CHAPTER I

INTRODUCTION

The present study intends to investigate the social dimensions of the health practices prevailing among the urban slum dwellers in the areas of reproductive behaviour, immunisation, malnutrition and diarrhoea. It also intends to locate the nature of the impact of health interventions in certain slums as compared to slums where no such interventions have been so introduced.

There are two aspects of the present study. Firstly, health behaviour of individuals is influenced by the social and cultural factors as well as traditional health practices. This is particularly so in the contexts of varied economic backgrounds where the individuals hail from, literacy levels, religious backgrounds, gender, place of original domicile, the views of society as well as traditional and cultural practices that are adhered to by the social groups to which the individuals belong. Such social and cultural influences affect the general health status and the attitude to acceptance of health practices. It also leads to developments in the demographic profiles and health indicators, which may have interesting implications for policy makers. This study, through a primary survey of households, has looked into the health practices of slum dwellers that have not been exposed to preventive health interventions and has tried to analyse as to what extent the health behaviour of these slum dwellers have been influenced by the social and cultural factors. The specific areas of the study are reproductive health behaviour, immunisation, diarrhoea and malnutrition.

Secondly, this study has examined the health profile of slum dwellers that have received various preventive health services from projects and health interventions. There have been from time to time certain programmes and projects to improve the health status in the areas of reproductive health, immunisation, malnutrition and diarrhoea. Most of these programmes have looked at the health of women and children and have tried to influence changes in the behaviour pattern of the slum families with respect to accepting the scientific rationale for adhering to standards of preventive health. This study has tried to analyse with the help of primary data collected from such slum households whether such programmes have led to changed behaviour patterns and acceptance. It also examines whether the social and cultural factors continue to influence the health behaviour of the slum households and if so, what is the extent of such influence.

Background of the study

Human (resource) development is usually defined to include initiatives in nutrition, health, family planning and basic education. Human development, as a complementary aspect of broader economic development programmes, has become an important feature of anti-poverty policy and practice throughout the developing world. The success of such programmes is often predicted on behavioral changes. Consequently, the consideration of social and cultural factors and of their implications for influencing the outcome of programmes plays a central role in the design and implementation of such planned behavioral changes.

Two opposing views have dominated the thinking about development over recent decades. On the one hand, theorists in the 1960s explained the failures of development programmes as a result of the interference of social and psychological variables. The poor, for example, were blamed for being fatalistic, which allegedly explained why they did not adopt technological innovations in fields of health, family planning, nutrition etc. These theorists perceived social values as being very difficult, even impossible to change, at least in the short run. On the other hand, a school of development specialists in the 1970s attributed the failure of certain programmes to structural socio-economic constraints; values were viewed as the result, rather than the cause, of the changes in individual behaviour, which facilitated socio-economic development.

In 1980s, however, the dichotomous thinking of the past two decades has given way to a more comprehensive view of how behaviour determines socio-economic transformation. This broader view is rooted in cultural ecology, development sociology and economic anthropology. Values are seen in a historical context. The perceived sequence of events is that the environmental conditions lead to certain adoptive modes of subsistence to maximize group survival. These, over time, become "valued behaviours" which form the underlying ideology of a cultural system. The values are passed on to the next generation. In essence, "one generation's practical necessities become the next generation's exalted ideals" (Levine: 1969). If values are changed without any corresponding change in structural conditions, the result may be value conflict expressed in cultural aberration. Conversely, this implies ignoring the power of intergenerational cultural conditioning to undertake to transform structural conditions, e.g. through Land Reforms without initiating complementary changes in residual values deeply rooted in religious and supernatural belief systems.

The implications of this theory are that cultural ideology can serve to reduce or to enhance such potential conflict between values. The net result is that behavioural change underlying broader socio-economic change cannot be viewed as a short-term phenomenon. Strategies of revolutionary change, though often faster, may require re-socialization or an intervening process of de-socialization in which interpersonal relations are changed and the efficacy of old values erased (McHugh: 1966).

What does the actual experience of development tell us with respect to the theoretical considerations just outlined? The evidence that social values are often very difficult to change, even over years, is provided by largely unsuccessful attempts of many national family planning programmes to change the parental value of an ideal family size. By making contraceptive methods widely acceptable to eligible couples, several nations have been able to achieve an adoption rate of family planning procedures from 25% to 35%; the adopters are mainly couples that use contraception to avoid surpassing their ideal family size of 3 or 4 children. To achieve the rate of adoption (60% to 70%), which would be necessary to reach the national demographic goal of only 2 or 3 children, however, involves changing a strongly held value; the achievement of this goal has proven difficult in many nations. The investigation by Mamdani (1972) in the Indian village of Manpur, for example, showed that despite more than a decade of Government efforts at changing the ideal family size to 2 to 3 children, most village couples still felt that at least 3 or 4 children (including at least 2 living sons) were necessary to ensure their security at old age and provide

agricultural labour. Exceptional couples, which had accepted the norm of a smaller family size, were high class Brahmins for whom the formal education of their children was perceived as a route to security.

Similarly, nutritional and preventive health measures are typically the most strongly resisted programmes in human development primarily because of the difficulties presented, not only by the lack of immediate visible benefits, but also by the existing cultural beliefs and etiology. In India, in order to counter the supernatural belief of Hindu villagers that the anger of a local deity caused dysentery, the change agents of the anti-dysentery campaign not only showed movies on the cause of the disease, but also, more significantly, participated in a village prayer meeting to obtain the sanction of the deity before distributing the medicine. This example illustrates that even where traditional beliefs and etiology appear to strengthen resistance to an intervention, successful change can result immediately from a policy of adaptation or association with them, rather than one of confrontation. At the same time, the longer-term educational process of changing values can be contrived (Link and Mehta: 1964).

Analysis of the process whereby change is introduced into social systems or settings has, however, demonstrated that ignoring the influence of or failing to use indigenous cultural patterns and local environmental settings may lead to failure or rejection of development programmes. Niehoff and Anderson (1964), in conducting a content analysis of over 200 case studies of programmes of human development, found that many such programmes had failed because planners and implementers had not become aware of indigenous factors until they acted as barriers to the acceptance of an introduced innovation.

An indigenous socio-cultural element may be classified as positive, neutral or negative vis-à-vis development programmes. Some indigenous forms offer a means by which technological innovations may be introduced to a user system with greater success because the traditional element aids people in their process of fitting the new idea into old socio-cultural content. For example, several national family planning programmes in the 1960s in such Asian nations as India and Pakistan at first ignored the roles of traditional birth attendants. These midwives resisted family planning and started contrary rumours. In 1970s, however, national family planning programmes in Thailand, Malaysia, the Philippines and Indonesia began work through the traditional system of birth attendants, who contributed significantly to utilize traditional leaders in development programmes than to ignore them and risk their active resistance.

In many cases a particular socio-cultural form does not affect the performance of a development programme one way or another. Research and development programme experience shows that, in most cases, the hot cold complex in an indigenous culture does not affect the acceptance or rejection of nutritional food supplements.

Certain types of indigenous socio-cultural forms are clearly harmful and have negative consequences. An example is provided by the food taboos for pregnant women found in many cultures. In Malawi, it has been found that this taboo prohibits pregnant women from eating meat, sugar or milk because it is feared that consuming these food will transfer animal traits to the child. These affect the health of pregnant women who need these protein

rich food the most. Another illustration of negative indigenous cultural form in family welfare is unsanitary method of birth delivery used by the traditional midwives.

Indigenous etiology has an impact on almost every type of human development programme. Luschinsky (1963) established the village midwives' association of tetanus with mollification of Jam (a flying insect). The relation of "moon phase" with oral contraceptives in Pakistan was a similar example of cultural causal analysis. Indigenous socio-cultural forms may be more firmly adhered to by and therefore more particularly important for the absolute poor. Less educated and lower income members of system of users often give greater credence to indigenous socio-cultural leadership roles, communication forms, organisational forms, knowledge systems and etiologies. It is in this context, that the problem dealt with in this paper, is now presented.

Growth of slums in Kolkata Metropolitan area and the consequent health problems

The state of West Bengal is situated in the east of India. The capital of this state is Kolkata, which was the capital of India until 1911. The river Hoogly runs through most of the southeast districts of the State. An intense growth of slums had taken place in and around both banks of the river Hoogly. The reasons for such growth are not far to seek. The river Hoogly offered excellent navigational facilities and strategic advantages for setting up business and industrial ventures in and around Kolkata. In the subsequent centuries, introduction of Railway lines running almost parallel to the river, construction of two major highways - G.T.Road and the B.T.Road and the discovery of coal and iron in the eastern part of India encouraged setting up of engineering, jute and manufacturing industries in and around Kolkata. This in turn lured hundreds of working class people from all over eastern and northern India to Kolkata in search of a livelihood.

The low paid working populace was housed in mud and bamboo hutments with roofs made of tiles and iron sheets, constructed by middlemen, popularly known as "thika" tenants on land leased by the landlords. In physical terms the slums consisted of clusters of hutment having several rooms constructed with low cost building materials such as mud, bamboo, straw tiles and iron sheets. Each room was occupied by a family sharing a common latrine without adequate arrangement for water supply, drainage and disposal of solid waste. Needless to mention their condition was abominable. The slum dwellers and their descendants being migratory in nature were solely occupied with earning of their livelihood and hardly made any effort to improve their living conditions. The spurt in the industrial activities in the thirties of this century in and around Kolkata to support the war effort encouraged further migration of the working people to Kolkata, thereby accelerating the proliferation of slums in and around Kolkata with more deteriorating living conditions. The influx of refugees due to the partition of Bengal in 1947 further worsened the situation. The city of Kolkata and its suburbs gradually grew into a city of slums with degrading living conditions, characterized by the absence of any kind of recreational and educational facilities hindering and moral development of the young. With rapid urbanization as well as sharp rise in land prices in the post World War period, landlords were encouraged to evict "thika" tenants as well as slum dwellers. As income from tenancy was low, and landowners were unable to evict the tenants, landlords became less interested to maintain the minimum sanitary facilities in the slum areas. Over a period of time, due to lack of maintenance, the already overburdened minimum sanitary facilities broke down making the slum inhabitants

more vulnerable to all sorts of diseases including diarrhoea, malaria, acute respiratory illness, Measles and viral infections. These along with malnutrition effected mostly among the mothers and children, they being the most vulnerable group of population in this regard. Burdened with a higher population, smaller residential area, higher population density and a higher rate of population growth, slum dwellers lived in an unhygienic environment, infested with disease bearing flies and mosquitoes and troubled with social vices such as alcoholism and drug abuse.

Earning of the slum dwellers being meager, very little money, if any, is spent on health and nutrition of family members. Health problems affecting the women and children in the slums are even more acute. Infectious diseases, malnutrition, maternal and peri natal causes account for most of the disease burden. Because the nutritional status of girls and women is compromised by an unequal access to food, by heavy work demands and special nutritional needs, females are particularly susceptible to illness, especially anemia. Poor women of the slums are often trapped in a cycle of ill health exacerbated by child bearing and hard physical labour. Maternal mortality results primarily from infection, hemorrhage, eclampsia, obstructed labour, abortion and anemia. Lack of appropriate care at pregnancy and childbirth, especially inadequacy of services for detecting and managing complications, explains most of the maternal deaths. Prevalence of reproductive tract infections is high and spread of HIV/AIDS is a concern. Childbirth closely follows marriage, which tends to occur at young ages. About 80% deliveries occur at home, in unhygienic conditions leading to infections in mothers and newborn. Women often turn to traditional practitioners for abortions leading to consequent complications. Permanent methods of sterilisation are often, if not always, gender specific, with women having to undergo the sterilisation.

Lack of education and awareness as well as heterogeneity of slum population leads the slum dwellers to adopt several faiths, beliefs and taboos. These affect the health behaviour of the slum population significantly. Social and cultural practices also induce primary immunisation to take a back seat in slum areas, leading to persistence of vaccine preventable diseases such as tuberculosis, diphtheria, Measles etc.
Under this health situation, the following questions come to our mind

- Which health issues affect society in the urban slums especially in the context of women and children?
- To what extent is the existing health behaviour in the urban slums relating to women and children based on tradition and beliefs?
- Whether health interventions have been introduced in selected slums, and, if so, what have been the sociological impacts in such urban slums in terms of changed behavioural patterns and acceptance of improved health practices among the slum dwellers. ?

Review of Literature.

It is well recognized that the health status of a population is shaped by a variety of factors such as food, water, sanitation, housing, income, education and availability and accessibility of health care facilities.

Several scholars have discussed the relationship between the environment, social and economic factors, health and health care. Social philosophers like Engels(1973), Waitzin(1981), Dubos(1968) and Snow(1954) looked into the relationship between health

and society and had focused attention on the influence of social factors on the health status of the people. More recent works as that of Colletta, Clammer(1975) and Chambers(1979), Rosen (1971) and Mackinlay(1984), along with that of others, have also looked into the dynamics of the impact of socioeconomic and political factors on health and health services development. These studies have dealt primarily with Western societies.

There is substantial amount of literature in the area of Health Sociology. These writings, however, are mostly in the area of rural households or tribal settlements and the social and cultural factors, which influence the health behaviour of the various social and ethnic groups. There is little work in the area of health sociology in the area of urban slum settlements and the urban poor households. Hence, the literature reviewed in this section examines mostly the works attempted in the urban poor settlements and briefly on the literature available in the background of rural and tribal areas.

In India, several scholars like Banerji(1985),Panikar(1976), Qadeer(1985), Zurbrigg(1984), Djurfeldt and Lindberg(1980) have looked into the relationship between society, health status and health services development.

Ahluwalia (1972), while writing in the Indian context has commented that the study of sociology of medicine is a comparatively new development in India. Some sociologists and social anthropologists may have collected materials on social medicine during their work in the villages or while working with the tribes; otherwise, there is very little work in the urban areas. Even today, whatever research work and studies have been conducted in the area of social health has, with a few exceptions, mostly been conducted in the rural areas. Following Ahluwalia, health care may be sociologically viewed either as a cultural complex or as a part of social structure and organization. In the former category, studies have been made on traditional health systems, traditional systems of medicine, beliefs and practices concerning causes of illness, fertility, maternal and infant mortality, reproductive and child health behaviour. In the latter category, studies have concentrated on public health, the institutional structure of modern medicine and organisational structure of public health.

As early as in 1955, Marriott observed that the members of the same village or family in India hold highly varied medical beliefs. Lewis (1952) and Dube(1956) has confirmed that traditional views on disease coexist with various germ theories. Khare (1963), while studying health practices in Gopalpur (Uttar Pradesh), discovered that the higher castes related diseases more with ideas based on high tradition while the lower castes sought explanations in spirits, impersonal forces and tribal God's. Fuchs (1964), describes two kinds of medical men, "Jankas" who work through divination and Barwas who call to their aid a supernatural force. Harper (1966) describes a similar practice by "Shamans" in Mysore. Carstairs (1955) describes how traditional practitioners establish "faith" and "assurance" in the patient. Opler (1955) has listed immoderate behaviour and lack of harmony with the supernatural world to be commonly believed to be the causes of various diseases.

In the more recent literature in this field, we come across the work of Hasan (1979) who has studied the health behaviour of the multi-caste villagers of Chinwara in Uttar Pradesh. He has surveyed all the 215 families comprising 1190 persons. The two major religious groups are Hindus and Muslims with only 1 family of Brahmins. There are 621 males as compared

to 569 females and the age group of 15-54 made up 48% of the total population. There is no primary school in the village; only 111 males and 17 females were literate. Hasan has found that there are two kinds of social and cultural factors which have affected the health of community: direct factors such as custom and practices, beliefs, values, religious taboos etc. Indirect factors were those, which related to the sick and disabled including supernatural and physical causes. Hasan has found that the villagers had developed their preference for certain methods of diagnosis and treatment, while seeking medical aid from the modern physicians. Hasan, however, has advised that, to be effective, the medical practitioner, who belongs to a higher caste and intellectual level, can reduce the fear, suspicion and confusion of villagers considerably, if he tries to understand the rural life and culture and the health needs of the villagers. Through his case study, Hasan has taken a big step in pioneering an effective collaboration between health workers and social scientists. His method of anthropologically participant observation while actually living in the village for protracted periods is possibly the best way to reach an understanding of how village people cope with the health problems which beset them, and why they do what they do. This case study has collected quite a wealth of data and the author has ably analyzed the same. There are, however, certain limitations with this study. Firstly, the limited data generated through study of only one village is too inadequate for generalizations. Secondly, although an exhaustive study has been made of the village and its people, the village environment, sanitary habits of the people, personal hygiene, food habits and food taboos, drinks and drugs and the doctor patient relationship, greater emphasis could be laid on the impact of health interventions. Further, it needs to be examined as to whether the socio-cultural factors continued to play a dominant role in the health behaviour of the villagers after such interventions took place. This is absent in his work.

Gurumurthy (1990) has made another study on the causal relationship between culture and fertility in his documentation of the "Socio-cultural determinants of fertility among the Yanadis" tribal community in South India. The Yanadis, who are mostly hunters and fishermen nomads, are socially backward and economically poor and constitute a major tribal group in Andhra Pradesh. The work of Gurumurthy is a pioneering one in the field of tribal demography in South India. It has covered a wider area of socio-economic, demographic and cultural aspects besides the fertility behaviour, the perception of infant mortality and neglect of children among the Yanadis. The study has brought out well the need for population education, health education and residential schools in tribal communities to bring them into the mainstream of life.

A pioneering medico-anthropological research reported in India has been conducted by Bang and Bang (1995). The study has reported that in a backward tribal district in the Central part of India, 92% of the women suffered from gynaecological diseases. Though each woman had an average of 3.6 diseases, only a negligible 7% has ever sought medical care. Singh, Jaiswal and Chowdhury(1996), have pointed out how in traditional Indian societies, the woman was considered as a fertility incubator, which was subsequently attempted to be changed by recognizing her as a human person.

Piet Pelon and Rob (1996), in their study of Bangladesh, found that there are an alarmingly high number of women with confirmed reproductive and sexual tract infections; the authors have concluded that social conditions and traditional health practices for women favoured a continued high prevalence of reproductive tract infections in Bangladesh.

Nagi and Singh (1996) have studied a sample of scheduled caste and scheduled tribe women in connection with reproductive health behaviour in 7 states and 15 districts of India and observed that poor literacy levels and socio economic status as well as low Mean age of marriage of such women contributed to more number of children in the reproductive age.

Khan, Bhange and Phillip (1996), have pointed out that at societal level, sensitivity about abortion and lack of awareness on legal status on medical termination of pregnancy contribute to unsafe abortions in the country. A similar conclusion has been drawn by Tamang(1996) who has studied the level of induced abortions and subsequent reproductive behaviour among women in the urban areas of Nepal, where he has found that there exists a positive association between levels of education attained by a woman and her husband and that of safe abortion practices.

Ray (1989) has studied health care in some West Bengal villages and has stated that the social factors responsible for child marriage, large number of children, inadequate health care and dependence on folk or magico religious treatment were dominant in the daily lives of the people. The author further stated that majority of the health problems were rooted in malnutrition, conditions of public sanitation, non-availability of safe drinking water and working conditions in the field.

Jayasawal and Singh (1989), based on a stratified random sample of 800 rural tribal males and females have wanted to administer a health modernity scale to measure scientifically correct information, attitudes and behaviour in relation to physical and mental health, diet and nutrition, family planning, child care, breast feeding and health habits. The extent of health modernity on these dimensions has varied from 0 to 2 percent. The authors have summarised that near absence of health modernity was due to poverty and illiteracy and it was reflected in unhygienic living conditions, faulty food habits, high prevalence of diseases, disabilities and malnutrition in children under the age of five years.

Jayashree (1989) has made a study in a similar area. Her study on religion, social change and fertility behaviour is based on a study carried out in the Travancore region of Kerala. Kerala holds a unique position in the world of demographic literature. Although demographic studies have very rarely considered religion and caste as major social stratification variables, it is highly realistic and relevant to consider these factors along with the study of fertility and other demographic parameters. The methodology applied in this study is both unique and appropriate because it shows how various independent variables influence fertility among different cultural groups, both the younger and the older population. The application of path analysis for ascertaining the relative influence of each major independent variable provides scope for appropriate generalizations leading to theoretical developments. The comprehensive coverage and comparative basis depicts a fairly comprehensive coverage of social change in the society of Kerala as a backdrop to the understanding of this problem on a cross-cultural basis.

Another work, which attempts at a qualitative appraisal of some relevant aspects of reproductive health behaviour in the background of socio-economic characteristic, is that of Kar (1993). In his study, Kar looks at the social structure, culture, food habit, morbidity and traditional health seeking behaviour of the Nocte tribe of Arunachal Pradesh. Kar has found

that the health behaviour in general and reproductive health behaviour in particular of the Nocte women is intimately related to and are deeply influenced by their value systems and cultural traditions. Hence, Kar prescribes that any attempt to improve the health status of the Noctes should be integrated with a wider effort to bring about an overall transformation of the Nocte Society.

Another social factor influencing health behaviour is caste. Kopperty(1991) has made a contributory study in this area. Kopperty found in his study of Andhra Pradesh that caste stratifications influence life, occupation, income, education, values, norms and beliefs of the community. He has studied the Brahmin, Vyasya, Kamma and Kappus from the high castes and Malas and Madigas from lower caste groups. It is established that such differences in castes are strongly reflected in health practices, especially morbidity, maternal mortality, ante and postnatal care, nutrition and actual delivery. Similar to Kar (1993) Kopperty has advocated that any change in the health practices should aim at awareness and social change.

Patel and Capoor(1996), have reviewed human history in India and have observed that women have died young in child birth or ill health, often as victims of abuse, torture, violence, neglect and other forms of social discrimination. The authors have further observed that even in today's scientific world, the same situation still prevails due to the dominance of a complex socio cultural web, which has conditioned women not to complain but to cope silently with their diversified health problems.

Pachauri(1996), has described India as being in the middle of an epidemiological and health transition wherein diseases of affluence and new environmental and behavioral threats are being added to the already heavy burden of morbidity and the contributory factors are India's health transition, the ageing of the population, urbanisation and migration, changing lifestyles and the impact of health interventions.

Ringheim (1996) has emphasized on the important social factor that without fully engaging the male partner in family planning, potential acceptability of modern contraceptive methods for men will fail.

Referring to a few more studies in the area of relationships between socio-cultural practices and health behaviour, one can briefly refer to Arnold's (1989) study on smallpox and worship of the deity of the Sitala in Bengal.

Amartya Sen (1996), in his treatise on objective assessment of health, has observed that in terms of various directly observed criteria of mortality rates, literacy rates, nutrition related diseases, use of hospital and medical services, women appear as being systematically underprivileged vis a vis men in rural India. Papers by Banerji, Jeffery, Guha, Kabir and Krishnan, Dasgupta and Chen (1996), have discussed the social, economic and political factors linking health status with the process of development. Banerji has discussed the socio cultural and political forces that have shaped the public health practices in India. According to Banerji, the anti colonial struggle involves a struggle for immediate democratization of India's social and democratic life: the colonial government, was compelled to expand health services, though mostly for the benefit of the privileged classes and major urban populations—a trend which has been carried over to independent India.

The Kabir Krishnan paper (1996), contrasting health development in Travancore and Malabar, has shown that the political will to provide health care has to be sensitive to social conditions in order to succeed in its objectives. This paper has shown how education has proved to be an effective catalyst in initiating an interactive process between political and social processes through democratic mobilization of population. Meera Chatterjee(1996),has addressed some of the important issues revolving around nutritional levels, poverty, health and development. Ms Chatterjee analyses much of the data available on these issues and looks at policy changes, which have a bearing on them.

Visaria and Gumber (1996), have presented the results of the National Sample Survey on maternity and child care, focusing in particular on the question of how utilization of health services differ among income strata and groups stratified by caste and tribe. Such systematic analysis of differentials in health care by socio economic strata is very valuable. Ravindran(1996) has illustrated the health problems of a vulnerable group of population, namely the scheduled castes. This group constitutes a sizeable proportion of the total population and in her paper. The author has probed some important issues relating to differentials in health status between sub groups of the same population. The author has explored the causes, which inhibit use of health care facilities by these sub groups, and the extent to which the same is influenced by cultural, political and social factors. Another aspect of the poverty, social status and health nexus is the question of gender. Tim Dyson (1996), has shown that when census coverage deteriorates, women are disproportionately left out in the enumeration. Crook (1996) has given a systematic analysis of the specific problems of urban health and the advantages and disadvantages that living in urban areas confers as compared to that in the rural areas.

A few studies have been made in the area of health culture in the urban slums.

Gupta and Gupta (1989) have studied the primary health care needs in urban areas (especially slums) in cities with urban population more than 2 lakhs (.2 million). A workshop approach has been adopted for the study along with certain case studies conducted in the cities of Baroda, Kanpur and Hyderabad with a sample of 250 of the slum population. The study has found that most cities have different sets of medical practitioners who provide health services to the people to whom facilities are not easily available; there is an urgent need to provide basic health services to the slum dwellers; service delivery should be strengthened towards mothers and children; community based health centers should be set up to provide promotive and preventive health services. This study is not without its weaknesses: the data collected through the case studies and the output of the workshops conducted do not substantiate the conceptualization of the problem; there is no proper sampling procedure adopted to select representative slum populations and findings are based on case studies while most efforts went into workshops only.

Panda, Benjamin and Zachariah (1993) have made a study on the health status of under five children in a Ludhiana slum in a cross sectional study comprising 237 under 5 children, and concluded that 61.6% of diarrhoea diseases are found to be the major cause of morbidity and 19% suffered from malnutrition, demonstrating thereby that slum children are more vulnerable to illnesses. This study is based more on comparison of data rather than on its quality and conclusions drawn there from could not form part of generalisations. Guha

(1990), after a study, has presented the results of a study of urban slum dwellers in Kolkata and found as follows: While an urban bias did exist in the provision of health services, the urban bias discriminated against the urban poor; social, political and epidemiological parameters of the urban poor tend to be substantially different from that of the rural counterparts; the universally applied rural model of primary health care centers in India did not incorporate the differences in health and nutritional profiles of the rural and urban communities. Bhargava (1984) has conducted a research among the slum dwellers of Mumbai and established that variations occurred in fertility levels due to changes in age of marriage among the female slum dwellers. Reddy and Mahadevan (1984) have conducted a comparative study of the effect of infant and child mortality on slum and non slum dwellers in the city of Hyderabad and concluded that there is high fertility among slum dwellers due to high mortality, suggesting thereby that a significant reduction in fertility may be achieved by assuming greater survival of infants and children. This work, however, has failed to be a comparative study as the two study populations were totally different in nature. Vandana Desai (1995) while studying the slum population in Bombay, recommended community participation while providing basic services to the urban poor. Bala's (1991) study also establishes the influence of the socio-cultural factors. Chakraborty (1990) has studied the behaviour of slum dwellers of Kolkata and found that socio-economic factors such as age, sex, role of family occupations, ethnic background, religion, urbanization and industrialization led to mental disorders among the slum dwellers especially women. Hubley (1992) has made another study in the slums of Indore. It is found that the slum women related Measles to the anger of the Gods' and diarrhoea was associated with insect bites.

Certain studies have also been made in the slums and the resettlement colonies of Delhi. Basu (1990) has reported that in the resettlement slums of Delhi, chicken pox was attributed to the divine visitation and outside help was rejected. Bhatnagar(1990) has studied the conditions in the New Seemapuri resettlement colony of Delhi and recommended that social and economic conditions of the slum dwellers required a change in order to improve the health status. Ganguly (1990) has studied the conditions in Delhi's Jahagirpuri resettlement colony and established that health factors of the slum dwellers are associated with the larger cultural milieu of the people. Bhatnagar, Dosajh and Kapoor (1986) tried to develop health care delivery model in the urban slums of Delhi by selecting 1200 households through a stratified multi stage sampling technique. They, however, have only resulted in describing the quantum of problems of slum dwellers in Delhi. In another study undertaken in the Delhi slums in 1985, Bhatnagar and Dosajh have established that the incidence of diarrhoea was higher in the younger age group, the peak age of incidence being 7-12 months. Diarrhoea death rate of 4.9 per thousand children in the Delhi slums is higher than 3.6 per thousand children in the urban areas as established by the office of the Registrar general of survey on infant and child mortality. The authors have found that the incidence of diarrhoea is directly related to poor social and economic status, female illiteracy and unsanitary living conditions as well as lack of proper drinking water. Mullick, Bardhan and Shivadasani (1978), have selected the Kalkaji field practice area of New Delhi of the National Institute of Health and Family Welfare to create a local voluntary movement of women to encourage health and family welfare practices and form women's action groups. Being solely in the nature of motivational efforts, their findings on the survey of 1248 tenements has failed to be sustainable without external support. In another study conducted in urban slums of South Delhi, Rakesh Kumar et al (1991), have wished to understand the factors influencing the health seeking behaviour of the slum dwellers of Delhi. Their

recommendation on provision of mobile health services to the slum population fails to convince, as this is not a proper research study, not based on any research design or any authentic data and also lacked scientific conceptualization of problems to be studied.
Saikia and Aggarwal (1991) have studied the MCH (Mother and Child Services) services in ICDS (Integrated Child Development Scheme) and non ICDS areas in two resettlements colonies of Delhi and concluded that mothers in ICDS areas are more knowledgeable than their counterparts in the non ICDS area. This study is limited by the factor that the study is based on some systematic efforts and that there are no research problems as such for conceptualization of the problem.
Mulgaonkar (1996), studied the profile of reproductive health in the urban agglomeration of greater Bombay and identified the following socio cultural and behavioral factors: initiation of young males into sexual intercourse with experienced females; arranged marriages, seduction or sexual abuse of young women and girls by older and sexually active men; early sexual debut of young men and women combined with multiple sexual partners; divorce and remarriage resulting from STD (Sexually transmitted diseases) induced infertility of either partner; prolonged sexual abstinence following childbirth when accompanied by husband's casual extramarital sexual activity; labour migration leading to casual sexual indulgences by men; single, separated or divorced women seeking sexual contacts in exchange for money, gifts, favour or pleasure; infrequent use of condoms or spermicides in sexual intercourse; heterosexual practices. The author further established that women's social status and gender disparities influence the prevalence of reproductive tract diseases and that often socio cultural emphasis of premarital chastity, sexual fidelity and monogamy makes women reluctant to bring reproductive tract infections and sexually transmitted diseases to the attention of family members and medical practitioners.
Guha-Sapir(1996),has made a study of Kolkata slums based on data from a household survey of 2603 families with at least one child under 5 years of age living in 37 randomly selected slums recognized as such by the Kolkata Metropolitan Development Authorities. The main findings of the paper pertain to maternal and nutritional aspects of urban poor women and health specificities of the urban environment. The principal findings of the survey are as follows: the significance of the traditional sector in health care; the high cost of medical care and the high proportion of medical expenditure on medicines, the severe caloric and fat deficits among younger women and lactating mothers; the tendency to spend less on medical care for women; and the penury of space and consequent exposure to pollutants.

In the field of sociological studies on organizational and institutional issues, Preyer (1990) has made a study of the slums of Khulna in Bangladesh. Preyer established some implications for women and children on account of the incapacitating ill health of principal household earners. Oomen(1978) has studied the social structure and the system of health professionals. The author has studied the social and economic backgrounds of professionals including religion, caste, regional linguistic rural urban linkages and the family background of the professionals and has concluded on some interesting sociological issues concerned with occupational role structure of professionals.

It is seen therefore, that of the number of studies conducted in the area of health Sociology and Anthropology, most of the work has been done with reference to rural areas or among the tribes. Work in the urban slum areas have been mostly in the area of health systems and marginally in the area of urban health Sociology and Anthropology. Such limited studies

the year 1986-87. Among others, it sought to look at the health issues of women and children in the urban slums. The strategy of this approach was unique. A strategy for out reach health delivery services was designed to be brought to the doorstep of the beneficiaries through a cadre of honorary health workers. Arrangement for advocacy of permanent and temporary methods as well as distribution of contraceptives from door to door was made. Apart from this, antenatal check ups were to be arranged in sub centres. Regular advice was to be meted out to pregnant mothers. Tetanus Toxoid injections and iron folic acid tablets as well as guiding mothers in safe institutional deliveries were some of the other objectives in this approach. Immunisation of infants, control of diarrhoea and malnutrition were some other issues taken up by this project. This was followed by another health intervention during 1991-1997 addressed to the non intervened urban slum areas: the Kolkata Slum Improvement Project assisted by the British government funded by Overseas Development Authority (now Department for International Development). The principle was to follow a similar strategy of community participation and outreach method. In the Kolkata Slum improvement project, health services envisaged coverage of 2.75 lakh(.275 million) slum population in 15 wards of the Kolkata Municipal corporation area. The health care services included were as follows: outreach services focusing on health education, environmental sanitation, personal hygiene, nutrition, mother and child health, universal immunisation Programme, family planning as well as preventive services with basic thrust on immunisation and infant care and back up services including setting up of Extended Specialist Out Patients Department, Maternity Hospital/Homes for Family Welfare. Thereafter in 1994-95, the World Bank assisted India Population Project 8 was launched covering 38 lakhs(3.8 million) mothers and children of urban slums in the entire Metropolitan area. The strategy was to provide health services to the poor through community participation, provision of quality services relating to maternal and child health at the doorstep of the beneficiaries. It further ensured that women have access to accurate information on reproductive health as well as high quality care. It further proposed to change men's attitude towards sharing of responsibility relating to sexual relations, contraception, pregnancy and childcare. It also wished to encourage family and community support for delayed marriage and child bearing. It sought to provide opportunities to adolescent girls to protect their own health, to provide basic education to women in improved awareness of sexual life. It also sought to establish and strengthen the referral system through a network of health infrastructures. The End of project report of the Kolkata Slum Improvement Project (1998) and the mid term evaluation survey of the India Population project (1998) has led to further insights into the efficacy of these projects. The Kolkata Slum Improvement Project was also evaluated with the tool of Participatory Impact assessment (1997).

It would therefore be of interest to assess the impacts of these interventions in a sample of selected slums and to compare the results with the characteristics of slums not so selected for introduction of health facilities.
The present study looks at two categories of the slums:

(i) Those slums which have received inputs on health interventions; and
(ii) Those slums, which have not received such inputs on health interventions.

The study intends to ascertain the social dimensions of health care practices as are prevailing in such slums as well as the indigenous socio-cultural forms adhered to by the urban poor. The study also purports to test the hypothesis as to whether the lower income

- Influence of literacy of mothers in the analysis of children with incomplete immunisation ;
- Influence of media and translation of the knowledge created by media into actual receipt of immunisation ;
- Religion based differentials, on the incidence of children receiving immunisation;
- Social and cultural influences vis-à-vis conviction in the rationale of immunisation;
- Practice of social and cultural prescriptions in the context of vaccine preventable diseases of children.

In the area of **Malnutrition:**

To enquire about the

- Level of knowledge of mothers on the concept of malnutrition;
- Extent to which mothers believe that malnutrition is the result of cultural taboos/superstition;
- Knowledge of preservation of nutrition in cooking; influence of economic factors and social influences such as dictates of mothers in law in cooking;
- Gender preference in serving nutritious food to children of both sexes;
- Extent of underreporting of malnutrition in their children by mothers who fail to recognize symptoms of malnutrition;
- Actual incidence of malnutrition derived from growth monitoring reports.

In the area of **Diarrhoea**:

To enquire about the

- Level of knowledge of the conception of diarrhoea;
- Correlation with scientific causes vis-à-vis cultural taboos and superstitions;
- Level of belief in the process of lactation during diarrhoea;
- Association between religion and the incidence of diarrhoea;
- Degree of belief in exorcism to cure diarrhoea;
- Level of knowledge of home treatment of diarrhoea;
- Influence of media and actual conceptualization of the cause and the treatment of diarrhoea as a result of media influence.

While comparing the findings in the intervened slums as compared to that of the non intervened slums, the analysis would specifically look at the following:

- Demographic attributes of social and economic characteristics of the households of the non intervened and intervened slums;
- Analysis of the comparative practices of the sample households of intervened slums as compared to that in non intervened slums with respect to marriage, pregnancy, childbirth, reproductive behaviour and family planning; an analysis of whether the sample households in the intervened slums have adopted the scientific and rational approaches to these parameters.

- Analysis of the comparative practices of the households of the intervened slums as compared to that of the households of the non intervened slums with respect to immunisation of their children under 5 years of age; analysis of whether the sample households of the intervened slums have adopted scientific and rationale approaches with respect to immunisation of their children.
- Comparative analysis of the practices of the sample households as compared to households in the non intervened slums with respect to concept, incidence and control of malnutrition in general and that of children under 5 years in particular. Analysis of whether the sample households of intervened slums have adopted scientific and rationale behaviour with respect to malnutrition of their children.
- Comparative analysis of the practices of sample households in the intervened slums as compared to those in the non intervened areas with respect to concept, incidence and control of diarrhoea in children below 5 years of age. Analysis of whether slum households of the intervened areas has adopted scientific approach towards diarrhoea of their children below 5 years of age.

The final objective of this study, based on the results derived from the analysis of non intervened and intervened slums, would be to arrive at certain strategic policy options for reaching the urban poor through health development programmes.

Methodology

Selection of the Slums

At the very outset, slums of two different categories have been selected: those slums, which have not been, covered with any health programmes; the other category comprises slums, which have received inputs on health programmes. Slum dwellers of Titagarh areas of the district of North 24 Parganas of West Bengal had not yet experienced the facilities of modern medical and health technologies disseminated either by governmental or non-governmental institutions until the period of this study. Hence, the slums belonging to the Titagarh area, namely the Muchipara slums were selected. In Titagarh, the slums are not discrete settlements confined to specific wards. Rather, these are continuous barrack like structures associated with different landlords. The Muchipara slums comprise a multitude of such barracks and each barrack is a slum settlement in itself. Settlements were selected comprising the entire Muchipara slum area. The inmates are mostly from Bihar and Uttar Pradesh who had come to work in the local jute mills as labourers. On the other hand, all the families living in 12 slums spread within 15 Wards of the Kolkata Municipal Corporation have been enjoying health facilities rendered through certain government interventions. Of these four distinct slums were selected, three slums are from the settlements along the Kasba Jadavpur area of South Kolkata where the inmates are mostly from Bangladesh; the fourth slum was from the Garden Reach Metiabruz area frequented mostly by Muslims whose ancestors came from Uttar Pradesh with Wajid Ali Shah, the erstwhile Nawab of Lucknow.The purpose behind the selection of slums with populace from different religious, social and ethnic backgrounds was to assess the social and cultural attributes of slum dwellers of varied background and religion and to analyse the same in respect of their health behaviour.

Sampling procedure

The prime criterion of selection of a household as an ultimate sampling unit is that the household shall have an eligible couple with at least one child below 5 years of age.

In order to draw samples project of slums both from intervened and non intervened areas respectively, two separate lists of slums (sampling frame of the 1st stage) have been identified and numbered. The Department for International Development to assess the impact of the project had conducted a participatory impact assessment study of the health interventions in 12 slums of the Kolkata Municipal Area. To fit with the objectives of the present study, in the first stage sampling, 4 slums (that is, one third of the universe of 12 slums) have been randomly selected from the intervened slums under the administrative jurisdiction of the Kolkata Municipal Corporation. In these slums, for the last eight years, multi-faceted activities such as health promotional services, community development and augmentation of sanitary conditions have been offered to the slum dwellers.

For the selection of 4-sample slum size in the first stage, simple randomization sampling technique has been adopted. In a similar way (by adopting same sampling technique), the slums within Titagarh Municipality in the North 24 Parganas district, where health interventions have not taken place have been selected. Out of the 85 slums in these areas, 28 have been selected in first stage sampling to achieve the desired sample size. At the time of selection of the ultimate sampling unit (households) in the second stage sampling, all the households of each slum selected in the first stage were numbered independently. The only prejudicial judgment (may be called purposive) in selecting the household in the second stage sampling to fulfill the very objective of the present study is that the households having eligible couples with at least one child under 5 years of age has been taken into consideration.

In the process of selection of such specific households as the ultimate sampling unit, every third household has been selected from each of the slums by applying Systematic Sampling Technique. If by chance, during the time of selection of the next household, the preferential criterion of selection is not fulfilled (in this sampling design), the household following this, if agreed with, will be included in the sample size till in such process of selecting the household sample, the desired sample size that is 1/3rd of the total households of each slum is attained.

In this study, we have selected 443 households within the slums, which have received health interventions, and 105 households within the non intervened slums. These households comprise a total of 1515 men and 1448 women in the intervened area and 268 men and 273 women in the non intervened slums. The selection of the households interviewed in this study has been drawn from varying backgrounds so as to have an assessment of social and cultural practices followed in diverse cultures and social backgrounds. For example, the inmates from the non intervened slums at Titagarh are mostly population who have migrated from the slums of Bihar and Uttar Pradesh and are of a seasonal nature depending on the scope of jobs available in the local jute mills.The slum dwellers of the intervened slums adjoining the Eastern Metropolitan Bypass on the other hand are mostly refugees from Bangladesh who have adopted these slums as their permanent residences. The slum dwellers from the Garden Reach Area are Muslims from Uttar Pradesh whose forefathers had migrated with Nawab Wajid Ali Shah.

The reproductive health behaviour, traditions and cultural practices differ from each of these varied social groups and this is reflected very much in their attitudes, beliefs and practices towards reproductive health, especially in the context of issues such as age at marriage, child bearing, attitudes to antenatal care, postnatal care, deliveries at home or hospitals, contraception and family planning.

The Interview Schedule

In order to undertake a comparative study on the health assessment of different activities such as Family Welfare Programme, Nutrition Programme, Immunisation and Diarrhoea Disease Control Programme in the intervened areas, and non intervened areas with relation to specific social, cultural and socio-economic parameters, a sample survey in both areas has been conducted independently. Only those households have been interviewed which have eligible couples with children below 5 year of age. The respondent is the woman in the household, that is, the wife and mother of the child under five years.

The interview schedule developed for this purpose has been divided into five sections: section A with questions on demographic, social and cultural characteristics, section B with questions on reproductive health, marriage, pregnancy, childbirth and family planning; section C with questions on immunisation, section D with questions on malnutrition and section E with questions on Diarrhoea. A growth-monitoring chart as developed by the India Population Project 8 is used for actually assessing growth of children below 5 years of age in the sample households for both non intervened and intervened slums. Section A contains questions on religion, place of origin, number of family members according to age, occupation of family members including child labour. Section B records details of eligible couples, levels of literacy of both husband and wife, age of marriage of the respondent female, details on children, pregnancy, and places of delivery, antenatal and postnatal care and use of family planning methods. Each issue has been supported with questions on the opinion of the respondent woman as against the opinion of the community on issues such as age of marriage, choice of the number of children, family planning as well as their beliefs in social, cultural taboos and practices. Section C contains questions on status of immunisation of the children, vaccination of children, reasons to why mothers believed in immunisation *vis-a-vis* beliefs in cultural taboos and practices to cure children's illnesses. Section D has questions on concept of mothers on the symptoms and the treatment of malnutrition of children under 5 years and social and cultural taboos related with the same. The growth-monitoring chart has been used to record the weight of each under 5-year child in the households interviewed. Section E poses questions on respondent mother's concept of the occurrence and treatment of diarrhoea and social and cultural taboos associated with the same.

Total time taken in the fieldwork has been about eighteen months. Preparing the Interview Schedule and field-testing the same took about two months. This was followed by actual household interviews that lasted for about ten months. Tabulation of data and subsequent analysis took another six months. The actual writing, rewriting and revision of this thesis have taken another eighteen months.