

Research Article

Unmasking Health Inequities in the Slums of Hyderabad in India

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ABSTRACT

Although Hyderabad city in India offers unique opportunities for its residents to benefit from education, health and social services and to optimise their health and quality of life, at the same time health hazards such as poor housing conditions and lack of access to safe water and sanitation, etc., are causing health problems. The urban city of Hyderabad contains at the same time and within the same city the best and the worst for health and well-being.

This study used the two-stage random sampling technique for selecting slums in the first stage and households in the second stage. A total of four slums from the Municipal Corporation of Hyderabad (MCH) – one from an industrial area and three from non-industrial areas, one each from developed, medium developed and backward areas – were selected. The sample slums spread into different economic regions of the MCH. In the second stage, 75 households from each slum and a total of 300 households were selected.

The objective of this study was to know the determinants of health, health expenditure and access to health facilities in slums located in developed and backward areas. This study revealed that they were better in slums located in developed areas than in those in backward areas. This study suggests an involvement of organised communities and all levels of governments – local, state and national – for promoting urban health equity.

Keywords: Slums, Health Expenditure, Determinants of Health, Access to Health Facilities, Health Equity, Effects of Ill-health, Below Poverty Line

INTRODUCTION

Nearly one billion people – one-third of the urban population – are living in urban slums and in shanty towns. For the urban poor, the advantages of city life are either lacking or non-existent. For example, availability of and access to healthcare does not ensure affordability and utilisation of health services. Unfortunately, some city dwellers experience inequalities, various forms of exclusion and marginalisation (Chan 2010).

By far, the greatest share of health problems in rapidly urbanising contexts is attributable to living and working conditions. These conditions include social determinants

such as poor and overcrowded housing, unhealthy and unsafe working conditions, lack of access to clean water and decent sanitation, as well as social exclusion (Bjork-Klevby 2010).

Slum dwellers often experience difficult social and economic conditions that manifest different forms of deprivation – material, physical, social and political (Merkel and Otai 2007). Urban poverty has become highly feminised. Compared with their male counterparts, poor urban women tend to have lower-paying jobs and higher illiteracy rates. They are also excluded from certain types of jobs because of lack of education or discriminatory practices. On top of this,

women are often excluded from land and home ownership and inheritance (Environmental Health Project 2004). Health inequities refer to the subset of health inequalities that are systematic, socially produced (and therefore modifiable) and unfair (Whitehead and Dahlgren 2006). Health equity is an ethical principle and is closely related to human rights principles. Health itself has been enshrined as a human right at the international level since the adoption of the Constitution of the World Health Organization in 1946 (World Health Organization 1946).

The United Nations Millennium Declaration is an international framework that recognises the importance of action to reduce health inequities (UN 2000). The Alma-Ata Declaration on Primary Health Care (WHO 1978), the Global Strategy for Health for All (UN 1981), the Ottawa Charter for Health Promotion (WHO 1986) and the Bangkok Charter for Health Promotion in a Globalized World (WHO 2005) have all recognised the importance of different sectors in health promotion.

In general, it is believed that city dwellers on an average enjoy better health than do rural people. However, this study unmasks health differences that exist within the city and between slums. Although Hyderabad city in India offers unique opportunities for its residents to benefit from education, health and social services and to optimise their health and quality of life, at the same time health hazards such as poor housing conditions and lack of access to safe water and sanitation, etc., are causing health problems. The urban city of Hyderabad contains at the same time and within the same city the best and the worst for health and well-being. The urban averages do not reveal the whole story. There is a need for disaggregated data to know urban health inequities. Health inequalities are socially produced, which are the result of circumstances in which people live and health systems they can access. This study aimed to unmask the health inequity in slums located in developed and backward areas. The specific objectives were:

OBJECTIVES OF THIS STUDY

1. To know the determinants of health, i.e., housing conditions, access to clean water, toilet, drainage and kitchen facilities in slums.

2. To find out the health expenditure of slum dwellers.
3. To study access to health facilities by slum dwellers.
4. To examine the impact of ill-health on income and poverty in slums.

MATERIAL AND METHODS

This study was based on primary data collected from sample households during May-October, 2009, in Hyderabad. This study used disaggregated data. A two-stage random sampling technique was employed for selecting slums in the first stage and households in the second stage. While selecting the slums, it was kept in mind that slums from different locations and a slum from an industrial area be included in the sample.

Out of the four slums selected from the seven circles of the Municipal Corporation of Hyderabad (MCH), one slum was from an industrial area, i.e., Allahuiddin Koti, situated in the Sanath Nagar industrial area and three slums were selected from a non-industrial area. Out of these three, one was from a developed area, i.e., Singhadi Basti, located in the Jubilee Hills area, one was from the medium developed area, i.e., Ambedkar Nagar, located in the Musheerabad area, and one was from the backward area, i.e., Moosa Nagar, located on the banks of Moosa River at Chaderghat area in the old city. The sample slums spread into different economic regions of the MHC. In the second stage, households were selected at the rate of 75 from each slum randomly; a total of 300 households were selected.

The concepts of developed slum, medium developed slum and backward slum were adopted from the MCH, which was based on some parameters like availability of basic facilities in slums. The parameters were physical infrastructure, access to education and health facilities, social infrastructure availability within the slum, income pattern and consumption expenditure per annum.

A questionnaire was used to collect the primary data on demographic characteristics of the households, housing characteristics, sources of drinking water, electricity, toilet and drainage facility, income, health expenditure (curative and preventive), utilisation of health facilities, effect of ill-health on work participation and income, etc.

Health expenditure included both curative and preventive expenditure. Curative expenditure was amount spent on the treatment of disease during the last 12 months, i.e., fees of the doctor, medicines purchased, laboratory tests, etc. Preventive expenditure included expenditure on bed nets and mosquito coils, drinking water, toilet and polio, DPT and BCG. To calculate preventive expenditure, the amount spent on the above items by the households during the last 12 months was taken.

This study adopted the concepts of Below Poverty Line (BPL) and Above Poverty Line (APL), both which were developed by the MCH, i.e., BPL means a household income up to Rs. 24000 per year and APL means a household income more than Rs. 24000 per year.

To find out the impact of health conditions on work participation and income, information was collected on the number of working days reduced due to ill-health and income reduced was calculated on the basis of the number of working days reduced.

Data were analysed and conclusions drawn. Simple averages and percentages were calculated wherever necessary. Policy conclusions were drawn for the development of health facilities in slum areas.

RESULTS AND DISCUSSION

1. Housing Characteristics

Table 1 shows the housing characteristics of the sample households in all the slums under study.

Table 1: Housing characteristics of slums under study

S No.	Details	Singhadi Basti	Ambedkar Nagar	Moosa Nagar	Allauddin Koti	Total
1.	Nature of House					
A.	Hut	03 (4)	45 (60)	04 (5.3)	01 (1.4)	53 (17.6)
B.	Kacha	37 (49.3)	12 (16)	69 (92)	56 (74.6)	174 (58)
C.	Pacca	35 (46.7)	18 (24)	02 (2.7)	18 (24)	73 (24.4)
		75	75	75	75	300
2.	Ownership					
A.	Own	60 (80)	65 (86.6)	56 (74.6)	42 (56)	223 (74.3)
B.	Rented	15 (20)	10 (13.4)	19 (25.4)	33 (44)	77 (25.7)
		75	75	75	75	300
3.	No. of Rooms					
A.	One	27 (36)	50 (66.6)	51 (68)	33 (44)	161 (53.6)
B.	Two	48 (64)	19 (25.4)	16 (21.4)	30 (40)	113 (37.6)
C.	Three	-	06 (8)	06 (8)	07 (9.4)	19 (6.4)
D.	Four	-	-	02 (2.6)	05 (6.6)	07 (2.4)
		75	75	75	75	300
4.	Materials used for roofing					
A.	Leaves, bamboo	08 (10.6)	45 (60)	04 (5.3)	-	57 (19)
B.	Mud	01 (1.3)	-	-	-	01 (0.3)
C.	Concrete/ Cement	01 (1.3)	18 (24)	02 (2.6)	09 (12)	30 (10)
D.	Metal sheets	03 (4)	03 (4)	02 (2.6)	04 (5.3)	12 (4)
E.	Asbestos sheets	62 (82.8)	09 (12)	66 (88)	62 (82.7)	199 (66.4)
F.	Tiles	-	-	01 (1.5)	-	01 (0.3)
		75	75	75	75	300
5.	Materials used for flooring					
A.	Cement/stone	48 (64)	13 (17.3)	69 (92)	70 (93.3)	200 (66.6)
B.	Bricks	02 (2.6)	06 (8)	-	05 (6.7)	13 (4.4)
C.	Mud	25 (33.4)	56 (74.7)	06 (8)	-	87 (29)
		75	75	75	75	300

Source: Primary data.

Note: Figures in parentheses are percentages.

It may be observed that out of 300 sample households, 17.6 percent were living in huts, 58 percent were living in kacha houses and 24.4 percent were living in pacca houses; 74.3 percent were living in their own houses and 25.7 percent were living in rented houses; 53.6 percent were living in one-room houses, 37.6 percent were living in two-room houses, 6.4 percent were living in three-room houses and only 2.4 percent were living in four-room houses; 66.6 percent used cement/stone, 29 percent used mud and only 4.4 percent used bricks for floors of their houses.

The housing conditions were better in the slums of Allahuddin Koti and Singhadibasti, which were located in developed areas, than in Moosa Nagar and Ambedkar Nagar, which were located in backward areas.

2. Sources of Drinking Water

Table 2 shows the different sources of drinking water in the sample slums.

It may be observed that out of 300 sample households, the highest number, i.e., 123 households (41 percent) were using public tap/bore well, whereas own tap/bore well users were only 8.7 percent. The households using own and public over-head tank water were 25 percent each, respectively.

The sources of drinking water were better in the slums of Allahuddin Koti and Singhadibasti, which were located in developed areas, than in Moosa Nagar and

Ambedkar Nagar, which were located in backward areas.

3. Electricity, Toilets And Drainage Facilities

Table 3 shows electricity, toilets and drainage facilities in sample slums.

The above Table 3 shows that out of 300 sample households, 250 households (83.3) were having electricity facility and 50 households (16.7) did not have electricity facility; 51 households (17 percent) were using public flush toilets, 140 households (46.7 percent) were using own flush toilets, 83 households (27.6 percent) were using pit latrines and 26 households (8.7 percent) were using bushes; 81 percent were having covered drainage facility, 13.7 percent open drainage) and 5.3 percent did not have drainage facility.

Electricity, toilets and drainage facilities were better in the slums of Allahuddin Koti and Singhadibasti, which were located in developed areas, than in the slums of Moosa Nagar and Ambedkar Nagar, which were located in backward areas.

4. Kitchen and Cooking Facilities

Table 4 shows the kitchen and cooking facilities in all the sample slums

Table 4 shows that out of 300 sample households, only 11.6 percent households were having separate kitchens, 60 percent were using kerosene, 23 percent were using

Table 2: Sources of drinking water in all the sample slums

S No.	Details Basti	Singhadi Nagar	Ambedkar Nagar	Moosa Koti	Allaaddin	Total
1.	Overhead tank					
a.	Own	21 (28)	12 (16)	14 (18.6)	29 (38.6)	76 (25.3)
b.	Public	02 (2.6)	41 (54.6)	29 (38.7)	03 (4)	75 (25)
2.	Bore well/Tap					
a.	Own	-	-	07 (9.3)	19 (25.4)	26 (8.7)
b.	Public	52 (69.4)	22 (29.4)	25 (33.4)	24 (32)	123 (41)
		75	75	75	75	300

Source: Primary data.

Note: Figures in parentheses are percentages.

Table 3: Electricity, toilets and drainage facilities in all the sample slums

S No.	Details	Singhadi Basti	Ambedkar Nagar	Moosa Nagar	Allauddin Koti	Total
1.	Electricity					
a.	Yes	73 (97.3)	32 (42.6)	71 (94.6)	74 (98.6)	250 (82.3)
b.	No	02 (2.7)	43 (57.4)	04 (5.4)	01 (1.4)	50 (16.7)
		75	75	75	7	300
2.	Toilet					
A.	Flush					
(i)	Public	01 (1.4)	32 (42.6)	-	18 (24)	51 (17)
(ii)	Own	06 (8)	11 (14.7)	66 (88)	57 (76)	140 (46.7)
B.	Pit latrine	65 (86.6)	16 (21.3)	02 (2.7)	-	83 (27.6)
C.	Bush	03 (4)	16 (21.3)	07 (9.3)	-	26 (8.7)
		75	75	75	75	300
3.	Drainage					
A.	Underground	-	-	-	-	-
B.	Covered	60 (80)	65 (86.6)	43 (57.3)	75 (100)	243 (81)
C.	Open	12 (16)	04 (5.4)	25 (33.3)	-	41 (13.7)
D.	No facility	03 (4)	06 (8)	07 (9.4)	-	16 (5.3)
		75	75	75	75	300

Source: Primary data.

Note: Figures in parentheses are percentages.

Table 4: Kitchen and cooking facilities in all the sample slums

S No.	Details	Singhadi Basti	Ambedkar Nagar	Moosa Nagar	Allauddin Koti	Total
1.	Separate kitchen					
A.	Yes	8 (10.6)	4 (5.3)	9 (12)	14 (18.6)	35 (11.6)
B.	No	67 (89.4)	71 (94.7)	66 (88)	61 (81.4)	265 (88.4)
		75	75	75	75	300
2.	Sources of Cooking					
A.	Gas	19 (25.3)	11 (14.7)	12 (16)	27 (36)	69 (23)
B.	Wood	13 (17.3)	6 (8)	20 (26.6)	9 (12)	48 (16)
C.	Electricity	-	1 (1.3)	2 (2.6)	0	3 (1)
D.	Kerosene	43 (57.4)	57 (76)	41 (54.8)	39 (52)	180 (60)
		75	75	75	75	300

Source: Primary data.

Note: Figures in parentheses are percentages.

Table 5: Health expenditure (preventive and curative) per household per year in all the sample slums

S No.	Details	Singhadi Basti	Ambedkar Nagar	Moosa Nagar	Allauddin Koti	Total
1.	Preventive Expenditure (in Rs.)	1043 (40.1)	372.50 (96.06)	793 (59.2)	2048.70 (55.7)	1064.3 (53.1)
2.	Curative Expenditure (in Rs.)	1558 (59.9)	15.30 (3.94)	546 (40.8)	1631.30 (44.3)	937.6 (46.9)
3.	Total Health Expenditure (Rs.)	2601	387.80	1339	3680	2001.9
	Percentage	100	100	100	100	100

Source: Primary data.

Note: Figures in parentheses are percentages.

gas, 16 percent were using wood and only 1 percent were using electricity for cooking.

Kitchen and cooking facilities were better in Allahuddin Koti and Singhadibasti, which were located in developed areas, than in Moosa Nagar and Ambedkar Nagar, which were located in backward areas.

5. Health Expenditure of the Households

Table 5 shows the health expenditure per household per year in all the sample slums.

Table 5 shows that the health expenditure per household per year was Rs. 2001.9 in the study area, out of which the preventive and curative health expenditure were 53.1 percent and 46.9 percent, respectively.

It may be observed that total health expenditure as well as preventive and curative expenditure per household per year were higher in Allauddin Kothi and Singhadibasti, which were located in the industrial area, than in Moosa Nagar and Ambedkar Nagar, which were located in backward areas.

6. Access to Health Facilities

Table 6 shows the utilisation of health facilities in the sample slums.

Table 6 shows that there is no availability of hospital/clinic/pharmacy in the study area. Access to private hospitals/clinics was more in Allahuddin Koti and Singhadibasti, which were located in developed areas, than in Ambedkar Nagar. Although Moosa Nagar was located in a backward area, access to private hospitals/

clinics was more because there were no government hospitals in the area. It is not the paying capacity but the availability of government hospitals near the slum that determines the use of a private source. More percentage of households visited a Darga/Baba/Mandir for treatment in slums located in backward areas than in slums located in developed areas.

7. Effects of Ill-health on Work Participation and Income

Table 7 shows the effects of ill-health on work participation and income in the sample slums.

Table 7 shows that 62 percent households suffered from health problems in the study area. The percentage of households that suffered from health problems, the number of working days reduced due to ill-health and the income reduced was more in Allahuddin Koti, which was located in the industrial area, than in the non-industrial area.

8. Number of Households Reduced to Bpl Due to Ill-health

Table 8 shows the number of households reduced to BPL due to ill-health in the sample slums.

Table(8) shows that the number of households' BPL has increased by 3 percent due to ill-health in the study area. It may be observed that it was the highest in Allauddin Koti, which was located in the industrial area, i.e., 8 percent, whereas it was 1.3 percent in Singhadibasti, 2.8 in Moosa Nagar and nil in Ambedkar Nagar.

Table 6: Access to health facilities in the sample slums

S No.	Details	Singhadi Basti	Ambedkar Nagar	Moosa Nagar	Allauddin Koti	Total
1.	Availability of Hospital/Clinic/Pharmacy in slum	-	-	-	-	-
2.	Type of Treatment					
	a) Allopathic	75	75	75	75	300
	b) Unani	-	-	-	-	-
	c) Ayurvedic	-	-	-	-	-
	d) Homeopathic	-	-	-	-	-
3.	Treatment at:					
	a) Govt. Hospital	36 (48)	72 (96)	27 (36)	16 (21.3)	151 (50.3)
	b) Private Hospital	28 (37.3)	03 (4)	42 (56)	38 (50.7)	111 (37)
	c) Both	11 (14.7)	-	06 (8)	21 (29)	38 (12.7)
		75	75	75	75	300
4.	Visited for treatment at:					
	a) Darga	10 (13.3)	01 (1.3)	44 (58.6)	26 (34.7)	81 (27)
	b) Baba	-	-	06 (8)	-	06 (2)
	c) Mandir	13 (17.4)	43 (57.4)	06 (8)	02 (2.6)	64 (21.3)
	d) Did not visit the above	52 (69.3)	31 (41.3)	19 (25.4)	47 (62.7)	149 (49.7)
		75	75	75	75	300

Source: Primary data.

Note: Figures in parentheses are percentages.

Table 7: Effects of ill-health on work participation and income in the sample slums

S No.	Details	Singhadi Basti	Ambedkar Nagar	Moosa Nagar	Allauddin Koti	Total
5	Number of households that suffered from health problems	40 (53.3)	37 (49.3)	43(57.4)	66 (88)	186 (62)
6	Number of workingdays reduced due to Ill-health	11	19	26	33	22.25
7	Income reduced due to ill-health (Rs.)	1293	2085	2845	6450	3168

Source: Primary data.

Note: Figures in parentheses are percentages.

Table 8: No. of households reduced to BPL due to ill-health in the sample slums

S No.	Name of the Slum	No. of BPL H.H before ill-health	No. of BPL H.H after ill-health	Percentage of BPL H.H after ill-health
1	Singhadi Basthi	-	01 (1.3)	1.3
2	Ambedkar Nagar	09 (12)	09 (12)	-
3	Moosa Nagar	20 (26.6)	22 (29.3)	2.8
4	Allauddin Kothi	08 (10.6)	14 (18.6)	8.0
	Total	37 (12.3)	46 (15.3)	3.0

Source: Primary data.

Note: Figures in parentheses are percentages.

CONCLUSIONS AND SUGGESTIONS

This study revealed that there existed health inequity among slums located in developed and underdeveloped areas of Hyderabad city, with respect to the determinants of health, i.e., housing conditions, access to clean water, electricity, toilets, drainage, kitchen and cooking facilities, as well as health expenditure (both preventive and curative). There was no availability of hospital/clinic/pharmacy in the study area, whether developed or backward.

Although the determinants of health and the health expenditure were higher in slums located in the industrial area, the slum dwellers there suffered more from health problems than in the non-industrial area due to pollution. BPL households increased due to reduction in working days and income were more in slums located in the industrial area than in the non-industrial area.

This study suggested that there was a need to stop the sources of pollution in slums located in the industrial area. There was a need for involvement of organised communities and all levels of government (local, state and national) to achieve health equity. Solutions lay beyond the health sector and required the engagement of many different sectors of government and society. Local leaders and government could and should play a key role in promoting health facilities in the slums, especially in slums located in backward areas to achieve health-related Millennium Development Goals.

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