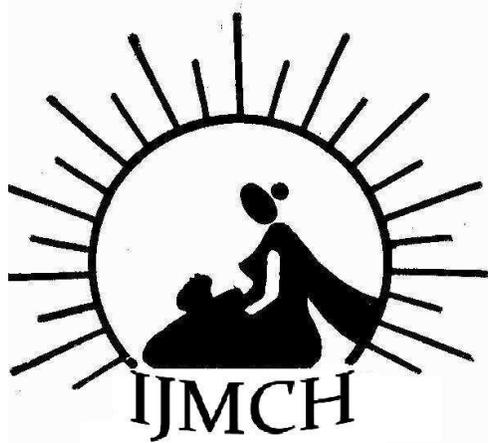


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NEHA MADHIWALLA

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QUEST EDITORIAL

Healthcare in Urban Slums in India*

NEHA MADHIWALLA

Centre for Studies in Ethics and Rights

Mumbai

Maharashtra, India

Contact : nmadhiwala@gmail.com

The growth of cities has always been accompanied by the growth of slums. The industrial revolution in western Europe led to the migration of people to slums in cities, which created new conditions of ill health due to overcrowding, poor housing and unsanitary environment, coupled with poverty (1). While public health crises were not unknown in earlier times, the institutions of family and church were primarily responsible for care and relief. Urbanization broke down those traditional family and community structures and the working class in particular was pushed to the brink of destitution in a crisis such as an epidemic or a natural calamity. It was left to the state (primarily the political and administrative wings) to become the moral 'parent' of the poor. As a part of this role, the health of the urban poor became a subject of enquiry for administrators and planners in the mid-nineteenth century. In India too, when large-scale urbanization took place after the First World War, the decades of the 1920s to the 1940s saw an upsurge of research in urban health. These studies were particularly notable for the exploration of the link between poverty, living conditions and ill health. (2–4)

Ironically, although a substantial proportion of the research on poverty and health emerged from cities in the pre-Independence era, urban health was not at the focus of public health practice in the years after Independence. India was viewed as a largely rural society and, thus, the government's conception of primary healthcare was almost entirely rural oriented. This bias was also not corrected by the voluntary community health movement, which too focused on the problems of providing primary healthcare to the rural poor. (5) With rapid urbanization, as in most developing countries, public health problems in India are increasingly assuming an urban dimension. In the 2001 Census, 27.8% of the population was found to be living in urban areas. Between 1991 and 2001, 14.3 million people were added to the urban population due to migration. In cities with a population over a million, nearly one-fourth (24.1%) of the population was residing in slums (6). The recent National Sample Survey also indicates that the proportion of the population living below the poverty line in rural and urban areas equalized in 2004–05. In each, it is estimated that about 22% of the population lives below the poverty line. It has been observed that the decline in poverty has been lower in urban compared with rural areas. (7) Understanding public health needs in urban areas requires a different conceptual framework. Traditionally, it is understood that alleviation of poverty is the most important precursor of improving general health. But in urban areas, the marginal increase in income for the poor, in itself, does not assure better living conditions due to wide disparities, which make decent accommodation, and clean water and air unaffordable. Moreover, certain necessities, which existed as free goods in rural settings, are commodities in urban areas such as drinking water, cooking fuel, housing

space, etc. The poor are typically driven to the margins of the urban space, where living conditions are the most degraded and of little economic value. The relative difference in income and wealth is much starker in urban areas. The higher purchasing power of the rich drives up the prices of food and healthcare goods, making them unaffordable to the poor. The rich also consume more than their fair share of public goods, for example, water, infrastructure, electricity, which are often subsidized by the state. Urban policies and laws look upon migration (particularly of the poor) as the root of the problem. They respond by imposing penalties on the poor in different ways, such as by denying them the right to housing, refusing them a ration card or neglecting to create adequate infrastructure for their use. As a result, slums become the focal points of punitive action, which aggravates the deprivation caused by economic uncertainty faced by those dependent on casual wage labour. A study found high levels of malnutrition among children below 5 years of age in Mumbai, and the levels of stunting, which is an indicator of long term chronic malnutrition, were almost similar in the sample of the urban poor children as in a sample of tribal children taken from the poverty-stricken Jawhar *taluka* in neighboring Thane district. This study found that while 17.6% of boys were stunted in urban slums, the figure was 17.8% for the sample of tribal boys in the same age group. The study concluded that the high levels of stunting in urban areas were not related to food scarcity, but to environmental and social factors such as access to healthcare, clean drinking water, repeated childhood infections, mother's nutrition and her ability to breastfeed. This was related to the uncertain availability of casual wage employment, especially for women (8). A review of studies on the situation of reproductive and child health in urban areas noted that there were consistent differences in antenatal care (ANC) coverage between slum and non-slum areas. While 74% of women in non-slum areas received 3 or more ANC check-ups, only 55% of the women in slums did. This study also found that 27% of infants in slums had a low birth weight compared with 18% of those born in non-slum areas. In addition, there were significant differences in health access among those living in 'recognized' and 'unrecognized' slums. (In Maharashtra, as per the slum rehabilitation policy, slum households which can prove residence before 1 January 1995 are 'recognized'.) While 78% of women living in the former had an institutional delivery, this figure was only 65% for the latter. While 81% of children in recognized slums received 3 doses of DPT, only 67% of those in unrecognized slums were fully immunized against DPT. (9)

Poverty and other forms of social disadvantage translate into poorer health status and outcomes for the urban poor. There is a need for a comprehensive policy for primary healthcare for urban areas, which takes into account the special concerns of the poor.

Such a policy would aim, first, to address the absolute deprivation of basic necessities—food, housing, water supply and sanitation that the urban poor experience. Second, there is a need to create an adequate and functional network of free services that are nondiscriminatory and reach out to all sections of the population. Finally, an urban health policy would need to address the problem of social inequality in a proactive manner. The urban poor will continue to depend on the market, not merely for healthcare but for all aspects of daily life, including employment and survival needs. The state must recognize its obligation to protect the poor against the vagaries of the market, because of which they are exploited or driven out by the overwhelming influence of the rich.

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