PERCEPTION ABOUT HEALTH CARE SERVICES OF SLUM DWELLERS; A STUDY IN UNION TERRITORY OF CHANDIGARH

Amandeep Singh

Assistant Professor in Sociology

Department of Evening Studies- MDRC

Panjab University

Chandigarh

ABSTRACT

The purpose of this research is to comprehend the socioeconomic and demographic traits of people living in slums of Sector 25, Chandigarh and it makes an effort to comprehend how slum dwellers use healthcare services. In order to create more accurate results, the paper also looks into how slum residents viewed the current health care system by conducting a field study and understanding the perspectives of slum dwellers regarding the health care services.

Keywords: *Slum dwellers, Perception, Health care.*

INTRODUCTION

In the period Between 2001 and 2011, the urban population increased by 3.2 percent annually. Additionally, the number of census towns has increased from 1362 to 3894, an increase of 2532. (Government of India, 2011:NP). According to 2009 statistics, there were 104.7 million slum dwellers in India, making up 29.4% of the country's population. The impoverished slum dwellers are particularly affected by the lack of essential utilities since they are compelled to live in unhygienic conditions. It enhances slum dwellers vulnerability to fall sick (United Nations 2012; Nandi & Ghamkar 2013:60). The issue worsened by the fact that the primary healthcare system is inadequate to address their demands. According to the Ministry of Health and Family Welfare, government of India, there are 0.5 doctors for every 1000 people, which is less than the W.H.O. benchmark of 1 doctor for every 1000 people (World Health Organisation, 2012). Those who reside in slums experience a bigger impact because they lack access to fundamental basics of life. This in turn has a domino effect, resulting in underdeveloped neighborhoods with poor health and wellbeing, which in turn affects people's chances for a healthy life. It is appropriate to assess the health of urban slum residents in Chandigarh in this regard.

The current study examines the socioeconomic and demographic characteristics of slum inhabitants in a sample of slums. The report also investigates how users perceive the current health care system by combining information from a field study with first-hand accounts from slum residents to produce more accurate results.

URBANISATION AN OVERVIEW

In terms of demographics, urbanization refers to an increase in the proportion of urban residents to the overall population. Urbanization is also described as a process of change in terms of people's values, attitudes, and lifestyles as they migrate to cities and how those changes affect those who remain in rural areas. the process of urbanization of poverty, in which cities are growing rapidly as the availability of essential resources deteriorates, making it more difficult for urban residents to attain these necessities. Urban regions are experiencing a sharp increase in inequality, which is reflected in the rise of depressed districts. The slums are areas where residents can actually see and feel poverty and deprivation in the form of deteriorating infrastructure. Slum dwellers are subject to the dangers that come with living in a city. Regarding the availability and need of essential healthcare services, a considerable gap exists.

The Millennium development goals stress on improving the lives of at least 100 million slum dwellers under target seventh where issue of accessibility to safe drinking water and sufficient sanitation facilities are underlined. The first, fourth, fifth, and sixth goals, respectively, address the problems of poverty, malnutrition, maternal and child mortality, and the fight against illnesses (UN Habitat, 2003:7-9). (Bajpai, 2003:3-5). As healthy bodies and minds would serve as a meter to gauge society's overall growth, we may therefore conclude that health is an important factor. Therefore, being healthy is vital for a person's whole development (Mehta, 1992:124).

HEALTH AN OVERVIEW

There are various ways to define health: The germ hypothesis of illness (Koch's), according to which health is defined as the absence of all disease, is the foundation of the biomedical approach. According to Bernard's notion, the disease is a pathological condition of the body that has an impact on the structure and operation of the body. This strategy aided in the development of the modern medical system, which is based on a mechanistic and individualistic concept and offers technical remedies as a treatment for illness (Bolaria, 1994:68, Mathew, 2011:388).

The activities aimed at promoting, restoring, and maintaining health are all included in the health system. A structured health delivery system, with supporting medical professionals, financial resources, and necessary institutional development, is required to achieve these objectives. Thus, one of the essential elements that make up the welfare functions of the state are health care services. Therefore, the most crucial factor is the state's willingness to commit and make measures to address health challenges (World Health Organization, 2008:5-6).

Health care services encompass prevention and curative services along with rehabilitative features to treat illness and providing cure for diseases. The preventative care services include vaccination programmes that are given to children and adults against a variety of infectious diseases. Following the commencement of illness, hospitals and dispensaries mostly provide curative treatments. However, both in the public and private sectors, a curative emphasis rules the current health landscape. Health professionals with suitable degrees and various hierarchies who are primarily concentrated in urban and metropolitan areas supervise the operations of healthcare facilities. Therefore, a well-established and efficient health system is required to meet the societal health needs.

An essential area of sociology is health sociology. It aims to research that how society operates. Sickness and disease are often results of the way society is structured, the way resources are distributed and organized. Under the paradigm of sociology, we examine the health system, its organizational structure, and the way that health policies are implemented and framed. The doctor-patient interaction is studied under the Parsonian approach to health. In his book Social System, Parsons defines illness as a type of deviance in which the role of the doctor is crucial for the treatment of the illness. Social factors do have an impact on illness and disease (Timmermans, 2008:659, White, 2002:5-35).

The concept of illness as a deviance-oriented social construct has been further explored. Howard Beckers examined the subject. He developed the labelling theory, which maintains that individuals with comparable symptoms exhibit divergent behaviours in a medical setting. This originated from common meanings and consequences. But once more, this has limitations because it is only applicable to patients' divergent behaviour in a medical setting (Mehta, 1992: 47-49). Within the aforementioned methods, the idea of illness and the sick character gains significance.

Many social, political, and economic elements that have an impact on health but are outside of the control of the individual are taken into consideration by materialist theories. The majority of research concentrate on a person's line of work and how it connects to their health, such when miners get chronic respiratory illnesses. This Marxist claim's living arrangements and nutrition can be examined from a health perspective. By controlling the issuing of medical certificates, diagnosis accessibility, drug access, and other factors, doctors uphold the fundamental principles of capitalism. In order to maintain a steady flow of commodities and prevent lost work hours, it is therefore vital to manage employee illness (White,2002:101).

Study method based on Foucault: His two landmark books The Discipline and Punishment (1977) and The Birth of a Clinic (1973), which properly depict his interest in medicine and the study of the human body, demonstrate how important health has been to him. How the concepts of disciplinary authority and sovereign power have shown themselves in the medical industry. Even in the book The History of Sexuality Vol. 1 in 1979 addresses the topic of body surveillance, particularly the challenges of population control and fertility that the government has adopted under the cover of family welfare initiatives. This method has been taken by

feminists who believe that women have no influence over their bodies in making decisions and gaining access to health care as patriarchal structures have, they are under state-sanctioned observation (Scambler, 1987: 66–71).

According to postmodernist Anthony Giddens, people are somewhat in charge of their own bodies. When analyzing concrete social events in terms of the actor's strategies and contextual restrictions, we can employ methodological interactions to comprehend the health care apparatus. The Anthony Giddens concept of agency can be seen as the ability for social actors to take action. Understanding the Health Care System requires classifying its components into Macro-level (Stakeholders) and Micro-level levels (social strategies). Identifying the limitations imposed by the political, social, economic, and symbolic systems is also necessary. There is a need for adaptability and innovations wherever they are required in order to overcome challenges (Sardan, 2005:53).

According to Erving Goffman, bureaucratic institutions use science and technology as a weapon to impose norms that aid in the smooth operation of society. Sociologists use a variety of social systems to examine how people who belong to different groups are given different life chances. Therefore, class, gender, ethnicity, and other forms of stratification are significant characteristics that add in our understanding of the status of people seeking access to healthcare. Further, the range of power relations determines who has access to health care and who does not (White, 2002:1).

As stated by Graham, we must examine the complex web of hierarchies that includes education, income, occupation, social status, housing, and location in order to fully comprehend social inequality (Crrib,2005:86). Health was cited by Parson as an ability of an individual to carry out the roles and responsibilities for which he has been socialized. According to the WHO, health is a resource for daily life (Ibid.:24). As stated in the WHO's definition of health: "Health is a condition of complete mental, physical, and social being and not only the absence of sickness," this suggests positive connotation when health is understood in the context of well-being. Thus, the provision of health care to slum residents becomes a crucial topic that needs to be examined and studied.

SLUMS

Slums were originally characterized in print by James Hardy Vauxs in 1812, when he used the term "criminal racket" in the vocabulary of a flash tongue. These slums are frequently home to the destitute. The Victorian middle classes viewed these areas as slums because they were filled with overcrowded, disease-prone housing that was in poor condition and had a high rate of poverty (Davis, 2006:21-22). Slums have generally been conceptualized in terms of their physical, and social characteristics. Slums are therefore described as crowded places with dilapidated housing, unhygienic conditions, and residents who either work in low-paying occupations or are unemployed and conduct immoral activities. Consequently, low income is frequently linked to slum-like circumstances. The housing situation has an impact on the health, safety, morality, and

residents' welfare. Housing is therefore a crucial concern. This affects other social circumstances. Residents of slums are not all the same their time in a city is defined by the opportunities that are present.

Oscar Lewis, a sociologist, developed the concept of "Culture of Poverty," which holds that poverty in general and slum life in particular have a number of associated traits in relation to family, interpersonal relationships, time-orientation, value systems, and spending patterns that are passed down from generations to generations in family setup (D'Souza, 2012:33–36). Whyte, a social scientist, asserted in 1943, however, that there is an overt attempt to draw attention to slums. He used The Street Corner Society as evidence for his contention that slums also have an organizational component.

Victor D'Souza, in Social Cultural Marginality: A Theory of Urban Slums and Poverty in India, (1979), stated a similar perspective with reference to studies on slums in India. He makes the argument that those who are socially and culturally marginalized live in extreme poverty and lack the will to assimilate into society (D'Souza, 2012:32:42). Paul Wiebe presented a perspective on reliance that emphasizes the economic causes of the pitiful situation of slum inhabitants, which are mentioned in Victor D'Souza's book. He contends that although Madras' slum dwellers are impoverished, they do not adhere to the culture of poverty.

Similar to Sandhu (1989), the bulk of slum dwellers came from the Scheduled Caste population, making them structurally marginal rather than culturally marginal. They are also acutely aware of their current and previous issues. They are well organized at all levels, whether they are social, political, religious, or economic levels. Thus, all three studies effectively reject Oscar Lewis's thesis with strong evidence backed by a theoretical framework that was studied in a sociological way (Stokes, 1970:58-59, Sandhu, 1989:168-170 and Dahiwale, 1997:36-37).

REVIEW OF LITERATURE

Numerous research projects on health-related themes have been produced in the past. The review gives us a critical analytical framework for studying these topics and introduces pertinent ideas and concerns effectively.

Ray (2002) focuses on how both slum and non-slum populations use public social services like health. This study, which was conducted in Ahmedabad, Gujarat, shows that the allopathic medical system is widely used, but that those who live in slums prefer public health facilities rather than private physicians. Because of the shorter wait times and improved services, slum dwellers have shifted their preferences for medical facilities. These slum dwellers utilize this effective and reliable immunization technique. So, for indoor services, slum residents visit the municipal hospital. The pricey private health care system is employed for specific instances. For those who live in slums and non-slum areas alike, the question of per capita service provision is crucial. The state's role in providing these services is crucial. The affordability of these services puts pressure on the cost of living for the poor, limiting them access to essential necessities.

Bhatia (2004) attempts to compare many aspects of the quality of care given to female outpatients by private and public sector doctors in the Indian state of Karnataka. The findings show that women seek out medical care from doctors for a variety of reasons. Obstetrics received the most referrals, followed by gynecology and then those with respiratory and circulatory system issues. There is an uneven distribution of cases between private and public health services. Even in clinical processes, it has been discovered that private practitioners use tools like barometers and thermometers more frequently. However, it is more common to take someone's pulse in public than in private. In the private sector, more expensive medications are prescribed than in the public sector, and private healthcare facilities prefer consulting specialists over public healthcare facilities. Thus, the overall conclusion suggests that private healthcare is superior to the public health care system in terms of doctor-patient communication and thoroughness.

Hay (1994) investigated the influence of social status on access to healthcare. Education, social class, and occupation were employed as the main indicators in this study, which also included explanatory variables like gender, age, marital status, and social support systems. In this paper, many reports that have been written about these factors are analyzed. For instance, a British study group's Black report and a report from the United States both produced identical conclusions, such as the fact that families from lower social classes experience more disability days. Low socioeconomic status has an impact on the mortality rate, general health, and malnutrition. Both of these investigations do note that deprivation-related mental illness increases.

In his writing, Ray (2003) discusses the issues that the urban poor face, including their low income, unsafe neighborhoods, unmet basic needs, and issues with their physical environment, such as lack of housing, insufficient water supply, and lack of proper sanitation. All of these issues contribute to a poor quality of life. This worsens the health of the urban poor, who already struggle with an array of urban ailments such infectious diseases, epidemics, and inadequate personal cleanliness. According to the study, children from lower socioeconomic classes are often sick for 21 days in a month as compared to children from higher socioeconomic backgrounds, who are typically only sick for about 10 days. As a result, the study suggests that enhancing PHC and the referral system is the best way to provide health care for the urban poor.

According to Bansal's 2007 study, it is crucial to provide for the needs of the impoverished. The impoverished reside in areas with poor air and water quality, which contributes to the spread of numerous infectious and communicable diseases. The risk that poor individuals face is rendered more severe by the fact that they are susceptible to both natural and induced conditions. The distribution of infrastructure explains the connections between health inequalities and poverty. Evaluating the effectiveness of current programmes is crucial for ensuring that the needs of the poor are satisfied. Examining concepts like quality, appropriateness, accessibility, and equity can help one comprehend the planning process and its feasibility. Therefore, an integrated approach must develop to examine inequities in health caused by poverty.

In her research, Chaterjee (2001) tries to connect three issues—population, poverty, and health—all at once. It is important to note that child mortality and morbidity are widespread among the poor because they lack easy access to healthcare. Mothers' health is crucial for the survival of the kid; in India, 53% of children are malnourished and 60% of moms are anemic. Beyond money, cases, and technology, the health sector needs to be redefined with a focus on community involvement where both formal and informal practices coexist.

In his study, Kundu (2002) outlines the function that various state actors play throughout the entire government apparatus. How the system has been structured to meet the demands of all levels of citizens. Depending on the type and degree of a person's illness, different health system levels represent the type of medical care that is provided to them. This ranges from basic illnesses to more complex surgeries that call for a specialized approach and medical care backed by diagnostic equipment. The text also emphasizes the functions given to central, state, and local government in supplying the necessary logistical assistance to run the system effectively. At the local level, the urban poor utilize government dispensaries and hospitals; however, certain factors deter them from using these public health services, such as the poor quality of the services offered, the lack of medicines, the lack of testing facilities, the absence of a referral system, and most importantly, the attitude of the doctors toward these underprivileged patients.

The Mumbai slum dwellers are the focus of Jaiswar, P.K. (2012) study. The study looks at the element that makes use of medical facilities easier. Their conception of sickness is influenced by their religious beliefs as well as a lack of awareness of cleanliness routines. An additional study reveals that system enabling elements such as staff conduct (48%) drug scarcity (60%) and staff shortage (40%) and lack of drugs all affect how much time people spend on their health, although working hours also have an impact. The migratory character of the people together with their lack of habitat in the slums do affect the emergence of diseases like tuberculosis, as cited by 88 percent of respondents as a key factor.

The review makes it clear that there are issues with infrastructure, deprivation levels, and economic inequality. These issues have a significant impact on health indicators, which have remained the same, negatively affecting the poor (Dreze, J. 2012 :3742–3745). At the same time, sociologists have not made a significant contribution to the study of marginalization and inequality in urban areas. The evaluated materials also don't have a strong theoretical foundation for understanding how slum inhabitants use the health care system. Given the aforementioned issues, there is a need to concentrate on urban health as slum inhabitants are increasingly marginalized and have limited access to essential services as a result of the rapid pace of urbanization (Aggarwal, 2011: 27).

OBJECTIVES

1. Examining how frequently slum residents use medical services.

2. To learn how slum people perceive the public health care system.

RESEARCH METHODOLOGY

Sector 25 slum dwellers in Chandigarh are used as a sample in the current study. The sample size is based on a total of 50 respondents. 25 male respondents and 25 female respondents made up the sample. The age groups of 21–40 years, 41–60 years, and 61 and over are investigated.

Area of Study

As there is no health care facility in the slums of sector 25, Chandigarh. The area is known by the name Bhaskar colony. People of this area have to go to Government dispensary of Sector 37, Sector 16 government hospital and PGI. the present study makes an attempt to study the perception of the slum residents of sector 25 regarding the public health delivery system.

Techniques of Data Collection

Both quantitative and qualitative methods were used to acquire the data. Through an interview schedule, the quantitative approach has been used. The researcher made numerous trips to the slums of Chandigarh to learn about their living conditions and the challenges they confront on a daily basis. People who live in the slum were interviewed informally. The interview schedule is broken down into the following sections: sociodemographic profile; health status; disease profile; and people's perceptions of the health system. The secondary sources of information, including books, articles, policy documents, committee reports, working papers, conference and seminar proceedings, newspapers records of the census, and official websites of various ministries, were also consulted. Both closed-ended and open-ended questions were on the interview schedule. The questions have been manually tabulated. A conclusion has been reached utilizing percentage analysis.

➢ SOCIO DEMOGRAPHIC PROFILE OF SLUM DWELLERS

1. Demographic Factors

These essential variables, such as sex, age, and marital status, all have an impact on how frequently people use medical services. Numerous studies have demonstrated that these variables affect how different everyone's health demands are. Understanding the population's overall structure is made easier with the use of demographic profiles. Understanding the organizational framework of the society has mostly been based on caste. The Indian constitutions defend untouchables' interests by referring to them as Scheduled Castes in order to protect them from being exploited, mistreated, or degraded (Sharma, 2007:113). The OBC are illiterate and socially regressive. According to Article 340, the president is permitted to form commissions to investigate the circumstances of the underprivileged in various regions of India. Caste is typically assumed to be the primary criteria when listing a backward class (Sharma, 2007:215-216).

Table 1 showing distribution of respondents based on "Demographic Factors"

Sex /Caste	General	O.B.C	S.C	**S.T**	Total
Male	5(20)	6(24)	10(40)	4(16)	25(100)
Female	6(24)	7(28)	11(44)	1(4)	25(100)
Total	11(22)	13(26)	21(42)	5(10)	50(100)
Age/Caste	**Male**		**Female**		**Total**
21-40	6(24)		7(28)		13(26)
41-60	11(44)		12(48)		23(46)
61& above	8(32)		6(24)		14(28)
Total	25(100)		25(100)		50(100)
Marital Status/Caste	**Male**		**Female**		**Total**
Married	16(64)		16(64)		32(64)
Unmarried	5(20)		3(12)		8(16)
Widowed/Widower	3(12)		6(24)		9(18)
Separated	1(4)		0(0)		1(2)
Total	25(100)		25(100)		50(100)

Figures in parentheses column wise percentages

Table 1 above clearly demonstrates that 46 percent of the population is in the 41–60 age category, 28 percent is in the 61–and-up age category, and the least amount is in the group of people who are the age group of 21 to 40, which makes approximately 26 percent of the sample population. The study reveals that there are 40 percent of male respondents who are from the S.C category who are more in number. While, there are 44 percent of female respondents who too belongs to the S.C category. The study shows that there were a greater number of S. C's category found in the slum areas. The study also found that both male and female respondents with 64 percent each were found to be married. With a total of 64 percent each. The study also reveals that there were 20 percent of unmarried males and 12 percent of unmarried female respondents. While, there were 18 percent of both male and female who were found to be Widowed/Widower.

The female respondents claim during the field study that the reasons for the higher rate of widowhood or widowers among female respondents are due to lack of timely health care, lack of resources among family members to pay for expensive treatment in case of chronic illness, and in some cases heavy drinking or accidents are the cause of premature deaths. During the field investigation, the researcher only encountered one example of separation.

2. Literacy level

Education level reveals a person's relationship to their earnings, chosen careers, and life choices that support healthy living and concern for their well-being. Along with having a broad impact on the household's socioeconomic standing in the community, education status is a key determinant of how a household approaches disease, the type of healthcare system used, and the location of treatment.

Table 2 showing distribution of respondents based on "Literacy level"

	Education	Male	Female	Total
Illiterate		14(56)	16(64)	30(60)
Literate	Up to Primary	4(16)	4(16)	8(16)
	Up to Middle	2(8)	2(8)	4(8)
	Up to Matric	2(8)	1(4)	3(6)
	Up to Senior Secondary	2(8)	1(4)	3(6)
	Graduate & above	1(4)	1(4)	2(4)
	Total	25(100)	25(100)	50(100)

Figures in parentheses column wise percentages

The above table 2 reveals that significant proportions of respondents are illiterate that is 60 percent. with 56 percent of male respondents and 64 percent of female respondents. Rest 40 percent of the respondents are literate. Majority (16 percent) of them are having educational qualifications up to primary followed by 8 percent up to middle. 6 percent up to both matric and senior secondary. Only 4 per cent of the respondents are educated up to graduation level.

3. Economic Factors

It is true that social and economic factors like income, occupation, and educational attainment have an impact on how frequently people use healthcare services. The type of work slum residents undertake reveals whether they are employed continuously or temporarily as well as the source of their income, such as regular salary or one-time wages. Due to the relationship between occupation and income and the household's financial situation, this does affect the possibilities of receiving medical treatment when needed.

Table 3: Distribution of respondents according to occupation

Occupation	Male	Female	Total
Government Job	2(8)	1(4)	3(6)
Private Job	2(8)	1(4)	3(6)
Self employed	4(16)	3(12)	7(14)
Daily wagers	10(40)	11(44)	21(42)

*Old / Women engaged in Household work	7(28)	9(36)	16(32)
Total	25(100)	25(100)	50(100)

Figures in parentheses column wise percentages

Table 3 shows that respondents from the slum are working in occupations that are primarily intended for the poor because the majority of them are performing menial tasks. Since their kind of employment requires inconsistent hours, their revenue fluctuates from day-to-day basis. Overall, 42 percent of those surveyed have low employment rates, with the majority of them working as laborer, rickshaw pullers, and rehra pullers. Since a result, they are living in misery and poverty as 32 percent of respondents are non-earners, the majority of them are housewives and elderly people who are unable to work. The study also found that there were 14 percent of the respondents who are self-employed. Only a mere 6 percent of the respondents work in both government and private jobs.

4. Income

Table 4: Distribution of respondents according to household income (On Monthly Basis)

Income Range (in rupees)	Male	Female	Total
Lowest (Up to 6000)	19(76)	20(80)	39(78)
Lower (6001- 12,000)	2(8)	3(12)	5(10)
Middle (12001-18,000)	2(8)	1(4)	3(6)
Higher (18001& above)	2(8)	1(4)	3(6)
Total	25(100)	25(100)	50(100)

Figures in parentheses column wise percentages

More than half of the respondents fall into the lowest and lower earning income categories, having incomes up to 6,000 and 12000 per month with 78 percent and 10%, respectively. This information is revealed in Table 4 of the respondents' household income. Higher incomes are reported by 6% of respondents.

➢ PERCEPTION OF HEALTH CARE SERVICES

Perception is founded on an individual's prior experiences. While utilizing the healthcare system, this covers things like how to go about getting treatment and what to consider while visiting a doctor. It includes the illness's cause and whether it is acute or chronic in nature. Attempting to find the closest available healthcare provider or looking for specialized care. People occasionally ask their friends and the community for advice on which doctors to consult for particular illnesses. As a result, those who have already sought medical attention from a health professional frequently speak highly about them.

In this part, perception is explored based on the types of health care respondents have access to, the challenges they encounter when using the public health system, and how they navigate this public space to meet their requirements.

5. Distribution of respondents by their level of satisfaction with the working of public health care facilities

The respondents are asked about their degree of satisfaction with the operation of government health facilities during the field survey in order to investigate perceptions of public health care facilities. The replies have been combined into several categories, which are listed in table 5.1 below.

Table 5: Distribution of respondents by their level of satisfaction with the working of public health care facilities

Level of satisfaction	***Male***	***Female***	***Total***
Quite satisfied	0(0)	0(0)	0(0)
Satisfied	2(8)	2(8)	4(8)
O.K	15(60)	17(68)	32(64)
Not satisfied	6(24)	5(20)	11(22)
Highly dissatisfied	2(8)	1(4)	3(6)
Total	**25(100)**	**25(100)**	**50(100)**

Figures in parentheses column wise percentages

From the above table 5 it could be summarized that there are 64 percent of the respondents (60 percent male respondents and 68 percent of female respondents) who states that the public health care facilities functioning is O.K. while, there were 22 percent of the respondents with 24 percent of male respondents and 20 percent of female respondents who were not satisfied with the working of public health care facilities. There were only 8 percent of respondents who were satisfied with the working of public health care facilities. A mere 6 percent of respondents were Highly dissatisfied with the working of public health care facilities. While, there were no respondents who were found to be Quite satisfied with the working of public health care facilities.

The respondent's level of satisfaction is based solely on the primary level of healthcare services provided by healthcare institutions. When people with chronic illnesses seek services from this health care sector depends on when they access tertiary health care institutions. The respondents, who make up 28 percent of the sample, are the ones that seek to the private health care system for alternatives because they are dissatisfied with the local medical facilities that are now available. Due to the lack of a healthcare center in each of their immediate surroundings. The respondents admitted that in order to get medical facilities, they had to travel to certain other sectors. Some like sector 37 dispensary, while others prefer Sector 16 hospitals. While some people

choose seeing private physicians. As a result, they are compelled to contact local doctors or RMPs (unqualified practitioners) working in their nearby areas.

6. Reasons for not seeking treatment from public health care facility

In order to better understand the barriers that respondents have in accessing the public health care system, questions have been raised throughout the field study. What are the obvious reasons for not seeking treatment from public health care or a government facility, is the question posed to the responders. In the table 6 below, the respondents' justifications are listed.

Table 6: Distribution of respondents based on their response to the Reasons for not seeking treatment from public health care facility

Reasons	***Male***	***Female***	***Total***
Distance of the facility	6(24)	7(28)	13(26)
Working Hours	14(56)	17(68)	31(62)
Lack of Facilities	18(72)	19(76)	37(74)
Lack of Medicines	21(84)	22(88)	43(86)
Medicines Cost	17(68)	16(64)	33(66)
Lack of Faith on System	20(80)	23(92)	43(86)
No Proper Check Up	21(84)	19(76)	40(80)
Financial Reasons	5(20)	7(28)	12(24)
Lack of Faith on Doctors	19(76)	21(84)	40(80)
Total	**25(100)**	**25(100)**	**50(100)**

Figures in parentheses column wise percentages

****The respondents have given multiple answers.***

The above table 6 above reveals that there were a majority of respondents with 86 percent who cited the reasons for not seeking treatment from public health care facility are Lack of Medicines, Lack of Faith on System. While 80 percent of the total respondents revealed that there is No Proper Check Up and Lack of Faith on Doctors to be the reasons for not seeking treatment from public health care facility. The majority of respondents said they weren't happy with the prescription medications they were given. Sometimes people who visit these health centres leave empty-handed because, contrary to what on-duty pharmacists frequently claim, the hospitals don't always have enough drugs on hand. In fact, people are frequently instructed to purchase medications from outside pharmacies using prescription slips, which means they must make an additional trip to do so. Madhu Nagla (2007) states that some of the respondents feel that there aren't enough of the basic medical facilities needed for receiving care, such as diagnostic tools like X-rays. The lab workers have little interest in having even the most basic blood and urine tests performed on-site.

7. Perception about doctors working in public health care facilities

What are the factors that encourage accessibility within the public health care system? is a question that was posed to the respondents during the field survey to investigate perceptions of public health care facilities. Is it distance, time, the provision of health information, or a health examination? In the table 7 below, the respondents' justifications are listed.

Table 7: Distribution of respondents based on their perception about doctors working in public health care facilities

Reasons	***Male***	***Female***	***Total***
Waiting Time	22(88)	21(84)	43(86)
Consultation Time	14(56)	17(68)	31(62)
Not happy with the behavior of doctors	23(92)	24(96)	47(94)
Not happy with Health Information provided to you	22(88)	21(84)	43(86)
Not happy with Health Check Up	21(84)	23(92)	44(88)
Total	25(100)	25(100)	50(100)

Figures in parentheses column wise percentages

****The respondents have given multiple answers.***

The above table 7 reveals the distribution of respondents based on their perception about doctors working in public health care facilities. The respondents find the way doctors interact with them to be unsettling. Patients claim that because there is a lack of a human relations approach, they are just numbers to doctors. The public health system lacks consultation time because medical staff are too preoccupied with patients and other tasks related to running these centres. According to the study, 94 percent of total of respondents are dissatisfied with how the doctors are behaving. According to the study, 88 percent of respondents are dissatisfied with health checkups. 86 percent of respondents said they were dissatisfied with the health information they received. It was found that 86 percent of the respondents were not satisfied with the waiting time in the health care facilities. While, 62 percent of the respondents were not satisfied with the consultation time. The respondents in the study revealed that the health care facilities should be opened 24/7. As whenever a person is not well for the emergency purpose, they have to go to government hospital in sector 16 from where they are referred to PGI, which leads to further harassment and they are totally disgruntled.

Patients who then wait are more likely to experience headaches because the lines are frequently long enough and there aren't enough room for everyone (Mathew, 2011:389). In order to avoid this embarrassing circumstance, doctors within the public health care system state that they must manage a significant influx of

patients, attend inspections, provide monthly reports to the civil surgeon office, and ensure the implementation of numerous national health programmes. According to doctors, the stress of their work prevents them from interacting with patients, even when they have no personal issues with them. The study conducted by Audinarayana in 2008 and 2011 underlined this fact.

8. Perception about infrastructure available in public health Care (government) facilities

Respondents were asked about their perceptions of the infrastructure present in government health clinics and satellite hospitals as part of a field study to assess public perception of such facilities. The respondents' explanations are listed in table 8 below.

Table 8: Distribution of respondents based on their Perception about infrastructure available in public health Care (government) facilities

Reasons	**Male**	**Female**	**Total**
Very good	1(4)	2(8)	3(6)
Good	6(24)	7(28)	13(26)
Fair	7(28)	6(24)	13(26)
Bad	11(44)	10(40)	21(42)
Total	**25(100)**	**25(100)**	**50(100)**

Figures in parentheses column wise percentages

The above table 8 reveals the Distribution of respondents based on their Perception about infrastructure available in public health Care (government) facilities. It was found that there were 42 percent of the respondents with 44 percent of male respondents and 40 percent of female respondents who said that the infrastructure available in public health Care (government) facilities are in bad condition. There were 26 percent of the respondents who feel the condition of the infrastructure available in public health Care (government) facilities to be both good and fair respectively. While, there were only 6 percent of the respondents who feel that the condition of the infrastructure available in public health Care (government) facilities is very good.

CONCLUSION:

Providing health care facilities to the members of society is considered essential both by national and international health care agencies and it is also mentioned in millennial development goals. Although, a lot of government effort has been put on to provide for health care facilities to all sections of society, but the marginalized or the socially excluded face a lot of problems in availing those facilities. The present study throws light upon the conditions of slum dwellers and their perception for the health care facilities provided to them by the government. Further it brings about the ground realities of adverse services in the area of health

care for the slum dwellers. According to the information provided by the respondents during the field research, visiting a nearby drugstore rather than a government facility is the best course of action when one becomes ill. The respondents frequently become impoverished because the available healthcare is too expensive for them to afford, thereby contributing to their poverty. The study also brings into light the measures to be taken up by the government for providing better health facilities to the slum dwellers. As they are not satisfied with the present scenario.

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