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Regional Centre for Urban and Environmental Studies
All India Institute of Local Self-Government, Mumbai

Regional Centre for Urban & Environmental Studies (RCUES), Mumbai

(Supported by the Ministry of Housing and Urban Affairs, Government of India)

Established in 1926, the All India Institute of Local Self Government (AIILSG), India is a premier autonomous research and training institution in India. The Institute was recognized as an Educational Institution by Government of Maharashtra in the year 1971. The Institute offers several regular training courses in urban development management and municipal administration, which are recognized by the Government of India and several State Governments in India.

In the year 1968, the Ministry of Housing and Urban Affairs (MoHUA), earlier Ministry of Urban Development), Government of India (GoI) established the Regional Centre for Urban & Environmental Studies (RCUES) at AIILSG, Mumbai to undertake urban policy research, technical advisory services, and building work capabilities of municipal officials and elected members from the States of Goa, Gujarat, Maharashtra, Rajasthan and UTs of Diu, Daman, Dadra & Nagar Haveli. The Ministry of Housing and Urban Affairs (MoHUA), Government of India added States of Assam and Tripura from February, 2012 and Lakshadweep from August 2017 to the domain of RCUES of AIILSG, Mumbai. The RCUES is supported by the MoHUA, Government of India. The MoHUA, Government of India has formed National Review and Monitoring Committee for RCUES under the chairmanship of the Secretary, MoHUA, Government of India. The Principal Secretary, Urban Development Department, Government of Maharashtra is the ex-officio Chairman of the Advisory Committee of the RCUES, Mumbai, which is constituted by MoHUA, Government of India.

The RCUES was recognized by the MoHUA, Government of India as a National Training Institute (NTI) to undertake capacity building of project functionary, municipal officials, and municipal elected members under the earlier urban poverty alleviation programme-UBSP. The RCUES was also recognized as a Nodal Resource Centre on SJSRY (NRCS) and Nodal Resource Centre (NRC) for RAY by then the Ministry of Housing and Urban Poverty Alleviation, Government of India.

The then Ministry of Urban Employment and Poverty Alleviation (MoUE&PA), GoI and UNDP have set up the 'National Resource Centre for Urban Poverty' (NRCUP), which is anchored by RCUES at AIILSG, Mumbai.

AIILSG, Mumbai is empaneled by the Ministry of Housing and Urban Affairs, Government of India, for providing technical support to the ULBs in the field of water supply, sanitation, sewerage and drainage systems. RCUES, Mumbai is also identified as a technical service provider in Municipal Solid Waste Management projects under Swachh Bharat Mission (SBM) launched by the MoHUA, GoI.

Over the years, RCUES of AIILSG Mumbai has been working in close coordination with state and local Governments to provide strategic, advisory, technical and capacity building support for assessment and improvement in infrastructure service delivery in cities.

Maharashtra Urban WASH and Environmental Coalition (Maha UWES-C) is a joint initiative of the RCUES of AIILSG, Mumbai, and UNICEF Maharashtra. The Coalition brings together local organisations, thought institutions and sector experts to strengthen municipal capacities and encourage collaborative action to enhance service delivery in WASH (Water, Sanitation, and Hygiene) in urban Maharashtra. The Secretariat of the Maha UWES-C is anchored at RCUES of AIILSG Mumbai. In 2022, MoU is signed with the Directorate of Swachh Maharashtra Mission, Urban Development Department, Government of Maharashtra for building capacities, facilitating partnerships, and supporting innovations under Swachh Maharashtra Abhiyan - Urban 2.0 under Maha UWES-C.

Along with ULBs, it is also engaging with multiple stakeholders like NGOs/CBOs, SHGs, private sector organisations, financial institutions at city level for providing technical and strategic support focusing on preparing action plans/strategies, technical assessment reports, CSPs/CDPs/DPRs as well as on-ground support by engaging with communities for improvement in various urban sectors to ensure improved quality of life to the citizens. AIILSG, Mumbai is also working at the grass root level in cities through field visits, guiding ULB officials, conducting situation assessments with the objective of bridging the gap between the cities and state for sustainable sanitation solutions under Swachh Bharat Mission Urban.

In February 2016, the then Ministry of Housing and Urban Poverty Alleviation, Government of India empaneled the RCUES of AIILSG, Mumbai for conducting training and capacity building programme for experts of SMMU, CMMUs, COs, Key Officials and other stakeholders of the states and ULBs under Deendayal Antyodaya Yojana – National Urban Livelihoods Mission (DAY – NULM).

In 2017, AIILSG was empaneled among one of the 35 agencies in India for conducting Integrated Capacity Building Programmes (ICBP). AIILSG Mumbai is supporting the states of Maharashtra, Rajasthan and Goa for the same.

Through all these activities, RCUES of AIILSG Mumbai is striving to transform the notion of capacity building by not limiting itself to trainings / workshops but engaging with the state and local governments at multiple levels. With a small but enthusiastic team, RCUES, Mumbai will continue to strive towards improving the capabilities of municipal officials with a broader objective towards developing able governments thereby enabling better cities.

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Editorial

Fast pace of urbanisation in India has posed major challenges in terms of social and physical infrastructural services, overcrowding, housing and sanitation, sprawling slums and squatter settlements, unemployment, economic crimes, transport, access to clean and safe water, sewerage problems, waste management, and health problem due to Urban Pollution.

In the current discourses by G20, major focus is given to addressing issues such as Poor air and water quality, insufficient water availability, waste-disposal problems, and high energy consumption are exacerbated by the increasing population density and demands of urban environments. Strong city planning has been envisaged with collaboration among different nations for the advanced technology that is essential in managing urban development.

Public health concerns for the urban India needs to tackle housing-related health risks arising from unplanned urbanization patterns. Major public health challenges due to overcrowded and substandard housing facilitate the spread of infectious diseases, such as tuberculosis, hepatitis, dengue fever, pneumonia, cholera and malaria. Women, children, elderly population faces aggravated intersectional vulnerabilities. Mental health issues have emerged as a serious concern in the post COVID19 deliberations by both state and non-state actors.

Fifty percent of the world's population currently lives in urban areas, which is projected to increase by 1.5 times to 6 billion. The current Union Budget also addresses the need to provide a good quality of life for the urban citizens. The policy Makers accept that the Urban Local Bodies (ULBs) must be empowered to facilitate strategic infrastructural needs, comprehensive economic growth and sustainable development for social justice and equity.

As a catalyst for global change, India's presidency of G20 holds a major responsibility for half the world's urban population by setting an example for city planners of the developing world to ensure the availability of and accessibility to essential civil amenities and infrastructural services. The urban local self-government bodies are also displaying major commitments under SMARY CITY MISSION to resolve the above mentioned pressing urban issues.

In December 2017, within G20 mission, a city diplomacy initiative, "Urban 20" was launched. Institutionalisation of U20 makes it possible for the member countries to transform the urban centres and bring about an attitudinal change through deliberation, partnerships, dialogues, cooperation and knowledge-sharing. Under India's leadership, G20's agenda for Sustainable Development aligns itself with doble actions to fulfil the targets of the 2030 Agenda.

The Urban World invites scholars, policy makers, practitioners, urban planners and researchers to send their original research-based articles and book reviews with special focus on developmental concerns of the Urban India.

Health Status and Health Seeking Behaviour of Women in Mumbai

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Abstract

The female work participation in India is relatively lower as compared to other countries due to various socioeconomic and cultural factors. Women face the double burden of domestic work and work outside the house. With the changing disease profile in the developing countries, the non-communicable diseases are rising among the men and women which require treatment for a long time. Hence, it is very important to understand the health seeking behaviour of women who are normally dependent on the family members and how in turn it affects their health status. It is also pertinent to examine how economic, social and familial pressures influence their choice of seeking health care service. The main aim of the study is to understand the factors that affect the health status of women, health insurance and the financial strategies adopted by women in Mumbai and its suburbs.

Introduction

Activities that are undertaken by individuals or households to prevent illness or treat any illness are termed health-seeking behaviour. As labour force participation among women is low in India and many work in informal sector, it is important to study the health seeking behaviour of women. According to the Periodic Labour Force Survey (PLFS) of April - June, 2020 the labour force participation of women in urban areas (age above 15 years) was 19.6%. According to ILO in 2021 it was 22.3%. It is also seen that half the women in urban areas are working without any social security. So, a majority of women may not have any social security or health insurance or any mechanism to pay for health care expenses. According to National Sample Survey Office (NSSO) 75th round, around 34 percent of women in urban areas have been reported as ailing. Non-Communicable Diseases (NCDs) such as cardiovascular diseases, and kidney diseases are on the rise among women [The George Institute for Global Health, India, 2016]. These NCDs require long-term treatment and check-ups/follow-ups and can push many women into poverty.

In countries like India, healthcare services are provided by the public sector. Many health Insurances are provided by the central and the state government to its employees. But the proportion of people with health insurance is hardly ten percent of the population. The Economic Survey of 2020-21 has shown the high out-of-pocket expenditure (60 percent) as many people do not prefer health insurance.

The PLFS survey also indicates that women are forced to accept jobs without any job security, written contracts, or paid leaves [PLFS, 2020-21].

Any health issues in the absence of any such security during the time of illness and without any insurance coverage may be pushed into financial difficulty. In this study, an attempt is made to find out if there is a difference between the health-seeking behaviour of employed and unemployed women, and also the factors which affect the demand for health insurance. This is an attempt to understand the factors which affect the health status of women and the health seeking behaviour for their health care.

Background

The burden of health expenditure mainly falls on the individuals and households leading to high out of pocket expenditure given the high proportion of people working in the informal sector. According to [Niti Aayog, 2019] report, the percentage of the total health expenditure level of Out Of Pocket Expenditure (OOPE) is 64 percent. This is very high when compared to other low-middle-income countries like China (35.7%), Pakistan (56.2%), Maldives (20.7%), Bhutan (13.3%) [WHO database, 2018].

For the present study, Mumbai and its suburbs were selected as it is the financial capital of India and the fastest growing region in the country. It attracts men and women for seeking employment in this city. The reports from organisations like [PRAJA, 2022] have shown that due to many problems in public hospitals, people are forced to use private hospitals. Also, the OOPE in Mumbai was at a higher level compared to these cities. So, studies must be taken up about the health and health-seeking behaviour of women in this city, as it is important for their well-being and also for their families.

This study mainly focuses to understand if the socio-economic characteristics of women in Mumbai affect their health status, health check-ups, health expenditure, and demand for health insurance.

The main objectives of the study are:

1. To understand and examine the relationship between various socio economic factors and health status of women.

2. To examine the demand for health insurance among women and understand the factors influencing the demand for health insurance.

Literature Review

A study by [Ranjan, et al., 2018] uses the 71st round of the National Sample Survey and tried to analyze gender into different parts and made an attempt to understand access and financial protection. It was found that both health problems and admission to hospitals were higher for females than males. Insurance coverage was equal for both men and women. Acharya, [2008] tries to understand the health issues and utilisation of hospitals urban poor in Surat using survey data which had a sample size of 544 households. The study revealed that many payments for hospitalisations for households were financed through borrowing or selling household assets. It also indicated that women are accessing public health facilities and hence the government needs to strengthen these services. So, in the background of Universal Health Care (UHC), there is a need to improve the public health hospitals. Other studies have also reported gender bias in the utilization of health care facilities and spending on health care by women. It was observed that most of the women utilized health care facilities and expenditure was incurred mainly on deliveries. Hence, is felt that more research has to be done to understand women's overall health status, health spending pattern, and health-seeking behaviour.

The 71st round of the NSSO was analysed to understand the demand for health insurance in

Mumbai among women. From the secondary data, it was found that only around 27 percent of women had any kind of support like government-funded insurance/employer-supported protection/insurance arranged by households/others. Those who had regular wages/salaries had the highest proportion of expenses covered by support. Around 95 percent of casual labourers were not covered by any scheme.

India has high gender inequality and there has to be more focus on studying health financing in India as India has large proportions of poor women [Witter et al., 2017]. The study [Kowsalya R, Manoharan S., 2017] does a literature review on health coverage and the gender aspects of it. There have to be targeted policies for female-headed households, poor women, unemployed men, etc. By presenting major indicators which can influence the health of women in India. The nutritional status of women is deteriorating. Malnutrition is a serious concern among mothers and children. Women are facing domestic violence and many other acts of violence. Not only the physical, but mental well-being of women going through depression be taken into account.

Data Sources and Methodological Approach

For studying the health-seeking behaviour of women in Mumbai and Navi Mumbai was selected as the area of study. Mumbai was divided into regions based on the division of the region in the Human Development Report of Mumbai. Thane district is also fastest growing urban economy and depending on the labour force participation rate and proportion of migration, Navi Mumbai was selected for the study from Thane district. The wards of Navi Mumbai were taken from Navi Mumbai Municipal Corporation (NMMC) office. The primary survey was conducted in Mumbai and its suburbs. The respondents were women in the age group of 18-59 which is the reproductive age group and women are expected to be involved in economic activities mainly in this age group. A tool was prepared based on the pilot survey of a selected area and the structured questionnaire was prepared to collect responses from women. The primary information was collected by visiting households and even schools, colleges, banks, and other places where women normally assemble for any work. Sample data was collected with the help of a structured questionnaire containing both open-ended and closed-ended questions complementing each other. The questions in the questionnaire were asked to the women in the sample.

Hypotheses

1. Employment has a positive impact on health status of women.

2. Health insurance has positive impact on in health status of woman.

3. Awareness about health insurance has positive impact on demand for health. The demand for health insurance is positively related to awareness.

Data Analysis and Findings

Socio Economic Profile of the Sample

As the socio economics variables are important indicators of health status and health seeking behaviour, various socio-economic variables of the sample are shown here:

Table 1: Education of the Respondents

Education	Frequency	Percentage
Illiterate	68	12.8
Primary (1-5)	56	10.5
Secondary (6-10)	196	36.9
Higher Secondary (11-12)	107	20.2
Graduate	40	7.5
Post Graduate	48	9.0
Higher than PG	16	3.0
Total	531	100

Source: Primary data survey

Almost 37 percent (36.9%) of the people have secondary education. That is, they have education between 6th standard and 10th standard. A smaller number of women have post graduate (9%) and more than post graduate degrees (3%).

Table 2: Monthly Family Income

The monthly family income was asked and it was categorised into different income groups.

Monthly Family Income	Frequency	Percentage
Up to 5000	62	11.7
5001-15000	130	24.5
15001-30000	171	32.2
30001-50000	87	16.4
50001-100000	52	9.8
More than 1 lakh	29	5.5
Total	531	100

Source: Primary data survey

Table 2 shows that the proportion of women in high income groups (that is, more than 50,000 to more than 1 lakh) is around 15 percent. The proportion of lower income (5000-15000) group consists of 24.5 percent and around half of the sample is in the income group of 5000 to 30,000.

Table 3: Occupational Status of Women

Occupational Status	Number	Percentage
Employed	202	38
Unemployed	297	55.9
Student	12	2.3
No answer	20	3.8
Total	531	100

Source: Primary data survey

More than half the sample (55.9%) of the sample are unemployed. 38 percent are employed and around 2 percent (2.3%) are students. It is a matter of concern as half the sample is unemployed and it is important to understand if they are able to take care of their health and have health insurance to reduce OOPE in health.

Health Score and Health Status

To understand the health status of women and to understand the factors which affect the health status, health score was calculated for each woman in the sample. The health score of each respondent was calculated using Principal Component Analysis (PCA) method. The continuous variables taken for the calculation of PCA were the age of the respondent, age at marriage, age at which first child was born, family monthly income, years of education.

The following steps were followed to obtain Health Score:-

i) Initially, the Z scores were calculated. The factor loadings (age of respondent, age at marriage) which came as the crucial values (eigenvalues >1) were multiplied with the Z scores and then these were added together to get an aggregate score.

ii) A Multiple Linear Regression was run to examine the relationship between independent variables like occupation and have health insurance and health score as the dependent variable and to see whether these variables positively or negatively affect the health status. Multiple linear regression was used there were more than one independent variable and the dependent variable was a continuous variable. For doing this regression, all the assumptions were checked using SPSS.

The equation of the regression is represented as

$$Y=b_0+b_1X_1+b_2X_2+\varepsilon \qquad (1)$$

where Y is the dependent variable,
b_0 is the regression coefficient of the constant,
b_1 is the coefficient of the first independent variable X_1,
b_2 is the regression coefficient of the independent variable X_2 and
ε is the error term.

In the following table, the results of the multiple regression model are given

Table 4: Factors affecting Health Status

Results of OLS with HDS as dependent variable				
Variables	Unstandardized coefficient		T test	Significance
	B	Standard Error		
Occupational Status	-0.221	0.296	-2.151	0.032
Have Health Insurance	0.337	0.144	2.338	0.020
Constant	0.784	0.296		0.008

Source: Primary data survey

Test at significance level 0.05.

The column labelled 'B' (unstandardized coefficients column) of Table 4, shows that for occupation regression coefficient 'B' is significant (p-value=0.032 which is <0.05) and positive (B= -0.221), which implies that, as the occupational status changes from unemployed to employed, the health score increases. So, the regression equation can be formulated as,

Y=0.78 - 0.221 (occupation status) + 0.337 (have health insurance)

Table 4.1: Statistics of Health Score

Mean	0.64
Max	6.90
Min	0.08
Range	6.80

The mean of the health score is 0.64. The maximum in the health score is 6.90 and minimum is 0.08. The range is 6.80. (Table 4.1)

The mean of the health score was calculated according to the different socio-economic variables which are shown in the Table 4.2.

Table 4.2: Statistics of Health Score according to various Socio-Economic Variables

Income	Mean
No Income	0.6
Upto 1000	0.6
1001-30000	0.58
30001-60000	1.16
60001-90000	1.2
90001-120000	1.23
120001-150000	1.25
150001-250000	2.1
Above 250000	2.2
Age of the respondent at the birth of the first child	
Below 18	0.5
19-30	0.71
31-45	0.4
Age of the Women	
18-31	0.7
32-45	0.5
46-59	0.41
Education of Women	
Illiterate	1.3
Primary	1.4
Secondary	1.46
Higher Secondary	1.48
Graduate	1.5
More than Graduate	1.6

Source: Calculated from Primary Data Survey

The tables show that the average health score increases as income and education increases. According to many studies like [World Bank, 2011], a right combination of health and education can improve the health of people. WHO, 2021 says that health is influenced by many socio economics factors like employment, education among many other. The low labour force participation is considered to be a factor for gender inequality in India.

Hospitalisation and Financing Strategies

It was seen from many studies that women suffered from non-communicable diseases like diabetes, cancers, coronary problems, blood pressure, joint pain, etc. According to ICMR, 2017, the main cause of Years Lived with Disability (YLDs) in 2016 was NCDs.

Table 5: Health Issues for the Women who were Hospitalised

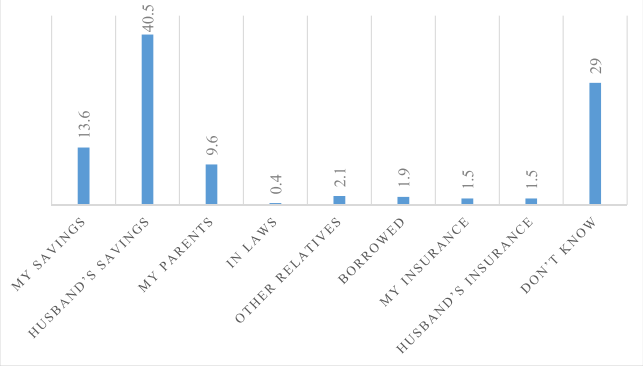
Category of Diseases	Number	Percent
Minor	30	5.6
Acute	49	9.2
Chronic	353	66.5
No answer	99	18.6
Total	531	100

Source: Primary Data Survey

The current analysis shows that more than 66 percent of the women (66.5%) were admitted for chronic diseases. [Puri et.al, 2021] find in their study that at least some women of reproductive age suffer from anyone morbidity or multi-morbidity. They have hypertension, diabetes, thyroid problems. These can be considered chronic diseases. These require treatment for a long time and in some cases, it may be required to admit the patients.

According to [Kumar, K et.al, 2020] there are few research studies available in the area of gender differentials in financial strategies during hospitalisation. The study has also proved that there is gender bias in distress financing during hospitalisation. Studies were done by [Saikia et.al, 2016] also show that there is high morbidity among females but the health care expenditure is less among women than men. A study done at Vadodara [Ranson et.al, 2012] found that most of the respondents paid from their savings and borrowed money from friends. A study done using NSSO 71st round by [Sangar et.al, 2020] shows that around half of the people in urban areas use distress financing. In NSSO 75th round also, it was shown that more around 84 percent (83.7%) of people in urban areas use household savings/income. As people in urban areas use more of the private facilities, they use more distress financing than people in rural areas. IRDA, 2016, the health insurance coverage is not at all satisfactory in India. So, the Figure 1 shows the sources of money for hospitalisation.

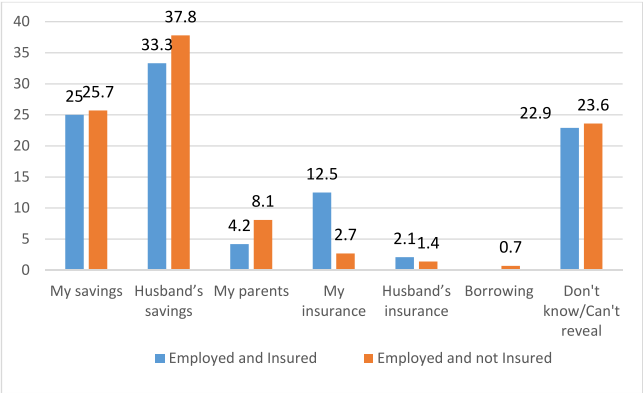
Figure 1: Financing Strategies during Hospitalisation by Women



Source: Computed from Primary Data Survey

The proportion of women who use their husband's savings for paying hospital bills is 40.5 percent. This is the highest source of payment hospitalisation.

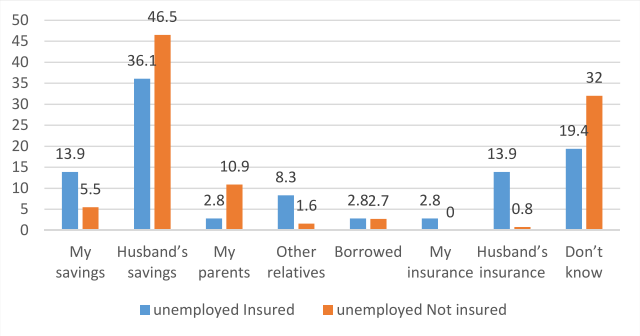
Figure 2: Sources of Financing of Hospitalisation of Women who are Employed given the Insured Status



From Figure 2 and 2.1 it can be seen that irrespective of the employment status and the insured status women use their husband's savings for paying hospitalisation bills. But it is used highest by the unemployed and not insured women (46.5 percent).

The survey also shows that the cost of medicines was highest among all other items during hospitalization like fees to doctor, radiology lab, room rent, cost of operation, travel cost.

Figure 2.1: Sources of Financing of Hospitalisation of Women who are Unemployed given the Insured Status



Health Insurance

Health insurance can reduce the OOPE of vulnerable groups of people [NHRM, 2005], to reduce the financial problems that are incurred due to the health problems and the expenses due to it, health insurances can be used. But it is shown from surveys like National Family Health Survey (NFHS) 4 only 29 percent household had at least one member covered with health insurance. NFHS 5 shows that there is a slight improvement in insurance coverage has increased to 41 percent. To understand the significance which affects the demand of health insurance, logistic regression was done. As the dependent variable was binary (Yes/No), the logistic regression was done. It is used to explain the relationship between one dependent binary variable and one or more nominal, ordinal, interval, or ratio-level independent variables. Many socioeconomic variables were taken for the analysis and those which are significant care shown in the Table 6 below.

The test is conducted at 0.05 level of significance alternatively 95 percent confidence level. As the dependent variable was binary, logistic regression was done. The below table shows the results of logistic regression by taking demand for health insurance as the dependent variable and age of the respondent and health insurance awareness as the independent variables. The significance level is taken as 5 percent or 0.05. The analysis revealed that awareness about health insurance is a significant factor (P value=0.000) which is which is less than 0.05). As P value is less than 0.05, the factor is taken as significant or awareness about health insurance can be considered as a significant factor which affects demand for health insurance. It is negatively related as Unstandardized B is -0.054. There is more awareness among young women and it is negative association between the response variable and age. The odds ratio column (Exp. B) says that the likelihood of having health insurance

Table 6: Factors affecting Demand Health Insurance

Variables	Unstandardized Coefficient		Degree of Freedom (DF)	Wald	significance	Exp. (B)	95% C.I. for Exp. (B)	
	B	SE					lower	upper
Awareness about Health Insurance	2.73	0.376	1	53.093	0.003	15.432	7.392	32.218
Age of the respondent	-0.039	0.013	1	8.684	0.003	0.96	0.938	0.987
Constant	2.177	0.504	1	18.702	0.001	8.824		
Cox and Snell R2=0.16, NegelkerkeR2=0.270								

is 15.4 times more than for those women who have health insurance than for those who do not have it.

As for the odds ratio of age, Exp. (B) =0.96, then there is 4 percent (1.00-0.96=0.04) lower likelihood of having health insurance if the age of the respondent increases.

As the awareness is increases, the demand for health insurance is also higher. According to [Bhat and Jain, 2006] knowledge about insurance and income are positively associated with demand for health insurance. Around 27 percent (26.5 percent) said that they do not feel the need to take insurance. High premium was the reason for 22.6 percent to not to take insurance. More than 20 percent responded that they will take insurance later i.e. there is a tendency to buy health insurance as the age progresses.

Main Findings

- Based on the analysis of health score, we can say that, women enjoy better health status if they have employment and health insurance.
- It was seen from the sample that more than 66 percent of the women in the sample were hospitalized for chronic diseases. This also confirms the point that disease profile in urban areas is changing very rapidly.
- The demand for health insurance increases if awareness among women increases and decreases as age increases.
- Mode of payment for hospital bills of employed and unemployed women were mostly husband's savings. NSSO data have also shows that household savings were used in household savings for paying bills. So, during the hospitalization a large part may go into paying bills. Also, if the women are having chronic diseases, the treatment may require a long time. So, the savings of the household may go into this.

Policy Recommendations

- Better communication of health-related information. Due to excessive out-of-pocket expenses and lack of sufficient knowledge about insurance and schemes, many families are becoming impoverished. Additionally, it might be beneficial to lessen the poor's documentation requirements.
- Better financing solutions in the form of insurance plans with cashless choices should be pushed for lower income groups since during hospitalisation, funds from the household serve as the primary source of payment for hospital costs.

The majority of the urban poor in our country have poor health, thus effective universal health care and better execution of the national health protection programme can be very beneficial.

Conclusion

Women are increasingly suffering from chronic conditions that call for ongoing care. When women are employed and have health insurance, their health condition appears to be better, according to research into the variables that influence this. Chronic and non-communicable illnesses (NCDs) can lead to early mortality, decreased productivity in women, and even premature death. Women need to be educated on balanced diets and healthy lifestyles. When a patient is hospitalised, the hospital fees are paid out of the husband's savings, which might lead to dissaving. For disadvantaged women, better funding solutions in the form of cashless insurance programmes should be advocated. In conclusion, public health insurance programmes, national health protection programmes, and education regarding successful universal health coverage can all have a significant impact.

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Attitude of Youth towards Reservations of Seats for the Senior Citizens

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Experience Shared by the Wife of a Senior Citizen in an Urban Area

It was a rainy day. From Nashik city, we had to go to Mumbai. For that, we had to reach the bus station from where ST buses would leave for Mumbai. My husband and I were waiting for the rickshaw for a long time but the rickshaw just did not stop for us. We had a big bag.

There was a bus stop very close to where we stood for the rickshaw. Then we decided to go by city bus. The bus to the station came and we both boarded it, the bus was full. I looked to see if there was any place for us to sit, but there was no place to sit. I didn't know what to do. I understood that it was a mistake to take the bus. We both stood on the bus taking care of our luggage. At this time my attention went to where it was written 'Reserved for Senior Citizens'. And I noticed that a young couple was sitting there with their little six-seven-year-old daughter.

While paying for the ticket I said to the Conductor Please, look, the young people are sitting in the reserved seat for senior citizens. Tell them to get up. Then the conductor said, "Look lady, do whatever you can. Don't you see how crowded the bus is, I have to ensure that everyone buys the tickets. I am busy". And he left.

Then, I went to the exact place where 'Reserved for Senior Citizens' was written. And said to the couple who were sitting there, "Please see, look what the plate says 'Reserved for Senior Citizens." So the well-educated gentleman said to me, "What are you saying, you just boarded the bus and you need a seat right away?" I said to that man "What do you mean immediately? Look it is written clearly: "Reserved for Senior Citizens".

Pointing to the written board, I said to the young couple, “Look at this, read what is written and act accordingly”. “Yes, we can read. Here, we are also educated and we both are graduates. But, when we took this bus, there was no one on the bus. We found this place convenient so we sat here on these seats.

I said, “Look, as per the rules you should give seats to those for whom these two seats are reserved. Don't make me talk too much”. But the man did not even look at me.

I felt "What's the use of that education if we don't use it just say that we are educated and graduates?" I was looking for someone to help us. I was disturbed due to the feeling of neglect and loss of confidence. Our rights were denied by the man and his young wife. I thought they had crossed my limits. I went away from that place because I didn't want to fight. But, I felt, I should get my due right. This situation made me feel upset, angry and sad but there was nothing we could do. My husband must have sensed my impulse, as said to the

conductor. Then, he said to the Conductor, “Please help”, you are not doing anything", he said, "Sir, I have to always take the initiative and tell the people to get up for such seats reserved for women, reserved for senior citizens, reserved for disabled people". Now you saw what happened? Everyone is interested in getting a seat. People are not concerned about elders. How many times I am supposed to fight alone? Sometimes some people even shoot a video of such a fight and send it on social media". I asked then what happened to those video shootings. The conductor became unresponsive. Then came our bus stop and we had to get down.

Analysis of the Situation

So the above-mentioned incident of the journey was an unsuccessful struggle at the individual level to get fair treatment. And maybe, many such elderly would have earlier faced such incidences. And these young people must have felt that such small struggles do not work, so they become tuned to the situation and do not show respect for the rules.

It is tragic that we have to mention the above incident. These sequels of events reported by the elderly persons had a feeling of how were they ill-treated by today's youth. And that they were concerned about the future of the growing number of elderly persons in Indian Society. What does it mean that we cannot exercise our rights? How to make people understand their responsibilities towards laws and rules, how to inculcate the value of social commitment and shared commitment to the new generation. Actually, the Conductor of the Bus was in charge of that bus. If he had done his duty properly, we would not have had to face such an unfair experience. Education is the foundation of the journey to justice. People need to be committed to being responsible for the rights of senior citizens. But that doesn't seem to be happening.

Our journey was short but as a nation, we all have a long journey ahead to provide better facilities to all the citizens of our country and to the growing population of senior citizens. According to the World Health Organization (WHO), all over the world, virtually all countries are experiencing continuous growth in the number of people above 60 years and the proportion of age in their population. Accordingly, the number of elderly in India is increasing day by day. The increase in the aged population will have implications for nearly all sectors of society including social, economic, labour, transportation, housing, social protection and family life.

The United Nations Population Division World reports that life expectancy is expected to reach 75 years by 2050 from the present level of 65 years. Ageing was not only an Asian trend up until 2000, but it is going to continue to dominate Asia in the next century as well (UNFPA, 1999). India with the second largest population of 1.3 billion (2015) in the world is projected to overtake China in its population growth and become the world's first country in population growth within 10 years or so from now.

The National Statistics Office India's report has mentioned that the elderly population is set to grow by 41% over the next decade to 194 million in the year 2031.

Census data show that the proportion of elderly persons in the population of India increased from 5.63 percent in 1961 to 6.8 percent in 1991 and from 7.4 percent in 2001 to 8.6 percent in 2011. According to United Nations Population Division, 2011 "the share of India's population ages 60 and older is projected to rise from 8 percent in 2010 to 19 percent in 2050" (Population Reference Bureau, 2015). With increasing age because of higher life expectancies females outnumber males. United Nations projections reveal that the number of elderly persons is expected to double by 2050. It is expected that by 2050, nearly 8 in 10 of the world's aged persons would be living in developing

countries. Globally, the number of people aged 80 years and above is growing even faster than the number of elderly people overall. Projections indicate that the number of people aged 80 years and above worldwide will increase more than threefold between 2017 and 2050, rising from 137 million to 425 million (UN, 2017). The number of elderly people living in urban areas will increase.

A review of the literature on the elderly reveals that the number of elderly persons is growing faster in urban areas than in rural areas. Due to the rapid decline in the fertility rate and increasing life expectancy in urban areas, it can be predicted that the percentage of elderly in urban areas is about to increase drastically.

In India the aged face problems like illiteracy, unemployment, widowhood and disabilities. The Global Report on Ageing in the 21st Century (2012) and UNFPA & Help Age International Report (2012) maintained that older persons in the family experience multiple discrimination and also society, particularly older women, including access to jobs and health care, subjection to abuse, denial of the right to own and inherit property, and lack of basic minimum income and social security.

Further, within India development has not been uniform, hence there is an unequal growth of the elderly population in different parts of the country. As some states have reached the advanced stages of demographic transition like Kerala, Mizoram, etc., and some states still need to catch up.

This kind of incident disturbed me and made me think, about what needs to be done to ensure that the youth would care for the elderly people. We keep talking about respecting elderly people but, we want to point out that youth need to respect the laws and rules made for the elderly people. This thought needs to be echoed by many people. The elderly people somehow succumb to the wishes of youth and their violent acts may be with fear and give in to their wishes. But, if the educated youth can do away with their acts that others cannot do. We have to insist on making the youth understand by saying, "Look you have to rise to respect the rules made for the elderly and show the same through your act as otherwise, you could do so if you would have been in some developed nation". As when educated youth would start respecting elders their behaviour could be emulated by the children. One has to be made to understand that it is wrong not to respect the elders. The elderly people need help. We have to empathize with elderly people. As they have contributed to society and now also contributing to the growth of their young children and grandchildren and great-grandchildren. Due to the earlier contribution of elder people, we have today's society which has become a better place to stay. In order to establish a cordial relationship between the youth and elderly people we have to work together and ensure that the life of elderly people matters. If the general people do not understand the issues of elderly people then all groups of society have to come together like groups of senior citizens, academicians, politicians, etc to address the issue.

Some people may not know that it is not easy to make any government policies, rules and regulations for anyone, particularly senior citizens. The government has not recognized the rights of citizens easily. In order to recognize these rights, many people like senior citizens' organizations, several researchers, active members, people from the education field, the elder community, its groups, NGOs, government officials involved in policy-making for senior citizens and mainly politicians all contribute. And that's how the rules like 'Reserve for seniors' are accepted by the government. Therefore, it is the need of the hour to accommodate senior citizens in the changing society properly. For this sake today there is a need to prepare the people of India for the changing population structure. This country of today exists because of the various taxes that the elderly paid in their young days.

India needs to do a lot to provide basic infrastructure to the elderly people to ensure that they get proper health and welfare facilities to live life with the dignity of care which they need at their aged life. As of today, the agencies working for senior citizens viz, Help Age India, Dignity Foundation, and Family Welfare Agency do try to establish good practices by designing and implementing projects to enable elders to express their concerns. They do the work of advocacy by raising awareness within communities of the rights of the aged. But, it seems their efforts need to be multiplied.

For that, everyone should be prepared to create meaningful and mutually respectful relationships with social awareness towards senior citizens. There is a need for advocacy work worldwide to promote awareness of the needs of older people. It is necessary for everyone to be committed to being accountable to senior citizens. To do that, it is necessary to start with ourselves first.

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Mental Health Diabolic of Urban Living: Challenges and Strategies

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Abstract

Mental health is an integral part of our general health and well-being and a basic human right. Being a lot more than the mere absence of illness, it is an intrinsic part of our individual and collective health. The current paper locates mental health concerns amidst the growing sprawl of urban spaces. Contextualizing the global and Indian mental health scenario, it locates the associated risk factors to mental health in a fast-paced urban society viz. pre-existing vulnerabilities, inequality, exclusion, social stigma, rising individuation, homelessness, diminishing social bonds etc. The paper concludes by enumerating few strategies to promote mental health and well-being in the context of urban living.

Key words: *Mental health, urbanization, challenges.*

Introduction

The world is undergoing the largest wave of urban growth in history. More than half of the world's population now lives in towns and cities, and by 2030 this number will swell to about 5 billion. While it took hundreds of thousands of years for the world population to grow to one billion – then in just another 200 years or so, it grew sevenfold. In 2011, the global population reached the seven billion mark, and in November 2022, it reached eight billion (UNFPA, 2023).

Urbanization is a global and growing phenomenon that poses significant challenges to mental health and well-being. Some of the interrelated features of modern-day urbanization include the rapid rate of urban growth and its effect on municipal governments; the upsurge in rural impoverishment and release of large work force into the urban informal economy; urban poverty and its impact on the urban economy; the proliferation of slums and their vulnerability, and; the impact of globalizing economy on urbanization through policies and programmes that promote urban activity and urban spread (Malathi, 2020). Rapid urbanization is also associated with unplanned urban growth, poverty, environmental degradation, and population demands that outstrip service capacity (Trivedi, Sareen and Dhyani, 2008).

One of the most significant concerns of the twenty-first century is urban health and the incipient mental health challenges. With the growing number of people migrating to cities, urbanization and its impact on health; the rural perspective of health services; failure to adequately link urban planning to public health; and barriers and accessibility to mental health services have emerged as major concerns in the context of urban mental health (Desai et al, 2004). Urbanization affects mental health through social, economic and environmental factors. It has been shown that common mental syndromes report higher

prevalence in the cities. Social disparities, social insecurity, pollution, and the lack of contact with nature are some of recognized factors affecting urban mental health (Ventriglio et al., 2021).

Contextualizing the Global and Indian Mental Health Scenario

The Mental State of the World Report 2022 released on 1st March 2023 by Sapien Labs as the annual report of their Mental Health Million Project provides glaring data concerning the mental health of the world's population in the post pandemic era. The report highlights the risk of mental health challenges being ten times higher among those who lack close family relationships and friendships as compared to those having many close family and friends. The report explicates the increase in feelings of loneliness among people across the world and also provides evidence for the globally diminished bonds of family and friendship.

In the Indian context, as per the estimates from the National Mental Health Survey 2015–16, one or more mental health conditions require active intervention for close to 15% of Indian individuals. In addition, since 1990, the proportion of mental illnesses in India's overall illness burden has nearly doubled. The survey also indicated that among the mental illnesses that develop primarily during adulthood, depression and anxiety disorders had the highest mental disorder burden in India, followed by schizophrenia and bipolar disorder. Moreover, anxiety and bipolar illnesses were identified to be the most common in the Union Territory of Delhi. In 2017, the prevalence rate of depressive disorders was more than 3750 per 100,000 people, and the prevalence rate of anxiety disorders was 3200-3399 per 100,000 population (Dandona et al., 2020; Anand, 2022b). According to a Lancet study conducted across Indian states spanning from 1990 to 2017, there were 197.3 million persons with mental disorders, comprising 14.3% of the total population of the country. Furthermore, mental disorders were found to the leading cause of YLDs (Years Lived with Disability) in India, contributing to 14·5% of YLDs. Evidence also suggests that suicide deaths increased by 40% from 1990 to 2016 making it the third leading cause of death in several Indian states (Dandona et al., 2020).

Urbanization: A risk to Mental Health?

The National Mental Health Survey 2015–16 reflects a high prevalence of mental morbidity in urban metros of India. The prevalence of schizophrenia and other psychoses (0.64%), mood disorders (5.6%) and neurotic or stress related disorders (6.93%) was nearly 2-3 times more in urban metros (Gururaj et al., 2016). According to Gruebner et al. (2017), with growing urbanization, more and more people are exposed to risk factors originating from the urban social (e.g., poverty) or physical environment (e.g., traffic noise), contributing to increased stress, which in turn is negatively associated with mental health. Social risk factors for mental health in cities include concentrations of low socio-economic status (e.g., education levels, income), low social capital (e.g., social support, efficacy), or social segregation (e.g., perceived minority status, ethnic group membership. The urban physical environment may contain higher rates of pollution (e.g., air, water), noise pollution (e.g., traffic), specific urban designs (e.g., tall buildings that may be perceived as oppressive) or more physical threats (e.g., accidents, violence).

WHO (2022) signifies the importance of understanding the individual, family and community as well as structural factors in the context of risk for mental health. A diverse set of individual, family, community and structural factors may combine to undermine one's mental health. Urban living has been listed as a potential risk factor under the family and community factors. In addition, the structural elements such as social

discrimination, exclusion, health emergences, and climate change that contribute to inequality in society are likely to increase the rate of mental disorders, people who are exposed to unfavourable circumstances – including poverty, violence and inequality – are at higher risk of experiencing mental health conditions. Risks can manifest themselves at all stages of life, but those that occur during developmentally sensitive periods, especially early childhood, are particularly detrimental. Figure 1 presented below enumerates the risk factors to mental health as listed by the World Health Organisation in its World Mental Health Report 2022.

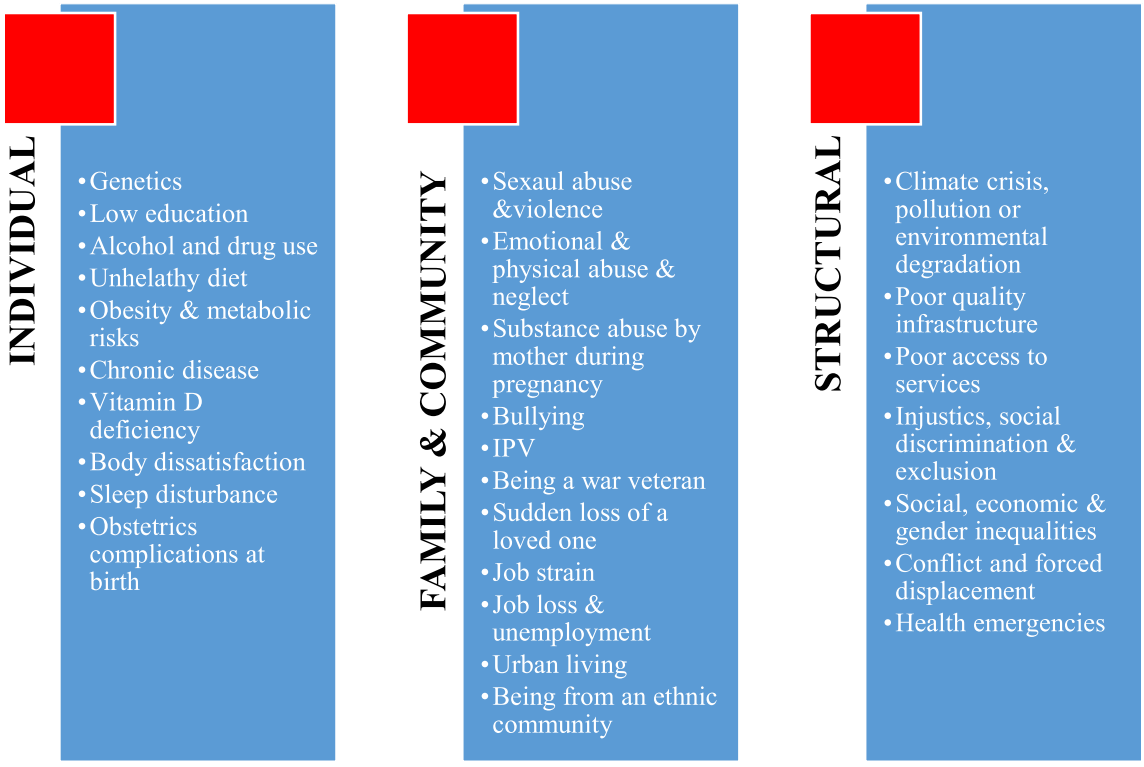
Mapping the Challenges of Urban Living

The significant challenges of urban living can be enumerated as follows:

Preexisting Vulnerabilities

Many people relocate to cities in quest of improved services, more economic and social prospects, and escape from tough socio-economic environment. Several of the causes that lead some people to seek various factors out e.g., poverty, unemployment, homelessness, physical and mental health issues, prior trauma, personal crises, family breakup, addiction, and immigration, are risk factors for mental health issues. This societal drift fosters a population that is especially susceptible to mental disorders. Those who move from the countryside to the city frequently leave behind their supportive social networks of friends and family, and it can take some time for these networks to establish again in the city.

Figure 1: Risk Factors for Mental Health



Source: WHO (2022). World Mental Health Report

Poverty and Lack of Basic Services

Mental health conditions are closely linked to poverty in a vicious cycle of disadvantage. It is a known fact that urbanisation is leading to extreme poverty, lack of basic amenities and facilities for health care. In addition to extreme poverty, the urban poor also face risky and unhealthy living conditions, such heavy pollution or high vulnerability to disasters. Available data also indicates a range of urban health hazards and associated health risks: substandard housing, crowding, air pollution, insufficient or contaminated drinking water, inadequate sanitation and solid waste disposal services, vector-borne diseases, industrial waste, increased motor vehicle traffic, stress associated with poverty and unemployment, among others (Trivedi, Sareen and Dhyani, 2008).

Inequality, Vulnerability and Exclusion

Socio-economic deprivation and poor access to facilities creates multiple life stressors and is linked with a range of mental health conditions. Social exclusion is said to be a concept rather than an objective state or 'reality', 'a way of looking at society' (de Haan, 2001). It refers to 'keeping out' certain groups or sections from mainstream society who are 'systematically blocked from' and denied access to resources or opportunities that are available to other members of society. Excluded sections are 'set apart' from, 'locked out' of, the rest of society, and 'left behind' with respect to overall development. The socially excluded are denied certain rights, and there is 'the cultural devaluation of people based on who they are or rather who they are perceived to be' (Kabeer, 2006). Social exclusion is an avoidable reality in the daily lives of many people in urban areas especially among the most marginalized and stigmatized groups. Their vulnerability and exclusion are indeed a risk factor for mental health.

Homelessness

Homelessness is not a passing phenomenon that is only caused due to natural calamities, it is due to many push factors that lead to people leaving behind their homes to come to cities. Today, there are 1.8 million homeless people in India, with metropolitan cities housing 52 percent of the people. The Indian Census in 2011 highlighted that there were 1.77 million homeless people in the country, accounting for 0.15 percent of the total population (Goel and Chaudhary, 2017). The factors that lead to homelessness include poverty, unemployment, destitution, social dissonance (riots, exclusion, caste-based atrocities), familial violence, natural calamities, state-based violence, evictions in cities and land usurpations for Special Economic Zone (SEZs), Special Tourism Zones (STZs) expressways and other projects (IGSSS, 2012). Homelessness is viewed as both a cause and a result of a psychiatric condition. Although not all homelessness is caused by or results from a mental disorder, when they co-occur, a lack of support makes it more difficult for homeless persons with mental disorders to break free from the destructive cycle of homelessness.

Augmented Stress

The high prevalence of mental morbidity in urban metros of India (Gururaj et al., 2016) may be attributed to the faster pace of lifestyle, accentuated stress, complexities of living, breakdown of support system, challenges emanating from economic instability, etc. The rise in mental disorders among youth may also be attributed to social change, including changes in the family structure, growing unemployment among youth and the ever-increasing educational and vocational pressures (Anand, 2022b, 2014; Deshpande et al., 2015).

Cultural Shift towards Individualism, Materialism and Performance Orientation

The Mental State of the World Report 2022 explores the nature of friendship across generations and geographies and reveals a decline in the percentage of people with friends to confide in and rely on with increasingly younger generations across the global internet-enabled world. The report shows progressive degradation over generations in the nature of family relationships and friendships. Younger adults report increasingly higher rates of family instability and conflict and lack of love and emotional warmth during childhood, despite growing rates of material support by their parents and investment in their accomplishments. These are indeed significant areas of concern from a mental health perspective.

The Internet and deteriorating social bonds

The Mental State of the World Report 2022 also alludes the impact of internet in exerting an impact on culture, that may play an outsized role in driving the deterioration of Social Self. With its command of individual attention for an average of 7 to 10 hours a day, it leaves little time for the effort required to nurture social bonds. For the younger generation who are born as digital natives, it diminishes from the outset the time available to both develop their social capabilities and form strong social bonds.

Gender Concerns

Gender and mental health have emerged as an important treatise in relation to the contemporary socio-cultural ethos in Indian society, its dynamics of power and politics. The social construction of gender is one of the significant underpinnings in this regard that makes one move beyond the understanding of the role of biology in the context of mental health. Understood as varying sets or relations, norms and identities related to ideas of what constitute femininity and masculinity, gender determines the differential power and control men and women have over the socio-economic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks. There is indeed an inextricable link between the impact of violence on women and their mental health. Furthermore, NMHS (2015-16) also provides evidence for the prevalence of significant gender differentials with regard to different mental disorders. Specific mental disorders like mood disorders (depression, neurotic disorders, phobic anxiety disorders, agoraphobia, generalized anxiety disorders) and obsessive-compulsive disorders occur higher among females (Anand, 2022a, 2014).

Normality-Abnormality Debate

The notions of normality and abnormality are often regarded along a continuum, merging indiscernibly at some undefined point. While mental health is regarded to be on one side of the dual continuum model, mental illness is perceived on the other. All behaviours fall along the continuum from normal to abnormal with varied cultures making subjective judgments with respect to where to draw the line between normality and abnormality. The spectrum ranges from normal (positive) behaviours on one hand, to abnormal or pathological (negative) behaviours on the other. Mental health and well-being are perceived on one side of the continuum while mental illness (professed as a deviation), on the other extreme, thereby considering human mind on a continuous linear perspective. Furthermore, notions related to bhoot, chudail, nazar, witchcraft, prevalent myths and misconceptions make it difficult to detect early signs of mental disorders. This situation is exacerbated by lack of awareness and non-availability of information and deep-seated attitudes towards mental illness.

Social Stigma

Living with mental illness poses multifarious challenges to the persons who experience it. They not only face the physiological symptoms but also have to battle various odds in their larger societal relationships as well as in their intimate relationships. Stigma is construed as 'a “mark” of social disgrace' and therefore it is not surprising that those with mental disorder are treated as socially disqualified, and are kept away from mainstream social life. The presence of stigma starts a vicious circle that leads to discrimination in all walks of life, decreasing self-esteem and self confidence, a low treatment effect or high probability of relapse for those in remission, and thus to a reinforcement of the negative attitudes and discrimination (Sartorius and Schulze, 2005). The fear as well as experience of stigma often leads to non-disclosure of psychiatric illnesses, and shying away from treatment facilities; thus, potentially leading to poorer outcomes in persons with psychiatric disorders (Anand, 2019).

Lack of Mental Health Professionals

India's public health system faces an acute shortage in human resources, a fact highlighted in the mental health discourse. The latest Indian statistics from the WHO Atlas 2020 show that “globally, the median number of mental health workers is 13 per 100000 population. There were 0.1 psychiatrists and 0.4 nurses per 100 000 population in low-income countries compared with more than eight psychiatrists and 29 nurses per 100000 population in high-income countries. Numbers of social workers and other specialized mental health workers (e.g., occupational therapists and speech therapists) were very low across all income groups, with the highest numbers reported by high-income countries (2.9 social workers per 100 000 population and 4.1 other specialized mental health workers per 100 000 population)” (World Health Organization, 2021). Though there has been an increase in the number of private practitioners and non-governmental organizations in the area of mental health, there is acute dearth as well as stigma associated with them.

Looking Ahead

Mental health is critically important for everyone, everywhere. It is an inherent and vital part of our overall health and well-being and affects our lives in many ways. Sustainable Development Goals (2030) promoting mental health and well-being vigorously advocates for persistent professional engagement and creation of healthy support system to infuse organic transformations. Well-planned urbanization can benefit mental health through improved access to work, education and housing as well as safe environments and green spaces. There is also a need for an urban specific mental health programme. Building strong health systems that integrate mental health with the larger public health system based on evidence backed practices is the need of the hour (Gururaj et al, 2016).

With an increasing number of people growing up, living, working, and spending their retirement years in cities, the mental health component of public health is not only becoming more recognized – it is rapidly becoming the remit of those involved in designing and building cities, from policymakers and planners to architects, engineers, and developers. The 'Urban Design: The Centre for Urban Design and Mental Health' has developed the Mind the GAPS: A Thematic Framework to Conceptualize Key Opportunities to Improve Mental Health. It is an approach that helps focus policy thinking and practical planning to support policymakers, planners, designers, and developers to improve mental health in terms of four key opportunity themes for good mental health, summarized by the acronym GAPS: Green places, Active places, Prosocial places and Safe places (McCay et al, 2017).

There is need for a vision for the development of community based and community intensive mental health program that is broad-based and inclusive of all the needs of all the people (Murthy, 2004). The thrust on de-institutionalization and rehabilitation of those suffering from mental disorders, especially women and children may be taken up at the mass level through creative and innovative strategies (Anand, 2016) including varied types of media. Preventive efforts gain paramount importance and therefore the need for professionals like social workers, psychologists with skills of working with individuals, groups and communities assumes great significance.

There is also the need for national programmes like Tele Mental Health Assistance and Networking Across States (Tele MANAS) that envisions to work as a comprehensive, integrated and inclusive 24 x 7 tele-mental health facility in each State and UT in India.

The specific needs of urban population, their unique challenges amidst the rising cases of mental, behavioural and substance use disorders calls for attention of political leaders, policy makers, health professionals, opinion-makers and society at large with specific strategies for dealing with issues related to urban mental health. In addition, focused programmes need to be developed and the existing programmes also need to be strengthened in the areas of child mental health, adolescent mental health, geriatric mental health, addiction management services, suicide, violence prevention and disaster management (Gururaj et al, 2016) with specific thrust on the urban population.

Multipronged efforts are needed at the preventive as well as promotive levels using life skills techniques that can aim at enhancing awareness programmes on mental health in schools/ colleges as well as communities, early detection of mental disorders, reduction in stigma etc. Conversations around mental health indeed need to be 'normalized' and the role of non-medical professionals in promoting mental health and well-being needs to be recognized and strengthened.

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Call for Research Papers!

The **Regional Centre for Urban & Environmental Studies** is pleased to invite contributions for **Urban World** in the form of articles and research papers from researchers, authors, publishers, academicians, administrative and executive officers, readers on : **Urban Governance, Planning and Development.**

Articles could be between 2000 to 4000 words. They may contain compatible tables, charts, graphs, etc. We reserve the right to edit for sense, style and space. Contributions may be e-mailed in digital form as a Word file to the Director, RCUES, Mumbai.

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ROUND & ABOUT

Mr. Fazalahmed Khan
Advisor, AIILSG, Mumbai.

Women's Day Special [8 March, 2023]

Contribution of the Founding Mothers to the Making of the Constitution

A common phrase that one hears or reads on the debate on the Constitutional mandate not being fulfilled is "Founding fathers of the Constitution" – on what they had envisaged or how the mandate is being ignored, etc. During a debate in the Supreme Court on 11 January, 2023, the Chief Justice heading a five judges' constitutional bench, in response to the use of the above-mentioned phase made a path breaking remark that he has not come across the expression 'founding mothers of India. He continued saying "traditionally the dazzling contributions from women, who played a great role in the framing of the Constitution is not highlighted. Their contributions were invaluable."…They made valuable suggestions to improve constitutional provisions keeping in mind the adverse conditions prevailing for women in those days." He further said that we are not taught about the great contributions from Durgabai Deshmukh, Begum Aizaz Rasul, Rajkumari Amrit Kaur and others. The Constituent Assembly constituted in December, 1946 with 389 members had 15 women, including Dakshayani Valayadhan, the first and the only dalit women to be elected to the Constituent Assembly.

(Reference: The Times of India, Mumbai, 12 January, 2023)

Women's Access to Bank Credit Doubles to 14% in 5 Years

Banking has made great strides of progress after Independence. Presently focus of the Reserve Bank of India and of the Ministry of Finance is on the financial inclusion envisaging that weaker sections of society are extended credit facilities. Jan Dhan Yojana, is a major example of the same. Under the urban poverty alleviation programs implemented by the Government of India since 1980s, making the targeted beneficiaries, particularly self-help groups of women, to take bank credit for their small entrepreneurial activities were a regular item. Under the National Urban Livelihood Program, one of the components is financial inclusion and affordable insurance for SHGs. Women take loans from the banks for personal items like education, home loan, vehicle loans, or for their entrepreneurial activities. According to a report widely published in the newspaper, "the credit access to women has doubled in the last five years. The loan penetration among women borrowers has shot up to 14% in 2022 from 7% in 2014. Similarly, share of women borrowers has increased to 28% in 2022 from 25% in 2017.

(Reference: The Times of India, Mumbai, 6 March, 2023)

National Air Quality Index & Mumbai's Current Position

The National Air Quality Index (AQI) was launched 17 October, 2014 as a major initiative under Swachh Bharat. Air Quality Index (AQI) is a tool for effective dissemination of air quality information to people. There are six AQI categories namely Good, Satisfactory, Moderately polluted, Poor, Very Poor and Severe. Each of these categories is decided based on ambient concentration values of air pollutants and their likely health impacts (known as health breakpoints). AQ sub-index and health breakpoints are evolved for eight pollutants (PM10, PM2.5, NO2, SO2, CO, O3, NH3, and Pb) for which short-term (up to 24-hours) National Ambient Air Quality Standards are prescribed.

(Reference: https://pib.gov.in/newsite/printrelease.aspx?relid=110654).

Mumbai was ranked the most air polluted city in the world on 2 February, 2023

According to IQAir rankings, Mumbai had the dubious distinction of being the world's most polluted city on 2 February, 2023. From 29 January to 8 February, 2023 it found place in 1 to 10 ranking in the world's most polluted cities. *[IQAir is a Swiss firm that operates AirVisual, a real time air quality information platform].*

Mumbai's AQI falling low

Between November, 2022 and January, 2023, Mumbai's AQI was worse than Delhi on several days. *[Reference to Delhi because it is infamous for poor air quality].*

> Air Quality Index (AQI) indicates the concentration of carcinogenic particulate matter (PM2.5) in air, ranging on a spectrum from safe to extremely unsafe.

(Reference: The Times of India, Mumbai, 14 February, 2023)

Mumbai's position in March, 2023

For many months it has been reported that pollution in Mumbai is on the increase. Mumbai being a coastal city has the advantage of sea breeze pouring in the city round the clock from the Arabian Sea. In spite of such an advantage, the city has been **getting POOR rank in all the locations from which air samples are taken.** The position as on **9 March, 2023** is cited below. One of the main reasons for this is the massive construction activities on account of Metro lines and redevelopment of buildings. In addition to the massive construction in the city (as mentioned above) another reason is the quarrying and stone crushing in Uran and Ulwe, whose dust is polluting Navi Mumbai, Thane and Mumbai.

The current concentration of PM2.5 in Mumbai is 56 (μg/m³). The World Health Organisation (WHO) recommends 15 μg/m³ as the threshold concentration of PM2.5 for 24 hrs mean. Currently, the concentration is 2.24 times the recommended limit.

(References: 1. The Times of India, Mumbai, 14 February, 2023. 2. https://www.aqi.in/in/dashboard/india/maharashtra/mumbai)

Measures to improve air quality in Mumbai

In view of the consistent poor air quality in the city, the Brihanmumbai Municipal Corporation (BMC) announced the following measures:

1. Mumbai has had 20 Continuous Ambient Air Quality Monitoring System (CAAQMS). On 8 March, BMC announced setting up of more 5 CAAQMSs.

2. BMC is monitoring the instructions in respect of constructions, namely, (a) providing dust screens along external face of under-construction buildings, (b) Sprinkle water on screens and at ground floor and open spaces (c) Washing of types of all vehicles while exiting from site.

3. BMC will procure 200 mobile air purifier vehicles to mitigate the dust particles generated from roads and areas where constructions woks are going on. It will also install air purifiers at five traffic junctions.

4. BMC is about to procure nine new electrical sweeping vehicles each equipped to clean 28 km of roads daily. It will also purchase 100 mist-spraying vehicles as well as set up 25 new electric vehicle charging stations.

(References: 1. Budget Statement of the BMC 2023-24. 2. The Indian Express, Mumbai, 9 March, 2023)

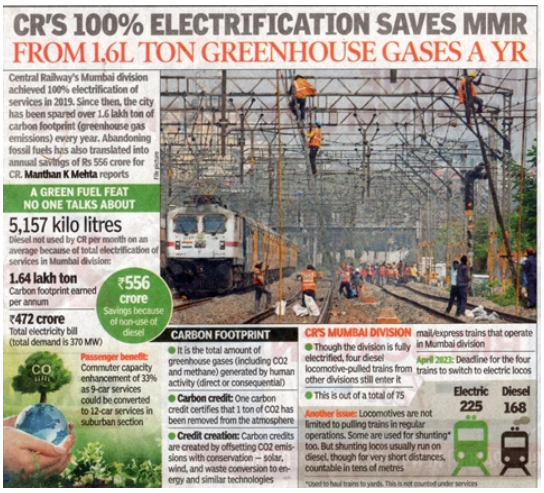
Uran, India's second most polluted town

Uran, a coastal town across the sea was ranked sixth globally for worst contaminated places on 28 February, 2023 and as India's second most-polluted site on March 2, as per the live rankings done by air quality index website (aqi.in). The reason is quarrying, stone crushing and constructions.

(References: 1. Mumbai Mirror, 12 March, 2023. *2. https://www.aqi.in/in/dashboard/india/maharashtra/mumbai)*

Climate Change Mitigation Actions in India

As a result of the nine action plans drawn up by the Government and the commitment made to the Conference of Parties under the auspices of the UNFCCC, thousands of positive measures are being taken at various levels in India. Example of one such measure is a tell-tale depiction, as below:



(Reference: The Times of India, Mumbai, 4 March, 2023)

Increase in e-vehicles during 2022-23 in Maharashtra and Mumbai

Any news concerning amelioration of environment is good news. The Economic Survey, whose publication precedes presentation of Budget in the State Assembly, is a precious document that presents a detail picture of the state of the economy of the State. It is a big size document but a spark of good news could be seen easily. In 2021, Maharashtra Government had adopted a policy for promoting fast adoption of electric vehicles till 2025. The policy is producing good results. The position for the year 2022-23, as mentioned in the Survey is as under:

Electric Two-wheeler registrations 2022-23 (till January, 2023)

Maharashtra	3,15,90,000	5% increase over 2021-22
Mumbai	26,53,290	6% increase over 2021-22

Four wheeler registrations 2022-23 (till January, 2023)

Maharashtra	66,32,370	7.3% increase over 2021-22
Mumbai	14,42,380	6.1% increase over 2021-22

(Reference: The Indian Express, Mumbai, 9 March, 2023)

Union Budget 2023-24: Urban Infra Boost for Tier 2, 3 Cities & Sanitation Reforms

There was good news for the urban sector in the Union Budget 2023-24. It requires a long discourse to mention them; in this column, a few salient points are mentioned.

1. An Urban Infrastructure Development Fund for creating infrastructure in Tier-2 and Tier-3 cities is being set up. This will be established through the use of priority sector lending shortfall. Government expects to make available Rs.10,000 crore per annum, according to the Finance Minister (FM), Government of India.

2. The FM has included infrastructure and investment as the seven important priorities of the government for the coming year. Currently there are 17 Mutual Funds schemes that invest in the infrastructure sector. Toppers in this category offer 13-19% returns in one year. The FM made mention of the Infrastructure Finance Secretariat set up in the Department of Economic Affairs (DEA), Ministry of Finance and said that the Secretariat will assist all stakeholders with more private investment in infrastructure including, railways, roads, urban infrastructure and power.

3. **On the sanitation front**, the FM said: All cities and towns will be enabled for 100% mechanical desludging or septic tanks and sewers to transition from manhole to machine-hole mode. Enhanced focus will be provided for scientific management of dry and wet waste.

(Reference: Reports in various prominent reports on the Budget 2023-24 in their issues of 2 February, 2023).

IPCC Synthesis Report – March, 2023

Practice of Intergovernmental Panel on Climate Change (IPCC) is that after the Assessment Reports of the three Working Groups in every cycle a report styled as **Synthesis Report** is published which incorporates key findings of its earlier report in the cycle. Thus, the Synthesis Report 2023 summarizes the key findings of the content of the three Working Groups Assessment, namely Reports: (1) IPCC 6th Assessment Report, Working Group I - the Physical Science Basis, (2) 6th IPCC Report, Working Group II - Impacts, Adaptation and Vulnerability, (3) IPCC 6th Assessment Report, Worrking Group III - Mitigation of Climate Change **PLUS** (4) Special report on the feasibility of keeping global temperature rise within the 1.5°C and (5) the report on the connections between land, ocean and cryosphere.

It was finalized at Interlaken, in Switzerland and released on 20 March, 2023 with the key message that Urgent **climate action can secure a liveable future for all.**

A few excerpts from the Press Release of the IPCC (https://www.ipcc.ch/report/ar6/syr/resources/press) and media reports, are briefly mentioned as under:

- "Mainstreaming effective and equitable climate action will not only reduce losses and damages for nature and people, it will also provide wider benefits," said IPCC Chair Hoesung Lee. "This Synthesis Report underscores the urgency of taking more ambitious action and shows that, if we act now, we can still secure a liveable sustainable future for all."

- In 2018, IPCC had highlighted the unprecedented scale of the challenge required to keep warming to 1.5°C. Five years later, that challenge has become even greater due to a continued increase in greenhouse gas emissions. The pace and scale of what has been done so far, and current plans, are insufficient to tackle climate change. More than a century of burning fossil fuels as well as unequal and unsustainable energy and land use has led to global warming of 1.1°C above pre-industrial levels.

- This has resulted in more frequent and more intense extreme weather events that have caused increasingly dangerous impacts on nature and people in every region of the world. Every increment of warming results in rapidly escalating hazards. More intense heatwaves, heavier rainfall and other weather extremes further increase risks for human health and ecosystems.

- In every region, people are dying from extreme heat. Climate-driven food and water insecurity is expected to increase with increased warming. When the risks combine with other adverse events, such as pandemics or conflicts, they become even more difficult to manage. Losses and damages in sharp focus.

- "Climate justice is crucial because those who have contributed least to climate change are being disproportionately affected," said Aditi Mukherji, one of the 93 authors of this Synthesis Report, the closing chapter of the Panel's sixth assessment. "Almost half of the world's population lives in regions that are highly vulnerable to climate change. In the last decade, deaths from floods, droughts and storms were 15 times higher in highly vulnerable regions", she added.

- The world had emitted 2,400 billion tonnes of carbon dioxide between 1850 and 2019 of which a little over 1,000 billion tonnes, i.e. about 42 percent had been emitted after 1990.

- In this decade, accelerated action to adapt to climate change is essential to close the gap between existing adaptation and what is needed. Meanwhile, keeping warming to 1.5°C above pre-industrial levels requires deep, rapid and sustained greenhouse gas emissions reductions in all sectors.

- Emissions should be decreasing by now and will need to be cut by almost half by 2030, if warming is to be limited to 1.5°C.

- The solution lies in climate resilient development. This involves integrating measures to adapt to climate change with actions to reduce or avoid greenhouse gas emissions in ways that provide wider benefits.

- "Accelerated climate action will only come about if there is a many-fold increase in finance. Insufficient and misaligned finance is holding back progress." Enabling sustainable development. There is sufficient global capital to rapidly reduce greenhouse gas emissions if existing barriers are reduced. Increasing finance to climate investments is important to achieve global climate goals.

- With significant investment in adaptation, we can avert rising risks, especially for vulnerable groups and regions. Climate, ecosystems and society are interconnected. Effective and equitable conservation of approximately 30-50% of the Earth's land, freshwater and ocean will help ensure a healthy planet. Urban areas offer a global scale opportunity for ambitious climate action that contributes to sustainable development.

- Changes in the food sector, electricity, transport, industry, buildings and land-use can reduce greenhouse gas emissions. At the same time, they can make it easier for people to lead low-carbon lifestyles, which will also improve health and wellbeing.

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