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Health Care Facilities And Accessibility In Slum Areas Of Meerut (Up), India

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ABSTRACT

The growth of cities has always been accompanied by the growth of slums. The industrial revolution in the world led to the migration of people to slums in cities, which created new conditions of ill health due to overcrowding, poor housing and unsanitary environment, coupled with poverty. While public health crises were not unknown in earlier times, the institutions of family were primarily responsible for care and relief. A study was carried out to know the present status of healthcare facilities in slum area and their accessibility on the real ground. The findings of the study are quite strange and dictating some challenging and strange circumstances. It can be concluded that the health infrastructure and the health scenario in India is not very good. The Government has to take some solid measures and implement them immediately. Increase in the number of hospitals, both in urban and rural sectors is needed urgently.

Key Words: *Slum Area, Healthcare facility, Meerut, Western Uttar Pradesh*

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Introduction

The number of poor people living in urban slums is rapidly increasing throughout the world. According to estimations of the UN almost one billion people residing in urban areas live under housing conditions that are characterized as slum areas or squatter settlements. In developing countries the process of urbanization is extraordinarily rapid due to extensive migration to the

cities in combination with high birth rates. In some countries the proportion of slum dwellers is currently higher than the number of residents living in non-slum areas.

Fast urbanization in India comes with myriad of problems including slum growth. Factors such as rural-urban migration and weak institutional and regulatory framework in the management of land in the cities are some of the causes of slum growth. The proliferation of slums changes not only the urban form and structure, but it also exacerbates poverty, housing problems, inequality and social exclusion in the cities. This poses socio-economic and developmental challenges to the management of the city, and this is the problem, which the present study investigated taking Meerut City as a case study for this research work.

Urbanization processes in the developing countries is leaving the poor with few other options but to seek temporary and inadequate shelter in urban slum areas. The World Bank has described the development in an alarming way. It states that during the time needed for the construction of one unit of permanent housing in the poorest of the developing countries, the equivalent of nine new households is being shaped. Urbanization processes in developing countries are resulting in a rapidly increasing proportion of habitants living in urban slum areas. In the international development debate the lack of tenure security for slum dwellers in developing countries is considered to be an essentially important problem. Within the framework of the development programme the necessity of efforts towards increased tenure security for marginalized urban residents was agreed upon.

Metropolitan cities of India are the regions where the overall progress towards improved living conditions for slum area residents is showing the least positive results. This research work investigates the occurrence of activities of availability and accessibility of health facilities and the region which show an ambition of improving tenure security for people living in Meerut slum areas.

Slum Areas: A theoretical framework

The word ‘theory’ here implies a system of suppositions and premises within a field of study which can be used in order to interpret, describe and explain a phenomenon, creating a framework for the understanding of the subject. As such, the word ‘theory’ is not equivalent to hypothesis or thesis.1 The theoretical framework of this research work will, in combination with the specified methodology, be used as a tool for organizing and structuring the research in a

manner that makes the research intelligible and comprehendible with regard to the problem area and definition. 'Concepts' are the central keywords connected to the theoretical framework which are used in order to analyze and organize the information at hand. The concepts are systematically necessary for a comprehendible framework, especially if there are doubts, discussions or alternatives regarding their definitions and meanings. They are either collected from existing theories or defined according to the research matter.2

Apart from these obvious negative effects, the Peruvian economist 'Hernando de Soto' goes even further in claiming that when people do not own their land or property, overall development is fundamentally hampered. Property ownership is in other words the foundation on which capitalism flourishes. One of the main differences between development in the westernized world and in developing countries can accordingly be found in the existence of a considerable amount of unused or inactive capital in the less developed parts of the world. The widespread absence of tenure security for poor urban residents is one of the main consequences of the situation. At global level there is an increased awareness that rapid improvements in this aspect are necessary. Goal number seven in the UN Millennium Declaration, which was signed by world leaders in 2000, declares a global effort to significantly improve the lives of at least 100 million slum inhabitants until the year 2020.3 The improvements to be achieved are divided into two main areas. On the one hand the ambition is to strengthen the supply of locally organized urban services such as water, sanitation, sewage, health and waste management and secondly the focus is on ameliorating bad housing conditions due to insecure tenure.4

Health services in slum areas

The growth of cities has always been accompanied by the growth of slums. The industrial revolution in the world led to the migration of people to slums in cities, which created new conditions of ill health due to overcrowding, poor housing and unsanitary environment, coupled with poverty. While public health crises were not unknown in earlier times, the institutions of family were primarily responsible for care and relief. Urbanization broke down those traditional family and community structures and the working class in particular was pushed to the brink of destitution in a crisis such as an epidemic or a natural calamity. It was left to the state (primarily the political and administrative wings) to become the moral 'parent' of the poor. As a part of this role, the health of the urban poor became a subject of enquiry for administrators and planners in

the mid-nineteenth century. In India too, when large-scale urbanization took place after the First World War, the decades of the 1920 to the 1940 saw an increase of research in urban health. These studies were particularly notable for the exploration of the link between poverty, living conditions and ill health.**6** Ironically, although a substantial proportion of the research on poverty and health emerged from cities in the pre-Independence period, urban health was not at the focus of public health practice in the years after Independence. India was viewed as a largely rural society and, thus, the government's conception of primary healthcare was almost entirely rural oriented. This bias was also not corrected by the voluntary community health movement, which too focused on the problems of providing primary healthcare to the rural poor.**7** With rapid urbanization, as in most developing countries, public health problems in India are increasingly assuming an urban dimension. In the 2001 Census, 27.8% of the population was found to be living in urban areas. Between 1991 and 2001, 14.3 million people were added to the urban population due to migration. In cities with a population over a million, nearly one-fourth (24.1%) of the population was residing in slums.**8** The recent National Sample Survey also indicates that the proportion of the population living below the poverty line in rural and urban areas equalized in 2004–05. In each, it is estimated that about 22% of the population lives below the poverty line. It has been observed that the decline in poverty has been lower in urban compared with rural areas.**9**

Understanding public health needs in urban areas requires a different conceptual framework. Traditionally, it is understood that alleviation of poverty is the most important precursor of improving general health. But in urban areas, the marginal increase in income for the poor, in itself, does not assure better living conditions due to wide disparities, which make decent accommodation, and clean water and air unaffordable. Moreover, certain necessities, which existed as free goods in rural settings, are commodities in urban areas such as drinking water, cooking fuel, housing space and health etc. The poor are typically driven to the margins of the urban space, where health conditions are the most degraded and of little economic value.

Primary health care is provided by city and district hospitals and rural primary health centers (PHCs). These hospitals provide treatment free of cost. Primary health care is focused on immunization, prevention of malnutrition, care during pregnancy, child birth, postnatal care, and treatment of common illnesses. Patients who receive specialized care or have complicated illnesses are referred to secondary (often located in district and tehsil / Block headquarters) and

tertiary care hospitals (located in district and state headquarters or those that are teaching and research hospitals).**12**

The purpose of this study is to analyze the way in which we have addressed and how we currently address slum issues in order to generate a broader and deeper understanding of how slum strategies could be better organized in the future. The departure point of this research is normative in the sense believe that such strategies should be enhanced and improved if our societies are to achieve real change in the endeavor towards a more equitable and sustainable development in the decades to come. Moreover, the purpose is also to break down a number of "myths" regarding slums which I believe affect the way we understand and relate to slum issues.

Methodology

This research work embraces a broad health problem of slum area and it is general in its character. The methodology used has been based on thorough literature studies within the area in order to gather the information necessary for analysis, interpretation and evaluation. The thesis has a qualitative character although quantitative data has been used for illustrating and addressing the problem at hand. An abductive re-contextualization of the "slum problem" provides the methodological basis of my research. An abductive approach commences in empirical data without discarding theoretical inspiration, allowing for a re-contextualization of the phenomena at hand during the process of research. Accordingly, this will be an exploratory study where the researcher has tried to deepen understanding of the issues constituting research by using information gathered from case studies and other writings and by relating these to a framework for analysis. These kinds of frameworks are often said to be most important in deductive, theory-testing studies but their importance in exploratory studies should not be reduced. Whether we are aware of it or not, we are in a sense always guided by a theoretical framework - our "pre-understanding" of the world around us. By making this implicit framework explicit it may be possible to avoid preconceived ideas of certain phenomenon and try to see the processes through a different set of eyes.

To put it simply, the methodology is the path leading from the problem definition and research questions to the potential answers conclusions in the end. It is the technique and process by which the problem is addressed in all stages of the research:

1. Gathering of information.

2. Analysis and explanation of information.
3. Interpretation of the analytical results.
4. Evaluation of the interpretation.

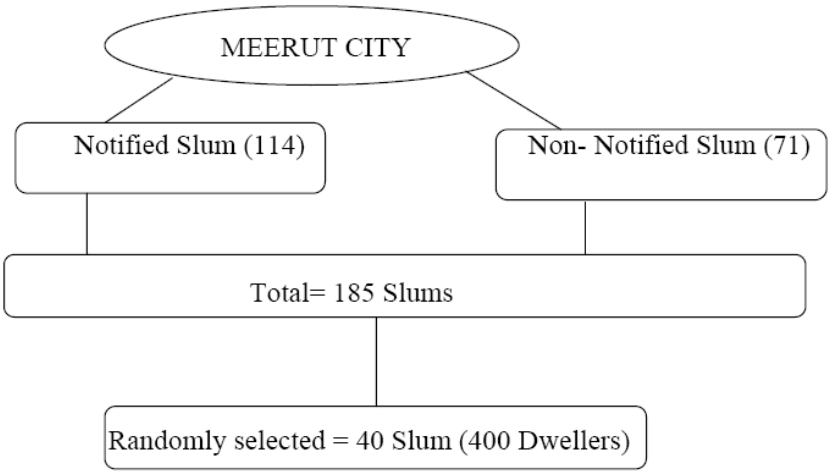

Fig-1: Status of slums in Meerut

Based on the above definition municipality, SUDA and DUDA have identified 185 slums. Out of 114 were notified and 71 were non- notified slums and total households are 130549. So for this purpose a sample of respondents was selected. In all there are 185 slums in the city; out of which 40 slums have been randomly selected based the concentration of slum dwellers. For the purpose of the intensive socio-economic and health care survey with a tentative schedule, ten households have been sampled from each slum. Thus, an all 400 samples were consulted for the collection of primary data. For analyzing the objectives of the study, percentage, simple averages has been used13.

Study Area- Meerut City:

Meerut, a well known city famous for ancient History, first Freedom Movement, Sports Goods, Scissors, Khadi and Nauchandi Mela, is situated between the plateau of two famous and holy rivers Ganga & Yamuna. It is big city surrounded by MuzaffarNagar, Roorkee, Haridwar, Dehradun and Mussorie on the North Side, Hapur the way to BulandShahar, Agra on southside, Garh the way to Moradabad Bareilly, Rampur, Lucknow on East Side and Modinagar, Muradnagar, Ghaziabad and Delhi in the West. It is approachable by Road as well as Railway

Meerut Cantt. and Meerut City are two main Railway Terminals while Bhaiswali, Garh, Hapur, Baghpat, Rohta and Mawana Bus Terminals are for road approach.

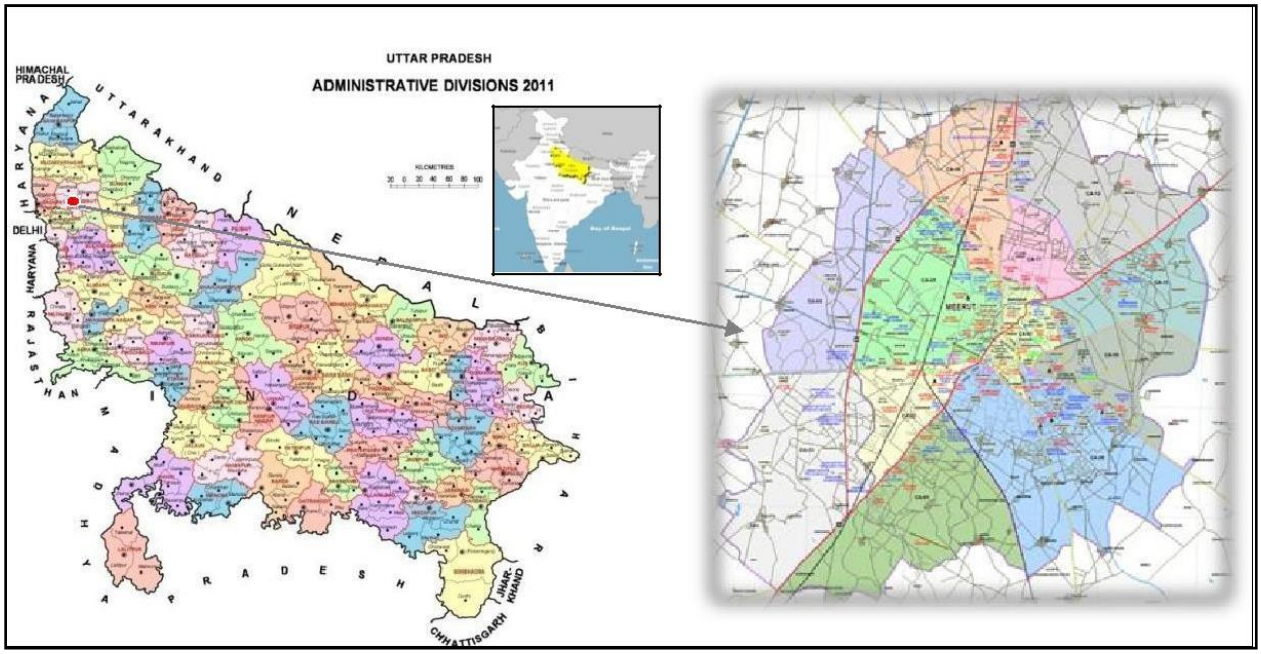

Fig. 2 : Location of Meerut city in Uttar Pradesh state

Meerut the primate city of western Uttar Pradesh accommodates 37.85% of the district population. The total population of the city as per the 2011, Census is 13.98 lacs.

Table- 2.2 : Decadal growth of Population in Meerut City (1901-2011)

Year	Population	Positive/Negative In Last 10 Years		Percentage
1901	121180	--	--	--
1911	119435	Positive	1745	1.44
1921	125506	Positive	6071	5.08
1931	141025	Positive	15519	12.44
1941	179155	Positive	38170	27.08
1951	239440	Positive	60245	33.62
1961	294853	Positive	55413	23.14
1971	382944	Positive	88091	29.88
1981	536615	Positive	153671	40.13
1991	846954	Positive	310339	57.83
2001	1170985	Positive	321186	37.92
2011	1398741	Positive	227756	19.33

Source:

1- Census Handbook of Meerut Districts- 1991,

2- Census data of 2001 and 2011

3- Meerut Nagar Nigam office, Meerut

Results and discussion:

Healthy mind and body itself may have intrinsic value in terms of fulfilling aspirations for enlightenment, self improvement and social interaction. Development of basic human capabilities such as ability to live long and to escape preventable illnesses not only influences the strata of life that the people can enjoy, but also affects the real opportunities of economic expansion.

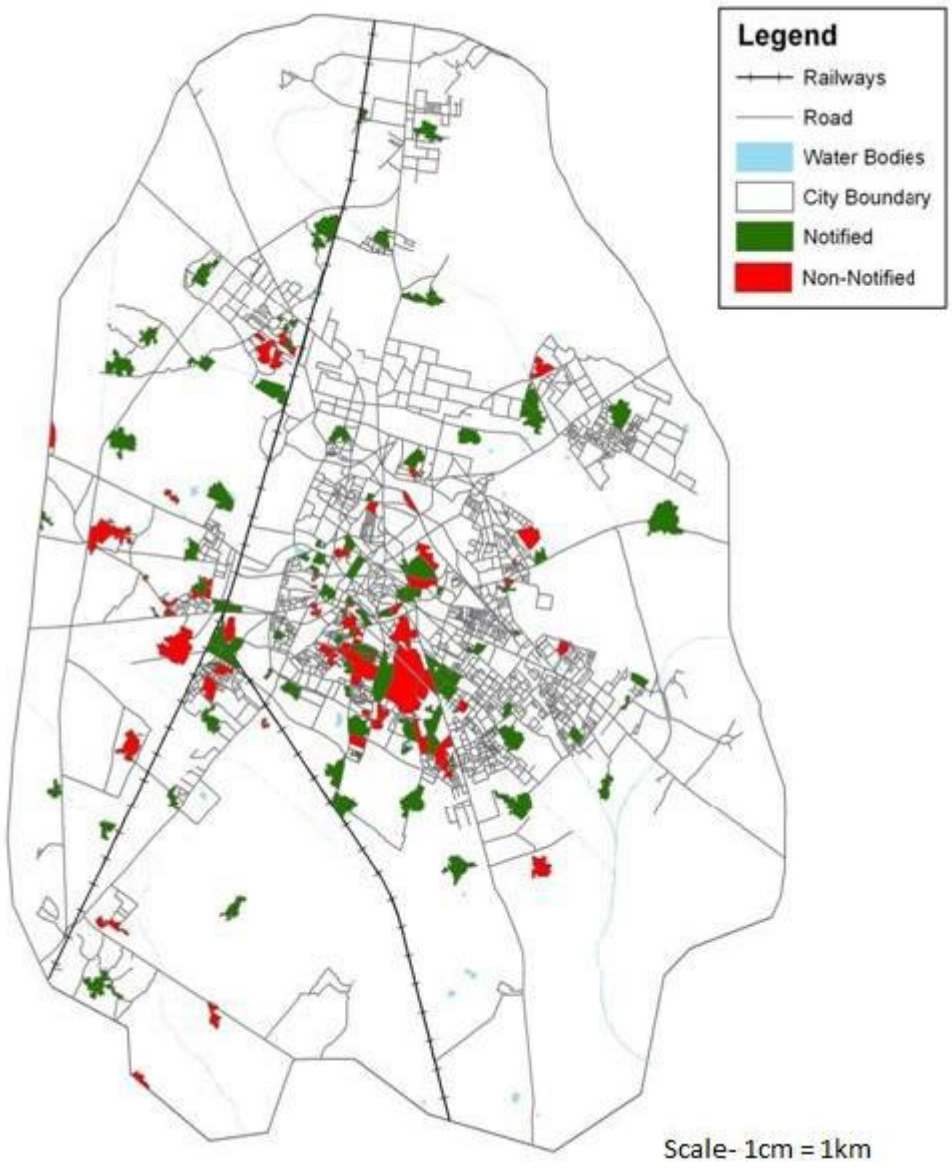

Fig. -3: Notified and Non-notified Slums in Meerut City

Majority of the health problems in urban slums stem from the lack of access to or demand for basic amenities. Basic service provisions are either absent or inadequate in slums. Lack of drinking water, clean, sanitary environment and adequate housing and garbage disposal pose series of threats to the health of slum dwellers, women and children in particular, as they spend most of their time in and around the unhygienic environment. Inadequate nutritional intake due to non-availability of subsidized ration or availability of poor quality to ration makes the slum

dwellers prone to large number of infections and lack of education or information, further aggravates the situation.

Health Problems:

The demands for basic services is lacking, because there is no agency or institution state or central that is willing to assess the needs and on that basis identify and fulfill the demand. Therefore, the urban poor see the futility in expressing their demands to those with the capacity to fulfill them. However, supply-side techniques alone cannot solve infrastructure problems-public sector agencies need to become more responsive to customer needs. Other than the engineering or logistical aspects that govern availability of services issues related to 'land' also pose serious constrains towards extension of basic infrastructure services to slums that can positively impact health and sanitation.

Inadequate nutritional intake due to non-availability of subsidised ration or availability of poor quality ration makes the slum dwellers prone to large number of infections and water borne diseases. Inability to access basic services results from a series of manmade institutional bottlenecks like legal status of non-notified settlements or the scattered poor/street homeless people that prevent the poor from accessing services created primarily in their name. Lack of education and information further aggravates the situation as residents depend on unreliable sources for prevention and cure.

Table 4.1: Availability of Medical facilities in the slums of Meerut City (2011)

Existence of Health Facilities	No. of slums Having accessibility
Urban Health Post	1
Primary Health Centre	8
Government Hospital	4
Maternity Centre	3
Private Clinic	16
Registered Medical Practitioner (RMP)	9
Ayurvedic Doctor/Vaidya	21
Total	62

Source:

1- RAY primary survey, 2011.

2- Office of Meerut Nagar Nigam, Meerut.

As per study of above data, 94% of the slums do not have access to any kind of health facilities. Within an accessible distance of 2 kms, 4% of slums have primary health centre, 2% of the slums have Government Hospital and only 1% of slums have urban health post. For about 9% of slums the private clinics are situated at an accessible distance. Health as well as medical facilities is provided and is serving the ailing people belonging to the slum areas item wise particulars are shown in primary health survey of RAY 2011.14

Table 5.1: Health condition indicators, index and ranking of the sample slums in Meerut City

Slum	Access to Healthcare % – Index	For ANC % - Index	Child Immunization % – Index	Infectious diseases % – Index	HCI Index - Rank
Notified Slums					
Jamna Nagar	76– 0.90	9 – 0.58	13– 0.47	42–0.81	0.69 – 3
Chandrashekhar Colony	82– 1.00	14– 1.00	22 – 1.00	36– 1.0	1.0 – 1
Uttam Nagar	56– 0.59	11 – 0.75	17 – 0.71	38–0.94	0.74 – 2
Non-notified	**Slums**				
Phelera	27– 0.13	6– 0.33	11– 0.35	59–0.28	0.27 – 4
Nangla Battu	19 – 0	2 – 0	5 – 0	68 – 0	0 – 6
Shobhapur	35– 0.25	3 – 0.08	8 – 0.18	61–0.22	0.18 – 5

Source:Data collect from CMO Office Meerut & several PHC Centres(2015)

Low status of antenatal care (ANC) was found in non-notified slums. Nearly 6% women in Phelera, 3% women in Shobhapur and only 2% women in Nangla Battu visited hospitals for pregnancy related health problems. Among notified slums Jamna Nagar has medium level of antenatal care where 9% women visited hospitals for check up. Chandra Shekhar Colony (14%) and Uttam Nagar (11%) have relatively higher status of antenatal care. Health seeking behavior is lower in most of the sampled households. Immunization of children was low in Nangla Battu and

Shobhapur non-notified slums where only 5% and 8% children receive full immunization. Phelera non-notified slum and Jamna Nagar notified slum have Non-notified slums also have large number of people suffering from infectious diseases than notified slums. Poor water and unsanitary conditions led to adverse health outcomes in the households living in the slums in the study area. Field surveys revealed that the conditions of the houses of slum dwellers were very

poor in terms of size, structure, multipurpose space where these people live, sleep and cook and share the company of animals. Their houses are characterized by dirt, filth with garbage pilfered everywhere. The surroundings were dirty, filthy and slushy. Conditions appeared to be worst in terms of access to certain basic amenities such as toilet facilities, sewerage facilities and garbage disposal. There is lack of drainage, toilet and drinking water facilities. Water logging of sullage around the houses was observed. Heaps of uncollected garbage were found lying open around the house. The unhygienic conditions attract vectors-mosquitoes, flies, cockroaches, rats, fleas, bugs, ticks, mites, etc. Bacteria thrive in the warm moist conditions. Rotting garbage spreads malaria, amoebiasis, dysentery, diarrhea, etc. Contaminated water contains viruses which cause jaundice, typhoid, etc. Stagnant sewage is a breeding ground for mosquitoes which causes malaria. A simple procedure of washing hands before eating and after toilets is not in habit. Due to these unhygienic environmental conditions, the slum dwellers are at a constant risk of health hazards and they suffer from a variety of diseases like malaria, typhoid, dysentery, skin problems, diarrhea, pneumonia, jaundice, etc.

Table 5.2 : Utilization of Healthcare Service by respondents in Slums of Meerut City (2015)

Ailment Category	Source of treatment					
	Public		Pvt. Regd.		Pvt. Unregd.	
General weakness fever etc.	75	18.75%	40	10.0%	285	71.25%
Accident and injury	157	39.25%	184	46.0%	59	14.75
Cardiological	61	15.25%	124	31.0%	215	53.75%
ENT infection	75	18.75%	62	15.5%	263	65.75%
Gynecological	132	33.00%	45	11.25%	223	55.75%
Nervous system	53	13.25%	95	23.75%	252	63.0%
Respiratory(Asthma, TB etc)	38	9.5%	40	10.0%	322	80.5%
Others Critical	35	8.75%	225	56.25%	40	10.0%

Source: Field survey(2015).

Generally Fever, gastro-intestinal diseases and respiratory diseases including asthma were the three major ailments, together constituting around 75% seen by the private unregistered practitioners, accidental and critical ailments almost 50% of all cases are seen by the private registered practitioners and 35% gynecological of all cases are seen by the public practitioners. People displayed a marked preference for private sources of treatment. In about 60% per cent of the cases a private doctor was approached for treatment. The most appalling finding however is that almost

40 percent of the ailing sample opted for treatment from an unregistered and unqualified private practitioners. These were the quacks, locally known as the "*bangali daakter*" who were quite conspicuous within the slums. These shady clinics attracted a lot of patients owing to their locational utility and low charges. People were aware of the limited efficacy and in certain cases even fatality of the treatment offered by these men. Still they approached them since the direct cost and opportunity cost incurred on treatment from their formal counterparts was often high and burdensome. The status of and the lack of confidence on public institutions is amply demonstrated by the fact that as low as 19.56 per cent of the ailing individuals opted for that mode of treatment.

Conclusion:

The following are the common findings in slum areas of Meerut city. A large number of people (51.75%) are living in joint families. The slum households in Meerut city are coming not only from Meerut and Muzaffarnagar but also from neighbouring states like Uttarakhand, U.P. East, West Bengal, Bihar, Chhatisgarh, Jharkhand and Madhya Pradesh. More than a half (76.75 percent) of the sample slum dwellers mother tongue is Hindi and Bhojpuri and the mother tongue of remaining slum households is Bengali and mixed. Most of the slum households are not the natives of Meerut District. It means that large number of them migrated to Meerut for different purposes. The major reason for migration is poverty in the native place of sample respondents. The slum households continuing their life due to their inability to pay high rents with low income levels. As many as 58.75 percent of sample slum dwellers settled in slums for the more than 20 years. As many as 82.25% households in the slum areas are having only one room.

It means that the slum dwellers have no privacy. In good number of slum households the communication articles like mobile phone or Television or Radio is available. The slum households are unhappy on their present pattern of spending. The bad habits like drinking and smoking has been found in 65 percent of sample households. Among them large number consuming liquor daily or once in two days or weakly. More than three-fourth of sample slum dwellers participated in 2010 urban body elections. It is important to note that good number of slum dwellers is not taking the problems of slum to the notice of elected representatives. For those, who representing the problems, the response of representatives is either indifferent or negative.

In India health has received low priority in the central and state budgets and it is one of the lowest in the world (i.e. less than 1.1% of GDP).13 The budgeting for the healthcare infrastructure is relatively much lower for the magnitude of population which is shooting up at the terrific pace. The crying need of the hour is to improve the health infrastructure to take stock of the local needs and to ensure adequate presence of healthcare manpower.

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