Health of the urban poor

By S.J.Chander, Community Health Cell, Bangalore

27.8% of India's total population lives in urban areas. That means 285 million urban citizens, as many people as there are in the United States totally. Urban India is a study in contrasts: it contributes 60% of the country's national income. There are 4,000 cities and towns in India. About 300 cities have population over 1, 00,000. Seven cities have population more than 3 million

31% of the urban population is poor (Source: Census 2001)
Urban poor in India will be 200 million by 2025

But 76 million urban Indians live below the poverty line, 21% of the urban population lives in slums, and 60% work in the unorganized sector, without any kind of social security***(Source: http://infochangeindia.org/urban_india.jsp)***

However, these estimates do not reflect the true magnitude of urban poverty because of the "un-accounted" for and unrecognized squatter-settlements and other populations residing in inner-city areas, pavements, constructions sites, urban fringes, etc. These places are undoubtedly compromised on health and sanitary conditions. (*Source: Environmental Health Project of USAID)*

Who are the urban poor?

They are day laborers, domestic servants, small service providers, drivers, hairdressers, vendors etc. Some however, work in factories or even as government employees at lower levels with wages that barely meet their needs. Most of them have migrated from villages. They do not go to the nearby towns as they are already saturated with employment opportunities, they go to far of towns and cities.

Most urban poor live on places that are overcrowding with poor sanitary conditions, not mean for human habitation lacking facilities such as water supply, toilet facilities, and place for waste disposal. Some of these places are permanent and others are temporary, (UN Habitat 2003).

Migration and rural poverty accelerating the process of urbanization

"Rural poverty is bad enough, but its problems are compounded when families leave their rural homes to seek a livelihood in overcrowded city slums, leaving behind deep-rooted traditions and ties to the extended family and the village seniors." Shahid Sadruddin Nanavati

Migration is influenced by pattern of development and social structure. The national commission on rural labour reported that uneven development was the main cause of seasonal migration. The migration of rural population to urban areas has made cities densely populated.

"*For India, development programs have been geared towards economic growth (as measured by GNP or per capita income). Once economic growth occurs, the planners believe, it is followed subsequently by many other changes in the areas of demography, stratification, polity, education and family."* (Chandrasekhar 1972; Dandekar and Rath 1971).

There is a huge gap in data on migrants. National data sets, the Census and the National Sample Survey, are inadequate in assessing the problem and therefore in developing plans and executing strategies to deal with it. Micro studies and qualitative data from NGOs, on the other hand, lack the credibility of official statistics as the bases for policy recommendations.

Recommendations

- **Mapping Migration**: Enhance national data collection and pool micro pieces of information from various sources to understand the scale/nature of migration

- **Identity & Entitlements:** Institution of a Migrant Cells, registration and Identity Cards; access to Public Services; cooperation between States/Ministries/Departments.

- **Labour Laws**: Time-bound implementation of minimum wages, social security and maternity entitlements; industry specific new legislations with Tripartite Boards particularly with regards to safety in places of work.

- **Childcare Services**: At worksites/through ICDS; special cadre of childcare workers; adequate budgets under current schemes/new legislations; replace "schemes" with a "per child norm" to allow flexibility; minimum wages to the worker.

- **Education**: SSA to mainstream the migrant child; options like mobile schools, bridge courses, etc. for migrant children; enforcing the law against child marriage as necessary pre-conditions to educating girls; review of the mid-day meal scheme.

- **Promote sustainable rural development which will prevent large number of rural people moving to urban areas.**

Inadequate resource allocation

Urban areas need an annual investment of $59 billion, but investment for all the ten years of the 9th and 10th Five Year Plans was only $57 billion." (Source: "Business line, Internet edition, Tuesday, Nov 29, 2005,) but the 11th five-year plan gives hope. The UPA government has earmarked Rs.500 billion under the National Urban Renewal Mission (NURM) during the 11th five-year plan.

Urban health Challenges

It is estimated that by 2020; about 50 per cent of India's population will be living in cities. This is going to put further pressure on the already strained basic amenities. The rapid growth of cities creates a major concern on infrastructures and basic amenities to make life comfortable both for the rich and poor. ***The urban dwellers continue face more problems such as inadequate housing, water, sanitation, employment opportunities and various pollutions affecting the environment.*** They also become vulnerable to industrial accidents such as Bhopal Union Carbide industry.

Inappropriate services

Needs in urban slums: The health needs of women and children in poor urban areas are comprehensive and include, at a minimum, reproductive health and family planning, diarrhea prevention and treatment, ARI treatment, and combating malnutrition. Source: (USAID-India Urban Health Program)

Govt. of India: We will meet the needs of the urban poor through RCH II

The urban poor: Who said these are our problems?
What we need is not RCH
Water, sanitation, housing, and employment, alcohol free environment

The USAID-India health programme: Water and sanitation belong to the non health sector,
Public health specialist: One of the key determinants of health of the urban poor is water and sanitation.

Goal of the Environmental Health Project by the USAID urban health programme

To improve the health status of the urban poor community by provision of **quality primary health care services** with focus on RCH services to achieve population stabilization.

But in the strategies the focus is only on RCH, Comprehensive Primary Health Care Disappeared, why?

The following are the strategies of the USAID

- Improving access to family welfare (FW) and maternal and child health MCH)

- Improving the quality of family welfare services
- Involving NGOs and the private sector in various aspects of urban primary health care delivery.
- Increasing the demand for family welfare services
- Promoting convergence of efforts among multiple stakeholders,
- Developing effective linkages
- Strengthening monitoring and evaluation mechanisms

National Urban Renewal Mission

Will the mission improve the quality of live of the urban poor?

Why do we say this when the mission's objectives are promising and full of hope with 1000 crorers? The objectives of NURM are to strengthen democratic governance structures and decentralization in urban local government. But the Ministry of Urban Development or the Ministry of Urban Employment and Poverty Alleviation is not clear on how to achieve these objectives.

The process of drafting the mission was highly influenced by corporate interests in real estate, construction, transport and urban services sectors lobbies.

Who formulated this mission?

The entire Mission formulation and related actions have been orchestrated by agencies such as the World Bank and USAID which have a vested interest and long history of promoting neo-liberal developmental policies.

Yes big promises come with big conditionality

What are the conditionaliteies?

Mandatory Reforms for cities wishing to avail of NURM assistance are:

- Drawing up public-private-partnership (PPP) models for development, management and financing of urban infrastructure
- Introduction of independent regulators for urban services
- Rationalization of stamp duty to no more than 5 per cent within five years.
- Repeal of the Urban Land Ceiling and Regulation Act
- Reform of rent control laws to stimulate private investment

Five Optional Reforms are also to be "freely" chosen from a list that includes:

1. VRS Schemes,
2. Non-filling of vacant posts and other administrative reforms
3. Revision of by-laws governing building construction,
4. Site development
5. Simplifying conversion of agricultural land for non-agricultural purposes.

Theses condtionalties will be implemented with the help of tool Model Municipal Law (MML developed by MoUD with the sponsorship of USAID. The Delhi Municipal Corporation has already adopted and brought in changes in building by laws and privatizing water.

Public services without public

In many cities the programme is being planned without the participation of many stakeholders

This Mission has the threat of trapping us under the liberalized, privatized multinational corporations vested interest. If the conditions are allowed, it will undermine the democratic process of achieving health and development. Therefore we should oppose all conditionaliteis.

Determinants of urban health

Poverty

In India, urban poverty is defined in terms of minimum calorie intake, at 2100 calories per capita per day. This is a convenient measure for identifying urban poor for the purpose of implementing Urban Poverty Alleviation Initiatives (UPAIs). The Planning Commission's revised methodology of 1997 results in an average poverty line for India of Rs. 353 per capita per month for 1996-97. This equals approximately Rs. 21,180 per household per annum. On this basis, Planning Commission data indicates that the urban poor were estimated to be 7.5 crores, comprising 38% of the total urban population in 1988. This number rose to 7.63 crores in 1993-94, i.e. 32% of the total urban population. (source:http://www.indiatogether.org/2003/sep/pov-upairev.htm)

Malnutrition

A study by environmentalists from Bombay, Calcutta and Madras shows prevalence of malnutrition to be very high, particularly among the urabn poor. In a 30,00 urban population of Ludhiana, mostly from the slums, it was found over all prevalence of malnutrition, in children under five years to be 67 per cent for males and 69 per cent for females. Further, the analysis of 280 deaths in children aged 1-5 years mostly from urban slums showed that malnutrition was an associated cause in two-third of the deaths.

Overcrowding

The population increased from about 36 crores in 1951 to 103 crores in 2001. This resulted in the per capita availability of agricultural land declining from about an acre in 1951 to 0.4 acre in 2000; and water availability declining from about 6000 cubic meters per capita per annum to 1869 — close to the water scarcity mark of 1700. Foodgrain availability remained more or less stagnant, from about 400 gm per day to 460 gm, which is below the minimum recommended nutritional level of 575 gm. That is one reason why about 47 per cent of our children are

underweight and our infant mortality rate, at 66 per 1000 , is much higher than that of our neighbours — it is 20 in Sri Lanka and 33 in China. When more children die, people tend to produce more.

India's population density of 324 persons per sq km is very high compared to the global density of 45, Asia's 116 and China's 133. With this extent of overcrowding, India's need for population control is obviously more urgent than that of China and other countries.

The policy makers pay inadequate attention to rural development, deteriorating soicio economic conditions in the rural areas force millions of rural poor migrate to urban areas. As a result the existing slums dwellers face the problem of overcrowding in the existing places and new slums are created on place unfit for human habitation. Clogged drains, presence of rodents, lack of facilities for garbage disposal, stagnant water are common seen around the residential areas of the urban poor. Under these conditions the urban poor fall prey to many illnesses such as diarrhoea, dengue, malaira, dysentery, cholera, jaundice and typhoid, which are closely related to poor environmental conditions.

Housing

About 45 per cent % of the people live in the slums of India live in single room tenements. About 50 per cent of houses are made of cement and concrete, while 17 per cent are made of mud and thatch. ***Out of the total housing shortage of 22.4 million units in urban areas, over 80% is the need of weaker sections and low-income group people.*** We must recognize that the poor and low-income groups are important constituents of the city development forces and they through informal sector contribute to the overall economic growth of the city and urban areas through various inputs. One of the critical inputs for housing needs of the weaker sections is access to land and infrastructure on affordable terms. ***(Source:INAUGURAL ADDRESS: By KUMARI SELJA Minister of State (Independent Charge) for Urban Employment & Poverty Alleviation, Government of India at the "NATIONAL CONFERENCE ON HOUSING")***

The following schemes such as NSDP, SJSRY, VAMBAY, Night-Shelter, 2-Million housing scheme, AUWSP, Low-cost sanitation-etc are available from the central government for the urban poor
How easily are these schemes accessed by the poorest of the poor and the neediest?

Resettlement

The UN Commission on Human Rights in its Resolution on Forced Evictions emphasized that, ***"the practice of forced eviction constitutes a gross violation of human rights, in particular, the right to housing. The Commission recognized that, "instances of forced evictions occur in the name of development (and) city beautification programmes" and cautioned; "state parties shall ensure, prior to carrying out any eviction, that all***

feasible alternatives are explored, avoiding or at least minimizing the need to use force and see to it that all the individuals concerned have a right to compensation." (Source: *Editorial: Nowhere to Live - Urban Housing in India,* ***Vol 3 Issue 3 September - October 2004, combat law)***

The Asian Human Rights Commission (AHRC) has received information about case of another forced eviction from West Bengal, India. On 15 December 2003, the West Bengal government and the Kolkata Municipal Corporation jointly carried out a forced eviction along the canal side settlements at the Bagbazar and Cossipore area. About 1,500 families were forcefully evicted without any rehabilitation plan and it is estimated that almost 75,000 people became homeless due to this eviction.

The city of Delhi has its own share of nearly 3.5 million urban poor out of which as estimated 52, 765 people are homeless. 90% of the homeless are productive and through their cheap labour subsidies the cities we live in.

The Working Group on Housing has observed that around 90 per cent of housing shortage pertains to the weaker sections. There is a need to increase the supply of affordable housing to the economically weaker sections and the low-income category through a proper programme of allocation of land, extension of funding assistance, and provision of support services. The problem of the urban shelter less and pavement dwellers has not been given the consideration that is looked for in a welfare or pro-poor polity, as seen from the lack of progress in the programme for the Night Shelter Scheme. (***Source: tenth plan approach on urban development urban housing & urban poverty)***

In Mumbai 80,000 homes were demolished between December 2004 and January 2005, rendering 300,000 people homeless. For majority of those evicted there was no advance notice, the evictions were violently carried out and their belongings damaged. Those evicted were not even offered alternative accommodation. **UN flays India for slum demolition**

While various declarations and commissions emphasizes housing right "The chief minister (Vilasrao Deshmukh) says that these brutal demolitions as the only way to create a world-class city."

Our demands

- **Housing rights for all;**
- **Security of tenure.**
- **Negotiated resettlement instead of forced eviction.**
- **Gender equity, to ensure active inclusion of women in development;**
- **Partnership, as a means to ensure sustainable development through the participation of all protagonists;**
- **Basic amenities and accessibility to work be taken into considered of the place where resettlement is planned.**
- **Land availability to meet the needs of urban poor.**

Water and Sanitation

Water supply and sanitation is the major concern particularly for the poor. It has been reported that inadequate supply and poor quality of service are the major problem. Over all 88 percent have access to potable water supply and the supply is erratic and unreliable. The urban water supply and sanitation sector in the country is suffering from poor quality of service, in adequate level of financial support and technical performance. In many cities, the slum dwellers have to queue for hours to get water from a pipe, where water is only available intermittently and is sometimes shared sometimes by 50 shelters, as is the case in Ahmedabad, India. A study conducted by the Jansahoyg an urban resource centre in Bangalore revealed that 10 out of the 14 samples collected form water source for the urban poor were unfit for consumption.

The urban poor also suffer from inadequate or lack of toilet facilities. In many places more people have to share a single common public toilet, which is poorly maintained. About one third of the population has no access to a lavatory, while another third share a latrine. Water, sanitation and hygiene interventions reduce the occurrence of diarrhoea, skin and eye infection, helminthes, schistosomiasis and dengue, all of which are related to inadequate water and sanitation services.

Healthcare facilities

Urban areas are flooded with hospitals, nursing homes and clinic of various type and size. They belong to both the public and private sector from multi storied posh corporate building, old building belonging to the government, and single room clinic by a private practitioner. These institutions would continue to thrive as the environment and living conditions deteriorates. Both the urban poor and rich fall prey to this situation but the poor are worst affected. While the affluent fill these institutions as result of certain life style including over consumption of food the poor struggle to lead life with dignity due lack of basic amenities. The present health care facilities available for urban poor are family welfare and family planning focused which should move towards a comprehensive primary health care, enabling people to take care of their own health not merely providing some services

The government of India appointed the Krishnan Committee in 1982 to address the problems of urban health. The health post scheme was devised for urban areas based on the recommendations of the Krishnan Committee. Its report specifically outlines which services have to be provided by the health post (pp 9-11). These services have been divided into outreach, preventive, family planning, curative, support (referral) services and reporting and record keeping. Outreach services include population education, motivation for family planning, and health education. In the present context, very few outreach services are being provided to urban slums.

The health post (HP) scheme was launched in 1983-84. A deputy director and joint director were assigned to urban health, but functioned chiefly to promote family planning goals [Verma and Bhende 1986]. In recent tiems the health planner propses one primary health centte for 100000 population. This is agians the Krishan committee reprot which said one center for every 50000 population.

The 3,600 odd cities and towns of India with some 40 million people living in slums have to depend largely on private practitioners (mostly quacks) for their health care needs. Out of the 3,000 plus urban local bodies in India only about 100 have been some semblance to a health care service while the rest have only a sanitary inspector or even a lower functionary to look after the health care system.
Sorcce:http://www.hansis.net/international/information/healtharticles/index.php

The national health policy 2002 recognizes that “In most urban areas, public health services are very meager. To the extent that such services exist, there is no uniform organizational structure. The urban population in the country is presently as high as 30 percent and is likely to go up to around 33 percent by 2010. The bulk of the increase is likely to take place through migration, resulting in slums without any infrastructure support. Even the meager public health services which are available do not percolate to such unplanned habitations, forcing people to avail of private health care through out-of-pocket expenditure.”

Alcohol and tobacco free environment.

Tobacco kills over 9 lakhs people in India and 70% of the deaths are due to alchol consumption takes place in India. Both the susstance have devastating effefcts on the family and nation. Both these substance have have a very strong lobbies that backs their exisitence. Addciton to subsstance rob the famlies of the limited resoruces that are availabel for leading a life belowe dignity. Young peoles lives are paralysed at their peak prodctive phase. Addiciotn to these substances takes place at a very young age. Both the substances have powerful lobbies that supports its aggressive marketing startegies by targeting children. Govt should take measures to check the grwoing trend by intiatiing approriate leg and social aciton. Easy acces of these substance to children and adolescent must be checked strictly. Most imporatntly leagal measeures must be framed to check both the deamn and supply and implemnted effectively.

We demand aggressitve marketting of these substance among the urban poor be stopped instead the uraban poor must be supported with recreational facilities. Progarmmes such as life skills eduaction promoted by the UNICEF must be condcuted for the urban adolescent boy and girls and yourt so that they could mange their lives without becoming dependant on alcohol or tobacco.

In the light of the above concerns, we demand

- Adequate attention is given to rural development so that the rural popluation do not migrate to urabn areas for livelyhood.

- When the rural poor are brought to urabn areas by the contractors of the construction industry, ensure basic necessties are not comopromised. Formulate standards of habitation that will ensure basiec ameneties sucah as housing, water and sanitation.

- Wherever slums/informal settlements are classified as Tenable, the ULB must facilitate the granting of tenure on all government occupied land and initiate acquisition proceedings and/ or negotiations on all privately occupied land in accordance with Section C.5 of the Draft ASlum Policy

- Recognize the slums that are in exisitence for more than

- There is a need to increase the urban infrastructure for health at all levels including big cities and small towns to cope with the growing urban population.
- Posts need to be created at various levels within the health department to ensure coordination, monitoring and review of all municipal bodies;
- All health posts should provide outreach services to slum and slum-like areas through the ANM and MPW;
- The recommendation of the Krishnan committee for a community health worker for population of 2,000 should be put into place;
- Ward committees should monitor and demand primary healthcare services from the health post system;
- There should be an intersectoral committee for public health for all municipal bodies;
- The provision of basic amenities for slum and slum like populations is required;
- Special provisions should be made for providing health services to pavement dwellers and temporary settlements;

- New guidelines on the role and functioning of the health post system in view of an integrated and decentralised primary healthcare programme need to be developed and implemented uniformly across all the municipal bodies in the state; There needs to be integration of all vertical programmes (such as TB, malaria, HIV/AIDs) with the primary healthcare system in urban areas.