SUMMARY AND CONCLUSION

The present study has been undertaken to examine utilisation of health care services and to explore factors which promote or hinder its utilisation among the slum dwellers in Amritsar city. The purpose of the study is to identify the nature and pattern of illness and to examine health care centre visited from which treatment has been sought. The study analyses utilisation of services offered under Maternal Child Health Programme, School Health Programme, and Health among the Disabled and Elderly Health. It entails to examine socio economic and demographic variables and its relationship with health index. The perception of health care services has been taken into account while focusing on health utilisation pattern. The study is divided into two sections: the first section deals with review of literature spell out the research questions, deals with methods of research, describes organisation of the study. The second section deals with findings of the study, provide insight about the respondents and examines conclusions drawn and suggest policy implications which could be helpful in improving the utilisation of health care services among the slum dwellers and their overall well being.

SECTION-I

Review of Literature: This section is broadly divided into five sub sections which have been described below on the basis of studies undertaken which are relevant to formulate research questions.

(a) Health and poverty related studies based on secondary data.

(b) Studies evaluating health based programmes.

(c) Studies focusing on inadequacies of Infrastructure and its bearing on utilisation.

(d) State level studies on health.

(E) Health related studies on Slums in Metropolitan cities

(a) Health and poverty related studies based on secondary data: The studies in this category suggest that issue of urban poverty and health need to be examined in coterminous way to overcome inadequacies related to health system and poverty. Such studies are Mechanic (1975); Saan and Belien (1995); Stephens (1995);
Martinez and Marineau (1998); Duggal (2000); Fraser (2003); Laterveer et al. (2003); Peters et al. (2003); Dreeesch et al. (2005); Reddy (2009c), Chandershekhar and Mukhopadhyay (2012). However most of these studies are theoretical in their orientation and are not based on empirical data pertaining to urban areas of India.

(b) **Studies evaluating health based programmes**: There is no dearth of studies that provide appraisal of how health has been prioritized within the realm of public health, further analyzing financial outlays meant for health sector, questioning the over prioritizing of some programmes over basic delivery of health care. Such as carried out by Banerji (1978); Chaterjee (2001); Kutty (2000); Ramachandran (2000); Kulkarni(1992); Qadeer (2002); Gill (2006); Jhabvala (2006); Bardhan (2008); Berman and Ahuja (2008); Guruswamy et al. (2008); Kurian (2008); Mehrotra (2008); Mukherjee and Karamkar (2008); Nath (2008); Bhargava (2009); Shah (2009a); Shah (2009b); Sule (2009), etc.

(c) **Studies focusing on inadequacies of Infrastructure and its bearing on utilisation**: Such studies examine health issues both at the state and district level. These include Deodhar and Mutatkar (1993); Bhat (1996); Bhat (1999); Schneider and Palmer (2002); Zamir (2002); Ager and Pepper (2005); Bose et al. (2005); Paul et al. (2007); Amrith (2007); Andaleeb et al. (2007); Hammer et al. (2007); Baru and Nundy (2008); Jackson et al. (2013), Nagla (2013& 2014a). The studies have identified the nature of health delivery system and its functioning, bringing into forefront inbuilt inadequacies. The studies highlight the barriers which people face with regard to health care in terms of distance, finances, awareness, behavior etc. But the studies focusing upon the issue of health care services in slums are very few. Many of the studies undertaken on health care are based on secondary data but very few based on field studies. Majority of the studies dealing with personal health and public health issues have been carried out at the State level in the Southern states only and some have been carried out in slums of metropolitan cities like Mumbai, Delhi, Chennai and Bangalore etc.

(d) **National and State level studies on health**:
- Some studies have been carried out at National level related to immunisation by Rao(2013), on health professionals by Baru(2010).
• Studies by Sindhu (2010) Roy and Chaudhari (2008), Pandey et al. (2004), whose main focus has been RCH issues used NFHS II and III data for the state level analysis.

• Studies on MCH and PHC in Tamil Nadu and Andhra Pradesh have been conducted by Prakasm (1995), Audinarayana (2008), Audinarayana (2011).

• Studies on epidemiological Transition in Maharashtra by Radkar et al.(2010)

• Bhatia and Cleland (2004), conducted study on out-patient care in Karnataka.

• Role of private practitioners have been examined in the study undertaken by Bhat (1999).

(E) Health related studies on Slums in Metropolitan cities:

• Studies on Mumbai slums whose main focus has been on Antenatal care have been undertaken by Jaiswal and Gupta (2014), Roy (2011); Karan et al. (2003), Kundu and Kantikar (2002).

• Studies on Delhi slums covered divergent health related issues of MCH, Illness and utilisation pattern, source of treatment etc. These studies have been carried out by Yadlapalli (2013); Patro (2009), Sundar and Sharma (2002), Khokhar et al. (2003).

• Ergler et al. (2011); Srilatha (1991) studies Madras slums focusing on private health care and PHC.

• Goli et al. (2011) examine health in relation to basic services available in eight metropolises across India. Both these studies examine health by constructing indices based on two parameters one relating to health risk index and the other focusing upon public health index of selected cities.

• City level studies have been carried out on Gurgaon,Bangalore and Ahmedabad on health care issue by Nagla (2013) Joseph et al. (2002), Bhat (1999) respectively.

But some of the questions remained unanswered as these studies have not examined health with in a larger frame of reference. These studies ignore living
environment and its relationship to illness pattern and treatment. Moreover no comprehensive study has discussed health care with respect to Punjab. There is no study on health care among slum dwellers living in Amritsar city, although substantial inputs about social, cultural and political organisational aspects have been highlighted in the study undertaken by Sandhu (1989). This study seems to contribute on health problems faced by people living in slums. The present study examines whether the generalizations drawn from our study hold true for other cities or if they are different.

Hence, the study attempts to answer the following research questions and addresses research gaps which have been identified above for this following objectives have been underlined which are specified

1. How and why slum dwellers are vulnerable to diseases typical to slums?
2. How far socio demographic factors play a role in health care services for Slum dwellers?
3. How far such vulnerability is related to housing, water, sanitation, education and income inequity?
4. How far professionals share people perception about the health care delivery system?
5. Which factors are decisive in determining levels of satisfaction with regard to health care among the slum dwellers?

**Objectives of the Study**

1. To analyse the utilisation of health care services among the slum dwellers
2. To know the user perception of the public health delivery system among the slum dwellers.
3. To examine the socio demographic and economic profile of the slum dwellers of Amritsar.
4. To study the role of State for creating health care facilities in Punjab with focus on slums of Amritsar in comparison to India.
5. To study the state role in provision of health care facilities in Punjab vis-a-vis India.

6. To bring-out the policy implication of the study.

**RESEARCH METHODOLOGY**

**Area of Study**

The universe of the present study is the ‘notified slums’ of Amritsar city. The number of notified slums is 63, which are within the limits of the municipal boundary. The city lies between 31°7’ and 32°3’ north latitudes and 74°29’ and 78° 23’ longitudes on the national highway No.1. Amritsar city is having an area of 11500 hectares with a population of 1,132,761 (in 2011). The health system has been analysed on the basis of allopathic medicine. The health facilities have been classified into government and private sector and within hierarchy of services health care offered at city level covering slum area dispensaries and the satellite hospitals which are comparable to primary health centers existing in rural areas. The outpatient information has also been collected from these health care facilities.

From these ‘notified slums’ five slums are chosen on the basis of urban services (water, sewerage and drainage facilities) available in these slums using the lottery method. Every tenth household was included in the sample and one adult member of each household was interviewed. In all 321 adult respondents from each household were interviewed. Data was collected initially by observation later on using interview scheduled to get reliable and authentic information.

The unit of investigation is household. A household for this study is defined as a person or group of persons related or unrelated, living and eating under same roof in above mentioned slums. Moreover to make the sample as representative as possible these slums are identified from three separate locations that is Western, Southern and Northern part of the city. Focused group discussions have been carried out to elicit response from the stakeholders with regard to quality of health care provided at satellite hospitals.
The first three areas include slums of Fatehpur, Bhrariwal and Angarh located in the Southern part of the city. Fatehpur and Bhrariwal are the two areas dotted by agriculture fields, where vegetable cultivation for the city of Amritsar is carried out. whereas, Anagarh has more of concrete structures narrow lanes and does not have open spaces as is the case of other two slums. In Fatehpur large number of diaries which have been shifted from the interior of the city are situated. This area has also been identified by improvement trust to house the new modern jail to be constructed by the government. This area is dotted with public health care facility in the form of the satellite hospital apart from having numerous private health care providers ranging from pharmacy shops to clinics to unqualified practitioners.

The second area is Kala Ghanupur which came under the municipal limit in 1981. It is in south west part of the city, having public health care facility i.e. the satellite hospital.

The last area further to the North of the city is Ganda Singh Wala a slum having narrow street crisis crossed by lanes. The Slum houses predominately scheduled caste population.

**Techniques of Data Collection**

The data was collected in the period from October 2011 to March 2012 through Quantitative and Qualitative methods. The quantitative method has been applied through interview schedule which was constructed after conducting pilot study. The researcher visited the slums of Fatehpur a number of times to know about their living circumstances and hardships they face at day today level. Informal interviews were conducted with people residing in the slum. The researcher also paid occasional visit to the satellite hospital to understand the working and interacted with the patients and their immediate family members. These visits have been of immense help in formulating the research problem. Interview schedule once prepared was pre-tested to overcome systematic error and also to add or delete certain questions. The interview schedule is divided into following sections: socio demographic profile ; health status; disease profile and utilisation pattern along with perception of health system. To overcome the
language problem the interview schedule was translated into Punjabi so that it could be administered to the respondents in each household in all five slums under study.

The interview schedule had both open ended and close ended questions. Data collection was not an easy task as often people would come to ask for medicines or brought prescriptions to describe about their illness. However once they were convinced that it is an academic exercise they were forthcoming in their answers sought by the researcher. The questions which dealt with MCH required the help of women who were present in the house (for reference see the annexure no. 6).

The secondary sources of data such as books, articles, developmental reports, policy documents, committee reports, working papers, conference and seminar proceedings, newspapers records of census and official websites of various ministries were also consulted.

**Code Design**

A code design was prepared for dealing with large volume of data to be properly classified. After completing the field work, the immediate task was to separate structure and unstructured questions in the interview schedule so as to allot appropriate code. Every interview schedule is coded according to the code number given to different questions, as to convert the qualitative data into the quantifiable data.

**Tabulation**

Tabulation of unstructured questions has been done manually whereas the structured data have been processed on computer by using the Statistical Package for Social Sciences (SPSS) software.

**Data Analysis**

Inferences have been drawn using percentage analysis and chi square. The most pertinent quantitative technique of factor analysis has been carried out to construct health utilisation index which helped in understanding health utilisation pattern in a better way and to arrange household on the basis of better or worst health status. On the basis of the data collected from the field relevant case studies have been constructed. The case studies are drawn taking into account health perception and their day today life. It also looked into their health seeking behavior and constraints they face from the
family and within the health system. These case studies are helpful in drawing more appropriate inferences and sharp generalizations.

**Organisation of the Study**

The present study has been divided into six chapters. The first chapter provides general introduction to the work. The second chapter traces the health related initiatives taken by state of Punjab vis-a-vis India and examines how health has been dealt in the development process and at city level (Amritsar) the working of satellite hospital have been detailed out. The third chapter examines the socio economic and demographic profile of slum dwellers and along with housing and civic amenities. The fourth chapter looks into utilisation pattern of health care services by slum dwellers by examining nature of illness, its pattern, diseases suffered by the respondents and members in the household, utilisation of national health programmes such as MCH, school health programme, disability and elderly health. The fifth chapter provides us with utilisation pattern where factors which facilitate usage of Public health care system have been detailed out. This utilisation has been examined by construction health utilisation index. Further health index of 321 respondents had been analysed to know about households enjoying good or worst health. The chapter also examines user perception of existing health care system. The sixth chapter describes the findings of the study and conclusions drawn from it and includes certain recommendations which would be useful in improving the utilisation of health care services among the slum dwellers; this would be the conclusive chapter.

**Background Characteristics of Respondents**

The analysis pertaining to the socio demographic and economic profile of respondents provide us with detail background of the respondents whose illness its nature and pattern have been dealt in the present study.

### 6.1 DEMOGRAPHIC

**Age**

About two fifth the respondents belong to middle age group corresponding to 41-60 years who constitute (38.9 percent) of the respondents, whereas about one fourth
of them belong to elderly age group. Therefore we can state that three fourth of the respondents fall in the age group of 21-60 years. The proportion of elderly is high in our study as often elderly stay at home while youngsters go away for work. Some of them because of age related health problems have stopped working and often spent time in taking care of their grandchildren in absence of their parents. Thus, they are valuable social support system for their children and grandchildren.

**Sex**

Overwhelmingly three fifth of the respondents are males who came forward to answer issues related to health and other issues which they confront in their day today life which affects their health profile. Whereas two fifth of the respondents are females. It reveals that four fifth of the respondents are married.

**Caste and Religion**

The caste wise analysis reveals that slums are dominated by scheduled caste population as more than one half of the respondents belong to Scheduled caste community and nearly one fifth of them belong to OBC community. Goli *et al.* (2011:464) highlights that less than two third of SC population lives in slums of Meerut which is higher than what is noticed in our study. More than four fifth of the respondents belong to Sikh community.

**Nature of Household**

Majority of the respondents are living in joint households whereas just 2.8 percent are found to be living alone largely because of familial circumstances such as spouse death, children living somewhere else or lack of support from them and uncaring attitude towards their parents.

**Education**

Education of the respondents reveals that two fifth of the respondents are illiterate. Those who are literate majority i.e. three fourth of them are educated up to matric (Secondary level of education) and less than one fourth are having education above Senior secondary up to graduate level.
Occupation

More than one half of the respondents are working as daily wagers. Two fifth of them are working as self-employed and some are also working in private sector. Thus majority of them are engaged in low paid jobs in unorganised sectors. Some of those who have education credentials are unable to get work as their skills are not appropriate according to work requirements. Very few of the respondents are employed in government sector; most of educated are often found working in private sector. About one fourth of the respondents did not earn their living and thus are economically dependent upon their family member for day today sustenance this included largely old and women respondents who are housewives generally belonging to middle and higher income group.

6.2 HOUSING

The analysis pertaining to the housing infrastructure of respondents reveals that a majority i.e. four fifth of the respondents are living in their own houses and more than one half of respondents are living in Pucca houses. This aspect has also been dealt by Sandhu (1989) study which mentions three fourth of respondents in slums reside in their own houses. From this we could arrive at the conclusion that the majority of the respondents originally belonged to the slum areas and hence are the natives and not the migrants as it is generally presumed. The study by Goli et al. (2011:464) highlights that more than two third of slum population in Meerut live in pucca houses which is higher than what is noticed in our study. More than one half of the respondents have two rooms in their houses. More than one half of the respondents have provision of separate kitchen. Less than one half of the respondents are using LPG as a fuel in kitchen. Goli et al. (2011:466) reveals similar figures in relation to LPG provision in slum households in Meerut. About one third of them are using wood residues for cooking purpose. Only two fifth of the respondents are having enclosed bathrooms. Majority of the respondents i.e. more than four fifth of them have toilet facility in homes.

The analysis of other household related variables such as room size, kitchen, and bathroom, courtyard provision of drinking water, drainage and roads indicates that basic amenities which are available to respondents do impact health of the respondents living
in slums. These findings do determine their living conditions and determine their health conditions in directly.

6.3 Public Utilities

The analysis pertaining to public utilities which are available to the respondents reveals that less than one third of respondents have accessed to pipe water supplied by the Municipal Corporation. Two third of the respondents have to arrange water on their own by installing booster pumps. Less than two third of the respondents have provision of pucca drainage facility.

Deprivations on Caste Basis

The analysis pertaining to housing infrastructure and public utilities further reveals that Scheduled caste population is the most deprived among all the caste categories. As many as three fourth of them are living in semi pucca houses. About two third of them are living in one room and two room houses. Majority of them do not have enclosed bathrooms. More than one half of them have latrine facility at home. About two third are using hand pumps for water supply As little as two fifth of them have provision of pucca drainage facility.

Deprivations on Income Basis

The analysis of the study also reveals that respondents whose monthly household income is less than 12000 per month are the most deprived in comparison to caste based deprivations More than four fifth of them are living in semi pucca houses. but the same number of them do not have enclosed bathrooms. More than four fifth of them are using hand pumps for water supply. Four fifth of them are having Kaccha drainage facility. As many as three fourth of them are living in one room and two room houses. About two third of them are having latrine facility at home. Hence socio demographic and economic characters are helpful in further analysis of utilisation of health care services. As these variables have been examined in relation to illness and treatment sought to do sociological analysis.

The analysis pertaining to utilisation of health care services has been carried-out by looking into the nature of illness, Illness pattern, health service utilisation for illness, Health service utilisation under various national health programmes, factors
determining utilisation of health care services along with health index analysis of respondents had been carried out.

SECTION II
FINDINGS

6.4 ILLNESS AND ITS NATURE

The analysis of the data reveals that four fifth of the respondents were ill. Less than two third of the respondents were suffering from acute illness whereas, the proportion of chronic illness was found in more than one third of the respondents.

Further when illness was examined on the basis of Age it emerges that one third of the respondents in the younger age group of (21-40) suffer from illness and more than one third of the respondents with in middle age group (41-60) suffer from illness. In elderly more than one fourth of the respondents are ill. It is found that two fifth of the respondents in the younger age group of (21-40) and middle age group (41-60) are suffering from acute illness. In the age group of 61 and above (elderly) close to two fifth of respondents are suffering from chronic illness

On sex basis it is found that three fifth of males and two fifth of females were ill. In terms of the nature of illness it is found that of total male respondents two third of them are suffering from acute illness. Whereas close to one third of women out of total women respondents suffer from acute illness. The study reports that out of the total male respondents more than half of the male respondents suffer from chronic illness. In women more than two fifth of them suffer from chronic illness.

Further analysis reveals that of the total four fifth of respondents who are married out of these four fifth married are ill. Similarly one seventh of respondents are widow or widowers out of this one seventh of widowed/widower respondents are ill. There was hardly any difference in percentage levels between acute and chronic illness among the married as in both cases more than four fifth of them suffer from acute illness and chronic illness. Whereas the higher proportion of widows i.e. one sixth of them suffer from chronic illness and less than one eleventh of the respondents are suffering from acute illness.
6.5 ILLNESS PATTERN

Fever

With reference to knowledge about any illness being reported during last six months, the respondents mentioned occasional episodes of fever. More than one fourth of the respondents suffer fever the causes are multiple malaria, dengue etc. reason noted for frequent occurring of fever episodes is related to the reasons such as change of season, lack of physical strength as they are less immune to infections. In certain cases malaria and dengue cases have been confirmed after they underwent laboratory test on the recommendation of doctors.

Common Ailments (Skin, Stomach and Tuberculosis)

The data regarding common ailment suffered by respondents reveals that one fifth of the respondents suffer from stomach related complications, One seventh of the respondents suffer from Skin diseases and one fifteenth of them suffer from tuberculosis. The respondents suffering from tuberculosis are found undergoing treatment regularly from government run dispensaries and T.B hospital during the field study few exceptions have been there.

Physical Disabilities

Physical disabilities are either congenital or age related or due to accidental injuries suffered at home or at work. It was also gauged from their situation that very few are having access to the government sponsored welfare schemes. A little more than one tenth of the respondents are suffering from physical disabilities in the slums.

Addiction

About one fourth of the respondents faced problem of addiction. Out of these total respondents who have been suffering from addiction it is found that problem of addiction is affecting respondents in equal proportion in all age categories. The gravity of the situation is that largely those who are found to be addicted are unable to meet their household requirements and are generally out of work. Even to relax themselves from the fatigue due to hard labour they are found to be consuming alcohol in large
numbers. Higher proportion of scheduled caste respondents are suffering from drug addiction.

6.6 HOUSING INFRASTRUCTURE AND ILLNESS

Just one half of the respondents who are living in pucca households suffer from illness. This proportion was same for those who are living in Semi pucca households and are suffering from illness. More than one half of the respondents who are ill have been using water from bore wells. One third of them are using tap as source of water supply whereas one seventh of them are using hand pump as source of water supply.

The analysis of the data reveals that one fifteenth of respondents who are suffering from tuberculosis and among them three fifth of the respondents are living in semi pucca households. It is found from the field study that one seventh of respondents suffer from skin ailments and three fifth of them who are living in semi pucca houses. Similarly one fifth of the respondents has been suffering from stomach related illness. More than two fifth of the respondents are using tap as source of water supply followed by bore well..

6.7 HEALTH SERVICE UTILISATION FOR ILLNESS

Health System

Less than one fifth of the respondents in our study utilised public health care system which means that about four fifth of the respondents utilised private health care system. The study of Meerut slum by Goli et al. (2011:464) identifies that 91.0 percent does not utilise government health care system. In our study 82 percent of respondents living in slums are not using public health care system. These findings do question the kind of health facilities provided by PHC system in both these cities of North India.

Health System and Caste Criteria

Less than one fifth of the respondents in our study utilised public health care system. Among them less than one half are SC respondents who access public health care system. Audinarayana (2011:75) mentions that more than one half of SCs visit government health care facility which is slightly higher than our findings. More than
one fourth of the respondents in OBC category access public health care system. Less than one seventh of the respondents from the general category access public health care system.

With regard to private health care system it is found that majority of the respondents’ access private health care system as more than four fifth utilised them during their illness. Among them three fourth are SCs followed by one fifth OBCs and less than one seventh from the general category.

Health System and Income Criteria

Among the three income categories corresponding to the lowest income group (up to 6000), lower income group (6001-12000) and middle income group (12001-18000) utilisation of private health care system is in the same proportion as more than four fifth of the respondents sought care from private health system. Whereas, in higher income category (18001 and above) utilisation of private health care system is little higher.

Health Provider

A little more than one half of the respondents frequently visits RMP (unqualified practitioner) during the time of illness. About two fifth of the respondents visit doctors (qualified practitioners). Hence RMPS (Unqualified practitioners) are providing higher proportion of health services in the slums in comparison to the doctors.

Health Provider and Caste Criteria

About two fifth of the respondents visit doctors (qualified practitioners) among them a little more than two fifth of the SC respondents went to doctor for treatment of illness and more than one fourth of the OBC went to doctor In case of General Category only one fifth sought treatment from doctors.

A little more than one half of the respondents frequently visits RMP (unqualified practitioner) during the time of illness. Within this category more than two third of respondents who visit them are SC, followed by one fifth OBC and less than one tenth from general category.
Health Provider and Income Criteria

Only one fifth of the respondents falling in higher income group (18001 and above) consulted the doctor, and less than one fifth went to the doctor in the middle income group (12001-18000). About two fifth in lower income category (6001-12000) consulted the doctor. Whereas more than one fifth of respondents falling in the lower income group (6001-12000) consulted the doctors.

Little less than one twelfth of the respondents who are falling in the higher Income group (18001 and above) accessed RMP. More than one fifth went to the RMPs in middle income group (12001-18000) and more than two fifth of respondents whose monthly income falls in lower income group (6001-12000) consulted RMP. More than one fourth of respondents whose monthly income falls in lowest income group (up to 6000) consulted RMP.

6.8 HEALTH SERVICE UTILISATION UNDER VARIOUS NATIONAL HEALTH PROGRAMMES

Maternal Child Health (MCH)

As regards to the Maternal and child health care, the expectant mothers are accessing health care services from public health care system, private health care system and Dais (Traditional birth attendants) as well. During course of pregnancy women went for prenatal check-up, immunizations for tetanus toxoid and followed procedural blood or urine tests.

Maternal Child Health (MCH) and Health System Consulted

The analysis of the data reveals that less than one third of respondents who are found to be expecting sought care from public health care system. One third of respondents who are found to be expecting sought care from private health care system. One third of respondents who are found to be expecting sought care from traditional birth attendants (Dais). Thus all system have been equally utilised by expectant women. More than two third of respondents have institutionalised delivery. Houlton et al. (2007) study reveals that 86 percent have undergone institutionalised deliveries. These figures are higher in comparison to our study.
MCH and number of children born to those who were utilising MCH system for Second Child

During the course of study it has been observed that 29.0 percent women have two children, 24.0 percent of them have three children, and 34.6 percent of them have more than four children respectively. In majority of the cases children survived through in spite of many odds. During the course of pregnancy it has been observed that in just 10.5 percent of cases miscarriage happened, Out of these, nine cases went for treatment as per requirement. Among these eleven cases, two sought home remedies.

Place of Birth and Caste

In the context of child delivery it is found that respondents access different types of health care systems for the delivery of the child. Less than one third of deliveries are home based deliveries. In this category about two thirds of home based deliveries are largely preferred by SC, among the OBC more than one fourth (27.0) preferred this as place of delivery, among the general category no one preferred this as desired place for delivery.

More than two third of the deliveries are institutionalised. Among this category more than two fifth of respondents in SCs preferred institutionalised delivery. More than one fourth of respondents in OBC category went for institutionalised and only one fifth of respondents in general category went for institutionalised delivery.

Place of Birth and Nature of Household

More than three fourth of respondents who went for institutionalised deliveries live in the joint households. More than one fifth of them who preferred institutionalised delivery live in nuclear household.

In case of home based deliveries three fourth are preferred by expectant women living in the joint households. More than one fourth is living in nuclear families who sought home delivery.

Place of Birth and Level of Education

One half of the respondents are illiterate who preferred home based delivery and two third are educated up to primary level only and one tenth are having middle level education and one fifteenth have education up to 10+2 level.
More than two fifth of the respondents who preferred institutionalised delivery are illiterate. One fourth of the respondents are educated up to middle standard and rest more than one fourth are educated above secondary level up to graduate level.

**Place of Birth and Household Income (on monthly basis)**

More than two fifth of home based deliveries are preferred by respondents whose household income levels are lowest (less than Rs.6000 per month). One third fall in the low income category (Rs.6001-12000). It is found that one eighth of the respondents who belong to middle income group preferred home based delivery. Whereas, one fifteenth of home based deliveries are preferred by those who fall in the higher income group.

More than one fifth of the respondents whose income is less than Rs. 6000 per month preferred institutionalised delivery. Less than one third of institutionalised deliveries are preferred by those who are earning less than Rs.12000 per month. But more than two fifth of the respondents went for institutionalised delivery whose household income per month was above 12001 up to 18001 and above.

**Treatment given to expectant Ladies by health Professionals**

During the course of delivery the poor women often have bitter experience as they are often taunted by nurses and in some instances doctors for undergoing repeated pregnancies in spite of poverty. During the child birth one fifth of the respondents did not have any reply to behaviour faced by them at the hands of health professionals. Those who went for institutionalised delivery did get payments. Very few complained about nurses or dais never giving them the money. Various reasons are given by women for not preferring hospitals for birth as pro-poor approach is missing towards them by health professionals. Foucauldian approach to study maternal and child health care had been important as women have frequent encounters with health professionals who often indulge in unruly behaviours while providing them information regarding pre natal, peri-natal and post natal care. Even study points out how women are afraid of getting institutionalised deliveries especially at public health care facilities as often the health professionals lack humanistic behaviour during child births. In spite of that about two
third of women respondents showed level of satisfaction as O.K. The findings of our study are in tune with Hulton et al. (2007) study that women do experience negative care from health professionals while accessing MCH in a slum in an Indian metropolis.

**Utilisation of Post Nataal Services and Family Planning Services**

A majority (Fourth fifth) of the respondents are satisfied with regard to post natal services utilised by them. In context of post natal care it is observed that higher utilisation is found for immunisation schedule, dispensing of polio drops, regular check ups of young infants. In the study very low usage has been reported by couples with regard to family planning methods.

**School Health Programme Service Utilisation**

The outcome of school health programme reveals that one half of children are availing facilities under school health programme. The children who are chronically ill belonged to poor families and lack resources for treatment. There is provision for free treatment under this programme. In government hospitals medical treatment or operations are performed. The whole expenses are borne by the state government.

A majority (50 percent) of students underwent health check-up and health Counselling. Only one fifth of the students are given Vitamin A tablets. About two fifth children are given advised about balanced diet. As many as four fifth of the students are aware about sanitation and personal hygiene. About one half of the students knew ill effects of drugs.

**Disabilities which Hinder Functional Roles (Eyes, Hearing, Speech, Locomotor)**

Thus it is found during the field study that one ninth of respondents suffer from problem of low vision ,whereas other disabilities are not of considerable proportion. It is again found that higher proportion of scheduled caste respondents are suffering from disabilities related to Low vision, Speech, Hearing, Locomotor problem. The study reveals that more than one third of women suffer from problem of low vision, two fifth of them are suffering from speech and hearing related problems. In men these problems are in higher proportion in comparison to the women.
Health Problems of the Elderly

One half of the elderly persons are suffering from a kind of illness, one third of them are suffering from more than two illnesses and one fifth of them are suffering multiple type of illness. Majority of them are suffering from joint pains, problems of ENT, Diabetes and kidney ailments among women thyroid and digestive system problems are more common whereas among men CHD, diabetes, tuberculosis and drug addiction is more profound.

6.9 FACTORS DETERMINING UTILISATION OF HEALTH CARE SERVICES

The factor analysis has been carried out on fifty four (54) factors out of which (17) seventeen factors emerge which explained 70.377 percent of total variance. Some of the factors have been detailed out below which determine Utilisation of health care system among the respondents.

- Health availability factor, Pregnancy related factor, Perception of health care factor, Accessibility to health care, Disease pattern (epidemiology of health care), Post natal care, Communicable plus behavioural disease factor, Utilisation of health care factor, Self-rated health status, Perception cum trust factor, Perception cum professional factor, Family planning factors, Approachability factor, Disability factor (mental illness),Birth related complications factor.
- Factor 1 accounted for maximum variance 7.377% of the total variance which included following variables such as health information, health check-up, building conditions, connectivity and costly medicines all these can be termed as Health availability factor.
- Factor 2 accounted for 6.754% of the total variance which included health check-up of the spouse, immunization of expectant mother and laboratory test carried out on expectant lady, Place of delivery which can be clubbed together as Pregnancy related factor.
- Factor 3 accounted for 6.130% of the total variance which included variables such as behaviour of paramedical staff, keeping of medicines, facilities available
at the health centre, health seeking problems and health facility in locality which can be termed as Perception of health care factor.

- Factor 4 accounted for 6.043% of total variance which included variables such as lack of facilities, time of work, waiting time, consultation time and lack of medicines all these can be combine together to be called as Accessibility of health care factor.

- Factor 5 accounted for 5.783% of total variance which included variables such as skin ailments, nature of spread, treatment followed as factor related to Epidemiology of health care.

- Factor 6 accounted for 5.346% of the total variance which included variables such as number of children born, number of children born survived, Immunization of children, Behaviour of attendants during child Birth and feeding practices etc. All these were clubbed together as Post-Natal Care factor and so on.

6.10 EXAMINING HEALTH UTILISATION INDEX ALONG WITH SOCIO-DEMOGRAPHIC AND ECONOMIC VARIABLES

Further using factors as weights health utilisation index has been constructed on its basis 321 respondents are divided into four quartiles lowest, lower, higher and highest. Those who are falling in the lowest quartile have maximum health related deprivations. Health utilisation index has been examined along socio demographic and economic variables.

Health Index and Community

Religion Basis

Majority of the respondents belong to Sikh community and they are in equal proportion across all the health quartiles. Among Hindus more than one tenth fall in the lower quartile and rest of them fall in other quartiles in equal proportion. Thus religion does not influence one’s health profile.
Caste Basis

About two third of SC respondents fall in the lowest quartile, and less than one seventh OBC fall in lowest, and one sixth from general category falls in this quartile and rest followed by no caste. Among SC less than one half fall in the lower quartile, among OBC a little more than one fourth fall in the lower and one sixth from general category falls in this quartile followed by no caste.

Among SC more than two fifth fall in the higher followed by OBC who are less than one third and one sixth belong to general category and rest followed by no caste. Among SC less than two third fall in the highest and followed by less than one fifth of the OBC respondents in the highest quartile and one seventh by the general category and rest followed by no caste. Thus among the general category all respondents fall in equal proportion in all respective quartiles.

Health Index and Occupation

As many as two third of the daily wagers fall in the lowest and less than two third in lower health quartiles hence facing worst health. About two fifth of daily wagers fall in the higher and the highest health quartiles hence enjoying better health. Among the self- employed little more than one fourth falls in lowest as well as lower quartiles. About one fifth in higher and little more than one fifth in the highest health quartiles. So among self-employed majority fall in lowest and lower thus suffer from health inequalities. Among private job category one seventh fall in lowest and lower quartiles and less than one tenth fall in higher quartile.

Index and Household Income (Monthly Basis)

As many as three fourth of respondents whose monthly household income is up to 12000 have the lowest health index. Whereas one fourth of them who have middle and higher incomes yet face health based deprivations. Less than two third of the respondents having monthly household income up to 12000 have the lower health index. Whereas more than two fifth (47.5 %) who fall in middle and higher incomes have lower health index. Hence facing health related deprivations less in comparison to the previous group.
More than two third of the respondents having income up to 12000 have higher health index and one third whose income falls in middle and higher income levels enjoy higher health index. Less than two fifth whose income level is up to 12000 have highest health index in comparison one third whose income levels falls between 12001 to 18000 (middle) 18001 and above(highest) have highest health index and enjoy better health in comparison to other respondents.

The analysis pertaining to the second objective reveals that perception of health services is based on the nature of current illness and its duration whether it is acute or chronic. This determines whom to access and the nature of treatment followed. The respondents mention that severity of the health problem diminishes the distance as an issue and cost of transportation. In our study 1.9 per cent of respondents discuss distance as an issue. Even if the health centre is located near by the attitude of the health personnel treating patients is a problem.

6.11 PERCEPTION OF HEALTH CARE SERVICES

Experience of Care

As many as four fifth of the respondents states that the time spend prior to consultation and time spend by doctors in treating them are the major constrain which forces them to visit private health care system. About two third of the respondents’ states that health check-up and health information given to them are not of appropriate level. Only one third described that behaviour of doctors towards them lacked any rapport as well as warmth. One third describes that training of doctors are not of sound quality. Hence, the adverse reaction of respondents on this issue forced them to seek health care services from the private health sector.

Provision of Care

The public health sector suffers from scarcity of resources which act as impediment to health care utilization. Three fourth did not seek health care due to financial constraints. As many as two third of the respondents reported lack of availability of medicines as the reason for not accessing public health care facilities. More than one half of respondents states that appropriate facilities are lacking at PHC.
About one third did not have faith on health professionals as well as on the health system thus refraining from accessing PHC system. Only one fourth of the respondents states that no proper diagnosis is done by doctors who are working at satellite hospitals and slum area dispensaries. Similarly only one fourth of them did not utilise PHC system because of working timings as they failed to visit PHC during working hours.

**Overall Physical Infrastructure Available in the Satellite Hospitals**

The study reveals that one half of the respondents stated that building of the satellite hospital is in good condition. (45 per cent) of the respondents i.e. more than two fifth states that approach to the satellite hospital was good. Even they insist that para medical staff are polite and helpful in nature as two third of the respondents are satisfied with the way the paramedical staff are available and helping in running the Satellite hospital. Only one fourth of respondents stated that the health facilities at the satellite hospital are good. A little more than two fifth are satisfied with the way the medical instruments are kept at the facility.

However there are some exceptions to the above mentioned findings as one third of the respondents reported that building of satellite hospital is really in bad shape. This is also observed in the field study by the researcher in case of Kala Ghanupur. Further only one fifth of those who have mentioned approach road in bad shape also belongs to Kala Ghanupur. The reason is that the satellite hospital is located in low lying place where water gets accumulated during rainy season. Moreover due to the lack of sewerage facilities dirty water flows in the compound of the hospital and collects there which made it impossible for employees and patients to visit the satellite hospital. However, as per medical professionals and other health cadre overall functioning of satellite hospitals is not better due to constrains financial , manpower and medical supply which have been highlighted in second chapter in detail.

**6.12 STATE AND CENTRAL LEVEL HEALTH INITIATIVE**

The analysis of the fourth objective which forms the backdrop on which this study is based gives brief account of India’s health planning mechanism and policy issues and how it assumes importance in changing set of legal norms, guidance and institutions by adopting evolutionary approach along with political economy approach.
Over a period of time various policy pronouncements brought health issues into forefront. At times steps have been initiated to strengthen national as well state level hierarchies of health infrastructure. The state went ahead with identifying participation of other societal sectors for generating multiple options with regard to health care as along with ministry of health and family welfare, ministry of women and child development and ministries of urban development and housing and Urban Poverty Alleviation.

The central government initiated steps in form of centrally sponsored schemes for national level disease eradication programmes such as for prevention & control of cancer, diabetes, cardiovascular diseases & stroke programme (NPCDCS), Polio and small pox eradication campaigns, Malaria campaigns.Tuberculosis Control Programme and Aids control etc. Sometimes in pursuing these programmes the state often overlooked other health issues such as providing basic preventive care to large masses. The health policies contained measures related to health services provision, influencing health status by prevention and promotion, taking into cognizance of inter sectorial measures such as Integrated Child Development Services (ICDS), National Rural Health Mission (NRHM), Mid-Day Meal Scheme etc.

The state also went to adopt life cycle approach by emphasising upon maternal and child health care, prioritising issues of pregnant and lactating mothers, immunization schedules for infants and children. The state is also focusing on emerging issues such as those linked with increasing accidental injuries on Indian roads. Framing programmes for handling issues related to habit forming drugs from tobacco to alcohol to synthetic drugs etc. The state has initiated programmes catering to the health needs of the school children, issues of disability, mental health, injuries suffered by individuals due to violence faced at homes and in conflicting situations. The affordability of health care has been translated in terms of access to medicines under selective programmes such as Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) along with Janani Suraksha Yojana (JSY) & Janani Shishu Suraksha Karyakram (JSSK) were two key steps introduced to attain MDGs. Hence some policies were related to direct outcomes, other address financial issues whereas some have been linked to protection of health and maintaining healthy life.
The objective looked into state level initiatives undertaken by the Punjab government and does describe the detailed account of health infrastructure both at government and private level available in the Amritsar city. It also described the working of the satellite hospital and slum dispensaries located in slums. Health providers because of role commitments (Doctors, Nurses LHV ANMs Midwifes) have clash of performances within the public health care system which affect user perception of health care system as study reveals at various points.

**The study provides certain important insights about the respondents living in the respective slum areas**

The people reporting higher percentage of lowest health index are the ones who are living in Ganda Singh Wala. It assumes significance as this place is situated two kms away from district hospital which is a tertiary level health care and ESI hospital on the Majitha road. These people do visit these places for accessing emergency care which requires hospitalisation and for seeking MCH care.

However the primary health needs often remain unmet as they seek care from quacks and medical shops located in their vicinity. It is remarkably interesting to see that this slum has a better metalled roads and the laid out sewerage in comparison to other two sample slums but it stills suffers from worse health indicators. It has been questionably related to the kind of water supply which they get from municipal corporation.

The other factors which come to light are as this slum is located near busy road and traffic passes from two interior roads to other colonies the pollution levels significantly harm people who often complain of respiratory tract infections and irritation in the eyes and dumbness in the ears. This area is relatively better served by vehicles from the municipal corporation.

The respondents who are living in Kala-Ghanapur enjoy medium health index in comparison to other two areas. In this area RMPs are functioning but their say is less as not frequent rush is observed at these shops during the field study. The area suffers from infrastructure related issues and lack of hygiene. However due to mixed population profile on caste and occupation basis people have the buying capacity to ensure better
health care from private providers who are located next to GT road especially in Khandwala to Putlighar stretch. Thus some- what better placed than those living in Ganda Singh Wala. The satellite hospital location is a matter of concern as it is non approachable during rainy season. The area suffers from problem of proper drainage facilities which creates unhygienic environment which affect the health profile of the respondents.

The respondents who are living in three slums of Fatehpur Bharariwal and Angarh are having higher health index in comparison to respondents of other two areas. The area basic infrastructure has improved over a period of time. Basic services like water supply are being provided through overhead water tanks. The location is such that these three settlements are aloof from hustle and bustle of city life. These areas have larger green space which defines its quality of life as better environment to breathe in comparison to other two slum areas. It is also having lowest population density in comparison to other slum area. Thus less congestion ensures less chance of spread out of communicable diseases.

The satellite hospital which is located on outskirts of this slum cluster is approachable by pucca road and the availability of health professionals and other paramedical staffs are the two main reasons which make it feasible for respondents to visit this facility during period of illness. This area also has qualified medical practitioners who are providing health care to community at their door step. They are providing healthcare from the past 15-20 years. The unqualified practitioners (quacks) are also providing multiple system of care.

The respondents are hopeful that further improvement in their lives could be possible by rectifying civic problems which confront them regularly. How it has a bearing on overall quality of health has often been largely spoken out by respondents. They are critical of health care system and (unqualified practitioners )who are practicing in slums which is catering to the health needs of the respondents and general public health being maintained in the slums by the Municipal Corporation. In spite of these problems the slum dwellers are doing their best to overcome their present problems.
6.13 CONCLUSION

Our findings show that four fifth of the respondents are ill. This is self-reported morbidity. These figures do reflect greater vulnerability of slum dwellers to poor living conditions. Some studies have reported the same proportion of illness as undertaken by Sen et al. (2007). One third of respondents who are found to be expecting sought care from traditional birth attendants (Dais) in our study. These results are not comparable with findings of the study undertaken by Sen et al. (2007) as that study reported two fifth of women who sought home deliveries. The results vary due to different study settings and sample size. Our study is slum based and other study is based in rural area.

Level of Deprivations

In our study we found that respondents face multi-level deprivations which are related to unclean physical habitat and lack of basic services provided by the state which cause vicious cycle of illness among the respondents. The analysis pertaining to the housing infrastructure of respondents reveals that A majority i.e. four fifth of the respondents live in their own houses and more than one half of respondents are living in Pucca houses. Majority of the respondents i.e. more than four fifth of them have toilet facility in homes. Less than one third of respondents have access to pipe water supplied by the Municipal Corporation. We can give further explanation to our findings that in slums studied three shelter indicators are of appropriate level excluding water and sewerage which are lacking and questionable hence, enforcing poor shelter conditions. In our study it has been established that illness is determined by nature of housing and water supply available to the respondents. These are also examined by studies of Martinez et al. (2008:90) which indicate that poor level of sanitation, lesser level of water connections and lack of living space and sewerage are multiple deprivations which affect slum dwellers.

Deprivations Faced on the Basis of Housing and Public Utilities

The analysis pertaining to the housing infrastructure and public utilities further reveals that scheduled caste population is the most deprived among all the caste
categories and income based deprivations are more severe than caste based deprivations hence poverty emerges as major challenge faced by the respondents living in slums which further translates into inadequacies of housing, lack of basic services, missing links of social capital and shortage of human capital which are essential for human survival.

**Inadequate Utilisation of Public Health Care System**

From the study it emerges that less than one fifth of respondents are accessing public care health system. They went to the government facility when they have to seek prenatal care, children underwent immunisation, for child birth and for availing services under MCH programmes. Even for episodes of chronic illness which required hospital stay, they seek health care from public health care facilities. This finding suggest that the lowest tier within structure of public health system is least frequented which implies that there is inadequate utilisation of urban health post (satellite hospital and slum area dispensaries). Further indicating that they failed to serve the population for which they have been established. Majority of the respondents often went to RMP (Unqualified practitioners) Two fifth of the respondents visit doctor followed by nurses and dais. The doctors generally include private physicians in higher numbers than the government doctors. Our results are also supported by studies undertaken by Kumar *et al.* (2000). Even there had been underutilisation of programmes dealing with elderly, disabilities and Maternal Child Health as indicated by our study. In our study one third utilised MCH services these are less in comparison to what has been observed in study undertaken by Srilatha(1991).

**Factors Determining Utilization of Health Care Services**

The present study makes contribution to the wider literature regarding decision making in facilitating the role of key factors which affect utilisation of health care services: health availability factor, perception factor, approachability factor, accessibility factor, utilisation factor, self-rated health status, pregnancy and post natal care and family planning, disease factor which includes communicable, behavourial, disability, mental illness, related problems The results of other studies Akin *et al.*
Kusuma et al. (2013) support our findings of health care utilisation. However, our results are more broader in relation to these studies as apart from attributes linked to facility factor, factors such as self-rated health status, post natal care, family planning services and disease factors related to communicable diseases, behavioural diseases, disability, mental illness, approachability factors all equally determine health care utilisation. Thus our work goes beyond variables within the medical setting which are generally included in earlier studies.

**Perception of Public Health Care System**

Perception of services had been examined at three levels:

- Experience of care
- Provision of care
- Overall functioning of health care system

The most important factor often cited by the respondents for not accessing public health care system within the category of experience of care includes waiting time, consultation time, health check-up and health information, behaviour and quality of care provided (reputation). In Audinarayan study (2011:78) one third of the respondents are not accessing PHC system due to waiting time. These figures are comparatively less than our figures as this study relates to both rural and urban study whereas in our study slum people do faced biased behaviour at hands of health professionals.

Goli et al. (2011:467) findings are similar to our results as 60 percent of slum dwellers in Meerut indicate that lack of health check-up and health information are enough reasons for not accessing PHC system. Krishna (2009:32) study also mentions quality as an important attribute affecting perception of health care facilities in two slums of Dacca which he studied. Morgan (2001) study does indicate that doctors are taught to be authoritarian as they have power to diagnose and cure. This is inbuilt aspect of biomedicine system. The most important factor often cited by the respondents for not accessing public health care system within the category of provision of care includes cost of treatment followed by availability of medicines and diagnostic techniques.
Krishna (2009:34) study provides perception about health care facilities in two slums of Dacca which mentions that cost factor and lack of medicines are the main reasons for not seeking proper treatment from government health care system. Krishna (2009:26) study provides perception about health care facilities in two slums of Dacca which mentions that 26 percent stated lack of proper treatment for not accessing PHC system.

However in the third category pertaining to overall health infrastructure existing in satellite hospitals higher level of satisfaction is stated by the respondents. This more includes components like building, medical instruments used and their up keep, approach road and appropriate paramedical staff (numbers and experience). Thus from findings we can make out that accumulation of two factors one of experience of care and second provision of care which are acting as major deterrence for proper utilisation of public health care system. Whereas, the overall functioning of health care system in terms of physical infrastructure is not a problem according to the respondents who have utilise this place for health care services. Hence, mere presence of the satellite hospital or slum area dispensaries does not ensure adequate utilisation. So proper utilisation of public health care system requires focusing more on software part which runs the system and later focusing on hardware part. The results of other studies Akin et al. (2005) do support our findings in relation to perception of health care facilities.

Overall the study looked into health status of respondents in local setting. The illness faced by them and the treatment sought. The study also reveals pattern of illness and factors which propel or hinder their health care utilisation. The way health care system is accessed by the respondents describes the overall functioning of health care system at micro level. The interaction between health professionals and the respondents and intra departmental working environment has been vividly presented by taking into account both user and providers perspective. Thus, this study has brought in whole lot of issues into fore front which questions the very essence of health care system.

6.14 POLICY IMPLICATIONS

Thus need of the hour is to take appropriate measures to overhaul the working of health care system. Inferences from the study could be drawn into appropriate policy decisions which must be integrated in drawing concrete plans for better utilizations of
health care facilities existing within slums. The proper coordination between slum levels, sanitation committees and health centre to be institutionalised for better public health. Better response system should be exhibited by medical fraternity for poor patients who often fail to get access because of lack of communication channels between the two so as to build patient and doctors role in an integrationist perspective

**Urbanisation Related Issues**

- Urbanisation has profound impact over the health of slum residents in Amritsar which is revealed from the field study. The civic amenities which are existing are of questionable nature as the municipal corporation has failed to ameliorate their sufferings. Hence, affecting the health status of the respondents. Thus mechanisms need to be placed so as to ensure that health needs of growing city can be met properly.

- The respondents in the study do question the efficacy of urbanization which has not brought any positive change in their lives. They have to pay development cost of the city expansion. They are forced to house diaries, garbage treatment plant, prison, places of unauthorised colonies. The changes in land use do affect their living spaces at social level. Hence changing the character of group relations. Slowly and steadily informal relations are becoming more formal ones with coming of settlers from other villages in search of livelihoods. Simultaneously two parallel processes are working one Push factors for those who can afford better places move out and second pull factors for those who want to reside next to city to get the able employment come here. Hence, time bound initiatives need to be carried out to look into their problems.

- These areas studied are ignored by respective departments like Health Department, Municipal Corporation and as no one come forward to meet their genuine pleas. Ways must be formulated at community level so as to look into matters reported by community members from all sections of the society to overcome emerging inequities due to cleaning operations, infrastructure maintenance etc.
Health Related Issues

- All health based programmes carried out by government must be evaluated by health professionals who deliver them as their suggestions are often overlooked while implementing them. Various components of health especially public health, manpower and infrastructure available in the satellite hospitals need to be strengthened.

- The health cadre should be more socialised along value lines of community which it was serving and must acknowledge them as citizens rather than mere receivers of health.

- Registered medical practitioners (unqualified practitioners) that run their practice in slums must be frequented inspected by the health authorities. RMPs (Unqualified practitioners) are providing curative care for day to day illness such as pains and fever whereas the satellite hospitals largely function as MCH and family planning centres which is grained in minds of the users which needs to be rectified.

- The study found out that the satellite hospitals are lacking the basic facilities if laboratory are there technicians are missing ,if technicians are there health kits are not available, if doctors are there medicines are not available. Most of the staff which is working at these hospitals is on deputation. There is need for permanent staff at these places as rapport building and faith are two important criteria which have been highlighted by respondents during field study which facilitate health care utilisation.There is a need for male health workers for field work, for chlorination of water tanks, for acting as educators for maintaining hygiene in the area which are the main components of public health are missing in preventive health care offered by the satellite hospitals.

- The medical staff working in the satellite hospitals are of the opinion that component of urban health within NRHM should start as early as possible as budgets heads and grants could be given to them as in many cases staff spend
from their own pockets for maintenance of building and other basic infrastructure.

Community Related Issues

- The community participation is required in overall structuring of slums to make them better places to live in. It was noted that these slums are more akin to village life than city life thus more informal relations could be strengthened to evolve better community rights which ensures wider participation in the democratic setup.

- The working of the health system needs to be improved by initiating dialogue between the hierarchies of health personnel involved in delivery of health care from ANMs to LHV to multipurpose male health workers to nurses to laboratory technicians to pharmacists to doctors. This chain which has over a period of time become cold chain need to be worked upon as people seeking health care often blame these actors' attitude for not accessing public health care services.

- The school health programmes can be designed in such a manner where medical staff and teachers of the school could coordinate for better formulation of objectives and its delivery.

- The satellite hospital /SLAD must have integrated membership of councillors of the area along with principal of the government school, plus members of religious based organizations and elderly and educated members of the community along with Medical officer. This committee need, to be constituted and is important because medical officers do face problems with cash provisions to carry out public health programmes. Moreover coordination is important to motivate people to access health care from government practitioners and public health care system rather than falling prey to RMPs. (unqualified practitioners or quacks)

- Slum Mohalla committees need to be formed so as to ensure that youth participation in constructive activities of slum can be undertaken.
• From the study it emerges that relationship of poverty, living environment and health matters a lot which needs to be looked into properly and basic services need to be made available to the people living in slums and public health measures need to be adopted to safeguard their health by initiating preventive measures. It also requires better health facilities and its mandatory functioning by looking at tangible and non-tangible factors. Thus slum people can overcome triple jeopardy of insecure lives, insecure living and insecure livelihood.

• Lastly there is a need to examine slum peoples perspective in relation to insecurities mentioned above for which their thinking, perception and attitude can be acknowledged, understood and comprehended by health professionals to form close relationship with community at large which is need of the hour.

Issues Related for Further Actions and Research

• On the basis of present study health care utilisation can be compared between slum respondents and non slum respondents at various levels of health hierarchy from PHC to CHC to District hospitals.

• At local level benchmarks need to be created and maintaining data profiles of basic services and population which could help future researcher’s to carry out better studies

• An initiative should be started in slums where children who are school going are made to participate in endeavours like know your area campaign and to seek solutions for the problems of their areas.

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