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# Urbanisation of pandemics

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*The urban nature of the pandemic becomes clearer when we consider the megacities and the large Indian cities.*



The COVID-19 pandemic has been amidst us barely for a few months. Despite this, the phenomenon has generated a huge volume of data, research and debate and has dominated media discourse globally. On almost a daily basis, aspects of the disease, its understanding and its treatment are evolving and laboratories around the world are working overtime to find a vaccine to provide mankind a safety net. Furthermore, responses beyond the sphere of health on account of the virus — economic, political, social and psychological — are finding expression.

strongly indicate that COVID-19 almost over the entire world is very urban-centric. This is a trend that started quite some time ago. However, with an ever-larger shift of populations to urban areas in conjunction with a shift of a very large percentage of national economies to large urban centres, the concentration of a succession of epidemics and pandemics in cities has become stronger. This article wishes to place before the readers a gist of that data with some analysis. At the same time, it attempts to go into a band of possible causes that assist the virus to dig in its heels in urban areas.

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The global report provided by [worldometer.com](https://worldometer.com) reveals that the top-ten countries that have suffered the highest number of COVID-19 cases are among the very highly urbanised countries. Seven of them (Spain, Italy, France, UK, Germany, Turkey and Russia) are in Europe and have about three-fourths of their populations or more in urban areas. Iran and China are in Asia and the US completes the list of ten. US is among the most urbanised countries. Iran's level of urbanisation is more than 70 percent. While China has close to 60 percent urbanisation, it has, because of the mass of its population, the largest number of megacities. These countries put together have more than a whopping 74 percent of the total cases of coronavirus as of 30 April 2020.

Within their countries, their larger cities have borne the brunt. In China it is Wuhan (population 11 million); in the USA it is New York (8 million), its largest city, with about 165,000 cases. In the UK, its capital city London (9 million) became the epicentre of the virus. In all other countries in this group of ten, cities have the preponderant number of patients that have suffered or died on account of this virus. In regard to USA, [a New York Times](#) analysis discloses interesting COVID-19 death figures. Till 2 April, non-metropolitan areas had a rate of 0.43 deaths per 100,000 population; small metros were slightly higher at 0.72 deaths; mid-sized metros stood at 0.85 and large metros with low-density suburbs at 0.94 deaths. Large metros with high density suburbs and large metros that were urban counties stood at 1.59 and 3.98 deaths per 100,000 population respectively.

In India, the story appears to be similar. As of 26 April, in general, the more urbanised states are among the top ten states impacted by corona. These are Maharashtra (45

Andhra Pradesh (29 percent), Telengana (39 percent) and West Bengal (32 percent). While Rajasthan, Madhya Pradesh and Uttar Pradesh are less urbanised than the national urbanisation average, they have been catapulted into this list on account of their geographic and demographic size as well as the presence of large cities such as Jaipur, Indore and Hyderabad in their fold. Together, they make up more than 90 percent national cases of COVID-19 and account for all the top dozen cities barring Bengaluru.

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The urban nature of the pandemic becomes clearer when we consider the megacities and the large Indian cities. It was **reported** that as on 20 April, ten cities of India had over half the coronavirus cases. These cities comprised Mumbai, Delhi, Ahmedabad, Indore, Pune, Jaipur, Hyderabad, Chennai, Surat and Agra. They aggregated a total of 8,958 cases of 17,265 cases in India. Their share as a total percentage of cases is increasing over time. If we take the **figures** of 30 April, Mumbai and Delhi, the two largest Indian cities alone have about 30 percent of all the cases in the country.

The uppermost reason scholars of urbanisation globally recognise is that this phenomenon is due to larger human densities within cities. Urban activities of agglomeration require people to come together. This goes against the mandate of social distancing. The other factor especially recognised both globally and in India is the much higher densities within a city in which the urban poor live and where many public amenities such as toilets and collection of water are shared. Avoiding crowding in this situation becomes almost impossible. The consequence of this city deficit is borne out by a very large number of cases among slums and the urban poor.

Globally, cities do not merely have their own share of resident citizens. They also attract travelers and tourists from across the world. Indeed, European cities and countries rely heavily for their buoyant economies on the revenues that are brought in through tourism. Over a period of time, they have especially crafted their policies and city services to assist and facilitate these visitors. One of the reasons why European countries suffered so badly was due to the ingress of Chinese and other tourists that helped a larger and quicker spread of the virus. The sheer volume of today's **population movements**, both on account of migration and travel across countries makes it faster and easier for viruses to spread around the cities of the world.

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Many of the urban health issues that one witnesses in cities are stimulated by the living conditions of the urban settlement. Diabetes, hypertension, heart disease, obesity and respiratory illnesses are considered diseases of the urban rich and middle class. But these have now diversified and have begun to affect the urban poor as well. These urban diseases make city populations more vulnerable, as one has seen being played out in cities. Fatalities have been much higher among the virus patients who exhibited symptoms of comorbidity. The fertile ground for such comorbidities was prepared by the nature of the cities.

Cities are also marked by large congregations for events in hotels and halls, movie shows in theatres, stadia for sports and celebrations and religious observances where the spread of the virus could happen. It is for this reason that most countries around the world have locked down city activities for fear of the pandemic assuming a larger shape through community spread.

Some of the factors narrated above are common servers of all pandemics. The discovery of a vaccine and a certain line of treatment may substantially rein in COVID-19. However, we have been witnessing a series of viruses before this pandemic, targeting the cities. The likelihood of this trend receding if cities refuse to reinvent themselves is very remote. This is because the global population is still on the rise, it is rapidly urbanising and cities are also becoming large centres for climate change. The combined strength of these cited factors is highly potent in creating the kind of carnage we have seen. There is, therefore, no escaping the fact that cities for the future will have to think through a new paradigm that would perforce have to operate in cities.

*The views expressed above belong to the author(s).*



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