INTRODUCTION
CHAPTER - I
INTRODUCTION

The contribution of human capital to the overall economic growth has been universally accepted. The enhancement of this intangible form of capital through the enrichment of human capabilities has received considerable attention in recent times. Improvement of health status plays a vital role in the enhancement of human capabilities (Sen, 1987). The challenge before the developed countries is to maintain a higher level of health status than what they have already achieved. For the developing countries, the challenge is to attain a better health status.

Few subjects can be more important than health as a constitutive element of the well-being and freedom of a nation. And yet health care has been one of the most neglected aspects of development in India. Despite stirring statements in planning documents on the centrality of health and health care, the field has suffered from persistent neglect in public policy in general and development planning in particular (Dreze and Sen 2002). A direct consequence of inadequate official attention to health matters is that, the Indian population continues to be exposed to a high incidence of communicable diseases and readily preventable illnesses. Communicable diseases are seen to be responsible for more than half of the burden of disease in India (Murray and Lopez 1996). Many basic illnesses that have radically declined in large parts of the developing world in recent decades (such as tetanus, measles, pneumonia, leprosy, malaria, hepatitis, tuberculosis etc) continue to be
common in India. To illustrate, India’s share of worldwide leprosy cases is estimated to be as high as 68 percent\(^2\). It is worth noting that the burden of disease falls very unevenly on different sections of the population. Indeed, health inequalities are very sharp in India, in comparison with many of the other countries, even of the poor ones.\(^3\)

Poverty often causes sickness and determines the disease patterns - hence the expression ‘diseases of poverty.’ The poor can even to some extent become biologically adapted to substandard condition of life and consider their sickness as normal. Access to health system is moreover deeply conditioned by one’s possessions and income (Joseph et al 1983). The underlying cause of disease and health among the poor is this cruelly unequal distribution of wealth of land, of educational opportunity, of political representation and of basic human rights and this inequality is the primary disease (Joseph et al 1983). Though all varieties of health services are available in our cities, not all sections of the community are benefited by these facilities (Umashankar and Misra 1993).

**Health Status Difference: A global view**

Health improvement is influenced by three sets of factors: a) health factors which include medical intervention b) health promoting factors such as housing, water supply, sanitation and hygiene and c) non health factors which include social and economic factors. Historical analysis shows that the second and third sets of factors had considerable bearing on health improvement.
A comparison of the developed countries and developing countries with respect to some of health status and human development indicators would reveal that, wide disparities exist between these countries basic human development and health status like, life expectancy, infant mortality rate, maternal mortality rate, infants with low birth weight, adult literacy etc. (Refer Appendix 1.1) There exist wide disparities among nations and regions of the world in the basic human development and health status indicators. It can be seen that the population of industrialized economies are almost fully literate, whereas this was only 50.7% in least developed economies. A comparison of many of the human development indices in India with other countries (see Table 1.1) reveals that India is no exception as in the case of other low-income economies and in many cases the indicators are less than the average of the developing countries taken as a whole. However, within the Indian Union, Kerala State is an exception. The health status of Kerala is far advanced and higher than the all India average and is even comparable with advanced countries.

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Source: Dreze and Sen 2002. Table A.1 and A.2
IMR – Infant Mortality Rate
In 1999 the Infant Mortality Rate (IMR) for India as a whole is 71, whereas that of Kerala is 14. In the case of adult literacy also Kerala is far ahead of the all India average. Similarly for life expectancy, birth rate and death rate to some extent Kerala is at par with the advanced countries.

Not withstanding the advanced levels of human development of Kerala, the question that arises is whether the fruits of human development are fairly shared by all segments of population. Studies held in this regard revealed that all sections of population have not benefited fully out of the development process. (Kannan K.P. 1991, Kutty VR 1993, Antia 1999, Surekha 1999, Rajan and Navaneetham 1994, Madhava Menon 2000).

The economic status of a family has a significant effect on whether a child is immunized or not. Recent study on Kerala revealed that (Rajan and Navaneetham 1994) only 56% of children were immunized among families without any assets, whereas it was 77% for families who possessed household assets. The highest percentage of children (77%) immunized is among the Christians, among households with highly valuable assets and among mothers whose education exceeds ten years of schooling. The lowest percentage (39%) of immunization is among the children of illiterate mothers. As the immunization is a precautionary measure to prevent the illness among the children, the poor slum folks, due to their low economic status are not utilizing the health services fully and thereby succumb to more diseases.
Urbanization: At the beginning of the 19th century only 3% of the people in the world lived in urban areas. This figure rose to 10% at the turn of the 20th century and increased to 25% in 1950, 46.1% in 1997 and is projected to about 54.4% by the year 2015 (Govt. of Kerala 1997). In India urban population has been growing at a rate of 3.8% during 1971-81, which was higher than that of the 2.4% national growth of population. Urban population, which was 77 million in 1961 (18%), increased to 156 millions in 1981 (23.34%). As per the 2001 census the urban population in India was estimated at 285.3 million that accounts for 27.78% of the total populations.

In Kerala, the degree of urbanization was low in the pre-independence period. It was only 7.11% in 1901 and it has increased to 13.48% in 1951. From 1951 to 1991 the growth of urban population was 31.18% and in the 1991 census it accounts for 26.39% of the total population of the state and it reduced slightly to 25.97% in 2001. The degree of urbanization varies considerably from 3.76% in Wynad district to 50.46% in Kannur (Govt. of India, 2001).

The scarcity and contamination of water supplies and the lack of sanitation and appropriate sewage disposal makes the diarrhoeal diseases one of the most important health problems among the poor in urban areas. Environment of urban poverty with its inadequate services, over crowding, poor and dangerous housing, pollution etc. causes a variety of infectious disease and malnutrition to the urban poor. The first and foremost effect of rapid urbanization is the problem of homelessness and it varies from city to city. In some cities such as Bombay and Calcutta
most of the population lives in slums. In addition to the large number of slum dwellers there are many people who are completely homeless. Case studies from Calcutta, Los Angeles and Manila particularly mention the homelessness. It is very difficult to obtain reliable estimates of the numbers but it is suggested that in Los Angeles there may be as many as 30,000 people in this group (WHO 1992). The higher degree of urbanization may lead to problems of housing, sanitation, and drinking water etc. among the urban dwellers. The N.S.S. 44th round revealed that 18.67% in urban Kerala had no latrine facility and another 15.39% were sharing with other households and only 65.94% had latrines for exclusive use. The condition of Maharashtra, another highly urbanized state is pitiable, where 49.1% was sharing the latrine with other households and 23.2% had no latrines at all. In the field of housing it can be seen that 13.79% urban houses in Kerala are Kachcha houses and another 17.55% are semi-pucca type. The link between urbanization, degraded environment, inaccessibility and a deteriorating quality of life is particularly significant. A study by the Centre for Science and Environment in 1988 showed that more than 40% of the drains in the slums are water logged giving rise to intestinal, respiratory and skin diseases. In 1985 nearly 27.1% urban population in India did not have access to safe water and 71.6% were without basic sanitation. It is also estimated that in 1987-88, 25% urban females and 14.6% urban males have no regular employment (Mukhopadhyay, 1997).

Urban malaria, tuberculosis, pneumonia, leprosy, meningitis and preventable infections in children such as measles, whooping cough,
diarrhoeal diseases, and intestinal worm infections are some of the most common health problems apart from higher morbidity and mortality due to accidents. The health hazards of the urban poor are directly related firstly to poverty, secondly to polluted and stressful urban environment and thirdly to social instability and insecurity.

The urban health environment in Kerala: The health situation of urban Kerala is different from that of rural one. Due to the existence of large urban slum population, the health problem is severe in urban areas. The number of slums identified in Kerala in 1985 was 705 with a population of 2,78,674 whereas in 1996 it increased to 1169 slums with a population of 3,58,012 indicating a growth rate of 28.5% in the slum population over a period of 10 years (Govt. of Kerala 1997). The district wise analysis of slum population revealed that (see the table given in appendix) 8.1% of the population in the statutory towns in Kerala belongs to the slum category. The 1981 census revealed that 8.6% of urban population in Kerala were categorised as slum dwellers and this had risen to 15.9% in 1991. It also reveals that at the all India level the proportion of slum dwellers was 17.5% and 21.3% respectively for 1981 and 1991 (Govt. of India 1997). This raises the question, whether the available health services are properly utilized by all sections of urban community. Some crucial problems are mounted in the utilization of health services in urban area. It is to elicit such problems that the study is carried out in the most urban populated district in Kerala.

Another disturbing trend in the public health delivery system is that it is getting alienated from the people and only 30% of the people
even from the lower income group seek medical help from Government hospitals (Govt. of Kerala 1998). This is because of the fall in the quality of services at the Government hospitals. The poor state of Government hospitals may be due to lack of political commitment, financial stringency, bureaucratic inefficiency, corruptions at various levels, lack of proper planning etc.

The unprecedented growth of urban slums in Kerala in recent years consequent on the hike in the price of pucca shelter and land in urban centres would ultimately tell up on the general urban health in Kerala (Ratna Raj 2001). The task force appointed by the Government in 1998 to study about the health and sanitation situation in Kerala reveals the hidden dangers that lies behind the health advancement of Kerala and also about the poor health service utilization by people in certain pockets like urban slums in the state (Madhava Menon 2000).

Research Problem

Kerala has achieved outstanding progress in human development, which is reflected in the high level of education and health of its population. Crude death rates, infant mortality rates and life expectancy at birth in Kerala are comparable even to those in the developed countries (World Bank 1993). Though low mortality rate has pushed Kerala into the forefront of other Indian states and developed countries in health status, the people of Kerala, especially the urban slum population is facing the problem of high morbidity both from communicable and non-communicable diseases. Different studies done
across the country revealed that, among the urban population, slum dwellers have higher rate of morbidity prevalence and their living condition is extremely worse (Jha 1986, Kumar and Kumar 1987, Bhatnagar Dosajh and Kapoor 1988, Nangia Praveen, Kamla Gupta and Tiwari 1996, Underwood & Marget 1987, Ebrahim 1984, Rossi Espagnet 1984). The incidence of low birth weight babies is much higher in slums as compared to average. Consequently, infant death rate is also higher. Low birth weight babies are three times more likely to die in infancy than babies of normal weight at birth (Kumar and Kumar 1987). From a comparison of children in urban slums with that of children in rural areas, it is clear that urban advantage disappears. Urban slum children suffer higher rates of morbidity and attain growth status comparable to that of rural children (Underwood and Margett 1987). The study held in certain areas of Bombay slum revealed that 36% of the slum dwellers had one or other type of illness (Jha 1986). In a Delhi longitudinal study (Ebrahim 1984), which reviewed the state of health of 100 children during the first 2 years of life, revealed that morbidity and mortality rates increased from higher to lower socio-economic classes of families who mostly lived in poor environmental conditions.

The major health problems identified in the urban slum areas include diarrhoeal diseases, infectious diseases, malnutrition, tuberculosis, malaria and gynaecological disorders. Among the chronic diseases cardiovascular diseases, cancer, and diabetes emerged at the top. As far as the proportion of morbidity is concerned, urban Kerala is subjected to more of non-infectious than infectious diseases. The
NCAER study (Shariff 1995) about prevalence of morbidity among different states in India proved that the morbidity rate is very high among the urban male population in Kerala which is recorded as 185 per 1000 population and for female it was 166 per 1000 population, whereas the national average of morbidity rate was 96 for males and 106 for females. The NCAER study also revealed that 42.3% of the diseases of the urban areas are non-infectious in character and 29.5% are infectious and remaining 28.2% account for fevers. The study clearly revealed that urban Kerala suffers from serious problem of morbidity. The study conducted by the population Research Centre of Institute for Social and Economic Change through the rapid household survey under the RCH project revealed that 13.7% children had diarrhoea complaints in urban Kerala. Similarly, 22% of the children in urban area in Kerala suffer from breathing problems due to acute respiratory infections, whereas this was only 14% in rural areas (ISEC 1999). The urban environment is responsible for certain special health problems and high morbidity. The iron deficiency resulting from the attack of hookworm results in the problem of anemia. Waterborne infectious diseases, like dysentery, typhoid, diarrhoea is also common in urban areas and it is mainly due to poor household hygiene resulting from overcrowding, congestion and also due to shortage and interrupted supply of drinking water. Airborne diseases results from air pollution create chronic health impacts among urban people and are responsible for chronic coughing in children (Appaswamy 1993). Diseases spread by solid hazardous waste, rotting garbage and blocked drains are quite common in urban areas. The incidence of cholera is directly related to improper sanitary facilities for
human waste disposal (Azurin and Alvero 1974). Malaria, which is a vector disease, is also common in urban areas in Kerala due to stagnant pools of water, water storage system in houses and high population density, which leads to fast spread of diseases. In 1960s the problem of malaria persisted only in hill areas and coastal belt was free from the attack. But the trend in 1990s is that malaria infection is more in coastal region and persist more in urban slum (Govt. of Kerala 1999). In Kannur district alone 1110 cases of malaria (Govt. of Kerala 1995) was reported in 1995 and out of this most of the cases were reported from urban centres.

Slums are pockets of poor houses, poor people and poor environment either in the middle or in the periphery of a big city. Dirt, filth and stink fill the whole terrain. In one room the human beings of three generation are huddled together like sardines. The same room is used for cooking, co-habitation and breeding. The area of health and welfare is conspicuous by its absence. Slum has been variously described as a cancer on the body of a city, a veritable hell and utmost form of human degradation. Crimes, vices, diseases and illiteracy consistently show higher degree of occurrence in such surroundings. There are abundant cases of starvation, malnutrition of children, women and the old, unemployment and under employment, exploitation, torture, delinquency, desertion, and heinous crimes. They are devoid of food, sanitation water, electricity, privacy, quietude, and protection against diseases, health, medical care and above all any help. (Kumar and Kumar 1987).
The health status of urban population is peculiar in character as majority of them are floating population and the awareness of urban slum population about various health problems like curative, maternal and child health differ widely due to differences in their socio-economic set up. The vulnerable sections in the urban areas are suffering from morbidity problems especially diseases of poverty and are not having enough access to health care services. Due to the low income, they provide first priority to food and later only for treatment. Since income being low, they first usually approach the public hospitals, but the poor and inadequate services rendered by them compelled to go for private health care and in certain cases no treatment at all. The availability of physical presence of health functionaries competent enough to handle the user's problem is also crucial. Laboratory facilities and supply of drugs needed for diagnosis and treatment often play a vital role in determining access to health care services. Access to health care systems is deeply conditioned by one's possession and income (World Bank 1998). The study intends to focus the basic problem faced by the urban slum dwellers regarding the utilization of public health care service system, utilization pattern of health care services by different socio-economic classes of the urban slum and urban area about the perception of these people with regard to various health problem and also on the cost of health care of these people. Though health services in the form of doctors and hospitals may be accessible to slum dwellers, they lack the purchasing power and basic infrastructure like sanitation, housing and pure drinking water. Some crucial social and environmental factors are responsible for the high morbidity in the urban and slum areas and also
in the limited utilization of health services. The study is focused on such factors by dividing the households according to their socio-economic status.

**Objectives**

1. To examine the linkage between morbidity and socio-economic status of the people in urban slum and urban.

2. To identify the important determinants of health status of urban population and to review the problem of urban health in the utilization of health services.

3. To compare the differences in the perception of need for curative care and to find the kind of health services sought, the type of health centres approached by different socio-economic groups to meet their health needs in urban and slum areas.

4. To assess the extent of utilization of maternal and child health services in urban slum and urban areas.

5. To examine the extent of utilization of Government and private health services in urban and slum areas.

**Hypothesis**

The following are the important hypothesis postulated for the study.

1. As SES status (Socio Economic Status) comes down the overall morbidity prevalence increases steadily.

2. As SES Status comes down morbidity of diseases due to infection increases whereas chronic illness decreases.
3. The living environment is the important determinant of health status.
4. The better the social and economic position better would be the perception of the people about different diseases and higher would be the utilization of health services.
5. The utilization of MCH (Maternal and Child Health) services is high among the urban and high among the higher SES groups.

**Methodology**

The details of the methodology followed in the study are discussed in detail in the following chapter.

**Importance of Investigation**

A study of inter relationship of socio-economic conditions of different segments of community with the nature and pattern of morbidity and their medical aid, health needs and their health services utilization is a significant area of exploration. Such a type of an investigation will not only highlight the health and medical problems of a community, but will also provide insight into the understanding of inherent socio-economic disparities in society and its consequences on further aggravating the structural inequalities of the existing socio-economic order.

Health is a major determinant of human development, as it has socio-economic relation with the quality of life. Therefore, health development is an integral part of national development. Though there exist studies which deal with the health status and health care utilization
in general (Kannan et al. 1991, Panicker and Soman 1984, Panicker 1985, Irudaya Rajan and Mohanachandran 1999, Irudaya Rajan and Navaneetham 1994), there are no specific studies related to health care utilization of urban and slum communities in Kerala. Though the urban rural disparities are not as severe as that of other Indian states, there are certain urban centers and urban slums where health status is worse. The study is concentrated in one such urban region of the Kannur district in Kerala. The study revealed a clear dichotomy that exists between the urban and slum communities in their perception about symptoms and diseases seeking treatment, morbidity pattern, treatment process and health services utilization.

In the process of urbanization, the cities are swelling due to population growth. This has resulted in further deterioration of physical environment in these cities not backed by adequate expansion of civic amenities as well as health and other service. Though all types of health facilities are available in our cities, not all sections of the society are benefited by these facilities. The worst sufferers in the urban areas are the people belonging to the economically weaker sections of the society. Hence it was thought important to study the impact of socio-economic variables on the health status and health services utilization in the urban context.

Limitations

The study suffers from the following limitations.

1. Since morbidity rates are sensitive to seasonal factors, this raises the issue of reliability of rates reported from the present study based on a
single time point. Hence the rates and pattern of illness captured by this study pertains to only a specific period of the year namely the end of summer and starting of monsoon. So the chances of infectious illness may be slight less compared to the monsoon period.

2. Measurements of morbidity are based on self-perceived basis, most of the deprived sections neglects fever of short duration (i.e. one or two days) as acute illness. If it is also included then morbidity rate would have been much higher.

3. The findings of the study cannot be generalized for the state of Kerala as a whole as the study is limited to Thalassery Municipal Corporation area. All the factors responsible for the utilization of health services are not dealt within this study, as the data was collected only from beneficiaries, hospital authorities medical and paramedical personal were avoided from the data collection.

4. The definition and method of SES grouping of the households intended to reflect the socio-economic class (SES Class) of households has been arbitrary though based on Kuppuswamy’s scientific method of SES classification for urban families.

**Chapter Scheme**

The study report is divided into nine chapters for the sake of clear and meaningful presentation.

The first chapter deals with a general introduction, objectives, hypotheses, significance, limitations of the study and also attempts to review the available literature and related studies in the area.
The second chapter presents a conceptual framework for the study and it deals with the detailed methodology followed in the study.

The third chapter provides the basic problems and determinants of urban health with special reference to Kerala.

The fourth chapter provides the profile of the study area by giving stress on health infrastructure.

The fifth chapter examines the linkage of morbidity prevalence and socio-economic status of the sample population.

The sixth chapter examines the treatment process and utilization of curative health services.

The seventh chapter examines the utilization of Government and private health services.

The eighth chapter provides the detailed analysis of the utilization of maternal and child health services.

In the last chapter, a summary and conclusion of the study is provided.

**Review of Literature**

A country like India whose people experience adverse health problems in addition to high levels of illiteracy and poverty needs to have consistent and multi-pronged strategy and plans to ensure an equitable health status for its people. Resource crunch does not seem to be the prime reason for failure to implement a satisfactory health care system in most countries. India and Kerala is no exception to this (Panicker 1979, Nayar 2000). The WHO has also pronounced the
equitable policies and political will are the two important factors for achieving success in improving the health of a nation's population (Nayar 2000).

The review of literature on the health care utilization shows that urban health is still a less researched area in the context of its complexities. In the process of urbanization, the cities are swelling due to population growth and migration. This has resulted in further deterioration of physical environment in these cities not backed by adequate expansion of civic amenities as well as health and other services. Though all the varieties of health services are available in our societies, not all sections of the society are benefited by these facilities. The worst sufferers in the urban areas are the people belonging to the economically weaker sections of the society. As part of review of literature important studies reviewed here is mainly related to morbidity, socio-economic status, factors affecting health services utilization including utilization of maternal and child health services, factors affecting the perception of diseases and certain specific studies related to health services utilization in urban and slum areas.

A noteworthy feature of studies on immunization of children in Kerala was that incomes were not the major determinant of immunization. From a study on childbirth in an urban slum and a more prosperous middle class area in Thiruvananthapuram in 1987-88 (Soman et al 1990) concluded that although the morbidity load in the slum was greater, vaccine preventable diseases against which immunization services were freely available did not pose a particular problem in either
area. The spread of education especially among the women is the vital factor for improved health awareness and better health services utilization in Kerala (Panicker 1979). The vital factors responsible for better child and general health include a higher average age at marriage, a higher rates of female employment in the organized sector, higher levels of health awareness and information among women about better utilization of maternal health system and greater decision making roles of women in Kerala households. The expansion of literacy among females, higher emphasis on public health and education provided by the Govt. and above all the poor are more aware of their rights to use health, accounts for high utilization of health services in Kerala.

Since Anderson and his colleagues have proposed the structural model for health services utilization, a great deal of research has been carried out in developed countries to examine the factors that influence the health services utilization. Wan and Soifer (1974) had found that the most important factors related to health services utilization are the need for care (illness level) average cost per visit, health insurance coverage and age. Other variables either have an indirect or negligible effect.

Haynes (1991) examined the relationship between socio-economic status and health service use. He found that morbidity was related to housing tenure and care availability, rather than to occupational status. He also found that age adjusted morbidity ratios were higher for females in multiple occupancy dwellings in inner city areas.
Anderson and Adey (1978) found that in a national US survey for non-institutional population in 1975, health services are equitably distributed and that age and level of illness are the main determinants of health service use.

Brink and Nader (1981) examined the pattern of primary care utilization in tri-ethnic–urban school children in Galvestno, Texas USA. They found that social class and ethnic group have a strong relationship with the use of medical services. Brink and Nader also found that Anglican’s with a low socio-economic status used the service less often than others. Gesler and Meade (1988) examined the relationship between the health service use and distance and socio-economic status. They found that the distance from home to the regular source of care was relatively more important factor for inner city residents than for suburban and urban residents. There was no clear difference by race sex age and occupation.

Health needs at different ages influence utilization patterns. A study conducted in Tunisia, found ‘U’ shape utilization pattern with peaks at both extremes of age (Benyoussef and Wessen 1974). High morbidity rates in the very young and the elderly explained this study.

Sundar (1995) in her study based on NCAER data of 1992 revealed that the utilization of health services depends on the availability of quality health care services at a reasonable distance and on the ability of the people to utilize health services effectively. The provision of appropriate health infrastructure is a necessary but not a sufficient
condition for health care utilization. A number of socio-economic factors such as financial status, caste, occupation, education and gender have great influence on the perceived need for medical care and affect the access to health care facilities. The study categorically proved that with an increase in the level of education, utilization of private health facilities goes up and the utilization of public health facilities comes down.

The impact of socio-economic status on health services utilization is clearly revealed by Shariff (1995) by analyzing the NCAER data of 1992 on health services utilization and expenditure. The first and foremost index of better health services utilization is with regard to treatment procedure adopted for curative care on morbidity. At the all India level 8.5% of the reported morbidity in urban areas are untreated. In the urban areas highest percentage of untreated morbidity was reported from Andhrapradesh (16.1%) followed by Karanataka (11.9%) and then Kerala (10.8%). In the problem of untreated morbidity, the urban Kerala is above the national average, which reveals the proportion of poor living in the urban areas in Kerala and their inability to pay for health care and denied of health care services.

Yesudian (1981) studied the health behaviour of four social classes - high, middle, low and very low in the utilization of health services in Bombay city. He observed that as the low and very low social class households are educationally backward, their knowledge, level of diseases, available health services, and their perception, desire to seek health services are found to be lower than that of middle and high
class households. The low and very low social classes use mostly the Government health services because of their poverty. They are also not aware of all the services available in General hospitals and as a result their use is restricted to out patient department mostly. In the caste wise utilization of health services in India, the awareness of medical facilities is the lowest among scheduled castes and scheduled tribe groups. They prefer Government hospitals; choose a place where treatment is offered free of cost and rarely to go a private practitioner (Rao 1981).

Heller (1969) revealed that social stratification refers to the arrangement of various groups in a hierarchy indicating the relation of superiority or inferiority with respect to property status and power. It provides differential status and roles to individuals and groups to constitute a basis for human behaviour in relations to each other. Mukherjee (1971) discussed about sanitation and water supply and give a list of diseases, which incapacitates a person for less than a week and those for more than a week. The structural constraints like poor image of primary health centre due to lack of medicines, over crowding long queues and cultural and social gap between the health worker and the patient also limits utilization of health services (Banerjee 1973).

K. Sureender (2000) in a field study in the slum areas of Bombay revealed that squalor, filth, overcrowding and environmental pollution are the root causes of many diseases leading to high mortality in slum areas. Though the health facilities exist in adequate measure, the needy do not utilize them sufficiently due to the ignorance about health issues. Women and children suffered from malnourishment and anemia were
mostly underweight. Gastroenteritis, typhoid, malaria, measles, and hepatitis and tuberculosis were the major diseases engulfing the area. Due to overcrowding, inadequate drainage system, unplanned house structures and shortage of potable water, infectious diseases of all types were rampant. The study proved that the project undertaken with the object of improving the health status and health services utilization of the urban slum dwellers through a package measures resulted in bridging the gap that exist between health problems and health services utilization.

Sundar (2000) in her field study conducted in Dakshinpur a low-income re-settlement colony of Delhi reveals the under utilization of Government health services by the slum dwellers. Poor environment and living conditions have given rise to high incidence of diseases like tuberculosis, respiratory tract infection, worm infestation, and diarrhoeal diseases. The study revealed that poor health status of population is mainly due to ignorance and a greater reliance on traditional practices than due to lack of purchasing power or non- availability of health services. The study pin points that the health project undertaken for the area with the objective of improving awareness of family planning, antenatal care, post partum care and checking malnutrition succeeded in spreading General awareness among the target population about the need for practicing family planning and importance of maternal and child health care. The study proved that the reason for under utilization of health services mainly rests with an array of functionaries involved in the health care system and their dedication is a must for the success of any health services utilization programme.
Inequalities in medical care access are a severe problem in the utilization of health services in both urban and rural areas. A study on inequalities in access to medical care (here access stands for empirical relationship between the need and probability of using the health care system for treatment) where the need use probability relationship for one population group which was compared with that of another in Canada, England, Finland, Poland and USA revealed that the findings for the adult varied considerably. The access differentials among children were surprisingly consistent and unrelated to health care system and structures. It appeared that higher family income was associated with greater access to health care among children at all levels of need (Salvekar David 1975).

The significance of socio-cultural factors, behaviour and beliefs in the utilization of health services is increasingly being recognized. In the United States it was found that black children make substantially less use of health services than their white counterparts and this was due to differences in beliefs, related to illness (Tangerose et al 1984). The social status of family has also vital influence in the degree of utilization of health services. Children of less educated mothers with low socio-economic status and ethnic origin received less care than the others. The trend was statistically independent of the family’s economic situation or level of activity faced by them suggesting a greater influence of child receiving practices rather than as a consequence of pure economic circumstance (Fergussan et al 1984). Behavioural characteristics and attitudes of mother alongside the age and health status of the child have
been revealed as significant and important predictors of utilization of health services (Tessler and Mechanil 1978).

P.R. Sodani and S.D. Gupta (1988) in their study on tribal segment in Rajasthan made an analysis of pattern of utilization of health care facilities with urban and rural breakup. The study proved that 50.7% of the ill persons in rural area utilized the services of traditional practitioners, while in urban areas 45.1% of the ill persons utilized the services of traditional public health facility. It is suggested that the poor equipped and low quality of public facility was the root cause for the escalation of health expenditure in both rural and urban centers.

The literature on utilization of health services has mainly looked in terms of access, in relation to geographical distance and time. Access to health care services is linked to the distance of the facility and also the time involved to reach there by the ill person (Shanon et al 1973).

To study the utilization pattern and factors determining the utilization of private and public health care services, a cross sectional study undertaken by Shenoy (1997) in both urban and rural community of Thiruvananthapuram district in Kerala state. The study was clinical and epidemiological. The study revealed that out of 4800 subjects from 1001 households consented to participate, 2237 participants had morbidity problem and out of this 1552 utilized health care services. Of the total patients utilized health care services, 67% utilized private and 33% utilized public health centers. The Study showed that for the age group 45-59 was significantly less likely to use private service as
compared to adults with 14-44 years. Low SES was significantly less likely to use private service as compared to those with acute illness. The study points out the need for devising strategies to improve the accessibility and utilization of public health care services in a better manner.

The utilization of Government health services is very poor in India in general and particular in Kerala (Purohit and Siddique 1994). Based on NSS and NCAER data of 1992 he gives a picture of degree of health services utilization in India across three stage categories i.e low medium and high expenditure group. It is found that the level of government expenditure had direct influence on the availability as well as utilization of various health services in the country. The pattern of utilization shows that public institutions are utilized more for inpatient care and for outpatient care, majority of them prefer private doctors and private clinics. They revealed that the cost of hospital treatment in urban areas is higher compared to private sector hospitals. The study observed the growing popularity of indigenous non-allopathic systems and growth in private sectors involvement in expensive tertiary care.

Sreenivasa Redely (1998) highlighted the significance of accessibility, availability and quality of services in the proper utilization of maternal and child health services in Andhra Pradesh. The study reveals that utilization of antenatal services, immunization status of children, and deliveries attended by ANM (Auxiliary Nurse Midwife) increased considerably.
Sivaraju S (1987) in his study on the differential utilization of Government hospital services in Andhra Pradesh revealed that the respondents who are either partly or fully satisfied with the Govt. hospitals are relatively more in coastal Andhra Pradesh as compared to those in Rayalaseema. On the other hand in Rayalaseema nearly one third of the respondents were not at all satisfied with the Govt. hospitals, which reveals the poor image of Govt. hospitals in the minds of the public. Better economic conditions prevailed among the people in coastal Andhra Pradesh made the people to utilize medical services in a better manner compared to other region. Cleanliness and orderliness of the clinic, time spent by the doctors in examining the patient, time spent by the patient to see the doctor, privacy provided at the clinic, facility to rest and facility offered to the accompanying person etc. was relatively better in coastal Andhra Pradesh, because of the accessibility of good infrastructural health facilities namely, optimum doctor population ratio, higher socio-economic conditions of the people as compared to their counterparts in Rayalaseema.

Pawar R.G. (1983) conducted a utilization study in five clinics of Jamnagar Medical College in India with the objective of studying factors associated with the acceptance of vaccination. The higher awareness and utilization of available immunization was observed in younger parents in both rural and urban situations. It was observed that urban children were brought at a younger age as compared to rural children. Parent’s option for immunization of their children was comparatively higher in better-educated sections than in the general population of the district. The
differences in social class pattern of urban and rural attendants, comparatively wider range of knowledge about vaccines was revealed among the urban acceptors. Health education about availability, and utilization of vaccine was recognized as an important weapon to boost acceptance.

Samuel et al (1992) in their study on utilization of health services in Karnataka, India found that the low level of economic status group had higher prevalence of sickness. It was observed that 32.2% got treatment from private sources, 41.3% from the Govt. sources and 26% from either private or the Governmental sources. It was found that for every increase of the availability of Government health facilities, there was a decrease in the proportion availing proper medical care and the reasons for choosing a particular place of treatment was due to convenience and good treatment.

The study conducted in an urban community of Meerut city in India (Garg and Singh 1985) reveal the role of elder persons in the utilization of health services. All the persons aged 50 years and above in 500 registered families constituted the study sample. A positive association between educational status of the patients and the utilization of modern medical practice was also observed. It was found that on the one hand the choice of medical care depends on factors like availability, convenience, expenditure involved and the quality of services provided, while on the other hand the belief regarding causation of diseases also plays a very important role in its determination. The education of the people about health is therefore of paramount importance in persuading
the people to make proper utilization of available medical facilities more
so that of the aged people, as their advice is sought in all the matters
pertaining to the family health in the present social set up.

Rama V Baru (1999) made an inter-state analysis about the
structure and utilization of health services in India. It shows that in most
states public sector is the major provider of curative services. Uneven
spread and regional variations could be seen in the private and voluntary
sectors. The study warns that if there are cut backs in the public sector,
then it is likely to distort the provision of health services even further. It
also noted that with the cut back of public services, the private and
voluntary sectors will not immediately move into fill the gap. The
private and voluntary sectors will move only into those areas where they
can show profits. Since majority of the lower socio-economic groups are
dependent on public provisioning, any slashing of investment in this
sector will further marginalize this group. So he warns against the
cutback in public provision of health services, which further deteriorates
the gulf between advanced and backward areas and access among
different socio-economic groups and classes.

Perception of disease is also an important factor affecting the
health services utilization. Poor perception is a reflection of faulty health
practices and results in health inequality compared to better perception
group in the high-class families. In his study, Stanley H King (1962)
gives the symptoms of three well-known diseases, cancer, diabetes and
poliomyelitis. The analysis revealed that the number of respondents who
were not able to identify even a single symptom steadily increased with
decreasing education and income. Many low-income respondents perceived that cancer was a communicable disease.

Mandhakini Khandikar (1974) had conducted a study in the city of Bombay to examine the utilization pattern of maternal health services by middle-income groups and low-income groups. In addition to income she had analysed the role of age, family size, education and occupation. Within income groups she found that they too played a role in the utilization pattern of health services. The level of utilization was higher in those middle-income households, where the head of the household was engaged in white-collar job, well educated and the size of household was small.

Social class and health inequalities project the inherent inequalities, which exist not only in health but also in health care utilization services (Blexter 1976). Accordingly, the complex factors such as occupational risks, education, income living environment etc. are responsible for creating health care inequalities. To avoid health care inequalities, he suggest for providing more doctors (women doctors) health visitors, district nurses, medical and psychiatric social workers with more responsibility.

Jatinder Bajaj (1999) in his paper attempts to study the knowledge and utilization of maternal and child health services available to woman residing in the slums of Delhi. It reveals that sanitation facilities were very worst with chocked drains and foul smell. Nearly 46% of the slum dwellers depend on private sector for their health
problem. The services of NGO’s are also utilized by the slum dwellers to an extent of 22% and another 22% on Government health centers and hospitals. The remaining households approach private practitioners. The study reveals low utilization of maternal and child health services provided by the public health care system. The reasons for non-utilization of these services are the lack of knowledge about these services, offered by the Government due to their illiteracy and lower accessibility of these institutions providing the services. The proportion of immunization was also very low and fell short of the achievement of the goal of universal immunization against major vaccine preventable diseases. The study points out the need for augmenting awareness among slum woman for better utilization of maternal care services provided by the Government.

Shelah S Bloom and et al (2001) studied the dimensions of women autonomy and the influence of maternal health care utilizations in India. It revealed that women’s freedom of movement appears to be a major determinant of maternal health care utilization among poor to middle income woman.

Rosenthal (1965) in his study found that hospital admission rate increased with the increase of age. Rodney M Coe and Albert Wessen (1965) too found in their study on the utilization of community health services that the use of health services increased with age for both sexes. The study conducted by Jerry A Solon (1966) in an outpatient Department of Beth Israel hospital at Boston showed that older age group utilized the outpatient department more than the younger age
group, but the difference was not statistically significant. The difference is justified on the ground that for younger people other healthy services like school health clinic, and clinics at the place of employment were available, whereas the older people were fully dependent on Beth Israel Hospital.

Odin W Anderson (1963) analysis of health statistics of United States showed that women utilized all sorts of health services including surgery more than men. Rodney M Coe and Albert Wessen (1965) too found female domination over males in the health services utilization. The field data of the present study also provides a similar trend of high utilization among females especially for chronic illness as they exhibit high chronic morbidity over males.

Rajana and et al (1998) in their study on impact of maternal education and health services on child mortality in U.P India shows that improvement in health services education and provision of safe drinking water; all have desirable impact on child survival. The study categorically established that maternal education seems to have direct as well as indirect effects through the mothers’ antenatal care as well as family formation patterns in the case of neo-natal mortality. Higher risk of death was observed for those depending on water from public sources than those having their own sources at their residence. The study proved that irrespective of socio-economic or demographic condition, mere utilization of antenatal care by pregnant woman would help in reducing neo-natal mortality to a greater extent.
Bhatnagar et al (1988) in their study on maternal and child health status and patterns of health status utilization in urban slums of Delhi revealed the poor health of woman and children and low level of health services utilization. The data related to utilization of maternal health care services shows very poor performance indicating the poor perception of slum dwellers about antenatal, pre-natal and postnatal health services utilization.

Financial factors were seen to be vital determinants of physician contact for the minorities, while perceived health needs seem to be the more important contributors to entry into health care (entry defined in terms of free medical care). Entry into health care found to be strongly linked to socio-economic factors. For instance a large family size cursed with low income and low education among Hispanics was a detractor from utilization than among non- Hispanics (Guendelman and Sebwalbe Joan 1986).

The significance of socio-cultural factors, behavior and beliefs in the utilization of health care services is increasingly being recognized. In the United States it was found that black children make substantially less use of health services than their white counterparts. This was due to differences in beliefs related to illness (Tangerose et al 1984).

Maternal use of services was identified as a powerful predictor of utilization, when the associations between maternal and ambulatory care utilization was studied. The comparison of maternal and child ambulatory care utilization patterns as measured by presence or absence
of a physician visit over the course of a year as well as annual volume of use showed a close association between maternal physician utilization and child utilization. Mother’s occupational and educational status along with family income and size influenced a great extent in the utilization of health care services and cause for reduction in morbidity and mortality rate (Newacbeck and Halfon 1986).

Kamal Hazari (1993) considers certain hurdles in the fuller utilization of these health care outlets. The rapid and un-organized increase in the migrant population and some attitudinal misconceptions are the limiting factors in their fuller utilization. The concept of community-based approach is the only possible way to remove such bottlenecks.

Elo Irma (1987) on the basis of data collected from Peruvian demographic and health survey made an attempt to find out the relationship between women’s education and utilization of maternal health services in Peru. It was found that the formal education of woman influenced the use of maternal health services by place of residence, suggesting that much greater efforts on the part of Government are required to reach women in rural areas.

The impact of mother’s education on utilization of maternal and child health services was studied with data sources from three districts of Kerala (Rajan Irudaya and Navaneethan 1994). Educated mothers use better antenatal and postnatal care, which results in better health of the mother and child. The study proved that illiterate mothers who received
Tetanus injections during pregnancy was only 41%, whereas this was 82% among mothers who received 10+ years of schooling. Though the study failed to analyze the urban rural break up in the utilization of maternal and child health services and the special problems of urban mothers in Kerala, the study revealed that the education of mothers is responsible for better health status of the state compared to other states in India.

Donaldson (1976) in his study based on data from urban and inner urban areas revealed that, it is the inner urban area in which slum households are huddled together which suffers a lot due to health in equalities. The health services and health status of inner urban area is worse compared to the urban centre. The problem of un-employment, over-crowding, air pollution, infant and child mortality, birth rate and mortality rate etc are also high in inner urban areas compared to urban centers. The study suggests for adopting a package measures for improving the health status and encouraging the health services utilization on the part of people in the inner urban areas. The health services and health status of inner urban area is worse compared to the urban centre. The problem of un-employment, overcrowding, air pollution, infant and child mortality, birth rate and mortality rate etc. are also high in inner urban area compared to urban centers. The study suggests for adopting a package measures for improving the health status and encouraging the health services utilization on the part of people in the inner urban areas.
Daksh Pandit and et al (1996) observed that there are socio-cultural and behavioral barriers like female illiteracy, poor economic status of women etc, which affect the maternal and child health services utilization. The study revealed that there is no dearth of health care facilities in terms of hospital beds, equipments, sophisticated treatment methods and highly specialized health manpower, still the health status of large proportion of population specially mothers and children in urban areas remain poor.

Rajna and et al (1998) in their study on impact of maternal education and health services on child mortality in U.P. India shows that improvement in health services, education and provision of safe drinking water all have desirable impact on child survival. The study categorically established that maternal education seems to have direct as well as indirect effects through the mother’s antenatal care as well as family formation patterns in the case of neo-natal mortality. Higher risk of death was observed for those depending on water from public sources than those having their own sources at their residence. The study revealed that irrespective of socio-economic or bio-demographic condition, mere utilization of ante-natal care by pregnant woman would help in reducing neo-natal mortality to a greater extent.

Bhatnagar et al (1988a) in their slum study revealed the high utilization of private sources of health services by the urban dwellers in Delhi. It shows that 62% use purely private sources, 24% both Govt. and private and only 14% used Govt. sources alone indicating the sad state of
affairs of the Govt. health centers and the need for improving the accessibility and utilization of Govt. health centers.

Duraiswamy (1998) examines the levels, differentials in overall and gender specific morbidity prevalence rates across the socio-economic and demographic groups in rural and urban Tamil Nadu based on the NSS data of 1986-87. The age and sex specific distribution of ills are presented and the determinants of morbidity at the individual level are analyzed. The study revealed the need for targeted health intervention to reduce the morbidity among children and elderly persons. The study also revealed that communicable diseases are concentrated in the younger age group, while aged people suffer more from non-communicable ailments. The sex wise morbidity prevalence shows that males have higher risk of being sick compared to females.

Dhanalakshmi and Moorthy (1993) in their study of socio-economic and demographic factors influencing child morbidity in two districts of Andhra Pradesh proved that without socio-economic epidemiology, bio-medical epidemiology could make a limited contribution to the reduction of morbidity. They revealed that morbidity is influenced by the size of the household, type of family, occupation of the husband and surviving children. Larger households, joint and extended families increase the level of infant and child morbidity due to more members in the families. The study empirically proved the effect of socio-economic and demographic factors on the morbidity pattern. But it neglects the environmental factors affecting morbidity.
Due to overcrowding, inadequate and poor housing, lack of adequate safe drinking water, lack of drainage, non-collection of waste water and its improper disposal etc. led to pollution of water and land in urban towns and cities to a degree much greater than in rural areas. The environmental degradation is the vital factor responsible for the emergence of both communicable and non-communicable diseases in an urban community (Shreekant V Khandewala 1996).

Adolescents and youth are exposed to many health problems including STDS, HIV and teenage pregnancies, primarily because of hypersexual activity and general ignorance. The study provides (Ramachandra Sastry 2000) the vivid picture of city slum with high incidence of promiscuous adolescent and youth sex, lack of hygiene ignorance and poverty generally have a very high incidence of sexually transmitted disease and other re-productive tract problems. There is also a high degree to morbidity due to termination pre- marital and out of wedlock pregnancies which are terminated by quacks and untrained birth attendants.

Primary urban health problems are neglected at the expense of specialty health services offered in the urban centers. Yesudian (1984) focused the poor health status of the metropolitan cities inspite of spending major chunk of funds on health services. His study based on morbidity and mortality analysis of the city of Bombay reveals that primary health care is the vital need of the city, but which is neglected for providing special health care through major hospitals including medical college hospitals and certain municipal General hospitals. The
poor living in the urban slums are facing the problem of safe drinking water, the sewage problem of latrine facilities. All these worsen the prevalence of communicable diseases in the city. He observed that the health sector has failed to meet the primary health problems of the people in the urban slum.

High mortality rates associated with lower socio-economic status people are unable to utilize better health care services. Persons in lower socio-economic positions die on an average at a younger age than those in higher positions. In-equality in the face of death has been observed in almost all states in different population and using different indicators of socio-economic positions, such as social or occupational class, educational attainment, income and housing characteristics (Antonovsky 1967, Feinstein 1993, Mackenbach and others 1997). One percent increase in the schooling of woman will result in 9% of reduction in mortality rates (Jeffrey 1987).

Malati Damodaran and et al (1994) in their study about the breast feeding practice of mothers revealed that urban mothers introduced commercial milk supplements at an earlier period compared to mothers in rural which accounts for higher morbidity among the urban children. They suggested that the effect of urbanization on breast-feeding and supplementary feeding was striking in urban centers. It also revealed that attack of all child diseases was higher in urban areas compared to rural one.

Chojhacka and Adeybola (1984) in their study proved that although both medical and non-medical factors contributed to the change
in morbidity pattern, the role of socio-economic factors were also found to be significant. Kaplan and Taylor (1985) have shown association between the occupation of the father and infant and child morbidity.

After reviewing the health scenario in the country Kapilalakshmi (2000) suggested that Government and the community should take steps to improve the quality of life of the people. Non-communicable diseases are a major health problem and the study empirically proves the effect of socio economic and demographic factors on the morbidity pattern.

**Conclusion**

Many studies have been done in the general area of health services utilization. As is clear from the preceding detailed review, existing literature in the field of health services utilization and morbidity problems in urban India; attempts made so far suffer discerningly from the following significant limitation. None of the studies touch the core reality of health issues of the down trodden and under privileged groups in the urban slums and urban areas. The present study also take into account the perception of health needs before analyzing the utilization pattern which is also an improvement over the existing literature on health services utilization. Major studies are based either urban or urban rural comparison in health services utilization and health problems and none of the studies compares the health problems and health services utilization of urban and urban slum on the basis of their socio-economic set-up, and other variables related to health services. All these studies have a predominant bias of being macro studies. Such studies by their
nature do not touch the core-reality, since it is not possible to know from
the top what is going on at the inner base of the mountain of the problem.
The correct approach necessarily is the slicing method that is to divide
the problem into small pieces and then an intensive effort to assess them
really.\textsuperscript{6}
Notes

1. The burden of disease is not easy to assess and information on morbidity patterns in India is extremely scarce (this is one symptom, among others, of the low priority assigned to health matters in public policy). Nevertheless, a number of recent studies throw useful light on disease patterns in India. See particularly Murray and Lopez (1996) Vaidynathan (1997) Sheriff (1999) Duraiswamy (2000) International Institute for Population Sciences (2000); also World Bank (2001a) and the studies summarized in that report.

2. World Bank (2001a), P.28 This proportion is much larger than India’s share of the world population, which is about 17%.

3. See World Bank (2001a) PP 32.9 and 81-9

4. Though literacy is not a direct measure of health status, it can indirectly contribute to the enhancement of health status.

5. The number of identified slums increased from 705 in 1985 to 1169 in 1996 and population also increased from 2,78,674 to 3,580121 over the same period.

6. What is intended to highlight is the fact that, it is always better to have several representative micro studies before undertaking a micro level study for making safe generalization at the national level. In any empirical exercise having a bearing on policy study remains evergreen.
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## Appendix 1.1

### Health status and Human Development Indicators - a global view

<table>
<thead>
<tr>
<th>Countries</th>
<th>Life Expectancy</th>
<th>IMR 1997</th>
<th>MMR * Per10,000 live births 1990</th>
<th>Infants with low birth weight (in %) 1997</th>
<th>Doctors per 10,000 people 1997</th>
<th>Adult literacy (in %) 1997</th>
<th>Population Without access</th>
<th>To safe water (in %) 1997</th>
<th>To sanitation (in %) 1997</th>
<th>Real GDP per capita 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>All developing Countries</td>
<td>64.4</td>
<td>64</td>
<td>491</td>
<td>18</td>
<td>14</td>
<td>71.4</td>
<td>28</td>
<td>57</td>
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<td>Least developed countries</td>
<td>51.7</td>
<td>104</td>
<td>1041</td>
<td>22</td>
<td>16</td>
<td>50.7</td>
<td>41</td>
<td>63</td>
<td>992</td>
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<tr>
<td>Sub Saharan Africa</td>
<td>48.9</td>
<td>105</td>
<td>979</td>
<td>15</td>
<td>16</td>
<td>58.5</td>
<td>50</td>
<td>56</td>
<td>1534</td>
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</tr>
<tr>
<td>Arab State</td>
<td>65.1</td>
<td>53</td>
<td>396</td>
<td>11</td>
<td>111</td>
<td>58.6</td>
<td>18</td>
<td>29</td>
<td>4094</td>
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</tr>
<tr>
<td>East Asia</td>
<td>70.0</td>
<td>37</td>
<td>96</td>
<td>9</td>
<td>116</td>
<td>83.4</td>
<td>32</td>
<td>73</td>
<td>3601</td>
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</tr>
<tr>
<td>East Asia (excluding China)</td>
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<td>15</td>
<td>114</td>
<td>9</td>
<td>134</td>
<td>96.1</td>
<td>10</td>
<td>1</td>
<td>14300</td>
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<td>South East Asia &amp; the Pacific</td>
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<td>449</td>
<td>12</td>
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<td>87.9</td>
<td>31</td>
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<td>52.2</td>
<td>18</td>
<td>64</td>
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<td>South Asia (excluding India)</td>
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<td>48.4</td>
<td>15</td>
<td>46</td>
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<td>India</td>
<td>62.6</td>
<td>71</td>
<td>570</td>
<td>-</td>
<td>48</td>
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<td>19</td>
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<td>-</td>
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<td>-</td>
<td>-</td>
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