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Urbanization, Urban Poverty and Health of the Urban Poor: Status, Challenges and the Way Forward

Introduction

ONE of the dominant concerns of the present age is the improving the living conditions of the rapidly increasing population living in cities. For the first time in human history beginning 2007, more than half of the world's population will live in cities (Sclar *et al*., 2005). Estimates by the United Nations suggest that the world's urban population has been increasing at a rate of 1.8 per cent annually and will soon outpace the overall world population growth rate of 1 per cent (United Nations, 2005). Nearly 48 per cent of the world's population lives in urban areas and the prime locus of this spurt in city dwellers are the developing countries such as India (Sclar *et al*., 2005; United Nations, 2005).

India, as the rest of the developing world, is urbanizing rapidly. 27.8 per cent of the country's population comprising 285.4 million people, live in urban areas (see Fig. 1). India's urban population grew by 31.2 per cent during the decade 1991-2001 which is significantly higher than the rural rate of 17.9 per cent. During this preceding decade, the urban population increased by 68 million persons. Population projections by the United Nations indicate that by 2030, India's urban population will grow to 538 million with more than half of the total population living in urban areas (United Nations, 2005). 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

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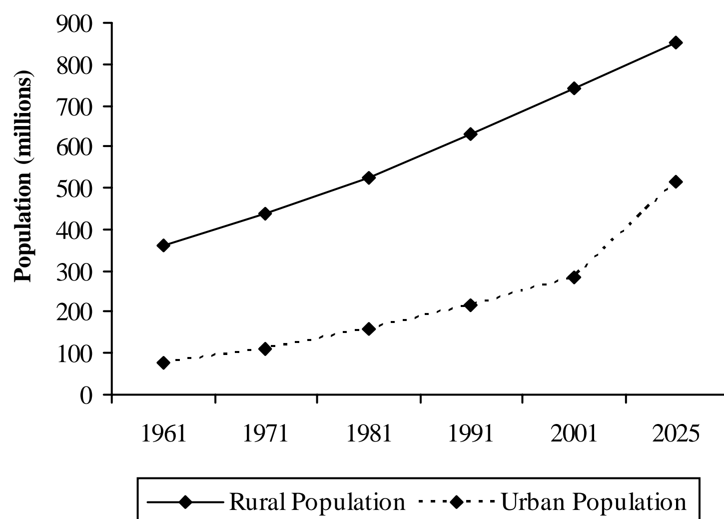

Fig. 1. Trends in urbanization in India

TABLE 1: SHARE OF URBAN POPULATION IN INDIA

Year	*Number of towns*	*Urban population (in million)*	*Per cent (urban)*
1901	1916	25.9	10.8
1911	1908	25.9	10.3
1921	2048	28.1	11.2
1931	2220	33.5	12.0
1941	2422	44.2	13.8
1951	3060	62.4	17.3
1961	2700	78.9	18.0
1971	3126	109.1	19.9
1981	4029	159.5	23.3
1991	4689	217.6	25.7
2001	5161	285.4	27.8

Source : Office of the Registrar General & Census Commissioner, 2001.

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 by economic status. 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 23.6 per cent of the urban population or 67 million persons is poor (Planning Commission, 2001)[1]. Over a fourth (25.7 per cent) 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 as per the Census of 1991. 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 2001 census enumerated 40.3 million persons comprising 22.6% of the total urban population in slums (Office of the Registrar General and Census Commissioner, 2005). As the census enumerated slum population only in cities/towns having population of 50,000 and above as per 1991 census and further only in registered slum settlements, the enumerated slum population in the country can be safely considered to be an underestimate. This can be substantiated by the fact that 6 states and union territories did not report slum population. 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 which are summarized as follows (see Box 1):

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[1] Poverty reflects the inability of an individual to satisfy certain basic minimum needs for a sustained, healthy and a reasonably productive living. The Planning Commission uses a minimum consumption expenditure, anchored in an average (food) energy adequacy norm of 2400 and 2100 kilo calories per capita per day to define State specific poverty lines, separately for rural and urban areas. These poverty lines are then applied on the NSSO's household consumer expenditure distributions to estimate the proportion and number of poor.

Box 1: Factors and Situation Affecting Health Vulnerability in Slums

Factors	*Situation affecting Health Vulnerability in Slums*
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 heath 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 diarrhea, 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 1998-99 NFHS-2 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 24.8 per cent of mothers receive complete antenatal care (3 ANC visits, IFA tablets for 3 months and 2 TT injections) during pregnancy. As high as 74.3 per cent deliveries among the urban poor women are home deliveries (see Fig. 2) and about 42.9 per cent of children are not completely immunized by 1 year of age (see Fig. 3).

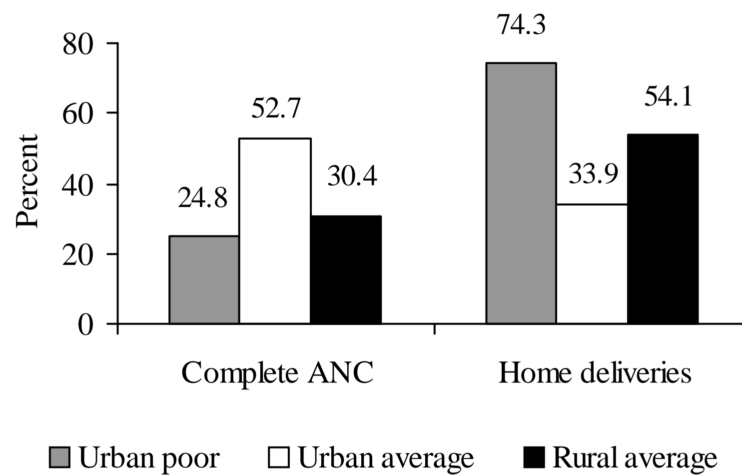

Fig. 2. Antenatal care and place of delivery by economic groups in urban and rural areas

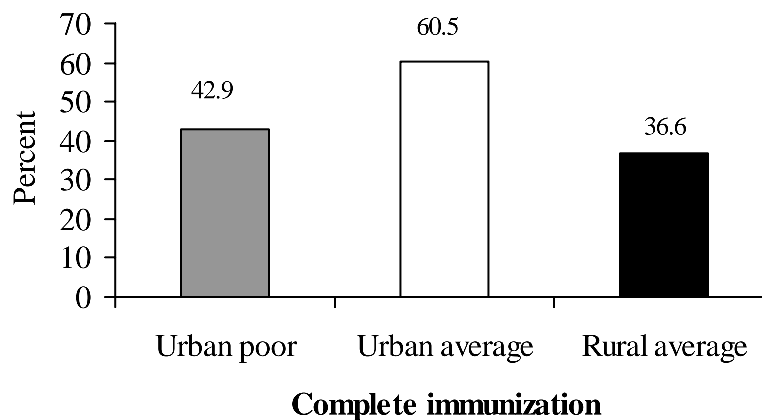

Fig. 3. Immunization status among children 12-23 months by economic groups in urban and rural areas

Under-nutrition is an important factor contributing to poor health in urban slum communities (Pelletier *et al.*, 1995). More than half of India's urban poor children are underweight and/or stunted. In most states, under-nutrition among the urban poor is worse than among rural areas (see Fig. 4). 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 diarrhea contributed in part due to poor sanitation and hygiene, and improper care during illness (Ruzicka and Kane, 1985; Pelletier *et al.*, 1995).

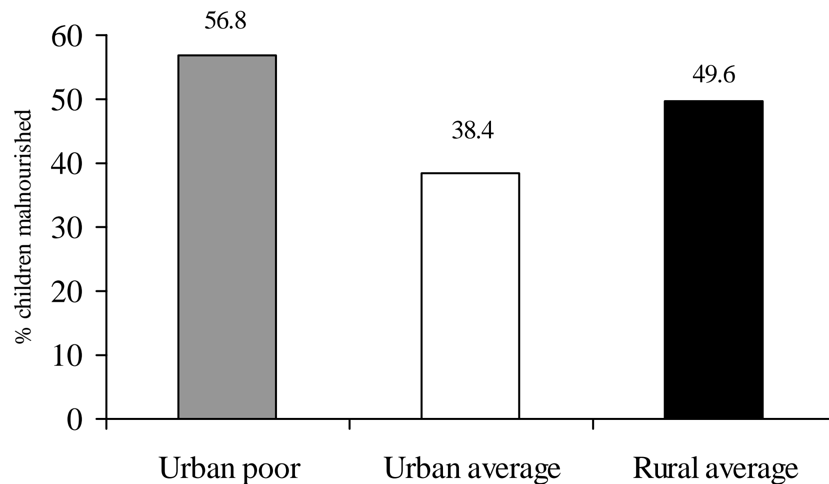

Fig. 4. Nutritional status of urban poor children 0-3 years by economic groups in urban and rural areas

Another contributing factor to poor health among the slum dwellers is the low awareness and practice of recommended health practices. Only 18 per cent of newborns in urban poor households in India are breastfed within the recommended 1 hour after birth. Moreover, nearly 40 per cent of children are not initiated complementary feeding on time (see Fig. 5). 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 counseling activities.

The above factors of poor access to services, poor health behaviours and nutritional status among the urban poor result in high infant and child mortality which are considerably higher among the urban poor as compared to national and state averages (see Fig. 6). As seen from the figure, one in ten children do not live to the age of five among urban slum communities in India.

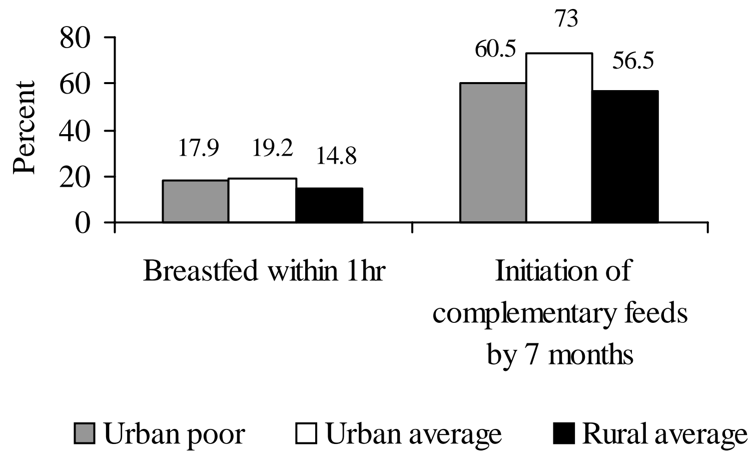

Fig. 5. Infant feeding practices by economic groups in urban and rural areas

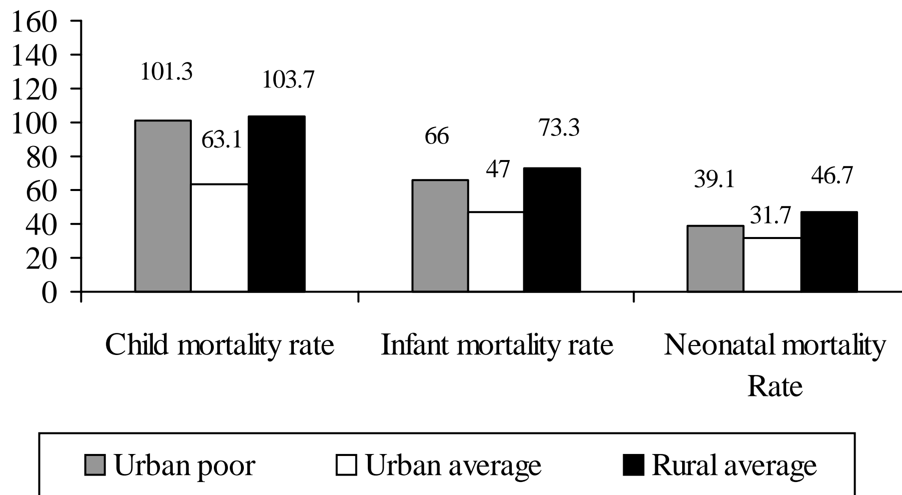

Fig. 6. Neonatal, infant and child mortality rates by economic groups in urban and rural areas

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). For instance, in Agra city, as per the list of Department of Urban Development Authority (DUDA), there were 215 slums with an estimated population of 3 lakhs. The identification and mapping of slums in Agra by Urban Health Resource Centre (UHRC), in 2004 for formulating a strategy to improve health services in the city, identified 393 slums with a population of approximately 8 lakhs (Government of Uttar Pradesh, 2004). Similarly, assessments in other cities have revealed a large number of unlisted slums (see Table 2).

TABLE 2

City	*Slums on Official List*	*Unlisted Slums*
Agra	215	718
Dehradun	78	28
Bally	75	45
Jamshedpur	84	77
	452	328

Source : Office of the Registrar General & Census Commissioner, 2001.

Planners and service providers often harbor the perspective that providing service to ‘illegal slums’ implies giving them legal sanctity. For example, in Indore, 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

Unlike rural areas which have a dedicated primary health infrastructure, such structure is absent in urban areas. Moreover the rapidly growing urban population especially of the urban poor renders the already scarce urban health infrastructure further inadequate. One primary health care facility in an urban area caters to a much higher population compared to the norm of 1 center for every 50,000 population (Shekhar and Ram, 2005). Taking the

urban population of 285 million and a total of 1529 Urban Family Welfare Centers/Urban Health Posts operational in the country, the population served per health facility works out to 1,86,369. Thus, most of the urban slum communities are either completely outside the purview of health services or receive very poor quality services. Through the World Bank funded India Population Project (IPP-VIII) (1993 to 2002) 531 new facilities were constructed and 661 facilities were upgraded/renovated in Bangalore, Delhi, Hyderabad and Kolkata (Institute for Research in Medical Statistics, 2003). Such systematic efforts of urban health programming focused at slum dwellers have remained limited to few cities.

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.

Weak Linkages between Slum Communities and Service Providers and Low Demand for Services

An important barrier to improving health of the urban poor is the poor linkages between slum communities and health providers. Residents of slums have limited knowledge on appropriate health behaviours and they are likely to be unaware of the location and services provided in health facilities, out-reach visits of health workers etc. This results in poor demand and utilization of health services. As a significant proportion of the urban poor are recent or temporary migrants with little social support, the situation of poor knowledge about services and therefore poor demand is therefore exacerbated. Similarly, from the providers' perspective health service delivery in slums is an enormous challenge given the large and rapidly mobile population.

Greater Focus on Rural Poverty

Poverty reduction initiatives and programmes in India have largely shown a rural bias (NIUA, 1998). This has resulted in most attention being paid to rural poverty while the poor

in urban areas have been neglected or at best provided passing reference in government policies and programmes. The relative neglect of urban poverty is reflected by the fact that the flagship health programme of the Government of India is called the National Rural Health Mission. Though the mission has a sub-component for urban areas, the rural focus is clearly evident. This is inspite of the fact that the urban poor comprise one-fourth of the total poor persons of India and as discussed earlier in this paper, the health conditions of the urban poor are comparable to the rural population.

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 over-crowding at secondary and tertiary care centres. Recent policy documents such as the National Population Policy (NPP) (Government of India, 2000), National Health Policy (NHP) (Government of India, 2002), Tenth Five year Plan (Planning Commission, 2002) and the second phase of the Reproductive and Child Health Programme (RCH II) 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 in RCH II, several State Governments have started implementing programmes for enhancing RCH 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 recently launched National Rural Heath Mission (NRHM) (2005-2012) has a section on urban health a task force has been constituted to frame appropriate strategies for urban health care under this Mission.

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)

As discussed earlier, 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).

The National Population Policy 2000 (NPP) lists partnership with NGOs as one of the strategic themes. The experiences of India Population Project VIII (IPP) in urban health programmes in Bangalore, Chennai and Delhi and several other such initiatives reveal that partnership with NGOs can rapidly expand health services to previously underserved slums. Moreover, through these partnerships better quality of services could be provided to the slum populations in these cities.

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). Experiences from NGO programmes such as Apnalaya in Mumbai and Urban Health Resource Centre in Indore and government programmes such as the World Bank funded IPP VIII in West Bengal and Delhi have demonstrated the potential of capable community volunteers and organizations in improving health of slum communities (Duza *et al.,* 2003; Taneja and Agarwal, 2003). These innovative approaches have indeed resulted in better health outcomes in some of the cities.

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 Eergetic 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 has posed several challenges to policy makers and program planners. Poverty can no longer be seen as a rural phenomena 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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