



Strategic Report 12

Improving the Health
of the Urban Poor

Learning from USAID Experience

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Acronyms

ANE	Asia and the Near East
CBO	Community Based Organization
CWSF	Community Water and Sanitation Facility
DCA	Development Credit Authority
DCOF	Displaced Children and Orphans Fund
DHS	Demographic and Health Surveys
EHP	Environmental Health Project
GDA	Global Development Alliance
HKI	Helen Keller International
HNP	Health Nutrition Population
IFPRI	International Food Policy Research Institute
MCW	Making Cities Work Program
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NGO	Nongovernmental Organization
NSDP	NGO Service Delivery Program
PPP	Public-Private Partnership
PVO	Private Voluntary Organization
RCH	Reproductive and Child Health
SLI	Standard of Living Index
STD	Sexually Transmitted Disease
TAG	Technical Advisory Group
USAID	United States Agency for International Development
WASH	Water and Sanitation for Health Project
WHO	World Health Organization

Executive Summary

Why urban, why now?

The world's cities are exploding, and by the year 2030, the proportion of urban dwellers is expected to be 61% of the world's population. Currently, the proportion is pushing the halfway mark. The highest urban growth rates are occurring in cities in Asia and Africa. By 2030, Asia will house half of the world's urban dwellers. Mega-cities with 10 million plus inhabitants will expand, but most of the growth will be in smaller cities and towns of 500,000 to 1.5 million. The poor are the fastest growing segment of urban populations, living mainly in slums and squatter settlements. The Asia/Near East Region (ANE) contains 60% of the world's slums, which in absolute numbers represents about 550 million slum dwellers.

Urban health shows disparities between the urban poor and urban nonpoor for indicators such as child mortality, disease morbidity, and child nutritional status. An analysis of DHS data showed urban poor children may be less healthy than rural children in terms of weight for height (acute malnutrition/wasting). Poor urban slum dwellers tend to suffer more from environmental and infectious illnesses. Death rates for diarrhea, measles and TB among urban poor children can be up to 100 times higher than counterparts in industrialized countries. Poverty, crowded living conditions, outdoor and indoor pollution, and food insecurity are among the factors causing ill health. However, there are numerous advantages to working in urban areas. These include defined geographic zones, people grouped in workplaces, availability of urban services such as water, electricity, trained people and health centers (although they may be unavailable to the urban poor), and urban openness to new ideas. Given the rapid spread of urbanization and urban poverty, there are potential political, social, economic and epidemiological costs to not addressing the needs of the urban poor. This challenge is stated directly in the Millennium Development Goals: "achieve significant improvement in the lives of at least 100 million slum dwellers by 2020." It's a start.

Understanding our urban clients

The urban poor are hard to categorize, and include a wide range of workers such as vendors, hustlers and government employees and social characteristics such as low caste, transplanted traditional hierarchies, or migrant youth. The urban poor frequently find themselves in illegal circumstances, without identification or squatting on others' property. Many are informal sector wage earners, and a large proportion are children under 15.

Urban poverty has many facets that need to be considered such as housing as well as levels of income and consumption. In urban poor populations, housing/shelter is of poor quality, overcrowded or insecure, and inadequate provision of public infrastructure (piped water, sanitation, drainage) increases health burdens. Related to piped and in-home water, urban poor households are more likely to have access than rural households. It is not uncommon for urban poor households to spend 10–20% of their cash income on water. Many studies have also reported intermittent water supplies or long outages. Furthermore, studies of individual studies confirm DHS data that poor urban households must defecate outside or resort to unsanitary "wrap and throw" methods. Heaps of

uncollected refuse also pose a health hazard. Often, however, garbage is a source of income through scavenging. Additionally, urban air quality is polluted from industry and vehicles, and indoor air can be especially toxic from fumes of indoor cooking stoves. Children are especially susceptible to lung disease from air pollution.

While urban access to health services might be geographically better than in rural areas, a variety of factors block the urban poor's access to these services. For example, services may be far from main transport routes preventing residents from reaching nearby health and education facilities. The private sector is a prominent presence in urban health care. Fee-for-service is the focus of the private sector, and for the urban poor this raises the issue of the ability to pay. For example, the urban poor women are little better off than rural women in relation to reproductive health and access to services and in some cases their situation appears to be worse.

Reliable information about the health of the urban poor is not easy to come by. All-urban averages in large data sets such as the Demographic and Health Surveys (DHS) mask the information for the poorest population segments, leading programmers to believe that there is an "urban advantage" compared to rural populations. When urban surveys are disaggregated by socio-economic status, gross inequities in health status and access to services can be seen between the poor and non-poor groups. Credible efforts at survey disaggregation include the World Bank asset-based reanalysis of the DHS, EHP/India's reanalysis of the Urban Madhya Pradesh NFHS, UNICEF/India's 1996 MICS for Gujarat State, and nutrition surveillance in Asia by Helen Keller International.

Issues to consider when developing urban health programs

1. Social issues include how communities are organized, what networks exist for coping, healing beliefs and systems, and which NGOs or CBOs provide what services.
2. Economic issues include sources of income, economic coping strategies, affordability of health care and preventive strategies such as good nutrition, channels for associating livelihood improvement with health interventions (e.g., locally managed insurance schemes).
3. Gender issues take into account women's economic and social status among the urban poor. Women may head the majority of households, be the main wage earner, lack access to family planning services, credit, and legal standing, and be barred from home ownership. Children often bear the effect of gender inequities. Participation by women in urban health programming is key to understanding and addressing such disparities.
4. Political issues in urban settings can be volatile, especially where slums and poverty are involved. Analysis of governance and decentralization policies and progress identifies leaders, gaps and resources for improving the health of the urban poor. Political will is often key to successful implementation, and urban elected officials want to be responsive to their constituencies.

5. Health and social services issues often refer to availability and access to such services by the poor. Barriers such as cost of services, inconvenient hours, lack of transportation or required identification papers often exclude the poor from nearby services.
6. Differences in urban vs. rural health problems means taking into account both different factors such as air pollution and the increased effect other factors, such as lack of sanitation can have in an urban setting. Annex 1 reviews the urban characteristics of the main health program areas.

Finding and using good data to develop programs

The place to start is finding existing quantitative or geospatial data with a large enough urban sample size to permit reanalysis by disaggregated socio-economic segments. Next, it is possible to sponsor the collection of disaggregated data through DHS or other mechanisms. Urban data collection has its own challenges, such as the illegality of many settlements, which are addressed in Annex 2. Finding so-called “gray literature,” unpublished reports by NGOs, UN agencies or development projects might yield useful data.

Qualitative data collection can be a starting point for community mobilization for improving health services. Active participation by residents is critical. An approach used by a number of USAID-funded projects follows these steps:

1. Identifying and involving stakeholders. Stakeholders can come from the public, nongovernmental and/or private sectors, and from the community itself. Involvement can be in program data collection, development, management, and evaluation. Urban stakeholder groups such as Urban Health Alliances have been active in city-wide improvements of health, environmental and social services.
2. Conducting a Situation Analysis. This can include community mapping, interviews, secondary data research, risk assessment, focus groups, and more. The purpose is to collect as much information from as many sources as possible together to form a picture of urban health and environmental conditions, services, health status, government structure and stakeholders.
3. Prioritizing areas and populations. Limited resources for programs make this necessary. Criteria for prioritizing can vary. EHP/India has developed a methodology for prioritizing slums by “health vulnerability.” This methodology finds existing slums, then ranks slums by criteria such as access to water and sanitation, health and nutritional status of children, presence of NGO/CBOs and other services, then triangulates the results among local stakeholders.
4. Baseline and household surveys. Efforts are underway to support MACRO/DHS to collect good urban data, but limitations of the DHS make it important to also consider separate urban research that focuses on neighborhoods and households as distinct entities that can be implemented at more regular intervals than the DHS. Such research should measure

outcomes or impacts of interventions and use measures of poverty and environmental health adapted to the urban setting.

Implementing health programs for the urban poor

1. Deciding what to do and finding points of entry. The multiple urban stakeholders from the community, municipality and donors can analyze information from a situation analysis and decide what program interventions to design and carry out, based on the most critical problems facing the urban poor. Points of entry for a program range from adding on to existing programs or data collection efforts, to starting in older established slums, to enlisting an urban health champion with political clout to get the ball rolling.
2. Service delivery issues to consider. Decentralization efforts often impact legal and regulatory frameworks, making it necessary to clarify who is responsible for what services, and sometimes provide institutional and managerial capacity building for newly empowered service delivery agencies. Working with the private and corporate sectors is a sensible urban strategy since these sectors often are already key service providers for the urban poor. Among these are pharmacies, factories, and not-so-qualified health care providers. They may require service quality upgrading and other inputs to strengthen their capacity. Working with mobile and transient populations is an area in need of experience and models. These populations are a special challenge in urban settings, but successful ways to provide them with the health services they require have not often been documented. Working with NGOs and CBOs is logical since they are often the only service providers in poor urban areas. They may need organizational, technical, managerial or other capacity building. They can form networks or consortia and coordinate efforts for maximum coverage and impact. Facilitating access to existing health services can be accomplished by addressing existing barriers such as staff attitudes, opening hours, costs, and locations. Willingness to pay for services can be assessed, and municipal services such as water can be brought to poor neighborhoods where officials feel residents are not willing to pay, when in fact they are.
3. Multisectoral and multidisciplinary collaboration. Determinants of urban health problems are interwoven and often synergistic. Successful programming will find mechanisms for different sectors and technical disciplines to work together. Among the most important sectors to collaborate with are water and sanitation, education, housing and urban development, democracy and governance.

Technical assistance, procurement and financing

Resources for supporting urban health programs are available from various sources within and outside of USAID. Within USAID are:

- Making Cities Work Partnership Grants
- Development Credit Authority

- Displaced Children and Orphans Fund
- Global Development Alliance (GDA)
- Environmental Health/Hygiene Improvement IQC
- Title II Food for Peace
- HIV/AIDS Small Grants
- CORE Initiative
- Community REACH

Resources that can be accessed outside of USAID include:

- World Bank Small Grants Program
- Cities Alliance Community Water and Sanitation Facility
- CityNet: The Regional Network of Local Authorities for the Management of Human Settlements
- Business Partners for Development: Water and Sanitation
- International Youth Foundation

Hallmarks of successful urban programs

A “successful” urban program is tailored to meet the needs of the most vulnerable and is sustainable in the long run. Factors in this success include good data, urban “champions,” community empowerment, coordination and linkages among stakeholders, pro-poor advocacy, and plans for sustainability at the outset.

USAID can play a leadership role in urban health by including components into existing programs, advocating for and conducting urban data collection, developing program models, convening, facilitating and coordinating stakeholders meetings, leveraging resources.

What is next in urban programming?

Participants at the ANE Regional Urban Health Workshop held in Agra, India, February 2004, made the following recommendations:

- Conduct household surveys of the urban poor and publish results
- Create a network and information sharing mechanism for urban health practitioners
- Organize regional urban health workshops for Africa and LAC
- Consolidate the ANE regional urban health network
- Address the big urban health programming questions

1. Introduction

USAID Asia Near East (ANE) health programming has not kept pace with the region's rampant urbanization and the health needs of urban slum dwellers living in the vast and growing cities of Asia and the Near East. Until recently, USAID's involvement with urban programs has primarily focused on housing, governance and decentralization. Most recently, Urban Programs has found a home in the Bureau of Economic Growth, Agriculture and Trade, and has branched out to promoting urban health. Various missions carry out health programs in urban settings, but as large-scale policy for the health sector, urban programming has not been the norm. Now, however, USAID's Asia Near-East Region and others are responding to the urgency of the urban conditions and growth of the urban poor. They are initiating various actions to promote health and other programs geared specifically to the needs of poor urban dwellers and to support missions who are conscious of these needs and primed to respond.

USAID's ANE Regional Bureau launched a three-phase Urban Health Initiative in 2001. During Phase I, EHP completed a literature review of existing studies on child health in urban slums in select ANE countries (EHP Activity Report 109). Phase II called for implementation of demonstration urban health programs, and with support from USAID/Egypt Mission, the Cairo Healthy Neighborhood Program was initiated in 2002. The program includes quantitative and qualitative assessments, regular stakeholder meetings, water/sanitation infrastructure improvement, hygiene behavior change through literacy programs, and clinical MCH/nutrition services. ANE, EGAT/Urban Programs/Making Cities Work, and the USAID/Mission PHN office jointly support the program. Complementing the Cairo effort is the USAID/EHP India Urban Child Health and Nutrition Program, a multi-year Mission-funded effort that includes city-based child health interventions in neonatal health, immunization and hygiene improvement, advocacy, improved knowledge inventory, and technical assistance to state and national government.

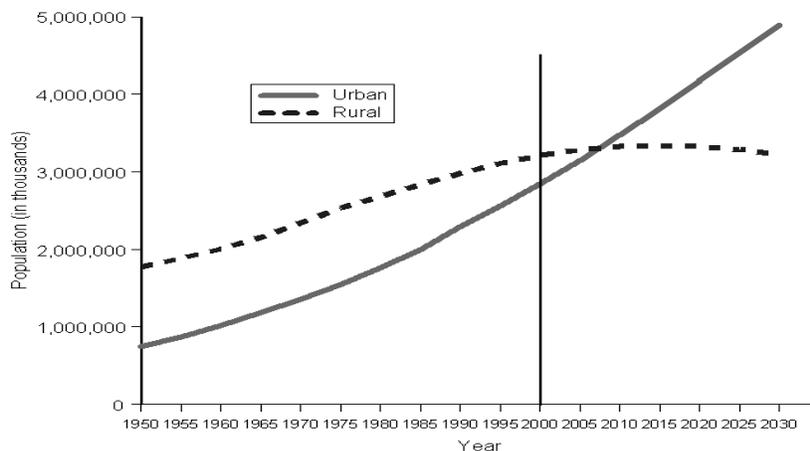
The final phase of the Initiative calls for producing a document to advocate for USAID urban health programming using accumulated lessons from Cairo, the India Urban Child Health program and others. "*Improving the Health of the Urban Poor*" draws on recent urban health programming experiences within or involving USAID. It reflects lessons learned from these experiences that can benefit others who are either contemplating or already embarked on developing and delivering health programs in urban settings and targeting the urban poor. It does not represent official policy, but tries to offer a challenge to USAID health and population officers and their colleagues in ministries of health and related sectors to respond to the urgent situation of the urban poor by directing program resources toward addressing their needs.

2. The Urban Health Challenge: Why Urban? Why Now?

2.1. The challenge of current and projected worldwide urban growth

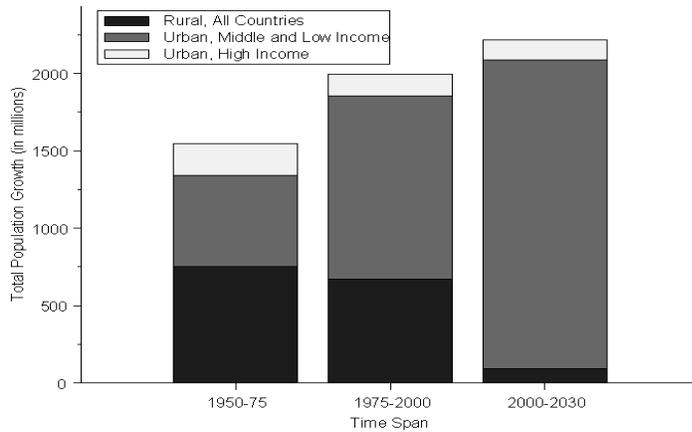
The world's cities are growing at unprecedented rates. This growth is concentrated in developing regions of the world and posing a serious challenge to development efforts across the board. From the late 1970s to 2000, the world's urban population doubled, and soon, more than half the world's population will be urban rather than rural. Worldwide, the number of people living in urban centers is estimated at 3 billion, or 48%. By 2030, this proportion is expected to be 61% (World Urbanization Prospects 2003).

Figure 1. Population Growth Trends



During 2000-2030, the world's annual urban growth is expected to be 1.8%, a rate that is nearly double the average total population growth rate. The highest annual urban growth is in developing countries, where it averages 2.3%. To compare, the annual growth rate of New York City between 1995 and 2000 was 0.24%. Migration and the transformation of rural settlements into urban centers will account for most of the urban growth in developing regions.

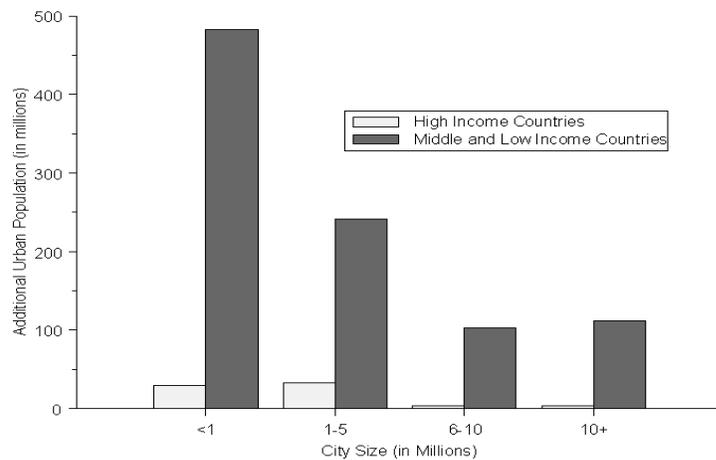
Figure 2. Total Population Growth



Over the next 15 years, many large cities in Asia and Africa will nearly double in population. The number of cities with 5 million or more inhabitants is projected to increase from 46 in 2003 to 61 in 2015. By 2030, Asia and Africa will each have more urban dwellers than any other region, with Asia alone accounting for over half of the world’s urban population.

While mega-cities (population greater than 10 million) will continue to expand, three fourths of the projected urban growth will be in smaller cities with a population of 1.5 million, or towns under 500,000. Over half of the world’s urban population lives in these smaller cities.

Figure 3. Additional Urban Population



2.2. Growth of poverty, slums and squatter settlements — the challenge of ANE

Demographers have long emphasized the contribution of natural increases to urban growth. Reclassification, whereby urban status is conferred on formerly rural residents and territory also deserves consideration. An analysis by Chen et al. (1998) reconfirms 1980 estimates by the United Nations of the share of urban growth due to migration and reclassification combined at about 40%. The remaining part of urban growth — roughly about 60% — is due to urban natural increases. The Chen et al. findings underscore the point that both migration and natural increases make substantial contributions to urban growth (Montgomery et al. Eds. 2003).

Poverty has long been associated with the rural masses in developing countries, who have rightly been the targets of development and food assistance programs. With the growth of cities, poverty is increasingly becoming urbanized. Many of these urban poor live in absolute poverty.

Urban population projections for select ANE cities by 2005

Dhaka	15.9 million
Delhi	15.3 million
Jakarta	13.1 million
Metro Manila	10.6 million
Cairo	10.0 million
Phnom Penh	1.2 million

"The Challenge of Slums" UN Habitat 2003

UN Habitat estimates that there are currently 924 million slum dwellers in the world, making up one third of the global urban population. This number could grow to *1.5 billion* by 2020 unless significant health and infrastructure interventions and pro-poor housing and land tenure policies are undertaken. The poor are the fastest growing population in urban areas. A quick look at the absolute numbers of urban poor populations living in the ANE region reveals a challenge of staggering proportion. India, alone, is home to 88 million urbanites living below the poverty line. More than 16 million people live below the poverty line in Indonesia, 13 million in Bangladesh, and 10 million in the Philippines. As a result, Asian cities, already facing significant challenges to targeting these populations with services, will face a greater burden in the coming years. *Sixty percent of the world's slums are in Asia. In absolute numbers, Asian slum dwellers outnumber those of any other region, with about 550 million people living in Asian slums. Africa follows with 187 million urban slum residents* (UN Habitat 2003).

Urban poverty has many facets that need to be considered — such as housing as well as levels of income and consumption. Poverty is conventionally defined in terms of incomes that are inadequate to permit the purchase of necessities, including food and safe water in sufficient quantity. In such populations, housing/shelter may be of poor quality, overcrowded or insecure. Inadequate provision

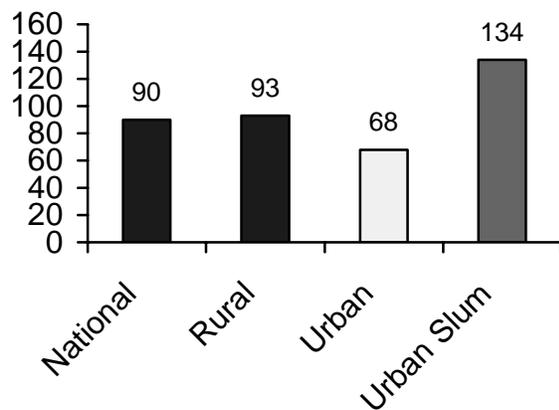
of public infrastructure (piped water, sanitation, drainage) can increase health burdens (Montgomery et al. Eds. 2003). Another factor is the lack of a voice within political systems that keeps the concerns of the poor from being heard.

2.3. Health implications of the urban growth scenario

Information on the health of the urban poor is increasingly becoming available. It is showing large disparities between wealthier and poorer socio-economic groups for such indicators as child mortality, disease morbidity or the burden of illness, wasting and stunting. In some cases, data show that the health of children in urban slums is worse than their rural counterparts, and that the urban poor suffer disproportionately from environmental and infectious illnesses. Diarrheal disease, malnutrition, respiratory illnesses, tuberculosis, neonatal and maternal mortality, HIV/AIDS — USAID's main health program thrusts and areas of expertise — are all critical urban health challenges.

Key determinants of ill health among the urban poor are lack of clean water, sanitation, and crowding. Solid waste disposal, substandard housing, and exclusion from health and other services exacerbate the situation. The most vulnerable — small children, women and people whose immune systems are compromised — are the most affected. Infectious diseases such as measles, tuberculosis and cholera spread quickly in crowded urban environments. Infectious disease knows no boundary — if slums are affected, all areas of the city are threatened. Small children living in urban slums are extra-vulnerable. It is likely that poverty-related differences in children's health are due, in part, to differences in access to services. If poor households have worse access to sanitation and clean water, children in those households may be at greater risk of exposure to communicable diseases, in particular diarrheal diseases (Montgomery et al. Eds. 2003). The mortality rate of children under 5 in urbanized South Asia is 120 per 1,000 (as compared to highly urbanized industrialized countries, where the infant mortality rate is 5 per 1,000). Death rates for infectious diseases such as diarrhea, measles and TB among urban poor children in developing countries can be up to 100 times higher than those for urban children in industrialized countries. In addition, an increasing number of children (an estimated 100 million) are facing new dangers associated with homelessness and street life in cities (World Resources 1996-97) and are prevented from attending school because of poor health.

Figure 4. Infant Mortality: Higher in Dhaka Slum than in Rural Bangladesh (Harpham 1991)



Population density, crowding and indoor air pollution from biomass cooking fuel lead to high exposure to pollutants and respiratory illnesses. A recent report (ITDG 2003) states that smoke from indoor cooking fires kills 1.6 million people a year, nearly 1 million of them children. Use of biomass fuel is increasing in developing countries. Industrial and vehicular air pollution also compromises lung health and predisposes vulnerable groups such as small children to respiratory infections. In addition, ambient air pollution from lead-based vehicle fuel adds the threat of educational/developmental disabilities in children.

Food security is a critical health issue for the urban poor — most households are food-insecure. Contrary to some hypotheses, an analysis by Montgomery et al. (2003) of DHS data related to children's height and weight between urban and rural areas shows that on average, urban children are advantaged. The evidence is strong in showing that by the measure of height for age (stunting), the urban poor children enjoy better health than do rural children, at least, on average, whereas in terms of weight for height (acute malnutrition/wasting) urban poor children may be less healthy than rural children. As poverty increasingly urbanizes, more and more women with young children are entering the workforce at lower wages than men, often as the main wage earners. Their own health is precarious, and if a key wage earner falls ill, the entire family spirals deeper into poverty.

2.4. Advantages of working in urban areas

The high density of urban health clients, and the availability of numerous human, technical and financial resources in cities, makes urban health a smart, cost-effective programming choice. The urban poor can make good partners for program development because they deal with the daily challenges of earning a living, of obtaining shelter, water, transportation, health and other services. As a result, they can influence health program strategies to fit their realities. Working with city dwellers can have other advantages. Urban migrants are often more adventuresome than those who stay behind and might therefore be quicker to accept new approaches to health care, water supply and sanitation, if minimal services are provided. Some other examples of urban advantages include:

- Most municipal services — water, power, sanitation, medical treatment, and education, can all be provided more cost effectively to people living in close proximity.
- Urban health programs can reach huge numbers of people in a delimited geographical area, thus achieving high coverage rates for services such as immunization and food fortification.
- Urban areas, given their greater modern health resources, offer more opportunities to extend the reach of modern hospitals/clinics through mobile outreach and satellite programs.
- Urban areas offer possibilities for health promotion at the workplace, although the benefits may be geographically dispersed since workplace-based and area-based interventions may not be linked.
- More cohesive urban communities can be concentrated political masses, and most urban communities will at least be more aware of political forces impinging on their lives than rural ones, and be able to activate political connections if potential benefits are perceived (Parker et al. 1999).

Municipalities might have health and urban development resources that are earmarked for the poor or for slums, but are underused because of lack of programming or lack of understanding of how to work in slums. USAID can facilitate the leveraging or programming of these resources by creating partnerships among donors, municipalities and other government agencies, and by developing solid and comprehensive plans for health and environmental service improvement in urban slums. Municipal capacity to provide services to the urban poor can be strengthened in the process, and poor urban dwellers can be helped in organizing to advocate in their own interests for receiving the resources and services they are due.

Donor Partnership Example from Bangladesh

Two simultaneous major health programs are funded by USAID and the Asian Development Bank respectively. The two organizations signed a Memorandum of Understanding between the NGO Service Delivery Program (USAID) and the Urban Primary Health Care Program (ADB) to work side by side in four major cities of Bangladesh. As part of the MOU, UPHCP is handing over Primary Health Care Clinics to NSPD partner NGOs. This is an example of successful collaboration between urban stakeholders. In the long run, this will help assure the sustainability of NGO clinics in the community, even if there is no donor funding in the future

2.5. The cost of not acting

In today's world, there are serious potential costs to society if the needs of the urban poor are ignored. These costs are political, economic, social and epidemiological. Some scenarios are:

- The urban poor live side by side with the more affluent, and the disparities and inequities between them are plainly visible. Local and international inaction to redressing these intra-urban inequities will likely lead to increased social unrest including violence.
- Economic costs can be high when sickness and death occur among primary wage earners and when households must spend money on curative medical treatment for sick children.
- Chronic nutritional deficits and exposure to toxins affect child brain development, condemning the poor to remain poor for generations.

- There is a danger of deadly epidemics starting or taking off in overcrowded urban slums without access to health services and programs (e.g., SARS, cholera, TB). Epidemics, once started, will easily cross between slum and non-slum areas. Food vendors, servants, even childcare workers, regularly cross these boundaries as does polluted air, water and solid waste.
- Inaction from health and other sectors will mean a continued lack of experiences and understanding of working with the urban poor while urbanization spreads and slums proliferate. The time to act is now.

2.6. The challenge of the Millennium Development Goals

One Millennium Development Target and several Millennium Development Goals (MDGs) have direct relevance to working in urban settings. Target 11 states: “achieve significant improvement in the lives of at least 100 million slum dwellers by 2020.”

Another MDG aims to “reduce by half, by 2015, the proportion of people without sustainable access to safe drinking water.” The World Summit on Sustainable Development’s 2002 Plan of Implementation states “[W]e agree to halve, by the year 2015, the proportion of people who are unable to reach or to afford safe drinking water (as outlined in the Millennium Declaration) and the proportion of people who do not have access to basic sanitation.” According to the International Year of Fresh Water’s website, in order to meet these targets in urban areas, more than one billion additional people in cities will need access to both water supply and sanitation over the next fifteen years.

Other Millennium Development Goals addressing poverty reduction, child mortality reduction, maternal health improvement and environmental sustainability are all pertinent to the urban setting (see www.developmentgoals.org for details). One hundred million slum dwellers barely represent the numbers in need, but it’s a start, and USAID can be a leader in working toward achieving the Millennium Development Goals.

3. Understanding Our Urban Clients

A Note about Urban Poor vs. Urban Slums: Readers of this document have noted that the terms “urban poor” and “urban slums” seem to be used interchangeably, so a note is in order. Programs often need to target a geographic area in order to be effective. However, urban health programming must reach the thousands upon thousands of urban poor who are the most underserved. Experience shows us that the poor do not necessarily live in urban slums but in many forms of settlements or at no fixed address. It also tells us that urban slums can be home to many middle class and wealthier people (UN Habitat 2003). The point for programmers is that each program must decide how it will define its urban target population: by spatial or economic criteria or a mix of both (Montgomery et al. 2004).

3.1. Who are the urban poor?

The urban poor can range from recently arrived migrant youth from rural areas in search of work and a better life, to urban victims of economic crises such as the ones of the 1990s in Asia, to slum dwellers whose families have lived in slums or on sidewalks for generations. They can come from socially disadvantaged classes or “low” castes. Many of the urban poor are traditional slum or even pavement dwellers with no fixed address. Lack of birth certificates and other documents make many of the poor invisible and ineligible for citizens’ rights.

The urban poor can be internally organized according to traditional social systems, replicating rural village hierarchies and customs. Or they can be organized in newly emerged structures based on current needs and situations. The majority of the urban poor work in the informal sector and depend on a cash economy — a precarious situation with health, food security and nutrition consequences. They are day laborers, domestic servants, hawkers, small service providers, drivers, hairdressers, prostitutes, and hustlers. Some, however, work in factories or even as government employees, with wages that barely meet their needs. Children and youth represent a large proportion of the urban poor. Many of them work — against child rights conventions. In urban Bangladesh, for example, children under 15 are the majority of the population.

3.2. Where and how do the urban poor live?

Most, but not all, urban poor live in slums and squatter settlements. These vary widely but in general are characterized by poverty, lack of services such as water supply, sanitation and solid waste disposal, substandard housing, overcrowding, social exclusion (especially from formal sector employment), and insecurity. Some settlements are permanent, and some are temporary. Some are

legal, but many are illegal with uncertain land tenure. When not squatting, the urban poor are renters (UN Habitat 2003).

Settlement sites can be on unwanted land such as flood plains or garbage dumps, or on dangerous ground next to railroad tracks, or on riverbanks, and near worksites such as factories or construction sites. Squatter settlements and many slums lack accessible roads, which prevents the urban poor from access to nearby health facilities and services such as trash collection.

Slum and squatter settlement housing ranges from high-rise tenements to shacks to plastic sheet tents on sidewalks. Most of it tends to be unregulated, precarious, overcrowded, and often open to the elements.

An analysis by Montgomery et. al. based on DHS data showed that for several key access measures — piped water, access to a flush toilet and electricity — the urban poor are “in a distinctly inferior position compared with urban nonpoor residents, but in a decidedly better position than the average rural household.” In “Living in the City: Challenges and Options for the Urban Poor” (2002), IFPRI cites one study that shows that less than 20% of the urban poor worldwide have access to safe water, compared with 80% of the rich. Related to piped and in-home water, urban poor households are more likely to have access than rural households. It is not uncommon for low-income households to spend 10-20% of their cash income on water (Cairncross 1990). Many studies have also reported intermittent water supplies or long outages. A study carried out in Mombasa showed that very few neighborhoods had an average of only three hours of water a day and some have seen no water in their pipes for several years (Rakodi et al. 2000). Related to access to pit toilets or latrines or access to drinking water through standpipes and other neighborhood sources, poor urban households can be on a par with rural households in some geographic regions (e.g., South, Central and West Asia).

Studies of individual cities confirm DHS data that poor urban households must defecate outside or resort to unsanitary “wrap and throw” methods.

More than 420 million urban residents do not have access to even the simplest latrine. In less developed countries, only 8% of urban low-income dwellers have a house sewer connection, while 62% of urban high-income dwellers do have a connection (World Resources 1996-97). The tens of millions of urban dwellers, who have no toilet in their homes, rely on pay-as-you-use toilets or use open spaces or plastic bags (Satterthwaite 2001). Only 2.8% of the population of Jakarta is connected to municipally operated sewers (McCarthy, P. Human Settlements 2003).

In developing countries, it is estimated that more than 90% of sewage is discharged directly into rivers, lakes and coastal waters without treatment of any kind. Waterways, canals, and rivers are often used to dump raw sewage. More than 2 million Bombay residents have no sanitary facilities, and most sewerage collected is discharged untreated or partially treated into creeks or coastal waters. In Metro Manila, about 11% of the population is served by piped sewerage; the majority of sewage is conveyed through open ditches and canals untreated into Manila Bay (UN Habitat: UN Cyber School Bus).

Solid waste services are also rare in poor urban settings since most slums do not benefit from municipal services. As a result, residents live among mountains of garbage and the associated

vermin. Trash burning causes air pollution, and in some communities, scavenged hospital or medical waste poses a particularly dangerous health hazard. Garbage, however, can be a source of income and many urban poor are rag pickers or informal garbage collectors and recyclers.

The air that the urban poor (and even the urban affluent) breathe is often polluted from outdoor sources such as industry, motorized vehicles, and burning trash. WHO estimates that 1.5 billion urban dwellers face levels of outdoor air pollution that are above the maximum recommended limits (City Mayors Report 2003), and UNEP reports that one billion urban residents are exposed to health-threatening levels of air pollution (UNEP 1999). Indoor sources of air pollution include smoke from indoor stoves and machinery in small, poorly ventilated workshops producing noxious fumes. In Asia, more than 500,000 people die every year from diseases related to air pollution. (City Mayors Report 2003) Children under 5 account for more than 80% of all deaths in developing countries attributable to air pollution-induced lung infections (Davis 1999).

Urban poor populations often rely on street food, fast food, processed and cheap food leading to nutritional problems such as vitamin/mineral deficiencies, obesity, diabetes, cardiovascular problems, and dental problems. Street food can also be dangerously unhygienic and spread cholera, typhoid, and other diarrheal diseases.

3.3. What do we know about the health of the urban poor?

Health conditions and issues of the urban poor in traditional large data sets have been masked by urban averages for all socio-economic groups, as documented in demographic analyses that concentrate on rural/urban dichotomies. The results show that urban dwellers appear to be better off than rural populations, with lower morbidity and mortality rates and better access to health services, confirming the supposed “urban advantage” to health programmers. But these are advantages enjoyed only by large urban areas. Studies have found that smaller urban areas — i.e., those under 100,000 in population — are significantly underserved. The urban poor are distinctly inferior in terms of access to basic amenities (Montgomery et al. Eds. 2003). All-urban averages often show up to 90% or higher water and sanitation coverage. These surveys are not measuring barriers preventing the poor from access to water and sanitation, such as cost, hours of service, and functionality of systems. The surveys are not showing inter-and intra-urban differences either.

The urban poor are also more vulnerable to economic, social and political crises and environmental hazards and disasters compared to the urban nonpoor. In recent years, demographers and urban advocates have made an effort to demonstrate the gross intra-urban inequities in health status and access to services by socio-economic status, either by reanalyzing existing data sets such as DHS, or by designing new research to capture these differentials. In general, reliable efforts to study the health of the urban poor — especially children under 5 — reveal that their health status is as bad if not worse than their rural counterparts, but that they suffer and die from illnesses we know how to treat and prevent: diarrheal disease, acute respiratory infections, and malnutrition. In addition, the urban setting increases environmental risks for accidents, toxic pollution, domestic violence and stress-related conditions.

Limitations of urban DHS data have been discussed. However, the data lend themselves to a variety of different analyses, which can be useful to missions looking to program their scarce resources appropriately. Below are two examples of DHS data reanalysis:

3.3.1. World Bank reanalysis of DHS data by wealth quintile

The World Bank applied an asset-based wealth index to existing DHS household data. Country reports on health, nutrition, population (HNP) and poverty provide statistics on intra-country differences between rich and poor quintiles with respect to HNP service and status use (<http://www.worldbank.org/poverty/health/data/index.htm>). Urban populations in the lower quintile exhibit many of the same health challenges as their counterparts in rural areas. The data also show consistent disparities between lower and higher income quintiles. However, there are methodological issues that limit the interpretation of the data.

3.3.2. EHP/India Madhya Pradesh NFHS urban reanalysis

The EHP/India Urban Child Health Program has undertaken a reanalysis of state-level Family and Household Survey (India’s version of the DHS) data that was disaggregated according to a “Standard of Living (SLI) Index — Low, Medium, High” by using ISSA (Integrated System for Survey Analysis) developed by ORC MACRO International. The SLI is a summary household measure and is calculated by adding up the scores for house type, toilet facility, source of lighting, main fuel for cooking, source of drinking water, separate room for cooking, ownership of house, ownership of agricultural land, ownership of irrigated land, ownership of livestock and ownership of durable goods. Some highlights of findings from this reanalysis include:

Figure 5. Neonatal, Infant and Child Mortality by Standard of Living Index, India NFHS II Reanalysis for Madhya Pradesh

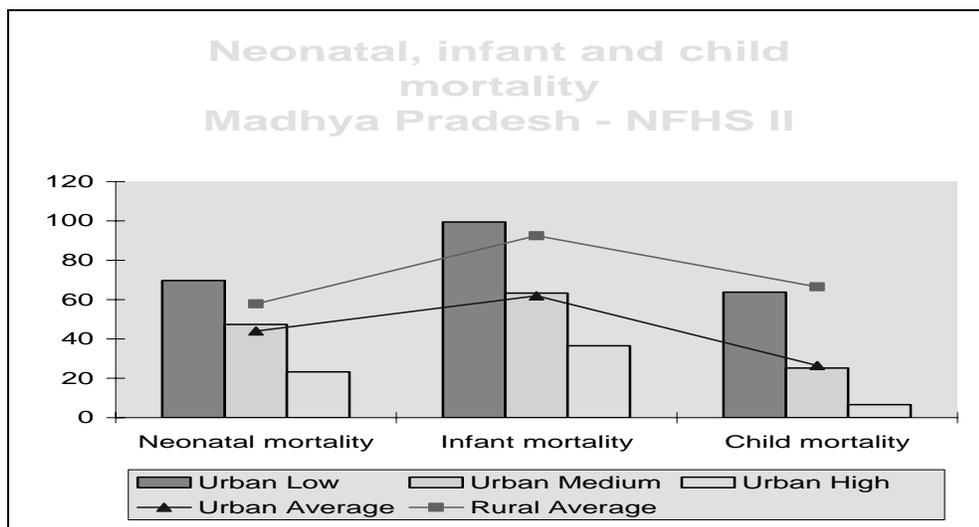
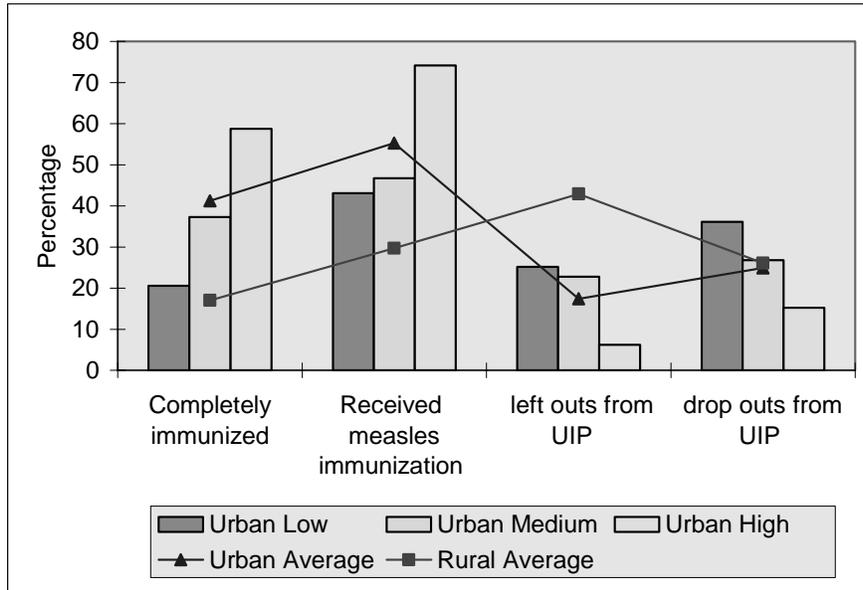


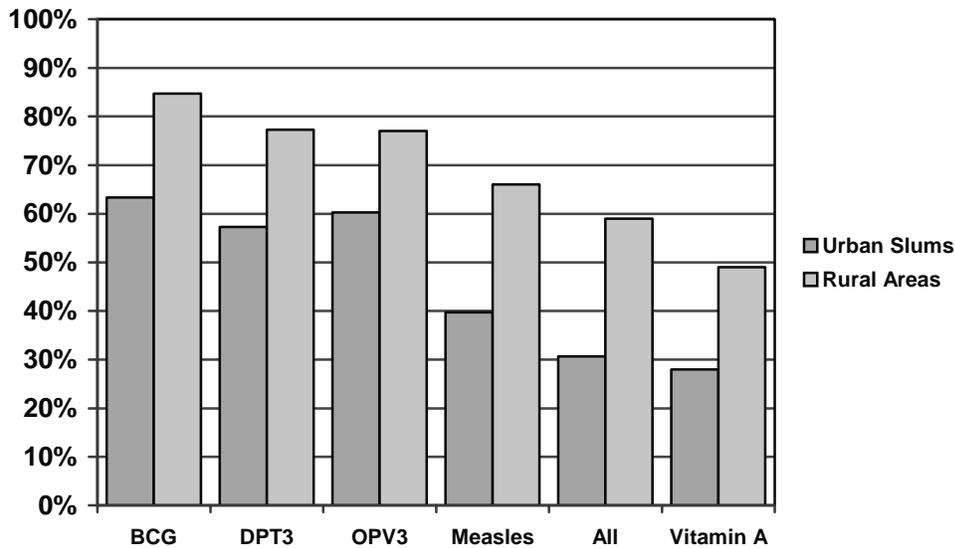
Figure 6. Immunization Coverage by Age 1 among Children 12-23 Months, India NFHS II Reanalysis for Madhya Pradesh



Some examples of other urban data collection and reanalysis efforts that show the urban poor vs. all urban and rural disparities include:

UNICEF India: Gujarat State Multiple Indicator Cluster Survey (MICS) 1996.

Figure 7. Coverage of Child Health Services in Urban Slums of 6 Municipal Corporations and Rural Areas of Gujarat



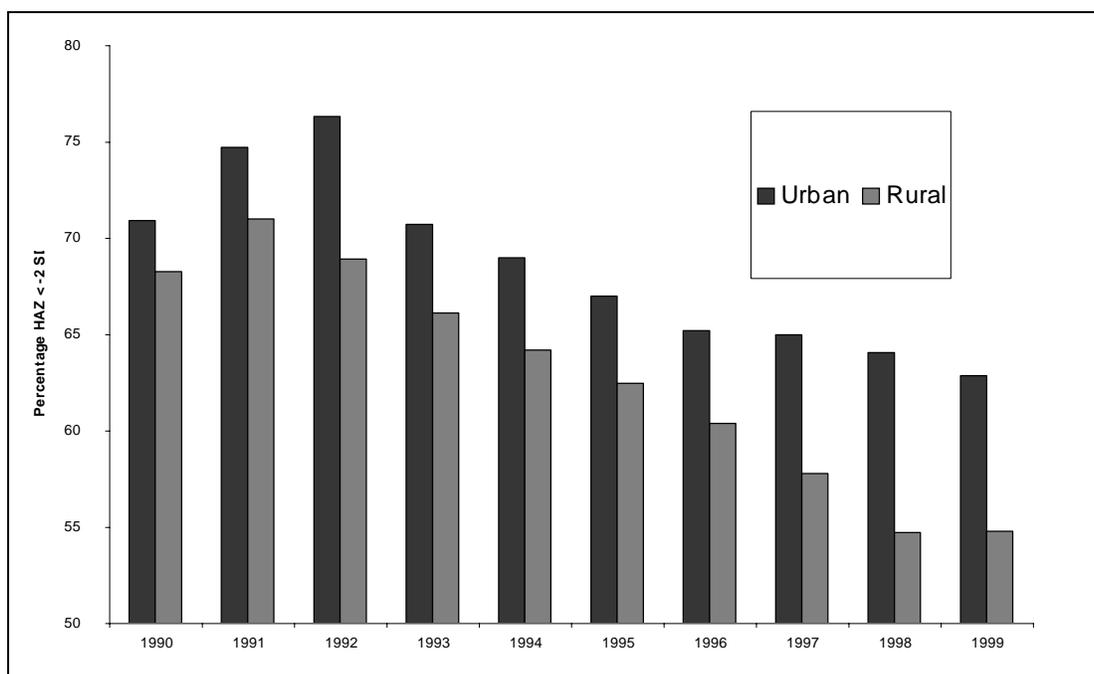
International Food Policy Research Institute (IFPRI) data

In an IFPRI Discussion Paper entitled “Socioeconomic Differentials in Child Stunting are Consistently Larger in Urban than in Rural Areas,” analysis of DHS and other data from 11 countries in three regions showed that the gap between low and high socioeconomic status was markedly larger in urban than in rural areas, and differences were statistically significant. In most countries, stunting in the poorest urban quintile was almost on par with that of poor rural dwellers. The study also showed that children living in urban areas might be up to 10 times more at risk of being stunted if they are from poor households compared to children from households of higher socioeconomic status. (Menon 2000)

Nutrition Surveillance/Helen Keller, International

HKI has conducted numerous long-term nutrition surveillance programs in Asia, tracking trends in rural and urban slum areas. In Bangladesh, the NSP from 1998 to 2002 included 24 rural sites and slums in three cities. In 2003, six more cities/slum areas were added. The surveillance included indicators on nutrition, health, food consumption, household food security, health environment and services, disasters and coping strategies. Six hundred thousand households were included and surveyed every two months to capture seasonal variations. The NSP found higher rates of stunting in children and of female illiteracy and lower rates of grain consumption in urban slums as compared with rural areas. These rates remained similar over time (Bloem et al 2003).

Figure 8: Trends in Stunting, Bangladesh 1990 – 2000, Helen Keller International



4. Issues to Consider When Developing Urban Health Programs

4.1. Social

Understanding the social complexity of urban slums is an important first step in developing health programs. Scenarios can range from existence of social networks to address the many problems related to life in urban slums, with coping mechanisms for all manner of health issues, to social disarray and extreme vulnerability. Traditional financial or social support networks, transplanted rural healing and health belief systems, or health belief systems adapted to the slum and socio-economic setting, may be operating.

Implementation strategies will be most effective if they are developed with input from the urban poor themselves. Questions designed to learn about and eventually utilize the social environment, especially health advice and care-seeking networks and channels, are critical elements of initial qualitative research.

Community-based organizations (CBOs) or NGOs work among the urban poor and have an understanding of the social characteristics of urban poor groups or neighborhoods. The presence of an NGO/CBO may be a proxy for better living conditions as community organizing often results in increased demand for services and/or increased efforts at community improvement. Including these organizations as sources of information and also as implementation partners can be an important factor in program success. These organizations can also offer reach and guidance to the urban poor related to health services and initiatives, especially in urban settings where information overwhelmingly comes from so many sources but may not reach the urban poor.

4.2. Economic

Poor health status of urban slum dwellers and its determinants are linked to poverty. Poverty means chronic undernourishment of poor urban women and children; it means that the urban poor cannot afford adequate housing and suffer the consequences of overcrowding; it means that health care, even if accessible, is often unaffordable; it means exclusion from the formal economic sector and from benefits of urban development. In the Philippines, 37% of the urban workforce is in the informal sector. In Dhaka, 63% of all employed people are in the informal sector (UN Habitat 2003).

Specific poverty-driven conditions, such as child labor, prostitution, domestic violence and substance abuse, exploitation by unqualified providers (quacks), and use of hazardous biomass fuels for cooking, all have direct health consequences that are often overlooked.

Livelihood — needing an income to survive — is a fact of life for the urban poor. Poor households are more likely to send children to work (rather than to school), to cut back on medical care or to restrict food consumption. Health improvement efforts would be most effective if associated with livelihood improvement and local empowerment strategies. Examples of this are:

- Development of health insurance schemes managed by the poor
- Local manufacturing and selling of health improvement items such as soap and containers for safe household water storage
- Local ownership and management of services with health implications such as solid waste removal, water supply, childcare, and ambulances for medical emergencies

4.3. Gender

Urban poverty has become highly feminized. Compared to their male counterparts, poor urban women tend to:

- have lower paying jobs
- have higher illiteracy rates
- be excluded from certain types of jobs because of lack of documentation, low education levels or discriminatory practices
- move in and out of the workforce more because of family reasons, sacrificing advancement opportunities
- be responsible for household chores

Land and home ownership and inheritance laws often exclude women. Many urban households are women-headed without legal standing or recourse. Discrimination often prevents women from being able to obtain credit to start small enterprises, although credit is generally hard for the urban poor to obtain. Children and other family members depend on women's daily wages to eat. The income these women earn "may give them greater control over the household's resources and may lead to greater expenditures on food and children's needs," but they "may not be able to spend as much time managing the household, buying and preparing food, or taking care of children. Urban women end breastfeeding two to three months earlier than rural women, perhaps depriving their children of needed nutrients and reducing immunity" (IFPRI 2002). In addition, children are often poorly supervised or left to their own devices during the workday, increasing their vulnerability.

4.4. Health of urban poor women

The urban poor women are little better off than rural women related to reproductive health and access to services and in some cases appear to be worse off (Montgomery et al. Eds. 2003). The urban poor have very little access to information they need to make informed decisions about

reproductive health. Additionally, it often appears that the time and money costs of access to services are seen by women more as social barriers and less as economic barriers since women must often negotiate for money from the husbands and other family members (the “decision makers”) to access services that require payment. Levels of unmet need for contraception are higher, and levels of contraception use are lower in urban poor women and they appear to be more exposed to unintended pregnancies and risks of unsafe abortions than nonpoor urban women. Based on DHS survey findings, urban poor women are also less likely to know how to protect themselves against the risks of STDs, including HIV/AIDS.

Successful urban programs have strong participation from women. Advocacy for pro-poor and pro-woman health and social policies should be considered a part of urban health strategies. Women can design, organize, build, manage, counsel, teach, start enterprises, and advocate.

4.5. Political

The focus on improving health and other services for the urban poor is timely. Many governments are concerned that urban slums and urban poverty breed civil unrest and insurrection. In a number of places with potential for civil strife, USAID and other donors or agencies are focusing attention and resources toward mitigating urban health and other problems.

Many countries are introducing decentralization policies. These political reforms focus on giving responsibility to multiple units of government and away from national ministries where expertise and funds were previously concentrated. Thus, although the mandate to provide health, social and environmental services is given to local or municipal government agencies, often the human resources or the technical capacities to utilize them are inadequate. Building up the capacity of local governments to deliver services to the urban poor can be a critical component of an urban health program. Decentralization can facilitate addressing urban health problems. Local and municipal governments are closer to the situation, and they may welcome capacity building assistance to improve health and environmental services in urban slums.

Political will to develop and carry out health programs aimed at urban slums is often linked to elections. Elected officials want to prove their responsiveness to the needs of their constituencies, especially during election times, and urban health programming efforts can capitalize on this motivation if the timing is right. A thorough analysis of governance and decentralization policies and current status will reveal the technical and political stakeholders and identify available resources within a given municipal or local government setting that can be leveraged for the urban poor. However, a good understanding of the local political scene and careful consideration about potential political fallout from addressing issues of urban poverty and health is suggested.

4.6. Health and social services in urban slum settings

While urban access to health services might be geographically better than in rural areas, a variety of barriers frequently block access by the poor to these services.

The private sector is a prominent presence in urban health care and offers a range of providers from traditional healers to pharmacists and pharmacies to highly trained specialists. Fee-for-service is the focus of the private sector and for the urban poor this raises the issue of the ability to pay. Even at “free” public-sector services, patients are required to pay for drugs and supplies, if not for consultation.

A key characteristic of urban slums is also access, particularly when services are located far from main transport routes. In fact, the Egypt MOHP defines a slum as a neighborhood without a health center. The problem of services can be due to the unrecognized status of slums or to a lack of knowledge on the part of municipal and other officials of where and how large poor urban settlements are. Many cities are also simply overwhelmed by the rapid growth of slums and poor urban populations and do not have policies or programs in place for addressing their needs.

Where the distance is not so great (inner city slums), the urban poor face barriers such as:

- lack of transportation
- inappropriate hours or services offered
- unaffordable services
- unrecognized status — lack of identification or other official papers
- homelessness or transient status
- social barriers of prejudice on the part of health personnel

4.7. Difference in urban vs. rural profiles of key health problems

When developing health interventions for the urban poor, a critical element of success is to develop an understanding of the urban character of health determinants. In urban settings, factors such as housing, indoor air pollution, and absence of sanitation facilities, can have far more serious health consequences than in rural settings. Some determinants are purely urban in nature. Socio-economic status, strength of municipal capacity, and employment, are examples.

Annex 1 reviews urban characteristics of the main health program areas with suggestions on program approaches specifically addressing the urban manifestations of the targeted health problems. These suggestions are based on USAID and other experiences and demonstrate that USAID can take action to address health issues of the urban poor.

5. Finding and Using Good Data to Develop Programs

The availability of good urban data is a continuing issue for urban programming. The place to start is with a search for already existing urban data, not limited to DHS. The problem with large data sets, however, is that they tend not to capture the urban poor. If DHS or other data exists, and the urban sample size was big enough to yield valid data (see Annex 2 for details), a reanalysis of the data to disaggregate it by urban socio-economic segments may be possible. Reanalysis of large DHS urban samples using asset-based indices has yielded good results in India. In addition to quantitative data sets, geospatial data (maps) may exist within government PR program offices.

Another possibility is to sponsor the collection of disaggregated data through the DHS (or other mechanism) using separate indices for urban and rural areas, then compare the lowest urban quartile with the highest rural quartile. Data collection in urban areas has a specific set of challenges, including being able to sample a large enough population to capture the urban poor randomly, sampling illegal settlements where many of the urban poor reside, using indicators adapted to an urban setting, addressing the problem of finding people without fixed addresses, and more. Annex 2 is a “How To” for conducting the DHS and similar surveys in urban areas to arrive at data on the urban poor or for slums. There is much work to be done on a macro-level, but for program development, what matters is to understand the situation of the urban poor in a specific locale.

The next place to look is for reports of studies (gray literature) on the urban poor, carried out by NGOs, UN agencies, or various projects, but not widely published. Creating a compendium of such literature is of value to the many potential actors in urban settings, and the data it contains can be a good basis for program development or further data collection.

Qualitative data collection should be viewed as a means and an opportunity to mobilize the urban poor, those who are tasked with providing services, and those who govern, toward addressing the problems of lack of services, poor health and social conditions. Analyzing health and living conditions in partnership with the urban poor through various participatory data collection exercises is a path that leads to partnerships for attaining urban health goals. Community or slum mapping exercises with participation by the residents of the mapped area will be richer and more accurate than if done without them.

The approach proposed here has been used successfully in USAID-funded programs in India, Egypt and other places.

5.1. Identifying and involving stakeholders

An important step in mobilizing for urban health programs is to systematically identify urban stakeholders and the stake they have in improving the health of the urban poor. The universe of urban health stakeholders can be described as those who:

- have an official or non-official role in urban health
- already carry out urban health improvement programs
- maintain funds allocated for urban programs
- benefit financially or politically from improved health of urban slum residents
- and of course, the urban poor themselves

Stakeholders can be from:

Public sector

- Municipal, state or national elected or appointed officials whose mandate includes providing public, preventive and curative health services for cities or whose constituency includes slum dwellers. It is important here to try to separate out municipal or local government functions from state or national ones, and the interrelationship between the different government entities, especially in a decentralized or decentralizing context.

Nongovernmental sector

- NGOs and Community Based Organizations (CBOs) with health or community organizing capacity operating in slums, or, already in urban areas with possibility of expanding to slums
- Multilateral or bilateral donors, who are funding or planning urban health, environmental or other slum improvement programs and who might be interested in partnering with USAID

Private sector

- Private health care providers such as independent doctors, midwives, or pharmacists, operating in or near urban slums, who could participate in trainings or in franchising of certain services such as family planning
- Private clinics or hospitals operating in slums or who could expand activities to nearby slums, through franchising or other means
- Local industry with a worker pool from urban slums and/or with health insurance schemes or on-site health care for workers
- Companies manufacturing items with potential health benefits such as soap or food that can be fortified, and who might have an interest in partnerships
- Finance institutions including insurance companies

Deciding whom to involve in different phases of program development and implementation and when requires strategic thinking about what the stakeholders' potential roles could be and what the potential is for future partnership. Advocacy may be required to bring stakeholders on board. The value of an urban health program may not be evident to all. Governments may be concerned that they will attract migration by delivering services to slum populations. Municipal officials may not be used to working with personnel in other departments and may be afraid that they will compromise their legitimacy as an agency by doing so. Politicians may or may not see the value in working with poor urban populations. Some slums are privately owned or controlled by landlords

who would raise the rent if additional improvements were made to a particular slum area. Nevertheless, the effort of bringing them all to the table pays clear dividends.

Some recent successful approaches include

- Creation of city-wide stakeholder coordination mechanisms such as an Urban Health Alliance or Council with a secretariat and membership
- Promotion of regular stakeholder meetings to share information, coordinate actions and exchange lessons among and across stakeholders and sectors
- Providing a forum for community-level and government stakeholders to interact and communicate about slum health needs and possibilities for meeting those needs through existing funds/programs or other means. This approach strengthens urban poor capabilities for negotiating their development priorities with officialdom.

5.2. Conducting a situation analysis

The purpose for conducting a situation analysis prior to designing health programs in urban slums is to:

- Get a better picture of the health profile of the urban poor
- Develop an understanding of the urban situation as it affects the health of the urban poor
- Identify needs for and gaps in programs or services
- Identify potential points of entry and determine possible flow of resources and commodities

An urban situation analysis can combine qualitative participatory methods such as interviews, focus group discussions, community mapping, ranking of health priorities from a community perspective, with a search for secondary data and information collected from different government agencies.

Many approaches have been developed, including the Risk Assessment Methodology utilized by USAID in Bangkok and Cairo. In addition, USAID has effectively used an “Environmental Risk Mapping” process under the regional RUPEOMAN project in several cities in Nepal, India and Sri Lanka.

An analysis of an urban situation starts out broad-based and city-wide to get a “big picture” perspective and can include information on the following:

- Overall city and slum populations, density, growth rate
- Official/informal slum delineations
- Water/sanitation infrastructure coverage in slums
- Municipal and local government agencies responsible for health services, health surveillance and water/sanitation and environmental services
- Policies in place (and gaps) covering health, water, sanitation in urban slums
- Urban development or slum upgrading plans, slum demolition plans

- Legal/illegal settlement patterns
- Intergovernmental or interagency relations
- Decision-making power and processes of municipalities about service provision and program directions

Suggested sources: census data, urban planning literature, reports, surveys, GIS, municipality, regional planning GIS/maps

Next, the situation analysis focuses on the urban health sector and can include:

- Data on infant/child mortality/morbidity indicators (especially diarrheal disease, ARI, nutritional status)
- Health facilities inventory, locations, usage rates, personnel numbers and qualifications, equipment, private vs. public
- Existing urban MCH, Family Planning, TB control, immunization, HIV/AIDS, malaria, nutrition/food security programs
- Coverage of these programs of urban slum populations, gaps and barriers to service coverage

Suggested sources: surveillance reports, health facility reports, MOH annual reports, surveys, and literature review

Finally, an important portion of an urban health situation analysis takes place in the slums or neighborhoods themselves and involves the residents in the collection and analysis of the information. This phase can be an empowering activity where residents arrive at a better understanding of themselves and their health and general development situation, have an opportunity to articulate needs and priorities, develop some political acumen and learn to negotiate with those who have political power and funds for development activities.

Information to collect can include:

- Population (numbers and makeup)
- Density and crowding
- Legal status of neighborhood/settlement
- Sources of income
- Community maps indicating location of health providers and facilities, schools, administration buildings, water sources, community toilets, etc.
- Settlement and history timeline
- Immigration patterns
- Formal/non-formal leadership
- Sources of drinking water
- Cost of water

- Places of defecation (adults and children)
- Solid waste situation and collection services
- Housing conditions
- Institutions (schools, churches, mosques, community centers) and the role they play
- Health providers (MDs, healers, pharmacists, midwives)
- Cost of services
- Access to health services (public vs. private, relative affordability and accessibility), health status data
- Health and hygiene practices in the home, in the workplace or schools

Suggested sources: interviews with informal leaders and key informants, focus groups, community transect walk, participatory mapping by community groups, health center surveillance data and records, NGO reports, surveys.

Example: In Cairo, neighborhood situation analysis results and community priorities for action were presented to government, donor and NGO stakeholders, resulting in actions being initiated on several fronts including adding the neighborhood to the family planning mobile clinic route, establishment of a government health center, and repairing of critical water/sanitation infrastructure problems.

5.3. Prioritizing areas and populations

In many cities, the numbers of poor neighborhoods or official slums is huge. For instance, Indore (India) counts 438 official slums. Because of exponential and unrecorded urban growth, slums are often not completely identified or mapped. Careful mapping of Indore slums revealed 539. A first impression is that the health needs of the slum residents appear to be uniformly great. Experience has shown, however, that slums can vary one from the other, in terms of socio-economic composition, health profile, service coverage, and a number of other aspects. In order to target resources and interventions for maximum impact, programs can identify and map the most vulnerable and needy areas and begin addressing their needs, while planning to phase in other areas. A useful methodology for prioritizing slums by assessing health vulnerability has been developed by the USAID/India Urban Child Health Program.

5.4. Health vulnerability assessment

This methodology was developed and tested in a number of Indian cities. Its purpose is to identify the most needy and underserved urban areas and populations for targeting of interventions. It is generally conducted after a situation analysis and identification of key stakeholders.

Methodology:

- Together with key stakeholders, develop criteria and a ranking system for classifying slums. Criteria for assessment can include poverty levels, social conditions, access to water supply and sanitation facilities, access and use of public health services, health status, nutritional

status, mortality, disease incidence, immunization coverage, presence of NGO/CBOs (see example in Table 1)

- Use results of the Situation Analysis if possible, or carry out an assessment using the established criteria.
- Steps should include city-wide mapping (legal and unauthorized settlements) and pinpointing the location of NGOs, health providers and services, water sources such as public taps, community sanitation facilities.
- Rank the slums, then triangulate assessment results among local and government stakeholders and identify priority slums according to the vulnerability criteria.

Table 1. Example of Vulnerability Ranking (USAID/EHP/India)

Vulnerability Criteria		Points			
		0	1	2	3
Social conditions	Education	Minimal levels of education with the majority of children not going to school	Two of the conditions enumerated in previous column	One of the conditions enumerated in previous column	None of the three conditions present; also reasonable social conditions present
	Alcoholism	High levels of alcohol abuse			
	Gender equations	Gender insensitivity, with high domestic violence incidence			
Poverty levels	Access to employment opportunities and nature of work	Extremely limited because of distances. Uncertain flow of income for those who are daily wage workers	Irregular and unsystematic patterns, but better off than previous category	Working in small shops or as semi-skilled laborers	Working as domestic servants, semi-skilled jobs or as workers in factories
	Access to fair credit	None. High rates of interest/ mortgaging and selling of assets. High rates of indebtedness.	Close to previous description	A few organized systems – through community saving groups, banks or moneylenders.	Through community saving groups, banks, employers, money lenders at low rates
	Proportion of population below the poverty line (BPL)	>75% BPL	50 – 75% BPL	25 – 50% BPL	<25% BPL
Infrastructure	Toilets	No facility; use open fields.	Public toilets unusable	Public toilets functional	Majority of families have private toilets
	Drainage	No facility; clogged facility causing harm	Clogged drains/ineffective	Open semi-functional drains	Underground/cover-ed drainage.
Water supply		No access within 200 m	Public facility within 100-200m	Public facility within 100m	Majority of families have individual taps

Vulnerability Criteria	Points			
	0	1	2	3
Health Facility (Government. facility)	Not accessible with a transport cost of minimum Rs 15 return	Accessible within 3 – 5 km but not used	Available nearby, but limited use	Easy access to and use of facility
ICDS services (Anganwadi center)	No AWC	AWC present		
Health & morbidity status	High incidence of diarrhea, fever, pneumonia; no/very low immunization coverage	High incidence of diarrhea, fever, pneumonia; low immunization coverage	Marginally better than previous category	Lower incidence of diseases; reasonably & promptly treated; high immunization coverage
Presence/capacity of CBO	No CBO	Weak or dysfunctional CBO	CBO functional, with limited activities	CBO proactive with a wide range of activities and strong links with government departments

5.5. Baseline and household surveys for urban programs

Good urban program development will depend on good, compelling data. The DHS is the vehicle for collecting data to guide strategic USAID health/population programming, and efforts are underway to support MACRO/DHS in developing research approaches for urban slums (see Annex 2). However, there are limitations to the DHS (time, national vs. local scale) that are important to recognize. A two pronged approach will be the most useful when dealing with complex urban settings: A DHS that includes urban areas in a way that can be disaggregated by slum/non-slum and by wealth index, but also alternative urban research that focuses on neighborhoods and households as entities distinct one from another, is adapted to the individual context and can be more frequently implemented than the usual DHS five year interval. Such urban research should be able to measure the outcomes or impacts of interventions and should be designed once the program strategies are in place. Attention needs to be given to more robust measures of poverty and environmental health conditions that affect urban dwellers disproportionately beyond assets that will exhibit changes over time.

An important program strategy that contributes to sustainability of urban health interventions is building the capacity of local or municipal governments and other official agencies tasked with surveillance to routinely sample urban slums and focus on the urban poor. Additional challenges may arise when different agencies representing sectors such as health and sanitation all have mandates to conduct surveys of the same areas. Urban health programs can help form collaborative efforts where information is shared and not supplicated.

Annex 2 is a “How To” for conducting a DHS in urban slums, but its principles can be applied to other slum-based surveys.

6. Implementing Health Programs for the Urban Poor

6.1. Deciding what to do and finding points of entry

Successful implementation of urban health interventions requires a multi-sectoral approach involving a diverse set of stakeholders. However, it may take a while for all the vested partners to see the importance of interventions of this kind. Connecting community representatives, program/service providers, donors/funders to analyze results of baseline surveys, situation analysis, vulnerability assessment, literature review and any other information collection effort is the first step to deciding what to do. A participatory, problem-posing approach to intervention design is valuable: Data and information from the situation analysis and can be organized in such a way as to define a problem, which is posed to various urban stakeholders (including slum dwellers) who are challenged to find approaches for addressing these problems.

A decision by stakeholders about what to do based on available information leads to identifying viable points of entry and platforms for urban health programs.

Examples of points of entry or platforms for program launching:

- Existing NGO programs in health or other areas, where health programs can be built and/or strengthened
- Existing government plans for delivering public health services to poor urban areas but without adequate plans, experience or funding
- Existing private sector initiatives (e.g., factory health facilities or programs)
- Community-based champion for urban health, with experience and good connections but lacking technical and financial means
- Decentralized government where responsibility for urban public health falls on local or municipal governments without enough prior experience and needing support
- Existing national disease control program (TB, HIV/AIDS, micronutrients, immunization) focused on rural areas but ready and willing to move into urban areas
- High level government official who is an urban health champion, or who champions the cause of working with the urban poor

- Ongoing or planned urban slum upgrading or urban environmental infrastructure improvement program where a health or hygiene promotion component could play a complementary and synergistic role
- Older, established slums with more stable social networks and more likely to have secure tenure and thus more likely to be willing to invest in their homes and surrounding infrastructure and more likely to house private sector health providers and have supportive local government institutions
- A planned DHS where an urban component with large enough sample for disaggregation could be included, and results used for advocacy and program planning

6.2. Service delivery issues

6.2.1. Decentralization, local governments and the delivery of public health services

A key component to implementing successful and sustainable urban health programs is strengthening the will and ability of governments (central and local) to augment and better target health resources. In cases where decentralization has recently occurred, local governments may or may not be prepared to analyze need and allocate resources appropriately, and resources may not be sufficient to carry out the new mandates. In urban areas, there may be confusion over what agency (central or local) is responsible for which service. In decentralized settings, urban health programmers are faced with numerous challenges related to clarifying legal and regulatory frameworks, institutional capacity building, strengthening of management and service delivery systems, etc.

Since 2001, USAID/Indonesia and Management Sciences for Health is carrying out a successful “Management and Leadership Program” to provide technical assistance to strengthen the capacity of leaders and managers responsible for primary health care services, including family planning, at all levels of the decentralized health sector. Program strategies include establishing a legal framework for obligatory authorities, basic health services, and minimum service standards for districts and municipalities, training local facilitators to carry out health provider performance assessment and improvement activities, improving the management of essential drugs, and strengthening the disease surveillance capacity at all levels of the health system (For more information see <http://www.msh.org/projects/mandl/4.5.html#top>).

6.2.2. Working with the private and corporate sectors

There are many reasons to work with the private sector to accomplish urban health goals. First, in many developing countries the urban poor receive at least half of their health services from the private sector, be it from practitioners of traditional medicines (including birth attendants), qualified or not-so-qualified MDs, or local pharmacies. The quality of these services can range from good to highly doubtful. Improvements in the health of the urban poor can be achieved by improving the quality of services they receive from the providers they already frequent.

A second reason to work with the private sector is that, in many cases, they are able to bring additional resources to bear upon addressing a problem. Where there is a convergence between the goals of the private sector (e.g., soap companies) and that of the public sector (e.g., hygiene improvement), partnerships should be actively pursued.

Finally, there may be ways in which private sector activities could be altered to improve the lives of all city residents. Governments and donors could work with the private sector to find cost-effective ways of reducing the emission of pollutants that damage the health of city residents. Public/private partnerships can be developed to ensure that factory labor is given a healthy environment in which to work.

Urban HIV/AIDS prevention program

The HIV/AIDS peer education project in garment factories in Dhaka was funded by the United States Agency for International Development (USAID) and others. The baseline study for the project revealed that women had poor knowledge about HIV/AIDS risks. The women also suffered untreated STDs and did not like using condoms. Pre-marital and extra-marital relationships were frequent. The women also faced sexual coercion in the workplace as well as poor hygiene and sanitation. Thus, there is a need for a peer education program to encourage these workers to seek information and services on HIV/AIDS.

The program is being piloted in one of the biggest factories in the capital city of Dhaka with 7,000 workers. Within the workplace, the project implemented a peer education program with the support of the employer. As an incentive to sustain the interest of peer educators, they were given certificates for attending training, badges for recognition, picnics for recreation, and study tours to enable them to observe the programs of other factories.

The project found peer educators to be effective in disseminating information in the workplace. They were able to increase the level of knowledge and awareness about HIV and STDs among workers. The project also succeeded in improving health-seeking behavior as seen from the number of women going to the PSKP clinic. Moreover, the project has been able to generate the support of the employers, thereby providing some sort of guarantee that the project's goals and activities will continue to be pursued.

(International Council on Management of Population Programmes – Best Practices)

One approach to working with the private sector gaining attention is social franchising. This entails the licensing of private health providers to provide goods and service for a social goal, thereby increasing access and use while ensuring quality of services. Franchising is particularly attractive for reaching tens of thousands of urban dwellers, considering economies of scale in advertising and purchase of bulk goods for distribution to franchisees. Franchisees can include existing private providers who are preferred by the urban poor, un- or underemployed medical professionals, private, NGO or public clinics already operating in urban zones. Franchisees pay a membership fee and receive training, follow-up visits, supplies and display materials of a brand of goods that is recognized and valued by the public.

6.2.3. Working with mobile and transient populations

This is an area sorely needing examples and experiences to inspire programmers, but few exist. Clearly, creative approaches such as deploying mobile health teams and community based outreach workers who know client population movements, are known and trusted by the client population, are called for. This programming area could learn from experiences in the United States and other

countries who provide public health services to urban homeless populations. As an example, the website of the American Medical Students' Association has an entire page devoted to dealing with homeless populations, with a section describing "Characteristics of Responsive Health Programs for the Homeless: Accessibility, Comprehensiveness, and Non-Judgmental Attitude, Health Concerns of Homeless Children." Its website offers links to many programs and other resources and could be a starting point for someone wishing to develop a program for the homeless in Asian or other cities (<http://www.amsa.org/programs/gpit/homeless.cfm>).

6.2.4. Working with NGOS/CBOs

An important and successful model for implementing health programs in urban slums is to work through existing NGOs and community-based organizations (CBOs). If a capacity building component is included to help the organizations build financial, management and technical skills, sustainability becomes possible.

In the city of Indore, the USAID/India urban child health program helped create consortia of a strong NGO partnered with five or so fledgling CBOs. These consortia cover the most needy slums with neonatal health and hygiene improvement activities. The program assessed TA needs and trains the NGOS/CBOs at regular intervals. A sustainability strategy is being developed to ensure continuity after the program support ends.

In Bangladesh, The NGO Service Delivery Program (NSDP) provides high impact and high quality primary health care services and increases the public's demand for these basic services in both rural and urban areas of Bangladesh. Begun in 2002, the NSDP's strategy for achieving this objective is to improve NGOs' role in meeting primary health care needs of the population, with special emphasis on the poor and under-served.

6.2.5. Facilitating access by the urban poor to existing health service centers

Programs can do this by addressing attitudinal barriers: provide training in cultural sensitivity for clinic or hospital workers. Lack of information can be addressed by including community outreach efforts to publicize available services. Access can also be improved by bringing certain services such as family planning and immunization to where people live or work through satellite clinics.

6.2.6. Willingness to pay for services

Assessment of "Willingness to Pay" has been effectively used by USAID and many others and has conclusively shown that the poor are often willing to pay substantial amounts for basic urban services. Unfortunately, government officials typically refuse to provide water supply and waste management services to poor neighborhoods on the grounds that "they can't afford them." The irony is that when these municipal services are denied, this rationale becomes an excuse to condemn the poor to pay ten times as much as the residents of wealthier neighborhoods. EHP and USAID/India/Urban Programs conducted a study in Dehradun, India, showing the poor were willing to pay for good quality water service delivery. In fact, the study also showed that because the coping costs associated with intermittent water supply (water loss, extra tanks, pumps,

treatment, etc.) were so great that it would be cheaper for them to pay for a good quality continuous water supply.

6.3. Multisectoral and multidisciplinary collaboration

Improving health in poor urban settings is hardly a target that the health sector can achieve on its own. Urban determinants of health are interwoven and synergistic. Health sector folks must reach out to other sectors, find common ground and interests, and program collaboratively. Similarly, the health sector must remain open to opportunities offered by other sectors for coordination and joint programming. Maximum health impact will only be achieved through such coordination and collaboration. Some key sectors that might be partners for programming in urban settings are as follows.

6.3.1. Water and sanitation

Health risks associated with environmental factors such as lack of potable water and access to sanitation are extremely high in urban slums. Poor sanitation and hygiene especially pose a high health risk. For urban health programs to make a difference in urban slums, the environmental factors will have to be taken into consideration in programming. Hygiene improvement can greatly reduce the incidence of diarrheal disease, but in order to be effective, hygiene promotion should be carried out in tandem with provisions for improved water/sanitation hardware. Hardware can be more than pipes and pumps. It can mean household water treatment systems, it can mean soap, and it can mean potties for small children.

The health sector can coordinate and collaborate with planned or ongoing urban water/sanitation programs, thereby producing a synergistic effect for each sector. One good role for health is developing and disseminating appropriate hygiene behavior change messages through NGOs/CBOs, women's groups, schools, workplaces, and literacy programs, that are coordinated with hardware improvement.

In Agra, India, USAID's PHN, Economic Growth (EGAT), Urban Programs and Environment offices are developing a collaborative program to improve the city's services to the urban poor.

6.3.2. Education

Educational institutions abound in urban settings although most will be inaccessible to the urban poor. Schools that serve the urban poor can be partners in health and hygiene promotion, immunization campaigns, de-worming efforts, and Vitamin A and iron distribution. Adult literacy programs can be partners in addressing concerns of the urban poor through urban-appropriate materials and can help empower the urban poor, especially women. USAID/Asia Near East Bureau is funding the development of a series of slum-specific literacy lessons on environmental hygiene and child diarrhea themes. World Education will train slum-based community literacy teachers to use these materials with local women.

6.3.3. Housing and urban development

Any urban environmental improvement effort such as slum upgrading or housing improvement can have a health component since the health problems of the urban poor are so tightly connected to environmental factors. Good components might consist of promoting hygiene through various community groups or NGOs to complement improvements in water and sanitation or garbage disposal. Conversely, any public health effort targeting urban slums can be enhanced by collaboration with sectors that also address critical problems such as inadequate housing, solid waste collection, air pollution control, roads or pathways, and flood prevention. Understanding who urban stakeholders are, and creating possibilities for coordination among sectors through regular meetings and information sharing, will help promote collaboration between health and other urban development efforts.

6.3.4. Democracy and governance

Urban growth and urban problems are an increasing phenomena of smaller cities rather than of megacities, where the local government structures have even less experience than the big cities in managing growth and addressing need for services and infrastructure. USAID has many D&G programs supporting decentralization of authority to local governments. The health sector can collaborate and coordinate with D&G programs to connect health services with other local government services and strengthen capacity of local government agencies.

7. Technical Assistance, Procurement and Financing

7.1. Funding and technical assistance resources available within USAID

1. Making Cities Work Partnership Grants

Making Cities Work (MCW) Partnerships promote and demonstrate that multi-sectoral, collaborative approaches are the best way to address the myriad issues that converge in urban areas. The fund supports the goal of the USAID Making Cities Work strategy to help enable cities to function well. The Office of Urban Programs of USAID is attempting to help the Agency prevent future problems and address current ones through technical support, contract mechanisms, awareness raising activities, collaboration with pillar bureaus and field missions, cooperative agreements and — the Making Cities Work Partnership Grant Program.

<http://www.makingcitieswork.org/www/files/docs/Tools/MCWPartnershipFundRFPFINAL.doc>

2. Development Credit Authority

The Development Credit Authority (DCA) provides USAID Missions the authority to issue loan guarantees to private lenders, particularly for local currency loans. These guarantees cover up to 50% of the risk in lending to projects that advance USAID's development objectives. In addition to mobilizing financing for specific projects, DCA partial guarantees help demonstrate to local banks that loans to underserved sectors can be profitable. This fosters self-sustaining financing because lenders become willing to lend on a continuous basis without the support of guarantees from USAID or other donors. DCA is a powerful catalyst for unlocking the resources of private credit markets to spur economic growth while advancing development objectives.

http://www.usaid.gov/our_work/economic_growth_and_trade/development_credit/

3. Displaced Children and Orphans Fund (USAID)

The U.S. Agency for International Development's Displaced Children and Orphans Fund (DCOF), established in 1988, began with the realization that increasing numbers of vulnerable groups of children were slipping through the cracks of larger child-centered programs. These children were losing the care and protection of their natural families, were being affected by war or HIV/AIDS, and were increasingly at risk of or were actually living or working on the street. The concern for these children has manifested itself in many ways, among concerned citizens, service organizations, and large and small donors. The Displaced Children and Orphans Fund is one of those donors, and

in the more than a dozen years of its existence, has identified principles, approaches, and methodologies, which it currently supports through more than 28 programs in 19 countries.

http://www.usaid.gov/our_work/humanitarian_assistance/the_funds/

4. Global Development Alliance (GDA)

The Global Development Alliance (GDA) is USAID's commitment to change the way its assistance mandate is implemented. GDA mobilizes the ideas, efforts and resources of governments, businesses and civil society by forging public-private alliances to stimulate economic growth, develop businesses and workforces, address health and environmental issues, and expand access to education and technology.

http://www.usaid.gov/our_work/global_partnerships/gda/

5. Environmental Health/Hygiene Improvement IQC

USAID's Bureau for Global Health has made hygiene improvement a key component of its environmental health agenda, largely as a contribution to objectives in improving child health, and works in close partnership with USAID Missions and bilateral programs, other donors, intergovernmental organizations, non-profit organizations, and the commercial private sector. Through its support of the Water and Sanitation for Health (WASH) project in the 1980s and early 1990s, and its support for the Environmental Health Project (EHP) since 1994, USAID's programs have evolved from hardware-centered water supply and sanitation activities to a behavior-focused approach in which hardware plays an important supporting role. USAID's environmental health activities also include work on indoor air pollution from household energy use and on integrated vector management for the control of mosquito-borne diseases, especially malaria.

IQC to be awarded. Contact John Borrazzo, GH/ENV, jberrazzo@usaid.gov

6. Title II Food for Peace

USAID, through funding provided by Public Law 480, Title II, makes commodity donations to Cooperating Sponsors (Private Voluntary Organizations, Cooperatives, and International Organization Agencies) to address the needs of food security in both through five-year development projects and through emergency food assistance.

http://www.usaid.gov/our_work/humanitarian_assistance/ffp/

7. HIV/AIDS Small Grants

In addition to its global HIV/AIDS program, the U.S. Agency for International Development has two small grants programs that provide funding to organizations working on HIV/AIDS: The CORE Initiative and Community REACH.

http://www.usaid.gov/our_work/global_health/aids/Funding/grants.html

8. CORE Initiative

Through the CORE (Communities Responding to the HIV/AIDS Epidemic) Initiative, USAID provides strategic assistance — organizational development, direct grants, and other support — to community and faith-based groups in developing countries. Priority is given to groups who commit their own resources and demonstrate the ability to meet needs for care and support (especially care for orphans and vulnerable children), and to help confront and reduce the stigma and discrimination.

<http://www.coreinitiative.org/index.php>.

9. Community REACH

USAID established this fund to facilitate the efficient flow of grant funds to organizations playing valuable roles in the fight against HIV/AIDS, including regional and local non-governmental organizations, universities, and faith-based organizations. Grants made under this mechanism will typically range from \$100,000 to \$500,000, with award terms of one to three years. Competition for grant awards will be announced at periodic intervals. Awards will be made in three broad categories: primary prevention and education, voluntary counseling and testing, and care for those living with HIV or AIDS.

<http://www.pactworld.org/reach/>

7.2. Funding and TA resources available outside of USAID

1. World Bank Small Grants program

<http://lnweb18.worldbank.org/ESSD/sdvext.nsf/64ByDocName/SmallGrants>

The purpose of the Small Grants Program is to support the empowerment of citizens to have greater ownership of development processes, thereby making these processes more inclusive and equitable. The Small Grants Program is interested in supporting activities related to this purpose. Activities should also:

- Promote dialogue and disseminate information for the empowerment of marginalized and vulnerable groups.
- Enhance partnerships with key players in support of the development process. Key players could include government agencies, civil society organizations, multilateral and bilateral agencies, foundations, and the private sector.

2. Cities Alliance Community Water and Sanitation Facility

<http://www.citiesalliance.org/citiesalliancehomepage.nsf/0/F44C7090C5F75EF086256CBB00771E6B?OpenDocument>

The Community Water and Sanitation Facility (CWSF) was designed to increase slum residents' access to water and sanitation and to enhance donor impact by partnering the ideas, efforts and resources of the public sector with those of the private sector and nongovernmental organizations. The CWSF is a facility designed to support community-endorsed construction of improved water and sanitation services in slum communities and to encourage risk sharing and innovative financing of these services.

3. CityNet: The Regional Network of Local Authorities for the Management of Human Settlements

<http://www.citynet-ap.org>

With an aim to help local governments provide better services to citizens, CITYNET is committed to capacity-building at the city level. Every year, it organizes around 25 activities, including seminars and training programs, which address burning issues in urban planning and development.

4. Business Partners for Development: Water and Sanitation

<http://www.bpd-waterandsanitation.org/english/index.asp>

BPD Water and Sanitation is an informal network of partners who seek to demonstrate that strategic partnerships involving business, government and civil society can achieve more at the local level to improve access to safe water and effective sanitation for the poor than any of the groups acting individually.

5. International Youth Foundation

<http://www.iyfnet.org>

Recognizing that no one sector of society has the resources or expertise to effectively address the challenges facing today's young people, IYF serves as a catalyst to create strategic alliances among the corporate, government, and civil society sectors as a way to maximize the impact and reach of youth development programs. Many of these multi-sectoral partnerships are multi-million dollar initiatives carried out in multiple countries, funded over a period of three to five years. IYF also partners with multi-lateral institutions such as the United States Agency for International Development (USAID)

6. Other possibilities

- Public-Private Partnerships
- Inter-donor urban forums with funding available
- Tapping earmarked funds (national slum improvement programs, special initiatives)

7. Other agencies/donors with good urban health track record

DFID, World Bank, CARE, Ford Foundation, IFPRI, Helen Keller Worldwide, ICDDR/B, ORC/MACRO, London School, IIED, UN HABITAT

8. Hallmarks of Successful Urban Programs

A “successful” urban program is one that is appropriately tailored to help the most vulnerable, achieves its targets and is, above all, sustainable in the long run. Here are characteristics that enhance the chance of “success”:

- Careful targeting and strategies to reach the most vulnerable urban populations.
- Well done baseline survey and program evaluation leading to valuable, credible data.
- Presence of an urban “champion” who advocates for and draws attention to health issues of the urban poor, and has access to both the urban poor and decision makers.
- Neighborhoods or communities are organized and truly empowered with a strong voice in decision making and the ability to negotiate with municipal and other authorities.
- Good mechanisms are in place for coordination and linkages between multiple urban stakeholders such as government agencies, elected officials, service providers, program managers, representative community organizations/individuals, technical assistance and other stakeholders.
- Advocacy for increased resources and improved services directed to the urban poor is an energy stream for all participants.
- Plans for sustainability of activities after program support ends are included from the start.

8.1. Potential roles for USAID in urban health

- USAID can play a leadership role by demonstrating a commitment to programming in urban slums through partnerships among its PHN, Environment, Economic Development, Democracy & Governance, Urban Programs offices.
- USAID can demonstrate the need and advocate for urban health programming via targeted data collection, demonstration projects, program choices, resource commitment, and interactions with policy makers in countries with high rates of urbanization.
- USAID can be a trailblazer for the collection of disaggregated data on the urban poor, by advocating for and financially supporting the inclusion of urban indicators and urban sampling methodologies for new rounds of the DHS.
- USAID can develop models for urban health programs and support scaling up to achieve equitable coverage, with a focus on collaborating with the private sector.

- USAID can play the role of convener and coordinator of urban stakeholders, by sponsoring urban slum situation analyses and stakeholder meetings and workshops to develop strategies and partnerships to address the health, social and environmental needs of the urban poor. These meetings and workshops can identify and leverage sources of funding for different parts of an urban health program.
- USAID can partner with and support governmental and non-governmental organizations whose mission involves work in urban slums, to carry out urban health programs with USAID support.
- USAID can document and disseminate successful efforts to address the health needs of the urban poor.

9. What's Next in Urban Health Programming?

This section is based on suggestions and discussions by the participants at the ANE Urban Health Workshop held in Agra, India, February, 2004.

9.1. Household surveys of the urban poor

Clearly there is a need for increasing the household-level data on the health of the urban poor, beyond the DHS. The DHS mandate is to generate country-level data to inform policy and program direction in general, and to be able to compare across countries and regions.

City-level conditions must be assessed through other means and USAID PHN and other officers in missions can make urban data collection disaggregated by wealth part of their strategy. Publishing the results of these studies will help to increase available information about the urban poor and also provide models and lessons for different approaches to research in the urban environment.

9.2. Mechanisms for sharing information

Participants at the ANE regional workshop expressed a sense of working in isolation on urban health programs. There is a strong need for collecting and disseminating research, program experiences, various resources for technical assistance, to those who are or who want to be engaged in urban health programs. Several good ideas have been proposed:

- Creation of an urban health website, or a page on another organization's website for posting information and downloadable documents, and for linking people with resources
- Creation of a "listserv" of urban health practitioners who could receive information via email
- Creation of an e-group for sharing experiences and asking for/receiving technical support for urban health programs
- Creation of a virtual Technical Advisory Group (TAG) who would address specific urban health activities and themes

Obviously, creating these mechanisms will require the commitment of someone and/or some office and some funding. This remains to be worked out in order to be "what's next."

Organize regional urban health workshops for Africa and LAC

Building on the positive feedback on the usefulness and timeliness of the ANE workshop, USAID should consider repeating similar events in the other regions with serious urban growth and poverty conditions — Africa and Latin America/Caribbean. If these could happen in the near future, there is potential for momentum and cross-fertilization.

Consolidate the ANE regional urban health network

Also building on the conclusion that the ANE workshop was timely and useful, it would make sense to strengthen the regional network of urban health practitioners who have established a relationship, via electronic means or through other mechanisms.

9.3. Addressing the big urban health programming questions, namely how to...

- Find and provide services for the homeless, the pavement dwellers, those lacking identification and any official recognition, i.e., the most vulnerable of the vulnerable
- Bolster the ability of local or municipal governments to design and pay for effective public health programs targeting the urban poor
- Develop and maintain effective urban health partnerships
- Work effectively with the private (especially the “unorganized”) sector to ensure service delivery and quality of services
- Balance locally appropriate approaches with the need to rapidly go to scale with urban health programs
- Help diverse government agencies to collaborate and coordinate environmental infrastructure and health interventions and services for maximum health impact
- Create and manage the information needed for effective urban programs
- Develop the field of “Urban Health”

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Annex 1. Urban Implementation of Health Interventions

Since health problems of the urban poor are not always the same as in all-urban or rural areas, health intervention program strategies must often be adapted to fit their realities. A number of health programs targeting the urban poor have generated experiences and lessons that can provide useful support and guidance. This Annex provides an overview of urban considerations and suggestions for urban programming based on various program experiences in the ANE Region and elsewhere. It is in no way intended to represent official technical guidelines for implementing urban health interventions. Instead, it reflects lessons learned and can be viewed as a work in progress, to be expanded as more experiences are compiled.

The following health issues are addressed:

- Diarrheal disease prevention and control
- Maternal/Neonatal survival
- Reproductive Health/Family Planning
- HIV/AIDS
- Immunization
- Nutrition
- Food Security
- Tuberculosis Control
- Child Health: Special urban considerations
- Dengue Hemorrhagic Fever

Diarrheal disease prevention and control

Diarrhea, which spreads easily in environments lacking in sanitation and hygiene, kills 1.5 million children under 5 each year (WHO 2002) and has a morbidity impact that may outweigh the impact of mortality (Guerrant 2002). According to UNFPA, diarrhea is almost twice as prevalent in slums of Dhaka as in rural areas (State of the World's Population 2002). In an IFPRI brief, Stephens states, "In one poor part of Calcutta that contains 4 million people, about one out of every fifth child under 5 and adult over 65 dies due to diarrheal and respiratory diseases." (IFPRI 2000) The inadequate hygiene conditions, lack of potable water and sanitation facilities, contribute to this serious problem. Urban women suffer greatly from lack of toilets, often having to wait until night for privacy, and then risking being assaulted.

Diarrhea prevention in urban slums

- It is estimated that from one third to one half of all the incidents of diarrhea in children and one third of deaths due to diarrhea could be avoided through readily available and inexpensive hygiene improvement interventions (Huttly 1997; Curtis and Cairncross 2003, Jones et al 2003).
- A comprehensive approach to preventing diarrhea through hygiene improvement is advocated by USAID/EHP, UNICEF and others. This approach - called the *Hygiene Improvement Framework* - includes improving access to water and sanitation infrastructure, promotion of hygiene behaviors such as handwashing, safe water storage, feces disposal and food safety, and strengthening the enabling environment (EHP 2004). This is an opportunity for multi-sector collaboration in urban settings, both within USAID and also by creating coordination mechanisms between those responsible for municipal infrastructure development and public health. In Cairo, a successful collaboration among stakeholders resulted in hygiene promotion through adult literacy classes and community women's meetings, and simple repairs and improved management for neighborhood water and sewerage infrastructure.
- Urban slums are notoriously devoid of toilet or latrine facilities but are also in great need of them. Barriers such as lack of space in densely built environments, lack of sewer and water connections, or high water tables present real challenges. Many have addressed these successfully and provide lessons and models. The Sulabh Community Toilet Movement of India promotes community or private ownership and management of community toilets. Community-managed toilet facilities provide possibilities for income generation.
- Household treatment of drinking water is another viable diarrhea prevention strategy for urban slums where drinking water is polluted. Social marketing of low cost chlorination systems was effective in CARE/Madagascar's Urban Program in preventing a cholera epidemic in 2001. Making Cities Work/Egypt is experimenting with ceramic water filters in Cairo slums. The private sector or local entrepreneurs can be involved in manufacturing or marketing of containers or chlorine solution.

Maternal/neonatal health

Women and newborns are among the most vulnerable populations. Of the 585,000 maternal deaths that occur each year, 99% take place in developing countries. Poor maternal health conditions result in 3 million neonatal deaths and 22 million low birth weight babies a year. Many complications of pregnancy and childbirth are preventable through inexpensive interventions. Safe motherhood depends on available, accessible and affordable quality maternal health services. Cities have numerous health facilities for women and children. However, poor urban women often have less access to urban hospitals than do rural women to the closest hospital. Barriers to using urban health services include distance from facilities, social marginalization and prejudice against the poor by urban providers, inability to pay for services, lack of education about the importance of pre- and post-natal care, and services that are not adapted to the needs of the urban poor. Women in the urban slums of Bangladesh have limited access to reproductive health information and care because health centers are not conveniently located; as a result, 93 per cent of married teenagers have begun childbearing, 22% of girls give birth before age 15, 63% of women have never used a modern

method of family planning, and 40% became pregnant unwillingly due to a lack of knowledge of services. (Narayan 2000)

Among the urban poor, births mostly occur at home with traditional midwives who are nearby, affordable and trusted (much like rural areas). In Bangladesh, trained medical personnel assisted only 8% of women delivering a baby in Tongi and 25% of women in Jessore, two Bangladeshi cities. (IFPRI 2003.)

Urban poor women are often main breadwinners. A maternal death or severe illness puts the family, especially the children, at risk of malnutrition and death.

Maternal/Neonatal Health Programming in Urban Slums

- **Qualitative and quantitative investigation** into maternal and neonatal mortality rates, current beliefs and practices surrounding pregnancy, childbirth and immediate post-natal period, as well as availability and use of local health facilities will provide a basis for programming maternal/neonatal interventions adapted to poor and underserved urban residents
- **Increase skilled attendance at deliveries at household or facility level.** There is debate over whether TBAs can and should be trained to provide safe delivery services. Competency-based training of birth attendants is time and resource intensive and every program must decide whether to do this.
- Traditional and modern maternity care providers must be trained in **counseling** for appropriate care for neonates, to include warming and drying, cord care, breastfeeding support, and recognition of danger signs and referral. Counseling can also come from trained community volunteers, facility outreach workers or home-based peer counselors. Counselors must also be trained in **cross-cultural sensitivity and two-way communication** to overcome prejudices toward the poor.
- 500,000 neonatal deaths a year are due to tetanus. **Tetanus Toxoid immunization** campaigns for pregnant women are an affordable and effective intervention for urban poor women (see immunization section for more).
- Maternal and neonatal health programs for the urban poor require **facility mapping** and an assessment of quantity, quality and accessibility of existing facilities. Programs should be prepared to include **construction, renovation, and refurbishing** of maternal health facilities, along with **technical and attitudinal training** of personnel.

Reproductive health/family planning

The unmet need for reproductive health and family planning services in urban slums is high. Women in slums do not have the same access to family planning information, products or services as their better off neighbors in wealthier sections of a city. Fertility rates, underage marriage and pregnancy, and STIs tend to be more prevalent in slums. In urban Bangladesh, for example:

- 93% of married adolescents have begun childbearing
- 22% of girls give birth before age 15
- 63% of women have never used a modern method of family planning
- 40% became pregnant unwillingly due to lack of knowledge of services

(State of the World's Population 2002. UNFPA)

A household-based study of married women of reproductive age (15-45) conducted in slum settlements in 6 cities in Pakistan showed that psychosocial barriers were the greatest obstacles to family planning service use. Half of these urban poor women identified psychosocial reasons such as the opposition of religion, husband, or personal opposition to family planning. The second most commonly reported barrier to the use of family planning services among the urban poor were administrative barriers, and only 15% reported economic barriers. (DFID 2003)

The rapid spread of HIV/AIDS in poor urban areas is of particular concern. The 2003 UNAIDS Report states that in two states of India, a HIV prevalence rate of 50% was found among sex workers in some cities. See section on HIV/AIDS below for more.

Reproductive Health/Family Planning Programming in Urban Slums

- **Outreach** is critical. Using trained house to house volunteers recruited from the community, to counsel women about family planning, keep records, and if possible, provide FP supplies, with a backup referral system of health centers and NGOs with family planning services, can provide increased coverage and improved follow-up.
- **Expanding services**, via satellite or mobile clinics is another way to reach the underserved
- Special communication strategies and program interventions **targeting young people (adolescents)** and focusing on prevention of early marriage, delay of sexual debut, prevention of pregnancy and STIs and lowering the number of sexual partners should be important components of RH/FP in urban settings.
- Urban women are breadwinners and often not available during working hours. RH/FP clinic hours need to take this into account and **set hours acceptable to working women**. Safety and security are also issues – women might not be willing to go out at night so solutions acceptable to each situation must be found.
- Because perceived barriers to family planning services vary among different urban poor populations, the urban poor cannot be treated as a homogenous group. It is important to **identify perceived barriers** among urban slum dwellers before determining the best approach to address the problem. For example, as mentioned above, a study in Pakistan found that despite the fact that the urban poor are economically and physically disadvantaged in access to services, women identified socio-cultural factors as the greatest barrier to family planning service use. This finding highlights the importance of targeting family planning messages not only to the potential users of such services, but also to those who influence a woman's decision to utilize the services (husbands, mothers-in-law, elders, etc.) (DFID 2003).

- **Working with the private corporate sector**, especially factory owners who employ poor urban women, to provide health and FP services, condoms and HIV/AIDS prevention education, during or just after working hours, is a viable program approach.
- **Targeting men** in reproductive health has also been shown to be beneficial. In the Philippines, UNFPA through the local IPPF affiliate, established special men's clinics providing vasectomies, condoms, treatment for STIs, and education. Services are supported through contraception social marketing targeting men. This approach fosters a positive attitude toward RH/FP among men, and increases use of services. In 8 months, over 10,000 condoms were sold.
- **Social marketing** of RH/FP products makes sense in urban settings, where nearly everyone is exposed to mass media such as radio, TV, billboards, displays in shops. Many program examples of effective social marketing exist. In Pakistan, social marketing by PSI targets men, promoting condoms and addressing men's resistance points. The program assures institutionalization through skill-transfer training of commercial sector partners and subcontractors. Similar contraceptive/condom social marketing efforts in Viet Nam and the Philippines also aim to reduce the spread of HIV/AIDS, and include door-to-door sales of condoms. Social marketing requires the availability of goods and services, and can be effective when linked with the next approach, franchising.
- Family planning and contraception programs lend themselves to creative approaches. One such approach getting increased attention is **Social Franchising** (Montagu 2002, Ruster 2003). Social franchising entails the licensing of health providers to provide goods and service for a social goal. It aims to increase access and use while ensuring quality of services. Franchising is particularly attractive for reaching tens of thousands of urban dwellers, considering economies of scale in advertising and purchase of bulk goods for distribution to franchisees. Franchisees can include existing private providers who are preferred by the urban poor, un- or underemployed medical professionals, private, NGO or public clinics already operating in urban zones. Franchisees pay a membership fee, and receive training, follow-up visits, supplies and display materials of a brand of goods that is recognized and valued by the public. The Greenstar Network in Pakistan is an example of successful social franchising in urban poor neighborhoods. Franchisees are mostly OBs or other doctors from disadvantaged neighborhoods, including 2,850 female doctors and 11,867 other health care providers, who receive subsidized contraceptives and clinical supplies, 40 hours' training, and are supported by intensive radio, TV and print advertising. Greenstar brand recognition is high, franchisees use special lit signage to advertise themselves. Effectiveness depends on a strong referral network that is promoted via Greenstar handbills and referral cards sending patients from one outlet to another. (See <http://www.greenstar.org.pk>).

Providing Essential Services through NGO clinics in urban Bangladesh

The National Integrated Population and Health Programme (NIPHP) (1997-2002), supported by the United States Agency for International Development (USAID), to address the issues of missed opportunities and sustainability. Under the NIPHP, the Urban Family Health Partnerships (UFHP) supported NGO clinics providing ESP to the urban population of Bangladesh. The UFHP, one of the partners of the NIPHP, provides essential health services to city dwellers in urban areas through

27 local NGOs since 1997. These NGOs operates 124 static clinics and 280 satellite teams to run the outreach satellite clinics. One doctor and a paramedic were responsible for providing services in each static clinic; there was also a counselor and a senior service promoter. The satellite clinics were managed by a two-member team, comprising a paramedic, who provided health services, and a service promoter, who was mainly responsible for behavior change communication (BCC) and mobilization of clients. On average, 325,000 clients receive ESP from these facilities in each month (*UFHP unpublished documents*).

<http://www.icddrb.org/pub/publication.jsp?pubID=4382>

HIV/AIDS

Over 7.4 million people in Asia are living with HIV/AIDS, comprising nearly one fifth of the world's HIV infections, according to UNAIDS. Mixing between population groups with different levels of risk behavior is the most important determinant of the spread of HIV in Asian countries. Physical movement is also a contributing factor in spreading the epidemic. The urban economic boom in much of Asia means that many people are highly mobile to fill the jobs this boom creates. Data from three cities in Indonesia show that 44% of clients of sex workers paid for sex in two or more cities in the past 12 months and that the sex workers only stay in one city for about a year before moving to another city. HIV/AIDS prevention education and services are largely urban, in recognition of the determinants of its spread. (from *What Drives HIV in Asia?*, Family Health International, 2001).

South Asia

Almost two thirds of those infected with HIV are living in India. However, high-risk behaviors and infection rates are growing in most other South Asian countries. In India alone, around 4.6 million people are infected with HIV. Although the rate in the population at large is still low, in absolute numbers, due to its large population, India has one of the largest HIV-positive populations in the world, second only to South Africa. Other countries in the region, such as Bangladesh, Pakistan, and Nepal, are characterized by a low prevalence among the general population, but have significantly higher rates among subpopulations that are engaging in high-risk behaviors, such as injecting drugs and engaging in the selling and buying of sex. (from www.worldbank.org/sarAIDS)

East Asia and Pacific

HIV/AIDS was first detected in the EAP region around the mid-1980s, and the epidemiological profile of HIV/AIDS in the region is complex. By the early 1990s, it became evident that epidemic spread of HIV was occurring in female sex workers, their male clients and injecting drug users in several EAP countries. Among EAP countries, the epidemic varies in stage with a spectrum of low, moderate and high prevalence rates. In Cambodia, Myanmar, and Thailand, HIV prevalence has already exceeded 1% among the general population. (from www1.worldbank.org/hiv_aids/regional.asp) Papua New Guinea now has the highest reported rate of HIV infection in the Pacific, with an estimated HIV prevalence of almost 1% among pregnant women attending antenatal clinics in Port Moresby. (from AIDS epidemic update, UNAIDS December 2003) For large and diverse countries such as China, Vietnam and Indonesia, there is no single epidemic. In such countries, relatively low national HIV prevalence rates often mask "hot spots" where transmission takes place at an alarming rate.

HIV prevalence has declined in Cambodia and Thailand, but could be on the rise in the other countries. The epidemic is mostly concentrated in large cities and in “hotspots” along the borders. It has been concentrated in such most at-risk populations (MARPs) as sex workers (SW), injecting drug users (IDUs), males who have sex with males (MSM) and migrant and mobile sub-populations. These MARPs have been bridges to the spread of the disease to general populations. The epidemic is now mostly male-driven and exacerbated by risky sexual behavior and rapidly growing, cross-border mobility. (From HIV/AIDS Strategic Plan for the Greater Mekong Region, FY 2003-2006, USAID, February 2004)

HIV/AIDS Programming in Urban Slums

Use of media to widely disseminate preventive messages. Media exposure in urban settings is very high. However, media habits and exposure of the urban poor should be studied prior to developing BCC strategy, since they may be different from all-urban habits/exposure. Family Health International found that 72% of urban youth watch television, making it a powerful medium for raising youth awareness of HIV/STD prevention and other issues.

Identifying concentrations of high-risk populations. These can include migrant male workers, commercial sex workers, intravenous drug users, etc.

Local governments can play an important role in HIV/AIDS programs since they are close to the community and often have the mandate for providing preventive and treatment services. The World Bank and AMICALL have produced a guidebook that advocates for mainstreaming of HIV/AIDS activities into all municipal functions. The following table is excerpted from it:

What does Mainstreaming for HIV/AIDS Mean?

In most instances LGA responsibilities cover provision of:	Examples of what Mainstreaming for HIV/AIDS may include:
Administrative infrastructure and services	Provide, display, disseminate information and education materials on HIV/AIDS prevention. Ensure that non-discrimination policies are implemented and monitored in all areas of LG work.
Water and waste infrastructure and services	Collaborate with local hospitals and parks to ensure that there is a system for safe disposal of needles and effective waste management.
Road and transport infrastructure and services	Condom distribution and prevention messages on public bus routes and at bus depots (for drivers, truckers). Contracts awarded for road building should include HIV/AIDS awareness activities for road builders.
Health and education infrastructure and services	Ensure that all health workers have adequate information about HIV/AIDS. Support needle exchange programs where IV drug use is prevalent. Establish a referral system for all HIV/AIDS related testing, counseling, treatment and care as well as a referral system (with depts. of social welfare and education) for vulnerable families.

In most instances LGA responsibilities cover provision of:	Examples of what Mainstreaming for HIV/AIDS may include:
	<p>Include HIV/AIDS awareness training in school curriculum.</p> <p>Provide referral system between schools and adolescent health services.</p>
Social and welfare infrastructure and services	<p>Coordinate with health department to establish a referral system for families affected by HIV/AIDS.</p> <p>Support micro-credit and insurance programs for people and families effected by HIV/AIDS.</p> <p>Set up a school-fees fund for orphans.</p>
Economic infrastructure (markets) and services	Use market infrastructure to display HIV/AIDS prevention messages.
Land/ Buildings for residential, business or other uses such as burial grounds	<p>Identify and assist in meeting the housing needs that may result from HIV/AIDS (e.g., those taking in orphans, child-headed households).</p> <p>Integrate HIV/AIDS awareness activities into slum upgrading projects.</p> <p>Identify buildings that may be used in HIV/AIDS projects.</p> <p>Address the growing need for burial plots (due to deaths from HIV/AIDS) within the planning of land uses.</p> <p>Support the establishment of burial societies.</p>
Agricultural extension (in some cases)	<p>Identify families affected by HIV/AIDS and provide additional subsidies.</p> <p>Provide training in AIDS prevention and nutrition to peri-urban agricultural areas</p> <p>Investigate the use of less-labor intensive farming technologies for families affected by HIV/AIDS.</p>
Regulations to ensure a healthy and safe environment	Fight HIV/AIDS stigma through legislation, advocacy, and awareness campaigns.
Libraries, parks, sports and recreation	Integrate HIV/AIDS awareness and anti-stigma messages into public leisure events.

From Local Government Responses to HIV/AIDS: A Handbook. World Bank et al 2003

Immunization

Immunization is a key component of child survival in urban areas. For instance, measles can be easily transmitted in densely settled areas and is especially dangerous for urban children who tend

to be more malnourished and affected by diarrheal disease than their rural counterparts. Immunizing pregnant women against tetanus can help lower high neonatal and infant mortality rates in slums

Urban challenges relate to missing or misleading data. Often, coverage data on immunizations coming from government sources claim high immunization rates for an entire urban area. NGOs working in slums provide much more modest estimates. In some cases this reflects the legal status of slum areas as the government may not consider slum dwellers to be legitimate city residents and exclude them from the catchment area. Unfortunately diseases do not follow legal classifications in their infection train.

Another challenge to be faced is that of ensuring that poor children receive the complete rounds required for full immunization. Keeping records on poor children who rely on ad hoc outreach mechanisms for services can be quite difficult. It is most difficult to ensure full immunization of children in temporary and illegal settlements who may not live in one place long enough to establish a routine relationship with a health provider.

In many ways, immunization is well-suited for an urban environment: Large groups of target populations can be immunized in crowded urban settings; issues of cold chain and vaccine supply are more easily managed, trained health personnel is available; awareness campaigns can be easily disseminated and reach large numbers. Cost-effectiveness of immunizing in urban settings is a clear advantage.

Immunization Programming in Urban Slums

- **Timing** of immunization days or hours in health facilities covering urban poor populations needs to coincide with working mothers' daytime schedule – there are economic consequences to not showing up for work
- Completion of a full course of immunizations presents special challenges in urban slums. **Outreach** programs and the use of community-based organizations and/or outreach health workers are vital to immunization programs in urban slums, especially where finding or preventing drop-outs is concerned. Coordination among these agencies is critical.
- A bigger challenge is reaching mobile or homeless populations or people who have no legal identity, who can number in the thousands. Holding **immunization “fairs”** or camps in areas where hard-to reach people live, to attract and register people for immunization and provide on-the-spot services, may be effective. However, people may be afraid of any form of registration for fear of eviction or other official action, so special communications by trusted people to raise awareness and demand may be necessary.
- Immunization programs in urban areas will often require **collaboration** among the local public health officials responsible for providing these services but lacking resources to expand into all urban areas, with NGOs and CBOs operating in slum areas and having access to residents. Public health officials should be included as stakeholders in the situation analysis stage of program development, where urban mapping of vulnerable slums and health service coverage takes place.

- Immunization “camps” or “fairs” can be **opportunities for other health activities** such as promotion of improved hygiene or child nutrition practices, or family planning/HIV/AIDS prevention.
- Relative effectiveness of communication channels (TV, radio, health workers) for health promotion messages must be studied as part of program development.

Nutrition

Proper nutrition and vitamin intake are essential components to child health. Malnutrition underlies 60% of child deaths each year. Existing data sets consistently show that poor children living in urban areas suffer from severe malnutrition, stunting and wasting - again, showing numbers that are often worse than that of their rural counterparts (IFPRI). In Manila, three times as many children living in urban slums suffer from malnutrition than in the rest of the city (World Resources 1996-97). In addition to economic vulnerability, lack of education about the elements of good nutrition is a serious problem among the urban poor. Studies have found that improving nutritional practices of mothers can improve children’s health status as much as increases in income. PD Hearth is effective for promoting behavior change.

Much of the urban poor working population depends on food vendors for meals, which is costly. One result of eating from food vendors can be illness due to unhygienic food preparation and storage. The urban poor also often cannot eat traditional diets or are lured by advertisements, and buy prepared or processed foods with little nutritional value, or high in sugar, fat or salt. All have health consequences similar to health issues of the better off (high blood pressure, diabetes, heart disease) related to consumption of processed high-fat foods.

Nutrition Programming in Urban Slums

- Expanding programs to educate families about healthy and balanced nutrition, dangers of prepared foods or foods from vendors, increase awareness about the importance of breastfeeding, and the provision of key micronutrients, such as iron and Vitamin A, can do much to improve child health in urban areas. Best of all is demonstrating and practicing new, improved nutrition behaviors using the PD Hearth program approach.
- Targeting pregnant and breastfeeding women in urban poor areas with **micronutrient supplementation** can influence child nutrition status.
- Donors can work with governments to find innovative ways to **partner with the private sector to fortify the foods** most often consumed by the poor. Governments can not only promote food fortification as a marketable good, but they can give special incentives to private sector producers who target poor urban populations with educational ad campaigns
- The very poor will require **subsidized micronutrient fortified food and weaning foods**, and these should be carefully targeted to the most vulnerable groups.
- Women’s education level has long been positively associated with improved nutritional status of children. IFPRI found that among factors reducing child malnutrition by 15%, women’s increased education was responsible for 43% of that reduction, with food availability coming a distant second at 26% (Smith and Haddad, 2000). Policies and programs that aim to **increase school attendance** by girls and literacy among women, as

well as to **improve the status of women**, are likely to have an impact on nutritional status of children in the short and long term.

- **Nutrition surveillance** in urban slums has been found to be useful in detecting nutrition consequences of economic downturns and help in targeting food and nutrition interventions to areas where children are faltering.
- **Social franchising and marketing** of fortified foods or iodized salt can reach large numbers of people in dense urban settings, and provide a business advantage to participating small entrepreneurs serving the urban poor (see discussion about social franchising in Family Planning above). Nutrition counseling must accompany these programs, since the food being marketed is often more expensive than the standard type. People must be convinced that it is in their interest to spend the extra money.

Food security

Food insecurity is a serious challenge in cities. Poor urbanites rarely own enough land to subsist off the food they grow or the animals they keep. Instead, they rely on cash incomes from informal sector employment to purchase food they need for survival. Nearly all income goes to food (and often water) purchasing, with little left for expenses such as health care. In times of economic crisis where there is hyperinflation and surging unemployment, poor families in cities often cut expenditures on nutrient-rich food vital to the health of their children. Fluctuation in currency rates directly impact the urban poor first.

Food insecurity is a phenomenon of urban poverty that has grown in magnitude over the past decade. Efforts to address urban poverty will need to address macro and micro economic policies that foster job creation and security, and food affordability. It will require support to small business and private sector initiatives. Programs may need to address land and housing tenure, as well as the potential for urban agriculture. Urban and rural livelihoods are often entwined, so policies that affect one may affect the other.

Food security programming in urban slums

- **Food for work/Title II** can be used in innovative ways in poor urban areas. In Madagascar and other countries, women were paid in food and soap rather than in cash, for work on community environmental improvement projects. Child care was provided by participating women on a rotating basis.
- Food security, malnutrition and poverty are intimately linked. Any program that increases income of the urban poor is likely to have a nutrition impact. **Income generation and job skill enhancement** opportunities should be integrated into nutrition programs and other health and development programs.
- Credit for small businesses and entrepreneurs can lessen insecurity by strengthening livelihoods, but need to be bigger than small stopgap measures
- Governance systems that connect the needs of the poor to responsive local government, and strengthen the ability of the poor to express their needs to local authorities, will foster policies and programs that address priority concerns of the poor themselves.

Tuberculosis control

USAID's Infectious Disease Control Strategy clearly delineates Tuberculosis Control as one of its priority areas. A TB program includes case detection, provision of drugs, treatment using DOTS, surveillance for monitoring trends and detecting resistant strains, research, and strengthening of health systems tasked with implementing national TB control programs.

Implementing DOTS appropriately requires investments in: strengthened health systems including trained personnel; a functional system to procure, deliver, and manage a dependable supply of high quality TB drugs; and an effective monitoring and surveillance system.

TB has made a resurgence with new multi-drug resistant strains and large urban centers such as New York, Paris, Milan, as well as throughout the developing world report increasing numbers of resistant cases (WRI 1998-99) in slum populations are all considered at risk for TB infection. Crowded, poorly ventilated housing, workplaces such as factories, sweatshops or mines, and congested public spaces are risk factors for transmission. One person with TB, if not properly treated, will transmit the infection to between 10 to 15 other people each year (Stephens, 1996). Higher urban HIV/AIDS prevalence also increases vulnerability to secondary (and for + people, deadly) TB infections. Studies show that TB is the leading infectious complication in between 50 to 70% of AIDS patients in Asia (WHO 1995).

Poverty, homelessness and malnourishment are also associated with increased urban vulnerability to TB. Consequences of urban TB rates include increased poverty due to inability to work. Children suffer when a parent has TB and can't provide food, or uses available resources for treatment. In Manila, TB incidence per 1,000 residents is 9 times higher in urban poor settlements than in the rest of the city. (Government of Philippines DOH, 1993)

USAID's priority countries for expanded TB control through implementation of DOTS strategy country-wide are Bangladesh, India, Philippines, and Indonesia.

Tuberculosis Control Programming in Urban Slums

NB: TB control is a highly technical health area. It is assumed that TB Control programs have strategies for working in poor urban areas where presumable a high number of cases are to be found. The general suggestions for working in poor urban settings may be of use to TB programs, but TB specialists must be sought to carefully develop a TB control program that targets the urban poor.

Some general suggestions:

- TB treatment presents special challenges among marginalized, hard-to-reach populations since the course is several months long, and must be completed to be effective. To drop out of the treatment increases the risk of multi-drug resistant strains of TB developing. All known means to reach drop outs (community volunteers, outreach workers, satellite clinics, training family members) must be activated in TB treatment.
- Similarly, case detection in urban slums presents challenges.

- Operations research is needed for understanding and addressing the challenges of TB control in urban slums. Urban programs should implement Operations Research as part of a TB control strategy.

Child health: special urban considerations

In addition to succumbing to diarrheal and respiratory illnesses, infectious diseases, and malnutrition, children in urban slums face additional physical and psycho-social hazards, namely accidents in the home or in the street from traffic, ingesting or breathing toxic substances, lack of adult support, sexual exploitation, crime, drug use and homelessness. Urban health programs can include these aspects of health in the situation analysis and work to build community capacity in child protection.

Special child health programming in urban slums

- When children still live with their families, programs can work with parents and other adult caretakers to understand and promote healthy child development more broadly, including the importance of education and involvement in positive social institutions.
- Challenges to childcare are often difficult to overcome in an urban environment where social networks may be weak and the extended family may be absent altogether. Parents may be forced to choose between supervision of their children and earning enough to be able to feed their families. Child health interventions in cities must inevitably deal with the challenge of supervision and care.
- Slum dwellers can be recruited to work in local daycare centers and paid a stipend by customers. Cities may want to find ways to augment their salaries by providing targeted subsidies. These care facilities can become loci for a variety of other interventions from the distribution of nutritional supplements to immunizations and hygiene education.
- House to house outreach is important for identifying children at high risk, and creating a safety net for them through social programs. Community committees can be established to identify and support at-risk families.
- Advocacy is needed to create government incentives for polluters to reduce emissions of air and water toxins into the environment.
- Advocacy is also needed to prevent exploitation of children in the labor force or through prostitution. Government must be on board in this fight.
- Community mapping exercises can include questions about hazardous areas for children (hazardous waste dumps, RR tracks, dangerous school crossings, etc) and areas that might be utilized for safe play.

Dengue hemorrhagic fever

Dengue Hemorrhagic Fever (DHF) has increased dramatically over the past 2 decades and is now a serious public health problem in Asia. Its rise is due in large part to urbanization, especially the growth of poor and unplanned settlements that don't have adequate drainage and solid waste disposal, leading to the development of breeding grounds for the mosquito vector, *ae. Aegyptis*. This mosquito is well-adapted to dense urban populations with an influx of vulnerable persons from

rural areas. It breeds in small containers such as household water storage or in trash. WHO estimates that 2.5 billion people in Asia, the Americas and the Pacific - 2/5 of the world's population - are at risk for Dengue. The principal symptoms of dengue are high fever, severe headache, backache, joint pains, nausea and vomiting, eye pain, and rash. Children under 15 are especially vulnerable.

Dengue Control Programming in Urban Slums

- Insecticide treated bednets, environmental management such as improved solid waste disposal and water storage, are strategies for preventing dengue transmission.
- Community-based prevention programs that remove vector breeding sites and promote use of bednets and protective clothing are critical. They can be included in other community environmental action programs or health education via mass media.
- Use social marketing for promotion of treated bednets and networks of private shopkeepers or pharmacists to distribute;
- Create franchising opportunities for small businesses operating (or willing to operate) in urban slums – they can be trained as prevention promoters and make a small profit by selling bednets.

Annex 2. Implementing the DHS in urban slums

Data from DHS and Multiple Indicator Cluster Surveys (MICS) allow a disaggregation into rural and urban areas. Within the urban group where data were collected for large urban centers, it is virtually impossible to distinguish slum from non-slum areas. In the absence of slum-specific data, reanalysis of urban data using the wealth quintile methodology (World Bank) and the Standard of Living Index (USAID India) have been useful to compare the urban poor with urban non-poor populations. However, methodological issues limit the usefulness of such a comparison. A major reason is the generally small sample sizes from urban areas that are typical for the DHS and MICS for most countries. The following approach proposes to improve data collection about the urban poor and from urban slums.

Sample size

The ability to disaggregate data on the health status of urban populations is dependent on the size of the samples. DHS urban samples tend to be too small to permit disaggregation. The rule of thumb is that between 1,000 and 1,500 households need to be surveyed in order to get data on infant and child mortality for a particular population. Data on nutrition and family planning can be obtained with smaller samples.

To obtain good DHS data on urban poor/slum populations, specific requests have to be made to ORC/MACRO for including an appropriate number of urban households in the DHS.

The Sampling Frame

Building a proper sampling frame for cities is a challenge that can be difficult at first, because slums may only be subsets within primary sampling units or not be captured at all in census data that are usually used for establishing a sampling frame. Once a proper sampling frame has been set, it can be used again with minor updates.

Urban Poor vs. Urban Slum

The Millenium Development Goals (MDG) set targets for slums. Target 11 states: “achieve significant improvement in the lives of at least 100 million slum dwellers by 2020.” However, there are many kinds of slums and not all would be considered “poor”. In Bombay, for example, it costs a great deal of money to live in even the worst of slums. Therefore, the poor are usually found far outside the city boundaries. It will be important to reach consensus about a definition of what constitutes a slum prior to conducting a survey.

There is considerable room for discussion around whether it is most appropriate to target “slum” or the urban poor. The sampling frame will take a different shape depending on the decision.

Targeting poor populations

If the target is the “urban poor”, then the samples must be high enough to capture the poor in a random sample. In some cases, the cost of doing this will be prohibitive. The other challenge is that the DHS is a **household** survey, meaning that if you don’t have a house, you are not included in the survey, which leaves out large numbers of homeless people. A third challenge lies in the structure of the Primary Sampling Units (PSUs). Sampling clusters are often defined by census tracts. Those who are not included in the census will not be included in the survey. This *can* mean that illegal settlements or settlements that the government does not want to formally recognize (i.e., tent cities in Bangkok) are not included in the survey. A typical sample of the urban poor will include a mix of poor households in slum neighborhoods and poor households in non-poor areas. A good example of how this can be captured in a survey is the 1999 NFHS in Mumbai/India.

Assets and Poverty

ORC/Macro in collaboration with the World Bank has constructed an innovative asset index that it uses to express *relative* wealth. Asset-based indices are often an effective way of measuring well-being. However, they must be well constructed and used with caution. A benefit of asset-based indices is that they approximate household income, which is very costly to measure. Assets have been used to approximate poverty but this remains to be validated. Asset indices are limited in their meaning because they do not measure income, savings or insurance against disaster. (<http://www.worldbank.org/poverty/health/data/index.htm>).

As the DHS is a national survey, it uses one index and applies it to both urban and rural areas. The benefit of this is the ability to derive results that compare populations with like assets across rural and urban populations. The disadvantage is that different kinds of assets may mean different things in urban vs. rural environments. This leads to a skewed classification where most households in rural areas become slated into the lowest wealth quintiles and most of the urban households in the highest quintiles.

Targeting Slums

Given that the MDG target slums and the fact that donors are most able to deal with populations in defined geographic areas such as slums from a programmatic level, “slums” may be better targets for the DHS in cities. The challenges of targeting slums with surveys, however, are significant unless a city is properly mapped ahead of time. Surveyors must decide what characteristics define “slum” in a particular country. UN Habitat uses an index based on five indicators as a reference for slum:

- Secure Tenure (almost impossible to determine)
- Overcrowding (defined by a ratio of residents to rooms in addition to an assessment of houses per square kilometer)
- Housing Quality
- Access to Water Services
- Access to Sanitation

“Access” must be carefully defined. WHO defines access based on the existence of the infrastructure that could/should support “improved” (a loosely and generically applied concept) access to water and sanitation. Assessments applied in the urban context must consider whether water actually flows from the pipes that serve slum communities and how often if it does. Irregular water service seriously affects water quality and quantity and can lead to prohibitive barriers (such as long lines at odd hours) that have been shown to either prevent access or add a punitive cost to access.

Nonetheless, it is possible for missions to establish a slum index that is appropriate for their country context and use that to delineate slum areas that will be sampled in the DHS. UN Habitat’s experience has been that it may take 2-3 weeks to establish a complete list of slums that complements census information before PSUs can be selected. The most reliable methods usually involve conversations with community leaders and walking tours of areas that are thought of as slum.

Geospatial data collection

If a municipality has good GIS maps of their city, it is possible to use these maps to set appropriate PSUs. However, **it is important to make sure that all slums are actually included in these maps.** If a municipality does not want to acknowledge the existence of slum areas, they may be left off the map.

Other kinds of geospatial data can also be useful. Aerial photographs and satellite data may be available and can be used to establish draft boundaries between physically distinct neighborhoods. Teams can then walk selected neighborhoods and engage community leaders in a discussion that can further refine the physical data with demographic detail. All of this can become layers in a GIS map and can help increase their accuracy.

Note: Mapping exercises can and should have a development impact that goes well beyond the goals of the DHS. The maps along with appropriate TA can ultimately be given to city governments and local universities as a management tool to help them make better decisions about the allocation of resources and plan programs based more on need rather than influence. Participation in the mapping by community leaders can give the slum dwellers a voice in the shaping of programs. Mapping has been successfully used by city managers for improving delivery of services as a component of USAID/India’s urban programs.

Asking the Right Questions

If it is impossible or prohibitively expensive to generate good maps of a city before the survey is conducted, it is possible to retrospectively analyze the data and divide the urban population into slum and non-slum categories. However this can only be done if the DHS included questions that accurately reveal slum characteristics (see NFHS in Mumbai). Questions on security of tenure, overcrowding, housing quality, and access to water and sanitation services allow an assessment of the health challenges faced by slum populations.

Notes on cluster sampling in cities

Cities are homes of cultural, demographic and economic diversity, which is part of their appeal. However, this diversity makes for a very challenging sampling using the cluster approach. Demographically heterogeneous and highly segregated populations can mean that it is difficult to get a representative sample from cluster rather than a true random sample survey. The DHS uses cluster sampling techniques to choose households. However, it does not stratify its sample into small enough geographic units that ensure that representatives of each or even most of the demographically distinct groups in an urban environment are surveyed. More work needs to be done to determine the extent to which this cluster approach skews the data we get from cities. However, it is important to consider this as the survey is conducted. Further and oversampling to yield data that are representative for small population groups will require additional resources. **Missions can examine the sampling maps for urban areas with folks who are able to help them ensure that the sample taken is a representative sample.**

If the PSUs are mapped in a way that reflects demographically distinct populations, it is much easier to ensure a representative sample. This is easier to do in cities that are highly segregated. In cities such as Cairo, where poor and middle-class populations are living in the same neighborhood, this is much more difficult. In this case, a mission would need to examine the data retrospectively and derive its results from a well-constructed questionnaire.

Annex 3. Summary of Government of India Guidelines for Developing Urban Health Proposals within the RCH Program

(These Guidelines were developed with technical assistance from the USAID/India Urban Slum Child Health Program during workshops held in Dehradun and Haridwar in the State of Uttaranchal with state and municipal officials.)

Goal & Objectives of the Urban Health Program

Goal:

To improve the health status of the urban poor community by provision of quality Primary Health Care Services with focus on RCH services to achieve population stabilization.

Objective:

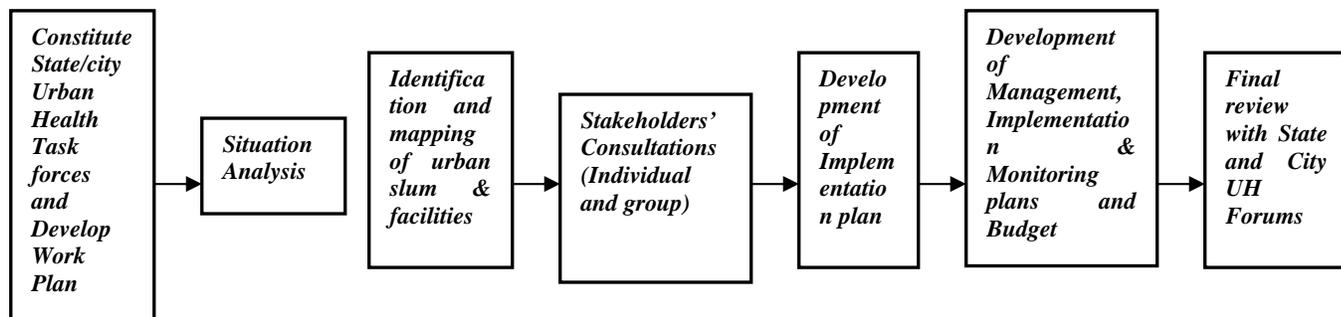
The main objective of the program is to provide an integrated and sustainable system for primary health care service delivery, with emphasis on improved family planning and child health services in the urban areas of the country, for urban poor living in slums and other health vulnerable groups.

Coverage

The proposed Urban Health Program envisages the implementation of Urban Health Projects in a phased manner in all the cities with priority being accorded to 8 Empowered Action Group (EAG) and the Northeastern States. Under the program, States are required to prioritize the cities, which bear the biggest burden of the urban slum population. These cities have been broadly classified into 4 main categories: a) Mega cities with more than 10 million inhabitants; b) Million plus cities; c) Large cities between 1 million and 100,000, and d) Towns with less than 100,000.

Process for Proposal Development

The process of formulation of urban health plans in the identified cities will include a) Situation analysis including assessment of health facilities (public / private / NGOs / Trusts etc.) available in the city along with their functional status and type of services provided by them; b) consultations with multiple service providers and stakeholders in the city; c) identification and mapping of urban slum population and other vulnerable groups; d) development of management implementation plan and budgets, and e) development of review, monitoring and evaluation mechanism. The illustration depicts the recommended road map to development of urban health proposals for identified cities.



Key strategies

Based on the information from the above activities, and identification of gaps in the existing system, urban health projects will be developed in close coordination with the city level Urban Health Task Force/Forum and the state level Urban Health Task Force. The process will also require identification of a nodal officer / establishment of a cell at the State level to plan, coordinate and supervise the urban health projects in the identified cities. Detailed strategies for the following broad program directions are to be developed:

1. **Improving access to family welfare (FW) and maternal and child health (MCH)** services by slum population through renovation/up-grading and re-organization of existing facilities and redeployment of available staff from the state government health department and ongoing programs and schemes
2. **Improving the quality of family welfare services** through supervisory, managerial, technical and interpersonal skill to all levels of health functionaries including training of female volunteers to help outreach service delivery through pre-service, in-service and on-the-job training.
3. **Involving of NGOs and the private sector** in various aspects of urban primary health care delivery.
4. **Increasing the demand for family welfare services** comprising modern contraceptive usage, adoption of terminal methods, delivery care and child health services such as immunization and newborn care.
5. **Promoting convergence of efforts among multiple stakeholders**, including the private sector to improve the health of the urban poor.
6. **Developing effective linkages** between the communities and 1st tier service delivery point and between the 1st tier facility and referral units at 2nd tier.
7. **Strengthening monitoring and evaluation mechanisms**

Service delivery model:

The program proposes implementation of a uniform service delivery model with a common nomenclature by a) integration of the facilities run by state governments/municipalities and other

private agencies under various schemes, b) upgrading/strengthening of the existing infrastructure, and c) establishing new facilities in rented building. Though the program envisages flexibilities in implementation of different service delivery models suiting to local situations, a suggestive model is described below:

The first tier (i.e. Urban Health Centre) will be set up, one for approximately 50,000 population (the norm may be suitably modified by the state/city UH task force to ensure coverage and access by the most vulnerable populations) and second tier will be the referral hospital (city/district hospital/maternity home/private and NGO nursing homes). Existing service delivery system should be reorganized and restructured to serve a defined geographical area for a defined population

Potential private partners for either tier should be identified to improve the quality and standard of health among the urban poor, to capitalize on the skills of potential partners, encourage pooling of resources, and to reduce the investment burden on the government.

Timings of UHC should be such that services can be made available to the target population at a time convenient to them. It is recommended that UHCs operate for 8 hours a day.

Package of services:

Minimum package of services should be provided in either tier. The first tier Urban Health center will provide only outpatient services. The UHC will provide a comprehensive package of Family Welfare services (family planning, child health services, including immunization, treatment of minor ailments, basic lab facilities, counseling and referral to 2nd tier) in order to encourage slum dwellers to utilize the 1st tier facility. The complicated referral cases and indoor services will be available only at the first referral institutions.

Human resources:

Based on the vulnerability of slums, existing facilities may be relocated to ensure adequate coverage of the marginalized settlements. Efforts should be made to redeploy the existing staff from existing facilities of the State Government, Urban Local Body and ongoing programs and schemes. Any new staff will need to be appointed through contractual appointment. An Urban Health Center would have 1 lady medical officer, 1 public health nurse, 304 auxiliary nurse midwives (for 12-15000 population each), 1 lab assistant, 1 clerk, 1 guard, and 1 peon. Second tier facilities could engage the services of part time or full time specialists on contractual basis.

Referral systems

For each UHC catering to a specific population in a defined geographical area, options of 2nd tier facilities which can provide subsidized, affordable, and quality referral services (such as institutional deliveries, emergency obstetric care, terminal methods of family planning) should be identified, which may be public or private. Upgrading of existing facilities may be considered, and linkages with central Government/ state Government / corporate hospitals / charitable hospitals should be promoted. Mechanisms for referrals through UHCs should be developed.

Community level activities

To develop and maintain a link between health facility and the community, the program envisages engagement of social community workers/link volunteers, a female from the community able to spare 3-4 hours a day. The capacities of the link workers to facilitate health improvements in the community should be built through capacity building efforts, preferably by NGOs. Women's health groups may be formed by the link workers to expand the base of health promotion efforts at the community level and to build sustainable community processes. Efforts to stabilize link workers as well as women's health groups through linkage with slum welfare schemes and to minimize dependence on program funding should be promoted.

Outreach activities

Activities that reach out to the most vulnerable and the underserved should be planned as a means of increasing usage of critical health care services and for creating rapport with the community. An outreach plan for each UHC focusing on the most vulnerable slum communities with poor health indicators should be developed. Collaboration with NGOs may be planned for outreach services, if required.

BCC activities:

It is suggested that context-specific demand generation strategies should (a) focus on IEC for behavior change in RCH; (b) establish linkages, and if necessary, enhance selected activities of other schemes that provide benefit to the project beneficiaries. Private sector and NGO partnerships for IEC may also be promoted, particularly where potential partners with skills and proven experience in IEC/BCC are available.

Capacity building/training

The different agencies involved in the implementation, management, and monitoring of the proposed urban health program would need training on a range of issues at different phases of the project to handle additional responsibilities and to develop skills to work towards desired impact. Training requirements at various levels of implementing agencies should be identified and a capacity building plan proposed. Public private partnerships for capacity building should be promoted, wherever possible.

Public-private partnership

Successful implementation of the project will require a vibrant partnership between the Department of Family Welfare (DFW), GOI, state government and the Urban Local Bodies. While the DFW will provide technical assistance, the state government will provide leadership to the project facilitating ground implementation by the Urban Local Bodies. It is envisaged that the private sector can be economically and formally engaged for service delivery to fill in gaps. Cities are encouraged to develop context appropriate public private partnership approaches: e.g. by contracting out first tier delivery system to NGOs or the private sector where public infrastructure is not available; by engaging NGOs or specialized agencies for enhancing utilization of existing health services through BCC or other community level activities; by utilizing the services of private medical practitioners on part-time basis for first tier and second tier facilities; by outsourcing laboratory and other

diagnostic services to a private facility, etc. Appropriate mechanisms for partnering (or entering into agreement) with the private sector needs to be proposed including accreditation methods for ensuring quality, memorandum or partnership, reporting and monitoring systems.

Coordination and convergence with other departments and private sector:

This will focus on developing / strengthening mechanisms for effective linkages and coordination between various departments and the private sector at the health center level, city level and state level for improving access to quality health care services e.g. sanitation, drainage and water services.

Management plan

Monitoring and Evaluation plan: The M&E plan should include an appropriate process for benchmarking, development of urban health management information system (HMIS) consistent with the national MIS, mechanism for monitoring of key processes and results, pertaining to promotion of family planning and child health services, and periodic assessments of field activities and end-line evaluation. At first tier facility monthly monitoring of key processes and outcomes by the city program management unit is envisaged.

Management and human resources plan: A state program management unit may be established for the periodic review of program implementation and to undertake discussion and decisions on UH program activities. A city program management unit at the city level to review and strengthen program implementation should be established at the ULB wherever possible. Nodal urban health program officers at state and city level would be responsible for coordinating the implementation of the Urban Health program.

Fund flow mechanism: The funds will be released to the state government / state RCH society who in turn will release funds to the implementing authority within one month of the receipt of funds. At the state level, the health & FW department will be the nodal department for implementation of Urban Health Program, overall coordination, collection of SOEs from implementation agencies and their onward submission to the GOI, audit etc.

Cost recovery mechanism and sustainability:

Mechanisms for cost recovery based on the principle of inclusion of the poorest and from experiences from previous projects, may be built as an integral part into the proposal. These funds may be utilized for building a corpus fund, which could partially sustain the recurrent costs after project completion. Several sources of contribution may be explored such as user charges (from middle class and upper class families) for diagnostic services, surgeries etc. at second tier; registration fees/family health card charges from all families collected at first tier and during outreach camps; donations from business houses, individuals, banks etc; appropriation received from National Slum Development Program of GOI; and portion of lease and rental income from municipal or other public sector buildings. In addition to the corpus health fund, a) institutional capacity at community level (through federation of community groups for linkage with urban poverty alleviation schemes of the Government, and b) enhancing the capacity of the Urban Local Body to plan and manage such programs are approaches towards sustainability.