td>3.17</td>
</tr>
<tr>
<td>3. Gujarat</td>
<td>Total</td>
<td>38</td>
<td>22</td>
<td>302</td>
<td>5.79</td>
<td>12.89</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>11</td>
<td>8</td>
<td>197</td>
<td>3.53</td>
<td>2.35</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>27</td>
<td>14</td>
<td>105</td>
<td>14.14</td>
<td>16.49</td>
</tr>
<tr>
<td>4. Haryana</td>
<td>Total</td>
<td>16</td>
<td>11</td>
<td>117</td>
<td>12.43</td>
<td>3.74</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>9</td>
<td>8</td>
<td>103</td>
<td>13.77</td>
<td>4.12</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>7</td>
<td>3</td>
<td>14</td>
<td>3.84</td>
<td>0.94</td>
</tr>
<tr>
<td>5. Jammu &amp; Kashmir Total</td>
<td>2</td>
<td>12</td>
<td>2.36</td>
<td>0.56</td>
<td>3,144</td>
<td>13,171</td>
</tr>
<tr>
<td>I</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>II</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Karnataka</td>
<td>Total</td>
<td>30</td>
<td>23</td>
<td>311</td>
<td>4.31</td>
<td>0.44</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>14</td>
<td>13</td>
<td>256</td>
<td>3.92</td>
<td>0.42</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>16</td>
<td>10</td>
<td>51</td>
<td>7.37</td>
<td>0.56</td>
</tr>
</tbody>
</table>

Cont.....
<table>
<thead>
<tr>
<th>Class-size</th>
<th>No. of Towns</th>
<th>No. of Slum notified</th>
<th>Slum population (%)</th>
<th>Slum area (sq.km.) in town (per sq.km.)</th>
<th>Density in slums (%)</th>
<th>Density in towns having slums (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India/States and no. of cities and towns</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7. Maharashtra</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>29</td>
<td>1478</td>
<td>22.24</td>
<td>0.89</td>
<td>9,540</td>
</tr>
<tr>
<td>I</td>
<td>14</td>
<td>22</td>
<td>1392</td>
<td>22.11</td>
<td>0.85</td>
<td>10,067</td>
</tr>
<tr>
<td>II</td>
<td>27</td>
<td>7</td>
<td>86</td>
<td>25.92</td>
<td>1.49</td>
<td>5,926</td>
</tr>
<tr>
<td>8. Madhya Pradesh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>38</td>
<td>416</td>
<td>15.63</td>
<td>8.94</td>
<td>3,433</td>
</tr>
<tr>
<td>I</td>
<td>29</td>
<td>13</td>
<td>233</td>
<td>15.05</td>
<td>15.63</td>
<td>3,520</td>
</tr>
<tr>
<td>II</td>
<td>25</td>
<td>25</td>
<td>183</td>
<td>17.13</td>
<td>16.43</td>
<td>6,235</td>
</tr>
<tr>
<td>9. Rajasthan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>6</td>
<td>141</td>
<td>6.82</td>
<td>0.89</td>
<td>3,682</td>
</tr>
<tr>
<td>I</td>
<td>11</td>
<td>4</td>
<td>136</td>
<td>7.31</td>
<td>0.69</td>
<td>3,527</td>
</tr>
<tr>
<td>II</td>
<td>10</td>
<td>2</td>
<td>5</td>
<td>2.62</td>
<td>4.11</td>
<td>5,926</td>
</tr>
<tr>
<td>10. Tamilnadu</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>62</td>
<td>31</td>
<td>1222</td>
<td>15.16</td>
<td>3.02</td>
<td>10,371</td>
</tr>
<tr>
<td>I</td>
<td>21</td>
<td>13</td>
<td>1114</td>
<td>16.02</td>
<td>2.30</td>
<td>12,688</td>
</tr>
<tr>
<td>II</td>
<td>41</td>
<td>18</td>
<td>108</td>
<td>10.20</td>
<td>4.66</td>
<td>5,053</td>
</tr>
<tr>
<td>11. U.P.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>24</td>
<td>249</td>
<td>5.39</td>
<td>7.39</td>
<td>6,990</td>
</tr>
<tr>
<td>I</td>
<td>30</td>
<td>14</td>
<td>202</td>
<td>5.05</td>
<td>5.65</td>
<td>7,346</td>
</tr>
<tr>
<td>II</td>
<td>38</td>
<td>10</td>
<td>47</td>
<td>8.41</td>
<td>14.61</td>
<td>4,878</td>
</tr>
<tr>
<td>12. West Bengal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>24</td>
<td>1348</td>
<td>28.34</td>
<td>17.29</td>
<td>10,751</td>
</tr>
<tr>
<td>I</td>
<td>24</td>
<td>12</td>
<td>1225</td>
<td>28.28</td>
<td>16.64</td>
<td>11,771</td>
</tr>
<tr>
<td>II</td>
<td>40</td>
<td>12</td>
<td>123</td>
<td>28.63</td>
<td>21.77</td>
<td>6,784</td>
</tr>
</tbody>
</table>

Source: Census of India 1981, Occasional Paper No. 3 of 1988;
Negative aspects of Organization.
138, out of the total class-I cities and towns have slums. In the states of Andhra Pradesh, Bihar, Gujarat, Haryana, Jammu & Kashmir, Karnataka, Madhya Pradesh and Maharashtra, and their 70% of class-I cities and towns have reported the existence of slums. All the million plus cities (above 10 lakh population) have notified slums. As against this, only 45% of class-II cities and towns in these states have also the reported existence of slums. However, in the states of Bihar and Rajasthan, the class-II towns have slums but their percentage are 16 and 20 respectively. In all these towns and cities, 6741 slums areas have existed giving an overall average of 25 slums. In class-I cities the notified slums are 5787 and on an average 42 slums existing in each of them as against 7 in class-II towns. An estimated number of slum population and its' proportion in cities of various size range is given in the table no. 2.

In view of, the situation in million plus cities is more alarming. There are such cities, namely Greater Bombay, Calcutta, Madras, Delhi, Kanpur, Ahmedabad, Bangalore, Hyderabad and Pune; Calcutta has the maximum number of slums (1015) followed by Madras (782), Greater Bombay (619); Hyderabad (455) and Pune (327). Among these
metro-cities, the percentage of population living in slum areas is the highest in Calcutta (30.26), followed by Greater Bombay (27.63), Pune (22.81), Madras (19.34), Hyderabad (15.89) and Nagpur (13.16). Proliferation of slums in large urban settlement and metro-cities severely affects the health of the urban poor.

In this regard there are some studies that already revealed the facts of the slum situation in India. With the country's slum population at present nearly 30 million slum dwellers form 32% of the population in Delhi, 38% in Bombay, and 42% in Calcutta. The situation is not better in the eight other metropolises such as Bangalore, Hyderabad, Ahmedabad, Kanpur, Pune, Nagpur, Lucknow and Jaipur. The slum population, the governmental efforts notwithstanding is expected to show a sizable increase by the decade adding further to the housing and sanitation problems (Bhatnagar 1986).

3. Nature and Characteristics of Slums:

According to Charles Abrams, slums are punctuated almost every city of the world. Few countries deny their existence; they can be found in the Casba of Tunis - or the restore centres of Havana and Bermuda. In some places a whole city may be a slum.
Types of slums vary from one place to another, as does the definition; they include metropolitan and rural slums, new slums, hand made and prefabricated slums. Some are made of scrap; others are put together with mud, adobe, thatch, plastics or wood findings. There are single room slums of Calcutta, Bombay, Ahmedabad, Kanpur, and Nagpur which are unfit for habitation. Factory workers live in insanitary chawls or airless, flimsy mud huts.

Since there is no general agreement on the definition of a slum, some writers regard it as a special type of disorganized area. Others treat the terms "slums" and "blighted area" as synonymous. Bergel (1970) stated that slums may be characterized as areas of sub-standard housing conditions within a city. But, according to Desai and Pillai, opinions differ on the definition of a slum. As there are varieties of slums, definition too are not a few. However, Anderson Nels (1970) in his article entitled 'Characteristics of Slums' quoted a definition of slum which is offered in the report on Urban Land Politics of the United Nations. It is as follows with others.
4. Definition of Slum:

"... a building, group of buildings, or area characterized by over-crowding, deterioration, unsanitary conditions or absence of facilities or amenities which, because of these conditions or any of them, endanger the health, safety or morals of its inhabitants or the community." 22

It is observed that while the slum is all this, Anderson says, it may be something more, as when it is seen in relation to urban change and growth. It may be an interstitial areas of apparently static character, surrounded by areas in process of change. Or, in time perspective, it may be a habitation area in an interim position between a former better use and a coming new use of the space. 23 Without doubt, individuals may be blamed for some aspects of the slum, but it is too much to blame them for its' existence. It becomes somewhat apparent when we enumerate some of the characteristics of slums. They are; appearance, economic status, overcrowding population, urban land politics, health and sanitation, morals, way of life, social isolation, mobility, slum
permanency etc. 24

Again, slums can be classified along a continuum. 25 They differ in physical setting, overcrowding, permanence of the inhabitants, degree of organization among the residents and type of problems presented. Physically, slums may be more shanty towns, collections of hovels made of scrap materials, hastily erected on unauthorised land and without even the basic comforts of water and sanitation facilities.

Others may range from substantial multistoried tenements to palatial old houses formerly occupied by wealthy citizens. Slums may be either rented or owner occupied, either legal or illegal. They include cabins, shanties, dens, dugouts, sheds, stalls and other manifestations of poverty. 26

However, according to Abrams (1946) 27 the slums in the United States have been classified as: (1) the "metropolitan slum", which dates from the time of the great immigration; (2) the "rural slums"; (3) the "ghetto", characterized by congestion, because of limited range of available dwellings; (4) the "company slum", homes owned by employers, for workers in coal mines and textile plants; (5) the "perpetuated slum", shacks and
cabins intended for temporary use but continues as homes for families who can afford nothing better; (6) the "depopulated slum", ghost towns and section of cities hit by depression; (7) the "over-run slum" a once livable area invaded by factories, a high-way or railroad, smoke, dust, noise odors and ugliness; (8) the "land-me-down slum", once fashionable buildings subdivided into small units; (9) the "regenerated slum", kept going by occasional repairs, though many defects exist; (10) the "home-owned slum", and (11) the "potential slum", a poorly built and designed sub-division, which will turn into a slum within a few years.

Actually slums differ in the degrees of organization among their residents. In some, few ties beyond the immediate families and even family ties may be weak. In other more stable slums, quite close group and family relationships have developed. In the sense they constitute real slum communities, with set of 'norms' and 'values' that differ sharply from those of the outside world.28

On ever-present phenomenon of the rapidly developing cities of Africa, South America, and Asia particularly India and Pakistan, is the extensive communities of squatters and shanty-town swelters that
have sprung up in and around peripheral areas of cities. In many cities of the world, particularly in Asia, large numbers of pavement dwellers live, either alone or in families, on the streets. They are "mobile squatters" with out houses. Here, the pavement dwellers in Bombay and Calcutta have not been considered as slum dwellers because, many live in non-slum areas, some are transient, and they have little distinct physical and social unity.

There are various types of squatters: the "owner squatter tenant", the "squatter holdover", and the "floating squaller". Latin American cities have many older and more permanent slums and probably some of the worst shanty-towns in the world. In these cities during colonial days, public buildings and the houses of wealthy were grouped around large plazas, while, outside the city proper, semiautonomous villages of workers, Negroes and Indians grew up without municipal services or streets. Such slums are known as "Jacales" or "colonies proletarios" in Mexico; "favelas", mocambos", "algados", in Brazil; "Callampas" in Chile; "Villas", "miserias" in Buenos Aires; "barrios clandestinos" in Colombia and Peru; and "ranchos" in Venezuela.

5. An Overview of the Slums in the World:

In an attempt made by Desai and Pillai (1972) to
draw a picture on slums situation all over the world, it has been stated that the slum has come to be accepted as a living reality, an inevitable phenomenon accompanying urban growth in all countries. Most of the cities have slums, be it in developed or developing countries.

It is well known that even the United States, the richest and technologically the most advanced country in the world, has slums. There is the "Other America" with its shocking conditions of sub-standard housing, poverty, ill health and hopelessness.35

Migration to the United States began in the last century itself.36 The problems are much more depressing in the developing regions. There is hardly any big city in Latin America which does not have slums. Mexico city, Cartagena city, Buenaventura, Barranquilla, Lima, Caracas, Buenos Aires, Medellin, Calli — all have slums and shanty towns. They call it by their own names. All of them are usually found in the periphery of the city, and in vacant spots within the city, including even hills where they live in huts of clay,37 stick and scrap materials.

In the case of a slum called "Chambacu", near Carlagena in Colombia, the majority were unskilled workers and those with irregular or unavoidable occupations. Their income was so low that they spent 80 % on their food
alone and 70% of the children were undernourished. The Chambacu slum grew on an island which sprung up due to garbage-dumping in a lagoon.38

According to Oscar Lewis (1958),39 in Mexico city, one-third of the population live in slums. He found that in one Vecindad about 85% of the families had an average monthly income of less than 200 pesos or less than $16. Many families i.e., about 6 members, lived in with 8 to 10 pesos per day.

However, from his extensive study of slums life in the Latin America region, Lewis has developed the concept of "culture of poverty" to quote him, "the culture of poverty would apply only to those people who are at the very poor bottom of the socio-economic scale — the poorest workers, "the poorest peasants, plantation labourers and that the large heterogeneous mass of small artisans and tradesmen; they are usually referred to as the lumpen proletariat".

He also found that "culture of poverty" has economic, social and psychological characteristic. Unemployment, low wages, an assortment of unskilled occupations, child labour, absence of savings, chronic shortage of cash, the habits of frequent buying of small quantities of food as and when they need arises — all
these are under economic characteristics. Social and psychological characteristics are included as overcrowding, congestion and lack of privacy, alcoholism in a high degree, beating of children and wife as a matter of course, authoritarianism, emphasis on male superiority, a sense of resignation and a high tolerance for psychological pathology at all kinds.

According to UNICEF (1986)\textsuperscript{40} report, about one third of the children of slum dwellers go to school. 60\% of their children suffer from malnutrition and have highest morbidity due to diarrhoea. The women in slum area seek work to support their families in adverse and low income jobs and run a risk of physical and mental stress. Once again, according to Rossi-Espagnet (1984)\textsuperscript{41} in addition to all the diseases there are three other groups of factor which are detrimental to health that operate heavily against the poor slum dwellers. The first includes low income, insufficient diet, overcrowding, under protection and limited education. The second relates to man-made conditions of environment such as industrialization, pollution, traffic, stress and alienation. The third is the result of social and psychological instability and insecurity. It is just the excessiveness vulnerability of the urban poor and their
exposure to the pathogenic agents. It means that malnutrition and infectious diseases are severe health problems in the slums and shanty towns.

The slum is a distinctive sub-cultural group within the larger socio-cultural milieu or in other words an independent phenomena. According to Lewis (1976) the solution of their problems was not static or stable in the slums of New York City. It was not like in Paris, because of 'culture' of poor people like puertoricans and their legacy of the rural custom and habits as their culture reflecting upon the activities of the peripheral urban squatter and in their daily life.

Slum people in the United States have a higher standards of living than many in higher social classes in other parts of the world. For example, the radio, television, electricity, processed food and other material possessions that slum dwellers generally have in the United States today would have been considered luxuries years ago, and they are still not available to large number of the people in many countries. A slum person in the western world may have many more goods than a slum person in India has.
6. Slums of Asian Cities:

As believed by Desai and Pillai the main characteristic of the Asian city is the rural look that some of its area have perhaps the "neo-rural" image that is sought to be created in these cities, is characteristic of the early stages of urbanization. While in the western countries it has been brought about largely by a nostalgia for the rustic past, and the consequent fashions in neo-rustic civic design - says, Ruth Glass (1964). 43

In this regard a good example of the rural or neo-rural pattern is the "Kampong" sector in Malayan and Indonesian towns such as Kuala Lumpur and Jakarta. 44

In the case of the "China-town" in Singapore it is described as a grid of streets consisting almost entirely of two and three storey shop-houses. Actually it was originally intended for one or two families, but later on, began to accommodate the ever flowing migrants from China after the Taiping Rebellion of 1848-65 that sent multitudes of pauperised peasants away from home in search of work, as far as they could. 45

Apart from shop-house slums, Singapore has slums
of the hutment type. In the out-skirts of Singapore two and a half lakhs of people live in such conditions. It is said that "the highest incidence of general crime and gangsterism" is in the central city slums.

There are some squatter colonies established in some of the south-east Asian cities due to bombing-damage of the second world war. After Independence, Manila gave squatters the freedom to grab land and put up snacks. Thus, the inner core of Manila city surrounded by walls of Spanish fort of Intramuros.

However, in some South-East Asian Cities foreign bases have been created around such shack towns of those local people who earn their livelihood directly or indirectly from the bases. This is also particularly true in Thailand, Philippines and South Vietnam.46

Zajae Vincent and his group (1984)47 presented a manual in the World Bank technical paper on appropriate technology for water supply and sanitation that was an important contribution to the International Drinking Water Supply and Sanitation Decade, 1984-90.

This manual describes a computerized methodology based on a limited survey for identifying, delineating and quantifying the sanitation improvement needed in an urban slum area in order to achieve a desired minimum level of
community sanitation and cleanliness; and also illustrates its' application to an urban slum area in Jakarta (Jakarta Sewerage and Sanitation Project Sanitation Survey).

Angel Shlomo (1983)\textsuperscript{48} tried to layout the function for a more systematic study of the objectives, interests, preferences and motives of the key parties involved in the provision of infrastructure services to slums and squatter areas. As such can only provide a general framework for analysis, using the existing body of information on the subject.

Shlomo and Thiparat (1984)\textsuperscript{49} suggested that a method called 'slum reconstruction' — granting land tenure and improving the housing conditions of slum dwellers in the urban areas of Thailand.

Leimsombat, Chuaytong and Sangchai (1983)\textsuperscript{50} stated that family planning and pregnancy knowledge and practices were studied in 1097 low income married women ages 15-49 in Bangkok's Din-Daing community in 1980. 587 women were from the slum areas and 510 women were from the government housing projects (flats). There was an average of 3.3 pregnancies, 2.79 children ever born, and 2.68 living children 6.98% women had never been pregnant, 7.38% were currently pregnant, 71.3% wanted no more children, 25.6% had experienced abortion, and 7.6% had experienced
The women's average age at marriage are as 20.6 years. Of the 502 respondents who had been pregnant during the previous 5 years, 87.5% of slum women and 96.8% of flats women had received antenatal care. However, 17.5% did not seek such care until the 3rd trimester. The main reason given for non-attendance was time constraints. It is hypothesized that this is due to difference in mean age at marriage among the two study population (20.6 years and 22.2 years, respectively). This results indicate the need for an educational campaign on the benefits of antenatal care and for antenatal service during the weakened or evening hours.

Talumassawat (1980)\textsuperscript{51} carried out an overview of migration and resettlement in Thailand. He considered the impact on the migrant themselves; discussed slums and the lower income groups; and reviewed the self-help government settlement programmes, the interrelationship of migration with the country's development projects, and its implications for integrated urban rural programme.

Schoorl and his Colleagues (1983)\textsuperscript{52} reviewed and evaluated the execution of a slum improvement project in Karachi by the Amsterdam Free University (AFU) that ended
in 1979. The substantial knowledge and understanding of the problems of low income housing in Karachi were recorded and reported in this volume. Articles have been assembled to reflect the developments of AFU's activities in Karachi.

Anyway, the first part is on Karachi in general. The next on concerns the squatters settlements of Karachi. The third part is devoted to policies for the squatter settlements. Part four is on the translation of policy into action, whilst the fifth part deals with the problems in execution. In this connection, finally one article has also been included which deals with technical and methodological problems encountered during research in Karachi's squatter settlements and the attempted solutions to these problems.

Abeysinghe and Selvarajah (1982)\(^5^3\) gave a brief description of Colombo, including the problems of slums and squatters, revenue for the city and public facilities provided (health services, public transport, water and sewage). Outlined the relationship between local councils and the central government Colombo is administered by the Colombo Municiple Council. Revenue is raised from taxes rents, licenses and governments grants.

Blunt (1982)\(^5^4\) presented in his article of case

24
studies of Philippine experience in a slum Improvement and Resettlement Programmes (SIR) with focuses on the involvement of the community in physical planning.

7. Slums in India:

The slums in India have been described as chaotically occupied, unsystematically developed and generally neglected. They are over populated and overcrowded with ill-repaired and neglected structures, insufficiently equipped with proper communication and physical comforts. Indian slums are inadequately supplied with social services and welfare agencies to deal with the needs and social problems of families who are victims of biological, psychological and social consequences of the physical and social environment. Shortage of water, electricity and sanitary facilities are common in these slums.

The social aberration among the poor of the slums, as well as their apathy is a product of their being the poorest rather than of their being 'poor'. Their alienation and apathy, withdrawal from the general society appear to be maximum under urban slum conditions. In rural areas, the relative effects of poverty are counter
balanced by stronger tradition and group ties. In areas of extensive urbanisation and industrialization, traditional and primary group ties are weakened. The lack of power and status among the poor, particularly those in urban areas, is much greater.\(^58\)

Slum areas are frequently swept by epidemics of cholera, gastroenteritis, typhoid and diarrhoea.\(^59\) Even, it is commonly said, when they are approached about immunisation, they often refuse it.\(^60\) Their poor personal hygiene is reflected in their clothing and unkempt appearances. Even babies are quite dirty, covered with scabies or suffering from other skin diseases that result from uncleanliness. Their poverty often affects the quality and quantity of food which in turn affects the poor slums dwellers who live with hunger and undernourishment.\(^61\)

There are some studies carried out in Indian slums. They have mostly dealt with different dimensions. One study was carried out by Varadachar (1982)\(^62\) in the slums of Madras. He had reported significant change among the slum dwellers in the processes of social interactions and social mobility along with some changes in their health status. A review of Indian slum situations was done by Hiranath (1983).\(^63\) In his India's Urban Slum he
concluded by saying that let us commence with cleanliness activities in our slums. It means in his observation the sanitation, garbage disposal and sewage system were the main concerns which need to be improved. It was also meant that slum improvement does not imply creation of more slums. Slum improvement can not be taken up in isolation. In his suggestion it was also stated that to improve slum situation one has to impose other factors which are directly or indirectly affecting slums.

In another study conducted by Pillai (1972)\textsuperscript{64}, the problems in India which have come to stay in Indian slums are malnutrition, unsanitary conditions, poverty, crime, indebtedness prostitution and unemployment. He has also mentioned that there are multiples affect to the growth of slums in Indian cities. Besides, he described, in general, the constant growth of the Bombay slums.

A study was carried out by Banerji\textsuperscript{65} in Calcutta Metropolis with an emphasis on the under developed area, by city standard, of Beleghata and Chetla to find out health status — specially the living conditions of the slum dwellers. The scholar found that the health hygiene and sanitation has been improved relatively in late eighties than what it was in mid-seventies. Some of these developments were attributed by the state's intervention.
and political will of the ruling party in West Bengal.

Another study by Klein (1965) was entitled "Calcutta A Metropolis". With emphasis on the slums or under developed area he had portrayed that high rate of mortality in Calcutta bastees or other areas were due to material development and its effect on causing environmental problems and nullifying the benefits of public health measures. So, the high mortality rate was not due to plague or famine. He also said that the over-crowding, bad housing, high cost of living and primacy of laissez faire market in urban development posed threats to human life.

Studies on Bombay slums have been carried but by many scholars like Desai and Pillai (1970), Ramchandran (1971). Recently a team of governmental officials of Bombay and University of Edinburgh carried out a study on the health status of the Dharavi slum children in 1985. The earlier studies have gone into the detailed processes of slum formation in Bombay, and the contemporary socio-cultural and socio-economic status of a slum dwellers. It was revealed in every study that heavy industrialization led to slum formation in Bombay. Particularly the textile mills of nineteenth and early twentieth century brought in the unskilled and
semi-skilled labourers from the Ratnagiri and Satarna.

Habitat International (1982) published an article on Delhi city. This paper attempts to illustrate, using an Indian city as an example, problems of slums, squatters and the urban poor. It examines the factors and basic constraints commonly found in developing countries and concludes with new strategies for urban planning.

Deshpande and Aruranchalam (1981) revealed in their paper that part of the phenomenal demographic expansion in India during the last three decades finds expression in the vast urban sprawl of Greater Bombay where one person in five lives in slum conditions. The paper traces the functional and spatial changes in the city's urban fabric since 1947. The discussion focuses on the major issues of housing, traffic management, service provision and environmental problems such as flooding, sewage disposal and pollution. The major planning objectives for the city are also presented along with the development of a new urban area on the mainland.

Prakasa Rao (1983) carried out an empirical analysis of urbanisation in India. He presented it from a geographical standpoint. Some theoretical and political aspects of urbanization are also discussed. The first part of the book is concerned with urbanization as a
whole, including the process of urbanization, the urban system, and urban and regional interrelationships. The second part deals with the Indian city and includes consideration of city structure, population density and slums. A final section considers policies implications.

Datta-Ray (1984)\textsuperscript{71} states that Bombay, India's richest city, continues to grow by about 4\% a year, adding over 300,000 to its population of 9 million in 1984. Half of the 9 million are slum dwellers, and another 2 million live in dilapidated tenements called 'Chawls' built for factory workers at the turn of the century. The natural growth rate for the city as a whole is thought to be less than that for the state of Maharastra, which is growing by 2.2\% a year despite a relatively good family planning record. And local authorities like to think that most of Bombay's migrants come from outside the state. A recent sample survey revealed that most of Bombay's slum inhabitants are Maharastrian. Yet, if Bombay continues increasing by 4\% a year, there will be a shortage of 2.5 million houses by 2000 when 75\% of the projected population of 16 million plus will live in huts or on pavements. Bombay will then have 2 million unemployed and a daily water shortage of 350 million gallons.
8. Urban Health Services in India:

In the report of Eight Five Year Plan (1992-97) it has been stated that more than one quarter of the population in the country now lives in urban areas. In metropolitan and large cities about 40-50% of the urban dwellers are estimated to be living in slum areas where the health status of the people is as bad as, if not worse than, in rural areas. But infrastructure on primary health care in urban areas hardly exists.

What the Krishnan Committee Report recommended was that there are many differences between rural and urban slum health problems which need to be taken into consideration, while suggesting the health infrastructure for urban slums. Some of major differences are:

(i) Urban slum population mostly belongs to poor and middle class as such have comparatively higher morbidity and mortality, while rural areas have a mixed population of upper middle, middle and poor classes.

(ii) Environmental conditions are much worse in urban slums compared to rural areas and as such slum population is more exposed to illness.
(iii) Most of the cases, entire family do some work and contribute to the income of the family. Under these circumstances, it may often be difficult to get a purely voluntary health workers from the residents in the slum areas. But, such workers may be available on payment of some honorarium.

9. Health Problems of Urbanization:

Urbanization is not only irreversible in practice but is also necessary to the political, economic, social and cultural development of the country. Apart from positive aspects like higher standard of living with access to education, health, training and other facilities, urbanization brings in its trail a series of consequences prejudicial to the health of the individual and of the community. They are mostly as follows:

(1) Lack of adequate housing, water supply, and sewage, increased risk of communicable diseases and inadequacy of preventive and curative medical care are often the results of rapid increases in the urban population, swollen by a number of migrants.
(2) Their hygiene may be offensive to their fellows and their dietary habits difficult to maintain in a market economy.

(3) The physical and mental stresses which may affect these people due to the necessity to adopt quickly to a strange way of life, and which may lead finally to anti-social behaviour such as delinquency and adult crime, alcoholism, promiscuity and mental illness.

(4) The stress to be suffered by the urban population is noise from vehicles, industrial activities, railways, etc. — both day and night, not only creating discomfort but also perhaps causing fatigue neurosis and even deafness.

(5) The concentration of population is a prime area for epidemics and a variety of specific diseases such as tuberculosis, upper respiratory infections. Venereal diseases are more frequently encountered in urban than in rural areas.

(6) Migrations of population as part of the process of urbanization are also dangerous factors in the spread of diseases such as chicken pox, typhoid and cholera.
(7) Inadequate supply and poor quality of water for drinking and domestic use, multiply the chances of exposure to gastrointestinal infections.

(8) Storage of water for domestic use in uncovered storage tanks, and accumulation of surface water, and sullage due to inadequate drainage, provide condition conducive to the dissemination of filariasis, malaria and other mosquito borne diseases.

(9) Lack of sanitary facilities, leading to fouling of ground and accumulation of garbage, causes pollution of soil and spread of infections such as ascariasis and ancylostomiasis.

(10) Development and expansion of modern means of transport, with the increasing numbers of vehicles and pedestrians on inadequate and anti-quoted road systems, cause increase in road accidents.

(11) Even in developed countries where the essentials of life — food, housing, clean water and adequate sewage — are available, there is increasing evidence that may be special forms of urban pathology and that an altered disease pattern may include increased prevalence of such condition as heart disease, cancer and
hepatitis.

Consequently, there are a number of existing or newly emerging problems in the cities which need the active intervention of health authorities the world over.

10. Health Problems of Slum Areas:

The physical and social conditions of today's Indian slums are generally the worst. For example, the streets, lanes, and open drainage in typical slum areas are filthy and people sleep as many as six to twelve in a room or hovel or sacks covered shed. Rates of disease, chronic illness and infant mortality remain high. Personal hygiene, sanitation, nutrition and child care are very poor in quality. Illiteracy is exceedingly high and cultural and recreational activities are almost entirely lacking.

Unemployment, underemployment and low wages are common rule in the slums. There is a constant struggling for economic survival. Work patterns are likely to be irregular, and lack of stable employment often contributes to unstable family patterns. Any treatment of slums solely as product of poverty, however is far too simple.
Poverty is both an absolute and a relative term. As societies vary in the degree of poverty characterising them, individuals and the slums themselves vary in the degrees to which they are "poor".

11. Need for the Study:

During 1970s, number of literature published on poor people changed the view on marginality. It stressed that poor can make significant contribution to the urban economy. Janice Perlman (1976)\(^1\) has categorically stated that the poor are not economically marginal but manipulated and repressed. The poor are not separate sub-society, but act much like every one else. In short they have the aspirations of the bourgeoisie, the preservance of pioneers, and the values of patriots what they do not have is an opportunity to fulfill their aspirations.\(^2\)

In this regard, it has, therefore become an interesting subject of health research in the slum population of the urban centres while the large cities consist of hospitals, dispensaries, MCH and Urban Family Welfare Centres run by the Government, Municipal Corporation, CGHS and ESI. Beside these, private clinics, nursing homes, qualified medical practitioners, RMPs etc
are also independent but parallelly existing for the purpose of several health problems of the people. Indian systems of medicine has also been surviving in urban centres not because, a large number of people have faith in it but also because, it is an alternative system of medical care.

The existing model of urban health establishment and the process of health service development, as visualised might not be able to cope with the problems of ill health in slums. Even health for all by 2000 AD would likely to remain on paper without much action on not only health development for the slum population but also in general health improvement, unless we would understand the approaches and forces of their "health culture" identifying the causative factors and implications concerned with the given socio-economic conditions.

In the process of urbanization and the formation of slums there are social, economic and political dimensions. The forces of economic and political power determine the economic conditions of the people and their resultant economic capacity determines their lifestyle and socio-cultural patterns. In this practice, their 'health' as sub-system is also influenced by the
above attributes of entire social system. How, this mode of action is taking place among the slum residents is an important area to be studied.

With the fundamentals mentioned above and its multi facet health problems, the present study has been designed to understand the process of urbanization in an average size city like Gwalior and to explore how the 'health culture', — specially health perception, meaning, attitude and behaviour or action, is determined by the larger socio-economic and political conditions of the slum dwellers.

The broad perspective of health in urbanisation of the industrial city like Gwalior which contributes quite a lot to the states economic growth in particular and country's economy in general depends on the understanding of its socio-cultural and socio-economic conditions. In fact, public health service for people dwelling in the urban slums, is required a kind of special orientation of local health needs that present in the forms of health behaviour or action perpetuating within their cultural milieu in a given situation. For example, a sick person may have to wait hours for treatment in a public dispensary or hospital, even if the services are available. Nevertheless many people themselves would
not avail modern medical care or such preventive measures as vaccination, when they do seek medical care, they often go to "quack".94

Being a fourth largest city in Madhya Pradesh, Gwalior has by this time, become very significant not only from the health point of view but also from the mode of production and production relations.95 Several health research studies and projects on different health aspects have already been initiated by the national and international agencies like NIHFW and DANIDA for couple of years-covering the entire population of the district.96 But no study except one health survey conducted by G.R. Medical College, Gwalior has tried to understand the dynamics of health and health problems of the slum residents whose contribution are not ignorable in the development of industrial city, Gwalior.97 A total of 78,682 persons were concentrated in about 11,485 households and they were out of the total of 7,70,150 urban population in Gwalior.98 There were almost no attention towards their vulnerable situations such as housing, sanitation, streets/lanes, sewer system, drinking water supply, occupation along with medical facilities and health planning.

In view of such heterogeneity in the slum life
pattern and the enormous amount of population in small area which produces its own impact on the people's behaviour, the health perception, meaning and attitude towards medical and health programmes, relationships with health institutions and workers and even community participation would be different from one part of the area to another.\textsuperscript{99} These and other factors like various linguistic, cultural, religious and occupational stratifications in relation to the local private health practitioners, RMPs, healers and quacks and their effects on such behaviour would have also been expected to give us some idea about way of intervening or influencing their sanitation, water supply housing etc.\textsuperscript{100} Therefore, the study is an attempt to explore the forces and approaches, which are determining the health culture or patterns of health behaviour of the people dwelling in the slum area with in a systematic framework.

12. Conceptual Framework of the Study: An Understanding:

World Health Organization has defined health as "a state of complete physical, mental and social well being not merely absence of any disease".\textsuperscript{101} There are also some queries regarding this definition of health.
Traditionally absence of disease or infirmities has been viewed synonymous to health. In other words, like in many other area of human endeavour, in the areas of health too, absence of negative has been regarded as positive. This had been happening even after global acceptance of a definition of health that says health happens when an individual is able to have a socially and economically productive life and not merely being free from diseases or infirmities. Even though, we might have accepted this definition, we continue to pursue things using indicators that may not tell us what we exactly want to know. For example, mortality and morbidity rates by themselves do not take care of the various aspects of social and economic life. As individual human beings, we have experienced situations where we might have been clinically fit and yet did not always had the point being made is that, as in the cases of other things like quality, for health too, it is the user who really knows when it happens. No doubt, the providers by virtue of their intimate knowledge of psychology and anatomy of human body are expected to play some important roles. Yet, these roles are primarily catalytic in nature as opposed being regulatory.
After all, health happens only when one has a sense of physical and mental well-being, the same would have to be measured using a scale that capture this sense of well-being and not on the basis of availability of drugs and doctors, hospitals and beds, nurses and paramedics, or for that matter instruments for carrying out radiological or pathological diagnostic tests.107

Apart from the connotation of physical and mental well-being, social well-being depends on the social systems or cultural system of the human beings.108 Therefore, health of an individual or group or community can not be understood in isolation from the cultural belief system of the people.109 In fact, the propositions or attributes of culture or total way of life in relation to the perpetuation of health form an axis that is called as 'Health Culture' in which health system may, on the one hand, be considered as a product of health actions and, on the other it's a continuing element of further health action. So, in this regard to understand culture requires first attention to the theoretical framework before the articulation of the characteristics and description of health culture.
13. Culture: An Overview:

The term "culture" can be used to convey various meanings. As stated the philosophers like Cassirer and sociologists like Sorokin and Maclver 'culture' stands for moral, spiritual and intellectual attainments of man. 110

But the anthropologists have used the term "culture" differently. Tylor was the first anthropologist to define and make extensive use of the term. 111 He said, that "culture stands for the beliefs; ideas, customs, laws morals, arts and other capabilities and skills acquired by man as a member of society." 112 Half a century later, A.L. Kroeber (1948) 113 described culture as consisting of speech, knowledge, beliefs, customs, art, and technologies, ideals and rules; what is learned from other men, from users, and what is added to it. This description of culture is very close to Tylor's earlier definition. However, Malinowski and others have paraphrased the definition of Tylor to point out that the social heritage may be said to consist of material part and non-material, intangible, imponderable part. 114 Or to put it in other words, culture is a total way of life and the instruments, mental, social and material, of which this way is
constituted. This view has been extended and yet put in a summarised form by Bidney who defines culture as the product of agrofacts (products of agriculture), artifacts (products of industry) socio-facts (products of social organization) and mentifacts (language, religion, art and soon).\textsuperscript{116}

Nevertheless, the definition of culture given by A.L. Kroeber and Clyde Kluckhohn in 1952 emphasised new discussions of the concept.\textsuperscript{117} They stated that culture consists of patterns, explicit and implicit, of and for behaviour, acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artifacts. The essence of culture consists of traditional ideas and especially their attached values. A culture system may, on the one hand, be considered as a product of action and, on the other, as a conditioning element to further action.

While anthropologists have been pre-dominantly concerned with the patterning aspects of culture, it was sociologists, particularly, Talcott Parsons (1951) who analytically separated its' components.\textsuperscript{118} He pointed out that a cultural belief system can be classified into four segments through cross cutting principles of whether the beliefs are concerned with cognitive or evaluative ideas.
and whether those ideas are empirically verifiable or not. He has also indicated that the components of a culture can be classified in relation to the type of motivational orientation that a person has in an interacting situation. Such situation has three dimensions, namely, cognitive, cathetic and evaluative. There are value standards for judging the relevance of an object in respect of each of these dimensions. In fact, these all in relation to the health form a sub-cultural complex of the entire way of life.119


"Health Culture" has been considered as sub-cultural complex of the entire way of life of the people.120 Within the popular definition of 'culture', 'health culture' may again be redefined as that complex whole which includes both subjective and objective environments as external inputs in the action of internal (organic) environment of human beings in a certain situation.120a In other words it may be termed as the action in the form of health behaviour is influenced by the material and non material culture of the people at a given ecological setting. Since health is a sub-cultural
complex, its' defined characteristics pertain the basic components that culture persists. So the concept of health culture may be perceived in this context that stands for knowledge of health and health problems, health beliefs, arts of healing, norms and values related to health and diseases, limits of medicine, health action embodied in customs and rituals, habits determining health status acquired by man as a member of society. In other words, all these factors interplay within a systemic framework, that could be termed as "health system".

According to WHO health system means "a set of cultural beliefs about health and illness that forms the basis for health seeking and health promoting behaviour, the institutional arrangements within which that behaviour occurs and the socio-economic, political and physical context for those beliefs and institutions." In the light of this conceptualised frame of reference 'health culture' is basically fallen into the account of established definitions of 'culture' articulated by E.B. Tylor (1871), A.L. Kroeber and C. Kluckhohn (1952), Talcott Parsons (1951) and others. So, the 'health culture' may be described as learned health behaviour, to distinguish it from that aspect of health behaviour caused by biological stimulations. As it is
learned, it is transmitted from person to person and from generation to generation. As it is cherished by a major section of the society, 'health culture' is considered to be shared.\textsuperscript{123}

The material characteristics which are determinants of economic paramount of an object are defined in terms of cognitive standards of health and health problems.\textsuperscript{124} The appreciative standards of health culture lay down its' appropriateness for the satisfaction of one's health needs, felt-needs, demands etc. and evaluative standards lay down the basis with reference to which the cognitive and appreciative standards are evaluated and finally the object is treated as an acceptable or non-acceptable one. Since cognitive and appreciative standards are finally checked against evaluative standards, they provide the basic frame work of value orientation.\textsuperscript{125} They constitute the genetic code of a system of health culture patterning various aspects of it. This results in each system of health culture developing and maintaining its own distinctive patterns.\textsuperscript{126}

Health culture is an autonomous component of social action, and has an existence of its own, independent of individuals and is external to them.\textsuperscript{127} In
fact, for example, when a child grows up in a community or society, it assimilates various objects or material components of day to day life, including it's value orientation.\textsuperscript{128} Through this process of socialization, health culture in the entire way of life becomes internal to the individual, a part of the personality, providing the framework for organising one's actions and expectations.\textsuperscript{129} This directs health actions or health behaviour in accordance with the value and norms. Thus, health system as health culture becomes a part of individuals and becomes the basic desiring/stimulating force for health behaviour or action.\textsuperscript{130} In fact, the organic needs that operate the internal environment or system of individual such as needs for food, sex, protection etc. are sources of stimulers forces — or motivation independent of the system of health culture. The level of satisfaction of these needs takes place in accordance with the values of health culture acquired by man as a member of community or society.\textsuperscript{131}

Since 'health' has been defined by WHO as "a state of complete physical, mental and social well being not merely absence of any disease",\textsuperscript{132} in the entire way of life, it is a sub-cultural complex. As the ingredients of health attribute are ascertained from the axiom of
culture, making manifest the dynamics of health culture in the complex social system requires a holistic or wider frame of reference.\textsuperscript{133} The circle of 'health' and 'culture' determines the essence of health culture and its axis in the given situation where man or a community live in.\textsuperscript{134}

For health culture, the conceptualizations have been initiated by the several scholars who have experience in the field of health and health service development. They were basically characterised by the different elements of culture which consists of the systematic network of health and behavioural pattern of health and diseases. Be that as it may, the most applicable concept of health culture characterised by Banerji (1982)\textsuperscript{135} is very much suited here in the present study undertaken. As believed by Banerji, health culture means health behaviour of the people in the context of the availability and accessibility of health institutions and health care facilities, and their cultural meaning and cultural perceptions of several health problems existing in a given socio-economic condition.

Commensurate with this concept of health culture as the base, within a ecological surrounding the changing process of socio-economic condition of people brings about
a change in their socio-cultural patterns (Charlse Valentaine).\textsuperscript{136} This change in culture as a whole brings about a change in their health culture transforming their health status.\textsuperscript{137} Thus, the culture of particular group of people (like slum dwellers) shapes the perception and attitude of different health problems, which in turn, determines the response of the group both in terms of formation of health institutions for dealing with different health problems and in determining the health behaviour of individuals when they encounter such problems (Banerji 1986).\textsuperscript{138} While, the forces of culture bring a change in people's health culture, there is a change or modification in their health behaviour in the given ecological settings (Sahu 1992).\textsuperscript{139} People usually develop their felt-needs regarding their health generated after stimulus by their changing levels of socio-economic condition, seeking some alternative ways out and actions to resolve them within the given environmental conditions.\textsuperscript{140}

In the light of this conceptualization of the study specially health culture, some other concepts of well known scholars who had carried out their valuable work in the field of health and culture have also been reviewed. In their detailed anthropological descriptions
and analysis of health and health problem within the cultural frame work, there were the clues on the basis of which the present study of health culture has received insight to some extent at the conceptual level.

While Zurbrigg (1984)\textsuperscript{141} stated that people's struggle for health became a part of the broader struggle to wrest their democratic rights from the ruling class. However, being an anthropologist Marriot (1955)\textsuperscript{142} was able to find out that western system of medicine has not totally been accepted by the rural Indian masses because of their culture. He understood the importance of cultural factors in health and health problems as health behaviour. But due to western bias he tried to fit or channelize western medical practices according to the culture of the local people.

Just like Marriot, Castairs (1955)\textsuperscript{143} also found that health problems of the people in India is as much a moral as a physical crisis. He realized the cultural factors in the health and health problems. But finally he also propagated how the rural people could adopt western system of medicine within their cultural milieu.

Nevertheless, a number of social scientists who have studied health culture of rural population in India including Paul (1955), Hasan (1967),\textsuperscript{144} Gould (1967),\textsuperscript{145}
discussing superstitious health beliefs and practices but they have not paid adequate attention to the forces — which have possible been articulated in the present form of conceptualization — that have been instrumental in causing decay and degeneration of their health culture. Consistent with these studies, a further review of health studies has also been initiated to understand the contextual reference and empirical evidences of the subject under investigation.

15. **Review of Health Studies:**

Gupta and Gupta studied the Primary Health Care Needs in Urban Areas (specially slums) in cities with population more than two lakhs. The main objectives of the study were to assess family welfare, MCH and primary health care needs of slum population and to identify the gaps between people's health needs and health service facilities for formulating package schemes in order to strengthening family welfare and primary health care. Workshop approach was adopted for the study along with some case studies. Workshops were held at 10 centres, covering 95 cities each with more than two lakhs
centres, covering 95 cities each with more than two lakhs population from 17 states and union territories. Three case studies were done in Boroda, Kanpur and Hyderabad cities for factual data on the perceived needs for primary health care and family welfare of the slum population. Thus, a fixed number of households (200-250) selected on the random basis.

After all, they revealed some important findings in the study. Most of the cities had different types of medical practitioners who used to provide health care services. These facilities were not easily available to the people. There was an urgent need to provide basic health care and family welfare services to the slum dwellers. In the 'model' delivery system emphasis is on mother and children with some kind of special attention to those at risk. Finally they suggested that community based service centre should be set up for a population of 50,000 which will cover preventive, promotive and simple curative health services.

It has been noted in the study that the conceptualization of the problem was not systematically substantiated with the data collected and output of the workshop conducted, salient findings were articulated on the basis of three case studies while maximum efforts were
done for two round workshops. There is no proper sampling procedures adopted for representiveness of the slum populations.

During 1990-91, the study of MCH services in ICDS and Non-ICDS areas had been conducted Bikash Saikia and A.K. Agarwal. It was a study of mother's knowledge and practices in resettlement colonies of Delhi. It was basically a descriptive study in which two resettlement colonies namely 'Tilak Vihar' and Govindpuri having a total of 300 and 297 mothers who had a child of the age group of 12 - 23 months respectively covered. The people were clustered and 10 mothers were interviewed from each cluster of both ICDS and Non-ICDS areas.

The authors found that the extent of utilization of ICDS services by mothers in the ICDS area (i.e., about 73.00%) was quite high compared to the non ICDS area. According to them 70% respondents had been advised by the Angawadi workers for various MCH services while the remaining 30% did not receive any such services/advises.

However, on the basis of the data, they came to conclusion that the mothers in ICDS area were more knowledgeable than non-ICDS areas. Accordingly they propagated the joint strategies of MCH delivery with ICDS schemes.
In fact, the study was only based on some systematic efforts, there was no research problems as such for conceptualization. In other words it could be called an exercise that's all in the field of health and health culture of the urban colony residents in Delhi.

A study conducted by Panda, Bengamin and Zacharish in 1993 on "health status of under-five in a Ludhiana slum". According to them Ludhiana, a highly industrialized city in North India with a population of two million, has more than 200 slums. The slum dwellers constitute 2-3 lakh people. The study was undertaken to find out the health status of under five children in the "Ash Deep Slum" and to observe their immunization and nutrition status in relation to a selected socio-economic variables. A cross-sectional survey was carried out, covering 205 families selected at random from the total 1512 families living in the Ash Heap Slum. The study group comprised of 237 under-five children. But it was not clear how, they were taken for the study.

Apart from age and sex distribution, mean per capita family income and migration status about 89% of the children were breast-fed for more than six months. It was more than in the slums of Bombay, Calcutta and Madras
where the same were 71.9%, 20.9% and 36.4% respectively. 61.6% diarrhoeal diseases were found to be the major cause of morbidity. It was higher than in the slums of Calcutta. Only 27% of children were fully immunised for age and about 28% had received no vaccines. This was higher than in the slums of Lucknow, (17.2%) and in the country (17%). About 19% were found to be suffering from severe malnutrition which was much higher than the national average (9.9%). Thus, the authors demonstrated that 'Ash Heap Slum' children had higher vulnerability even in infancy and equal in both sexes. They also stated for provision of priority care specially with respect of safe water and sanitation. In fact, the study was basically based on the comparison of data not on its quality.

Rakesh Kumar and his associates\textsuperscript{150} conducted a study in an urban slum of South Delhi called Rajiv Gandhi Camp, situated adjacent to Jawaharlal Nehru Stadium. It has a population of about 11,000. There are about 700 jhuggis in which mainly the construction labourers are residing as daily wagers. According to the authors, the main objective of the study is to understand the health seeking behaviour of slum dwellers in Delhi. But, in the practical sense, they have studied some aspects which are
systematic and scientific performance evaluation of Mobile Health Clinic ran by All India Institute of Medical Sciences under urban health programme. However, they have administered semi structured open-ended interview schedules to a total of 198 adult members for which there were no sampling methods adopted so far. Even then, 40 out of 198 did not reply to the questions regarding different types of health services.

Thus, they highlighted the Mobile Health Clinic activities which were carried out last one and half year. A majority of respondents visited mobile clinic on their own, while 29.8% were motivated either by their friends, neighbourers or relatives. Finally the authors stated that the role of mobile health services in provision of medical relief to a slum population is quite important.

In fact, this study lacks many things. It is not a proper research study. There is no authentic data and proper research design based on the main objectives. The study lacks proper and systematic conceptualization of the problems to have been studied.

In the urban areas, populations are not homogeneous. Very little is known about the health conditions of different socio-economic groups. Guha, for instance, presented the results of the study of urban slum
dwellers in Calcutta. She pointed out that while an urban bias did exist in the provisioning health and other services vis-a-vis rural areas, the urban bias in the provisioning of health care services discriminated against the urban poor. The lack of access of the urban poor was accentuated by the severe shortages of good health services. Social, political and epidemiological parameters of urban poor also tend to be substantially different from their rural counterparts. The universally applied rural model of primary health care centres in India does not incorporate differences in health and nutritional profiles of the rural and urban communities.

The variation in fertility levels due to changes in female age at marriage among people residing in slums which mostly represents the lower socio-economic segments of urban population studied by Bhargava (1984). The study was basically a research project entitled "Demography Profile of Hutment Dwellers" undertaken by the International Institute for Population Studies, Bombay. There were 3950 married women selected randomly from 9 slum localities of Chembur area in Bombay. In fact the author revealed that even among those people who belonged to the lower socio-economic class of urban society in which the fertility level is higher and the average age at
marriage is quite low. There is negative relationship between female age at marriage and fertility. Basing on the study finding the author had also suggested some amenable forces in this context. According to the author, a substantial decline in fertility could be achieved by increasing the age at marriage, particularly for female. Beside, an increase in the age at marriage associated with the effective use of contraception would lead to a considerable decline in the fertility levels.

However, this study findings highlighted the poor socio-economic conditions as the main reason of fertility behaviour of the slum dwellers. But the author suggested to increase the age at marriage, instead of socio-economic condition to be improved. It would give much comprehensive results of the study, if the author could correlate the economic endeavour in relation to fertility and age at marriage.

According to an intervention study conducted by Mullick, S.; Bardhan, A and Shivdasani (1978) it was found that there was an experience in organization with mother's club in an urban slum area in Delhi. The main objective of the study was to create a local voluntary movement of women to encourage health and family welfare
practices. And to develop a methodology of developing similar women's action groups in the country to promote people's participation.

For this purpose, Govindpuri Extension, Kalkaji Urban Field Practice and Demonstration Area of NIHFEW was selected. A baseline survey of 1248 Tenements was conducted to identify different needs of social, economic and educational. Curriculum was also prepared particularly for educational classes of women with film shows about MCH and Child Care. Thus, suitable dates were fixed up for different programmes. At the initial stage, there were only 25 women who registered for membership paying Rs. 100/-.  

In these processes, mentioned above, the authors could have come to the final statement that (a) participation of women in self-income generation activities, (i.e. preparation of pickles, Jams etc) improved their economic status. (b) They had become more conscious about anti-natal, post-natal care through immunization programmes (c) Husbands were also interested to see and experience regarding reproduction and contraceptives through the programmes organized. (d) Finally, it was stated that there were little improvement about the leadership — voluntary leadership and
accelerating community participation.

It was basically a motivational efforts. People do not continue such activities while external efforts are not continued.

Ghei P.N. (1983) 154 reviewed the urban health services in metropolitan city of Delhi highlighting the various problems of health care delivery systems. The problems were as follows: (a) absence of identification by and large, between community and medical care institutions; (b) overlap and duplication of services; (c) possibility of medical shopping; (d) absence of special efforts to cover the slum and jhuggis; (e) multiplicity of agencies involved in provision of health care; and (f) lack of coordination of various health care agencies. To solve these problems he suggested that there is an urgent need of implementing the regional concept of delivery of health services which in essence means planning, organization and coordination of total health services in the territorial boundary of Delhi.

According to the Report of the WHO, (1987) 155 the health problems of big cities have been summarised as follows: (a) Rapid population growth; (b) uncontrolled urban growth; (c) population and other environmental problems; (d) inadequate civic services; (e) poverty; (f)
unemployment; (g) legislation which hinders improvement in health misplaced health care facilities; (h) lack of access to health care for large segment of population; (i) vested interests of institutions and elements of health professionals; (j) lack of information on which to base plans; (k) uncoordinated organization of health care; (l) inadequate collaboration between government and non-government services and (m) lack of community involvement and participation".

There is another study on magnitude of morbidity due to Diarrhoeal Diseases in Children Below Five Years in Slum Areas of Delhi conducted by Bhatnagar and Dosajh in 1985. The main objective of the study was to determine the magnitude of morbidity due to diarrhoea among children below 5 years of age and to find out the types of medical facilities used in slums. Four slums namely Mangolpuri, Seelampur, Nehru Place Construction Site and Ballimaran were randomly selected. 3695 children under survey chosen by cluster sampling formed the sample size.

The major findings, the author revealed, are as follows: (1) The incidence of diarrhoea was higher in younger age group with peak incidence between 7.12 months followed by 1-2 years age group. (2) Diarrhoeal death rate of 4.9 per thousand children in Delhi slums was found
to be higher compared to 3.6 per thousand for urban areas by Register General Survey on infant and child mortality. (3) Finally, the authors found that diarrhoea incidence are directly related to poor socio-economic status, female illiteracy, unfiltered drinking water, unsanitary living conditions, filthy environment and lack of health facilities.

But the recommendation made by the authors, was to promote mass media coverage of health educational activities specially ORS packets. However, the study has exposed some issues what are very pertinent in understanding diarrhoea problems among the children below 5 years in the slum areas of Delhi.

Reddy and Mahadevan (1984)\textsuperscript{157} conducted a study on effect of infant and child mortality. It was a comparative study of non-slum and slum dwellers of Hyderabad city. The investigation initiated by the author was to examine the impact of personal experience and perception of infant and child mortality on the fertility behaviour of the non-slums and slum dwellers of Hyderabad city. From the two independent list, an equal sample of 240 non-slum and 240 slum households were selected at random as a total of 480 sample size.

The authors revealed that the incidence of infant
and child mortality is higher among the slum dwellers than non-slum dwellers. The significant higher fertility among the slum dwellers was primarily due to high infant and child mortality experienced by them. They also revealed that mere perception of infant and child mortality influences the actual family size of those who perceive the current levels of infant and child mortality as the same or worse than before.

On the basis of these and other findings of the study, the author suggested that a significant reduction in fertility can be achieved by assuming greater survival of infant and children. To bring down about the high fertility of slum dwellers, particularly those with high risk of infant and child mortality, suitable infant and child welfare programme should be taken up in slum areas on a priority basis, since children are the main economic security for them. It could be noted about the study that it can not be a comparative study because the two study populations were totally opposite by nature. But the findings were well articulated and very significant.

In another study, Bhatnagar, Dosajh and Kapoor had tried to establish health care delivery model in urban slums of Delhi. The aim of the study was to find out the problems of urban slum dwellers, their dimensions and
health implications in order to evolve a model for the
delivery of health care suitable to varying characteristics of urban population. The authors used stratified multi-stage sampling technique for the selecting Mangolpuri, Seelampur, Nehru Place Construction site and Ballimaran slum areas of Delhi, 1,200 households selected through cluster sampling and interviewed through comprehensive multi dimensional questionnaire.

According to the authors, most of the findings revealed in the study are as follows. The vast majority of households lived under poor living conditions including lack of potable drinking water, defecation facilities, uncovered drain and lack of electricity. A higher proportion death were due to respiratory problems. The average age of tubectomy acceptors was 34 years parity between 3-4 children for IUD and pill acceptors about 31 years with 3.1 living children respectively. Most of the delivery conducted at home. 62% of population used to utilize services for private doctors. However, 74% of the respondents expressed need of hospital/dispensary followed by environmental sanitation (63%). Finally it has been concluded that all parameters of morbidity showed positive association with poor socio-economic status of
the people, including unsafe drinking water, unsanitary living condition, filthy environment and lack of health facilities.

After all, the objective of the study was to develop health care delivery model but instead of reaching the objectives, the study had only described the quantum of the problem of slum dwellers of Delhi.

A study on 'city health development' conducted by R. Biswas (1994). At present, as his study findings show, urban population is growing as much higher rate (3.1% per year) than the total (2.0 % per year) or rural population growth (1.8% per year). The population of urban to total population has increased from 11% in 1901 to 26% in 1991.

In accordance with his conceptualization of the study problems, convergence of services at community level in urban areas was the thrust area for last one decade; such as urban Revamping Scheme, Urban Basic Services for poor, Calcutta Urban Development Project, Nehru Rojgar Yojna, Environmental Improvement of Urban Slums etc. The emphasis was given on Family Welfare and Preventive Health Services in Primary Health Care Model for rural areas, while provision of basic amenities, self-employment ventures etc. were for slum dwellers. As another
understood, that there was not healthy city development which is still a far fetched dream. City health plan has been conceived very lately.

On the basis of the findings, author has stated that planning for overall city health development is an urgent necessity. Primary health care concepts and principles have potential for city or urban health system also, because of the discrepancy between allocation of resources and health needs is equally striking in cities and gaps between rich and poor, between need and provision are also widening.

The author has also suggested that the strategy of health planning and management for urban areas. Cities should incorporate systematic approaches, up-grading of civic services which influence public health, slum bias, high risk approach, emphasis of preventive and promotive measures, strengthening out reach services, better coordination between health and other concerned sectors, stress on MCH and F.W. services and vigorous implementation of National Health Programmes and of course effective implementation of regulatory provisions.

Finally, the author was very much optimistic, to stop, further deterioration of city environment "pressure
group" creation is mandatory. In this regard people's mobilization for health city movement should be initiated for sustainable city health development.

Whatever the conceptualized framework of the study problems and methodological validation and reliability, the author has of course highlighted some emerging issues in the field of health and health service development.

Bhattachariya and his associates (1994) conducted a community based study in urban areas of Delhi city. Aim of the study was to find out the nature and extent of tobacco smoking in a defined community of Delhi. Apart from their methodological bottlenecks, they revealed that smokers constituted about 32% of adult male in Delhi Administration Flats, Timarpur. This smoking prevalence was highest in 41-50 age groups. 31% of school teachers. Out of all - 8% reverted back after absence of 2/3 years. About three fourth were worried about ill effects on them and others. Significantly higher number of non smokers expressed that advertisement should be totally stopped and there should be a ban on selling smoking tobacco.

dwellers and systematically analysed in different chapters of the book. The main genesis of her interpretation of the data contains that community participation in projects for the provision of housing and basic services for the urban poor is a crucial component for the successful design of such schemes. This not only ensures that projects are designed in consonance with the need of the community, but also makes them cost effective and better managed.

Apart from the findings of the study, it has been visualized that the author has discussed the needs of slum dwellers for housing and basic services and pointed out these towards the attention of the policy makers and planners how to articulate the aspirations and such needs and fulfill in a systematic measure.

A Report of the Working Group\(^{162}\) (1985) revealed that primary health care facilities in urban areas specially in thickly populated pockets, slums, or areas inhabited by vulnerable sections of society are, almost absent and health services in the city tend to be largely care oriented through hospitals and clinics. The need to remedy the existing situation and to improve the outreach of the family welfare and primary health care services in the urban slums were discussed at the conference of Chief
Executive Officers of Municipal Corporation held on 7th April, 1982 in New Delhi. The conference recommended for setting up a working group to go into the various aspects relating to improving the outreach services in urban areas, including review of existing norms for establishing urban family welfare centres, setting up a family welfare bureaus etc. According to the Ministry Health and Family Welfare, with the terms of reference the group had gone into various suggestions to improving the outreach and quality of family welfare and primary health care services in the urban areas, including review of the existing norms for reorienting the Family Welfare Centres, city family welfare bureaus etc.

A study on the health status of Delhi slum and resettlement colony was conducted by the National Institute of Health and Family Welfare in 1986. The study revealed the facts that the existing health care in Delhi slums is not adequate. So, there was a need of an alternative health care system for the slum population. It was found that due to the conflict situation amongst the population, the government health functionaries and the political leaders the welfare programmes do not reach up to the people.

Consequently in the brief critical review these
studies mentioned above have also shown that the people of resettlement colonies or slums are living a life of appalling misery. The vulnerable conditions of the slum dwellers were basically due to their very typical nature which deserve a great deal of attention, to be paid and an urgency on the health situation to be studied in depth. Although the studies referred so far, have established that the slums are by product of industrialization and urbanisation. Due to capitalistic path of development and lack of proper initiation in capital investment, specially on need based health establishment and health care delivery system, a congregation of unorganised unskilled and semi-skilled workers has been leading a sub-human poverty stricken life with no sanitation or hygiene in and around their dwellings.

In fact, on the other hand, there are few studies that have some similarities with the present study. They are basically consumer or people oriented studies by nature. A study by Gupta (1990)\textsuperscript{164} was carried out in a resettlement colony of Delhi. The aim of her study was to find out or to identify the socio-economic, political and cultural factors and their interplay which determine the environment and shape the health institutions. The mechanisms of coping devised by the people to deal with
their health problems. The study area was New Seemapuri, resettlement colony of Delhi. F Block which comprised with 2,200 population in 368 households and divided into waste recyclinder segment and others was selected. 43 households from waste area and households from other parts constituted 97 as total sample size and every 5th household selected on the random sampling. It was found in the study that the people of the resettlement colony are having several health problems in their dwelling areas because of their poor economic conditions. In the study, the author has also revealed that the change in their socio-economic condition can bring about a change in improved quality of life of the residents as well as their better health status.

Another study carried out by Ganguli (1990) in Jahangirpuri resettlement colony of Delhi. Aim of the study was to investigate the role of hospitals in determining the health culture of Delhi's resettlement colony in relation to a North Delhi resettlement area. An adjoining village, Bhalasawa was also considered for the study. 300 households were selected on the basis of systematic random sampling and every 10th household was interviewed. Jahagirpuri and Bhalasawa were comprised of a total of 16000 and 1006 population respectively. In
this study the author has revealed that the health culture of the people of the resettlement colony is a sub-cultural complex of their entire way of life. The author found that many factors of health and diseases are associated with the larger cultural milieu of the people. The cultural pattern of that community and their need of health services from the nearby hospitals determined the existing health status and the pattern of health problems of the same group of the people.

A study by Bir (1990) has also explored an interesting area of the subject of health development in Daspara slum of Calcutta city. The finding of the study was that the community participation and involvement in improving socio-economic conditions through mass mobilization and politicization amongst the slum residents along active association with people oriented development efforts of the government have ameliorated standard of living — socio-economic conditions — along with improved health status of the people.

It has also been visualized that the prioritization of needs at grass root level through politicization and active community participation in any action of development could bring about a change in economic structure along with psychological state or peace.
of mind of the slum residents. These altogether could lead to bring about a change in their way of life (culture change) and their health status (sub-cultural complex of their entire way of life).

Thus, the facts revealed in the studies mentioned above sustained the conceptualised framework of the study undertaken. For health culture is a sub-cultural complex of the total way of life of the people. Health behaviour of such people would have been the outcome of their cultural determinants in a given economic condition. The people of this circumstance might have required help from different ways to maintain their health and quality of life. Therefore, the present study, is an attempt to explore the dynamics of health culture of the people dwelling in the urban slums with precarious socio-economic conditions.