

CHAPTER V

SUMMARY AND CONCLUSION

Two sets of urban slums have been selected for comparing the health practices of the slum dwellers in the areas of reproductive health of the mother, immunisation, diarrhoea and malnutrition of children under 5 years of age. Such eligible couples have been selected in the sample as those who have children below 5 years of age. The first group of slums is those where no health projects/ programmes have been specially introduced until the period of the study. The second group of slums is those where health and family welfare programmes and projects have been particularly introduced over a period of time. The purpose of the study was to look at the health and family welfare practices of the dwellers of these two sets of slums and to compare their health practices relating to the areas of reproductive health, immunisation, malnutrition and diarrhoea. The main basis of comparison was the influence of social parameters such as literacy, income, religion, origin of domicile, influence of family members and adherence to social traditions, rituals, social and cultural practices, cultural taboos and superstitions. The study has led to certain findings, which are summarily presented here, with a comparative perspective.

Reproductive Health:

The levels of education of the husbands in general are superior as compared to that of the wives of both the sets of slums. Again, the overall standards of education in the intervened slums are superior as compared to that of the non-intervened slums. In the non intervened slums, the proportion of illiterate males are ~~44.2%~~^{41.55%} and that of illiterate females are 66.28% among the Hindus. In comparison, the proportions are 10.53% illiterate Hindu males and 21.67% illiterate Hindu females in the intervened slums. Similarly, among the Muslims in the non intervened slums, 68.4% of the females and 42.10% of the males are illiterate. In the intervened slums 23.33% males and 41.67% females form the illiterate group.

The suitable Mean age at marriage as opined by the respondent mothers and as desired by the community in the intervened slums lies in the range of 18.66 years to 20.17 years for the Hindus and between 16.89 years to 22.33 years for the Muslims. In the case of non intervened slums, the individual opinion of mothers on the suitable age of marriage was overridden by the community. In the intervened slums also, there was a significant difference in the ages preferred for marriage and the actual age of marriage in the Hindu community. In the Muslim community, however, the community closely guides the individual opinion. While conducting the statistical T-test between the Mean age at marriage and the age at first pregnancies, the association is found to be highly significant between both religions.

In the non intervened slums, 90% of mothers of both communities believe in God's blessings in order to be able to conceive a child. In the intervened slums, the corresponding proportions are 15.5% of the Hindus and 40% of the Muslims. While 50.5% of the Hindus and 7.5% of the Muslims have stated that their pregnancies resulted out of self planning, in the non intervened slums, 8.1% of the Hindus and none of the Muslims have subscribed to such a view. Further, in the non intervened slums, 32.22% Hindus and 46.7% of the

Muslims have stated that the desire of their in-laws is an important social factor influencing the birth of their children. Hence, in the intervened slums, 50.5% of the mothers of the Hindus are more prone to rational and scientific thinking on the issues of conception and pregnancy. This difference becomes all the more palpable when compared with 90% of the respondents of all literacy levels and of both religious groups in the non intervened slums who have expressed faith and belief in traditional social dictates as against rational thinking. The corresponding proportion among the Muslims, however, even in the intervened slum, is only 7.5%.

In the non intervened slums, nearly 90% of the Hindus and 79% of the Muslims have reported their faith in social and religious dicta to get a child. In the intervened slums, the proportions are 52.63% of the Hindus and 69.16% of the Muslims respectively. In another interesting contrast, 11% more Hindus of the non intervened slum believe in such dicta as compared to their Muslim counterparts. In the intervened slums, 17% more of the Muslims believes in the dicta as compared to the Hindus. Hence, despite health interventions and creation of awareness, majority of the urban slum dwellers of both the intervened and the non intervened slums believe in the social, religious and cultural practices to beget a child.

In the non intervened slums, the average number of living children, born to illiterate Hindu mothers of different income levels ranges from 3.3 to 3.7 for the Hindus. In the intervened slums, the average number of living children ranges from 1.0 to 2.7 for the same community. For Muslims, the average ranges between 2.0 to 3.4 and between 1.84 and 2.7 in the non intervened and intervened slums respectively. Hence, family planning interventions have had a favourable impact in reducing and stabilising the family size between both religious communities in intervened slums. In the non intervened slums, there is 35.1% greater preference for the male child among illiterates and 27.3% more preference for the male child among the secondary educated. In the intervened slums, the predominant choice is for one child of each sex.

The opinion of the likely Mean age as to when the mother should have the first child has been computed for the intervened slums and it oscillates between 20.84 years and 21.8 years. This is at a higher level than 19 years as opined by the mothers, in general of both religious groups of the non intervened slums. While advancing various reasons for justifying the age for childbirth, mothers of the intervened slums mostly advocate physiological and health grounds (47% Hindus and 78.33% Muslims) as against their counterparts of the non intervened slums who have mostly advanced social and religious grounds.

In the intervened slums, mothers of all religious groups have prescribed a reasonable interval of 3 to 4 years between two consecutive childbirths. They have justified this concept of spacing on grounds of health, social and economic reasons as well as domestic advantages and the desire to take appropriate care of each child. The statistical T-tests prove strong association between the Mean ages at marriage between both religious groups but insignificant association between the age at first pregnancy between them. Among the eligible couples 99.38% of the Hindu mothers and 97.5% of the Muslim mothers have preferred to take recourse to antenatal care in the intervened slums. Of this proportion, 47.35% have wanted to ascertain the needs of pregnant mothers, 85.66% have wished to ascertain the status of blood pressure with the foetal position. About 33% have wished to have access to immunisation, pathological examinations and nutrition packets. Among the

Muslims, the proportion of mothers are 95%, 1.7% and 28.20% respectively. The corresponding proportions for Hindu and Muslim mothers in the non intervened slums are 32.05%, 7.69%, 53.8% and 23.1% respectively. In the non intervened slums, 8 Hindu mothers believe in traditional beliefs and taboos and hence have rejected the scope of antenatal care. 2 Hindu mothers are totally fatalistic. This faith in fatalism is shared by 1 Muslim mother also. 5 Muslim mothers believe in traditional beliefs. Surprisingly, even in the intervened slums, 2 Hindu and 1 Muslim mothers fell back on fatalism. 2 mothers, each from either religious group have wished to adhere to the traditional concepts. In the intervened slums, 94.11% of the Hindu and 93.33% of the Muslim mothers have desired to avail of institutional facilities to ensure safe delivery. This is in contrast to 32.6% of the Hindu and 26.3% of the Muslim mothers of the non intervened slums. Hence, while in the non intervened slums, there is significant dependence on home deliveries, in the intervened slums, the eligible couples prefer institutional deliveries, showing better awareness and greater access to health infrastructure.

In the intervened slums, a greater proportion of respondents prefers hospital delivery and agrees to services of male doctors. While 94.73% of the Hindu mothers agree to the services of male doctors, among the Muslim respondent mothers, only 83.33% of those agreeing to hospital delivery have assented to the services of male doctors. This shows greater permissiveness especially in the latter society. In the non intervened slums, while 67.4% of Hindu mothers have agreed to hospital delivery, 82.6% have agreed to the services of male doctors, 73.7% of the Muslims mothers have agreed to hospital delivery but only 63.2% have agreed to the services of male doctors.

In the intervened slums, respondent mothers are more aware of and more desirous of availing of postnatal services for better health of mother and child. There are, however, nevertheless some elements of reluctance as well as ignorance with the sample population. 97% of the Hindu mothers of the intervened slums, 10% more than their counterparts in the non intervened area and 96% of the Muslim mothers, 17% more than their counterparts in the non intervened areas have actually availed of antenatal services. While similar proportions of the Hindu and Muslim mothers have availed of antenatal care in the intervened slums, 8.3% more of the Hindu mothers have availed of such services. Mothers shying away from visiting hospitals for antenatal and postnatal care facilities have stated that they are thwarted by the apathetic attitude of the hospital staff, lack of transport as well as want of escorts to the hospitals.

In the intervened slums, 93.49% of the Hindu mothers and 88.33% of the Muslim mothers have visited the hospitals to give birth to 89.66% and 80.56% of their children. In the non intervened slums, 79.1% of the Hindu mothers and 63.2% of the Muslim mothers have taken admission in the hospitals to deliver their children. Those visiting hospitals have an average of 2.08 confinements; those giving birth at homes have an average of 3.94 confinements, proving thereby that institutional deliveries encourage eligible couples to have smaller families. Chi-square tests statistically prove that there is no association between the two places of confinement on the basis of the religion of the two communities. Coming to the rationale underlying home deliveries, such deliveries have been prompted by apathy, dominating attitude of the mothers in law (for Hindu respondents only), sudden labour pain as well as lack of escorts and money to attend hospitals. Hospital deliveries, on the other hand, have been prompted by the decisions of the eligible couple themselves,

advice of husband, in laws and neighbours. In the intervened slums, most mothers have decided on their own to attend the hospitals for delivery, which indicates stronger decision-making position in the family for these women of the intervened slums. In the non intervened slum, on the other hand, social issues have stood in the way of the would-be mothers from taking recourse to hospital services.

Statistically speaking, literacy has not proved to have any effect on the communities on their decision making process on family planning. Illiterate Hindu mothers have resorted to family planning more as a compulsive measure to avoid further childbirths. Literate Hindu mothers, on the other hand, have used family planning more as an instrument of choice. Among the Muslim mothers, even illiterate respondents have used family planning both on compulsion as well as choice. In the intervened slums, only 1.23% of the Hindu mothers and 2.5% of the Muslim mothers of the sample population do not believe in family planning. No rationale is forwarded to support the negative attitude either. In the non intervened slums, the proportion of non believers is as high as 75.5% and 68.42% in the Hindu and Muslim communities respectively. Social grounds such as apathy towards the concept of family planning, faith in God's blessings and sometimes, economic reasons as expenses on contraceptives explain such reluctance towards adoption of family planning. Misconception about adverse effects of male sterilisations prevail both in the intervened and non intervened slums. This has led the women in the families to take recourse to tubectomy. As in the non intervened slums, choice of family planning methods is literacy neutral.

In the non intervened slums 86% of respondent mothers have not accepted family planning after the birth of the first child. This is in sharp contrast to the intervened slums, where 76.74% have accepted family planning after the birth of the first child. In the non intervened slums, even after the birth of the third child, 88% have failed to accept contraception. This shows that while there are conscious efforts on the part of the eligible couples of the intervened slums to accept family planning, in the non intervened slums, deep rooted traditional beliefs prevent such scientific and rational thinking.

Immunisation of Children

In the intervened slums, the cohort of children aged between 1 year and 2 years is 5% more than the cohort of children in the non intervened slums. The proportion of children who have undergone complete immunisation in the intervened slums is as high as 94.7% among the Hindus and 90.3% among the Muslims. In the intervened slums, only 4.4% of the Hindu children and 4.8% of the Muslim children are incompletely immunised. In the non intervened slums, on the other hand, the proportions of incomplete immunisation among the Hindus and Muslims are 41.75% and 83.3% respectively.

In the intervened area, 100% of the eligible couples of all literacy levels and from both religious groups are found to be firm believers in the immunisation of their children. More than 93% of the mothers of all literacy levels of both religious groups believe that immunisation protects the child from 6 killer diseases. In the non intervened slums, only 26.5% of the Hindu mothers and none of the Muslim mothers believe that immunisation protects their children from the 6 killer diseases.

Analysing disease wise, 100% of the eligible couples of both religious groups affirm that immunisation protects the child from developing Polio. In the non intervened slums also, there is some belief in the Polio immunisation, thanks to the effect of the media. The reality, however, is that 55.6% of the children are not immunised completely in the non intervened slums. Hence, possibly there is more hype than rationale in the influence of media in as much as the information generated is not translated into practice in the non intervened slums. Similarly, in the case of Diphtheria, awareness has been generated in both areas. In the intervened slums, such awareness has led to complete immunisation of 93% of the infants. In the non intervened slums, 44.4% of the children have received such complete immunisation. Measles vaccination presents an interesting picture. In the intervened slums, the proportions of actual immunisation in the Hindu and the Muslim community are 95.3% and 99.2% respectively. In the non intervened slums, the proportions are 33.6% and 52.6% respectively.

Even in the intervened slums, 15 Hindus and 1 Muslim respondent have refused to immunise their children. 11 Hindu respondent mothers believe in '*Sitala Puja*' (worship of local goddess) along with traditional herbal treatment. Other 4 mothers rely on homeopathy and *kabiraji* (indigenous method of treatment) treatment. One of the mothers wishes to tie a thread on the holy tree around the tomb of the *Fakir baba* (Holyman of Muslim community).

Hence, it may be concluded that in the intervened slums, extension and outreach services have generated both belief and demand for immunisation and there is almost universal immunisation of children. In the non intervened slums, there has been some responses to the initial rounds of immunisation thanks to the effect of media. This influence, however, has not been sustained and the process of immunisation has not been completed for majority of the children. Social beliefs and cultural taboos have held their sway over the mothers of the non intervened slums and there has not been much rational thinking in this area. There have been a large number of drop outs among the infants who should have received immunisation in the non intervened slums. Lack of facilities and lack of contacts by health workers have led to non sustenance of the interest of the community in the process of immunisation.

Malnutrition

The sample respondent mothers of both the religious groups of the intervened slums have almost complete knowledge of the malnutrition of children under the age of 5 years. About 100% of the Muslim and 99.37% of the Hindu mothers in the intervened slums have this knowledge as compared to 20.95% and 22.1% of the corresponding respondents of the non intervened area.

About 6.97% of the Hindu respondent mothers of the non intervened slums ascribe the causes of malnutrition to the influence of ghosts and evil spirits. In the intervened area, the proportion of respondents believing in ghosts and evil spirits is 0.62% only. One Hindu mother educated up to the primary level and one illiterate Hindu mother belonging to the intervened area subscribes to this social taboo.

Upon analysing those factors which have led to the awareness of the respondent mothers regarding knowledge of malnutrition, 74.9% of the literate respondents of the intervened area and 12.5% of the literate respondents of the non intervened area have stated that health awareness is the motivating factor which has subsequently ~~caused~~^{prevented} malnutrition. 11.7% of the illiterate and 1.2% of the literate respondent mothers of the intervened slums and 2.98% of the illiterate and 6.25% of the respondent mothers of the non intervened slums have stated that due to economic stringency, their children could not be administered nutritious food which has subsequently caused malnutrition.

99.8% of the respondents in the intervened slums have sufficient knowledge of how to retain nutrition in food in the process of cooking as against 23.8% respondents of the non intervened slums who have such knowledge. 76.2% of the respondents have not have any knowledge regarding preservation of nutrients in the cooking process in the non intervened slums. Nearly 98% of the mothers of both religious groups in the intervened are satisfied with the cooking procedure followed in their kitchens. In the non intervened area, the proportion of satisfaction is 45% of the sample respondents of combined religious groups. In the non intervened slums, the reasons for dissatisfaction are mainly on account of social causes, namely, that mothers in law dictates the cooking procedures, there is not enough money to buy nutritious food and a section of the respondents believe that God's grace on the household will prevent malnutrition. In the intervened slums, three mothers of the Muslim community have stated that as the cooking procedure is being followed under the directions of their mothers in law, it is not possible to preserve nutrition in the prescribed fashion.

In the intervened slums, 99.3% of the mothers of all literacy levels and both religious groups have perfect knowledge about preservation of nutrition in foodstuff even after specific methods of cooking. In the non intervened area, 45.4% of Hindu mothers and 47.4% of Muslim mothers have this knowledge. There are four basic cooking procedures which help to preserve nutrition in cooking, namely, retaining the starch of boiled rice, preparing pulses by mixing a few varieties, slicing vegetables in big pieces and chopping vegetables after washing the same. The proportions of respondents in the intervened area who have this knowledge are 76.7%, 86.9%, 89.6% and 93.2% respectively. In the non intervened areas, the proportions are 9.52%, 82.9%, 34.3% and 13.3% respectively, that is, the mothers of the non intervened areas believe in mixing of pulses during cooking but they do not believe in the other nutrition preserving cooking procedures.

In the intervened slums, 100% of the Muslim and 99.6% of the Hindu mothers, and in the non intervened slums, 89.47% of the Muslim mothers and 75.58% of the Hindu mothers believe that both animal protein and vegetables are to be administered to their children's food to administer nutritious food to their children. 89.6% of Hindu mothers and 96.6% of the Muslim mothers in the intervened slums and 89.5% of the Hindu and 100% of the Muslim mothers in the non intervened slums do not support any "gender discrimination" while administering nutritious food to their children. Health awareness has influenced 63.9% of the Hindu mothers and 87.1% of the Muslim respondent mothers in the intervened slums. They have accordingly agreed to provide nutritious food to their children irrespective of gender. No mother of the non intervened slums, however, has been motivated by health awareness. 3% of the mothers of the intervened slums want to administer more nutritious

food to their daughters, as they were the would-be mothers. No mother in the non intervened area subscribe to this view.

In the intervened slums, there are 443 mothers with 616 children under the age of five years. The ratio of children under five years to mothers is 1.39:1 in the intervened slums as compared to 1.58:1 in the non intervened slums. Hence, the proportion of children under 5 years of age is 13.67% lower than that of the non intervened area. Mothers of the 347 males and 269 female children in the intervened slums have identified 59 male children and 43 female children as malnourished on the basis of identifiable symptoms. The incidence of malnourished children in the intervened slums among children under the age of 5 years as derived by actually analysing the growth chart of children is 7.46%. In the non intervened slums, the incidence of malnutrition as derived from an analysis of the growth charts of children under 5 years of age is 31.33%. This is 4.19 times higher than that of the intervened slums. When the mothers of the non intervened slums, however, were asked to identify malnutrition in their children, they could identify only 3.125% children as malnourished. This is because the mothers of the non intervened slums, have very poor knowledge of malnutrition of children under the age of 5 years and hence have failed to identify the symptoms of malnutrition in their children. The correct incidence of malnutrition could be deciphered from the nutritional growth charts. Hence, it is concluded that the incidence of malnutrition is 4.19 times higher among the children under the gap of 5 years in the non intervened slums as compared to the children under the age of 5 years in the intervened slums. The high proportion of malnutrition in the non intervened slums is based on ignorance, lack of health awareness, domination of mothers in law, economic stringency, lack of knowledge of preservation of nutrition in cooking and influence of taboos and superstition.

Diarrhoea

Undoubtedly, awareness of the causes and symptoms of diarrhoea is more in the intervened slums as compared to that in the non intervened slums. The respondent mothers, irrespective of their religion, are able to diagnose diarrhoea in the intervened slums. The mothers in the non intervened slums do not have this knowledge. The mothers in the intervened slums, irrespective of religion, are totally competent to cure diarrhoea at homes with Oral rehydration solution or home made remedies. In the non intervened slums, most children suffering from diarrhoea are rushed to the hospitals for treatment because of lack of proper knowledge of their mother to treat them at homes. As a result of this ignorance diarrhoea becomes acute and condition of children's health becomes serious. The mothers of the intervened slums, unlike their counterparts in the non intervened slums, are also aware of the benefit of colostrums. Mothers of the intervened slums have derived their awareness from the health workers and popular media such as the television and the radio. The mothers in the non intervened slums have depended on whatever knowledge they have received from the media. Income effect has not been established as a determining factor in influencing respondent behaviour in either category of the slum settlements.

General observations

The main determinants of social behaviour relating to health practices in the urban slums which were selected in this study were levels of literacy, religion, income, influence of family members, social beliefs, prejudices, taboos and superstitions. Some of these determinants have been established as significantly influencing health care seeking behaviour of the slum dwellers selected for this study.

Religion has been established as an important factor in deciding on the age of marriage, childbirth, and family size, availing of services of male doctors, acceptance of immunisation, detecting malnutrition and resisting diarrhoea. Literacy levels were better in the intervened slums as compared to that in the non intervened slums. Hindus, on an average, were found to be more educated than their Muslim counterparts. Male members (husbands) were found to be more educated than the female members (wives). Belief in God's blessings as against self-planning was universal and literacy neutral in the non intervened slums. Illiterate mothers have been found to have higher average number of children. Literacy has not been proved to be a determinant in influencing decision-making process of family planning. Choice of family planning methods is also literacy neutral. Decision to immunise children in intervened slums has been proved to be literacy neutral. Practice of home treatment of diarrhoea was established as literacy neutral but in the intervened slums, literacy has been established as an important determinant in influencing and knowledge of and treatment of diarrhoea. Breastfeeding of infants during diarrhoea was found to be literacy neutral but belief in fasting children during diarrhoea was found to be sensitive to literacy. The need for antenatal care and postnatal care was found to be literacy neutral. Income has not been established as a major determinant in the health seeking behaviour. In fact in non intervened slums, those in highest income groups have reported the highest number of children. The need for antenatal and postnatal care has been found to be income neutral. Income effect has been found to be nil in families with malnourished children. Similarly the decision to adopt family planning as well as the choice of contraceptives has been found to be income neutral. Family members have been of strong influence, especially mothers in law and husbands. This influence has been reflected in areas of places of delivery, acceptance of family planning, cooking procedure in homes and satisfaction with the level of nutrition in home made food. Community has strongly influenced the age of marriage. Beliefs in prejudices, taboos and superstitions have been a strong factor in the practice of reproductive health behaviour, acceptance of immunisation and addressing malnutrition and diarrhoea.

Health interventions have overcome most of the negative influences of these determinants especially influence of social beliefs, illiteracy and that of the community by creating awareness through extension work, establishing accessible health facilities and availability of health service providers. This has been evidenced in the findings in the intervened slums.

SOME POLICY OPTIONS

The present study on intervened and non intervened slums studied the social dimensions of health practices in urban slums. Some of these social dimensions so examined are literacy, religion, income, influence of family members and influence of community. The purpose of the study was to ascertain that given these social dimensions, to what extent behaviour of slum dwellers are influenced by social traditions, rituals, social and cultural practices, taboos and superstitions.

The findings of the study helps to observe and suggest a few policy options for the health planners and policy makers while designing and implementing any preventive/promotive health programme for the urban poor.

It is suggested that to be able to intervene successfully in the area of health of the urban poor, there are certain social and cultural requirements to be met. Firstly, it is necessary to adjust to the local culture. While social factors such as age of marriage, influence of in laws and social punishments are to be reckoned with, it is very important to work through the local beliefs, superstitions, traditions, taboos and carefully move towards process of behaviour change. Secondly, it requires empathy and client sensitivity of the service providers for the underprivileged who mostly require such services. Thirdly, health professionals are required to be trained in social sciences such as social and individual behaviour, the dynamics of urban slum life and its politics. Fourthly, it is also relevant to be aware of the causes and effects of socio-economic disparities, gender differentials and religious background. This study has shown that religion is an important factor in deciding on many aspects such as age of marriage, childbirth, size of family, availing of services of male doctors, accepting immunisation, detecting malnutrition and resisting diarrhoea. Fifthly, an awareness of the difference between education, literacy and intelligence along with gender differentials therein is required. Sixthly one needs to understand the complexities of cities, towns and peri urban areas, the politics of slum life and how to deal with these. It is equally important to understand the necessity of translating the hype of media into actual practices especially in the areas of immunisation and diarrhoea. Most importantly, it is necessary to understand the culture of service providers that is doctors, auxilliary nurse midwives, community health workers, male multipurpose workers and other extension workers. Thereafter, an updated strategic framework for reproductive and childhood illness, health and development is needed. Religion and social influencing factors need to be taken as a variable for segmentation of behaviour change and focus both on the target age groups and the influential social groups to reinforce the behaviour change effects.

The present study has shown that some of the areas which need careful approach could be providing services of lady doctors for antenatal, postnatal care, actual delivery and family planning counselling. Working through reluctance and ignorance to introduce behaviour changes among the target group of clients is another suggested approach. Training extension workers to escort mothers to hospitals and providing referral transport to mothers to avail of emergency obstetric care is also suggested. As women in a position of stronger decision making are able to decide on many issues relating to reproductive health, the policy makers could work through providing facilities for economic empowerment of women and helping women to form self help groups among themselves. Male health workers need to provide proper counselling to men to remove the prejudices on adverse effects of male sterilisation on their working abilities. Health extension workers need to dissipate the

influence of taboos such as the presence of Goddess *Sitala*(local goddesses) to overcome the traditional reluctance to Measles immunisation. Follow up of the complete cycle of immunisation is advocated strongly in the case of infants. Health workers also need to remove social beliefs that evil spirits cause malnutrition. Intensive work needs to be put in to help mothers detect actual malnourishment in children, Similarly mothers in law need to be informed about the nutrient preservation in cooking by actual cooking demonstration. Health workers need to conduct actual growth monitoring of children under 5 years of age and assist mothers of malnourished children to provide early remedies to such conditions. Health workers also need to advise mothers on the actual cause of diahorrea and how to adopt simple home made remedies to tackle dehydration.

States with a large proportion of urban poor will need to include policy options for innovative approaches to health service delivery including increased access and use of quality services provided by private providers and non-government organisations. While addressing the needs of the urban poor, it may be necessary to design and expand multi-sectoral approaches for prevention and care in slum areas, improve involvement of private sector to increase the reach of quality healthcare services for the urban poor and to review and raise protocols and procedures to allow more practical and feasible approaches for private healthcare providers.

While designing preventive health policies, it would be necessary to pay attention to certain important social realities, which prevail in this country. These are malnutrition, inadequacy of safe water supply, sanitation, illiteracy, poverty, maternal and child health care services. Traditional beliefs, perception of people towards utilisation of health services, corruption levels at primary health centres, long wait, non availability of doctors and improper behaviour of the health staff are the important social factors which are required to be addressed suitably by properly sensitising the health personnel towards the community.

Certain social factors contribute significantly to motivating families to adopt the small family norm. Placement of personnel trained to understand the cultural milieu, to understand the social and economic constraints that the urban poor face and motivated educators sensitive to socio economic realities will perhaps go a long way to motivate people to accept family planning.

It is required to introduce a fundamental shift in the relationship between the community and the health technology that is to be offered by the health services. Health technology and health services need to be made responsive to the community who are to be given social justice in a favourable social, cultural and economic milieu.

Increasing awareness and innovative communication methods helps to dispel the social/religious beliefs regarding conception, contraception and seeking of antenatal care as well as choice of places of delivery. The awareness and knowledge regarding immunisation, nutrition and diahorrea also needs to be strengthened.

In fine, it is concluded that social cultural, environmental and behavioural factors influence the cycle of maternal, child health and nutrition and its main determinants. The challenges hence will be to jointly address the most important determinants with affordable, cost effective, feasible and culturally appropriate interventions and to involve the community in identification of its needs and priorities.