Defining the Urban

In India an official definition of the term urban by Census is: over 5000 population; a population density of over 400 persons per sq km; over 75% of male workforce in non-primary activities.

According to the 2011 census, 30% of India’s population lives in urban areas.

Visible Differences Between the Urban and the Rural

What would be the specific features of the urban that are immediately visible? Roads are relatively better, there is some drainage system that may or may not work very well. Some form of systematic centralized water supply occurs, badly or well, depending on availability. Often private suppliers make money in areas with water scarcity. Buses, trains, auto-rickshaws, cars, planes all may be part of the transportation system. Institutions like schools, hospitals, government offices are widespread. Physical access to essential services like health care and education is easier. Communication through phones or internet is much easier though in recent times the advent of mobiles have made things a little easier for the rural population.

Life in a city in India today is congested and unpleasant.

One characteristic aspect of the city is anonymity. It is possible to spend a whole day in a big city without encountering someone you know. It gives some privacy in the most public spaces, and at the same time it results in few social contacts that can be called on in times of urgent need.

The thing to notice is that the urban is automatically imagined in opposition to the rural. Without the idea that something is rural, the idea of the urban wouldn’t exist. In many ways, from the urban perspective, the rural is the opposite of the urban. It is less congested, has fewer job opportunities, it lacks robust transport and communication systems, and there is no “privacy”.

The Spread Between the Urban and the Rural

The opposition between the rural and the urban is an abstraction. In fact, there are over 5000 intermediate towns and 53 cities (with a million plus population). The metropolitan cities are six in number, and the broad details discussed here are largely with respect to these metropolises.

There is much literature on the growth and the weakness of small towns in India, and the existence or lack of dynamism in them. This is a picture that is too complex for a short paper of this type. However, we will broadly outline some differences with respect to smaller towns wherever we find ourselves competent to comment.

Urban and Rural: Economic Relationship at First Sight

It is a commonplace that the urban provides more avenues of employment given the intensity of agrarian distress in the rural economy – manifest as landlessness, lack of non-farm employment and the growth of mechanized agriculture. In contrast, urban employment options appear to be aplenty: white collar, blue collar, informal labour, self employed small businesses, delivery jobs, upkeep services of all kinds, rag picking, drainage cleaning, selling toys at street corners, watchmen, domestic work, sex work, collection agents for money lenders, strongman, etc. This differential has been theorized as the ‘urban advantage’ – which in the scenario we describe seems a misnomer for the complex survival tradeoffs that migrants make (See Rahul’s contribution in this volume).

Yet, employment is often not tempting enough to make the rural population migrate lock, stock and barrel. There are economic ties to the village that remain a means to survival. Most important is food. “In my childhood”, (Prabir Chatterjee says) “grain
would come from my village to the town I lived in every year. Even today, bags of rice come from the village to youth and migrant families to mitigate the cost of living. Many people like ‘D’ of SHRC, Chattisgarh, live and farm in the village while using the cash from their salary to dig wells or buy seed or insecticide”.

This fluctuating availability of different forms of labour opportunity results in a cyclical migration pattern where individuals migrate to the city on a seasonal basis, coming in for the available informal employment avenues, and returning during harvests, times of distress or to add to income using the NREGA as an opportunity (see Mithun Som’s contribution in this volume).

Yet, there is a desire among rural individuals and communities to come to the city for a better future. This leads to different kinds of migratory patterns, through family, community, occupation, caste, etc.

Broadly speaking, urban agrarian distress has been recognized as the covert engine of large scale migration to urban areas.

**The Desire for the Urban, the Desire of the Urban**

In spite of the extremely difficult life in the city, the desire for the urban is strong and nearly universal among the rural young. Wave upon wave of youth arrives at the city. While some youngsters succeed, many are marooned between an impossible dream that cannot be achieved and a life left in the village that cannot be fully returned to.

This unending desire is based on many perceptions. One, media, advertising, movies and television programmes promise a dream life in the city. The freedom, anonymity and individualism in urban areas are in sharp contrast to the community constraint, constant recognition and submission that is experienced in traditional village communities. This desire is also set against an experience of social discrimination in an atmosphere of fully visible, known, community and caste relationships. The perception of rural discrimination is strengthened by dalit and oppressed caste movements and history. Further, those who come back to a village after a stint in the cities with their different clothing, increased confidence and liberatory ideas also lure more youth to the cities.

On the other hand, the urban dreams of the rural, its wide spaces, its idyllic life and peace. This dream is most vivid in cinema through the 1960s and 1970s. This is a romantic view that also draws upon a political history of praising the village and its resistance to the evils of modernity.

For women, the urban opens out a new dimension of existence. The relative weakening of extended and joint family structures makes the urban space seem both more risky and free. The anonymity permits latitude of conduct that is wider than in the more closely supervised rural context. There is a constant necessity to go beyond the confines of the home in the urban context of an overcrowded public life. New relationships open out different worlds to women’s experience of gender and its forms of freedom and inequity. (In rural areas, women who don’t belong to the upper caste and class are seldom trapped at home. They have to go out on farm related activities, fetching water, taking care of cattle, bathing, etc. The difference is that rural women move in familiar territory whereas the urban women have to learn to deal with unfamiliar territory, strangers and public transport).

The small town provides a stepping stone for educated youth, in that their first step of college education usually takes place there. It is after the preparatory step of the small town that the major migratory step of the educated classes to the city takes place.

The town is also a place where the traditional power politics of the village clashes with the more democratic political imagination of a city. The first steps of politicization after the Tsunduru massacre in Andhra Pradesh (1991) took place in the town of Tenali after which intervention through civil liberties, legal and political bodies from cities like Guntur, Vijayawada and Hyderabad became possible.

**Urban and Rural Economy: Deeper Structural Relationships**

In modern India post independence, industrialization, the development of core industries like steel plants, fertilizer, cement, power stations, dams, machine tools, heavy equipment, etc., have been priority. They were the thrust areas of modernization, i.e., of urbanization and capitalist development. Rural and agricultural development was intended to provide cheap food for urban labour in national industries without losing self sufficiency in food production. Thus, for the first three decades the economy of rural India was planned by an administration that was essentially urban in its composition.

All forms of planned development in the rural areas such as development blocks, intensive agriculture areas, green revolution zones, etc., transformed the rural economy beyond recognition in the states in which they were implemented. Yet social change was slow to follow. To put it another way, the already uneven transformation of the rural economy was geared not to disturb existing relations of social dominance and oppression.

After the eighties, with liberalization, the erstwhile support for agriculture was gradually withdrawn, with fertilizer subsidies, grain purchase prices, stockpiling of grain coming under criticism from structural adjustment and neoliberalism. Decline
in rural bank branches and of agricultural credit resulted in increasing reliance on informal sources. Increasing health care and education costs also put people in debt. In this situation of distress, migration intensified, in turn vitiating scope for any sustainable livelihood in the rural areas. More and more villages in different parts of India are being abandoned, with people moving to the cities. Even more have mobile populations trying to eke an existence through a combination of survival strategies in both rural and urban areas.

Urban areas as economic and social spaces too have undergone a transformation. With neoliberalism, labour laws have been diluted. The influence and fervor of trade unions have become faint memories, eclipsed by the pervasiveness of contractualised, ad hoc labour arrangements. As the labour manager of the Jindal Steel Plant in Karnataka put it, by the early 2000s, their ‘philosophy’ was to use informal labour – to be precise, 30,000 informal labourers ‘clothed’ in rags brought in by trucks to the plant every day! This trend is also seen in government and public sector units where informal workers now dominate the lower cadres. Informal labour drives the worker to frantic extremes, forcing him/her to work long hours for a pittance, with complete lack of any legal protection or even any identity as belonging to the factory. Cash wages less debt repayments is the norm.

In relation to both caste and gender, new structural relationships have begun to emerge. Traditional caste patriarchy urbanizes itself as it struggles to keep control of the mobility of both women and dalits (e.g., medieval curfew timings in women students’ hostels, a ‘natural’ shepherding of dalit men toward menial jobs). In addition, urban public labour requires a modern, industrial discipline and evolves new codes of conduct and forms of power.

The continued invisibility of unpaid labour vexes further the roles women play in the care economy in urban areas – their roles variably intermingled, replaced, challenged, and complemented with those in other class, caste, religious and occupational categories. Take for instance, four connected women: one is a mother who leaves her child in her mother’s care, to care for the child of a professional nurse providing care to the elderly mother of a daughter who has forsaken being a mother for her career. These relationships and roles affect how women see themselves, each other, and understand their position and possible role in the world.

The contradictions of the rural and the urban in relation to caste and gender express their ugliest manifestations in the professions that relate to urban households: servants, cooks, drivers, etc. Verbal and sometimes physical abuse, subtle insult, everyday discrimination, sexual harassment and public humiliation are often the common language in the domain of the private – all this over and above a subsistence wage. The upwardly mobile middle classes plant their feet squarely on caste advantage to make the maximum of an urban life while paying a pittance to workers who take on domestic drudgery.

So while the urban dream is fostered and remembered with some fondness, the city becomes a space of ambivalent promise and struggle, deeply rooted in the emerging capitalist structure of the nation state.

It is in this broadly emerging scenario that we have to understand the recent idea of ‘smart cities’ in India. Clearly the idea is intended to provide structured markets for capital through streamlining and beautification of cities from the perspective of the better off. What does this mean for the lives of the dispossessed and expropriated? What does ‘smart’ mean? Do we rather not need ‘wise and humane’ cities?

The Other of the smart city is the much reviled municipal corporation that is expected to run and maintain the city today. These corporations struggle under budgetary constraints, administrative corruption through land mafia and real estate pressure, and in addition suffer a definite dimension of ‘untouchability’ that comes from their involvement in the often polluting task of keeping the cities clean and healthy. The political impasse for the poor arises between the barely functioning municipal corporations and the spectre of the smart city managements that threaten to replace them.

Urban Health

Urban health is a non-concept for the poor; it is only ill-health that surfaces rudely in the form of an emergency or catastrophe. The more common and regular concerns are around livelihood, which of course determines health in critical ways. Unsteady employment, self-employment and hidden unemployment lead to inadequate wages. The legal minimum wage is not adhered to. This leads to inadequate food and poorly balanced, unhealthy diets. Cramped and exorbitantly priced living spaces, dismal sanitation and unhygienic drinking water supply add to the risk. Savings are minimal, and informal daily wage labour makes any discontinuity economically crippling. Yet the cyclical pattern of migration to garner a livelihood and meet obligations make it difficult for these individuals to claim governmental benefits on the basis of identity documents, employee records, ration cards, etc.

In addition, the urban poor are also prey to instability and survival risk due to disasters, epidemics and conflict.

Minor illnesses like coughs, fatigue and inadequate bodily energy become chronic. The body’s immune systems weaken, and tip the unfortunate over into disease – tuberculosis, infections of the gut, etc.
Accidents due to increasing traffic, disadvantageous living and transport conditions (like overcrowded buses and trains) also occur. The toll of worsening transport, pollution and fatigue on the body and mind cannot be overestimated.

Work in hazardous locations either as self employment (rag picking) with no scope of protection or in industries (metal plating, chemical, explosive) with criminal neglect on the part of employers adds to the heavy overload of risk. The heartlessness of employers in the drive for more profits is doubtless related to caste arrogance and a callous contempt for the working classes.

The double load of household and paid labour outside on the one hand, and the characteristic self-sacrifice in food and well being on the other haunt and take their toll on married women in urban working classes.

Then the catastrophe that was waiting in the wings happens – illness, serious chronic conditions, accident – and access to a livelihood is threatened.

The highly excluded in urban areas – such as the destitute, face a unique toll, exposed to the physical and social brutality of cities and towns, living open to the elements and on the fringes of legality, the threat of violence, injury, insult, and exploitation. The toll of mental illness and substance abuse is high, just as the predictability of services and support – usually in the form of charity – is low.

**Medical Treatment**

At some point (often of desperation and last recourse), the urban-dweller seeks health care. A majority of the workforce isn’t covered by the Employees State Insurance (ESI) scheme. Those who are may find that the employer hasn’t paid the ESI share he was supposed to pay. However, it is the worker who is penalized through a lack of treatment at her most vulnerable moment. She finds that government hospitals treat her illness, but also treat her badly. She is abused, discriminated against and regarded as an unavoidable nuisance by many of the employees of the government health system.

The person finds that private hospitals often charge a fortune for tests, scans, to cure an illness that he can’t understand. Everything costs money, which leads either straight to a debt trap, or to the complete pauperization through the sale of meager assets. Even schemes like the Rashtriya Swasthya Bima Yojana don’t cover the bulk of costs that are typically incurred. Instead, he often first goes to the unqualified health providers where he may or may not get well.

As Veena Das’ contribution suggests, the informal medical system in the poorer urban areas is seen as unwanted, remains unplanned and chaotic, and is thus squandered as a potential resource for genuine health care.

Probably the biggest impact on the urban health care scene has been the entry of the corporates in health care from 1980s. This has been accompanied by the general belief that government health care is poor, while private health care is good. Another massive change has been the weakening of primary health care and the dominance of tertiary care. With these changes the disparities between urban and rural health care facilities/services has widened since the 90s. The tertiary health facilities and private facilities are full of both urban and rural consumers. But are they really looking after primary needs?

In actual fact, some primary health needs are better met in rural areas (e.g., can one get immunization, ORS or Paracetamol free in the town without standing in a long line?). Secondary Hospitals should have been in the districts and at the next stage in the blocks, but these are looked after by small nursing homes in small towns and cities as government secondary hospitals are poorly run.

**The Woes of Government Hospitals and Urban Health Posts**

The complexity of the urban is among the first features that preclude equitable and efficient service delivery. Authority is vested in state governments and municipal authorities (which are themselves sub-divided and furcated). Funding arrangements are deliberately tenuous and complex: including central, state, municipal, ad hoc and private funding. These are often linked, feebly, with various urban renewal and development projects and fragments or remnants donor-driven project components.

Government hospitals in urban areas are understaffed, underfunded and often chaotic. Sometimes, for various reasons, they fall into the cracks of the system and lose out on a proper source of supplies and funds.

The logic of salaries tends to run against the dominant free market pattern without adequate ideological support or mobilization. Thus, to take one example, urban government doctors in one state get 35,000 Rs per month, 10,000 less than rural government doctors who also collect hardship pay. While this is a useful motivator for rural postings among the young, only retired and senior doctors with a private practice opt for urban postings. They devote barely 2-3 hours to the government clinic per day. In other places, doctors are given free accommodation by the private pharmacies in return for what may be called ‘preferential prescription rights’.

Medical supplies to government medical posts are irregular and follow complex organizational routes that lead to the familiar unavailability of drugs. Facilities thus depend on diverse and sometimes irrational authorities for their disbursement. Staffing and administrative patterns are chaotic. The queues...
to see the doctor are inevitably long, and the patient is often seen by the pharmacist. Medicines are given for three days at a time, forcing a loss of wage labour every three days for any systematic treatment.

As Ravi Duggal puts it in his paper, primary healthcare facilities in the public sector are grossly inadequate in urban areas. The administrative expectation is that municipal governments should pick up the tab or urban healthcare should be left to the mercy of the market, especially the rapidly growing private health insurance market – in fact the defunct NUHM policy document actually suggested that!

And yet, urban health care does provide some basic minimal care with all the limitations it suffers from. There are many of both private and public practitioners of medicine who work with commitment towards alleviating morbidity among the poor. Government hospitals in urban areas in particular are beacons of hope to many migrants – especially the disabled – whose health needs drive them into particular cities and towns.

The chaotic and amorphous structure of governmental urban health care is the outcome of a complex struggle between economic forces that push the state to liberalize the economic agenda completely on the one hand, and a disorganized, yet sturdy resistance by some wings of the state apparatus to maintain some autonomy and responsibility to the people on the other.

**Privatized Medical Care and Insurance**

Although the origins of privatized medical care go far back, the last decade has seen the profusion of insurance models for catastrophic illness functioning through corporate hospitals. Schemes like Rajiv Aarogyasri are designed to provide the poor free medical care for catastrophic illness, but de facto serve the purpose of using the illness of the poor as a vehicle for transferring government funds to private corporate hospitals. In this system of health care, appropriate, timely and economical treatment of illnesses with minimal medically induced trauma is replaced by expensive, delayed and completely outlandish forms of treatment. Even though this is purportedly free, it ends up extracting from the patient out of pocket expenditure often exceeding what he or she would have paid without insurance.

The net effect of the steady erosion of the primary health infrastructure and the power of the corporate hospitals is that the poor have no memory or comprehension of timely, appropriate, low cost (including loss of wages), easily accessible and genuinely useful medical care. They only know that when the catastrophe occurs, the government pays the bill (and the poor pay a quite large sum too, but don’t realize it). This results in a false and completely unjustified sense of gratitude towards the programme and the corporate hospitals who earn their profits through them.

Invisibilised thus are the commitments that such hospitals pledge, of providing free care to economically weaker populations, in return for prime land (at throwaway prices) on which their medical “cities” are built. In rare cases these requirements are actually met, and rarer still are they monitored by the government.

As a further twist and as an extension of the urban dominance over the rural, corporate hospitals through the vehicle of privatized insurance are using primary health camps to attract fee paying patients to their tertiary hospital setups in the city. Thus the privatized urban health care system now begins to prowl the countryside to fulfill its thirst for profits.

**Conclusion**

Between the collapsing public health care systems and the zeal for profit of corporate hospitals, the urban ill encounter an impasse. Any choice (public, private, alternative care) will lead quite often to a situation where a rational recovery of ‘full’ health is impossible (this is of course presuming they had full health in the first place). As an earlier essay by Lakshmi Kutty on the urban poor in the old city of Hyderabad has suggested, the poor know the impossibility of their predicament and try to make the best of a hopeless situation – a kind of ‘pragmatic agency’. They seek some form of palliation in an endless struggle to live and sustain their bodies.

And yet, there are some small but important possibilities of change: Using the informal network through strengthening its resources (as Das’ paper for this meeting and others earlier have suggested); experimenting with new kinds of community self-help organizations that draw on available public and private resources; depending on ‘new’ actors, for instance, women, as described in the essay Siddharth Agarwal, et. al. have contributed to this meeting; advocacy to improve and implement existing strengths. It is up to a kind of democratic inventiveness to find new ways of engaging with these complex problems. Before we dismiss this as applying a band aid on a problem that needs more radical intervention, let us remember that having a participatory democratic process, however small, is perhaps the most radically transformative step of all.

[Inputs from Prabir Chatterjee, Dhruv Mankad, Devaki Nambiar, Adithya Pradyumna, Sheela Prasad, and R Srivatsan]

1In Towards a Critical Medical Practice (Hyderabad: OBS, 2010)
Urban Healthcare Issues and Challenges

I. The Context

The public health system in urban India was fairly robust until the end of the eighties. It was an era when public hospitals reigned supreme and had some of the best medical care expertise and facilities. The economic policies of liberalization, privatization and globalization which had its beginnings in the early eighties and accelerated after the structural adjustment reforms of the early nineties under push from the World Bank changed all this. The trusted and well-functioning, albeit overcrowded, public hospitals in the cities as well as in many district places became victims of the economic reforms through budgetary neglect – declining investments and expenditures in public health budgets from up to 1.5% of GDP in the latter half of eighties down to 0.8% of GDP by mid-nineties (Duggal 2009) – which stifled the functioning of these hospitals creating dissatisfaction not only amongst users but also frustration amongst healthcare providers working in these hospitals. At the same time private healthcare, already well-entrenched for outpatient care or primary care, started to expand rapidly to fill the spaces that the neglect of public hospitals was creating.

This private sector growth was facilitated by an unprecedented growth of medical education in the private sector, entry of the private sector in health insurance and the corporate sector in healthcare. This changed the political economy of urban healthcare. From relative equity in access to expensive hospital care there was a clear shift to increased inequity with the urban middle classes, supported by employers and/or insurance, moving to the private sector. The middle classes, including government employees, were the voice of public healthcare but their exodus to private healthcare in an environment of fiscal withdrawal of the state crippled the public healthcare system and left the public health institutions to become providers for the poor. It is well recognized that a public system functions best when it is based on universal access and anything which becomes a structure or scheme for the poor becomes a poor system. A further blow to the public health system came with the so-called health sector reform projects led mostly by the World Bank and bilaterals like DFID and USAID. These projects introduced the notion of user fees in public hospitals and added further to the difficulties of the poor who had become the main users of these institutions.

Thus through the nineties and the new millennium the urban public healthcare system deteriorated and is today a mess which can only be redeemed through a radical transformation hinged on universal access to healthcare and a rights based approach. This paper will discuss the urban healthcare challenges in this context.

II. Policy Framework

These changes in the urban health scenario post-eighties happened because there was no urban health policy or even an understanding of urban health. The 1982 National Health Policy (NHP) (GoI 2002) was largely about rural primary care. Until then cities were seen as development centres and for healthcare hospital facilities were the hallmark of cities and hence medical care characterized the health image of the city. Thus the hospitals were more important than the dispensaries or clinics which provide primary care and consequently resources were primarily directed at hospitals and the latter besides providing secondary and tertiary care also became huge primary health centres with thousands of patients seeking primary care daily and overcrowding the hospitals. The inadequate investments in primary care in the cities prevented the development of a referral system and this has had its consequences for the inefficiencies of the public health system in urban areas. However in urban areas with teaching hospitals urban health centres as extension of the medical college’s preventive and social medicine department were set up to provide comprehensive primary care in selected urban pockets (Pandit, et.al., 1996). These were in sense first attempts at urban primary care but instead of evolving into that they became mainly field practice areas for medical students and interns.

Further overall urban policy itself is a problematic area. Historically it has been an arena of tension between the state government and the local bodies (Shaw 1996). Notwithstanding the 74th amendment of the Indian Constitution the tension continues and in most urban areas the state governments continue to reign supreme and this has stifled local initiative in urban policy development and reform.

However in the latter part of the eighties a different trajectory for urban health policy was shaping up under the direction of the World Bank. This could be seen as the first initiative in urban health policy making. This was the fifth India Population Project (IPP V) under which as per suggestions of the SV Krishnan Committee (1982) health posts were recommended for Mumbai and Chennai (and later IPP VIII in

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The health post concept was to help strengthen primary healthcare in urban areas but this opportunity was not used in the best possible way. In reality the IPP V and VIII instead of being comprehensive primary healthcare projects became family planning and RCH (Reproductive and Child Health) projects directed at changing the demographics and not healthcare of the cities. They were targeted mainly at slum dwellers and the poor and the result was that they developed into a poor primary healthcare system. In the meanwhile India underwent structural adjustment which reduced budgetary allocations to healthcare and opened the gates for the expansion of the private health sector, especially hospitals. This changing trajectory is well reflected in the National Sample Surveys (NSS) on morbidity and utilization (NSSO 1998 and NSSO 2006).

The utilization and health expenditure data across the 42nd (1987, pre-structural adjustment), 52nd (1996, early post-structural adjustment), 60th (2004, full impact of structural adjustment) and 71st (post-NRHM) Rounds of NSS shows a very alarming trend. (Table 1)

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Hospital Utilization (percent)</th>
<th>Hospitalization Expenditure (Rs.)</th>
</tr>
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<tbody>
<tr>
<td>Public</td>
<td>71st 60th 52nd 42nd</td>
<td>71st 60th 52nd 42nd</td>
</tr>
<tr>
<td>Public</td>
<td>32 38 43 60</td>
<td>6120 3877 2195 385</td>
</tr>
<tr>
<td>Private</td>
<td>68 62 57 40</td>
<td>25850 11553 5344 1206</td>
</tr>
</tbody>
</table>

*Source: NSSO 60th Round – 2004, Report No.307, NSSO, New Delhi, 2006; NSSO 71st Round 2014 – Key Indicators of Social Consumption in Health, NSSO, New Delhi, 2015; *rural and urban combined*

Realizing this, the Central government announced a National Urban Health Mission (NUHM, 2010) to bring back life into the urban health services but it is now over five years since its announcement and there is nothing on the ground as yet.

However even if the NUHM was implemented one is not sure if it would have changed the situation for the better because its policy prescription in its framework document is problematic, “The National Urban Health Mission aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening the existing capacity of health delivery for improving the health status of the urban poor. This will be done in a manner to ensure that well identified facilities are set up for each segment of the target population which can be accessed as a matter of right.” Further the mechanisms being suggested like public-private partnerships (PPPs), community risk pooling schemes, insurance for secondary/tertiary care etc., for targeted groups is very clearly an extension of the selective approach which the IPPs promoted. And such an approach will only further damage the public health system in urban areas (Dasgupta and Bisht 2010). As things stand today NUMH and NRHM have been integrated into the National Health Mission and one outcome of this is speeding up of setting up the state level AIIMS type of tertiary care institutions – while physical infrastructures have been provided in a number of states there remains the huge challenge of getting faculty and other human resources to come and work there. Further Niti Ayog is giving a huge push to expanding insurance based healthcare, especially for secondary and tertiary care. If the latter goes through we will see another huge shift in the political economy of healthcare in India towards further consolidation of the private health sector and consequently increased inequity in access to healthcare.

### III. Debates and Key Challenges

Urban areas account for three-fourths of healthcare infrastructure and provisions - doctors, hospital beds, expenditures etc. Urban areas definitely have
healthcare resources on par with developed country averages and definitely within the framework defined by the WHO. And these resources were indeed being effectively delivered until the late eighties to a reasonably satisfied urban population with effective health outcomes. But post 1990, the declining expenditures and investments contributed to the neglect of the public health system and especially the urban health system which, with much lower budgetary allocations, had to now compete with the fast growing private health sector. Under structural adjustment programmes, social policies also veered towards marketization and a clear shift in healthcare policy was seen – from comprehensive care a clear shift to a preventive / curative divide, the former being public responsibility and the latter being the domain for the private health sector.

It can be argued that these trends are closely linked with the wide spectrum of changes in the economy since the mid-1980s, which have led to the large and unregulated growth of the private health sector, especially corporatization of healthcare, privatization of various services in public health institutions, including introduction and increase of user fees, deregulation of drug prices, expansion of private medical education, increased reliance on market mechanisms to address welfare needs, the introduction and rapid growth of private health insurance, the weakening and privatization of social insurance, and consequently the overall weakening of public health systems. All this clearly happened by design as evidenced by health policy statements supporting private sector growth as well as the state reducing its role by virtually stopping any new investments in public health since the turn of the nineties and a declining trend in public budgets both as a percent to total government budget as well as a percent of GDP. Thus the main hurdle to healthcare access is a weak and declining public health sector contradictorily in an environment of high economic growth on the one hand and the continuing high levels of poverty in the changing political economy and the inequities associated with it on the other. The consequence of this is that even the poor are forced to access market based healthcare as we have seen above in the trend of increasing indebtedness due to healthcare seeking as well as an increase in proportion of untreated ailments as revealed by the trends from the NSS healthcare surveys.

Despite NRHM the public healthcare system in India still favours much larger allocations for urban areas. Urban areas in 2014 accounted for about 60% of the Rs.1250 billion public resources expended on healthcare by central and state governments combined. This works out to about Rs.2000 per capita for the urban population (almost 3.5 times that of Rs.575 per capita that gets allocated to rural healthcare). In addition cities and towns also have municipal governments spending resources on healthcare. For instance Mumbai Municipal Corporation with a budget of Rs 25 billion in 2014 will be spending over Rs.1450 per capita on healthcare in addition to what the state government spends. (MCGM 2014) Yet Mumbai city’s public healthcare system does not meet more than 18% of ambulatory care demand and 36% of hospitalisation demand (Dilip and Duggal, 2004). The rest is taken care of by the private for-profit and not-for-profit sector at an estimated cost of over Rs.4000 per capita and at least two-thirds of it as out of pocket burden.

Yet a large proportion of the poor as well as lower middle classes have inadequate access to healthcare resources in urban areas. Why is this so? Urban healthcare, both public and private is over medicalized. Preventive and promotive care as well as environmental health in urban areas is grossly inadequate. This leads to a lot of unnecessary medical care and hence a waste of valuable resources. So the issue in urban areas is not adequacy of resources but unnecessary usage and wastage, both in the public and private domain. The public sector does not invest adequately in public health and the private sector benefits as a result with a large clientele of avoidable medical care. Thus urban healthcare is completely curative oriented. All resources invested in health deal primarily with curative services. Public health measures are grossly inadequate and this results in poor hygiene and environmental health. Filth, pollution, epidemics, insanitary living conditions all lead to preventable health problems. All this leads to avoidable medical care expenditures.

Urban health resources as we have seen above are largely in the nature of medical care. Public health situation is quite poor in most urban areas, despite the volume of public and private health resources committed to urban areas. Primary healthcare facilities in the public sector are grossly inadequate in urban areas and as a result the burden of primary care falls on urban public hospitals, apart from the large variety of private providers. The social determinants of health and environmental health like water, sanitation, sewerage system and garbage disposal, housing conditions, pollution etc and overall poverty itself are also a huge challenge which goes beyond the domain of the healthcare system and at the same time impacts the latter substantially. Some of these social determinants of health are being addressed under the Jawaharlal Nehru National Urban Renewal Mission (JNNURM, undated) – water supply, sanitation, sewerage, etc. So clearly strong policy initiatives backed by pumping in of resources for these social determinants or environment health
initiatives are being addressed and will in turn impact urban health positively. The new government at the Centre is pushing hard on the Swachh Bharat (Sanitation and Hygiene) campaign but unfortunately the resources needed for it have not been provided in the required quantum – it has been a largely public relations exercise and a platform for hygiene product manufacturers. But urban healthcare, both primary care and with declining investments and expenditures even hospital care still remains an issue due to weak policy level interventions. Urban health under the new NHM, though weak in itself, continues to be sidelined and one can only conclude that urban health policy is clearly not a priority with the government as they would prefer to continue focusing on rural healthcareas the first demand on the limited budget of the health department. The expectation is that municipal governments should pick up the tab or urban healthcare should be left to the mercy of the market, especially the rapidly growing private health insurance market – in fact the defunct NUHM policy document actually suggested that!

Given the above urban health policy environment a collapsing public healthcare system can only add to the misery, especially of the poor. The collapse as we have seen above is largely due to falling investments and declining expenditures in public health spending and this is largely a post structural adjustment programme phenomena. Within the public health system there is pressure for privatisation because we are accumulating debt burdens. At another level the private health sector is expanding rapidly and the corporate sector is also increasingly getting into provision of healthcare. This has raised the cost of healthcare substantially. In fact even in public health institutions user charges have been raised substantially. This makes access to healthcare ever more difficult not only for the poor but also for the middle classes. And with gross inadequacies within the public health system even the poor are being forced to migrate to the booming private health sector, and often with huge indebtedness as a consequence.

The private health sector, especially in urban areas, that operates in a completely commercialized and unregulated environment is consequently plagued by large-scale malpractices, unnecessary interventions, negligence etc. that has made use of private health care more risky and hence more unaffordable. This also leads to exploitation of patient vulnerability and violates basic rights of users of such provision. The complete lack of ethics and self-regulation within the profession makes matters worse and has affected the status of the medical profession which is today labeled as a dhhandha(trade), instead of being regarded as a profession. Even the government has been unconcerned about regulating the private health sector. Civil society pressures have forced the government to at least start thinking about this and regulatory laws are being formulated and debated but little action has happened as yet.

**Conclusions**

Urban healthcare is certainly at the crossroads as the new health policy still remains undetermined. From a position of strength in the eighties it has collapsed due to its neglect and underfinancing on one hand and the unfettered growth of the private health sector on the other hand. Inequities in the context of urban healthcare have grown substantially post nineties and especially in the new millennium and today urban health is at the crossroads of either succumbing to private health insurance if the NitiAyog has its way wherein inequities would increase or the new health policy that emerged under the shadows of the HLEG report is saved and implemented with a strong political will.

**References**


Women and Urban Health Governance: a Study of Empowerment and Entitlement

- Agarwal Siddharth,* Verma Shabnam,* Verma Neeraj,* Agarwal Kabir,* Sharma M.R.,* Sharma C.B.*

Introduction

Behind the sheen of city life is a large section of people that is deprived, hidden, voiceless, often food-insecure, with poor access to healthcare and basic services like sanitation, drinking water, housing, education (Agarwal S, 2014). By urban slums, we usually mean those who live in slums, on pavements, in informal housing, construction sites, brick and lime kilns, and those who live in disadvantaged settlements—in short impoverished populations. These populations are insecure, excluded, with poor representation, social capital in spite of being on the border of world class facilities. There is weak family support and community cohesion in slums. Unlike in rural settings, women and children do not enjoy a socially well knit community that ensures them physical safety, a fair level of food security, and the availability of social support, often from extended family connections, for childcare. Without these safeguards, women’s mobility in urban areas is limited, compromising their ability to avail of healthcare services for themselves and their children when required. Slum residents often have very limited knowledge and access to services and entitlements and owing to lack of confidence seldom are capable of demanding their rights. Disempowered with the lack of Government ID and Proof of Address in the city, they are often threatened with eviction and often live in fear. Many families tend to not want to be known owing to the risk of being exploited by police, municipal and other authorities.

Poor working conditions, water and food vector borne diseases like repeated episodes of diarrhea, typhoid, other fevers, jaundice, dengue and malaria; migration for work, low confidence in public systems, lack of social cohesion and weak negotiation skills, all render them vulnerable, leading to powerlessness and a sense of resignation. Women suffer more owing to lower social status, lack of control over household finances, decision making and are often forced to borrow from traditional money lenders to meet daily food needs and health and education needs of the family.

Slum Women’s Groups as Agents of Change

Most social choice theorists have moved beyond the early negative interpretations of Kenneth Arrow’s “impossibility theorem” (1951) and are identifying the trade-offs involved in finding satisfactory collective decision procedures. Amartya Sen has promoted this ‘possibilist’ interpretation of social choice theory (e.g., in his 1998 Nobel lecture). Amartya Sen used the dimension of ‘Participatory Freedom’ to propose that individuals can acquire the “freedom” to participate in and contribute to collective decisions both social as well as governance related. The key issues here are democracy, political and social liberty, and particularly a society based on public debate and decision (Sen, A.1999). In this theoretical background, UHRC learnt with practical experience that when stimulated to think, determine, judge and act in larger social interest, community groups in most instances proceed towards positive social choices. Over time, they learn from their own errors of judgment and from experiences of other neighborhood groups which further stimulates positive social choices. Amartya Sen has noted that “gender inequality has many faces including in the areas of mortality, natality, opportunity, and ownership and that these faces “hurt the interests of men as well as women” (Sen 2001).

A women’s empowerment focused program approach has been adopted based on the well-documented premise that mother’s education level is a strong social indicator of child and family health in addition to research showing the health consequences for females of gender inequality (Agarwal and Srivastava. 2009). Thus stimulating women to be drivers of slum-level improvements has far reaching implications on health and socioeconomics of slum life. Bandura theorized that an intervention enhancing people’s faith in their own capacity improves their actual collective ability to tackle challenging situations (Bandura, 1994).

The ‘theory and practice of change’ that the UHRC has been fortunate to learn from first hand is that organized slum women who are trained, mentored, and supported have a greater capacity to access government services and entitlements. This has been evident through UHRC’s program experience across 410,000 urban vulnerable populations in
Agra and Indore. Urban Health Resource Centre (UHRC) extends these principles to programming for poor/vulnerable slum communities, sustaining efforts to incrementally build socioeconomic and environmental self-confidence, self-efficacy through community organizations. UHRC forms, mentors and strengthens women’s groups in slums, informal settlements in Indore and Agra to build confidence along-with strong social cohesion, grassroots level community based organizations that work towards reducing health, environmental, socio-economic risks.

Methodology and Program Approach

Community-based Interventions

Slum women are initially stimulated to think whether and how collective organized effort could help them better deal with challenges. Then, they were encouraged to assess whether they would be interested to form groups. Interested women were helped to decide how such groups should be formed and operated. UHRC encourages slum women to pursue health, nutrition and hygiene education sessions to improve household health behaviours and care-seeking practices to experience small instances of success. Noting lack of information about government schemes, services, entitlements among slum families, UHRC conducted awareness and capacity building sessions on obtaining Government picture-ID and address-proof of the city, voter-cards. These strides of modest wins help families develop confidence of being legitimate citizens, and lead to bigger successes such as access to government welfare schemes, bank accounts, and children’s birth certificates issued by city’s authorities. UHRC’s social facilitators help women’s groups and communities write petitions/applications, reminders to civic authorities, learn about importance of paper-trail of to ensure responsiveness, good governance. Armed with negotiation skills, women’s groups interact and engage with government officials, functionaries for slum-level infrastructure improvement and improved access to government services and schemes.

How UHRC’s Slum Women’s Empowerment Process Progressively Digs Deeper and Works

UHRC’s approach focuses not just on individual self-efficacy but collective self-efficacy, which can be defined as a group’s shared belief in its aggregate ability to a) mobilize collective motivation, b) access and utilize information required, and c) pursue courses of action to accomplish a valued social goal. Slum women are encouraged to think, decide and participate in problem solving actions in a collaborative environment in which to steadily build and develop their capacity develop higher levels of motivation, support, and belief in their own capability as well as the ability of those around them. Collective self-efficacy and individual self efficacy positively reinforce one another, creating a virtuous, positive feedback loop influencing what people choose to pursue as a group, how much effort they put into the group’s objectives, and their persistence when group efforts fail to produce results (Bandura, 2000).

There is recognition in literature that local community networks which facilitate collective action have a positive impact on health (Israel, 1994) both through the psychophysical benefits of feeling group solidarity (Rogers, 1996) and through direct engagement with health outreach work (Yen and Syme, 1999). A crucial dimension of this process is encouraging groups to develop at their own pace while providing support and training. Of course standards, of group member accountability are established, but that process is facilitated by the naturally emerging leaders within the groups and by the group members. Along with the methods, described above, Urban Health Resource Centre’s programme also motivates women’s groups to consider developing a community group based savings and loan system. Once developed, this community level savings and loan mechanism also contributes to enhancing the self-reliance of the group and the community. Such grassroots institutions are able to promote a sense of collective responsibility, group cohesion and initiative among the people. Increased knowledge, improved links with service providers and local agencies encourage the community organizations to aspire to work towards improved quality of life.(Agarwal and Sarasua, 2002).

Results and Outcomes

Outcomes from Monitoring Data of 125 Women’s Groups in Indore-Agra: During April 2013-March 2014 shows that negotiation power of in women-groups led to improved access to services and government proof of address and picture ID:

- 5600 women availing deliveries in government, private-affordable hospitals,
- 3350 of these availing Government’s Maternity-
Benefit scheme (called JanniSurakshaYojana)

- 4656 children availing immunization
- 8422 persons not previously having govt. picture ID obtained proof of address and picture-ID (important for feeling of legitimate citi-zens and for availing benefits of government schemes and entitlements)

**Improvement in Community Access to Civic Services:** Periodic assessment of progress of community petitions/requests and reminders to civic authorities and gentle negotiation show that during April 2013 and March 2014 through community petitions/reminders submitted by women’s groups perseveringly:

- 37000 slum population was benefitted from improved water supply,
- 6000 slum families could avail legal electric connections,
- Streets/lanes in 23 slums have been paved benefiting 60,000 slum population and
- 120,000 population benefitted from regular cleaning of drains

**Use of Community Social needs fund by Slum Women’s Groups:** 125 slum women-groups across 410000 slum population in Indore/Agra save regularly and provide low-interest loans to members and other needy families. During April-2013 to March-2014, 3327 loans were given. 550 loans served maternal-child health needs, 375 loans other health needs, 531 loans helped uninterrupted children’s education, 524 loans helped start/expand livelihoods, 424 loans supported grain-storage at harvest time, 221 loans supported girl marriages, 302 loans enabled repaying moneylender debts, 190 loans were used for food/kitchen expenses, 210 loans enabled house improvements, including toilet.

**Results of a Comparative Study Conducted During May-June 2013:** To assess the difference in access to health, children’s education, basic services and government proof of address and picture ID between a) slum women’s group member families, b) non-intervention slums and c) non member families in intervention slums, a study was carried out during May-June 2013. The study showed that:

- Access of group-member families to address-proof/picture-ID was nearly twice as high (45% vs 27%) as compared to families in slums without women’s groups;
- Toilet in house was twice as high in group member families (60% versus 30%) than in slums without women’s group intervention.
- Appropriate household garbage disposal was four times higher (59% versus 14%) as compared to families in slums without women’s groups.
- Usage of public health facilities thrice as high (31% versus 9%) among group member’s families as

<table>
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<tr>
<th>Access to Services</th>
<th>Group member slum families (%)</th>
<th>Non-Group member</th>
<th>Non-intervention</th>
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<tr>
<td>Access to government health facilities</td>
<td>31</td>
<td>15</td>
<td>9</td>
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<tr>
<td>Usage of Family Planning measures</td>
<td>77</td>
<td>76</td>
<td>26</td>
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<tr>
<td>School/pre-school enrollment of Children</td>
<td>67</td>
<td>68</td>
<td>42</td>
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<tr>
<td>Toilet facility in house</td>
<td>60</td>
<td>58</td>
<td>30</td>
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<tr>
<td>Appropriate garbage disposal</td>
<td>59</td>
<td>61</td>
<td>14</td>
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<tr>
<td>Family members having Aadhar (Govt. Address proof and Picture (D) or applied for Aadhar)</td>
<td>45</td>
<td>38</td>
<td>27</td>
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<tr>
<td>Having Bank Account</td>
<td>47</td>
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compared to non-intervention slum families.

- Usage of any family planning method was thrice as high (77% versus 26%) as compared to families in slums without women’s groups.
- School/pre-school enrollment of children was 1.6 times higher (66% versus 42%), among member’s families over non-intervention slum families.
- Non-group members from intervention slums show improvement similar to group-members in indicators pertaining to toilet in house (58%), continued education of children (68%), disposal of household garbage (61%), use of family planning measures (76%), slightly lower access to government address proof and picture ID (38%); but much lower access to government health-facility (15%).
- Having a bank account was 1.8 times higher in group member families than non-group member families; 2.5% higher as compared to non-intervention slums.

The above study demonstrates that organized, trained, empowered slum-women’s groups help improving access of their families to healthcare, children’s education, facilitate environmental improvements. Observing value in the program efforts, slum women develop confidence to represent their families and communities to demand rightful services. Non-parameters (e.g. children schooling, toilet in house, garbage disposal) studied, while on others (usage of Govt. facilities, access to Bank) further inputs are needed for benefitting intervention slum communities at large.

A Practical Perseverant Step towards Inclusive Urbanization

According to 2011 Census data, Indore’s population in 2011 was 1,960,631, of which 590,257 people lived in slums, accounting for around 30% of the population (Census of India, 2011). In 2011, Urban Health Resource Centre, with the help of social facilitators and 500 women’s group member’s knowledge of their neighborhoods updated Indore’s slum list and estimated population for the District Health Department of Indore. This exercise revealed a total of 633 slums in Indore city with an estimated population of 918.575, nearly 50% of Indore’s population. This effort of over 9 years of close partnership with civic authorities of Indore helped bring 328,000 urban vulnerable populations on the radar for health services planning.

Discussion

Learning Gained: Civil-society organisations can strengthen community’s ‘expertise’ and facilitate identification and implementation of context responsive doable solutions in the slum context. Skills and understanding of how the system works e.g. maintaining paper trail, seeking receipt of petition during Public Hearing are important approaches that the women learn.

How Women’s Empowerment Helps Family and the Community: Slum women’s groups gradually contribute to a positive gender equation at family and society levels, provide social support to needy families. Women’s enhanced access to resources and greater capacity to take timely care of themselves, children, and the family helps the family and community.

Simple ‘Indicators’ can Assess Slum Challenges and Improvements: To identify the exclusionary mechanisms and interaction of social inequalities that need to be countered, the programme draws upon knowledge, wisdom and efforts of disadvantaged community representatives.

What keeps them Motivated: Recognition from the community and enhanced self-esteem motivate group members and other slum women to participate and work for their socio-economic development. Honouring active women’s groups at city-level conclaves promotes higher self-esteem energizes the groups, helping them continually strengthen the organisation that they are steering. Training them in outreach health and nutrition promotion skills and facilitating them take on roles which also help livelihood e.g. opportunities as Govt. mandated health volunteers: Urban ASHA, AWW, AWW Helper also serves as a motivating factor.

Implications and Significance for India

Government, Non-government stakeholders are encouraged to adopt the approach that enhances collective and individual self-efficacy of community individuals and group-members. Lessons from Indore and Agra, have resulted in India’s National Urban Health Mission (NUHM)mandating Women’s Health Groups (MahilaArogyaSamiti) as the demand side the intervention, and creation of a Collective Savings or Revolving Community Fund as two of the eight core NUHM strategies (Government of India, 2013). The approach of slum women’s group led negotiation for services, entitlements is adaptable across cities of developing countries.
Relevance in Global Development Agenda

The 11th goal of the Sustainable Development Goals (SDGs), as drafted by July 2014, focuses on the conditions of human settlements and demands inclusiveness, safety, resilience and sustainability towards making a human settlement more livable. Slum women’s group empowerment, collective slum, community savings approaches and linking slum-community groups with service providers (supply side) and motivating and mentoring these groups to express demand through written community petitions/requests to civic authorities is an effective programmatic method that improves utilization of public sector services (Agarwal et al., 2008) is an approach adaptable in other developing countries to work towards SDG 11.

As the world moves to pursue SDGs, the UHRC women’s empowerment approach demonstrates in practice how a) disadvantaged urban people can be encouraged to build a more equitable citizens’ position and a strong voice in the city, b) take up negotiating roles for themselves that contribute utilization of well-being in urban centres of developing countries, c) demonstrate the community’s ‘expertise’ in analyzing challenges, problems and with facilitation, identifying and implementing solutions towards long-term social progress, d) that slum women’s groups can proactively reach out to politicians and authorities and create their own space on the table and ensure that priorities of slum/vulnerable communities are included in decisions and actions.

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Ensuring Identity and Entitlements of India’s Urban Poor

K.R. Antony

About 31.2% of Indian population live in urban areas (2011 Census) and 30-40% of them live in slums or similar habitations. No city or municipality, however pompous and glamorous it is, could ever camouflage its ugly slums. Slum clearance or city beautification drive was an ever going incomplete agenda. Slums are even categorized as “legal and illegal slums”.

Slum dwellers are always needed for the productive economy of the city. Why then they are treated illegal, unwanted and undesirable? Their caste, class, religion, occupation or dwelling makes them socially excluded. This social exclusion has all the administrative backing, as many of them do not have legally valid papers or documents. And so they have to bribe or pay extra for their water supply, sanitation, toilets, bathrooms, electricity connection and the list goes on. Even to sleep on the pavement in night or beg in the day time they have to pay “manual” to the power structure of the area which includes police. They are exposed to crime and violence, actively or passively, day and night and even “implicated” as “crime suspects”. That gives police or underworld goons to exploit them continuously or regularly or undertake demolition drives of their dwellings.

How do we bring some legitimacy and authenticity to their existence? Trade unions and political party affiliations bring some protection to them at a premium. But is there a better way? What could be a “rights-based” approach? All of them are citizens of this country and “internally displaced population” for various reasons. It is the collapse of the rural economy that expelled them to urban areas in search of greener pastures which they soon realise as nothing but a mirage. They also need services and privileges which other citizen enjoy as a routine. Geographical relocation or forced migration should not deny their basic rights as a citizen of this country. How do we go about it?

Any rights-based development worker among urban poor should start with efforts to establish their client’s identity. 1) To ensure an identity of the poor the first document required is generation of a Birth Certificate of young ones through the local hospital and urban authorities. The older ones can get themselves enrolled in the Voters’ List at the earliest opportunity of an election coming next. All verifications are diluted when the party workers get activated during election time. Once a voter’s identification card is in hand, the other cards are easier. The periodical enrolment process for Aadhaar Card is another golden opportunity. The generation of BPL Card and Caste certificate are difficult tasks. Residence proof is another road block towards many entitlements. When the residence itself is in an unauthorized colony or settlement it is difficult to get. An LPG connection address or phone connection address may also face similar difficulties. Photo identity through PAN card or Passport is not applicable in this segment of population. They never had an income level that is to be taxed and the only travel document they had is a second class ticket to this city from the railway station nearest to their home village. Who can vouch for them and whose authority government can rely on is a question never answered.

2) To ensure entitlements for basic services of urban poor we must ensure that they undertake certain essential steps of getting enrolled and registered in government records. Say registration of pregnant women in anganwadi centre or health centre will make antenatal and maternity services, nutrition supplementation, early child care, immunization services, emergency transportation in medical emergency, etc., much easier. Development workers must facilitate them to obtain Ration Card, Disability Certificate, Widow/Old age pension, etc.

3) To facilitate seeking care and protection through dialling 100, 101, 108, 1098 for Emergency services. As a step towards empowerment, these community groups must be given information and education on the importance of knowing the scope of these services, the way to call for these services without delay and the importance of taking leadership in a crisis. Mock drills under technical supervision will make them more confident. A number of summer time fires could be put off early and damages minimised had they been trained to call for help by dialling these numbers.

4) To ensure dignity and protection of women and children, “Crime Mapping” exercise can be undertaken and thereby identify vulnerable areas and timings. The remedial measures can be worked out by the neighbourhood groups in collaboration with municipal/Corporation authorities and Police as demonstrated in some municipalities of Kerala.

5) To facilitate financial empowerment through entrepreneurship and banking, the first step must be opening and operating a bank/post office saving account. To fill up forms and gathering supportive documents need some help from knowledgeable persons. Once an account is opened and they see that their savings are safely growing without their alcoholic menfolk snatching it away or they themselves yielding to the temptation of spending money on luxurious purchases, they will feel confident. This minimises their dependency on money lenders and agents of easy loan and so will avoid “debts trapping and indebtedness”. An empowered neighbourhood group through responsible banking will boost their micro enterprises and marketing avenues of goods produced by them.

6. To ensure coverage of services for all so that nobody is left out, we need to walk that extra mile to reach that “unreached”. It needs search or inquiry and interaction with the most underprivileged. Once we have identified the unreached, we need to connect them to whom they are supposed to serve them. This exercise is called “mapping of habitations of Urban poor and mapping of resource institutions like AWC, health posts, hospitals, government schools, PDS centres” and identifying uncovered areas of habitations and bringing this disconnect to the attention of Municipal/Corporation authorities.

By no means the above “To do” list is complete and exhaustive. It is learning by doing and we will be coming across many other issues as we go along tackling one by one. Launched in May 2013 with 942 cities and towns above 50,000 populations, the National Urban Health Mission is a concrete step taken to ensure right to health of the urban poor.

(The writer is former Health & Nutrition Specialist for UNICEF and former Director, State Health Resource Centre, Chhattisgarh.)

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Life and Work in Jeedimetla: a Montage

- Mithun Som

Brij Kishore, belonging to a village in Samastipur, Bihar has settled in Hyderabad for the past six years. He lives along with other migrants in an apartment in Subhash Nagar area of Jeedimetla, which is an industrial hub of Hyderabad. He works in a factory which prints on packaging materials. And like others, he has also worked in quite a few factories in Jeedimetla and has explored other cities for work. He lived for a year and half in Delhi, before coming to Hyderabad. In Hyderabad, he worked for a year in a company which made pistons, after which he worked in another company which makes CFL holders for four years until he was sacked for joining the union and making demands for a temporary wage equal to that of permanent employees. Back in his village, he tried managing a kirana shop but could not sustain it as people didn’t have money and bought things on credit. He has studied till the tenth class. His wife and son stay in the village. He now shares his one room with his own brother and a cousin. They work 12 hours a day and take one or two off in a month. They cook their food in a stove inside their small room.

Living in Cities

Most of the other eleven interviewed residents who work in small and large industries in Jeedimetla have similar life stories. They each share a single room, not more than 100 sq ft with two to three other tenants or in some cases, their entire family lives in one room.

Drinking water comes at a specific time on the ground floor and people stand in a queue to fill their pots and cans and carry them to their houses. None of the people in the apartment have a gas connection. They rely on a single stove which takes a long time to cook a meal for the entire family. This has also brought in a change in their food habits, for instance, Sanga Reddy from Telangana, replaced jowari roti with wheat roti as the latter takes far lesser time and energy even though he does not like it. The men who stay by themselves also usually cook rice and one sabzi.

They have common bathrooms and toilets in the floor shared by up to ten houses. Many of the women bring water to their room and bathe there instead of using the common bathroom.

Lata who stays in a nearby house gets water once in three days, which she has to store. Their landlord has a bore well as a standby, but bathing in this water leaves the skin itchy and so they prefer the municipal water.

The workers have to put up with poor housing and living conditions that cramp and disrupt their family lives. There is no government plan to house these workers when industrial areas like in Jeedimetla are planned. Workers are forced to stay close to industries exposed to hazardous gases and polluted water. With no check on the pollutants released by these industries in air, water and land the workers staying in the area have to suffer. Workers report that during night, especially summers when they sleep on the roof, they can smell foul odors as some industries release harmful gases in the dead of night.

In some of the bigger factories, the workers are provided accommodation inside the premises. A token sum of Rs. 150 is cut from their pay (one room in a tenement can be 1500 to 1800 rupees per month). The rooms are very small and five people may be accommodated in it. Since the workers have shift duties, at a given time there are not more than two or three people in the room. This allows the factories to maintain reserve labor to cover a shortfall in any shift or during strikes, since these resident workers are not allowed to join a union.

When Pramod joined a plywood company, he used to stay outside and often was five to ten minutes late. He was then asked to stay within the premises so that he could be on time. Such workers are not allowed to go out even during evening. He resisted this curfew as he wanted to go out at least once a week. As penalty, his bicycle was impounded so that he did not have any means of going out. One day when he managed to get his bicycle and went out, he was caught, his services terminated and his belongings impounded!

What brings them to cities? Debt, agrarian distress, lack of opportunity and hope for a better future

These people have migrated to the city as they have no sustenance in their villages. In many cases, they or their family have incurred debt due to which they had to migrate. Pramod’s family had to spend about two lakhs in the two and half year treatment for their son who was not able to walk, talk or speak. Their sole source of income was the Kirana shop which his brother also wanted partnership in. They realised they won’t be able to meet their huge expenses and shifted to the city in search of work. Kusum’s family incurred debt due to a prolonged court case followed by her sister-in-law’s cancer
treatment. Ashok Kumar used to be unwell as a child and his family had to spend a lot of money for the treatment. His father worked in Calcutta and later Ashok also had to leave his studies and join his father.

Debt in many poor households is a major reason which leads to migration as debts incurred due to ill health, a bad agricultural season, marriage, death, or any other catastrophic expenditure pushes the people out to the urban areas. Debts from formal sources in rural areas have declined after 1992 (Chavan, 2012). While the indebtedness of small & marginal farmers from formal institutional sources is lower than that of large farmers, the reverse is true of informal sources (Dev, 2012). Debt from formal sources as a percentage of total debt has seen more decline in Dalit households compared to non-dalit households. By 2002, moneylenders replaced commercial banks as the largest source of debt for Dalit households. And the share of debt at an interest rate of above 20% saw an increase for the same period (Chavan, 2012).

Sanga Reddy’s parents spend a vast amount of money on their children’s private education. Later they got their daughter married by mortgaging land. In two consecutive years his family tried digging bore well for his farm which failed. They spent Rs. 70,000 each time. He says that had the bore well succeeded, he wouldn’t have been here. Sanga Reddy himself had an ear problem, even though it was covered under Aarogyasri, he had to spent a lot of money for travel from his village and for lodging in the city. His family grows cotton and onion. Production of cotton is highly influenced by weather. They sell off the onion produce immediately even though selling off later would fetch higher price. This is because they do not have government storages for onions nearby and the private ones are very expensive. These financial conditions and the lack of a successful farming enterprise led him to migrate to the city for work.

There has been a decline in public investments in irrigation and other related infrastructure. This inadequate investment in canals and other infrastructure has resulted in ‘private investments in bore wells’ (Mishra, 2009: 2). This difference in ability to invest also brought about a disparity in earnings between small and large farmers. Here again, the large farmers used canal water for 40% of their irrigated areas, whereas for the small farmers, this figure was only 25%. Effectively the small farmers could not capitalize on cheaper sources like canal and had to depend more on ground water (NCEUS, 2008)’ (Dev, 2012 pp 5).

Samayya’s father had owned land but had to sell a third of it to meet the legal expenses for a land dispute. After splitting the land between his two sisters and brother, he retained only a small share. Hari’s grandfather had land but some of it was lost to a river during a flood and the rest divided among his sons. Finally since Hari’s family did not have land, they used to sharecrop and work in other’s fields but the income was not sufficient. He tried working in rug weaving but that too did not work out. He initially started seasonal migration then later shifted permanently to Hyderabad seven years ago. Both Kusum and Lata followed their husbands to the city.

There is an increase in the share of small and marginal farmers in the last few decades. The area farmed by small and marginal operators has also increased from 19 percent in 1960-61 to 40 percent in 2002-03 (Dev, 2012). There is an increasing trend towards the more insecure casual labour rather than self employment or regular employment in rural labour. Casual labour is at its highest for rural men since 1970s (Chowdhury, 2011).

Raju was working under a tailor with the intention of learning the skill but the tailor asked him to do other odd jobs due to which he left. He worked under a mechanic but couldn’t see himself doing this all his life so he ran away to Surat. Brij Mohan’s village did not have any industries nearby. Ravinder’s father used to make houses with ‘lakdi’ (bamboo and other kinds of wood) but as such materials are no longer used, he has shifted to share cropping. Ravinder who belongs to the chamar caste and has a stepmother at home says that his village has a factory nearby but he didn’t want to stay in the village rather prefer to work in the city due to the isolation here.

Declining public investment, low institutional credit and changes in farming technology all result in high input cost and unavailability of credit at reasonable rates. This makes it difficult for the marginal and small farmers as well as farm labourers to sustain themselves (Reddy, 2009). Lack of alternate forms of income and disproportionate growth of industries leaves no choice other than to migrate.

Migratory Chains, Limits and Possibilities

People usually follow someone who is already there in a city. It can be a family member, friend or just fellow villagers. Pramod followed his in-laws to Delhi but did not like it there. Brij Kishore followed his cousin. Hari and Sanga Reddy followed their in-laws to Hyderabad. Of Raju’s eight cousins, five
work in Hyderabad, one studies in Chennai and two remain in village.

Once out of the village, they also explore different cities and different kinds of work. Brij Kishore and Pramod have first worked in Delhi. Raju was earlier in Surat and Ashok in Calcutta. Ravinder went to Delhi at the age of ten and from there went to Calcutta, Patna and even tried working in his village before coming to Hyderabad.

Caste and class boundaries follow migrants to the cities. ‘The upper and middle caste dominated the managerial and skilled labour whereas the lower castes and SCs ended up as semi skilled and unskilled permanent and temporary workers’ (Qadeer and Roy). Also a large proportion of the casual and contract labourers are tribals, dalits and OBCs (Qadeer and Roy, ). With limited skills and low education, these migrants have few choices other than joining this informal workforce.

Ashok Kumar has studied till class 11. He could not study further because of financial problems. He joined work in Calcutta after that. Ravinder has never been to school. When he was sent to school, he ran away. Then he started working at the age of 10 years as he went to Delhi with his cousin. Brij Kishore has studied till class 10. He says that when he was young he saw that there were not enough jobs. He thought that studying any more wouldn’t make any difference. Also his family did not have money so he could not continue. But he comes across as someone who has an interest in study, and he keeps himself updated by reading newspapers.

**Harsh Work Conditions**

Informal sector employment has increased, especially after the 1990s as a way to reduce expenditure on workforce. Subcontracting which has resulted in the rise of informal labour is more visible in unskilled labour. Informal employment has seen an increase even in the public sector from 29.5% in 1999-00 to 33.6% in 2004-05 (Reddy, 2013). The rate of growth of formal employment in public sector has also turned negative (Reddy, 2013, pp- 65). Absence of labour regulation is one of the main attraction for the employers ‘which allows for more intensive exploitation’ (Ghosh, 2004). These workers get lower wages without any benefits and almost no job security.

In Jeedimetla, overtime is a very important factor and people look for jobs which has overtime as this will supplement their meager earnings. Contrary to the legal regulations, workers do not get double wages for overtime. One of the workers said that no one has heard about double wages and no one will ask for it. The first thing they want is work, if they get overtime, they are very happy with the extra income. Different companies have different policies for overtime. For example, in Pramod’s company they have a 12 hour shift which means four hours of overtime. They cannot opt out of this overtime even though they work in a hazardous and physically draining work in a ferrous foundry. Brij Kishore’s company also has a fixed 12 hour shift. For Hari’s company, overtime means another eight hour shift, depending on the requirement. In this factory, overtime was designed to meet the shortage of manpower. Women like Kusum prefer to go to work on off days since she has to take care of the house and children and thus cannot do overtime in the factory on normal days.

These workers also look for an opportunity to work on their weekly offs. Even Pramod who works in a dangerous job takes off only twice in a month. Hari does not get any weekly offs. If he takes any leave, he does not get the money for that day. He is a helper (unskilled). The skilled operator on the other hand gets a weekly offs.

In case of piece rate wages, things are different. Sanga Reddy says that the management does not put any kind of pressure on them to work. But he feels a constant tension and pressure to work. He realizes that if he takes a break, he will lose the pay. Seeing his friends working, he feels that he should keep working.

Brij Kishore and Rajesh ask that since they have migrated so far for earning money, why miss an opportunity. They say that some factories prefer migrants from Bihar and UP for this precise reason: they work hard. The migrants also form the main workforce for dangerous jobs. Factories producing medicines, pesticides or chloride pay a little more, say Rs10000 per month, but working there is risky. The workers said that there are regular accidents and these factories emit gases which are harmful.

Employers also employ devious means to give the least amount of money possible. For example, in one of the worker’s slips it was seen that in case of overtime, they calculate the wage per day by dividing total wages by 31 (maximum days in a month). However while deducting money for leave, they calculate the daily wage by dividing the total wages by 31 (working days excluding weekly offs). The companies give only a print out on plain paper and the worker does not have any official document for their wages. The companies do not follow the minimum wages, safety norms etc. Poor working conditions and non-existent safety norms...
help to keep the production cost as low as possible (Gillespie, 1990). Cutting the expenses on safety is generally first on the list of the owners to lower their costs. Workers do not have the bargaining power to fight against this.

Unions have a very minimal presence in these small factories. Workers are wary and managements strongly dissuade unions. With no job security, the workers do not want to risk their job talking about unions. In Pramod’s factory some workers tried to form a union but the person who was leading it was sacked and so no one dared to do it again.

**Health and Health Care**

The strenuous working condition and poor living conditions have serious effects on the health of the workers and their families. Not all workers get ESI cards and for various reasons, not everyone who gets it uses it. They are forced to go to the local RMPs who charge less and when serious, go to the private sector for treatment which pushes them into debt and thus the cycle continues. The doctors not trained to deal with the politics of occupational health, and routinely prefer to ignore the link between the workers’ work and health. The workers can work as long as they are fit and they don’t have any financial security if they get injured or get ill. Pramod works in a ferrous foundry and is constantly exposed to high temperatures. He finds it very difficult to bear the summer sun and the even hotter air. He uses a lot of water to bathe as soon as he comes back from work. Sparks from the foundry routinely burn his skin. His wife says that a burn has barely healed when another is seen. He also has had some major injuries in the past few years. Other workers like Hari works in a chemical factory where chemicals cause itching. For Ashok, there is a lot of dust for which they are provided masks.

Kusum’s husband has an ESI card and he goes to the clinic because he gets sick leave. However, Kusum does not prefer this as she has to stand in a queue till 3.00 pm and misses her wages for that day. Others like Ashok who do not have ESI go to a private provider. Pramod who works in a dangerous job of iron melting said that for any emergency, the company takes them to a hospital and for anything else they have to go to the ESI clinic which is far away from their place. Raju has developed a toothache and he has taken medicine from the pharmacy. It is the end of the month and he does not have any money so he is waiting for his wages. However, when I met him next, his toothache had increased and he went to a doctor who advised him surgery. Raju would prefer to go back to his hometown where the expenses are less.

**Hoping for a better life…**

People work in these abysmal conditions, hoping for a better future for the next generation. They send their kids to English medium schools, which they can never access in their villages. Kusum believes that if her children get educated then all their effort will be worthwhile. Another worker says that they have moved out to provide a better environment to their children. Samaiya and Pramod want to work as long as they can and then go back to their respective villages and open a small ration shop. Raju thinks of going abroad to the Middle East and looks at this as a training period. Sanga wants to go back and work in his farm and secretly dreams of opening one small factory someday.

**References**


The Challenges in Urban Planning to Overcome Health Inequities in India
- Dhruv Mankad*

India has 8,928 urban areas or towns as per Census 2011, 53 are cities or metros having more than 1 million population (see Table 1)[1]. Till date, we had taken for granted that several health indicators were worse in rural rather than urban population. Generally speaking, chronic malnutrition among under five children is lower in urban as compared to rural areas [2,3]. But when the same is compared for those living in slum dwellers, their condition is worse[4]. Similarly, prevalence of TB-MDR is found to be higher in urban as compared to rural areas[5]. In 2000, a review of epidemiological studies estimated that the prevalence of mental disorders in India was somewhat lower than in urban population[4]. Most of these studies have been conducted in metros or towns near the metros.

Challenge 1: Gathering Data about Health Impact of Scale of Urbanization

Tamil Nadu, Uttar Pradesh, West Bengal, Maharashtra, Madhya Pradesh and Kerala have more than 500 urban areas each, with Tamil Nadu having the highest number of 1,111 urban areas. These 5 states cover 52% of total urban population and total number of urban areas of India. These towns include: Koothuparamba (pop. 29,619) of Kannur district, Kerala; Jaura (pop. 42,153) of Morena district, Madhya Pradesh; Malegaon (pop. 4,71,312) of Nashik district, Maharashtra; Nanapara (pop. 48,337) of Baharaich district, Uttar Pradesh; Alwarthirunagiri (pop. 9,289), Thoothukudi district, Tamil Nadu; and other such urban areas. Many of them are block and district headquarters as well as suburbs, not yet incorporated peri-urban villages, industrial townships or traditional market areas. Segregated data about health infrastructure and its accessibility, health status of the residents of such towns in general, and of ‘hidden cities’ of metros of these states are available but sketchily and sporadically. Research on relevant health related themes in towns other than metros have started only recently, in order to understand problems leading to epidemics like deaths due to dengue, TB with multi drug resistance, persistent malnutrition status and disasters like floods as well as its health impact. Such research is mainly done either by organizations working for the health rights of all, or by investigative journalists. Some data about environmental health of small towns and its impact on human health has been collated in isolated form (e.g. in context of Namami Ganga project, it is revealed that half of the 7300 million litres of sewage comes from major cities of Uttara Khand, Uttar Pradesh, Bihar, Jharkhand and West Bengal, like Kanpur, Varanasi and Allahabad). There are areas in these cities where there is no sewerage network, therefore its flow is not accounted for. We still do not have reliable data about air pollution level in these cities and its impact on human health. A Google search quoting health status in smaller towns has hardly generated published data by reputed and reliable health research institutes.

Challenge 2: Bringing Private Health Sector Under Public Health ‘Gaze’

Most of the towns of more than 20,000 population in many states are estimated to have at least few small private hospitals or clinics / public health facilities. In towns with population about 10,000, a PHC is likely to be available. If the urban area is the market place for surrounding area, certainly private health facilities would be present. Maintaining data and notifying public health authorities is a major gap in these private health facilities. Recent debate about use of USG and legal action on those doctors who could not comply in record maintenance indicates this gap. Co-ordinating the private health sector for government supported public health schemes like RSBY, JSY etc is an additional challenge, mainly because of burden of paperwork on single owners, attitudes of practitioners, absence of a Clinical Establishment Act etc..

Challenge 3: Governing the ‘Climate’ Changes within the Public Domain

Healthcare is just one component of healthy life. For making these towns liveable, there are factors like quality of drinking water, sanitation, food and finally psychological and social well-being. Urbanization brings out all these acts out of central and state government department’s purview and placed firmly in the hands of the public through decentralization process. Creating Nagar Parishad, Nagar Panchayat, Notified Town Committees, Municipal Boards,

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Cantonment Board without much legal power (since most urban planning is approved by the State Government and not the local bodies) and building their capacities to carry the responsibility of creating structures, planning its service provision, implementing the schemes and generating revenue to sustain them are the biggest challenges. Addressing these challenges would be good governance to eradicate health inequity and sustain high quality of life of its 'citizen'!

What can be done to Overcome Urban Health Inequities in India

With launching of Smart City Mission, there is an opportunity for us to focus on a proposed model that is being developed under this campaign. Smart City Mission of the present Government of India envisages major changes in 11 infrastructure elements of urban life: water and power supply, sanitation, public transport, housing, IT connectivity and digitization, good governance, sustainable environment, citizens’ safety, health, and education. Each of these is a modifiable factor related to health inequity. The program in its existing format cannot make an urban citizen, particularly of the vulnerable group, smart or healthy. Therefore, urban health advantage will not simply emerge, it needs to be actively created and maintained through policy interventions. Such policy interventions need to be incorporated in healthy urban planning and implemented. Health objectives for urban planners, as suggested by Barten et al., may be important to refer in this context (see box 1).
We can do the following:

- Create an alternative vision document to make one’s town, city to become a Livable City for the vulnerable groups – people of ‘hidden cities’, the children, the adolescents, women, elderslies and differently abled. CII has produced such a document for Thoothukudi city – certainly a good step forward, from ‘development’ perspective. This document is worth appreciating because under Healthcare, it does mention improving the quality of government hospitals; How these improved government hospitals would be affordable and hence accessible to the vulnerable groups is still not specified, probably because it was done by a consultancy firm and not through a participatory process. Similar processes are on, in cities wherein the Smart City scheme is on the agenda.

- Create a set of smart health indicators or Quality of Life indicators of Livable rather than Smart Cities e.g. crime rates, road accident rates etc; safety, accessibility and affordability of healthcare (private and public) services to all urban citizens; working, commuting and housing environment; quality of water, air and ‘noise’; space management parameters such as public space for pedestrians and cyclists (rather than for automobiles), gardens and playgrounds (rather than car parking and commercial complexes), sale of packaged drinking water (to assess quality of drinking water) etc.

- Analyzing data related to health indicators of urban dwellers, distributing them geographically, socially and economically. The new report from WHO-UN Habitat shows that “…with urbanization of poverty, many slum dwellers suffer from an additional urban penalty: they have a higher rate of child mortality, die younger and suffer from more diseases than their more affluent neighbors. To better understand the factors contributing to poor health, the report focuses on several factors including population dynamics, urban governance, the natural and built environment, the social and economic environment, and access to services and health emergency management”.

- Generate workable models in smaller cities like bike hiring for transportation between metro/ bus stations, hub-spoke model for residential to working areas, have a conical peak of sky scrapers so that the streets would have sunlight, low cost network of private health care etc.

- Raise the voices of the people of hidden cities and of the vulnerable groups about space to live in, air to breathe, jobs to earn and enjoy, public space to relax, health care system to access and afford and so on…

- Advocate with city development authorities along with relevant other departments to integrate their planning system with transport, housing, environmental and health policy.

Would the smartness of the Smart Cities agenda assure to reach these goals, I wonder! Would it overcome the pathos of Shahryar- a great Urdu poet from Aligarh so that he can say:

“Aag ke sholonse sara shahr raushan ho gaya,
Ho Mubaarak, aarzu-e-khaar-o-khas puri hui!”

(Flames of the Fire made the town enlightened, Congratulations! Desire for thorns and hey for a nest was triumphed!)

Endnotes:


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Urbanization and Cardiovascular Risk: Moving Forward from Framingham

Introduction

The cardiovascular epidemic in India is evolving affecting particularly the urban towns in India. Epidemiological data shows that poorer communities are being particularly affected with increasing number of risk factors (Kavita Singh, et al, 2015). The focus of cardiovascular prevention in western countries has been individualised prevention based on screening, drug management of risk factors of hypercholesterolemia, diabetes and hypertension and non-pharmacological management through diet, weight reduction, and exercises. However the primary focus of cardiovascular prevention has been on drug management through blood pressure, blood sugar and cholesterol screening and initiation of anti-hypertensives and statin therapy. In western countries, a significant proportion of the entire population is on drugs for risk factor modification. This is leading to overmedication and high cost and is not sustainable on the long run. Such an approach also does not appear to be addressing the underlying problem that is leading to the epidemic. Is the IHD epidemic a natural consequence of development? Is there any other possible prevention approach?

The Impact of the Framingham Heart Study on Modern Medicine

Framingham study of cardiovascular risk was an epochal study. It brought in a new methodological approach in studying disease causation, the cohort study method and the use of multivariate statistics (Syed S Mahmood, et. al. 2014). It brought in a new conceptual framework of thinking about complex chronic disease, the risk factor approach as an explanatory framework of disease causation and risk factor based prevention.

“A new style of explaining cause and responsibility, one which used probabilistic language to link quantifiable and elementary properties of individual physiology, behaviour, and social and familial background to specific and untoward outcomes. By the late 1960’s, this type of explanation became the dominant way of expressing and conceptualising what individuals contribute to CHD.”(Aronowitz 2012)

Most importantly the Framingham study brought in a new way of thinking about public health, an individualized public health based on risk factor modification.

Shifts in Framework of Chronic Disease and Prevention with Framingham Study

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<tr>
<th>Pre-Framingham</th>
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<tr>
<td>Macro-epidemiology</td>
<td>Micro-epidemiology</td>
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<td>Role of epidemiology in studying infection</td>
<td>Epidemiology in study of disease causation in the</td>
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<td>disease in the population</td>
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<td>Population at risk</td>
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<td>Risk factor- insurance concept (investment</td>
<td>Risk factor- disease causation, clinical prediction</td>
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<td>against risk of dying)</td>
<td>of risk, initiation of disease prevention</td>
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<td>Governmental mode of public health- population prevention interventions</td>
<td>Private mode of public health- individualised disease prevention</td>
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<td>Method of study of etiology- through study in the laboratory (laboratory medicine)</td>
<td>Clinical epidemiology- clinical method of study of disease causation, disease prediction and Prevention</td>
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The Framingham Model

The model of research was not based on the social medicine model of public health to find out the social determinants of CHD (macro-epidemiology). If that was the case, then a different set of factors would have been identified and a different set of prevention strategies would have been conceptualised (Elodie Giroux 2012, Gerard Oppenheimer 2006).

The model was based on a clinical model: what are the clinical factors that can be reliably documented which are early predictors for CHD? This reflects the active involvement of cardiologists who were involved in a study of “clinical epidemiology”

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The model of prevention that was propagated by the National Heart Association was an individualised model. This has to be understood in the background of the American private health care system and also the setting of health care provision in Framingham. The model of prevention that was developed was one that could be delivered by the private health care system to the individual patient. It was a medical model of prevention for the individual patient, an individualised public health not for improved health of the population.

This has to be contrasted to other kinds of public health initiatives for population health and prevention. For example John Snow’s work showing that the contamination of the hand pump had led to the cholera epidemic led to public health interventions to improve sanitation. In this case, a structural improvement led to a dramatic change in the incidence of the disease. Another example is immunisation, where vaccine is administered to the entire population to prevent disease in the population. Here, the vaccine may prevent disease in the individual. However the individual may or may not benefit from the intervention. If interventions are given to only select individuals as in the Framingham model, it can prevent disease in the individuals but may not prevent disease in the population. In order to arrive at a rational method of disease management, different models of prevention and their economic, social and biomedical presuppositions would have to be studied and analysed to arrive at a possible breakthrough.

With the risk factor model there has been the blurring the margin between normal and pathological. Each of these parameters of hypertension, hypercholesterolemia and diabetes is not defined by symptoms or signs or pathology but by a set of clinical or laboratory measurement. These asymptomatic parameters can predict risk in the future. There is an incremental increase in risk of cardiac events with elevation of each of these parameters. Even at quite normal levels cholesterol, blood sugar and blood pressure there is risk of cardiac events (i.e., there is no level below which there is zero risk to the patients). Most of the randomised controlled trials of risk factor modification treatments have been conducted by pharmaceutical companies. These drug trials have shown that as you bring BP and cholesterol lower, there is a progressive reduction in cardiovascular risk. This has led to lowering of cut-offs for initiation of preventive treatment and new diagnostic categories such as ‘pre-diabetes’ and ‘pre-hypertension’. The concept of risk is malleable and infinite, rendering normal and pathological indistinguishable and open to manipulation by the pharmaceutical industry.

The combination of shifting goal posts for initiating risk factor reduction, an individualised model of cardiovascular risk reduction and a privatised health care industry has led to a situation where there has been a change in the nature of health care. Most of health care delivery for cardiovascular prevention is focussed on drug therapy not to treat pathology, but to treat risk in the future. We moved to the age of a risky society, where health care is governed by cardiovascular risk.

Problems of Risk Factor Model for India

How relevant are the risk score calculators based on the Framingham study for India? Can they be used for calculation of 5 and 10 year risk of cardiac events? We know that there are differences in the relationship of risk factors and cardiac events in India. The contribution of smoking and hypertension to cardiac events is greater. The relationship of smoking and hypertension to cardiac events is greater. The relationship of BMI and cardiac events shows increase in cardiac events at lower BMI. Abdominal obesity is considered to be a cardiovascular risk factor in India even at normal BMI. Data also seems to suggest that risk of cardiac death in patients presenting from lower socioeconomic background is higher. If the relationship between risk factors and cardiac events is population specific, is it possible to have uniform cutoffs for risk factor definition and initiation of treatment guidelines? Is it possible to extrapolate results of cardiovascular risk reduction treatment guidelines from one population to the other?

Is there Another Way to Conceptualise Cardiovascular Risk?

In India we know that there are larger development changes that are leading to the cardiovascular epidemic: large scale urbanisation with poor living conditions, reduced physical activity related to urban occupations, use of motorised transport and lack of physical space, high carbohydrate diet with increased fat intake due to high cost of vegetables and fruits and urban stress and smoking. There has been reversal of coronary risk factors with improvement in socioeconomically better off and worsening in the lower socioeconomic groups.
The point is that there are larger development forces that are leading to cardiovascular epidemic. Viewing the problem from an individualised risk factor model renders invisible the larger development forces that are leading to the epidemic.

Studies of Chronic Disease in Gudalur

Our work with the Gudalur Adivasi hospital provides interesting insights into the link between development and cardiovascular epidemic (Zachariah and Srivatsan 2015). There are four tribes in the Gudalur valley who together form the Adivasi Munetra Sangham. Our studies examined changes in development, cardiovascular risk factors and mortality.

Changes in Development

The tribes used to live in the forests and off the land till the 1970’s. During the last 30-40 years within one generation there has been large scale development change. They have entered a cash economy. The current adults remember that in their childhood they had a wide food basket which was primarily obtained from the land and forest. This included range of cereals, millets, tubers, leaves and fruits from the forest, a variety of hunted meat and fish from the streams. Although there were periods of starvation, the food quality was better. Today their primary food source is PDS rice. Most of the food is bought with scanty amounts of vegetables and fruits, minimal protein and fat. Although physical activity has reduced from their childhood, the most members interviewed are still very active. The levels of stress are quite high related to entering a cash economy (education, health care, alcohol, jobs, loans, house construction etc).

In short, the processes of urbanization, i.e., the development of small towns in the vicinity and the entry of urban concepts, processes and organizations like health care, education, wage labour, and development/community health groups have all led to changing health profiles among the adivasis.

Cardiovascular Risk Factors

The Mullukurumba tribe which is socioeconomically better off has higher rates of diabetes, obesity and hypertension. All the other three tribes had almost non-existent diabetes, moderate rates of hypertension and high rates of low BMI (chronic energy deficiency). The villages which were more developed had higher rates of diabetes, hypertension and obesity. The villages which were less well developed had higher rates of hypertension and low BMI.

From this data we inferred that the villages and tribes had different cardiovascular risk profiles based on their development parameters.

Cardiovascular Mortality

Review of community mortality statistics showed that the foremost cause of death in the community was heart attacks and strokes. The overall rates of deaths...
due to strokes and heart attacks are equal to urban Kerala. In Mullukurumbas, the main cause of death was heart attacks probably secondary to obesity, diabetes, hypertension and less physical activity. In the other three tribes the chief cause of death was stroke probably due to wide-spread hypertension.

Model of Cardiovascular Disease in Gudalur

We suggested that the current cardiovascular epidemic in Gudalur may be linked to large scale development change in the tribal communities. Development and urbanization are differentially affecting different tribes causing different chronic disease risk factor profiles (See Figure 1). All tribes had increased cardiovascular deaths though they were mediated through different risk factor profiles. The risk factors of blood sugar, BP and BMI can be conceived as intermediate risk markers in the true sense of the word. The proximal development factors that are leading to these changes may include changes in food, activity, stress and economic changes. Exactly how this web of development changes exerts itself through the risk factors to cause heart attacks in Mullukurumbas and strokes in other 3 tribes is unclear.

Implications for Cardiovascular Prevention in Gudalur

One approach to cardiovascular prevention in Gudalur is the individualised model of risk factor prevention based on the Framingham approach. However the Gudalur community is a democratic community, consciously making decisions about its mode of development for the future. Does the community have development choices it can exert in addressing the cardiovascular epidemic? For instance, can the traditional knowledge about gathering food from the land and forest be used to widen the food basket through non market modes of food security? It is important for the tribes to maintain good levels of physical activity. Can the community develop new modes of dealing with modern stress, through their main strength of strong tribal identity and sense of community. What modes of democratic action can work in Gudalur to address the cardiovascular epidemic?

Conclusion

This article discusses the limitations of our current model of cardiovascular prevention that emerges from the Framingham study. The limitations of our current model of cardiovascular prevention are (a) public health model based on drug based individualised prevention; (b) blurring of margin between normal and pathological and downward mobility of treatment cut-offs for risk factor prevention and (c) market approach to prevention using private health care.

It discusses the limitations of application of this model in India. The relationship of risk factors to cardiac events in India is different and hence risk factor calculation and guidelines developed in other countries may not be readily application. There is a large scale epidemic among poorer section and drug based prevention will require high investment may not be sustainable.

Based on the Gudalur experience we argue for the need for a public health approach for cardiovascular prevention based on social determinants and a development model of disease. Whilst these suggestions may be intuitively applicable to urban settings, they need to be validated by more extended studies. What are the possibilities for a model of primary care and public health that involves communities to deal with the cardiovascular epidemic that seems to accompany processes of urbanization?

References


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The article, “My Perspective on the Chronic Disease Epidemic in India” by Anand Zachariah (AZ) in mfc bulletin of Mar-Oct 2015, tries to understand the complex, somewhat perplexing scenario of chronic diseases in India and their relationship with theory and practice of modern medicine and epidemiology in the current era in India. It however suffers from two problems.

Firstly it equates misuse of medicine and epidemiology with these sciences as such. AZ says “the epidemiological techniques of modern medicine are leading to overmedicalisation - he probably want to say “overdiagnosis” - stating that a large proportion of the normal population is diseased. I would point out that this is a result of misuse of epidemiology and not a result of epidemiology as such.

As regards the science of medicine, AZ says that “changes in glycaemia, blood pressure, cholesterol and weight ... modern medicine has only one way to deal with this epidemic, i.e., to medicalise it.” Here again, AZ does not distinguish between the science of modern medicine and its misuse in the commercialized, profit-driven system.

The science of clinical medicine gives due space for preventive methods and non-drug therapy. For example, in the chapter on Diabetes Mellitus, in the world renowned textbook, Harrison’s Principles of Internal Medicine, there is a short section on Prevention at individual level before the section on Treatment. It recommends “intensive changes in lifestyle (diet and exercise for 30 min/d five times/week).” Later, in the section on Treatment, the sub-sections on diabetes education, nutrition, exercise precede the sub-section on drug-treatment. In capitalism, in practice, this science of clinical medicine takes a backseat and medicine is misused in the commercialized, profit-driven system.

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Secondly this article fails to take into account in clear terms that disease causality operates at all three levels – cellular/biophysical, socio-cultural and economico-political – and hence the remedy is also at three levels. Disease-causality at cellular/biophysical level (pathogenic germs or chemical-derangements - deficiency or excess of certain biochemicals, etc.) is addressed by the science of clinical medicine. Disease-causality at social level (deficient sanitation/water supply at community level or wide-spread alcoholism or unsafe transport conditions or sedentary, stressful life-style at social, community level etc.) is addressed by the science of epidemiology and community medicine. It explains why in a community so many people get diarrhoeas or get alcoholic cirrhosis or get fatal head injuries; something which cannot be explained by clinical medicine. Disease-causality at economico-political level (capitalist path of development, especially its monopoly phase which generates pathogenic model of development, or the paradigm of growth for the sake of growth in degenerated state socialism) is explained by economico-political analysis. It explains why social pathology continues to reproduce itself, something which cannot be explained by epidemiology.

The above is a very sketchy framework. But it indicates that all the three levels of disease-causality and of remedies need to be recognised clearly. It is pointless to focus attention only on one of the three levels. Secondly, misuse of medical science under the influence of capitalism has to be distinguished from the science of medicine as such, inclusive of both clinical and social medicine, though this science also tends to get vitiated by capitalism.

Unfortunately AZ fails to recognise this.
A few years ago, during an ‘interface meeting’ of community members and the staff at a BBMP (Bruhat Bengaluru Mahanagara Palike) Referral Hospital, one woman stood up to tell the story of her daughter Fatima* who had recently had a normal delivery in the hospital. She had complained of discomfort, but the nurse said that this was normal and discharged her. A week later, the discomfort had not abated, fever had set in and her family noticed a bad smell. Fatima’s husband, who was against the decision of going to a government hospital, now took her to a private nursing home. There, the doctor pulled out cotton from her cervix and discovered an infection. Fatima was admitted in the nursing home for a number of days and her family incurred expenses of about Rs. 10,000. On hearing this from her family, the Superintendent of the Referral Hospital promised an investigation. When activists met her a couple of weeks later, she said that the hospital’s practice was to insert tampons to protect the women’s episiotomy stitches from blood. The nurse had forgotten to remove the tampon before discharge!

In response to this incident (and 2 similar ones reported at the interface meeting), the Superintendent stated that she had called a special meeting and changed the discharge procedure, with a doctor now examining each woman before discharge. But the story does not end here. While no new cases have been reported at this hospital, field activists working with SPAD (Society for People’s Action for Development, who had organized the meeting) recently heard of another such case in a BBMP Maternity Home some 15 km away. Unfortunately, they were not able to trace the woman as she had moved away from that locality. There is no functioning grievance redressal system in hospitals, plus the BBMP Health Department has become hostile to the SPAD activists and is unlikely to investigate the matter further. In this impasse and other such situations, activists have asked ‘Should we be trying so hard to convince women to go to government hospitals?’

SPAD began working with Dalit and Muslim women in 27 slums in south west Bangalore in 2010 to improve their access to government health services. While no community monitoring programme exists in Bangalore’s government hospitals, the community women have formed their own monitoring committees which regularly visit various hospitals run by BBMP and the State Health Department. Their reception by hospital staff ranges from tolerance to indifference to hostility. But they have been able to achieve some results - abuse of Dalit and Muslim women has reduced, as have demands for bribes, and some services have improved. The structural issues and disputes over appropriateness of care, referrals etc. have proved harder to tackle. At the local (slum) level, solidarity groups set up by SPAD have found it easier to take up social determinants of health such as water, waste management and security issues. Here too, financial demands such as loans for savings groups and cash compensation for flood damage have been easier to realize than, say, better services at the local anganwadi.

The Urban Health Care Scenario

Like other cities, Bangalore suffers from fragmentation of government health services, with institutions and outreach services run by BBMP, the State Health Department, the State Medical Education department (through Bangalore Medical College and autonomous institutions), ESI and national institutes such as NIMHANS. Within BBMP itself, services are fragmented – for example, a woman delivers at a Maternity Home or Referral Hospital, but has to collect some of her maternity benefits from the Urban Family Welfare Centre (UFWC) which initially registers her through its outreach programme. Fragmentation is present in other social-sector and essential programmes – for example, the zones for services through BBMP (wards) are different than those for water and drainage (provided by BWSSB, the Bangalore Water Supply and Sewerage Board), which are further different from the school zones of the Department of Education. For any person, but especially one from a marginalized group, negotiating these various jurisdictions and getting one’s work done is not easy.

The outer, newly expanding areas of the city are poorly covered, with some wards lacking any government health facilities. Further, many existing primary facilities are poorly staffed or underequipped. As a result, secondary and tertiary hospitals in the city have a huge primary care load. A survey conducted by SPAD at Vani Vilas Hospital, a tertiary-level institute for gynaecological and obstetric care managed by Bangalore Medical College, revealed that more than half of the 320 women interviewed had normal deliveries (with most being uncomplicated).
Ironically, 96.6% of them had visited another facility before coming to Vani Vilas. They either found them closed, lacking staff/facilities, or were referred out for reasons like having high BP, anaemia, or need for a C-section. One woman was referred because the BBMP Maternity Home didn’t have the ‘injection to increase labour pain’ (most likely oxytocin).

In addition to all this, the out-of-pocket expenditure for patients accessing government health services is striking – some examples:

- Pregnant women spend thousands to pay for diagnostic tests and scans as well as medicines from private labs as government facilities don’t provide these services – various surveys by SPAD have revealed median costs of Rs. 2000-5000 for antenatal care per pregnancy.
- The treatment for dengue, chikungunya etc. has been missing in most government hospitals. Those that do have services have sometimes refused to admit patients. In one slum, SPAD activists found many families who had 2-4 members admitted in private hospitals for these diseases and had taken crippling loans to cover the costs.
- Very few government hospitals provide medicines for chronic diseases, which cost at least hundreds of rupees each month.
- Some poor patients are able to get free or discounted tertiary care through government-supported insurance schemes, CM relief fund etc. but incur routine post-operative expenses. Some cases examined recently by JAAK (Janaarogya Andolana Karnataka) were of patients who had heart surgery at Jayadeva Hospital, a government autonomous institution and were paying about a thousand rupees every month for medicines thereafter.
- At hospitals managed by Bangalore Medical College (an autonomous government institution), BPL patients receive a discount of 50% for diagnostic tests. Given the volume of tests prescribed, even this amount can add up – a wastepicker recently operated in one of these hospitals incurred almost Rs. 40,000 for tests, scans, blood and travel even though her bed and surgical charges were waived.

City-level Advocacy on Health Issues

City-level health issues in Bangalore have been taken up by informal and formal networks such as Janaarogya Andolana Bangalore Urban (JAABU), the city chapter of JAAK, which is in turn the state chapter of Jan Swasthya Abhiyan. From 2011-2013, JAABU’s advocacy ranged the spectrum from reports and consultations to protests. Many important issues were raised and discussed, but no real progress was achieved on any of them. In late 2012, JAABU representatives were informed that the National Urban Health Mission (NUHM) was to be launched with Bangalore and Bhuvaneshwar as pilot cities. There was an opportunity to participate in a series of roundtables organized by the Karnataka Health Systems Resource Centre (KSHSRC) with the support of the Public Health Foundation of India (PHFI). This led to deep divisions within JAABU on whether to participate or not in these deliberations, with some considering the process co-option and others looking at it as an opportunity.

Eventually some members participated in the roundtables, including myself. There was strong participation from ‘civil society’ and medical and social issues, communitisation, convergence and governance were discussed. The draft approach paper developed by KSHSRC reflected this (though, with inputs from all stakeholders, it turned into a confusing document!). But the subsequent Programme Implementation Plan (PIP), drafted based on specifications from the MOH, GoI, was disappointing. The focus was on building new PHCs, upgrading old ones and communitisation (through Mahila Arogya Samitis and ASHAs) to ‘generate demand’ without any horizontal or vertical integration. There was little focus on referral systems, comprehensive care, and other issues highlighted in the roundtables. Also, the plans for NUHM changed to a nationwide launch and the promised funds were reduced significantly.

Another opportunity came up when the Technical Resource Group, chaired by Harsh Mander, visited Bangalore in late 2013. This time SPAD and other organizations presented very specific recommendations at the primary level, such as:

- Rather than appointing ASHAs (who could get controlled from above), the members of MASs should be allowed to manage the responsibilities jointly. The NUHM draft framework provides this as an option.
- MASs should be federated at the ward level and members included in the ward committees (mandated under the Karnataka Municipal Corporation Act)
- BBMP Link Workers should be absorbed into NUHM, possibly by training them to become ANMs
- Members of ward committees and the staff of referral centres should be included in the ARS of the local PHC to address social determinants, referrals from the PHC etc.

Our recommendations were discussed and similar concerns have been raised by NUHM staff and consultants later, but none of them have resulted in any concrete changes as of yet. NUHM was ‘launched’ in Bangalore in January 2014, but implementation in the field began more than a year later. So far, some MASs
have been formed and ASHAs selected with the help of SPAD and other field organizations. But the fragmentation continues – recently, a newly-minted ASHA (who is also a SPAD field activist) escorted a woman in labour to the nearby Maternity Home, where the doctor refused to admit her because she had moved to Tamilnadu after marriage. When the ASHA protested, the doctor responded that ASHAs report to the nearby UFWC and Maternity Homes have nothing to do with them! Ultimately, the ASHA had to take the woman to Vani Vilas Hospital for delivery.

There is some energy and an influx of funds into the cash-strapped BBMP after NUHM activities commenced – health camps are being organized regularly in slums and there is improved outreach. But there are some puzzling developments as well – when asked about medicines for non-communicable diseases, officials stated that these would be provided in facilities based on demand and that ANMs/ASHAs would conduct field surveys to estimate the burden of disease. Aren’t there enough published studies on NCDs to use as reference – why is a fresh survey required? However, it is early days yet for NUHM-redux.

In the meantime, the divisions within JAAK led to a split and JAABU went into hibernation. Individual groups continued their work and advocacy to differing levels of success. In the past year, organizations have started coming together again and the announcement of JSA-NHRC public hearings have given an extra fillip.

‘Are you the Doctor or am I?’ Experiences at the Local Level

While mobilizing communities for health rights in Bangalore has had some successes, there have been many setbacks as well. In March 2014, the Chief Medical Officer (CMO) attended an interface meeting organized by SPAD and was shocked at some of the evidence presented. Some Medical Officers and staff were hauled over the coals for poor attendance, corruption and high numbers of referrals. The CMO promised to overhaul the BBMP health system. But subsequent developments indicate that political pressure was brought on her to reverse her stand. She refused permission for SPAD to conduct further interface meetings, and since then not a single one could be organized.

In the meantime, the activists and solidarity groups members have become more confident and, in some cases, politically active. There is regular interaction with elected representatives, and this bode for recently when one sympathetic Corporator became the Chairperson of the Standing Committee for Health, BBMP. He invited SPAD representatives to raise the problems faced in one particular hospital in a public meeting with media presence. He identified with and agreed to tackle issues of corruption, though it is not clear how much he connected with the other issues. In fact, political ‘interference’ may be detrimental in increasing the number of deliveries at the hospitals – BBMP doctors have become extremely risk-averse and have said that they do not want to deal with the fallout from a death in the hospital. The result is that BBMP hospitals, even Referral Hospitals which have specialists, rarely go above 2-3 deliveries a day, while Vani Vilas conducts 60-80 deliveries every day and faces almost all the maternal and infant deaths.

Some doctors do appreciate the community’s involvement – a newly upgraded CHC near Kengeri (formerly a satellite town, now part of Bangalore) has specialists and the requisite nursing staff, but lacks furniture and equipment. Their OT has been poorly constructed (with windows!). The Health Department has asked the doctors to use ARS (Arogya Raksha Samiti) funds or user fees to get the OT repaired! The solidarity group in the area approached the elected representatives and was able to get some necessary equipment for the CHC. They are still trying to address the OT problem – elections have delayed a public meeting with the local MLA.

At the organizational level, there are also challenges in building capacity on health issues and in overcoming the adversarial relationship between the community and hospital. An activist recently shared the story of a woman who said she was told by her doctor that her infant had died in utero. She then rushed to another hospital where she delivered a live baby normally. But after the case was documented, it was found that the doctor had given a referral slip and called for an ambulance. How this reflects on her skills is a different question, but she cannot be accused of callousness. Unfortunately, some genuine cases get missed or buried in this atmosphere of suspicion.

Conclusion

Community-led advocacy, with the requisite capacity-building and support, can play a crucial role in improving access to health services and thus address health inequities. But the challenges of the urban space, along with information and education assymetry as well the unwillingness of the health system to cooperate, can limit the effectiveness of this advocacy. The challenge is to create effective partnerships between health systems, political structures, health experts and the community to effectively address community health needs.
Women’s Health in Urban Vadodara: Reflections based on SAHAJ’s Experience

-Manushi Sheth, Sangeeta Macwan, Renu Khanna*

The Context: Health Indicators in Gujarat

Gujarat is generally recognised as a ‘developed’ state. However, compared to other states at the similar level of development – the mid-range states in India (for example, Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu, Punjab, West Bengal) – Gujarat fares worse than most of them on several indicators (see Table 1).

- Gujarat’s Infant Mortality Rate is higher than Maharashtra, Karnataka, Tamil Nadu Punjab, West Bengal
- Gujarat’s Maternal Mortality Ratio is higher than Maharashtra, Andhra Pradesh, Tamil Nadu Punjab, West Bengal
- The Fertility Rate is higher than all the other comparable states
- The Sex Ratio is worse than all the other states, the Child Sex Ratio is worse than all the other states except Maharashtra and Punjab
- Anaemia in women (15-49 years) is worse in Gujarat than all other states except West Bengal and Andhra Pradesh.
- Female literacy rates are worse in Gujarat – only Karnataka and Andhra Pradesh have lower female literacy than in Gujarat.

About Vadodara

Vadodara, the third largest city of Gujarat, and 20th largest in India and is one of the metropolitan towns of Gujarat State. Presently, Vadodara Municipal Corporation is divided into four administrative zones and twenty eight wards.

During 1991 and 2001 the population growth rate in the district was almost 20% and between 2001 and 2011, it was 14.38 %. In 2011 the urban population in Vadodara District was 49.59%. The city itself has a population of 20.6 lakhs (2011 census). Increase in city population is probably due to migration of people from villages towards the city which in turn creates

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Table 1: Demographic, Socio-economic and Health Profile of Gujarat State as compared to India and other Comparable States

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Gujarat</th>
<th>Maharashtra</th>
<th>Karnataka</th>
<th>Andhra Pradesh</th>
<th>Tamil Nadu</th>
<th>West Bengal</th>
<th>Punjab</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality Rate (SRS 2013)</td>
<td>36</td>
<td>24</td>
<td>31</td>
<td>39</td>
<td>21</td>
<td>31</td>
<td>26</td>
<td>40</td>
</tr>
<tr>
<td>Maternal Mortality Rate (SRS 2010-12)</td>
<td>122</td>
<td>87</td>
<td>144</td>
<td>110</td>
<td>90</td>
<td>90</td>
<td>117</td>
<td>155</td>
</tr>
<tr>
<td>Total Fertility Rate (SRS 2012)</td>
<td>2.3</td>
<td>1.8</td>
<td>1.9</td>
<td>1.8</td>
<td>1.7</td>
<td>1.7</td>
<td>1.7</td>
<td>2.4</td>
</tr>
<tr>
<td>Crude Birth Rate (SRS 2013)</td>
<td>20.8</td>
<td>16.5</td>
<td>18.3</td>
<td>17.4</td>
<td>15.6</td>
<td>16</td>
<td>15.7</td>
<td>21.4</td>
</tr>
<tr>
<td>Sex Ratio (Census 2011)</td>
<td>918</td>
<td>925</td>
<td>968</td>
<td>992</td>
<td>995</td>
<td>947</td>
<td>893</td>
<td>940</td>
</tr>
<tr>
<td>Child Sex Ratio (Census 2011)</td>
<td>886</td>
<td>883</td>
<td>943</td>
<td>943</td>
<td>946</td>
<td>950</td>
<td>846</td>
<td>914</td>
</tr>
<tr>
<td>Schedule Caste population (In Core) (Census 2001)</td>
<td>0.35</td>
<td>0.98</td>
<td>0.85</td>
<td>1.23</td>
<td>1.18</td>
<td>1.84</td>
<td>0.74</td>
<td>16.6</td>
</tr>
<tr>
<td>Schedule Tribe population (In Core) (Census 2001)</td>
<td>0.74</td>
<td>0.85</td>
<td>0.34</td>
<td>0.50</td>
<td>0.065</td>
<td>0.44</td>
<td>Not Notified</td>
<td>8.4</td>
</tr>
<tr>
<td>Prevalence of anaemia in women 15-49 years (NFHS 3)</td>
<td>55.5</td>
<td>49.1</td>
<td>52.2</td>
<td>62.7</td>
<td>53.9</td>
<td>63.8</td>
<td>38.3</td>
<td>56.2</td>
</tr>
<tr>
<td>Total Literacy Rate (%) (Census 2011)</td>
<td>79.31</td>
<td>82.91</td>
<td>75.60</td>
<td>67.6</td>
<td>80.33</td>
<td>77.08</td>
<td>76.68</td>
<td>74.04</td>
</tr>
<tr>
<td>Male Literacy Rate (%) (Census 2011)</td>
<td>87.23</td>
<td>89.82</td>
<td>82.85</td>
<td>75.56</td>
<td>86.81</td>
<td>82.67</td>
<td>81.48</td>
<td>82.14</td>
</tr>
<tr>
<td>Female Literacy Rate (%) (Census 2001)</td>
<td>70.73</td>
<td>75.48</td>
<td>68.13</td>
<td>59.74</td>
<td>73.86</td>
<td>71.16</td>
<td>71.34</td>
<td>65.46</td>
</tr>
</tbody>
</table>
demand for provision of basic facilities like health, water and sanitation, to all the people.

**Vadodara’s Public Health Facilities**

Vadodara has 336 slum areas. The health infrastructure managed by the Vadodara Municipal Corporation is as under:

- Government hospitals: 2
- Urban health centres: 19
- NGO centres: 6
- Integrated health centre and Nursing home: 1
- Staff dispensaries: 2
- Full time/Part time dispensaries: 15
- Mobile units: 4

Many health facilities are either working partially or are in a non-working condition. There are staff shortages when compared to the Human Resource norms for Urban Public Health Centres. Because of insufficient staff and lack of other resources in Urban Primary Health Centres, tertiary Government hospitals are getting overcrowded.

**SAHAJ and its Field Areas**

SAHAJ has been working with marginalised and deprived urban communities of Vadodara since 1984. We focus on health, education and developing responsible citizenship among the youth. At present SAHAJ covers about in 15,000 people in 18 slum areas. Based on a survey done by SAHAJ in 2011 of 12 slum areas, following points are indicative of the slums’ status:

- 28% people are non-literate.
- 42% people are daily wage labours.
- 17% houses are permanent, 65% houses are semi-permanent and 10% houses are non-permanent and 32% houses do not have toilet-bathroom facility.
- Only 28% house-holds have drinking water facility.
- 5% households do not have electricity/light facility.

The survey revealed that 75% of families have ration cards and of them only 22% have the BPL card and 9% have the Antyoday card. The families even after living in a city lack basic facilities needed for a dignified life. These families should come under Below Poverty Line if we were to consider poverty as a multidimensional concept and not just based on incomes. Because of lack of the requisite ‘cards’, many poor families are unable to avail of the benefits of Government Schemes like the PDS, Janani Suraksha Yoyana, Chiranjeevi Yoyana, Kasturba Sahay Yoyana.

**Our Interventions**

SAHAJ has been working in between 16 to 20 bastis in Vadodara on adolescents’ rights issues since 2003, and on Comprehensive Women’s Health since 2006. The objectives of our last 15 years’ work are to create

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**Table 2: Status of Human Resources in Urban Primary Health Centre**

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Name of the Cadre</th>
<th>Posts approved as per level of UPHC</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medical Officer</td>
<td>1+1 part time</td>
<td>1+1 part time</td>
</tr>
<tr>
<td>2.</td>
<td>LHV (only in Corporation)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3.</td>
<td>Pharmacist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4.</td>
<td>Lab Technician</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5.</td>
<td>Staff Nurse</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>Public health manager / community mobilizer</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7.</td>
<td>ANM/FHW(one @10000 population)</td>
<td>5 to 6</td>
<td>5 to 6</td>
</tr>
<tr>
<td>8.</td>
<td>M&amp;E</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>9.</td>
<td>Support staff (peon + Aaya + Security)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>

(Source: Presentation by State Project Management Unit in orientation of MAS meeting on 21 November, 2015)
awareness among community about health rights and entitlements and to generate demand for health services. The initiative also seeks to strengthen basti level committees to negotiate determinants of health and health care issues.

Participatory action research processes, awareness generation and community mobilization by peer educators and community health workers; provision of services through community health workers and advocacy through local people’s groups comprising of basti development committees, health workers, peer educators etc., are some of the strategies being used.

Our data shows that most women go to the private sector for most of their reproductive health needs. After our early interventions, eligible/BPL women began availing of the benefits of the Chiranjeevi Scheme when it started in 2007 (one free ANC and delivery at a private maternity home that is reimbursed by the State Government). However, quality of care was an issue – the promise of Skilled Birth Attendants was belied because the doctors employed traditional dais to do the normal Chiranjeevi deliveries! For complications and serious gynaecological complaints, poor women went to the Medical College Hospital which was choked with patients from neighbouring and distant districts. The absence of secondary hospitals in the city where they can get affordable health care for their gynaecological problems is felt acutely.

In fact, affordability is a big issue – women who go the tertiary medical college hospital for Caesarian Sections complain that they incur up to Rs. 5500 for their surgery. Attitude and behaviour of services providers at Government hospitals make women opt for normal deliveries at private hospitals where the costs range from Rs. 3000 to Rs.5000. Cost of medical abortion at private hospitals range from Rs. 675 and Government hospitals is Rs. 300. Average cost of treatment for Reproductive Tract Infection is Rs. 372 in private hospitals and Rs. 100 in Government hospitals. Parents have to spend a minimum of Rs. 200 at private clinics for treatment of minor illness of their children. In special cases they have spent as much as Rs. 60,000. They have to shell out the cost of the first visit by the paediatrician for their newborn, when deliveries take place in private hospitals which is a minimum of Rs. 500. (Source of all cost data: Vyas, Swati. Evidence Based Advocacy for Maternal and Child Health of the Urban Poor: A Case Study from Vadodara. SAHAJ. 2009)

The following issues emerge from the experience of working on health of the urban poor in Vadodara City:

- Frequent demolition of bastis, resulting in poor people getting scattered and invisibilized, as they rent houses/rooms in different parts of the city.
- Lack of basic amenities for safe drinking water, sanitation, street lights, etc., even in bastis that have been in existence for many years. Lack of toilets in homes with adverse consequences particularly, safety of women and girls, as they use public toilets in and around their bastis.
- Public health facilities are inaccessible due to their distant locations, and require repeated visits and lengthy procedures to access services.
- People end up spending even in Government services, so they prefer private services. People going to hospitals feel lost, as there are no directions and

<table>
<thead>
<tr>
<th>Parameters</th>
<th>In bastis with Anganwadi</th>
<th>In bastis without Anganwadi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home delivery</td>
<td>8 %</td>
<td>10 %</td>
</tr>
<tr>
<td>% of women accessing Ante Natal Care</td>
<td>63 %</td>
<td>44 %</td>
</tr>
<tr>
<td>% of women accessing Post Natal Care</td>
<td>30 %</td>
<td>42 %</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>34 %</td>
<td>37 %</td>
</tr>
<tr>
<td>% of children receiving Vaccination</td>
<td>94 %</td>
<td>75%</td>
</tr>
<tr>
<td>Child deaths as a % of total live births</td>
<td>3%</td>
<td>10%</td>
</tr>
</tbody>
</table>

(Source: Annual data of child rights program of SAHAJ from October 2014 to September 2015)
they are not aware of all the services that they are entitled to and can obtain from various levels.

- Absence of maternity services at the primary level by the public health system, and lack of attention to adolescents’ reproductive and sexual health (ARSH).
- Schemes like Chiranjeevi and Janani Suraksha Yojana (JSY) are available for people in the Below Poverty Line (BPL) category. However, many eligible families do not have a BPL card and there is a general lack of awareness of the various schemes - JSY, Chiranjeevi - that poor women can avail of.
- Non compliance of private providers with requirements of government schemes, for example the Chiranjeevi Scheme as mentioned above.

Right to Health Care

Availability of ICDS Services in SAHAJ’s Working Area

AWCs are easily accessible and provide primary health care centre to pregnant woman and education to young children and girls. Our data shows the importance of the AWC for improving the health indicators. Table 3 shows the differences in health indicators in the bastis where we work, which have AWCs and those that do not: Home deliveries and Malnutrition are slightly higher, ANC and Immunisation lower, in bastis with no AWCs in comparison with bastis with AWCs. Child deaths are higher in bastis where there are no AWCs. Differences are significant in the terms immunisation and child deaths; others need more working upon.

Despite the recent Supreme Court Order on universalisation of the ICDS programme, out of the 18 existing work areas of SAHAJ, four bastis still do not have Anganwadi Centres. The communities in Subhashnagar and Hanuman Tekri have been constantly following up on their demand for an Anganwadi Centre (AWC) since last three years. Finally the sanction for an AWC in Hanuman Tekri came through in December 2015 and it started functioning recently. Gayatripura and Bhensasurnagar also, after constant follow-up action, ultimately got their AWCs. The Anganwadis in Jalaramnagar and Gayatripura got the appointment for the Helper after two years’ follow-up by the community. Subhashnagar is a basti where people live in abject poverty and this basti has still not been successful in getting its Anganwadi.

Quality of Health Care

Health care services without the requisite quality, is a violation of health rights (ICESCR General Comment 14). The urban poor suffer from this violation very often.

Service Provision through the Mamta Diwas

Observations of 45 Village Health and Nutrition Days (Mamta Diwas) in urban Vadodara showed
- Absence of doctors on Mamta Diwas.
- Poor quality ANC - tests and checkups are not done, for example, Blood Pressure measurement, blood tests, abdominal check-up of pregnant women.
- Information related to ‘high risk’ was given only during 7 Mamta Diwas out of the 45 Diwas observed.
- No referral facility was provided to sick children on any of the Mamta Diwas.
- Adolescent girls are deprived of Mamta Diwas services.

Weak Monitoring of Janani Shishu Suraksha Yojana

Government of Gujarat introduced the Janani Shishu Suraksha Karyakram (JSSK) in 2010 to provide cashless services for ANC, institutional deliveries and neonatal care in Public health care facilities. A study undertaken by SAHAJ during October 2014 to September 2015 found:
- 87% families incurred costs during pregnancy and delivery even though they were enrolled under this Yojana.
- 81% women had to bear the cost of transportation.
- 19% pregnant woman had to bear the cost of sonography.
- 16% pregnant woman had to bear the cost of medicines.

Women’s Perceptions of Quality

Focus Group Discussions with women in around 12 bastis in 2011 and our sustained interaction with them over the last ten years give us an idea what the women in the bastis in Vadodara want from health services.

Systems or Processes for Regulation and Accountability

As indicated above, there is an absence of systems for regulation of the private providers both in terms of quality and cost of health care, just as in rural areas. There do not seem to be many models for promoting
What Urban Poor Women Want from the Health System

I. Services at the Primary Health Level
a. Quality and regular health services at the Anganwadi.
b. Proper follow-up of maternal health at the basti level on Mamta Diwas.
• Health education (specific) to all pregnant and lactating mothers.
• Vaccination at basti level (women).
• Availability and distribution of IFA and Calcium tablets on Mamta Diwas.
c. Competent Link Workers/USHAs which implies appropriate training to link workers on follow up and documentation of cases.
d. Not being ‘chased’ repeatedly for permanent contraception. (Emphasis on temporary contraception rather than permanent contraception.)

II. Improvement in Ward Level Services.
a. Appointment of lady gynecologist in all the Ward clinics for 8 hours, all working days.
b. Deliveries, Ante Natal Care and Post Natal Care checkups (with Hb test, sonography, urine tests etc.), abortions and all contraceptive care including tubectomies at Ward level.
c. Availability of all medicines including IFA and Calcium tablets, pregnancy confirmation strips, medicines for reproductive tract and sexually transmitted diseases throughout the year. No prescription which means purchase of medicines from outside.
d. Appointment of pediatricians at all Ward level clinics for 8 hours, all days of the week.
e. Availability of treatment of child health at Ward level including incubators.

III. Tertiary Level Services
b. Doctors should use I-cards or have name plates on their coats so that they can be identified.
c. Interns should not be given complicated cases without constant supervision of experts because majority of cases fail due to inability of handling them properly. The ICU Ward for the neonates should not have interns without experts.
d. Availability of all medicines at all times free of cost (nowadays medicines are prescribed from outside).

IV. Private Health Care
a. Protocol of quality health care for private practitioners including Chiranjeevi doctors.
b. Standard cost of care at private hospitals (because hospitals are charging any amount of money and it is not the same everywhere).

Conclusion
In this paper, we have tried to show that in the ‘developed’ state of Gujarat, in a big city like Vadodara, there are several problems from the perspective of equity, quality of care and accountability measures. Our experience of over a decade and engaging with women as partners in primary health care provision have provided important learnings. Training of outreach workers (Link Workers/USHAs/ASHAs) and capacity building of Mahila Arogya Samitis must be carefully and creatively done so that they become vibrant agents of change. Women from the bastis have specific expectations from the health services which must be considered in any model of urban health care.
As long as solid waste determines the physical environment in which a person lives, works, and the social environment in which a person interacts, it determines the health of that person. Solid waste is a material reality of life resulting from human consumption and developmental activities. Huge quantity of domestic solid waste is experienced largely in urban centres because of the horizontal as well as vertical population density. Growing production and consumption of goods were the mark of industrialised societies and this magnified the problem of waste. Globalisation has enhanced this magnitude further by allowing free flow of goods for global consumption. Urban India generates more than 1,00,000 MT of waste per day today and the waste once discarded is assumed to be the responsibility of urban administration. Failure of Urban Local Body in collecting, processing and disposing the solid waste in an effective manner poses a threat to public health.

City streets filled with garbage are breeding grounds for disease carrying vectors and pathogens. Living and working in a physical environment posing such health threats therefore should be concern for the society. This paper looks at the living and working environment of different sections of population in relation to solid waste and the impact of the same on their health, in India.

Urban Solid Waste and Resulting Health Issues

Existing literature on solid waste management and its impact on health shows that different sections of population are affected differently (both positively and negatively). Solid waste is a major determinant of health and if untreated has differential impact on various sections of the society. In the process however, the poor are affected disproportionately.

Effects on People Whose Livelihoods Depend on Waste: Recyclable wastes like plastics, paper scraps, bottles and other wastes give employment opportunities to a large section of urban poor. A chain of waste relationship is found in this kind of economic activity. The lowest strata of this chain of relationship are the rag pickers. Often, this section of population includes the migrants hailing from economically and socially deprived communities and street children. However, the consequences of this kind of waste relationship are the occupational health hazards. Scavenging through the garbage heaps, a rag picker confronts various pathogens, injury due to sharp materials, and exposure to toxic chemical substances and hazardous hospital wastes. Animal bites and associated threat of rabies, and musculoskeletal pains are also reported rampant among the rag pickers. The casualties due to the occupation therefore could be serious, if it is not adequately addressed. Currently few NGOs take initiative to organize these workers and support their needs (ex. Chintan and Kajag Katch Patra Khabtakari Panchyut). In the formal setting waste is collected either by the permanent employees of the local body or casual labourers belonging to different collectives (ex. Kudumbashree in Kerala and SWaCH cooperative in Pune) or to other labour contractors. Lack of precautionary measures and lack of awareness about the health hazards has a great impact on the waste workers. Protection of the workers both in formal and informal setting should therefore be a priority in ensuring public health protection to waste workers.

Effect of Accumulated Waste on Urban Poor: Accumulated solid waste in the streets emanates noxious odour and breeds disease carrying vectors that affect human lives. Therefore, it is important that the waste is removed from the households and the city streets on a daily basis. A closer look at the waste service provision in cities shows that there is marked difference in the services provided to the communities based on their income status in the society. In most cases urban poor receive minimal or no waste collection services. In India, this kind of segregation has a colonial tinge to it as well. According to Morenas (2010) early urban planning in colonial India was spatially segregated by keeping the elite living spaces at a safe distance from the raging contagions that affected the common citizen. Latter day urbanization process continued this spatial segregation. Today, slums in the cities are mostly deprived of waste collection services. This is also due to unplanned growth of the slums and the non-notified status. In such slums, as there is inadequate space for waste disposal, piles of garbage are dumped outside the hutments mixed with drain water attracting rodents, dogs and flies. The threat of ill health resulting from the waste, thus, looms large over the living spaces of the urban poor.

Effects of Urban Waste Disposal Strategies: Similarly, waste that leaves the city determines the living condition of a different set of population. Antidumping movements and struggles against various waste treatment and disposal methods are manifestations of this fact. Usually wastes collected by the municipal authorities are transported to the centralized waste treatment facilities located at the outskirts of the city. The centralized systems include either composting systems or incinerators. The rule is that if the waste is disposed off by open dumping, Solid wastes thus accumulated pollute air, water and land. Leachate percolation from the dump sites and landfills on reaching the surface water bodies pollute them. Leachate from the central disposals pollute the air, water and land. The threat of ill health resulting from the waste, thus, looms large over the living spaces of the urban poor.
urban peripheries, occupied mostly by economically or socially underprivileged classes.

**Waste Governance in Cities**

Waste governance in India is not a recent phenomenon. The Indus Valley city of Mohenjo-Daro had an effective scavenger service. Fully developed waste governance however became a part of city administration during the colonial era, mainly to protect the gated communities including Army barracks (cantonments) and elite living spaces. The office of the ‘Municipal Health Officer’ (MHO) was encharged with the overall administration of the determinants of health including solid waste management, and was therefore a key fonctionary in waste governance. This office had the powers to impose quarantine if need be, forcibly dispose bodies, ensure cleaning of sewers, collect and dispose waste and do whatever additional to avert or abort epidemic. In the present context, the office of the Municipal Health Commissioner discharges duties of public health functions focusing on both the clinical and social determinants aspect. However, there are variations in these roles across the cities of different typologies. For example, while the Municipal Health Commissioners of the Type 1 Metro cities (Chennai, Kolkata, Mumbai) retain both the public health and SDH functions, that of second tier cities concentrate more on the SDH functions (Madurai, Bhubaneshwar). In Type 3 cities the office of the health officer is found to be in a declining state (or absent) leading to disorientation in the provision of SDH services.

The other aspect of waste management is technological interventions. Technological interventions are experimented in each stage of waste management from- designing the waste collection techniques to waste treatment and resource recovery techniques. However, such technological interventions are constrained to a large extent by the gaps in municipal finances and therefore, several cities often find themselves at a disadvantage.

Due to the large scale urbanization and increasing consumption waste generation in the country is increasing. It is in this context that solid waste management was given a major policy thrust through the Swachh Bharat Mission-Urban. However, positive impacts of such an endeavour are yet to be visible. Swachh Bharat Mission urban guidelines emphasize that waste management should be context specific and successful waste management practices should be developed and replicated. However, not many successful waste management experiments are reported except for few decentralized waste management models like that of some cities in the state of Kerala, Mumbai, Pune etc. These successful decentralized models are however greatly different from the existing mainstream waste management processes. Most often waste governance is seen from the environmental and technological perspective and therefore it fails to invoke the public health and equity angle of the whole debate.

**Way Forward**

When observed from a public health and equity perspective it is clear that waste is a major determinant of health impacting the living, working and social conditions of the urban poor. It is in this context that waste governance from the public health and equity perspective gains importance. Strengthening the office of the Municipal Health Officer, especially in the second and third tier cities is therefore inevitable, and necessary technical and financial support for effective waste management needs to be provided. Since the effective utilization of existing technologies demands the proper segregation of waste, city dwellers should play a proactive role in waste segregation at the source itself. Also, since informal waste recyclers are beyond the purview of the government, roles and spaces for Non-Governmental Organizations or the waste workers’ collectives need to be built within policies and practice. Present day initiatives like Swachh Bharat Mission-urban should also be made conversant with specific waste management as well as health needs of the urban poor, and cities are allowed with sufficient financial allocations to address these needs. Social aspects of waste management should be brought into the focus of planning too, in addition to the technological and environmental aspects.

**References**

Soon after its formation as a state in the year 2000, Chhattisgarh introduced programmes for strengthening its health system. The Mitanin programme, covering all its rural areas with more than 60,000 Community Health Workers (CHWs), was a key intervention amongst the above. The sustained and near-universal coverage of the programme in rural areas led to demands for its expansion to urban areas. Also, the state had seen impressive decline in IMR in rural areas while it had remained stagnant in urban areas. However without visualising urban health as a complete system, introducing CHWs alone was unlikely to be fruitful. Efficacy of Mitanins in urban localities was doubtful without outreach sessions, ANMs, sub-centres, PHCs and laboratory services. There were at least three attempts till 2010 to introduce urban programme that failed. In the last of these attempts ANMs were introduced in Rajnandgaon city with NRHM funding, as an innovation. However, this piecemeal attempt was not replicated further as the NRHM funding was found to be unreliable.

In 2011-12, the state seemed to be closer to a consensus for initiating an urban health programme. The impending state elections of

Box 1. Questions, Debates and Final Choices Towards the NUHM Design in Chhattisgarh

1. **Do we need more health facilities in urban areas?**
   One view was that urban areas already had district hospitals or other government health-facilities and if any more facilities are needed, the abundantly available private clinics should be roped in through Public Private Partnerships (PPPs). The other view was that the existing facilities were more suited for secondary healthcare and the new programme should focus on primary health care for the urban poor by introducing sub-centres and PHCs. Provision for secondary care by using private sector was already there through a universal health insurance scheme. The latter view prevailed in the final design, however, mobile clinics were also provided through PPP arrangement though their relevance for urban areas remained debatable. Though the draft National Urban Health Mission (NUHM) (under discussion at that time in 2011) did not have a component on sub-centres, the state decided to have sub-centre like facilities called Swasth Suvridha Kendra (SSK), serviced by urban ANMs as the constrained spaces in Anganwadis was not sufficient for provision of antenatal care.

2. **Is a volunteer CHW feasible in the urban context?**
   Chhattisgarh had a decade long experience of implementing the Mitanin CHW programme. The common belief was that the sociology is different in urban areas wherein communities lack the cohesiveness to allow ownership of CHW. However, the other view was that CHWs were still very much needed for promotive and preventive health work amongst the urban poor and for linking them to the formal healthcare services. Finally, the latter view prevailed.

3. **Should the programme cover only slums or entire population of the cities?**
   This debate was also going on at the central government level with regards to NUHM design. While the NUHM talked of providing services to the entire urban population with priority to slums, Chhattisgarh decided to have an explicit focus on slums. It however expanded the definition of slums to include non-recognised settlements as well.

4. **Are the health challenges very different in urban areas?**
   One perception was that urban areas have very different health challenges like poorer sanitation, HIV, lack of demand for preventive services with an excessive demand for curative services etc. and therefore the urban programme should focus on these issues. The other opinion was that Chhattisgarh’s urban IMR was amongst the worst in the country and therefore the programme should address primary healthcare more comprehensively. The final design was dominated by the latter view.
2013 and the health minister heading the urban administration department facilitated this too. However, designing the programme still involved making several choices and the main debates were around the issues as detailed in Box 1.

Baseline Study Findings

A Baseline Study was conducted in 11 cities in early 2012 by the State Health Resource Centre. The survey focused on understanding utilization of maternal and child health services by urban slum population. The baseline survey showed that in comparison to rural areas, urban slums were doing better in terms of literacy rates, access to toilets, ARIs amongst children, malaria and child malnutrition. However, the urban slums were worse off in terms of immunisation, breastfeeding, diarrhoea and utilisation of family planning services. More pregnant women from urban slums were having ANC check-ups and institutional deliveries, though mostly in the private sector. One-third urban slum households had National Health Insurance Scheme (RSBY) cards, however, 60% of them incurred high out of pocket expenditure.

NUHM in Chhattisgarh: Variations from the National Design

Overall, the Chhattisgarh urban health initiative has tangible variations from the prescribed NUHM design, as detailed in the table 1.

NUHM: Progress in Chhattisgarh

The urban health programme was piloted in two cities (Bilaspur and Rajnandgaon) in 2011 and was subsequently expanded to 11 cities having population greater than 100000, in 2012. The programme was initially fully funded by the state budget. In early 2014, the programme was merged with NUHM as funds were sanctioned by GoI. The programme now covers 19 cities with a total urban population of 4.12 million, including 1.62 million slum population (as per 2011 census). The key achievements of the programme implemented over last three years are projected in Table 2.

<table>
<thead>
<tr>
<th>Table 1: Comparison of Arrangements for Health Care Provision: NUHM National and Chhattisgarh Norm</th>
</tr>
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<tbody>
<tr>
<td><strong>Component</strong></td>
</tr>
<tr>
<td>Urban ASHAs (CHWs)</td>
</tr>
<tr>
<td>Mahila Arogya Samiti (Women’s Health Committee)</td>
</tr>
<tr>
<td><strong>ANM</strong></td>
</tr>
<tr>
<td>Swasth Suvidha Kendra (sub-centre)</td>
</tr>
<tr>
<td>Urban PHC</td>
</tr>
<tr>
<td>Urban CHC</td>
</tr>
</tbody>
</table>

The Urban Mitanin Initiative: Implemented in similar way as the rural Mitanin Programme, the training modules for urban Mitanin initiative emphasized on social determinants of health, home visits, and community based care and counselling for common health problems. Analysis of activities reported by Mitanins during January to September 2015 showed that:

- They mobilized 80% of expected deliveries to institutions, 76% of them in government facilities
- 82% of newborn received designated home visits from Mitanins and 16% referred to health facilities after Mitanin identified signs of sickness
- 87% of pregnant women received more than three home visits from Mitanin
• 63% of children under-3 years age received home visits on nutrition and prevention of infections
• 68400 cases of diarrhea given ORS
• around 120000 other patients provided drugs by Mitanins using drug-kits
• 155 TB suspects per 100000 population screened and referred for sputum examination resulting in 2140 confirmed cases
• 2796 Leprosy suspects screened and referred resulting in 611 confirmed cases.
• Mitanins, with the help of Mahila Arogya Samitis, intervened in 4540 cases of violence against women.

The Mahila Arogya Samitis (MASs): The MASs provided a forum for the women of urban slums to come together and participate in civic action. The MAS has acted as a support group for the Mitanins. The MAS has worked on Social Determinants of Health like drinking water, sanitation, functioning of nutrition programmes and violence against women.

Introduction of ANMs in Urban Slums: This bridged a very important gap with around 1600 immunisation sessions getting organised every month. Mitanins were able to facilitate linkages with government hospitals for ANC, deliveries, TB testing etc. and convince a significant section of slum patients to access Government health facilities.

#### Challenges Being Faced

The Key challenges were around gaps in provision of safe drinking water, inadequate responses to disease outbreaks, issues in attending the health issues of urban homeless, fund constraints leading to non-fulfillment of certain critical needs.

#### Disease Outbreaks Resulted by Lack of Access to Safe Drinking Water:

Though the Mahila Arogya Samitis have been very active on the issue of safe drinking water, severe gaps in access to safe drinking water persist and have resulted in Hepatitis E outbreaks. For example, an outbreak of Hepatitis E in Raipur town was reported by media in April 2014. Medical College Raipur tested 264 patients and found 114 positive for HEV antibodies. According to the Mitanin program data the outbreak had started earlier in December 2013 when around 30 persons from in an impoverished slum locality showed symptoms of jaundice, with some of them had been confirmed by Bilirubin test. Throughout the season, CHWs reported 2070 cases of Hepatitis including 74 pregnant women and 32 deaths including of eight pregnant women. It was found that there are leakages in drinking water pipelines and ingress of sewage into them. Moreover, some pumping stations are close to sewage. Water testing by Mitanins at 800 points across the city showed that 53% of sources, including big pumping stations, hand-pumps and even the alternative water supply tankers, had contamination. Another outbreak occurred

<table>
<thead>
<tr>
<th>Component</th>
<th>Requirement as per norms</th>
<th>Status as of Dec 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mitanin (CHW)</td>
<td>3883</td>
<td>3770 selected, trained so far for 25 days. A support structure in place, of 200 ASHA Facilitators and 25 Area Coordinators, supported by the State Health Resource Centre</td>
</tr>
<tr>
<td>Mahila Arogya Samiti (Women’s Health Committee)</td>
<td>3883</td>
<td>3700 formed, trained so far for 2 days, regularly facilitated by the support structure</td>
</tr>
<tr>
<td>Swasthya Suvidha Kendra (sub-centre)</td>
<td>388</td>
<td>249 operational</td>
</tr>
<tr>
<td>ANM</td>
<td>388</td>
<td>296 appointed</td>
</tr>
<tr>
<td>Urban PHC</td>
<td>36</td>
<td>30 Operational</td>
</tr>
<tr>
<td>PHC Medical Officers</td>
<td>72</td>
<td>26 appointed</td>
</tr>
<tr>
<td>PHC Staff Nurses</td>
<td>108</td>
<td>59 appointed</td>
</tr>
<tr>
<td>PHC lab Technicians</td>
<td>36</td>
<td>26 appointed</td>
</tr>
<tr>
<td>Urban CHC</td>
<td>0</td>
<td>Not planned</td>
</tr>
<tr>
<td>Mobile units (MMU)</td>
<td>12</td>
<td>12 operational</td>
</tr>
</tbody>
</table>

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Table 2: NUHM in Chhattisgarh: Achievements Against Requirements
from January 2015, though in different areas. A repeat round of water-testing was done by Mitanins in April 2015, which reported worsened contamination. Despite getting recognized as an issue at top levels of government, focus of the civil administration was on curative care and hospitalisation of patients, as well as chlorination of water. The drinking water issue could not gather sustainable media attention too. As a result, the issues in supply of safe drinking water remain unsolved.

Reaching out to the Homeless: The programme has faced challenges in reaching out to the homeless population. Though Mitanins identified around 3000 homeless families, they could cover less than half of them. Attempts to link the homeless with municipal shelter facilities failed and almost none of the 26 shelters in 11 cities were found to be functional. Linking homeless rag-picking communities posed further difficulties because of the discrimination being practiced by health facilities against them. In a shocking case, nurses in a district hospital refused to deliver a pregnant woman belonging to Dewaar caste because of untouchability. The programme came across a large number of migrant men labourers working and living in poor conditions around industrial areas but could not find ways of engaging with this section of urban poor.

The Fund Crunch: There are some differences in funding norms of NUHM compared to the state scheme which has created problems. Broadly speaking, NUHM sanctions lesser number of Health-HR at almost all levels. The salary norm for MO under NUHM proved to be a big hindrance in getting enough MOs for urban PHCs. Moreover, funds sanctioned by NHM for urban health seem to be shrinking year by year. While the sanction was adequate for first three months of implementation in 2013-14, it has been reduced by the central government from 2014-15 onwards. Table 3 presents the comparative financial situation for NUHM in Chhattisgarh.

The community processes component has suffered the worst cuts with no funds being sanctioned for Mitanin-training and support-structure for 2015-16 and the allocation for Mitanin incentives being cut to half. This is despite the fact that the financial utilization of funds allocated for Mitanin and related components has been close to 100%, while other urban programme components have lagged behind. Thus the component showing the best progress has suffered the worst damage in funding.

Conclusion

NUHM can be extremely valuable for bridging the gap in access to health for the urban poor. The Chhattisgarh experience has shown that community processes and outreach through ANMs, combined with strengthening of the formal healthcare institutions are crucial. Despite visible achievements, there is a threat to the Chhattisgarh urban programme due to funds crunch. There is a need for the government to persist with full roll-out of NUHM not only in Chhattisgarh, but across all states.

References

In spite of his continuous victimization, Rohith Vemula did live a life of the mind that militated against the caste of the mind.

Let me start with what might be seen like an overstatement, that Rohith Vemula’s tragic death marks an exit from the larger phenomenon of social death that Dalit students and teachers face through everyday forms of discrimination and worse, humiliation.

In the Indian context, social death gets defined in terms of the social stigma that Dalits, particularly students, are forced to silently suffer. The social stigma acts in stages. First it seeks to reduce a person or a group to a repulsive or undesirable other and then cancels out the severed other from all forms of human civilizational interaction. It has been our general experience particularly with the institutions of higher learning that the ‘stigmatised other’ gets produced through active as well as passive forms of social boycott.

An active mode involves imposition of social sanction mostly by the pre-modern authority such as caste. And hence the social boycott imposed by public authority on the five Dalit students, including Rohith, is unknown to any modern penal system. Curiously, it resembles the state authority that existed in the 19th century Peshwa state in Maharashtra.

The passive mode of social boycott, on the other hand, is enacted through a very subtle social matrix, like non-Dalit students refraining from joining courses that have strong Dalit component, and non-Dalit teachers avoiding opportunities to guide Dalit students. Such passive social boycott finds its expression in Dalit students’ efforts to force some universities to introduce reservation in the allotment of supervisors. Passive social boycott also find its tragic expression in Dalit research scholars committing suicide on account of not getting supervisors for three years, as in Hyderabad Central University.

Hostel life on university campuses in the country has been socially hostile to Dalit students, while campus civic life is less hospitable towards the marginalised sections including Dalits. Needless to say the institutional support is inadequate and at times completely lacking as in the case of the five Dalit students from the central university in question. Other social resources such as the interventions of concerned teachers is fast depleting on the university campus.

This is not to suggest that non-Dalit teachers lack moral commitment to stand by Dalit students, but such motivated teachers are unable to focus required attention on the issue of caste-based discrimination on the campuses. The failure has to be understood in terms of the existential struggle in which such teachers are engaged. They are driven to make survival attempts in a professionally hostile atmosphere which is replete with destructive envy and enmity. In the end such failure on the part of the faculty does lead to passive injustice to the much traumatised Dalit students who feel increasingly more vulnerable to the fear of victimization should they speak against discrimination on their own.

It is hence irony to imagine that the institutions of higher learning are supposed to encourage the academic community including Dalits, so that they can later enjoy enjoy individual autonomy that constitutes the minimum moral condition to live a life of the mind. A life of the mind motivates one to develop ambitions for ideas, thus seeking to outgrow narrow caste identities and to become the part of a universal idea.

Universities are supposed to enable Dalit students to appear in different spheres of learning and scholarship without the sense of shame and stigma. Institutions of higher learning are not supposed to perpetuate a deep sense of stigma leading to loss of self-worth and meaninglessness. Every student, including Dalits, has a right to gracefully exit from the university both into opportunity structures as well as into a more humane, decent society.

The question that one needs to ask is: how far have we fulfilled these conditions that are necessary for a graceful exit?

Universities are egalitarian structures that should encourage students to speak in a universal language that concerns the well being of humanity. This was the normative thrust of the philosophically reflective letter written by Rohith Vemula. Rohith’s lived academic existence on the campus, though unfortunately short, however, has enormous moral significance. In spite of his continuous victimization, he did live a life of the mind that militated against the caste of the mind. Ironically his profoundly intellectual expression, scholarly depth and commitment to universal human values shows the intellectual limits of Dalit leaders from the ruling parties.

Rohith’s letter has issues some everlasting moral guidance around which we can organize our future life. The letter in its philosophically reflective tone has suggested to us not reproduce the barbaric cycle of hatred. In a profound sense, he has morally surpassed all those university kids who otherwise wear merit on their sleeves and walk proudly on campuses.

Honesty speaking, one requires moral/ ethical capacity to fully grasp if not earnestly appreciate Rohith’s intellectual depth and normative commitment to both human as well as values in nature. Hence, conveniently constructing a counterfactual that Rohith provided reasons for his own fate amounts to reducing his intellectual calibre to banality.

Let me end this essay, by drawing first on Baburao Bagul, one of the doyens of Marathi Dalit literature, and Rohith. Both seem to be suggesting that being born in a particular caste that robs one of his/her moral essence is indeed a fatal mistake. One has to rectify such a mistake by waging war against all forms of discrimination. But the necessary condition to eliminate the condition that produced social death in society is to create transformative consciousness among those who do not think that their birth in a particular caste is not a fatal accident.
Notes on Rohith Vemula and the Movement After

The essay by Gopal Guru highlights the ground of endemic caste discrimination in places of higher learning in India. It offers the critical concept of ‘social death’ to understand the lethal effect of this discrimination. We have the following observations to offer MFC readers for consideration and reflection:

Mental Illness or Social Discrimination?

It is a well known fact that dalit students have often committed suicides in universities and colleges all over India. In 2011, Anoop Kumar, the dalit activist listed 18 suicides by dalit students in the preceding four years. In Hyderabad, too there have been enough to warrant a Suo Moto PIL intervention by the Chief Justice of the AP High Court in 2013 to determine the cause of student suicides on campuses. An implead petition filed by senior academics in this case listed four suicides of students from marginalized communities in the preceding four years in the central universities of Hyderabad. In every case, dalit opinion points to caste discrimination as an overwhelming factor. Caste discrimination has been documented and fought in several battles, including at AIIMS and Safdarjung Medical College. The Thorat Committee Report (2007) clearly states that caste based discrimination was widespread at AIIMS and more recently, the National Commission for Scheduled Castes found AIIMS guilty of caste discrimination against an Assistant Professor of Nursing (2015). The dalit students of Safdarjung Medical College filed a case of caste discrimination against the college in the Delhi High Court in 2012.

As Guru argues, active and passive discrimination leave dalit students (and faculty) in a state of existential abandonment. This is the outcome of venomous discourse, cultural ostracism and social exclusion that surround dalit students who are physically included in the university space. In addition to this, there is also the major problem of systematic institutional punishment of dalit and marginalized students that needs to be understood. Take for example, a dalit student who comes from a village with no relative in the city (or as recently seen in Hyderabad, a Kashmiri woman student). Expulsion of such a student from the hostel is an intolerable cruelty that those of us with relatives and friends in the city can never understand. Such forms of extreme punishment are increasingly meted out for minor infractions or for demanding student facilities and rights, and many central university regulations legitimize them through their ambiguous wording. This fact of brutal and excessive punishment of marginalized students is also under severe criticism by the student movement that has followed Rohith’s suicide.

The institutional response to such instances, in our observation in Hyderabad, has been to see the suicide as an individual’s failure to cope with life, and to portray it as a psychological problem that is specific to the individual. This is a kneejerk response to the crisis that is provoked by a suicide event. In fact, the AP High Court, after hearing the Suo Moto petition mentioned, passed Orders with several administrative safeguards and procedures to minimize student distress. However, what universities selectively implemented were the recommendations to set up psychiatric counseling centres for students in distress. These centres are dysfunctional, and the one in the English and Foreign Languages University, has been shut down. Such a kneejerk response is reminiscent of the manner in which distressed women were theorized to be ‘psychologically frail’ when the distress was clearly an effect of overt and unbearable social and familial violence. It is thus an attempt to sweep the larger political issue of caste discrimination under the carpet of individual weakness.

The implead petition by senior academics argued that the theory of individual failing leading to suicide was wrong, and that the social determinant of caste discrimination was the main cause. The petition argued that it was important to work towards changing the academic culture and administrative environment of these institutions.

The political developments after Rohith Vemula’s suicide have completely delegitimized the individual psychological flaw theory. It has become impossible for the university administration, the ABVP and the BJP to sustain any theory of individual failure in the face of the massive national protests against the caste-oppressive academic and administrative culture in institutions of higher learning. There is no possibility of talk of ‘failure of love affairs’, ‘psychological weakness’ or ‘counseling’. This is a positive development at this stage in the battle against caste discrimination. It remains to be seen how this progresses. All political and administrative attempts to discredit Rohith Vemula have simply exposed their inherent tunnel vision.

Urbanization

What is understated in the above discussion of suicides among dalit students is that these suicides have occurred in the wake of large scale dalit migration to cities in search of a dignified life, equality and freedom from caste oppression as promised by the Indian Constitution. The dalit migration to the city, not only in search of wage labour, but also and especially in pursuit of higher education, is driven by a desire to escape the static, oppressive constraints of caste-Hindu dominance in rural India. The opposing positions on urban and rural have been staked out by BR Ambedkar and MK Gandhi respectively.

Gandhi, starting with his early essay Hind Swaraj (1908) and his essay in Nav Jivan (1921), was an advocate of rejuvenation of the village economy and social life through constructive work. He was an unrelenting critic of modern industry, cities and Western civilization. These views have been sustained through his arguments over several decades.

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regarding education, Khadi, the Constructive Programme, and the various practical experiments such as the Sabarmati Ashram and Sevagram.

Ambedkar was a severe critic of the rural social structure, seeing it as suffocating, oppressive and antimodernistic. He saw the Gandhian village thesis as pre-modern, politically reactionary and economically backward. In What Congress and Gandhi did to the Untouchables (1945), Ambedkar subjected the Gandhian perspective to a withering critique ending with a call to shun obsolete social constraints, remove caste barriers to equality and economic well being for all, and therefore to modernize at all costs by moving to an urbanized, wage labour based economy.

The Constitutional provisions for reservations among the scheduled castes and tribes are a clear recognition of the validity of Ambedkar’s argument for urbanization as the way to escape caste oppression. They provide a space for dalits and tribal students (both from largely rural or remote hill areas) to enter an urbanized civil society as equals.

The dalit and tribal students who have suffered in the past and continue to do so come into universities and colleges through reservations. The Ambedkar Students Association (ASA) works to mitigate the distress of such students in the University of Hyderabad. The difference with Rohith Vemula is that he came in as an open category student because his brilliance did not need any vindication even in the traditional terms of ‘merit’. He was an outstanding intellectual and activist of the ASA.

The ASA’s battle with the ABVP was sparked by two events in the following order: first, the ASA, which opposed death penalty in general, conducted a protest in the context of the hanging of Yakub Memon. Second, the screening of the film Muzzafarnagar Baki Hai, was forcibly stopped in Delhi University by the ABVP. In the University of Hyderabad, the ASA launched a protest against ABVP’s action in Delhi (as did several student organizations in other universities). This second event led to a scuffle between the ASA and the ABVP, which was exacerbated by the BJP’s interference. The BJP posted a complaint to the university and the MHRD and filed a police case. This complaint foregrounded the Yakub Memon incident (to attack the ASA as part of the BJP’s tirade against what they call ‘anti-nationalism’). The MHRD then exerted pressure on the university to expel five ASA students from the hostel. Rohith was one of these five students.

What is remarkable is that though these events were entirely secular in nature, it is clearly accepted by the student and social movements that have exploded after Rohith’s suicide that the ASA was hounded by the ABVP and the BJP and punished by the university administration and the MHRD, as a dalit organization. The remaining four expelled students continue at the head of a national protest against the actions of the MHRD, the University of Hyderabad and the BJP.

Thus, the current crisis in the institutions of higher education must be seen as a historical turn that complicates Ambedkar’s analysis. The institutions of higher education have now become fortresses of caste privilege, seeking to retain that privilege at all costs. This does not delegitimize or disprove Ambedkar’s thesis of the oppressiveness of rural life, or the need to move towards a more modern civilization. This is a political reaction of caste domination that must be noted and fought.

Three Implications for a Politics of Health
One implication for a politics of health relates to the struggle against individualizing and psychiatricizing such suicides as personal psychological flaws. Suicides and mental distress in universities are the effect of the intersection of severe social disadvantages and institutional oppression. They point to structural flaws that haunt Indian society. This social distress cannot be medicalized or individualized -- it haunts whole communities subject to chronic discrimination. It is utterly erroneous and reactionary for psychiatry to try and resolve distress by individual counseling or medication without taking into account the oppressive context it arises in. It is also thus important to see these suicides as symptoms of the chronic social illness that haunts India today: caste discrimination.

More specifically and yet more broadly speaking, we at Anveshi strongly advocate a culturally rooted psychiatry that is aware of and actively engages with social discrimination of dalits, tribals, women and the marginalized communities of India.

The second implication is that the way forward is to address in an active political manner the general problems of social health that arise in the tide of urbanization and migration to the cities. It is crucial to see that many forms of morbidity and mortality (not only related to mental distress) occur in relation to the deep structure of social discrimination that perpetuates itself in modern urbanizing India. Medicine needs to find ways to understand and theorize the social determinant of discrimination in the pattern and scale of morbidity that characterize Indian populations.

The third implication we would like to draw is that medical activists with a social conscience and political commitment must pay special attention to the political and administrative struggles of embattled students in medical and allied institutions and exert pressure to change the academic culture and administrative environment. It also means that such activists need to make a special effort to understand the larger political perspective and the context of these marginalized student struggles, so that they can effectively support the students, helping them cope with the enormous social pressures they face. It is such students who will develop a way of thinking about health care that takes into account the larger frame of distress in contemporary times.

First allow me to apologize. I am not a community medicine expert. I am a surgeon, a teacher, an administrator and essentially a professional who has spent all his time in hospital management of the sick. Secondly, due to prolonged period of convalescence after prostate trouble, I could not devote adequate time to study the subject in full details. However, I will try to do my best within these limitations.

MMC (Municipal Corporation of Greater Mumbai) is a very rich corporation. Its annual budget exceeds that of many states like Kerala, Goa, Chhattisgarh, Jharkhand, etc. It is probably the only Municipal Corporation in Asia to run - not one-three medical colleges; and a fourth one is in the offing. It is also one of the rare government bodies which spend a very high amount on health and medical education -- at one time nearly 15% of its revenue expenditure but now it has dwindled to about 8% or so. In absolute terms, the MMC has presented a budget for the year 2015-16 wherein its income is Rs. 33,000 crores and expenditure is Rs 31,000 crores. Out of this expenditure, it has allotted Rs. 2,552 crores for health and medical education for the total population of 13 million people. The percentage works out to be nearly 8%. It has allotted a little more than Rs.600 crores for Primary health, Rs. 744 crores for its peripheral hospitals, another Rs 108 crores for TB (Rs 100 cr) and Acworth Municipal Hospital for Leprosy (Rs 08 cr) Hospital. However it is spending a whopping Rs. 1,100 crores for its 3 medical colleges and their hospitals plus 1 dental college. These are tertiary care hospitals and, no doubt, some of the best medical centers in India offering CT scans, endoscopy, laparoscopy, angiography, angioplasty, open heart surgery, neurosurgery paediatric surgery, ICUs, nephrology, dialysis, kidney transplants, all sorts of emergency services and what not!
The Mumbai Municipal Corporation has a network of health services and, despite all its deficiencies, it has one of the best health services in the country - probably exceeded only by Tamil Nadu State. The network consists of primary health services consisting of 174 dispensaries, 168 outreach Health posts, 15 RCH health posts, and 30 maternity homes. Secondary health services comprise of 18 peripheral hospitals plus 5 specialty hospitals, namely, one ophthalmic, two ENT, one TB and one leprosy hospital, besides one large Infectious Diseases Hospital, namely the Kasturba Hospital. Tertiary care, as mentioned above, is offered by 3 major teaching hospitals which also offer complete secondary care too. The public sector is ably assisted by State Government hospitals like J.J. hospital (a teaching hospital) and other 4 secondary hospitals. There are many other state and central health services and their hospitals which cater to specific groups: their own workers. Two Railway Hospitals, a Naval Hospital, CGHS, BARC (atomic energy), ESIS hospitals, Port Trust Hospital, etc. These, however, are not available for the general public. Yet, the health care needs of the Mumbai population are hardly satisfied and private sector has expanded like never before. Earlier, till the year 2000, it was the small hospitals/Nursing Homes which rapidly increased in number, especially in suburban areas. This was because, as is seen in the map, public sector hospitals were concentrated in the island city till 1980. It was during Municipal Commissioner V.B. Deshmukh’s time that peripheral hospitals were established in suburban areas, the number rose to 16 (and now to 18). The total population at that time (in seventies) was around 52 lakhs. But in this century, tertiary care hospitals are growing very rapidly in the private sector, due to high expectations of the people from modern technology and its affordability among the increasing percentage of Mumbaaites. At least 30% are now covered by insurance or reimbursement by their employers. They do not feel the pinch of steep rise in the cost of health care but the rest of the population suffers heavily as the cost of management rises for them, too. Private sector in Mumbai comprises of around 1500 hospitals - mostly small or big Nursing Homes - but now at least a dozen major tertiary hospitals with all modern high tech facilities have sprouted in various regions of the city.
The total number of beds available are: Municipal 12000: 28%, Government 8000: 22% and Private 21000: 50%.
The total of 40,000 beds or more fall too short for the population of 13 million, with a ratio of 1 to 3000 when the most minimum ratio should be 1 to 1000. (These are old figures about 12 years back and differ widely from what Dr. Jotkar, Dy. Director, Health Services, Maharashtra, reported in 2005 According to him Mumbai had 203 beds per lakh population, that is, 2 beds per 1000. It is strange and highly regrettable that we do not have any authentic data as to the number of (allopathic) doctors in Maharashtra and especially in Mumbai. MMC is stuck with the figure of 80,000 doctors since the year 2002. But, if we consider that 16,000

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students that pass MBBS every year in Maharashtra alone, the number ought to reach 1.5 lakhs by now. Mumbai has 10% of the total population but doctors are more concentrated in Mumbai than elsewhere. Presuming that just 15% of the doctors practice in Mumbai – it must be more – it still means that there are more than 22,000 doctors in Mumbai – a ratio of 1 doctor per 600 people. It could well be 1 to 500 – almost the same as for U.K. Thus, Mumbai has enough budgetary provisions, the corporation is spending 8% of its budget on health. There is a good network of health care centers and public sector caters to 50% of the city population, there are more than enough doctors and almost all facilities that a developed nation has. One should expect that health care indices of Mumbai should be very good at par with the developed nations. NO. IT IS NOT SO.

There is a gross disparity in availability of health services and the health indices are very poor in slum and peripheral areas. The life expectancy at birth is around 64 years for India, 67 or 68 for Maharashtra but for a Mumbaikar it is a dismal 57 years. Tuberculosis is increasing and there is near 100% increase in deaths due to TB. The incidence of malaria is also on the increase and in both diseases, resistant strains are causing a serious threat. Extremely resistant TB accounts for nearly 10% of the total cases. There are probably 2.5 lakh patients of TB in the city. The Infant Mortality Rate (IMR) is around 40/10000 but it is deceptive. It was found that IMR was as high as 55 to 60 in some slum areas and inaccessible peripheral localities. Luckily population has stopped growing, family planning and reduced influx of migrants assisting to curb the population growth. Immunization is 90 to 95% successful. But 45.5% of children and 37.4% of women are anaemic – the percentage rises to 76% and 42% respectively for the slum areas. More than 50% children under the age of 3 years are underweight, 49% are stunted and 21% are wasted. Though HIV/AIDS was under control, the withdrawal of assistance by Bill Gates foundation js resulting in shortage or non-availability of drugs and there is a lurking fear that AIDS may re-appear. The teaching hospitals are over-crowded – OPD attendance being around 32 lakhs in a year. KEM Hospital claims to see 4,000 to 5,000 OPD cases every day; the figure for LTMMC (Sion) being 2,500 or so. Sion Hospital conducts 16,000 to 17,000 deliveries every year – a child is born every half an hour. How can one do justice to these patients? Same is true of peripheral hospitals. But mostly they are under-utilised. There is dearth of full-time specialists and honorary specialists avoid taking responsibility due to “lack of modern facilities.” Similarly, primary centers are more concerned about government programs like immunization, MCH, DOTS, etc., but early primary care is hardly administered there. The result is people are forced to attend private clinics and nursing homes despite financial difficulties. The growing middle class is squeezed to pay high price in private hospitals only because of the mad rush and confusion at public hospitals. The total outcome is very poor health service for the large majority of the people except those who can afford – the organized section of the society.

And I have not touched upon the burden of non-communicable, life-style diseases. Cardiac diseases take the highest toll of even the young population. About 10% of the adults are likely to be having diabetes. And the poorer sections of the society are equally vulnerable to these illnesses. The biggest killer is trauma. Assaults and accidents bring nearly 4 to 5 thousand patients per month to Sion Hospital alone with mortality of 20% or more. Majority of emergencies of all sorts are managed in public hospitals in Mumbai - private hospitals have hardly any emergency service worth the name except for cardiac emergencies. Thus, there is a great burden of modern diseases on the public hospitals which they cannot handle efficiently.

Why are these inequities, insufficiencies? The main reason is unregulated system. There is NO SYSTEM. Anybody can attend any clinic or hospital. Even tertiary care is given to the patient who goes there – not to the patients who need them. Any medical officer can refuse to treat a patient quoting one reason or the other – usually lack of facility and sometimes lack of assistants. If we look at the duties for health service personnel (see Table 1) it will be realized that administering primary and secondary care is but one of the multiple functions and is being given the least importance. Even if a case was seen and then referred to a hospital for further care, there is no preference given to such a patient. He/she is just one among the crowd and may not be seen at all by the relevant speciality. On the other hand most people seek direct consultations at the teaching
taught recent advances in medical technology. Thus, the teaching pattern as well and the medical student is moving fast towards high technology. That affects the role of primary physician. The medical world is a post-graduate seat, should be specially trained for 25% beds will have to be reserved for the latter group to the public sector for further expansion About 20 to but with reasonable charges that will bring revenue barely affording middle class will also be looked after ensure that the poor are properly treated, and the market price) Such a duel system of charging will be seen at a different timing and other patient attending directly will be charged fees (at least 25% of the market price) Such a duel system of charging will ensure that the poor are properly treated, and the barely affording middle class will also be looked after but with reasonable charges that will bring revenue to the public sector for further expansion About 20 to 25% beds will have to be reserved for the latter group in the hospital. b) MBBS doctors who do not secure a post-graduate seat, should be specially trained for the role of primary physician. The medical world is moving fast towards high technology. That affects the teaching pattern as well and the medical student is taught recent advances in medical technology. Thus, he becomes totally incompetent to practice medicine with more observation and less investigations and cheap but effective medicines or surgical procedures. These graduates should be offered a two year course in general practice wherein they will work partly in primary centers and spend part of the time in hospitals rotating through various departments. At the primary centers, they are allowed to prescribe only simple investigations and cheap effective medications as stated earlier. In two years time they will develop immense confidence to treat the patients “under adverse circumstances” and c) the advanced technology needs to be de-glamorized. It is extremely sad to see the social activists strongly supporting the demand for more and more new modern equipment “to improve the health service.” MODERN FACILITIES CANNOT REDUCE COSTS. THEY IMPROVE SERVICES ONLY SELECTIVELY. De-glamorizing is a difficult task so I leave that discussion here.

The biggest hindrance to the scheme above is Consumer Protection Act made applicable to the medical profession. Almost 100% of the doctors are unwilling to take any risks, lest they are sued or punished – or even assaulted by the mob. The Act does not protect patients from negligent management by doctors, it is punishment to patients who now pay through their nose to get paltry treatment – it destroys the faith between the doctor and the patient and is mainly responsible for self-protecting practices of the present generation. Unfortunately, most NGOs and main responsibilities strongly believe that such “punitive” action is necessary. Not all but more socially oriented doctors will definitely work better for their patients – if only this law is repealed.

The city needs more beds. Lack of space and money are the biggest obstacles. The present small hospitals and nursing homes are managed most wastefully – the manpower and equipment are not used even to 30% extent. The report of Mr. Jatkar reported on the condition of nursing homes in Mumbai and it is an eye-opener. The problem could be solved by PPP – public-private participation. Government/Municipal Corporation could build the suitable hospitals for joint practice and community primary centers as shown: a community primary center and a 30 bed hospital for Joint Practice per 20,000 to 25,000 population and give it on rental basis to groups of doctors with specified controls on pattern of charges. The charges would be quite affordable in these centers. The development plan for the city should have mandatory provision for such centers and hospitals. Universal Health Coverage is ideal but cannot be achieved till every citizen is made to

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<th>Table 1: Duties of the Directorate of Health Services</th>
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<td>Registration of births and deaths and maintenance of statistics</td>
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<td>Regulation of places for disposal of dead</td>
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<tr>
<td>Maternity and child welfare and family welfare services, school health services</td>
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<td>Control of communicable diseases</td>
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<tr>
<td>Food sanitation and prevention of adulteration of food</td>
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<td>Control of trades likely to pose a health hazard</td>
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<td>Insect and pest control</td>
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<td>Impounding stray cattle, immunisation and licensing of dogs</td>
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<tr>
<td>Regulation of private nursing homes</td>
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<td>Medical relief through hospitals</td>
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<td>Issuance of international health certificates for travelling abroad</td>
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<td>Ambulance and hearse services</td>
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<td>Treatment of contagious diseases</td>
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should be a primary care center for every 20,000 population as shown in the design. It will run round the clock, served by about 4 doctors in each of the morning and evening shifts and helped by a physiotherapist, and a psychological counselor. Only simple investigations (not costing more than Rs 500) will be allowed and only simple medications (not costing more than Rs 250 per daily dose) will be prescribed. The patients will have to be referred to the hospital if more is needed and in the hospital these patients will be seen with priority at specified time of OPD. THEY WILL RIGHTLY BE TREATED FREE OF CHARGE (or nominal charge as of to-day). ANY OTHER PATIENT ATTENDING DIRECTLY WILL BE SEEN AT A DIFFERENT TIMING AND WILL BE CHARGED FEES (at least 25% of the market price) Such a duel system of charging will ensure that the poor are properly treated, and the barely affording middle class will also be looked after but with reasonable charges that will bring revenue to the public sector for further expansion About 20 to 25% beds will have to be reserved for the latter group in the hospital. b) MBBS doctors who do not secure a post-graduate seat, should be specially trained for the role of primary physician. The medical world is moving fast towards high technology. That affects the teaching pattern as well and the medical student is taught recent advances in medical technology. Thus,
pay a certain percentage of his salary/income for health services. In my opinion, UHC THROUGH TAXATION MONEY IS A MYTH.
Lastly, we must become cost conscious. Anything can be done with money but money is not easy to get. Social activists must propose and struggle for facilities within the financial capacity of the community or the State. They can certainly point out the discriminations and unjust practices in the management but must advocate facilities within the
capacity of the community. Politicians take advantage of the very demand of the people and dump costly modern technology on our heads – not much relief but extra-ordinarily high costs.

If proof were necessary, Mumbai is a startling example to prove that the best health can be provided not by hospitals and modernity, it is by simple other means such as hygiene, de-congestion, clean water and nutritious food, along with a pollution free atmosphere and a stress-free peaceful society. The contribution of the state towards primary health care and at least 50% of the health expenditure helps a lot. Bhutan has 2 doctors per 10,000 people but is declared a happy and healthy country. Thailand has 3.5 doctors but a good system and they live up to 72 years; so also Sri Lanka 5.3 doctors but has a life expectancy of 72-73 years. It is difficult to show a city with more pollution and more stress than Mumbai (Delhi excluded) and all medical advances and numbers of doctors do not help.
How Inclusive is the Universalised Insurance Scheme (RSBY) in Chhattisgarh?

- Sulakshana Nandi, Rajib Dasgupta, Samir Garg, Dipa Sinha, Sangeeta Sahu, Reeti Mahobe

Sumitra was taken to a private Nursing home late at night when she experienced labour pains. Despite carrying her RSBY card, the hospital staff told them to pay extra night charges of Rs. 2000, without which she would not be admitted. She had a Caesarean section, for which the hospital deducted Rs.12000 from her RSBY card and additionally demanded Rs.16000 cash, which the family had to pay up.

When twelve-year old Pravin fractured his leg, the local quack referred them to a private hospital. Despite having the RSBY card with them, they were told to first deposit Rs. 6000 for his operation. His parents foraged for the money and could deposit it only on the second day, after which he got operated on. At the time of discharge seven days later, the hospital additionally deducted Rs. 10,000 from their RSBY card. The Mitanin of their locality suggested that they register a complaint with the RSBY helpline. But the family refused, saying that they have to keep going back to that hospital and so they cannot complain against it.

Both Sumitra and Pravin were entitled to completely ‘cashless’ service in empanelled private facilities. However, despite utilizing RSBY, their families were forced to incur expenditure, putting them in great financial distress.

The Rashtriya Swasthya Bima Yojana (RSBY) became a ‘flagship’ programme of the Chhattisgarh Government with its universalisation in 2012 through expanding coverage to the Above Poverty Line (APL) families under the state funded Mukhyamantri Swasthya Bima Yojana (MSBY). But, the above two case studies beg the question, what really has been the impact of this universalisation on the urban poor? Are they able to utilize it effectively?

This paper explores this question through a study that was undertaken by the Public Health Resource Network and Chaupal Gramin Vikas Prashikshan Evum Shodh Sansthan (Chaupal) Chhattisgarh in the urban slums of Raipur. The objective of the study was to understand the experience of poor women in accessing RSBY/MSBY for hospitalization.

Raipur city (Municipal Corporation), with a population of over ten lakhs, has nearly 40% of its population living in some 282 slums. The healthcare services in Raipur are provided by the health department, Raipur Municipal Corporation, and by the formal and non-formal private sector. In 2013, the state government expanded primary health care services by implementing the Mukhyamantri Sheheri Swasthya Karyakram (MSSK), and thereby introducing 103 sub centers or Swasthya Suvidha Kendras (SSKs) managed by an ANM, one Mitanin (Community Health Worker) per 1000 slum population and 10 Urban Primary Health Centres (PHCs). Tertiary public sector institutions in Raipur include the District Hospital, Medical College and the All India Institute of Medical Sciences (AIIMS), Raipur. More than one third of the empanelled private hospitals in Chhattisgarh under RSBY/MSBY, are situated in Raipur and thus account for the highest claim amounts sought in the state. In the last couple of years, the city has seen strengthening of the public health system leading to increased coverage of primary outreach services like immunization and increased institutional deliveries. But it has also seen recent annual outbreaks of hepatitis E, with the private health sector continuing to play an extortionist role in such vulnerable situations.

In this quantitative study, 367 patients who had been hospitalised in the six months prior to the study were identified through Mitanins (Community Health Workers - CHWs) and interviewed using a structured interview schedule. Family level data was collected using a family questionnaire. The tools were piloted in two rounds. The survey was undertaken during February 2014 by a team of surveyors, supervised by SN, SS and RM. Data was entered in Excel and analysed using SPSS by the authors. Informed consent was taken verbally from the respondents and noted. Confidentiality has been maintained during data analysis and report writing.

Of the hospitalised patients, 282 were women (65% from OBC category, 17% SC, 13% General Category and 4% ST) who accessed health facilities within the state. Their experience is enumerated as follows:

Enrolment

The study shows that coverage of the universal scheme is only a bit more than half (57 per cent) among the families of the women patients with the rest still remaining uninsured. However, enrolment among women (68%) was slightly higher than men (65%).

Though nearly 90% of the families were aware of the scheme, many were unable to enrol due to problems in the enrollment process, like not being informed of the enrolment drive, name not being on the list, family members being absent, etc. Nearly 40% of the families surveyed did not receive the insurance smart card on the same day of enrolment, as is the rule. However, most families reported not having to pay any extra money for enrolment, other than the stipulated amount of Rs. 30. Though it is stipulated that the list of empanelled facilities should be given along with the insurance smart card, only 5% reported receiving it. Similar gaps have been found in the official evaluation RSBY/MSBY in Chhattisgarh. This aspect is significant as one of the stated objectives of this scheme is to provide ‘choice’ to the patient in selection of facilities. However, in the absence of information on empanelled facilities, what nature of ‘choice’ could people be expected to make?

Hospitalisation

The challenges faced by women accessing healthcare is well documented. Here too, there was a gender bias in accessing hospitalisation for non-obstetric/gynaecological conditions. A greater proportion of men, as compared to women, reported hospitalisation for non-obstetric/ gynaecological conditions. This was seen specifically in conditions like respiratory disease, jaundice/typhoid, gastrointestinal problems and others.

Most women, regardless of enrolment status, went to public health facilities for obstetrics/gynaecological conditions. Around 63 per cent of women who delivered,

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went to public facilities for delivery, a pattern which seems to have been brought on due to the efforts of the MSSK. However, a greater proportion (55%) of women went to private facilities as compared to public facilities for non-gynaecological conditions (respiratory diseases, fracture, and heart related conditions and so on).

The reasons for selecting a particular facility did not include RSBY/MSBY as a determinant. In fact, the main determinants in hospital selection were being familiar with the hospital, and referral by a friend or acquaintance. Moreover, the study shows that out of the enrolled women who visited private facilities, 42% visited non-emplaunched facilities. This puts a question on just how useful the patients perceive RSBY/MSBY, considering that it does not significantly determine hospital selection.

**Utilization of RSBY/MSBY**

The efficacy of insurance is seen in whether an enrolled patient was able to use insurance and get cashless treatment. Raipur district, with the largest number of empanelled facilities and claims, all concentrated Raipur city, should have seen very high utilisation by the urban poor. However, the study finds that for poor women, usage of RSBY was very low and also selective. Only one third of women whose families had insurance reported its use for treatment, more so in the private (71% of women) than in the public (25% of women) sector. When used, it was used mainly for non-gynaecological conditions (49%), and that too mostly for surgical procedures.

**Out of Pocket Expenditure (OOPE)**

Protecting people from financial risk and catastrophic expenditure is the primary stated goal of RSBY/MSBY. However, the study finds that nearly all (96%) women had to incur OOPE with an average OOPE of Rs. 9,947 per hospitalisation case. Nearly all women (90%) had to spend money on transportation, two-thirds had to spend on medicines and nearly half of the women had to pay money for health personnel and fees charged by the facility. In terms of how each item contributed to the total OOPE, we find that the largest expenditure, i.e. 52% of the total OOPE, was on fees or unspecified amounts charged by the facilities, 18% on medicines and 15% on diagnostics. Condition-wise, the highest expenditures were on hospitalisation for heart related conditions (Rs. 1,22,800 per hospitalisation case), cancer (Rs. 52828 per hospitalisation case), appendicitis (Rs. 52980), fracture (Rs. 44000) and kidney related conditions (Rs. 40780). Such high expenditure can be catastrophic for the urban poor and such medical conditions should have been covered by insurance.

For women who used insurance, the OOPE in private facilities (Rs. 10,733 per hospital visit) was more than six times higher than the public facilities (Rs. 2,518 per hospital visit). In order to meet the hospitalisation costs, around 61% women used their own savings, while more than one third (37%) had to borrow money and seven women (2%) had to sell or mortgage valuables.

**Conclusions**

The health sector in urban areas is characterized by multiple health providers, both formal and non-formal and is usually highly medicalised. Raipur city is no different. The study shows that universal health insurance has not been able to provide coverage to all the urban poor. Even when the poor are covered, they are often not able to utilize the insurance, nor receive free treatment. This has led them to believe that ‘cashless’ treatment even under RSBY/MSBY is really not possible. On the other hand, the claims data show that the private hospitals in urban centers like Raipur are actually the largest beneficiaries of the universal health insurance scheme. These are the health providers who also negotiate aggressively with the government through the Indian Medical Association (IMA), in order to increase the RSBY/MSBY package rates. In fact, prior to this survey, in the beginning of 2013, they went on strike for nearly three months when they suspended all services under RSBY/MSBY.

The study shows that the urban poor, especially women, are utilizing the public health system wherever it is providing services, regardless of insurance coverage. For the rest of the services, they have to go to the private sector, which remains very expensive and exploitative and selective in its use of RSBY/MSBY. The study raises doubts regarding the efficacy and utility of universal insurance in providing free and quality health services to the urban poor and this needs to be kept in mind while building strategies for providing healthcare to the poor and vulnerable groups in urban areas.

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Lives of Urban Migrant Workers in India: Need for Reflection and Action

- Rahul ASGR*

The Context

In India, about 31% of the population currently lives in urban areas and it is predicted that this would increase to about 50% by 2050. The population growth will be driven in parts by natural increase, inclusion of newer areas with urban limits and internal migration (henceforth migration). Around 30% of India’s urban population are of internal migrants, majority of who are women with marriage being the predominant reason for women to migrate, while for men employment is the most common reason for migration. While marriage might be the actual reason for migration; women do often join the workforce at the destination too.

Those who migrate, from the rural to urban labour markets, largely find employment in the informal sector that contributes to about 50% of the GDP and accounts for more than 90% of the total work force of the country. Temporary or circular migrants, who mainly are Adivasis and Dalits, are the most vulnerable migrants. A large proportion of rural to urban migrant workers find jobs in sectors such as construction, manufacturing, textile, transportation, brick-kilns, hotel and domestic work. However, data regarding migrants in India is inadequate, with the existing data sources such as Census and National Sample Survey unable to capture seasonal migrations adequately.

Situation of Urban Migrants

While it is recognised that migration contributes to both growth and development in economic terms it is important to reckon that the migrant workers subsidise the cost of such development that is to say while the urban middle and upper classes get the ‘good’ the migrants receive the ‘bad’ in the process. Urban migrants working in the informal sector and their families are forced into conditions characterised by a lack of job security, low wages, interruption of work, unsafe working conditions, low level of skill, and lack of access to social security measures.

Migrants face social exclusion in various forms, the range extending from having no identity that is then linked to absence of electoral representation; lack of access to basic amenities such as housing, water and sanitation, educational opportunities for children, public distribution system, financial mechanisms and public as well as private health system. Further, infrastructure required to support the current population as well as the future increases in population is not in place with infrastructural development not keeping pace with population growth. All these necessitate measures for the protection of migrants which do not exist.

Though migrants come under the purview of various labour laws, evidence points to that the provisions stipulated by them are not provided for. This can be explained by a lack of concern on part of the contractor, employer and authorities, and poor bargaining power on part of the migrants, also due to lack of organised strengths. For instance, the Building and Other Construction Workers Act, 1996 (BOCWA) stipulates that state governments set up a welfare board, funded by cess collected from employers, for the benefit of construction workers registered with it. In most states registration of construction workers is very poor. Lack of awareness of the benefits of scheme as well as the unfavourable procedures for registration in terms of time and documentation required are responsible for such a situation.

Even within the schemes formulated, there exist differences between states, right from eligibility criteria for availing the provisions of these schemes. A parliament committee had studied the situation in 2014, to find that most of the states did not spend more than 10% of the cess collected for the purpose, with a spending less than 15% at all-India level.

Health and Access to Healthcare

The health problems of migrants mainly result from the biological, chemical, mechanical, and physical hazards they encounter day to day at both work sites and living spaces (which are common for some). This is aggravated by the fact that they have poor or no access to occupational safety and health measures. Evidences suggest that urban migrants have poorer health outcomes as compared to the non-migrants across the spectrum of communicable and non-communicable diseases, maternal and perinatal conditions, nutritional disorders, and injuries.

This is partly related to the living and working conditions and partly to healthcare access. Migrants are excluded from various national health programmes due to their vertical structure and procedural difficulties. Migrants access to curative healthcare is limited due to the knowledge gaps about healthcare facilities, language problems, timings of their work and distance to services in

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terms of availability and accessibility\textsuperscript{18,19}. The accessibility of private health providers/facilities is better as compared to government health facilities which is reflected in the pattern of utilisation\textsuperscript{19,20}. Here, a feeling of alienation from the public sector and higher costs of care in the private sector together create barriers for optimal utilisation of health care services\textsuperscript{19}. In the absence of enrolment to any health insurance schemes and lack of compensation as stipulated by the Inter State Migrant Workers Act, 1979 (ISMWA), except for expenditure incurred on getting injuries suffered at the worksite treated, healthcare costs are a significant source of expenditure for migrants\textsuperscript{19,21,22}. Knowledge about the Rashtriya Swasthya Bima Yojana, one of few schemes that provide portability across states, and enrolment, is seen to be poor\textsuperscript{19}.

Compared to male migrants, female migrants have poor knowledge of nearby health facilities leading to a situation where they either delay seeking care or resort to treatment from informal providers\textsuperscript{18,19,23}. The health seeking behaviour is further dependent on age, social support at the destination, health awareness, health beliefs, health behaviour and time since shifting to present place of work. The issues faced by women and children are sometimes similar but not similar always. Migrant women face additional burden of experiencing violence physical as well as sexual at worksite and at home\textsuperscript{18}. Using a life-cycle approach, the poor health of migrant women transferred from one generation to the next is further affected by poor nutrition, low immunisation coverage, and lack of early childhood care and education associated with lack of support structures for working women. While evidence highlights that the migrants face health inequalities and have poor access to health services and facilities, it is also important see this through an equity perspective, since they are not a homogenous population. The vulnerabilities faced by migrants vary based on health environment at departure and destination sites, pattern and duration of migration, nature of work, living and working conditions, access to healthcare and social services, and familiarity with culture and language of the host communities\textsuperscript{18}. Further, the duration and pattern of migration also varies based on the source states, land owning pattern and skillsets of the individual. One example to illustrate the equity issues here could be of migrant workers in construction industry, wherein Individuals could be working both at smaller and larger construction sites. The workers at smaller construction sites, less in number, usually tend to migrate with their families. At the larger construction sites employing larger number of workers, there might be better working and living conditions and better access to social security schemes but the workers tend to be alone mostly due to the adverse relationship with the contractor/principal employer. The requirement and availability of amenities are visibly varying here, based on the conditions.

**Differing Perspectives**

One view about migration is that it is a negative phenomenon resulting from a failure of rural development. Such view is associated with measures to control it such as common property resource management, watershed management, and agricultural development\textsuperscript{24,25}. These measures are also supplemented by employment generation schemes, also by creation of towns to limit migration to cities wherein urban municipalities consider migrants as a burden on their stretched resources\textsuperscript{26}. The other view is that migration plays some role in poverty reduction and economic development, hence has positive impacts. This view is associated with the demand for better access for migrants to basic necessities and public services. This has led to efforts by various NGOs and CSOs to address the issues faced by migrants in the informal sector across the spectrum of Social Determinants of Health (SDH), which in itself is a pointer to the vacuum in the policies to cater to the legal and social protection of migrant workers\textsuperscript{8}. Although some of these interventions would have helped in the social inclusion of migrant workers and resultant improvement in quality of their lives to some extent, there is a contention that the policies and governance systems are still in favour of urban elite at the cost of migrants\textsuperscript{2}. The approach of such measures are important too, whether they are welfare based or rights based, which shapes the control of these workers over various determinants of their lives.

**In Conclusion**

The larger question here is about optimising the role of the state in improving the health status of migrants. Here, the state interventions need to focus on better working and living conditions of migrant workers and their families, their access to basic amenities and public services. This would essentially require coordination between various ministries, urban local bodies, stakeholders such as migrant workers themselves, NGOs, CSOs, trade unions, social activists and researchers. We need to have clarity about roles and responsibilities of various actors, approaches for improving the lives.
of migrant workers, nature of the changes required and strategies for the same. While it is important to recognise that migrants are key contributors to growth and development, equally important is to ensure that the migrant workers and their families are getting the due benefits from such growth and development.

Disclosure: My interest in migration and migrants stems from the experience of being one all my life.

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'Culture' Lens Matters while Thinking Urban Health Inequity

- Anuj Ghanekar*

Introduction

“Sir, zopda (slum) will be ultimately a zopda ... certainly much different from well-off society... the cattle would be roaming everywhere... the children would be playing in dumped garbage, the uneducated residents would be often quarrelling in a raised voice and using abusive language...” An auto rickshaw driver shared a view while driving me to the field location. He narrated nothing but a perceived culture of a typical urban basti (slum). An urban basti shows more complexity due to possible factors like high population density, less socio-economic resources and higher heterogeneity in terms of ethnicities, religions, backgrounds, migration patterns, occupations and political backgrounds. An urban basti may stand out based on its cultural diversity. “Basti culture” can be characterized by a great number of “strangers” staying together in a limited place, unlike largely homogenous rural culture.

One eighth of urban population of India lives in slums. The urban poor constitute a sizeable percentage of population in any city, and are socio-economically and geographically marginalized. The National Urban Health Mission (NUHM) calls urban poor as “crowded out” while talking about their health situation. Several causes are enlisted by researchers and practitioners behind the health inequity in cities including inappropriate funding, rising private sector, weak governance, weak public healthcare systems, disproportionate exposure to hazards and urban infrastructure. However, there is dearth of information around cultural factors that influence the health determinants in urban basti (slum).

In this context, the key analytical framing question posed here, was: What different cultural factors within urban basti influence its health determinants? This paper deals with influence in terms of physical and social determinants of health, perceptions of illness, health seeking behaviour and approaches to health promotion. The scope of present paper was limited to culture of basti itself rather than culture of entire city or that of clinical settings.

Defining Culture and its Relationship with Health

Culture in simple terms, is the “way of life”. Characteristics of culture reflect from its several definitions. Anthropologist Edward Tylor defines culture as “a set of practices and behaviours defined by customs, habits, language, and geography those groups of individuals share”. Some definitions emphasizes on group element where culture is a knowledge that is “shared” by a group of people. This knowledge is transferred from generation to generation. Culture sets boundaries, shows what an individual can do and is allowed to do. Culture is integrated into all aspects of an individual’s life.

For the sake of working definition of culture, this paper considers commonly shared ideas and symbols within basti, and their translation into everyday behaviour and practices. Literature speaks about how culture of community as well as clinical settings influence health.

Research Setting

This paper examined the role of culture in urban health inequity by drawing a case of a basti in Surat (City in Gujarat, India). Like many other Indian cities, Surat is vulnerable in terms of population growth, rapid area expansion and urban poverty. But, what makes Surat appropriate for studying cultural influence on health is highest in-migrant population across India, heavy industrialization, climate and natural hazard vulnerability and health challenges like infectious diseases or new resurgent infections.

This paper is based on fieldwork conducted in “Azadnagar-Rasulabad” basti from Bhatar ward of Surat. This basti was established on the legal Surat Municipal Corporation (SMC) land 30 years ago. As per local Anganwadi centre records (2014), the total population of Azadnagar-Rasulabad counted 8537 and average family size was 5. There were 841 female per 1000 males. Urban health centre and Vector borne disease control unit was located 1.5 km away while some private clinics operated within and nearby basti area.

Methods and Approach

Culture of Azadnagar-Rasulabad was studied from both the point of view of external observer (an etic perspective) and of local people (an emic perspective). The study was conducted under a project of Urban Health and Climate Resilience Centre, during March-September 2015. A variety of methods were followed in studied cultural context – Participant observations of day-to-day behaviours and practices, open-ended interviews, group discussions, photography and participatory mapping exercises were conducted. Data were manually analysed in inductive manner where themes and subthemes emerged during and after the process of data collection.
Findings
The findings present a descriptive account of cultural factors: explicit ones like practices based on religious and migration backgrounds, neighbourhood structure, language and communication, material culture; and implicit ones such as attitudes and behaviours towards healthcare facilities and access, gender roles, past experience of disasters and work culture. The linkage of each factor with health inequity is presented ahead with quotes and observations from fieldwork.

Explicit Cultural Factors
Explicit factors were the visible ones and their thrust was upon shared “symbols” rather than mental ideas.

Practices Based on Religious and Migration Backgrounds
The Basti dwellers were settled migrants from five different states - Maharashtra, Bihar, Rajasthan, Karnataka and Andhra Pradesh. Religion-wise mixed population of Hindu-Muslim-Neo Buddhist was present. This heterogeneity on the basis of ethnicity and migration backgrounds indirectly would interfere in health matters - Interestingly respondents reported few unique practices.

• While reporting “festival” as a major source of expenditure, basti dwellers explained their “expenditure burden” in monsoon season when most festivals are celebrated, daily wage income sources are uncertain and disease proneness is high.

• Certain religion specific customs were found linked with health status, for example, Burkha dress pattern causing skin infections in summer or lack of health insurance due to religious prohibition were reported by Muslim residents.

• Journeys to native place and return, via long, congested rail travel, were often associated with health problems.

Neighbourhood (basti) Structure
Different social groups intermingle with each other but they seemed to retain unique identity through settlement pattern within basti, for instance, neo-buddhist population in Rasulabad had formed separate Ambedkar nagar. Additionally, separate worship places and community gathering sites were visible. Religious harmony was evident in day-to-day life; however, the basti was perceived as one of the “dangerous” ones when communal riots take place anywhere else in country.

Nuclear family structure also seemed motivating people to gather on ethno-religious and migration status basis. Basti functions with too many informal leaders and political affiliations. Routine conflicts resulted out of garbage dumping or quarrels of children had tendency to bring social group based identities on surface for example, through abusive language.

Basti Structure was found Influencing
• Mobilization efforts of local Non-Governmental Organizations for community health (e.g. cleanliness campaigns or promotion of medical camp at urban health centre),

• Formation of Mahila Arogya Samitis as proposed nationally (NUHM, 2008)

• Cooperation of basti dwellers with community health workers

There is further scope to inquire possible mental health issues in basti arising out of complex neighbourhood structure.

Language and Communication
Established since long, the local Gujarati language of Surat and National language Hindi were widely used in public sphere. Usage of native languages, on the other hand, dominated private sphere (families and extended relatives) even after migration. The native languages included Marathi, Urdu, Kannada, Telugu and local vernaculars of Bihar & Rajasthan, which were often mixed with Gujarati or Hindi. Marathi and Urdu medium municipal schools were located within basti. However, Gujarati language was a subject and its education was given importance by parents for their children.

The working Hindi-Gujarati knowledge had certainly minimized the role of language as a “barrier” in healthcare access and health education. The Guajarati speaking urban health centre staff and a private practitioner from Bihar were able to manage with their patients in Hindi unless the patients were Kannada or Telugu speaking. However, there were some concerns expressed. A medical officer from nearby urban health centre stated,

“Our services must get communicated to illiterate basti-dwellers in a dialect and manner which they easily understand and can comprehend”.

The local understanding of diseases was also expressed in popular language which must be understood by healthcare professionals. The malaria, for instance, was classified, according to community members, as “sada malaria/ (simply) malaria” (P. vivax) and “jeheri malaria” (P. falciparum). Sada malaria can be recognized with fever in night, chills etc. Jeheri malaria is dangerous and it cannot be recognized by us... it can be only told by doctors once patient is admitted. Jeheri malaria is dangerous and it has symptoms like stomach upsets, vomiting etc. Jeheri malaria can lead to the death.”

Health communication material, say, posters displayed in health centre, medical camp publicity
pamphlets and mosquito larvae identification exercises for schools were in Gujarati language. Their utilization was reported minimal by basti-dwellers. Noteworthy actions from other parts of Surat like printing Malaria action pamphlets in Oriya language for Orissa migrants could not be found here.

**Material Culture**

Material culture included physical objects and artefacts affecting health directly or indirectly. It was reflected through plastic bags, garbage dumps, street food stalls, lack of playground for children, commonality of televisions and smart phone usage in youth.

**Implicit Cultural Factors**

In contracts with the explicit factors, the implicit factors were more underlying in nature and psychological.

**Attitude and Behaviour Towards Healthcare Facilities and Access**

Attitude and behaviour of basti dwellers seemed to be forming roots of health practices. A 42 year old woman from Rasulabad, showing inclination towards private healthcare utilization, told: 

"In private clinics, doctors and nurses talk very politely to you... they listen to you... They allow you to talk. We don't feel like going urban health centre cum maternity home for child delivery. Women over there shout at us or refer to civil hospital".

In another instance, a 55 year old informal leader whose opinion indicated a religious take on how might he not opt to take precautions for preventing cardiac diseases, since he believed that nothing could be done to stop such ‘plans’ of the god. Although, it falls outside the direct purview of present paper, attitude and behaviour patterns of healthcare staff were worth considering too. One of the health department staffs, for example, identified Azadnagar-Rasulabad residents as a "naffat praja" (people who don’t listen and act)

**Past Experience of Disasters**

Like other parts of Surat, Plague (1994) and massive flood (2006) were reported as major events by basti-dwellers while recollecting their history. Memories of Tetracycline drug distribution as a remedy of Plague, rescue activities during flood, tremendous helping spirit shown by community irrespective of religion boundaries, lessons learnt from 2013 Swine Flu episode were proudly narrated. Such kind of community wisdom would be helpful, especially, for maintaining health post disasters.

**Gender Roles and Habits**

Men worked as casual wage labourers in unorganized sector (in construction, textile industries, carpentry etc.) or were engaged in self-employment (like auto rickshaw driving, street vending, meet selling etc). Women often played the role of earning member in many families. However, traditional gender roles of cooking, rearing children and household chores persisted for women along with new role of earning. They worked as housemaids, cleaners, rag pickers or were into “earn from home” textile jobs. Adolescents girls were helping hands for parents. Gender roles in basti were influential in several ways, for example: Most rag pickers in basti were women. Centre for Social Studies, Surat has documented how rag pickers in Surat are subjected to skin infections and physical injuries due to dog-bites, dead animals, spoiled food etc. Tobacco addiction to get “high” while doing laborious job was “natural” for men and women. Alcohol and gambling spots within basti were popular and used to be crowded by casual wage male labourers. Interviewed group of women perceived substance abuse as a priority health area which needs attention.

**Work Culture**

The “work culture” i.e. beliefs and practices associated with work and workplace also mattered. Most of the basti residents were daily wage labourers. They preferred private clinic utilization. Their timings were suitable for labourer men and women rather than public health facility. Preferred access to private facilities was also driven by the thought that the medicines from private facilities provided instant relief.

“Lack of time” was reported as the main barrier for community participation activities in health, for example, difficulties in Mahila Arogya Samiti formation in Rasulabad or demand of “ready to eat” food to Anganwadi workers by community rather than raw food material.

Certain occupation specific habits were also harmful to local environmental health, for example, throwing empty tobacco packets by auto drivers in Rasulabad at auto junction point or families into cattle rearing having low acceptability for mosquito reduction insecticide in stored drinking water due to its perceived risk for animals.

**Cultural Competence: a Brief Discussion**

The study brings forth useful knowledge about cultural factors that tend to influence the health determinants in urban slums. However, the study is not free of limitations. In terms of theoretical limitations what counts as a cultural influence, is at times somewhat open to debate as there are several views on culture as a concept. The proposed categorization of “explicit” and “implicit” factors can also be deepened further at theoretical level. On methodological grounds, the
possible subjectivity of researcher can be reduced with further validation of responses and ensuring maximum representation of social groups. Using quantitative research methods will substantiate qualitative insights. Several questions raised in this paper provide ample scope for in-depth inquiry.

Culturally competent care has been proposed as a means to reduce health disparity. Cultural competence is defined as awareness of the cultural factors that influence another’s views and attitudes, and an assimilation of that awareness into professional practice[13]. Considering the limit of present paper, few world-wide experiments are mentioned here as an idea.

In case of language and communication, for example, the programs to recruit bilingual and bicultural health care providers, development of interpreter services and language-appropriate patient education materials, the use of lay health advisors, and cultural competency training for health care providers are being implemented[12]. The case studies of interventions in Indian urban context are, however, can be the way forward.

Another example could be, The Diagnostic and Statistical Manual of Mental Disorders DSM (2000) of the American Psychiatric Association introduced a method what is now called the Cultural formulation [13] where the patient is asked to develop a life story i.e. a culturally embedded biographical narrative[14]. Other cultural factors proposed here can be seen as opportunity, for example, trend of using smart phones in youth provides the scope for m-health interventions or past experience of disasters can be documented for advocacy of epidemic management in future.

Summary and Conclusion

In this paper, an attempt has been made to illustrate how the “urban” culture of bastis influences health. The cultural factors were thematically categorized as explicit and implicit.

Each factor seemed fostering urban health inequity by limiting the opportunity to become healthy but it also offered scope to minimize health inequity. The policy makers, trainers and medical practitioners are suggested to provide culturally competence in health and healthcare delivery. The paper simultaneously provides direction for future in-depth inquiry, such as whether migrant basti dwellers were having struggle with being ‘between cultures’ – balancing the ‘native’ and the ‘new urban’.

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Medical Pluralism and Health Care for the Poor

Veena Das*

The existence of medical pluralism has often been understood in terms of cultural differences in the understanding of health and disease, or as predominance of folk models of disease versus biomedical models in the functioning of health care for underserved populations. From the policy perspective, the presence of a large number of providers in rural and urban areas who are either trained in alternate systems of medicine or have no training except garnered through experience of working as paramedical staff or as informal apprenticeship but who have the status of Rural Medical Practitioners (RMPSS) is seen as a major impediment to rational health care delivery. Yet, the issues are much more complex and regrettably, there is little curiosity on how health care institutions actually function in both public and private sectors. My aim is to open up some of these issues for discussion by looking at the legal framework within which the right to practice is negotiated and the structure of markets, within which health care providers of different kind strive to sustain their medical practice. What implications do these institutional factors have for the character of health care for the urban and rural poor?

The Legal Landscape: Who is a Doctor?

A detailed analysis of the corpus of court cases pertaining to the issue of who has the right to practice allopathic medicine in the country is not possible in the short space of this paper. However, it is important to note that while the Indian Medical Council Act of 1956 (last amended in 2011) limits the right to be registered as an allopathic doctor to those with degrees in biomedicine awarded by an accredited medical college in India, individual States have the right to issue notifications under Clause (iii) of Rule 2(ee) of the Drugs and Cosmetics Act (last amended in 2015), through which exceptions are allowed to the above rule in order to meet specific needs of underserved populations. Several key judgments of the Supreme Court have noted that while the Indian Medical Council Act of 1956 discouraged the practice of cross-pathy (when a medical practitioner trained in one branch of medicine practices another branch of medicine), the need to serve people living in areas in which there were not enough allopathic doctors made it necessary for States to permit limited rights to prescribe allopathic medicines by those practicing other streams of medicine. Thus the judgments of the Supreme Court have generally deferred to the right of State Medical Registry to determine the qualifications of Indian medical practitioners holding degrees in integrated courses to practice modern systems of medicine. For instance, as recently as in January of 2014, the Maharashtra State Cabinet decided to allow homeopaths to prescribe allopathic drugs provided they had taken a linked course in pharmacology. In February of 2014, the Maharashtra State cabinet decided to allow Ayurveda and Unani practitioners to perform minor surgeries, in addition to legally prescribing allopathic drugs.

In effect, these judgments reflect a struggle in which the associational politics of different kind of practitioners have played a crucial role to retain their market shares. However, the plethora of court judgments and State notifications create tremendous uncertainty at the ground level for providers trained in alternate systems of medicine as to what constitutes legitimate medical practice. During fieldwork in urban slums in Delhi, Mumbai, Patna and Allahabad, our team of researchers at the Institute of Socio-economic Research on Development and Democracy (ISERDD), documented a proliferation of degree granting institutions. This data was collected in different phases. Initially, through mapping exercises of providers in seven neighborhoods in Delhi in the years 1999-2002, our team identified the various kinds of providers by noting the degree or the training recorded on billboards (see Das 2015). This exercise was complementary to weekly morbidity surveys conducted on 1600 randomly chosen households in these neighborhoods for a four month period every year for a total of three years (see Chapter 2 in Das 2015 and also Das, Hammer, and Sánchez-Paramo. 2012, for a detailed discussion on methodology and results and particularly the latter for differences in recall in weekly versus monthly morbidity surveys.)

Recently there has been welcome scaling up of these exercises, based on a systematic survey of a random sample of households in one district in every state in India, authors of a recent study find that an average household in rural India can access 3.2 private and 2.3 public paramedical staff within their village (see MAQARI, cited in Das J: 2011). In Delhi there are 70 practitioners (most of whom are private practitioners) within a 15 minutes walk of every household. The extent of medical training varies in all these sites – in rural Madhya Pradesh 65% of practitioners accessed had no formal training while in Delhi only 10% to 15% had no formal training although what this formal training consisted of showed wide variation including, for instance degrees in ayurveda through correspondence courses. (see Das, Holla et al 2012).

The ISERDD team also encountered a large number of providers who might have gained some knowledge of specific medical procedures through apprenticeship in hospitals or nursing homes as compounders, laboratory technicians, or, those who were integrated...
in government schemes as health workers or Auxiliary nurse midwives, and who have subsequently drifted into the provider markets that serve the urban poor and the rural areas. From the perspective of providers trained in biomedicine, these practitioners fall in the category of “quacks”. There is a marked vigilantism in such organizations as the Quackery Eradication Wing of the Indian Medical Association (as well as at State level associations), which advocates the use of police force to stamp out this segment of the provider market in low-income areas of the cities.

Such vigilantism leads to periods when there are raids in the markets in low-income areas to locate “quacks” and subject them to criminal proceedings that then give way to periods when it is business as usual. It is important, however, to realize that though landmark judgments of the Supreme Court such as Verma v. Patel (1996) that held a doctor with a homeopathic degree responsible for the death of a patient and stipulated that all States should take action to see that those not trained in biomedicine would have no right to practice it, there are other judgments in which litigation undertaken on behalf of the associations of doctors with different kinds of training led to considerable leeway in this matter through the recognition of the right of States to issue notifications to meet specific needs of the moment. (See for instance Dr. Mukhtiar Chand & Ors vs The State of Punjab, 1998; L. c. H. Doctors’ Association vs State of Maharashtra 2013)

Two questions that are rarely asked in this context are as follows—first, what are the institutional mechanisms through which these providers are able to sustain their practice? Second, what kinds of needs do these providers fulfill and what are the gaps in health delivery that lead to a demand for their services?

**Markets and Networks**

Regardless of the system of medicine they have been trained in, there are certain features that are common to all providers in low-income areas in urban areas as well as in rural areas in the way they diagnose and treat diseases. First, rigorous research on the basis of systematic observation has shown that on average a doctor in low-income areas spends about three minutes per patient regardless of the number of patients waiting in the clinic, and independent of the kind of training he has. Patients do not demand and doctors do not offer diagnosis—instead, patients are treated on the basis of symptoms. Most doctors practicing in low-income areas first give medicines for two to three days on the basis of symptoms—usually a mix of pills, capsules and a syrup consisting of a common antibiotic, analgesics, a vitamin, and a steroid (see Das and Hammer 2004; Das, Hammer and Leonard 2008; Das, Holla et al 2012; MAQARI Team 2011). Work in progress in Patna and Medicines by a joint team of researchers from McGill University, World Bank, and ISERDD, has found that medicines dispensed are usually unlabelled in low-income areas in Delhi and Mumbai, while in Patna and in Allahabad district we found that the medicines are labeled and dispensed in their original packaging. Patients are given medicines for a maximum of two or three days in all these places and asked to return if they do not feel better. Very often a serious disease such as tuberculosis might be treated as a common flu initially and only over time when the patient returns with worsened symptoms are tests prescribed or the patient referred to a trained doctor. Thus the strategy the doctors employ is to use the medicines not only as therapeutic agents but also as diagnostic ones. Rigorous research using a combination of a vignette methodology that measures knowledge and a standardized simulated patients methodology that measures actual practice, has demonstrated that although providers trained in biomedicine (with degrees of MBBS) have more knowledge on diagnostic techniques and treatment, they do not apply their knowledge in the actual clinical setting (Das, Holla et al 2012, Das and Hammer 2014)).

This know-do gap, as it has come to be known, accounts for the fact that regardless of the kind of training that a provider has received, the treatment given to patients in low-income urban areas and in rural areas, shows little variation. In fact, providers trained in biomedicine are likely to prescribe more unnecessary antibiotics than those trained in other streams, although they might ask more questions pertaining to the history of the disease. The point is that a degree in biomedicine is no guarantee that a patient will receive a proper diagnosis or correct treatment if he or she lives and uses the services of doctors in the neighborhood markets in these areas (see also Mohanan, Vera-Hernández and Das et al 2015). Researchers have also shown that despite expansion of PHCs and government dispensaries, in 2015, there were 11.9% vacancies in PHCs and a staggering 81.9% for specialists in Community Health Centers (Pulla 2015). Add to that the rampant absenteeism – on a typical day, 40% of doctors might not be present in the PHC (Banerjee and Duflo 2006; Chaudhury 2006; Muralidharan and Chaudhury 2011) — and we can see why people will not bother to go to the PHC for treatment. Given these shortcomings, the typical illness trajectory in a poor family is that patients continue to visit local doctors for symptomatic relief unless the disease becomes critical when they might shift to a government or private hospital. Catastrophic health expenditures are often a result of the fact that a disease that could have been treated earlier goes undiagnosed and inappropriately treated till it becomes a crisis.

What kind of business models have providers in poor areas developed to sustain and grow their practice? Detailed interviews with medical representatives employed by pharmaceutical companies, medical stockists, warehouse owners, pharmacists and medical salesmen reveal a complex structure through which pharmaceuticals are marketed. In general, in the cities ISERDD researchers have studied, we find a classification of medicines, which tells us a great deal about the institutional structures of buying and selling, credit and debt, through which
providers in low-income areas sustain their practice. The three-fold classification of pharmaceutical products is that of “ethical medicines” – referring to medicines on which patents have not expired and which are, therefore expensive and are marketed through distributors and medical representatives to large hospitals and doctors practicing in more affluent areas. The second is “generic” which refers to off-patent drugs produced under license by small manufacturers and marketed to pharmacies in middle income and low-income areas. Finally there is the category of “dispensing medicines” which are usually unlabelled medicines that are sold in bulk to certain distributors who specialize in stocking these medicines in Mumbai. In Delhi and Allahabad we found that patented, generic, and unlabelled medicines can be found in the same wholesale shops but the unlabelled medicines are not displayed. In other places, (e.g. Patna and Mumbai) stockists distinguish themselves on the basis of the kinds of medicines they stock but to examine variations we need more systematic work. Unlabelled medicines are either sold through the agency of medical salesmen (and not MRs) who we might describe as freelancers or bought directly by providers in bulk. There are well worked out credit and debt networks through which supply chains are maintained and segmented markets are served. I do not have the space to describe the mechanisms through which generic medicines too move within specific networks such that some doctors will insist on patients taking only some brands while proscribing others, often leading to considerable price hike for the patient.

Finally, it is intriguing to see that different cities have evolved different patterns through which providers in alternate medicine and so-called informal providers (i.e. those who have learnt their craft through informal arrangements such as apprenticeship with a doctor) are linked with providers who are fully trained in biomedicine. We found that in Delhi, such informal providers and those with degrees in alternative medicine are not tied into any formal referral networks. If a disease worsens, they will ask the patient to go to either a government hospital or to a private facility. In only one area in Delhi, did we find that a local hospital provided incentives to providers in the local market to refer patients to that hospital by offering them a commission for every referral. These kinds of financial arrangement need more study.

A different kind of network between providers might be illustrated through a case study of an eight-bed nursing home from Korali, a relatively large and well-connected village near Allahabad. The owner of the eight-bed nursing home (I will call him Dr. Shailesh) had worked as a helper in the operation theatre of a private hospital in Allahabad in his youth, combining this with studying for a degree in pharmacology. After his B.Sc. degree, he set up a regular chemist shop in Korali with a small section of the shop separated by a curtain where he saw patients. As a pharmacist, he supplied medicines to neighboring villages and small towns, including to the informal providers in these areas but he supplemented this income by treating patients from the village for minor ailments. As his business expanded, he also expanded his clinic so that today he has in-house facilities for basic laboratory investigations, an OPD where ordinary illnesses can be treated, and provision of admission and treatment of patients who require minor surgeries or need to be admitted for complications such as delayed labor, or for treatment of wounds and injuries. Dr. Shailesh recognizes that his own ability to treat complicated cases is limited and hence has contracted with three doctors from Allahabad with different specializations who run OPDs in his nursing home in Korali for one day each every week and treat inpatients from Korali and surrounding villages. If a patient needs more specialized attention these doctors have the connections to have patients admitted in larger hospitals in Allahabad. This is an interesting model, for Dr. Shailesh, as his name plate characterizes him now, has effectively redefined himself as a rural health worker despite the title of Doctor. He limits himself to performing triage functions and treating minor diseases. His income comes from sale of medicines, laboratory investigations, and fees for consultations. He does not get any rent or commission from the three visiting doctors as he claims that they are crucial contacts for his plans to expand further and build other such facilities in neighboring small towns.

We found similar strategies for medical establishments in small towns in the vicinity of Patna. Providers trained in biomedicine in Patna are linked to multiple locations, some of which are outside Patna. These networks have been facilitated in part because of the rules regarding private practice in Bihar whereby state employees are allowed to engage in private practice and partly by emerging entrepreneurship in small towns or large villages on the fringes of big cities like Patna. Some of the results have probably been positive as more qualified doctors become available in poorly served areas, but we have also witnessed so-called operation theatres where visiting surgeons who work in government hospitals perform such surgeries as appendicitis and hysterectomy as part of their practice but in conditions of very poor hygiene, no nursing staff, and no ambulance service for transferring patients who might develop complications. A future area of research is to investigate the conditions of possibility for different business models to evolve and their implications for quality of care. It is particularly important to inquire into the difference between fragmented markets in which the providers with different kinds of degrees move in separate circuits and remain isolated from networks of trained allopathic providers, laboratories and pharmacies; versus those located in more integrated markets in which either through ties of kinship or through different local business logics, informal providers become integrated into different kinds of referral networks redefining themselves as providing
first lines of contact with patients. The implications of these different models for quality of care, ability to diagnose, and access to expert knowledge provided by allopathic providers (with all the positive and negative implications), as well as the financial burden of treatment on patients, are likely to be quite staggering. While it has been very easy to blame “quacks” for all the ills of health care, it is salutary to keep in mind that providers trained in biomedicine participate fully in such practices as prescribing unnecessary antibiotics, performing surgeries in ill-equipped “operating theatres” with no provisions for after care and in some cases, not even the provision for clean bed sheets in what passes for a post-surgery ward. At ISERDD we have enough case materials to open up these questions but without a national level survey it is not possible to quantify these findings.

**Experiments on Policy**

I hope it is clear that the provider markets are not static and that quality of care is not easy to map on allopathic doctors versus doctors from different streams of medicine. On the basis of the present research, I suggest that policy debates need to take the existence of the large number of providers who use allopathic medicines but do not have access to information except through the mediation of medical salesmen – not as an impediment but as a resource that can be molded to stamp out harmful practices and provide better care to patients. One example of treating untrained providers as a resource is a training program run by the Liver Foundation located in Kolkata, which has been offering a training program for rural practitioners in Birbhum district in West Bengal in which trainees who are admitted to the program are given basic knowledge in subjects such as anatomy, physiology, and pharmacology. Unlike training that is oriented to diagnosis and treatment of single diseases, which is a pattern that has been often followed by government run institutions, these trainees are given more broad based information on how to do differential diagnosis for common diseases and above all to learn about harmful practices. On completing their training these providers have to agree to stop prescribing Schedule H and Schedule X drugs though they are allowed to dispense or prescribe first line antibiotics and to encourage patients to complete the full course of the medications prescribed. Most of all the idea is to teach such providers how to recognize serious illnesses and refer them to fully trained medical practitioners or to government hospitals (see Pulla 2015 for a very accessible discussion of the issues and the initiative taken by Liver Foundation for rigorous assessments and monitoring of their program). In some other States such as Telangana, the government has finalized schemes to train providers in a similar fashion. We saw earlier that already there are models evolving (as in larger villages and small towns in the vicinity of Allahabad and Patna) in which providers of different kinds are plugging themselves into referral networks that can give their patients access to fully trained providers and to specialists. How might policy build on these initiatives in urban areas so as to mitigate any ill effects while increasing access? One important question relates to the kind of continuing education and access to facilities, which could be devised for such providers who are currently responsible for more than 60% of clinical interactions in rural areas and in low-income areas in cities so that they may be able to serve their clientele better. There are related issues on how to improve the functioning of PHCs and Community Health Centers but simple expression of pious intentions will not work. Instead one must ask which kind of health needs are better met in the public sector and if, instead, of a uniform territorial model that we have at present, it might not be better to devide a series of alternate models that can take more local factors into account. In short, we need to get out of ideological debates and ask, instead, what are the ways in which health policy can work in tandem with the innovations and experiments that are already happening on the ground. Instead of punitive models of regulation it is important to recognize the solutions people have evolved and give these support and direction so as to eliminate dangerous practices while also giving much needed access to underserved populations.

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Fading twinkles

Something had caught the attention of the child,
There was surely a twinkle in her eyes.
She had stopped her routine acrobatic act
To take a better look before the traffic went by.
She had seen another child about her age,
Sitting royally in her father’s car.
With pretty clothes and fine jewellery,
She looked nothing less than a little star.
The poor child looked and dreamed on,
Peeping into the window.
But then the traffic light turned yellow
And it was time for the car to go.

Snapped back to reality with blaring horns all around,
The poor child moved away.
And the cars sped on to their cozy destinations
Leaving the child with dark smoke as pay.
The poor child’s mother appeared uninterested.
She’d seen it all before.
Her own eyes’ twinkle had long been extinguished,
By a society that wanted more.

-Adithya Pradyumna
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