Global Journal of human social science
Sociology, Economics & Political Science
Volume 12 Issue 14 Version 1.0 Year 2012
Type: Double Blind Peer Reviewed International Research Journal
Publisher: Global Journals Inc. (USA)
Online ISSN: 2249-460X & Print ISSN: 0975-587X

Health and Child Development Paradox: Findings from Raipur Slums

By Sribas Goswami
Serampore College, West Bengal

Introduction - Children in slums have a poor quality of life. The lack of basic services affects them the most. Children are most disadvantaged in slums. Girls have to look after younger siblings when both parents go to work. Combined with a traditional bias against educating girls they are often not sent to school or drop out at an early stage. Girls do not have the exposure to everyday city life situations, which men, women and young men have. As a result they are often anxiety prone and stressed. The unhealthy and polluted environment, lack of immunization, malnutrition and absence of educational exposure affects children in slums. Sadly, their physical, emotional and intellectual growth is stunted from a very early age.

Keywords : *malnutrition, infant mortality, child welfare, breastfeeding, food security, epidemic.*

GJHSS-C Classification : *340204, 111704*

Strictly as per the compliance and regulations of:

Health and Child Development Paradox: Findings from Raipur Slums

Sribas Goswami

Keywords : malnutrition, infant mortality, child welfare, breastfeeding, food security, epidemic.

I. Introduction

Children in slums have a poor quality of life. The lack of basic services affects them the most. Children are most disadvantaged in slums. Girls have to look after younger siblings when both parents go to work. Combined with a traditional bias against educating girls they are often not sent to school or drop out at an early stage. Girls do not have the exposure to everyday city life situations, which men, women and young men have. As a result they are often anxiety prone and stressed. The unhealthy and polluted environment, lack of immunization, malnutrition and absence of educational exposure affects children in slums. Sadly, their physical, emotional and intellectual growth is stunted from a very early age. The situation with respect to women's health in the urban slums is no different; rather their health is neglected most. Insecurity related to regular income, food, shelter, access to health care and other essential services, along with poverty and difficult physical and social environments, such as exploitation and abuse in the treatment of girl child, have an adverse impact on the health of the urban poor children.

There is a consensus among the leading international organizations (e.g. UN, WHO, World Bank, and ILO) and development scholars that to achieve an effective change for better health and quality of life for women and children, a dual approach is needed (UNDP, 1999; Kar and Acalay, 2000)[1]. These are: (1) reforming health and welfare systems that meet the specific and urgent needs of women (e.g. health care, day care), and (2) reforming socio-cultural systems that perpetuate gender inequalities which are the source of all day-to-day problems (e.g. equal opportunities for education, income, cultural practices and devaluation of women). These two approaches address what Moser (1987)[2] identifies as two types of women's and children's needs: "practical needs" and "strategic needs" respectively. The first approach focuses on day-to-day needs that are akin to the proverb, giving a fish to a starving person; while the second approach is giving a fishing rod and opportunities to fish. There is synergy between health systems, human development systems, and broader social reform. Empirical studies show that children suffer most of the brunt of poverty and abuses due to persistent inequalities and relative powerlessness (Sen, 1990)[3]. Both in rich and poor nations, women and children suffer various forms of institutionalized injustice and abuse including: denial of basic needs (education and health care), feminization of poverty, unfair opportunities for employment, income, and leadership; sexual harassment and exploitation; physical mutilations and deaths, domestic violence; insufficient interest in gender related issues in policy and research; and culturally conditioned practices that endanger women's health and quality of life (e.g, dowry deaths, honor killing, early marriages).

From the time of its independence, India has committed itself to be against child labour. Article 24 of the Indian constitution clearly states that "*No child below the age of fourteen years shall be employed to work in any factory or mine or employed in any hazardous employment*" (Constitution of India cited in Jain,[4] 1985). Article 39 (e) directs State policy such "that the health and strength of workers . . . and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength" (Constitution of India cited in Human Rights Watch 1996)[5]. These two articles show that India has always had the goal of taking care of its children and ensuring the safety of workers. The Bonded Labour System Act of 1976 fulfills the Indian Constitution's directive of ending forced labour. The Act "frees all bonded laborers, cancels any outstanding debts against them, prohibits the creation of new bondage agreements, and orders the economic

[1] Kar, S.B., and R. Acalay. (2000). *Health Communication: A Multicultural Perspective.* Thousand Oaks, CA: Sage Publications.
[2] Moser. CON (1987). Women, *Human Settlements, and Housing: A Conceptual Framework for Analysis and Policy-Analysis*. In Moser C. & L. Peake (Eds); Women, Human Settlements, and Housing. London:Tavistock.

Author : Assistant Professor in Sociology, Serampore College, West Bengal. E-mail : sribasgsowami@gmail.com

[3] Sen, A.(1990). *Gender and Cooperative Conflicts,* In: Tinker I. Editor, p-123-149.
[4] Jain, S. N. (1985). *Legislation and Government Policy in Child Labour. In Child Labour and Health: Problems & Prospects*, edited by U. Naidu and K. Kapadia. Bombay: Tata Institute of Social Sciences p-218.
[5] Human Rights Watch. (1996). *The Small Hands of Slavery - Bonded Child Labor in India.* Human Rights Watch New York: p-29-30.

rehabilitation of freed bonded laborers by the state" (Human Rights Watch 1996). In regard to child labour, the Indian government implemented the Child Labour Act in 1986. The purpose of this act is to "prohibit the employment of children who have not completed their 14th year in specified hazardous occupations and processes" (Narayan 1988)[6]. Here brief discussion is made on the development of women and children and socially lagging class such as SC, ST, minorities, BPL etc. The urban community development programmes in Raipur Municipal Corporation started soon after it was upgraded as a municipal corporation in 1961. This is one of the successful and acclaimed programmes of poverty reduction in the country. In Raipur several urban poverty programmes are under implementation and similarly in the slums in the surrounding city the urban poverty alleviation programmes.

II. Methodology

The data collected from secondary and primary sources.

a) Secondary sources:

Some data are collected and compiled from the books, reports, published and unpublished papers, leaflets, booklets, notes, Municipal records and Governmental circulars.

b) Primary sources:

i. *Questionnaire:*

Some information is collected through questionnaire tool from the government officials, administration level.

ii. *Interviews:*

Interviews from the field with respondents, word counselors and slum leaders have been conducted to elicit their opinion and experience in slum life with the help of interview schedule.

c) Sample size:

The study was conducted in slums on the capital city of Chhattisgarh, Raipur. Here the sample size is 300 families from four slums taking 95 families from Gandhi Nagar, 88 families from Moulipara, 100 families from Kushalpur and 17 families from Kota basti proportionately distributed. For the present study ten percent of total numbers of families in each selected slum area are taken. In case of Gandhinagar ten percent total family size is 95.7, for Moulipara 87.8, for Kushalpur 100.3 and Kota 16.6. But the figures have been rounded off for the sake of convenience for calculation. Head or senior most persons of the family are the respondents.

[6] Narayan, A. (1988). *Child labour policies and programmes: The Indian experience. In Combating Child Labour*, edited by A. Bequele and J. Boyden-146.

III. Food, Nutrition and Various Issues on Health

The growth of slum areas and concentration of the poor people in the slums is a rather depressing aspect of urbanization in Raipur city. Majority of the people who live there belong to lower socio-economic classes and have migrated to the city with the hope of better means of livelihood. Having basically no education, skill and work experience, they have no choice in the competitive job market and pick up lowly paid jobs such as construction labourer, domestic servants, casual factory workers and petty trading business. With their meagre income, they are forced to live in slum areas in the most unsanitary and unhygienic conditions, and are carrying out their existence with the barest necessities of life. Even if people have some money, they do not invest it in house improvement, because of its temporary status or illegal occupation of the public lands and constant threat of eviction. Therefore, the housing of the slum dwellers is of lowest quality. Poor housing conditions, overcrowded environment, poor sanitation, occupational hazards, group rivalries and clashes, stressful conditions together with lack of open space for children's recreation etc. are detrimental to the health of people in the slums. An overview of women's and children's health status presents a sobering picture. Deaths and illnesses from reproductive causes are highest among poor women particularly in slum areas. In addition to the suffering of women, yet another cause of concern is their almost apathetic attitude towards their own health and its management during illness. Girl children are found to seek treatment only when their health problem caused great physical discomfort or when it affected their work performance. The situation with respect to women's and children's health in the urban slums is no different; rather their health is neglected the most. Insecurity related to regular income, food, shelter, access to health care and other essential services, along with poverty and difficult physical and social environments, such as exploitation and abuse in the treatment of women, have an adverse impact on the health of the urban poor children.

Low education and ignorance leads to continuation of wrong beliefs and unscientific attitude towards health. The outcome is incomplete immunization, insufficient gynecological check up during pregnancy, unsafe deliveries at home and improper post-natal care of mothers and children especially in terms of diet and immunization. Incomplete tuberculosis (TB) and malaria treatment leads to recurrences and relapses. The need for fast cures helps propagate the myth that expensive treatment is good treatment. The unhealthy and polluted environment, lack of immunization, malnutrition and absence of educational exposure affects children in slums. Sadly, their physical,

emotional and intellectual growth is stunted from a very early age. Access to community facilities and health centers in these settlements is limited and not adequate. Across all the slums, the health centers are not adequately equipped with medicines and the households have to procure medicines from open market. These health centers are also not equipped to provide antenatal and postnatal care. Studies reveals that the most common diseases prevalent in slums include gastro-enteritis, malaria, Diarrhea, cholera, Typhoid, Malnutrition, ringworm etc.

To overcome these health problems the corporation runs three maternity hospitals, one Government hospital and several health centers. The corporation has also started reproductive and Child Health project and it is being implemented through non-governmental organizations. With their participation, many urban health centers were established to provide better health services to the women and children, particularly in slums and hill areas. There are also government dispensaries, which are visited by the poor. There is need to strengthen health infrastructure. Ensuring food and nutritional security, however, cannot be enough. There are far too much vulnerability in the lives of the poor and those just above the poverty line. Around 93% of our labour force works in the informal sector, without any form of social protection, especially against old age. With growing migration of younger rural residents to urban and fast-growing rural areas, elderly parents are often left behind in the village to cope on their own, or are dependent upon women who also have to tend to the family farm, as agriculture feminizes with growing male migration. Old-age pension is thus becoming a crying need for those dependent on insecure employment in the informal economy as well as for parents left behind. Moreover, vulnerability in respect of health arises from the under-funding of the public health system and its inability to provide comprehensive care, which is a major concern for the majority of the population. At the beginning of the Eleventh Plan period there are serious concerns around food and nutritional security for children. Low and stagnating incomes among the poor have meant that low purchasing power remains a serious constraint to household food and nutritional security, even if food production picks up as a result of interventions in creation of urban infrastructure.

IV. Assessment of Food Security

Measurement of food security is an integration of many factors like agro-ecological, environmental, socio-economic, political and biological factors. The concept is generalized into three main aspects like (WFP, 2002):

- Availability of food
- Access to food
- Utilization of food

Availability of food is examined through sufficient supply of food to satisfy domestic need. Food availability is determined by supply and demand oriented approach while supply of food is integrated with domestic production, imports (public, private, food aid) and changes in national stock. But the issue of food aid in food availability is often being questioned. Also, it is found that availability of food cannot often measure what people actually obtained. In this case access to food depicts people's purchasing power to buy food. Poverty is one of the main obstacles affecting people's purchasing power. Access to food is not only enough in food security, while utilization of food guarantees one's capacity to absorb and utilize nutrients in food consumed. Utilization of food is determined through caring practices, eating habits, hygiene, access to health and sanitary facilities (WFP, 2002) .

V. Types and Frequency of Consumption of Food by Slum Dwellers-

Quality of food is major concerned for the slum dwellers. Taking nutritious foods and frequency of consumption of foods is important determinate of good health. Poor water and sanitary conditions lead to adverse health outcomes in the households living in the slums. Specially the women and children in the slums are most vulnerable section. So here the study will reveal the actual health scenario by providing fowling data. Protein energy intake is widely low in urban slums. According to experts, protein is one of the key components of proper diet and more than half of Raipur populations suffer from malnutrition. Protein deficiency hinders physical growth of children and their brain development. As milk is expensive, 20 amino acids can be obtained in eggs and 10 of them are important for children. Poultry and eggs are first class sources of protein. A large amount of vegetable protein can be found in some food items like peas, beans, pulses, but 20 amino acids are not available in them (Zannat, 2008).[8]

This study shows the most frequently consumed food items to be potatoes, fresh vegetables, sweets and eggs. Most of these items are both relatively cheap and typical of the slum diet. In contrast, butter, soft drinks, milk and ghee were the least frequently consumed items. They are also relatively expensive and are not considered essential to the diet, particularly among persons with low income. The consumption of fruits, snacks and sweets is very highly significantly correlated. All these items are relatively inexpensive and

[7] World Food Programme (WFP), 2002. Food Security Assessment in Bangladesh, Issues and Implications for Mapping Food Insecurity and Vulnerability, Vulnerability Analysis and Mapping, Bangladesh.
[8] Zannat, M. 2008. Children's protein intake at stake. The Daily Star.

are regularly eaten not only at home but also on every special and auspicious occasion. Moreover, the practice of offering these items to guests or as gifts is prevalent among Chhattisgarhi's, regardless of socio-economic status. They are also routinely offered to various Hindu deities and then consumed by the devotees on every religious occasion.

Table 1 : Daily food habit and frequency of consumption of food.

Name of slum	Vegetarian						Non vegetarian						Total Respo-ndents
	Light food	%	Heavy food	%	Total	%	Light food	%	Heavy food	%	Total	%	
Kota Basti	2	11.77	2	11.77	2	11.77	15	88.23	15	88.23	15	88.23	17
Kushalpur	12	88	12	12	12	12	88	88	88	88	88	88	100
Gandhinagar	15	15.79	16	16.84	16	16.84	80	84.21	79	83.16	79	83.16	95
Moulipara	15	17.04	8	9.09	8	9.09	73	82.96	80	90.91	80	90.91	88
Total	44	14.67	38	12.67	38	12.67	256	85.33	262	87.33	262	87.33	300

Source : Personal survey, 2011.

Table 1 shows the nature and frequency of consumption of the food practices by the slum dwellers. 12.67% respondents are vegetarian and 87.33% respondents are non vegetarian. Large numbers of slum dwellers take heavy food twice daily. As maximum people work in informal sector they leave home early in the morning. So they take heavy food in morning before leaving home. Usually they also take Tiffin with them. At night they take again heavy food. But the habit of women and children is little bit different than of men. So far the non vegetarians are concerned they also practice same food habit as vegetarians. The only difference is in nature of the food they consume. Non vegetarians use to take meat, fish, egg, chicken etc. Interrogation reveals that generally Brahmins are vegetarians in Raipur with few exceptions. But few non Brahmin people also found vegetarians. According to respondents, children are provided with three meals in a day. But inadequate quality and lack of diversity of food are matter of concern in food habit. Consumption pattern of slum dwellers depict that rice, potato, vegetable and edible oil are consumed on daily basis. The food habit is almost same in four slums. General practice of people shows that they use to take heavy and light food daily.

Table 2 : Consumption of stored food by slum dwellers.

Name of slum	Often take	%	Some time take	%	Not take	%	Total Respondents
Kota basti	6	35.29	7	41.18	4	23.53	17
Kushalpur	45	45	44	44	11	11	100
Gandhinagar	29	30.53	49	51.58	17	17.89	95
Moulipara	15	17.05	54	61.36	19	21.59	88
Total	95	31.67	154	51.33	51	17	300

Source : Personal survey, 2011.

In many places of Raipur the practice of taking stored food (popularly known as *basi)* is general habit of the slum dwellers. This stored food is used in such a way so that it would not rotten or get decomposed. Usually rice is kept into the water and left for a day and eat it several times. By doing this they think they can save time and money. They also believe this kind of food is not harmful for health. Not only that they also claim that this type of food helps to sustain for a long time. The table 2 shows that 31.67% respondents use stored food often. 51.33% respondents take occasionally and 17% people don't take stored food. Stored food is taken sometime uniformly in almost all sums. Moulipara has less number of people consuming stored foods but Kushalpur is in the top in this regard. Consumption of stored foods may sometime create food poising, and people have complaint for having stomach related problems in these areas.

VI. Quality Assessment of Drinking Water and Food

Good nutrition forms the basis for good health of a child. Nutrition is required for a child to grow, develop, stay active, and to reach adulthood as well. An adequate supply of safe drinking water is universally recognized as a basic human need. Consequently, the urban poor often use inexpensive pit latrines and at the same time may draw domestic water from nearby wells or taps. Overcrowding in slums limits the adequate distance between wells and pit latrines so that micro-organisms migrate from latrines to water sources. Sanitary practices in these overcrowded slums are also poor, leading to contamination of these wells. This study sought to assess sanitary practices of residents of slum and fecal contamination of their domestic water sources. Children's food habit and health status are directed by household's socio-economic condition. Also, children are susceptible to environmental sanitation while they are found most of the time playing around or spending outside environment which is very unhygienic. Socio-economic factors like income, expenditure and education are analyzed to depict households' ability and knowledge about dietary practice and prevalence of disease occurrence among children.

Table 3 : Consumption of nutritious foods by children.

Name of slum	Daily				Some time				Don't / Can't take		Total Respondents
	Milk	%	Baby food/fruits	%	Milk	%	Baby food/fruits	%	Total	%	
Kota basti	3	17.65	1	5.88	3	17.65	-	-	10	58.82	17
Kushalpur	25	25	3	3	31	31	4	4	37	37	100
Gandhinagar	38	40	5	5.26	32	33.68	2	2.11	18	18.95	95
Moulipara	33	37.5	11	12.5	22	25	9	10.23	13	14.77	88
Total	99	33	20	6.67	88	29.33	15	5	78	26	300

Source : Personal survey, 2011.

According to respondents, children are provided on an average three meals in a day. But inadequate quality and lack of diversity of food are matter of concern in food habit. Consumption pattern of slum dwellers depict that rice, potato, vegetable and edible oil are consumed on daily basis. Food composition sometimes is only rice with potato or peas or fish which are cheap to them. But access to protein rich animal product (milk and milk product, meat or chicken, eggs) is very low among the poor. They can provide their children these foods mainly on monthly basis or sometimes on special occasion like *Dashera* festival. According to households these are expensive food item and most of them cannot afford it. Though, a large number of households can manage fish or meat in weekly basis. Most of them answer that they eat fruits on weekly basis. In this case, they can afford mainly banana which is relatively cheaper than other seasonal fruits. The data show us that 33% people can afford milk for their children. But only 6.67% can daily provide nutritious foods other than milk. 29.33% children sometime take milk whereas 5% respondents can provide fruits or baby foods seldom. Still 26% can't provide such types of foods to their children. Actually providing nutritious foods is quite expensive now a day, where half population earns less than Rs.5000/- per month and household units are more or less comprise of 5 persons per family. In Kota Basti more than 58% respondents can't provide expensive foods to their family members. In this regard Moulipara's situation quit better than other slums.

Table 4 : Practices of breast feeding after the birth of child

Name of slum	Within 1 hour		Above 1 hrs to 12 hrs		Within a day		Above 1 day		Total Respondents
	Total	%	Total	%	Total	%	Total	%	
Kota Basti	2	11.77	4	23.53	6	35.29	5	29.41	17
Kushalpur	17	17	28	28	12	12	43	43	100
Gandhinagar	7	7.37	18	18.95	37	38.95	33	34.73	95
Moulipara	12	13.64	27	30.68	36	40.91	13	14.77	88
Total	38	12.67	77	25.67	91	30.33	94	31.33	300

Source : Personal survey,2011.

Exclusive breastfeeding (EBF) is recommended as the optimum method of feeding for the first 6 months of life to meet the physiological requirements of the infants. It has been reported from the study that the practices of early introduction of breast feeds and late introduction of semi-solids are widely prevalent, more so in slums areas. Study reveals serious erosion of breastfeeding practices. Use of pre lacteal feeds is almost universal; use of feeding bottles, animal milk, and commercial milk formulae are very common. Also it has been found that the introduction of complementary foods is markedly delayed with this background, the study have been conducted to assess the breastfeeding practices of the children in slum and to determine the factors influencing it, if any. 12.67% mother has given colostrums within 1hour. 25.67% has provided milk to their children after one hour but before 12 hours of the birth. 30.33% mother has given breastfeed within the day and 31.33% provided breastfeed after one day. In Kushalpur and Gandhinagar slums major respondents admitted that they provide breast feeding to their children after a day. As we know that mothers' milk is very vital for the new born baby as soon as possible after the birth.

vii. Health Awareness and Health Practices and Expenditure on Food

In addition, poverty, lack of literacy, widespread ignorance and the low social status of women result in malnutrition, low immunization rates, low maternal and child care and neglect of health, thus further contributing to the ill-health of the poor. The problem is further aggravated by the absence of a user friendly health care system. Clinics and hospitals are often far from poor settlements and entail a long and expensive trip. The hospitals are also often overcrowded and staffed by unfriendly, unsympathetic doctors. Therefore, despite of good numbers of highly subsidized government hospitals, dispensaries and maternal / child health centers in Raipur, the poor remain unattended and untreated. Most urban poor, when they fall ill, prefer to consult a private practitioner, and since these doctors charge a heavy fee, the tendency is to avoid consulting a doctor until the illness becomes very serious. Housing in slums becomes a major health concern because residents of slums live in overcrowded situations. One fourth of households are simple one-room structures, a majority of them with dirt floors and poor ventilation. Such overcrowding can lead to rapid spread of respiratory and skin disease.

Easy access to drinking water in slums is another major problem. More than two thirds of slum residents lack access to safe drinking water on their premises. The main sources of water are municipal taps, connections of tap water is available in some homes. Lack of safe drinking water facilitates the spread of water borne diseases. The presence of stored water further promotes the breeding of mosquitoes and diseases such as malaria. Many waterborne diseases can be noticed during rainy seasons. Absence of available latrines is a major health problem as well. It is estimated that over one third of slum households have no access to bathroom facilities, promoting open defecation, which in turn leads to spread of fecal-oral disease and parasitic infestation. Awareness regarding health requires more attention in these areas. Some major aspects are given bellow for detailed study.

Table 5 : Action during minor sickness.

Consult register doctor	%	Consult non-register doctor	%	Prescribe himself/herself	%	Don't take any action	%	Total respondents
8	47.06	7	41.18	1	5.88	1	5.88	17
65	65	25	25	7	7	3	3	100
65	68.42	8	8.42	21	22.11	1	1.05	95
34	38.64	16	18.18	38	43.18	-	-	88
172	57.33	56	18.67	67	22.33	5	1.67	300

Source : Personal survey, 2010.

The study shows that slum dwellers often neglect minor sickness and do not consult doctor for remedy unless they fall ill. In this situation it is become obvious to know the medical practices of slum dwellers of Raipur city. Among the surveyed population (table no5) 57.33% respondents said that they consult doctor. Government hospitals provide comparatively cheaper treatment. Some of them (18.67%) consult the local doctor or quack. But most dangerous practice is done when 22.33% respondents prescribe medicine themselves without proper knowledge. 1.67% people say that they don't take any medicine for minor cases. In Moulipara and Gandhinagar many people use this practice. Often people neglect minor sickness in slum

areas which can be seen through data in the table in which Kota Basti has ranked top. In slum areas local doctors like RMP or quack are operative. They often take the chance of ignorance of slum dwellers which can be also seen in the table. In Kota Basti such cases can be seen clearly.

Table 6 : Place for purchasing medicines.

Name of slum	Medicine center	%	Local grocery/shop	%	Other place	%	Total respondents
Kota basti	13	76.47	3	17.65	1	5.88	17
Kushalpur	80	80	20	20	-	-	100
Gandhinagar	63	66.32	32	33.68	-	-	95
Moulipara	50	56.82	38	43.18	-	-	88
Total	206	68.67	93	31	1	0.33	300

Source : Personal survey 2011.

Another most important factor indicates the health concern of slum dwellers which plays vital role for purchasing medicine. The big medicine centers are located in city hearts. These slums have few little shops. The quacks are indirectly involved with these shops. Few low cost medicines generally available here. Even in grocery shop they use to keep medicines without having any proper license. So doubt if ingenuity remains in the mind. Table 6 reflects 68.67% people take medicine form the medical shop. But 31% people depend on the local shop. .33% people still take medicine from the road sides. One respondent said on the day of local vegetable market many people seats with stone and medicinal plants (Jaributi), from them also people use to take medicine.

If the informal means of obtaining medicine suppose not genuine then many people is taking poison even after spending money. Local grocery preserves medicine for long time, which may exceed the date of expiry. Many so called educated people sometime overlook the expiry date of medicine, then how these marginalized people can notice? These kinds of incidents show the worse condition of health and medical awareness among the slum dwellers which brings far reaching consequences.

Table 7 : Preference for Medical Treatment

Name of slum	Government hospital	%	Private treatment	%	Total respondents
Kota basti	15	88.23	2	11.77	17
Kushalpur	69	69	31	31	100
Gandhinagar	75	78.95	20	21.05	95
Moulipara	72	81.82	16	18.18	88
Total	231	77	69	23	300

Source : Personal survey, 2011.

It is ironically said that good medical treatment is costly. Indirectly it indicates to the private institutions providing medical services across the country. It is fact that good health treatment is still unreachable to many poor living in the slums. So far the government hospitals are concerned they have tremendous pressure, patients come from the various places throughout the state. Here in the Raipur the numbers of large / good hospitals are limited. The condition of local hospitals and dispensary is miserable and unable to handle the critical cases due to lack of infrastructure. The table 7 shows that 77% people depend on government hospitals. But 23% respondents say that they avail private institutions for health treatment. So good health for all and the right to good health which is in many cases unreachable to the urban poor. The data show that more or less maximum people are dependent on government hospitals. Few among them can effort the private treatment as and when required. All slums are projecting the same picture in this regard.

viii. Types of Epidemic, Diseases and Disabilities

The slums present the worst forms of health conditions. Their deplorable environmental and economic conditions result in malnutrition among children. Infant as well as maternal mortality rates were very high in the slums. Due to poor hygiene conditions people died of hepatitis, encephalitis, typhoid and rabies. The incidence of respiratory diseases like fever, viral infection, tuberculosis, skin diseases, diseases of the kidney and urinal diseases were high in the slums. The most conspicuous and highest degrees of incidence could be noticed for some special diseases: the incidence of tuberculosis was ten times higher in the slums than in the city as a whole, viral infections are 2.5 times higher, skin diseases 2 times, respiratory diseases 1.4times, heart and circulatory system about 10 times and allergic diseases 1.9 times higher. As the slums have no open spaces and playgrounds, children in the slums developed mental complexes and physical imbalances. Elaborately the discussion is made bellow.

Table 8 : Infant mortality incidents in the family of the respondents.

Name of slum	1 case				More than 1 case				No case		Total respondents	Total no of case	%
	M	%	F	%	M	%	F	%	Total	%			
Kota basti	-	-	1	5.88	-	-	-	-	16	94.12	17	1	5.88
Kushalpur	1	1.33	3	3	-	-	-	-	96	96	100	4	4
Gandhinagar	1	-	4	4.21	-	-	-	-	90	94.74	95	5	5.26
Moulipara	4	4.54	4	4.54	2	2.27	-	-	78	88.64	88	10	11.36
Total	6	2	12	4	2	0.67	-	-	280	93.33	300	20	6.67

Source :Personal survey, 2011.

Here in the present study table 8 shows that in some families either boys (2%) or girls (4%) died after birth. .67% respondents have reported more than one infant death incidents. 93.33% respondents don't have any such type case. It is seen that the total number of infant mortality recorded in this table is 6.67%. Infant mortality is not a single problem with a single solution. Multiple and interrelated determinants interact demanding a chain of approaches and policies that to be evolved to deal with and to bring down the mortality rates. Mostly the women's and children's health is often neglected resulting poor health and development. Over population and poverty are pervasive in and causing health hazards such as mortality. Infants are naturally innocent, vulnerable and dependent on their parents mainly mother's nutrition status and child feeding practices and often suffer from viral and infectious diseases. The lower case of infant mortality shows the greater level of awareness. It is seen that among four slums Moulipara has the maximum number of infant mortality cases. But the overall scenario is encouraging in this regard.

Table 9 : Information showing physically / mentally challenged children among family members of the respondents.

Name of slum	Yes						No		Total respondents
	M	%	F	%	Total no of disability	%	Total	%	
Kota basti	1	5.88	-	-	1	5.88	16	94.12	17
Kushalpur	4	4	1	1	5	5	95	95	100
Gandhinagar	1	1.05	7	7.37	8	8.42	87	91.58	95
Moulipara	4	4.55	-	-	4	4.55	84	95.45	88
Total	10	3	8	2	18	6	282	94	300

Source : Personal survey,2011.

The unprivileged people who include impoverished slum children, physically and mentally challenged. Since the health facility can refer children to hospitals, there are certain disabilities, which can be cured when detected at an early stage; for example the clubfoot disease, the most common physical handicap among small children. It is reported that there are 6% disabled persons living in the slum at present as per the table 9. These disabled persons generally treated as marginalized section among marginalized community. In Kota Basti 5.88% males are reported either physically or mentally challenged but no female victim can be seen. On the contrary in Gandhinagar slum it is seen that 7.37% females are having disabilities with highest number of disabilities cases among other slums.

IX. Concluding Remarks

We suspect that there is an untapped demand for clean, habitable and decent living conditions amongst the slum dwellers that can positively impact on health. Unfortunately these demands are not important, relevant nor deemed necessary to be fulfilled due to a series of arguments (excuses) - 'migrant population', 'illegality of settlement' (specifically land), 'encroachers' and 'insufficient financial and human resources'. What are required are not assumptions or broad generalizations or complete neglect/apathy but focused thinking towards accommodating the growing population of cities with adequate housing and decent quality of life for 'all'. There are main issues that require attention if health services for the poor are to be improved and made more accessible - while inadequate health facilities maybe partly responsible for the poor health status of slum dwellers the answer does not lie in simply providing more services. Although it is extremely important to invest in more services like reorienting and sensitizing doctors/nurses, additional beds in government hospitals, well equipped dispensaries and maternity clinics near slums and settlements inhabited by the poorer sections; focus needs to be on accepting and understanding that although medical facilities for the urban poor are both inadequate and the poor have limited access, the poor can avail of the same in cities that are not available to them in the villages; and this demand must be fulfilled keeping in mind the felt needs of the poor. For the poor private doctors are approachable for small ailments or coughs/cold, but free services at government hospitals is always the option in case of severe health problems. Being close to government hospitals and dispensaries is a positive factor but more information regarding health, reproduction, availability of better government resources for illnesses like TB , for both men and women needs to be appropriately addressed. Education can play vital role in influencing parent's knowledge about nutrition, hygiene and health. Sometimes respondents are found to be conscious about food habit but can't afford healthy food which is expensive to them. As slum dwellers do not own any land and stay in public and private land, so they cannot grow food in their own land. Consequently, they are diarrhea patient mostly dependent on market price of food. However, market price fluctuates without considering their ability to buy. So this state of price fluctuations has to be given priority in case of household level to make them food secure. The guardian should be more active about the health care of their offspring. Some special child care clinic and child development programme may be initiated by the government. Mentally and physically challenged children are worst victim of our social system, thus their condition is miserable in the surroundings they live. Therefore children in slums need urgent attention of their pathfinder.

References Références Referencias

1. Anker, R and Sandhya, B (1998): "*Economics of Child Labour in Hazardous Industries in India"*, Centre for Operations Research and Training, Baroda.
2. Aranganannal (1975): "*Socio-Economic Survey of Madras Slums, (1971 Survey*)", Tamil Nadu Slum clearance Board, Madras.
3. Bhanumurthy, N.R (2004*): "Economic Growth, Poverty, and Inequality in Indian States in the Pre-reform and Reform Periods",* Asian Development Review, Asian Development Bank, vol. 21, no. 2, Manila.
4. Chatterji, R (2005): "***Contributions to Indian Sociology, Plans, habitation and slum development: The production of community in Dharavi"***, 39, 197 – 218, **Mumbai**.
5. Dev, M. S. and Ravi C. (2002): "*Food Security and Child Work in South India: Determinants and Policies".* In Ramachandran and Massün, eds. (2002): 192-215.
6. Edelman, B (2006): "*Slum Dwellers' Access to Basic Amenities: The Role of Political Contact, Its Determinants and Adverse Effects"*, Review of Urban and Regional Development Studies, Vol. 18, No.1, U.S.A.
7. Gupta, I (1998): "*Slum Dwellers in Delhi: An Unhealthy Population"*, Fourth Asia Pacific Social Science and Medicine Conference, Dec, 1998, Yogyakarta, Indonesia.
8. Lipton, M (1980): "*Why Poor People Stay Poor*", Temple Smith, London.
9. Khan, Z.T (2001): "*Socio-Economic level of Muslim slum dwellers in Raipur city".* Vol 39 2001, The Deccan Geographers, Pune.
10. Mishra, R.P (1984): "*Development issues of our Times",* Concept publishing Co. New Delhi.

This page is intentionally left blank