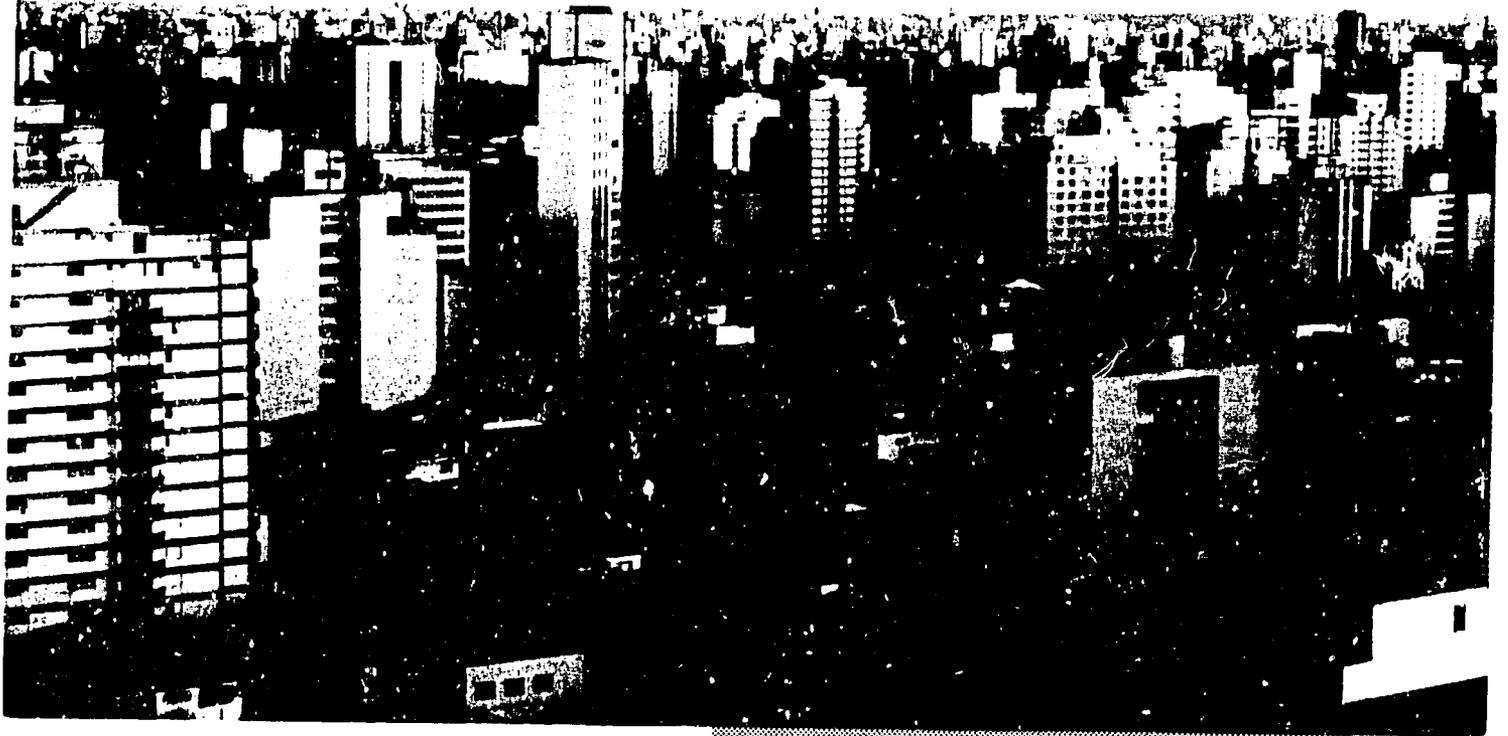


PW-ABM-662

# Health in the Urban Setting 79990



Agency for International Development  
Bureau of Science and Technology  
Office of Health

Workshop Report

March 25, 1991  
Rosslyn, Virginia

# HEALTH IN THE URBAN SETTING

Agency for International Development  
Bureau of Science and Technology  
Office of Health

March 25, 1991  
Arlington, Virginia

## **ACKNOWLEDGEMENTS**

**A.I.D.'s Office of Health would like to thank Ann Van Dusen, Nancy Pielemeier, Bob Emrey, and Holly Fluty for contributing their ideas, time and talent to this workshop. Thanks to the presenters and speakers Ken Olivola, Dennis Long, Shelley Smith, Linda Valleroy, Robert Clay, William Jansen, Charlotte Cromer and Diana Silimperi for their insights. At Pragma, we appreciate the work of Cari Leviste and Craig Carlson for managing the workshop, Mohammad Fatoorehchie for the striking slides, Maggie Chadwick for preparing the report, Neil Schlecht for his editing work and the cover photo, and Susan Kolodin for reviewing the report.**

## **EXECUTIVE SUMMARY**

A.I.D.'s Office of Health convened a workshop in March 1991 to examine the changing picture of urban health conditions and problems in the developing world. Speakers emphasized the tremendous urgency of urban health matters and discussed what is currently known, what should be known, and what can be done to address the health problems of the urban poor. Professionals in urban planning and medicine, in addition to A.I.D. and its cooperating agencies, attended the workshop and contributed their observations and perspectives.

Urban growth in the developing world is proceeding at a rate seven times faster than in developed countries, and the urban poor constitute the fastest growing segment of that population. The health care climate in urban areas is rapidly deteriorating, as the rate of growth in cities fast outpaces the supply of social services. A traditional municipal government response, emphasizing physical infrastructure, does not adequately address the critical issues of social service provision and access in the 1990s.

Contrary to common perceptions, urban dwellers may be as disadvantaged in terms of health care services, if not more so, than rural populations. The most vulnerable are the poor, especially women and children. In addition to infectious diseases that one commonly associates with rural areas, the urban poor face health problems that tend to be more associated with developed countries: environmental pollutants, accidents, cancer, hypertension, substance abuse and violence. Compounding the problem, the urban poor often possess inadequate information about health services and access to such services, or too few resources to take advantage of them.

Workshop participants concurred that the health needs of the urban poor are reaching critical levels. Factors that indicate an imminent or already existing crisis include:

- the sheer size of urban populations in need
- the increased possibility for disease transmission in poor neighborhoods
- extremely limited access to health care among urban poor
- humanitarian concerns, given the gravity of the health situation

Despite these enormous challenges, certain factors endemic to the urban environment present distinct opportunities for improved health delivery systems. For example, the concentration of urban populations facilitates cost-effective dissemination of health messages. Private sector health providers and public organizations (PVOs and NGOs), often concentrated in cities, offer significant opportunities for improving access to health care. Health care facilities and professionals are present to a greater extent in cities than in rural communities. In many cases, there may be opportunities for donors to strengthen alliances with private, for-profit health care providers. Finally, it may be more possible in urban than in rural areas to identify agents of social change, such as women, to act as positive mechanisms for community-based empowerment. Despite the fact that such

opportunities for care are often underutilized by the urban poor, the infrastructure does, for the most part, exist.

Themes raised at the workshop reflected challenges, opportunities and target areas. The main themes were:

- health problems as viewed from an urbanist perspective
- new systems are required to collect disaggregate data to provide a clear picture of the health problems and health care seeking behaviors of the urban poor subset
- problems of health service delivery
- A.I.D. experiences in urban health
- the need to develop a framework for future activities

Several important questions for health care provision and assistance were raised, including:

- How can strategies be formulated to address uniquely urban needs?
- Do health service programs have the same impact among both rural and urban populations?
- To what extent do health concerns reflect underlying factors, such as poverty, lack of knowledge and illiteracy?

The Urban Health Workshop produced nine general findings:

1. There is a need to define what constitutes "urban" so that data from different cities and countries may be compared.
2. Urban health indicators from different areas in cities are needed to make more informed decisions about urban health needs.
3. Given A.I.D.'s long-time focus on rural development issues, specific attention to urban health would need to be incorporated into the dynamics of the larger agency agenda to achieve a workable rural-urban balance.
4. Health care financing is a matter of considerable concern: Who will pay for programs that target the urban poor?
5. A.I.D.'s role in urban health development and assistance should be explored.
6. Only an integrated, multisectoral approach, involving the public and private sectors, as well as donor groups, will be effective in a serious effort to combat urban health problems.
7. Grassroots participation and targeting is essential; change agents must be identified in local communities and empowered to bring about positive and sustainable change.

8. **Political support and coordination--among A.I.D. missions, host country officials, health organizations, and other donors--are essential.**
9. **Current A.I.D. activities that are effective in urban areas should be acknowledged in order to build upon previous successes.**

## TABLE OF CONTENTS

I.	INTRODUCTION.....	1
II.	SETTING THE CONTEXT: HEALTH IN THE URBAN SETTING..... Ken Olivola	1
III.	OFFICE OF HEALTH EXPERIENCES IN URBAN HEALTH..... Communicable Disease Division Applied Research Division AIDS Division Health Services Division A/PRE S&T/POP	4
IV.	VIDEO: VIEW FROM A BRAZILIAN SLUM.....	7
V.	HEALTH SERVICE DELIVERY FOR THE HIGH RISK URBAN POOR..... Dr. Diana Silimperi	8
VI.	ESTABLISHING A FRAMEWORK FOR FUTURE ACTIVITIES.....	10

### ANNEXES

- Annex A: Agenda
- Annex B: Attendance List
- Annex C: Materials List
- Annex D: Background Paper, Ken Olivola
- Annex E: Presentation Notes, Diana Silimperi

# WORKSHOP REPORT

## HEALTH IN THE URBAN SETTING

### *Introduction*

A.I.D.'s Office of Health convened a workshop March 25, 1991 to discuss urban health conditions in the developing world. The Office of Health and its cooperating agencies reviewed their cumulative experience, identified issues, and considered strategies A.I.D. might use to respond to the health needs of the urban poor.

A diverse group of speakers, including health administrators, urban planners and A.I.D. officers, discussed health services delivery, epidemiology, health care financing, trends in urbanization, and the effects of urbanization on family structures and family coping mechanisms. Data provided strong testimony to the increasing vulnerability of the urban poor, especially women and children. Discussions focused on A.I.D.'s role in urban health issues and the numerous issues that would need to be addressed in any possible future A.I.D. activities.

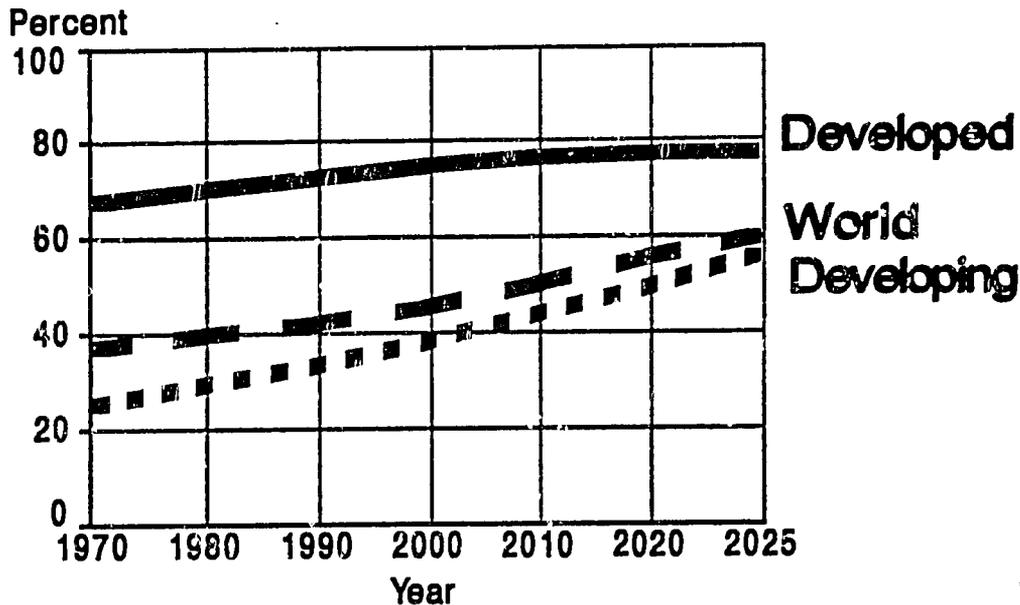
### *Setting the Context: Health in the Urban Setting*

KEN OLIVOLA, an urban planner who has worked in Asia and Africa with UNICEF and A.I.D., presented a background paper outlining urban trends and future implications for health concerns (see Annex D). While he based his talk on an urbanist point of view rather than a public health perspective, Mr. Olivola emphasized that professionals from many disciplines increasingly will need to work together to study, understand and address the myriad problems of the urban poor in the developing world. Mr. Olivola pointed out that those working in international health are still in the preliminary stages of understanding urban health issues; much more information is needed in order to have a comprehensive view of the problems and possible responses to them.

Mr. Olivola presented data demonstrating the increased urbanization of the world's population. Urban areas are growing faster than rural areas, and cities in the developing world are growing at a much more rapid pace than cities of the developed world. As depicted in figure 1, on page two, urban-rural population divisions in the developed world are expected to level off by the year 2010. However, the shift to an increasingly urban population balance will continue in developing countries. By the end of the century, Latin America will be 75 percent urban, with the majority of urban populations living in poverty. By the year 2010--less than 20 years from now--one billion people in the developed world will be urban dwellers, but 2.6 billion people will live in the cities of developing countries. More than one billion children, ages 0-14, will be living in urban areas around the world

by the year 2000. More than two-thirds will live in cities of the developing world, and of those, half will be living in poverty.

## **World Population in Urban Areas**



Source: United Nations

Continued urban growth is the result of a number of factors. Natural increase accounts for two-thirds of urban growth, while in-migration accounts for one-third. The primary reason for in-migration is economic pressure; people move to cities for searching for work. Secondary reasons include the availability of education and social services that are often lacking in rural areas. Urban annexation is also a growth factor; the peripheries of metropolitan areas, which often encompass the most marginalized populations, extend outward and absorb what were previously considered "rural areas."

Poverty statistics for Third World cities are staggering. Mr. Olivola estimated that the percentage of the population in various cities in developing countries living in slums or squatter settlements was between 33 and 90 percent in the 1980s. In these poor households, 65-75 percent of household expenditures is used to purchase food, while the second greatest expense in a number of cases is health care. Treatment of a typical case of malaria in West Africa, for example, can demand as much as one-third of a poor person's monthly income--most of which may be spent on drugs of questionable value for that treatment.

Mr. Olivola discussed the overall developing country situation over the last four decades, during which governments--seeking agricultural independence and trying to stem the tide of rural to urban migration--focused on rural development. Rural development projects did not anticipate increased dependency upon urban structures, markets and support services. In fact, some rural development projects may have indirectly contributed to urban migration. For example, newly constructed roads, intended to make markets more accessible, have in some cases facilitated the flow of rural populations to cities.

Governments have tried four primary approaches to deal with the rapidly growing urban poor populations, but with negligible results. First, believing that migration was a temporary phenomenon, governments returned slum dwellers to their "rural homes" through slum clearance schemes. When this approach failed to have any significant impact on rural-to-urban migration, local governments tried constructing new housing. However, the needs were far greater than resources available, and housing was affordable for only middle and upper income residents. A third stage in government planning brought improvements in infrastructure (water, sanitation, roads, etc.), but, again, needs far exceeded the ability of governments to provide services to all but a small number of urban dwellers. In a fourth phase, governments tried slum upgrading, taking advantage of existing housing and social structures, and making improvements through house upgrading and improving basic infrastructure.

Local governments now seem to recognize the limitations of past approaches and the current need to deal with complex, interrelated urban problems. Many governments are thus redirecting the previous focus on physical infrastructure to an emphasis on human needs. Statistics demonstrate the desperate living conditions in which slum dwellers live. In some cities, infant mortality rates in slums are twice the average of the city as a whole. For communicable diseases, the situation is even more grave. In Manila, for example, tuberculosis is nine times more prevalent in slum areas than in middle class areas, and diarrheal disease is double the city-wide average.

Health services for the poor, if included in city budgets at all, are seldom adequately funded. Local governments, though essential to the success of health services have little capacity to plan and implement successful programs, due in part to their highly centralized structure. Federal government involvement, which tends to focus primarily on the ministry of health, is not likely to be much more successful. When urban health services are in fact available, often they are cost-prohibitive, or the poor have little access to the services. A further complication in urban settings is the competitive nature of health provision from non-governmental sources, which results in a range of choices for health services.

While not advocating that urban health should necessarily become a new program area for A.I.D., Olivola suggests a review of current efforts to assess what has been done in national programs and how well these programs have reached urban residents. To ensure adequate health program coverage in cities, both the overall health situation and specific interventions that respond to the unique challenges of cities must be addressed.

## *Office of Health Experiences in Urban Health*

DENNIS LONG spoke for A.I.D.'s Communicable Diseases Division, which is concerned with environmentally based health conditions--those which are worsened by environmental degradation. The magnitude of environmental problems in urban areas of the developing world cannot be overestimated. The urban environment is especially precarious for a number of factors. More people are killed and injured in auto accidents in urban areas than by disease. More than 25,000 tons of hazardous waste are sent to developing countries every year, and in many cities, squatters live on solid waste sites. More than one billion people live without potable water, and the poor in urban slums often spend their money for food that carries disease. Another one billion people live in cities with serious (and potentially very harmful) air pollution problems.

The issues in environmental health include: occupational hazards; solid waste management; toxic hazards and radiological waste; water supply and sanitation; wastewater management; indoor and outdoor air pollution; vector-borne disease control; materials used in housing and shelter; and food-borne diseases. The challenge in environmental health is to emphasize community intervention rather than treatment of individual patients. Environmental health interventions--such as zoning laws, pollution controls, occupational safety regulations, and water treatment plants--are not "classic" health care: they require bridges to other spheres such as engineering, industry, and labor relations. Community-based interventions could help prevent accidents and disease due to environmental factors, ultimately saving money and reducing widespread suffering.

SHELLY SMITH of the Applied Research Division discussed urban health focused around three themes: 1) changing disease patterns; 2) changing family structures; and 3) changing health service profiles. Ms. Smith noted that the socio-cultural setting of the urban areas--especially peri-urban areas--influences access to and quality of health care.

Disease patterns are rapidly changing in many developing countries. The epidemiologic transition, as the change is referred to, is often thought of as a linear progression from the infectious, childhood diseases to the chronic, adult diseases. In reality, many developing countries will be experiencing both problems simultaneously. Therefore, there is a need to have a continued focus on child survival, defining interventions that can be utilized in a peri-urban setting, as well as beginning to explore the extent of "emerging or neglected health issues." Over time, illnesses such as TB, cardiovascular diseases and cancers will make up a greater share of the disease burden.

A.I.D. is exploring ways to define the nature of the emerging health problems, evaluate the burden they present to developing countries, and determine the most successful interventions. Pivotal to these activities are analyzing resource allocation issues and understanding the cost effectiveness of different interventions.

Changing social structures are also important factors in the evolving picture of urban

health. Urbanization affects "traditional family" structures in particular ways, just as family structure has affected the ways in which urbanization occurs. Yet these interactions are not always fully understood. To minimize differential access to services, organizations and governments that make and implement policies and design programs in urban settings need to recognize family dynamics as well as comprehend the resource allocation that exists within and between families and rural/urban communities. Exploring existing data sets is one way to begin an examination of these factors. However, it is critical to remember that the peri-urban poor are often neither seen nor counted in surveys. Innovative research methodologies are needed to reach these populations.

As urban demographic patterns, disease patterns, and social structures change, there is an increasing need to tap into new delivery systems. Organized professional groups, worksite health programs, and municipal health systems provide opportunities to reach a variety of urban populations. In addition, changing urban health needs and social dynamics illustrate a need for new health technologies that are uniquely appropriate for the urban environment.

LINDA VALLEROY of the AIDS division discussed the rapid increases in HIV infection and death due to AIDS in the last several years. AIDS is an urban phenomenon, primarily contracted in metropolitan areas; since many infected persons return home to rural areas to die, however, they increase rural mortality rates and swell the economic burden in those areas. AIDS predominantly afflicts the young and productive members of society; peak infection for HIV is between 30 and 40 years old. Mothers in this age range often pass the infection to their infants, which presents an additional, growing urban health problem.

Urban areas are an important battleground for containing the spread of AIDS. Information campaigns that target hard-to-reach, often illiterate communities are critical. For example, Mexico City's AIDS prevention agency has been using high visibility city services such as subway and bus systems for a mass communication campaign. Throughout the mass transit system, posters and murals are seen by the five million people who use the system every day. In a single year, 900,000 handbills, 67,000 posters and 2,500 fifteen-foot murals were placed on metro cars, walls and metro booths. AIDS information booths, where people can speak one-on-one with an AIDS counselor, have been set up throughout the subway system. Another approach with a popular appeal used a traditional Mexican card game, modified to teach people that because AIDS is not restricted to particular social groups, they need to protect themselves either through exclusively monogamous relationships or the use of condoms.

In Rio de Janeiro, Brazil, where there are large numbers of street children, AIDS prevention messages have focused on the two to three thousand sexually active, homeless children who are living lives of violence, sexual aggression and prostitution. Information on HIV infection and death neither reaches nor holds much meaning for this marginalized population, for whom prevention is a totally alien concept. Successful intervention with

these children has been in the form of nighttime focus groups, which discuss AIDS as a form of violence. Counselors cast AIDS avoidance in terms of personal strength and weakness, concepts with which street children, in their daily struggle to survive, are intimately familiar. T-shirts with AIDS messages reward the children for attending the focus groups.

A lesson from the Mexico City and Rio de Janeiro programs is: Though cities have large numbers of people at risk, they also have large institutions that can be used effectively to spread health messages. Particularly in Mexico City, multi-sectoral political cooperation was vital to gain access to city institutions where health messages could reach large numbers of people.

ROBERT CLAY of the Health Services Division noted that, though A.I.D.'s programs historically have had a rural focus, at the same time they have often addressed nationwide concerns. Two on-going programs have studied urban EPI (Expanded Program on Immunization) services: the REACH project in Bangladesh and the HEALTHCOM project in Metro Manila.

REACH has been operating in 20 to 30 communities in Bangladesh. Project activities include: taking an inventory of where people go for immunizations; investigating health coordinating teams; analyzing demand activities; and exploring periphery organizations such as garment factories, which participate in vaccination campaigns.

HEALTHCOM carried out an immunization campaign in Metro Manila, a large metropolitan area consisting of 13 cities and municipalities. HEALTHCOM cooperated with existing health services; the objectives were to increase outreach and user rates over time, upgrade health worker skills, and broadcast health messages.

Lessons learned from these two urban health programs are:

- In the urban environment, illnesses spread faster than they do in the rural setting. Due to overcrowding, disease spreads rapidly among urban dwellers and is then transmitted from urban to rural areas.

- Data, either unavailable or aggregate, often are not useful from an epidemiological perspective. More data need to be collected about health services-accepting behaviors, migration patterns, birth rates, and pockets of poverty.

- Physical access to services is often not the most important issue. The greater challenge is quality of service--including expanding hours and training health workers to be sensitive to needs and attitudes of the poor.

- NGOs, schools and private industry have the potential to play vital roles, especially in broadcasting health messages.

- Behavioral changes can be rapid in urban areas. Urban dwellers appear willing to accept new ideas, and the urban areas have the advantage of access to communication channels, such as television, which influence the population quickly.
- Innovative political leaders who use their offices and skills to provide feedback and incentives are integral to the process of health behavior change.
- Future activities in urban health include initiatives in breastfeeding and financing.

WILLIAM JANSEN of A/PRE noted that though some of the largest urban areas are in the A/PRE region, A.I.D.'s experience has been largely rural and is not well suited to urban issues. Additionally, the bulk of A.I.D.'s experience has been in public sector primary care facilities, while responses to urban health problems are likely to require private sector secondary and tertiary care approaches. This has not been a level of care on which A.I.D. has historically focused.

In the A/PRE region, A.I.D. has traditionally worked to improve services in the public sector health delivery system. However, in the urban setting, a vibrant network of competing private health care systems already exists, with a wide range of health care available. The private sector can be key to providing a range of services. Private health care delivery systems, which may provide donors the means to work in private sector hospitals and with private practitioners, offer opportunities for sustainability. However, unanswered questions remain in the areas of cost recovery and opportunities to target assistance most appropriate to private sector. An additional complication is that urban governments often plan health care for the entire urban area, rather than targeting slums and the poor. Jansen asserted that A.I.D. needs to examine further the issues in urban health. What specific issues should be included? What are the targets, limitations and most important interventions? Why do people seek care, from what source, and how do they make health-seeking decisions?

Finally, CHARLOTTE CROMER of S&T/POP discussed her experiences working with a complex family planning project in Egypt. This large-scale effort managed clinics in 18 urban areas, each of which had a distinct set of problems. On several occasions, administrators made decisions that ignored available data; in each instance, they found this to be a mistake. Clinic location seemed the single most important factor in determining access to services for poor and lower middle class women.

### *Video: View from a Brazilian Slum*

A World Bank-produced video, "The Neighborhood of Coehlos," depicted the wretched living conditions of the "rabbit hutch" urban slum in Brazil. A program of community action, which includes job skills training, education and land tenure rights, seeks to address urban problems there. The entire community--including children, the disabled, and the aged--is actively working together to improve living conditions. The video showed

that initiative and empowerment on the part of the urban poor themselves are critical to improving conditions.

### ***Health Service Delivery for the High Risk Urban Poor***

DR. DIANA SILIMPERI, a pediatrician and epidemiologist who over the past 10 years has worked in public health throughout South and Southeast Asia, examined urban areas from a public health perspective (Annex E). She provided further testimony that the impact of urbanization on public health matters is reaching a crisis stage. According to Dr. Silimperi, a "fourth world"--the urban poor--exists in both developing and developed countries. (And in most countries, poverty disproportionately affects women and young children.) Dr. Silimperi corroborated Ken Olivola's assertion that the poor are subject not only to infectious diseases, but also to conditions usually associated with industrialization, such as cancer, hypertension, substance abuse, sexually transmitted diseases, accidents and violence.

For the urban poor, even routine activities such as preparing healthy meals become very difficult. Not only is adequate nutrition a problem, but unclean food and poor personal hygiene contribute to unhealthy conditions and poor health. Prevention of illness through personal hygiene, relatively simple in a clean environment, is virtually impossible in the urban slum. Contrary to popular assumptions, clean water is not readily available, and facilities for household sanitation, neighborhood drainage, garbage and solid waste disposal are all sadly lacking.

Dr. Silimperi's slides dramatically depicted the urban poor's struggle for survival, barriers to application of knowledge, and lost human potential. A lack of good, disaggregate data, reflecting the health conditions of the urban poor subpopulation, complicates the comprehension and improvement of urban health and inhibits delivery of effective health services. Effective decision-making and implementation on local, national and donor levels is difficult at best; without reliable information about the health-seeking behaviors, perceptions and practices, subset health status differences, and urban migratory patterns of the poor, the task becomes nearly impossible.

Dr. Silimperi outlined seven reasons to focus on delivery of health services to the urban poor:

1. Magnitude--demographic trends point to the fact that by the year 2000, the majority of the world's inhabitants will be urban dwellers. Most of them will be poor. This rapid growth affects not only the capital cities and large metropolitan areas, but also secondary and tertiary cities. The rapid rate of increase strains existing services and creates demand for health services much faster than resources become available.

2. Humanitarian concerns--the appalling conditions in which urban poor live cannot be ignored or tolerated from a humanitarian perspective. Children growing up in

conditions of dire poverty have little chance of contributing in any meaningful way to society. If they grow to adulthood, they may become subversive or sociopathic citizens, involved in crime, family abuse, substance addiction or suffer from persistent unemployment.

3. Reservoirs of disease--the urban poor constitute a major reservoir of disease, particularly for childhood diseases targeted in child survival programs.

4. Conduits for Disease Transmission--given high rates of rural-urban migration, social exchange, and intra-urban movements of the urban poor, these individuals serve as ready conduits for disease transmission among urban and rural poor and to middle and upper classes as well.

5. High Risk Status--Although disaggregate data are difficult to obtain, it appears that childhood communicable diseases and malnutrition are at least as prevalent among the urban poor as among rural populations.

6. Low Utilization of Existent Facilities--even when facilities are present, there are still many obstacles to utilization, even for curative services. Such obstacles include: socio-economic constraints; socio-cultural traditions that prohibit or decrease mobility, especially among women; safety factors; language and educational barriers; distance and transportation costs; ignorance of facility location; limited hours of operation; and staff attitudes toward the poor. Because of poor coordination and planning among agencies, there are gaps in outreach and services to the urban poor.

7. Limited Access to Health Care Knowledge--many of the neediest and highest risk groups are illiterate women and children who do not have access to even the basic health knowledge usually imparted in school.

The challenge of the 1990s is the delivery of services to those masses. Technological information is available, but it is not effectively transmitted, utilized or delivered to the urban poor. As mentioned earlier, lack of accurate health information, including disease statistics, health-seeking behaviors and utilization of health services, are among the barriers to creation of effective health services for the urban poor. In part due to the low utilization of existing health facilities where this information is normally collected, little basic information exists on urban poor populations, their health knowledge, or health indicators (including nutrition).

Urban poor populations may not recognize the need for periodic, preventive health services; the idea of preventive health care is foreign to most of them. In addition, they may fear medical attention. Both factors contribute to the under-utilization of health facilities that are needed and available.

Complications that occur when multiple, parallel agencies are involved without

integrated planning or coordinated systems create challenges for urban EPI. In some cities, urban EPI services are provided by municipal health agencies, the national government and dozens of non-governmental organizations. Heterogeneity of the population complicates health education messages and requires careful monitoring for effectiveness. Consistency of health education messages and quality assurance of EPI procedures are very difficult to achieve when each organization has its own system of record keeping, information collection and monitoring. It is difficult to obtain consistent comparable data or to assess the quality and impact of a given program. Inconsistent services and health education messages may result in confusion about health needs, services and options.

Despite what may seem an overwhelming list of urban health problems, there are many advantages to working with the urban poor on health concerns. Large populations live within relatively short distances of each other. Urban poor women, an important untapped resource, often can serve as effective purveyors of health messages to other urban women and their families. Because of migration and travel patterns, the poor also carry health education messages to rural areas. Uneducated poor urban women can demonstrate an openness to new ideas and flexibility that is quite different from their rural counterparts; they can thus serve as potent community motivators. The Urban Volunteer Program in Daka, for example, found that women from the slums were a critical link between women and children from these neighborhoods and existing health services and facilities. It is clear that while health services exist in cities, linking those services to poor people has proved difficult to accomplish.

Dr. Silimperi argued that it is essential that there be a concerted effort to respond to the plight of the urban poor, to understand their unique needs, and to develop and finance alternative health care delivery systems. Methods that collect and compare data on the health status of the urban poor worldwide need to be devised and employed. In addition, coordination among health providers and the various levels of government involved will be vital.

### ***Establishing a Framework for Future Activities***

Participants identified nine main areas of special concern. Workshop participants agreed that the health conditions in the urban setting deserve recognition, and the cost to society for ignoring urban problems may be very high. However, it is still uncertain how best to address the varied and immense problems of the urban poor.

Areas of greatest concern to the workshop participants were:

1. **DEFINITION** - Virtually every country has its own system for classifying its population into urban and rural components. For example, many African nations define as urban those localities with a population of 2,000 or more. Nigeria defines as urban those towns with 20,000 or more inhabitants whose occupations are not agrarian. In Latin America, Peru defines cities as those areas with 100 or more occupied dwellings. India defines an

urban area according to the existence of specific municipal administrative bodies. In Japan, urban areas are defined as those with at least 50,000 inhabitants. Inconsistent definitions of "urban" render it impossible to compare data from different countries; the term "urban" may refer to a small rural settlement or an enormous metropolis.

**2. NEED FOR DISAGGREGATE DATA** - Lack of appropriate and accurate data was a recurring theme throughout the workshop. Most data to date are not useful for epidemiological or public health use. However, the basic information that is available, including comparison of urban-rural mortality rates, clearly indicates that urban poor are as disadvantaged--if not more so--than their rural counterparts, despite being closer to concentrations of health professionals and facilities. Participants agreed that new methods need to be developed to collect disaggregate data on the health situation of the urban poor.

Currently available data provide an incomplete picture of the health and nutrition circumstances of the urban poor. Public health officials, donors and local governments need to be able to assess the magnitude of the problems and the costs of ignoring them. They then need to present the data to decision-makers, so that policies and necessary responses can be appropriately formulated.

**3. RURAL VS URBAN**- Participants raised concerns that a new focus on the urban poor might displace some rural development activities. Participants felt that it is important to have a balance between rural and urban activities, so that resources would not be diverted from the long-time rural focus of A.I.D. assistance. One group of participants cautioned that rural and urban populations and problems are not unrelated, but are rather part of a continuum--what affects one affects the other.

In addition, participants raised concerns about "reinventing the wheel." How can lessons learned in the rural areas be applied to the urban setting? Certain problems are clearly specific to the urban setting; however, other lessons learned in rural areas can and should be applied to the urban environment.

Participants also questioned how much change is necessary to respond to urban needs. In fact, A.I.D. has already been active in this arena; its knowledge and experience in urban areas, especially in MCH and family planning, need to be acknowledged.

**4. HEALTH CARE FINANCING** - While donor organizations cannot ignore one quarter of the world's population, a primary question is: Who will pay for urban health services? Given that economic vulnerability of the urban poor is probably even greater than in rural areas, to what extent do urban health strategies need to have an explicit economic component, such as income generation?

Participants asserted that though many urban poor now use household funds for health expenses, many of those purchases may be ineffective medicines or services. Clearly, some urban poor already pay for water and sewerage and are willing to pay for upgrading

infrastructure, but what can be expected in the case of tremendously expensive activities?

Finally, urban health problems present an opportunity to work with the private sector. Is it possible to encourage private sector health providers to invest in their local area and provide better services to the urban poor?

5. WHAT IS A.I.D.'S NICHE? - Do gaps in service provision exist? If A.I.D. decides to become more active in urban health, how will targets be chosen? Should the emphasis be on prevention or service delivery? Several participants felt that it was important that no matter what A.I.D. does, the focus should be on prevention, rather than on an "endless" provision of services.

One possibility is to target health problems that are not being addressed by the host government or other donors. To some extent, existing targets for populations served (immunizations, ORT, etc.) will direct A.I.D. into urban areas in order to meet numerical targets.

A.I.D. has experience with projects in urban areas, through family planning and private sector initiatives. Particularly in Latin America, where massive urbanization has occurred to a greater degree than in other regions, A.I.D. has long been active. Perhaps we need to document and share information on urban initiatives between AID/W and the missions so that we can be better informed about lessons learned around the world.

Opportunities may exist in the Administrator's new initiatives. In particular, the Family and Development, Private Sector and Business, Democratization, and Environment initiatives all relate to urban health. A.I.D. may want to identify areas in which it already operates and to demonstrate to decision-makers how present activities could be expanded in those key areas.

Changes in society are being played out first within urban populations, and urbanizing families are those who are under the greatest stress. However, change and stress can prompt positive mechanisms, such as women assuming the roles of change agents and volunteers.

Incontrovertibly, urban health is fundamentally related to environmental issues. This interdependence is another opportunity for A.I.D. to combine initiatives and effectively respond and intervene.

Decisions about efficiency and allocations are necessary. How can people be motivated to be more efficient with their resources? If the poor spend resources on inappropriate medicines, how can we help them make better choices--to receive immunizations, for instance?

**6. MULTISECTORAL, INTEGRATED NEEDS** - Participants viewed the urban health situation as tremendously complex, requiring a response that would allow private and public sectors to work together with donors. Diverse issues of income generation, infrastructure, economics, training and education, empowerment, health knowledge, pollution, environmental dangers, family planning, and urban planning activities all have impacts on health matters.

**7. EMPOWERMENT** - How can change agents and local leaders be used positively? How can community groups be empowered? One group referred to the lunch time video tape as evidence of positive change initiated by a community. However, not all social change is positive. Certain change agents, such as organized crime and youth gangs, induce negative effects. Obviously, the need to minimize the negative effects is important.

Another group in the workshop stressed the need to train women and other potential change agents to work as volunteers in the dissemination of health education and communication. Such a strategy has had positive impact in several locations.

**8. POLITICAL SUPPORT** - Political support within the host country and A.I.D. missions is essential to begin a focus on urban health. Complex issues abound, including questions of authority and sensitizing decision-makers to desperate urban circumstances.

A need for greater understanding and sharing of responsibilities among the many levels of government involved in health policy and delivery of health services is also required. How will A.I.D. Missions forge new relationships with ministries and municipal governments with whom they traditionally have not been partners?

One participant suggested that health may serve as an entree to begin discussions of democratization with local governments. The impact of governments seen providing health services and people willing to contribute to infrastructure improvement projects, knowing that they will benefit individually, could be significant and far-reaching.

**9. ACKNOWLEDGEMENT** - Finally, recognition of A.I.D.'s current agenda, projects and strategy is important. By documenting and discussing activities, presentation of a program that is appropriate given A.I.D.'s existing policies and priorities may be possible. Improved data collection, tabulation and documentation, as well as two-way communication with missions are essential.

## ANNEXES

A. Agenda

B. Participant List

C. Notebook Materials List

D. Paper by Ken Olivola

E. Speaker's Notes  
by Diana Silimperi

## **Annex A**

### **Agenda**

*Agency for International Development  
Bureau of Science and Technology  
Office of Health*

**AGENDA**

***HEALTH ISSUES IN THE URBAN SETTING  
The Hyatt Arlington, Rosslyn, Virginia  
Monday, March 25, 1991***

- |               |  |
|---------------|--|
| 9:30          | Coffee and Danish  |
| 10:00 - 10:15 | Welcome, Introductions<br>S&T/H, Ann Van Dusen   |
| 10:15 - 11:00 | Setting the Context: Health in the Urban Setting<br>Ken Olivola  |
| 11:00 - 12:30 | Experiences in Urban Health<br>S&T/H/CD, Dennis Long<br>S&T/H/AR, Shelley Smith<br>S&T/H/AIDS, Linda Valleroy<br>S&T/H/HSD, Robert Clay<br>A/PRE, William Jansen<br>A/PRE, Charles Lerman<br>S&T/POP, Charlotte Cromer |
| 12:30 - 1:30  | Lunch and Showing of<br>"The Neighborhood of Coehlos"<br>(video)   |
| 1:30 - 2:30   | Health Service Delivery for the<br>High Risk Urban Poor<br>Diana Silemperi   |
| 2:30 - 3:15   | Establishing the Framework for Future Activities   |
| 3:15 - 3:30   | Break  |
| 3:30 - 4:00   | Discussion and Conclusion<br>S&T/H, Nancy Pielemeier   |

## **Annex B**

### **Attendance List**

*Agency for International Development  
Bureau of Science & Technology  
Office of Health*

**WORKSHOP ON HEALTH IN THE URBAN SETTING**  
*March 25, 1991*

**ATTENDANCE LIST**

Massee Bateman  
WASH II  
1611 N. Kent St., Suite 1001  
Arlington, VA 22209  
tel. # 703/243-8200

Sharon Benoliel  
AID/APRE/DR/TR/HPN  
SA-2, Rm. 50  
tel. # 202/663-2296

Robert Bernstein  
AID/S&T/H/AIDS  
SA-18, Rm. 606  
tel. # 703/875-4548

Stewart Blumenfeld  
ARCSS  
7200 Wisconsin Ave, Suite 600  
Bethesda, MD 20814  
tel. # 301/654-8338

Craig Carlson  
Pragma Corporation/ASSIST  
1601 N. Kent St., Suite 902  
Rosslyn, VA  
tel. # 703/237-9303

Robert Clay  
AID/S&T/HSD  
SA-18, Rm. 714C  
tel. # 703/875-4519

Ellen Coates  
AID/FVA/PVC/HN  
SA-2, Rm. 103C  
tel. # 202/663-2641

Karen Code  
AID/S&T/H/AIDS  
SA-18, Rm. 606C  
tel. # 703/875-4494

Charlotte Cromer  
AID/S&T/POP/FPSD  
SA-18, Rm. 809  
tel. # 703/875-4484

Bob Emrey  
AID/S&T/HSD  
SA-18, Rm. 714E  
tel. # 703/875-4468

Lloyd Feinberg  
AID/S&T/HSD  
SA-18, Rm. 714F  
tel. # 703/875-4479

Charles Fields  
AID/FVA/PVC/HN  
SA-2, Rm. 103C  
tel. # 202/663-2632

Holly Ann Fluty  
AID/S&T/HSD  
SA-18, Rm. 714B  
tel. # 703/875-5508

Ruth Frischer  
AID/S&T/RUR  
SA-18, Rm. 309E  
tel. # 703/875-4089

Jerry Gibson  
AID/S&T/HSD  
SA-18, Rm. 714J  
tel. # 703/875-4730

Martia Glass  
AID/APR/DR/TR/HPN  
SA-2, Rm. 50  
tel. # 202/663-2296

Charles Habis  
AID/FVA/PVC/HN  
SA-2, Rm. 103C  
tel. # 202/663-2632

Diane Hedgecock  
REACH II  
JSI, 1100 Wilson Blvd., 9th Fl.  
Arlington, VA 22209  
(until 3/29/91)  
1616 N. Ft Myer Dr, 11th Fl.  
Arlington, VA 22209  
(new address)  
tel. # 703/528-7474

Carol Hooks  
PATH/Support/HealthTech  
c/o 4 Nickerson St.  
Seattle, WA 98109-1699  
tel. # 202/685-3500

Bill Jansen  
AID/APRE/DR/TR/HPN  
SA-2, Rm. 50  
tel. # 202/663-2296

Julie Johnson  
AID/S&T/H/CD  
SA-18, Rm. 702  
tel. # 703/875-5841

Richard Killian  
Pragma Corporation/ASSIST  
116 E. Broad St.  
Falls Church, VA 22046  
tel. # 703/237-9303

Rita Klees  
AID/S&T/H/CD  
SA-18, Rm. 702  
tel. # 703/875-4993

Steve Landry  
AID/S&T/H/CD  
SA-18, Rm. 705  
tel. # 703/875-4631

Bradshaw Langmaid  
AID/DAA/S&T  
NS Rm. 4942  
tel. # 202/647-4322

Robert Lennox  
VBC  
1901 N. Fort Myer Dr,  
Arlington, VA 22209  
tel. # 703/527-6500

Charles Lerman  
AID/A/PRE  
c/o Bill Jansen  
SA-2, Rm. 50  
tel. # 202/663-2296

Stacey Lissit  
AID/S&T/H  
SA-18, Rm. 613  
tel. # 703/875-4644

Dennis Long  
AID/S&T/H/CD  
SA-18, Rm. 702B  
tel. # 703/875-4743

Marty Makinen  
HFS  
Abt Associates  
4800 Montgomery Lane,  
Suite 600  
Bethesda, MD 20814  
tel. # 301/913-0500

Susan Marowitz  
AID/FVA/PVC/HN  
SA-2, Rm. 103C  
tel. # 202/663-2632

Gene McJunkin  
AID/S&T/H/AR  
SA-18, Rm. 720A  
tel. # 703/875-4540

Bill Miner  
AID/BIFAD/S/CP  
SA-2, Rm. 600  
tel. # 202/663-2584

Tom Morris  
AID/PPC/PDPR/SP  
NS, Rm. 3885  
tel. # 202/647-8953

Mike Mueller  
AID/S&T/H/AR  
SA-18, Rm. 720  
tel. # 703/875-6439

Kenneth Olivola  
2651 Weigelia Road  
Atlanta, GA 30345  
tel. # 404/636-0674

Tom Park  
AID/LAC/DR/HPN  
NS, Rm. 2247  
tel. # 202/647-9484

Eric Peterson  
AID/S&T/H/CD  
SA-18, Rm. 722B  
tel. # 703/875-4654

Nancy Pielemeier  
AID/S&T/H  
SA-18, Rm. 709C  
tel. # 703/875-4708

Mark Rasmusson  
HealthCom II  
1255 23rd St, NW, Suite 400  
Washington, DC 20037  
tel. # 202/862-1900

Petra Reyes  
AID/S&T/H/AR  
SA-18, Rm. 720D  
tel. # 703/875-4662

Diana Silimperi  
MSH-SHS  
165 Allendale Road  
Boston, MA 02130  
tel. # 617/524-7799

Shelley Smith  
AID/S&T/H/AR  
SA-18, Rm. 720  
tel. # 703/875-4474

Elizabeth Sommerfelt  
DHS  
Inst. for Resource Devt.  
8850 Stanford Blvd.  
Columbia, MD 21045  
tel. # 301/290-2800

Peter Spain  
PRITECH II  
1925 N. Lynn St., Suite 400  
Arlington, VA 22209  
tel. # 703/516-2555

Robert Steinglass  
REACH II  
JSI, 1100 Wilson Blvd., 9th Fl.  
Arlington, VA 22209  
(until 3/29/91)  
1616 N. Ft Myer Dr, 11th Fl.  
Arlington, VA 22209  
(new address)  
tel. # 703/528-7474

Pat Taylor  
MotherCare  
JSI, 1100 Wilson Blvd., 9th Fl.  
Arlington, VA 22209  
(until 3/29/91)  
1616 N. Ft Myer Dr, 11th Fl.  
Arlington, VA 22209 (new address)  
tel. # 703/528-7474

Julia Terry  
AID/ENE/TR/HPN  
NS, Rm. 4720  
tel. # 202/647-8694

John Tomaro  
AID/S&T/HSD  
SA-18, Rm. 714G  
tel. # 703/875-4663

Ioanna Trilivas  
AID/S&T/H/AIDS  
SA-18, Rm. 606H  
tel. # 703/875-4545

Martin Vaessen  
DHS  
Inst. for Resource Devt.  
8850 Stanford Blvd.  
Columbia, MD 21045  
tel. # 301/290-2800

Linda Valleroy  
AID/S&T/H/AIDS  
SA-18, Rm. 606J  
tel. # 703/875-4450

Ann Van Dusen  
AID/S&T/H  
SA-18, Rm. 709E  
tel. # 703/875-4600

Elizabeth Wadolowski  
AID/S&T/HSD  
SA-18, Rm. 709C  
tel. # 703/875-6436

Krystn Wagner  
AID/S&T/H/AIDS  
SA-18, Rm. 606K  
tel. # 703/875-6438

## **Annex C**

### **Materials List**

## URBAN HEALTH CONFERENCE

### MATERIALS LIST

1. Insert: Cities: Life in the World's 100 Largest Metropolitan Areas - Population Crisis Committee
2. Agenda
3. Attendance List
4. Background Paper for Urban Health Discussion - Kenneth Olivola
5. Policy Studies Review - Third World Urbanization and American Foreign Aid Policy: Development Assistance in the 1990's - Rondinelli and Johnson
6. Ten Best Reading in ... Urban Health Planning - Carolyn Stephens
7. Urban Health Literature Search - Medline/Popline
8. Planning in Squatter Settlements: An Interview with a Community Leader - Lauria and Whittington
9. Flyer: The Role of Urbanization in National Development: Bridging the Urban Rural Divide

**Annex D**

**Background Paper  
by**

**Ken Olivola**

## **Background Paper for Urban Health Discussion** (an urban point of view)

Kenneth Olivola

### **A. Trends in Urbanization**

In developing countries the growth rate of the urban population will remain high into the next century. Between 1980 and the year 2000, 85 percent of the world's total urban growth will take place in Third World countries, and looking toward the year 2025 this will increase to 90 percent. In fact, one of the significant phenomena of this century is the urbanization of the world. In 1920 only 14 percent of the world's population lived in cities. By 1950 this had grown to 25 percent, and projections indicate that by the year 2000 approximately half the world's population will live in urban areas. Into the next century, more than three-fourths of the total population in the developed countries will be city dwellers, and in developing countries this figure will approach 60 percent.

Annual urban growth rates will be around 3.5 percent, with the poorest countries having the highest rates. Within individual cities rates vary greatly with higher income neighborhoods typically in the 2 percent range, but lower income slums and squatter settlements exceeding 10 percent annual growth in some cities. High growth rates are primarily attributable to natural causes (about two-thirds) rather than the commonly held belief that in-migration (one-third) is the cause. One of the unique characteristics of the urbanization process in the larger cities is how they are increasingly becoming home to such a heterogenous population; wealthy and poor, consisting of a variety of ethnic and religious groups who make their living in the wide range of economic opportunities which only cities can provide. A significant indicator of countries advancing through the development process is the growing middle class which is principally found in the major cities. Of greater magnitude, though, is the growth of the poor segment of the urban population - by far the fastest growing segment of the urban population.

Changes in growth in the largest urban centers are the most profound. In 1960 there were 52 cities in the developing world with populations over one million. By 1980 this grew to 119 cities, and in the year 2010 this will include an estimated 500 cities. By the year 2025 about half of the urban population in the Third World - 2.2 billion people - is projected to be living in cities with more than one million people. In the same year it is estimated that 1.2 billion people (over 28 percent of the urban population in developing countries) could be living in '4 million plus' cities.

Through the end of the 1990s, cities of the developing world will add approximately 51 million residents per year, or 140,000 people a day. This compares with 30,000 per day in the developed countries during the same period. Between 1980 and 2000, the number of persons in the 0-14 age-group in the developing countries is expected to increase from 1.3 billion to 1.6 billion, or by nearly 25 percent. Some 80 percent of this growth is

25

projected to take place in urban areas, where the population of this age-group is expected to increase by nearly 15 million per year (half in poor families), compared with only 1 million per year in rural areas.

## **B. Government Responses to Urban Growth**

Since the 1950s, as many developing countries gained their independence, governments' development policies tilted toward a rural emphasis. This was, in part, a response to needs for agricultural independence, and was thought to have the secondary benefit of reducing migration from rural areas to cities. In fact, many countries found that rural development projects had a reverse impact, and actually contributed to accelerating rural to urban migration. Rural development policies, which leaned heavily on agricultural development, included road-building projects, agricultural extension training, agri-business development, and product commercialization, to name only some of the objectives. Unanticipated results of this policy have led to dependencies upon the urban structure to provide necessary markets for goods, both sold and purchased, and supportive services. Newly constructed roads provided the conduit; not only for the flow of agricultural goods to city markets, but also people.

While individual government responses varied, typically countries reacted to the increasing pressure on urban growth by going through a number of levels of awareness about how to handle the situation. The problem was primarily viewed in physical terms: how to house and provide physical infrastructure to a growing poor urban population. Approaches to deal with this included:

- (1) attempts at returning newly settled urban dwellers to their rural "homes";
- (2) government housing schemes to accommodate newcomers;
- (3) externally financed "sites and services" projects, and;
- (4) slum upgrading schemes.

With few exceptions, these approaches did not begin to meet the needs of a rapidly growing urban population.

In the 1990s we find that there is increasing awareness that in spite of disappointing past experiences, the need to address urban problems is reaching a critical point. Many countries do not have urban development policies, and those which do have policies view the issue in physical terms - how to increase the supply of housing and expensive infrastructure such as piped water supply and sanitation systems.

The urban poor, represented by half of today's population living in cities, are more often than not ignored when policies do exist. Basic services such as health and education are

simply not a priority for those who make and implement urban specific policies. This responsibility is left to national social service policy-makers.

### **C. Health Service Provision in Cities**

Lack of addressing urban social service needs can, in part, be attributed to the nature of how city administrations operate, and how they are viewed by national level governments. Historically, throughout the world, city administrations have been organized for the purpose of providing and maintaining urban physical infrastructure services: roads, markets, ports, water supply, etc. A complimentary role of equal importance includes collecting revenue from urban residents to fund these urban services. Provision of social services, such as health and education may be mandated in city charters, but generally will take second place (usually lower) in the list of city priorities. More often than not, municipal budgets are insufficient to cover the costs of staff salaries and physical services. Social services rarely are financed at adequate levels; if at all.

Most importantly, while suggesting that cities' involvement in health care provision is critical to the long-term success of any program, it must be acknowledged that in most countries local government capacity to plan and implement any programs is extremely weak. Working with municipal government, while essential, cannot be viewed as a "silver bullet" to successful program implementation in urban settings.

The problem is compounded by national level policies for providing social services. For a variety of reasons, national programs often are not applied to the largest urban centers (although small and medium size cities should not be left out of this group). In some cases it may simply be a political choice; in others, reasons may be more direct. The national ministry of health in some countries actually is forbidden legally from operating in municipal areas. In these cases the city government is responsible for providing health services; even though their health departments may be fragile, inadequately staffed and financed - and with no clear mandate.

Equivalent problems on the demand side of urban health care services also exist. Although a vast majority of national health investments have been made in urban centers for expensive curative services, there are significant access problems for vast numbers of the urban population. Costs may be prohibitive for the urban poor, who also must contend with lengthy and costly travel to hospitals or health centers. Should they depend upon the hospital system for their health needs, they typically find that primary health care services such as vaccinations or control of diarrheal diseases are not provided.

Poor families in cities have a particular burden in pursuing both the need to work and also tend to the family. Support of the extended family to care for children is weaker in the city, as the pressure to work - especially for women - is considerably greater in cities where cash is necessary for existence.

## D. Some Special Concerns for Ensuring Adequate Health Program Coverage in Cities

### D.1 Urban Health Indicators:

Urban health indicators, where they exist, are often misleading. In countries where rural and urban statistics are available cities often appear to be healthier. However, were it possible to disaggregate the urban figures, the poorer neighborhoods of the city would have figures similar to, or even worse than, rural zones. The infant mortality rate in urban slums is often double the rate for the entire city (worth noting that inner cities in the United States are beginning to mirror this situation). Unfortunately, these figures are rarely available, and they only exist when special programs have been undertaken in a particular low-income urban neighborhood (neither do they exist for the city as a whole in most countries). The weak state of the urban health information system is one of the major obstacles to coming to grips with health issues in cities. Included in the lack of urban health information are such things as consistent definitions for "urban areas" and the "urban poor", accurate census data, disease incidence at neighborhood levels, maps of adequate detail to locate neighborhoods and individual families, etc. Data are needed:

- 1) to define the situation;
- 2) to advocate for the need to address specific urban challenges, and;
- 3) to then proceed to design specific program interventions.

### D.2 Concentrated Populations:

One of the important urban characteristics - concentrated populations - provides both a challenge and an opportunity to health care providers. The obvious disadvantage is that densely populated cities are ripe for disease transmission. The urban poor in particular are reservoirs of disease, and because of their mobility (within the city, and to rural areas) are major vectors for disease transmission. More positively, reaching this same population through communication programs to inform families about preventable health practices would appear to be logistically relatively easy, and cost-effective. However, while this hypothesis is often attributed to the benefits side of urban health, in practice there is too little evidence to provide adequate proof. Urban PHC projects, dependant upon person-to-person contacts, tend to be more labor intensive than national equivalents, and thus can be expensive to administer. Further complications for comparing program efficiencies arise in cities as public

health activities must compete with private sector providers. More experience in urban health projects is necessary to show convincing evidence of the benefits of working in congested settings.

#### D.3 Local Government Involvement:

One of the major obstacles to delivering urban health services is resolving the sharing of responsibilities between the ministry of health and the municipal government. As public health specialists, who have historically worked through ministries of health, there is an essential need to become comfortable with and to understand municipal government's roles in health care provision. This includes re-orienting national health policies to respond to urban specific health needs, and to make room for municipalities as critical participants in this process.

#### D.4 Exploiting Existing Urban Facilities:

One of the obvious opportunities for meeting the needs of health care for the urban poor is the substantial investment in buildings which could be used as PHC centers. Public community structures such as schools, community centers, and municipal administrative, which are not in full-time use, could double as off-hour health centers. Large private sector corporations also provide possibilities for reaching segments of the population at the work place.

#### D.5 Private Sector Health Providers:

One of the unique characteristics of health care in cities is the important role played by private sector health providers (doctors, nurses, midwives, etc.). However, they are often not included in national training and reorientation programs, nor are they encouraged to provide preventive services, or report services provided to public health officials. Any sustainable urban health efforts cannot afford to leave out this important group.

#### D.6 Non-Governmental and Private Voluntary Organizations:

The majority of national NGOs and PVOs are urban-based. They provide excellent opportunities for reaching urban neighborhoods - especially the urban poor. Oftentimes they have established programs at neighborhood level, and thus have gained the trust of communities. Members may come from the target communities allowing for insights into local perceptions which would not otherwise be easily available. They know how to organize community leaders and how to maneuver through the municipal government structure. Most importantly, the NGOs/PVOs can be a source of personnel necessary to staff community-based health programs. The

possibility of involving local organizations is especially critical as municipal governments are oftentimes under-staffed and under-budgeted.

#### D.7 Support from Urban Employers:

The urban economy is highly dependant upon private enterprise which employees much of the urban population. In some countries the larger employers do provide health services to their employees and families. As with private health providers, there is an opportunity to exploit the benefits as already appreciated by some employers to maintain a healthy work force.

#### D.8 Environmental Improvements:

In returning to what cities now do best (no matter how weak), tighter links should be maintained between costly urban physical infrastructure (water, sanitation, drainage, garbage collection, etc.) and health benefits. Tying health benefit objectives to city services could help governments, national and local, to rationalize these costly investments, and appreciate the links between health, social well-being, and the environment.

#### D.9 Alternative Delivery Systems:

Urban settings provide numerous alternatives to traditional national approaches to health care delivery. These include: community participation, outreach to poor neighborhoods, religious organizations, alternative health providers such as volunteers, traditional health providers, private sector providers, and non-medical personnel. Innovative uses of urban resources, such as facilities, transport, communications, etc. should be considered when planning health programs.

### E. Summary

It is important to point out that this brief paper is not advocating that "urban health" become a new program area for public health pundits. Plates are already full with the large range of program areas. Rather, the intention is to begin to stimulate discussion on the fact that our clients are increasingly an urban group, and consequently their needs must be reflected in future health programs. While existing health programs have largely missed this group, due to many of the reasons stated above, the impending future demands that we re-examine how we consider health programs in the Third World (although this certainly applies to American inner-cities, as well) if we expect coverage to respond to a changing population.

With the little experience in health programs which exist in some cities, it does not appear that program interventions must change, but instead the challenge is to ensure that

we reach a rapidly growing, and heterogenous urban population. We ought to begin by examining past national and rural based health projects to learn what could be applied in cities.

To summarize, we are not talking about a new program. We are advocating that it is necessary to review current efforts to understand how well they do, or do not, reach urban residents.

# World Urban Population (in millions)

Year

1970	1980	1990	2000	2010
------	------	------	------	------

+73

DEVELOPED COUNTRIES
------------------------

698	798	877	950	1,011
-----	-----	-----	-----	-------

DEVELOPING COUNTRIES
-------------------------

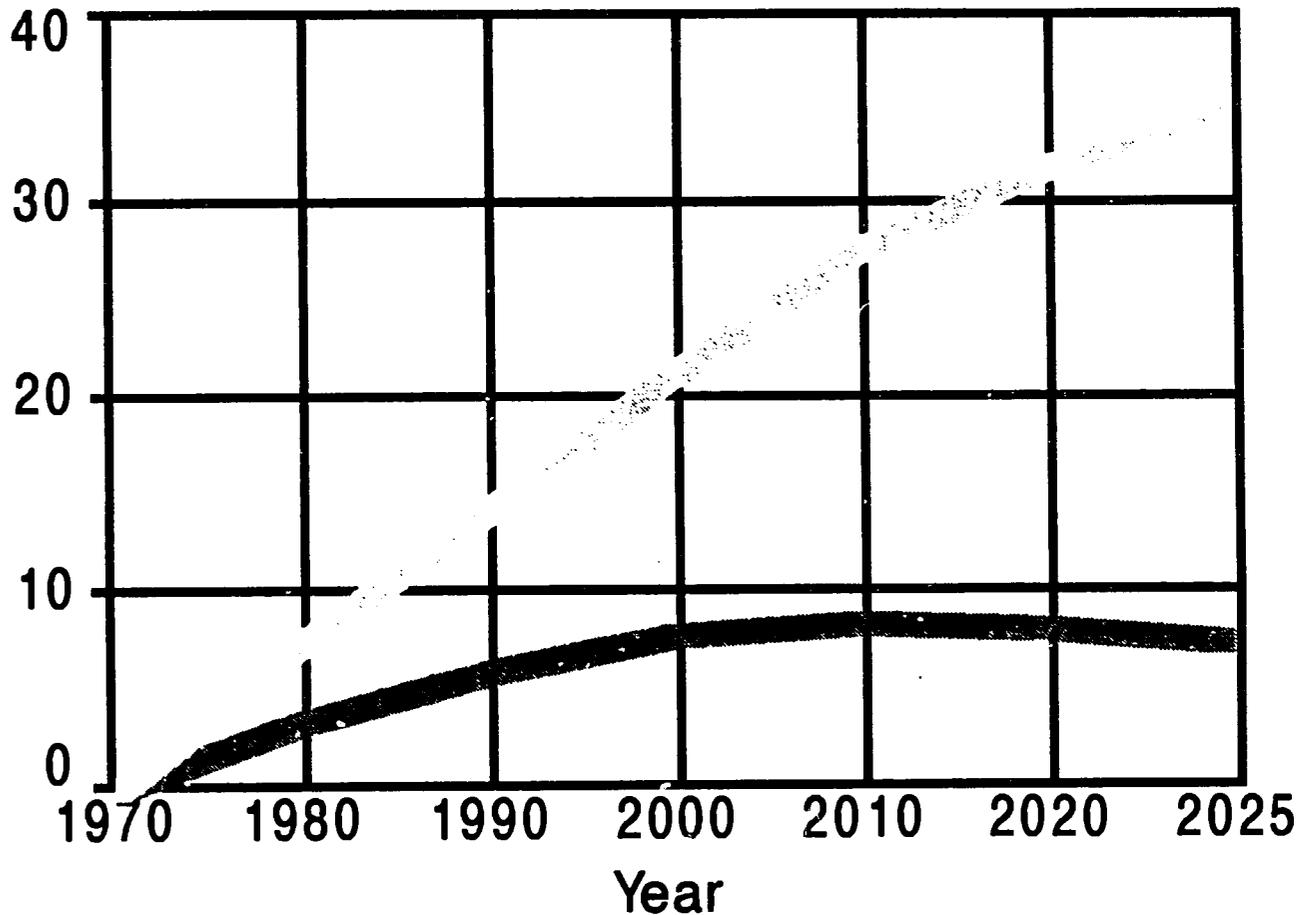
673	966	1,357	1,904	2,612
-----	-----	-------	-------	-------

+547

# Developing World

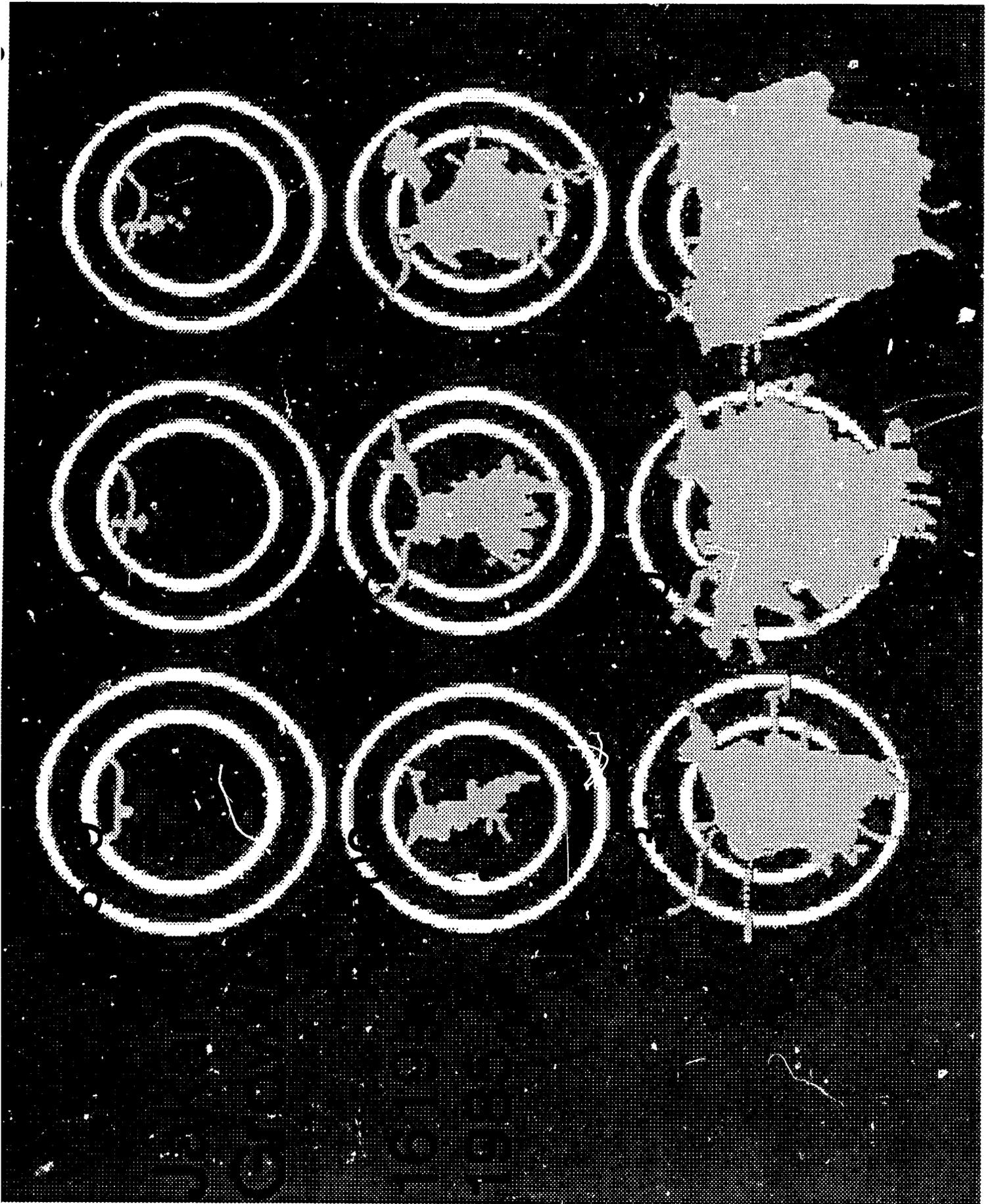
## Population Change

Cumulative percentage change



Source: United Nations

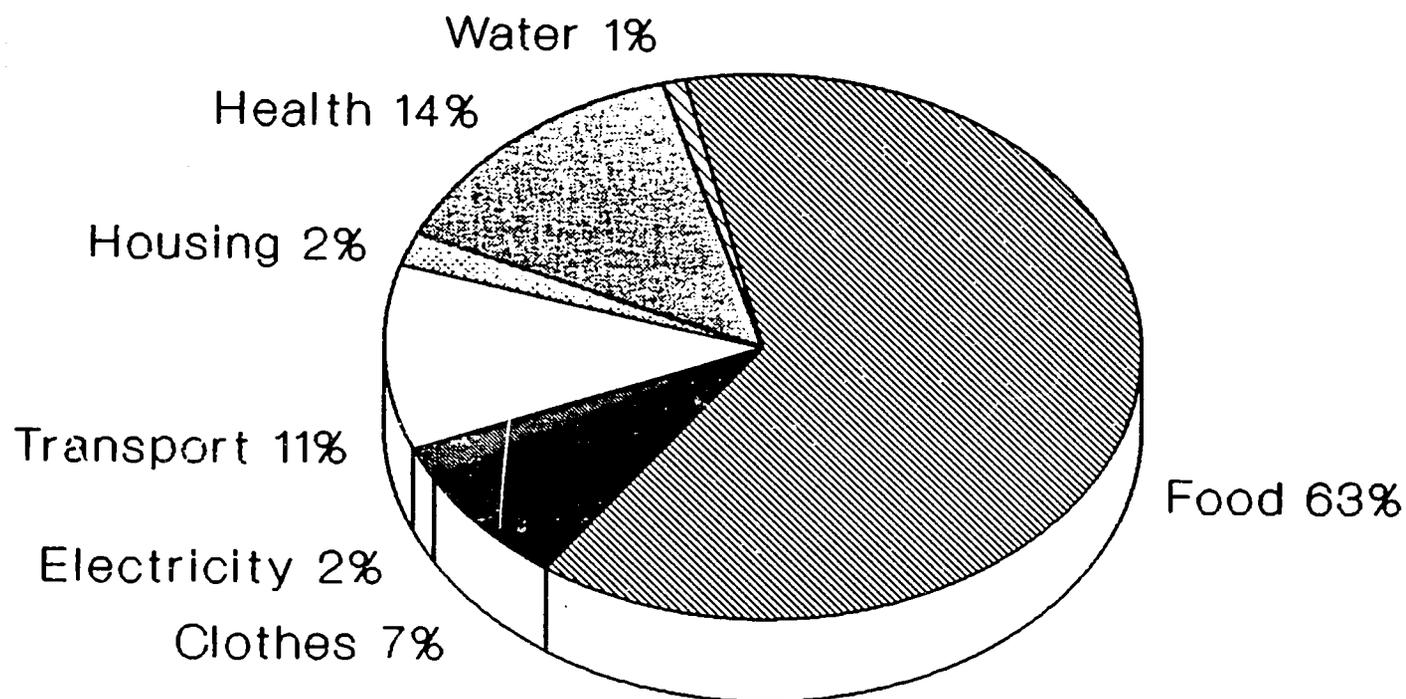
15



# Jakarta Annual Population Growth Rate (1980-1985)

Jakarta DKI (entire city)	3.26%
Eastern Neighborhood	12.05%
Downtown Neighborhood	-0.41%

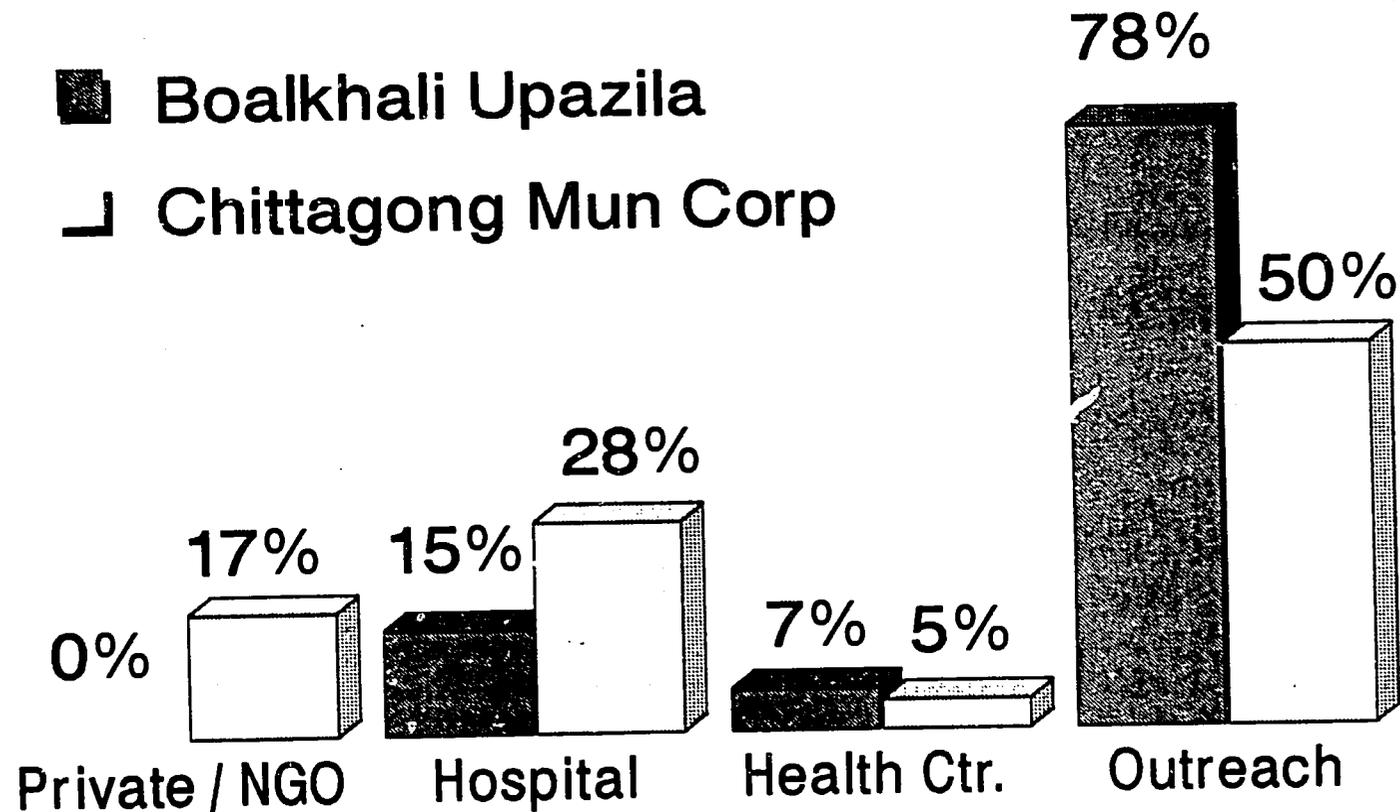
# Monthly Household Expenditures Conakry, Guinea



Source: MPCl (1986-87)

# 1989 Coverage Survey

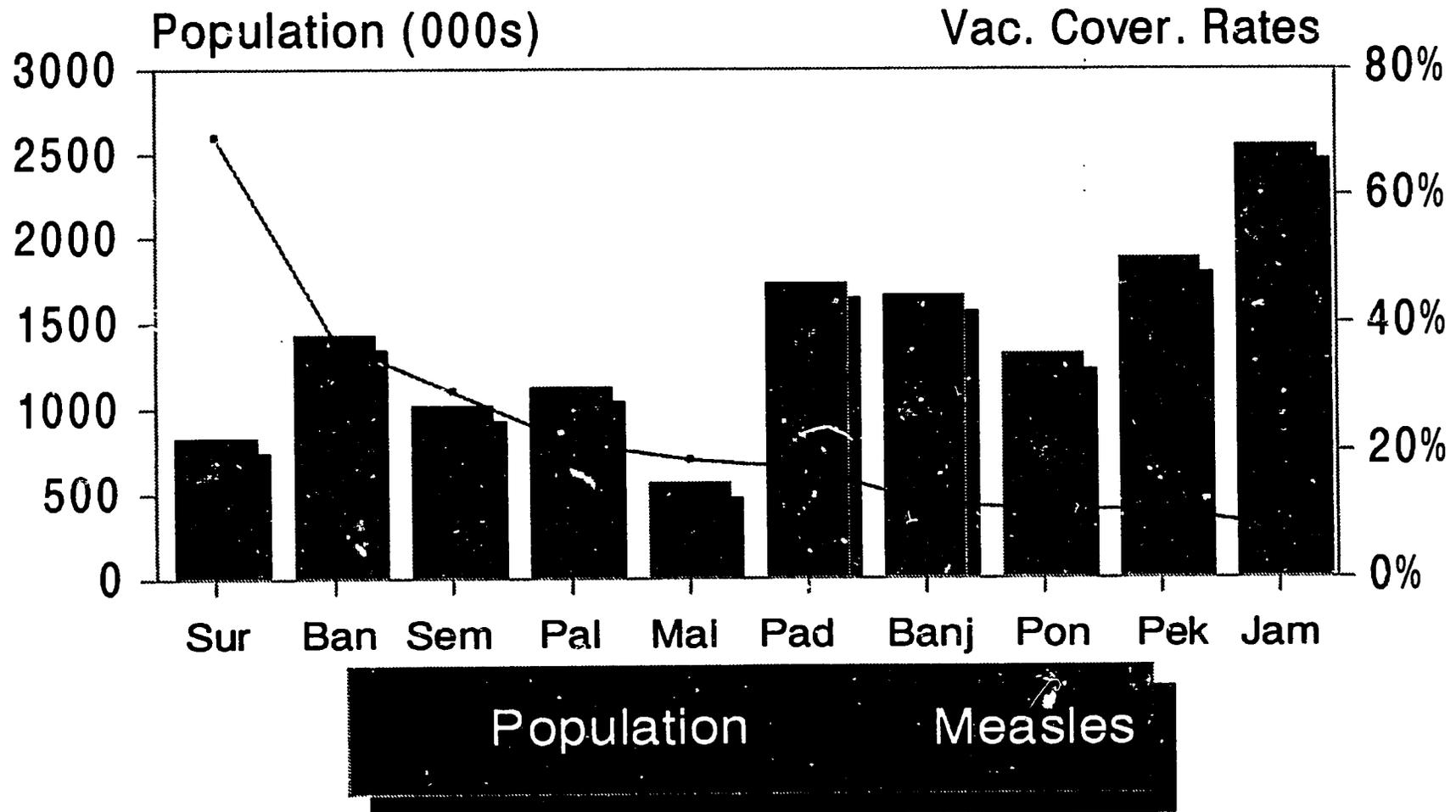
## Sources of Vaccinations



Source: Bangladesh 1989 EPI Review

# 10 Cities Indonesia

## Population / Measles

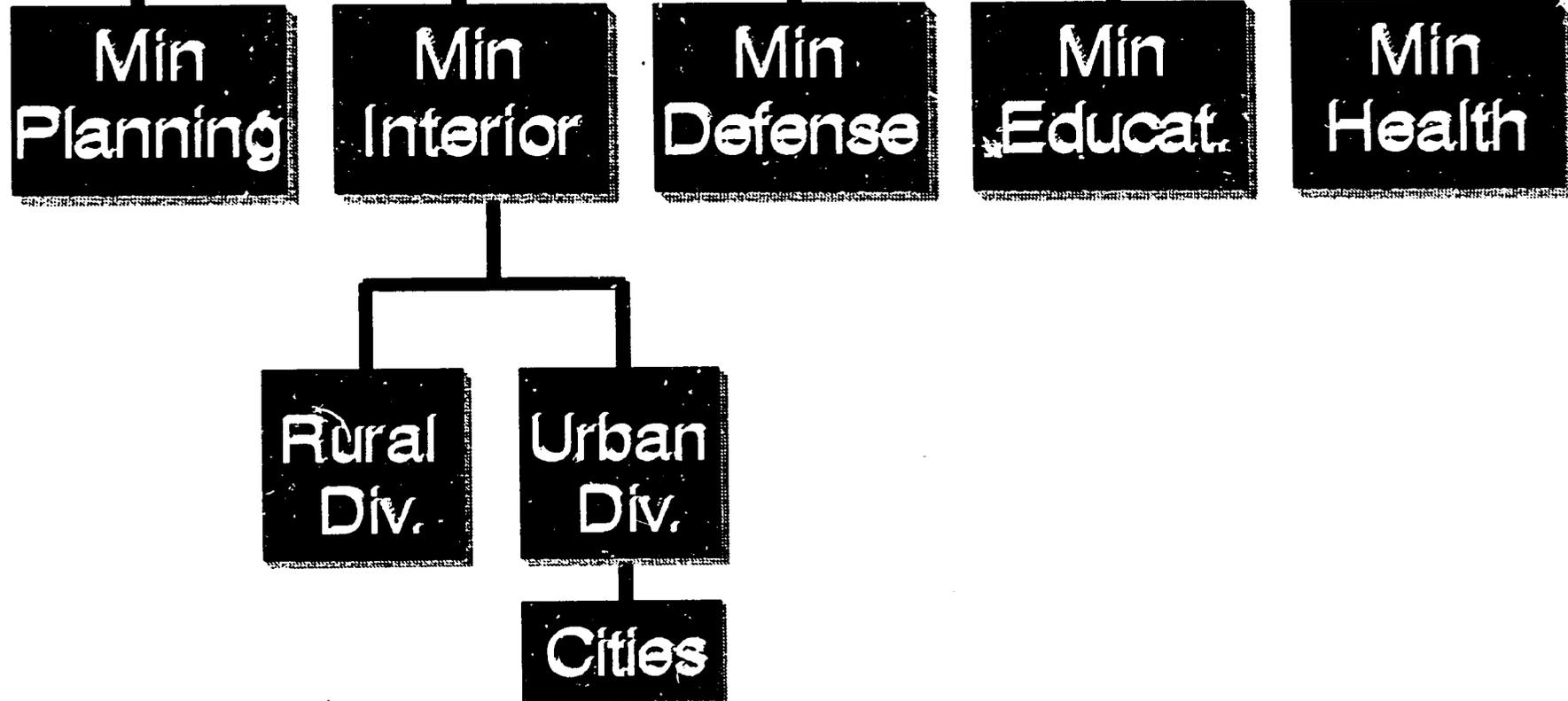


Source: UNICEF 1987 data

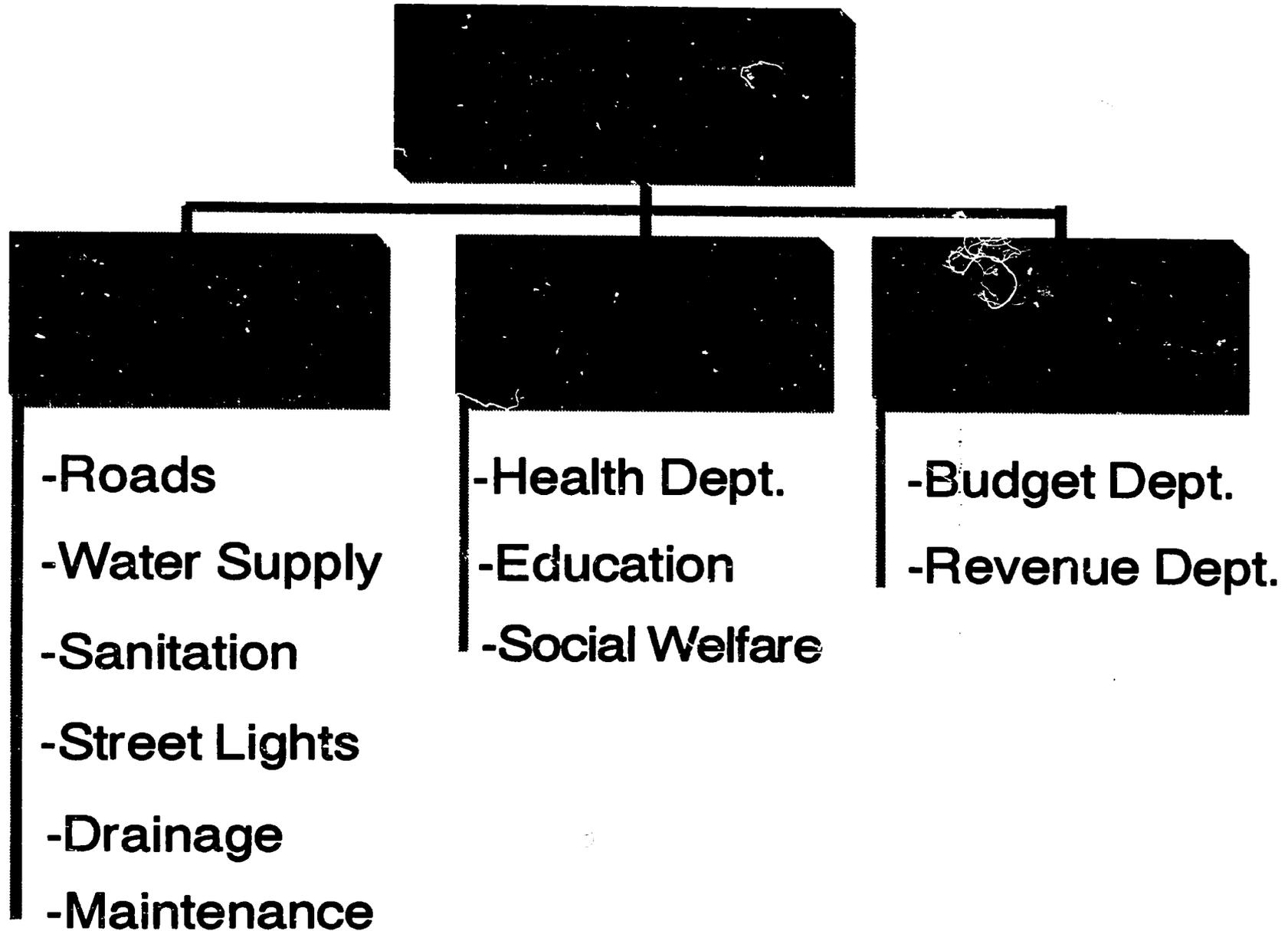
28

# National Government Structure

## Executive



# City Government Structure



1/10

**Annex E**

**Presentation Notes**  
by

**Diana Silimperi, M.D.**

**This paper was prepared for speaking notes only,  
please excuse typos and lack of acknowledgements.**

## DELIVERY OF HEALTH SERVICES TO THE URBAN POOR

We have already been given ample evidence of why urban populations are increasingly important to the welfare of the world. I would only like to briefly recap more specifically from a health perspective why it is critical that we focus resources and energies on the growing need of the urban poor.

1) **Magnitude -- Demographics:** Clearly, demographic trends point to the fact that by the year 2000 the majority of the world's inhabitants will be urban dwellers; in countries in Latin America this is already the case (72 %). In fact, urban areas in developing regions are expected to grow at an annual rate almost 3.7 times that expected in rural areas. Although there are major differences among countries, even those with low absolute levels of urbanization, such as sub-Saharan Africa and parts of Asia, are currently experiencing high levels of migration from rural to urban areas as well as internal growth. Such rapid growth is not confined to capital cities and large metropolitan areas, but also affects secondary and tertiary cities.

It is not simply absolute levels of urbanization that is having such negative consequences, but the speed with which cities are increasing in size, which causes a demand for facilities and services to grow much faster than resources available. Increasingly, it is apparent that the natural increase among urban dwellers accounts for a substantial proportion of total metropolitan growth. "Unfortunately, the direct result of this urban population explosion has been a disproportionate increase in the number of urban poor. By the end of the 20th century, many estimate that urban poor may represent a quarter of all humanity. Cities like Addis Ababa (which estimates that nearly 80% of its population exists in slum or squatter settlements) or Dhaka (ranked recently as one of the 3 worst cities in the world) where it is estimated that 60% of the population are very poor, increasingly bring to the fore the recognition of a "fourth world". This "fourth world" - that of the urban poor exists in both developing and developed countries alike. Certainly the recent article in the New England Journal of Medicine, which noted "the excess mortality in Harlem" was a case in point; this analysis revealed that black men in Harlem were less likely to reach the age of 65 than men in Bangladesh! The authors concluded that Harlem and other inner city areas have extremely high mortality rates that justify special consideration analagous to that given to natural disaster areas!

2) **Humanitarian Concerns:** Clearly, the plight of the urban poor which we saw exemplified in pictures at the start of this session, particularly urban women, and often single women heading households, as well as their children cannot be ignored from a humanitarian perspective. It should be on all of our consciences that same children continue to call sewage drainage pipes their home! Furthermore, it is increasingly obvious that children growing up under conditions of dire poverty will not be able to contribute in any meaningful way to their societies, and most importantly, if they grow to adulthood, will often grow into subversive or sociopathic citizens, involved in crime, family abuse, substance addiction and unemployment.

3) **Reservoirs of Disease:** The urban poor constitute a major reservoir of disease, particularly for those childhood diseases targeted in the expanded programs for immunization. Despite worldwide attention, for the eradication of polio, we will not be able to eradicate this disease without special attention to the reservoirs of disease among the hard-to-reach, high-risk urban poor.

1/2

4) **Conduits for Disease Transmission:** Given the high rates of rural-urban migration and social exchange, as well as the intra-urban movements of the urban poor -- these individuals serve as ready conduits for infectious disease transmission to other areas of the city and to their rural brethren. Thus, once again, if one is devoting extensive resources to rural and better-off urban areas, but neglecting the urban poor, they will carry disease to their better-off brethren, thereby minimizing and reducing the effectiveness of existent health networks.

5) **High-risk Status:** Although disaggregate information is difficult to obtain, increasingly studies in nutrition and infectious diseases continually reveal that except for malaria, there is little evidence that preventable diseases are more prevalent in rural areas than among the urban poor.

6) **Low Utilization of Existent Facilities:** To quote Dr. David Sencer, former Head of the Center for Disease Control and past Commissioner of the Department of Health in New York City, "The concept that disease prevention takes place because of physical proximity to an urban facility is an over-simplification. People use health facilities if they perceive they're sick, but that does not mean they will use the facility for preventive services -- nor does it mean that facilities in fact provide preventive services." (75% of children seen in the pediatric ambulatory service in Jakarta were in need of one or more immunizations when they entered the clinic; none had contraindications for immunization, but all 75% left the clinic without being immunized or being referred for immunization -- evaluations of lost opportunities in Bangladesh have revealed similar kinds of figures.)

In addition, there are many obstacles to utilization of existent health facilities, even for curative services. A few of these invisible barriers include: socioeconomic constraints; socio-cultural traditions which prohibit or decrease mobility, particularly of women; safety factors, such as the need to cross through sections of town with different ethnic groups, or to cross what is perceived as unsafe areas such as a highway; language barriers; educational barriers; in some cases absolute distance and lack of recompense for transport costs -- recent information from Afghanistan reveals that the majority of money spent by individuals was used for transport to the health facility rather than to buy medicinals; lack of knowledge as to location and/or services provided at health facilities; and finally facilities service issues such as limited hours and staff attitudes to the poor health.

7) **Limited Access to Health Care Knowledge:** Despite a multitude of agencies providing services in urban environments, because of a lack of coordination and planning, one often finds gaps in outreach and coverage - particularly to the urban poor. Furthermore, this sector often has very limited knowledge of the health care system as well as a dearth of absolute health care knowledge. Many of the most needy and highest risk groups are women and children who are illiterate, and are not part of the formal educational system and, hence, have minimal access to what could be perceived as standard routes of information, even information pertaining to essential health care.

8) There are special needs and constraints unique to urban settings which require that programs and materials be specifically tailored to the realities of the urban poor environment.

A recent study by the Population Crisis Committee entitled Cities, Life in the World's 100 Largest Metropolitan Areas: According to Dr. Joseph Speidel, the urbanization trend is a crisis. "When we looked at 57 metropolitan areas in developing countries -- 53 of the 57 scored fair or poor -- that means the average citizen living in those areas is experiencing a standard of

living which we would consider intolerable!" The study calls urbanization the dominant demographic trend of the late 20th century, and says it will continue well into the 21st century, "when population growth is expected to moderate." The study notes that the first necessity is for urban local authorities to strengthen their management capacity and to involve the people from the beginning. In some cases, the bulk of the cities' population lives in slums: 70% for Casablanca, Morocco; 67% for Calcutta; 60% for Bogota, Colombia, and Kinshasa, Zaire; and 42% for Mexico City! According to the Population Crisis Committee, 58 of the world's 100 largest metropolitan areas are in the developing countries -- 9 are in China and another 9 in India.

As far back as 1980, the Rhone declaration on population of the urban future pointed out that, "in the next two decades, the world will undergo, as a result of the urbanization process, the most radical changes ever in social, economic and political life." The declaration at that time castigated the inadequacies in most cities of the world of "virtually every service, amenity and support required for tolerable urban living." Thus, clearly this is not a new problem, but despite the recognition of this issue over the last decade, there has been minimal resources effectively directed to reaching children and women of the urban poor.

What are some of the challenges facing one sincerely dedicated to working with the urban poor?

- 1) Silent masses
- 2) Lack of accurate health information
- 3) Large numbers of functionally illiterate
- 4) Dearth of health materials adapted to the urban poor realities
- 5) Lack of urban slum maps or census data to establish targets and coverage ratios
- 6) Lack of basic information about the targeted urban poor population or the system to gather such information
- 7) Multiple parallel health agencies
- 8) Lack of capital
- 9) Visible and invisible barriers to access
- 10) Complex polities
- 11) Urban migration

After reviewing this veritable list of challenges, in fact there are some advantages of working in an urban environment which can be utilized to most effectively reach the urban poor.

- 1) Large populations within relatively short distances from each other (including factories)

- 2) Urban women as societal change agents
- 3) Urban poor women as untapped resources for community motivation
- 4) Large numbers of health facilities and trained health professionals; alternatives to health care

There are several key questions which frame the real issues in an urban environment.

- 1) Is there a need to develop specific strategies for urban health services?
- 2) Is the impact of health services in an urban area equal to that in a non-urban area?
- 3) If in fact the needs are specific or if the impact is different, can a health system be adjusted to effectively address these differential needs to have a successful impact in an urban environment?
- 4) Can a health system be used as an entre point to address greater system changes in the triumvirate areas of poverty, ignorance and illiteracy which clearly underline the health issues?

As already noted, there is in fact a dearth of good information regarding disaggregate urban poor health knowledge and health indicators, including nutrition. This is in part because of low utilization by the urban poor of key facilities which are traditionally used to collect such information. Therefore, whatever data exists generally does not truly reflect the status of the urban poor unless community-based, population survey methods are utilized. Another complicating factor is that ages are seldom not accurately known, and hence, all of the information which we will now briefly view must be clearly interpreted with a recognition that there are extreme limitations in the current database available to us. Nonetheless, several brief examples of nutritional and basic infectious disease rate comparisons, as well as mortality rates between rural and urban areas clearly indicate that the urban poor are as disadvantaged as their rural counterparts despite living in centers with concentrations of health professionals and facilities!

I would also like to share with you several interesting findings by Barry Popkin and Eileen Bisgrove in their article focusing on urbanization and nutrition in low income countries, facts which also counter current opinion. In addition to economic and health indicators of nutritional problems in low income urban areas, breast feeding, supplemental infant feeding and household consumption data provide direct information about the extent of nutritional risk in urban areas. Although one cannot determine the number or percentage of households at risk because of

deficient nutrient intake, or of infants at risk because of poor feeding practices, some data does provide a clear picture of the significant issues and problems existing in urban areas. Large proportion of infants are never breast-fed and the duration of breast feeding appears to be shorter in urban than in rural areas in many low income countries. Infants are also given supplementary foods early in many urban areas, particularly in Latin America.

Comparisons of household consumption data also reinforce the impression of important urban nutritional needs. Urban poor households in a number of countries have lower caloric intake than do their rural counterparts, and at the same time urban households consume greater proportions of energy from animal protein, fats, processed foods and lower proportions from cereal and tubers. As a result, while animal protein and fat intakes are likely to be deficient among the rural poor, the more Western diet of the urban poor is likely to be deficient in energy and total protein and to be associated with the number of chronic diseases including diabetes, hypertension, arteriosclerosis and various types of cancer.

An overriding issue facing urban women is their roles, especially in Latin America and Asia, as households heads. As a consequence, they may lack the social support network of rural women while simultaneously requiring more time for market employment. Furthermore, crucial home activities appear to be more time-intensive. The rural poor face different food market conditions than do rural poor, and they are more vulnerable to economic adjustments and inflation; they are much more reliant on away-from-home food purchases and may have to pay relatively more for food. An important social dimension facing the urban poor -- the proportion of female heads of households and the location and compatibility of urban work have not been adequately evaluated -- we have no large studies on differences in urban and rural areas with respect to these factors.

Among the numerous problems confronting families in low-income urban areas, the following are critical:

- 1) poverty, low income and unemployment
- 2) inadequate, overcrowded housing and insecurity of tenure
- 3) high-density population, unhygienic environment with inadequate or non-existent drainage, sanitation and refuse disposal
- 4) inadequate and irregular supply of poor-quality water
- 5) limited access to appropriate family planning services
- 6) high birth rates compared to affluent families with a high number of dependents to working adults

- 7) inadequate care for infants and children, especially working mothers
- 8) low literacy and school enrollment rates and high drop rates
- 9) children working to contribute to family income both in the informal sector and to care for younger siblings or to care for themselves in cases of abandonment
- 10) infant and child malnutrition due to early discontinuance of breast feeding, diarrhea due to poor health and environmental conditions and lack of cash income to maintain minimal nutritional levels required
- 11) child abandonment
- 12) single parent households headed by women - necessary absence from home to earn money often separates the child from any adult care and training during the day, and
- 13) disabled children.

Given the enormity of problems and challenges facing the delivery of urban health services, PVOs assume a significant role. A number of urban private voluntary organizations have been funded by USAID -- FVA-PVC over the last several years. Last September, members from 12 urban projects met in Mexico City to discuss lessons learned to date; their findings are worth considering today. The consensus among those participating were that while there were many aspects of project development and implementation in urban areas that were similar to that in rural environments: setting objectives, identifying targets, creating directed implementation strategies, and the role of integrated, collaborative efforts - they strongly advocated that there were also distinctive and unique aspects of the urban environment which require the creation of urban-specific strategies and interventions.

In the area of design, they noted that strategies for sustainability, a key concern today, were quite different in urban than rural areas. For example, in rural areas there is often emphasis on the community taking over the sole responsibility of the project after a certain amount of time, and there usually exists a community basis to make this feasible -- but in urban environments, with high migration rates, there is less of a community infrastructure - which makes a complete turnover to the community unrealistic -- particularly given the short time frames of many projects (2 to 3 years). Therefore, alternative strategies for sustainability need to be explored for urban environments.

2) Networking in an urban environment is much more complex than a rural one, so there is an increased risk of duplication, but as important is the increased risk of neglecting or missing key, high-risk populations -- particularly the urban poor. Coordinated efforts in planning and coverage are therefore necessary between multiple urban agencies.

In the area of monitoring, the group noted that because urban populations generally fluctuate, given the migration factor (both intra- and inter-urban migration), there are constantly changing denominators of one's target population which makes monitoring a very difficult process to perform. Although many of the projects did attempt to create family registrations - they noted the need for frequent updating if these registries are to function adequately.

Thus, any type of monitoring needs to include periodic rapid assessment surveys to supplement ongoing registries for data collection.

A number of interesting messages in the area of health education were noted by the participants including the fact that in most urban settings there are a variety of ethnic groups, often speaking distinctive languages, which makes the task of communication and promotion of health education much more difficult than in the more uniform rural environments. Furthermore, given the variety of resources performing health education in an urban setting, there is a greater risk for conflicting messages (especially private vs. public messages), necessitating a consolidated effort to assure that differences are not unwittingly transmitted by health educators. There is a greater need for assessments to evaluate the effectiveness of health education messages given the mixed ethnic and educational differences of an urban population. Furthermore, in an urban setting, given the high percentage of working mothers, health messages must also focus on alternative caretakers to a much larger extent than in a rural setting.

Staffing health programs in an urban setting becomes much more difficult than in a rural setting since there are many competing opportunities for health workers. Thus, cash pay is very important to avoid high drop-out rates and to keep competent people on staff. There is more of a need for ongoing training and directed recruitment programs in an urban setting, much more than in a rural setting where other economic possibilities are scarce. Finally, staff hours need to take into account flexible hours and days to accommodate working mothers and families.

Lastly, all of the groups involved noted that their efforts were very much in the experimental stage, that there are many lessons still to be learned in the areas of urban health. PVOs require technical assistance even more than their rural counterparts, given the newness of the working site and the unique problems which they are attempting to address. (I would like to personally thank the PVO Child Survival Support Project at Johns Hopkins for allowing me to participate in that conference and bring this information to you today).

Reviewing what has been published in the area of community urban health projects brings to the fore the lack of information in this area, similar to the dearth of disaggregate urban health statistics. Nonetheless, the Kellogg Foundation has recently put together a review of primary health care in six cities: Bogota, Pali, Jakarta, Manila, Mexico and Shanghai. One of the most interesting aspects of this review is the repeated need for the development of alternative health providers and delivery outreach systems in an urban setting. It is clear that the role of community workers in an urban environment, including community volunteers is a very important area which needs to be explored quite seriously.

In 1989, Strengthening Health Services of WHO sponsored a regional meeting in Karachi on city health. Conference participants discussed the finding that although high levels of traditional health problems (indicated by high maternal, perinatal, infant, and under 5 mortality rates or by the burden of infectious diseases) are clearly evidenced among the urban poor, increasingly the urban centers of the world reveal a bi-modal pattern of diseases characterized not only by infectious diseases but also by those health problems usually associated with industrialization, such as cancer, hypertension, problems of alcohol and drug use, sexually transmitted diseases (including AIDS), accidents (traffic and industrial), and violence. Thus, one increasingly sees a complex pattern of both infectious diseases as well as chronic and lifestyle disease patterns emerging in developing urban poor populations.

The extent of these health problems is very difficult to quantify, in part because of a lack of infrastructures to collect the data, as well as the migratory patterns of the urban poor, and finally, the fact that the most high-risk group of urban poor, migrants and squatters, do not have access or do not utilize hospitals and health facilities where most of the data is collected. Furthermore, the data for most cities are aggregate figures, which clearly mask the degree of need among the urban poor. There is a significant requirement for disaggregate data on urban health and social conditions. Nonetheless, what exists today indicates that the levels of malnutrition and infant mortality rates in urban slums may be 3 to 4 times higher than elsewhere in the same city, and that childhood mortality may be 4 to 5 times higher in shantytowns compared to their non-shantytown neighbors. Thus, there may be very large variations in mortality and morbidity rates within the same city. Clearly, there is a need for more documentation of these differences.

Population household densities are generally much higher in slum areas and age structures show a majority of young people in poor urban areas. But, other indicators of environmental and social conditions need to be collected, including access to domestic water and standpipes as well as other water and sanitation facilities. Existent data does reveal that only 30 to 55% of slum and squatter settlements have access to domestic water or standpipes, and that the ratio of cost of water between street vendors and piped water may vary between 10 and 100 times; finally, households with access to toilet facilities, including pit and bucket latrines, varies between 55 and 75% of slum and squatter areas.

Clearly, the determinants of health in an urban environment are quite complex and include many factors related to poverty: low income; poor living conditions (inadequate housing, overcrowding, lack of sanitation or clean water); low standards of education; inadequate nutrition (quality and quantity); lack of affordable transport. Furthermore, there are many man-made environmental hazards in urban areas, such as pollution (air, noise and water); solid waste accumulation; traffic; hazards at work; stressful conditions in the environment and culture which restrict healthy lifestyles. Other factors related to urban social conditions include: poor social networks; social instability; insecurity of land tenure; alcohol and drug availability and use; deterioration of interpersonal family relationships; personal violence; criminal activity; and a lack of political responsiveness to the urban poor. All of these issues clearly impinge upon the ultimate health status of the urban poor.

Thus, urban solution must be multi-focal and require a multi-disciplined approach involving diverse professionals (health and urban planning, engineers) as well as community members! One strategy which can be used to address the underlying problem of poverty in an urban setting (which clearly is the main determinant of ill health) may be that of using "health as an entre point" to the community, health as an empowerment vehicle, particularly focusing on women in the urban poor community. A number of urban projects have focused on the development of community health workers, paid or volunteer, to begin the process of health education from within the community and to promote knowledge about utilizing existent health facilities. It is clear that the most effective transmission of information comes from people within the slums, extending and outreaching to their fellow neighbors. Furthermore, given the social constraints of women in many countries of the world, the most effective communication of health promotion and interventions which can be applied within the context of households are women reaching out to women. This has been a grossly overlooked area of development in terms of alternative health infrastructures to reach the urban poor. Women reaching to women, women of the same educational status, same ethnic and community ties, reaching out to their fellow women is critical! Because the health of their children and

families is a major concern to most women in the world, it is a very easy entre point of interest within a community. Furthermore, because the care of children is virtually seen as women's responsibility in all of the world -- it is not transgressing local cultural norms to have women reaching out to women and addressing this common concern. However, the use of women as an untapped resource in communities must be examined further.

Women in urban areas are often conduits of information to other women since they frequently return to their rural villages, and thus may be very potent societal change agents which have been largely untapped. Furthermore, there is some indication that women in urban settings, perhaps because of their "extremis" conditions, are open to new ideas and may be very potent change agents, introducing new concepts, particularly in the areas of health, to their fellow urban women (and also to their fellow rural counterparts). Many women are trapped in cycles of poverty and ignorance; the experience of PVOs and programs like the UVP in Dhaka involved with urban women indicate an immense "thirst for knowledge" among these women. This thirst for knowledge, initially of health knowledge, can be used as a major incentive to attract women to serve as promoters or volunteers in their neighborhood. Furthermore, such women are critical in terms of linking local women with existent health facilities, therefore increasing utilization rates of such facilities. An example of this is the Urban Volunteer Program in Dhaka, Bangladesh, where women volunteers from the slums were successfully utilized to recruit and bring urban poor women to EPI centers. Even illiterate women were trained to purvey the messages and accompany their fellow women to EPI sites, thereby increasing utilization of local sites as well as having an amazing success rate of nearly 90% (6 antigen completion) rates among the women and children that they assisted to the centers.

In summary, there are several key issues requiring immediate attention if we are to accept the challenge facing us regarding effective delivery of services to the urban poor. In 1989 participants at the Interregional Meeting on City Health in Karachi "voiced a cry of alarm and launched an urgent appeal to all to save humanity from a crisis that is all too easy to foresee, but without immediate action would not be averted -- the urban crisis". If we are to seriously respond to this crisis, the following issues must be addressed:

- 1) There needs to be concerted effort to create systems to collect qualitative and quantitative disaggregate urban health status information focusing on the urban poor. There should be multi-country surveys performed, with attention to comparability of data using consistent information, definitions and methodologies. There must be intra-urban comparisons performed to more starkly reveal the existing differences in health status between urban poor and non-poor, even in the same city.
- 2) There should to be the creation of an advocacy group or consortium of agencies directing attention to the urban poor health plight, supporting funding for project development in this area, but also advocating central policy changes.
- 3) Urban research must be conducted to identify specific need areas in urban settings, and to assess alternative health delivery strategies and interventions tailored to the urban poor realities. Special materials must be developed taking into consideration the constraints and circumstances of the urban poor.
- 4) There should be serious attempts to develop alternative health care delivery systems, including the use of grassroots community-based health promoters and health extenders. Such systems should focus on women and may use volunteerism as a vehicle for empowerment.

Health is an entre point and should be capitalized upon in reaching out to urban poor communities. Women must be the foundation of the health outreach systems and can serve as potent societal change agents, as well effective outreach workers to link communities with existent health facilities.

5) Attention needs to be focused on the coordination between municipal and federal health plan, and implementation of services. Multi-lateral donors should concentrate efforts on strengthening municipal health departments or municipal corporations which often bear the brunt of responsibility for urban health care, but have few resources in terms of skilled staff or funding to address the problems.

6) There is a growing role for the use of private voluntary organizations in the provision of urban health services. Their efforts must be integrated with municipal and federal programs if they are to be effective.

7) Alternative modes of health financing and sustainability must be considered in urban areas where the capital infrastructure is weakest, yet the need is greatest. Given the fluctuation in urban populations, new methods for sustainability must be explored rather than simply applying traditional rural remedies.

Sources of information for this talk:

- 1) UNICEF Urban Basic Services: Reaching Children and Women of the Urban Poor -- Occasional Paper #3
- 2) Nutrition-Related Health Consequences for Urbanization -- Fernando E. Vitcri
- 3) The Challenges of Growth in an Urban Environment -- PVO Child Survival Conference Proceedings
- 4) Urbanization Sweeps the Globe and Urban Poor Face Health Problems -- Christian Science Monitor
- 5) Urban Primary Health Care Response to the Crisis of Urban Poverty -- WHO and UNICEF -- Primary Health Care in Urban Areas -- 1986, Manilla, Philippines
- 6) Spotlight on the Cities -- WHO
- 7) Excess Mortality in Harlem -- McCord and Freeman
- 8) Urban Volunteer Program -- Resource Papers - A Multidisciplined Approach for a Healthier Urban Future through Community-based Primary Health Care -- Silimperi and Olivola as well as Urban Volunteer Program -- ICDDR,B -- Immunization Services Targeting the Urban Poor -- Silimperi -- Urban Volunteer Program Documents
- 9) Urbanization and Nutrition in Low Income Countries by Popkin and Bisgrove
- 10) Urbanization and Hunger in the Cities by Hussein and Lunvin

- 11) **Bulletin of the New York Academy of Medicine -- Challenge of Health care in the Nation's Cities**
- 12) **Community Participation in Delivering Urban Services in Asia (IDRC)**
- 13) **Health System Decentralization -- WHO**
- 14) **Interregional Meeting on City Health -- Challenge of Social Justice -- Karachi, 1989**
- 15) **Urban Health Care by Kellogg, 1990**
- 16) **David Sencer**

# **WHY FOCUS ON URBAN POOR**

- **MAGNITUDE - DEMOGRAPHICS**
- **HUMANITARIANS CONCERN**
- **RESERVOIRS OF DISEASE**
- **CONDUCT FOR DISEASE TRANSMISSION**
- **HIGH - RISK STATUS**
- **LOW UTILIZATION OF EXISTENT FACILITIES**
- **LIMITED ACCESS TO HEALTH CARE KNOWLEDGE**
- **SPECIAL NEEDS/CONSTRAINTS UNQUE TO URBAN SETTINGS**

# **ESSENTIAL QUESTIONS**

- 1) ARE SPECIFIC HEALTH STRATEGIES NEEDED TO ADDRESS/REACH URBAN POOR ?**
- 2) IS THE IMPACT OF HEALTH SYSTEMS IN URBAN AND RURAL ENVIRONMENT THE SAME ?**
- 3) IF DIFFERENT NEEDS AND CONSEQUENTLY STRATEGIES ARE REQUIRED, CAN THE HEALTH SYSTEM BE ADJUSTED TO EFFECTIVELY ADDRESS THEM ?**
- 4) CAN HEALTH SYSTEMS BE USED TO ADDRESS THE GREATER SYSTEMS CHANGES UNDER - LYING POVERTY, ILLITERACY, AND ILL-HEALTH ?**

# **PROBLEMS OF WOMEN AND CHILDREN IN LOW - INCOME AREAS**

- **POVERTY, LOW INCOME AND UNEMPLOYMENT**
- **INADEQUATE, OVERCROWDED HOUSING AND INSECURITY OF TENURE**
- **HIGH-DENSITY POPULATION, UNHYGIENIC ENVIRONMENT**
- **INADEQUATE, IRREGULAR SUPPLY OF POOR QUALITY WATER**
- **LIMITED ACCESS TO FAMILY PLANNING**
- **HIGH BIRTH RATES WITH A HIGH NUMBER OF DEPENDENTS PER WORKING ADULT**

# **PROBLEMS OF WOMEN AND CHILDREN IN LOW - INCOME AREAS (CONT'D)**

- **INADEQUATE ADULT CARE FOR INFANTS AND CHILDREN, ESPECIALLY OF WORKING MOTHERS**
- **LOW LITERACY AND SCHOOL ENROLLMENT AND HIGH DROPOUT RATES**
- **CHILDREN WORKING TO CONTRIBUTE TO FAMILY INCOME**
- **INFANT AND CHILDREN MALNUTRITION**
- **CHILD ABANDONMENT**
- **SINGLE - PARENT HOUSEHOLDS HEADED BY WOMEN**
- **DISABLED CHILDREN**

# **URBAN VOLUNTEER PROGRAM RATIONALE**

- **NEED FOR LOW COST, COMMUNITY - BASED SOLUTIONS TO ASSURE SUSTAINABILITY OF HEALTH INTERVENTIONS IN URBAN POOR COMMUNITIES**
- **NEED TO SPECIFICALLY TARGET URBAN POOR WOMEN FOR PREVENTIVE HEALTH STRATEGIES**
- **URBAN POOR WOMEN ARE MOST EFFECTIVE OUTREACH WORKERS AND COMMUNITY MOTIVATORS TO REACH OTHER URBAN POOR WOMEN**
- **URBAN POOR WOMEN ARE HIGHLY MOTIVATED, UNTAPPED RESOURCES WITH HIGH DEVELOPMENT POTENTIAL**

# **URBAN VOLUNTEER PROGRAM RATIONALE (CONT'D)**

- **URBAN HEALTH STRATEGIES NEED TO BE MULTI-FOCAL, INVOLVING COMMUNITY DEVELOPMENT, PERSONAL EMPOWERMENT, AND INFRASTRUCTURE DEVELOPMENT**
- **INITIAL EMPOWERMENT GAINED THROUGH IMPLEMENTATION OF REALISTIC HOUSEHOLD LEVEL INTERVENTIONS**
- **HEALTH FACILITY AND (W&S) INFRASTRUCTURE DEVELOPMENT COMBINED WITH HOUSEHOLD LEVEL INTERVENTIONS THROUGH EMPOWERED POPULATION NECESSARY TO EFFECT AND MAINTAIN IMPROVEMENT IN HEALTH STATUS OF URBAN POOR**

25

# URBAN PVO FINDINGS

## I. DESIGN

SUSTAINABILITY  
NETWORKING, COORDINATION

## II. MONITORING

TARGET POPULATION FLUCTUATION  
REGISTRIES REQUIRE FREQUENT UPDATES  
SUPPLEMENT WITH PERIODIC RAPID ASSESSMENTS

## III. HEALTH EDUCATION

DIVERSE POPULATION  
MULTIPLE AGENCIES - CONFLICTING MESSAGES  
ASSESSMENTS CRITICAL  
ALTERNATIVE CARETAKERS

## IV. STAFFING

COMPETITIVE MARKET  
ROLE OF TRAINING, RECRUITMENT  
FLEXIBLE HOURS

## V. EXPERIMENTAL STAGE

TECHNICAL SUPPORT

# **ISSUES TO BE ADDRESSED**

- **CREATION OF SYSTEMS TO COLLECT QUALITATIVE AND QUANTITATIVE DISAGGREGATE URBAN HEALTH STATUS INFORMATION FOCUSING ON THE URBAN POOR**
- **CREATION OF ADVOCACY GROUP OR CONSORTIUM DIRECTING ATTENTION TO THE URBAN POOR HEALTH PLIGHT**
- **URBAN RESEARCH TO IDENTIFY SPECIFIC NEED AREAS IN URBAN SETTINGS AND DEVELOP ALTERNATIVE HEALTH INTERVENTIONS/MATERIALS**
- **DEVELOPMENT OF ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS, INCLUDING GRASSROOTS, COMMUNITY - BASED HEALTH NETWORK FOCUSING ON WOMEN, USING VOLUNTARYISM AS AN EMPOWERMENT TOOL**

# **ISSUES TO BE ADDRESSED CONTINUED**

- **COORDINATION BETWEEN MUNICIPAL AND FEDERAL AGENCIES IN HEALTH PLANNING AND IMPLEMENTATION OF SERVICES**
- **ROLE AND INTEGRATION OF PRIVATE VOLUNTARY ORGANIZATIONS IN THE PROVISION OF URBAN HEALTH SERVICES**
- **ALTERNATIVE MODES OF HEALTH FINANCING AND SUSTAINABILITY (CAPITAL INFRASTRUCTURE IS WEAK, YET NEED GREAT)**

# **ADVANTAGES OF WORKING IN AN URBAN ENVIRONMENT**

- **HIGH POPULATION DENSITY**
- **URBAN WOMEN AS "CHANGE AGENTS"**
- **DEPARTURE FROM TRADITION**
- **URBAN POOR WOMEN AS "UNTAPPED RESOURCES"  
FOR COMMUNITY MOTIVATION**
- **ALTERNATIVES FOR HEALTH CARE**

# **URBAN EPI CHALLENGES**

- **MULTIPLE PARALLEL EPI AGENCIES**
- **LACK OF CAPITAL**
- **BARRIERS TO ACCESS**
- **COMPLEX POLITICS**
- **URBAN MIGRATION**
- **LACK OF FEMALE SUPPORT NETWORK**

CA

# **URBAN EPI CHALLENGES**

- **THE SILENT MASSES**
- **LACK OF ACCURATE EPI DATA**
- **LARGE NUMBER OF ILLITERATE**
- **DEARTH OF EPI MATERIALS  
REFLECTING REALITIES OF URBAN POOR**
- **LACK OF URBAN SLUM MAPS OR CENSUS DATA**
- **LACK OF BASIC INFORMATION ABOUT TARGET  
POPULATION OR SYSTEM TO GATHER IT**

69

## **URBAN PROJECT FINDINGS**

- **ROLE OF URBAN CHW**
- **ROLE OF COMMUNITY-BASED OUTREACH WORKER  
(FROM THE TARGET COMMUNITY)**
- **ROLE OF WOMEN AS CHWs**
- **ROLE OF COMMUNITY/HEALTH VOLUNTEERS**
- **BIMODAL HEALTH PROFILE**
- **NEED FOR INTRA-URBAN COMPARATIVE HEALTH DATA**