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URBANISATION, URBAN POVERTY AND HEALTH STATUS OF THE URBAN POOR: ISSUES, CHALLENGES AND OPPORTUNITIES

Preeti Yadav
Research Scholar, Department of Sociology, Babasaheb Bhimrao Ambedkar University, Lucknow Vidya Vihar, Raebareli Road, Lucknow

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Abstract:

By 2040-50, urban India will constitute a 50 per cent share in the total population of the country. Though as per 2011 Census the share of the country's urban population to its total is still at 31 per cent, urban India has grown five times since 1961 in terms of population. India is going through a crucial phase of transition, from being predominantly a rural country to one where a majority of the people aspire to live in cities. While the number of people residing in urban India is on the rise, equally alarming is the rise in the number of the urban poor. Standing at no less than 76 million, the burgeoning size of the urban poor cannot be ignored. 13.7 million slum households in India live amidst inadequate amenities, poor health outcome, insecurity as well as unstable incomes. One of the key challenges faced by urban poor is their limited capacity to spend on health care. Overcrowded government hospitals often force them to seek treatment from unlicensed and untrained, yet more affordable private providers. Providing health care right from the pre-natal up to adolescence stage is vital in order to ensure healthy growth and quality of life. In this paper an endeavour has been made to contextualise the health problems and challenges faced by urban poor and solutions are being suggested to combat these problems.

Key Words: Urbanisation, Poverty, Urban Poor & Slums and Health.

Introduction:

One of the dominant concerns of the present age is improving the living conditions of the rapidly increasing population living in cities. According to United Nations (2012) estimates, the world urban population has surpassed rural population. About 52% (3.6 billion) of the world's population live in urban areas. By 2030 nearly 5 billion people will be living in urban areas. Much of this urbanization is predicted to take place in the developing world, with Asia and Africa being the major contributors. Like many other developing countries, India has also experienced rapid urbanization in last few decades. Recent estimates show that about 31% of the Indian population were living in urban areas in 2011, which is almost five times higher than in 1951. Though the level of urbanization in India is low, the country has the second largest urban population in the world with 377 million people living in urban areas and it is expected that 586 million population of the country will be residing in urban areas by 2030.

Accompanying this rapid pace of urbanization has been a faster growth in the population residing in slums. It is estimated that the slums represent the fastest growing segments of the urban population at about 5-6 per cent per annum (Chatterjee, 2002). This is double the growth rate of the overall urban population. Slums are characterized by crowded living conditions, unhygienic surroundings and lack of basic amenities such as garbage disposal facilities, water and sanitation. The near total absence of civic amenities coupled with lack of primary health care services in most of the urban poor settlements have an adverse impact on the health status of its residents. The health of the urban poor is significantly worse off than the rest of the urban population and is often comparable to the health conditions in rural areas (Islam et al., 2006; Montgomery and Hewett, 2005).

This paper analyzes the association between urban poverty and health of the urban poor in India. The health situation among the urban poor is described on the basis of the analysis of the NFHS-2 data. The paper also outlines some of the challenges in improving health outcomes of the urban poor and the potential operational solutions to address such challenges.

Urban Poverty in India:

The poor comprise a large and sizeable proportion of our cities and towns. Using a per capita consumption expenditure approach, the Planning Commission estimates that 26.4 per cent of the urban population or 102.5 million persons is poor (Planning Commission, 2012)1. Over 31 % of the country's population resides in urban areas. Poverty is therefore no longer a rural phenomena today. Haddad et al. (1999) estimated that the urban poor population in India is as high as 90 million. According to the UN-HABITAT estimates, the slum population in India was approximately169 million in 2005 and is projected to increase to 202 million by 2020 (UN-HABITAT, 2006).

Apart from the definition of poor households in urban areas based on consumption expenditure, the census provided an enumeration of persons living in slums for the first time in 2001 in towns having a population of over 50,000. According to the Census all the inhabitants of the areas, which have been notified as slums by the state governments under any legal provisions or even recognized by them, have been accordingly considered as slum population. Further, population living in any compact area of at least 300 population or about 60-70 households of poorly built congested tenements, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities have also been categorized as slums.

The 2011 census enumerated 65 million persons comprising 17% of the total urban population in slums (Office of the Registrar General and Census Commissioner, 2011). A large proportion of slums are illegal and therefore unlisted in official records. Most urban poor reside in unrecognized squatter-settlements, pavements, construction sites and urban fringes and part of the floating population. Therefore, census estimates are a gross under-estimation because they categorize population only in official slums as slum population.

Slum residents are especially vulnerable to health risks. 'Vulnerability' can be defined as a situation where the people are more prone to face negative situations and when there is a higher likelihood of succumbing to the adverse situations (Loughhead et al., 2001). With reference to health, it implies a situation leading to increased morbidity and mortality. Agarwal and Taneja (2005) discuss a number of factors that could increase health vulnerability among the urban poor:

- ✓ Economic conditions: Irregular employment, poor access to fair credit
- ✓ Social conditions: Widespread alcoholism, gender inequity, poor educational status
- ✓ Living environment: Poor access to safe water supply and sanitation facilities, overcrowding, poor housing and insecure land tenure
- ✓ Access and use of public health care services: Lack of access to ICDS and primary health care services, poor quality of health care
- ✓ Hidden/Unlisted slums: Many slums are not notified in official records and remain outside the purview of civic and health services
- ✓ Rapid mobility: Temporary migrants, denied access to health services and other development programmes, difficulty in tracking and providing follow-up health services to recent migrants
- ✓ Health and disease: High prevalence of diarrhoea, fever and cough among children
- ✓ Negotiating capacity: Lack of organized community collective efforts in slums among slum dwellers

Thus, the urban poor are exposed to a number of risk factors which result in poor health outcomes.

Health Status of the Urban Poor:

The rhetoric of urban bias in development and better conditions in urban areas vis-à-vis rural areas has masked the real picture of the health conditions of the urban poor. The commonly available health data which provide aggregate figures for rural and urban areas mask the inequalities which exist within urban areas. In order to unravel the existing intra-urban disparities, data from the NFHS-4 is disaggregated by economic groups. The Standard of Living Index (SLI), an asset based indicator is used to disaggregate health data by low medium and high economic segments within urban areas. In this paper, the figures for low SLI segment of urban population have been taken as representing the 'urban poor'. The remaining two categories of SLI—the medium and high SLI—are representative of the middle and high income groups respectively.

A disaggregation of data by economic status reveals the sharp disparities which exist between the urban poor and the better-off sections in urban areas. In fact, slum dwellers in cities suffer from adverse health conditions which are sometimes worse than those living in rural areas. In this section, we discuss some of the child and maternal health indicators and health care practices among the urban poor.

Utilization and reach of primary health services is poor among urban slum communities in India even though there is physical proximity to advanced health care facilities. Primary health care facilities have not grown in proportion to the explosive growth of urban population especially the poor. Also, the facilities may not be in physical proximity to urban slum clusters. Among the urban poor in India, only 31.1 per cent of mothers receive complete antenatal care i.e. 3 ANC visits, IFA tablets for 3 months and 2 TT injections during pregnancy. About 63 per cent of children are not completely immunized by 1 year of age. However, the percentage of institutional delivery has increased significantly.

Under-nutrition is an important factor contributing to poor health in urban slum communities (Pelletier et al., 1995). About 30 per cent of the India's urban poor children are underweight and/or stunted. In some of the states, under-nutrition among the urban poor is worse than among rural areas. Malnutrition among urban poor children is caused by the synergistic effects of inadequate or improper food intake due to poverty, repeated episodes of parasitic or other childhood diseases such as diarrhoea contributed in part due to poor sanitation and hygiene, and improper care during illness (Ruzicka and Kane, 1985; Pelletier et al., 1995).

Another contributing factor to poor health among the slum dwellers is the low awareness and practice of recommended health practices. Only 42.8 per cent of newborns in urban poor households in India are breastfed within the recommended 1 hour after birth. Moreover, nearly half of the children are not initiated

complementary feeding on time. Based on their observations in Ghana, Edmond and others (2006) emphasize that the longer the delay between birth and the start of breastfeeding, the greater the likelihood that infants will die before they are four weeks old. Other practices among the urban poor such as hygiene, sanitation and utilization of services are sub-optimal. It is therefore essential to change behaviours through frequent and sustained communication and counselling activities.

Challenges in Improving Health of the Urban Poor:

Improving access of health services to the urban poor is a challenge for a variety of reasons. The first and foremost is the rapid growth of slum population which renders the meager health infrastructure inadequate. As most slums are illegal and are on encroached land, they suffer from social exclusion. Providing services to these communities is seen as rendering them legal sanctity and hence they remain outside the purview of services. There is also poor awareness and low demand for health services resulting in poor utilization. Above all, poverty is an overarching factor which intervenes through poor nutrition, compromised ability to seek health care and poor living conditions resulting in poor health outcomes among slum communities. The challenges in improving health conditions of the urban poor is described in this section.

Illegality of Slums and Social Exclusion:

Slums are almost always initially informal settlements with no land tenure rights. The illegal nature of occupied land prevents their inclusion in official slum lists (Ramanathan, 2004). Civic and health services usually do not reach hidden and missing pockets of urban poor that are not a part of official slum lists. Owing to long delays in updating of official slum list in most cities, slums may remain unrecognized for years (Taneja and Agarwal, 2005). Planners and service providers often harbor the perspective that providing service to 'illegal slums' implies giving them legal sanctity. Immunization services scarcely reached non-notified slums while notified slums received benefits of repeated interventions (Agarwal and Taneja, 2005). When infrastructure and services are lacking, urban settlements are amongst the world's most life threatening environments (WHO, 1999). Social exclusion, insecurity relating to land tenancy and lack of basic amenities increase slum dwellers' risk and vulnerability to ill health.

Inadequate and Ineffective Public Sector Health Services:

Most of the urban slum communities are either completely outside the purview of health services or receive very poor quality services. Though health facilities in the private sector have a wide presence in urban areas, they are often not accessible to the poor because of the high cost. The poor are therefore forced to fall back on the unqualified private providers who provide poor quality services. Moreover, these informal providers do not provide preventive health services such as immunization, antenatal care, health education and family planning services as these services do not have any demand and therefore not profitable.

Unclear Accountability and Weak Coordination among Different Stakeholders:

In addition to the limited infrastructure, there is lack of clarity of roles, coordination and accountability for providing services to the urban poor among the various service providers. There exist a number of agencies which are responsible for providing health services in urban areas. These include the health department of the state government, health services of municipal bodies, ICDS, NGOs, charitable organizations etc. There is little coordination between these agencies and often service areas of different agencies overlap while there are large areas where there are no services. There is considerable scope for improving coordination and synergy in the activities of the different agencies by pooling and utilizing resources in a complementary manner.

Poor Environmental Conditions:

Slums are characterized by overcrowding, poor sanitation, access to safe water and garbage disposal facilities. About half of urban poor households do not receive piped water supply and about two-thirds do not have a toilet. Improving sanitation services and safe water supply is an effective health intervention which has shown to reduce the mortality caused by diarrhoeal disease by an average of 65 per cent and related morbidity by 26 per cent (WHO and UNICEF, 2002). This should be given high priority in slums given its poor status and its impact on health outcomes.

Opportunities for Improving Health of the Urban Poor:

As discussed in the previous section there are several challenges in improving the health status of the urban poor, but these challenges are not insurmountable. Several opportunities such as government programmes and increased participation of various stakeholders which can be tapped for improving health of slum communities are discussed in this section. The Government has acknowledged the limited availability as well as substantial under utilization of available primary health care facilities in urban areas along with an overcrowding at secondary and tertiary care centres. Recent policy documents such as the National Health Policy 2017, Urban Health Mission have clearly recognized the shortcomings of the existing health delivery system to effectively address the health needs of the urban poor, particularly the vulnerable slum populations. With the strengthened focus on urban poor several State Governments have started implementing programmes for enhancing health services for slum/other vulnerable urban groups in cities with high slum populations. The prevailing policy environment appears quite responsive to bring the urban health agenda into the forefront of national efforts to ensure health for all.

The number of potential partners in urban areas is also a significant advantage for slum health improvement efforts. These stakeholders include the Health Department, NGOs, private and charitable hospitals which have large presence in urban areas. Corporate houses in urban areas as part of their Corporate Social Responsibility (CSR) activities can contribute and play a key role in efforts at improving health of the urban poor. Unlike rural population which are dispersed and accessibility is a challenge, crowded living conditions of slum dwellers make larger number of people geographically accessible for outreach activities. Decentralization of powers under the 12th Schedule of the 74th Amendment of the Constitution of India is a clear opportunity for improving health services in urban areas. Under this amendment, health services and slum improvement programmes are mandated as functions of Urban Local Bodies (ULBs) and appropriate financial powers were sanctioned to ULBs to carry to these responsibilities. This not only enhances resources available for urban health but also the decision making process involved in managing city health programs is made significantly faster. Slum upgradation and improving access to health care in slums are functions requiring local knowledge and active participation by local communities that can be best handled at the local level, with necessary support from the Central and State Governments. Utilizing the resources and mandate under this amendment, local elected representatives and municipal officers can strengthen health services in their cities. This will help better serve and nurture their constituencies. However, several states have yet to utilize this opportunity to broaden the spectrum of their current interest and activities to include health services to the urban poor.

Approaches to Improve Health of the Urban Poor:

In order to overcome the urban health challenges, there is a need to focus on the "supply" of health services as well as the "demand" side. The private sector has a vast untapped potential which can contribute at improving both supply as well as the demand for health services among the urban poor. The corporate sector can also play a vital role in meeting this challenge with its resources and management capabilities. The approaches to improve the health of the urban poor are discussed below.

Private Public Partnership (PPP):

The health infrastructure for the urban poor is grossly inadequate. It is difficult for the government to upscale its infrastructure rapidly to ensure health services to all the urban poor. Given the large presence of the private sector in providing health services even to the disadvantaged sections, it is imperative that the government partner with this sector to achieve its goal of improving health. Over the last decade there is growing recognition by the government of the need to encourage the private sector to participate in provision of services under different kind of formal arrangements (partnership).

Innovative Urban Health Programming:

Experiences of NGO as well as government run programs have shown that training slum based health volunteers or community based organizations can be an important strategy for improving health of the urban poor. These groups can spread health awareness messages, promote appropriate behaviours, generate demand for health services and facilitate the conduct of health events such as outreach camps. These organized groups can also engage and effectively negotiate with service providers to improve regularity of services in their slums (Barua and Singh, 2003; Islam et al., 2006). It is also imperative that programs involved in slum improvement efforts are backed by sound planning so that they have the desired impact. As discussed earlier in the paper, a large proportion of slums are illegal and therefore do not form part of official records. These slums therefore remain outside the purview of basic civic services. It is therefore necessary to identify and map all slum clusters prior to initiating an urban health program. It has also been observed by several programmes (Agarwal and Taneja, 2005; Loughhead et al., 2001; Falkingham and Namazie, 2002) that all slums are not equally vulnerable to health risks. It is therefore imperative that an assessment of slums is conducted before implementing an urban health program and the most vulnerable slums are targeted. Slum improvement programs must involve local stakeholders including slum communities so that their wisdom, experience and resources are utilized in improving their well-being.

Policy Advocacy and Focus on Energetic Policy Implementation:

Advocacy is a key function to achieve the objective of urban poor friendly policies and also to ensure that the policies are translated into effective programmes that have significant impact on the health of the urban poor. There is a need to sensitize diverse stakeholders such as National and State governments, municipalities, donor agencies, NGOs, media, business houses, academia and other professional bodies such as medical associations. Each stakeholder can play a significant role by chipping in resources and skills to fulfill the objective of improving health of slum communities. Media and civil society can also play an important role in keeping the agenda in the limelight and ensuring effective implementation.

Conclusion:

Rapid urbanization and the concomitant explosive growth of the urban poor have posed several challenges to policy makers and program planners. Poverty can no longer be seen as a rural phenomenon, as a large and rapidly growing section of population in cities live in slums under deplorable conditions. Slum residents suffer from poor health outcomes which is often similar to the rural population and significantly worse off than the urban middle and high income groups. It is imperative that the policy and programmes focus on this

section of this population. Achieving the goals set out in our national health and population policies and those of the Millennium Development Goals (MDGs) is not possible if the health conditions of this large section of our cities are not improved. At the policy level, it is necessary for enhanced attention and resources for improving access of health services to urban slum communities. It is also necessary to ensure that the resources are actually utilized as it is observed that sanctioned fund are not utilized in many programs and schemes. An institutional mechanism is essential to ensure programme focus, fund allocation and specific accountability for effectively addressing the health needs of the urban poor. In order to make health services accessible to the urban poor, it is necessary to augment urban primary health infrastructure. Partnership with the private sector is an effective way to improve access to health services in urban slums. It is also necessary that different agencies which influence the health of the urban poor work in close coordination so that there is better impact of urban improvement programmes. The capacity of health department officers needs to be enhanced so that they are able to tackle the challenging problem of improving access of services to the urban poor and manage new initiatives like public-private partnerships. Migratory trends need to considered while planning for services in slums as a large section of the urban poor are rapidly mobile. There exists vast talent and resources within slum communities. Strengthening community capacity in the form of self help groups will help in improving awareness, demand and utilization of health services.

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