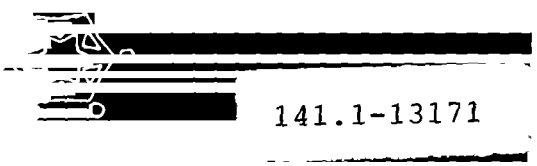

Experiences in Health and Community Development

URBAN HEALTH

The **Anubhav series** is published to disseminate information on innovative projects providing health, nutrition, family planning and community development services in India The series was developed out of a widely shared concern about what could be done in order to strengthen the performance of health and community development programmes in India The Indian government has assumed the primary responsibility for the provision of basic services to India's 844 million people, particularly to the disadvantaged living in rural areas. As a pluralistic society, however, India has also witnessed the growth of a rich variety of private efforts, complementing the work of the government. Though limited in resources and scale of impact, many voluntary agencies have been experimenting with innovations learned through many years of extraordinary dedication.

Information about these small, private, and widely dispersed projects has been limited Lack of descriptive information, project analysis, and presentation in a readable format have prevented the many lessons learned from these innovative efforts from reaching the broader audience of policy-makers, programme managers, academics, social activists, and the interested public The **Anubhav series** attempts to disseminate the experiences of these voluntary organizations, with the goal of contributing to greater understanding of their work and thereby improving the delivery of health and community development services in India. In the documentation endeavour, effort has been made to stress on the process of development of these voluntary organisations rather than development alone.

Financial support for the production of the **Anubhav series** is provided by the Ford Foundation. Selection and review of the case studies is undertaken by Mr Alok Mukhopadhyay of the Voluntary Health Association of India, working with an informal committee drawn from those in the field of health and community development

Individual acknowledgement could not be given due to paucity of space However, **Anubhav series** would like to express its deepest gratitude to all those but for whom the documentation of these projects would not have been possible

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URBAN HEALTH

PREFACE

Popular saying, "India lives in villages" perhaps does not hold true any more. At present 26 percent of our population live in unplanned, chaotic and ever-growing urban centres of India. The pace of urbanization is expected to increase even further in the coming decades in consonance with the envisaged economic growth in India.

In Post-Independence Indian planning, there has been considerable effort towards the process of rural development, though much of which may not have produced desired results, but in urban planning and development the process has been delayed, halfhearted and mainly concentrated for mega cities. Urban centres are referred to as 'engines of growth' for national economy as they contribute over half of the gross domestic product. Despite the apparent affluence of these centres urban poverty has increased, while the rural poverty incidences have declined sharply (Lakdawala Committee Report). Evidently, the high urban income is distributed unequally among the urban residents. Like in every sphere of our societal development, rich and the 'famous' have cornered most of the available facilities, leaving not so well off citizens to eke out a humiliating existence. In all of urban India, it is a 'Tale of Two Cities.'

The situation is directly affecting the health and well being of the people living in urban India. Unhygienic living conditions, squalor, lack of public conveniences, pollution, inadequate and unsafe water supply are all part of familiar commentary on these areas. This is further highlighted by recent outbreak of primitive diseases like plague, cholera and malaria.

This suggests that there needs to be a radical departure on the affairs of urban management. To begin with, could there be a semblance of equitable distribution of available infrastructure and resources among the entire population living in urban areas? Can we reorganize urban management into a decentralized, people-oriented system rather than current centralized state managed system? In this area Chinese experience of urban management is of considerable relevance. Lastly, can we ensure more rapid and balanced growth of the villages so that the process of migration is slowed down. Perhaps, balanced rural and urban growth in Punjab and its over all implication on the lives of people is worth looking at.

This issue of Anubhav is trying to understand some of these problems and present some of the interesting micro level alternative urban development initiatives. We hope it will generate more discussion and coordinated action on this important issue of our national development.

URBAN HEALTH: WHITHER LIE SOLUTIONS ?

Introduction

India's urban population of around 217 million, one of the largest in the world is estimated to grow to 290-350 million by 2000. As populations come together for security and a better city life, the urbanisation process in India and other parts of the world constitute a major demographic issue of the 21st century. Of the staggering expected figure of 460 million by the year 2000 comprising 45% of India's population, about 1/3 -1/ 5th of the urban population is expected to be living in slums.

The complexity of the urban environment and the social strata therein present a tough challenge to the sustainability and relevance of health and development programmes.

According to Seventh plan estimates, 50.5 million persons in urban areas were living below the poverty line in 1984-85 comprising 27.7% of the urban population. The pace of urban growth in India (See Table 1) has been high during 1951-91 and the

TABLE 1. Urban Growth in India (1901 - 1991)

Census Year	No. of Urban Agglomerations/ Town	Population in (thousand)			Decennial Growth Rate		
		Total	Rural	Urban	Total	Rural	Urban
1901	1,827	238,395	212,544	25,851	-	-	-
1911	1,815	252,092	226,151	25,941	5 75	6 40	0 35
1921	1,949	231,321	223,235	8,086	-0 31	-1 29	8 27
1931	2,072	278,976	245,521	33,455	11,00	9 98	19 12
1941	2,250	318,660	274,507	44,153	14 22	11 81	31 97
1951	2,843	361,087	298,644	62,443	13 31	8 79	41 42
1961	2,365	439,234	360,298	78,936	21 64	20 64	26 41
1971	2,590	548,158	439,045	109,113	24 80	21 86	38 23
1981	3,378	683,328	523,866	159,462	24 66	19 32	46 14
1991	3,768	844,323	627,146	217,177	23 56	19 71	36 19

Ref: Mathur O P 1993

(Persons in Lakhs)

TABLE 2. India : Estimated urban population and slum population, 1990

States/ Union Territories	Urban Population 1981	Identified Slum Population 1981	Estimated Urban Population 1990	Estimated Slum Population 1990
INDIA	1,597 27	279 14	2,415 44	512 28
States				
Andhra Pradesh	124 88	28 58	190 37	38 07
Assam	20 47	1 24	33 14	6 63
Bihar	87 19	32 70	137 72	32 70
Gujarat	106 02	15 32	155 05	31 01
Haryana	28 27	2 74	45 86	9 17
Himachal Pradesh	3 26	0 76	4 58	0 92
Jammu & Kashmir	12 60	6 27	19 44	6 27
Karnataka	107 30	5 74	165 62	33 15
Kerala	47 71	4 10	68 16	13 63
Madhya Pradesh	105 86	10 75	168 81	33 76
Maharashtra	219 94	43 15	312.55	62 51
Manipur	3 75	0 17	9 61	1 92
Meghalaya	2 41	0 66	3 99	0 80
Nagaland	1 20	–	2 75	0 55
Orissa	31 10	2 82	53 02	10 60
Punjab	46 48	11 67	68 93	13 79
Rajasthan	72.11	10 25	115 69	23 14
Sikkim	0 51	0 02	1 29	0 26
Tamil Nadu	159 52	26 76	213 78	42 76
Tripura	2 26	0 18	3 24	0 65
Uttar Pradesh	198 99	25 80	326 54	65 31
West Bengal	144 47	30 28	198 57	49 64
Union Territories				
Andaman & Nicobar Islands	0 49	N A	0 93	0 19
Arunachal Pradesh	0 41	N A	0 93	0 19
Chandigarh	4 23	N A	7 65	1 53
Dadra & Nagar Haveli	0 07	N A	–	–
Delhi	57 68	18 00	92 84	38 25
Goa, Daman & Diu	3 52	0 24	5 45	1 09
Lakshadeep	0 19	N A	–	–
Mizoram	1 22	N A	3 80	0 76
Pondicherry	3 16	0 94	5 13	1 03

Source. A Compendium on Indian Slums, Town and Country Planning Organisation, 1985

number of towns has increased from around 3,000 in 1951 to 4,689 in 1993 (Sivaramakrishnan 1993). With the present difficulties in estimating the urban and slum populations the actual facts about the urban poor especially relating to their health and nutritional status remain hidden. A somewhat conservative state wise estimate may be referred to in Table 2. At the national level trends indicate that while the rural poverty is declining, the urban poverty is increasing. The number of urban poor and the percentage of people below the poverty line in the 1970s and 1980s place the urban poverty estimate between 35 and 40 percent as can be referred to in Table 3. In 1991, 28% of the estimated 20 million people living in 23 major metropolitan areas reside in slums. The number of cities over 1 million has nearly doubled since 1980 from 12 to 23 with the urban population rising from 26.8% to over 35%. In just the major metropolitan cities more than 9 million people live in urban slums: 12,50,000 in Bombay, 11,00,000 in Calcutta, 9,00,000 in Madras and 7,00,000 in Delhi. By the year 2000 India faces the increasingly grim challenge of providing Primary Health Care to around 80-120 million slum population.

Urban Growth

Urban growth is influenced both by the 'pull' forces of economic opportunity in cities and the 'push' factors of rural poverty and unemployment. The rural-urban growth rates over 1971 to 1991 can be referred to in Table 1. The decennial rates of urban growth have been much higher than the rural rates for the past several decades. In absolute numbers the urban population has nearly quintupled in the last 50 years from 44 million to 217 million. A direct result

TABLE 3. Number of Poor and Percentage of People below the Poverty Line in the 1970s and 1980s

	Planning Commission Estimate (Per cent)	Direct All India Estimate		Aggregation of State Estimates	
		(No. in million)	(Per cent)	(No. in million)	(Per cent)
1970-71					
Urban	–	50 07	45 89	49 93	46 17
Total	–	301 76	55 05	305 90	56 25
1983					
Urban	28 10	65 96	38 33	68 39	39 74
Total	37.40	333 27	46 46	343 26	48 11
1987-88					
Urban	19 40	74 96	36 52	76 57	37 76
Total	29 20	336 42	42 70	357 83	45 85

Reference Minhas, Jain & Tendulkar (1991)

of this urban population explosion has been a tremendous increase in the urban slum population with inadequate access to basic health and social infrastructure and services. With the existing urban growth rate, the National Institute of Urban Affairs task force projected that there will be 62 - 78 million people in the slums out of an estimated total of 310 million urban population by the end of the century. Given the difficulties in estimating slum populations this projected figure appears to be a more realistic estimate from the estimated figure of 512.28 lakhs in 1990 as determined in 1985 by the Compendium on Indian Slums, Town and Country Planning Organisation (Table 2).

In 1990, 42.3% of the world population had been reported to be living in urban areas. By the year 2000 this is expected to account for 46% and by 2020 for 56.4% (United Nations 1987). Reasons for urban growth are mainly natural population growth, responsible for more than 60% and migration from rural areas (Harpham 1988). The present patterns of economic growth have been generating rapid rural-urban and urban-urban migrations. Underemployment in rural areas, fragmentation of landholding patterns due to the population growth and breakdown of joint or extended families, non implementation of land reforms due to political influences of rich peasants, increased awareness among landless populations of possible economic independence in urban areas all contribute to increase in migration.

The inability of the urban administration to cope with the pressures of urbanisation has led to serious deprivation among the urban poor.

The complexity of the urban environment and the social strata therein present a tough challenge to the sustainability and relevance of health and development programmes.

The inability of the urban

Urban Management Challenge

From 1990 to 2030, global population will grow by 3.7 billion people. Ninety per cent of this increase will take place in the developing countries. Ninenty per cent will be urban, virtually all of it will accrue to human settlements in the developing world. By 2030, urban populations will be twice the size of rural populations. Primarily due to a decaying urban environment, at least 600 million people in human settlements already live in life threatening situations. Up to one-third more live in substandard housing. At least 250 million urban residents have no easy access to safe piped water, 400 million lack sanitation.

"Sustainable Human Settlements Development-Implementing Agenda 21," prepared for the U N Commission on Sustainable Development by UNCHS (Habitat), March 1994

administration to cope with the pressures of urbanisation has led to serious deprivation among the urban poor.

Health and the Urban Poor

The health status of the urban poor is influenced by several factors. In this issue these have been explained under three sections :

A. Urban Economy
B. Urbanisation and Health
C. The Urban Environment

The section on Primary Health Care of the Urban Poor, their health problems and the Urban Health Care Delivery System (Section D) is followed by the Present Scenario of Government schemes and Interventions (Section E) and Future Urban Health Challenges (Section F).

The NGO Sector

Currently in India, a large majority of health care projects tend to emphasis approaches to provide curative care while others have evolved more multisectoral programmes with greater emphasis on involvement of slum communities and partnership with government and other NGO programmes. The outreach services to slum pockets who do not have access to services and their integration with government health programmes remain an important challenge.

There is an increasing interest among bilateral agencies to support several programmes and projects on urban Primary Health Care. In some cases efforts are made in the same areas, concentrating resources and duplicating activities under different approaches without strengthening referral mechanisms or planning community interventions in a coordinated manner. The gap in coordination and planning among organizations and the absence of a thorough community need assessment programme targeted at those sections who are most disadvantaged have reduced the success of these project interventions.

The search to provide equitable access to health services and to respond to the many needs of the urban poor in the light of severe health and environmental conditions have constituted the activities of several urban projects within the NGO sector.

To what extent have the Urban health care projects within the NGO sector acted as agencies of change to bring about a better quality of life within urban communities? Slum dwellers often labelled as 'social parasites' by the urban elite perform substantial valuable services within the urban economy. Can they become partners in the development

of the urban economy and receive their share of the benefits of this economy?

The search to provide equitable access to health services and to respond to the many needs of the urban poor in the light of severe health and environmental conditions have constituted the activities of several urban projects within the NGO sector. An effort has been made here to describe some of these initiatives as will be explained below.

Although various aspects of some NGO initiatives have been documented, the guiding forces behind projects, their extent of collaboration with governments, partnership with communities and allocation of resources still hold out important lessons as has been illustrated below through selected interventions made by three NGOs (Section G) Action for Securing Health For All (ASHA) in New Delhi, Youth for Voluntary Action (YUVA) in Bombay, Maharashtra and the Urban Health Care Project (UHCP) and other programmes in Kanpur, Uttar Pradesh. There remain crucial factors that influence why some project interventions are or are not successful and these need to be more widely understood and replicated.

These and other NGOs have been striving to find their own solutions through different forms of partnership with slum women and communities in parts of the country with heterogeneous communities. Can they influence the way in which urban planners and administrators view the urban poor in order to formulate more comprehensive and need based future strategies?

A. Urban Economy

Instead of being a sign of economic progress, urban growth as in the industrialized country model may become an obstacle to economic progress: the resources needed to meet the increasing demand for facilities and public services are lost to potential productive investment elsewhere in the economy. (Lob Levyt 1990).

The contribution of India's urban sector to the net domestic product rose from 29% in 1950-51 to 41% by 1980-81 and is likely to go over 60% by 2001. Almost two thirds of the employment in manufacturing, trade, transportation and commerce sector is concentrated in urban areas. However the benefits of this urban growth are not shared by all. In large cities one third to one half of the population lives in slums and around 15% of the male work force and 25% of the female work force have no regular employment (Mathur 1993). The significant addition to the urban population is not absorbed into the urban economy but remains marginally employed in unproductive fields or unemployed.

However, there have been innovative and successful initiatives with self employed women workers within the NGO sector that are directed at both economical and social integration

into the mainstream of society. SEWA operating in nine districts of Gujarat with a total member-ship of 53,000 self employed women is one such example. SEWA established in 1972 as a trade union for self employed women grew out of the Textile Labour Association, India's oldest union of textile workers founded by Mahatma Gandhi in 1920.

The **SEWA Union** organises women belonging to different trades, Cooperatives help the women to build alternative economic structures to increase control over the means of production. These include Land based, Livestock, Craft and Artisans, Services and Trading Cooperatives. The Supportive Services include Health Care, Child Care, Savings and Credit, Housing, Legal Services and Insurance.

There have been innovative and successful initiatives with self employed women workers within the NGO sector that are directed at both economical and social integration into the mainstream of society.

It appears as if SEWA has been effective in emphasising the role of women as vital workers in the household and local economy rather than as mere clients for welfare services.

A recent study by Jhabwala and Bali revealed that 92% of SEWA's members were interested in the health service for the curative services offered including the services of the community health workers, doctors and the availability of essential low cost drugs. SEWA has also helped act as a link to improve outreach of four government services namely family welfare, immunization, maternity benefits and hospital care. It was found that among the members 43.7% availed the immunization programme and 22% the maternity benefits provided.

According to the 1981 census, 15.6% of urban households did not have a single literate member. The non participation of men in the curative and preventive health care of families remains an important challenge. Socio-educational interventions targeted at both men and women in particular within the family context are clearly important. The family health status is closely linked to economic and social factors including unemployment, wasteful expenditures on drugs, alcohol and tobacco, lack of basic amenities including water supply, sanitation, housing and food security.

B. Urbanisation and Health

Urbanisation can be perceived as a positive phenomenon when it leads to resettlement of workers in rural populations in are as where non agricultural opportunities are available and lead to productive and gainful employment. In reality however, it tends

to be more of transfer of rural poverty to the urban environment. The link between urbanisation, environment, inaccessibility to health care and the

Proper water and sanitation facilities still remain beyond the reach of the majority of the urban poor

threat to the quality of life in particular emerge as important issues.

Slums have been described as subcultures with a set of norms and values which is reflected in poor sanitation and health practices, deviant behaviour and characteristic attributes of apathy and social isolation.

Slumification or slum expansion and its negative impact on the larger city environment constitute important processes of urban decline (VHAI 1992). An increase in female responsibility and their engagement in stressful occupations outside the home, places a double burden on them.

Urban areas in India can still be described as: 'A cultural Unity amidst diversity–A bundle of contradictions held together by strong but invisible threads.'

– Jawahar Lal Nehru

Despite this reality urban areas in India can still be described as Nehru said: 'A cultural Unity amidst diversity - A bundle of contradictions held together by strong but invisible threads.'

The urbanisation process has also been found to create individualistic lifestyles in contradiction with rural culture, impersonal interactions, increased social stress and ill health, specialisation of occupations and cash economy and breakdown of family norms, customs and traditions. Studies on internal migrants have also shown higher rates of mental morbidity (Chakraborthy 1990, Sethi et al 1972).

Amongst the urban poor, the rapid population growth makes poverty more visible. It is well known that in the developing world the problems of cities have exacerbated as a result not so much of the population growth itself, but of growth within the context of a legal and institutional structure unable to cope with the needs of the population and the tasks of providing and running city services (Hardoy and Satherwaite 1989).

Thus, urban policy issues pose serious challenges to planners in developing countries. The complexity and rapid growth of urban poverty accompanied by the deteriorating environmental conditions need serious attention and long term planning must replace adhoc decisions for implementing immediate solutions.

C. The Urban Environment

The urban environment enables one to gain a better understanding of the nature and magnitude of the problems affecting Indian cities and how these result in the deterioration of the urban environment. The city - a stage for a wide range of problems is also the silent audience of the consequences. Unfortunately, most of these problems rest beyond the perceived or real mandate of municipalities jeopardising any interventions with any real impact

on the health and quality of life or those averting further damage to urban environmental degradation. (Sivaramakrishnan 1993)

Around 39 to 43% of India's slum population is distributed in the metropolitan cities of Calcutta, Bombay, Delhi and Madras. Slum densities are around a national average of 243 persons/hectare. According to the 1983 task force Kanpur has the highest density of 1210 persons/ hectare while Delhi and Hyderabad have 638 and 525 respectively viz a range of 8-19 square meters of area per person in a slum. The NIUA 1988 study brought out data from twenty sample towns of various sizes revealed that about 50 percent of the slum population lives below the poverty line. The study also shows that 80 percent of the per capita expenditure of slum households below the poverty line is on food alone, excluding pan and tobacco, fuel and electricity.

Some major problems arising in such a context relate to inadequate water supply and sanitation, solid waste disposal, rights over land tenure, inadequate food supplies and increasing demand for employment and social services.

In 1985 nearly 27.1 percent of the urban population had no access to safe water and 71.6 percent was reported to be without basic sanitation. As can be seen in Table 4, in absolute numbers it is estimated that nearly 47 million people in urban areas are not covered by safe water supply, 124 million are without basic sanitation and 49 million (over 5 Years) are without schooling (Mathur O. P 1993).

The city - a stage for a wide range of problems is also the silent audience of the consequences. Unfortunately, most of these problems rest beyond the perceived or real mandate of municipalities jeopardising any interventions with any real impact on the health and quality of life or those averting further damage to urban environmental degradation.

With the rising densities of slum populations more than 90% of the slum households do not have access to individual latrines. A study done by the Centre for Science and Environment in 1985 showed that more than 40% of the slums in cities are waterlogged giving rise to intestinal, respiratory and skin diseases. The All India figure (NSSO 1987) displays that 36.82% households are without a latrine facility. Undoubtedly, a large majority of the households which do not have latrines

TABLE 4. Levels of Urban Deprivation							
	Not covered by water supply 1985	Without basic sanitation 1985	Without schooling (+5 years) 1981	Without any employment 1987-88		Without any regular employment 1987-88	
				male	female	male	female
Percentage of urban Population	27 1	71 6	35 2	6 1	8 5	14 6	25 0
Number of persons (million)	47 3	124 9	49 1	4 6	–	–	–

Reference (Mathur O P 1993)

belong to the lower socio-economic and slum populations. Among the households which have some type of toilet/ sanitation facility 57.6% share it with others, a large proportion of these are obviously slum dwellers.

In the early 1980s the concern for **water supply and sanitation** led to the adoption of the Master Plan for the Water Supply and Sanitation Decade. Many ambitious targets were fixed to provide these services to the urban areas with special provisions to extend these to the fringe areas, however these were not accompanied by allocation of resources or efforts to strengthen the existing delivery system and ensure it's better management. The per capita cost of implementation of the Environmental Improvement of Urban Slums programme is estimated at Rs 500 crores. In the mid 1980s when the slum population was estimated at around 40 million the Seventh Plan allocation for funds should have been 2,000 crores. The actual outlay however is only Rs 27 crores. As a result the access particularly of the poor to water supply, proper sewerage and sanitation at the end of the decade remains largely unchanged.

It is well known that the better off urban population in a few metropolitan and Class I cities of our country manage to have access to the **sewerage facilities.** Although the underground sewerage system is the best and most hygienic method of disposing sewage and sullage water, only 12.18 percent of the towns in selected states have this facility (1981 census) while only a small section of this population is being covered (refer Table 5A & Table 5B). Most towns depend on open surface drains (OSDs) for disposal of waste water which in the absence of proper maintenance pose a major threat to environmental health (Kundu 1993).

According to a survey conducted in 1988 by the Central Pollution Control Board, only 71 of the 212 Class I cities (population of over 1 lakh) had sewer systems. Cities with sewer population only provided coverage to about 60% of their population; State capitals of Lucknow and Jaipur had no sewer systems. Of the 6.5 billion litres of sewage generated daily in

TABLE 5A. Percentage Distribution of Towns by Classes and

Class of Towns/States	Class I				Class II			
	No. of Towns	% of Towns with			No. of Towns	% of Towns with		
		BSD	OSD	S		BSD	OSD	S
1	2	3	4	5	6	7	8	9
Andhra Pradesh	21	-	95 24	21 42	33	-	95 62	24.24
Bihar	14	21 43	92 86	21.42	25	8 00	100 00	-
Gujarat	11	-	36.36	63 64	27	-	51 85	51 85
Haryana	9	-	88.89	88 89	7	-	71.43	85 71
Karnataka	14	7 14	92 86	85 71	16	37 50	75 00	31.25
Kerala	6	-	50 00	50 00	8	-	25 00	62.50
Jammu & Kashmir	2	50 09	100 00	-	0	0 00	0 00	0 00
Maharashtra	29	6 89	96 55	13 79	25	16 00	96 00	8 00
Madhya Pradesh	14	57 14	100.00	-	27	25 92	100 00	-
Manipur	1	-	-	-	0	0.00	0 00	0 00
Orissa	6	16 62	100.00	33 33	0	12 50	100 00	-
Punjab	7	-	100 00	100 00	10	-	100 00	80 00
Rajasthan	11	-	100 00	18 18	10	-	100 00	-
Tamil Nadu	21	9 52	71.43	23 81	41	2 44	92 68	4 88
Uttar Pradesh	30	13 33	90.00	46 67	38	10 53	100 00	15 79
West Bengal	24	33 33	91.67	37 50	40	17 50	85 00	10 00
Total	220	11 60	87.22	41.36	307	10 15	88 57	19 04

Source: Based on date from Census of India (1981)
Note: BSD = Box Surface Drains OSD = Open Surface Drains S = Sewerage

Types of Sewerage/ Drainage Facilities in Selected States, 1981

Class III				Class IV & Below				All Towns			
No. of Towns	% of Towns with			No. of Towns	% of Towns with			No. of Towns	% of Towns with		
	BSD	OSD	S		BSD	OSD	S		BSD	OSD	S
10	11	12	13	14	15	16	17	18	19	20	21
91	-	95 60	25.22	107	-	86 91	30.84	252	-	92.86	31.35
75	4 00	100.00	4 33	106	3.77	100.00	3 77	220	15.45	99.55	3.64
56	-	46.43	30 36	160	2 50	58.62	21.25	254	1.57	77.65	28.33
15	-	80.00	66.67	50	-	88 00	20.00	81	-	85 10	41.97
71	28.17	88.73	8.45	180	21.67	91.11	7 78	281	23.49	89.68	13.17
64	1.56	15.62	26.56	28	-	10.71	10.71	106	-	16.98	26.41
5	40 00	100.00	-	51	13.72	98 84	-	58	15.52	98.27	-
89	2 25	95 00	3.37	164	3.66	92.68	4.87	307	4.56	94 14	5.54
48	-	97.92	-	2.38	-	94.54	-	327	4 59	95.72	-
2	-	-	-	29	-	-	-	32	-	-	-
26	-	92 30	15 38	68	4.41	76.47	8 82	108	4.63	84 26	11.11
27	-	96.24	77 72	90	-	98.89	4.11	134	-	98.51	54.48
55	-	96 36	1 82	125	-	95 20	4.80	201	-	96 10	4.48
89	-	79 77	3 37	2 83	1 06	78 09	4.24	434	1 38	79 49	5.07
98	2 01	94.90	9 78	538	0.74	99 07	3 90	704	1.99	98.15	7.09
52	5.77	84 61	2.69	175	-	66 28	2 28	291	6.87	74.25	7.22
863	5.82	83 54	15.78	2392	2 90	85 61	8.02	3790	4 35	83 44	12 18

TABLE 5B. Statewise Urban Population Coverage by Sanitation Services (Sewerage/Drainage). 1985		
States	**Urban Population coverage (Percemtage to total)**	**Below (-)/above (+) average**
Andhra Pradesh	10 9	–
Assam	15 7	–
Bihar	22 9	–
Gujarat	38 0	+
Goa	13 3	–
Himachal Pradesh	13 7	–
Haryana	28 4	Average
Jammu and Kashmir	7 7	–
Karnataka	38 4	+
Kerala	28 2	–
Madhya Pradesh	7 8	–
Maharashtra	39 8	+
Manipur	0 8	–
Orissa	9 5	–
Punjab	48 5	–
Rajasthan	9 6	–
Sikkim	32 9	+
Tamil Nadu	47 5	+
Tripura	13 2	–
Uttar Pradesh	14 1	–
West Bengal	19 5	–

Source: Mid term review of water supply and sanitation decade Ministry of Urban Development Govt. of India 1985

While employment may not be a major problem in urban cities like Delhi, housing is.

Sulabh International : Some Experiences

Sulabh International, is a low cost sanitation initiative, originally registered in 1970 as Sulabh Sauchalaya [illegible] access to sanitation, the initial [illegible] was the conversion of dry, traditional latrines into hand flush [illegible] latrines. It [illegible] extended to the construction of "pay and use" public toilets. Sulabh [illegible] over [illegible],000 private latrines and about 2,500 public latrine complexes in [illegible] towns in [illegible] states of India. In New Delhi itself, the [illegible] public complexes which [illegible]. In addition to the toilets, presently cater to [illegible] men and women daily.

The primary activities of Sulabh Sauchalaya include:

a) Construction of Community and individual Latrines along with the site selection for easy access based on community and individual needs

b) Education of local public and community members about the latrine construction process and the importance of sanitation facilities with regard to personal health and the urban environment

c) Information campaigns

d) Training of Scavengers to undertake new vocations

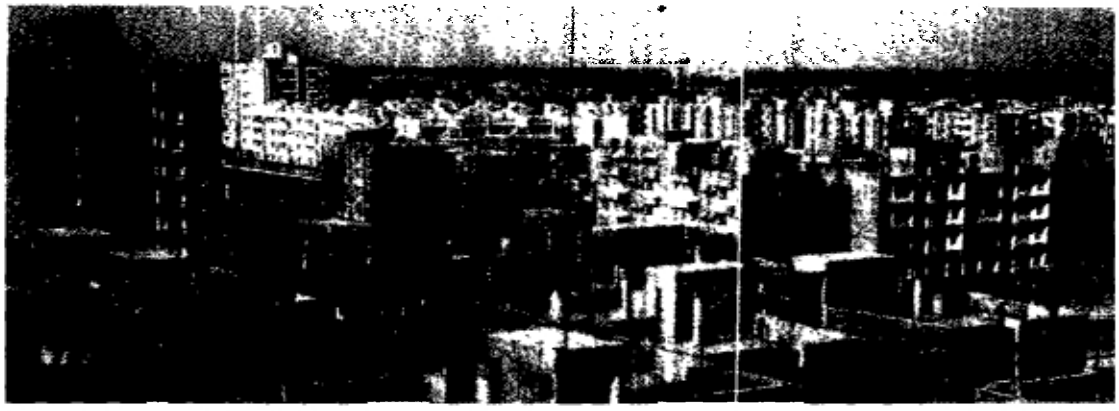
e) Maintenance of latrines when required (upto a period of 30 years for public latrines and repairs of private latrines upto a period of [illegible] years through the issuance of a guarantee card)

Lessons Learnt

Based on their experiences the following conditions can be identified as important for the transfer of Sulabh technology to a new urban context:

- Preparedness of community for acceptance of Sulabh technology
- receptivity to the concept of provision of these services by the NGO
- Extent of willingness of slum communities to share public latrine facilities and the recognition of their cost - effectiveness
- Availability of suitable sites based on needs and local traditions and norms and the chances of land donation
- Setting up of a suitable institution for strategic planning and effective implementation at reasonable cost with good rapport with residents, government and financial institutions.

The Sulabh initiative has a special significance for mega cities with their rapidly expanding populations and explosive growth rates (HUDA 1990). However, the administrative charges often become an additional burden on the beneficiary and the local body. Sulabh International charges 15-25 percent of the project cost in the case of individual latrines and 20 percent in the case of community latrines as their administrative cost. 20 percent of the project cost, including [illegible] has to be paid in advance and the rest within [illegible] months of [illegible]



Soaring above the fetid streets, sun-splashed luxury apartments - worth lakhs of rupees

the 12 major metropolitan cities only 1.5 billion litres were collected (Central Pollution Board 1991).

Under different urban schemes, low cost sanitation facilities have been extended to the urban population with 50% of the cost as a grant and the remaining as a loan at a low rate of interest. This still remains beyond the reach of the majority of the urban poor and the recovery of the implementation charge or the loan has been very poor. The recovery rate has risen when private organisations or NGOs such as Sulabh International have taken up the construction and maintenance jobs. (See Box 1)

The city is thus a stage for a very diverse range of problems and the silent audience of the consequences. The recent 'Plague' epidemic provides a glaring example of the repercussions of environmental sanitation and breakdown of essential public health facilities in small towns and growing cities. The urban environment enables one to gain a better understanding of the nature and magnitude of the problems affecting Indian cities and how these result in detrimentally affecting its deterioration. The urban slum environment, characterised by overcrowding, poor environmental sanitation, occupational hazards caused by small industries, violence and stressful occupations together with a lack of space for children's recreation, can be particularly detrimental to those in the younger age groups. Exploitation, abuse, maltreatment are part of the lives of worker children. The adverse effects of hazardous exposures related to occupations on children in selected urban slum areas in the country which are particularly vulnerable calls for further study.

For new migrants, the traditional extended family is replaced by the nuclear family and the changes of social structures increase their vulnerability. Single-parent households headed by women produce limited child care, children are often pressed to work to improve household income, at very young ages or to take care of smaller siblings while the mother is absent.

Housing

The Task Forces on Urban Development as also the Sixth and Seventh Five Year Plans have quite explicitly pointed out the inability of the government to provide minimum housing to the poor. According to the **Planning Commission (1983):** 'One of the key challenges for urban policy over the next couple of decades will be a search for means to provide for the possibility of giving access to the poor to adequate shelter.' The urban poor have very low paying capacities for the provision of housing, water supply and sewerage facilities and thus involves large government subsidies which are non existent. An important reason provided was the shortage of resources. **The Planning Commission in 1980 pointed out that:** 'In view of the severe constraints of public resources, the resources of institutions like HUDCO and state housing boards will need to be augmented to enable them to provide infrastructural facilities as a means of encouraging housing in the private sector.'

Many urban development programmes were thus launched in the 1980s with shelter, water supply and sanitation as major components. An overview of these urban development programmes which sought to reach a substantially larger segment of the uncovered population than the other formal programmes on housing and basic services can be referred to in Table 6.

Under the Basic Services Programmes only services are provided in deficient slum areas or settlements without altering the physical structure of the houses. The Shelter-cum-Services Programme makes available serviced land, security and basic services. The programmes under the Shelter-cum Sevices programme were initiated by the Central Government with funds provided by the apex public sector institutions like HUDCO as also from the World Bank. Initiatives and responsibility for the implementation of these programmes still lies with the State governments (housing boards, slum clearance boards and others) and as a result are taken up in only some states. The Basic Sevices programme however is spearheaded by the central government directly and hence to have a wider coverage.

Illegal occupation ('invasions') of public unproductive lands as well as Legal rights over land tenure imply the further development of squatter settlements. The lowest quality housing is generally found in slum communities in which the threat of eviction reduces the incentive to invest in house improvements.

D. Primary Health Care and the Urban Poor

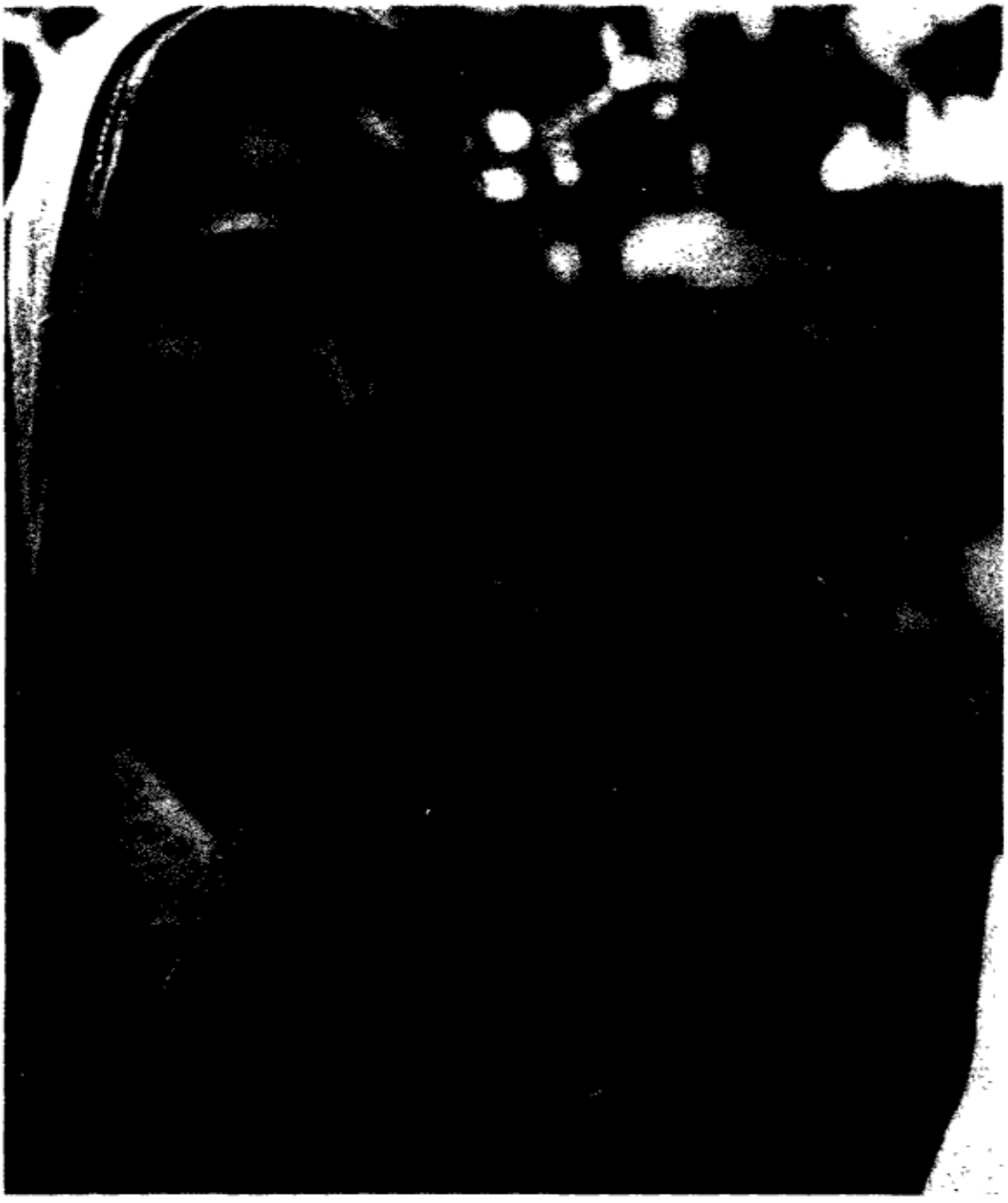
It is possible to understand urban primary health programmes as a 'set' of health and non health activities that include promotive and preventive health together with curative aspects, water sanitation and environmental improvement programmes,

TABLE 6. Details of the programmes for shelter and basic services

Programmes	Components	Financing Agencies	Mode of Finance
I Central Sector			
(a) Basic services			
(i) Environmental improvement of urban slums(EIUS)	(i) Water Supply (ii) Sanitation	(i) Central govt (ii) State govt	Grant
(ii) Urban Basic Services(UBS)	(i) Water supply (ii) Sanitation (iii) Health (iv) Education	(i) Central govt. (ii) State govt. (iii) UNICEF	Grant-cum-loan
(iii) Urban community development(UCD)	(i) Water Supply (ii) Sanitation (iii) Health (iv) Education (v) Shelter (vi) Employment	(i) Central govt. (ii) State govt. (iii) Local authority (iv) Overseas development administration	Grant-cum-loan
(iv) Special schemes	(i) Water Supply (ii) Sanitation	Central govt. (PM's fund & ninth finance commission)	Grant
(b) Integrated development of small & medium towns(IDSMT) development (v)Commerical development	(i) Water supply (ii) Sanitation (iii) Shelter (iv) Industrial	(i) Central govt (ii) State govt	Loan
II Outside Central Sector			
(c) Low-cost Sanitation	(i) Sanitation (ii) HUDCO (iii) World Bank (certain schemes by central govt)	(i) State govt	Loan-cum-grant
(d) Shelter-cum-basic services			
1 Sites & Services	(i) Water supply (ii) Sanitation (iii) Shelter (iv) World Bank	(i) Central govt (ii) State govt. (iii) HUDCO	Loan
2 Slum improvement and upgradation			
(i) SIP-I	(i) Water supply (ii) Sanitation (iii) Health (iv) Employment	(i) State govt. (ii) Local authority	Grant
(ii) SIP-II	(i) Water supply	(i) HUDCO	Loan-cum-grant
(iii) SUP-I	(ii) Sanitation	(ii) World Bank	
(iv) SUP-II	(iii) Shelter		

Reference: Kundu (1993)

communication and income generation activities. It may or may not be a process that is a part of wider urban community development programmes including community organisation, planning and implementation (Urban Examples 1983).



Arriving in urban cities with a little more than dreams, some hit it big While thousands of others - like this woman and child - suffer from poverty, starvation, medical and social diseases.

Inadequate out reach of public health care delivery system, drives a poor man to carry his ailing wife on his shoulders - But Who Cares !?!

Although the health services delivery system is concentrated in the urban setting this area presents a great resistance to any fundamental change in Primary Health Care. There is a lack of understanding of Primary Health Care on the part of medical professionals and hospitals. The actual implementation of Primary Health Care in urban areas is wrought with special problems :

- The heterogeneity of urban populations has proved a major obstacle to urban development. Individualism and a sense of collective responsibility is low as compared to rural areas.
- Voluntary efforts are less common partly due to this and the fact that households are headed by single parents crucially dependent on cash incomes.
- A multiplicity of agencies are

involved, both government and NGO, in health care provision making any form of coordination more difficult.

- It is the poorer sections of the urban population do not have access to primary health care. Vested interests come not only from medical professional but also the public and politicians.

Major Health Problems

There is a need to redefine health in the context of the urban poor. Rossi-Espagnet (1984) summarizes the condition of health in urban poor areas of developing countries as follows:

'The urban poor are at the interface between underdevelopment and industrialization and their disease pattern reflects the problems of both. From the first they carry a heavy burden of infectious diseases and malnutrition, while from the second they suffer the typical spectrum of chronic and social diseases'.

Health problems in the urban poor are practically determined by 3 main group of factors which act synergistically:

- direct problems of poverty: unemployment, low incomes, limited education, leading to prostitution, inadequate diet, malnutrition, lack of breast feeding, etc.
- environmental problems: already described, leading to infectious diseases (air and water-borne), accidents, etc.
- psycho-social problems: stress, alienation, instability and insecurity, leading to depression, smoking, drug addiction, alcoholism, abandoned children, etc. (Harpham 1988)

Major health problems identified in poor urban areas of developing countries could be summarized as follows: diarrhoeal diseases, respiratory diseases, infectious diseases prevented by immunization, malnutrition, tuberculosis, malaria, gynaecological infections, sexually transmitted diseases, socio-psychological problems: drug addiction, alcoholism, home violence, child abuse, etc. HIV/AIDS is emerging as an important problem that is fast spreading is a potential threat to public health, not only by its biological but also its economic and social consequences (Nabarro 1989).

Urban Health Care Delivery System

The existing model of health infrastructure is an expansion of that in rural areas viz. control of communicable diseases, MCH and family planning. By its very design it is biased in favour of public sector employees, workers in the organised sector and persons in the high income categories. About 48 percent of the urban poor go to private doctors and another 12 percent to private hospitals for outpatient treatment. Long distances and waiting hours as well as the attitudes of medical professionals' have been found to discourage them from using public hospitals (Kundu 1993).

The ground reality of multiplicity of agencies providing health care to the more opportune populations and the scores of existing private medical practitioners makes the present urban health care system a complex one. In the urban setting secondary and tertiary care is provided by a multiplicity of agencies viz. the medical college hospitals, voluntary and private hospitals and almost 30% of the available private practitioners in the country.

The health infrastructure in the public sector includes the: State Government Primary Health Care centres: PHUs established on the rural PHC pattern, industrial hospitals, ESI dispensaries and hospitals as part of the Employees State

Box 2

Urban Basic Services for the Poor

The Government of India centrally sponsored Urban Basic Services for the Poor Scheme has the important objective of providing social services to the urban poor in a convergent manner along with physical amenities to be provided through the state sector scheme of Environmental Improvement of Urban Slums (EIUS). The programme originally launched in 1985 in collaboration with UNICEF by combining three existing UNICEF supported programmes i.e. Urban Community development, Small and Medium Town Development and Low Cost Sanitation. By the end of the Seventh Plan, the programme was modified to include only the social elements excluding the physical inputs for sanitation facilities. It is proposed that the scheme will enable the urban poor to have access to basic social services including non formal education, health care and nutritional supplementation with special emphasis on women and children.

The Urban Basic Services for the Poor (UBSP) attempts to integrate water supply and sanitation services and other community development schemes with basic health care. It is thus not an exclusive health programme and aims at improving the social and economic conditions of the slum dwellers by providing a minimum level of basic services. The objectives of the scheme are to foster neighbourhood development committees in slums to ensure effective participation in developmental activities and for coordinating the convergent provision of social services, income generation activities and physical facilitates in slums through various programmes including ICDS, promotion of basic primary education programmes, adult education programmes, non formal education etc.

Major UBSP challenges that need consistent and long term attention include an accurate Community Need Assessment, effective Convergence Processes, Capacity Building by Training Community Volunteers, Interagency coordination and Community Participation through community organisation with slum populations.

Insurance Scheme particularly in larger cities and towns with a large industrial sector and the urban health and family welfare centres (UHFWCs) run by the city Municipal Corporations. All these except the latter provide essentially curative services and do not have outreach services for slum populations. The UHFWCs in most large cities has a theoretical coverage of 50, 000 focuses exclusively for maternal and child health and family planning services and is staffed by One Medical Officer and ANMs (1ANM/5000 population) (Sahni and Xirasagar 1993).

Rapid urbanisation with the present degradation in environmental conditions and changing life styles has seriously eroded the patient doctor relation which constitutes the core of the health care system in this country. Child Welfare Centres and the Juvenile Service Bureaus run by the Dept. of Women and Children's welfare exist in certain large cities. However the needs for outreach family and community services for prevention and rehabilitation of health problems arising out of the complex psycho social environment e.g. drug abuse, alcoholism, prostitution also need to be provided for.

Substantial restructuring in the organisation of the public health care delivery system and improvement in its quality are necessary to make it more sensitive to the urban poor. A better quality of services could be ensured if both the rich and poor are dependent on the same system (Kundu 1993).

Local and national governments have been unable to deal with these problems because their political and technical approaches, lack of skilled manpower and scarcity of financial and managerial resources. Central to this is the weakness of municipal and city governments and the poor available infrastructure. The problems have been further compounded by declining public investments in basic services and inappropriate models of interventions.

E. The Present Scenario: Government Schemes & Intervention

Given the present influence of structural adjustment within the framework of the liberal politico-economic order urban interventions for the provision of basic amenities i.e. drinking water, housing, sanitation and sewerage facilities, health care and the distribution of essential commodities through the public distribution system become crucial (Kundu 1993).

Our 74th amendment represents the culmination of this prolonged debate and seeks to promote strengthening of municipal authorities so that they acquire the institutional capability to deal with the problems created by urbanisation and urban growth. However, despite an increasing demand for services due to urbanisation and urban growth the local resource base has been shrinking. The share of Municipal authorities in the total public sector expenditure declined from 8% in 1960-61 to about 4.5% in

Box 3

The Kerala Experience

The new model of development evolved in Kerala enables successful operatinalisation of anti-poverty programmes by the poor themselves. Planning and implementation of newly created structure called the Community Development Society (CDS) which is a formally registered Society of women from the poor families within the jurisdiction of the Nagarpalika/Panchayat.

In Alleppey and in twelve other towns in Kerala this model has been successfully operationalised and is in the process of expansion to all 37 towns and one entire district of Malappuram covering both rural and urban population.

Poverty eradication is the goal and poverty is defined in an alternative way on the basis of Risk Index called the poverty index. High risk (poverty) is defined as the presence in a family of four or more of nine risk factors viz:

A familybelonging to Scheduled Caste or Tribe.
with children under five years old.
having even one illiterate adult.
with only one or no adult employed.
living in kutcha house.
without a household latrine.
with no access to safe drinking water.
consuming only two meals, sometimes one in a day.
with an alcoholic or drug addict.

Kerala's programme to better the lot of the poor has, to a large extent, been successful. This is mainly because the task of implementing the anti-poverty programmes was given to the people themselves.

The poor families who are identified by the community members themselves are found to be at high risk of hunger, malnutrition and ill health. This correlation has been established by an in-depth sample study in which the index was found to be significantly associated with malnutrition among children below 5 years (weight for age) and women in the age group 15-45 years (height and weight) and with family illness and deaths.

A poverty index is a simple tool that can be used by local community members with even very little education. The index analysis of each family gives a clear picture of what are the needs of the family and what specific package of interventions are needed. Planning of activities is made easier and more effective by this.

The organizational structure of the CDS provides a community administration system that enables women from poor families to plan, implement and monitor programmes for their own benefit. The CDS structure is a three tier system. The basic unit is the Neighbourhood Group consisting of women from 25-40 families. This group is represented by an elected five member committee. At the ward level, the women from high risk families from the membership of the Area Development Society (ADS). At the Town/Panchayat level, the Community Development Society (CDS) forms the apex body of which the ADS can be considered as its branches. The ADS and the CDS are each represented by elected committees/governing bodies. At NHG level, micro-plans are made based on analysis of local problems with the objective of eliminating the risk factors or reducing their impact. NHG plans are consolidated into Ward plans which are finally integrated to form the Action Plan of the CDS, called the CDS Town or Panchayat Plan.

The programmes for the poor are implemented by intended beneficiaries themselves. The CDS and ADS are empowered and authorised by the CDS bye-laws to directly approach and receive funds form Government, NABARD, Banks or other donors. The CDS and ADS maintain bank accounts are directly responsible for implementing all planned activities at Town and Ward level. At neighbourhood level, the NHG Committee is responsible for implementation.

The CDS are established as per the model bye-laws approved by the Government of Kerala. Funds are mobilised from donors such as UNICEF and from the banks and NABARD, and from the poor families themselves through beneficiary contribution and thrift and credit societies in addition to the pooling of resources under various existing anti-poverty programmes in the urban sector such as the Nehru Rozgar Yojana (NRY), Environmental Improvement of Urban Slums (EIUS), Urban Basic Services for the Poor (UBSP)

(An article by P K Gopinathan and V L Srilatha published in Hindu, April 2, 1995)

and Low Cost Sanitation (LCS) Projects etc.

Activities

The activities undertaken relevant to the three risk factors and the implementation of anti-poverty programmes, ensuring universal primary education for every child, assistance to the shelter upgradation, subsidy for housing and homeless, assistance for provision of safe water, elimination of leprosy and T.B. services, health and nutrition education, kitchen gardens, setting up of a foodgrain bank for better availability of food materials and several other activities.

The sustainability of the CDS is ensured in the following ways:

- The CDS being a formally registered society has institutionalized the empowerment process.
- The CDS bye-laws empower the society to approach and receive funds and resources directly from any source.
- The CDS is linked to the formal government and Local body system at the local and state levels and to national organisations such as NABARD.
- By being people centred and women centred, the CDS has generated a remarkable level of enthusiasm and energy and determination that clearly indicates the potential for sustainability.

The CDS has an in-built strategy for beneficiary contribution for activities. The initial and annual membership fees, the savings under the Thrift and Credit Society and Revolving Fund and the stipulation of beneficiary share for income generating schemes result in a sizable self generated fund for the CDS that can also ensure sustainability.

Great emphasis has been placed on training the CDS office bearers and members to develop financial, managerial, technical, oratorical and leadership skills for sustainability of the programme.

The innovations in Kerala that inspire a vision of national replication are the following:

- It is the existing formal agencies, the Municipality/Panchayat, the State Government and the banks which have actually created and strengthened the community based structure which has helped the poor identify their problems, generate their own resources and plan and implement their own programmes with very little overhead establishment costs. And it is this reason which makes the model replicable. It is not an impossibility at all to think in terms of creating one CDS in each and every Panchayat and Municipality.
- The programme is implemented as a women's programme for achieving the goals of improved health and nutrition status of families with focus on mothers and children. This programme is targeted to the family as a unit and incorporates all the basic concerns of the poor in their day to day living. By this approach political conflicts could be avoided and the programme has successfully kept away any influence of caste, creed, religion, politics and other divisive tendencies.
- There is legitimisation of the CDS by Government with a will to expand the programme state-wide. All issues pertaining to CDS have been analysed and recognised by the Government of Kerala, which has immediately responded with a strong commitment.
- The programmes and schemes of all concerned departments need to be targeted to the poor who are the members of the CDS, thus allowing optimum use of existing resources. To achieve this, the State Government should ensure convergence of all anti-poverty programmes. All departments concerned which are currently managing anti-poverty programmes need to be instructed to obtain beneficiary lists from the CDS and ensure that families on this list be covered. The IRDP, DWCRA, JRY, in rural areas and NRY, EIUS, UBSP and LCS programme in urban areas are to be brought under the scope of this decision. The CDSs are to be made responsible for monitoring and ensuring repayment of loans. The Kerala Government has set a precedent through statutory provision that funds from anti-poverty programmes such as NRY, EIUS, LCS and UBSP should be targeted to the CDS members. This bold decision has provided the necessary potential for resource mobilisation by the Community Development Societies and can be emulated by other State Governments.

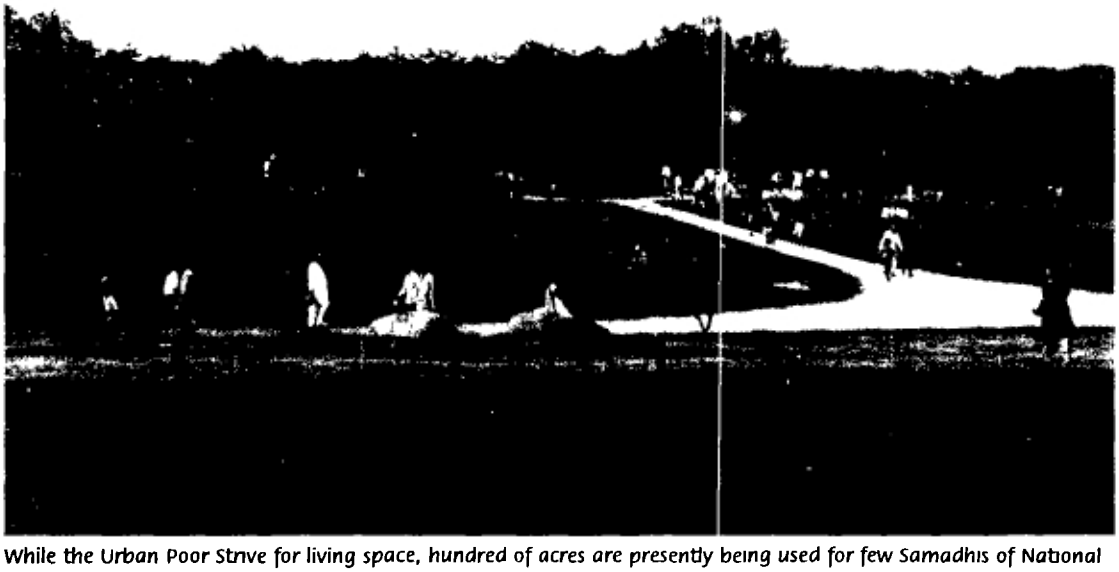
Kerala's programme to better the lot of the poor has, to a large extent, been successful. This is mainly because the task of implementing the anti-poverty programmes was given to the people themselves.

1977-78 with no evidence to suggest an increase thereafter obviously constraining the provision of services and their operational upkeep. Elaborate provisions have been made for initiating the planning process in the Panchayats, Municipalities and the urban settlements in setting up District Planning Committees but are wrought with practical difficulties. (Jha 1994)

Urban Community Development Strategies

To what extent do the development of local leadership, self help and people's participation in economic improvement influence living conditions and changes in health practices such as immunisation, family planning, personal use of nutritious and weaning foods. What are key factors responsible that lead to improved access to health and social services or even economic change?

Under the UBSP scheme, (See Box 2) collaboration with other urban development programmes like the Nehru Rozgar Yojana (NRY), Environmental Improvement of Urban Slums (EIUS) and Liberation of Scavengers through Low Cost Sanitation is an important principle. (Ministry of Urban Development 1994). Examples from the NGO sector constitute more innovative and effective solutions for this important challenge. Given below are two examples titled The Kerala Experiences and Urban Nutrition Project (See Box 3 & 4) which provide field insights into practical strategies and approaches to community development.



While the Urban Poor Strive for living space, hundred of acres are presently being used for few Samadhis of National leaders.

Box 4

Urban Nutrition Project

The multicentric 'Urban Nutrition Project' an integrated slum improvement (sponsored by IDRC-UNICEF) is being implemented in the cities of Bombay, Delhi and Calcutta. The community based initiative being presently implemented in the Village of Dharavi Domestic Slum in Bombay since 1991 with a population of over 1 lakh (100,000) will give important lessons on community participation in urban slum development. The intervention areas include health and nutrition, access to food, education, skill training and income generation by mobilising resources from community, government and NGOs. An important project objective is the improvement of health and nutritional status of slum families by enhancing access to nutrition and health services and improving utilisation through active community participation.

The initial challenges compare closely with others working with this target population and include:

- lack of collective responsibility among slum populations and negative perceptions of official bodies and representatives
- lack of community structures although there were interest groups which were polarised politically.
- Low status of women
- Lack of a common vision or cooperation

The project experiences have clearly shown that key strategies have revolved around mobilising community involvement to evolve self sustaining systems, capacity building of community workers and other slum women.

Capacity building of community workers has been an ongoing process of formal and informal orientation and training, meetings and project visits. This has helped them to undertake a variety of functions including assessment of problems through self survey, problem identification and prioritisation, resource mobilistion, monitoring and management. Support has been sought from local municipal bodies, existing government projects like the ICDS and the India Population Project V as well as NGOs. The need for collective action is one aspect which has become ingrained, as women began to work towards a community structure and adolecent girls realised that they are not helpless and that their situation is not 'hopeless'. The Mahila Mandal members today in 3 pockets serve as guides and liaison persons to access services and programmes which range from the Jawahar Rojgar Yojana/ Sanjay Gandhi Niradhas Yojana to Dedication services for alcoholics and child spacing services. Some of these women have started sewing classes for girls (with no demands for project funding) as well as a food outlet.

The women clearly perceive that women's empowerment and a social support network to achieve this will help in the long run. Through these structures the project team is now hopeful that the community will undertake independent problem analysis and appropriate action in the next phase.

Excerpt from an article contributed by Dr Shobha A Udipi, Programme Coordinator, Dept of Postgraduate Studies and Research in Home Sciences, SNDT Women's University, Bombay

Resource Allocation & Repercussions

Only 2% of the total government expenditure is allocated to the health sector which is obviously ranked as a very low priority. This is also reflected in the urban health sector. The per capita expenditure on health in India is only Rs 21 of which 75% is spent on medical colleges and large hospitals. For example, in Delhi's approved plan outlay for 1992-93 of Rs 20 crores, health is the last amongst the six priorities.

The hardships and inhuman existence that the urban poor encounter as part of their daily 'existence' are important forces that drive this section of the urban population to extreme measures and socially unaccepted forms of behaviour.

According to the Delhi Quarterly Digest of Economics & Statistics, Bureau of Economics & Statistics, Delhi Administration, for the next five years Energy retains top priority (275 crores), with General Education being Rs 72 and Health as only Rs 65 crore.

The appalling inequalities in the distribution and access of the basic amenities and services for the urban poor are obviously linked up closely with the maldistribution of resources. Over 55 percent of the country's gross domestic product accrues from the urban areas. Although the share of urban areas in experts, financial and trade transactions, manufacturing output and providing services are equ-alling significant, the benefits are certainly not shared by the urban poor who contribute significantly to the economy. The inadequacy of the urban administration to cope with the pressures of urbanisation is reflected in serious deprivation of the urban poor.

Forms of deprivation range from the absence of adequate employment opportunities to adequate shelter and absence of adequate access to water supply, sanitation and other health and education services (Mathur 1993).

In the city of Delhi for instance there is a tremendous shortfall between the requirements and the reality of services provided (Table 7). While the urban poor are striving for living space, there is a total of 300 acres that is presently being used for the Samadhi land with a future estimate of 115 lakh acres reserved for future samadhis. The annual expenditure on maintenanceand landscaping of these samadhis incurred by the Public Works Department has been estimated at Rs 50 lakh!

The other important 'left outs' in a city like Delhi with an estimated 9,370,475 population include the Child

TABLE 7. Existing shortfalls under various services in Delhi - 1993

Water	
Existing capacity of Water Supply (in million gallons a day)	444 3 MGD
Present requirement at the norms of 70 gallons per capita a day	700 MGD
Present shortage of water supply	255 6 MGD
Sewage	
Present generation (in million litre a day)	1700 MLD
Installed capacity of Sewage Treatment	1270 MLD
Untreated Sewage	430 MLD
Electricity	
Present power demand (in megawatt)	1700 MW
Generation of power by DESU	375 MW } Total 850 MW
Thermal Power Station	475 MW }
Shortfall	850 MW
Losses suffered by DESU approx	Rs 2000 crores
Total number of consumers	18 lakh
Housing stock (1989)	
Number of households in Delhi	11 6 lakh
Estimated current housing stock (including those in the slum, squatter, unauthorised colonied)	16 lakh
Shortage of Dwelling Units (DUs)	4 40 lakh
Shortage of DUs by 1995	8 25 lakh
Villages without sewage	
Total urban villages	108
Villages connected with functional sewage	83
Village without sewage	25
Milk supply	
Milk requirement	25 lakh litres per day (llpd)
Milk supplied by Mother Dairy (set up in 1974, autonomous)	6 5 llpd
Milk supplied by Delhi Milk Scheme (set up in 1959, state owned) (Accumulated losses of over Rs 200 crore till 1991)	4 5 llpd
Organised private sector and other stae cooperatives	4 llpd
Shortfall	10 llpd

(VHAI 1993)

Workers (41 lakhs-UNICEF estimate) mentally retarded (2.6 lakhs), Visually handicapped (1.5 lakh) (WHO estimate) and mentally ill (1 lakh) (Table 8). This city ranks second in India in criminality. Among the metropolitan cities Delhi ranks Number One in murder, attempted murder, rape, kidnapping, abduction, theft, criminal breach of trust and cheating (VHAI 1993).

The hardships and inhuman existence that the urban poor encounter as part of their daily 'existence' are important forces that drive this section of the urban

TABLE 8. Incidence of cognizable crimes (IPC) under different crime heads in four major cities

Cities	Murder			Attempt to commit murder			Rape			Kidnapping and abduction			Theft			Criminal breach of trust			Cheating		
	a	b	c	a	b	c	a	b	c	a	b	c	a	b	c	a	b	c	a	b	c
Delhi	417	4 9	1	438	5 2	1	195	2 3	1	767	9 0	1	12587	148 4	1	515	6 1	1	1331	15 7	1
Bombay	473	3 7	2	261	2 0	2	114	0 9	2	332	2 6	2	16201	127 1	2	687	5 4.	2	1255	9 8	2
Calcutta	92	0 8	4	149	1 4	4	17	0 2	4	110	1 0	3	6899	62 8	4	322	2 9	3	584	5 3	4
Madras	81	1 5	3	118	2 2	3	26	0 5	3	24	0 4	4	6135	113 6	3	126	2 3	4	394	7 3	3
Bombay Calcutta Madras (Combined)	646	2 2	–	528	1 8	–	157	0 5	–	466	1 6	–	29235	101 3	–	1135	3 9	–	2233	7 8	–

A = Number of case B = Volume of total cognizable crimes incidence per lakh of population C = Ranking

National Crime Records Bureau - 1991

population to extreme measures and socially unaccepted forms of behaviour. The large gap between the urban poor and others in cities cannot continue.

Half of Bombay's population live in ramshackle huts or like this - on the streets

Essential amenities that should be provided to the urban poor can no longer be neglected and constitutes a vital challenge for urban planners in the forthcoming years.

F. Future Challenges

The future challenge in developing viable urban health programmes lies in the increased self reliance among communities especially the poorer sections of slum populations in selecting priorities, their involvement in multi-sectoral interventions and greater accessibility to better quality health services.

◆ More innovative and systematic methods are required for the identification and understanding of urban poor populations to target and gauge the effectiveness of these interventions. Approaches that have been found effective need to take into consideration the heterogenous and migratory nature of urban slum populations. The use of

Building roofs with Delhi's only inexhaustible resource - TRASH

qualitative approaches actively involving slum communities have been found useful and have included mapping and other participatory methods for need assessment as well as the involvement of neighbourhood groups and other community structures. These approaches need to be developed further and incorporated into ongoing government programmes on a larger scale.

◆ Glaring differences between the urban poor and others in cities exist and need to be analysed more carefully. Interventions that focus upon the consequences of the underlying causes of ill health in order to solve health problems are in the long run much more significant than mere provision of services. In the urban context the multisectoral approach including water and sanitation, education, nutrition, housing, legal rights and income generation programmes becomes especially important. Efforts towards the coordination and convergence of health services and these programmes to reach the urban poor at the community level have been successfully demonstrated and have led

The inadequacy of the hardships and inhuman existance that the urban poor encounter as part of their daily 'existance' are important forces that drive this section of the urban population to extreme measures and socially unaccepted forms of behaviour.

to some visible changes. Their ongoing strengthening process and sustainability remains a challenge.

◆ The strengthening of the Community Worker movement in the Indian urban context presents another important challenge. Training strategies need to take into consideration the urban realities and the essentially intersectoral nature of their involvement. The role of community workers in the identification of the urban poor, formation and strengthening of community structures as well as participation in the community based monitoring and evaluation of programmes has been proved by several initiatives. Capacity building and training of community workers should be closely integrated with the more specialised professionals in community oriented interdisciplinary health teams with strong support and referral networks.

◆ Any policy that aims at improving the standards of the urban poor needs to address factors which are responsible for the manifest of diseases as well as the psychosocial dimensions. Policy formulation and planning in the health sector are weak at the city level. Compart-mentalised policies and the fractured and segmented services generating from them do not remove chronic urban deprivation. For any improvement within the urban health sector, a more comprehensive policy needs to include not only basic services but also land and housing issues, industrial and air pollution, crime and delinquency and mental and physical health.

◆ The strengthening of Convergence processes within each city, district and state could lead to better utilisation of limited resources. However this also requires the strengthening of municipal bodies, their involvement and formulation of area and city plans, capacity building and strengthening of management and accountability systems with a more realistic allocation of resources.

A search for a viable Partnership between NGOs and local government networks to reach the vulnerable sections of the populations in urban slums is certainly possible as has been demonstrated by ASHA, YUVA, UHCP and other examples in this document. This search to provide equitable access to health and other basic services has led to several innovations and community involvement strategies that have proved to be successful. Crucial factors and lessons from the NGO sector on why some project interventions are or are not successful need to be more widely shared and understood with the objective of adopting specific strategies on a larger scale. This will need a greater commitment and understanding about the needs of the urban poor and the potential that lies in their involvement in developing their own programmes.

Christina De Sa

❑

ACTION FOR SECURING HEALTH FOR ALL (ASHA)

ASHA a community health and development society is presently operating in 21 different slums of Delhi and covers an estimated population of 1,15,412. The health services provided to a single slum population in Dr Ambedkar Basti during the July 1988 Cholera epidemic have now expanded to encompass environmental improvement, housing upgradation, preventive and promotive health care.

The pioneering team led byDr Kiran Martin explained that despite the utter lack of infrastructure and funds during the first year, it was the sheer need of the cholera affected communities that challenged them the most. 'It was the slum people who were my biggest teachers' she says. Later in 1988, 15 women from the community were selected by some leaders and the ASHA team to be trained as Community Health Workers (CHWs). A slum development committee composed of the informal leaders and other interested members was formed to discuss and get involved in community development issues. The Delhi Development Authority's Slum Commissioner was instrumental in a large drain construction and provision of 4 deep bore wells with handpumps. These and other subsequent achievements including regular garbage disposal, road construction and the running of a Day Care Centre by the local Mahila Mandal brought about a measurable change in the slum population regarding health practices (especially preventive) promoted by ASHA and a greater confidence in their own ability to bring about change.

"It was the slum people who were my biggest teachers"

As a result of these and other similar interventions in other slum areas, Partnership with slum communities and collaborative ventures with municipal and government authorities with policy implications have been some important achievements of the project.

Partnership

Selection of Slum Area

Selection of slums areas for intensive activities are undertaken not only through close dialogue with the communities themselves but also with the local government authority. It is upon the insistence of either the community members directly or via the Slum Department that ASHA initiated

and expanded it's programmes in the area. This ensures that the selected slum land is not earmarked for some other use and therefore can be entitled to receive public services on demand.

Partnership between ASHA and the various government authorities has been quite extensive. Public authorities have provided health centres, community latrines, water points, roads, drains, building for the polyclinic and other facilities beyond ASHA's resources.

Partnership with Community

Mahila mandals are instrumental in working collectively to approach the public authorities and also ensure regular in the community. Other activities initiated by ASHA through the mahila mandals include Day Care Centres, health Sevices, Children's clubs, Non formal Education, Adult Literacy, Vocational Training. Collaboration with NGOs operating in the area or those who have expertise in the latter 3 programmes is sought through Mahila Mandals and comprises partnership in selected slums.

Progress made annually by project activities is monitored and reported to the Mahila Mandal representatives on a yearly basis and future priorities, tasks and challenges are discussed.

Environment Improvement

Water supply

With the help of municipal authorities water taps have been provided, tube wells dug and reservoirs constructed. As a result the number of households per water point in the project areas have decreased considerably. In fact it has been observed that the median households per water point is 67 with all but 2 of the areas it is presently less 102 to 156 a figure reported for Delhi slums in general (NIUA 1992). Vocational training programmes in most project slums include hand pump maintenance.

Waste Disposal

While only 46-88% of Delhi slums have a community latrine all selected project areas have at least one community latrine. In the past municipal authorities have been responsible for cleaning and maintenance of latrines with a charge of 25 paise for the use of the facility by community members. Presently the mahila mandals supervise the maintenance of latrines by outside contractors supported financially by the municipal corporation. Open defecation

Mapping of Slum Communities - A useful tool

by children and others is also strictly discouraged by mahila mandal and other community members.

Poor performance of cleaners are reported to management authorities by mahila mandals and ensures cleanliness and better utilisation of community latrines. These activities have been responsible for a city ordinance being passed that recommends this service in other areas in the city.

Surface water drainage and brick pavings have also been built in all areas. Municipal authorities have been approached to provide cleaners for collection of household wastes, keeping drainage passages clean. These municipal cleaners are supplemented by cleaners from within the communities whose salary is paid by them. Garbage bins have also been constructed by authorities and collection occurs on a regular basis.

Housing Upgradation Project

The slum upgradation project was initiated by the Delhi Development Authority Slum Wing Commissioner and jointly organised by ASHA and the community in two project areas.

It provides an example of a possible outcome that can be facilitated through political will and innovation.

A housing cooperative comprising community members was formed, the land was licensed to the cooperative for an annual fee and allocation of plots (12.5 sq meters/family) was carried out jointly by the community, ASHA and the DDA slum wing. Ownership of land plots was granted to women but not without some resistance from the male sections in the community. Low interest loans of Rs 5000/- were provided towards the construction of houses which was done by skilled labour from within the community with assistance from DDA engineers. On completion of the house the DDA slum wing also provided brick lanes, drains, water supply, community latrines and street lighting.

The housing cooperative formed in the two project areas in 1989 and 1991 respectively has now taken responsibility for all major decisions of programme implementation at the community level and also supervises community workers: cleaners and community health workers. Salaries of these workers are paid through monthly fees contributed by each family.

ASHA's slum upgradation project has been made possible by the unique relationship the NGO has with the DDA authorities and the urban poor and provide important lessons for future programmes. However the various stages of the community organisation process and the

period required is often underestimated and needs to be better understood by government authorities if expansion of such an initiative is desired.

Provision of Health Services

A four tiered referral system has been established through the Community Health Workers (CHWs), Health Centre, ASHA's polyclinic (Diagnostic centre) and Hospital.

ASHA's slum upgradation project has been made possible by the unique relationship the NGO has with the DDA authorities and the urban poor and provides important lessons for future programmes.

Community Health Workers often the informal leaders in the community are selected for a 3-4 month training by ASHA, responsible for preventive, promotive and curative care of upto 200 families in their zone. She receives an honorarium of Rs 350/month from ASHA which is supplemented by Rs 2 per case that includes dispensation of drugs (upto 10 essential drugs for common problems are used being provided free for charge from ASHA) as required. These CHWs who

A dynamic dialogue with Government officials holds the key to ASHA's progress

The Health Team at Kanak Durga Camp · ASHA

number around 46 in the 21 areas with a population of 1,15,412 are each accountable to a team leader (ANM or RNRM) who attends to referral cases as well as the family welfare and Under fives clinic at the health centre. The team leader also assists the physician during the weekly/biweekly general clinic and is assisted by 1-2 paramedical workers.

The facilitation of timely referral care remains an important role for health workers. Non participation of men in health services being provided and the curative bias, multiplicity of agencies providing health care and free services, Illicit Alcohol, Tobacco and Drug abuse coupled with increasing violence among communities and ongoing suspicion from local politicians comprise major challenges in community organising activities.

Tuberculosis Control

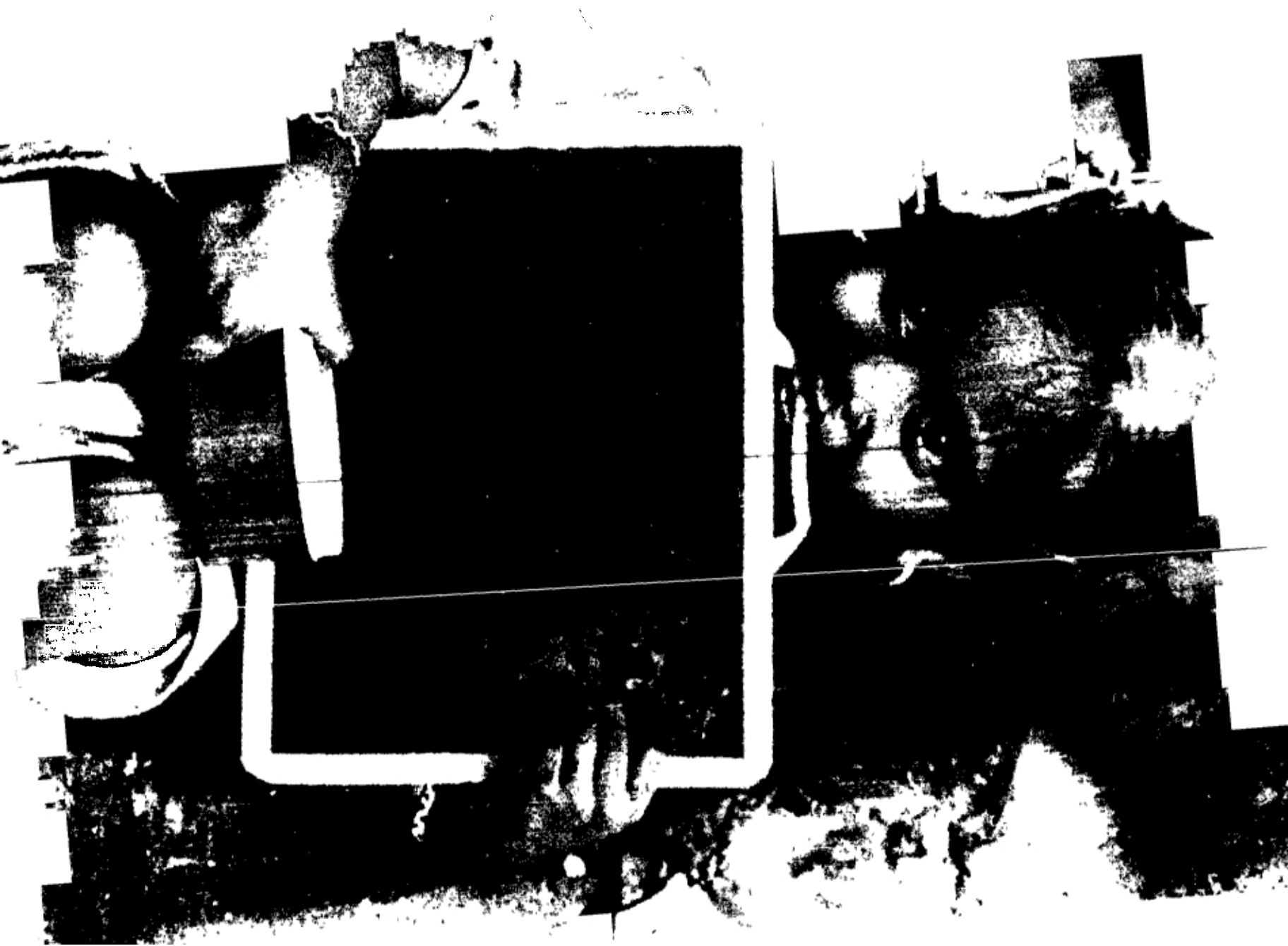
Case detection is the primary responsibility of CHWs. Suspected persons are first given a Mantoux test which if positive is followed by a chest X-ray at the Polyclinic. Each TB case is treated through weekly dispensation of

ugs at the health centre. If patients do not collect drugs personally home visits are made to follow-up and motivate them for drug compliance. Family members are also screened for the disease. In 1993 in the slum populations below 5000, 38% of TB patients have been brought to cure with a compliance rate found to be 49%. However in the project areas with a larger slum population the regular compliance rate is lower (37.5%) with only 17.9% of the patients having completed treatment.

In the Delhi slums non specific fevers has been reported as the most common complaint followed by diarrhoea and respiratory diseases (Vishwakarma 1993). A recent morbidity survey in Kanak Durga revealed a substantial decrease in acute respiratory illnesses. In Devi Nagar a control area without ASHA's intervention, diarrhoea, acute respiratory illnesses and fever comprise 83% of all illnesses in contrast to 52% in Kanak Durga where the health programme was initiated in 1990. Better environmental conditions and regular garbage disposal, improved water supply and latrines and persistence by the CHWs with regular visits and preventive health care have resulted in better community awareness and has no doubt contributed towards these findings.

Although the beneficiaries of ASHA's programme will bear only part of the programme costs, substantial capital contributions from public authorities, NGO participation and community beneficiaries have minimized programme costs.

Although the beneficiaries of ASHA's programme will bear only part of the programme costs, substantial capital contributions from public authorities, NGO participation and community beneficiaries have minimized programme costs. (Booth 1994) Several important factors in the ASHA project areas can be considered responsible for enhanced coverage and an effective referral system such as a manageable ratio of households per CHW, close and regular supervision by team leaders, close proximity of populations, a computerised information system that enlists target populations (pregnant women and under five children) and monitors coverage, easy transportation within the city, trained and committed health personnel and an efficient diagnostic centre at the third level.



YUVA

(YOUTH FOR UNITY AND VOLUNTARY ACTION)

Evolution and Structure

Formally started in August 1984, YUVA is committed to organising and empowering people in the poor urban sections of society for the struggle against injustice. Their approaches developed over a decade emphasise the development of a movement that would be a catalyst for social transformation.

YUVA's initial activities were directed at the community organisation project in a geographical slum area taking up the issues of communities: Basic amenities: sanitation, ration supplies, increasing accountability of existing political structures etc.

Today a decade later the organisation has evolved a multi issue approach based on a decentralised structure that is rooted in an ongoing process of dialogue and reflection to evolve responses and strategies to current issues and problems.

Activities

Presently activities among over a 10,000 population with 34 Slum Pavement Committees are in place with extensive activities in Jogeshwari, Ghatkopar and Dharavi slum areas and contact programmes in other areas. During the 1990 action reflection process which emerged out of a search for relevance, YUVA sought to shift implementation of projects towards a more issue based approach and also worked towards reorganising their organisational internal structure. Various 'Rights' groups for different target populations /issues are now in place ; (Housing, Children, Youth, Women) as well as forums at the community level comprising of community members encouraged and facilitated by YUVA staff. Shortly after this the organisation participated in a massive Eviction Spree as a response to the emergency issue of large scale evictions which threathened slum dwellers' basic rights to housing and livelihood connected to these areas. A coalition of NGOs was formed and YUVA provided leadership and direction to the Committee to the Right to Housing for around 4 years. The networking function of YUVA is an important one and has resulted in the formation of the National Campaign for Housing Rights, The Campaign Against Child Labour and the Development Collaboration Foundation. In addition, the Programme Support Group gives inputs and resources relating to training, research, media, legal expertise and documentation to YUVA's various programmes.

A. Housing Rights Group

The focus of the housing rights group has been on the slum and pavement

dwellers, street children and youth and destitute women. The objectives of this group are:

- to raise awarenesss and consciousness among communities, community base organisations and NGOs with regards to human settlement issues, alternatives and housing rights.
- to promote people's organisations and federations to work on housing rights issues.
- to train housing animators to work at different levels.
- to promote information and action network against demolition and displacement.

Three major issues have been addressed:

- Work in Workers colonies of Jogeshwari that has led to the comprehensive area involvement of community and the strengthening of the Jogeshwari People's Organisation. (See Box 1)
- Work with pavement communities and its process developing an organisation of Pavement Dwellers (PDO) including efforts to develop an aggressive campaign to seek legal status

YUVA's Vision

"The vision of a society where each individual, woman and man lives in dignity. Where each can participate in the social, cultural, economic and political decisions that affect their lives. Where woman/ man is a controller of her/his environment - a subject of development rather thatbn an object. A society where all individuals live in justice, equality and peace."

YUVA's evolution into it's various projects developed out of situations of need expressed by people being affected by particular problems, a major event demanding attention (eg housing) or within the organisation itself requiring certain support facilities to respond to grass root level needs.

The ideological framework of YUVA is the important basis that provides direction while also maintaining interconnectedness. (YUVA 1990).

YUVA's major objectives include working with youth, children and women from workers colonies and pavement settlements to organise them to take responsible stands and action on problems/ issues at the community and city levels. The principle of responsiveness has been a key factor in determining the growth of the organisation.

YUVA strives towards evolving programmes based on a more analytical understanding of the relevant issues affecting selected poor urban sections of society.

Box 1

Jogeshwari Rahivashi Sanghatana, YUVA and Bombay Municipal Corporation work in collaboration for the Tenants of Janata Colony, Jogeshwari (E)

Janata Colony measures about 65,500 sq mts and comprises 15, 000 families in Jogeshwari (E). The latter is a suburb of North Bombay with an approximate population of 300,000 a conglomeration of several small settlement pockets over an area of 2 sq Kms. A large proportion of the persons are employed in the small scale informal sector. While most tenements are constructed with formal building materials (bricks, cement etc.) approximately 20 % of the structures are built of informal materials like tin, plastic, bamboo and gunny sheets. Janata Colony is essentially a migrant settlement with about 1,957 families evicted at different points of time to make way for development projects in South and Central Bombay.

In a legal dispute between the tenants and Chawl Owners of Janata Colony, the tenants found themselves caught in the contradictions of unclear slum policies and legislations that have been exploited by the Chawl Owners and other vested interests, making life insecure and difficult. The cases at hand were : a) the cases between individual vacant Lands Tenancy (VLT) holders and tenants based on the Vacant land Act 1975, b) the cases between the VLT holders and the Bombay Municipal Corporation and others over the payment of service charges under the Maharashtra Slum Improvement Board Act 1973.

In many instances harassment constituted the denying of permission to repair huts, discontinue basic amenities etc. with an impending fear of eviction. For the Jogeshwari Rahivashi Sanghathana (JRS), the tenants represented a group of victimised citizens of the area who were not just prey to the legal dispute but also to the chawl owners. They helped tenants to obtain legal documents from within and outside the area. They supported and represented the cases from time to time and gave the tenants a collective identity. The Bombay Municipal Corporation in its capacity as a quasi-judicial authority gave adequate time to all parties involved to be adequately heard and to substantiate their arguments to build the case brief in order to deliver a fair judgement. Timely information sharing through available old records and documents was also found very useful.

For YUVA it has been an opportunity to influence the laws and its policy thereby creating a test case to benefit a large population of tenants who were victims of continued harassment for almost two decades. The wide gap between the basic amenities that the state has been able to provide and the actual needs of slum populations calls for an official policy that at the minimum encourages people to house themselves by providing infrastructural backup. As an NGO it was possible for YUVA to uphold the collection of service charges by BMC for utilising the revenue towards environmental upgradation. They undertook a study of all policy documents available and pointed out the violations by the chawl owners (VLT holders) after an analysis of the implications of the VLT Rules. Together with JRS they also facilitated legal literacy among slum dwellers. As a result the outcome of the case was that it was declared that the VLT holders has grossly violated the VLT rules.

The judgement served as a tremendous boost to the demoralised tenants, offered them greater security and confidence in their own abilities. Such collaborations and sustained efforts can, not only empower selected slum populations but also have obvious long term implications in other similar areas (Pandian et al 1998).

TABLE A. Some community based women's organisations & their issues of involvement

	Name of Group	Area	No. of members	Issue of Involvement
1.	Avhaan Mahila Madal	Dadgi Bldg Dharavi	20	Displacement Rationing Violence against women Unemployment
2	Utkrushta Mahila Mandal	Sakinabai Chawl Dharavi	25	Rationing Violence against women Police lethargy
3	Sangharsh Mahila Mandal	Shiv Shakti Dharavi	10	Exploitation by employers Self-employment Rape of 6 children Issues of deserted women
4	Indira Nagar Mahila Mandal	Indira Nagar Goregaon	30	Community Toilet Ration
5	Indira Mahila Mandal	Ram Nagar Ghatkopar	30	Goondaisa Ration IMF Pre-School Class
6	Varsha Nagar Mahila Mandal	Ram Nagar Ghatkopar	10	Adult Education Ration
7	Varsha Nagar Mahila Mandal	Varsha Nagar Ghatkopar	10	Support group Ration
8	Indira Nagar Mahila Mandal	Indira Nagar Ghatkopar	20	Issue of Dalits Self-Employment Water
9	Panchashil Mahila Mandal	Jagruti Nagar Ghatkopar	20	Police Goondise Ration
10	Jagruti Nagar Mahila Mandal	Jagruti Nagar Ghatkopar	20	Ration Police Self-Employment

for pavement dwellers as well as establish an identity.

◆ Influencing policies, data building and study work.

B. Women's Rights Group

The Women's Rights group has taken up two major issues:

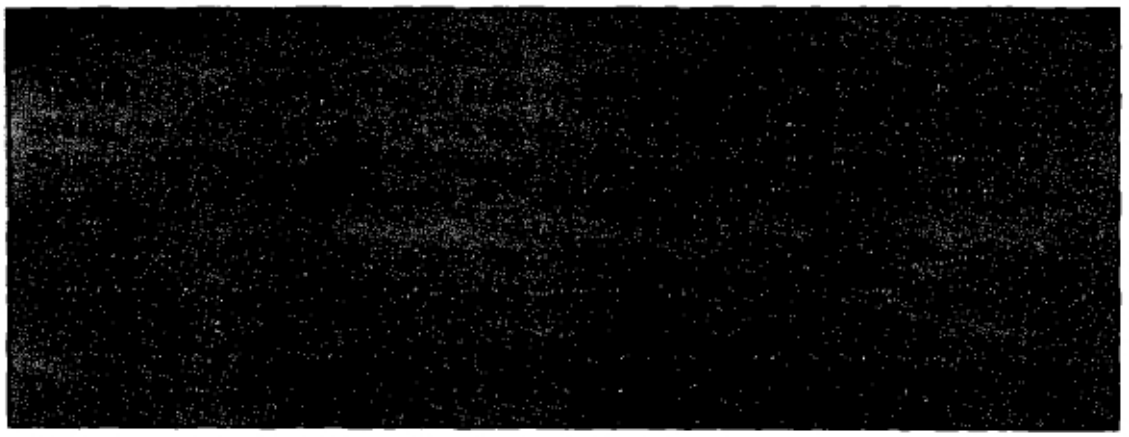
◆ The public distribution system and its impact on women

◆ Issues of Single women

The food ration issue had to be dealt with not only at the shopkeeper's level but also at the Food Corporation of India (Central) and State Ministry of Food and Civil Supplies.

The ration Jagruti Samiti was developed at the city level with other like minded organisations.

An overview of some of the



community based Women's Organisations and Issues of Involvement can be referred to in Table A.

Under the Women's Right Group efforts are also made in the areas of training research, networking with other local women's orgainsations and issues of violence against women.

C. Youth Rights Group:

The Youth Rights Group has focussed on the campaign against unemployment and its campaign has been based on two major demands: The Right to work should be a fundamental right and the Introduction of the Urban Employment Guarantee Scheme in Maharashtra.

Voluntary Intervention of Deprived Children Project

This initiative emerged as a followup to UNICEF's study on pavement children and was undertaken in a cross maidan community facing evictions which today is the Children's Rights Unit. Initiated as an informal open school in crossmaidan children communities and recreational activities by colleges of youth, this programme culminated in the opening of 3 schools in different areas. The fourth school was initiated by communities who selected and provided the two volunteers to conduct

Smiling, despite adversities

the activites for children. This initiative was then supported by YUVA through training and some additional resources.

The focus of this project was to initiate recreational cum educational activities with the pavement children and use this as an entry point to overcome problems concerning the pavement community as a whole.

Work was also initiated with street children not just issues of shelter and education but also activities to counter police harassment, (See Box 2) as well as illhealth through operating a mobile van providing basic health care.

These and other examples of children in similar circumstances raised new challenges for the YUVA team : The need for increased protection for street and working children, the importance of enhancing the role of NGOs and the sensitivity of the government system.

Thus from education YUVA moved to other areas: issues of Children's Labour, Health and Sanitation and mobilising health services for children on a regular basis. Among the target populations it has been found that existing perceptions of physical, emotional and social well-being are linked up very closely with self identity and financial stability. Trauma and insecurity especially among children are common and stem from frequent displacement, abuse and violence.

Through community organisation activities YUVA also seeks to improve access to and affordability to the health care system.

Women's Organisation

Although initial activities were directed at the Youth in selected areas, gradually the women became interested and with this YUVA initiated a women's forum - Mahila Mandal - to meet and interact on general community issues water, sanitation, ration cards etc. then on to more gender specific issues: reproductive rights, rape, health services delivery system. This also led to the involvement of government officers on duty in issues like ration supplies to provide information and increase awareness about access to services. A greater vigilance among suppliers and consumers and a decrease in corruption was encouraging for local communities and also provided opportunities for community forums to dialogue with officials at the higher level including the FAO.

Efforts are being made to increase understanding of urban slum women of macro issues based on specific problems encountered.

Thus, linkages between availability of ration supplies with dowry, family planning are being propagated. The Women's Rights Group and the Collective Stree Manch both contribute to influencing and evolving women's perspective and linkages of micro level understanding with macro issues.

Strengths

◆ The action reflection process is an ongoing process at the community level taking forms from mandals (of youth, mahila, tenants) to specific issue based committees dealing with issue based committees e.g. goondaism, ration supplies and a collective Stree Manch. One of YUVA's pioneers shared:

'Each time we go back to the Mandals'...what is the strategy we should take ? We keep moving back and forth.. When an issue comes up we take it up, achieve something, reflect upon it with the manadals, take stock of inclinations, resources, contacts, come out with strategies that can be more relevant.'

The whole process of action reflection is strengthened by forums, regular activities undertaken thought these forums, and responding to these issues that come up.

◆ The Multi-issue based approach is unique and has evolved based on expressed needs, major events demanding attention and from within the organisation for greater relevance and effectiveness.

◆ Efforts towards ideological infiltration into community have at certain levels promoted conscious decision making among women that have been empowering and productive.

◆ YUVA's efforts at local networking have promoted greater understanding among likeminded groups. Strong relationships have been established with other NGOs and activities that establish linkages with other local forums, trade unions, women's organisations, educational institutions, journalists, eminent personalities.

◆ The formation of NGO Coalition groups: Building coalition with other women's organisations has been effective so that community problems can be viewed more systematically expanding and strengthening the group's vision and activity.

Challenges Ahead

In such a multipronged issue based approach, it becomes difficult to keep an issue alive with the media and take it to it's logical end due to other problems or priorities which may be highlighted or come up spontaneously within the community. The demands at the urban slum community level, and the demanding informal approach within the organisation can often lead to heavy workloads on a few committed staff. Six monthly reviews of each project that not only deal with reporting and measuring progress and setbacks are also opportunities to strengthen staff and broaden and unify perspectives evolving on difficult or prospective issues and strategies.

Christina De Sa

THE JAJMAU CHALLENGE

Background

Kanpur is a typical example of cities which have become increasingly populous due to the forces of industrialization. With an average density of over 5000 persons per k.m., the city is considered to be one of the most congested and heavily burdened in terms of provision of basic services to the people.

The leather industry initially catered to the demands of the Saddelary and Harness Factory, which was established in Kanpur by the British in 1860. Slowly, due to erosion of textile industry and closure of many big units, leather became the second best option and the most lucrative occupation. In the past two decades, there has been an immense growth in the number of tanning units and Kanpur has become the second largest centre of leather tanning in India. Now, with an open export market and increasing demand for Indian leather, the industry is growing at an even faster pace.

Jajmau is the main industrial area of leather processing. This area is approximately 8 kms away from the city and is characterized with a large number of tanneries located in a cluster along the South bank of river Ganga. The area is mainly populated by leather workers and their families.

Jajmau comprises of 20 slum pockets. It falls under ward no. 49 of Kanpur Maha Palika which has got 50 wards under it. The oldest slum is approximately 100 years old and the newest is 8 years old. On the periphery of Jajmau industrial belt lie villages which still have fisheries or agriculture as their main occupation.

Situated at the banks of the river Ganga, the expansion of the city was a result of growth of textile mills and related industrialization. The villages which were situated at the periphery of the city slowly merged into it and became a location for an every expanding industrial belt. These villages, some of which got converted into industrial slums around 100 years back, house migrant communities from Bihar and eastern U.P.

Impact of Social Change

Making of Jajmau into a slum area has not been a sudden phenomena. It evolved through stages of social transformation in terms of industrialization, destruction of traditional occupations and growth of technology.

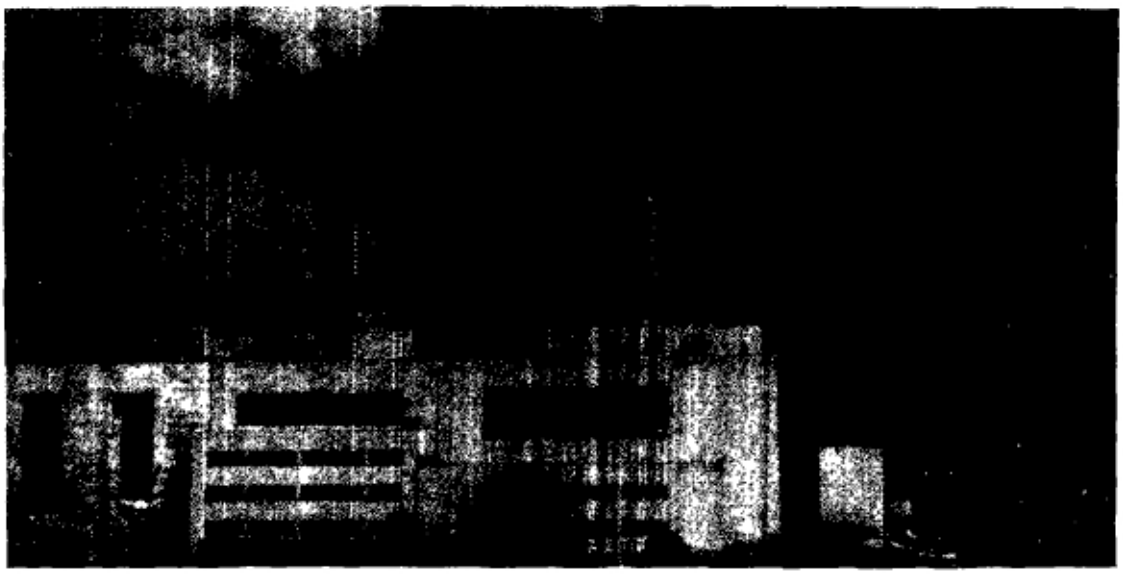
The forces of social change have mediated through the caste equations and have changed them significantly over time. Consequently, in Jajmau the composition of population shows a very distinct trend. Around seventy percent workers in the leather units are Muslims

and the rest thirty percent is a mixed population of fishermen, traditional leather workers and farmers. The rise in Muslim population is also due to social and communal tensions which led to the formation of these ethnic clusters.

As mentioned above, a few of these urban slums still retain their traditional occupations of fisheries and agriculture and people who originally belonged to these erstwhile villages. This group of people belongs to the communities of Mallahs (fishermen), Kurmis (backward agricultural farmers) and Chamars (traditional leather workers) who have been marginalised in the process of technological advancements and resultant destruction of traditional occupations.

The low social status attached to the flaying of the dead animals, poor working conditions and the reduction in economic returns have also contributed to the disappearance of the traditional village leather industries. At the same time, there has been a rise in the number of migrant labourers joining the industry. The landless marginalised rural communities, unable to sustain themselves in the villages, seasonally migrate to the city in search of employment.

Along with the change in the socio-economic and cultural environment there has been a clear shift in the choice of leather processing technology also. The traditional bio-degradable tanning agents have been replaced by hazardous chemical agents such as chrome, resulting into serious environmental and health problems. Lack of safe drinking water and sanitation facilities and ill-ventilated, overcrowded housing has added to these existing problems of water-borne diseases, tuberculosis and malaria.



Choking smoke and dust - additional bonus of industrialization

Box 1

Faces in the Crowd : Some Stories

Raju 18, has been working in the tanneries for the past 8 years. He was brought to the ESI hospital with severe problems of breathlessness and coughing. Reasons? Raju fell into one of the drums full of toxic gases & chemicals. He was sent back after first aid. He did not come to the tannery for work for 2 days. On the fourth day, I had a chance to meet him again at the tannery. "Back to work? So soon?" I was amazed. "Such 'minor' accidents keep happening. One can't just sit at home. I am feeling better so I came back for work" - Raju told me. There are no alternatives. Actually 'minor' or 'major' are such relative concepts. Don't we know of many of those who suffocated and died after falling into these drums?

Lallu, 70, worked in a tannery for 50 years. He started working from the age of 12 years. Became permanent after 25 years of work. He retired with Asthama and joint pains. Whatever little money he received after retirement, got used in the medicines. His nature of work involved operating glass machines, which eventually led to some skin problems too. He had an ESI card, but he hardly ever used it because he was highly dissatisfied with the hospital facilities. Lallu, has seen the area changing and developing over the past 40 years. He himself is bewildered with the fast growth of tanneries in the area which used to be an agricultural land. According to him this growth has taken place only in the past 20 years. Lallu, hardly has any assets besides the house he owns and has given a rent to some migrant labourers.

Health Services in JAJMAU

Generally speaking, the health services network in Jajmau slum area comprises of three different types of agencies:

1. Government hospitals, dispensaries/ urban PHCs
2. Non-Government agencies and others
3. Private clinics/community based health practitioners.

Most of these agencies are curative in nature with few exceptions e.g. some initiatives from the NGOs or the general prevention from the government side in terms of immunisation. A description of the nature and the scope of these agencies is as follows:

1. Government Services

The ESI Hospital

The most prominent one amongst the government run agencies is the ESI hospital and the dispensary. The hospital provides mainly curative services and caters to the Insured Persons (IPs, industrial workers) and their families. The hospital has a sprawling complex and has the in patient capacity of 100. Most patients are treated for general health disorders, minor surgeries and tuberculosis. The hospital records show a high incidence of waterborne diseases, tuberculosis, wounds and lacerations, fevers and common colds. Besides catering to these diseases the hospital also provides MCH and referral services.

In terms of its outreach the scope of the ESI hospital has remained very limited. Because of the dynamic and changing nature of the work force, unstable employment patterns and the siphoning of funds that are cut from the employees salaries, the number of persons covered under ESI has been very low. On an average ESI caters to only 20% of all the existing work force.

Urban PHCs

Balwant Kaur Family Welfare Center at Krishna Nagar PHC is the urban PHC in Jajmau, looking after mainly MCH services. The focus of the health centre has been on curative services and family planning. Lack of infrastructural facilities and motivation of the staff has resulted in a poor health care delivery system. Family planning and immunisation services have been mainly target oriented therefore in terms of actual impact the performance over the years has been marred by such priorities.

Urban Basic Services Programme (UBSP) has had health interventions through programmes such as Anganwadis, informal schools, Adult literacy programmes and ICDS. The focus has been on education, communication and maternal and child health. The health interventions are mainly in the areas of immunisation, nutrition and ante/post natal care. The UBSP worked closely with the Indo Dutch Environmental and Sanitation Project and the Urban Health care Project (UHCP) supported by Memisa Medicus Mundi, (Netherlands).

Training of Urban Community Health Workers · Calls for Innovative Approaches

Traditional Systems of Medicine

Ayurvedic/Unani Dispensaries

Jajmau has a government run Ayurvedic dispensary. This dispensary is looked after by the Nagar Mahapalika. Also for curative services, the dispensary is almost non-functional and caters to a very small segment of the community.

2. Non Government Agencies and others

Parivartan (CSR)

Parivartan, sponsored by Centre for Social Research, Delhi is mainly an income generation project aimed at the women of Jajmau slums. Parivartan identified a need for a health center which exclusively looks after women's health. Parivartan runs a bi-weekly dispensary in the area for Gynaecological disorders, with the help of a specialist.

Charity Hospitals

Besides the other health agencies operating in the area, there are a few small dispensaries run by paid physicians on behalf of a few tannery owners. These are charity dispensaries aimed at providing curative services to the poor workers community at nominal fee or sometimes without any payment.

Urban Health Care Project (UHCP)

In terms of outreach the UHCP has been a most successful government/non-government effort in the sphere of health. Although the focal areas are curative and preventive services, yet the project has tried to build a network with the help of other agencies in the areas of training of health personnel such as Community Health Volunteers (CHVs), health education, school health programmes etc. Major areas of intervention have been Tuberculosis prevention and cure, immunisation, MCH services and the control of water borne diseases. A profile of the UHCP Jajmau Tannery area may be referred to the Table A. The project also organizes health camps for immunisation and family planning services and distribution of ORT packets. The project has a dispensary where a regular OPD is held. In terms of data base the project data recording system is most well developed although it has its own limitations. In some programmes such as immunisation and MCH the approach is again target oriented although with its wide network of health workers the coverage has been much more than any other health programme run in the area. Initial activities were undertaken in close coordination with the Kanpur Medical College but now it functions independently.

Initially the project had close links with the Indo-Dutch Programme, who had already built a base in the community.

VHAI's involvement has been related to training aspects both for the UHCP

core staff and community health volunteers including Asha and several others (For details refer to Box 2 - "Rampyari and Asha: Two sides of a coin").

The long term objectives of the UHCP are to strengthen urban communities to maintain and improve their health and to support intersectoral activities, which contribute to improvement of urban health.

3. Private Clinics/Community based health practitioners

Private Practitioners

In the past few years private clinics have sprung up all over Jajmau. Roughly there are around 40 private clinics in Jajmau area. These clinics, mostly run by quacks are most sought after health institutions. There are many factors behind the proliferation of these clinics. One is, lack of faith from the community's side in the other health institutions specially government institutions due to poor access and health care delivery system. Secondly these practitioners have a firm base in the community and they are considered a part of it because most of them come from the community itself.

Besides such clinics, other private clinics are also been run in the area. These are clinics owned by specialised/ trained doctors. The treatment is priced very high and is given for a range of diseases common as well as specific. These private clinics range somewhere between the quacks and the government hospitals in terms of the community's preference in seeking treatment.

Popular Beliefs and Community Based Health Practitioners

Besides a range of prevailing health

TABLE A : Profile of JAJMAU Tannery Area

Total Population and family size in UHCP area Jajmau (Slum areas in Sector II)

Description	Number	Percentage
Total Slum Areas	30	–
Total Families	7,978	–
Total Population	42,054	–
Male	22,587	53 07
Female	19,467	46 29
Average Family Size	5 27	–
Total Births (per 1000)	1,805	42 92
Total Deaths (per 1000)	524	12 46
Infant Deaths (per 1000)	205	114

Box 2

RAMPYARI AND ASHA : TWO SIDES OF A COIN

Rampyari and Asha are residents of Gajjupurva and [illegible] respectively. Both of them are leaders in their own rights. Asha, 40 yrs, works as a Community Health Volunteer (CHV) for UHCP and also as a health worker for Parivartan. She is also a teacher in the non-formal school run by UBSP. The earnings are not much, barely enough to meet both ends. Although the family is not very big and the sons are on their own yet there is hardly any support from any side for her and her school going daughter. This has compelled her to take up these jobs.

Asha's husband is a gas mechanic and has already lost interest in her because of her social activities. Not that he was ever a responsible earning father and a loving husband. He drinks heavily [illegible] and beat her up. The [illegible] on the one side and the support she got from her neighbours and friends on the other made her break away from a traditional set up and she got involved in these activities. Most of Asha's money still goes into her husband's drinking and the little she saves goes into her daughter's education and other expenses. What is after all that drives her into working so hard? "Of course, the need for money, what else?" she says. "Slowly the work is also becoming [illegible]. It's a pleasure to meet people, talk to them and convince them to change their minds and attitudes towards more positive things." She doesn't care so much about what her husband has to say on her work. "It would have been a different story if he appreciated it".

Asha Devi (Centre)

Anyone who has been to Gajjupurva would know of Rampyari, 38 yrs. She is the most vocal woman around and the most active too. Rampyari is illiterate and she knows the limitations of being one. Still, experience is another way learning things and the ways of the world. It is because of her experience that people listen to her. Whether it is on savings, or health, or community organisation, Rampyari is good at everything. "The people who admire my capabilities today, have been the ones who pointed fingers at me when I began all this work" she muses. She has really come a long way.

Rampyari is an active member of Mahila Milan, a savings and credit initiative started by Kanpur Slum Dwellers Federation (KSDF) an offshoot of SPARC, Bombay. She also actively participates in another similar initiative from Shramik Bharati, Kanpur called "The Boond Bachat Yojana". Through these savings programmes, women feel so much better - so what if the savings are small!

Rampyari has all the support from her husband who is a tannery worker. He never tries to put a check on her activities. "Isn't it because of his support that I have been able to devote so much time outside home?" Her priorities are to do something for the 'Samaj' with or without support from any agency. Work and [illegible]
For some it may be [illegible]

systems and a network of quacks and private practitioners, there is another stream of community based health practitioners in Jajmau. These practitioners who are usually into practices of bone setting, distribution of medicines and herbs, witch crafts and rituals are widely popular among the people in the slum areas. The reason for this popularity is more or less the same which compels the community to opt for quacks i.e. the disillusionment brought forth by the failure of modern medical facilities and active interventions. The preference is also determined by their popularly held belief systems which have been time and again reinforced by this failure. The community resorts to such treatment when everything else fails and sometimes the other options are not even tried due to lack of faith and poverty. The community practitioners are sought for a variety of minor and major illnesses and are heavily relied upon.

Interaction of the Traditional and Modern Medical Facilities

Points of Divergence and Convergence

The above mentioned network of health institutions in Jajmau, reveals very interesting trends. There has been a tremendous growth in the number of the agencies which are willing to operate in the area of health interventions. Yet, there has been almost a parallel rise in the number of people who are increasingly seeking treatment outside the domain of modern medical facilities. Similarly, there is another analysis which goes on closely to the above mentioned one. This throws light on the trend that the reliability on modern medicine and health care delivery system has been at its lowest despite every programme having a component of 'Education' in it. This failure of the programmes shows that the context in which the communities operate is important to be understood in order to set priorities. The 'usage' of health services is very nominally determined by education only. There are various factors which mediate and determine the process of use. Poor accessibility, lack of enough faith, and poor quality of health services rendered are some such factors which have affected the patterns of utilisation of health services in Jajmau. There has been very little correlation between rising number of agencies creating awareness and the actual use of medical facilities provided by them. There have been exceptions but with very limited success.

One point of divergence is obviously the access to medical facilities. Besides the UHCP, there is no other agency which has a fully functional outreach programme. Other efforts have been very minor compared to the magnitude of the existing health problems. Similarly, health has not been taken up in an integrated manner. The problem of housing, water supply, proper disposal of sewage and problems of sanitation are not seen as parts of the

whole i.e. health. Therefore the extent of the problems has remained more or less the same over the years. Even UHCP with its total focus on health has not been able to bring the incidence of water borne diseases and Tuberculosis, significantly down. The reasons behind this are lack of an intersectoral development effort and the unidirectional operations of the agencies.

While some agencies/institutions have direct links with the community, some function from a distance. The ESI hospital for example works as a closed institution. Although it is a hundred bed hospital, the utilisation of health services remains poor because of the funds not reaching the Corporation on a regular basis. There have been problems such as lack of staff, infrastructure, drugs and above all lack of motivation in the hospital staff which has made people seek other services. The same is the case with other government agencies.

Keeping in view the above mentioned points of divergence the following trends emerge:

i) There is a lack of holistic thinking and intersectoral coordination in the health programmes run by different agencies.
ii) There is also lack of access of the poorer sections to the facilities due to the above mentioned factors and therefore the community has to bank upon alternative sources of treatment, the traditional ones being the most convenient.

The only point where the two systems converge is that the traditional system often works as a support system to an increasingly failing health services system in Jajmau. The reason behind the proliferation of the community based health practitioners is that, there is still scope for a parallel system to run with or without its proven efficacy in terms of curative services. Usually the choice

Table B : HOUSING AND SANITATION

Description	Number	Percentage
Status of Houses in Jajmau		
Kutcha	3608	45 22
Pucca	2056	25 77
Semi Pucca	2315	29 01
Total	7978	100 0
Status of Latrines		
No Latrines	3497	43 83
Dry Latrines	0867	10 87
Flush Latrines	3614	45 30
Total	7978	100 0

Note 56 percent of the households surveyed are one room settlements, 29 97 percent are two room and 13 39 have two or more rooms
Source · UHCP, 1994

is between the devil and the deep blue sea and hence the sea.

Role of Intervention

Water Supply & Sanitation

In the areas of water supply and sanitation facilities in Jajmau, the first and foremost agency is the Indo-Dutch Environment and Sanitary Engineering Project (IDP). This bilateral project worked closely with the Ministry of Environment (GOI), in the areas of clean water supply by cleaning the 'critical stretches of Ganga river' as a part of a high profile Ganga Action Plan. The project was launched in 1988 and was withdrawn in December 1993. Because of this long duration of stay the IDP is a better known intervention. The project was mainly directed towards tackling two problems in Jajmau:

i) Control of pollution through interventions like installation of primary and secondary sewage and tannery waste treatment plants.
ii) Creating infrastructure for safe supply of drinking water and controlling water borne diseases.

Besides these two major interventions the IDP also coordinated with other existing agencies for other interventions such as health, training inputs for health and maintenance of infrastructure and employment generation for women etc.

The focus of IDP has more or less remained on creation of infrastructure. For water supply as a major area of intervention installation of hand pipes has been the thrust area. Although some of the studies conducted by the IDP show increased access to safe drinking water, the reality is not the same. The flush latrines which were constructed through the project lie defunct due to lack of proper water supply and sewerage facilities. Therefore even if the coverage is 45.30% (approx. 3614 families out of 7978 families) covered under UHCP area (Table B), the actual use pattern shows a downward slide.

Lack of proper sewage channels has kept the sanitation scenario in the slum area as poor and dismal. The area is characterized with overflowing drains, toxic water flow from the tanneries, heaps of garbage and water logging. These have become a breeding ground for mosquitoes and flies compounding to already existing health problems. According to a rough estimate the main health problems are as follows:

- Cough and fevers (including Tuberculosis and Malaria).
- Gastro-intestinal disorders
- Skin Diseases
- Eye problems.

Most of these diseases are a response to failing environmental conditions which have remained the same despite interventions. The situation is enough to question the basis premise of these interventions. Is it enough only to create infrastructure or move beyond it and see its sustainability in terms of full utilisation and access of the community to these facilities?

Dr. Gunjan Chaturvedi

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Director, Anubhav Series	:	Alok Mukhopadhyay
Author	.	Christina M. De Sa
Editor & Coordinator		Bhavna Banati
Photographs		Achinto, Christina M De Sa, Ganeve Raj Kotia, Padam Khanna, Soumi Das, The Pioneer and Stree Hitkarni
Contributions		Dr Gunjan Chaturvedi Dr Shobha A. Udipi
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cy Painting

The air we breathe is full of the dust and fragrance of the past, as a
and piercing winds of the present. We face the good and bad of India

– Jawaharla

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