CHAPTER II

REVIEW OF LITERATURE

The requirements for health, education and recreation, three essential needs of families, seem more emphatic with regard to the urban poor, who neither have the money nor much know-how to satisfy these basic needs. The optimum utilization of community facilities in order to secure basic health, education and recreation goals, thus seems imperative. The vast returns that can be enjoyed by families, through the use of community facilities, on which the government is spending colossal amounts of resources, have of late, urged researchers to explore the utilization of these community resources, under the existing panorama of urban life, which contains several facilitators and constraints in its environment. The household sector, apparently, represents the major consumer of these tangible resources, hence efforts are being made to explore the reasons for under and optimum utilization of these community facilities, as, only a few sparce studies have been conducted in this direction, in India.

There exists a variety of literature regarding these basic human needs, coupled with several studies relating to the satisfaction of the same, of which only the most relevant aspects have been scrutinized and presented under the following broad heads:

I. The Urban Scenario

II. Indicators of Urban Development And Quality Of Life

III. The Urban Poor

IV. The Strategy Of Basic Services

V. Community Facilities And Services - Related Studies In India and Abroad

(a) Health facilities and services

(b) Educational facilities and services

(c) Recreational facilities and services

I. The Urban Scenario

Urban areas cover extensive tracts of land with their buildings, services, open space and transportation networks. The whole nature of society is deeply associated with and committed to life in cities. National prosperity depends to a considerable extent upon the adequate functioning, the economic accomplishments and social achievements of its urban areas (Jackson, 1972). The city is a focus of contacts and a centre of innovation. In addition, in many less developed

countries, it represents a pattern of social integration and a means of promoting national identity (Report of the meeting at U.N., 1977).

As a concept, an urban area is merely a place with (a) population density - number of people per unit area, and (b) absolute population level above some specified magnitude. The actual cut-off thresholds vary from country to country depending on factors like total population, and average nation-wide densities (Shukla, 1988). An urban area in India is defined as follows:

(a) All places with a municipality, corporation, cantonment board or notified town area, committee, etc. and,

(b) All other places which satisfy the following criteria:

(i) A minimum population of 5,000

(ii) Atleast seventy-five per cent of male working population engaged in non-agricultural pursuits, and,

(iii) A density of population of atleast 400 persons per square km. (1000 persons per square mile).

An urban agglomeration is by definition, the continuous urban spread consisting of a core town and its adjoining out-growths, which may be urban in their own rights, or rural (Government of India, Census, 1981).

The Urban Fabric In Individual Perspective

The city is made up of the people that live in it, hence it must be viewed as an area in which many people move around to meet for various purposes and different social groupings. They move and combine with different social purposes in mind. Individually they oscillate between family functions and occupational functions, between residence and place of work. Urban construction is geared to serve these various functions of social interaction and consequently determines the direction of such intra-urban movements. The city dweller enjoys the privilege of free choice with regard to the social relationships he wants to cultivate and those he wants to neglect. He enjoys, in this respect, an advantage over the farmer and the small town dweller, who are more or less bound to accept social relationships on the basis of geographical proximity.

In looking at the city through the eyes of the individual participant, one recognizes an important and characteristic aspect of urban life. The city dweller has an opportunity to pick and choose his friends, the activities he wants to engage in, and the type of urban construction he wants to make use of, in the pursuit of his daily routine. The urban fabric is primarily a social fabric, and as such, is of an exceedingly complex composition. It is difficult to follow the total stream of intra-urban movements, within the city environment. No attempt has been made to record individual movements in order to reconstruct schematically the urban fabric from its most elementary units.

Contact areas:- In the perspective of the individual city dweller, certain parts of the urban environment are highlighted as areas of more or less intensive contact. These contact areas spread out in the immediate vicinity of his residence, his place of work, the educational institution he attends, his places of recreation, the residences of his friends, relatives and places of civic participation. The desire for economy in movement, places a premium on contact patterns which place several of those contact areas in close proximity to each other, or which make them overlap entirely. Individual contact patterns differ on the basis of subjective inclinations, recreational preferences, occupational ambitions, and attitudes towards the associational life of the urban community (Riemer, 1952).

In recent years, the problem of an accelerated trend in urbanization has caused considerable anxiety in the minds of those concerned with civic administration in the country (Municipal Corporation of Delhi, 1961). For sociological purposes, a city may be defined as a relatively large, dense, and permanent settlement of socially heterogeneous individuals. The rapid urbanization process that currently characterises the majority of Third World countries represents a major challenge to governments, politicians, planners and not least, the communities, families and individuals involved (Potter, 1985).

Urbanization and modern civilization go together. It is seen as a product of increasing economic specialization of the

advancing technology (Carter, 1972). There is no parallel in the past to the scale and pace with which urbanization is changing the world landscape at present. The simplest and the most common definition of urbanization refers to the proportion of population living in urban settlements to the total population. Rightly did McGee call it, "a balcon into which each social scientist blows his own meaning" (McGee, 1971 by Misra, 1978).

Urbanization is broadly defined as a growth of towns and an increasing ratio of urban to rural populations of a country. The growth of a country's towns and cities is conditioned by the national, economic and social progress. The concept of urbanization must be able to account for urbanization as a set of related socio-economic progress, which implies a shift in focus from the city as a cultural artifact to processes that lead to the expansion of the cities and generate and diffuse elements of urban life and culture (Friedmann, 1973). The growing problems of urbanization are exercising the minds of people all over the world. The current technological advances have tended to add, than to check this trend towards urbanization with its attendant evils (Bhardwaj, 1974).

Urbanization has been on the increase during the past four decades or so. Only two Indian cities had over a million population in 1941, whereas in 1957 there were five - Calcutta, Bombay, Delhi, Madras and Greater Hyderabad. In twenty years, the ten larger cities of India have doubled in population. In 1951 there were seventy-one Indian cities with a population of more than one lakh (Municipal Corporation of Delhi, 1961).

There is a fundamental need to view urbanization in context of the total national economy, as the problems of urbanization are a reflection of economic under development and must be solved in the general framework of development. A joint UN-UNESCO Seminar on urbanization held at Bangkok in 1956, concluded that "a general device for promoting development in the urban area may be found in some of the techniques of 'Community Development Programme'" (Howell, 1957).

Suburbanization denotes the extension of urban values, urban functions, and urban land uses in the fringe settlements of central cities. Recognizing this character of metropolitan development in India, the census of India 1971, uses the term 'Urban Agglomeration' for the peripheral suburban settlements along with the central city (Census of India, 1971).

The industrially developed countries, are, by definition urbanized, and are becoming more so. The less developed countries are by definition predominantly rural, but as their population increases, it does so even more rapidly in urban than in rural areas. The growth of these huge urban agglomerations has been as striking in its speed as in its dimensions. The most dramatic examples of accelerated urban growth are the "shanty towns"; their tendency to appear without warning and to grow rapidly, is reflected in the use of such terms as "mushroom houses" and "squatter parachutists" in describing these fringe colonies. Their high density and lack of basic amenities are sufficiently well-known, but the process of settlement itself, is worth noting here, because it throws open the whole question of how far methods evolved in more stable slower-growing rural communities

can apply to urban communities of this type (Department of Economic and Social Affairs, 1961).

The majority of Indian towns and cities have indigeneous characteristics which stem from the indigeneous living conditions and the indigeneous ways of adaptation with them. Hence, the transplantation of the western concepts to the Indian situation is unrealistic (Pandit, 1986). Basically, the rual and urban environment is not much different in India. So much so that calling the Indian urbanization as "subsistence urbanization, the difference may be just one of locale".

There is a wide and growing range of economic and social problems in towns and cities, particularly in areas where urban growth is proceeding at a rapid rate because of migration from rural areas. The difference between rural and urban populations is that there is seldom any sense of belonging to the urban community. In cities, welfare services and facilities such as schools and hospitals are more fully developed and there are usually more voluntary organizations giving various kinds of assistance (Agency for International Development, 1956).

With the important place occupied by the cities in the Indian economy and political life, one might expect that city life would be an improvement over village life. This is not however the case for large sections of the population. The Sen Committee estimated that, slum population of our cities, varies from seven per cent to as high as sixty per cent. The number of urban slum houses totally unfit for human occupation

is estimated as high as 1.15 millions. Therefore, our concern should be not only to prevent the growth of slums endangering the health, safety, morals and well-being of the country, but also effect certain improvements in the existing framework, in spite of limitations (Municipal Corporation of Delhi, 1961).

A study recently undertaken by the United Nations Population Division indicates that natual increase in population accounted for about sixty-one per cent of urban growth compared to thirty-nine per cent from migration.

India with a 2.4 per cent of the global area, holds about fifteen per cent of the world's population, over twenty per cent of the share of developing countries and ranks second only to China with an estimated population of 725 million as of March 1985. With an urban population of 160 million and recording the highest growth rate of 4.6 per cent, it is the fifth largest country in the world. By 1991, it is expected that about 236 million people will be living in urban areas, the number may cross the 315 million mark by the end of this century and place urban-rural ratio at 4:7 as against its present ratio of 1:4 (Wishwakarma, 1986).

Men are increasingly assuming conscious control over the development of their cities. As societies group progressively, larger proportions of their populations in urban areas, the construction and reconstruction necessary to supply their elemental wants, enters a state requiring critical attention (Michelson, 1970).

Sanitation and community appearance

Mahatma Gandhi once said that those who do not know how to serve their own city, can never serve their country.

The effort to keep the city clean is an example of co-operation between the Municipality and the citizens. The haphazard growth of population in urban areas has created a problem for the local bodies affecting the hygienic conditions and sanitary standards which are proving beyond the capacity of the civic bodies in India. The Metropolitan cities are worse affected due to congestion and slum areas created by migration of rural population in search of employment (Bhardwaj, 1974).

Keeping the community healthy is closely related to keeping it clean and presentable. The man who sweeps the streets and the inspector who looks for rubbish-strewn places are among the functionaries in this service, but engineers, architects, doctors, and others are also engaged in activities related to santitation and beauty (Andersen, 1960). Cole (1958) mentions beauty as one of the essentials of urban design and he quotes Julian Huxley, "Beauty is part of the necessary emotional cement of society." Beauty or the appearances of the community is the opposite of ugliness and disorder. With this in mind neighbourhood groups bring pressure to have a mosquito breeding swamp made into a public park (as seen in the low lying Masab tank area of Hyderabad which is now converted

into the picturesque Nehru park.) Thus, as Tunnard, (1953) observes, beauty is a reality. Santitation means providing light and fresh air in buildings, ridding the city of unnecessary smoke fumes and odours and it may mean putting pressure on householders to clean their backyards (Anderson, 1960).

II. Indicators Of Urban Development And Quality Of Life

The indicators that focussed specifically on the urban sub-system on which planners and decision-makers are compelled to take prompt action, are the five areas of major social concern cited in the Interregional Seminar in social aspects of Housing, held at Holte, Denmark, in September 1975: health, education, safety, security, employment and accessibility. Both objective and subjective indicators have been considered.

Of the five sources of systems considered, the cultural and economic systems are found to be represented at a level of greater detail than the social, political and physical - ecological systems. UNRISD has developed several lists of indicators, many of which particularly reflect the kinds of institutional and environmental characteristics typically found in less developed countries. The lists are intended to measure real progress at the local level and provide one possible approach to the formulation of a comprehensive system of urban indicators.

The main paradigm implicit in the approach adopted in a study (Gottingen et. al., 1976), focusses on quality of life

in the urban area as experienced and seen by individual citizens, by experts and by politicians. Above all, however, the citizen is taken as the central focal point of his own urban universe. He is assumed to experience aspects or dimensions of urban life quality. Accordingly, the urban system is seen in the context of a social mechanism focussing on the interactions between the individual citizen and his environment, both physical and social. These interactions in turn reflect the manifold aspects of the proximate and more distant physical and social environment. Furthermore, part of the approach consists in recognizing the wide range of attributes, standards and norms that the individual applies in order to adjudge the quality of his urban environment.

The Stockholm Environmental Inventory was cited as an example of the particular use of indicators as a means for researchers and professionals to gain an understanding of a specific situation and to convey that understanding to decision-makers. In 1972, criticism of land-use policies in Stockholm Country and the failure of those policies to relate to social goals, as well as the prevailing lack of information on individual behaviour and goals, had led the Swedish Board of Health and Welfare to embark on a sociological survey of living conditions. In order to provide the necessary background information for the survey, a project was commissioned and given the code name 'Stockholm County Council Environmental Inventory.' The qualitative determination of the living environment in the Inventory was based on the following measurements.

(a) Quantitative and qualitative measurements within given areas to determine the living conditions in each area based on the occurence and types of individual amenities;

(b) Access to specific environmental amenities measured in terms of travelling time by specific means of transportation between sub-areas under peak and off-peak traffic conditions (Stockholm County Council, 1974).

The need to identify geographically defined areas within the boundaries of the conurbation called for functional criteria relating to planning and institutional levels, graded according to hierarchy. A deliberate attempt to match the area borders with census tracts would simplify greatly the collection and dissagregation of data.

The contemplating indicators to assess the performance of urban systems, attention must be paid to the perspectives from which such evaluations can be made. Essentially there are six possible perspectives:

(1) International organizations requiring comparative data for urban areas of the world

(2) The national government

(3) The state or provincial government

(4) The community or local government

(5) The user of the service or facility

(6) The provider of the service or facility

The last two perspectives differ from the others in that

the users' and providers' evaluations are manifested in their respective decisions to use the service or facility and to provide a particular level of service. The governmental perspectives are more complex, in that they involve a wider range of objectives and are constrained by a veriety of competing demands for public expenditures.

With regard to specific urban indicators, strong emphasis is given to the importance of spatial indicators, in terms of access to needed services (situational characteristics). Any attempt to assess urban quality, should, therefore, incorporate indicators that measure the differential access to public facilities, services, employment, etc. In some instances, spatial indicators of access may provide a more accurate picture of urban quality than other indicators.

The state of health of the population and the measures required to maintain and improve it are vital concerns in urban areas. Physical and mental well-being are basic to unhampered and effective participation in economic and social activities, to pleasure derived from engaging in these activities and to length of life itself. Series and indicators are therefore wanted, to monitor and assess the state of health and nutrition of the population, and the availability and use of services and facilities to protect and improve health, so also education, recreation, housing, etc.

Satisfactory housing is an essential aspect of adequate living conditions. The type and quality of shelter in which

people are housed, the space, the degree of crowding, the facilities, the surroundings, affect their activities of personal and family care and influence their health, social inter course and general outlook.

The components as parts or elements of the urban subsystem are shelter, land, population employment/income and urban services which comprised a continuing measurement of the level and distribution of costs of services and facilities, eg. physical facilities for water supply, manpower - based (social) services for health and education, transportation services and accessibility, etc.

Indicators should be related to a set of desirable standards, or norms, in line with the cultural, social and political preferences and economic resources of urban dwellers. Systems of urban indicators are only tools, which have to be shaped in view of, and placed into, the proper qualitative and value - oriented context (Report of the Meeting at U.N., 1977).

Social determinants exert a powerful sway on urban form and urban characteristics. There is the desire of people to live close to people of similar socio-economic characteristics. There are various travel interaction distances in modern society, such as from home to work-place or from home to cultural activities and behavioural characteristics generally. There is the location of community services and facilities such as schools, hospitals, parks and playgrounds. Changes in standards of living create new demands, for eg. interms of recreational

facilities and the size and location of homes (Jackson, 1972).

The large cities, for all their urbanity, seem to contain an impressive degree of local community life, within their metropolitan limits. But urban life involves more than this local level; many lives of functional interdependency extend out from any designated residential district. With adequate transportation, urban residents will go far out of their local districts to make use of many types of facilities. It is apparent, that most residents accept the longer trip as a counterpart of specialization that is so intrinsically a part of metropolitan growth (Foley, 1957).

III. The Urban Poor

A full human life - a fully developed human being - is the product of particular social, physical and psychological environmental conditions (Alliband, 1983). Millions of people in the large metropolitan cities are living in self-built homes on illegally occupied lands. It is estimated that about fifteen to twenty per cent of the cities with a population of 3,00,000 or more live in 'bastis'. The inhabitants of these settlements are the new urbanizing groups reflecting the process of change in the social structure of the cities. The proportion of such settlements in the cities has increased over the decades (Majumdar, 1978). Nevertheless, every inhabited part of the world is characterized by a variety of settlements of human occupance (Carruthers, 1957).

Ward and Dubos have opined that,

> " There is no single policy that deals more adequately with full resource use, an abatement of pollution, and even the search for more labour-intensive activities, than a planned and purposive strategy for human settlements."
>
> (Bell, 1976.P. 180).

Slums in developing countries tend to make up primary communities in an otherwise anonymous urban society. Intensive studies of slum areas in metropolitan Manila have shown that they tend to retain many of the traditional characteristics of rural life; a feeling of community solidarity; intensive face-to-face dealings; groupings according to ethnic, kinship, or economic ties; closed communication systems characterized by localized gossip; and a strong "we feeling" felt against the outside world. Although the lives of slum dwellers are often intermingled with the anonymity of the larger urban world, in the slum community, they find an oasis of personal warmth and security. As such, slums and squatter communities serve as a base from which the fomerly rural man may evolve into a truly urbanized man (Laquian, 1971). The same is true of Indian slum dwellers all over the country. Sub-standard living, broadly identified in slums, surfaced as an urban problem in India in the early part of this century. However, slums as a major urban issue was a result of rapid urbanization after World War II and more pointedly after Independence. Today, slums and more recent squatter settlements, which together embrace all types of low-income housing are not an isolated and temporary phenomenon but a national issue linked to the growing rural-urban migration.

In developing countries, the growth of low-income urban settlements is intimately related to the process and pace of urbanization. According to the 1971 census of India, out of a total population of about 550 million, nearly 110 million or twenty per cent, of the total were in urban areas. A working group on slums created by the Ministry of Works and Housing in 1972, estimated that in April 1971, approximately twenty per cent of India's total urban population lived in squatter settlements which is about twenty-two million people. It was also estimated that, in that period, nearly an equal number in most cities lived in slum tenements.

Government concern for this underprivileged group is increasing, and for maximizing its impact, integrated urban development assumes urgency. Under this, the various allocations being made for related activities in the realm of housing, water supply, sewerage, drainage, transportation, health, education, security, recreation and other facilities, require to be dove-tailed, with the stress being on persons below the poverty line, who would constitute a major group in the metropolitan areas and large cities.

The basic needs of the urban poor and their order of priority vary among communities but a general pattern in new slums and squatter settlements has of late surfaced in Indian cities. Thus, in most cities the demand for public water supply, electricity, health services and basic education has high priority after food and employment opportunities. Other social needs include adult education, development of skills, day-care centres, better public transportation and police pro-

tection. Finally, and only after these needs have been specified, the most highly developed of the low-income urban settlements begin to be concerned with environmental pollution, refuse collection, the lack of parks and other recreational facilities and postal services.

In 1947, the standards of infrastructure provided by the Delhi Development Act in resettlement colonies included:

(a) Facilities at neighbourhood level -

Higher secondary school	: One higher secondary school for 10,000 population
Primary schools	: Three for 15,000 population
Nursery schools/ creches	: Five for 15,000 population
Dispensaries	: One for 20,000 population
Community Hall/Library	: One for 20,000 population

(b) Facilities at District level -

College	: One college for 0.15 million population
Hospital	: One hospital for 0.15 million population

In the same year in Madras, integrated sites and services was a major thrust and the first such comprehensive effort in the country. About 174 hectares of land was developed at three sites, located west and north-west of the city centre. The component included, besides housing and industrial facilities, community facilities such as construction on each of the three

sites, of two primary schools, one high school, one clinic/ health centre and one community hall. Under the slum improvement component, ten primary schools, three high schools, plots for pre-primary schools were made available.

The maternal and child health component provides in addition to nutrition:

(1) Regular health examinations and in a serious case, referrals for expectant mothers and children below the age of six years.

(2) Immunization to children under the age of six years, and to expectant mothers.

(3) Nursery services for children under three years of age and pre-school education for children three to five years old.

(4) Health and nutrition education and functional literacy training to women in the age group fifteen to forty-four years.

These services are being provided through pre-schools or 'child welfare centres' each with a floor area of 41 m^2.

In large metropolitan cities like Delhi, Calcutta, Hyderabad etc., the infrastructure, services and facilities are continually inadequate to cater to the run-away growth of these agglomerations, and in the process, the urban poor are the hardest hit. The problems of the metropolitan areas of Hyderabad, Bangalore, Kanpur, etc. are not very much less severe with high proportions of persons below the poverty line (Ribeiro, 1983).

Urban poverty, an acute lack of housing and civic

amenities, dismal filth may be pointed out as much urban characteristics as rural. Hence, the Indian towns, particularly the smaller towns look like large villages, in which live atleast 1.2 per cent out of 19.9 per cent of urban population (Misra, 1978).

Poor slum housing is invariably associated with poor facilities and community services. Along with the shabbiness and dilapidation, the park facilities are inadequate, the schools are of poor quality, and other public facilities are often insufficient. Streets and sidewalks often go unrepaired, rubbish and garbage are infrequently collected, adding to the undesirable environment. These services may be especially neglected in slums inhabited by minority groups. In developing countries, this lack of facilities and services is often stressed in defining slums (Clinard, 1966).

The slums in India have been described as chaotically occupied, unsystematically developed and generally neglected, over populated and over-crowded with ill-repaired and neglected structures, insufficiently equipped with proper communications and physical comforts, and inadequately supplied with social services and welfare agencies to deal with the needs and social problems of families who are "victims of biological, psychological and social consequences of the physical and social environment" (Indian Conference of Social Work, 1957).

Children and women in poor communities are most susceptible to the poor living and environmental conditions, few opportunities

for schooling and health. Malnutrition - an invisible hand - touches and steals away the energy of about one-quarter of children in developing countries. Poor urban women and children are vulnerable, they are economically deprived, their access to basic services is inadequate or altogether absent, their incomes in informal sectors are meagre to meet their basic needs (Wishwakarma, 1986).

Community development programmes have been designed by the Government to promote better living for the whole community including farmers in rural areas, with an active participation, and if possible, on the initiative of the community. But, if this initiative is not forth-coming from the same, the use of techniques for rousing and stimulating it, in order to secure their active and enthusiastic response, has to be made (Bhattacharya, 1976).

TABLE 1

THE ESTIMATED URBAN AND SLUM POPULATION IN 1990, IN THE CITY OF HYDERABAD (PERSONS IN LAKH)

Total Population 1981	Identified Slum Population		Growth rate 1971-81	Estimated population 1990	Estimated slum population 1990
	Number	Percentage to Column (1)			
(1)	(2)	(3)	(4)	(5)	(6)
25.45	5,000	19.6	40.74	37.07	11.12

Source: Town and Country Planning Organization (TCPO), Government of India. A Compendium on Indian Slums, September 1985.

IV. The Strategy Of Basic Services

Urban social services may be considered a system of social and civic amenities, which the urban dwellers cannot provide on their own, but they require these services for their physical, social and emotional well-being. It has been recognized, that these services play a direct role in the development itself and are indispensible to the successful functioning of a highly organized modern urban society (Vaid, 1976).

Many city planners argue that the physical environment directly affect human behaviour. In response, social scientists tend to deny that the environment has significant causal influence, asserting that culture and social culture are the crucial variables. Between the physical environment and empirically observable human behaviour, there exists a social system and a set of cultural norms which define and evaluate portions of the physical environment relevant to the lives of people involved and structure the way people will use (react to) this environment in their daily lives. Physical environment is a poor concept, because it includes both non-manipulative variables, such as the natural environment, and the manipulative man-made environment. A park is a physical environment, but the choice and arrangement of flora, fauna, walkways and facilities are based on the decisions about the way society or the planner defines a desirable park (Gans, 1968).

A city must provide an optimum physical environment, aesthetic and cultural attractions, efficient administration and basic civil services and amenities (Bulsara, 1970). The careful disposition of amenities such as schools, hospitals, parks, playgrounds, community buildings, etc. would go a long way to solve the problem of "social balance", but the main key to a solution would be in the grouping of various types of dwellings in such a way that they satisfy the desires of various social groups in the matter of immediate convenience and use, and yet at the same time are part of the neighbourhood (Mann, 1965). If community facilities are strategically located in the neighbourhood, an environment is provided, which meets the peculiar needs of local community life.

From the view-point of individual experience, one can distinguish between residential neighbourhoods, roving neighbourhoods and occupational neighbourhoods. The roving neighbourhood consists of the immediate surroundings of the individual dwelling unit, and could roughly coincide with the walking distance area adjoining the family residence. Its perimeter may be extended or limited according to individual propensities. Within the residential neighbourhood, that is, within walking distance of the urban residence, one is apt to encounter services such as an elementary school, a grocery store, a drug store, possibly a movie theatre, and various commercial facilities. Also, there could be a laundry, a shoe repair shop, some inexpensive eating place and a playground or small park. Lack of such facilities within the residential neighbourhood imposes severe inconveniences

upon everyday life routines (Riemer, 1952).

The cultural needs of the community find expression in the city in the form of schools, theatres, museums, parks, monuments and other public enterprises. They exert an influence extending beyond the boundaries of the city itself, and may be regarded as agencies for the definition of the family's wishes. They are indicative of the level of social life which the community has achieved (Park, 1968).

A public utility may be any industry that supplies electricity, gas, water, transportation or communication within a political area, the municipality. The utility is a service that is recognized as indispensible to the community and "affected by a public interest" and it may be either public or private (Anderson, 1960). A service or a facility exists to cater to needs of comfortable family living at a certain standard. The nature of service centres varies from area to area depending upon the level of socio-economic development and institutional framework operating in a given physical set-up (Chandna, 1986).

The study of service centres is now receiving an increasing attention by Indian scholars (Brush, 1953). Part of this interest has flown from the potential application of such efforts to developmental planning. Most of these studies are confined to areas located either in the Northern plain or Deccan Peninsula of India.

Locational pattern

Service centres occupy specific positions in order to

perform functions for their surrounding areas. These positions, ultimately manifest in the locational pattern, are associated with matters like physiographic conditions, transport network, and distribution of population. The relative position of service centres in relation to each other is also one of the dimensions of their distribution.

Location in relation to population distribution

Since service centres evolve primarily to serve their surrounding areas, a close association is expected between the locational pattern of service centres and the distributional pattern of population. A positive relationship was found between frequency of service centres and degree of population concentration in the study done in district Sirmaur, situated in the outer Himalayas, and is one of the twelve districts of Himachal Pradesh. Of the 243 service centres identified here, some were middle school, high/higher secondary school, civic/ hospital, dispensary etc. Data were collected from all the 965 villages and three towns in the district, service centres were frequent and closely spaced in tracts where agricultural land existed in large patches. By contrasts there were hardly any service centres, on the thickly forested southern slopes of Dharti dhar along the Bata river.

A positive relationship between the population size and spacing of service centres was observed. Relatively large service centres were spaced at greater distance from each other than the small ones. The functional status and population size

of the service centres were also positively related notwithstanding a great difference in population of service centres belonging to a particular order of hierarchy.

Dispersion of service centres

A nearest neighbour analysis revealed that the distributional pattern of relatively high order service centres showed a tendency towards regular arrangement. The distribution became successfully more and more random in the case of lower order service centres. Most of the relatively high order service centres had evolved over a passage of time. The low order service centres were genrally of recent origin. They owed their emergence to the opening of a retail store by a shopkeeper or allocation of some facilities in the form of schools, post offices and dispensaries by the government (Chandna, 1986).

A study (Foley, 1957), made of facility use by residents of a district in northwest St. Louis, U.S.A., showed the use of facilities such as schools, churches, theatres and other facilities by 400 families. Health, education and recreation facilities, among others, were scrutinized. The relation between distance and the following were analysed.

(1) Type of facility use

(2) Type of transportation

(3) Certain other variables pertaining to family or personal background

The study revealed that forty-seven per cent of the reported facility uses were within one mile of the user's home,

twenty per cent were between one and three miles from home and thirty-three per cent were atleast eight milesaway. About thirty per cent were within 0.5 miles; ten per cent were atleast six miles away; the median distance from home was 1.2 miles. The transportation, as facility-use reports showed was: walking from home, thirty-six per cent; public transit from home, thirty-one per cent; and automobile from home, thirty per cent. Three per-cent were, classed in a miscellaneous category including "from other than home", such as shopping from place of work.

Elementary school attendance was found to be ninety-eight per cent within or adjacent to the district, and high school attend-ance forty-nine per cent; attendance at college or trade school was only eight per cent. The summer time participation in outdoor activities was completely non-local except for the children's use of playground facilities. Practically, 100 per cent out of the district, mere major league ball games, zoo, large parks, swimming, hunting and fishing, picnics and outings. Young persons, especia-lly those under twelve years, of age and persons under sixty-five made relatively more extensive use of local facilities. Young adults aged eighteen to thirty-four made the least. The less the user's formal education, the more use he made of local facilities, age and other factors not held constant. Females used local faci-lities more than males. On the surface there appeared to be a direct relation between lower economic status and greater use of local facilities, but when automobile ownership is held constant, the economic status factor loses most of its significant associ-ation with the major variable.

Factors influencing supply of services

Local authority fiscal capacity is expected to have a positive influence on service expenditures per 1,000 population. Other influencing factors include population density, and party political balance in local councils. Population size and geographical area seemed to be insignificant factors regarding supply of services.

Factors influencing demand for services

On the demand side, need for services will depend inter alia, on various demographic conditions. The rat of change of population over a period, population density as it affects the quality of the physical and social environment also influenced the need for social services. The class structure of the population influenced expenditure, as, the greater the proportion of population in lower income groups, the higher the expected expenditure per 1000 population. Other population characteristics, the proportion of population over fifteen years, permanently ill, the age composition and the immigrant structure influence the need for social services. The greater the proportion of population permanently ill and in very young and very old age groups, the higher is expected to be the per 1,000 expenditure (Schofield, 1986).

A study of Seshagirihalli and Ganakal, two small villages located in Ramanagaram block of Bangalore district in Karnataka State, revealed in 1981, that the former village did not have many facilities beyond a prayer hall and a community centre, which were also used for primary and nursery schools respectively.

Ganakal did not have many facilities either, only a primary-cum-middle school. Bidadi was the nearest point with facilities such as primary health centre, dispensary, and family planning clinic. It had a high school and served as the main centre for purchases of household requirements, a veterinary hospital, post and telegraph and bank facilities.

In both villages only a minority of adults had been to school, and the disposal of cattle dung and garbage very near the dwellings was quite common. The family planning program was not popular in Seshagirihalli; however in Ganakal, a total of sixteen sterilizations had been recorded (Dore, and Mars, Eds., 1981).

The urban land-use

The general land-use in Indian cities isshown in Figure 1. The characteristic feature of Indian urban land-use is its high mix. So much so, that it is often difficult to make out any pattern in it. "For example" remarks Breese,

> "it is quite common to find residential and commercial activities all taking place within the same block, perhaps within the same cluster of houses, or on the same lot."
>
> (Breese, 1969, P.17)

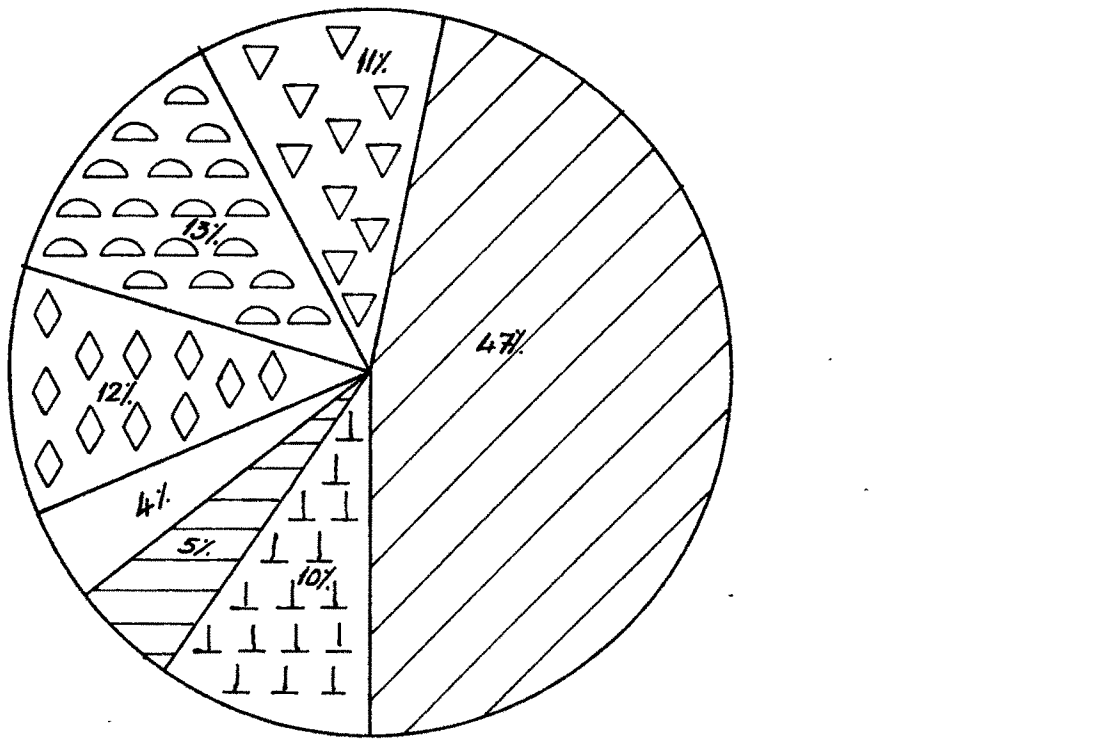

FIGURE - 1

GENERAL LAND-USE IN URBAN INDIA

SOURCE :-

Pandit. Urbanization, the Indian Way.
Cited in Comporative Urbanization; City Growth and Change.
Ed. C.S. Yadav, P. 289.

V. Community Facilities And Services - Related Studies In India And Abroad

(a) Health facilities and services

A universally acknowledged town/city is the primary instrument available to the society for protecting the public health of its citizens, assuring all of them an adequate supply of pure water/air, healthful housing and a reasonable standard of cleanliness (Nandy, 1987).

Health and sanitation is usually one of the problems in urban areas that is almost synonymous with slum life. Because of the overcrowding in the slums; the run-down condition of housing; the lack of such basic facilities like water, light, and fuel; and the low income that usually results in malnutrition, the health of the people in a slum community is usually not satisfactory. When the lack of medical, dental and nursing services is added to all these factors, the problem becomes serious indeed. Providing medical service, therefore, is one of the most effective ways of generating co-operation in the community. Aside from breeding dependence, free medical service is usually equated by the people, with poor or even inadequate service. Thus, people want to make sure that full-fledged doctors and not just medical students or interns are giving them service. A nominal fee for consultation and full charge for medicine may be introduced as part of the medical service. Aside from keeping the pride of the patients in tact, the payment is also some kind of assurance, that the people are getting worthwhile service (Laquian, 1971).

Health problems, health practices and population growth are closely linked with the ecological setting of a community. Health problems and, in effect, a function of the human ecology and the community's response to them is a function of its health culture. Thus, there exists a dynamic equilibrium between the ecological setting on one hand and the community's response to the health problems, on the other. The nature of this equilibrium, in turn, has a bearing on the rate of population growth (Banerji, 1985).

Health is more than the absence of disease or disability; indeed a person with a permanent disability may be as healthy, if not healthier than a person who is physically sound but mentally worried. A healthy person is one who feels himself to be a part of the society in which he lives; he is a person to whom life has both meaning and purpose (Geffen, 1960).

The needs for healthy living

In order to concretize the goal of high-level wellness, it is essential to shift from considering sickness and wellness as a dichotomy towards thinking of disease and health as a graduated scale. "Wellness" is defined as a wide range of good health, commencing at a condition just free of sickness and extending to a performance output of maximum potential. It is necessary also to realize that the level of wellness of the individual is influenced by the total environment - physical, biological and social - in which he finds himself and lives out his life (Dunn, 1961).

Health, by virtue of its direct relationship to the quality of life is a major determinant of human development; it is also one of the fruits of development. According to the WHO Constitution, health is a state of complete physical, mental and social well-being and should enable people to lead socially and economically productive lives (World Health Organization, 1983).

Good health constitutes an essential aspect of socio-economic development, since it is a major component of the quality of life, as well as a pre-requisite for high levels of productivity (Basch, 1978).

Health, defined as a state of complete, physical, mental and social well-being, is a basic component of the standard of living and is therefore a fundamental requirement for community development. (Agency for International Development, 1956).

Phenix (1961) views health as one of the fundamental values and the promotion of good health as one of the basic moral obligations, Health indicates a state of harmonious functioning of the body and mind in relation to physical and social environment to enjoy life to the fullest possible extent and to attain maximum level of productive capacity, so opines Singh (1987).

According to the Planning Commission of India (1973), twenty per cent of the population living in urban areas have the facilities of seventy per cent of the total hospital beds and eighty per cent of the doctors in the country. Though

all sorts of health services are available in major cities, not all sections of the community are benefited by these facilities. A wide gap exists between different sections of the community in the utilization of health services. Certain sections of the community are deprived of a fair share in existing medical care facilities (Yesudian, 1981). By health sector is meant, the combination of measures aimed at the prevention of illness and the promotion of health through organized community effort. Such measures include education for health, immunization against communicable diseases, environmental sanitation, provision of clean water supply, safe disposal of waste, early treatment of disease and maternal and child welfare services (Canadian International Development Agency, 1976).

Ill-health is perceived disharmony between the 'inner' and 'outer' man. This perceived disharmony, or perceived morbidity, is the link between disease and society, and is a necessary condition for the occurence of adaptive behavioural processes within the social system. When the individual perceives himself as sick, he adapts: distinctive and measurable behaviour changes, including taking to bed or staying off work, may result in restoring his equilibrium. One of the most important adaptive reactions is to consult a health worker, usually a professional, for counsel, diagnosis, and treatment (Kohn and White, Eds., 1977).

Health care is one of the most important of all human

endeavours to improve the quality of life of the people. It implies the provision of conditions for normal, physical and mental development and functioning of the human-being, individually and in the group. It provides a wide spectrum of serviees including primary health care, integration of preventive and curative services, health education, the protection of mothers and children, family welfare and the control of environmental hazards and communicable diseases. Primary health care is essential health care for all citizens easily accessible and at a cost that the citizens in the community can afford. The extent and depth of services depend upon the demands and health needs of the consumer. The factors which determine the health needs are the number of people in the community, age-sex composition, standard of living, educational status, health consciousness, morbidity and mortality pattern, customs, traditions and cultural patterns of the people (Srinivasan, 1983).

Health is one of the goods of life,to which man has as a right. Whenever this concept prevails, the logical sequence is to make all measures for protection and restoration of health accessible to all, free of charge; medicine like education is then no longer a trade. It becomes a public function of the state (Bhardwaj, 1974).

Utilization of health services and factors affecting it

The use of health services is a major tangible expression of the demand, though not of need, of health services. The use of health services can be universally and readily recognized

by both providers and consumers. Perception of illness, not the disease, prompts the person to complain, to consult a health worker and seek care. Interactions between family, friends, employers, and neighbours may influence health behaviour, such as whether to assume sick role, to participate in formal medical care process or whether or not to consult the practitioners of other medical systems.

Medical care is sought not only to correct disturbance in the individuals internal psycho-biological system but also to correct disharmony between it and the external social system.

Once people have reasons for seeking medical care, that is, perceived morbidity, the choice of using health services is influenced at the individual level by socio-cultural factors that predispose the use of formal health services (predisposing factors), and by the cost of pursuing that cause of action (enabling factors). Enabling factors also include expenditure such as transportation, expenditure of energy and effort and losses due to absence from work and other desirable activities (Figure 2). The expectation is that, everything else being equal, as these costs increase, relative to the expected benefits of receiving care, the individual will be deterred from using formal health services and will seek other solutions to his problems.

The perception of need does not lead to use unless the need itself is of sufficient severity to warrant action and

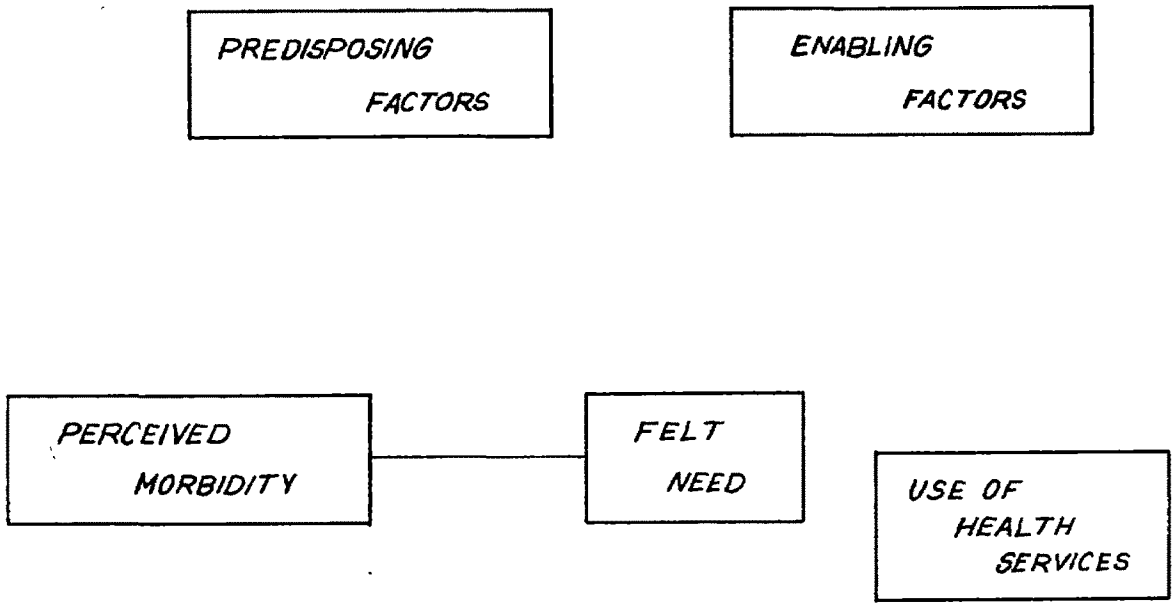

FIGURE - 2

CONCEPTUAL MODEL SHOWING RELATIONSHIP BETWEEN PERCEIVED MORBIDITY, PREDISPOSING AND ENABLING FACTORS AND UTILIZATION OF HEALTH CARE

SOURCE :-

Health and Population - Perspectives and Issues. 4(1), 1981, P. 85.

unless the resources are perceived to be appropriate, sufficient, available, accessible at the cost which the consumer can afford to bear. This decision-making appears to be a process through which the individual moves through stages (Pathak, 1981).

A systems approach to the use of health services

A convenient and pragmatic framework for organizing the diverse and complex forces involved in the use of health services is a general systems approach (Engel, 1962; Sheldon, 1970).

At the basic level of this analysis, man is viewed as a psychobiological system, comprised of an internal natural system of biochemical, physiological, psychological and other organic and sensing sub-systems. This internal system interacts with the external natural and social systems by receiving and seeking influences and information from them and emitting influences and information to them (Engel, 1962; Cole and Miller, 1965).

Man's psychobiological system equips him to perceive and interpret information, from his internal and external systems and to employ this information in decision-making and the regulation of his behaviour. These relationships are shown in Figure 3. The recognition of disorders constitutes perceived morbidity, which initiates the drive or internal tension motivating behaviour aimed at adjusting the disorders (Purola, 1972).

The health care process

The health care process may be represented as a series of interrelated stages, where the probabilities of moving from one

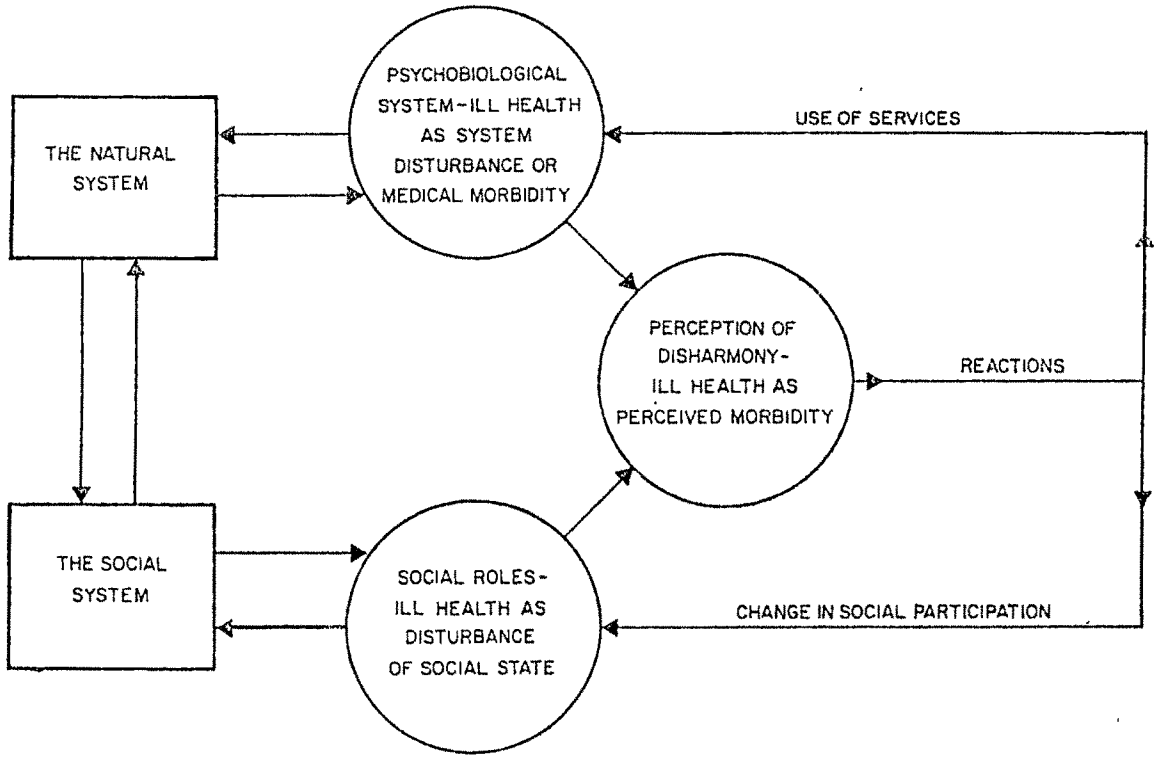

FIGURE 3

MODEL OF RELATIONSHIPS BETWEEN THE INDIVIDUAL AND SOCIAL SYSTEMS.

Source: Kohn and White, Eds., Health Care. An International Study. 1977. p.12.

stage to another are influenced by several sets of factors (Purela, 1972). This process, which is shown in Figure 4 begins with the perception of disorder resulting from discernible etiological processes. If these perceptions and the factors interacting with them, result in a decision to seek care from the health services system (P_2), then the interactions among patients and health professionals determine the derived demands resulting in mixes of services that will be employed in the treatment (P_3). This process describes what Kasl and Cobb (1966) have termed illness and sickness behaviour, for the seeking of care is motivated by a recognition that something is wrong with one's health. Of course, not all contacts with a health services system are motivated by existing disorders.

In particular, administrative, preventive and diagnostic services are often sought in the absence of illness in order to determine the state of one's health. This has been referred to as health behaviour (Kasl and Cobb, 1966; Rosenstock, 1966).

To some extent, the macro level of health services systems within which the health care process occurs, will determine the magnitudes of the probabilities shown in Figure 4, since the structure and supply of services as well as the philosophies underlying a given health services system regulate the individual's use of them.

The model of use and its components

The systems approach to the health care process, stresses

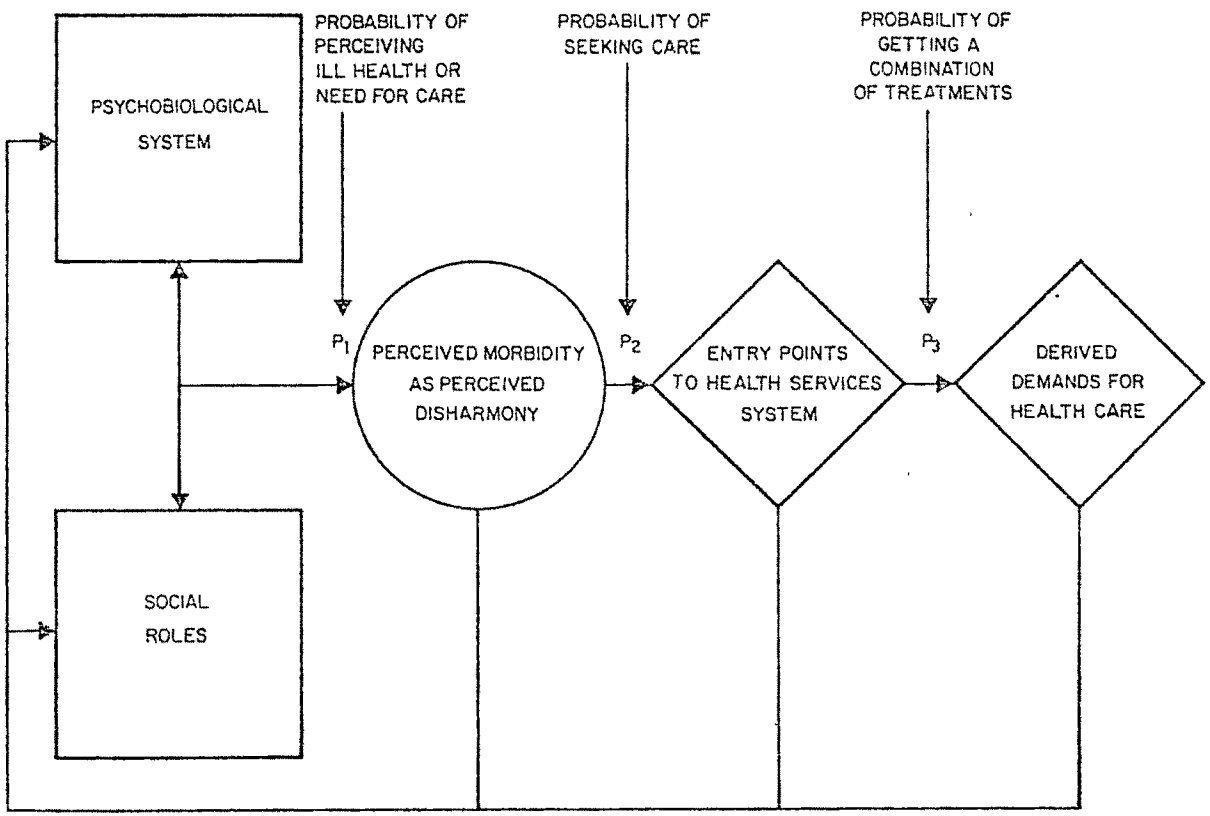

FIGURE 4

MODEL OF STAGES IN HEALTH CARE PROCESS.

Source: Kohn and White. Eds. Health Care. An International Study. 1977. p.13.

several dynamic stages and integrates forces on many levels. Several types of use are analyzed within and across study areas to isolate the factors which facilitate or impede the use of various services. The model shown in Figure 5 identifies the types of factors which influence primarily the second probability (P_2) in Figure 4, that is, the probability that individuals will seek care, once they have defined themselves or have been defined as ill or in need of care. Furthermore, it indicates that the effects of these factors may be modified by characteristics of the health services systems within which use occurs; the explanatory factors employed in the analyses therefore include both systems variables and three types of variables at the individual level: perceived morbidity, predisposing factors, and enabling factors.

Perceived morbidity

Most studies of health services use have illustrated the basic fact that the principal determinant of use is the level of either real or perceived morbidity in the population. The classic studies of Koos (1954) in Regionville served to emphasize socio-cultural determinants which disproportionately affect the perception and interpretation of ill-health, whether sickness behaviour will follow, and the type of response to perceived illness. Statistics compiled from several sources (White, Williams, and Greenberg, 1961) have emphasized that only a minority of persons who are ill within a month enter the health care system; this proportion was estimated to be

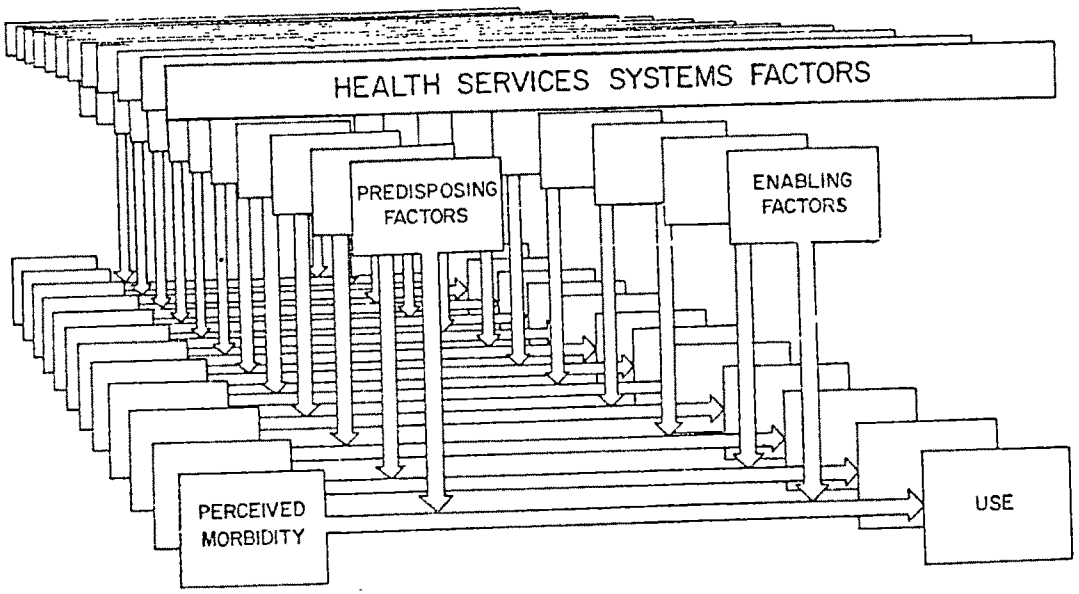

FIGURE 5

MODEL OF RELATIONSHIPS BETWEEN SYSTEMS AND INDIVIDUAL LEVEL INDEPENDENT VARIABLES AND USE OF HEALTH SERVICES AS THE DEPENDENT VARIABLE.

Source: Kohn and White. Eds. Health Care. An International Study. 1977. p.13.

about one-third. Kadushin (1964) has concluded that variations in use by socio-economic groups occur in the presence of rather similar disease incidence rates. On the other hand, in the feasibility study, differences found among levels of perceived morbidity and patterns of use of medical services in three geopolitically different study areas, were minimal for those population groups experiencing high or troublesome perceived morbidity (White et.al., 1967; White and Murnaghan, 1969). Unlike Kadushin's work, this study demonstrated by a multivariate technique that perceived morbidity, defined by restricted activity and discomforting symptoms, explained much more of the variance of physician use than any other of eight variables including occupation (Bice and White, 1969).

Perceived morbidity, then, is viewed in this model as the force which initiates decision-making about whether or not care should be sought.

Systems factors

The group of health services systems factors in Figure 5 is a third set of explanatory variables. Unlike perceived morbidity and predisposing and enabling factors, which are variables that are attributes of individuals, systems factors are constants for all people within particular populations. Systems factors may influence the magnitudes of association among various predisposing and enabling factors and use of services. The model indicates the role of relationships among systems and individual level variables in explaining variations in use.

The Behavioural model

Here the emphasis is upon the determinants of use within a given health services system (Figure 5) and the predisposing and enabling factors are viewed as independent variables affecting the relationship, at the individual level, between perceived morbidity and the use of health services (Anderson, 1968). In this context predisposing factors are those characteristics of the individual which existed prior to his perception of need but which either directly or indirectly determine the need or direct the behavioural response to it. Characteristically, they include factors derived from variables of a demographic nature such as age and sex; those of a social nature derived from such variables as marital status, educational level and household and family composition; and these of a psychological nature such as attitudes, expectations and values. Enabling factors are those which make it possible for the individuals to use health services consequent upon the action of the predisposing factors, or, as defined by Katona (1960), they are resources that change needs into demands.

As such, they include health insurance coverage and the availability and accessibility of medical services. However, the distinction between predisposing and enabling factors is based largely on whether the factor exerts its effect nearer to the beginning, or to the end of the pathway in the decision-making process that extends from perceived morbidity to use.

The Social model

The health services system of each study area, as described by its resources and organization also constitutes a unit in the analysis (Figure 6). Since the most important determinant of health services use is perceived morbidity, this is used as a controlling variable. High correlations between morbidity and the additional variables of age and sex mean that when this practice is followed, the perceived morbidity variable will probably incorporate many of its principal epidemiological determinants (Purola. et.al., 1968).

Health services are essentially social services; that is society accepts some - however limited - responsibility for their availability and performance. They minister to the needs of the ill, seek to prevent disease, and set goals for the maintenance and promotion of health. It is but one of many service systems that have emerged to facilitate the attainment of individual as well as societal goals, especially in increasingly complex, highly industrialized urban societies.

Health services are primarily provided within the context of explicit or implicit planning for health, and their principal objective is to deal with health problems (Kohn and White, Eds. 1977).

In urban areas the attainment of a reasonable standard of health services is linked with the provision of many basic civic amenities. The majority of the urban population depends upon private sources for medical care, community health services fall

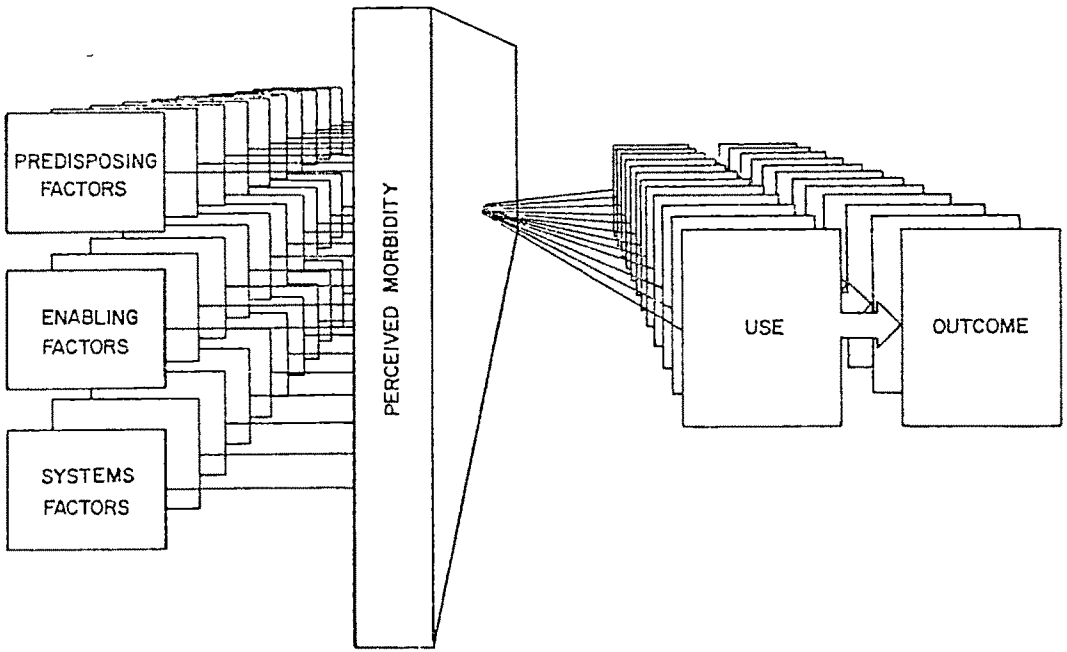

FIGURE 6

MODEL OF RELATIONSHIPS BETWEEN INDEPENDENT AND DEPENDENT VARIABLES, WITH PERCEIVED MORBIDITY AS CONTROLLING VARIABLE.

Source: Kohn and White. Eds. Health Care. An International Study. 1977. p.13.

short of the municipal requirements of basic sanitary facilities (Bhardwaj, 1974).

Medical facilities consist of the hospitals (with beds), dispensaries, maternity and other health centres; doctors, vaids, hakims, dentists and nurses, health visitors and midwives (Dharan, 1968).

Individual demand for health services has traditionally been regulated by physicians who have a monopoly control over medical information and judgement. The cultural beliefs about good health care include visits to a physician and the acceptance of the physician's opinions, prescriptions and referrals for any further necessary services. Physicians and their institutions (hospitals, medical laboratories, etc.) are the major determinants of demand; they are encouraged by the guarantee that the costs of these services will be met largely by third parties not involved in the original transactions (Kennedy and Robb, 1980).

The policy of the government is to bring health services closest to the people. With increased easy availability of health services, the expectation is that their utilization will increase so as to make feasible and practical the achievement of the national goal of providing health for all. As a result the programme is working progressively for providing a primary health centre for every 30,000 population and a subcentre for every 5,000 population (Bardhan and Dubey, 1989).

India is a land of paradoxes. The area of health (including medical services, etc) is not an exception. On the one hand it

is said that medical facilities in the country are inadequate. On the other hand it is said that there is under-utilization of these. Health facilities, as in other areas, have two sides. One is the demand side - demand for the health facilities by the people. Though the health status of the people is not satisfactory, by any standard, they are not using adequately, the services that are available. So there is under-utilization of the facilities. The other side is the supply side - the persons - medical and paramedical personnel - are unable to render their services to the society, due to some reason or the other. So, again there is under-utilization. The reluctance of people to utilize the services or inability to obtain or their ignorance of availability of services, might be attributed broadly to social, cultural and economic factors (Jorapur, 1989).

Utilization of health facilities is conditioned by a number of interacting factors. Among these, type of family, social class and literacy status are of vital importance. Other equally significant determinants are distance involved from medical centre, attitude of professional rendering the service, quality of health needs and health awareness of the beneficiaries (Anand and Srinivase, 1972; Sapru et. al., 1975; and Mukherjee, 1982).

Access to care has been most often considered in the literature as an expression of the time or money costs associated with obtaining medical care, such as waiting times to get an appointment or to see a doctor once in his office, and travel distance. Access is to be distinguished from availability, which is the mere presence of health care resources in an

area. More recently, access has been operationalized in terms of people's actual utilization of services - particularly their use of services relative to their experienced need for care, (Aday, 1977).

Health services exist to maintain and enchance people's health, and their effectiveness ought therefore to be reflected in improvements in the health status of the population. But in practice, things are not quite as straight forward as this. Ill-health is notoriously difficult to define and measure and the links between the provision of health services and the health of the community are not always clear to see (Butler, 1984). In general, health services are designed to meet the health needs of an area, taking into consideration the social and economic conditions of the area concerned and they are rendered through intimate co-operation between health workers and the people (Agency for International Development, 1956).

Health services have a strong urban curative bias, which favoured the rich and privileged, according to Bannerjee (1982). Health care utilization is concerned with the extent to which personal determinants of health and health behaviour, such as psychobiological, social and behavioural factors, affect the use of health services and how this relationship is modified by selected characteristics of the prevailing health services systems (Pathak, 1981).

Municipally provided hospitals and health centres cure people, but often fail to reach those who are most in need of them (Gans, 1968).

Comprehensive health services should embrace the complete range of all services directed upward towards the promotion of positive good health, application of established preventive measures, early detection of disease, prompt and effective treatment, physical and social vocational rehabilitation of these with residual disabilities. (National Center for Health Statistics, 1971).

The advantages of the modern hospital have been increased to such an extent that they are being sought today by all sections of the population from the well-to-do who can pay the full cost of care to those who receive entirely free service (Hiscock, 1950). In the past, hospitals were looked upon as "receptacles for the sick." Today the point of view has changed remarkably, the hospital is considered to have a responsibility to the total community health programme, in fostering and promoting public health and preventive medicine (Johns, 1954).

The low utilization of health services becomes a great frustration when the studies point close association between the presence of both the under utilization and unsatisfied health needs in the same areas. This is particularly true of tribal areas, slum population and in case of Mother and Child Health (MCH) services for mother and children. Before this problem can be remedied, it is essential to understand in practical and realistic terms, through research studies, the reasons and circumstances leading to this problem of low utilization by the very group who need the health services most in the country. One of the important factors which stands out to

explain low or no utilization of modern health services, is the problem of lack of compatibility between the providers and the users of health services (Bardhan, 1989).

According to Samir (1982) the levels of mortality, morbidity and malnutrition are much higher in less developed countries than in developed countries, and greater efforts and resources are needed to improve these conditions. Health indices for urban areas generally appear better than the averages for the country as a whole. The number of health facilities, especially hospitals, is proportionately higher for the urban population than for those in rural areas, and spatially closer to most of the potential users. Anderson (1960) is of the view that the quality of health services, has gained with the advance of technology and science; in fact, few services in the community are so quickly responsive to scientific and technological advance.

Gilbert and Gulger (1984) opine that despite the appalling conditions found in most Third World cities, more people have access to water drainage, electricity and health services than they do in rural areas.

The fundamental objective of health services should be to ensure essential health care at the community level, keeping in view specially the needs of the weaker and the more backward sections of the population. The other segments of the health system should be supportive and supplementary to this basic requirement (Singh, 1979).

Health facilities and services - related research in India

Rural research in India and abroad.- Findings of a study in the field of medicine and public health in Barpali village under the Barpali village services where a "Prepaid Medical System" was introduced, revealed the following conclusions.

(1) People were willing to pay for medicine

(2) Payment enhanced the patients' feeling of dignity, and distinctions between rich and poor were lessened by equal treatment.

(3) Payment increased patients' acceptance of the medicine (free pills are often thrown away, medicine paid for is usually taken) (American friends service committee, 1957).

Under the Action Project I of Junior Chamber International, an Indian Jaycee doctor and his colleagues visited Narol regularly every week. The men gave free medical aid to villagers, treating minor cases in the village. Serious cases were taken to hospitals in Ahmedabad where screening, X-rays and hospital facilities were offered free as a result of special arrangements made by the Ahmedabad Junior Chamber. A drug bank was established in Narol and a reserve of essential medicines was maintained. The number of illnesses was reduced after a few visits by the health unit. By fall fifty-four patients had been treated, twenty were taken to Ahmedabad for X-rays and detailed examination, with one hospitalization (Benson 1961).

A study conducted by John Hopkins University Rural Health Research Project in India in 1967, revealed that one ten per cent of the total number of patients sought treatment at the Govern-

ment Primary Health Centres (PHC) and subcentres (SC) while fifty-four per cent to private medical practitioners and the remaining thirty-six per cent sought some home medicines. In this case, both the villages studied in Punjab were within a radius of 2 miles from the HC and in one of the villages there was a sub-centre. The extent of utilization of services by people faraway from these institutions was noticed to be only marginal.

Studies on medical care services in India, conducted by the Union Ministry of Health, World Organization and some other foreign agencies, had observed that only ten to twenty per cent of the patients from rural areas had utilized Government Health Services and in the rest of the cases of sickness they either depended upon the private medical practitioners most of whom were unqualified, or had to go unattended (Bhatia, 1969).

The Family Welfare Project of the Agrindus Institute of the Banwasi Seva Ashram in 1970, started a Women's Training program, where health programmes, film shows and group discussions were held in three villages. Under the health programmes awareness of services of a clinic operating at Govindpur was found to be related to communication facility. Decreasing communication facility is paralleled by a corresponding decrease in the spread of awareness among the respondent sample about the existence of the clinic. The awareness was complete in the nearest two villages. It went down to sixty-nine per cent in the remote village of Supachunwa and it dropped to only twenty-nine per cent in the most far off village of Bichhiyari.

Utilization of services also goes down in the same manner, dropping to nil in the control village, no member from any of the sample respondents of this village having made any visit to the clinic. The extent of utilization was quite high, as high as forty-four per cent even in the remote village of Supachunwa. From the nearby three villages, the extent of utilization had been very high, i.e. thirty-nine (92.5 per cent) out of forty families knowing about the clinic and they sent their member(s) to the clinic. But in the remote Supachunwa Village only eleven out of the twenty-five families knew about the clinic and their members were sent there. In the far off Bichhiyari village, even though five respondents had heard about the clinic, none from their families had visited the clinic. The clinic was utilized for medical treatment, to call the doctor for urgent visits, and to seek advice. The benefits derived were good medicines, medical attention from a nearby place, free consultation, individual attention, medicines on credit.

A study of utilization of health and family welfare services in the rural area of Maharashtra revealed that only about one-fourth of the 3,306 households visited PHCs and/or SCs during the twelve months preceeding the study. The utilization of health and family welfare services varied according to the distance from the PHCs and SCs, religion, caste, household income and highest education of any member of the household (Ram et. al., 1976).

Another study in a rural area near Delhi by Murali and

Kataria (1980), analysed the positive correlation between literacy and awareness of antenatal care.

A study in Bhatar village (1980), twenty kilometres away from Burdwan, West Bengal and nearly one kilometre away from the upgraded Bhatar PHC, showed that out of hundred families, fifty-eight (fifty-eight per cent) utilized Maternity and Child Health (MCH) of PHC while forty-two (forty-two per cent) did not utilize PHC for maternal care services, which also included the six private practitioners utilizers. There was no significant difference between the utilizers and non-utilizers group of MCH clinic of PHC (Z=2.30; P .01) (Ray et.al., 1984). Another study conducted in three villages of Nuh PHC (Gurgaon) revealed that only sixteen per cent of the respondents used to visit the PHC and SCs frequently, because of their personal contact with staff and free medical aid. Among these visitors fifty per cent were government employees and twenty-five per cent educated perons in the vicinity. About one-fourth of the respondents never visited the PHC or SC and sixty per cent of them were against medical services provided to them. Lack of finance and free medicines were the main reasons for visiting the PHC (Punia and Sharma, 1981).

Ray et.al., (1981) reported that the knowledge regarding need for maternal care during pregnancy though high, the actual utilization of MCH clinic of a PHC was relatively lower, main reasons being non-cordial behaviour of staff, time consuming nature, lack of interest, etc.

A study of 1,331 currently married women in the reproductive

age group of fifteen to forty-nine and 1,299 husbands of currently married women in the same reproductive age group, in the rural areas of Karnataka, revealed that about sixty-nine per cent of the former and about seventy per cent of the latter utilized health and family welfare services available in government institutions during the twelve months preceeding the study. Utilization of services in government institutions varied according to religion, literacy level, age, number of living children, type of family of the respondents and also according to the per capita income of the households (Sholapur kar, et. al., 1983).

Talwar and Bhandari's (1983) study on different aspects of health services in the rural areas of eight districts of Madhya Pradesh revealed that the utilization of ante-natal, natal, post-natal care and child care services was very poor-none of these services were utilized by more than twelve per cent people. Thirty per cent sick persons did not take any treatment, another eight per cent went to untrained people, the remaining about sixty per cent sick people went to trained people for treatment about forty-two per cent to non-governmental infrastructure and twenty per cent to the government. In other words, only twenty per cent sick people sought services whenever they felt the need for it; the remaining went to private practitioners. Only one-fourth of the people used hospital services and this was the maximum use, the lowest utilization was that of sub-centre services, only about three per cent, during the past one year. In this study too the main factors which influenced under utilization of government health services were distance, poor services, long waiting time, lack of medicines or poor quality medicines and poor accessibility of the services. Almost

thirty per cent had said that services were not good or medicines not effective. Even accessibility of services had been reported as a probability by one-fifth of respondents. Two other factors reported were insufficient domiciliary services and insufficient facilities for major illnesses. Some respondents reported that government health staff charged money.

Reasons for preferring government or private service and the percentage using them as per reasons are as follows:

Reasons for preference	Government facility	Private facility
	Per cent	Per cent
Free treatment	51.4	1.1
Good treatment	30.4	59.3
Medicines effective	4.8	12.6
Near to house	9.6	19.6
Less time for service	2.5	3.2
Better facilities	0.8	4.1
Others	0.5	0.1

The major reason for preference of government facility is free treatment. In contrast, private facility is preferred because of good treatment, effective medicines and nearness to house. It is desirable that all these qualities should be brought in the government services.

Again, a study conducted in sample villages and taluk headquarters towns in district of Karnataka, revealed that utilization of health and family welfare services available at government institutions varied according to the literacy level, occupation and income of the heads of households (Devi, 1986). Some studies have shown that nearly fifty per cent of the people in a particular village were not knowing about the various services available to them. They were only knowing

about a part of the services. Lack of knowledge about availability reduces the utilization.

Urban research in India.- Desai and Pillai (1972) in a household survey of Bombay, point out that besides under nutrition, inadequate supply of potable water, the high levels of congestion and the lack of drainage and sewerage facilities, are certainly the major causes of diseases in the slums in all the major cities. The reasons that such diseases become chronic in nature are inadequate or insufficient treatment, and the constant re-exposure to the same diseases.

Household surveys conducted in Delhi slums in 1975, showed that allopathic practitioners were the ones most likely to be consulted by the poor when ill. The main reason for this is apprently that the poor utilize free clinics, dispensaries and hospital services when ill, rather than go to expensive private practitioners. However, they also do not generally seek treatment for an ailment, until home remedies have failed and the disease has reached an acute stage. Since medicine and consultations are very expensive, they take medicines only until the symptoms go away, and as a result, most of the leading ailments become chronic in nature.

Chuttani et.al.,(1976) in their study in a PHC and SC observed that only 10.2 per cent of antenatal women attended the clinic. The knowledge regarding the need for maternal care during pregnancy was eighty-one per cent while the actual utilization of MCH clinic of PHC was fifty-eight per cent and that of private practitioners was six per cent. Thereby, there

there lies a gap between actual knowledge and utilization, even though the study area is situated within one kilometre distance from the PHC. Main reasons behind this were non-cordial behaviour of the staff, time consuming, lack of interest etc., similar to those found in Ray's(1981) study. There was no significant difference between the utilizers and non-utilizers of the MCH clinic of PHC, so far as caste was concerned. The difference between utilizers and non-utilizers were statistically significant, though, in the case of literacy, which, it could be inferred, had a highly significant role in the use of, ante-natal clinic of the PHC, by the two groups.

Under the Indo-Dutch project for child welfare Composite Unit I (1976) the State Government of the Municipal Corporation of Hyderabad designed a practical and community oriented program wherein a Health Assurance plan which enrolled 134 families, and an immunization programme was organized. The analysis of 1,276 households surveyed, revealed that there were 2,137 children below ten years of age. A total of 1,717 children that is 80.3 per cent, had received one or more immunizations, 420 children that is 19.7 per cent, had not received any immunization at all. A total of 2,437 cases of minor ailments were treated on the composite unit clinic and at home by the ANM.

Under the Composite Unit II of the project, an integrated health assurance plan was stated, in which ninety-seven families had enrolled themselves as members of the health plan. Also, 110 persons were treated for minor ailments and thirty-six immunizations, DPT and polio were given. The ANM made 209 home visits. Three staff nurses from college of nursing made 119 home visits

and surveyed the families.

A number of factors such as awareness of different services, availability of government institutions, quality of services, waiting time, availability of medicines, payment of money for the services etc. are identified as factors affecting the utilization of health and family welfare services (Ram and Datta, 1976), similar to Devi 1986, Sholapurkar, Mouli and Gopal, 1983.

A Calcutta study (1976) found that even though the basti dwellers spent less on medical treatment than those living in the residential area (Rs.14.00 and Rs.20.00 per month respectively), the cost of medical care was proportionately higher for the basti dwellers (4.3 per cent of income) compared to the family in the residential area (3.2 per cent). The study also found that the rate of cure was very low, only about twenty-four per cent.

Qadeer's (1977) study indicated that, social class, which includes such factors as education, occupation and income, is another factor which makes for differences in the utilization of health and family welfare services. Upper and middle classes utilize these services more often than the lower class does, as was seen in the study by Yesudian (1981).

A study in the city of Ahmedabad, showed that an attempt was made to develop a low cost health delivery system through community level para-medical health workers. The three-tier arrangement which emphasized preventive health care and health education intended to move away from the highly trained doctor as the centre of health care. Ten community health workers were

trained by a qualified nurse, who also ran a community health centre (Shah, 1978).

Kaur et.al., (1978) found in an urban slum area, that fifty-nine per cent of pregnent mothers had a regular check-up and 13.2 per cent had an irregular check up at the MCH clinic of PHC.

Gopalan (1979) reported that out of the total sample of fifty who visited a hospital for consultantion and treatment, twenty-six were fully aware of all services provided by the co-operative society, whereas the remaining twenty-four did not know. The charging of nominal fees and good treatment had attracted many non-members also towards the services. Out of the total respondents, thirty-five were satisfied with the overall working of the society (seventy per cent), the rest were not satisfied (thirty per cent). Chandra et.al., (1981) identified that 253 mothers and 461 children attended the mobile clinic for utilization of its services in Kanpur.

A couple of studies were conducted both in rural and urban areas as a mode of comparison. Foley (1951) detailed the use of local facilities in St.Louis, from data drawn from 400 families to determine where each member of the respective families went for work, food, clothing, household equipment, school, church, medical care, outdoor recreation and miscellaneous indoor activities. The study reports that forty-one per cent of the total number of reports involved facilities located within the five-square-mile district itself, and that

another twelve per cent were located adjacent to it, that is within a one-fourth mile of its boundary. Only about fourteen per cent of the reports indicated use of facilities located in the central business district, and thirty-three per cent involved those located elsewhere. The median distance travelled by all persons in going to all types of facilities, varied by type of transportation as, 0.35 miles for those who walked, 2.7 miles for those who used automobiles, and 3.5 miles for those who used public transportation. The median distance travelled to all categories of facilities increased with age of participants from 0.7 miles for persons five to twelve years of age to 0.99 miles at thirteen to seventeen years and to a high of 2.29 miles at eighteen to twenty-four years, after which it dropped to 2.28 miles at twenty-five to thirty-four years to 1.51 miles at thirty-five to forty-nine years and to 1.18 miles at fifty to sixty-four years and to 0.68 miles for persons over sixty-five years of age. Home owners travelled about twice as far to reach facilities as did non-home owners and males travelled further than females 1.77 miles and 1.15 miles respectively. School attendance (at all educational levels combined) was reported at sixty-eight per cent within, nine per cent adjacent to and twenty-three per cent away from the district. In contrast the used medical facilities was reported as sixty-two per cent away from the district.

Under the Area Project called India Population Project (IPP-11) by the Government of India (1981) in Anantpur, Chittoor and Cuddapah of Andhra Pradesh, it was found that a vast majority of the respondents both in the project (97.5 per cent rural,

99.1 per cent towns) and control (99.9 per cent rural, 99.4 per cent towns) districts were aware that services were available in government health institutions for the treatment of sickness. The highest proportion of respondents utilized services for the treatment of sickness (Project - ninety-three per cent rural, 84.6 per cent towns; control - 95.9 per cent rural, 96.6 per cent towns). Regarding deliveries, a vast majority of women gave "convenience" as the reason for having deliveries at home (Project - 85.1 per cent rural, 83.3 per cent towns; Control - 91.5 per cent rural, 85.7 per cent towns). "Hospital far off" was the second most important reason for having deliveries in homes. Only a small proportion mentioned, 'previous bad hospital experience' and 'fear of hospital' as reasons for opting home deliveries. This shows that government hospitals are not as bad for conducting deliveries as they are sometimes made out. A lower proportion of illiterates, especially in the rural areas of the project districts, than that of others were aware of the family planning services. Majority did not encounter any problem while utilizing government health institutions. ~~Distance between peopleand government health institutions~~. Distance between people and government health institutions was mentioned as a problem by a considerable proportion of respondents in both rural areas and towns. (Project-21.9 per cent rural, 17.1 per cent towns; Control sixteen per cent rural, 31.9 per cent towns). About six per cent mentioned 'discourtesy shown by the staff' of government health institutions 'staff not available, non-availability of medicines, waiting for long hours, especially by those from towns, no

relief after taking medicines, and staff demand money, were also mentioned as problems encountered by respondents in both rural areas and towns.

Pathak's (1981) Survey of perceived morbidity in eight villages and four wards of Saoner town (Nagpur), revealed that out of 1,441 spells of sickness, health care agency was contracted during 529 (36.7 per cent) spells only. The difference between various age groups was statistically significant. The children were taken to health care agency more commonly than adults. Age had a significant influence on use of health services. Utilization of health services was significantly affected by literacy level. Among illiterate respondents, 14.4 per cent utilized health services, while 40.10 per cent, 10.2 per cent and 35.5 per cent of primary, secondary and metric school educated, respectively, utilized health services. The study further revealed a greater association between type of occupation and health services utilization. Also, 29.48 per cent of self employed, 31.37 per cent of those in service and 39.13 per cent of daily wage earners utilized the health services. Hence, occupation of an individual was found significant to affect utilization of health services. It was found that 158 out of 287 severe cases, i.e. 29.87 per cent utilized health services, 209 out of 506 (39.51 per cent) and 162 out of 648 (30.62 per cent) utilized health services. The nature of illness thus, also had a significant influence on use of health services. Availability or accessibility of health services is an important determinant of use, as, 79.94 per cent utilized health services which was available in the same

village, while 23.06 utilized health service facilities not available in the same village.

Lakshmamma (1984) exposed through her case study of Andhra Pradesh, that seventy-nine per cent of pregnant women had regular health check-up at the MCH centres during their pregnancy. It was seventy-eight per cent in the rural areas and eighty-one per cent in the urban areas. Among eldest children, only forty-nine per cent of the children got immunization against all diseases. In rural areas, it was forty-three per cent and in urban areas it was fifty-nine per cent. Thirty-three per cent of the sample children, that is, twenty-one per cent and forty per cent in rural and urban areas respectively were not given immunization against any diseases.

Yesudian (1981) reported that only one-fourth of the low and very low class respondents had good knowledge of diseases. The level of knowledge of a majority of very low class respondents was poor. There was a significantly differential perception of symptoms and diseases between social classes, which affected their health service consumption pattern. More symptoms were perceived as important to seek medical care by the higher classes and very few or none were recognised as important for the lower and very low classes respectively. Most of the higher classes go for medical care as soon as symptoms are discovered, while a majority of middle class households wait and see the severity of the symptoms and diseases, before approaching a health centre for treatment. A good number of low and very low class household members carry on with the symptoms and diseases until they

start affecting their day-to-day work. A few of them even carry on till they are incapacitated by illness.

Out of 465 patients, only 382 had sought some kind of health services. The numbers of patients who had not gone for medical care increased with the fall of social class position. It was reported that 27.3 per cent of the middle class patients had gone to public health centres. During the last five years, 275 households out of 400 had utilized one of the government general hospitals in the city. All the 200 low and very low class sample households had gone to these hospitals. Majority of the higher classes were aware of the departments in the general hospital, while lower classes were not aware of even one of the departments.

Dutta, et.al., (1982) revealed, through their study of estimating the prevalence of 'high risk' children under five years of age at a point of time, in an urban slum area of Pune, that out of 176 identified as 'high risk' children, only hundred (56.8 per cent) utilized available health facilities and the rest seventy-six (43.2 per cent) did not make use of it. Parents of forty per cent of children 'at risk' made use of health facilities of a general hospital. 'High risk' children from joint families (65.8 per cent) utilized health facilities more than those belonging to nuclear ones (41.5 per cent). The association between the utilization and type of family was found to be highly significant. Utilization of health facilities increased with the rise in educational status of the father.

When the father was illiterate, 21.9 per cent of the 'high risk' children used health facilities, at primary school/literate level of father 53.7 per cent utilized and so on. At the graduate and post graduate/professional literate level of father 83.3 per cent and 100 per cent utilization of health facilities was made, respectively. A similar case was seen with regard to the monthers' educational level, though not statistically significant.

The association between utilization of health facilities and occupation of father was highly significant. Type of occupation of the mother and utilization of facilities was not found to be statistically significant, so also the association between socio-economic class and utilization. However, in other studies, the utilization of health facilities was found to increase with improvement in the socio-economic class (Sapru, R. et.al., 1975).

Khan et.al., (1982), assessed the average daily turn out of patients to the Mirpur PHC was twenty-seven, and for the previous five years, the average daily turn out was twenty-five much lower than the corresponding averages for Gujarat (sixty-nine per day) and Kerala (eighty-four per day). Another PHC in the same district revealed a lower turn out of seventeen patients per day. Forty-nine per cent of the 213 patients came from a distance up to one kilometre, about twenty-nine per cent between one to three kilometre and the remaining about twenty-two per cent had covered more than three kilometres to reach the PHC. Thus the main "catchment area" of the PHC fell within a

radius of three kilometres from it. Almost all (97.7 per cent) had come on foot, only two used a bus. On an average, a patient had to wait for about seventy-two minutes from his/her arrival at the PHC for seeing the doctor. The average time the doctor spent with the patient in examining and writing the prescription was only about 1.4 minutes. The main cause of such a long waiting time was the late arrival of the doctor at the PHC.

Under the Indian Family Planning Programme, it was observed that by March 1984, 40.41 million, forming 32.7 per cent of the estimated 123.7 million eligible couples in the country were protected. Also sixty-five per cent of one-year old children were fully immunized by 1984-85 against T.B., fifty-one per cent against DPT and thirty-seven per cent against polio (Jena, 1989).

The Public Systems Group (1985), Indian Institute of Management, Ahmedabad, noted in their household survey of four states of India, viz. Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, that only 8.6 per cent of the households avail services offered by the PHC, while about forty-two per cent avail services of the sub-centre. In Madhya Pradesh thirty per cent to sixty per cent of persons interviewed did not know about the existence of sub centres, but most of them knew of the existence of dispensaries and private practitioners. The registration of ANC cases is only between ten to thirty per cent of the expectant cases while the PNC registration is even less than this.

The immunization coverage in all the four states is very poor ranging between eight to fifteen per cent for DPT and Polio. The drop out rates reported are between forty to fifty per cent from the first to third dose of DPT and Polio. In Rajasthan, only 8.7 per cent of the expected deliveries in the PHC are reported by health staff. Out of the total, forty per cent were in the centres and remaining at homes. In Bihar only seven per cent of the expected deliveries are being conducted by trained health staff which includes institutional deliveries also.

Das (1985), reviewed the utilization of health services by married labourers of Orissa and observed that more than fifty-five per cent of the respondents attend the port hospital at the time of emergencies. The rest of the respondents usually visit other dispensaries and private practitioners. Almost eighteen per cent go to private Homeopathic and Allopathic doctors. Almost twenty-eight per cent of the respondents reported that they were not satisfied by the behaviour of the medical staff. They were even kept waiting for hours together to meet the doctor, reason being that they belonged to the labour class and were poor and hence were not properly treated.

The Indian Institute of Population Sciences (1985), investigated the awareness about the availability of health services and their utilization. It was observed that in Osmanbad, in 49.08 per cent of families at least one person utilized the health services and so in 37.49 per cent of the families of Parbhani. Majority of the non-utilizers in both districts

gave reasons such as "no need, nobody fell ill, minor ailments are treated at home" for not using the services. Also proper treatment not given, behaviour of health staff not good" were mentioned as reasons by 16.55 per cent and 23.86 per cent in Osmanbad and Parbhani, as was seen in earlier similar studies. The study also indicated that less than one-third children had received BCG, DPT and oral Polio vaccine.

Kapoor (1987) organized a community based project in an urban slum of Bombay and observed that out of the 314 'Mandals' or committees only forty were actively involved in various religious, social and recreational activities. The Municipal Corporation supervises the functioning of two dispensaries, and one maternity hospital. Majority of the slum dwellers are dependent on the general practitioners (thirty-six) working in the area for all health related issues. In 1987, fifteen of them received training in different diagnosis for treatment and management of drug dependent persons.

Nandy (1987) analysed in his study of squatters of Faridabad, that almost three-fourths of the medicines prescribed by the doctors in the general hospitals have to be purchased by the patients from the open market. The medicines that are normally handed to the patients are the ones that are cheaper and they can themselves afford to buy. But, the costly medicines are never given, let alone the life-saving drugs. Beds are in short supply (315 in all), and there have been reports about the patients being asked to make their own arrangements.

"Scavenging staff would not clean up the area around the beds unless their palms are greased. Para-medical staff are also not helpful."

Rural research abroad.- Nelson et.al., (1949) examined the use of health services by 250 representative rural households in Cortland County and 283 households in Oswego County, New York, U.S.A. It was observed that over nine-tenths of the households and about four-fifths of all persons one year of age and over in each County had used one or more types of health services during the twelve month period ending September 1949. Out of every ten households in each County, about nine used a general physician, six used a dentist, over five used some type of public health service for individuals, a little less than three used a hospital and fewer than two used a medical specialist and less than one used an osteopath or other health care personnel. About four-fifths of the households in each County used two or more types of service.

Mezirow and Santopolo (1959) informed through their study of Community Development in Pakistan, that is an effort to expand basic health services in the development areas, 214 civil dispensaries were opened, and 3,501,009 villagers were given vaccinations and immunizations.

Gomaa (1967 and 1971) conducted a study in two similar Egyptian villages and reported results in two papers. A health unit was established in 1967 in village A (Kom - Eshfim) while village B (Kharkania) was retained without a health unit, as a

control. Absenteeism from work due to illness was tabulated in 1971. The results show that the average number of disability days per person in village A was twenty per cent lower than that of village B (Correa, 1975).

It is estimated that in Pakistan (1982) fifty per cent of the population is within two miles distance of the outlets of the modern health services of public and semi-public sectors. Nearly hundred per cent urban and thirty-two per cent of rural population is within two miles radius of the health units. About twenty-one per cent of the rural population has no access to any health facility even within five miles distance. It is evident that the rural population is comparatively poorly served by available health facilities, even if allowance is made for the fact that many hospitals and other health institutions located in urban sites serve people living in the rural areas as well.

A study was conducted in five villages of Mahendragarh district of Haryana (Yadav, 1985). Sixty homemakers each from the scheme and non-scheme villages were taken for the study, that is, those participating and not participating in income-generating activities in the scheme and non-scheme villages respectively. The scheme villages had nine community facilities in contrast to non-scheme villages where only four community facilities were available. The common community facilities which were available in both the groups were Balwadi, Consumer Co-operative, Bank and Post Office. In the scheme villages where Mahila Mandal and Training Centre were available, eighty

per cent and ninety-five per cent of respondents were aware of it and utilizing it, respectively. It was found that in scheme villages, women were more aware of bank facilities but utilization of these facilities was almost same in scheme villages (eighty-three per cent) and non-scheme villages (ten per cent). Whereas, for post office, awareness was almost the same (72.2 per cent) in both the villages, but its utilization was not the same in both groups of villages. In scheme villages, 13.85 per cent of the respondents were utilizing this facility frequently and twenty-five per cent occasionally, whereas in non-scheme villages no one used this facility frequently but it was occasionally used by 3.3 per cent only. In scheme (68.75 per cent) and non-scheme (68.33 per cent) villages, women were equally aware of consumer co-operative and were utilizing it frequently but the number of respondents who were never utilizing it (11.68 per cent) was higher for non-scheme villages. In scheme villages where Mahila Mandal and Training Centre were available, all the respondents were aware of it but 38.3 per cent were participating frequently and 21.6 per cent occasionally whereas forty per cent women never participated in this activity. This shows that out of eighty per cent women who were aware of this facility, only sixty per cent were participating. This seems to indicate that awareness does not necessarily lead to utilization of community facilities.

Training centre was utilized by ninety-one per cent of the women in the scheme villages. Utilisation of training centre

was relatively more, may be due to the fact that women who are participating in income generating activities need some training before starting income generating activity.

Credit co-operative and voluntary organization were available in scheme villages only. It was found that 66.66 per cent were utilizing it. On the whole, awareness and utilization of all these facilities was relatively more in the scheme villages as compared to non-scheme villages (Refer Table 45, Appendix VIII).

Urban research abroad.- Kessel and Shepherd (1965), indicated through their study that response rates varied from seventy-seven per cent of those who had not consulted their doctor for ten years, to eighty-six per cent of those who had not done so for just two years and to ninety per cent of the then recent attenders. The researchers conclude, broadly speaking those, who seldom or never consulted their practitioners, appeared to be healthy.

Umo (1969) summarized that Lagos alone had between eighty-six per cent and ninety-four per cent of daily attendance, annual inpatient admissions, bed compliments, number of nursing staff and number of doctors, while all other local government areas had to share the remaining proportion almost in proportion to their distance from Lagos.

Aday (1976) analysed data from a 1970 national survey in United States, and reviewed that the low income population were entering the health care system at higher rates in 1976

than ever before. The fact that they were less apt to have a family doctor and to experience longer waits to see a provider reflected that they were more likely to go to hospital emergency rooms or outpatient departments for care, while the high income patients saw physicians in private offices.

Figure 7 represents the per cent distribution of sources of health services in New York, United States. Andrews and Phillips (1970) examined the attitudes of inhabitants of selected barriades (communities) in Lima, Peru, to the provision of twenty-six basic services, and found that dissatisfaction was most acute in respect of the location of medical services and the provision of utilities such as street paving, lighting and water.

An overview of the literature reviewed, reveals certain common, salient features as generalizations regarding the utilization of community health services. It can be apparently inferred from a majority of the studies, that there are crystal clear evidences of utilization of health services, which promote under or no utilization rather than optimum utilization. Some of the major determinants of utilization of health services that can be identified in practical and realistic terms through the researches conducted, suggest that, the use of health facilities and services, varied according to religion, literacy level, per capita income, occupation, age, number of living children, type of family, distance of medical facilities, attitude of professional rendering the services, quality of health needs, health awareness, awareness of availability of government

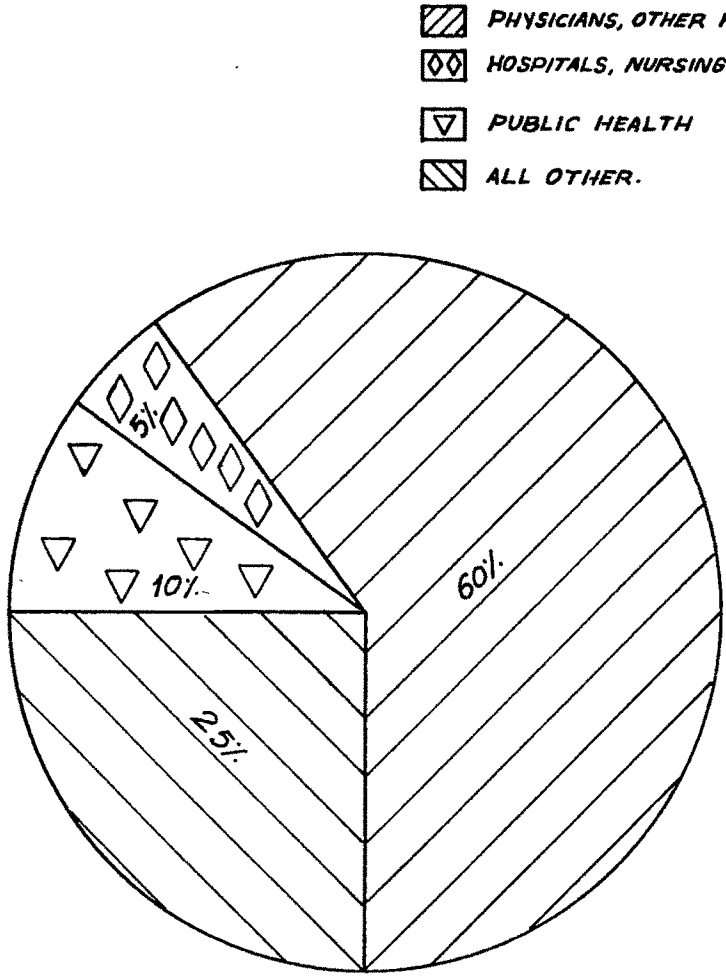

FIGURE - 7

APPROXIMATE DISTRIBUTION OF SOURCES OF HEALTH SERVICES IN NEWYORK, UNITED STATES

SOURCE:-

Aday and Anderson. Fostering Access to Medical Care in Health Services: The Local Perspective. Ed. Arthur Levin. 32 (3), 1977, P. 56.

facilities and services, expense involved, quality of services, quality of treatment, waiting time, availability of, cost, and quality of medicines. payment of money for services, perception of symptoms, nature of illness, severity of illness. availability of facilities and several other factors and circumstances.

Although modern urban health facilities are availed of by the poor, they are often far away from the slum, and too expensive. The poor voice an almost universal priority for better health facilities, nearby, at costs which they can afford. Besides general health services, there is great need for more maternity services. Mobile services and the training of local women in elementary diagnostic and treatment skills, would go a long way towards filling the gap which now exists between the demand and supply of health services for the poor.

(b) Educational facilities and services

It was John Deway (1859-1952), the American Philosopher, who started a new trend in education thought and practice. The question he asked was, what can be done to bring the school into a closer relation with the home, the neighbourhood and society, instead of having the school merely a place where the child comes solely to learn certain lessons? Is it possible to make the formal and symbolic mastering of the ability to read, write and use numbers, meaningful and purposeful to the child? (Kuppuswamy, 1982).

Education can be defined as "the process by which every society attempts to preserve and upgrade the accumulated knowledge, skills and attitudes in its cultural setting and heritage in order to foster continuously the well-being of

mankind and guarantee its survival against the unpredictable and at times hostile and destructive elements and forces of man and nature" (Nwagwu, 1976).

India seeks today a relevant education, to consolidate on the tremendous progress already made in providing basic infrastructure and facilities for education at the primary, secondary and tertiary stages including professional and research institutions. Indian's long tradition respects knowledge as well as those who possess it. Over the millenia, knowledge had divided society into a minority of haves and a majority of have-nots not only in India but also elsewhere (Kunnunkal, 1986).

In a democracy, education is of utmost importance, for no democratic institution can function satisfactorily for long, where the majority of its members are illiterate. A region should therefore be provided with an adequate number of schools, colleges, for the young and facilities for training and social education for those belonging to the higher age groups (Dharan, 1968).

Education, the process of relaying cultural experience from one generation to another, is a universal necessity, but urban communities, are by their very nature both unusually dependent on education and faced with special difficultires in insuring adequate performance of this function (Boskoff, 1970). Umo (1986) is of the view that education is an instrumental basic need since it facilitates access not only to other basic needs but 'higher' human needs.

Kirlin et. al., (1971) state that modern education has been considered the panacea which makes people rational. In the case of health innovation, it may not only be a choice of the father but the education of the wife or even of the children which may affect the use of health facilities.

Learning activities relate to and are part of all fields of human endeavour. Thus, given its general function, education must be studied as an element in all sectors, rather than a sector in isolation. Education is very widely defined; it may be regarded as a process of learning and assimilation of the techniques that are necessary to individual and collective living, as well as of those elements which make up a culture. Among the objectives of education, is the aim to integrate the individual well within a society in keeping with, and while participating in, its general development and evolving aspirations.

Society and education are very much interlinked, and the development of education is always subject to the interplay of various factors in the society: economic needs and resources of the society, social and cultural aspirations of the people, their political objectives and demographic structures. As those factors undergo modifications, so should education change in its roles, contents and structures.

Thus, demands upon education are great and varied. Learning opportunities vary as well, ranging from the myriad, interacting, usually unplanned experiences of life to organized or institutionalized learning and training. The following

definitions cover the wide range of educational possibilities.

(a) Informal education.- Largely spontaneous learning; a lifelong, often imitative process by which people acquire and conserve skills, attitudes and insights from daily experiences and exposure to their environment.

(b) Non-formal education.- Structured, systematic, non-school education and training activities, often of relatively short duration, such as agricultural extension, adult literacy and occupational skill training as well as community programmes in health, nutrition, household management, co-operatives and so on.

(c) Formal education.- Institutionalized, chronologically graded and hierarchically structured general or technical schooling, ranging from lower primary classes to postgraduate study. (These definitions are the ones generally accepted by the UN - UNESCO, in particular and the World Bank) (Canadian International Development Agency, 1976).

Mahatma Gandhi, while expressing opinion on the curriculum and the object of school education said that, the main object of the school is to strengthen the pupil's character. It is said that real education lies in teaching the pupil the art of learning. In other words, a desire for knowledge should grow in him.

The scope of adult education in India

Education does not end with schooling alone but is a life-

long process for moulding the career of the new generation. The scope of adult education is, as wide as life itself. To provide education to illiterates requires different course of procedure than the normal school system. It requires the support of several agencies like the universities, public institutions and libraries. It requires competent administrative machinery. According to the local conditions in the country, effective programme of adult education should be envisaged on several grounds like liquidation of illiteracy, continuing edcuation, correspondence courses, libraries, role of universities in adult education and finally organization and administration of adult education.

In Phillipines, the Radio has been referred to as the "University of the Air" for the people. The Bureau of Public schools conducts a Radio Broadcast on Sundays over stations in Manila, and several other cities. The topics presented to the people are environmental health, parent education, education for better citizenship and education for better livelihood.

In India too, fullest exploitation of the mass media of communication and films and other audio-visual aids like cinema, radio, wall-posters, pictures, etc., are already educating the people.

The adult education programme, as taken up by the Government with thepublic co-operation, relates almost the class of people living in urban areas. It is a fact that the people concentrate in cities for obvious reasons and population migrating from rural areas is mostly uneducated.

The Government of India are convinced that education is the key to national prosperity and welfare and that, no investment is likely to yield greater returns than investment in human resources, of which the most important component is education. The Government have also decided to mobilize all the resources of science and technology which can only be done on the foundation of good and progressive education, and to that end, to increase considerably their total investment in the deveopment of education and scientific research. The nation must be prepared to pay for quality in education and from the value attached to education by all sectors of the people, it is clear that they will do so willingly. It is desirable to survey the entire field of education and development as the various parts of the educational system strongly interact with and influence one another. It is not possible to have progressive and strong universities, without efficient secondary schools and the quality of these schools is determined by the functioning of elementary schools. What is needed therefore is a synoptic survey and an imaginative look, as education is donsidered as a whole and not fragmented into parts and stages (Bhardwaj, 1974).

Pandit Jawaharlal Nehru, once explained the objectives of University education and its role in national life, in the following words:

> "A University stands for humanism, for tolerance, for reason, for the adventures of ideas and for the search of the truth. It stands for the onward march of the human race towards even higher objective."

The functions of Universities in the modern times have been defined by the Kothari Commission as below:

> " to seek and cultivate new knowledge, to engage vigorously and fearlessly in the pursuit of truth, and to interpret old knowledge and beliefs in the light of new needs and discoveries;
>
> to provide the right kind of leadership in all walks of life, to identify gifted youth and help them develop their potential to the full by cultivating physical fitness, developing the powers of the mind and cultivating right interests, attitudes, moral and intellectual values;
>
> to provide society with competent men and women trained in agriculture, arts, medicine, science and technology and various other professions, who will also be cultivated individuals, imbued with a sense of social purpose;
>
> to strive to promote equality and social justice and to reduce social and cultural differences through diffusion of education; and to foster in the teachers and students and through them in society generally, the attitudes and values needed for developing the 'good life' in individuals and society." (Report of the Education Commission, 1964-66).

To achieve the ideal of a welfare state, it is necessary that every citizen should be made aware of responsibilities, duties to the family, the community and the country. This education for democratic citizenship, is, however, a collective function of many social organizations and individuals, The neighbourhood school, playground, religion, community and government, all help in promoting such education.

There are various activities through which education is promoted, viz. literacy classes, libraries and reading rooms, festivals, exhibitions and melas, village leaders' training

camps, etc. All these activities form an integral part of the programme carried out in the community centres organized by the initiative of the villagers themselves (Ministry of Community Development, Government of India, 1959).

Levels of literacy and education vary in every city according to factors such as religion, caste, length of residence in the city, income, sex and age. Thus, the topic defies easy generalization. Nonetheless, some of the more important findings may be highlighted here. First, there is everywhere a very large difference between the access of males and females to literacy and education and while levels of education and literacy for both sexes are improving, the gap between males and females seems to be increasing. Second, a fairly large number of those who have achieved literacy or who have received special training in skills, have done so outside the formal educational system, but very little is known about this process of informal education. Third, poverty is the main reason why children of a school going age do not attend school, though cultural and environmental factors also exercise a significant influence on education. Fourth, neither the formal system of education, nor informal education programmes, are at present adequate to meet the needs of the poorer sections of urban society. In general, the major factors affecting access to education, literacy and special skills, are economic, environmental and cultural. These factors need to be taken into consideration in any effort to improve the current situation (Singh, 1980).

The community school lays increasing emphasis upon its

responsibility for the life-long education of community members. Under this new concept there are several different or additional activities included in the function of the school. First, learning is organized more around problems and situations in the community itself than knowledge in isolation. As a result, resources within the community are utilized to a greater extent to enhance the learning process and add first-hand experiences. Second, groups and individuals from the community become more deeply involved in the learning process as educational resources and as advisory planning groups. Third, closer communication between school and community is affected, with the result that the community participates more actively in making decisions respecting the function of the school. Fourth, education opportunies for adults are made a normal part of the school's function so that adults can continue learning. Fifth, school facilities become generally available to the community at large, becoming the centre for the active social life of the community (Nelson, 1960).

The school can readily become, particularly in smaller communities, a community centre, where a number of community activities, such as meetings, dramatics, recreation and adult classes can conveniently be placed (Technical services contributing to Community Development, 1956). In many high schools or even elementary schools, night classes in electronics, stenography and typing, cooking, automotive skills, tailoring and dress-making, and other useful skills are taught. Where an urban community development programme can be tied up with such

opportunity classes, they provide long-range solutions to the problems of slum dwellers and squatters (Laquian, 1971).

To stimulate the child for learning, pre-school education in a non-formal setting, forms the backbone of the urban basic services programme, as all services converge on the pre-school centre. Children between ages three to five years should be made to attend Anganwadi for three hours a day. This is to stimulate the curiosity of the child rather than follow any rigid learning curriculum. To increase the coverage of pre-school children complementary approaches have been suggested - common facilities for primary schools and day care centres, expansion of existing facilities of pre-school education including ICDS and Balwadis and large scale training programme for pre-school education teachers (Wishwakarma, 1986).

In the present age, education for any society is of vital importance. Since the achievement of political Independence, India is making a continuous effort through its Five Year Plans to increase the percentage of literacy, with special efforts in rural areas. There are facilities for all types of education, general, technical, social, rural, audio-visual, for handicapped and medical. The general education can be divided into pre-primary, primary secondary, basic and higher education (Dahama, 1968).

The initiative for change and development rests with the people. They should be helped to discover their own

potential, to initiate development themselves, with little outside assistance. As long as illiteracy continues to be the major problem among the rural people, any attempt to bring about rural development - economic and social, would not meet with the desired results. Adult education hopes to remedy the educational deprivation of adult population, in order to develop their full potentiality and make the development process self-reliant, self-generating in regard to opportunities and initiative (Muthayya, 1979).

Adult education has not developed to any sufficient point in the urban areas, but it is still further advanced in the city than in the rural areas - where it is almost non-existent. Library services for adults, for instance, are readily accessible to urbanites, but, except in a few areas, have not until recently even been recognized as a necessity in rural areas (Ericksen, 1954).

> "There are no necessities, but everywhere possibilities; and man, as master of the possibilities, is the judge of their use. This, by the reversal which it involves, puts man in the first place - Man and no longer the earth, nor the influence of climate, nor the determinant of localities."
>
> Lucien Febvre
> (Ericksen, Urban Behaviour, 1954.P.346)

Slum dwellers are usually not only uneducated, but also largely illiterate. Although there is great need for a mass adult literacy programme and facilities are often available, a major drawback to effective literacy campaigns, has been the urban slum dwellers' lack of desire to become literate. They often see no purpose in learning to read and write, which is

usually difficult for adults, as it may result in little economic advantage. Few pre-school arrangements of any kind are available in Indian cities (Clinard, 1966).

Educational services

One phase of education, that which is primarily associated with the schools, is concerned with the formal imparting of knowledge. Another phase, usually identified as training, is concerned primarily with the imparting of skills. The two phases can be included under the term education.

As community life becomes more complex, the demands on education become greater, and special demands are increasingly made. For particular kinds of work, special training is necessary, and as the work a person does, changes, additional special training may be needed. Dubin (1958) emphasizes that each type of work has its own language, and language changes much as tools and workways do.

Educational institutions are increasingly being provided in the urban and rural areas. However, people send their children to different types of schools as suits their class, so to speak, such as convents, Government-aided schools, Municipal Councils' and Zilla Parishads' schools, Therefore, education is partly responsible for the continuance of class patterns (Vaid, 1976).

Furthermore, the quality of education is in a sorry state of affairs, as has been pointed out by Desai (1974). The

number of institutions are limited therefore there is a constant pressure for admissions. ~~Many privately owned schools and constant pressure for admissions~~. Many privately owned schools and colleges are also stated to be the strongholds for scandalous profiteering politics. Adequate facilities are not provided and caste, regional and similar considerations govern their functioning.

Education being costly and prolonged, only those who belong to the rich and the upper-middle classes, can take advantage of it. Various studies have revealed that most of the students spring from the upper strate of the Indian Society. They monopolize higher education, and therefore, higher lucrative posts in economic, administrative, political, educational and other spheres. Those from the lower-middle and lower classes, who receive limited education, find it difficult to get jobs, and unemployment amongst the educated is found to be increasing. Though some concessions and preferences are now made available, to the scheduled castes and backward classes, the plight of the other lower strata is still very deplorable. Scientific and technical training facilities at various levels, which can help in promoting numerous skills and new outlooks in people are still not adequately available. Especially in areas where industries are coming up or where irrigation and power projects are being established, it is necessary to extend such facilities (Kopardekar, 1986).

<u>The underlying education concepts</u>

Education can no longer be viewed as a time-bound, place-

bound process, confined to schools and measured by years of exposure. Therefore, there exists a concept that equates education with learning, regardless of where, how or when the learning occurs. Thus defined, education is obviously a continuing process, spanning the years from earliest infancy through adulthood and necessarily involving a great variety of methods and sources (Coombs, 1974).

The capacity of man to develop himself through education is one of the most fortunate characteristics of the human race. His ability to improve himself and the conditions of his environment that hinder or control his progress, are the primary differences between man and the lower species of the animal kingdom. Man's progress, therefore, is highly dependent upon his education. With appropriate education, man does not have to exist continuously in a state of poverty, ignorance and disease (Leagans, 1961).

Location of educational facilities

The distribution of the school system over the city area is a point of concern to the city dweller, more so to the urban poor. The service range of the elementary school should be limited to walking distance. City finances cannot afford to make high school services available within walking distance of all urban residences. Public means of transportation have to be relied upon to cover the distance between residence and school building. Needless to say, certain residential areas find themselves placed more advantageously than others (Riemer, 1952).

According to Strayer and Engelhardt, an elementary school should be provided for every thousand or 1,200 children of school age, or, in a normal distribution, for approximately every five thousand or six thousand people. The maximum travel distance for the pupil should not exceed one-half mile. A school located in the centre of a district should be so situated that no pupil would have to travel as much as one-half mile. The next requirement is that no pupil should have to cross an arterial street to reach the school.

Libraries and cultural centres

Every large city has a public library system in which its citizens take pride. Not only do such libraries supplement school books, but they play a large and increasingly important part in adult education. Thousands of books circulate daily from main libraries and branches. Numerous reading rooms are provided by large central libraries and here books are classified by subjects so that they can be used conveniently. Special services are given by larger libraries. Many thousands of persons who have been unable to go to high school or college, secure an education by making full use of the services afforded by public libraries (Burgess, 1927).

Educational facilities and services - related research in India and Abroad

Rural research in India.- Only a handful of studies have been carried out in the aspect of educational facilities and services in the rural areas, which the investigator came across, and these too were conducted several years ago.

As early as 1957, the Government of India, under the Programme Evaluation Organization of the Planning Commission, started some Community Projects in the rural areas of various States, on different facets of education.

In Bihar, quite a few education centres with libraries attached to them were organized during the Project period. Night literacy classes were run satisfactorily and attracted under privileged groups also. Two Mahila Mandals were organized in the whole project area. Literacy classes, craft training in needle work and singing were programmes of these centres, Ambar Charkha was also introduced.

In Himachal Pradesh, the adult-literacy-cum-recreation centres of the Project have given opportunities to the youth in some villages to get together for recreational activities. Although a number of women's welfare centres were started, where, sewing, knitting embroidery, home-economics, child-care, etc. were taught, yet, except for knitting, no item was popular with the women of the area.

In Kerala, there had been an increased activity under the programme relating to the forming of libraries, reading rooms, and samajas etc., but the intensity varied according to the enlightenment of the youngsters in the village welfare activities.

In Madras, two adult education centres had been opened in a village to spread education among adults, while the young men attended a nearby high school.

In Orissa, community work like village schools, libraries, recreation centres, village roads, culverts, drinking water wells, etc., were undertaken. Young persons in many villages participated in activities like organizing libraries and clubs and taking part in village welfare works.

In Bombay, social education classes for women were conducted, and training in sewing and tailoring (Planning Commission Report, 1957).

According to Bhagwatwar's (1972) study, educational facilities were reported to have improved much by forty per cent of the respondents of Purandhar taluka, Pune, contrasting with only eight per cent of the respondents of Mulshi taluka of Pune, who claimed improvement of educational facilities in their area. Similarly, the percentage of respondents answering 'nil' progress in this area in Purandhar was almost one-third (10.68 per cent) of such villagers in Mulshi. This showed that the improvement in educational facilities was certainly perceptible. It is quite obvious that the government is trying its best to have atleast a primary school in almost each and every village and secondary school in some of them.

Urban research in India.- In the urban areas in various parts of India, many research studies in the field of use of educational facilities have been conducted since the year 1958, but none that the investigator came across were conducted during the last about one decade or so.

Under the Delhi Pilot Project (1958), it was seen that

illiteracy was widespread in all the projects, varying from 80.3 per cent in one Vikas Mandal to 17.9 per cent in another. Illiteracy was particularly high among the women in all projects. Several Vikas Mandals purchased books co-operatively for a small lending library of twenty-five to hundred books. Other Vikas Mandals subscribed jointly to one or two newspapers each. Several reading rooms were made by constructing simple shelters or converting rooms, that the mandals had secured either free or on rental basis. Newspapers were read by the literate to those who could not read. Two television sets were watched by 1,000 people, packed closely.

Education of children and young people was encouraged greatly, by hiring teachers to conduct tutoring classes, painting classes etc. Five Vikas Mandals held essay competitions involving 225 students; nine had competitions in drawing in which 226 students participated and two held 'general knowledge' competitions, with seventy-three students participating.

Achievements under Community Development Programme in Andhra Pradesh showed the cumulative achievements from inception to March 1962 as the following:

	Numbers
(1) Adult literacy centres started	12,643
(2) Adults trained	4,61,078
(3) Youth clubs started	43,600
(4) Mahila samithis started	10,010

(Planning and Local Administration Department Report for 1961-62)

The physical targets achieved under Community Development Programme in Andhra Pradesh during 1962-63 showed that in Hyderabad ninety-six adult literacy classes were started and 1,181 adults were made literate, 104 youth clubs and seventy-five Mahila Samithis were started (Panchayat Raj Department, 1962-63).

The Chanda Committee report in 1966, has thrown light on the use of radio and television for adult education.

Lynch (1967), who studied a large slum inhabited mainly by Scheduled Castes from Tamil Nadu found an exceptionally high rate of literacy of atleast seventy per cent. As many as eighty-three per cent of the literate said they read newspapers daily, which according to Lynch, keeps political interest and contact high.

In Calcutta, a study by Siddiqui (1968) estimated, that, while the literacy rate for the ~~slum population as a whole was relatively high,~~ slum population as a whole was relatively high (about sixty-four per cent) nonetheless, about eighty-six per cent of the women were illiterate, and only nineteen per cent of the boys and twelve per cent of the girls of school-going age were in school.

The educational methods employed by Agrindus Institute (1973), for spreading knowledge were many and those which attracted attention of the members of sample households (228) most regularly, were film shows, puppet shows, dispensary and adult literacy schools.

In Madras in 1971, it was found that forty-two per cent of the city's slum population was literate, including fifty-four per cent of the males and thirty per cent of the females (Arangannal, 1976). The 1971 census survey found only twenty-eight per cent of the males literate and four per cent of the females literate (Gandotra, 1976).

In Delhi in 1971, the TCPO survey found that while fifty-four per cent of the adult male population was literate, only ten per cent of the adult female population was literate (Majumdar, 1977). Furthermore, it was found that forty-seven per cent of the adult males in Delhi's squatter settlements had less than high school education and eighty per cent of these were educated outside the school system. Two per cent had high school education and one per cent were degree holders; of the ten per cent adult women who were literate ninety per cent had less than high school education and only ten per cent had higher secondary education.

Desai and Pillai's (1972) study of a large slum in Bombay found that more than seventy-two per cent of the wives of respondents were illiterate which was nearly three times that of men. The difference in education according to age and sex, also comes out clearly in the study (1972). They found that there was a clear difference in education levels between the younger and older generation: only 8.6 per cent of those thirty five years and above had reached or crossed the high school level as against twenty-five per cent of those below thirty-five years. On the whole, twenty-one per cent of the children in the age group of six to fourteen years were illiterate and

forty-one per cent of them did not attend school. However, seventy per cent of the boys compared to only forty-six per cent of the girls in this age group attended school. The main reasons for children not being sent to schools in these studies, was distance of schools; buildings provided in adequate protection against rain, facilities available to children were negligible, teachers were not interested in teaching, children were not interested in studies, parents did little to encourage their children in their studies, and poverty as the main cause.

Ramachandran (1972) reported that 74.32 per cent of the pavement dwellers surveyed were illiterate. The 1975 study of four squatter settlements in Delhi found that thirty-seven per cent of all males and only twelve per cent of all females were literate (Singh and De'Souza, 1976). In the study, it was found that only forty-one out of 497 married women (8.2 per cent) had any education at all, and of these only two (0.4 per cent) had gone beyond the eighth standard. For the population as a whole (all those five years old and above) the average number of years of school for males was 2.41 and for females 0.64.

In the slum studied by Wiebe (1975), there were slightly higher literacy rates, with fifty-seven per cent of the males and thirty-three per cent of the females, literate. The evening literacy programmes in the Madras slum which he studied had to be discontinued because of poor attendance and lack of teaching personnel. Courses in tailoring for women are

notorious for not being able to market the goods they produce or find other employment opportunities for women after completion of the course.

The case study of Karnataka state (1976) revealed certain particulars of general education in the state as a whole. The pre-primary schools had gone up to a figure of 1913 (1976 - 77) with 1.18 lakh students. For 1,278,680 urban children (zero to four) and 1,264,722 (five to nine)children, the number of schools required are many, compared to the existing number of schools. Primary schools have increased from 22,250 to 33,471 over twenty years while enrolment has gone up to 45.30 from 19.3 lakhs. There were 2,406 secondary schools with 6.18 lakhs pupils during 1976-77 (Rao, 1986).

The study by Singh and De Souza (1976) found a high level of stated interest in non-formal training among the women, but a low level of interest in programmes for men. The major problems with most non-formal programmes appears to be that they are poorly organized, they do not cater to the felt needs of the people and they do little to link the participants with marketing facilities or employment opportunities after they have completed the programme.

Under the Composite Unit I of the Urban Community Development Project Municipal Corporation of Hyderabad, the plans introduced were pre-school education, Balwadi having a strength of forty-eight children at the end of December 1976, with eighty-two per cent of average attendance for about seven-and-a-half months, with twenty-eight boys and twenty-three

girls, the children were in the age group of two-and-a-half to five years. There were twenty-nine children - thirteen boys and sixteen girls by December 1976 in the creche. The average attendance per day was eighteen children. Children admitted were of a very low socio-economic group and of a very low health status. Vigyan Mandirs, to help youth gain knowledge and skills in specific areas according to their aptitude were also started. Through Mahila Mandals, lessons in tailoring and stitching were given. Twenty-seven members were enrolled with an average attendance of twenty per day. Twenty-five members participated in economic activities, such as stitching clothes for which they earned Rs.134/- by stitching 403 different types of clothes. Balgyan Kendras for the unfortunate group of six to twelve years who had either never been to school or dropped out pretty early in order to take care of the younger ones, or burdened with household chores, were started. Here the initial strength was fifty-two children and by the end of the year there were forty-seven children - fourteen boys and thirty-three girls with an average attendance of twenty-nine. A special feature of enrolment in this centre was the predominance of girls which indicated the neglect towards girls' education in the community, as is the case of several other parts of India, evinced through the many researches mentioned earlier, in this section. In addition there were four to five children who, by mere fact of mental or physical handicap, had to remain out of regular schools.

The adult literacy classes started because of the

interest shown by a large number of illiterates in the age group of around fourteen years. Thirty youths were interested in night classes, commencing from seven to nine p.m., the average attendance being twenty-three per day.

From the Telugu section of the population, students of the primary school in the age group of five to seven years, mostly poor, and who had no way of guidance in their school work: twenty-nine children, were coached, paying a contribution of rupee one per month, for these classes.

Families benefitted by one or more plans

As many as 372 families have benefitted in some way by the Project Programmes initiated in Block I during the eight months of the functioning of Composite Unit I in 1976.

Scheme	Total
Balwadi	83
Balgyan Kendra	113
Health	134
Creche	46
Youth club	27
Mahila Mandal	65
Adult literacy	47

Under the Composite Unit II, a creche was started with twenty-six children - twelve boys and fourteen girls. The average attendance per day in December 1976 was twenty-two children, that is eighty-eight per cent. In Mahila Mandals, the strength increased to forty by the year end and twenty members actively participated in sewing and tailoring, and the Balwadi had fifty children.

The community workers, in co-operation with the district

panchayat, started a primary school with an enrolment of 550 children - immediately after the families began moving to the new township. In an experimental education programme for the pre-primary and primary school children, opportunities were offered to bring out the creative abilities of children. They are provided simple tools - newspapers, discarded tooth brushes, charcoal, colour, water bowls etc., - to express themselves creatively in drawing, painting, music and other media. Another important dimension of the social component is social welfare. A creche which employs women from the community itself looks after seventy-five children while their mothers are working. A family planning programme has been integrated into the health care system (Shah, 1978).

The Urban Community Development Project (1979) had non-formal education, film shows and seminars, charts and toys were purchased for Balwadis, Mahila Mandals were established, youth clubs and sports clubs were also started and groups were organized for particular activities such as cultural programmes. Forty-one such organizations were started and two hundred organizations exist throughout the project area. Other activities of the project included medical schemes, family planning work, cooking, etc. Special nutrition programme and the mid-day meal programme, had 2,000 Balwadi children, being fed mid-day meals. Under the project there were thirty-six project Balwadis with about 2,200 children. Night schools and adult literacy classes were started and in one basti, twenty women participated. Under vocational training, sewing centres, typewriting and shorthand etc. and

several other activities were taught. The impact of the project on education was most significant. In two areas, practically all the children were being sent to school (Cousins, 1979).

Scholarship to the physically handicapped, to pursue education is available from ninth standard and above, given by Government of India. Only 0.02 per cent of all the handicapped children avail the scholarship. Due to rigours of application procedure, only middle-class children make use of this scholarship according to Armaity Desai's study conducted in 1979. This leaves the poor handicapped children uncovered. Even the few educational facilities that are available in our country are located in major cities (Rao, 1983).

Rural research abroad.- With regard to rural research in the Western Countries, only a couple of studies in the field of utilization of community educational facilities and sercices, including one community development programme in the rural areas, came by way of the investigator, and three combined and comparative rural-urban studies.

One of the most important objectives of any community development programme is to raise the level of education and literacy of rural people. To this end village AID (Agricultural and Industries Development) workers assisted villagers in the development areas to build 879 new schools, to remodel 970 others, and to obtain the services of 706 teachers, villagers were also assisted in opening 4,094 adult literacy classes, in which 91, 462 adult villagers were enrolled. By 1959, there

was one school for every ten villages in development areas of Pakistan.

Nearly all of the 1,189 new adult literacy classes functioning between 1958 to 1959, were operating in the villages. There was one class for every 3.8 villages in the development areas as of March 1959, a striking improvement over the September 1958 rate of the literacy class per every 5.4 villages (Mezirow, and Santopolo, 1961).

Under the Saemaul Movement in Korea, the schools serve as cultural centres for the community and offer adult education programmes. The community in Comilla, Bangladesh, have learning opportunities where everyday of the week 700 villagers attend the Thana Training and Development Centre (TTDC) from over 400 village co-operatives, 120 schools, and nearly 100 feeder schools (UNICEF, 1978).

A UNESCO study in Latin America in the 1960's revealed the sharp contrast between the members completing primary education in rural and urban areas. In Guatemala, for example, of every 1,000 urban children starting primary school in 1962, 496 could be expected to complete six grades, whereas of 1,000 rural children starting school, only thirty-five would finish six grades. In Columbia, the same study showed 273 urban children completing five grades as compared with thirty-seven rural children (of every 1.000 enrolled in the first grade). In Uruguay, the comparable figures were 736 urban children to 417 rural (UNESCO, 1970).

In urban centres visited by the International Council for Educational Development (ICED) teams, not only were there more and more accessible schools than in rural areas, but there were many modern economic activities, media (newspapers. magazines. books, movies, radios and television broadcasts) and modern consumer goods - all the hallmarks of modern life. In contrast, the rural areas visited had far fewer of these educative resources. A repeated question concerning literacy, for example, was what persons in a remote, traditional rural area would find to read, after they went through the trouble of learning how? (Coombs, 1974).

Under the rural-urban balance study in Pakistan in 1982, special emphasis has been laid on the expansion of primary education. It was expected that all boys of five years of age would be enrolled in schools by 1987 and girls by 1992. The mosque which had been an effective institution of learning, was revitalized for this purpose. It had been programmed to open 5,000 mosque schools, during the next five years in those villages which did not have primary schools. The mosques were also used for adult education. Similarly, five thousand Mohallah (locality) schools were opened, where educated elderly ladies would impart education to Mohallah girls on religion and other household work. In order to impart useful skills to the boys who drop out of schools in villages, village workshop schools were opened. The literacy rate in urban areas in 1976 was forty-two per cent and rural areas fifteen per cent (Maqsud, et.al., 1982).

Urban research abroad.- Library user behaviour based on a number of studies made over two decades, were synthesized and evaluated by Berelson and Asheim in 1949. Their data precede the era of television and the paper back book, but they indicate that in those days about twenty-five to thirty per cent of the American people read a book a month and of these twenty-five to forty per cent found their reading primarily in the public library. In an average community, the regular clientele consisted of not quite ten per cent of adults and a third of the young people.

The largest group of users were elementary and high school students who used the library primarily for homework purposes. They took between fifty and sixty per cent of the books circulated in the average library. The next largest group were adults who read the best sellers and other fiction (Gans, 1968).

According to one study noted by Berelson, twenty per cent of the library users borrow three-fourths of the books. (Another study sets this figure as high as ten per cent of the borrowers reading ninety-eight per cent of the books). These readers come mainly from middle and lower-middle income groups and white collar occupations. They have high school diplomas or some education beyond grade school. A majority were under thirty-five and many were women. This is by far the largest adult public (Gans, 1968).

An action research project (1970) in a local secondary school to provide a limited community based curriculum proved

a qualified success and at lower levels of the school system. Under the Coventry Community Development Programme (CDP) (Hillfields, 1970), a survey of Hillfields indicated that the under fives represented twelve per cent of the area's population. CDP's education project involved curriculum development, language development for the immigrant community and the beginnings of an informal adult education programme involving trade unions and local community groups.

The Southwark CDP (Newington) Project (1970) made available a mini bus to all local primary schools and an unattached youth worker appointed. Another appointment was an educational co-ordinator who organized an educational advice scheme for parents and their children at preschool level and a home and school liaison service.

In the Newham CDP (Canning Town, 1971), one programme aimed at mounting a video television project at a local school. Some research was carried out into adult education and discussions held with both parents and teaching staff to clarify educational issues.

The main thrust of the upper Afan CDP (Glyn Corrwg, 1971) education programme was devoted to raising attainment levels at local primary schools. The project also attempted to mobilize a Teachers' Forum in the area and was instrumental in getting the new local education authority to declare Upper Afan a social priority area in 1974.

The New Castle CDP (Benwell, 1972), Benwell's Nursery

Action Group examined the need for, and current provision of nursery and other preschool facilities for the under fives in the context of assessing how working mothers were coping.

Under the Paisley CDP (Ferguslie Park, 1972), an education working party was set up by the project in response to the high rates of one parent households, truancy and vandalism in the area. Preschool provision, to include home visitors, remedial programmes and all day nursery facilities, was a major recommendation.

In the case study of Lagos, (Umo, 1986) the then capital of Nigeria, the primary school population ratio in 1972 declined from 60.22 to 22 for Lagos division (Mainland) to 5.51 per cent for Epe. This same pattern repeated itself in 1979-80. The primary school enrolment rate was a declining function of distance from the core in 1972 but stabilized at a plateau of 105 per cent in 1979-80 reflecting the impact of free universal primary education which was launched in 1976. Secondary school educational services are also characterized by distant decay from the core in respect of school-population ratio and enrolment ratio.

More interesting perhaps, is the observation that when the trends in all areas are observed from the view-point of Lagos as a Metropolitan area, the decline in services become very sharp, eg. the primary school population ratio were 206.19 for Metropolitan Lagos, 98.59 (for Badagry), 58 (for Epe) and 30 for Ikorodu. In the same vein, the secondary school population ratio in 1979/80 were 35 for metropolitan Lagos 4.6 for

Badagry, 2.91 for Epe and 2.31 for Ikorodu. It is therefore clear that in general something like a step-declining function like S (BN) in Figure 8 is observed. A piece of research carried out in 1973, looked at the transition from school to work, the idea being, to compare the organizational contexts of local schools and firms as experienced by young school leavers. This formed a preliminary survey to a comprehensive study later carried out by the Grubb Institute which conducted interviews and surveys in local schools, factories and shops. A major conclusion was that schools proved themselves inadequate in introducing school children to the world of work and a recommendation was made that the distinction between places of work and places of education be broken down in policy terms (Lees et.al., 1980).

In Pakistan (1974) there had been a steady increase in the number of educational facilities, and students, since the time of Independence, The following table indicates progress made in this field since 1974 (Maqsud et.al., 1982).

TABLE 2

NUMBER OF EDUCATIONAL INSTITUTIONS AND THEIR ENROLMENT

Name	Number 1979 - 80	Enrolment (million) 1979 - 80
Primary Schools	56,920	6.57
Middle Schools	5,290	1.97
High Schools	3,463	
Colleges	440	0.31
Universities	12	0.27

Source: Economic Survey of Pakistan, 1979-80.

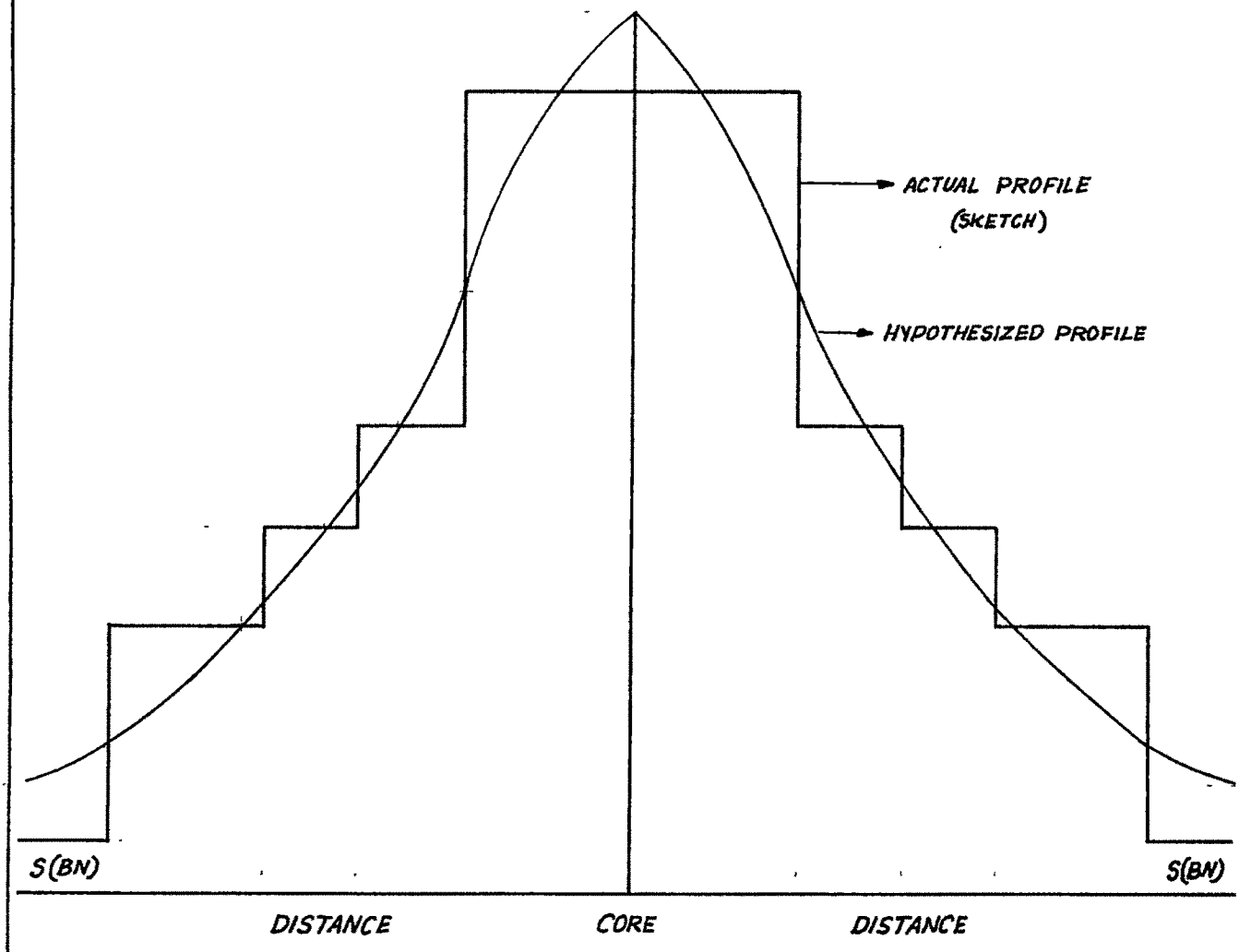

FIGURE-8

SKETCH OF STEP-FUNCTION PROFILE OF
EDUCATIONAL SERVICES IN A PRIMATE CITY-STATE

SOURCE:-

UMO, Joe U. Basic Needs Gradients in a Primate city-State. The case of Lagos in Urban Research Methods. Ed. C.S. Yadav. 1986, P.165.

An important part of the Barbados Survey, revealed that 4.73 per cent of the total 148 interviews, gave inadequacies of infrastructure and public service provision, notably education and schooling difficulties in relation to Trinidad and Tobago (Potter, 1985).

(C) Recreational facilities and Services - related research in India and abroad

Recreation is commonly referred to as a type of experience, as a specific form of activity, as an attitude or spirit, as an area of rich and abundant living, as off-the-job living, as an expression of the inner nature of man, as the antithesis of work, as an organized movement, as a phase of the total educational process or as a profession. It has been variously described as refreshment, as diversion or as the less serious and more passive type of play activity; but these definitions are inadequate, too general or too limited in scope.

Expressed in terms of activities, recreation may be considered as any activity which is not consciously performed for the sake of any reward beyond itself, which is usually engaged in during leisure, which offers man an outlet for his physical, mental or creative powers, and in which he engages because of inner desire and not because of outer compulsion. The activity becomes recreation for the individual because it elicits from him, a pleasurable and satisfying response. In short, recreation is any form of experience or activity in which an individual engages from choice because of the personal

enjoyment and satisfaction which it brings directly to him. This concept emphasizes the personal nature of recreation and indicates why recreation activities are as diversified as the interests of man. Recreation is not a tangible, static thing but a vital force influencing the lives of people. It is essential to happiness and satisfaction in living. Through recreation, the individual grows and develops his powers and personality.

Butler's definition of recreation reflects the viewpoint of the National Recreation Association. Recreation has been variously defined as experience engaged in either alone or with others for its own sake and for the gratification in the doing; as an expression of the inner nature of man; as the satisfaction of basic human appetites; as a form of leisure-time experience in which physical, mental or spiritual satisfaction comes to an individual for participation in certain forms of activity (Butler, 1959).

Sanders (1958), observed that recreation is the way people spend their leisure time, but some make the word recreation apply, and apply it "to what they and the community generally might describe as 'constructive uses' of leisure, giving it the idea of creativity, refreshment and renewal of energy for the work-a-day world." Sanders reminds one of the wide area of activities and interests covered by the term. It includes all sorts of activities engaged in by individuals or groups, in all types of situations.

> "Leisure must be made to contribute to man's advancement, to aid him in his pursuit of happiness, and to give him a sense of worthwhileness. Otherwise, it will be a liability and lay the basis for his destruction. Man, must grow through doing, achieving and creating" (Nash, 1953).

Leisure is regarded as a gift, something that man should use to enrich his personality, to gain knowledge; in short, to improve himself.

Recreation - A fundamental human need

Among all peoples and in all stages of history, man has found outlets for self-expression and personal development in forms of recreation which have a striking similarity. Recreation is a common heritage of all peoples, although its expression takes various forms. The significance of play to man's well-being was emphasized by Dr. Austin Fox Riggs when he wrote: "The function of play is to balance life in relation to work, to afford a refreshing contrast to responsibility and routine; to keep alive the spirit of adventure and that sense of proportion which prevents taking oneself and one's job too seriously, and thus to avert the premature death of youth and not infrequently the premature death of the man himself (Butler, 1959).

In these days, when recreation, is looked upon as a necessary part of life, it is difficult to realize that only a generation ago leisure - time activities were much less emphasized and in many cases were even frowned upon as a waste of time, and energy. Recreational grounds provided at govern-

ment expense were rarely found. From the point of view of the present generation, the recreational opportunities of the past century were decidedly limited. The urban parks of today with their crowded beaches and swimming pools and athletic fields stand in striking contrast to the scenic but little-used parks of an earlier period. No modern recreational programme is complete unless it is varied enough to meet the needs of people of all ages with their widely varying interests and capacities (Steiner, 1942).

Leisure is not a separate compartment of life but closely bound up with the whole web of human activities (Report, 1977).

Play for children and adults is as necessary as food and water. Without some form of recreation, life would be very dull. Indeed, it is doubtful that life could long continue without those activities that bring so much pleasure and relaxation. Recreation is any form of activity in which a person engages solely because he wishes to do so. In it he feels a sense of freedom and self expression. He seeks no rewards other than the pleasure afforded by the activity itself. The public library is a source of pleasure to thousands of city people, and yet, it is unvisited by thousands more. Private source of recreation could be supplemented by city parks, beaches playgrounds and community centres. The facilities for recreation usually offered by cities are parks and playgrounds (Elwood, et.al., 1949). Real rest revitalizes the body, repairs decay and lengthens life. It also consolidates the defensive powers of the organism. It is also said that adequate rest and

relaxation are invaluable to middle-aged people. Moreover, leisure improves efficiency of work and increases productivity of the worker (Bharathan) 1987).

Recreation facilities like parks, playgrounds, swimming pools, etc., are provided and the members of the community play an important role in the provision and maintenance of these facilities (Singh, 1986).

If the poor and even adults are not provided with a healthy programme of recreation and utilization of leisure period, they can indulge in vices like drinking, gambling, etc., and there will be more quarrels, litigations, wastage of money leading to indebtedness, so there is need of a programme of utilization of the leisure period and provision for recreational facilities (Dahama, 1968).

Lack of recreational facilities

The constant pressure of poverty and poor living conditions, along with the added pressures of monotonous and inadequate activities, make adequate recreational outlets even more important in the Indian Slums than those of the western world. Such a need, however, has not been recognized, partly because of failure to comprehend the importance of recreation, the absence of adequate space, limited experience in assuming initiative for organized recreational programmes, and the decline in importance of such traditional recreational activities of village life as dance and music in urban areas.

Young children, particularly those who are not in

school seem to suffer the most from this lack of recreation. In the slums, hundreds of young children roam about aimlessly seeking something to do. They may stand and watch something, play in the dirt or with one or two marbles in groups, or find a board for teetering. Some parks and organized recreation do exist, but they are often inaccesible, and their limited equipment is often in disrepair. Families generally own few games themselves, partly because they do not recognize the importance of such recreation, but also because of the prohibitive costs of most games in India. Such studies have shown that the men of the slums spend money they can ill-afford on frequent attendance at motion pictures, or gambling (Sen, 1960 and Bopegamage, 1957).

The notion of providing parks and recreation grounds may be new to the rural population but these are necessary in modern times when the tediousness of village life tends to drive the younger generation to towns. Recreation grounds may appear an extravagance but they are necessary to enable the youth of the area to lead a healthy and vigorous life (Dharan, 1968).

Recreational facilities and services

The provision of recreation facilities in any community is to a large extent dependent on the level of development of that particular community. This in itself depends upon a variety of factors, some of which are the nature and structure of economy, the rate of capital formation, the degree of industrialization, the level of productivity, the average

annual income, and the levels of educational and socio-cultural development (Onokerhoraye, 1984).

To the extent that monotony, strain and interference with neighbours are likely to characterize larger segments of urban than of rural populations, and in the degree that leisure-time activities affect these conditions, cities have greater need for formal controls over recreation than do farm areas, even though such efforts are highly important in the latter. A bewildering variety of leisure-time activities have arisen to meet the needs of urban dwellers.

(1) Commercial and non-commercial facilities

Both these types of facilities abound in the city. Commercial recreation includes those activities designed to bring financial profit to owners or managers. It embraces such diverse facilities as privately operated theatres, dance halls, amusement parks, swimming pools, sports and spectacles, clubs, and rental libraries for which patrons pay directly for recreational opportunities. It also includes commercially sponsored radio and T.V.Programmes, for which patrons in general pay by buying the sponsored products. Non-commercial recreation, not aimed at producing financial profit to private individuals, includes such varied activities as games, parties, picnics, touring, etc.

Active and passive recreation

The former involves direct active participation as players. In contrast, passive recreation characterizes,

non-playing spectators at a ball game, members of a theatre audience or viewers of T V programmes. Passive recreation has greatly emphasized the employment of professional entertainers such as actors, atheletes and professional hosts (Quinn, 1967).

Community recreation services of park, school and recreation departments are similar in many respects, and playground and indoor-centre activities are essentially the same whether conducted under park, recreation or school department auspices.

Municipal park and recreation properties have been developed for a variety of recreation uses and are enjoyed by people of all ages. Activities include picnicking by individuals or groups; boating or canoeing on streams or lakes; swimming, diving and water sports at pools, fishing, observing animal, fish or plant life at the zoo, acquarium or botanical garden, enjoying the beauty of a park landscape etc. and many more. The richness, variety and value of these activities, most of them carried on out of doors, are obvious.

The Public library

The primary function of the library is to provide opportunities for reading - the most common of all recreation activities. The library not only supplies books and magazines, for people to read but it offers guidance in the selection of suitable reading material, and literature dealing with all forms of hobbies and leisure-time pursuits. It is a commodity storehouse of avocational information. Other special library

services are the operation of outdoor libraries in city parks, branch or travelling libraries at city playgrounds, and the libraries-on-wheels which have proved so valuable and popular in rural counties.

The Museum

The museum is a building in which are displayed works of art or collections of natural, scientific, literary, or historic interest. In many cities, museums are located on public property, although they are commonly administered by a quasi-public agency and financed primarily from private funds. At the art museum, masterpieces in painting, sculpture and other art forms can be enjoyed by all the people. Likewise, historical museums record the early story of a city, state or region. The highly popular zoological and botanical gardens, belong in a sense under this general category; many of them are administered by the municipal recreation agency.

Hyderabad is famous for its "Salarjung Museum" the "Nehru Zoological Park", "The Public Gardens", the "Indira Park" and several other recreational spots of culture and beauty.

Reasons for Municipal recreation

In law and in public opinion, recreation is recognized today as a suitable and essential function of government. Since most people must spend a large portion of their leisure in the locality where they live or work, the focal point of their recreation is the local community. The participants in a

national recreation workshop concluded "The primary responsibility for recreation is in the local community; because recreation contributes to the welfare of the people, it is a primary responsibility of local government".

Following are some of the reasons why recreation is distinctly a part of the city's job and why the provision of basic community recreation facilities and services is a primary concern of local government.

(1) Municipal recreation affords a large percentage of the people their only opportunity for forms of wholesome recreation. For a great many people, recreation opportunities are very limited except as facilities, areas, activities and leadership are provided by governmental or public agencies. Especially in the cities, simple, traditional ways of spending leisure are no longer possible so that local government has a responsibility for making sure that needed recreation facilities and services are provided. The benefits society gains from participation in recreation will be largely lost if public funds do not make possible recreation programmes and services.

(2) Only through government can adequate lands be acquired. Only through governmental action can the city be supplied with ample and property located neighbourhood playgrounds, parks and other outdoor areas.

(3) Municipal recreation is democratic and inclusive. Municipal recreation, unlike that provided by most other agencies, is for all the people. In large measure, it is equally

available for rich and poor; for people of all ages, racial backgrounds; social status, political opinions, and religious preferences; for boys and girls, men and women. It gives to all, the opportunity to engage in activities of their choice.

(4) Municipal recreation is comparatively inexpensive. Local Government can furnish recreation at a much lower cost by use of taxes.

(5) The local government gives permanency to recreation. Private agencies depend for their continuance upon the interest and support of individuals or special groups. The government, on the other hand, is a perpetual agency and can alone assure the continuity of an adequate recreation service.

(6) The job is too large for a private agency. The increase in leisure and the growing need and demand for recreation make the task of providing recreation for all the people too large for any agency except the government.

(7) Recreation plays an important role in the local economy. The effective development, operation and maintenance of recreation areas is a potent stabilizer of property values; assessments tend to rise following the acquisition of park lands.

(8) The people demand it and are willing to be taxed for it. In the final analysis, the services provided by local government are determined primarily by the expressed will of the people and their readiness to pay for them from tax funds.

Recreation has become a governmental function not from consent, but by the demand of the governed.

Area types and standards

Because of divergent conditions and resources in different cities and neighbourhoods, as well as varied recreation interests, habits and desires of people, present day recreation systems comprise many different types of properties developed for a variety of uses.

The play lot or Block Playground

Play lots are small areas intended for the use of children, of preschool age. They serve as a substitute for the backyard and are rarely provided by the municipality except in large scale housing projects or underprivileged neighbourhoods where backyard play opportunities are not available. Small children should be able to reach a play lot without crossing a busy street.

The neighbourshood playground

This area is primarily intended to provide opportunities for children especially between the ages of six and fourteen, inclusive to take part in a variety of constructive and enjoyable play activities. When the neighbourhood playground adjoins an elementary school site, it is called a neighbourhood park-school.

The Community Playfield

This area provides varied forms of recreation for young

people and adults although a section is usually developed as a children's playground. At times the playfield is a part of or adjoins a high school site, when dual maximum use is made, and at times this arrangement is called a community park-school.

The large park

This area is intended, in part, to provide the city dweller with an opportunity to get away from the noise and rush of the city traffic and to enjoy contact with nature (Butler, 1959).

The reasons for high parks expenditure scarcely needs comment - the economic success of a resort partly depends upon beautiful and extensive public parks (Newton, 1986).

The Reservation

This is a large tract of land which is kept primarily in its natural state, although sections of it are made available for such activities as hiking, camping, picnicking, nature study and winter sports. Most municipal areas of this type are located either near the boundaries of the city or outside its limits.

Special recreation areas

Areas that primarily serve a particular active recreation use contain facilities such as the golf course, camp, bathing beach, swimming pool athletic field and stadium.

The neighbourhood park

This area is primarily a landscape park with trees, shrubbery, and lawn and is intended to provide an attractive neighbourhood setting and a place for a quiet, informal recreation.

The parkway

This is essentially an elongated park with a road running through it, the use of which is restricted to pleasure traffic. Portions of a parkway are sometimes devoted to playgrounds, picnic centres, or other recreation uses.

Other types of recreation properties

In this group are squares, plazas and areas acquired as sites for museums, zoological gardens, botanical gardens, nurseries, bird sanctuaries, community gardens, outlooks, nature trails and other special purposes.

The usefulness of a city's recreation areas depends not alone upon their size and location but upon the way in which they are designed, developed, equipped, maintained and operated for recreation use. Most of the activities that comprise the municipal recreation programme are possible only when fields, courts, buildings, facilities and equipment are provided. The extent to which a city's recreation system furnishes such features, determines largely the nature and scope of its recreation service (Butler, 1958).

Regardless of the type of recreation area, certain

factors to be considered and objectives to be sought in planning are:

(1) Effective use of the entire area
(2) Location and arrangement of the areas and facilities
(3) Adequate space for the facilities
(4) Ease of supervision or operation
(5) Accessibility
(6) Utilization of natural features
(7) Safety
(8) Economy in construction
(9) Economy in maintenance
(10) Conveniences for people using area
(11) Appearance

The operation playground

The neighbourhood playground is the type of area designed to afford a wide range of enjoyable and desirable activities for children of elementary school age and limited activities for preschool children, youths, adults and families living in the neighbourhood. The operation of playgrounds is a major feature of most community recreation programmes.

The playground "should intensify the natural functions of play, offering the richest possible experiences of sensation, creation, socialization, physical development, aesthetics" (Nelson Van and Marona, 1957).

Besides providing community centres with attached playgrounds, metropolitan authorities need to do much more for

providing a variety of avenues of healthy recreation for their citizens of both sexes and various age-groups. There is a considerable amount of stress and strain caused by the hectic tempo of urban life and the dullness and fatigue caused by the monotony of a large number of conveyor belt occupational operations. A city must provide an optimum physical environment, aesthetic and cultural attractions, efficient administration and basic civil services and amenities (Bulsara, 1970).

Recreational facilities in our large cities are rarely spaced so that their services spread equitably to all sections of the residential population. In the past, the location of parks has been left to historical accident, and peculiarities of topographical conditions. Parks and playgrounds have been called the "lungs of the city". They serve many different recreational facilities, therefore serious consideration must be given to the recreational equipment made available in the park areas distributed through the urban fabric. Playgrounds for children of preschool age are unsuitable for relaxation of the aged and the team play of adolescents (Riemer, 1952).

Recreational facilities and services - related research in India and abroad

Rural research in India.- Very scant studies mainly as a community development approach, on the utilization of recreational facilities, in the rural areas in India, have been conducted, so far as the review done by the investigator goes. These few studies were carried out several years ago.

The study conducted by the Planning Commission, Government

of India (1957) showed that in Bihar, youth clubs as sports clubs for games were started which were attended by several. In Himachal Pradesh, the project have given opportunities to the youth in some villages to get together for recreational activities like dramas, sports, etc. In Kerala, the Women's Clubs centre round activities like music, dance, folk-songs, etc. In Madras, a volley ball club was opened in a nearby school. The game is played daily. In Orissa, during the Project period, community work like recreation centres were undertaken, in which young persons in many villages got an opportunity to participate. Women centres were organized for recreation purposes. In West Bengal, the village youths organized activities for recreational purposes in some villages. Musical soirees on special occasions and staging social plays are common activities. A community hall exists in one village. A radio set was a great attraction to the village youth for hearing the news and rural programmes. Such facilities are confined to among the higher castes and are a taboo to the lower caste youths.

Under the Delhi Pilot Project (1961) from 1958-60, community - organized recreational and cultural programmes supplemented limited municipal and other programmes. They also provided recreation where the people lived and encouraged them to assume as much of the responsibility for recreation as possible. Other recreational and cultural programmes in the city were for the most part, located some distance from where most slum families resided, visits to public parks, playgrounds and centres often meant long walks. The facilities

were therefore used only by a small proportion of the city's people, most of whom lived near them. In addition, as the maintenance of recreational and cultural equipment was generally the responsibility of the public authorities, playgrounds were often misused and the equipment stolen. The self-help programme was instrumental in making the citizens more responsible for public facilities. Other recreational activities of the Vikas Mandals were, organization of Bal Sabhas and youth clubs, sports meets, cultural programmes of music, dance and drama, also bhajan mandalis and the singing of kirtans. Educational and cultural tours were also organized and the celebration of national holidays and festivals and craft and sewing classes for economic improvement.

Urban research in India.- There were no research studies on the use of recreation facilities, in urban areas in India, which came by way of the investigator. This reveals a total dearth of urban related studies in the field, and hence emphasizes greatly the need for such research. Only one community development project in Delhi, in the early 60's, revealed that, in the housing colony for displaced persons, about ten miles from the centre of the city, about 275 families reported a lack of cultural and recreational activities in the area (Ed. Turner, 1962).

Rural research abroad.- Here again, very few studies on recreation facility-use have been carried out abroad, and those also took the form of a community development approach.

In the Upper Afan Community Development Project Glyncorrwg,

(1971), several holiday play schemes and a subsidized transport scheme and youth club in the village, to try to overcome transport difficulties in getting to and from the site, were organized. A bus service and proposals to run services to isolated villages were other intiatives of the Project.

Maximum temperature and daily sunshine duration appear amongst the most significant factors, though windspeed and rainfall may also play a part. Meteorological factors may explain over fifty per cent of the variations in attendance at outdoor rural sites, including urban parks (Duffel, 1972).

The relationship between weather factors and participation levels at outdoor recreation sites shows that both participation levels and overall trip-making patterns are affected by weather conditions (Coppock, 1975).

Urban research abroad.- Several urban studies abroad have been made related to recreational facility use. Perhaps, the reason why research seems more abundant abroad than in India and that too urban research, may be attributed to the fact, that in western cities, besides a large number of playgrounds for all kinds of games, there are a large number of avenues for recreation such as, art galleries, science, folk, historical and Ethnographic museums and collections, swimming baths, Planataria, Zoo, Botanical gardens, open theatres, and National parks covering about sixty to hundred acres and more, and a vast variety of entertaining collections, houses and attractions for the visitors' diversion and enjoyment.

The earliest recreational surveys, Burgess (1927) show that, small children will not ordinarily travel more than one-quarter mile to use a playground. If it is more distant they stay away, from it. A good school yard in the center of 160 acres affords a public play space that is within a quarter of a mile of most of the families.

The summertime participation in outdoor activities was completely non-local except for the childrens' use of playgound facilities. Practically hundred per cent of the district were major league ball games, Municipal opera, Zoo and large parks, swimming, hunting and fishing, picnics and outings (Foley, 1947).

The South-East study (1961-81) concluded that a recreational supply and demand balance sheet would be helpful in identifying present and future problems and in establishing priorities for investment.

The Warwickshire study (1966) as befits the latest contribution, makes more extensive, but nevertheless, still uncertain projections. A model was constructed of available leisure time at 1966 and 1991, taking into account various demographic and socio-economic factors. Little or no evidence is available about changing patterns of leisure and therefore, many important assumptions have to be made. The demand for all kinds of recreational facilities is certain to increase by 1991 and probably at a much faster rate than due to the sub-region's population growth alone.

The Greater London Council (GLC) survey of open spaces (1968), demonstrated the fact that the distance people are likely to travel to urban open space is related to the quality of the open space measured in terms of its size and of the variety and type of facilities offered.

The Notts-Derby study (1969), notes that "quantifying the expected demand is an extremely complex problem in view of the large number of variable factors which affect it. There is no information which is adequate for refining the global estimate into demands for particular types of recreation. There is no body of information on a consistant basis for the sub-region which allows present level of activity to be assessed. The conclusion is that, 'a substantial shift in preferences, influenced by the charges levied for facilities, may mean that the rise is much greater in some types of recreation than others. The only way to meet this uncertain situation will be to provide further facilities, whenever those existing become overcrowded'".

In the urban context, the relationship between attendance of childrens' playgrounds and both the direct distance and the numbers of road crossings between the facility and the child's home, had been measured. It was found that the latter was more significantly related to attendance. Similar to the findings of the GLC study, reported earlier, this study too revealed that the travel distance is related to quality of the open space (Dee, 1970).

The Gloucestershire County Council (1970) concluded that the demand for outdoor recreational facilities is likely to increase rapidly during the next few decades, as a result of growth of population, car ownership, and leisure time available.

The Southwark Community Development Project (Newington, 1970) sponsored an afternoon play-group with the part-time professional help of a local mother, to enable mothers to work in order to supplement comparatively low family incomes, in Newington. Several adventure playgrounds were provided to make up for the desperate shortage of open space and to lessen the risk to children from play in local streets used for commuter parking and rush-hour short cuts. Two play houses were refurnished for use during school holidays.

In the early part of the existence of the Batley Community Development Project (1971), it concentrated on service provision for immediate needs such as playspace, pre-school provision and leisure facilities. A youth club was set up and a resident run Playground Association organized.

A Government sponsored study reported in 1971 that leisure activities were the most frequently mentioned amongst the things that the disabled missed. The study showed that only a relatively small proportion (upto fifteen per cent) of the non-housebound disabled were actively prevented from getting to a desired destination. The study revealed that parks as a recreation facility were unattainable by eleven per cent of the males and nine per cent of the females

among the persons aged sixteen to sixty-four years, due to transport or access problems (Central Steering Group, 1977).

The North West Regional Study (1972), noted that the distance between a person's home and the nearest facility must influence participation as well as the number of facilities available. There is ample evidence from site user surveys to demonstrate that an inverse relationship exists between distance and use of any facility. Distance decay curves can be calculated for many different types of facilities showing a decreasing participation rate with increasing distance from the facility. The slope of the curve varies according to the type of facility (urban facilities generally having a smaller catchment area than most rural facilities), and according to the quality or attractiveness of the facility.

Community recreation is concerned with the provision of leisure opportunities for all sections of local communities. Surveys indicate that even for 'regional' level facilities, the vast majority of users come from the local level area. The 'metropolitan' parks in London barely attract more than twenty per cent of their visitors from over three miles; seventy per cent of the sports centre users come from within three miles. Participation surveys show the fifteen to twenty plus age group to be the highest participants in virtually all types of out-of-home recreation pursuits, both in terms of the proportion of the group taking part and in terms of the frequency of participation

(Central Steering Group, 1977).

Under the Paisley Community Development Project, in Ferguslie Park (1972), play schemes were set up, deliberately relying on the organizational skills of local residents, with liaison provided by three specialist workers. Following these play schemes, provision to meet the needs of older adolescents was investigated and outdoor activities and bus trips were organized. Another scheme involved the organization of holidays for children in caravans presented by the local Round Table.

The Cumbria CDP (1973) an action research study of leisure provision for young people was carried out, revealing a great deal of unmet need. A coffee bar and detached youth workers were recommended as immediate priorities, while, in the longer term, a complete review of the funding of youth services was regarded as necessary. For younger children a toy stall project was set up to make toys available to children of poorer families and to provide toys which were both stimulating and educationally beneficial. An Area Play Organizer was appointed to support three play-schemes, on a permanent adventure playground. A play leader training course was mounted and older children involved in the development of the schemes.

The North Tyneside CDP (1973) embraced the question of recreational provision for young people, as a major issue in the first three years of its life. A Play Organizer was

appointed and various play schemes organized; other efforts involved preschool provision such as play groups and a creche which was run by parents themselves. Only the Meadowell Adventure Playground was seen as a permanent facility, the other initiatives being temporary summer schemes or dependent on the willingness of local people to keep them going.

Four local experiments in the development of leisure activities, known locally as "Quality of Life" or "Experiments in Leisure Project", were announced in London in 1973. Mobile leisure facilities was a trial in the experiments, of taking leisure to the community rather than making people travel, as transport was a barrier. Hence there were facilities on wheels, such as playbuses in Stoke-on-Trent and Sunderland; the Sunderland Nature Bus (a travelling biology laboratory for school children) and the Dumbarton Arts Bus (a mobile Arts Workshop, Cinema). This approach was often successful in reaching people who could not travel because of age, infirmity or some other disadvantage. Other features were community theatre, community festivals, equipment pools, projects for young people, etc. which were greatly participated in by respondents (A report, 1977).

The study on school leavers, regarding participation on externally based activities undertaken with friends, showed that among 164 boys there were fourteen mentions of swimmings and 8.5 per cent who did the activity and 13 mentions of fishing with 7.9 per cent who did the activity. Ranks eight and ten were given to the activities respectively. Among the

154 girls, seventeen mentions of swimming with eleven per cent who did the activity and one mention of fishing with 0.6 per cent who did the activity. Ranks given in this case were ten and twenty-five respectively (Spry, 1977).

Less et.al., (1980) conducted a neighbourhood-based experiment aimed at finding new ways of meeting the needs of people living in areas of high social deprivation; by bringing together the work of all the social services under the leadership of a special project team and also by tapping the resources of self-help and mutual help which may exist among the people in the neighbourhood.

In most of the small and medium size towns of Pakistan, it was found that financial, transport and recreational services were extremely inadequate, constituting less than one per cent of the total establishments in each town (Siddiqi, 1986).

As can be seen from the above studies, the ones in India are very scarce, while a good many studies on use of recreational facilities and services have been carried out, for probable reasons mentioned earlier. Nevertheless a scrutiny of all the studies conducted abroad and the few in India, reveal, essentially, that distance of the facility from residence, is a very important variable governing its utilization.

Along with this, is the communication variable or mode of reaching the facility or service. If the location of the facility is convenient, families do utilize the facility

optimally. Age of members, education, sex and quality of the facility are also found to be crucial variables in optimum utilization of recreational facilities.