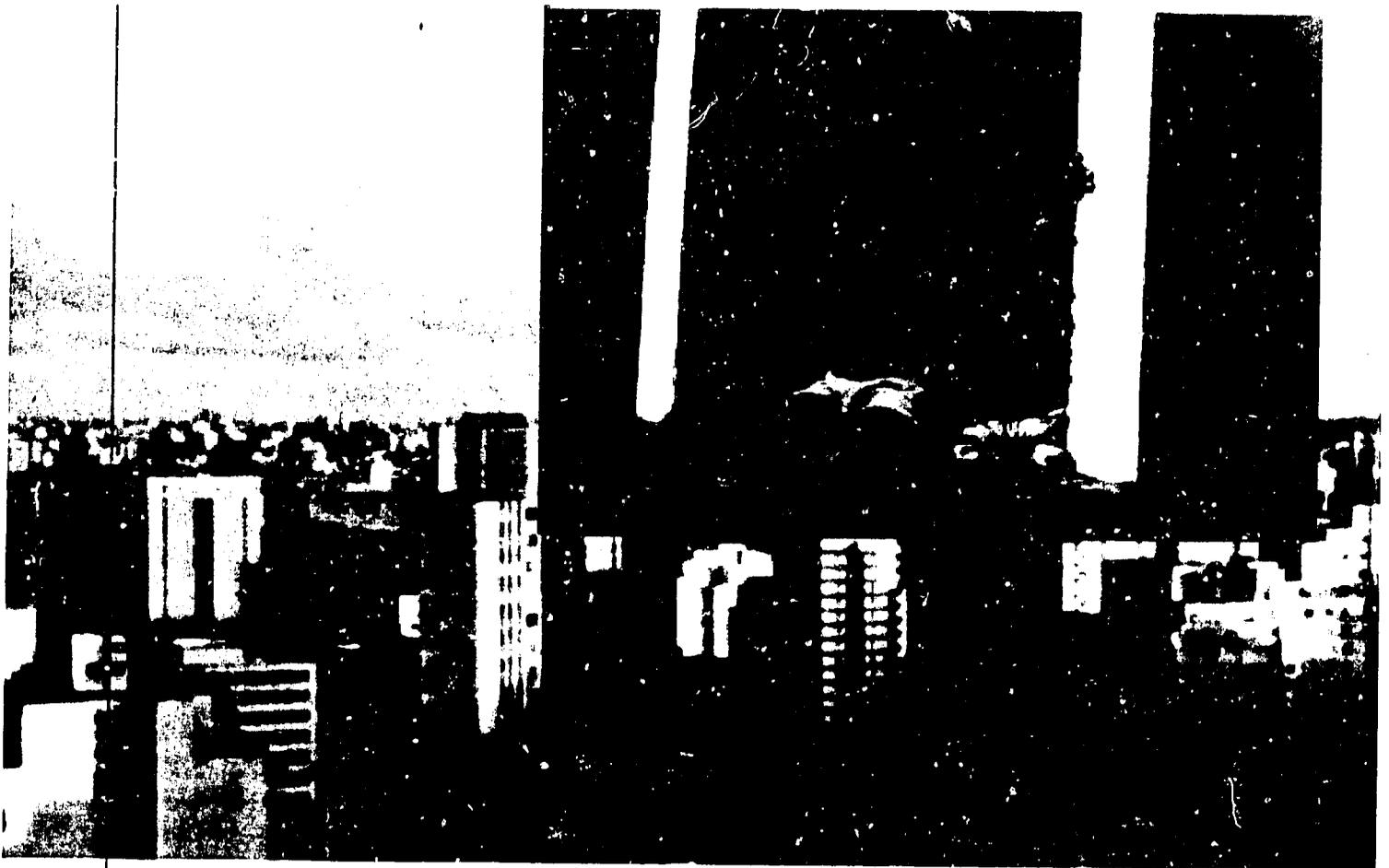


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URBAN HEALTH: SHARPENING THE FOCUS



**U.S. Agency for International Development
Bureau for Research and Development
Office of Health**

June 1991

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PREFACE

This report is a result of the second A.I.D. Office of Health: Urban Health Workshop, held in June 1991. The first workshop on urban health, also organized by the Office of Health, was convened in March 1991 to examine the changing picture of urban health conditions and problems in the developing world. The first workshop sought primarily to identify and discuss the urgency of urban health matters and outline what is currently known, what needs to be known, and what can be done to address the health problems of the urban poor. A report of the first workshop, "Health in the Urban Setting," has been produced and is available through the Office of Health and The Pragma Corporation.

"Urban Health: Sharpening the Focus" attempts to do exactly that: document the advances in discussion and understanding of particular urban health situations exchanged during the second workshop.

The A.I.D. Office of Health wishes to thank Holly Fluty and Susan Kolodin for their efforts in organizing and managing this workshop, as well as Ann Van Dusen and Bob Emrey for their comments and participation. We would especially like to thank the panel discussants, Ken Olivola of JSI, David Scott Luther, who traveled from the Dominican Republic, Carl Bartone of the World Bank, Marilyn Pocky of CHILDHOPE USA, and Margaret Price of Drew University; and also the A.I.D. staff persons who facilitated the small group discussions. The Pragma Corporation was instrumental in coordinating the workshop and producing the report. Our appreciation goes to Neil Schlecht for serving as rapporteur, writing the report and editing the small group materials; Richard Killian, for his input in the workshop plans and organization; and Cari Azores and Njoki Mwhia for their administrative and logistical support.

EXECUTIVE SUMMARY

The second 1991 A.I.D. Health in the Urban Setting workshop focused upon unique aspects of the urban environment affecting health and health services in the developing world. The first workshop, held in March, presented a preliminary examination of changing urban health conditions and problems. Immediately following the NCIH Annual Conference, the June meeting afforded professionals from varied fields and backgrounds the opportunity to advance current thinking and contribute to the knowledge base currently available on urban health issues. The primary objective of the workshop was to identify organizations and individuals active in urban health care programs and to gain an overview of what such groups and persons have done, are doing currently, and the results of these efforts.

The workshop, which included both formal presentations and small group discussions, allowed public health officials, A.I.D. staff, and representatives from cooperating agencies, NGOs and PVOs to compare experiences and perspectives on the numerous and varied health challenges of the urban environment. It also challenged participants to begin to identify means available to address urban health needs. A.I.D. stressed that urban health and urban development do not constitute a new vertical program for the agency; however, participants clarified possibilities and needs to incorporate urban health matters into current programs. A panel discussion of "Experiences from the Field" followed by small, interactive focus groups propelled the workshop beyond the previous, introductory exploration of issues in the first Urban Health workshop and sharpened the focus on the problems, challenges and opportunities in urban health.

The urban environment is unique in terms of health care for several reasons:

- o Urban populations are much more heterogeneous than in rural areas; urban residents thus require a greater variety of health services, approaches and communication efforts.
- o Policy administration in cities frequently is focused upon municipal government, rather than the national ministry of health.
- o Epidemiology in large urban areas differs dramatically from rural areas: new diseases uniquely associated with urban living conditions bring about new challenges and demand unique responses distinct from traditional, rural-oriented health care programs.

Proceedings

Ken Olivola, an urban planner with John Snow, Inc., opened the workshop with a background paper, "Health in the Urban Setting." Olivola outlined characteristics of urban areas that concern both urbanists and public health officials.

The four panelists that followed presented unique perspectives on urban health and development. Their talks included a discussion of health care problems in poor urban

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settlements in the Dominican Republic, health problems faced by homeless and working street children worldwide, a World Bank policy perspective, and a view of government health care policy-making, principally in Swaziland. Panelists were David Scott Luther, executive director of Instituto Dominicano de Desarrollo Integral, based in Santo Domingo; Marilyn Rocky, director of CHILDHOPE USA Foundation; Carl Bartone, senior environmental specialist of the Urban Development Division, the World Bank; and Margaret Price, interim director of the International Health Institute of Drew University.

Following the panel discussion, workshop participants formed small issue groups based on their particular backgrounds and interests. Small group discussions focused on nine specific issues and their unique urban components, including:

- o Orphans and Street Children
- o Health Care Financing
- o AIDS, STDs and Family Planning
- o Changing Epidemiology
- o Community Participation and Communication
- o Hospitals, Clinics and Alternative Care Providers
- o Health Care Communication: Advantages & Disadvantages
- o Nutrition and Breastfeeding
- o Intersectoral Coordination

The small groups, facilitated by A.I.D. staff, provided opportunities for dynamic interchanges of ideas, personal experiences and viewpoints. Group participants first brainstormed for 10 minutes, identifying particular issues related to their topic. They then ranked issues and critical factors, discussed personal experiences working in related areas, and sought to identify possible solutions, particularly mindful of their feasibility. Each group appointed a spokesperson to present main highlights of the group's findings and discussions to the plenary session.

Bob Emrey from the A.I.D. Office of Health concluded the workshop with closing remarks that pinpointed and tied together the principal issues and concerns raised in the day's presentations and small group discussions. Emrey observed that certain themes introduced by the panelists had repeatedly surfaced and were developed by small-group discussants. Workshop participants agreed that urban health needs include the following:

- o **Increased awareness of the challenges and needs faced by urban dwellers in the developing world:** planners must balance short- and long-term challenges and needs.
- o **Goal clarification:** on the part of local governments, government agencies, PVOs, NGOs and private firms, as well as **definition of specific strategies for urban health** defined within the larger development community.
- o **Understanding and addressing the larger development context of health issues in urban areas:** urban poverty, marginal infrastructural/government support.

- o **A focus upon the actual people** who are affected and in need of health care. Accordingly, efforts at community organization and empowerment are paramount.
- o **Good, reliable, comparable information**--data on urban populations, health care and delivery--to understand better the complexity of health problems and their linkages and to design proper strategies.
- o **Institutional involvement:** needs to be varied and extend beyond the traditional scope of national health programs. Those involved in urban health issues will need to tap successfully and innovatively into alternative sources for health care services, such as local and municipal jurisdictions, various types of community groups, the private sector, and ministries other than ministries of health.

URBAN HEALTH: SHARPENING THE FOCUS

I. INTRODUCTION

The second A.I.D. Office of Health workshop on urban health afforded professionals from varied fields and backgrounds the opportunity to advance current thinking and contribute to the knowledge base currently available on urban health issues. The primary objective of the workshop was to identify organizations and individuals active in urban health care programs and to gain an overview of what such groups and persons have done, are doing currently, and the results of these efforts.

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II. SETTING THE CONTEXT: HEALTH ISSUES IN THE URBAN SETTING

Ann Van Dusen of the Office of Health introduced the panel discussion by citing several reasons why the urban environment is unique in terms of health care:

- o Urban populations are much more heterogeneous than in rural areas; urban residents thus require a greater variety of health services, approaches and communication efforts.
- o Policy administration in cities frequently is focused upon municipal government, rather than the national ministry of health.
- o Epidemiology in large urban areas differs dramatically from rural areas: new diseases uniquely associated with urban living conditions bring about new challenges and demand unique responses distinct from traditional, rural-oriented health care programs.

Ken Olivola, John Snow, Inc.

Ken Olivola is an urban planner with John Snow, Inc. who has worked in Asia and Africa with UNICEF and A.I.D. Olivola presented a background paper outlining urban trends and future implications for health concerns at the first urban health workshop; please see the A.I.D. Office of Health report "Health in the Urban Setting" (March 1991) for discussion of Olivola's presentation, including a copy of his original paper and specific urban data on various countries.

Governments in developing countries have attempted several approaches to counteract massive urban growth and increased demand for services. Since the first wave of development projects aimed at urban growth, primarily in the 1950s, governments gradually adopted more realistic, though less encompassing tactics, finding it all but impossible to provide the necessary infrastructure to cover adequately the growing marginalized populations in large cities. Gradually, with few or no resources to provide housing and infrastructure, governments sought to provide only the most basic of services.

Urban health care is inextricably linked to urban conditions such as housing and food availability, and urban growth. Accordingly, government programs designed to address particular concerns of the urban poor invariably have impacts on other issues. Even programs with the best intentions may have inadvertent, adverse effects on health conditions. For example, governments in several countries, including Bangladesh, Peru and India, have provided loans for low-income families to build their own houses. However, the sudden ability to purchase land or enter the housing market often came at the expense of family nutrition; families' reorientation of their incomes and budgets toward such purchases resulted in proportional increases in child malnutrition.

Showing slides of precarious living conditions in urban slums, of horrendous housing and sanitation conditions and tremendous congestion, Olivola observed, "It is amazing that people survive at all." The stakes of health care are enormous. For most urban poor, health care does not merely concern treatment of occasional illnesses; rather, whether adequate health care is available and accessible often determines whether many live or die. Accordingly, health care in the form of treatment services is frequently the second greatest household expenditure, after food.

Three issues are salient in urban health:

1. **The information base on urban areas is extremely poor.** For effective planning and implementation of health programs, good, detailed data, which give an accurate picture of what is actually happening in cities, are greatly needed.
2. **Challenges and needs are great in urban areas, but so are the possibilities for making progress.** Due to the concentration of populations of five-to-ten million in relatively

small areas, pure logistical concerns usually associated with rural areas--how physically to get the people to services and the services to the people--are reduced as obstacles.

3. Local government involvement is imperative in urban health care provision. However, in most countries the local government's capacity to plan and implement programs is weak, and national-level programs frequently do not apply to the largest urban centers. The ministry of health, then, is not the sole provider; indeed, in some countries, it is actually barred legally from operating in municipal areas. Involvement of other organizations located in cities, such as NGOs, PVOs and private sector urban employers, which often have their own health programs, are thus indispensable components of health care initiatives.

Urban health should not be viewed as a new intervention, but as part of a larger development strategy (or strategies, tailored to individual country and city needs). A basic need exists for greater and more practical experience working in health in urban areas. Even though rural-to-urban migration may have tapered off in certain countries since its peak in the 1970s and 1980s, urbanization is a fact of life in the developing world. Recent increases in urban population as a result of natural growth place further burdens on limited urban health services. If these countries are to have a healthy populace, a focus for health initiatives must be cities, where such populations can be addressed directly.

III. PANEL DISCUSSION: EXPERIENCES FROM THE FIELD

The four panelists that followed Ken Olivola's discussion presented unique perspectives on urban health and development. Their talks included a discussion of health care problems in poor urban settlements in the Dominican Republic, health problems faced by homeless and working street children worldwide, a World Bank policy perspective, and a view of government health care policy-making, principally in Swaziland. Panelists were:

David Scott Luther, Executive Director, Instituto Dominicano de Desarrollo Integral
Marilyn Rocky, Director, CHILDHOPE USA
Carl Bartone, Senior Environmental Specialist, World Bank
Margaret Price, Interim Director, International Institute of Health,
Drew University of Medicine and Science

Scott Luther, IDDI

Scott Luther is the executive director of Instituto Dominicano de Desarrollo Integral, the largest non-profit organization working in urban development in the Dominican Republic. IDDI is active in education, income generation, housing and health projects.

Quality of life is rapidly deteriorating in the Dominican Republic's urban areas. In Santo Domingo, 64 percent of the population--more than one million people--lives in slum areas.

However, this segment of the population occupies only 19 percent of the land, creating situations of overwhelming density. Slum dwellers occupy the land that no one else wants.

This marginalized population has no electricity, communication systems or sanitation services (no garbage collection or drainage system). If the poor has any public water supply, it is often contaminated by chemical pollutants. The national government, beleaguered by severe economic constraints--last year, for example, the country averaged but two hours of electricity per day--has found it exceedingly difficult to intervene in efforts to improve living conditions.

Luther accompanied his talk with a series of dramatic slides, vividly depicting the "wretched living conditions and physical anarchy" of Santo Domingo, where intense competition for food, water and shelter are horrifying but daily realities for many urban poor. Most development measures seem to deal only with symptoms rather than causes: efforts are mere palliatives, rather than effective efforts at problem resolution. The magnitude of the problems and near-bankruptcy of the government are such that stop-gap measures are the best that can be hoped for in the short term. It does little good for officials to discuss improved hygiene, when garbage is piled at the windows of the poor; the development community talks in grand terms about nutrition and supplemental feeding when great numbers of marginal populations have no means to buy even minimal food supplies. Health and development administrators need to assess what effect their efforts are really having: "Are these stop-gap, emergency measures? Or are we trying to develop these people? Are these people the objects of development or subjects of development?" In assessing program impact, it is important to remember that most true indicators of development are not actually quantitative, even though these are the indicators most commonly used. Improvements that make a difference in people's lives are considerably more complex and primarily qualitative in nature. Since it is virtually impossible to measure qualitative differences empirically, it must be recognized as acceptable for improvements to be qualitative rather than predominantly empirical.

For qualitative, long-term change in health conditions, societal structures must change. Poor health care and coverage must be viewed in terms of the larger development picture. What should be the focus of develop efforts? Simply health? Or can health serve as a catalyst for greater, systematic change? A new model of development, one which focuses explicitly on the people themselves and includes them as part of the process, is required. Such a model must strive to raise consciousness and develop mechanisms for self-development, providing actual opportunities to individuals. The prevailing system in most developing countries benefits some groups more than others; certain segments of the population do not receive even minimal government support. At the most basic level, communities must be educated and organized. People must know what their future is, what their development possibilities and opportunities are. They must know why, and they must know how.

A balanced strategy, mindful of both short- and long-term goals, must be implemented. To have any recognizable impact, persons and organizations involved in public health and development must be much clearer about goals. In the short term, living conditions, sanitation and employment opportunities--the short-term realities of the urban poor--should be incorporated

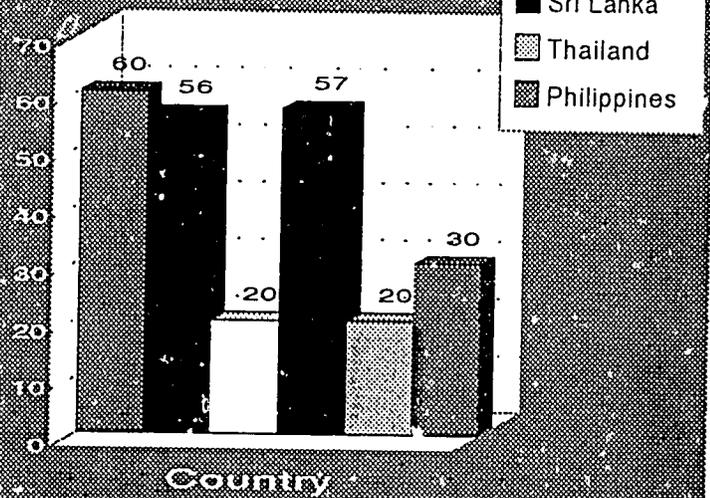
into an inclusive health and development strategy. In the long term, strategies must integrate the people themselves into the decision-making process.

Percentage of Urban Poor in Substandard Housing with Inadequate or No Services, 1980*

(SOURCE: WHO, 1988)

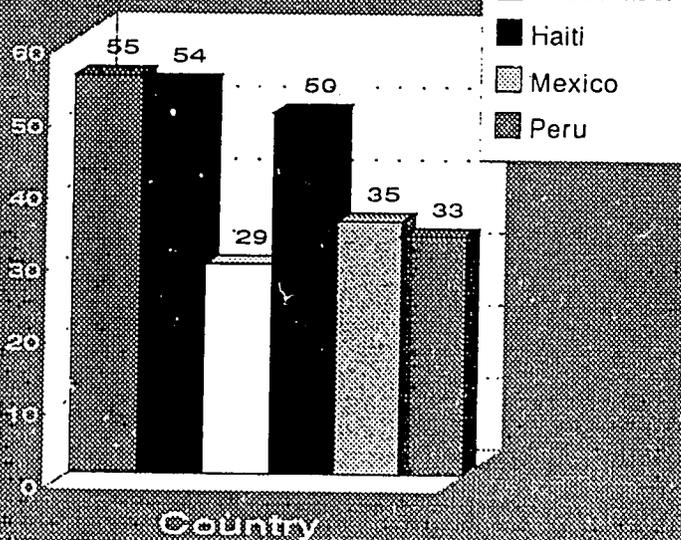
Southeast Asia

Percentage (%)



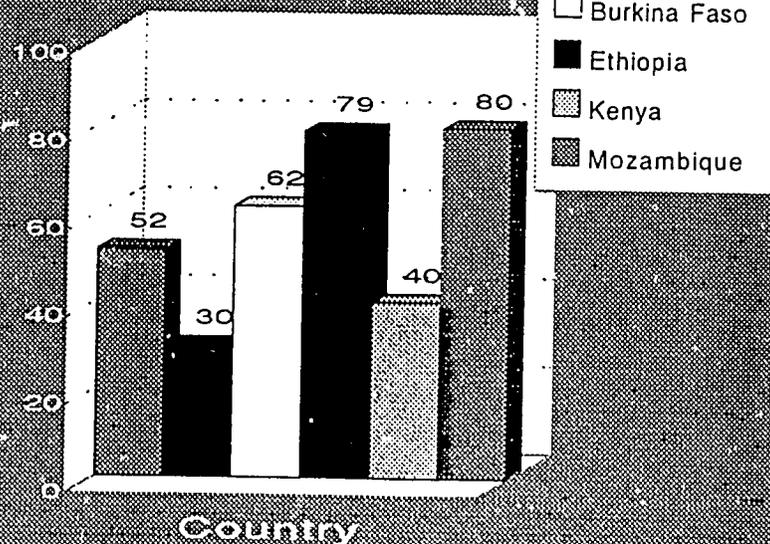
The Americas

Percentage (%)



Africa

Percentage (%)



* Latest data available

Carl Bartone, The World Bank

Carl Bartone is senior environmental specialist of the Urban Development Division of the World Bank, where he works on issues of waste management, pollution control and urbanization. Prior to joining the Bank, Bartone was with the Pan American Health Organization in Latin America for 15 years, where he served as research director of PAHO's Pan American Center for Environmental Engineering and Sciences, in Lima, Peru.

Urban lending at the World Bank is receiving increased attention: The Bank's urban portfolio over the next three years is expected to double, including lending for urban management and environmental projects in areas such as water and sanitation, industrial pollution control and transportation. However, a significant problem is the lack of sectoral knowledge of what is being done and what impacts programs are having in terms of improving living and working conditions in the cities. Toward this end, the World Bank is engaged in research and policy analysis and evaluations. The Urban Development Division is seeking to define a new urban development policy and has set up a special vice presidency expressly for this purpose. In April, the Board of Directors adopted a new strategy for urban lending, based on a policy paper issued by the Bank.

The Urban Management Program, a joint effort of the United Nations Development Program, U.N. Center for Human Settlement in Nairobi, and the World Bank's Urban Development Division, is an example of Bank efforts to focus on issues critical to improving the management of cities in the developing world. It is dedicated to ensuring that cities remain "productive and healthy places," with the resources and infrastructure necessary to manage the urban environment. The program aims to provide a critical look at urban poverty, firmly placing environmental and health concerns in a development context. Urban poverty is a function of both environmental factors, such as housing quality and access to water and sanitation services, and "deprivation factors" extending from control over resources, education and social support. However, as found in the Bradley et al. study of relative health impacts of environmental problems in urban areas, poverty remains the most significant predictor of urban morbidity and mortality.¹ The urban poor suffer the "worst of both worlds" in terms of health hazards: not only are they exposed to infectious diseases at rates much higher than their rural counterparts, but environmental conditions in cities, including deficient pollution controls, increase vulnerability to health problems.

The confluence of not having dealt adequately with health problems of underdeveloped areas and not possessing the capacity to confront the health issues resulting from modernization, industrialization and increased life expectancy, all of which have contributed to a changed epidemiological profile, has plagued local government and donor organizations efforts in urban

¹ David Bradley et al., "Relative health impacts of environmental problems in urban areas of developing countries," a report submitted to the World Bank, 1 June 1990.

health. Changing profiles have considerable implications, as yet unaddressed, for health care programs.

A strategic framework analyzing the problems and determining appropriate action plans and approaches is being developed by the Urban Management Program. The research orientation of the program aims to counterbalance the dearth of reliable information about cities. The World Bank sees as one of its primary roles the development of better information bases for decision-making, seeking an understanding, for example, of what health and economic impacts result from environmental problems in urban areas. The Population and Human Resources Department of the Bank is currently conducting 16 case studies of cities worldwide to study the links between health and the environment. It is expected that these studies will identify emerging health priorities.

Based on the World Bank's policy paper, six matters are included on the agenda for the environmental management of cities in the developing world:

1. **Increase awareness of environmental health problems among all population groups.** Such consciousness is essential for effective community participation and the building of political will needed to prompt political leaders to invest the necessary resources to address environmental and health problems. For example, in Cubatão, Brazil--one of the world's most polluted industrial areas--community mobilization and political pressure have effected positive change, establishing a public commitment to more stringent pollution controls.
2. **Improve understanding of the dynamics of urban environmental problems and linkages to health.**
3. **Address and protect city productivity to ensure that urban areas continue to contribute to increased wealth and quality of life in developing countries.**
4. **Identify specific strategies for environmental health management in cities.** Generic strategies developed across regions and countries will be insufficient, as they fail to address the particulars of individual cities and their unique health and environmental problems.
5. **Increase attention on high-priority, curative actions,** which focus on the severe infrastructural failures facing the urban poor, such as industrial pollution control and municipal waste management.
6. **Focus on long-term, preventive measures, such as incentives and policy changes attendant to health problems and build a base for confronting problems now rather than in the distant future.** Governments must confront issues such as pricing policies, which leave great numbers of the urban poor unserved because certain areas of cities, primarily middle and upper class neighborhoods, receive municipal services free of charge. Local governments must have strengthened regulatory capacities. They can play an important part in urban health, but at present they have very weak regulatory roles.

**ESTIMATED CAUSE-OF-DEATH PATTERN IN DEVELOPING COUNTRIES
AROUND 1985 (Adapted from Lopez, 1990)**

Cause of Death	Number of Deaths (millions)		
	< 5 yrs	> 5 yrs	All Ages
1. Infectious and Parasitic Diseases	10.5	6.0	7.0
1.1 Diarrhoeal Diseases	4.0	1.0	5.0
1.2 Tuberculosis	.3	2.7	3.0
1.3 Acute Respiratory Diseases	2.8	2.0	4.8
1.4 Measles, Whooping Cough, Diphtheria	2.2	-	2.2
1.5 Malaria	.7	.3	.1
1.6 Schistosomiasis	-	.2	.2
1.7 Other Causes	.4	.4	.8
2. Maternal Causes	-	.5	.5
3. Perinatal Causes	3.2	-	3.2
4. Neoplasms	-	2.5	2.5
5. Chronic Obstructive Lung Diseases	-	2.3	2.3
6. Circulatory & Degenerative Diseases	-	6.5	6.5
7. External Causes	.2	2.2	2.4
8. Other/Unknown Causes	.7	2.8	3.5
ALL CAUSES	14.6	23.3	37.9

Marilyn Rocky, CHILDSHOPE USA

Marilyn Rocky is the director of CHILDSHOPE USA and regional director for North America of CHILDSHOPE Foundation. She serves as an expert witness on children's issues before the U.S. Congress and actively works to keep the matters of homeless and orphaned children on the agenda for national policy-makers.

The Independent Commission on International Humanitarian Issues reports that populations of cities in the developing world are dramatically younger today than in previous decades. By the year 2000, half of the world's population will be under 25 years of age. There will be 247 million more urban children between the ages of five and 19 than there are today; of those, 233 million will live in developing countries. Latin America by the year 2020 will have nearly 300 million urban minors, of whom 30 percent will live in extreme poverty. Consequently, the number of street children living in complete or partial abandonment is likely to grow by the tens of millions.

Children work and live on the streets either because of a lack of economic opportunities in smaller cities or rural areas or because they are orphans with no other support system. Rapid processes of urbanization also have severely disrupted the support systems usually extant in rural areas. More than 100 million youths are estimated to live and work--throughout the majority of their lives--on the city streets in countries of the developing world. In Brazil, for example, UNICEF reports that 17 million children work on the streets, their marginal economic activities ranging from trinket sales to prostitution. Seven million actually live on the streets. More than 10 million youths work on the streets in Mexico. In Thailand, 800,000 girls under the age of 20 work on the streets or in brothels as prostitutes. Formerly, these children have virtually been ignored, left to fend for themselves, or regarded as a public nuisance. Today in several countries death squads operate, targeting children and "disappearing" them as a quick "solution" to street crime and unemployment.

Street youth have been described as one of the most exploited populations in the world and one of our most poignant social challenges. Health concerns of this marginalized population focus primarily on survival. Street children are especially vulnerable to under- and malnourishment, AIDS and other STDs, drug addiction and work accidents, from which they receive little or no protection or compensation. Work and living conditions render them highly susceptible to infectious diseases; many of the children work in dangerously polluted and contaminated areas such as city dumps, and many resort to "survival" drugs, sniffing glue and petrol, substances that attack their central nervous systems. The AIDS pandemic is especially frightening among street youths, many of whom have frequent unprotected sex with paying customers as well as among themselves. The World Health Organization estimates that 10 million children worldwide will have AIDS by the year 2000. Despite these realities, street children receive only the most rudimentary health services, if any at all.

CHILDREN ON THE STREETS

Brazil	17 million children working on the streets
Mexico	10 million children working on the streets
Thailand	800,000 child prostitutes (female)
Philippines	50,000 - 75,000 street children (30% are prostitutes)
Guatemala	1.5 million children living on the streets

Worldwide (Developing Countries) 100 million youths live and work on the streets

* UNICEF estimates

CHILDHOPE Foundation's activities on behalf of homeless, orphaned and unprotected street children focus on two areas:

1. **Development of alternative health delivery systems.** CHILDHOPE seeks to train people who can develop access to street youths. Access is itself very difficult; the children trust few outsiders and do not respond well to traditional approaches. CHILDHOPE believes it must give them the will to survive beyond their meager day-to-day existences. The children somehow have to be convinced that their lives are worth living, though psychological appeals are certainly diminished by physical maladies and needs.

2. **Developing alternatives to street jobs, providing income and means for economic survival.** If street children have ways to survive without resorting to inherently dangerous alternatives such as prostitution and sorting through garbage dumps, they are more likely to lead healthier lives.

Margaret Price, Drew University

Margaret Price is the interim director of the International Health Institute of Drew University. For the past three years, she serve as an advisor to the Ministry of Health in Swaziland, assisting in efforts to improve the management of clinic services.

As illustrated in Swaziland, an urban health program must emphasize the people themselves and development of opportunities for the community. *Sine qua non* for implementing such change is the need to build communities and political will in order to empower local, poor urban populations. Many government agencies are overwhelmed by the vast problems of mega-cities; they do not know where to begin, and strong technical skills are required to effect

significant change. Thus, it is important to generate and build political will on the part of the people. In the process, developing problem-solving skills is essential, so that communities can act on their own behalf.

Price contended that "water comes from the top down"--government and international development and health agencies/organizations must be fully involved in implementing change on a policy level to support and nourish community-level change. Teamwork is absolutely necessary; individual organizations do not singularly possess the requisite resources. Persons working in agriculture and education, for example, may serve as important resources in health campaigns.

Instituting health programs on the community level involves the incorporation of multiple and diverse organizational tiers. Improving the health of the urban poor is a function not only of the health system, but the entire public system and all levels of government and decision-making--central, regional and local. "Program movers" operate at all three levels. Usually it is the central level that determines such critical factors as logistical support, supply provision and staff funding; thus it certainly is necessary to gain access to this highest tier of decision-making. Structural battles encountered at various tiers are frequently the result of varying perspectives and agendas. (Please see the diagrams on the following pages for a depiction of factors affecting clinic management in Swaziland.)

One level of the power structure often overlooked in developing countries are traditional systems, an essential element of the social infrastructure. To gain access to traditional lines of decision-making, it is imperative to recognize and understand socio-cultural parameters, to build a support base among, and gain the confidence of, the communities that are the actual subjects of local-level planning. Encouraging community participation among fragmented urban communities is especially demanding, since few real community structure and support systems exist to the extent that they usually do in rural communities.

Efforts to improve urban health must be firmly situated within a larger development context. Neither governments nor the people themselves rank health as a top priority. Budgets for public health programs in most developing countries are lamentably small. Many international organizations do not assign funds directly to health-only initiatives. Thus, the need to combine efforts and resources is fundamental.

As illustrated by the case of clinic management in Swaziland, efforts focused on community-building and empowerment. Previous efforts to organize and mobilize the urban poor of slum communities had failed, and government agencies as well as NGOs had essentially abandoned such projects, citing a lack of problem-solving skills and adequately trained personnel. To overcome such difficulties, a multidisciplinary team was formed to implement an approach based on training, action plans and training of trainers. Several problem areas were identified in the local health care of slum dweller communities, including:

- o Community-building and establishment of community participation;

- o Utilization and demand for health services;
- o Continuity of care;
- o Supervision;
- o Personnel development; and
- o Quality of services delivered to slum dwellers.

Achievement was primarily in three areas:

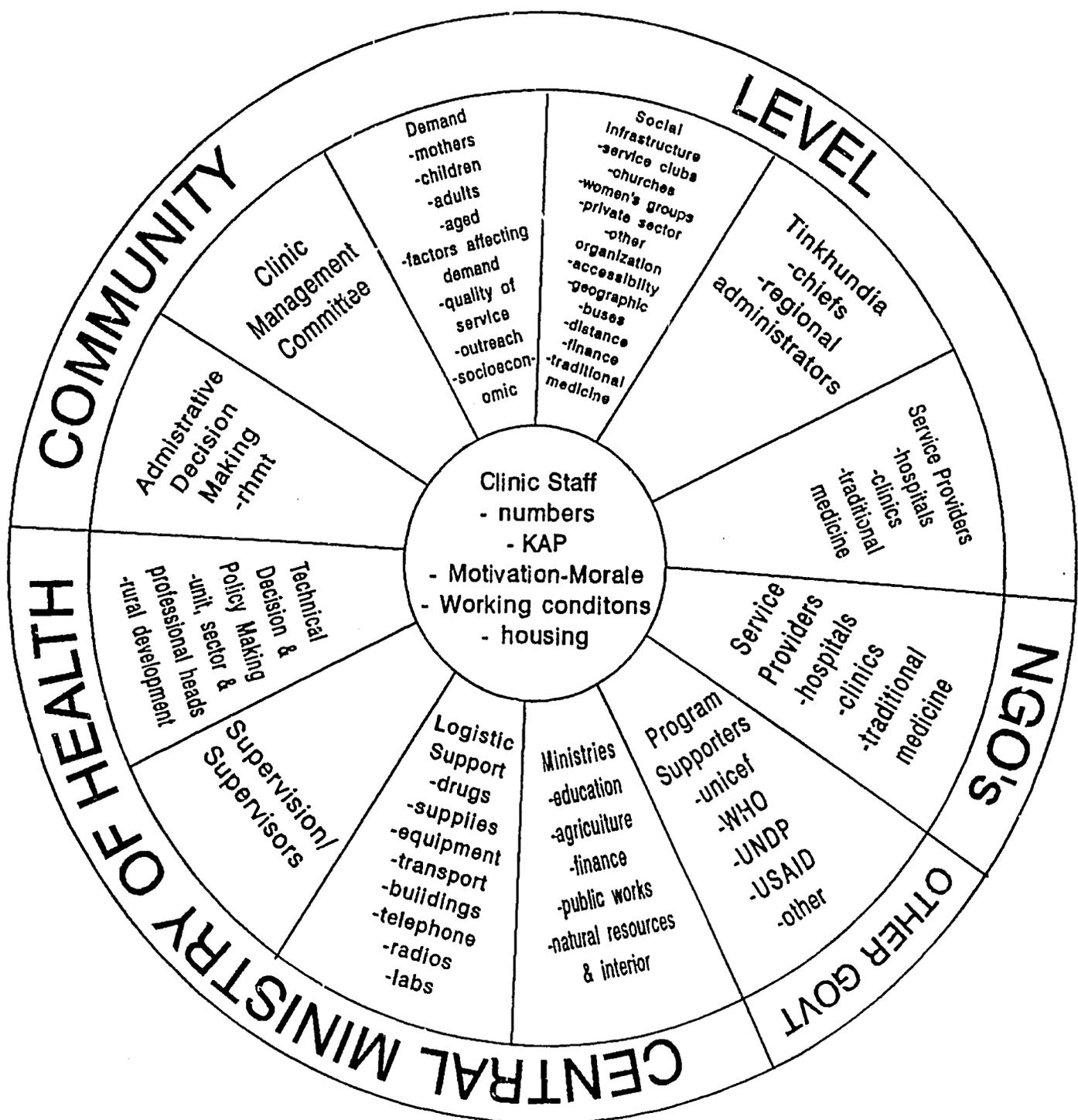
1. Effecting structural changes within the local community and prompting its involvement;
2. Establishing a base for local-level political decision-making; and
3. Prompting a parliamentary-level committee to study the problems of slum communities.

Basic problem-solving and decision-making skills were imparted to the urban poor; applying these skills resulted in the development of agreed-upon priorities. Participants decided if particular health needs and proposals were desirable and/or achievable and what their costs and impacts would be. The project's interdisciplinary training approach identified needs and expectations--using learning logs so that participants could record what they were hearing and discussing--and emphasized training of trainers to create continuity in the process. Community members were themselves responsible for the entire teaching and learning process. The program sought to instill a sense of achievement and confidence among the community, tackling problems one layer at a time, so that individuals would not feel overwhelmed by the enormity of the challenge.

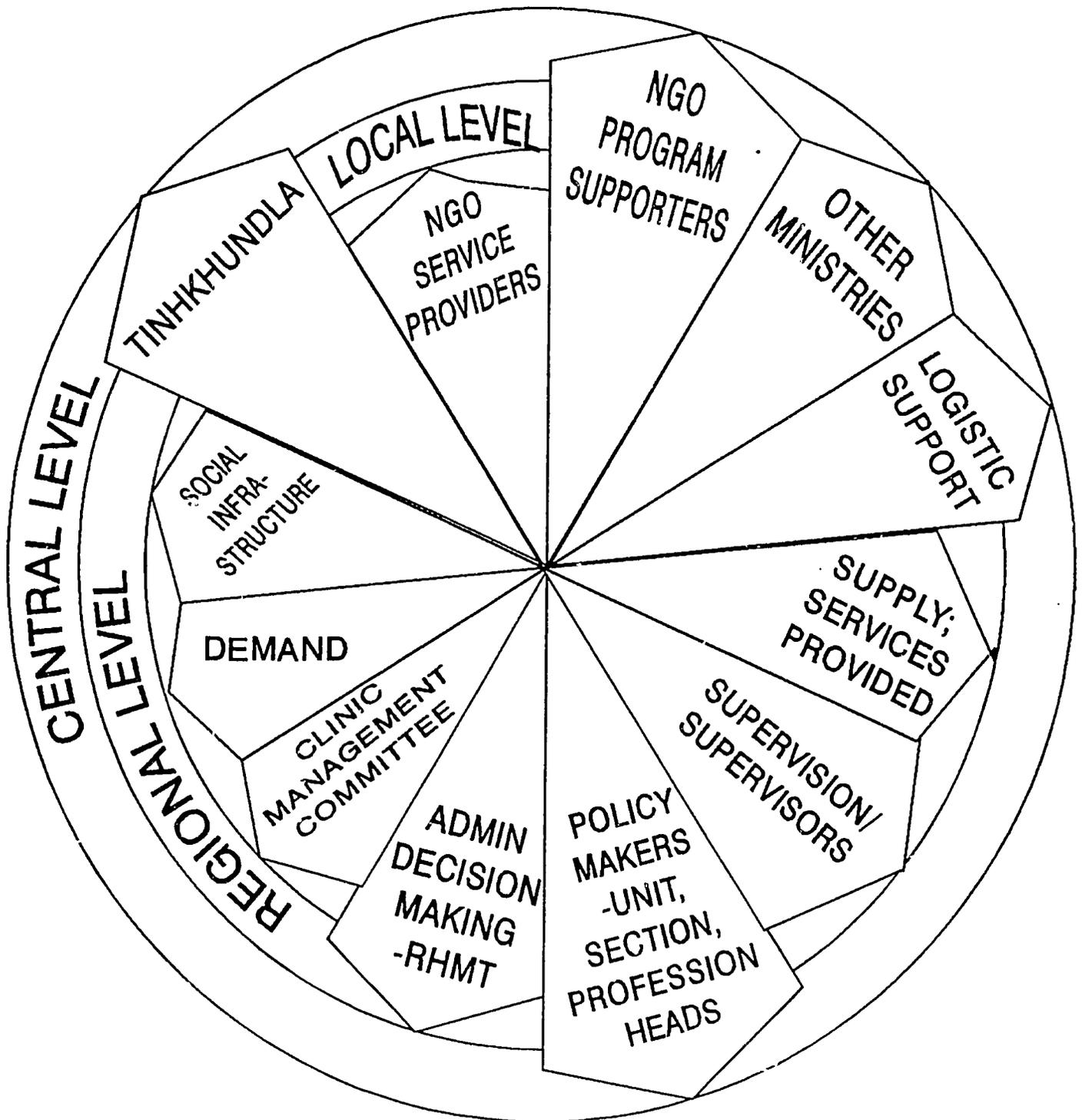
Success of the community-based health initiative in Swaziland was a function of several elements:

1. Intersectoral and intrasectoral collaboration for parallel growth;
2. Focusing on comprehensive community development rather than a singular focus on health issues;
3. Generation of political will to effect change;
4. Commitment, based on true involvement in and taking responsibility for community affairs, and the resulting confidence and sense of achievement;
5. Manageable size of problems addressed; and
6. Respect of the dignity and rights of the population in all approaches to the community.

FACTORS INFLUENCING CLINIC MANAGEMENT IN SWAZILAND



FACTORS AFFECTING CLINIC MANAGEMENT WITH LEVELS FROM WHICH THEY OPERATE



IIV. SMALL GROUP DISCUSSIONS: SHARPENING THE FOCUS

Immediately following the panel discussion, workshop participants formed nine small groups, of eight to 15 persons each, to explore specific aspects of urban health, including present and foreseeable problems, impacts and possible solutions. Each group discussion was facilitated by an A.I.D. staff member.

DISCUSSION GROUPS

- o Orphans and Street Children
- o Health Care Financing
- o AIDS, STDs and Family Planning
- o Changing Epidemiology
- o Community Participation and Communication
- o Hospitals, Clinics and Alternative Care Providers
- o Health Care Communication: Advantages & Disadvantages
- o Nutrition and Breastfeeding
- o Intersectoral Coordination

Small groups provided opportunities for dynamic interchanges of ideas, personal experiences and viewpoints. The groups, instructed to focus on the particular significance of the urban setting on their group issue, were asked to:

1. Brainstorm on issues pertinent to their topic;
2. Rank issues according to how critical they are to health and, given economic, political and socio-cultural realities, how likely (and realistic) is positive change; and
3. Identify group members' experiences in the issues under consideration, to illustrate the range of projects undertaken and by whom, specific actions taken, and their outcomes and consequences.

After their hour-long discussion, each group, having appointed a rapporteur and speaker, reconvened in plenary session and presented a summary of its major findings and viewpoints.

1. Displaced and Orphaned Street Children (Lloyd Feinberg, A.I.D. Office of Health)

A number of factors fundamental to the health problems of and threats to street children in urban areas were identified. The most critical factors were determined to be: survival and strategies for survival; large and rapidly increasing numbers of children on the streets; government/institutional capacity to respond to the children's plight; and lack of recognition of or advocacy for this marginal population. Other issues considered extremely important included the problems of abandonment; disintegration of the family and community; AIDS; economic and structural adjustments/pressures; and lack of basic support systems, such as education, health care and shelter.

The group emphasized that the growing problem of street children is not a condition unique to developing countries; it is a global problem. However, the numbers and problems of street children appear to be most rapidly worsening in LDCs. Group participants related several professional experiences working with street children. One group member discussed UNICEF's projects that address this marginalized group through working with NGOs like CHILDSHOPE. Another participant noted that the Peace Corps has adopted a new organizational initiative that targets youth at risk.

The "street children" small group identified a number of needs and areas in which government agencies, PVOs and NGOs could effectively intervene and protect or ameliorate the living conditions of street children. For example:

- o **Provide street children with skills and access to health care, education and shelter.** Forcibly removing children from the streets is only a temporary "solution" that solves none of the underlying factors that place them on the streets.
- o **Accept children in their own right and implement children's rights.**
- o **Recognize the street as the center of the children's lives; allow them to remain non-institutionalized.**
- o **Provide alternative programming to meet the special needs of street children.**
- o **Recognize the role of NGOs and their capacity to support international agencies.**
- o **Mobilize and sensitize development institutions to the critical issues and program needs of street children, as well as the implications of major development programs on poor and marginal families.**
- o **Address the underlying causes of large numbers of children living and working on the streets--population pressures, un- and underemployment and**

urban migration, for example.

- o Mobilize governments to *react to* and *act on* the needs and issues of street children.

2. Health Care Financing

(Bob Emrey, A.I.D. Office of Health)

The cost of health care programs and individual services was a factor in several of the panel discussions, especially as panelists discussed limitations and lamented government inabilities to pay for health care improvements. In the course of its brainstorming session, the group identified 15 urban-related aspects of health care financing:

1. Financial management;
2. Decentralization;
3. Mobilization and allocation of resources (employers, unions, etc.);
4. Priority-setting (according to treatment, transportation, etc.);
5. Efficient use of concentrated health care services in urban sectors;
6. Competitiveness for funds within and between sectors, as well as between private and public providers, and coordination/collaboration with outside funders;
7. Disparate social and economic strata;
8. Failure to tap available resources;
9. Demand for health services outstripping supply;
10. Changing epidemiology, toward more "expensive" (i.e., chronic and or lifestyle) diseases; and
11. Health services concentration on curative care (hospitals).

The health care financing group ranked three issues as most critical in terms of urban concern: management; demand vs. supply; and resource management.

Management

Management concerns included the concentration of capacity and resources; the possibility of more widespread corruption in urban than rural settings; and complicated coordination among various levels of government related to health services--multi-level and sector coordination of resources.

Demand

Demand for basic health care services is a sizable problem in cities of developing countries. In most countries, considerably more urban dwellers are in need of health services than there are services available. In addition, health care among the urban poor is plagued by a lack of access to and utilization of available services.

Resource Management

The fundamental problem associated with resource management, as decided by the group, is the tendency to allocate funds disproportionately to curative services.

In its dialogue on group member experiences in these three critical areas, the group focused upon examples of programs that seem to have been effective.

Management (multi-level and sector coordination of resources)

- o Niger: Institution-building and training fortified accounting systems at various levels.
- o Zaire: Direct grants to local NGOs circumvented ineffective coordinating capacity.
- o Dominican Republic: Indigenous HMOs were expanded by channeling funds through non-corrupt organizations.

Demand-vs.-Supply:

- o Swaziland: Provided health education to improve access and utilization.
- o Niger: Encouraged use of private sector resources by allowing individuals to leave the MOH and set up their own health care service businesses. The program also encouraged a number of doctors to establish their own practices, thus reducing pressure on public facilities that supply services to the poor.
- o User fees/barter systems: Encouraged traditional community participation in several countries.

Resource Management

- o Jakarta, Indonesia: Developed employee insurance schemes in slums to relieve public resources for curative care.
- o AIDSTECH/AIDSCOM: Has focused upon preventive approaches for STDs and AIDS.
- o Generation or freeing-up of funds through Bangkok initiative-like programs for PHC.

In a "last-minute brainstorming session," the health care financing group added two important points in need of attention. First, many donor organizations, contractors and

government agencies appear to have the mistaken perception that cost control of treasury funds is the exclusive responsibility of the ministry of finance. In reality, cost control is also the responsibility of the ministry of health. Second, the group agreed--and urged--that user fee exploration must be expanded to include services for barter, so that the urban poor can trade services or goods for medical services, in lieu of cash payment.

3. AIDS, STDs and Family Planning

(Ruth Frisher, A.I.D. Office of Research and University Relations)

AIDS and sexually transmitted diseases had been mentioned in several contexts in the earlier panel presentations, and they were subjects of many of the small group discussions as well. AIDS and STDs, along with family planning, are obvious concerns to those working in urban health. Brainstorming in this discussion group produced a plethora of issues endemic to AIDS, STDs and family planning in the urban setting, such as:

- o Role of prostitution in spreading AIDS & STDs;
- o High risk populations: identification linked to data;
- o AIDS: risky groups vs. risky behaviors, including sexual behavior and drug use;
- o Migration/rapid population growth/density/overcrowding;
- o Quality of care in family planning;
- o Adolescence: legal and political constraints to provision of condoms; links to high risk groups;
- o Access to urban health care services and products;
- o Fear of government services; gulf between literate and non-literate populations; culturally appropriate information, education and communication (IEC) and integration of these three: how to promote the integration of reproductive health;
- o Financial resources and sectoral separations; need for intersectoral collaboration;
- o Relationships: notification of status;
- o Homeless populations and the spread of AIDS and STDs;
- o Availability of supplies;
- o Scarcity of urban-specific data on demography, KABP, epidemiology;
- o Unwanted and/or sick babies;
- o Cultural/traditional attitudes and methods toward birth control, STDs;
- o IEC/KABP issues (media, methods, content); and
- o Community-based initiatives and voicing of demand for family planning services.

The group ranked these issues according to their urgency, in short-, medium- and long-term time frames.

Short term

The participants placed data for decision-making systems and high-risk populations in the first

group of issues, requiring short-term action. Immediate progress can be achieved in both areas, the group concurred.

- o Data for decision-making are especially needed in demographic, epidemiologic and technological capacity issues: fertility/unwanted pregnancy; high risk populations/behaviors/drug abuse; urban overcrowding and migration patterns; data on epidemiology; and joblessness situation and trends.

Medium term

IEC and KABP interventions were judged priorities among issues requiring a medium-time frame response. The group warned that initiatives involving mass media, entertainment, social marketing and peer groups must be aware of ethnic, cultural, religious and political variability among communities.

- o Discussants felt that reaching heterogeneous urban populations demanded a wide range of media and tactics. Members believed that this was in fact achievable, even without a great amount of funding. The mass media--rock videos and radio shows, for example--could be especially effective in such efforts, though precise targeting would be essential for effective message transmittal.

Long-term

Over the long term, organization and delivery of services and resources need to be addressed. Particular issues include: community and political commitment; sectoral separations; funding resources and recoverable financing; quality assurance to overcome fear and distrust; and integration of STD/FP/MCH/AIDS services.

- o The group terminated its discussion by ranking the top issues in order of progress to date. The most significant progress, the group maintained, has been made integrating and organizing resources and services. Somewhat less successful has been the establishment of data decision-making systems and last in terms of progress, the group listed KABP/IEC interventions.

4. Changing Epidemiology

(Jim Shepperd, A.I.D. Office of Health)

The small group that discussed changing epidemiology focused on identifying changing denominators, indices and changes in EPI related to urban areas.

Epidemiological concerns of the group were many, including: polio and measles; stress and mental health; homelessness; family breakdown; pollution; auto accidents and occupational

injuries; continuity of care; problems in education and mobilization; drug and alcohol abuse; domestic violence; chronic diseases such as hypertension, cardiovascular disease, diabetes, and cancers, particularly as they occur at younger ages; smoking; environmental hazards; overcrowding; reproductive health; TB; AIDS; disabilities; and nutritional factors undergoing change in the urban environment, such as dietary changes and breastfeeding among working mothers.

The group maintained that a number of urban-related factors are exhibiting considerable impacts on epidemiology: demographic dynamics, such as changing age and class structures; transfigured population pyramids (due to an aging work force and introducing a higher rate of health problems among the young); populational heterogeneity (affecting matters such as immunization and susceptibility); and urban vs. rural population flows.

The group concurred that the following factors complicate epidemiological problems of urban areas:

1. Needs and demand for delivery capabilities, tied to exponential growth rates, have increased dramatically.
2. Present resources cannot support growth, and many existing resources are poorly distributed within cities.
3. Health concerns frequently occupy low priority among national and municipal governments.
4. The urban poor suffer the "worst of both worlds"--suffering from both chronic and communicable disease.

Areas requiring attention by governments, donor organizations, NGOs and PYOs dominated the discussion of the changing epidemiology small group. So-called "response issues" were:

1. **Comprehensive database:** Need to identify the agreed-upon numerators and denominators, establish what data are valid and reliable, and what approaches should be developed.
2. **Intersectoral competition and problem-solving:** Funds are limited, and health services must compete against other big budget items like road services. Yet, various sectors must find ways to coordinate resources and areas of expertise.
3. **Intertwined policy levels:** Many issues affecting health fall under diverse policy areas and levels (ex: pollution controls).

4. **Curative issues:** Need to be addressed if officials are to acquire a solid understanding of what preventive measures are necessary.
5. **Cultural values:** Certain traditional and family values present in rural areas, which might serve to protect communities, can be lost when families move to urban areas. In rural areas, the family tends to be the center of decision-making, a structure which is not necessarily the norm in urban areas. In addition, some families relocating to urban areas may actually be more resistant to change in their new environment.
6. **Policy analysis:** Studies of environmental health issues and policies followed by the health and economic sectors are required.
7. **Incentives/Disincentives:** Need to induce behavioral changes, especially among rural-to-urban migrant populations.
8. **Politics of health:** Health care services and delivery may be more complicated and controversial in large cities. Levels of education and awareness affect political influence, political participation is low, and political leadership and representation for marginalized communities is frequently difficult to identify. Policy-makers must be educated to comprehend the economic benefits of addressing community-wide health concerns.
9. **Information exchange:** Development of a forum for ongoing interchange of information and knowledge of successful programs is vital.
10. **Transience/Dislocation:** Problems and follow-through issues brought on by displacement and population movement need to be addressed.
11. **Class imbalances:** Most health initiatives either overlook or adversely affect at least some groups of people; the discussion group agreed that it is usually the poor that are hurt the most. Urban resources are not currently reaching the neediest populations. Yet, poor health conditions affect all classes (through the spread of communicable diseases, for example). A more equitable distribution of health care services must be achieved.

According to the group, then, health care needs in urban epidemiology fall into five general areas:

1. *Population:* definitions of denominators; definitions of urban areas; exponential growth; change in population pyramid; gap between needs and delivery; ethnicity/age/occupational factors; and host susceptibility;
2. *Multiplicity of health conditions:* both chronic and communicable;
3. *Balance:* between immediate health care treatment and long-term prevention;

4. *Information:* for data collection and case identification; and
5. *Politics of health:* Policy and health care provision are generally more controversial and complicated in the urban setting.

5. Community Participation and Communication

(Shelley Smith, A.I.D. Office of Health)

Community participation--a focus on the people themselves--was a principal theme of the urban health workshop. The group discussing community participation identified many concerns and priorities needing to be addressed to stimulate greater community involvement in health issues.

The brainstorming session produced the following ideas and needs:

- o Initiatives need to focus on the poorest of the poor: what is appropriate at the community level often differs from larger health services issues. Programs must seek to combat the traditional paternalism that often overshadows community-based initiatives.
- o Cost recovery/health financing may not reach intended target populations--i.e., efforts may reach the middle class rather than the poor. However, user fees, which may act as barriers to the poor's consumption of health services, also create value for service or program and a sense of ownership for the community.
- o Partnerships and linkages within the community need to be leveraged.
- o Communities must be accurately defined. In urban areas, if "communities" exist, they are usually more heterogeneous and families are less cohesive.
- o Marginalized communities--many are almost entirely unseen or inaccessible--in need of services in urban settings must be targeted.
- o Community participation is important on all levels, including municipalities and the central government.
- o Training for empowerment within communities is an essential component of any health initiative.
- o Evaluation/feedback is needed to sustain community interest.
- o Small steps and individual successes for motivation are extremely important.

- o Community leaders, both formal and informal, need to be identified and brought "on board."
- o Qualitative research is needed to identify community structure. Quick fixes are unlikely.
- o Programs must seek to match target interventions to the community level--i.e., some goals require macro (national policy level) change, while other interventions are more relevant to the micro-community level.

The group concluded that the foremost priorities for advancing community participation were:

1. **Allowing the community to set the agenda:** imparting a sense of ownership and response to perceived needs.
2. **Identifying and building communities:** defining what the community consists of in an urban setting and identifying the formal and informal leaders; and ensuring that needy groups are recognized, through class- and gender-based initiatives.
3. **Progress by small steps and successes:** starting with small projects and build on those successes.

Group participants identified several positive experiences fostering community participation in urban health matters:

- o *Community-initiated tenant management of public housing, Washington, D.C.:* One woman served as the catalyst and assembled a group of residents and trained them to assume the project's management. The initiative produced a number of spin-off projects, including the establishment of a health clinic and public health projects. The discussion group viewed this project as a clear example of the community taking the initiative and setting its own agenda.
- o *Healthy Cities Project:* Discovered that projects achieve greater success when they encourage communities to work on their own agenda and needs. People care about their communities.
- o *Health care in the Dominican Republic:* Demonstrated that promoting health care consciousness is very important in working with communities. The care group in the DR tapped into existing organizations, both formal and informal.
- o *Ghana neighborhood policy:* The community instituted its own regulation mandating

garbage collection once a week within the compound, requiring all households to keep their property clean or face a fine.

- o *Catholic Relief Services in Cité Soleil, Haiti:* "Poverty loans" were developed for small business expansion. The initiative formed peer groups for obtaining small loans, rather than directing loans at individuals, finding that such a project developed accountability within groups and established groups that could work together to develop the community.
- o *Urban Family Planning (CARE) in Peru:* Project directors discovered that among a group of Peruvian women, family violence was the greatest concern; only when this had been addressed could the group begin to tackle other community problems and issues, including health. The project demonstrated the importance of the group or community setting the agenda.
- o *Women's groups in Nepal:* Nepalese women are traditionally very isolated and reserved; thus, it took a long time for outsiders to gain their trust and form a group, and persuade the women to speak frankly on subjects close to them. In this project, the outcome was the process itself rather than a quantifiable goal. Lesson: quick fixes do not exist.

The small group emphasized the importance of developing sustainability within communities without fostering reliance on outside agencies. The ability to draw upon people within the communities is a strength of PVOs and NGOs. Discussants concurred that the overriding, as well as most positive, theme of their discussion was that health issues can serve as a useful and natural entree into the community and as a unifying mechanism, since they are matters to which everyone can relate and which most value highly.

6. Hospitals, Clinics and Alternative Care Providers

(Susan Kolodin, A.I.D. Office of Health)

The group addressing hospitals, clinics and alternative care providers began its discussion by posing a series of related questions. How can hospitals and clinics expand their roles in the community? Could hospitals provide more facilitative care? How can public health officials take advantage of the current interest in urban health to "co-opt" hospitals into providing improved services? How to serve the needs of those not covered by the traditional system? How does the general definition of "urban" differ from the slum settings health officials must face? What cultural issues, owing to the heterogeneity of the population, need to be addressed? What is health care-seeking behavior in the urban setting and why do health services consumers make the decisions they do? How can research about the consumer and his or her consumption of health care services be incorporated into public sector health planning, so that decisions are based on utilization and latent demand?

Hospital outpatient clinics are overcrowded, while urban-based clinics tend to be underutilized. The discussion group contended that reliable information about the consumer and consumption of health care is absolutely essential to be able to provide appropriate health care alternatives. Multiple systems, where present and available, are often used simultaneously (e.g., clinics, traditional and "informal" sectors). Convenience is an important factor for users, as is a facility's image--such as that normally associated with hospitals, connoting high technology, professional competence and status. The group argued that hospitals and clinics are "fertile ground" to provide and develop services that can extend beyond their walls, such as education, outreach, or subsidiary treatment facilities. Further, it is known that regardless of socioeconomic status, people ascribe a high value to quality health services and are willing to pay for health care that they consider worthwhile.

Changes at the organizational/policy-making level are necessary to improve the way that health policies are implemented. Generally, policies are formulated within government-to-government channels. Alternative care providers traditionally have not been part of the government policy development and health planning process. Since non-government and alternative care providers provide an increasing percentage of health services in many developing countries, it is imperative that they be included in the policy dialogue. A necessary focus of policy must be long-term solutions; results cannot and should not always be seen in the short-term. Public health officials and donor organizations are too often entrenched in present public sector, western style medical systems. They frequently lack the financial means and political will to address adequately the need for long-term planning, such as tying medical needs to demographic trends.

Health care through hospitals, clinics and alternative care providers demands a multidisciplinary approach. It was suggested that health personnel training be adapted to emphasize the role of health care "practitioners" rather than rely solely on doctors. In addition, communities should have a role in developing health-related projects.

The group ranked four issues as the most critical facing health care provided by urban hospitals, clinics and alternative care providers:

1. **Use and improvement of existing systems:** Governments and public health and development organizations must work with and build upon the infrastructure and services that currently exist--there is no "either-or" strategy.
2. **Integration of information on patterns of health care consumption (health care-seeking behavior):** Given the segmentation and heterogeneity of user/consumer populations in cities, alternative service delivery systems may be more appropriate for certain segments. In addition, the public sector hospital/clinic system may serve only a small percentage of users.
3. **Structural limits of public sector hospital/clinic systems:** Health planners must recognize that the number and quality of improvements that can be made are

limited; many systems are simply not structured to respond well to the excessive demand from urban users. Alternative systems will be required to expand services in urban areas.

4. **Selecting an alternative:** Alternatives for donor investment are most likely to originate outside the public sector. In private sector alternatives, fees are essential; they confer value upon services provided and, if service-providers are dependent upon user fees, the service provider is more likely to be responsive to health care user needs.

In general, discussants proposed that health care officials, government agencies and donors identify and emphasize alternatives to hospitals and clinics, which are currently the majority of funding at the expense of preventive services. Specifically:

1. *Donor organizations and public sector health planners need to know whom to serve and how to make information practical.* They must know how people seek care and how services can be provided to respond to consumption patterns.
2. *Community participation and planning are essential components of public health strategies for the urban setting.*

7. Health Care Communication: Advantages & Disadvantages *(Stacey Lissit, A.I.D. Office of Health)*

The need for good communication was also a recurring theme of the urban health workshop. The health care communication group decided that its topic lent itself better to a broad-based discussion of the implications of an urban setting for health communications than a ranking of issues. Accordingly, the group discussed a number of qualities intrinsic to cities that members felt were advantageous or disadvantageous to health communication and selected one issue of greatest need. The discussion group reached a consensus, deciding that, overall, urban areas pose greater advantages for innovative and effective health communication than disadvantages, and that efforts to reach "hard-to-reach" communities must be a priority.

The group viewed the following as advantages of urban environments in facilitating health care communication:

- o *Greater access and exposure to mass media, especially radio and television, even in very poor communities:* One participant observed that, in a campaign in Dhaka, 85 percent of the urban population had been exposed to a mass media campaign, and immunization coverage efforts in Bangladesh successfully used not only radio and TV, but also alternative media such as bumper stickers.

- o *Multiple health resources to tap:* community groups, schools, political groups, churches, local businesses, PVOs, NGOs and local government.
- o *Greater receptivity (flexibility) to new values and ideas--and* the corresponding opportunity to create new norms.
- o *Good physical (geographical) access to health services.*
- o *Opportunity for innovative approaches to facilitate communication--in* the workplace and through large employers.
- o *Possible higher rates of literacy,* facilitating health education campaigns.

The group viewed the following qualities of the urban environment as disadvantages or constraints to effective health care communication:

- o *Breakdown in traditional family and community values* according to changing values in the urban setting.
- o *Absence of community--cities* are increasingly fragmented, heterogeneous conglomerations.
- o *Difficulty of organizing interpersonal communication channels and networks.*
- o *Difficulty of identifying appropriate leaders and catalysts.*
- o *Need for a variety of research and multiple messages* to address multiple target (heterogeneous) groups, and cost associated with such needs.
- o *Chronic difficulty of reaching urban "fringe groups"--those* marginalized individuals with tenuous ties to urban communities.

The group agreed that the principal failure of most health communications in cities was the persistent inability to tap the "hard-to-reach," the marginal and poor, fragmented socioeconomic groups that, because of such factors as poor geographic access and high illiteracy rates, often do not receive generalized health messages. Possible strategies were identified that could provide access to hard-to-reach communities, and were tied to specific group member experiences in or knowledge of alternative communication efforts.

Strategies that might allow governments and donor organizations to reach the hard-to-reach include:

1. **Identifying nontraditional channels:** Examples of communication efforts that might improve access by employing alternative media included a Mexican effort to use a traditional, popular card game to teach mostly illiterate groups about AIDS risks, and graffiti murals with similar messages in São Paulo, Brazil. A medium such as art murals may be successful in urban areas because receptivity is different than in traditional rural communities, where the notion of street art--much less, educational, message-oriented street art--may not be widely understood or well received.
2. **Devising appropriate mobilization strategies:** The use of city health workers or volunteers, for example, has numerous management and cost implications.
3. **Identifying what types of messages work with the hard-to-reach:** Messages must be readily understood and culturally sensitive, as well as targeted to reach a heterogeneous population. Such efforts must identify the motivating benefits that would induce changes in health care behaviors among marginal populations. Use of recognizable cultural figures may be one way to motivate people. For example, in Egypt, a state mass media campaign used a popular movie star to communicate health messages on television and motivate viewers to act appropriately.
4. **Consumer research that identifies the appropriate values and vocabulary of diverse communities:** Efforts to identify and establish community norms must also be made. Communicating messages that extend beyond simple health messages may be necessary to reach certain communities.
5. **Education and "sensitizing" of opinion leaders, to create awareness among them that health care communication is a vital component of urban health.**

Much of the small group discussion in health communication focused on the additional opportunities presented by urban environments, which ought to facilitate government and donor organization efforts to reach difficult-to-reach populations. It is thought that principal advantages lie in the different values and greater receptivity to new ideas that are generally associated with urban living.

8. Nutrition and Breastfeeding

(Tom Park, A.I.D. Latin America and Caribbean Bureau)

The group that discussed nutrition and breastfeeding issues focused on four areas needing to be addressed in this important area of health care in urban areas: 1) information-related problems; 2) urban environmental impact; 3) pressures on and needs of women; and 4) policy formulation, to address deficiencies.

1. Information-related problems: Among the most prominent informational needs are practical studies on birth trends; epidemiology of problem diets; influence of modernity and cultural taboos.

o The group contended that decisions are often inappropriately based on misinformation on nutrition, birth rate trends and urban-rural migration. Efforts to improve nutrition are plagued by lack of information detailing factors that influence diets of the urban poor and why many experience dramatic changes in the quality of their diet, which tends to be more unbalanced in urban areas.

2. Urban environmental impact: A number of factors endemic to the urban environment affect nutrition, including: the quality and availability of water and sanitation; low income and purchasing power; overcrowding; age structure; increasing numbers of female-headed households; and the high urban cost of food and food preparation, as well as the general high cost of living.

o The discussion group viewed the modern health sector as a problem for adequate nutrition. The health system tends, in cities of developing countries, to be predominantly curative rather than preventive, a potentially negative aspect of the formal health sector.

3. Pressures on Women: Especially in large cities of developing countries, women are faced with new, expanded responsibilities and difficulties, in terms of status and roles. For most women, the opportunity costs of reducing their work load and alternatives to cooking and child care are extremely high.

4. Appropriate policy: In most instances, policy that adequately addresses food and nutrition issues is lacking. Policy that contains a multisectoral approach is needed.

The Nutrition and Breastfeeding group decided that the two problem areas of greatest priority and in need of increased attention were: 1. the need for additional, more thorough information on the urban poor; and 2. reduction of the increased pressures on women that appear to be an intrinsic part of urban lifestyles.

Additional issues in nutrition and breastfeeding need to be addressed, according to the group, including: overcoming cultural taboos; promoting the benefits of birth spacing;

improving the quality and quantity of foods available to the urban poor; and poverty and low income urban employment, which is the fundamental determinant of poor nutrition.

In exploring possible solutions to the problems identified, the group proposed that public health officials and donor organizations focus upon women, through:

1. **Identifying urban women as a target group** for nutrition and breastfeeding concerns;
2. **Supporting the capacity of women to confront urban pressures** through income enhancement, education, cooperatives and a minimum wage that exists in reality and not merely on paper. The group noted that subsidized food, while it may assist urban women and their families with nutritional problems, can adversely affect rural women who produce it.

In seeking to identify existing workable solutions, group members shared individual experiences and/or knowledge of successful initiatives that address current needs in the areas of breastfeeding, nutrition and family participation. These included:

Breastfeeding

1. Rooming-in hospitals.
2. Establishing a code for breast milk substitutes.
3. Training health workers.
4. Forming women's support groups.

Nutrition

1. Creating and supporting community day care centers (creches).
2. Providing community-based growth monitoring and surveillance to address food and nutrition at the community level.
3. Establishing community kitchens (in Peru) and community stores or coops (Ecuador).
4. Creating energy-efficient stores.

Family Participation

1. Efforts to increase male awareness of nutritional problems.
2. Campaigns to involve men in identifying solutions.

9. Intersectoral Coordination

(Pamela Mandel, A.I.D. Africa Bureau)

The small group discussing intersectoral coordination had the difficult task of seeking common ground--interests and capacities--among diverse, and often competing, sectors with roles to play in urban health care. The group recognized four issues that form the foundation for discussion of intersectoral coordination.

1. *Participants in urban health care and delivery are numerous and complex.* Many policy-makers and program implementors, both public and private sector are involved, including municipal and provincial governments, NGOs, political groups and associations, as well as medical and private sector participants. Groups need to identify potential partners and their linkages clearly.

2. *Health is fundamentally a component of development strategies.* Water, sanitation and other sectors affect health care efforts and resources, and their jurisdiction is often divided among national and district government offices. Many groups that seemingly would have little to do with health are necessarily involved; thus, a significant need to develop a common language among sectors as disparate as agriculture, housing and small business development exists.

3. *Competition among sectors, for resources, time and funding, is keen.*

4. *Greater opportunities exist in urban areas, given the greater range of administrative purview and choices of private and public providers.* However, the range of choices also indicates greater competition among health care providers in cities.

Priority issues for intersectoral coordination include:

1. **A catalyst is necessary to initiate intersectoral coordination around specific issues.** Key sectors critical to the solution of a given health problem or situation must not only be identified, but coordinated to tackle the problem. Potential players must be involved from the point of project conceptualization and planning to facilitate solutions to common problems.

2. **A common set of interests, goals and objectives must be identified so that various sectors share or speak the same language.** Common ground needs to be found, for example, among environmental, housing and health points of view. Groups need to determine where interests and needs overlap, and it is imperative to define goals properly across sectors. In addition, political coordination is a key element of any health initiative; all players involved in improving health in urban areas need to find ways to encourage political participation among varied sectors.

3. Resources of the various sectors need to be combined and applied to common goals. Examples of group member experiences in projects that benefitted from intersectoral coordination included:

- o *Honduras:* Ministries of public health, water administration and other sectors collaborated on a national mobilization plan for the environment, including water and sanitation. While the joint project was politically difficult to bring about, the different sectors seemed to recognize the value of collaboration.
- o *Bangladesh:* Establishment of a maternity center was a collaborative effort of the local business community, government and an NGO.
- o *Zanzibar:* Ministries of health and agriculture worked together on a project aimed at preventing malaria.

Group participants recommended that case studies of urban examples of intersectoral collaboration be selected and studied by various sectors involved in urban health. In view of goals for intersectoral coordination, the group identified several *immediate needs*:

- o **Sectors need to define the specific needs of the urban poor and then identify the sectors that can address those needs (while recognizing that needs may vary among peri-urban and urban populations).** How can a needs assessment in a heterogeneous population be conducted?
- o **National and local governments, NGOs and sectors themselves need to be better informed to understand common health problems and the potential benefits to be derived from joint actions.** As a sector-wide resource, information on what has worked, lessons learned, and instances of multisectoral coordination would be very useful.
- o **Communities themselves must identify needs and leaders.**

V. CONCLUDING REMARKS

After the four panelists made their presentations to the plenary session, Ann Van Dusen remarked that a common theme had emerged in each of the speakers' presentations: the need to define goals clearly. Was it health improvements per se that the public health community wished to address, or did it view health as a catalyst for larger, structural social change? Whether health initiatives are confined to the health sector or broadened to include a larger development agenda, goals will significantly affect what strategies are adopted.

At the close of the small group presentations, Bob Emrey focused on five common themes expressed by both panelists and small-group discussants: goals, people, policies, institutions and information.

1. **Goals:** Governments, the donor community, PVOs, NGOs, and others involved in public health have not yet successfully understood or targeted the underlying causes of health problems in cities. Goal clarification must concentrate on addressing causes, not mere symptoms.
2. **People:** The people themselves--and their communities--affected by deficiencies in health care services and delivery must be an emphasis of improvement efforts. Efforts to empower and organize the people in marginal urban areas, prompting them to participate in solutions to health problems, through self-help and self-development, are essential. It is incumbent upon government/health officials and donor organizations to recognize the diversity of communities that they are dealing with in urban environments, and to identify and train persons who can gain access to these diverse populations.
3. **Policies:** Policy must be carefully coordinated across varied government levels, agencies and competing interests.
4. **Institutions:** For effective change in public health care and services, one must look beyond traditional national programs, to NGOs, local self-help groups, and cooperatives, for example. Those involved in and concerned about urban health must search out innovative ways to reinforce programmatic areas among groups and discover a "workable synergy."
5. **Information:** An obvious lack of and need for hard information exists, to be able to document what problems are occurring and what is currently being done. Good, disaggregate data, which can illuminate problem areas that are otherwise smoothed into averages, must first be made available and then shared with other groups working in various areas in urban health.

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