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THE INTEGRATION OF A *GYPSY* COMMUNITY IN SOCIETY : A MODEL OF CO-EXISTENCE OF PEOPLE OF DIFFERENT ORIGIN AND CULTURE (*THE CASE OF* GURËZ *VILLAGE,* KURBIN DISTRICT, ALBANIA)

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Abstract

This paper pertains to the Vendali[1] quarter of Gurëz[2] village in the commune of Fushë-Kuqe[3]. The basic focus is on the role of the gypsy population in the establishment and development of their residence, the population dynamics of this socio-cultural group, the demographic and social indicators, the analysis of the economic status of their families, the communication within the group and between this group and the rest of the population of the commune. Special attention has been paid to study the role of this specific group in the social and economic life of the village. The efforts of this group towards improvement of their educational, cultural and professional status, and their will for coexistence with the other inhabitants of the commune are also described. Through this study it is intended to suggest the ways and possible means to improve some aspects of their social and economic characteristics. The study is based on information and data available in written documents, gazetteers and interviews with the inhabitants of the commune and the local authorities.

1. History of Settlement of Gurëz village

Vendali quarter forms the core of Gurëz village, which is situated on the left side in the down stream direction of Mati river, in the northern part of Fushë-Kuqe[4] commune. According to the oral and written accounts, this territory first came to be inhabited in the first half of the 18th century. Up to 1750 the habitation was seasonal in nature due to the use of the territory by shepherds coming from northwestern part of Albania only during the winter season. Every year during this season the shepherds looked after the cultivation of some small pieces of land and during the summer season they returned with the flock of sheep to the pastures of the highlands and alpine areas. This migratory process continued up to the second half of 20th century. During this period of about 200 years the interest in the territory on both sides of the river Mati increased but the regularity of annual migration declined. During this period some of the shepherd families started leaving some of their family members behind to look after the dairy farms, pastures and pieces of cultivated land during the summer season also.

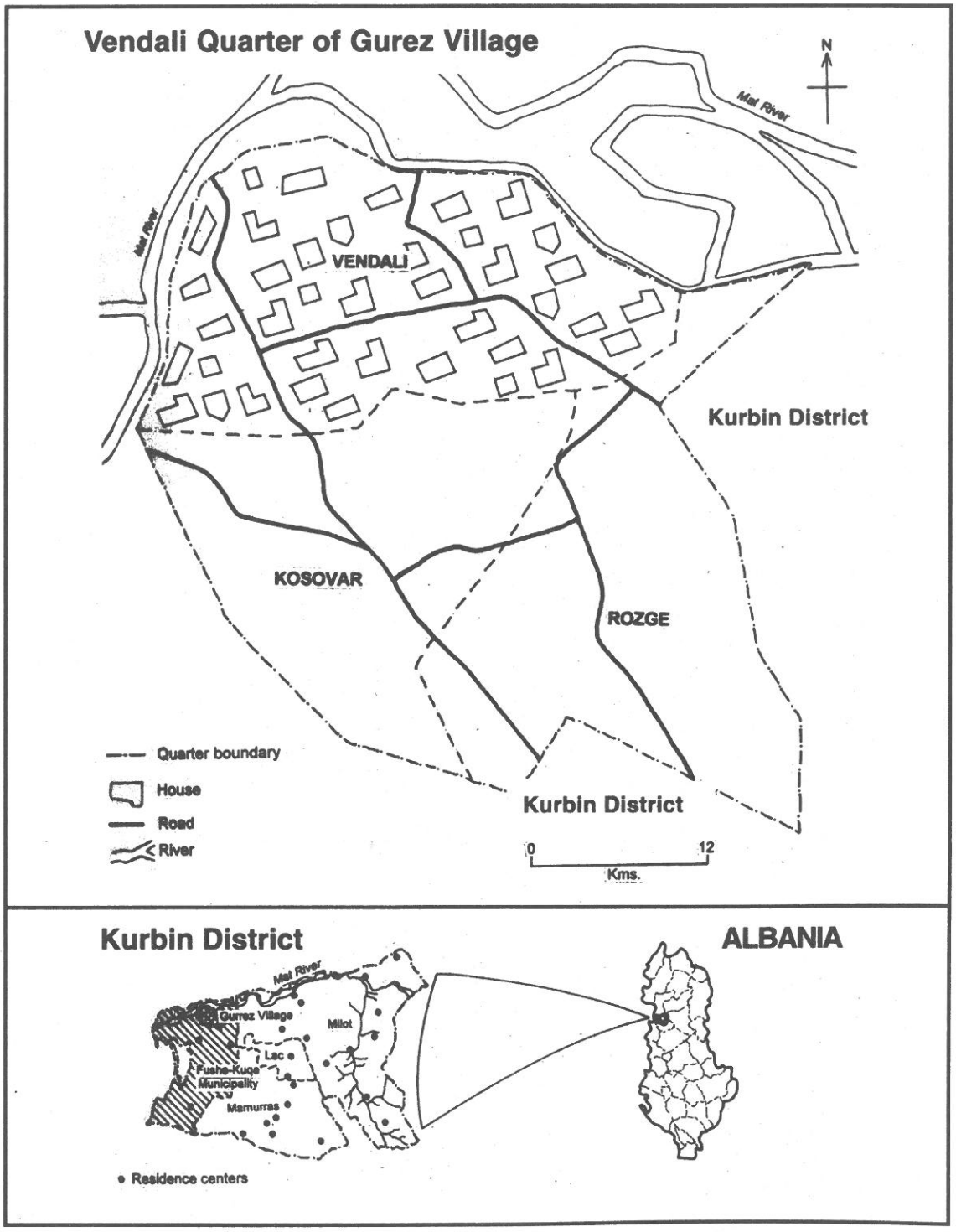
Vendali Quarter of Gurez Village
N
Mat River
Mat River
VENDALI
Kurbin District
KOSOVAR
ROZGE
Kurbin District
Quarter boundary
House
Road
River
0
12
Kms.
Kurbin District
ALBANIA
Mat River
Gurez Village
Milot
Lac
Fushe-Kuqe
Municipality
Mamurras
Residence centers

Fig. 1

These persons, mainly young boys, living in isolation on their own dairy farms, gradually started the process of constructing permanent residences in this area from the second half of the 18th century.

There is evidence[5] that the first inhabitants and founders of Vendali[6] quarter, were 2-3 gypsy[7] families who came from Lezha town in 1770's[8] . Another family which had come from the highland[9] of "Guri-i-Zi" village of Shkodra district around 1800 started living near them. Earlier this family had been bringing their flock of sheep during winter on the other side of the river, at the village "Bregu-i-Mates".

The creation of this permanent pith by these families provided motivation for other inhabitants also to come and settle in the area because it offered the advantages of scenic and serene natural beauty, fertile soils, forests, pastures, rich flora and wild fauna, adequate water, and a mild climate during winter. It was also located close to the main markets of Lezha (12 km.) and Milot (9 km.). (Fig.1)

The families who migrated to this area due to their familiarity with the area and tribal connections, were gypsies from Lezha comprising the Duka, Demiri, Dalipi, and Dini families. These families also settled in Vendali quarter of Gurëz village resulting in the enlargement of the residential pith.

In addition, the existing territory of Fushë-Kuqe commune continued to attract inhabitants from the highland of Lezha and Malësia-e-Madhe. However, these settled on their own dairy farms, far from each other, further expanding the habitation area of the entire quarter (Rrozgë, Malësore, Alk, Stomi-i-Stakës) and laid the foundation for the coming up of villages in future (Fushë-Kuqe, Gorre[10] , Patok[11] and Shëllinzë[12]). The influx of the highlanders (catholic) increased during the period of Tanzimati reforms (1830-1842), when the Ottoman Empire liberalised the rules related to the highland population. Initially, the population which came to this area built temporary seasonal dwellings using wood and straw. Later on, a large section of this population started building permanent high dwellings using wood, to protect these from river floods. The dwellings were connected by narrow foot tracks. Some lanes were also laid for the movement of animals and carts mainly during the dry period of the year.

Throughout the 19th century, Gurëzi and the other habitations continued to attract population from other zones. The Vendali quarter of Gurëzi also received additional gypsy families. However, these had come from such diverse places as Alushi (Bukli) family from Elbasani; Selimi, Ndreu and Tara families from Kruja, and Doda family from Mati. This was the third influx of inmigrants. It resulted in a considerable increase in the area of their residence, which currently forms a compact quarter situated around a centre with 2-3 shops and small spaces for artisan crafts such as blacksmithy, and making of musical instruments etc. This formed the beginnings of the first elements of the social life and the creation of a mini-market.

Along with the coming up of the gypsy quarter, other residential areas also increased and took the shape of villages. The arable areas were expanded and agriculture became an important activity besides stock breeding which continues to be the main economic activity.

The influx of migrants from the highlands of northeastern Albania to this zone remained high, especially during 1910, 1911 and 1912, because a part of the population of the highlands was involved in the flames of wars[13] and was forced to leave for other areas. A large number of families of the Fushë-Kuqe commune have their origin from this area. However, during this period the only people who arrived in the Vendali quarter were from Kraja family[14] . They opened the first "Coffeo bar" in Gurëz.

The most reliable data about the population of Gurëz, along with that of the other quarters and villages which currently belong to the commune of Fushë-Kuqe,are available from the works of *Franz Seiner*[15] , who states that in 1918 this zone had 213

houses (families), 1093 inhabitants (547 males and 546 females), out of which 38 were gypsies (*zigeuner*). Thus there were about 7-8 gypsy families with an average of 5 members each. The studies make it clear that not all the incoming gypsies had settled to a family life in this village and had left successors. Anyhow, the data testify to the existence of a consolidated group of people of gypsy origin, the largest one being in the area of Kurbin and Kruja districts, who have played an important role in the creation and development of a residential area, and in the emergence of the social, cultural and economic life of a rural community of considerable size.

The cycle of gypsy incomers in Vendali quarter of Gurëzi was closed with the coming of Hima family from Shijaku during the 1930s. Since then, some families belonging to other communities from Mirdita, Mati and Kruja districts, have come and settled in this quarter at a distance of 500-1500m away from the old pith resulting in an expansion of its territory. Thus, in addition to the increase in the number of inhabitants, there has also been an increase in the number of places from where people have come and settled in Vendali.This has created a heterogeneous community in terms of the origin, traditions and cultural point of view. Among the various communities the gypsy group is the most significant.

Unlike the highland families who preferred to settle far from each other, to maintain the same living style as in their mountainous places of origin,[16] the incoming gypsy families, who came during different time periods to Gurëz and settled in Vendali quarter, have created a compact residential area. This pattern of settlement helped in the preservation of the identity and cultural characteristics of this social group for a relatively long period till the time when the international proletarian theory, whose basis was the unification of people irrespective of their religious, regional and ideological differences, was applied in Albania. It was expected that the unification of culture, traditions and living styles would lead to the creation of the so-called "new people".

An important event for Gurëzi and surrounding villages was the opening of the elementary school in 1919[17] and later on in 1925, the seven years school at Vendali quarter. The school was open to all communities including gypsy children, some of whom later on became specialists in agronomy[18], economics[19], education etc.

The population of the current territory of Gurëz village was high during 1925-1928, due to the exile [20] of many Albanian families from their own motherland of Gjakova, Peja, Prizren, Drenica etc. from Serbian regime. Some of them were placed in the central part of Gurëz village, where even today exists a so-called "Kosovars' quarter" (Fig.1).

During the period of Ahmet Zogu's rule (1925-1939) and during the IInd World War, the significant characteristic for the stock breeding population remained their seasonal presence in this zone, because 30-40% of the family members during the summer season, moved away from the village together with their flocks to the highlands of Boga, Shkreli, Dedajt etc. Gurëzi remained an attractive location during this period as well. According to Don Shtjefën Kurti, in 1932 Gurëzi together with other villages of the zone, had about 250 houses[21], that means at least 1250-1300 inhabitants. In the periphery of Vendali quarter lived five non-gypsy muslim families: three of them had come from Borizana village of Kruja district and two from Kurbin village. During this period the economically most powerful families started constructing two storied houses using bricks and shingles. Besides the positive migration the natural population increase has also influenced the population density.

During this period an important event for the community was the construction of a mosque in 1930, at an equal distance from Vendali quarter (with mainly muslim population) and the "Kosovars'quarter" (with entirely muslim population), as well as the construction of a Catholic Church[22] in 1936, located inside the Vendali quarter very close to the school. According to the notes of Ordinarit Zef Bici in his report of

24th June, 1964[23], although the Catholic population (about 7 times more than the muslim population) lived in other villages and quarters of the existing commune territory, the Church, together with qelen[24] and cemetery, was placed right in this place at the request of heads or chiefs of Gurëz which also had shops and inns located in the Vendali quarter. Two other reasons seem to have influenced this location: firstly, it offered the locational advantages in terms of access to water and proximity to the main road leading to Miloti and the national road etc. and secondly, it contained the social, economic and administrative centre of the zone, where people were obliged to come for different reasons. The fact that the church[25] and the house of the priest were situated in this quarter, shows that the gypsies had wisely selected their residence area.

The construction of the school and religious objects at Vendali quarter or in its vicinity prompted further constructions such as inns of Gurëz, and an increase in the number of shops to 35. The library of Gurëzi was also established, with a book rack and reading hall, which continued to exist up to 1954. Interaction with the villages of "Bregut -të-Matit" and Lezha, which were under Gurëzi administration, was maintained through the use of trapa[26].

From the inter-war years till the agrarian reform of agricultural cooperation in the 1960's, the villages which comprise the existing commune territory were administered by the "old people group" and later by the regional authorities in Milot[27] which was the police centre.

The population of these villages, specially after 1960's increased rapidly, mainly due to natural increase, because free movement of population was not allowed by the politics of that time. The increase of population during 1945-1990 made possible the intensification of the economic activity, mainly agriculture, stock breeding and artisanship and the creation of the new social structure. The intensity of human impact on environment increased. There was an expansion of residential area and the area under cultivation increased by bringing new lands under agriculture. The wetlands and marshes were dried and bonified to establish some stock breeding enterprises in Gurëz, Gorre, Fushë-Kuqe etc.; new roads were constructed to connect villages with cooperative centres as well as Laç and Milot towns; power supply was provided to the entire zone by 1967; the Laç-Patok road was asphalted in 1974; the utilisation of Patok beach was started; some pumps for providing fresh water supply were installed; stores were constructed for agricultural produce; schools, kindergartens, health centres, cultural centres were opened and sport sites developed in the large villages.

In 1990 this zone had the highest population when many families coming from the north and northeast settled here. About 139 families who came from Puka (Iballa, Fushë-Arrëzi, Fierza), Tropoja (Lekbibaj, Margegaj, Tplan) and Shkodra (Thethi) were settled in Shëllinza village (Adriatik); 64 families from Puka, Mirdita and Tropoja were settled in Fushë-Kuqe village, 6 families from Dibër and Tropoja districts were settled in Patok village; and a considerable number of other families were settled in different areas of the commune.

After 1990, only one gypsy family from Mati district and two/ three highland families from Puka district have migrated to the territory of Vendali quarter. This has made the population of this zone more heterogeneous.

1.1 REASONS FOR POPULATION MIGRATION

Information collected from the inhabitants of Vendali quarter through questionnaires suggests that the main reasons for population migration to this place were different during different time periods and for different groups.

The main reasons for the migration of gypsy population are: lack of living sources, lack of space to carry out their profession, fear of blood feuds, inadequate living space for a growing family etc.

The main reasons for migration of population from the mountainous zone of north-east Albania are: lack of living sources; very difficult natural conditions and territorial isolation (especially in winter); fear from blood feuds, lack of life security from Serbs; and lack of basic conditions for education.

In the first phase the gypsy population migrated to this zone for three main reasons: quietness, water and good climate; availability of raw material for construction of their cottages and for carrying out their traditional professions; and proximity to the main markets to sell their products. Another reason specific to the migration of gypsy mixed[28] families was the desire of the wife to be closer to her parents' family.

As has been mentioned above, after 1990 there has been a high influx of migration from mountainous areas. The reasons for this migration are economic, social, natural, political and military, e.g., limited resources for living, education, health and information access and the war situation in Kosovo. But the reason which had a great influence on population migration was the flooding of the villages of Drin valley as a consequence of the construction of artificial lakes for hydro-projects; high unemployment rate due to complete stagnation of industry, destruction of the agricultural cooperative system and the distribution of the agricultural land [29].

The incoming population has been accepted warmly by the resident population. The majority of the incoming population has been settled in buildings of the former camp of the people in internment in Shëllinzë (Adriatik) village, while the rest have built houses of their own after paying for the land; the children are accepted without any problem in the schools of the villages where they are settled; all the families who came before 1st August, 1991 have received a piece of land according to Law No. 7501, a part of the families have received lands of the former agricultural enterprise, while the rest who have not received any land from the reforms, have bought it themselves from the resident people. There has not been any significant property problems, although some cases still remain unsolved.

2. Change in Numbers and Quality of Life

2.1 MARRIAGES AND THE GYPSY INTEGRATION IN SOCIETY

Marriage constitutes a very important event in the gypsy community. At wedding occasions the members of this group display such community values as acting as hosts to the guests and the family members of the bride and display their skills in music and dancing etc.

How does the institution of marriage function at Vendali quarter of Gurëz village? What is the age of marriage for the boys and girls? Where do they marry their daughters and where do they look for wives? What is the position of out of the community marriages (with white women or men) and what is the community reaction to the mixed couples? How have the mixed marriages influenced the integration of the gypsy community in the Albanian society? Answers to such questions have been obtained through questionnaires and interviews with representatives of this group, mainly the community leaders, in a survey carried out during October-November 2005.

The majority of engagements (about 90%) among the gypsy of Gurez village are arranged through such match makers as uncle, aunt, etc. This is considered the safest way to provide sustainable friendship and to have successful marriages. The weddings are planned with great care and attention to details and the parents try to prepare for their daughter a dowry[30] . The entire community is involved in the wedding preparations and the boys, girls and married women of the family play hosts and serve the guests throughout the wedding. The girls get married very young, between the age of 14 to 18 years. In most cases the age of marriage is 16 to17 years. Boys get married at a little higher age as compared to the girls, usually between 18 to 22 years. In most cases

the boys get married after finishing their military service. Except for two cases, all the girls in this community are married in towns located close by such as Lezhë, Shëngjin, Rrëshen, Burrel, Milot, Fushë-Krujë, Tiranë, Durrës and in some cases in towns located a little further away e.g., Lushnje, Skrapar and, Peqin. The community males look for wives from the same places as well. In many cases the community maintains a record regarding the places where the fathers or grandfathers got married.

Of special interest are the cases in which marriages are performed with individuals not belonging to the gypsy community. Such marriages have existed for at least four generations, but their frequency has increased among the younger generation. Among those who got married before 1945, there are three cases of mixed marriages, in two cases the husband was gypsy and the wife white, while in the third case the husband is white[31] and the wife is gypsy. After 1945 there have been two mixed marriage cases, in the first one the husband was gypsy and the wife was white[32], and in the second case the husband was white[33] and the wife was a gypsy. Later on the number of the mixed marriages increased considerably because all the children of the mixed couples are married to white spouses. The mixed family marriages constituted about 1/3rd of the total number of marriages in the gypsy community up to 1990 in Vendali[34]. In general, these marriages do not face any conflicts. However, in cases where the marriages were performed without going through the process of engagement, and without any consultation with parents, there have been many problems. The situation is generally resolved through the intervention of the families or relatives from both sides involved or with the intervention of the local authority. In extreme cases the conflicts[35] have lasted for over 5 to 6 years.

The analysis of data on mixed marriages suggests that this has been a subtle, but very fruitful way, used by the representatives of the gypsy community to get integrated totally in society. The socialist system has also favored such a process, in the same way as it has encouraged marriages between persons of different religions, because the ideology existing at that time gave prime importance to political and ideological identity and not to the ethnic or cultural one.

Another effort to get integrated totally in the society has been through the migration of majority of the mixed couples (about 90%) from the village, before or after the marriage, to large cities or abroad. In the cities the couples feel themselves to be completely equal with the rest of the population, i.e. white people, especially in those cases where they do not have dark color of the skin.

2.2 NATURAL INCREASE AND MIGRATION

It is a fact that the gypsy traditionally have a high fertility rate. However there have been major changes in the number of children per couple during different time periods. The data from the Civil Office and personal observations suggest that up to 1950, due to high mortality rate, the number of children per couple who remained alive was not more than five. Between 1950 and 1980, when the hygiene and health service improved, the married couples had the highest biological reproduction level of six children per couple, and one couple had 10 children. The number of children has decreased to four among the couples who got married after 1980 due to their poor economic condition during the time of cooperatives. The few couples who married after 1990, and have remained in the village, have only three children per couple.

The gypsy of Vendali quarter have been migrating consistently. Up to 1990 the migration was only for employment or marriage reasons, for example one family to Durres (1960), four to Tirana (two in 1965 and two in 1989), one to Lezha (in1970), one to Shullaz (in 1974), one to Laç (in 1978), two to Milot (in 1979 and in 1982) and one to Kruja (in 1986). During 1975-1990, three families moved to other quarters or to other villages of the commune. In these cases the movement was due to search for more living

space.

After 1990 the movement of this community has been mainly toward Tirana (four families) and abroad (three families in Greece, two in Italy and one in Turkey). The reasons for migration were mainly economic.

The decrease in the number of deliveries per couple and the continuous migration of members of this community (gypsy and especially mixed) has influenced the size of their population. There are about 77 gypsy inhabitants or those with blood relationship with gypsy inhabitants, due to birth from a gypsy parent, in the commune of Fushë-Kuqe. However, the mixed marriages have made the counting of the gypsy population practically very difficult, not only because the majority is not gypsy even from the blood or physical features, but also because they do not consider themselves as gypsies. They do not speak gypsy or any other language except Albanian. A considerable proportion of the existing children of gypsy origin, born of one gypsy parent, not only have one of the parents, but even one of the grandparents and in some cases even one of the great grandparents of gypsy origin. These arguments do prove the idea of some scholars[36], who do not consider this category of people a minority, but simply a social cultural group.

3. Family and Community Relationship

3.1. FAMILY SIZE AND LIFE STYLE

The gypsy family has passed through the same changes as the Albanian society in rural areas. The traditional extended joint family, with each branch of the family headed by an elder, typical for the Albanian society, started disintegrating in the 1960s. It was replaced by the modern joint family system[37]. In more recent years the family size has further decreased due to (i) reduction in the number of children born per couple and (ii) increasing incidence of family separation to avail benefit on the basis of food items distributed to each family [38]. The result of this process is the current small family with an average of 5 to 6 members each. The young couples have an opportunity to lead their own life as they like, even to adopt family planning and birth control measures. Even in the case of nucleated family the couple relationship is transparent and in many cases the decisions are taken after a discussion with all the family members.

The main source of income for majority of families is the private occupation in agriculture and farming. Each family, on an average, looks after 16 to 30 dynym of land[39]. Two-three families utilize about 7 dynym each, while the rest have a case in court against the former land owner. Land use is similar in all the families: about 30% of the land is planted for wheat, 30% for fodder, 15% for green beans, 15% for water melon, vegetables and potatoes, 10% for fruit trees and vine yards. Almost all the families sell their agricultural products either at Milot market or directly from the field, where the merchants buy it. Each family on an average has 5-10 chickens and a cow, to provide them with milk, butter, meat and eggs.

The sources of additional income for gypsy families are: fishing and providing different services to close by families who need help in agriculture, construction, iron and tin collection etc. Some of the young gypsies have been tempted to emigrate but often they are turned back due to lack of documents. Only 4-5 families declared that they are helped financially by their children in emigration. The retired gypsies receive a retirement pension (approximately 24 USD/ per month). One person receives 40 USD per month as invalid pension[40], another one receives social assistance (40 USD) as a person with physical problems, while his mother gets 60 USD to take care for her son.

The average monthly income per family ranges between 100 USD (1 USD per person/ day) to 200 USD (9.5 USD/day). The wide differences are related to the fact that two families with high incomes have two sons abroad who provide economic help to their families.

The majority of the families (90%) use their income for food, dress and agricultural services. Eight-nine families have used the last 15 years savings to reconstruct, enlarge or construct houses. Two-three families have taken mortgage to buy a cow or some essential item.

The results of the questionnaire survey about the standard of living suggest that 25% of gypsy families live in extreme poverty, about 40% live in poverty (average 2 USD per person/day), about 22.5% live on an average of 3-4 USD /per person/day and only 12.5% live with more than 5 USD/person/day.

3.2. INTER - FAMILY RELATIONSHIP

The solidarity and mobility to help each other is a very important aspect in the relationship between gypsy families. This is expressed both at occasions of misfortune as well as at doing important things such as the construction of a house (particularly roof) when the families of the community volunteer to contribute.

Social aspects in the country have changed in response to the larger changes which the entire Albanian society has undergone. The particular life style, community organisation, daily activities, life in family, relationships with neighbors etc., have undergone major changes which are related to the new social cultural spaces, information, free movement etc.

The neighbourhood plays an important role in the organisation of personal and social life of the inhabitants. Living in village is particularly significant in terms of the special way in which a certain territory is organised. The relationship with neighbours defines the construction space, the house position, streets and sewage lines etc. In our case study the fact that the relationships in Vendali quarter have remained good is evidenced by the location of houses inside the quarter territory. The selection of site for the houses inside the quarter is not by chance. The houses are grouped on the basis of blood relationships (brothers, relatives). Even other living aspects such as economic activity or small business, ceremonies, religious feasts etc. are based on blood relationships.

The village inhabitants have their own perception and understanding of the social cultural and economic matters.They have their special living organisation and social relationship and their own reaction to new phenomena of life etc.

The work related to economic activities in Vendali quarter (mainly in agriculture, stockbreeding and construction), is often divided among the family members or close family relatives. This shows that after the end of the phase of cooperative system, the inhabitants are reverting back to the traditional way of economic life and organisation in the village. The impact of economic change on this quarter is expressed in the way the inhabitants furnish their homes, their life style, dressing and food etc.

The personal relationships in the community were termed as normal by 73 per cent of the respondents and the remaining 27 per cent termed these as limited. The only reason for the limited relationships in the community is the property right issue. The distribution of land based on Law 7501, without taking into consideration the claims of land owners before 1945, has caused dissatisfaction. Some of those who benefitted from Law 7501 have not allowed the gypsy families to use the land received under this law. In two-three instances the cases have been taken up in the court but without any solution so far.

The answers to the questionnaire suggest that as compared to the pre-1990 situation, currently there is a kind of indifference in the relationships among the people. There is greater emphasis on individual and isolated life within one's own house and everyone cares only for his business. This is partly related to the migration of young population from the village. The inhabitants do meet as a community but only at national and religious feasts or weddings. Only in mortal ceremonies all the families of the community participate, and help the bereaved

family materially for meeting the expenses of the ceremony.

3.3. CHANGES IN LIVING SPACE

Up to the beginning of 20th century, the houses were mainly cottages or wooden ones built over a wooden base in order to be protected from the moisture and floods. Usually located close to the house were places for the animals, working tools, agricultural products, places to practise their artisan activities etc. The first brick houses, located in the center of Vendali quarter, were built during the inter-war period. Two or three of these continue to exist even today.

After 1960 the new houses are constructed only with bricks. These have only one floor and are surrounded by a garden. The places for the animals, working tools, agricultural products etc. continue to be built in the garden but out of the house. The houses have a simple structure with few rooms and, poor wooden furniture. The sheets and blankets were produced in artisan style by the inhabitants themselves. The dresses were traditional, mainly woollen and simple. The food was very limited, and comprised of cereals, dairy products (produced by the family itself), fish and meat of wild fowls.

The houses built after 1960 are still in use. Some new ones have been constructed adjacent to these. Only two families[41] (one out of the Vendali quarter) are building modern houses like a villa with two or three floors. The first floors are already finished and have been furnished with the latest fashion furniture. Unlike during the time of the cooperatives, when the villagers had no right to have animals, chickens etc., after 1990 the residents have started to breed these again, and provide shelter to these in a corner of the garden, some meters away from the house. The modern ways of dressing have replaced the traditional ones, and the food now has more variety.

4. Traditional Crafts and Integration of the Community

Traditionally[42] the gypsy population has been known as comprising of artisans, musicians, horse breeders and ambulant merchants. All these professions (except horse breeding) have been practised by the community of gypsies studied in this paper. The number of the folk professions has been increasing continuously.

Blacksmithy has traditionally been a profession practised by different generations of gypsies[43] . Earlier there were three masters in the village engaged in this profession, but in response to the demand from agriculture, one of these has become a mechanic for agricultural tools. At present this profession has been inherited by a successor of a mixed couple, who has moved to the centre of Fushë-Kuqe commune.

The musician band is another profession inherited from one generation to another. At least since the inter-war period, music has been played in the centre of Vendali quarter by the gypsy masters[44] at feasts or weekends. Interestingly the band plays music for their own pleasure or for admirers without any payment. The musical instruments used by the two families comprising the band suggest that the great grand fathers of these initially lived in Leskovik (south east of Albania). From there the families migrated first to Lezha, and then to Gurëz. During 1945-1990 the gypsy instrumentists have participated in the artistic group of the Cooperative, directors of the Palace of Culture, and have represented the region in the National Folk Festivals. Today this profession continues to be practised by the representatives of Duka and Demiri families, who play music at weddings and family celebrations in the territory of the commune and even beyond[45] .

The knitting of the baskets, buckets etc. by the gypsy population of Vendali quarter might have probably been the first handicrafts activity because the area is rich in the raw material required. This could also be one of the reasons for the settlement of this community in this area. Broom making[46] and Rrogoz knitting [47] probably started when the construction of the permanent houses started. Interestingly these products were sold by

members of the gypsy community themselves, by moving from house to house or to the market at Lezha or Milot, even during 1945-1990, when private economic activity was prohibited. This reveals the heritage of itinerant trading profession among the gypsy population.

After the creation of the cooperatives[48] and the consequent socio- economic changes, the gypsy population of Gurëzi were obliged to adopt other professions such as: cane knitters for ceilings, brick and tile bakers, fishermen, farmers and mechanics etc. Out of these professions the gypsy population took up the former three ones in larger numbers, while farming and stock breeding never became a preferred profession to them. In this context it is worth mentioning that a woman from Selimi family practised folk medicine[49] serving the entire community throughout her life. The craftsmen of the gypsy population have been very useful to the entire community and this has made their integration in the rest of the community easier.

Conclusions

The Vendali quarter constitutes the pith of Gurëz village. It started getting populated in the middle of the 18th century. The first residents were three gypsy families who came from Lezha and, a highland family who came from the village of "Gur-i-Zi" in Shkodra district. The process of populating the zone continued throughout the 19th and 20th centuries, but the maximum migration to this area took place during the first quarter of the 20th century. The gypsy population, with its characteristic physical and social cultural features has mainly come from Lezha, Kruja and Mati. One family has come from Elbasani and one from Shijaku.

The other inhabitants of Vendali quarter, who came from various regions of north Albania, settled at a distance of 0.5 to 1.5 km. away from the old pith. The centre of the quarter was changed into the centre of Gurëz village as well as the whole zone, because of the location of shops, school, religious structures and cult objects and, health centre etc. in it. After the bonification and the creation of the agricultural cooperative, the centre of the Gurëz village shifted by about 1.5 km to the southeast of the old pith. The administrative centre of the cooperative, the new school, the health care centre, and social cultural structures etc. were established at the new location.

The mixed marriages have been a subtle but very fruitful process for the integration of the gypsy community with the rest of the population. The movement of about 90 per cent of the mixed couples from the village to large cities or abroad has also influenced their integration in the society.

The decrease in the number of deliveries per couple and the continuous migration of population (gypsy and mainly mixed) have influenced the total number of their population. Actually, in Fushë-Kuqe commune there are about 77 gypsy inhabitants, but the mixed marriages have made the registration of the exact number of gypsy population practically impossible.

The gypsy family has undergone the same changes as the rest of the Albanian families in rural areas. The result of this process has been the current small family with an average of 5 to 6 members each.

The main source of income for majority of the families is private work in agriculture and stock breeding. Each family looks after 16 to 30 dynym of arable land and has one cow. The average income per family is 100 to 200 USD per month.

About 25 per cent of gypsy families live in extreme poverty, about 40 per cent live in poverty and 22.5 per cent live with an average of 3 of 4 USD/per person/day and only 12.5 per cent live with more than 5 USD/ per person/day.

The relationship within the community is considered as normal by 73 per cent of the interviewed persons and as limited by the remaining 27 per cent. The only cause for conflict in the community is the issue of the land property.

The dwellings at Vendali quarter have undergone some change. The location of spaces for animals away from the house and the introduction of modern furniture have been the significant changes.

The gypsies of Vendali quarter have enjoyed the reputation of being arstisans, musicians, brick and tile bakers, horse breeders and ambulant merchants. These professions have made their integration in the society easier.

Notes and References

1. Vendali is pronounced "Venali" by the residents of the zone.
2. There are two opinions concerning the origin of the name of this village. The first one links it with the word "gurë" which means stones. The village is situated on the left bank of Mat river, where the pebbles or stone deposits of the river are accumulated. The second opinion links the origin of Gurezi to "Guri-i-Zi" (a village in the commune of "Vaut të Dejës" in Shkodra district) one of the first families who founded this village.
3. The commune was created in 1992 in Kurbin district (Lezha Prefecture). It is bordered on the north by Mat river, on the south by Droja river, on the east by Laçi municipality, and on the west by Adriatic Sea (Fig. 1). It has a total area of 33 km². The commune consists of five villages: Gurëz, Gorre, Fushë-Kuqe, Patok and Shëllinzë (Fig. 1). The population of the commune is 7,552 persons, with an average density of 229 persons/km².
4. There are three main opinions concerning the origin of the name. According to Marin Barleti, who mentions about our national hero Gjergj Kastrioti, in his book, that the field on the west of Gjormi of Zheja became red by the blood of the Turkish in the battle and ever since this place is called Fushë Kuqe. The second opinion relates to a plant called "ferrë-kuqe" or "lulëkuqe", which bursts with red flowers in spring making the whole field look red. The third idea pertains to the fact that a part of all residences on the mountainside extends into the fields such as: Fushë-Miloti, Fushë-Mamurrasi. Somewhere between Gjormi and Zheja a residential area called Kuq has existed and due to that the field on the west of it is called Fushë-Kuqe.
5. The most reliable testimonies belong to the people who dealt with the history of the village and with the preparation of documentation for the museum of the village, which was burnt in 1997.
6. Vlash Prendi, Don Shtjefën Kurti – "Kronikë e një jete në amshim", Volume II, 1945-1971, Skanderbeg Books, Sh.B. "Arbëria", Tiranë, 2003.
7. According to the Dictionary of Albanian Language (Tiranë, 1980), "evgjitë" refers to some groups of inhabitants of some towns of Albania and other countries of Balkan, whose origin is thought to be from Egypt.
8. Family of *Thum Beqirt*, of *Bruk Loku* (nephew of Th. Beqiri) and of *Col Meta*.
9. Familja *Corri*.
10. The denomination "Gorre" is created by gaining the first syllables of two words "gorgë", which in the dialect of the zone means "basin of water" and "rrelë" meaning "water channel": go + rre = gorre. 'Gorgat' and 'rrelat' were the most significant features of this marshy land, till the bonification was carried out.
11. The village, which is situated close to the lagoon with the same name, is called so because during winter many migratory birds, such as ducks and drakes, come here.
12. The denomination "Shëllinzë" derives from "shëllinë", meaning liquid matter resulting from the salt dilution in water and it is used to preserve cheese. The village is called so because the soils in its territory are salty.

13. During the years 1910, 1911 and 1912 Northwestern Albania was a battle field for the wars between the Albanian riots, fighting to protect their lands (Plavës, Gucisë, Hotit, Grudës, Ulqinit, Tivarit etc.), and Serbo-Montenegrian armies.

14. Kraja –a well known Albanian settlement which is currently within the Republic of Monte Negro.

15. Franz Seiner, Schriften der Balkankommission, Linguistische Abteilung, XIII, Ergebnisse der Volgzählung in Albania, in dem von den Österr.-Ungar. Truppen 1916-1918, Besetzengebiete.

16. In the mountainous northwerstern zones of Albania the dispersed type of residences predominate. The houses are far from each other and the inhabitants communicate with each other with *piskama* (calling with loud and strong voice) or with such signs as fire or smoke.

17. The school was opened under the care of Don Mati Fishta.

18. Viktor Selimi is the first agronomist with a university degree, in Gurëz village.

19. Ali Bukli is the first accountant with a university degree in Gurëz village.

20. The historian, Marenglen Verli in his book "Reforma agrare kolonizuese në Kosovë 1918-1941" (Edition of Academy of Sciences of Albania, Publishing House "Iliria", Tiranë, 1992), writes that the movement of the Albanian population from their lands was made under the so called "Agrarian reform", whose main aim was the replacement of the Albanian population by Serbs and Monte Negrian colonists, in order to change the ethnic structure of Kosovo.

21. Vlash Prendi, *op. cit.*, p. 113.

22. This is the second church because a little further to the northeast, close to the Mjeshtri family, has existed a chapel since about 1910-1912. According to Zef Bici this chapel was planned to be built in the "Malësore"quarter, on the land of Rrok Bicit.

23. Vlash. Prendi, *op, cit*, pp. 109-113.

24. The building where the priest and the sisters lived. It was a nice two storied building. At present a gypsy family lives there.

25. It is a well known fact that churches and buildings of the priests were constructed at the best locations everywhere.

26. A simple sailing object made of wood.

27. During the reign of king Ahmed Zog, Miloti had the status of "krahines"- a region which depended on the sub-Prefecture of Kruja (Prefecture of Durrësi), while after World War II till 1970's Miloti enjoyed the status of a "lokalitet"- zone.

28. Families formed due to the marriage of a white citizen with a gypsy and *vice versa*.

29. In the mountainous zone of the northern part of the country the land is distributed on the basis of the borders that existed before 1946 resulting in a majority of the families remaining without land - the main resource for living.

30. Dresses, furniture etc. which the bride takes to the house of the bridegroom at the time of her marriage.

31. They came from the Albanian sites in Monte Negro, but the couple had no successor.

32. The couple got to know each other at a training course for teachers and the marriage was performed without any resistance, because the bridegroom was a member of the Communist Party and the bride belonged to a family from Gjirokastra and was connected with the Party.

33. In the second case the husband was a farmer from the village of Skrapar, and came to live in the village of his wife, whom he got to know during the war.

34. There is only one case of a highlander (divorced) and a gypsy woman, both inhabitants of Gurëz village since 1980.

35. Based on the information provided by the important families, in three cases of mixed marriages within the village during the last decade, the most unhappy have been the white or metis families, but even these difficulties were overcome. In two cases the couples have emigrated to Greece, where they are still living. They do come back to see their families for feasts or celebrations and help their families economically also.

36. Sh. Delvina (historian and journalist), R. Memushaj (linguist), K. Biçoku (historian), M. Kotini (historian and journalist), F. Sheri (demographer) etc.

37. In some cases there is still a tradition of one of the sons, generally the youngest one, to live with the old parents for looking after them.

38. In 1980s, when Albania was in total economic collapse due to its isolationist politics, the government decided that a part of the food (meat, eggs, milk, olive oil, coffee, sugar etc) be distributed to the citizens on the basis of a list (a certain amount for each family). This made some families to get separated at the Civil Status Office in order to get more food (more families more food). In many cases even the not married children over 18 got separated.

39. According to Law No. 7501 "On land", in Gurëz village the average land distributed is about 4 dynym per inhabitant.

40. The person is wounded and lost one leg during military service in Gjadër.

41. Both families have two sons in emigration for six years now and the house has been constructed mainly from their contribution.

42. (a). Encyclopédie Bordas, Vëllimi IV, fq. 2173, 5331-5332, SGED, Paris, 1994.

(b). Le Robert, Dictionaire alphabétique et analogique de la langue française, Vëllimi II, fq. 572, 920, Montréal – Kanada, 1987.

(c). Judith Okely, Ciganët shtegtarë (translated by Mimoza Gjika), Sh. Bot. Dituria, Tiranë, 2002.

(d). Mark Tirta, Etnologjia e Përgjithshme, Sh. Bot. "GEER", Tiranë, 2001.

(e). Minoritete: e tashmja dhe e ardhmja, Raport i GSHDNJ mbi situatën e pakicave në Shqipëri, Sh. Bot. "Kanun", Tiranë, 2003.

(f). Luan Dino, Egjiptianët e Shqipërisë, Sh. Bot. "ERI", Tiranë, 2004.

43. The most well known among them was Shit Alush (Bukli), who lived till the end of 1970s, and practised his profession in the new centre of Gurëz village.

44. The group had three instrumentalists: Hysen Lami played mandollit (a kind of mandoline), Dervish Hima – violin and, Man Selimi – *llahutës* (musical instrument of southeast Albania).

45. The current group has an intrumentalist playing the clarinete, another playing the organo and the third playing the *jazband*.

46. Hamdi Selimi, the master craftsman for making brooms, was called by the inhabitants of the zone as "Kazi".

47. *Rrogoz* or *haser* is a kind of carpet, made of straw, 2m long and about 1.5m wide.

48. The agricultural cooperative of Gurëz was established in 1957.

49. She was called Hane Selimi and knew the curative effects of some medicinal plants.

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ACCESS TO BASIC AMENITIES IN URBAN INDIA: IMPLICATIONS FOR HEALTH AND WELLBEING*

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Abstract

The access to the basic amenities like electricity, drinking water, toilet facility, wastewater outlet and LPG are critical for the health and wellbeing of the urban population. For example, about 13 per cent of the urban households have no access to electricity, 16 per cent have no access to safe drinking water and 27 per cent have no access to toilet facility as per 2001 Census. Further, about one-fifth of the urban households are not covered by any sewer system. On the other hand, several policy makers and planners believe that shortage of civic amenities is the result of rural to urban migration that is more directed to the bigger cities. The analysis of basic amenities by size class of cities and towns is likely to show to what extent these problems are serious in bigger or smaller urban centres. This study shows that small urban centres (less than 100 thousand persons) are suffering more from lack of basic amenities compared to cities (population more than 100 thousand persons). Further, among various amenities, sanitation facility (toilet and drainage) is the most lacking and needs far more attention than others in view of its close association with infectious and parasitic diseases.

Introduction

The rural and urban areas differ in terms of size, density, economic activities and in the organization of local governance. These differences reflect the life style of the rural and urban populations, the potential differences in the pattern of diseases and their capacity to control them through the provision of health care facilities. The rural is more associated with infectious diseases, while urban with chronic life style diseases (Clegg and Garlick :1979). However, this may not be true due to the presence of a large number of slum dwellers in big cities that lack basic services amounting to unhealthy and undignified living. The infectious diseases continue to dominate the urban areas, and also there is a resurgence of some of them due to increased population mobility, communication and urbanization (Ali, Isa and Rahman : 2004).

Access to clean air, water, fuel and other civic amenities like electricity, LPG, sewers etc. are critical determinants of health and wellbeing of population both in rural and urban areas. While bigger cities are known for air pollution, it is not always clear how towns and cities differ in terms of the provision of clean water, electricity, LPG etc. It is expected that urban areas are better served not only by civic amenities but also by health care services compared to rural areas. However, it is worthwhile to mention that urban areas are not a homogenous entity. These comprise of very large urban centers like mega cities (5 million and more population) on the one hand

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and small and tiny towns (population of less than 20,000 persons) on the other. To what extent basic amenities vary across states? Do more urbanized states show higher levels of basic services? Further, is it that bigger cities are better served by civic amenities compared to smaller towns? What are the implications of unequal access to civic amenities by size class of cities and towns in terms of urban governance and health of the urban population?

The paper attempts to show how basic amenities like access to electricity, safe drinking water, toilet facility, and clean fuel like LPG vary across the size class of towns and cities which are critical elements of health status and wellbeing of the urban people. An attempt has also been made to present the situation in six mega cities namely Delhi, Mumbai, Kolkata, Chennai, Hyderabad and Bangalore, which not only have a very high concentration of population, but are also the engines of economic growth in the country.

Pattern of Urbanization by Size Class of Towns and Cities

According to 2001 Census, India's urban population was 286 million, which constituted 27.8 per cent of the country's population. The urban population grew at the rate of 2.7 per cent per annum during the 1990s compared to 1.7 per cent per annum growth rate of rural population. The urban-rural growth differential was one per cent during the 1990s, down from 1.3 per cent during the 1980s. This shows that the speed of urbanization has slowed down during the 1990s. In spite of deceleration in the speed of urbanization, the net addition of population in urban areas was nearly 70 million during 1991- 2001. At the state level, the level of urbanization varies from nearly 50 per cent in Mizoram and Goa to around 10 per cent in Himachal Pradesh and Sikkim. On the whole, it is higher in the states of Tamil Nadu (44 per cent) Maharashtra (42 per cent), Gujarat (37 per cent), Karnataka (34 per cent) and, Punjab (34 per cent). In most of the other states the level of urbanization is either below the national average (27.8 per cent) or close to it.

The Census of India follows a six-fold classification of cities and towns. Class I urban centres comprise of Cities with 100 thousand and more population, and Class VI consists of tiny towns with a population of less than five thousand persons. The urban centres below 100 thousand persons are referred here as small urban centres. There were about 400 Class I Cities out of a total of 5000 odd cities and towns identified in 2001 which comprised 69 per cent of the total urban population of the country. The share of Class I Cities in India's urban population has also been increasing over the decades. It went up from 45 per cent in 1951 to 69 percent in 2001. This is happening because of addition of new Class I Cities from the lower size class over the decades. For example, from 1991 to 2001, nearly 100 towns acquired Class I status. At the state level, the increasing concentration of population in Class I Cities goes as high as 83 per cent in West Bengal, 80 percent in Maharashtra and 76 per cent each in Gujarat and Andhra Pradesh. The distribution of Class I Cities and their share in total urban population of the state shows the nature of hierarchy of urban places, and the extent of dominance of cities in their economies. Punjab, Orissa and several other smaller states show either a balanced distribution of population across size class of cities and towns or a lesser dominance of Class I Cities in their regional economy. Further, within Class I Cities, there were 35 metro cities with a population ranging from 16 million in Mumbai UA to one million in Rajkot. According to 2001Census, these cities consist of 107.9 million urban residents and constitute nearly 39 per cent of urban population in the country. The high concentration of population in Class I Cities reflects that cities are more attractive, having a higher level of employment opportunities compared to the small urban centres. The section below describes the nature of data on the basic amenities available from 2001Census and presents results and their implications for urban governance and health of urban residents.

Data on Basic Amenities

The 2001 Census provides data on basic amenities at the household level by rural and urban areas at the state level, and at the town and city level as well. The data are available for administrative towns and cities administered by Municipality and Municipal Corporation as well as for non-Municipal towns. Availability of several basic amenities like electricity, safe drinking water, toilet facility, use of LPG, and drainage for the outlet of household wastewater are critical for a good living, health and wellbeing of a household. In the Census tables, the households were classified by access to electricity as a source of lighting as well as cooking. It is possible that many households in urban areas may get lighting through streetlights. Because of this reason, the households were also again classified by availability and non-availability of electricity in a separate table in 2001 Census. The latter information on electricity has been taken as a measure of the access to electricity in this study. It is surprising that data on electricity and toilet facility is not provided for the state of Andhra Pradesh, although data on rest of the facilities are available. The data on sources of drinking water were provided in terms of tap, hand pump, tubewell, well, ponds, spring and rivers etc. The sources based on tap and hand pump may be considered as safe sources of drinking water. Similarly, the data on types of toilet facility includes households with pit latrine, water closet and other latrines, and wastewater outlets at household level is provided by type of drainage which includes both closed and open drainage. LPG is considered as a clean fuel and information on it was provided by the Census as one of the sources of fuel used for cooking. All selected indicators used in this study show the level of living, sanitary and hygienic conditions of the households, and also reflect how far the urban local governments are able to meet the needs of the citizens, the success of urban governance and challenges before them if a large proportion of the households is not provided with these basic amenities.

Table - 1

India : Percentage of Households with Selected Basic Amenities in Rural and Urban Areas (2001)

Amenities	Total (percent)	Rural (percent)	Urban (percent)
Electricity	55.85	43.52	87.59
Toilet facility	36.41	21.92	73.72
Drinking Water	72.36	67.49	84.90
Separate Kitchen	64.04	59.41	75.96
LPG	16.19	5.10	44.74
Drainage	46.40	34.18	77.87

Source: Tables on Houses, Household Amenities and Assets, H Series Tables, Census of India 2001, Compact Disk.

Results and Discussion

ACCESS TO BASIC AMENITIES: NATIONAL AND STATE LEVEL PATTERNS

Table 1 presents percentage of households with access to different basic services in rural and urban areas derived from 2001 Census. About 44 per cent households have access to electricity in rural areas compared to 88 per cent in urban areas at the national level. Similarly, toilet facility in rural areas was abysmally low at 22 percent, which goes up to 74 percent in urban areas. About one-fifth households resort to open defecation even in urban areas. Another aspect of sanitation

Table - 2
India : Percentage of Urban Households with Access to Selected Basic Amenities in States and UTs (2001)

State /UT	Electricity	Toilet Facility	Drinking Water	LPG	Drainage
Jammu & Kashmir	97.95	86.87	94.40	60.03	81.84
Himachal Pradesh	97.38	77.22	96.27	76.58	86.08
Punjab	96.49	86.52	96.26	62.72	89.77
Chandigarh	96.70	80.07	99.49	65.36	89.89
Uttaranchal	90.92	86.88	97.15	70.88	88.24
Haryana	92.94	80.66	94.19	64.26	88.41
Delhi	93.38	79.03	94.64	68.78	91.04
Rajasthan	89.61	76.11	90.41	52.80	80.19
Uttar Pradesh	79.92	80.01	95.53	46.01	92.38
Bihar	59.28	69.69	84.30	32.01	68.61
Sikkim	97.09	91.79	97.12	63.90	94.19
Arunachal Pradesh	89.42	86.95	89.11	56.30	63.26
Nagaland	90.33	94.12	38.92	34.17	72.24
Manipur	81.99	95.31	59.03	46.89	57.14
Mizoram	94.42	98.03	46.53	66.46	63.00
Tripura	86.36	96.96	72.35	48.98	53.06
Meghalaya	88.15	91.58	72.25	31.05	76.66
Assam	74.29	94.60	65.65	53.49	52.62
West Bengal	79.56	84.85	79.58	37.38	67.14
Jharkhand	75.61	66.68	64.38	28.09	72.36
Orissa	74.08	59.69	56.76	31.44	57.49
Chhattisgarh	82.85	52.59	85.18	34.82	62.96
Madhya Pradesh	92.26	93.72	81.41	53.10	75.93
Gujarat	93.39	80.55	90.11	58.70	78.29
Daman & Diu	98.31	65.43	93.00	80.17	50.87
Dadra & Nagar Haveli	95.84	77.20	80.32	54.74	52.18
Maharashtra	94.28	58.08	93.67	57.02	87.58
Andhra Pradesh	NA	NA	83.61	46.10	82.29
Karnataka	90.53	75.23	84.62	44.04	80.97
Goa	94.73	69.23	81.70	65.91	69.03
Lakshadweep	99.67	83.77	4.58	27.13	NA
Kerala	84.34	92.02	40.82	35.06	30.89
Tamil Nadu	88.00	64.33	79.79	36.78	70.02
Pondicherry	91.41	65.03	94.52	52.15	68.07

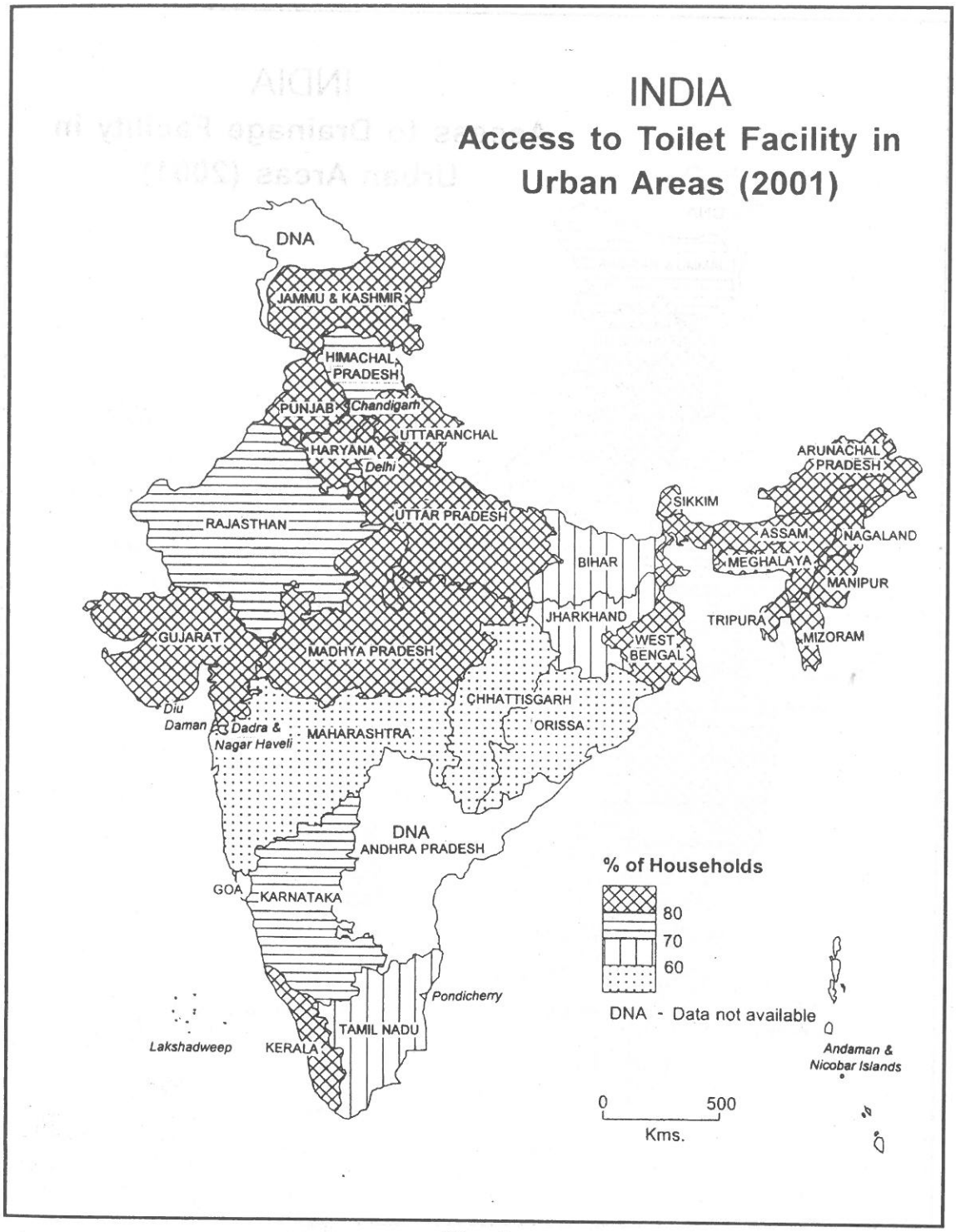
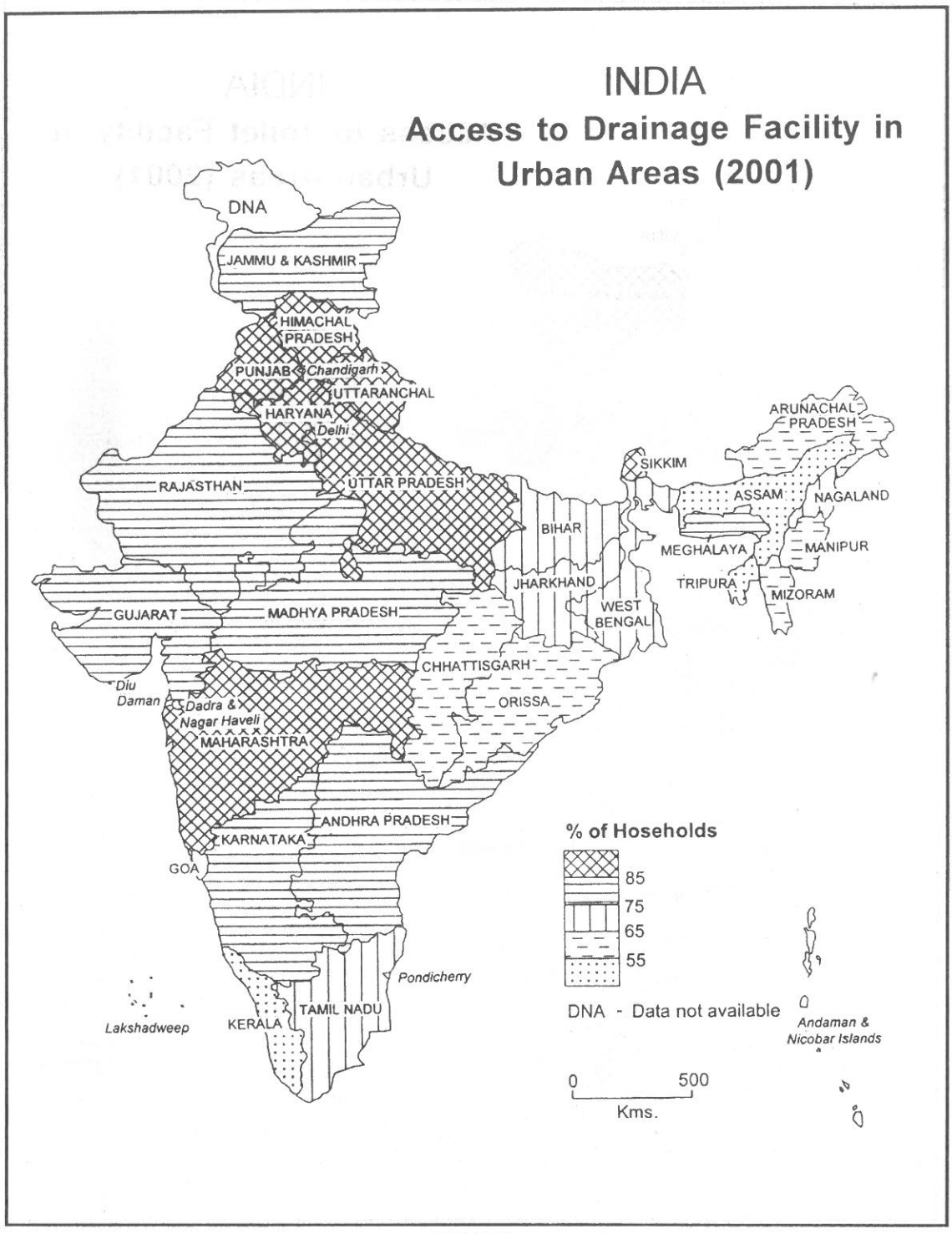

INDIA
Access to Toilet Facility in Urban Areas (2001)
DNA
JAMMU & KASHMIR
HIMACHAL PRADESH
PUNJAB
Chandigarh
UTTARANCHAL
HARYANA
Delhi
RAJASTHAN
UTTAR PRADESH
BIHAR
SIKKIM
ARUNACHAL PRADESH
ASSAM
NAGALAND
MEGHALAYA
MANIPUR
TRIPURA
MIZORAM
JHARKHAND
WEST BENGAL
GUJARAT
MADHYA PRADESH
CHHATTISGARH
ORISSA
Diu
Daman
Dadra & Nagar Haveli
MAHARASHTRA
DNA
ANDHRA PRADESH
GOA
KARNATAKA
Pondicherry
TAMIL NADU
KERALA
Lakshadweep
% of Households
80
70
60
DNA - Data not available
Andaman & Nicobar Islands
0
500
Kms.

Fig. 1


INDIA
Access to Drainage Facility in Urban Areas (2001)
DNA
JAMMU & KASHMIR
HIMACHAL PRADESH
PUNJAB
Chandigarh
UTTARANCHAL
HARYANA
Delhi
RAJASTHAN
UTTAR PRADESH
BIHAR
SIKKIM
ARUNACHAL PRADESH
ASSAM
NAGALAND
MEGHALAYA
MANIPUR
TRIPURA
MIZORAM
JHARKHAND
WEST BENGAL
GUJARAT
MADHYA PRADESH
CHHATTISGARH
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Dadra & Nagar Haveli
MAHARASHTRA
ANDHRA PRADESH
KARNATAKA
GOA
Pondicherry
TAMIL NADU
KERALA
Lakshadweep
% of Hoseholds
85
75
65
55
DNA - Data not available
Andaman & Nicobar Islands
0
500
Kms.

Fig. 2

closely associated is the wastewater outlet through the provision of drainage. The proportion of households either with open or closed drainage was 78 per cent in urban areas, whereas the figure goes as low as 34 per cent in rural areas. Compared to toilet and drainage facility, access to safe drinking water is better with 67 per cent households in rural and 85 percent households in urban areas which are provided with water either through tap or hand pumps. Table1 also provides information on the use of clean fuel like LPG. In urban areas every alternate household uses LPG compared to every 20th household in rural areas. Thus rural-urban gap is glaring in each of basic services and this is true at the state level as well. In the next section, we describe the situation only for urban areas because sustaining urban life without access to electricity, toilet facility, water, fuel and drainage is far more difficult in view of crowding, lack of open spaces and non-availability of such natural sources of water as ponds, lakes, springs and, rivers and forest resources for fuel.

In urban areas of most of the states the situation with regard to the availability of electricity is better compared to sanitation facility like access to toilet and drainage (Table 2). Among the states, the availability of electricity varies from 59 per cent in the urban areas of Bihar to 98 per cent in the urban areas of Jammu and Kashmir followed by Himachal Pradesh, Sikkim and Punjab. On the other hand, Jammu and Kashmir not only shows a better picture in terms of access to electricity but also has higher availability of toilet, drainage, safe drinking water and LPG facility as well. In the urban areas of eastern and north-eastern states like West Bengal, Orissa, Jharkhand, Assam and in the state of Uttar Pradesh the availability of electricity is much below the national average (87 per cent). The regional disparity in the availability is very pronounced and closely follows the level of urbanisation at the state level. The states with a low availability of electricity in urban areas are also the states with a low level of urbanisation. The correlation coefficient between proportion of households with electricity in urban areas and percentage of urban population shows a positive significant relationship ($r = 0.403$ at 0.05 significant level). On the other hand, none of the other facilities like availability of toilet, drinking water and drainage is significantly correlated with level of urbanisation at the state level. Apart from economic reasons, there are a variety of natural, social, cultural and behavioral factors that determine the access and use of basic services like toilet facility, drinking water and clean fuel.

The access to toilet facility is the lowest in the urban areas of Chhatisgarh (53 per cent) followed by Maharshtra (58 per cent) and Orissa (60 per cent) and highest in the urban areas of Mizoram (98 per cent) (Fig 1). In the urban areas of most of the north-eastern states including Assam, the availability of toilet facility is much higher than the national average (74 per cent). The data on type of toilet shows that pit latrines are more prevalent in both rural and urban areas of north-eastern states.

Access to safe drinking water is low in most of the north-eastern states as a large number of households depend on streams and rivulets for water. Kerala also shows a very low percentage of households with safe drinking water (41 per cent) as people use well water for drinking purposes (Kundu :1999). The access to drainage in Kerala is also one of the lowest (31 per cent) (Fig 2). At the state level, the availability of safe drinking water follows closely the availability of drainage facility ($r = 0.651$, significant at 1 per cent level).

As a measure of using clean fuel, the proportion of households using LPG varies from 28 per cent in Jharkhand to 77 per cent in Himachal Pradesh. In states where use of LPG is high, the availability of electricity is also high ($r = 0.58$, significant at 1 per cent level). On the other hand, toilet facility is not significantly related to the basic amenities like electricity, supply of drinking water, availability of drainage and use of LPG in the urban areas of States and UTs.

When we correlate toilet and drainage facility with per capita income at the state level, we find that these two amenities are not sensitive to per capita income. Earlier studies have also found that increasing level of development does not reflect improvement in the provision of sanitation facility at the household level (Kundu:1991). On the other hand, electricity, drinking water and LPG are significantly and positively correlated with per capita income at the state level (electricity r = 0.57; drinking water r = 0.36 and; LPG r = 0.49).

Table – 3

India : Households with Access to Selected Basic Amenities by Size Class of Urban Centers (2001)

Size Class	Population /Amenity	Electricity (percent)	Toilet facility (percent)	Drinking water (percent)	Kerosene (percent)	LPG (percent)	Drainage (percent)
Class-I	More than 5 million	97.21	57.67	97.52	33.35	63.02	82.80
	5 million to 1 million	86.69	78.49	89.75	27.71	59.92	90.09
	1 million to 0.1 million	80.99	72.93	85.06	18.45	50.50	78.43
Class-II	50 to100 thousand	77.70	66.40	81.82	13.92	43.71	73.31
Class-III	20 to 50 thousand	76.56	62.49	78.25	12.14	35.55	67.31
Class-IV	10 to20 thousand	78.28	57.39	78.89	12.61	29.76	63.96
Class-V	5 to10 thousand	76.27	53.86	78.61	9.54	26.42	57.96
Class-VI	Less than 5 thousand	77.93	62.53	71.29	7.16	26.59	50.82

Source: same as in Table 1

Access to Basic Amenities by Size Class of Cities/Towns

As mentioned earlier India's urban population is distributed across 5000 odd towns and cities with different size, economic base and ability to generate resources from tax and non-tax sources. Class I Cities (100 thousand and more) have a higher employment in organized sector compared to small urban centres. In many small urban centres, a sizeable proportion of workforce is also dependent on agriculture. Thus, size as a measure of urban centres not only reflects population concentration but their economic strength as well. It is expected that the provision of basic services is directly related to the size of urban centres. Table 3 which presents basic amenities by size class of urban centres confirms this conjecture except toilet facility. Toilet facility is not only low (close to 60 per cent) in small urban centres, but also in mega cities with more than 5 million population (58 per cent). These cities have a high proportion of population living in slum areas that have either no access to toilet facility or access

Table – 4
India : Distribution of Selected Basic Amenities among Mega Cities (2001)

Name of City	Electricity (percent)	Toilet facility (percent)	Drinking water (percent	Kerosene (percent)	LPG (percent)	Drainage (percent)
Delhi +New Delhi (M Corp.)	96.13	79.82	95.25	71.07	23.62	94.18
Mumbai (M Corp.)	97.89	43.57	98.98	57.73	39.80	96.31
Chennai (M Corp.)	94.03	89.78	78.10	59.44	33.88	88.67
Hyderabad (M Corp.)	NA	NA	95.68	48.36	45.55	95.63
Bangalore (M Corp.)	96.03	92.70	88.01	55.17	38.78	95.20
Kolkata (M Corp.)	94.01	95.59	83.36	47.62	38.72	89.22

Source: Same as in Table 1.

Table – 5
Greater Mumbai (UA) and its Constituents : Distribution of Households with Access to Selected Basic Amenities (2001)

Name	Electricity (percent)	Toilet facility (percent)	Drinking water (percent	Kerosene (percent)	LPG (percent)	Drainage (percent)
Mumbai (UA)	97.92	55.24	98.23	60.90	36.15	95.60
BMC	97.89	43.57	98.98	57.73	39.80	96.31
Non-BMC	97.97	70.68	97.24	65.09	31.31	94.67

only to community toilets. But the situation with respect to electricity and supply of drinking water is better in Class I Cities where more than 80 per cent of households have access. This figure goes as high as 98 per cent in mega cities with 5 million and more population. On the other hand, about one-fourth households are denied access to electricity and drinking water facility in small urban centres.

So far as the access to LPG is concerned, the highest use of 63 per cent is found in mega cities and as low as 26 per cent in the small urban centres. While it is obvious that Class I Cities have in general an advantage in the use of clean fuel like LPG, a large proportion of residents (one fifth) of these cities also depend on kerosene, and the rest on other sources of fuel. The situation in the use of clean fuel is worse in small urban centres where not only use of LPG is low (less than 35 per cent) including one-tenth using kerosene but where households are more dependent on coal, charcoal and wood as source of fuel which are sources of indoor pollution and ill health among a substantial section of urban population.

At the state level, the situation remains unchanged with regard to Class I Cities, which show a higher provision of basic services compared to smaller urban centres. But the Class I Cities of poorer states like Bihar, Orissa, Jharkhand and Uttar Pradesh show a much lower provision of basic services compared to Class I Cities of Punjab, Maharashtra, Gujarat and Karnataka. Thus, within same size class inter-state disparities exist.

A further analysis of six mega cities namely Delhi, Mumbai, Kolkata, Chennai, Hyderabad and Bangalore shows that the toilet facility is available to a maximum of 95 per cent households in Kolkata and only to 44 per cent in Mumbai (Table 4). It is to be noted that nearly half of Mumbai's population lives in slums, which are mostly served by community toilets. Community toilets are often not well maintained and a large proportion of population resorts to open defecation. About one-fourth of slum dwellers (about 1.5 million out of the six million slum population in the BMC area as per 2001 Census) defecate in the open (Times of India, March 5, Mumbai Edition, p. 6). Providing toilet facility is a great challenge for Mumbai, which is rarely recognized in the government circle. The problem is also serious in Delhi where one-fourth of the households do not have access to any type of toilet. About one-fifth of households have no access to drinking water in Chennai, while most of the households (99 per cent) have access to drinking water in Mumbai. Chennai and Kolkata are the two mega cities where one-tenth of households do not have access to either closed or open drainage for the outlet of wastewater. The use of LPG varies from nearly 70 per cent of households in Delhi to a low of 48 per cent in Hyderabad and Kolkata. In Hyderabad about 46 per cent of the households also use kerosene followed by nearly 40 per cent households in Mumbai, Hyderabad, Bangalore and Kolkata. It seems that LPG is more easily available in Delhi than in other mega cities. Except Delhi, nearly half of households not using LPG in other mega cities show that the demand may be higher in future if income levels of the poor increase. The access to electricity is found high in all the mega cities (more than 94 per cent) as compared to the average of 88 per cent for the urban areas at the national level.

Mumbai is the largest mega city with a population of 16 million as per 2001 Census. It is found that its periphery is growing faster whereas population growth in the core of the city (i.e Brihan Mumbai Municipal Corporation area) has slowed down or even declined in absolute numbers in several parts of the island city (i.e south of Sion) (Sita and Bhagat : 2007). It would be interesting to see how basic amenities differ between core and periphery of the city. Table 5 presents data on access to basic amenities in the core and periphery of Mumbai. The areas served by Mumbai Municipal Corporation (BMC) are treated as core and the adjoining urban areas namely, Thane, Mira-Bhayander, Kaylan-Dombivili, Ulhasnagar, and Navi Mumbai forming part of the Mumbai Urban

Agglomeration as per Census definition are treated as periphery. The level of basic amenities between the core and periphery show that there exists a wide gap in toilet facility between the two areas. In the periphery nearly one-third of the households do not have access to toilet facility as compared to more than half in the core of Mumbai city. The same situation remains with respect to LPG also, but the difference between core and periphery is not as large as that of the toilet facility. The core of Mumbai also has a very high concentration of slum population (about 50 per cent of population of BMC area live in slums). On the other hand, the supply of electricity, drinking water and access to drainage facility are almost similar between the two parts of Mumbai Urban Agglomeration. The example of Mumbai shows that the slum population is greatly affected by the lack of proper access to sanitation facility as compared to other basic amenities.

Discussion and Conclusions

The access to basic amenities varies in accordance with the size categories of cities and towns. Class I Cities show better availability of basic services compared to small urban centres. Also, variations in the availability of basic amenities like electricity, LPG and drinking water show a direct relationship with the size of cities and towns. However, this is not true for toilet facility as mega cities show a lower access to it due to the higher presence of slum households. In general the pattern in the distribution of basic amenities at the national level by size class of urban centres is found true at the state level as well, but the Class I Cities of high income states like Punjab, Gujarat and Maharashtra show a higher level of basic amenities as compared to the Class I Cities of low income states like Bihar, Orissa and Jharkhand.

It is worthwhile to mention that in spite of higher population growth, Class I Cities have maintained a higher coverage of basic amenities as compared to smaller urban centres. The annual exponential growth rate was 2.7 per cent in Class I Cities, (common cities between 1991 to 2001) as compared to 2.3 per cent in small urban centres. This indicates a higher level of migration to large urban centres. But the fact remains that a substantial growth of urban population is also contributed by natural increase in most of the urban areas (about 60 per cent for all urban areas) (Visaria:1997). Notwithstanding high contribution of natural increase in urban areas, migration is often blamed for poor basic amenities in Class I Cities. In fact, migration is a force to the city development, it alerts the city administrator to plan for the future of the city to realize its potential. The higher level of basic services, higher migration and investment are mutually reinforcing which is generally lacking in small urban centres.

The 74th Amendment to the Constitution came into force in 1992, which mandates the urban local bodies to take up several areas of urban planning and development including public health, sanitation and solid waste management (Chakrabarti:2001). It is expected that urban local bodies would generate their own funds to meet their needs. This requires enormous investment in infrastructure projects on water, sanitation, recreation and transport. Many small urban centres have no financial capacity and lack technical capabilities to design projects and raise funds from the market. The state governments have not suitably empowered them to take up urban governance independently including the power to raise money through taxation and market. Several state governments have abolished octroi- a major source of income to the urban local bodies (Bhagat : 2005). On the other hand, the Central Government's urban development policy through Jawaharlal Nehru National Urban Renewal Mission (JNNURM) is designed to serve a handful of large urban centres. This is likely to marginalize the small urban centres, which are playing an important role in the development of trade and service at the district and *tehsil* levels. As noted earlier the provision of basic amenities is low in the small urban centres, but their population is growing on an average rate of about 2 per cent per annum mainly through natural

increase. Are we able to meet the challenges of even this moderate growth of population in small urban centres? In fact, the challenges of providing basic amenities in general and sanitation facility in particular among small urban centres are enormous as they lack resources of their own and are not able to attract investments from the private sources. It is emphasized in the UN reports that the overall target to halve the proportion of people without access to basic sanitation and safe drinking water as a Millennium Development Goal between 1990 and 2015 will not be met unless there are significant improvements in the provision of services in small urban centres (UN-Habitat:2006). The problem is equally serious for the mega cities as well with their large slum populations, which not only require the provision of basic services but also proper maintenance on sustainable basis at the community level. It can be hoped that the adequate provision of safe drinking water, proper disposal of human excreta and waste water would prevent occurrences of many infectious and parasitic diseases in the urban areas.

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RICHARD HARTSHORNE'S CONTRIBUTION TO THE FIELD OF SOCIAL GEOGRAPHY

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Introduction

Prior to the publication of his magnum opus – *The Nature of Geography* (1939)- Richard Hartshorne was engaged in the fields of economic and political geography (Martin:1994:480-492; Khan:2000-2001:13-22). But during the same period he also produced some interesting and significant papers in other branches of geography (Khan:2007). Among these, his 'Racial Maps of the United States' (1938:276-288) has been rightly considered as one of the two "outstanding examples of the study of population in terms of its cultural characteristics" (James:1954:115). However, it is not easy to determine the exact branch of geography in which this paper may be placed. It may be considered as a contribution to each of the fields of political geography,[1] population geography,[2] racial geography,[3] and social geography.[4]

Despite the pedagogic difficulty of exactly locating its place in various branches of the field of geography, it needs emphasis that the paper may appropriately be placed under all those rubrics in that the empirical domains to which they relate are largely overlapping rather than mutually exclusive. Nevertheless, the paper may be considered as having signal importance in the field of social geography. It would, therefore, be interesting to evaluate the contribution of Richard Hartshorne to this branch of geography.

Richard Hartshorne and Social Geography

At the outset it must be pointed out that Hartshorne produced only one paper in the field of social geography (Hartshorne:1938 : 276-288). However, it has acquired a place of distinction because of the novelty of research problem neglected by fellow geographers. A summary of this paper is being produced here.

In the introductory part of the paper Hartshorne pointed out that the problem of national minorities, culturally and nationally associated with countries other than their own, was one of the most difficult problems of political geography of European countries. On the other hand United States, which was free from this form, had a more permanent problem of racial minorities that was essentially unknown in Europe.

He emphasized that the problems of racial minorities in the United States are fundamentally regional in nature. A large proportion of negroes in the southeastern states is considered as the single most important factor in the geography of the region. Moreover, he also analyzed the distribution of Chinese and Japanese and pointed out the importance of another racial problem of Mexican Indians in the Southwest. Further, he also described the distribution of native Indians and foreign-born whites in the United States.

In this section, Hartshorne pointed out the purpose, method and the source of data for the analysis of the problem. He defined the purpose of the racial maps as to depict the relative importance of different races in various sections of the United States. Since

the chief interest of Hartshorne was in the regional differences, instead of actual numbers, he measured the races, as taking their proportion in the total population of the areas concerned. Moreover, without entering into the argument regarding the meaning of word race, he accepted its ordinary interpretation as used in the United States. He believed that, "... the only definition of a negro is one who is known to be a negro; i.e. one who, either because of obvious physical characteristics, chiefly color, or because of known origin, is recognized as having any degree of negro ancestry, regardless of how much white ancestry he may also have" (Hartshorne:1938:227). This definition was that of the United States Bureau of the Census, whose data for 1930 were used by Hartshorne in this paper.

While discussing the 'Negro Areas,' Hartshorne referred to their distribution in the region of hot, humid summers and mild winters – the southeastern part of the country. But he refuted the ideas of foreign observers and emphasized that it is not a direct reflection of climate. Hartshorne emphasized that climate cannot explain the presence of large number of negroes in Northern cities as well as their absence in a number of Southern districts. He explained it through the factors of certain crop system, which depends not only on climate but also on certain conditions of land surface and soil, and the historical condition i.e. the institution of slavery (Hartshorne:1938: 277-278).

The older areas of intensive cotton production were in 1931 the areas of overwhelming negro proportion. The upper Coastal Plain and the Piedmont of South Carolina and Georgia, the 'Black Belt' of Mississippi-Alabama and the Yazoo-Mississippi flood plain were the areas best suited for cotton production. The plantations that had large number of slaves left their impact on the distribution of negroes. "Undoubtedly this population situation, with the social and economic structure that became associated with it, remains, even after the abolition of slavery, a strong factor discouraging diversification away from the simple, foolproof, cotton-and-corn cropping system" (Hartshorne:1938: 278).

Hartshorne pointed out the smaller proportion of negroes in the Black Waxy Prairie of Texas, that was the most important cotton producing area, because of its development since the abolition of slavery. He also referred to the areas of negro majority in non-cotton areas along the Atlantic coast where slavery was introduced on the tobacco, rice and indigo plantations of colonial days.

Moreover, there are areas of relatively low proportion of negroes in the South. The poor farming areas of the Appalachians, the poor-soil areas of the highland rims in Kentucky and Tennessee, a belt in northern Alabama and the sandy-soil areas of Gulf Coast come under this group. These were the areas where plantation culture was impracticable. A significant fact was the absence of negroes in the Ozark Highlands of Arkansas and Missouri, whereas immediately to their north they were in large numbers. In fact, the fertile valley of Missouri River had 'Southern' settlements that kept Missouri among the slave states until the Civil War (Hartshorne:1938: 278).

Hartshorne emphasized the effect of historic boundary, between the slave states and the free states, in the form of evolving a sharp line instead of a transition zone. Significant negro population, more than 10 per cent, overlapped this line in only two places.

He pointed out that as per the 1930 Census, about one-fifth of the total population of negroes resided in the traditionally 'free' states. Almost 90 per cent of these were urban dwellers and arrived in recent decades. Moreover, nearly half of them were found in three largest metropolitan districts. In New York and Chicago they were as a rule extremely segregated but only in Philadelphia they amount to one-tenth of the total population (Hartshorne:1938: 279).

Hartshorne also indicated an interesting contrast, though not revealed by the map "...that in the cities the proportion of negroes is relatively smaller than in neighboring rural

areas in the South but relatively larger in tiie North" (Hartshorne:1938: 279). This was because the cities, in both cases, offered employment to many of both the races so that they were less homogeneous than the surrounding rural areas.

Furthermore, Hartshorne pointed out the legislative implications of their distribution. Although all the states had white majority, the presence of negro majority counties within some, with their consequent social and political problems, presented legislative problems to the state as a whole. The eleven states having two or more negro majority counties formed the familiar 'Solid South', the Confederacy of 1861 – 1865. Along their northern boundaries lie the border states. Moreover, "Few of the other states have any serious negro problem except in the large cities. In some of these, however, segregation has produced a situation unknown in the South: individual wards or other electoral districts, for Congress as well as for local offices, have as high as 90 per cent negro population" (Hartshorne:1938:279).

In the next section of 'Mexican Areas', Hartshorne discussed the distribution of the second most important racial minority, Mexicans. He believed that they are practically all Indians and are recognized as 'colored' race. (In fact, most of them were Meztizos, but regarded in 1930 as Indians). They speak Spanish and inherit a different culture. He also mentioned that the Census includes only those who were born in Mexico or one of whose parents was born in Mexico.

The largest proportion of Mexicans is found in the Southwest. Of all the principal immigrant groups they are the only ones who entered in by land.[5] They were attracted by the need for cheap labour in cotton fields and sugar-beet fields and irrigated fruit and truck farms. They formed a majority along most of the Mexican border. Hartshorne also pointed out that in this belt the population was sparse hence their number was also small except in few areas. Much larger numbers were found in cities like San Antonio and Los Angeles.

Hartshorne compared this situation, of their larger concentration in border areas where they were racially and culturally more affiliated to the neighbouring country, with many European borders. But he indicated that this similarity should not lead to erroneous conclusions. There was no evidence of any nationalist movement among these Mexicans. But, "...the presence of this 'alien' race, [believed to be] permanently unassimilable because of color, leads to certain social and political problems in these areas similar to those of the old South" (Hartshorne:1938 :281). These problems were especially evident in Texas and California.

On the other hand, in the eastern United States, their proportion was small. However, their actual number was very large in Chicago itself, more than in seven mountain states west and north of Colorado.

In the next section, 'Native-Indian Areas,' Hartshorne described the distribution of aboriginal inhabitants of the country. Because of their sufficient dispersal they formed a majority in a few scattered areas. In fact, the white settlers had driven them out of the agriculturally suitable land and only in the negative areas did they have some relative importance. Besides the very small reservations from New England to Mississippi, in the entire humid half of the country, only in the eastern half of Oklahoma were they highly concentrated. "This is the only important area of valuable land from which the Indians were not later removed into less valuable regions" (Hartshorne:1938: 282).

Hartshorne further observed that in the western half of the country the map does not represent their distribution accurately because the size of the counties was larger than most reservations. Apart from reservations, where population was almost wholly Indian, it was difficult to determine their proportion in other parts.[6]

He emphasized the difficulty in generalization because of the method of locating the reservations. They were of some importance in the northern part of the country

west of Great Lakes, in the southwest from California to New Mexico and in eastern Oklahoma. Moreover, "Politically the problem is different from that of the other minorities because the Indians are defined not as citizens but as wards of the United States" (Hartshorne:1938:283).

While discussing the 'Oriental-Race Areas', Hartshorne pointed out that with the exception of Filipinos in one county, Orientals amounted to less than ten per cent in any county or city in the country.

Moreover, he emphasized that socially and politically these races were as separate from each other as from the whites. Therefore he had also depicted them separately, in round numbers on the dot maps, for the Pacific Coast States. Japanese were the major Oriental group on the Pacific Coast and were concentrated in the Los Angeles Plain and the Sacramento Valley. In general, Japanese farm labourers were found in the irrigated districts of the intermontane region and were distributed up to the Great Plains. On the other hand, Chinese were found mostly in the cities. They were concentrated more or less equally in the cities of San Francisco and New York and eight other cities. Filipinos in California were mostly employed in rural areas. Moreover, they were also scattered in eastern cities. In fine, the eastern half of the country had two-fifths of the Chinese, one-fifth of the Filipinos and four per cent of the Japanese. But in no county or city did their total population exceed one per cent.

Most of the coloured minorities in the United States were found in the Pacific Coast. Originally, Chinese came in large numbers but after 1882 because of the anti-Chinese agitation their immigration ceased. The need for cheap labour brought in Japanese; but they also suffered due to anti-Japanese attitudes and their immigration virtually ceased by 1908. But continued demand for labour further brought in Mexican Indians. However, there are reports of difficulties that may lead to their exclusion and more opportunities for negro farm labourers in southern California. So far the negroes were confined largely to the cities.

While discussing the 'Composite Map of Colored Races', Hartshorne pointed out that different racial areas were distinctly separate. However, in parts of New Mexico and Arizona native Indians and Mexican Indians jointly formed a majority. Because of difference in language and culture they may not feel racial unity, "but continued ostracism by the white population might eventually lead to such feelings" (Hartshorne: 1938:286). But these areas were of little importance. On the other hand, in the overlapping areas of Mexicans and negroes in southern Texas population was distinctly divided into whites, American negroes, and Mexican Indians. In eastern Oklahoma native Indians and negroes had intermingled for more than two centuries and hence this was expected to lead ultimately to more cohesion of both the coloured races.

In the section 'Foreign- Born Whites', Hartshorne indicated that this special type of temporary minorities, though not racial, was treated as if it were. Recent European immigrants, distinguished by their language, clothing, customs and attitudes, were clearly regarded as unassimilated elements. But their children, born in this country and educated in public schools, generally became full-fledged Americans. Arguably, this is a very broad generalization. North European stock who came in their early years were generally accepted as Americans, while native-born children of south and east European immigrants were likely to be discriminated as un-American. "Where such foreign-born peoples constitute a considerable part of the population of any area, their presence is one of the significant characteristics of that area and has important social and political consequences" (Hartshorne:1938:287). The urban zone from Boston to Philadelphia; the industrial districts around Youngstown, Cleveland, and Chicago; and the sparsely populated mining and lumbering districts of Upper Lakes, were areas where foreign-born whites constituted as much as one-fourth of the population.

In the last section of the article, 'Total

of All Minorities', Hartshorne described the distribution of minorities, both cultural and racial, which were not fully accepted as Americans. He emphasized that those areas where the proportion of all these minorities was less than 10 per cent had no problems because of their presence. The areas where their proportion fell below one per cent were especially interesting. "Most of these are areas of less desirable land where the native-white population has had all it can do to wrest a meager living from the inhospitable soil, with no chance of developing either plantations or industries requiring immigrant labor"(Hartshorne:1938:288). Even in the areas where mining and industry had lately developed, the over crowded native-white population can provide cheap labour.

Discussion

Sometimes a paper may stand out conspicuously as a major contribution in a field of study, not only because of the paucity of studies in that category but also by the novelty of the topic of research itself. Richard Hartshorne's paper (Hartshorne:1938) may be considered a case in point. Despite its simplicity and lack of any methodological breakthrough the paper has been considered, very appropriately, as having considerable importance. In fact, the significance of this paper lies in its taking into consideration a relevant problem of immense importance that was then neglected by other American geographers. Obviously, the wonder is not that Hartshorne did what he did, but rather that it should have taken so long for any geographer to do so, even allowing for the small size of the profession during those days in the United States. Undoubtedly, the most effective use of distributional maps for the interpretation of the phenomenon concerned has made this paper a seminal contribution.

Richard Hartshorne was perhaps the first American geographer who analyzed, so incisively, the distribution of racial minorities and their consequent socio-political implications in the United States. Moreover, it is to be emphasized here that the brief but very instructive comparison of racial minorities in European countries with the situation in United States, in the introductory section, placed the problem in an international context. However, the detailed analysis of the problem sharply illuminated the regional specificity of racial minorities in the United States. Likewise, it also highlighted some unique characteristics of each of the racial groups and their consequent impact on distributional patterns.

A close look at the paper reveals that Hartshorne had not only made use of the Census data very judiciously but also explained carefully the meaning of terms like negroes, Mexicans or native Indians etc., as defined by Census authorities. Moreover, the inclusion of foreign-born whites as a type of temporary minority in the United States reveals the sensitivity of the problem based on ground reality.

Another characteristic of the writings of Richard Hartshorne, which may also be observed in this study, is the appropriate use of relevant literature not only in geography but also in the allied fields. He has referred these studies in text or footnotes wherever necessary. In fact, the intelligent use of these co-lateral studies has made this paper well informed and has certainly enhanced the level of analysis.

"The most important contributions of geography to the world's knowledge have come from an application of the technique of mapping distributions and of comparing and generalizing the patterns of distribution" (James:1934: 82). Hartshorne's paper may be considered a fine example of having demonstrated the effective use of distribution maps, their comparison and making generalizations on the basis of these.

Further, in order to overcome the weakness of the technique of choropleth in the analysis of the distributional patterns Hartshorne supplemented the maps not only by taking into account the lower administrative boundaries i.e. townships instead of counties (Hartshorne:1938:280, Fig.3) but also substantiated them with the

application of dot maps indicating the actual number of minorities in those areas (Hartshorne:1938:284, Fig. 6). Consequently, the interpretation of maps became more effective and realistic.

Moreover, it should be emphasized that such distributional maps automatically become, over time, a powerful source of historical evidence. Richard Hartshorne's paper, in this context, acquires the status of having signal importance even in the present scenario, wherein his maps may be compared with the present day distributional patterns of the racial minorities in the United States.

It also needs emphasis that as a strong protagonist of the chorological concept of geography, Richard Hartshorne never fell into the trap of environmental determinism (Khan:1995–1996:47-48). A close look at the causal factors, used in the explanation of distributional patterns of racial minorities, reveals that he had given more emphasis to social, economic, political and historical factors than to physical ones. In this context, it would be more pertinent to consider the following statement: "The areas that are relatively high in negro population (Fig. 1) lie in the region of hot, humid summers and mild winters – the southeastern part of the country. But it is clear from the map that this is not a direct reflection of climate, as some foreign observers have supposed. The large number of negroes in Northern cities cannot be dismissed as exceptions; nor can the absence of negroes in many Southern districts be explained climatically. Rather the well known concentration in the South can be understood only in relation to certain crop systems, which depended not only on particular climatic conditions but on certain conditions of land surface and soil, and also in relation to a certain historical condition no longer present–the institution of slavery" (Hartshorne:1938:277-278). This statement aptly reveals his explanatory method. In fact, it was characteristic of his method of reasoning that he assigned to each factor its proper role.

It would be most appropriate here to note the characteristic expression of Preston E. James who considered Richard Hartshorne as an 'innovator' in many of his studies published during those days and specifically mentioned this paper as an example (Dow:1972: 82). Despite the lighter mood in which Hartshorne replied to the question, and ignoring the fact that the paper discussed all the racial minorities, rather than black people only, it needs emphasis that James was too serious in pointing out the importance of this piece of research.[7] Here, it is only fair to add that Hartshorne was interviewed by James thirty four years after the publication of this paper. Undoubtedly, this paper acquires a place of distinction in the historical development of the area of research concerned.

Conclusion

A close perusal of the contribution of Richard Hartshorne to the field of social geography reveals that the single paper that he wrote in this branch has been considered as outstanding. In fact, the novelty of the research problem, excellent use of maps and their comparison in highlighting the regional specificity of the patterns, logical interpretation on the basis of physical, social, economic, political and historical factors and arriving at generalizations make this study a seminal contribution. Moreover, these maps as a source of historical evidence are of tremendous importance in comparing the contemporary distributional patterns of racial minorities in the United States.

Notes

1. The paper considered, basically, the distribution of racial minorities in a country. In fact, the first paragraph of Hartshorne's paper clearly indicated its inclusion in political geography (1938:276). Moreover, as is well known, during those days Hartshorne was vigorously engaged in teaching as well as research in the field of political geography.

2. The paper had taken into account skin colour as one of the cultural characteristics of a section of the population in

U S A. Hence in his review article Preston E. James included this paper as a significant contribution to the field of population geography (1954: 115-116).

3. Undoubtedly, the title of the paper implied its inclusion in the field of racial geography. Taking into account Hartshorne's own views on this point can further substantiate this. While pointing out that the use of cartographic techniques was of great importance, Hartshorne also referred, in this context, besides others to his own "study of the racial geography of the United States" (1939:249)

4. In fact, the term race had been considered in this paper not in the 'biological sense' but in the 'social sense.' Moreover, it is appropriate to note here the following statement of Richard Hartshorne which indicated the place of this paper in the systematic branches of geography: "In 'sociological geography,' Kniffen has used the method [ratio method] in mapping house-types and the writer has used it to show the areal differences in racial construction of the population of the United States" (Hartshorne:1939:427).

   Furthermore, it would be more interesting to have a close look at the following statement of Hartshorne wherein he himself referred to the branches of geography in which his substantive papers may be placed: "The variety of topics on which I had written in substantive papers - on transportation, location factors in industry, agricultural regions, urban districts, social and political geography, and even a paper in climatology – provided a wide background of experience against which to test methodological concepts"(Hartshorne:1979:68). A close perusal of the bibliographic records of Richard Hartshorne (Martin:1994:480-492; Khan:2000-2001:13-22) reveals that it is only his "Racial Maps of the United States" (1938), which can be appropriately placed in social geography mentioned in the above statement.

5. In fact, many of the Mexicans in the Southwest are descendents from people who resided there before 1848 when it was ceded by Mexico to the U S A.

6. It may be pointed out that many reservations did (and still do) permit some white settlers (e.g. teachers, ministers, Indian agents, etc.).

7. In this context, it would be interesting to carefully go through the following dialogue between Preston E. James and Richard Hartshorne (Dow:1972:82):

   James : But you, of course, were interested in a lot of other things during this time and you were an innovator in many of them. For instance, those maps of the distribution of black people in America, which were published. Where? In the Geographical Review?

   Hartshorne: The Geographical Review. Yes. I was the geographer who discovered that there were Negroes in the United States. (Laughter).

   James: This is about the truth and those maps are of tremendous importance today - to compare the patterns of distribution...

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HEALTH CARE BEHAVIOUR AMONG GUJJARS: A CASE STUDY OF DARA, SRINAGAR (KASHMIR)

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Abstract

The present study aims at understanding the perception of Gujjars - an ethnic group distinctly different from other sections of society - towards disease occurrence among them and their preference for indigenous practices in remedial procedures and in disease control. The Gujjars are scattered all over India in small groups. In Jammu and Kashmir they prefer to have their settlements at comparatively higher altitudes. The study area is quite close to Srinagar city adjacent to the famous National Park of Dachigam, and is thus rich in fauna and flora resources.

Geography has emerged as an applied subject in the changing socio-economic scenario at global level and takes interdisciplinary approaches in to consideration to arrive at some what realistic conclusions. As such the present paper has its focus on two aspects - health care behaviour and health care facilities - which provide an impetus for policy makers and planners to implement appropriate strategy for better health care facilities so that people are benefited by the development programmes. The study is based on a primary survey which was conducted during the months of February and March 2007.

Introduction

Health behaviour investigations have recently acquired an important place in medical geography. Health behaviour may be defined as the process through which a person who perceives himself or herself to be ill, chooses and implements strategies to facilitate the restoration of health. An understanding of health behaviour is vital to the study of disease transmission and the planning of disease control. Geographers have studied both, illness and health care behaviour in the framework of socio-economic and cultural dimensions, in order to arrive at some strategy towards human welfare (George: 1985; Annas :1998).

Kloss and Thompson (1979) worked on the behaviour of people related to water contact to the occurrence of schistosomiasis in an upper Egyptian village. The study of behaviour of individuals in a community can lead to an understanding of their level of understanding, their perception about a variety of given choices on the basis of their knowledge and experience in understanding the factual and thereby the optimum utilization of available resources. Health behaviour includes all activities undertaken individually or collectively for the purpose of curing and preventing diseases.

The present study deals with understanding of the health care behaviour of Gujjar community in Jammu and Kashmir State through a case study of Dara, a micro region, located in district Srinagar in Kashmir Division (Fig.1). The community represents a distinct social group, moulded by the physico-cultural beliefs, and therefore having their own concepts of health, sickness and health promotion, depicting values, beliefs,

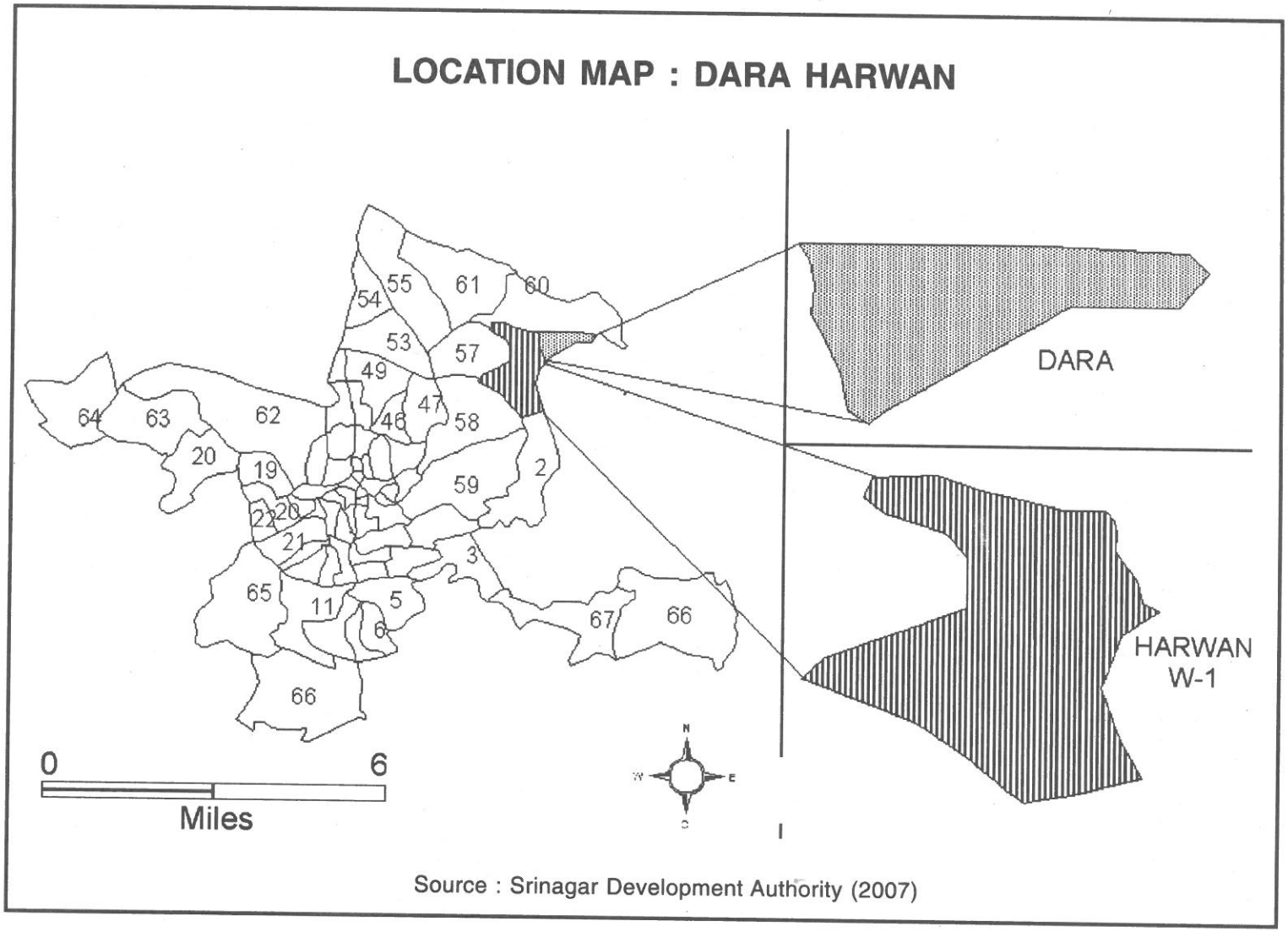
LOCATION MAP : DARA HARWAN
DARA
HARWAN
W-1
54
55
61
60
53
57
49
47
64
63
62
46
58
20
19
59
2
22
20
21
3
65
11
5
67
66
6
66
0
6
Miles
N
W
E
S
Source : Srinagar Development Authority (2007)

Fig. 1

knowledge and a host of other practices which distinguishes them from the non-Gujjar community in the neighboring area.

An attempt has been made to ascertain the status of health of this community on the basis of their health care behaviour. Various factors affecting, influencing and determining their health care behaviour have been taken into consideration. It is expected that this can go a long way in promoting health and improving the status of health of this community.

Significance

Health status is an important indicator of human development. It is intricately related to fertility, mortality and life-expectancy, which form the very basis for various socio-economic and cultural studies. The status of health has a direct bearing on the nutritional status, educational achievement, disease resistance, intelligence, productivity and purposeful pursuit of definite development objectives. For the successful and effective planning related to health and for the successful and efficient policies and programmes directed to improve the conditions of health, it is important to understand the health care behaviour of a particular population group.The concept takes into account the role and impact of factors that influence the health of people.

Health and health care behaviour explores social and behavioural change in population as these affect health status and quality of life. It also examines the processes of planning, locating, implementing, managing and assessing health education and social – behavioural interventions. Keeping in view the significance, relevance and importance of the study of health behaviour, the present study has been carried out among the socio-economically backward and technologically untouched Gujjar population of Dara, Harwan in Srinagar district.

Study Area

Dara, a micro region in Harwan, is situated in Srinagar district of Jammu and Kashmir State, located at a distance of 21 kms. from the main city. Dara has a total area of 9.2 square kms. It is surrounded by Haripora in the south, Syedpora in the west and Kohistan in the north – east. The area has a total population of 5250 persons, forming 1212 households (Census 2001). It is located between 34^0 10' North Latitude and 74^0 54' East Longitude. The area is dominated by Gujjars and is, therefore, representative of other Gujjar areas scattered in Jammu and Kashmir State.

Objectives

The main objectives of the study are:

(1) to ascertain the status of health of the Gujjar community in Jammu and Kashmir;

(2) to assess the community's perception about disease causation;

(3) to assess the methods and strategies devised by the community to restore health;

(4) to ascertain the perception about various systems of medicine and the preference for a particular medical system;

(5) to analyse the physical, social, cultural, and economic factors which determine the optimum utilization of various health care services; and

(6) to suggest measures for promoting health and improving the health status among the community.

Data Base and Methodology

The study is based on data collected from primary as well secondary sources. Primary data has been collected through household surveys, personal narrations, and observations of 843 households out of a total of 1212 households in the area, accounting for about seventy percent of the total households. Interviews were conducted with the help of a structured questionnaire containing questions pertaining to income,

educational qualifications, health facilities available, perception of diseases, preferences and prejudices related to utilization of health facilities, system of medicine preferred, prevalent diseases, management of health problems and physical and economic accessibility to health care facilities.

A separate questionnaire was prepared for medical practitioners active in the area, both in private clinics and government run Primary Health Centre to collect information about the prevalent diseases among Gujjars, their efforts to report in time in hospitals or clinics, attitude towards the advice given by the practitioners and any peculiar health behaviour exhibited by the community.

Secondary data for this study pertains to the location, areal extent, population, number of households and health facilities available in the area. Sources for this data are Directorate of Revenue and Statistics and Evaluation, Srinagar, and the Census of India, 2001, Series 8, J&K.

Discussion

The Gujjar community in the area represents a distinct social group, having their own set of values, beliefs, customs and traditions. In fact, the geo-ecological environment of their habitat has exerted a determining influence in shaping their mode of life, cultural ethos, values, customs, and traditions and of course behaviour related to any observed phenomenon (Ali:1994).

The community is socially, economically and technologically backward living a marginalized life. This is adequately exhibited by the unhygienic and unsanitary conditions in their residential environment. Their houses are nothing more than hollow mounds, made of mud and thatch, having not more than two dingy rooms, supporting a family of more than five members in most cases. These structures are locally known as *Dhokas* or *Kothas* (Hussain:2003). The number of persons per room in these houses is three.

The literacy rate among the population is very low (24.50 percent) which has perpetuated ignorance among them and a narrowing of their outlook. The community is superstitious and willing to adhere to their age-old traditions and customs and reject new ideas (Akhtar:1988).

Thus, it is interesting to understand that within the existing socio-economic, cultural, psychological framework what is the status of their health, what is their perception of disease and illness, what measures they undertake to restore their health and how they make use of their available health facilities and systems of medicine and how far they are successful in treating themselves.

Perception about Health/ Diseases

The community's perception about diseases is a reflection of their socio-economic and cultural environment. On the basis of the data collected for this study, it was found that 14 percent of the community perceives disease as that condition or state of body in which a person is unable to work. 37.1 percent of population perceives disease as a liability which affects not only the sufferer but the entire family and is a hindrance in the way of improvement of economic status. 11.3 percent of the population perceives disease as an obvious outcome of poverty. 38 percent of population considers disease an ordeal from God and sometimes a result of magic and witchcraft.

Perception of Causes of Diseases

The causes which have been attributed to the diseases by the community range from unscientific ones based on mere ignorance, superstition and lack of knowledge to scientific ones, based on observation and experience. These may be summarized as under:

1. CONTAMINATED WATER: Water is essential for the sustenance of all living organisms, including man. In the study area, water is used mostly for domestic purposes and is drawn directly by majority of the households from the flowing river in the lower reaches of the area where water pipelines are

virtually absent. Some of the households in the upper reaches have their waste outlets, containing human and animal excreta, draining into the river. This has led to contamination of water and has consequently contributed to the causation of various helminthic diseases. 12 percent of the population perceives contaminated water to be a cause of ill health and disease.

2. POVERTY: A section of the population considers poverty to be the cause of disease. Poverty results in provision of inadequate diet and other facilities which are responsible for disease causation. Poverty is considered as a cause of disease by approximately 11 percent of the population.

3. MAGIC AND WITCHCRAFT: 38 percent of the population attributes the causation of disease and illness to magic and witchcraft. Females were more particular towards this factor. It is contended that people who cannot see their counterparts flourishing switch over to black magic and witchcraft with a view to harm them as much as possible. This factor is neither rational nor logical. It shows the degree and extent of ignorance of the people which is an obvious outcome of illiteracy and lack of awareness among the people.

4. AN ORDEAL FROM GOD: A sizeable proportion of the community considers disease as an ordeal from God. People believe that it is a punishment from God for the sins they have committed.

5. BAD LUCK: 24 percent of the community were of the opinion that disease is contracted by those who have ill luck. Again ignorance, sheer backwardness is the main reason for the perception that disease causation is an ordeal from God and victimizes people who have bad luck.

Determinants of Health Care Behaviour

The most important observed determinants of health care behaviour in the community under study are:

1. EDUCATION AND AWARENESS: Level of education and awareness is one of the important determinants of health care behaviour in Gujjars. There is a very low level of education in the community, with a majority being illiterate and only a few having managed to go through pre-primary education. As a result their outlook is narrow and they are least exposed to social life outside their families. This has led to treating disease as an ordeal from God, a consequence of bad luck, witchcraft and magic by them and is a manifestation of ignorance.

2. TRADITIONS AND CUSTOMS: Traditions and customs play an important role in influencing the health behaviour of the community. Many of the people when questioned about their preference for a particular strategy to restore health, insisted that it was because their forefathers also did the same the tradition has continued. Following traditions and customs blindly, without applying logic determines the health behaviour of Gujjars, as these have been passed on from one generation to the next and have got incorporated into their culture. A peculiar custom followed by some households was of not washing hands after consuming dry meals as a symbol of paying respect to the person who has prepared the food.

3. PHYSICAL ENVIRONMENT: Physical environment in terms of terrain and topography also determines the health care behaviour among the Gujjars through its effect on the availability and accessibility to the health care facilities. People are aware of the shortcomings on account of the unfavourable physical environment and have adapted themselves to the conditions and accepted the fact that, health care facilities cannot be developed adequately in the area and have thus devised their own ways of preventing and curing diseases (Campbell:2001).

4. LOW ECONOMIC STATUS: Most of the people in the area work as labourers which is not a secured economic activity. The income of the people ranges from Rs. 500-2000/- per month. With such meagre income, it is impossible to satisfactorily fulfil even the basic

needs. This also affects the choice of people for utilization of healthcare facilities, management of health problem and, utilization of various systems of medicine.

5. SOCIAL INTERACTION AND COMMUNICATION: Lack of knowledge and awareness has led to a very low level of social interaction and communication among the people outside their families. Thus, the community remains under the grasp of orthodoxy, conservative traditions and customs, ignorance and superstition. People are socially inactive, less progressive and exhibit a different health care behaviour, in comparison to their non-Gujjar neighboures.

Prevalent Diseases among Gujjars

1. MALNUTRITION RELATED DIS-ORDERS: Malnutrition refers to faulty nutrition. It is more common among females. Both macro-nutrient and micro-nutrient malnutrition is common. Females are anaemic (deficiency of iron). Fatigue, bone and joint ache as a result of deficiency of vitamins and calcium are prominent health problems. Early marriage, very small gap between having children has lead to severe malnutrition among females.

2. RESPIRATORY DISEASES: Bronchitis is common in both males and females. Improper ventilation, together with use of firewood *Chulhas* is the main cause of the disease. The smoke keeps hanging in the room for several hours due to poor ventilation. Sharing of a single small room by 3-4 family members also aggravates the situation. If one suffers from communicable chest infections the others are also at risk.

3. TOOTH CARIES: Tooth caries are also common among females on account of poor oral hygiene and subjection of self-medication in case of tooth infection. Prolonged self-treatment with the use of herbs and spices aggravates and worsens tooth complicacies. In males, in addition to poor oral hygiene, chewing tobacco (snuff) is the cause of tooth caries.

4. HELMINTHIC DISEASES: Helminthic diseases are common in both males and females. These occur on account of improper sanitation, using open latrines, using human and animal excreta for manuring, drinking unboiled water, and living in extreme unhygienic conditions.

Utilization of Health Care Facilities and System of Medicine

Utilization of health care facilities depends upon the availability of and access to such facilities. The utilization of a particular system of medicine is determined by the faith in the system.

As far as availability is concerned, Dara has one health sub-centre situated at its periphery which consists of an auxiliary nurse and one dispenser, and one Primary Health Centre in Harwan at a distance of 5 Km. from Dara. There is one Lady Doctor specializing in Indian System of Medicine and a traditional faith healer.

The services of the health sub-centre are not being utilized by the Gujjars on account of absence of staff. It is nothing more than a brick-walled structure, lacking not only the facilities which it should provide but also the workers. The Primary Health Centre is being visited by a majority of the population. People visit other hospitals located at quite a distance only in case of serious complications in health problems.

About 90 percent of the expecting women avail the facility of institutional delivery in the Primary Health Centre, whereas more complicated cases may be referred to other Government maternity hospitals. Services of Lady Doctor, specializing in Indian System of Medicine are being availed of by just 2 percent of the community only when no other choice is left. Besides, there are a number of private allopathic clinics, which are seldom visited by Gujjar patients due to their high fee charges. The community has a strong belief in the faith healer, who is visited frequently upon contracting a particular disease.

Management of Health Problems

Management of health problems refers to the way in which one who perceives himself/ herself to be ill devises methods to restore his/her health (Izhar:2004). The management of health problem among Gujjars depends upon their perception of a disease and the type of disease contracted by them. Some resort to self-treatment while others prefer to visit doctors, faith healers etc. Health problems like cold, headache, toothache are subject to self-treatment. For treating headache, garlic is ground to paste and mixed with mustard oil. The paste is then applied to the forehead. In doing so, people do not take into consideration the cause of the headache, which may have resulted due to hypertension, strain, anxiety or any other complicacy. For treating cold, a beverage locally called as "*Kahwa*" is prepared by boiling water and adding sugar, tea leaves, pepper, cinnamon and a special herb called "*Shangri*" to it. Some apply warm mustard oil on the nose to relieve the symptoms. For treating toothache, a special herb called *Gujjar Kund* is ground and mixed with clove oil and is applied to the painful tooth. It does relieve the pain temporarily but how far the treatment is effective is evident from the tooth caries which are common in almost all households. For treating jaundice, the faith healer, who is considered to have a spiritual hand is visited, whatever may be the outcome.

People do not visit doctors until they are so ill that their routine work is hampered or they are unable to walk. Females do not visit Health Care Center unless they are accompanied by one or two of their family members, mostly males. Most people consume only those medicines which are available free of cost in the Primary Health Centre. Very few buy medicines from retail outlets.

One of the peculiar characteristics of the health care behaviour is the attitude toward immunization. People consider immunization useless and show very poor attendance at P.H.C when an immunization programme commences. During the two day immunization programme held on Jan.5 and Jan.6, 2007, out of a total of 216 families, who were expected to get their children immunized only 75 arrived at the P.H.C on the first day. On the second day, the people visited the P.H.C only on frequent requests by social and family welfare workers. (Records Register of P.H.C. Harwan, 2007).

Yet another peculiar characteristic of the health behaviour of this community is that Gujjars do not consider hygiene to be related to health in any way. Maintaining proper hygiene would be the last choice for correcting underlying cause of a disease if it happens to strike their mind at all. Gujjars get so much panic stricken when ill, that they lose their ability to make the right decision and even then they are unwilling to visit health centres well in time.

Though diseases like bronchitis, tooth caries, helminthic diseases and malnutrition related disorders are common among Gujjars, and they occasionally visit doctors but they are indifferent to take any initiative to remove the underlying cause. When enquired as to why they do not take any initiative, they satisfactorily answer that they are used to it.

Conclusions

Health is a state of complete physical, mental and social well-being and not merely the absence of a disease or infirmity. It depends upon a complex web of environmental, physical, biological, cultural and socio-economic factors.

The status of health determines the level of social, economic, physical and spiritual well being of an individual. A healthy population is a resource and is in fact considered as an investment to achieve broader social and economic goals. It is truly an indicator of human development.

There are various etiological and geographical factors which determine the status of health of an individual and explain the causes of glaring differences in the health status across the globe. Geographical study of health takes into account three main aspects, namely, disease ecology, location/allocation

pattern of health facilities and health care behaviour. Health care behaviour studies seek to analyze the impact of human behaviour on disease occurrence, acceptance of a particular system of medicine and methods adopted to prevent and cure diseases (Mayer: 2007).

Every culture has its own concept of health, sickness and health promotion, depicting values, beliefs, knowledge and a host of other practices shared by its people. Thus health care behaviour is socially, economically and culturally determined. The study of health care behaviour is very interesting and is essential for planning, managing and assessing health problems for disease prevention and health promotion.

In the present study a distinct social group "Gujjars" have been selected because of their distinct social organization, value system, culture and economy. In the area under study, Gujjars live in poor conditions and are unable to maintain a hygienic environment. Poor economic, unsanitary and, unhygienic living conditions present a conducive environment for the occurrence of diseases like bronchitis, helminthic diseases, malnutrition related disorders and tooth caries which are common among the community. Males are mostly engaged in casual labour earning between Rs 500-2000 per month. Women perform domestic tasks of cooking, washing, drawing water, upbringing of children and collection of wood. The people are ignorant and backward due to a very low level of education and awareness, very poor social interaction outside their family, poverty and a number of physical constraints. All these factors have influenced the health care behaviour of this community. While some perceive disease as a liability for the family and an ordeal from God, others consider it as the outcome of magic and witchcraft. Still others consider it as the condition of body that hampers daily routine and ability to work.

Management of health problems by this community ranges from self treatment to treatment by faith healers and practitioners depending upon the perception and type of the disease. When ill, Gujjars get panic stricken but are too indifferent to seek medical help in time and ensure regular check-ups. They show a frequent shift from one healing pattern and method to another.

One of the characteristic features of health care behaviour of Gujjars, apart from factors mentioned above, is the fact the community conceals information about their health and it is only after a great effort that facts can be elicited from them.They seldom take an initiative on their own.

Suggestions

Following are some of the areas which could be looked into for accomplishing the desired goal of productive health among Gujjars:

1. INCREASE THE LEVEL OF EDUCATION AND LITERACY: The first and foremost step to improve health conditions of the community and change the existing health care behaviour is to increase literacy among them. Education and its related activities expose people to social life outside family and is an important means of creating awareness. Increase in literacy and education would essentially mean a decrease in ignorance, poverty, mental and social isolation and people's perception and activities would be determined scientifically with practical solutions rather than imaginative and irrational ones.

Though the government aims at providing education to all and is in fact taking steps towards achievement of the goal but for this to be effective, people should be encouraged and provided means to get their children educated. This is possible only if the programmes are managed efficiently and honestly.

Literacy and education will surely broaden the outlook of the community. They will be better informed citizens, more aware of the realities of their surroundings, better able to understand the important issues facing their community and better prepared to contribute to their solutions.

2. AWARENESS CAMPAIGNS: Awareness campaigns refer to those collective efforts by people which are meant to recognize and analyze problems, so that solutions are suggested and evaluated. These are very vital for promoting health and changing the health behaviour among the community. Awareness campaigns should aim at making people aware of the health problems confronted by them, their causes and methods by which health could be restored. Such campaigns should be carried out at least twice a month and followed by a follow-up to see if it has been effective and whether the situation has improved. People should be made aware that no measure proves to be fruitful, unless people themselves make efforts and take initiative to solve their health problems and overcome difficulties.

3. HEALTH EDUCATION PROGRAMMES: These refer to programmes which help communities to consider their health concerns in a broader context of the socio-economic and cultural situation in order to develop their own plan of action to deal with any problem. People should be educated about the factors which contribute to disease causation or aggravate the symptoms of a disease. People should be educated about the ill effects of tobacco chewing, living in unhygienic conditions and mode of transmission of various diseases with adequate examples from the community itself. Health educator can play a crucial role in helping the community to increase their problem identifying and solving ability.

4. ENSURING COMMUNITY PARTICIPATION IN HEALTH PROMOTION PROGRAMMES: In order to improve the status of health of the community and change their health care behaviour towards good, it is necessary that people should be made to participate in these programmes. Community participation could be a channel to eliminate mental isolation and ignorance among people. In health planning and policy making community's views should be sought and taken into consideration. This would ensure proper implementation, adoption and acceptance by the community. Participation would help people to identify their health problems and issues, define their goals, mobilize resources and develop "action plans" for meeting the needs they have identified collectively. Community participation stresses consensus, co-operation building, group identity and a sense of community.

It is suggested that the combined effect of the stated suggestions would surely ensure empowerment, which is the process by which individuals and communities gain mastery over their lives by becoming enabled and act effectively to change their health seeking behaviour and improve their status of health. Further, it would ensure increased "community competence" which may be thought of as the equivalent of self – efficiency and behavioural capability at the community level by which both, the confidence and the skills to solve problems related to health, are effectively ensured.

Health is an index of a prosperous country. A country cannot progress unless it pays adequate attention towards the health of its people. To overcome the health problems, it is necessary to understand the health behaviour of the people which provides a basis for "where to look" to identify problems and take curative, corrective and preventive measures.

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SLUM POPULATION IN MILLION PLUS CITIES OF INDIA: SOME ISSUES AND POLICY CONCERNS

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Abstract

Slum population is as much a part of the urban centres as are other urban residents. Yet there is little recognition of the role slum dwellers play in the urban life. Often the accusing finger is pointed at the slum dweller whenever discussion on crime, filth and squalor takes place. In such a situation, slums are considered the breeding ground of everything that is detestable. Civic administration by and large everywhere follows negative policies such as forced eviction and involuntary settlement in the belief that this will curtail the growth of slums. Such efforts seldom yield results. This paper in similar vein brings forth some pertinent issues about this section of the society which require immediate attention of the policy makers.

Though it is fashionable to claim that India lives in its villages, the reality is that villages are getting poorer. They are no longer in a position to support a large base of population. Consequently more and more people have been migrating to the urban centres. This in turn puts a severe strain on the civic facilities, thereby pushing the new arrivals to the slums. As greater volume of migrants are compelled to leave the rural areas and swarm into cities, the essential urban services, such as, water supply and sanitation, drainage of solid and hazardous wastes, supply of adequate and safe food and drinking water and providing affordable housing for the teeming millions of urban poor become extremely difficult tasks. The quality of life in the big cities, especially million plus cities, has been declining very fast, resulting in the spread of hazardous diseases, poor physical and mental health and overall urban environmental deterioration. At the same time the slum dwellers appear to be indispensable to the cities, since the manual labour that keeps cities clean and running, comes from them. All these problems need very urgent redress and remedies before the cities become unsustainable.

It has been rightly remarked, "Mankind's future will unfold largely in urban settings..... A major challenge for mankind is, therefore, an informal response to such unprecedented urban growth and intelligent management of urban settlements, which in future, will serve as abiding place of majority of mankind"(Fuchs, et. al. :1994:1-2).

This paper in a similar vein brings forth some pertinent issues which require an immediate redressal. An attempt has been made to understand the population characteristics of slum population in million plus cities and raise some issues that require serious consideration and deliberation. The paper has been divided into two sections. The first deals with a select demographic profile of the slum population and the second deals with issues and policy concerns.

The mere fact that the 27 million plus cities have recorded 41.6 percent of the total slum population of the country explains the rationale of this paper. In fact the million plus cities succinctly illustrate the concentration of slum population. Greater Mumbai alone accounts for about one seventh (15.2 percent)

Table – 1
India : Proportion of Slum Population in Million plus Cities (2001)

Sr. No.	Name of Million plus City	State / Union Territory*	Percentage of slum population to total population
1	Greater Mumbai	Maharashtra	54.1
2	Faridabad	Haryana	46.5
3	Meerut	Uttar Pradesh	44.1
4	Nagpur	Maharashtra	35.9
5	Kolkata	West Bengal	32.5
6	Thane	Maharashtra	27.8
7	Ludhiana	Punjab	22.5
8	Surat	Gujarat	20.9
9	Pune	Maharashtra	19.4
10	Chennai	Tamil Nadu	18.9
11	Delhi	Delhi*	18.7
12	Indore	Madhya Pradesh	17.7
13	Hyderabad	Andhra Pradesh	17.2
14	Jaipur	Rajasthan	15.9
15	Kanpur	Uttar Pradesh	14.4
16	Vadodara	Gujarat	14.2
17	Ahmadabad	Gujarat	13.5
18	Nashik	Maharasthra	12.9
19	Varanasi	Uttar Pradesh	12.6
20	Pimpri Chinchwad	Maharashtra	12.2
21	Haora	West Bengal	11.7
22	Bangalore	Karnataka	10.0
23	Agra	Uttar Pradesh	9.5
24	Bhopal	Madhya Pradesh	8.7
25	Lucknow	Uttar Pradesh	8.2
26	Kalyan-Dombivli	Maharashtra	2.9
27	Patna	Bihar	0.3
	TOTAL		**24.1**

Source: Census of India, 2001.

of the total slum population of the country and more than one third (36.6 percent) of the total slum population of the million plus cities. Greater Mumbai, Kolkata, Delhi and Chennai put together account for 25 percent of the total slum population of the country and around 60 percent of the total slum population in million plus cities.

SECTION - I

Slum Population : A Select Demographic Profile

This section deals with a select demographic profile of the slum population

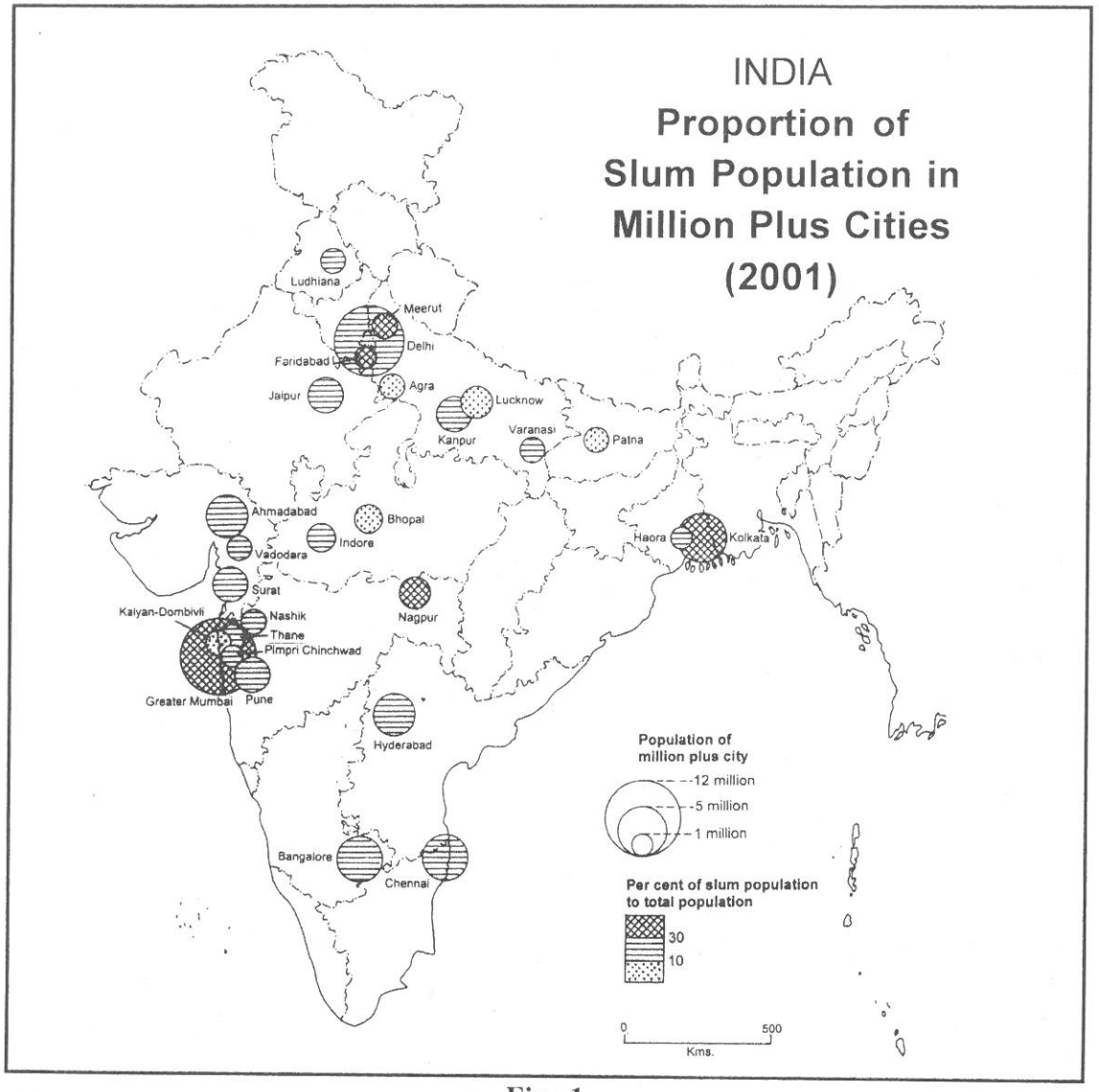

Fig. 1

which could serve as an input towards understanding the issues and formulation of strategies to tackle various problems being faced by the slum and non-slum population in million plus cities. Some of the important characteristics of slum population are discussed below:

(1) POPULATION SIZE

The slum dwellers in the country constitute nearly one seventh of the total urban population of the states and union territories reporting slum population; and 23.1 percent of the population of 640 cities / towns reporting slums. Among the states, Andhra Pradesh has the largest number of cities and towns (77) reporting slum population followed by Uttar Pradesh (69), Tamil Nadu (63), Maharashtra (61), West Bengal (59), Madhya Pradesh (43) and Gujarat (41). On the other hand in states like Jammu & Kashmir, Tripura, Meghalaya, and Goa slums have been reported from less than six towns each.

Slums in the 61 towns of Maharashtra account for 11.2 million people which is more than one fourth of the total slum population in the country. This is followed by Andhra Pradesh (2.2 million), Uttar Pradesh (4.4 million), West Bengal (4.1 million) and Tamil Nadu (2.9 million).

In fact, these 5 states account for about two third (65.3 percent) of the total slum population of the country. Among other states, Punjab, Haryana, Delhi, Rajasthan, Gujarat and Karnataka have reported more than 1 million slum dwellers each in the cities and towns in 2001.

As percentage of the total urban population Maharashtra has the highest proportion of slum population (27.3 percent) followed by Andhra Pradesh (24.9 percent) and Haryana (23.2 percent). In other thirteen states / UT's this percentage varies between 10 to 20 percent. These states are Jammu & Kashmir, Punjab, Chandigarh, Delhi, Uttar Pradesh, Meghalaya, West Bengal, Orissa, Chhattisgarh, Madhya Pradesh, Tamil Nadu, Pondicherry and Andaman & Nicobar Islands. The state of Kerala (0.8 percent) has the lowest percentage of slum population.

In the 27 million plus cities about 17.7 million population lives in slums which is about 41.6 percent of the total slum population in the country. In absolute numbers, Greater Mumbai has the highest slum population of around 6.5 million followed by Delhi (1.9 million) and Kolkata (1.5 million). Further, the slum areas of Surat, Hyderabad, Chennai and Nagpur have more than half a million population each. Except Patna and Kalyan-Dombivli, all cities have population above 100,000. The size of slum population in these cities is an indicator of the scale of migration which has taken place.

As evident from Table 1 and Fig.1 Greater Mumbai (54.1 percent) has the highest proportion of slum dwellers, followed by Faridabad (46.5 percent), Meerut (44.1 percent). Kolkata (32.5 percent), Nagpur (35.9 percent), Thane (27.8 percent), Ludhiana (22.5 percent) and Surat (20.9 percent). All these cities are industrial hubs of their region and recipients of streams of migrants. In other words more than one fifth of the population of these cities resides in slums or every fifth person is a slum dweller.

(2) SCHEDULED CASTES AND SCHEDULED TRIBES POPULATION

Out of the total 42.6 million people enumerated in slums in 2001 census, 7.4 million are Scheduled Castes and one million Scheduled Tribes contributing 17.4 percent and 2.4 percent of the total slum population respectively. When compared with corresponding percentage of Scheduled Tribes and other castes, the proportion of Scheduled Castes is notably higher in slums. Of the total Scheduled Caste population in urban areas, 22.1 percent is in slums. This figure is 16.5 percent for Scheduled Tribes and only 14 percent for other population.

In absolute terms Maharashtra (1.3 million) has the largest number of Scheduled Castes living in slums followed by Uttar Pradesh (0.9 million), Andhra Pradesh (0.8 million), Tamil Nadu (0.7 million) and West Bengal (0.6 million). In Rajasthan, Punjab, Haryana, Karnataka and Gujarat more than 2,00,000 Scheduled Caste population lives in slums.

In terms of concentration - measured as their percentage to total slum and urban population - of Scheduled Caste population, the slums of Chandigarh have the highest percentage of Scheduled Castes (39.1 percent) followed by Punjab (28.6 percent). Similarly in the slums of Delhi, Rajasthan, Tamil Nadu and Pondicherry more than one-fourth of the population belongs to the Scheduled Castes. In some States/UT's like Chandigarh, Uttaranchal, Rajasthan, Assam, Gujarat, Karnataka, Tamil Nadu and Pondicherry the percentage of Scheduled Caste population is almost twice that of the total urban population.

Among the million plus cities Delhi with 4.8 lakh Scheduled Caste slum dwellers tops the list followed by Greater Mumbai (3.9

U S A. Hence in his review article Preston E. James included this paper as a significant contribution to the field of population geography (1954: 115-116).

3. Undoubtedly, the title of the paper implied its inclusion in the field of racial geography. Taking into account Hartshorne's own views on this point can further substantiate this. While pointing out that the use of cartographic techniques was of great importance, Hartshorne also referred, in this context, besides others to his own "study of the racial geography of the United States" (1939:249)

4. In fact, the term race had been considered in this paper not in the 'biological sense' but in the 'social sense.' Moreover, it is appropriate to note here the following statement of Richard Hartshorne which indicated the place of this paper in the systematic branches of geography: "In 'sociological geography,' Kniffen has used the method [ratio method] in mapping house-types and the writer has used it to show the areal differences in racial construction of the population of the United States" (Hartshorne:1939:427).

   Furthermore, it would be more interesting to have a close look at the following statement of Hartshorne wherein he himself referred to the branches of geography in which his substantive papers may be placed: "The variety of topics on which I had written in substantive papers - on transportation, location factors in industry, agricultural regions, urban districts, social and political geography, and even a paper in climatology – provided a wide background of experience against which to test methodological concepts"(Hartshorne:1979:68). A close perusal of the bibliographic records of Richard Hartshorne (Martin:1994:480-492; Khan:2000-2001:13-22) reveals that it is only his "Racial Maps of the United States" (1938), which can be appropriately placed in social geography mentioned in the above statement.

5. In fact, many of the Mexicans in the Southwest are descendents from people who resided there before 1848 when it was ceded by Mexico to the U S A.

6. It may be pointed out that many reservations did (and still do) permit some white settlers (e.g. teachers, ministers, Indian agents, etc.).

7. In this context, it would be interesting to carefully go through the following dialogue between Preston E. James and Richard Hartshorne (Dow:1972:82):

   James : But you, of course, were interested in a lot of other things during this time and you were an innovator in many of them. For instance, those maps of the distribution of black people in America, which were published. Where? In the Geographical Review?

   Hartshorne: The Geographical Review. Yes. I was the geographer who discovered that there were Negroes in the United States. (Laughter).

   James: This is about the truth and those maps are of tremendous importance today - to compare the patterns of distribution...

Acknowledgement

I am extremely thankful to Prof. Joseph E. Schwartzberg, Professor Emeritus, University of Minnesota (U S A), for having gone through the paper and making some valuable suggestions. Any error, of course, is solely the responsibility of the author.

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HEALTH CARE BEHAVIOUR AMONG GUJJARS: A CASE STUDY OF DARA, SRINAGAR (KASHMIR)

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Abstract

The present study aims at understanding the perception of Gujjars - an ethnic group distinctly different from other sections of society - towards disease occurrence among them and their preference for indigenous practices in remedial procedures and in disease control. The Gujjars are scattered all over India in small groups. In Jammu and Kashmir they prefer to have their settlements at comparatively higher altitudes. The study area is quite close to Srinagar city adjacent to the famous National Park of Dachigam, and is thus rich in fauna and flora resources.

Geography has emerged as an applied subject in the changing socio-economic scenario at global level and takes interdisciplinary approaches in to consideration to arrive at some what realistic conclusions. As such the present paper has its focus on two aspects - health care behaviour and health care facilities - which provide an impetus for policy makers and planners to implement appropriate strategy for better health care facilities so that people are benefited by the development programmes. The study is based on a primary survey which was conducted during the months of February and March 2007.

Introduction

Health behaviour investigations have recently acquired an important place in medical geography. Health behaviour may be defined as the process through which a person who perceives himself or herself to be ill, chooses and implements strategies to facilitate the restoration of health. An understanding of health behaviour is vital to the study of disease transmission and the planning of disease control. Geographers have studied both, illness and health care behaviour in the framework of socio-economic and cultural dimensions, in order to arrive at some strategy towards human welfare (George: 1985; Annas :1998).

Kloss and Thompson (1979) worked on the behaviour of people related to water contact to the occurrence of schistosomiasis in an upper Egyptian village. The study of behaviour of individuals in a community can lead to an understanding of their level of understanding, their perception about a variety of given choices on the basis of their knowledge and experience in understanding the factual and thereby the optimum utilization of available resources. Health behaviour includes all activities undertaken individually or collectively for the purpose of curing and preventing diseases.

The present study deals with understanding of the health care behaviour of Gujjar community in Jammu and Kashmir State through a case study of Dara, a micro region, located in district Srinagar in Kashmir Division (Fig.1). The community represents a distinct social group, moulded by the physico-cultural beliefs, and therefore having their own concepts of health, sickness and health promotion, depicting values, beliefs,

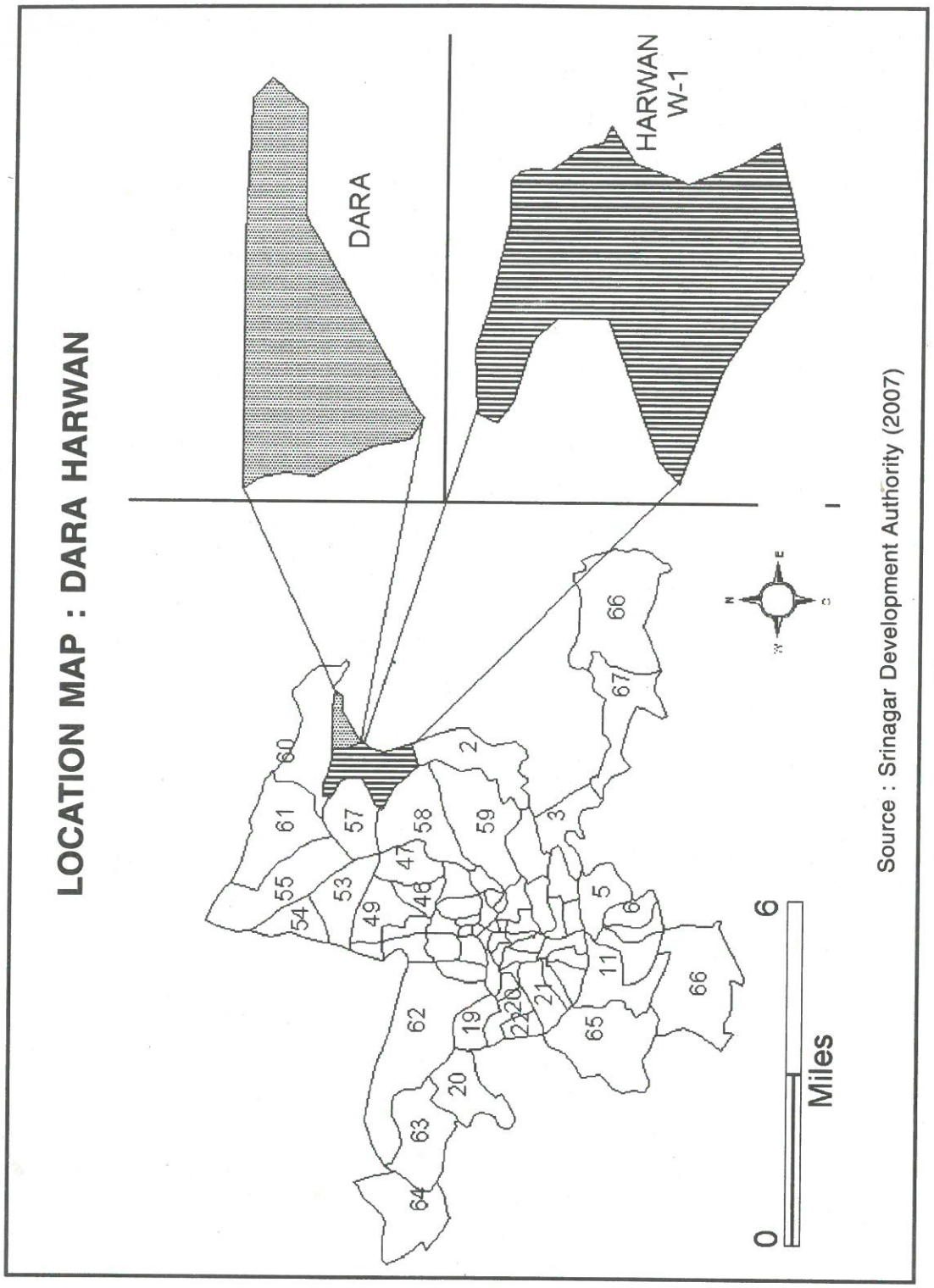
LOCATION MAP : DARA HARWAN
DARA
HARWAN W-1
0
6
Miles
Source : Srinagar Development Authority (2007)

Fig. 1

knowledge and a host of other practices which distinguishes them from the non-Gujjar community in the neighboring area.

An attempt has been made to ascertain the status of health of this community on the basis of their health care behaviour. Various factors affecting, influencing and determining their health care behaviour have been taken into consideration. It is expected that this can go a long way in promoting health and improving the status of health of this community.

Significance

Health status is an important indicator of human development. It is intricately related to fertility, mortality and life-expectancy, which form the very basis for various socio-economic and cultural studies. The status of health has a direct bearing on the nutritional status, educational achievement, disease resistance, intelligence, productivity and purposeful pursuit of definite development objectives. For the successful and effective planning related to health and for the successful and efficient policies and programmes directed to improve the conditions of health, it is important to understand the health care behaviour of a particular population group.The concept takes into account the role and impact of factors that influence the health of people.

Health and health care behaviour explores social and behavioural change in population as these affect health status and quality of life. It also examines the processes of planning, locating, implementing, managing and assessing health education and social – behavioural interventions. Keeping in view the significance, relevance and importance of the study of health behaviour, the present study has been carried out among the socio-economically backward and technologically untouched Gujjar population of Dara, Harwan in Srinagar district.

Study Area

Dara, a micro region in Harwan, is situated in Srinagar district of Jammu and Kashmir State, located at a distance of 21 kms. from the main city. Dara has a total area of 9.2 square kms. It is surrounded by Haripora in the south, Syedpora in the west and Kohistan in the north – east. The area has a total population of 5250 persons, forming 1212 households (Census 2001). It is located between 34^0 10' North Latitude and 74^0 54' East Longitude. The area is dominated by Gujjars and is, therefore, representative of other Gujjar areas scattered in Jammu and Kashmir State.

Objectives

The main objectives of the study are:

(1) to ascertain the status of health of the Gujjar community in Jammu and Kashmir;

(2) to assess the community's perception about disease causation;

(3) to assess the methods and strategies devised by the community to restore health;

(4) to ascertain the perception about various systems of medicine and the preference for a particular medical system;

(5) to analyse the physical, social, cultural, and economic factors which determine the optimum utilization of various health care services; and

(6) to suggest measures for promoting health and improving the health status among the community.

Data Base and Methodology

The study is based on data collected from primary as well secondary sources. Primary data has been collected through household surveys, personal narrations, and observations of 843 households out of a total of 1212 households in the area, accounting for about seventy percent of the total households. Interviews were conducted with the help of a structured questionnaire containing questions pertaining to income,

educational qualifications, health facilities available, perception of diseases, preferences and prejudices related to utilization of health facilities, system of medicine preferred, prevalent diseases, management of health problems and physical and economic accessibility to health care facilities.

A separate questionnaire was prepared for medical practitioners active in the area, both in private clinics and government run Primary Health Centre to collect information about the prevalent diseases among Gujjars, their efforts to report in time in hospitals or clinics, attitude towards the advice given by the practitioners and any peculiar health behaviour exhibited by the community.

Secondary data for this study pertains to the location, areal extent, population, number of households and health facilities available in the area. Sources for this data are Directorate of Revenue and Statistics and Evaluation, Srinagar, and the Census of India, 2001, Series 8, J&K.

Discussion

The Gujjar community in the area represents a distinct social group, having their own set of values, beliefs, customs and traditions. In fact, the geo-ecological environment of their habitat has exerted a determining influence in shaping their mode of life, cultural ethos, values, customs, and traditions and of course behaviour related to any observed phenomenon (Ali:1994).

The community is socially, economically and technologically backward living a marginalized life. This is adequately exhibited by the unhygienic and unsanitary conditions in their residential environment. Their houses are nothing more than hollow mounds, made of mud and thatch, having not more than two dingy rooms, supporting a family of more than five members in most cases. These structures are locally known as *Dhokas* or *Kothas* (Hussain:2003). The number of persons per room in these houses is three.

The literacy rate among the population is very low (24.50 percent) which has perpetuated ignorance among them and a narrowing of their outlook. The community is superstitious and willing to adhere to their age-old traditions and customs and reject new ideas (Akhtar:1988).

Thus, it is interesting to understand that within the existing socio-economic, cultural, psychological framework what is the status of their health, what is their perception of disease and illness, what measures they undertake to restore their health and how they make use of their available health facilities and systems of medicine and how far they are successful in treating themselves.

Perception about Health/ Diseases

The community's perception about diseases is a reflection of their socio-economic and cultural environment. On the basis of the data collected for this study, it was found that 14 percent of the community perceives disease as that condition or state of body in which a person is unable to work. 37.1 percent of population perceives disease as a liability which affects not only the sufferer but the entire family and is a hindrance in the way of improvement of economic status. 11.3 percent of the population perceives disease as an obvious outcome of poverty. 38 percent of population considers disease an ordeal from God and sometimes a result of magic and witchcraft.

Perception of Causes of Diseases

The causes which have been attributed to the diseases by the community range from unscientific ones based on mere ignorance, superstition and lack of knowledge to scientific ones, based on observation and experience. These may be summarized as under:

1. CONTAMINATED WATER: Water is essential for the sustenance of all living organisms, including man. In the study area, water is used mostly for domestic purposes and is drawn directly by majority of the households from the flowing river in the lower reaches of the area where water pipelines are

virtually absent. Some of the households in the upper reaches have their waste outlets, containing human and animal excreta, draining into the river. This has led to contamination of water and has consequently contributed to the causation of various helminthic diseases. 12 percent of the population perceives contaminated water to be a cause of ill health and disease.

2. POVERTY: A section of the population considers poverty to be the cause of disease. Poverty results in provision of inadequate diet and other facilities which are responsible for disease causation. Poverty is considered as a cause of disease by approximately 11 percent of the population.

3. MAGIC AND WITCHCRAFT: 38 percent of the population attributes the causation of disease and illness to magic and witchcraft. Females were more particular towards this factor. It is contended that people who cannot see their counterparts flourishing switch over to black magic and witchcraft with a view to harm them as much as possible. This factor is neither rational nor logical. It shows the degree and extent of ignorance of the people which is an obvious outcome of illiteracy and lack of awareness among the people.

4. AN ORDEAL FROM GOD: A sizeable proportion of the community considers disease as an ordeal from God. People believe that it is a punishment from God for the sins they have committed.

5. BAD LUCK: 24 percent of the community were of the opinion that disease is contracted by those who have ill luck. Again ignorance, sheer backwardness is the main reason for the perception that disease causation is an ordeal from God and victimizes people who have bad luck.

Determinants of Health Care Behaviour

The most important observed determinants of health care behaviour in the community under study are:

1. EDUCATION AND AWARENESS: Level of education and awareness is one of the important determinants of health care behaviour in Gujjars. There is a very low level of education in the community, with a majority being illiterate and only a few having managed to go through pre-primary education. As a result their outlook is narrow and they are least exposed to social life outside their families. This has led to treating disease as an ordeal from God, a consequence of bad luck, witchcraft and magic by them and is a manifestation of ignorance.

2. TRADITIONS AND CUSTOMS: Traditions and customs play an important role in influencing the health behaviour of the community. Many of the people when questioned about their preference for a particular strategy to restore health, insisted that it was because their forefathers also did the same the tradition has continued. Following traditions and customs blindly, without applying logic determines the health behaviour of Gujjars, as these have been passed on from one generation to the next and have got incorporated into their culture. A peculiar custom followed by some households was of not washing hands after consuming dry meals as a symbol of paying respect to the person who has prepared the food.

3. PHYSICAL ENVIRONMENT: Physical environment in terms of terrain and topography also determines the health care behaviour among the Gujjars through its effect on the availability and accessibility to the health care facilities. People are aware of the shortcomings on account of the unfavourable physical environment and have adapted themselves to the conditions and accepted the fact that, health care facilities cannot be developed adequately in the area and have thus devised their own ways of preventing and curing diseases (Campbell:2001).

4. LOW ECONOMIC STATUS: Most of the people in the area work as labourers which is not a secured economic activity. The income of the people ranges from Rs. 500-2000/- per month. With such meagre income, it is impossible to satisfactorily fulfil even the basic

needs. This also affects the choice of people for utilization of healthcare facilities, management of health problem and, utilization of various systems of medicine.

5. SOCIAL INTERACTION AND COMMUNICATION: Lack of knowledge and awareness has led to a very low level of social interaction and communication among the people outside their families. Thus, the community remains under the grasp of orthodoxy, conservative traditions and customs, ignorance and superstition. People are socially inactive, less progressive and exhibit a different health care behaviour, in comparison to their non-Gujjar neighboures.

Prevalent Diseases among Gujjars

1. MALNUTRITION RELATED DIS-ORDERS: Malnutrition refers to faulty nutrition. It is more common among females. Both macro-nutrient and micro-nutrient malnutrition is common. Females are anaemic (deficiency of iron). Fatigue, bone and joint ache as a result of deficiency of vitamins and calcium are prominent health problems. Early marriage, very small gap between having children has lead to severe malnutrition among females.

2. RESPIRATORY DISEASES: Bronchitis is common in both males and females. Improper ventilation, together with use of firewood *Chulhas* is the main cause of the disease. The smoke keeps hanging in the room for several hours due to poor ventilation. Sharing of a single small room by 3-4 family members also aggravates the situation. If one suffers from communicable chest infections the others are also at risk.

3. TOOTH CARIES: Tooth caries are also common among females on account of poor oral hygiene and subjection of self-medication in case of tooth infection. Prolonged self-treatment with the use of herbs and spices aggravates and worsens tooth complicacies. In males, in addition to poor oral hygiene, chewing tobacco (snuff) is the cause of tooth caries.

4. HELMINTHIC DISEASES: Helminthic diseases are common in both males and females. These occur on account of improper sanitation, using open latrines, using human and animal excreta for manuring, drinking unboiled water, and living in extreme unhygienic conditions.

Utilization of Health Care Facilities and System of Medicine

Utilization of health care facilities depends upon the availability of and access to such facilities. The utilization of a particular system of medicine is determined by the faith in the system.

As far as availability is concerned, Dara has one health sub-centre situated at its periphery which consists of an auxiliary nurse and one dispenser, and one Primary Health Centre in Harwan at a distance of 5 Km. from Dara. There is one Lady Doctor specializing in Indian System of Medicine and a traditional faith healer.

The services of the health sub-centre are not being utilized by the Gujjars on account of absence of staff. It is nothing more than a brick-walled structure, lacking not only the facilities which it should provide but also the workers. The Primary Health Centre is being visited by a majority of the population. People visit other hospitals located at quite a distance only in case of serious complications in health problems.

About 90 percent of the expecting women avail the facility of institutional delivery in the Primary Health Centre, whereas more complicated cases may be referred to other Government maternity hospitals. Services of Lady Doctor, specializing in Indian System of Medicine are being availed of by just 2 percent of the community only when no other choice is left. Besides, there are a number of private allopathic clinics, which are seldom visited by Gujjar patients due to their high fee charges. The community has a strong belief in the faith healer, who is visited frequently upon contracting a particular disease.

Management of Health Problems

Management of health problems refers to the way in which one who perceives himself/ herself to be ill devises methods to restore his/her health (Izhar:2004). The management of health problem among Gujjars depends upon their perception of a disease and the type of disease contracted by them. Some resort to self-treatment while others prefer to visit doctors, faith healers etc. Health problems like cold, headache, toothache are subject to self-treatment. For treating headache, garlic is ground to paste and mixed with mustard oil. The paste is then applied to the forehead. In doing so, people do not take into consideration the cause of the headache, which may have resulted due to hypertension, strain, anxiety or any other complicacy. For treating cold, a beverage locally called as "*Kahwa*" is prepared by boiling water and adding sugar, tea leaves, pepper, cinnamon and a special herb called "*Shangri*" to it. Some apply warm mustard oil on the nose to relieve the symptoms. For treating toothache, a special herb called *Gujjar Kund* is ground and mixed with clove oil and is applied to the painful tooth. It does relieve the pain temporarily but how far the treatment is effective is evident from the tooth caries which are common in almost all households. For treating jaundice, the faith healer, who is considered to have a spiritual hand is visited, whatever may be the outcome.

People do not visit doctors until they are so ill that their routine work is hampered or they are unable to walk. Females do not visit Health Care Center unless they are accompanied by one or two of their family members, mostly males. Most people consume only those medicines which are available free of cost in the Primary Health Centre. Very few buy medicines from retail outlets.

One of the peculiar characteristics of the health care behaviour is the attitude toward immunization. People consider immunization useless and show very poor attendance at P.H.C when an immunization programme commences. During the two day immunization programme held on Jan.5 and Jan.6, 2007, out of a total of 216 families, who were expected to get their children immunized only 75 arrived at the P.H.C on the first day. On the second day, the people visited the P.H.C only on frequent requests by social and family welfare workers. (Records Register of P.H.C. Harwan, 2007).

Yet another peculiar characteristic of the health behaviour of this community is that Gujjars do not consider hygiene to be related to health in any way. Maintaining proper hygiene would be the last choice for correcting underlying cause of a disease if it happens to strike their mind at all. Gujjars get so much panic stricken when ill, that they lose their ability to make the right decision and even then they are unwilling to visit health centres well in time.

Though diseases like bronchitis, tooth caries, helminthic diseases and malnutrition related disorders are common among Gujjars, and they occasionally visit doctors but they are indifferent to take any initiative to remove the underlying cause. When enquired as to why they do not take any initiative, they satisfactorily answer that they are used to it.

Conclusions

Health is a state of complete physical, mental and social well-being and not merely the absence of a disease or infirmity. It depends upon a complex web of environmental, physical, biological, cultural and socio-economic factors.

The status of health determines the level of social, economic, physical and spiritual well being of an individual. A healthy population is a resource and is in fact considered as an investment to achieve broader social and economic goals. It is truly an indicator of human development.

There are various etiological and geographical factors which determine the status of health of an individual and explain the causes of glaring differences in the health status across the globe. Geographical study of health takes into account three main aspects, namely, disease ecology, location/allocation

pattern of health facilities and health care behaviour. Health care behaviour studies seek to analyze the impact of human behaviour on disease occurrence, acceptance of a particular system of medicine and methods adopted to prevent and cure diseases (Mayer: 2007).

Every culture has its own concept of health, sickness and health promotion, depicting values, beliefs, knowledge and a host of other practices shared by its people. Thus health care behaviour is socially, economically and culturally determined. The study of health care behaviour is very interesting and is essential for planning, managing and assessing health problems for disease prevention and health promotion.

In the present study a distinct social group "Gujjars" have been selected because of their distinct social organization, value system, culture and economy. In the area under study, Gujjars live in poor conditions and are unable to maintain a hygienic environment. Poor economic, unsanitary and, unhygienic living conditions present a conducive environment for the occurrence of diseases like bronchitis, helminthic diseases, malnutrition related disorders and tooth caries which are common among the community. Males are mostly engaged in casual labour earning between Rs 500-2000 per month. Women perform domestic tasks of cooking, washing, drawing water, upbringing of children and collection of wood. The people are ignorant and backward due to a very low level of education and awareness, very poor social interaction outside their family, poverty and a number of physical constraints. All these factors have influenced the health care behaviour of this community. While some perceive disease as a liability for the family and an ordeal from God, others consider it as the outcome of magic and witchcraft. Still others consider it as the condition of body that hampers daily routine and ability to work.

Management of health problems by this community ranges from self treatment to treatment by faith healers and practitioners depending upon the perception and type of the disease. When ill, Gujjars get panic stricken but are too indifferent to seek medical help in time and ensure regular check-ups. They show a frequent shift from one healing pattern and method to another.

One of the characteristic features of health care behaviour of Gujjars, apart from factors mentioned above, is the fact the community conceals information about their health and it is only after a great effort that facts can be elicited from them.They seldom take an initiative on their own.

Suggestions

Following are some of the areas which could be looked into for accomplishing the desired goal of productive health among Gujjars:

1. INCREASE THE LEVEL OF EDUCATION AND LITERACY: The first and foremost step to improve health conditions of the community and change the existing health care behaviour is to increase literacy among them. Education and its related activities expose people to social life outside family and is an important means of creating awareness. Increase in literacy and education would essentially mean a decrease in ignorance, poverty, mental and social isolation and people's perception and activities would be determined scientifically with practical solutions rather than imaginative and irrational ones.

Though the government aims at providing education to all and is in fact taking steps towards achievement of the goal but for this to be effective, people should be encouraged and provided means to get their children educated. This is possible only if the programmes are managed efficiently and honestly.

Literacy and education will surely broaden the outlook of the community. They will be better informed citizens, more aware of the realities of their surroundings, better able to understand the important issues facing their community and better prepared to contribute to their solutions.

2. AWARENESS CAMPAIGNS: Awareness campaigns refer to those collective efforts by people which are meant to recognize and analyze problems, so that solutions are suggested and evaluated. These are very vital for promoting health and changing the health behaviour among the community. Awareness campaigns should aim at making people aware of the health problems confronted by them, their causes and methods by which health could be restored. Such campaigns should be carried out at least twice a month and followed by a follow-up to see if it has been effective and whether the situation has improved. People should be made aware that no measure proves to be fruitful, unless people themselves make efforts and take initiative to solve their health problems and overcome difficulties.

3. HEALTH EDUCATION PROGRAMMES: These refer to programmes which help communities to consider their health concerns in a broader context of the socio-economic and cultural situation in order to develop their own plan of action to deal with any problem. People should be educated about the factors which contribute to disease causation or aggravate the symptoms of a disease. People should be educated about the ill effects of tobacco chewing, living in unhygienic conditions and mode of transmission of various diseases with adequate examples from the community itself. Health educator can play a crucial role in helping the community to increase their problem identifying and solving ability.

4. ENSURING COMMUNITY PARTICIPATION IN HEALTH PROMOTION PROGRAMMES: In order to improve the status of health of the community and change their health care behaviour towards good, it is necessary that people should be made to participate in these programmes. Community participation could be a channel to eliminate mental isolation and ignorance among people. In health planning and policy making community's views should be sought and taken into consideration. This would ensure proper implementation, adoption and acceptance by the community. Participation would help people to identify their health problems and issues, define their goals, mobilize resources and develop "action plans" for meeting the needs they have identified collectively. Community participation stresses consensus, co-operation building, group identity and a sense of community.

It is suggested that the combined effect of the stated suggestions would surely ensure empowerment, which is the process by which individuals and communities gain mastery over their lives by becoming enabled and act effectively to change their health seeking behaviour and improve their status of health. Further, it would ensure increased "community competence" which may be thought of as the equivalent of self – efficiency and behavioural capability at the community level by which both, the confidence and the skills to solve problems related to health, are effectively ensured.

Health is an index of a prosperous country. A country cannot progress unless it pays adequate attention towards the health of its people. To overcome the health problems, it is necessary to understand the health behaviour of the people which provides a basis for "where to look" to identify problems and take curative, corrective and preventive measures.

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SLUM POPULATION IN MILLION PLUS CITIES OF INDIA: SOME ISSUES AND POLICY CONCERNS

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Abstract

Slum population is as much a part of the urban centres as are other urban residents. Yet there is little recognition of the role slum dwellers play in the urban life. Often the accusing finger is pointed at the slum dweller whenever discussion on crime, filth and squalor takes place. In such a situation, slums are considered the breeding ground of everything that is detestable. Civic administration by and large everywhere follows negative policies such as forced eviction and involuntary settlement in the belief that this will curtail the growth of slums. Such efforts seldom yield results. This paper in similar vein brings forth some pertinent issues about this section of the society which require immediate attention of the policy makers.

Though it is fashionable to claim that India lives in its villages, the reality is that villages are getting poorer. They are no longer in a position to support a large base of population. Consequently more and more people have been migrating to the urban centres. This in turn puts a severe strain on the civic facilities, thereby pushing the new arrivals to the slums. As greater volume of migrants are compelled to leave the rural areas and swarm into cities, the essential urban services, such as, water supply and sanitation, drainage of solid and hazardous wastes, supply of adequate and safe food and drinking water and providing affordable housing for the teeming millions of urban poor become extremely difficult tasks. The quality of life in the big cities, especially million plus cities, has been declining very fast, resulting in the spread of hazardous diseases, poor physical and mental health and overall urban environmental deterioration. At the same time the slum dwellers appear to be indispensable to the cities, since the manual labour that keeps cities clean and running, comes from them. All these problems need very urgent redress and remedies before the cities become unsustainable.

It has been rightly remarked, "Mankind's future will unfold largely in urban settings..... A major challenge for mankind is, therefore, an informal response to such unprecedented urban growth and intelligent management of urban settlements, which in future, will serve as abiding place of majority of mankind"(Fuchs, et. al. :1994:1-2).

This paper in a similar vein brings forth some pertinent issues which require an immediate redressal. An attempt has been made to understand the population characteristics of slum population in million plus cities and raise some issues that require serious consideration and deliberation. The paper has been divided into two sections. The first deals with a select demographic profile of the slum population and the second deals with issues and policy concerns.

The mere fact that the 27 million plus cities have recorded 41.6 percent of the total slum population of the country explains the rationale of this paper. In fact the million plus cities succinctly illustrate the concentration of slum population. Greater Mumbai alone accounts for about one seventh (15.2 percent)

Table – 1
India : Proportion of Slum Population in Million plus Cities (2001)

Sr. No.	Name of Million plus City	State / Union Territory*	Percentage of slum population to total population
1	Greater Mumbai	Maharashtra	54.1
2	Faridabad	Haryana	46.5
3	Meerut	Uttar Pradesh	44.1
4	Nagpur	Maharashtra	35.9
5	Kolkata	West Bengal	32.5
6	Thane	Maharashtra	27.8
7	Ludhiana	Punjab	22.5
8	Surat	Gujarat	20.9
9	Pune	Maharashtra	19.4
10	Chennai	Tamil Nadu	18.9
11	Delhi	Delhi*	18.7
12	Indore	Madhya Pradesh	17.7
13	Hyderabad	Andhra Pradesh	17.2
14	Jaipur	Rajasthan	15.9
15	Kanpur	Uttar Pradesh	14.4
16	Vadodara	Gujarat	14.2
17	Ahmadabad	Gujarat	13.5
18	Nashik	Maharasthra	12.9
19	Varanasi	Uttar Pradesh	12.6
20	Pimpri Chinchwad	Maharashtra	12.2
21	Haora	West Bengal	11.7
22	Bangalore	Karnataka	10.0
23	Agra	Uttar Pradesh	9.5
24	Bhopal	Madhya Pradesh	8.7
25	Lucknow	Uttar Pradesh	8.2
26	Kalyan-Dombivli	Maharashtra	2.9
27	Patna	Bihar	0.3
	TOTAL		**24.1**

Source: Census of India, 2001.

of the total slum population of the country and more than one third (36.6 percent) of the total slum population of the million plus cities. Greater Mumbai, Kolkata, Delhi and Chennai put together account for 25 percent of the total slum population of the country and around 60 percent of the total slum population in million plus cities.

SECTION - I

Slum Population : A Select Demographic Profile

This section deals with a select demographic profile of the slum population

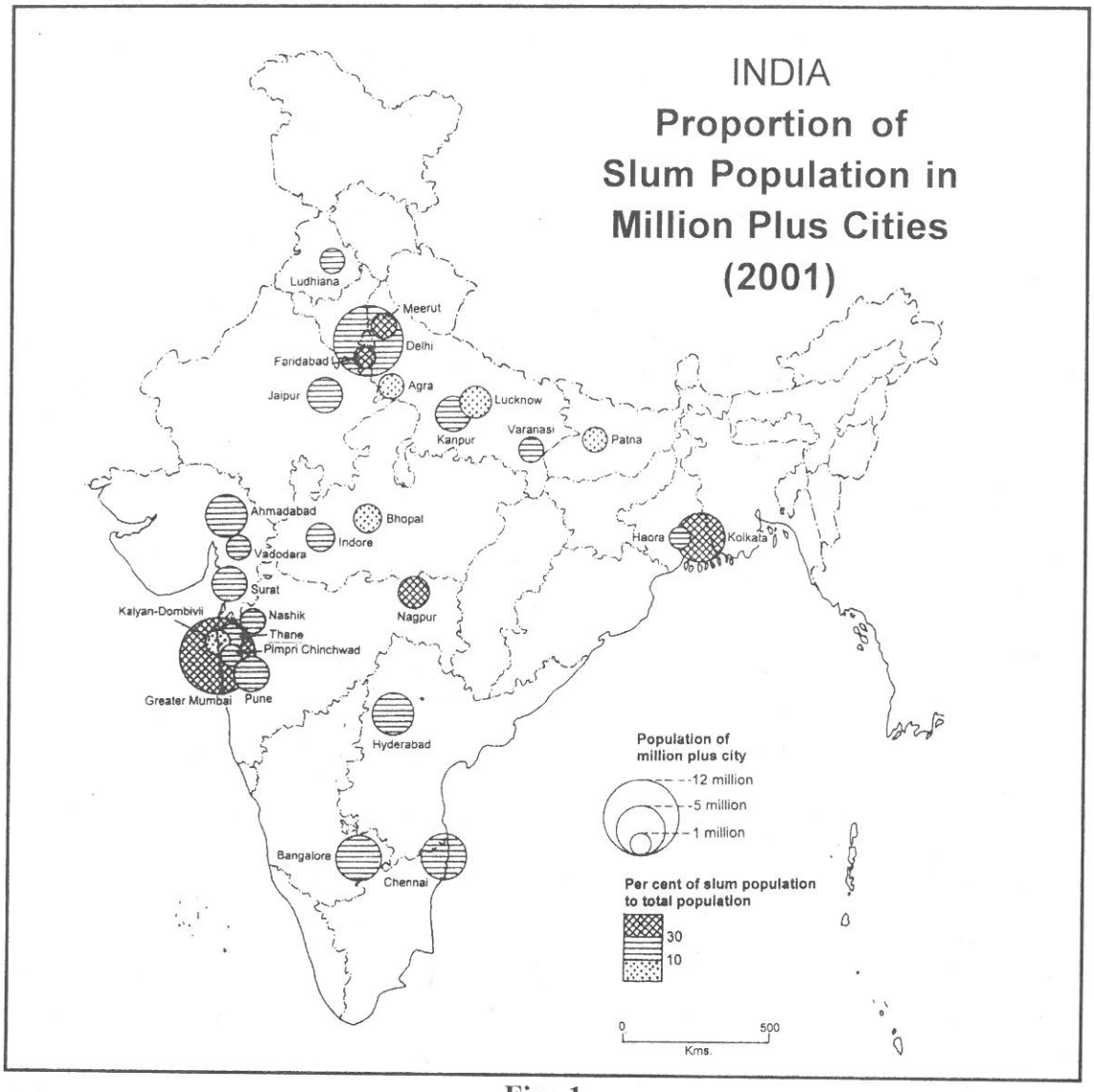

Fig. 1

which could serve as an input towards understanding the issues and formulation of strategies to tackle various problems being faced by the slum and non-slum population in million plus cities. Some of the important characteristics of slum population are discussed below:

(1) POPULATION SIZE

The slum dwellers in the country constitute nearly one seventh of the total urban population of the states and union territories reporting slum population; and 23.1 percent of the population of 640 cities / towns reporting slums. Among the states, Andhra Pradesh has the largest number of cities and towns (77) reporting slum population followed by Uttar Pradesh (69), Tamil Nadu (63), Maharashtra (61), West Bengal (59), Madhya Pradesh (43) and Gujarat (41). On the other hand in states like Jammu & Kashmir, Tripura, Meghalaya, and Goa slums have been reported from less than six towns each.

Slums in the 61 towns of Maharashtra account for 11.2 million people which is more than one fourth of the total slum population in the country. This is followed by Andhra Pradesh (2.2 million), Uttar Pradesh (4.4 million), West Bengal (4.1 million) and Tamil Nadu (2.9 million).

In fact, these 5 states account for about two third (65.3 percent) of the total slum population of the country. Among other states, Punjab, Haryana, Delhi, Rajasthan, Gujarat and Karnataka have reported more than 1 million slum dwellers each in the cities and towns in 2001.

As percentage of the total urban population Maharashtra has the highest proportion of slum population (27.3 percent) followed by Andhra Pradesh (24.9 percent) and Haryana (23.2 percent). In other thirteen states / UT's this percentage varies between 10 to 20 percent. These states are Jammu & Kashmir, Punjab, Chandigarh, Delhi, Uttar Pradesh, Meghalaya, West Bengal, Orissa, Chhattisgarh, Madhya Pradesh, Tamil Nadu, Pondicherry and Andaman & Nicobar Islands. The state of Kerala (0.8 percent) has the lowest percentage of slum population.

In the 27 million plus cities about 17.7 million population lives in slums which is about 41.6 percent of the total slum population in the country. In absolute numbers, Greater Mumbai has the highest slum population of around 6.5 million followed by Delhi (1.9 million) and Kolkata (1.5 million). Further, the slum areas of Surat, Hyderabad, Chennai and Nagpur have more than half a million population each. Except Patna and Kalyan-Dombivli, all cities have population above 100,000. The size of slum population in these cities is an indicator of the scale of migration which has taken place.

As evident from Table 1 and Fig.1 Greater Mumbai (54.1 percent) has the highest proportion of slum dwellers, followed by Faridabad (46.5 percent), Meerut (44.1 percent). Kolkata (32.5 percent), Nagpur (35.9 percent), Thane (27.8 percent), Ludhiana (22.5 percent) and Surat (20.9 percent). All these cities are industrial hubs of their region and recipients of streams of migrants. In other words more than one fifth of the population of these cities resides in slums or every fifth person is a slum dweller.

(2) SCHEDULED CASTES AND SCHEDULED TRIBES POPULATION

Out of the total 42.6 million people enumerated in slums in 2001 census, 7.4 million are Scheduled Castes and one million Scheduled Tribes contributing 17.4 percent and 2.4 percent of the total slum population respectively. When compared with corresponding percentage of Scheduled Tribes and other castes, the proportion of Scheduled Castes is notably higher in slums. Of the total Scheduled Caste population in urban areas, 22.1 percent is in slums. This figure is 16.5 percent for Scheduled Tribes and only 14 percent for other population.

In absolute terms Maharashtra (1.3 million) has the largest number of Scheduled Castes living in slums followed by Uttar Pradesh (0.9 million), Andhra Pradesh (0.8 million), Tamil Nadu (0.7 million) and West Bengal (0.6 million). In Rajasthan, Punjab, Haryana, Karnataka and Gujarat more than 2,00,000 Scheduled Caste population lives in slums.

In terms of concentration - measured as their percentage to total slum and urban population - of Scheduled Caste population, the slums of Chandigarh have the highest percentage of Scheduled Castes (39.1 percent) followed by Punjab (28.6 percent). Similarly in the slums of Delhi, Rajasthan, Tamil Nadu and Pondicherry more than one-fourth of the population belongs to the Scheduled Castes. In some States/UT's like Chandigarh, Uttaranchal, Rajasthan, Assam, Gujarat, Karnataka, Tamil Nadu and Pondicherry the percentage of Scheduled Caste population is almost twice that of the total urban population.

Among the million plus cities Delhi with 4.8 lakh Scheduled Caste slum dwellers tops the list followed by Greater Mumbai (3.9

Table - 2
India: Percentage of Scheduled Caste and Scheduled Tribe Population living in Slums in Million plus Cities (2001)

Sr. No.	Name of Million plus City	State / Union Territory*	Percentage of Population in slums		Percentage of Non-Slum Population	
			Scheduled Castes	Scheduled Tribes	Scheduled Castes	Scheduled Tribes
1	Pimpri Chinchwad	Maharashtra	40.8	1.9	13.9	1.9
2	Chennai	Tamil Nadu	32.8	0.2	13.8	0.2
3	Bangalore	Karnataka	32.5	1.6	11.1	1.1
4	Agra	Uttar Pradesh	32.1	Neg.	21.5	Neg.
5	Nashik	Maharasthra	31.8	12.1	12.5	6.8
6	Bhopal	Madhya Pradesh	28.7	4.6	12.4	3.0
7	Patna	Bihar	26.3	0.0	8.5	0.3
8	Delhi	Delhi*	26.1	0.0	15.8	0.0
9	Pune	Maharashtra	25.4	1.1	11.8	1.0
10	Jaipur	Rajasthan	24.6	5.4	12.6	3.7
11	Meerut	Uttar Pradesh	23.6	Neg.	16.3	Neg.
12	Indore	Madhya Pradesh	23.5	1.7	13.7	2.5
13	Kanpur	Uttar Pradesh	22.9	0.2	11.1	0.1
14	Nagpur	Maharashtra	20.5	14.6	16.7	8.9
15	Kalyan-Dombivli	Maharashtra	20.4	0.9	5.8	2.1
16	Ahmadabad	Gujarat	20.2	1.4	12.1	1.0
17	Ludhiana	Punjab	15.2	0.0	13.1	0.0
18	Hyderabad	Andhra Pradesh	14.3	1.4	7.4	0.9
19	Lucknow	Uttar Pradesh	13.9	0.1	10.1	0.1
20	Varanasi	Uttar Pradesh	12.0	0.0	7.2	0.0
21	Faridabad	Haryana	11.8	0.0	9.1	0.0
22	Vadodara	Gujarat	11.2	6.9	6.6	3.6
23	Haora	West Bengal	8.0	0.3	4.8	0.4
24	Thane	Maharashtra	6.8	3.1	4.6	2.5
25	Kolkata	West Bengal	6.2	0.2	6.0	0.2
26	Greater Mumbai	Maharashtra	6.0	0.9	4.9	0.8
27	Surat	Gujarat	5.9	7.1	3.6	3.5
	TOTAL		**14.6**	**1.7**	**10.3**	**1.2**

Neg.: Negligible population
Source: Census of India, 2001

Table - 3
India: Sex ratio in Slum / Non-Slum Population in Million plus Cities (2001)

Sr. No.	Name of Million plus City	State/Union Territory*	Sex Ratio	
			Slum Population	Non-Slum Population
1	Chennai	Tamil Nadu	974	953
2	Nagpur	Maharashtra	948	930
3	Bangalore	Karnataka	947	915
4	Hyderabad	Andhra Pradesh	938	930
5	Pune	Maharashtra	928	920
6	Nashik	Maharasthra	924	864
7	Bhopal	Madhya Pradesh	907	897
8	Indore	Madhya Pradesh	901	905
9	Lucknow	Uttar Pradesh	894	890
10	Jaipur	Rajasthan	892	873
11	Pimpri Chinchwad	Maharashtra	888	846
12	Varanasi	Uttar Pradesh	884	875
13	Vadodra	Gujarat	880	915
14	Meerut	Uttar Pradesh	875	886
15	Patna	Bihar	874	831
16	Kanpur	Uttar Pradesh	857	857
17	Ahmedabad	Gujarat	850	891
18	Agra	Uttar Pradesh	850	846
19	Kalyan-Dombivli	Maharashtra	845	885
20	Thane	Maharashtra	821	890
21	Kolkata	West Bengal	805	841
22	Faridabad	Haryana	795	837
23	Delhi	Delhi*	780	835
24	Haora	West Bengal	779	850
25	Greater Mumbai	Maharashtra	770	859
26	Ludhiana	Punjab	759	764
27	Surat	Gujarat	701	794
	TOTAL		**820**	**874**

Source: Census of India, 2001

Table 4
India: Literacy rate of Slum and Non-Slum Population in Million plus Cities (2001)

Sr. No.	Name of Million plus city	State/Union Territory*	Literacy of Slum Population			Literacy of Non-Slum Population		
			Person	Male	Female	Person	Male	Female
1	Nagpur	Maharashtra	85.4	91.5	78.9	91.4	95.2	87.4
2	Thane	Maharashtra	83.1	90.1	74.4	90.4	94.5	85.7
3	Greater Mumbai	Maharashtra	83.0	89.0	75.0	91.0	93.8	87.7
4	Indore	Madhya Pradesh	78.8	87.0	69.7	84.5	89.9	78.5
5	Ludhiana	Punjab	77.9	80.6	74.3	80.4	82.4	77.8
6	Chennai	Tamil Nadu	76.3	82.9	69.6	87.4	91.6	82.9
7	Pune	Maharashtra	75.0	83.6	65.8	89.0	93.4	84.2
8	Haora	West Bengal	74.4	79.7	67.5	85.4	89.1	81.1
9	Faridabad	Haryana	73.5	82.7	61.6	84.8	90.5	78.1
10	Vadodra	Gujarat	73.4	82.8	62.7	89.8	93.9	85.4
11	Kolkata	West Bengal	73.3	77.7	67.8	84.4	86.7	81.6
12	Hyderabad	Andhra Pradesh	71.0	77.1	64.5	80.3	84.9	75.3
13	Lucknow	Uttar Pradesh	70.6	76.0	64.6	77.7	82.2	72.6
14	Nashik	Maharasthra	70.4	80.7	59.1	88.6	93.7	82.8
15	Kalyan-Dombivli	Maharashtra	69.8	79.3	58.4	90.6	94.6	86.0
16	Bangalore	Karnataka	69.3	75.3	63.0	87.3	91.2	83.0
17	Kanpur	Uttar Pradesh	68.6	75.2	60.9	80.4	84.1	76.0
18	Varanasi	Uttar Pradesh	68.2	75.9	59.3	72.6	79.2	65.0
19	Pimpri Chinchwad	Maharashtra	68.1	78.8	55.8	88.1	93.3	81.9
20	Delhí	Delhi*	67.4	73.6	59.2	86.4	90.9	81.1
21	Surat	Gujarat	66.3	74.5	54.1	87.3	91.8	81.6
22	Ahmedabad	Gujarat	65.3	74.9	53.8	85.5	91.1	79.3
23	Bhopal	Madhya Pradesh	65.3	74.6	54.9	81.1	86.5	75.0
24	Jaipur	Rajasthan	60.7	73.0	47.0	81.2	88.9	72.3
25	Agra	Uttar Pradesh	60.7	68.9	51.1	70.9	77.0	63.8
26	Meerut	Uttar Pradesh	60.7	68.7	51.6	72.6	78.1	66.5
27	Patna	Bihar	52.5	56.9	47.5	81.3	86.9	74.4
	TOTAL		**75.8**	**82.4**	**67.6**	**85.2**	**89.5**	**80.2**

Source: Census of India, 2001.

lakh) and Chennai (2.7 lakh). In Bangalore, Pune, Nagpur and Meerut more than one lakh slum dwellers have been recorded as Scheduled Castes. In the slum areas of Kolkata, Faridabad, Pimpri Chinchwad more than 50,000 Scheduled Castes each were enumerated.

The proportion of the Scheduled Caste population in the slum areas (14.6 percent) is higher than their proportion (10.3 percent) in the non-slum population of million plus cities(Table 2). In 16 cities the Scheduled Caste population is more than 20 percent and in 5 cities it is between 10 to 20 percent while in only 6 cities it is below 10 percent.

Pimpri Chinchwad has the highest proportion of Scheduled Caste population (40.8 percent) followed by Chennai (32.8 percent), Bangalore (32.5 percent) and Agra (32.1 percent). In these cities the proportion of Scheduled Caste population is far higher as compared to their population among non-slum population. Surat with only 5.9 percent has the lowest scheduled caste population in its slums followed by Mumbai and Kolkata (6 percent each).

As far as Scheduled Tribe population is concerned, Nagpur (14.6 percent) has the highest proportion of Scheduled Tribe population in its slum areas followed by Nashik (12.1 percent), Surat (7.12 percent), Vadodra (6.9 percent) and Jaipur (5.4 percent). In other cities their proportion is below 5 percent.

(3) SEX RATIO

There is a preponderance of male population in the slum areas. The sex ratio of population in slums is 876 females per 1000 males which is lower than that of non-slum population (904 females per 1000 males). Only the slum areas of Meghalaya, Pondicherry and Kerala have the distinction of having more females than males. The lowest sex ratio in case of slum population has been recorded in the slums of Union Territory of Chandigarh.

In the million plus cities the sex ratio of slum population stands at 820 females per thousand males against 874 recorded for non-slum population(Table 3). Surat has recorded the lowest sex ratio of 701 followed by Ludhiana (759), Greater Mumbai (770), Haora (779), Faridabad (795) and Delhi (780). Interestingly, the sex ratio is more balanced in the slums of Chennai, Bangalore, Hyderabad, Pune, Jaipur, Lucknow, Nagpur, Bhopal, Patna, Agra, Varanasi, Pimpri Chinchwad and Nashik as compared to non-slum population of these cities (Table 3). Kanpur has registered an identical sex ratio of 857 both for non-slum as well as slum population. In these cities migration to slum areas more often is of the complete families.

(4) LITERACY

The literacy rate for slum dwellers is 73.1 percent, 80.7 percent for males and 64.4 percent for females. The literacy rate of slum dwellers varies from a low of 54.8 percent in Chandigarh to 88.3 percent in Meghalaya. In all the States/UT's literacy rate among slum dwellers is lower as compared to the urban literacy rates of their respective States/UT's. The low literacy is attributable to migration from areas with low literacy rates.

Among million plus cities, Nagpur is the only city which has recorded literacy among the slum dwellers above 85 percent. The lowest literacy is found in Patna with 52.5 percent literates. Most of the other cities fall in range of 60 to 80 percent (Table 4). As far as male and female literates among slum dwellers are concerned, Nagpur has the highest male (91.5 percent) and female (78.9 percent) literacy. On the other hand Patna has the lowest male literacy (56.9 percent) and Jaipur has the lowest female literacy (47 percent).

When compared with the non-slum population male literacy in non-slum areas is higher by almost 7 percentage points and female literacy by 13 percentage points. In Patna, Agra, Meerut and Ahmedabad literacy in slum areas is distinctly lower than the non-slum population.

(5) CHILD POPULATION

More than 6 million children live in slums in the country constituting 16.4 percent of the total child population of urban areas in

states/UT's reporting slums. In other words, every sixth urban child in the country in the age group 0-6 is a slum dweller. More than 25 percent of the urban children live in slums in the states of Maharashtra (30 percent), Andhra Pradesh (26.8 percent) and Haryana (25.7 percent).

In million plus cities of India around 2.5 million children in the age group 0-6 live in slums which constitute 27.3 percent of the child population in these cities. Greater Mumbai, Delhi and Kolkata together account for more than half of the child population registered in the slums of million plus cities.

Among individual cities the proportion of child population registered in slums is more than 50 percent of the total child population of Greater Mumbai (62.8 percent) and Faridabad (50.6 percent). These are followed by Meerut (48.5 percent) and Kolkata (38.3 percent). The high proportion of child population could be related to higher fertility among slum dwellers and also to a higher migration of complete families to slums.

SECTION - II

Issues and Policy Concerns

The million plus cities face a great challenge given the rapid rate of growth and the sheer numbers of urban poor to be employed, housed and serviced. Following are some pertinent issues which need to be addressed by the planners and policy makers:

1. Will the rapidly growing million cities in a developing economy like India live up to their potential as dynamic engines of growth and social modernization or, will they get mired in poverty, pollution, congestion and crime?

2. Most of the slum dwellings are illegal encroachments on land belonging to government agencies / organizations. At the time of setting up, their illegal possession goes ignored which subsequently becomes a menace when land owning agency tries to retrieve the land. While claim of the original landowner cannot be denied, would the eviction of dwellers from their residences, where they have resided for decades, be a rational and logical course of action?

3. A significant portion of this burgeoning slum population in million plus cities remains illiterate (40 percent), most of these cities exhibit a higher concentration of Scheduled Caste population (15 percent), child population (27.3 percent) and a lower sex ratio (820 females per thousand males) *vis- a- vis* the urban areas in these cities. What kind of social milieu would be created in these cities in times to come? Would the slums appear as zones of social conflicts and tensions on the city map?

4. Most of the slum dwellers are distressed migrants whose migration is poverty induced. Indeed it is a movement from rural poverty to urban poverty. What could be expected from such illiterate or semi-literate and unskilled or semi-skilled migrants? Will such slum dwellers in million plus cities be able to overcome poverty, improve their livelihoods and adapt to the rapidly changing life styles of these cities?

5. Mushrooming of slums creates an enormous pressure on the already weakening infrastructure of million plus cities. In these cities power supply, water supply, sewerage network, transport system and solid waste treatment facilities are not capable of dealing even with the current demand. In many of these cities the sewerage and water supply system dates back to the colonial period, and needs considerable overhauling. There is often severe breakdown of basic amenities in these cities. Will these cities ever cope up with the increasing demand for various amenities and facilities?

6. Million plus cities are under great pressure on three counts (a) inadequacy of existing services to cater to the ever increasing flux of migrants, (b) the ever increasing cost of maintenance which has resulted in many of the services being run down for want of requisite repair and

replacement and (c) their resources are drying up both in financial and physical terms. Would it be possible to make such cities sustainable?

All these issues urgently require remedial measures and solution. The policy makers need to understand the causal relations between various phenomena related to distressed migration, urbanization, poverty, underdevelopment and development while formulating strategies. The problem of slums can be best understood as a migration - urbanization problem.

For redressing this problem at a macro scale it is very essential to realize that it is the consequence of imbalances in spatial economy of our country, which in turn is the consequence of excessive polarised economic activities and resources at a few urban nodes and improper policies that arose out of past colonial rule.

At the micro scale, slums reflect the failure of government to guide and facilitate the growth of low income housing and basic services for incoming migrants through appropriate policy and planning. The city administration should adopt a participatory approach to involve the slum dwellers and coinvest with them for improving access to better housing facilities, water supply, sanitation and other basic services in the slums. Involving the urban poor in various activities of their locale will not only enhance the openness and accountability of local government but also increase the responsibility and responsiveness of the slum dwellers as stake holders in various developmental activities.

In the coming years, population growth as well as economic prosperity will increase resource utilization putting a heavy burden on housing, industry and service sectors. For a long term sustainable development the government should plan a two pronged strategy viz. immediate measures to make the existing congested million and mega cities sustainable and long term strategies to reduce the burden on urban areas. For such a situation, planners need to prepare programmes for economic revitalization and improvement of the quality of life of the urban population across the country. The success of programs in shaping the future of our cities and particularly the quality of life of slum dwellers depends on the kinds of policies we pursue. The problems can be resolved by the creation of new institutional arrangements of urban governance through collective planning and participation of state as well as central government and non-governmental organizations (NGOs) and public at large. The involvement of the private sector as well as local user groups is essential to solve many of the problems. When quality of urban life is improved, there will be greater pressure of rural-urban migration. To tackle such a situation we need a long term strategy, where the planners should take initiative to retain the rural population in rural areas so that rural migration to urban is reduced. This can be achieved through industrialization, increasing rural employment through agro-based industries, food processing industries etc. There is also an urgent need to think in terms of integrated urban-rural policies for sustainable development.

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SPATIAL PATTERN OF SCHEDULED CASTE LITERACY IN HARYANA (1991 – 2001)

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Introduction

Literacy and education are important indicators of human development. Not only education is essential for social reconstruction, improvement in quality of life and preparation for skilled manpower, it is also a necessary first step towards the attainment of higher goals in an individual's life. According to the Census of India 2001, there has been an increase in Scheduled Caste literacy in Haryana from 39.22 percent in 1991 to 55.44 percent in 2001, indicating an average growth rate of 1.6 percent per annum. Out of 33.69 million (excluding 0-6 age group population) Scheduled Caste population in the state only 18.68 million persons are literate.

The state was divided into sixteen districts in 1991 for administrative purposes. Three districts were bifurcated after 1991. The bifurcated districts are Panchkula from Ambala, Fatehabad from Hisar and Jhajjar from Rohtak (Fig. 1). These bifurcated districts have been used again for comparison with 1991 Census.

This paper is an attempt to understand the spatial pattern of literacy among the Scheduled Caste population in Haryana.

Objectives

The main objective is to find out how this socially and economically backward group is being brought into the mainstream through changes in its literacy level. The other objectives are to find out the spatial, urban/ rural and male/female variations in literacy rate and examine the relationship between literacy and various socio-economic variables. The study tests the hypothesis that there is a positive correlation between literacy and urbanization and literacy and workers engaged in non-primary activities.

Data Base and Methodology

The analysis is based on secondary data. The data relating to literacy rates and socio-economic variables have been collected from the respective Census of India, Haryana, Scheduled Caste Table and Social-Cultural Table, 1991 and 2001. The tabulated data have been depicted on maps by using choropleth technique, to identify regions with different levels of literacy. Karl Pearson's Correlation has been used to determine the r values between literacy and socio-economic variables.

$$r = \frac{\Sigma xy}{N\sigma x\ \sigma y}$$

r = Karl Pearson's Correlation, Σxy = The sum total of the literacy and other variable deviations of x and y, σx = Standard Deviation of X-series, σy = Standard Deviation of Y-series, N = Total number of pairs of items.

Gender Disparity in literacy has been computed by the following method:

$GS = \text{Log } X_2 / X_1 + \text{Log } 200\text{-}X_1 / 200\text{-}X_2$
Where $X_2 > X_1$

GS stands for gender disparity, X_2 (Male) and X_1 (Female) are the first and second groups of population respectively. The value of the index should always vary between +1 and -1, and in ideal case it should be zero. If

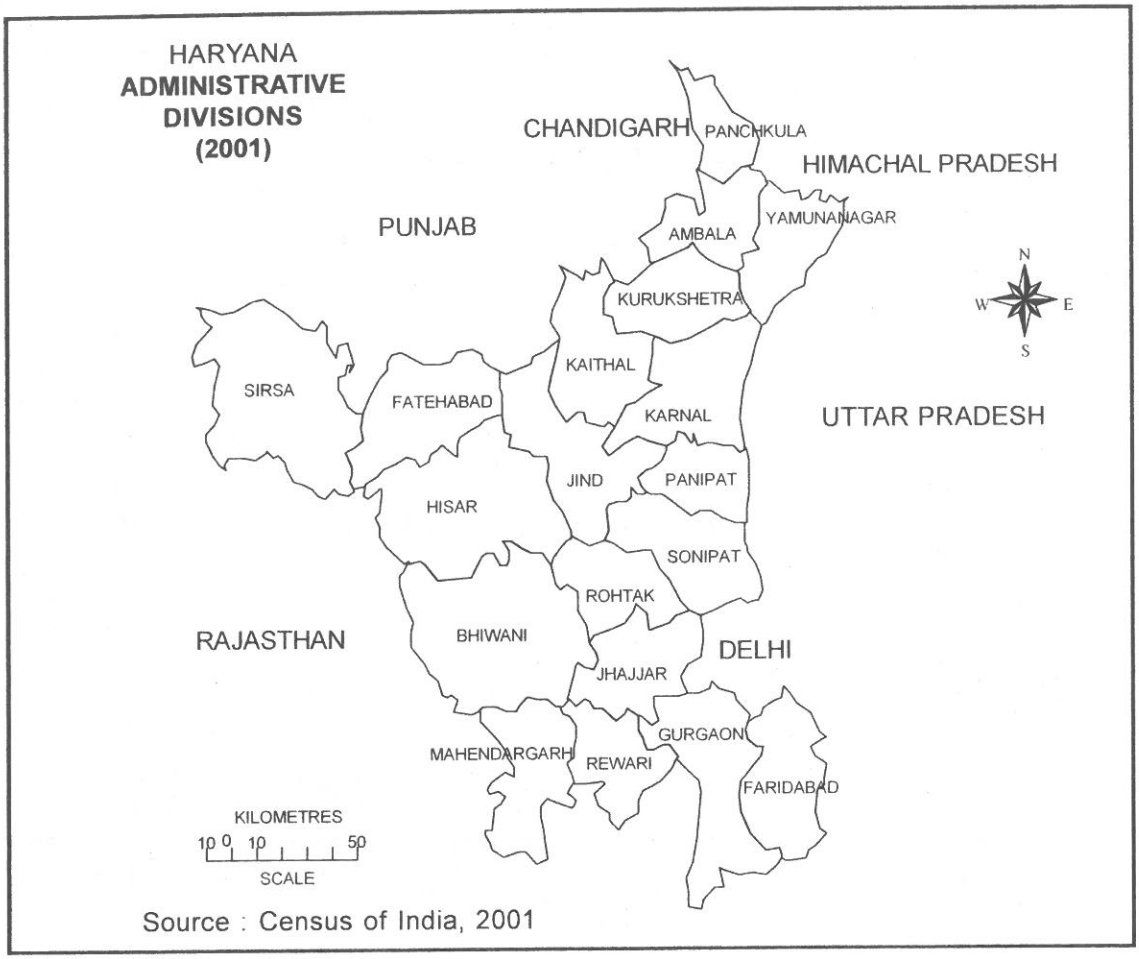

Fig. 1

Table - 1

Haryana : Literacy Rate of Non-Scheduled Caste and Scheduled Caste Population by Residence and Sex (1991-2001)

Year	Non - Scheduled Caste Population											
	Total			Gender Disparity	Urban			Gender Disparity	Rural			Gender Disparity
	P	M	F		P	M	F		P	M	F	
1991	55.85	60.1	40.47	0.23	73.66	81.96	64.06	0.17	49.85	64.78	32.51	0.39
2001	67.91	78.49	55.73	0.22	79.89	86.58	72.05	0.13	63.82	76.13	49.77	0.27
	Scheduled Caste											
1991	39.22	52.06	24.15	0.41	46.42	58.69	31.89	0.34	37.67	56.2	22.48	0.49
2001	55.44	66.92	42.26	0.27	60.19	70.67	48.01	0.24	54.13	65.88	40.64	0.28

Source : Primary Census Abstract, Census of India, Haryana, Series-6, 2001 & 1991.
Note : The percentages have been calculated on the population aged 7 years and above in 1991 and 2001.

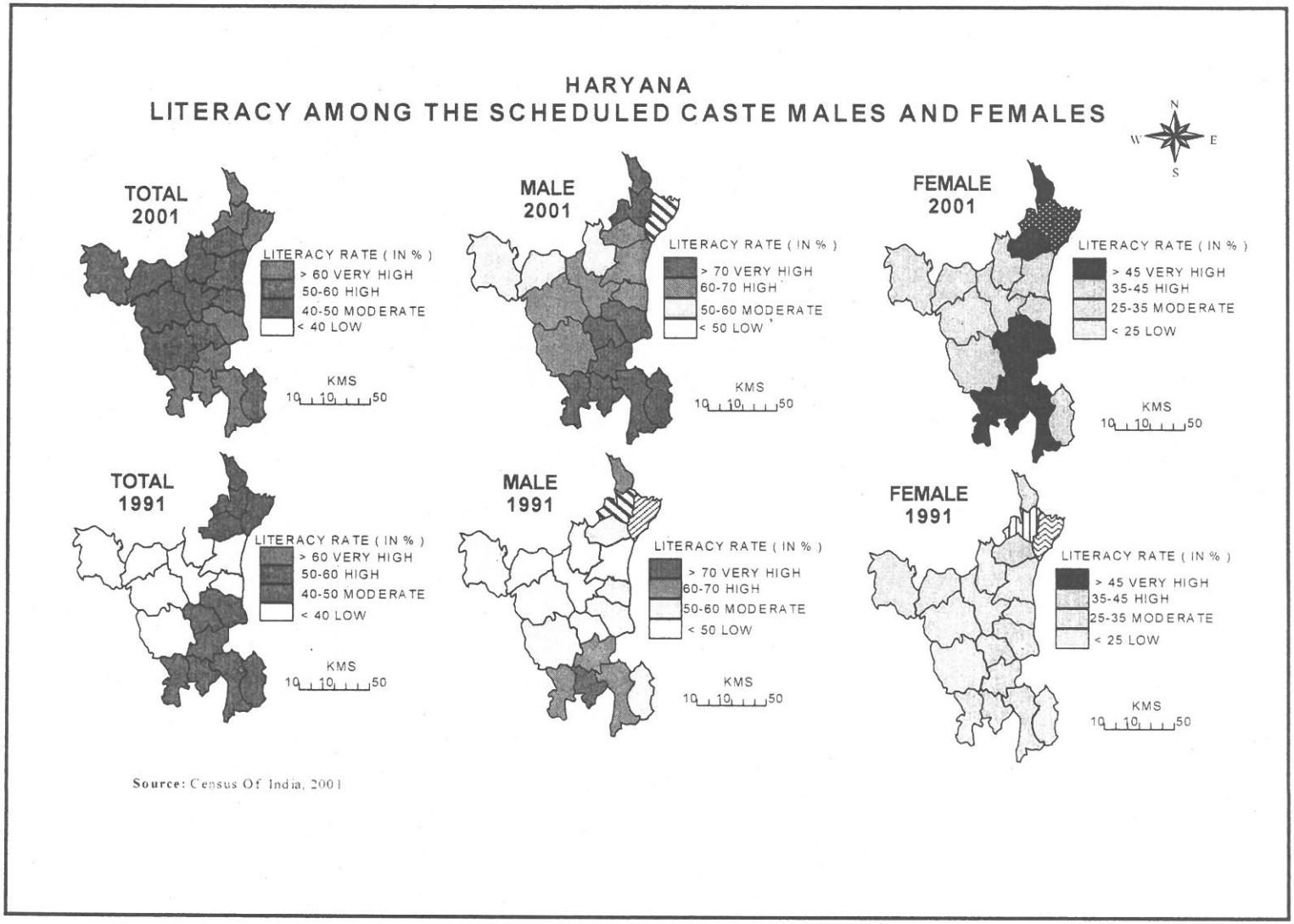
HARYANA
LITERACY AMONG THE SCHEDULED CASTE MALES AND FEMALES
N
W
E
S
TOTAL 2001
LITERACY RATE (IN %)
> 60 VERY HIGH
50-60 HIGH
40-50 MODERATE
< 40 LOW
KMS
10 10 50
MALE 2001
LITERACY RATE (IN %)
> 70 VERY HIGH
60-70 HIGH
50-60 MODERATE
< 50 LOW
KMS
10 10 50
FEMALE 2001
LITERACY RATE (IN %)
> 45 VERY HIGH
35-45 HIGH
25-35 MODERATE
< 25 LOW
KMS
10 10 50
TOTAL 1991
LITERACY RATE (IN %)
> 60 VERY HIGH
50-60 HIGH
40-50 MODERATE
< 40 LOW
KMS
10 10 50
MALE 1991
LITERACY RATE (IN %)
> 70 VERY HIGH
60-70 HIGH
50-60 MODERATE
< 50 LOW
KMS
10 10 50
FEMALE 1991
LITERACY RATE (IN %)
> 45 VERY HIGH
35-45 HIGH
25-35 MODERATE
< 25 LOW
KMS
10 10 50
Source: Census Of India, 2001

Fig. 2

Table - 2
Haryana : Literacy Rate among the Scheduled Caste Population (1991)

Districts	Total			Urban			Rural		
	Persons	Male	Female	Persons	Male	Female	Persons	Male	Female
Haryana	39.22	52.06	24.15	46.42	58.69	31.89	37.67	56.20	22.48
Panchkula	53.42	63.99	40.58	60.33	70.56	48.01	50.69	61.39	37.67
Ambala	50.96	60.71	36.28	57.52	67.22	46.68	48.08	59.68	34.52
Yamunanagar	46.06	57.39	32.95	49.01	59.60	36.61	45.49	56.96	32.25
Kurukshetra	40.23	51.27	27.63	49.59	60.10	37.62	38.89	50.00	26.19
Kaithal	25.58	35.61	13.50	33.27	43.40	21.34	24.78	34.81	12.68
Karnal	37.17	48.91	23.28	48.09	58.46	36.08	34.69	46.77	20.34
Panipat	36.99	50.23	21.25	41.72	53.14	28.19	36.05	49.66	19.86
Sonipat	44.96	59.71	27.23	47.47	60.88	31.67	44.40	59.38	26.34
Jind	30.36	41.89	16.34	41.56	53.69	27.13	28.91	40.39	14.93
Fatehabad	23.96	34.05	13.87	27.80	38.67	16.93	20.12	29.43	10.81
Hisar	35.17	49.56	20.79	42.10	57.14	27.07	28.24	41.97	14.51
Sirsa	31.58	44.15	16.51	34.12	44.29	22.34	21.29	29.37	12.04
Rohtak	43.45	57.46	26.37	47.35	60.21	32.30	42.43	56.82	24.75
Jhajjar	48.54	62.89	31.34	57.25	71.20	40.75	47.40	61.81	30.07
Bhiwani	39.96	54.16	23.41	41.59	55.09	25.93	39.62	53.97	22.89
Mahendargarh	49.13	68.02	29.00	53.81	71.02	34.19	48.55	67.63	28.38
Rewari	55.41	74.23	34.69	58.76	75.67	39.15	54.90	74.01	34.03
Gurgaon	49.58	66.11	30.38	53.58	68.48	35.46	48.47	65.45	28.66
Faridabad	41.94	58.31	21.79	44.24	58.06	26.23	40.43	58.49	19.01

Source: Scheduled Caste Population Tables, Census of India, Haryana, Series-8, 1991.
Note: The percentages have been calculated on the population aged 7 years and above

Table - 3
Haryana : Literacy Rate among the Scheduled Caste Population (2001)

Districts	Total			Urban			Rural		
	Persons	Male	Female	Persons	Male	Female	Persons	Male	Female
Haryana	55.44	66.92	42.26	60.19	70.67	48.10	54.13	65.88	40.64
Panchkula	63.42	72.75	52.72	67.41	76.96	56.36	61.58	70.78	51.04
Ambala	63.16	72.58	52.53	68.91	76.64	60.30	61.71	71.57	50.57
Yamunanagar	62.88	72.18	52.20	65.62	74.34	55.57	62.18	71.63	51.34
Kurukshetra	56.94	66.91	45.65	60.96	70.50	50.11	56.17	66.23	44.80
Kaithal	44.67	54.90	32.62	50.37	60.07	39.06	43.66	53.99	31.47
Karnal	53.77	63.92	42.04	59.96	68.86	49.70	52.24	62.69	40.14
Panipat	56.69	68.69	42.63	58.98	69.45	46.44	55.79	68.39	41.16
Sonipat	62.33	74.43	48.22	65.32	76.32	52.77	61.49	73.91	46.77
Jind	48.94	60.30	35.58	57.30	68.10	44.95	47.37	58.86	33.78
Fatehabad	41.01	51.46	29.36	48.17	57.03	38.25	39.95	50.63	28.05
Hisar	49.82	61.80	35.99	57.33	68.84	44.19	47.83	59.94	33.80
Sirsa	41.39	56.19	31.21	48.12	57.56	37.71	39.48	48.57	29.36
Rohtak	59.46	70.72	46.25	61.32	71.39	49.79	58.61	70.41	44.61
Jhajjar	62.51	74.59	48.23	69.07	79.66	56.63	60.87	73.34	46.14
Bhiwani	56.26	68.70	41.79	59.05	70.07	46.31	55.58	68.37	40.70
Mahendargarh	63.64	79.18	46.85	66.48	81.25	49.95	63.27	78.91	46.45
Rewari	68.68	83.90	51.84	71.82	83.75	58.17	68.09	83.93	50.66
Gurgaon	63.98	77.48	48.69	66.36	78.21	53.13	63.18	77.24	47.19
Faridabad	55.84	70.24	38.78	57.58	69.78	42.67	54.59	70.58	36.05

Source: Social - Cultural Tables, Census of India, Haryana, C - Series, 2001 from the CD.
Note: The percentages have been calculated on the population aged 7 years and above.

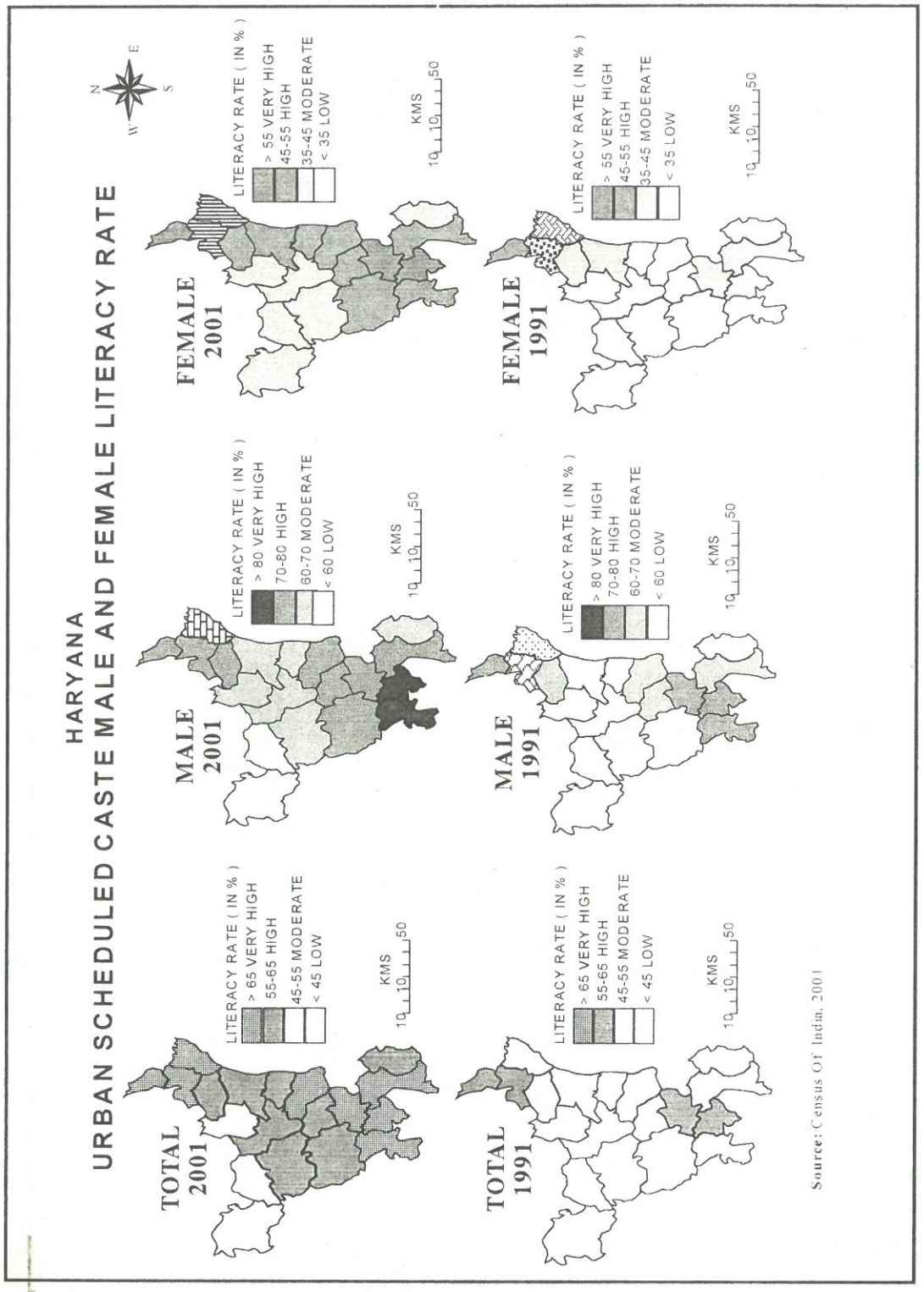
HARYANA
URBAN SCHEDULED CASTE MALE AND FEMALE LITERACY RATE
TOTAL 2001
MALE 2001
FEMALE 2001
TOTAL 1991
MALE 1991
FEMALE 1991
LITERACY RATE (IN %)
> 65 VERY HIGH
55-65 HIGH
45-55 MODERATE
< 45 LOW
> 80 VERY HIGH
70-80 HIGH
60-70 MODERATE
< 60 LOW
> 55 VERY HIGH
45-55 HIGH
35-45 MODERATE
< 35 LOW
KMS
10 0 10 50
N
S
E
W
Source: Census Of India, 2001

Fig. 3

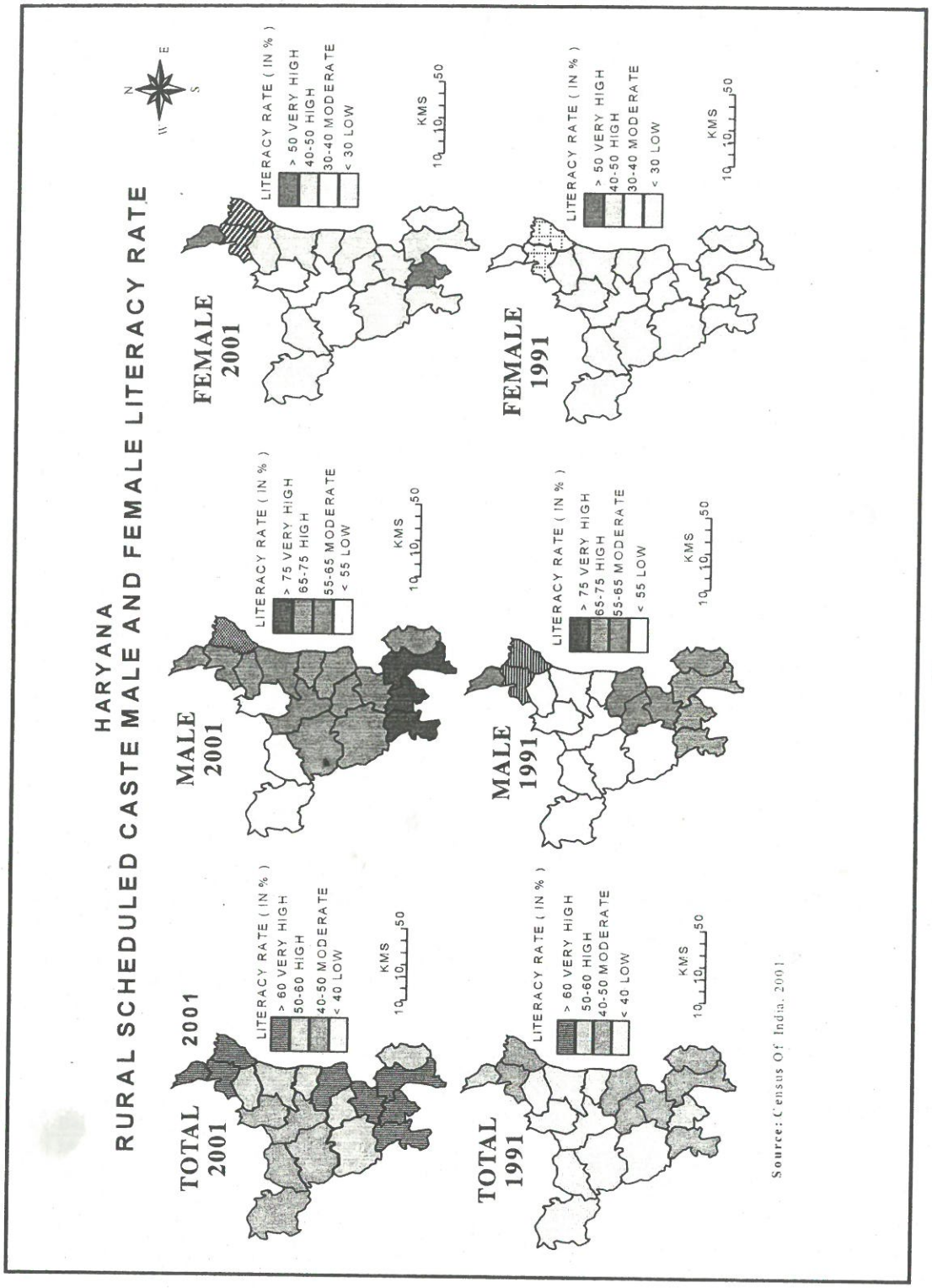
HARYANA
RURAL SCHEDULED CASTE MALE AND FEMALE LITERACY RATE
TOTAL 2001
LITERACY RATE (IN %)
> 60 VERY HIGH
50-60 HIGH
40-50 MODERATE
< 40 LOW
KMS
0 10 50
MALE 2001
LITERACY RATE (IN %)
> 75 VERY HIGH
65-75 HIGH
55-65 MODERATE
< 55 LOW
KMS
0 10 50
FEMALE 2001
LITERACY RATE (IN %)
> 50 VERY HIGH
40-50 HIGH
30-40 MODERATE
< 30 LOW
KMS
0 10 50
TOTAL 1991
LITERACY RATE (IN %)
> 60 VERY HIGH
50-60 HIGH
40-50 MODERATE
< 40 LOW
KMS
0 10 50
MALE 1991
LITERACY RATE (IN %)
> 75 VERY HIGH
65-75 HIGH
55-65 MODERATE
< 55 LOW
KMS
0 10 50
FEMALE 1991
LITERACY RATE (IN %)
> 50 VERY HIGH
40-50 HIGH
30-40 MODERATE
< 30 LOW
KMS
0 10 50
N
S
E
W
Source: Census Of India, 2001

Fig. 4

Table - 4
Haryana : Gender Disparity in Scheduled Caste Literacy (1991 and 2001)

Districts	1991			2001		
	Total	Urban	Rural	Total	Urban	Rural
Haryana	0.41	0.34	0.49	0.27	0.24	0.28
Panchkula	0.27	0.24	0.28	0.20	0.20	0.20
Ambala	0.29	0.22	0.31	0.20	0.16	0.22
Yamunanagar	0.31	0.28	0.32	0.20	0.19	0.21
Kurukshetra	0.33	0.27	0.34	0.23	0.21	0.23
Kaithal	0.48	0.37	0.49	0.29	0.25	0.30
Karnal	0.39	0.27	0.43	0.25	0.20	0.26
Panipat	0.45	0.34	0.48	0.29	0.25	0.30
Sonipat	0.43	0.37	0.44	0.27	0.24	0.28
Jind	0.47	0.37	0.50	0.30	0.25	0.31
Fatehabad	0.44	0.41	0.48	0.30	0.23	0.32
Hisar	0.47	0.41	0.48	0.31	0.27	0.32
Sirsa	0.50	0.41	0.53	0.32	0.24	0.27
Rohtak	0.42	0.35	0.45	0.26	0.22	0.28
Jhajjar	0.39	0.33	0.40	0.27	0.22	0.29
Bhiwani	0.45	0.41	0.46	0.30	0.25	0.31
Mahendargarh	0.48	0.43	0.49	0.33	0.31	0.33
Rewari	0.45	0.40	0.46	0.31	0.24	0.33
Gurgaon	0.44	0.38	0.46	0.29	0.25	0.31
Faridabad	0.53	0.43	0.59	0.35	0.30	0.39

Note: Gender disparity calculated from table 2 and 3.

it is negative then there is no disparity against X_2.

Literacy Pattern in Haryana

A comparison in the literacy rates between non-Scheduled Caste and Scheduled Caste population indicates that about 55 percent of non-Scheduled Caste population was literate against the Scheduled Caste population of 39.22 percent in 1991. Scheduled Caste literacy rate was lower in 2001 as compared to non-Scheduled Caste. It was 55.44 percent as against 67.91 percent (Table1).

Scheduled Caste male literacy in 2001 Census was 66.92 percent. For non-Scheduled Caste it was 78.49 percent. Scheduled Caste female literacy rate was 42.26 percent, compared to 55.73 percent for the non-Scheduled Caste female literacy. The increase from 1991 to 2001 for Scheduled Caste and non-Scheduled Caste male is 14.86 and 18.39 percent points and for Scheduled Caste and non-Scheduled Caste female is 18.11 and 15.26 percent points respectively. It shows that increase is faster in the case of Scheduled Caste female and non-Scheduled Caste male than in the case of Scheduled Caste male and non-Scheduled Caste female.

In the urban areas the literacy rate of Scheduled Caste population was 46.42 and 60.19 percent in 1991 and 2001 respectively. This figure is far below the non-Scheduled Caste urban literacy. The non-Scheduled Caste urban literacy in 1991 was 73.66 which increased to 79.89 percent in 2001.

According to 2001 Census 71 percent non-Scheduled Caste population lives in rural areas where as 78.48 percent Scheduled Caste population lives in rural areas. In 1991 only 37.67 and 49.85 percent Scheduled Caste and non-Scheduled Caste population respectively were literate in the rural areas and this increased to 54.13 and 63.82 percent respectively in 2001. Scheduled Caste male

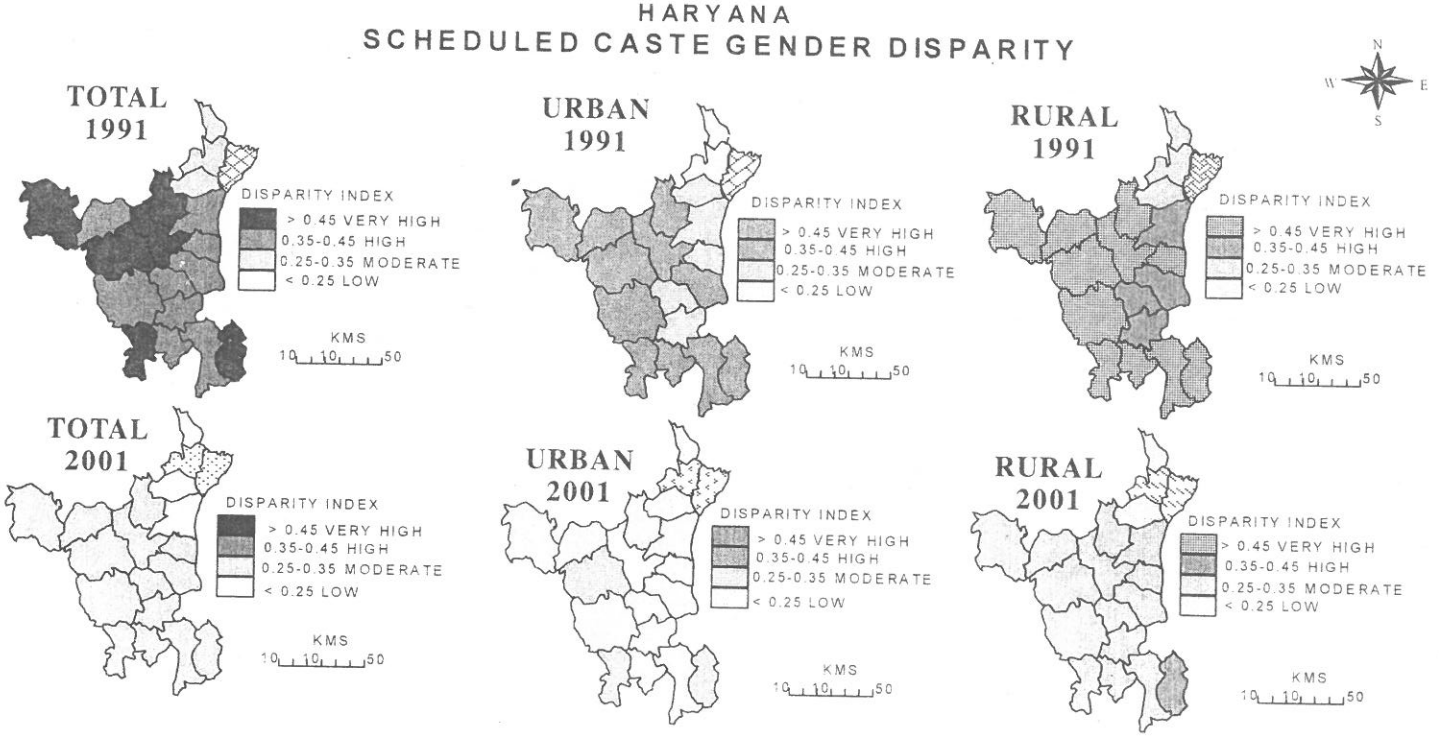
HARYANA
SCHEDULED CASTE GENDER DISPARITY
TOTAL 1991
URBAN 1991
RURAL 1991
TOTAL 2001
URBAN 2001
RURAL 2001
DISPARITY INDEX
> 0.45 VERY HIGH
0.35-0.45 HIGH
0.25-0.35 MODERATE
< 0.25 LOW
KMS
10 0 10 50
N
W
E
S
Source: Census Of India, 2001

Fig. 5

and female literacy is also low in urban and rural areas than non-Scheduled Caste.

Gender disparity for Scheduled Caste during 1991 was 0.41 and has gone down to 0.27 in 2001. Non-Scheduled Caste shows a gender disparity of 0.23 in 1991 and 0.22 in 2001. Non-Scheduled Caste gender disparity is very low as compared to the Scheduled Caste gender disparity for rural and urban area at both points of time. The disparity has gone down over the period of time for both Scheduled Caste and non-Scheduled Caste but reduction is much sharper for Scheduled Caste than non-Scheduled Caste. Scheduled Caste gender disparity in rural areas was 0.49 and 0.28 in 1991 and 2001 respectively. The gender disparity in urban areas is quite low than rural areas for Scheduled Caste and non-Scheduled Caste. Scheduled Caste gender disparity in urban areas was 0.34 in 1991 and it decreased to 0.24 in 2001.

Regional Pattern of Scheduled Caste Literacy

An attempt has been made to identify spatial pattern of Scheduled Caste literacy covering various components such as urban/ rural and male/female. For the convenience of this study the literacy values have been grouped into four categories separately for 1991 and 2001. On this basis the following four types of areas comprising of districts mentioned against each type have been identified :

1. Very high literacy area : Panchkula, Ambala, Yamunanagar, Sonipat, Jhajjar, Rewari, Mahendragarh and Gurgaon.
2. High literacy area: Kurukshetra, Karnal, Panipat, Rohtak, Bhiwani and Faridabad.
3. Moderate literacy area : Hisar, Jind.
4. Low literacy area : Kaithal, Fatehabad and Sirsa.

A description of the attributes of each type of literacy area identified above is given below :

VERY HIGH LITERACY AREA

The districts of the northern and southern part of the state, Panchkula, Ambala, Yamunanagar, Sonipat, Jhajjar, Mahendragarh, Rewari and Gurgaon have shown very high literacy (Fig. 2). Panchkula, Ambala and Rewari were the three districts falling in high category in 1991. The highest literacy has been shown by Rewari followed by Gurgaon and Mahendragarh . The northern and southern districts namely Panchkula, Ambala, Rewari, Mahendragarh , Sonipat, Jhajjar, Rohtak, Gurgaon and Faridabad consistently showed very high literacy for Scheduled Caste total, male and female for both points of time (Fig.2). Jhajjar, Gurgaon, Mahendragarh, Panchkula, Ambala shifted up from high to very high category in 2001. Rewari showed very high literacy only in 1991. Sonipat, Rohtak, Jhajjar, Mahendragarh , Rewari and Gurgaon shifted from moderate to very high category in 2001. There were no districts from central and western part of the state showing very high literacy. Only one district of south Haryana, Faridabad, could not feature in very high category at the two points of time. Panchkula and Rewari always registered the highest literacy and showed very high literacy for total, male, female, urban and rural areas at the two points of time (Fig.3). The districts of northern and southern part of the state also showed very high literacy in rural areas (Fig.4). Ambala, Yamunanagar, Sonipat, Jhajjar, Mahendragarh and Gurgaon shifted up from moderate to very high literacy in rural areas in 2001.

Sirsa, Jind, Kaithal, Hisar, Mahendragarh and Faridabad showed very high disparity in 1991. These districts shifted from very high to moderate category in 2001. Except for Panchkula, Ambala, Yamunanagar, Kurukshetra, Karnal, Rohtak, Jhajjar and Sonipat all the districts showed very high disparity in rural areas in 1991. Except Panchkula, Ambala, Yamunanagar, Kurukshetra and Faridabad these districts shifted from very high to moderate category in 2001. None of the districts had consistently very high gender disparity for total, urban and rural in 2001 and for urban literacy in 1991 (Fig. 5).

HIGH LITERACY AREA

Eastern and south-western parts of the state had high literacy (Figs. 2, 3 & 4). The districts in this category are Kurukshetra, Karnal, Panipat, Rohtak and Bhiwani. These districts shifted up from moderate to high category in 2001. Yamunanagar, Kurukshetra, Karnal, Panipat, Jind, Hisar and Bhiwani had high literacy in 2001 while Karnal, Jind and Hisar shifted up from low to high category in 2001. A similar pattern can be identified for male and female high literacy. These districts shifted up from low to high literacy in 2001 (Map 2). The districts in the central, eastern and south western parts namely Jind, Rohtak, Kurukshetra, Karnal, Panipat, Bhiwani and Hisar have shown high literacy for urban population (Map 3). These districts shifted up from low/moderate to high category. The districts of eastern and southern part have also shown high literacy in rural areas (Map 4). These districts shifted to high category in 2001 from low category in 1991.

Maximum number of districts falls in this category for total and urban literacy in 1991 (Fig.5). This shows that a large area comes under either very high disparity category or high disparity category. Fatehabad, Karnal, Panipat, Sonipat, Rohtak, Jhajjar, Bhiwani, Rewari and Gurgaon had high disparity in 1991 as well as in 2001. Karnal, Sonipat, Jhajjar and Rohtak had high disparity in 1991 only in rural areas. These districts shifted from high category to moderate category in 2001. None of the districts of the state showed high disparity for total, urban and rural literacy in 2001. Faridabad was the only district having high disparity in rural areas in 2001 (Fig.5).

MODERATE LITERACY AREA

The districts situated in western part of the state show moderate literacy. In Sirsa, Fatehabad and Kaithal districts male and female literacy was moderate in 2001. But these districts shifted up from low to moderate category (Fig.2). The districts situated in western and central western part of the state exhibit low literacy in urban and rural areas (Figs.3 & 4).This is the region that has been consistently showing moderate and low literacy at the two points of time.

Four districts of the northern part of the state, namely, Panchkula, Ambala, Kurukshetra and Yamunanagar show moderate gender disparity for total and rural areas in 1991. Except these four, and Karnal district, all districts of the state showed moderate disparity for total and rural areas in 2001 (Fig.5). Yamunanagar, Kurukshetra, Karnal, Panipat, Rohtak and Jhajjar showed moderate disparity in urban areas in 1991 and Hisar, Mahendragarh and Faridabad showed moderate disparity in 2001.

LOW LITERACY AREA

There were no districts in the low literacy category for total, male and female in 2001 while for urban male and rural male and female districts like Fatehabad and Sirsa come under low literacy category in 2001 and 1991. For total, male, female, urban male and female, rural male and female central and western parts of the state during 1991 showed low literacy. None of the districts in northern and southern parts of the state had shown low literacy.

No district of the state showed low disparity for total and rural literacy in 1991, but in urban areas of Panchkula and Ambala low disparity in 1991 has been identified. However Panchkula, Ambala, Yamunanagar, Kurukshetra and Karnal districts had low disparity in 2001 and except for Karnal these four districts showed low disparity in rural areas in 2001. Except Hisar, Mahendragarh and Faridabad all districts of the state in urban areas showed low disparity in 2001 (Fig.5). The gender disparity has gone down over the period of time in total, urban and rural areas.

The regional pattern of disparity and literacy show negative correlation and high literacy shows moderate gender disparity. But in the western part of the state high disparity is associated with low literacy. The area of very high literacy corresponds to the area of low disparity. The northern and southern part

of the state show low disparity.

The regional pattern identified roughly shows that the districts of northern and southern part of the state are a region of very high literacy. Central and eastern part is a region of high literacy. The western part has been identified as a region of low literacy. The districts of low literacy in western part of the state are Kaithal, Jind, Fatehabad, Hisar and Sirsa.

Correlates of Literacy

Being one of the indicators of development, literacy too is dependent on socio-economic and cultural variables, which help in raising or lowering the literacy status. It is well known that literacy level in any society is the net result of a complex set of interrelated factors. An analysis of relationship between literacy and different aspects of socio-economic reality can give a clear picture. The growth rate of Scheduled Caste literacy in the state and particularly for females is likely to be influenced by a number of factors. These factors are economic, socio-cultural and, demographic etc. In this section an attempt has been made to identify the socio-economic factors which seem to be significant in determining the level and change in literacy and to examine the impact of some of these factors on literacy statistically. Karl Pearson's correlation method has been used to test the hypothesis stated earlier.

Scheduled Caste literacy has a positive and significant correlation with urbanization (0.184). Districts like Panchkula, Ambala, Yamunanagar, Sonipat, Rohtak, Jhajjar, Rewari, Gurgaon and Faridabad have high level of urbanization which has promoted literacy among the Scheduled Castes. The correlation between Scheduled Caste literacy rate and Scheduled Caste persons engaged in primary activities (-0.487) suggests that primary activities tend to lower the literacy rate. Percentage of Scheduled Caste workers engaged in non-primary activities has a positive relationship with literacy (0.487). Thus the hypothesis that literacy will have a positive relationship with the proportion of persons engaged in non-primary activities holds true.

The above correlation exercise shows an increase in literacy with an increase in urban population, persons in non-primary activities and a decrease in gender disparity while literacy tends to decline with an increase in number of persons engaged in primary activities.

Conclusion

It can be concluded that there is an increase in literacy rate in the state. There are wide gaps between urban and rural and male and female literacy rates. In rural areas, parents discriminate between boys and girls, preferring to give education to the boys. Poverty also compels the parents to engage their children in sundry jobs rather than sending them to schools. In the area of the state which is less urbanized, located in western and south-western parts of the state, Scheduled Caste literacy is very low. On the other hand, in areas of the state which are highly urbanized and industrialized the levels of Scheduled Caste literacy are quite high. These areas are located close to the national and the state capitals.

On the whole it has been observed that even after persistent efforts, both by Central and State Governments, achieving total literacy is still a distant objective in Haryana. Although the percentage of illiterates has declined, the number of illiterates continues to grow. According to 2001 Census, about 45 percent of total Scheduled Caste population and 58 percent of Scheduled Caste females of Haryana are still illiterate and this is attributed to causes like population explosion, lack of adequate literacy programmes for females, lack of universal primary education, poverty and ignorance etc.

The Scheduled Caste literacy status in Haryana continues to be a matter of great concern. The basic problem is how to motivate the Scheduled Castes for enrolment. This cannot be achieved only by providing some educational infrastructure and a few incentives.

The attitude of Scheduled Caste people will have to be changed. Until and unless the rural Scheduled Caste female understands the importance of literacy and comes forward to participate in the literacy programmes, the desired results are not possible. Apart from the government sponsored programmes, active involvement of voluntary agencies can prove to be a factor in motivating the Scheduled Caste population for education.

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FEMALE LITERACY IN RURAL PUNJAB (2001)

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Abstract

Women are the pivot around whom family life revolves. They play multiple roles simultaneously, specially in Indian society. They are supposed to look after the elderly in the family and to inculcate perfection in the younger generation to face the challenges of life. To meet all these requirements successfully females will have to be educationally well equipped. As literacy is the first indispensable step towards education, it is imperative to make females literate for our bright future. Various definitions of literacy are followed by different nations. The Indian Census follows the definition by Population Commission of United Nations i.e. ability to read and write with understanding in any language. Literacy being the first step towards education should be given greater attention. Keeping in view the importance of female literacy, rural Punjab has been selected for this study. The study area is traditionally divided into three geographic regions i.e., Majha, Bist-Doab and Malwa, and comprises of 17 districts. Among the 35 States and Union Territories of India, Punjab is ranked 16th in case of general literacy whereas its rank was 14th in case of female literacy in 2001 Census. Urban-rural female literacy differentials are quite wide i.e. 17 in percentage points. The study has been designed to analyse the rural female literacy. It is based on the district wise data drawn from the Census of India 2001.

Introduction

Advancement of science and technology can provide material comforts but the quality of life is related to the level of literacy/education prevailing in a society. Literacy and education are a prerequisite both for maintaining and further developing a society in all spheres of modern social life i.e. social, economic, political and ethical etc. (Desai, 1988). It is commonly accepted that if a male is educated only one member of the family is educated, but if a woman is educated the whole family becomes educated. It highlights the role of women in family as well as in society. She plays multiple roles simultaneously especially in Indian society. She is supposed to look after the elderly in the family and has to inculcate norms and values in the younger generation to face the challenges of life. To meet all the requirements successfully, women will have to be educationally well equipped. Thus, literacy enables a woman to improve the living of her family and assure better conditions for her children. In addition to it literacy/education helps to improve the quality of village life when we combine it with community development (UNESCO, 1992). Literacy and education increase female's capability for participation in economic activities by broadening the available job opportunities and by giving more knowledge about the job market etc. (Harish, 1991). As literacy is the first indispensable step towards education it is imperative to make females literate to usher in a bright future.

Various definitions of literacy are followed by different nations. The Indian Census follows Population Commission of United Nations which defines literacy as the ability to read and write with understanding in any language. Literacy being the first step towards education should be given greater

Table - 1
Punjab : Percentage of Female Literates (1881-2001)

Year	Percent Female Literates
1881	0.06
1891	0.15
1901	0.24
1911	0.45
1921	0.48
1931	1.20
1941	N.A
1951	6.59
1961	15.76
1971	25.90
1981	33.69
1991	42.22
2001	56.00

attention. Keeping in view the importance of female literacy, rural Punjab has been selected for the present study. The study area is traditionally divided into three geographic regions i.e. Majha, Bist-Doab and Malwa, and has 17 districts.

In 1881 the rural female literacy was only 0.06 percent (Table1). The situation was more or less the same during the pre-Independence period. During this long span of six decades female literacy rate was less than one percent. This was due to the overall low level of development including educational facilities and rampant poverty among the masses. In the post-Independence period female literacy increased at a faster rate i.e. from 6.59 percent in 1951 to 56 percent in 2001. During this period the government played a significant role in the socio-economic development of the people.

Table - 2
Punjab: Percentage of Rural Female Literates (2001)

State/District	Percent Rural Female Literates
Punjab	**57.91**
Hoshiarpur	73.67
Nawanshahr	68.27
Jalandhar	68.17
Ludhiana	66.73
Rupnagar	66.71
Fatehgarh Sahib	65.83
Kapurthala	64.41
Gurdaspur	63.58
Moga	55.87
Patiala	55.29
Amritsar	52.69
Faridkot	52.27
Sangrur	48.98
Bathinda	47.16
Firozpur	45.78
Muktsar	45.49
Mansa	40.03

Source: Census of India 2001, Punjab, Provisional Population Totals, Series 4.

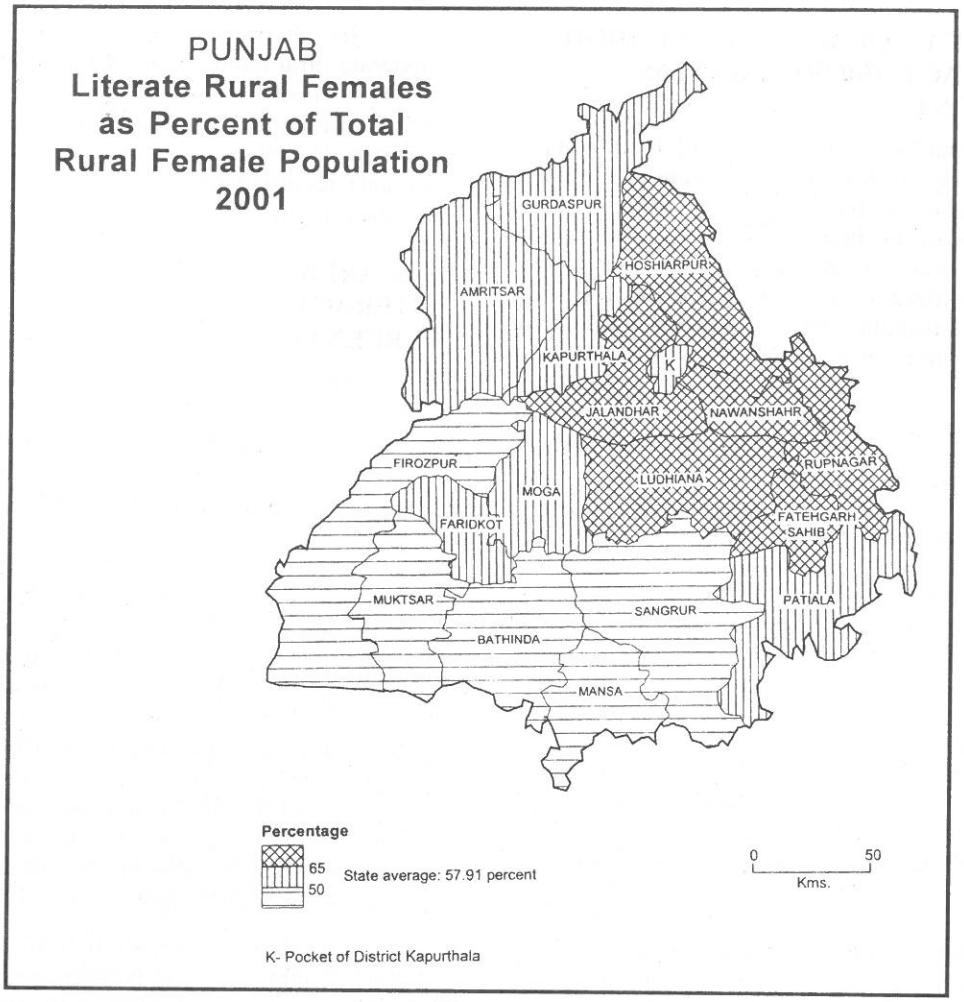

Fig. 1

Moreover, emigration to the developed countries, transformation of agriculture (Aggarwal,1977), urbanisation, development of transportation and communication were the supporting factors.

Among the 35 States and Union Territories of India, Punjab is ranked 16th in case of literacy. Urban-rural female literacy differentials are quite wide (17 percentage points).

Spatial Patterns

In 2001 about 67 percent of the total female population of the state was rural. Despite its not so large an areal extent, the state is marked by significant spatial variations among the rural females. On the basis of the spatial distribution of rural female literacy rates following three types of areas can be identified (Fig. 1) :

(i) Areas of relatively high literacy (more than 65 percent);

(ii) Areas of moderate literacy (between 50 percent and 65 percent);

(iii) Areas of relatively low literacy (less than 50 percent).

(i) AREAS OF RELATIVELY HIGH LITERACY (MORE THAN 65 PERCENT)

Out of the 17 districts of Punjab state, six belong to this category where the literacy rate was more than 65 percent. Most of these districts are located in the north –eastern parts of the state. Hoshiarpur district with 73.67 percent literacy rate was at the top followed by Nawanshahr (68.27 percent), Jalandhar (68.17 percent), Rupnagar (66.71) and Fatehgarh Sahib (65.83) (Table 2). It has been observed that all those areas showed a lead in rural female literacy where general literacy rate was also high. In most of these areas emigration to advanced countries and the Arab world has been very common. This has contributed to overall socio-economic upliftment of the area. In addition, the migrants brought social awareness which gradually inspired greater attention to female education. Money remitted by the emigrants to their local areas also helped a lot to enhance the female literacy in rural areas. The general approach of the people in Bist- Doab to marry their daughters in foreign countries also paved the way for female education. Tradition of defence services in these areas is also an important contributing factor. As level of exposure and general awareness are positively correlated, it supports female literacy level by diffusing the idea of importance of female literacy for the society. Historically speaking, due to early start and relatively less effect of social prejudices, districts with relatively high literacy rate among the urban females show high female literacy rate. The trend of high literacy in urban areas gradually diffuses into rural areas because the degree of urban influences and interaction between urban-rural areas are the contributing factors (Krishan & Shyam, 1971). Relatively high literacy rate among the males also encourages female literacy due to matrimonial requirements.

(ii) AREAS OF MODERATE LITERACY (BETWEEN 50 AND 65 PERCENT)

Six districts constitute the area of moderate rural female literacy rate. Kapurthala (64.41), Gurdaspur (63.58 percent), Moga (55.87 percent), Patiala (55.29 percent), Amritsar (52.69 percent) and Faridkot (52.27 percent) recorded moderate (between 50 and 65 percent) literacy rate among rural females.

(iii) AREAS OF RELATIVELY LOW LITERACY (LESS THAN 50 PERCENT)

About one third of the total area of the state registered relatively low literacy among the rural females. More than fifty percent of rural female population living in this region showed their inability to read and write with understanding in any language. Five districts namely, Sangrur (48.98 percent), Bathinda (47.16 percent), Firozpur (45.78 percent), Muktsar (45.49 percent), and Mansa (40.03 percent) had rural female literacy of less than fifty percent (Table 2). It is important to mention here that in general literacy/education of a girl depends on a number of factors, some of which relate directly to the availability of schooling while others depend on the life chances of a family and the social set-up of the specific area and whether female education is regarded as worthwhile (Wazir, 2000).

The main reasons behind the low literacy among the rural females could be: (i) prejudices against female education; (ii) restricted out-of-home female mobility; (iii) their subordinate position to men; (iv) late start of education; (v) perception of low social and private returns from female literacy and education (Harish, 1991). Generally females do not join literacy campaigns because they are most of the time involved in domestic chores and find little time for attending literacy classes. Lastly health problems during the reproductive period prevent women from being active participants in this regard (Mishra, 2004). A low level of interaction between child and parent (specially illiterate mothers from relatively low income groups) is one of the disguised reasons in this respect because they usually have to struggle for survival

Table - 3
Punjab: Urban-Rural Disparity in Female Literacy (2001)

State/District	Disparity Index Value
Punjab	**0.330**
Faridkot	0.767
Firozpur	0.463
Patiala	0.429
Mansa	0.428
Amritsar	0.416
Bathinda	0.401
Rupnagar	0.357
Muktsar	0.355
Gurdaspur	0.310
Moga	0.291
Sangrur	0.263
Hoshiarpur	0.230
Kapurthala	0.227
Jalandhar	0.226
Ludhiana	0.214
Fatehgarh Sahib	0.213
Nawanshahr	0.199

Source: Census of India 2001, Punjab, Provisional Population Totals, Series 4.

For calculation of disparity index the following formula has been used:

$$\text{Log } 10 = \frac{p(1-q)}{q(1-p)} \quad \text{(Sopher, 1980)}$$

(Snow and Tabors, 1996).

Urban - Rural Literacy Differentials

About 35 percent districts recorded a relatively low disparity index i.e. less than 0.250. All the districts of Bist-Doab region fall in this category (Table 3). In addition to this, districts of Ludhiana and Fatehgarh Sahib in Malwa region also show low disparity. In five districts the disparity index values were moderate i.e. between 0.250 and 0.400.This category includes two districts of central Malwa (Moga and Sangrur), one district on the north-eastern side (Rupnagar) besides Muktsar district of south–western Malwa. Gurdaspur district from Majha region also falls within these limits of disparity index (Table 3). Six districts had relatively high urban-rural literacy disparity in case of females.

Out of these, four districts are located in south-western Malwa region (Firozpur, Faridkot, Bathinda and Mansa). Urban-rural literacy disparity among the females is generally low in areas which had traditionally recorded overall relatively high literacy rate. Urban-rural literacy disparity and general literacy have been found to be negatively correlated. Low degree of general awareness of social benefits of female literacy among the rural masses was the key factor for low literacy among the rural females. Parents prefer economic returns from child labour more than the social returns from educating their female children. Socio-cultural framework of rural areas has a low degree of positive impact on parental motivation for female education (Bhatty,1998). Broadly speaking, rural females are caught in a web of cultural practices and social prejudices from the moment of their birth (UNESCO, 1992) which creates hurdles to achieve the desired goal of literacy/ education. Centuries old patriarchal social setup has inculcated such strong feelings in society's behaviour towards females that they are transmitting (to some extent) continuously even to contemporary generation. Ultimately these thoughts condition females to believe that they are inferior and subordinate to men (Coonrod, 1998). Obviously due to such a social environment females are historically victimised and lag behind in almost all spheres of life, no doubt education being one of them.

Conclusion

Broadly speaking, areas with relatively high general literacy also have high female literacy in rural Punjab. General female literacy rate and urban-rural disparity in female literacy were negatively correlated. To enhance the rate of eradication of illiteracy among the rural females, improvement in economic accessibility should be topmost priority followed by the breaking of traditional social approach regarding outdoor female mobility. Similarly, determined efforts in case of adult literacy programmes, especially for females, are required.

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