CHAPTER XI

SUMMARY AND CONCLUSIONS
In India population explosion, poverty and unemployment lead to slum eruptions. The spectacle of one half of the city living in wealth, comfort and luxury and the other half in dirt and squalor is the universal urban phenomenon in India. The urban population has nearly doubled over the past two decades. In 1971 it was 109.2 millions and in 1991 it was 217.2 millions. In Calcutta, Delhi, Bombay, Madras and Kanpur over one third of the population are living in slums.

Around 40 million people in urban areas, constituting 20 per cent of the total urban population were found to live below the official poverty line. Of them, around ten per cent have monthly per capita expenditure of Rs.60 less than half the level necessary to stay above the poverty line. The most visible manifestation of urban poverty is the unabated growth of urban slums.

The slum population in Tirupati constitutes about 24 per cent of its total population. Most of the slum clusters developed were the encroachments on Government lands. Majority of the slum dwellers could be categorised as the lowest ring of the society in realms of economy and education. Most of the one-room thatched huts with mud walls were the mute witness to fathom the grim poverty in the
cluster under study. Acute water problem and inadequate lavatories precipitate the crisis with symbolic insufficient personal cleanliness and filthy open area with night soil.

An indepth study was made to arrive at an inference with maximum certainty taking into account of various personal information collected from the slum families. Seventy two families (33.33%) were living in own huts and the remaining 144 (66.67%) in rented huts. Most of the slum houses are thatched huts with mud walls. One hundred and seventy five houses are with one room and the remaining have two rooms. Out of the total 1030 population, males out number females and similarly male children out number female children.

Majority of the slum dwellers are illiterates which includes 305 (57.55%) of males and 325 (65.00%) of females. There are 121 male and 107 female children going to school. Most of the couples (78.32%) have children and the remaining have no children. Several social and cultural factors influence the age at marriage which varies from 15 to 19 years for girls and 18 to 25 years for boys. Majority of marriages (91.15%) are by negotiations and the remaining are by mutual consent. About half of the total number of families 119 (55.95%) are nuclear.

Twenty one families get house rents. Majority of the families earn an income of Rs.300-600/- per month through various skilled and unskilled occupations. Some of
the women are engaged as domestic servants. Rice being the staple food for the slum people, about two thirds of their income is to meet the expenditure for food, fuel, shelter and clothing. Comparatively very little of their income is being spent for medicines, education and in celebrating festivals while the remaining is spent for cinema, smoking and drinking.

Some of the slum dwellers visit Government hospitals and very few people go to private doctors for treatment. The doctors from Rayalaseema Seva Samithi (a voluntary organisation located in Tirupati) visit the slum for their medical care. However, most of the slum dwellers try to cure the diseases by herbal and home made medicines. Several customs and traditional beliefs were associated with the slum women, viz., worshipping God to bless with children, barreness as a bad trait, preference of male child over female, characteristic psychological behaviour during pregnancy, selective food habits, pregnancy related symptoms in body and health care, abortions and after care. These practices in preference to modern medical care were followed.

There were many taboos connected with pregnancy particularly food during pregnancy. A great deal of various aspects including family planning, first pregnancy, first delivery, places of delivery, patterns of delivery, period of pollution, rest time after delivery, dietary habits...
before and after delivery, medicare before and after delivery, oil massage after delivery, causes of child mortality were dealt in detail keeping in mind of the various prevailing factors in the slum.

The data reveals that there is remarkable flexibility in the practices of pregnancy and child birth which were bound to be integrated with socio-economic and cultural triangle. As such it could not be possible to arrive at a straight forward conclusion to have a consistent record of their practices in pregnancy and child birth among the slum women as they belong to different ethnic communities. Poverty also seems to be the greatest puzzle that any family has to experience wherein there were no set patterns to practise. However, the present study indicates the adherence to traditional practices during pregnancy and after child birth is paramount.

Though there was an impact of neighbouring urban communities on the performance of rituals associated with pregnancy, child birth and childhood, most of the families would not be able to perform these rituals due to poverty and illiteracy. A special ceremony called "Seemantham is performed" by a very few families usually during the fifth or ninth month of pregnancy. Purificatory ceremony (first bath after delivery) is performed on the 9th or 11th day after child birth. The naming ceremony is performed only among a few families. The naming ceremony of a child is performed after 41 days of its birth in Muslim community by
its parents and Halal (Priest). Tonsure ceremony is the rite of the first hair cut of the child and it is performed at any time from 3rd month to eleventh year of the child. The adolescence of a girl starts when she attains first menstruation.

Infant feeding is an important factor for the protection of baby's health, physical as well as mental and is the main feature of interaction between the baby and the external environment during the early infancy. The children in the slum are usually breast-fed for one year, in some cases for two years and in a few cases even up to five years. The optimum breast feeding recorded in the present study is two years, under the discontinued category, mother's pregnancy takes the heavy toll (68 children). Ninety one (36.4%) and 76 (30.4%) children were weaned at the age of 2 and 3 years respectively. The abrupt weaning of the majority of the children reflects the socio-economic differences prevailing among the slum population. The illiterate and poor women did not follow any time-schedule in feeding their children.

The study indicates that breast feeding and supplementation with other nutrients are always below optimal requirement for the slum children. Duration of lactation, reasons for its discontinuation, substitute arrangements for breast feeding, weaning patterns and sex-discrimination at weaning stage clearly depict the child's
health foundation and influence the adult cultural behaviour.

An attempt has been made to assess the prevailing habits inculcated by parents for their children on dental care, bathing patterns, preventive health measures, training in bladder and bowel control, sleeping arrangements, immunization and curative practices of various ills of the children. With regard to the dental care, most of the children in the slum learnt the habit of cleaning their teeth within 3-4 years of age. But this care by brushing the teeth with their finger using cow-dung ash as cleaning agent by about 50% of the slum children indicates the economic constraints of the slum families.

Water scarcity is a common phenomenon in this temple-town and this inherent problem is more acute in slum area and thereby the bathing consciousness in slum children was developed at the age of 7 years. In bathing habits, variations in bathing schedules, preference to hot-water bath, different types of headbath, special ingredients used in infant bathing were related to the social customs associated with their families. Preventive health measures adopted for slum children are more of prejudiced in nature than of scientific such as putting on old cloths, black dots on the forehead, cheek and foot of the baby after bath.

Irrespective of economic and sexual discrimination, slum children developed significant control over bowel...
bladder at the age of 2 to 3 years. As the slum is devoid of proper in-built toilet facility, using the drainage canal and surrounding open space for defecation is an eye sore in the swelling vicinity like in other slums of India. The recent bizarre demonstration by several thousands of poor jhuggi dwellers against the ban on the right to defecate in the open is a point. Their question: Where else should we go? has no answer. (The Hindu, 24th May 1992.)

Not all the infants were bestowed with cloth cradle as a sleeping arrangement. For grown up children, the companions for sleep vary in different families and children sleeping in open space around their hutment is a striking scene to expedite the activities under "shelter for homeless programme".

Immunization against various diseases for children was effectively carried out by health department of the Municipality and voluntary organisation (Rayalaseema Seva Samithi). Umbilical sepsis mostly due to traditional practices of delivery was noticed among the slum children. Constant cry, abdominal pain, constipation, diarrhoea, vomiting, cough, cold, fever, small-pox (Ammavaru), jaundice, and pakshi dosham (low birth weight) were the major health problems suffered by children and for which they believed in folk therapy. Parents seek the hospital facility as a last resort for curing the diseases of their children when all their folk therapy failed.
The study reveals that 70.4 percent of the children were literates. As parents were poor and bread winners to the entire family and the elder children have to look after the younger ones, the literacy of the above age group could not be attained to 100 per cent. It is noteworthy to record that a few respondents, whose children attended pre-primary at Anganwadi school were of the view that their children became social, disciplined and less shy.

The socio-economic web of slum families surmounts to the over-all efforts of educational institutions to uplift the slum children through education. Though a formidable task was being carried out by different institutions, a series of domestic hurdles hinders the expected target of literacy achievement among the slum children.

Though majority of slum children were admitted to school at the age of six, initial reluctance in attending schools was more and different measures were adopted by their parents. Most of the female children were forced to live with all hardship as the parents were out of home for most of the day. The girl acts as a surrogate mother for young children and assist their parents in all domestic work. Therefore most of the female children were on the list of dropouts from school.

It is pertinent to record the general observations of the recreational activities of the slum children. The
types of games played by the children and the play equipment owned varied considerably in different families. Domestic and socio-economic constraints again prevent female children's participation in recreational activities. The form and nature of recreation preferred by the slum children reflects on the impact of urban culture and parents had little role in encouraging and supporting these activities. The children enjoy cinema entertainment which again is a culmination of socio-economic status. There was no control over grown up children who watch movies indiscriminately which leads to ill-effects on the young minds. There was no discrimination on selective preference of entertainment activities in Radio and Television among slum children from that of elite families. Also majority of the children (76%) had no specific hobbies because parents were poor, illiterate and not aware of the artistic inclination of their children.

Mead (1939) expressed that the differences in personality are seen very early. The baby is completely under the influence of the family's cultural and psychological integrity. Most of the mothers working as servant maids and casual labourers depend on their elder children to look after the younger children. Mostly nuclear families suffer from taking care of their infants during working time.

The toddler's tastes, activities and play things are considerably more diversified than when it is an infant.
Speech development depends not only on the child's general health and intelligence but also on its environment, the speech pattern to which the child is accustomed and the amount of encouragement given by its parents and elders. Most of the behavioural problems are of normal occurrence at younger age. Children may cling to immature behaviour because they are yet to learn their needs in a more mature manner.

It was observed that the majority of children shows aggressive behaviour, reflecting slum culture and environment. Telling lies, fear complex and frequent quarrels among slum children are influenced by the parents' and neighbours' behaviour. Several habits like thumb-sucking, nail-biting, bed wetting, noisy, dependency took more time to shed due to illiteracy and poor economic conditions of parents when compared to other urban children. Poor in studies, irrespective to elders, delinquent behaviour and aggressive attitude reflected the socio-economic conditions of the heterogeneous slum population.

The modus operandi of discipline among slum children varies from child to child even among the same age group. If there are more number of children in the family, the less attention and supervision by the parents, generates sibling jealousy and animosity which leads to quarrelling and other forms of troublesome behaviour among the children.
Even in small families the children get less attention as the parents were busy with domestic and labour work.

The slum population follow various disciplinary methods, punishments for children of more than one year age. It is observed that the punishments such as beating, branding, scolding, sparking, were found to affect childrens' emotional adjustments or behaviour in the family, school and society. Generally, rejected children tend to be fearful, insecure, attention-seeking, jealous, aggressive, hostile, lonely and isolated, slow in conscience development and have difficulty in later life expressing and responding to affection. They indulge not only in such activities but also pick up abusive and silly language.

No significant difference in the pattern of controlling the behaviour of children is noted in families belonging to different caste groups and different economic and literacy levels. Frequently older children show regressive behaviour in an attempt to maintain their central position in the matters of affection. Slightly educated families were more receptive to strangers.

Generally, father gives no attention to home, wife or children. Small families, usually planned and therefore consistent with parental desires in size and spacing. If the children lose both the parents, the effects are doubly serious. A home broken by divorce can be even more damaging to children and to family relationships than a home broken
by death because they tend to make children 'different' in the eyes of the peer group.

Parental quarrelling, nagging and general tension are bad conditions for a growing child. He responds to family tension by developing tension in himself. Periodic quarrels of parents leads to severe feelings of insecurity during childhood. In some of the families mother is the bread-winner and the father is a drunkard. In these families the children's personality depends on the parental moods and economic conditions. The most aggressive girls in the slum were daughters of prominent widows.

Infancy and childhood is a period of physical growth and personality development. The child is completely under the influence of the family's cultural and psychological integrity. The child shows different development of personality-physical and mental growth. The uneducated parents did not pay much attention to the emotional needs and adjustments of children. The behaviour is influenced by the culture, environment, socio-economic conditions, family, peer group and neighbourhood.

The peer group controls the behaviour and personality of the child. As the child grows in age, their influence gets stronger and stronger. The peer group is not only a mirror of society as it is, but also a reflection of society. (Rita Poulani, 1971). The differences in personality are seen very early. The play group is an important factor
in their lives and the children were more like their playmates than they were like to members of the family.

The care of young children by slightly older children themselves without defined personalities, perpetuates a far lower level of development of social individuality (Mead 1939). It was observed that among the slum children, as most of the parents are workers and most of the time are away from their houses, they left the children to the care of elder siblings or older people in the family. Such a fostering group may present an effective barrier through which the influence of father or mother does not penetrate.

In a heterogeneous community, like the slum, the children with different castes and religious socio-economic background, growing in poverty culture and interaction with a larger urban culture develop such a personality in which both the cultures and environment play very important role.

In social organisation, the children found no interesting adult patterns upon which they could draw. The kinship system with its complex functions and obligations of relatives was not taught them; it was too complicated for them to group readily themselves. Their habitual contempt for grown-up life kept them from drawing on it for play purposes.
Though the physical surroundings are not ideal and safe to play as they are unhygienic and no space in or outside the houses, the children play on the streets and in the houses. They have materials with which they would imitate adult life playing at trade and so on. They have neither formal organisations nor clubs, parties, codes and secret societies. But there was nothing permanent about the play groups, no continuous rivalry between the children.

Generally children's conversation is about the peer group activities like play, cinema and other aspects. The adults give the children no story-telling pattern, no guessing games, riddles, puzzles as most of the parents are busy in their daily activities. Children do not listen to legends and they do not know legends. However, they are interested in discussing cinemas. Their mental development is determined not by some internal necessity, but by the form of their culture in which they are brought up.

The integrated child development services (ICDS) programmes of the Government of India have been implemented in the slum through voluntary organisation viz., Rayalaseema Seva Samithi (RASS) since 1983. The services include supplementary nutrition, health education, health checkup, immunization, non-formal pre-school education in the age group of 0-6 years and pre-natal and post-natal care for mothers. In addition to these packages of services, non-formal education for school dropout girls, training and assistance to women through income generating schemes.
maternal and child health care centres were provided as extra components under the ICDS programme. By and large the impact of these programmes was encouraging in the slum.

Under women income generating schemes (WIGS) to improve the economic status of slum families appropriate programmes were undertaken. In view of the prevailing informal credit systems with exorbitant interest rates, self help groups (SHG) were synthesized in the slum for income generation in sustainable process. But these programmes have a little impact on the slum women as they were forced to remain out of doors for most of the day time to earn their livelihood. Moreover, unnecessary expenditures met for the costly conventions and traditions in their families made insignificant effect on these income generating schemes.

The existing infrastructure was not adequate to cope with the emerging needs. The administrative complexities and financial capabilities to undertake various social service sector programmes varied vastly from state to state and between bigger and smaller cities. The limited availability of resources, manpower and information base made matters worse. The root causes for the inadequacy of the reach of the existing services to the target population should be identified and the bottlenecks removed. The nutritional and health status of the children could not be improved by any vertical programme alone and this should be combined with programmes of environmental improvement of
slums and provision of basic amenities like water supply and sanitation.

The NGOs deeper involvement in ensuring that the services meant for the urban children reached the target population. The functional literacy combined with creation of skills for income generation would attract slum children to the school system. If the slum children were not brought into the educational system, they would roam around the streets, become juvenile delinquents or they would be forced to become working children. There was no dearth of legislation to safeguard the interests of the street children and working children. But their enforcement was very weak. The result was that thousands of children continued to work in hazardous occupations and were denied basic rights to education, health care and nutritious food.

As Dr. Bose noted, street children are not recognised in the plans as a separate target group. They are under the category of children in need of care and protection. But in the Eighth plan, for the first time, a programme for welfare and development of street children through grants to voluntary organisations has been given a separate identity with a separate budget provision.