BUILDING HEALTHY CITIES

IMPROVING THE HEALTH OF URBAN MIGRANTS AND THE URBAN POOR IN AFRICA

Edited by
Samson James Opolot

Comparative Urban Studies Project

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Cover Photograph: Mothers and Children at a Health Clinic, Kampala, Uganda
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PREFACE

His Worship John Sebaana Kizito
Mayor of Kampala City

I am happy that Kampala City was chosen as the venue for this international conference on "Building Healthy Cities." The choice of Kampala could not have come at a better moment for a city grappling with epidemics such as HIV/AIDS, malaria, and cholera, that have, in combination with many others, strained her already limited health services infrastructure.

On the other hand, the choice reflects recognition of Kampala City and Uganda's concerted efforts to reconstruct an economy that is coming out of decades of turmoil that had reduced the country to the status of the pariah of Africa. In its reconstruction effort, the Ugandan government has placed a lot of emphasis on improving social service delivery, recognizing that access to good health and education play a very important role in development. This emphasis has begun to yield fruits as evidenced in the declining levels of HIV/AIDS prevalence in Kampala City and the country at large, as well as the increasing resources being availed for improving health services. At the same time, the Government of Uganda has been implementing universal primary education (UPE) since 1997 and thereby greatly enhancing literacy among the poor and other disadvantaged children, with special emphasis on the education of female children.

Policies aside, Kampala City faces enormous challenges in improving the health services for its fast-growing population, the bulk of whom live below the poverty line. The city's efforts to consistently provide equitable health services are hindered by limited fiscal and human resources. Over 10 percent of the Ugandan population lives in Kampala City, much too great a population for the city's 11 health clinics to serve. This obvious inadequacy needs to be confronted and mitigated to ensure the provision of sufficient health services to Uganda's citizenry.

I therefore thank the organizers of the conference for taking urban health issues seriously. I expect that the conference papers and delibera-

tions captured in this volume will raise issues and solutions that urban authorities can use to improve health in respective cities. On behalf of Kampala City Council, I pledge to take the recommendations in this volume forward for implementation and also encourage other urban authorities to do the same.

ACKNOWLEDGEMENTS

The workshop summarized in this report, co-sponsored by the Comparative Urban Studies Project of the Woodrow Wilson International Center for Scholars and the Centre for Basic Research, was held in Kampala, Uganda on July 2-3, 2001. This conference represented an attempt to further underscore the linkages between urban poverty and urban health. As a follow-up, this volume accentuates the need to further examine better strategies for preventative health care in urban areas as well as better mechanisms for the coordination of urban services.

We are grateful to the United States Agency for International Development and the University of Michigan Population Fellows Programs for making this workshop and publication possible. We also acknowledge the work of Senior Program Associate Andrew Selee of the Latin American Program for his help in organizing this conference and the dedication of Project Associate Diana Varat in making this volume a reality.

Lastly, we are grateful for the constant support and encouragement of the co-chairs of the Comparative Urban Studies Project, Blair A. Ruble and Joseph S. Tulchin.

INTRODUCTION

Samson James Opolot
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Global urbanization, also variously referred to as 'urban inflation' or 'hyperurbanization,' is one of today's foremost development concerns. Of particular concern is the paradox that despite rapid urbanization, there seems to be a corresponding increase and deepening of urban poverty. Indeed, all over the developing world, major cities are growing at a faster rate than industrialization, modernization and the provision of basic economic and social infrastructure, bringing about shortages in health, shelter, education, employment — among other equally important services — with negative consequences for human development. Whereas the above scenario is more a manifestation of problems of urbanization in developing areas, stark inequalities of incomes and welfare are increasingly the norm in major cities of developed countries as well.

Current debates on urbanization are, therefore, focusing attention not only on the challenges of developing urban infrastructure, but above all on the distribution of services among different sections of urban populations. Herein lie concerns that urban populations are increasingly characterized as poor people who most of the time tend to be migrants and/or minorities. It is increasingly clear that urban poverty could surpass rural poverty in depth, scope, and potential to undermine human development. For example, whereas rural poverty in Africa almost entirely relates to an inability to access modern services, most of the time it does not preclude access to food. On the other hand, urban poverty in the same context includes people's inability to access food. Occurring in socially fluid environments, which cities are, urban poverty in developing countries epitomizes the catastrophe of unmet basic needs that would ensure that the bulk of the developing world's population enjoys a decent living.

This book arose out of the concerns over the unfortunate universality of underdeveloped urban health service delivery systems in Africa and the

attendant impacts on poor and migrant constituents therein. The authors of the papers within this volume draw from a rich empirical and theoretical heritage, demonstrating that there is good reason for concern over the limited and inequitably distributed urban health infrastructure in Africa. This volume is organized into four chapters, beginning with papers with empirical data on the state of health delivery in selected African cities, and ending with theoretical pieces on urban governance and possible steps for the improvement of health delivery.

The first chapter contains three papers commenting on the state and consequences of limited health infrastructure in cities of developing countries, including case studies from Kenya, Tanzania, and Chile. Francis Dodoo's research in Kenya's capital, Nairobi, reveals that the bulk of the population is composed of poor urbanites residing in slums where conditions of health, housing and sanitation infrastructure as well as livelihood strategies raise both moral and urban planning concerns. The key finding of this ongoing study is that for the slum-dwellers of Nairobi, poor access to health infrastructure is the principal bottleneck to improvement in their health status. Dodoo argues that given the dire conditions of urbanization in Africa, demographers would do well to pay some attention to urban areas and, more particularly, to the urban poor.

Roselyne Nderingo's case study of Dar es Salaam, the capital of Tanzania, notes that the city faces high population growth rates mainly as a result of increasing rural-urban migration. Yet, under the context of IMF/World Bank structural adjustment programs, there is an obligation to channel the bulk of resources to debt repayment, thus hindering the availability of resources for the health sector and other social services. Consequently, trends show increasing urban poverty and underdevelopment. Nderingo calls for increased social sector development funding, particularly in health delivery, and stresses the need to engage the private sector in this endeavor. Above all, Nderingo maintains that communities themselves, especially women, must continue to participate in decisions and planning related to the development of urban health infrastructure.

Unlike the papers on Nairobi and Dar es Salaam, María Elena Ducci's paper on Chile provides us with a success story. Despite being a developing country like the African cases discussed in this book, Chile has managed to realize positive health development indicators. Comparative data for Chile, Uganda, Tanzania and Zambia shows that Chile has indeed

made impressive advances in health delivery. Ducci attributes this to a number of factors, including the fact that Chile has pursued a strategy of incremental investment in urban primary health care infrastructure. However, unlike cases where the emphasis has been on modern medicine per se, Chile has chosen to develop old (traditional) and new (modern) medicine concurrently with community participation at center stage. That strategy has been less expensive and allowed for greater ease in delivering urban health services in the context of limited resources.

Chapter two contains papers on health delivery systems focusing on the management of health services in Kampala, Uganda; Nairobi, Kenya; and the experience of non-governmental organizations in the delivery of health programs in Africa. In the opening paper, Jessica Jitta provides empirical insights into health delivery in Kampala. She argues that the delivery of health services directly affects the health status of individuals. However, in Uganda delivery of such services is constrained by both inadequate budgetary resources — less than 1% of GDP goes to the health sector — and the heavy bias in favor of curative services. Consequently, Uganda has some of the poorest health indicators in the world. Kampala City presents even bigger health delivery gaps than national averages, considering that this is where the bulk of the country's population lives. As a result, the bulk of the city's population resorts to alternative health-seeking behavior such as home treatment, herbal treatment, and purchasing cheap and unreliable drugs from drug shops.

In the case of Nairobi, Benjamin Nganda notes that the city remains the hub of congestion and poor service delivery in Kenya, resulting in extreme poverty and ill health among the poor. The author notes that health services in Nairobi are inadequate due to financial, logistical, political, and administrative constraints. Nganda recommends that the Government's Health Policy Development Plan address more health research, invest in primary health care that is more pro-poor, and improve the management of public health amenities to create a dependable health delivery system.

Wendy Prosser's paper on the contribution of non-governmental organizations concludes this section. According to Prosser, certain characteristics of international non-governmental organizations such as flexibility, innovation, and community focus have enabled them to be successful in addressing urban health problems. Her analysis of innovative ways of

strengthening the non-governmental sector's contribution to health delivery, which includes using intersectoral approaches, creating selective collaborations, and fostering community participation and cooperation, provides lessons for vertical and horizontal partnerships in health delivery.

The third chapter focuses on responses of the urban poor and migrants in the context of dire health systems and program delivery. Samson Opolot employs a historical dimension to argue that although stigmatized as "pathogens," and therefore, perceived as a negative influence on public health in their host communities, migrants have contributed to the development of public health infrastructure and service delivery through their labor and struggles for equitable access to services. Using the example of migrant labor in Uganda, Opolot demonstrates that the public health debate and investments are linked to the struggles of migrant labor. A brief case study of Kampala city is used to draw conclusions to the effect that health delivery remains very poor for the migrant community. However, the solution both requires the creation of a new perspective on urban government and service delivery as well as greater commitment of material resources.

Winnie Bikaako presents the example of The Aids Service Organization (TASO) that was initiated by urban migrants. TASO emerged in the early 1980s when HIV/AIDS was on a rampage amidst a community that was still too naive and recalcitrant to take action. TASO filled this gap by beginning to gather and disseminate information on positive living and, as resources increased, provide medication and other support to communities affected by AIDS. From its origins as a small organization, TASO is now internationally recognized as a vanguard organization in the struggle against HIV, one that has helped Uganda to realize decreasing levels of new HIV infections.

Finally, the fourth chapter examines the role of urban governance in building healthy cities and improving the poor and migrants' access to health services in Africa. Gilbert Khadiagala's paper on urban governance and health in East Africa asserts that governance and health issues are inextricably linked to the distribution of power and resources in the context of urban infrastructural and fiscal constraints. Yet, the practice of health delivery bifurcates between health scientists posing as the epidemiological experts on one hand and, on the other, political scientists grappling with the modest concern of participatory development. The author argues that what compounds the lack of collective action in urban service

delivery is the fact that African cities are a locus of power, in contexts where national elites are less secure and where mechanisms of participation and accountability are still new and untested. The author goes ahead to suggest remedial actions that aim to bring the public, authorities, and community into collective action for better urban governance.

In the next section, Lynn Dalrymple provides a glimpse of the historical and current practice of governance and health delivery in South Africa. She notes that under apartheid the health system was one of the most unequal, fragmented and wasteful in the world. Health administration, distribution, and supplies were all organized along racial lines that sought to systematically privilege the white minority at the expense of the black majority. However, since 1994, with the coming into being of majority democracy in South Africa, governance and service delivery have been undergoing fundamental changes for the better. The current health policy, for example, is based on the principle of primary health care with safeguards to ensure that: resources are distributed equitably; communities are involved in the project cycle, with emphasis on preventive measures; and finally, South Africa has adopted a multi-sectoral approach.

The final paper by Richard Stren seeks to propose a model to ensure improved urban governance and better health delivery. Stren argues that the human capital model or the asset enhancement approach is a prerequisite for improved health care in African cities. Most especially, this model focuses on the potential for improved productivity among the most vulnerable members of any society, notably the poor, women, minorities, and traditionally marginalized ethnic and racial groups. Stren suggests that health is as much a governance issue as it is a technical matter for physicians. Therefore, a critical approach calls for a new understanding of governance as the relationship between government, civil society and other stakeholders working together in the delivery of social services and urban development as a whole.

We wish to conclude by acknowledging the funders and the organizers of this important conference to whom we are most indebted for this book. The book originates from the conference on "Building Healthy Cities: Improving the Health of Urban Migrants and the Urban Poor in Africa," that took place on July 2-3, 2001, in Kampala, Uganda, co-sponsored by the Woodrow Wilson International Center for Scholars and the

Centre for Basic Research. We would like to thank the United States Agency for International Development for their generous support of the Comparative Urban Studies Project and the Wilson Center and for making this workshop and publication possible. We hope readers will find the product helpful in highlighting the challenges and possible solutions on how to improve the health of the urban poor and migrants in African cities.

PART I

THE STATE OF URBAN HEALTH INFRASTRUCTURE

CHAPTER 1

The Urban Poor and Health Systems in East Africa: Voices from Nairobi's Slums

F. Nii-Amoo Dodoo
University of Maryland

The focus of African demographic research on rural areas has rested on at least two pillars. First, rural areas have been considered worthy of this concentration because they are home to the majority of the continent's population (United Nations 1998). Second, and ironic in the context of a conference on the urban poor such as the one at which we are presenting, is the rationale that urban development biases have relegated rural areas and their residents to a relatively deprived situation as far as both health and reproductive services and facilities are concerned (Lipton 1976; Harrison 1982; Kelley and Williamson 1984; HABITAT 1996).

Yet, emerging data on urbanization trends on the continent suggest that demographers would do well to pay some attention to urban areas and, particularly, to the urban poor. The rate of urbanization across the developing world portends that roughly 90 percent of world population increase in the first twenty-five years of the current millennium will stem from growth in the urban areas of the developing world (United Nations 1998). In Africa, the growth is such that the continent is expected to be over 50 percent urban by 2016. Many cities on the continent have grown at rates of up to five percent per annum over the last three to four decades (Todaro 1989; Obudho 1997). Unfortunately, contrary to the urban boom in the West in the late nineteenth century, Africa's growth is occurring amid deteriorating economic circumstances. At the same time, whereas cities like London, New York, and Paris added barely two million people in the last quarter of the nineteenth century, Nairobi, Addis Ababa, Lagos, and Kinshasa are each expected to increase their populations by about five million in the next fifteen years (Brockerhoff and Brennan 1998).

Nairobi, Kenya's capital, represents a good case study of the urbanization phenomenon and the plight of the urban poor. With an average annual growth rate of about five percent since the 1970s, the city's current population of 2.3 million people is expected to more than triple by 2015. The bulk of this growth can be traced to the in-migration of poor migrants from the rural hinterland, many of whom end up in marginalized slum communities in Nairobi. Already, close to 70 percent of the city's population lives in slums or informal settlements, as they are officially referred to by the government of Kenya (Matrix Development Consultants 1993; *East African Standard* 1998). Living in informal settlements represents a legal status that enables the government to avoid providing medical and social infrastructure and services, including the most basic amenities such as water, electricity, appropriate sanitation, and garbage collection.

The interaction of rapid urban growth and dire economic circumstances has created serious health concerns for the growing vulnerable and increasingly marginalized slum population. With the virtual absence of adequate services—save the scattered efforts of nongovernmental organizations (NGOs) and dynamic residents—the plight of slum dwellers is particularly acute. The evidence that certain segments of urban populations may actually be as deprived as, if not more so than, their rural counterparts is then hardly surprising (Todaro 1989; Oberai 1993; HABITAT 1996; White 1996; Brockerhoff and Brennan 1998; Zulu, Ezeh, and Dodoo 2000), given the severe lack of adequate basic social and health services in such contexts where exceedingly high unemployment would make it virtually impossible for residents to patronize health services, even if these existed.

The health implications of the noted trends are startling, and with the continent soon to become urban by majority, the justification for continued preponderance of research on rural areas weakens. Indeed, the urban bias of the HIV/AIDS epidemic is itself indicative of the urgent need for research attention to urban settings. In this paper, I will report on the rationale, process, and early results of a unique ongoing study of the urban poor in Nairobi, Kenya. The evidence presented here should crystallize the urgency of the health dilemma in the continent's cities, as well as the inadequacy of the existing health system to cater to the needs of the urban poor.

The Nairobi Study

Rationale

This study, carried out by the African Population and Health Research Centre (APHRC), came into being for a number of reasons. Beyond the urban trends discussed above, and the deprivation of slum residents, the study's initiation can be traced to research findings that reported statements from rural field respondents in two separate studies carried out by APHRC (Bauni and Jarabi 2000; Fapohunda and Rutenberg 1998). In both studies, rural respondents appeared to place the blame for the escalation of sexually transmitted diseases (STDs) and HIV/AIDS at the doorstep of their urban peers. They argued, first, that STDs were seasonal phenomena in rural areas that coincided with the return of urban residents for Christmas, Easter, and other holidays;[1] and, second, that all of the media evidence was of urban deaths, the bodies from which were then brought "home" to the rural areas on weekends for burial.

It became of interest to the APHRC to understand what the sexual networking of urban residents was; what they knew about the risks associated with certain sexual behaviors; and whether their knowledge had any influence on their behavior. We focused on Nairobi's slum population, and our initial foray involved focus group discussions in four selected slums, with the goal of understanding the sexual networking behavior of slum residents and how this might relate to the spread of HIV/AIDS.

The Nairobi Qualitative Study

The primary goal of the study, titled "Sexual networking and associated reproductive and social health concerns: an exploratory study of the urban informal settlements in Nairobi, Kenya," was to understand sexual networking patterns of slum residents, and to examine how these relate to their understanding of the risk of contraction of HIV/AIDS and other STDs. A related objective was to gain understanding of the basic, health, and reproductive health needs of slum residents. We also wanted to explore what support mechanisms exist for slum dwellers, as well as the coping strategies they adopt to negotiate the difficult health and economic circumstances in the slum. These issues covered seven modules of a focus group discussion instrument that comprised the tool for obtaining the data from the field.

Four slums were purposively selected from a list of 19 informal settlements represented in the 1989 Kenyan census by the Central Bureau of Statistics. The selection of slums was based on a set of variables that affect sexual networking, including population size, age distribution, sex ratio, and marital status distribution. Selection also took into account the spatial location of slums, because selecting proximate slums would increase the likelihood of contamination. Ethnicity represented the final selection criterion because of its presumed relationship to reproductive and sexual behavior, in particular, and other behaviors in general, across the continent. The study sought slums that were more heterogeneous than homogenous in their composition; this was operationalized by looking for slums in which the representations of the four major ethnic groups in Kenya were not extremely dissimilar to their representations in the census.

The data were collected through focus group discussions. In each location, discussions were held separately with males and females of four different age groups (13-17, 18-24, 25-49, and 50+), and with community leaders and service providers, resulting in information being gathered from ten groups in each of the four slums. Rather than presuming that these data give us definitive conclusions about causal linkages, the similarity in responses across slums is taken as an indication of a set of general needs that reflect health-related causes and highlight some of the fundamental needs and concerns of slum dwellers.

Findings

The discussion groups were asked to list, discuss, and then rank their needs. With little variation across slum, age, and sex, the most significant general needs turned out to be housing (cost, quality, and ownership), employment, toilet availability, and water access. As far as health needs, slum residents' articulation of their problems included the prevalence of diseases and sicknesses (malaria, diarrhoea, typhoid, TB, HIV, STDs), as well as the lack of medical (and particularly maternity) facilities. There was also considerable concern about the quality and cost of health care in the slums. Not surprisingly, the concern with the water situation expressed under basic needs reared its head in health-need discussions about sanitation and toilets, as well as in the type of diseases that residents complained about.

"Yes, there is no water in the whole of Kibera all the way to Laini Saba. You may find that one tap is here and about one thousand people use that tap and that particular tap does not even bring enough water. You will stay there up to evening waiting for your turn to fetch water. Even if you are buying, it is not available. It is not there." (Kibera service providers)

"You find so many people using the same toilet. For example, ten people using one toilet. That shows that if you have diarrhoea, you have to queue for the other person to come out first. You could even diarrhoea at the door and that is very unhygienic." (Kibera women, 13-17 yrs.)

"When people build houses they do not care about toilets. . . . The City Council toilets are overstretched. There is only one City Council toilet." (Embakasi women, 13-17 yrs.)

"Some people go to the railway line to relieve themselves." (Kibera men, 13-17 yrs.)

"Toilets are full until we have come to a point of getting 'flying toilets'. . . . At night, somebody takes a [plastic] bag and this becomes the toilet and in the morning you tie it well and throw it far away where it may fall on people's roofs! You don't care where it lands." (Kibera community leaders)

"You see next to a house is the toilet which is not even 15 metres deep. Rats come from there and enter our kitchens walking all over the food." (Kahawa North men, 25-49 yrs.)

"All these diseases we have mentioned, most of them are brought about by poor sanitation and drainage. This has to do with the drains blocking. If water gets there it stagnates. Mosquitoes breed there. Malaria is spread and even typhoid can be spread." (Majengo men, 50+ yrs.)

The combination of poor sanitation services and inadequate water resources lead to the prevalence of diseases and ailments as articulated by the residents. With inadequate health facilities and lack of quality care, convoluted by cost and corruption, slum residents are extremely vulnerable to the vagaries of disease and illness.

"It is because the private hospitals we have here are very expensive and so when you fall sick you have to go to Otiende. However, it is far and so if you had a seriously sick child, he can even die on the way to the hospital. The transport to Otiende is very unreliable, especially when it rains, the bridge is impassable." (Kibera women, 25-49 yrs.)

"The drugs are there but there is corruption and so the drugs end up in people's private hospitals." (Majengo men, 25-49 yrs.)

"City Council dispensary nurses are nasty, rude and insolent. Those private doctors are very nice and understanding but we cannot afford their fees." (Majengo women, 18-24 yrs.)

"We do not have maternity clinics here. So, it is a real problem when a woman has to deliver especially at night because even the transport may not be there." (Kibera women, 25-49 yrs.)

The list of reproductive health needs includes STDs (including HIV/AIDS), unwanted pregnancies (with much reference made to teenage pregnancies), abortion, and lack of family planning services. The discussion about reproductive health concerns highlights the inadequacies of the health care delivery system.

Undoubtedly, appropriate health services and care constitute a major concern for slum residents. It was no surprise, however, given the poverty of the slum contexts, that the other overwhelmingly significant concern of residents regards employment and earnings. Indeed, many residents see the lack of decent paying jobs as the root cause of their problems. The argument heard over and over again was that if they had work that garnered them decent incomes they would not need even basic health interventions, as they would be able to make and exercise rational decisions about their competing needs.

"The problem of lack of jobs is the greatest because there are so many other problems that arise from it like rent, education, food, etc. That is why we need jobs." (Kahawa North women, 50+ yrs.)

"Without employment there is nothing to eat. That is why I say that employment is important." (Kibera men, 18-24 yrs.)

Another key finding from this research regards the vulnerability of children and adolescents to the sexual culture of the slums. The interaction of space constraints, social contextual factors, and economic difficulties works to make young residents extremely susceptible to sexual health problems. This is particularly critical in settings where the reproductive health care system is geared toward those aged 15 and above, and even older adolescents are not very keen to use the existing services because of the nature of interactions they have with service providers (nurses, doctors, and so on) who often chastise them for "early" engagement in sex.

Space Constraint Considerations

One way in which slum poverty manifests itself is in dwellings that are constructed of cardboard, tarpaulin, and/or corrugated tin sheets. These homes often consist of a single room, generally about six feet by nine feet in dimension, sometimes internally partitioned by only a curtain. This single room is used as living room, kitchen, bathroom, and also the bedroom, which parents and children share. The result is that there is no privacy and children get to see and hear sexual activity taking place at very tender ages. Consequently, extremely young children are already engaging in sex. Next-door neighbors' business is also public, given the flimsy materials that separate dwellings.

"The houses are like this and you know there is no privacy. There is another paper that is put called curtain that divide "the bedroom" and "main room". The so called bedroom is for wife-husband and children sleep on the floor of the same room." (Embakasi male, 25-49 yrs.)

"I think there is no secrecy in our houses when the parents are having sex. You see a child of about fifteen years sharing the same room and only separated by a curtain. When the parents start having sex, they start wondering the kind of noise the parents are doing. . . . So they will pretend that they are asleep when they are actually hearing everything. So next time, they will want to try the same things. . . ." (Kahawa North males, 18-24 yrs.)

"The major problem here is the house. If people had proper houses, some things would be private. Children would not be trying to imitate what they hear. Because now even children of 9 years are conceiving and giving birth. It is not strange, they do give birth at 9 years of age." (Majengo male, 50+ yrs.)

Economic Considerations

The economic downturn of the city is nowhere more evident than in the slums, where the acute lack of jobs forces residents to resort to whatever means they have available to make ends meet. Even those who find jobs are hardly able to get decent-paying ones, or continuous or consistent work. Thus, in addition to selling second-hand clothing or vegetables, or brewing illicit alcohol, exchanging sex for money becomes a significant means of subsistence. Multiple partnership can then be related to the ongoing search for money; women often have to interact with many men to get sufficient money for their subsistence needs. Oftentimes, the sums of money involved are extremely small.

Question: "What about the practice of someone having more than one sexual partner? #1 "They are many." #2 "Yah, that is money . . . because the money you are given by one person is not enough." #1 "Yes, it is not enough . . . you go to this one, to this one… so that you can be given more." #2 "Maybe you have children here, or there is one who pays rent, there is another one who educates the children." (Kibera service providers)

"For instance if a woman stays/lives alone i.e., a single mother with children, and she wants to buy her children milk, the only solution would be to look for someone with money. She sells her body and gets the 20 shillings ($0.20) to buy milk." (Kibera female, 13-17 yrs.)

"Mainly women have many sexual partners, some have children and maybe they do not have food. They try to go to people to ask for money and they are told there is no money, she goes on from one person to another until she gets money." (Embakasi female, 13-17 yrs.)

"Money, there is nothing else. But if you understand, you cannot accept that. Now when your problems are solved, you will never know whether you got a

disease or not. That time, you might not be thinking about the diseases because you have problems. That is the problem that girls have. . . . So, when I get an illness is when I will come to regret." (Embakasi female, 18-24 yrs.)

Social Contextual Considerations

The influence of slum life on children is critical because the young frequently imitate what they see as prevalent in the social contexts of their communities and come to deem as the norm. Children even younger than ten years of age are sexually active, with little access to information, services, or facilities that protect them from disease and pregnancy. The visibility of existing prostitution and the role of substance abuse are highlighted by the following quotes:

"Maybe I stay with them [prostitutes] and they depend on that. It is a business, and if I stay with them, I see them clean and they live well. Then I will envy them; I will therefore be influenced to start that job." (Embakasi females, 18-24 yrs.)

"And the fact that, you see if you walk in the hidden streets here in Majengo you find a woman seated on a stool outside her door. You want to tell me that the small child does not know?". . . "There are those who sell sex. When a child sees a woman sitting outside her house and then a man goes in there, and the woman follows him and they lock the door."' . . . "Maybe I can control it in my house. Maybe, like me, I have my wife and two children. My children are small. I could wait until they are asleep. You see something like that! I could use all my tricks. But from the fact that my neighbor is a sex dealer, will I have helped anything?" (Majengo males and females 13-17 yrs.)

"Plus this alcoholism it has spoilt very much. You come when you are drunk, your wife is also drunk. Now you "beat the drums in front of the children" because you are drunk. We are teaching these children bad manners because of poverty." (Kibera community leader)

Subsequent Steps

The main findings from this research were that economic and health concerns were seen by slum residents to be the principal bottlenecks to improvement in their health status. The African Population and Health

Research Centre subsequently initiated a field experiment to test the relative impacts of health and livelihood interventions on health status. The study design seeks to identify which strategies are the most effective, efficient, and cost-effective means of ameliorating health problems.

Pilot testing of software and instruments is currently in its third round. Prior to this pilot, a demographic and health type survey was carried out in all nineteen slums of the city, in March – September 2000, of about five thousand slum households, with interviews of females aged 12-49 years and males aged 12-24 years. The goal of the survey was to see whether those data would corroborate the findings of the qualitative work, establish the magnitude of articulated problems, assess the extent of variance in problems across the slums (in order to get a context within which to make generalizations about the ensuing longitudinal experiment that would follow in only four of the slums), and to provide a slum comparison to the 1998 Demographic and Health Survey (DHS). The hope was that using DHS currency would make it easy for other demographers to acknowledge the peculiar circumstances of slum dwellers and, thereby, pay more attention to those contexts. The data are not yet publicly available, so no attempt at a conclusion will be made here. What is key, however, is to note the severe health problems that slum dwellers face (which compare very unfavorably with DHS results, and in many cases even against rural areas), the severity of the sexual health problems that slum children face, and the lack of access to facilities. These are serious issues that relate directly to the topic of health and health systems of the urban poor in Africa.

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NOTES

1. The financial advantage and elevated status of these urban returnees (or "been-to's") presumably enable them to easily implement their sexual preferences in encounters with rural partners; decisions about choice of partners, number of partners, and nature of sexual interaction (including non-use of condoms) were all within their power to dictate.

CHAPTER 2

Improving and Increasing Access to Maternal and Child Health Services for Urban Migrants and the Urban Poor in Africa: The Case of Dar es Salaam City, Tanzania

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Africa's Unhealthy Cities

Africa is witnessing an unprecedented pace of urbanization. Undoubtedly, rising levels of urbanization contribute to the wealth of nations, but they also place enormous pressure on the scarce resources available and hence pressure on governments to create effective social service delivery mechanisms, including health services. In recent years, there has been growing recognition that better management and substantially higher levels of investment in the health sector are urgently needed if Africa is to avert a major health crisis and economic slowdown in the coming years.

Meeting the health challenge for Africa's burgeoning cities will require concerted efforts of all actors and stakeholders of society: governments, the private sector, and the communities themselves. Traditional roles must change and new alliances forged to harness the diverse resources of civil society. In this partnership, each stakeholder has a unique role to play. Governments and local authorities must create an enabling environment for partnerships to flourish. In many African and other developing countries, the existing legislative environment leaves no room for such partnerships in the health sector. A review and necessary reform of such legislation should provide a level playing field and set the rules of the game for all players. Where appropriate, the state may need to readjust its role by withdrawing from some activities and taking on new ones.

Additionally, community participation in the health sector has special

advantages. This not only ensures that the community is provided with what it wants rather than what the government thinks it needs, but it also provides the community with a sense of belonging and ownership. Inevitably, this results in a greater dedication to the investment and a greater willingness to pay for services, which contributes toward both cost sharing/cost recovery and the long-term sustainability of services. In particular, the women of the community, who are the direct beneficiaries of maternal and child health services, should be considered important agents of change. In addition, the private sector can bring significant efficiency gains and much-needed investment funds to encourage health sector growth and effectiveness.

The Case of Dar es Salaam City, Tanzania

Dar es Salaam City has three municipalities: Ilala, Kinondoni, and Temeke. The city has an estimated land area of 1,350 meters squared. One census estimated that the city's population in 1988 was 2.8 million. Although there are no official statistics, to date the population is projected to have reached four million.

The rampant population growth in the city is a result of an increasing rate of migration. The services available in the city are not enough to cater to this population; as such, the larger portion of the population, and particularly the urban poor and, especially, women, cannot access basic social services. Debt repayment, costing more than 40 percent of total government revenue, has made the situation worse since the government cannot allocate sufficient resources for putting in place an effective and efficient service delivery mechanism for the urban population. Poverty among the majority of the urban poor is also a limiting factor. For example, based on the 1991-92 Household Budget Survey, about 48 percent of the households were unable to meet their food and non-food basic requirements (Tanzania, *Poverty Reduction Strategy Paper (PRSP),* October 2000).

The health sector in Dar es Salaam City faces major challenges, one of which is to meet the demand of over two million people who cannot easily access the available health services, and more particularly maternal and child health (MCH) services. Poor access to these services is a result of interrelated problems that, over the past years, have included lack of a

comprehensive urban health sector policy; shortage of financial resources to cover both the cost of investments and proper operation and maintenance (recurrent costs); and shortage of qualified and experienced manpower. These have resulted in the sector increasingly failing to deliver an acceptable level of service to the ever-increasing urban population, the urban poor, and especially, women. Moreover, it is important to note that the severity of poverty among the majority of the urban population has made it very difficult for them to meet the costs related to health care services.

Details of the health services and health personnel available in the city are shown in Appendices 1 and 2, respectively. The situation in the city in relation to MCH services is summarized in tables shown in Appendices 3–6. Statistics for 1999, which are considered most recent, have been used as a reference.

In brief, these summaries show that the number of health facilities available is insufficient to meet the demands of the fast-growing urban population. With regard to MCH services, it is also evident that there is an acute shortage of qualified and experienced personnel. The information available also shows that the number of mothers who utilize MCH clinics is far below target. Maternal mortality is also evident, the leading killer diseases being anemia, eclampsia, and primary pulmonary hypertension (PPH). Although HIV/AIDS has not been recognized as a problem, it claims the lives of many people, especially those in the 15-59 years age group (HIV/AIDS accounts for as high as 35.5 percent and 44.5 percent of male and female deaths, respectively, in that age group in Dar es Salaam City [*PRSP*, October 2000]).

The problems facing the health sector in Dar es Salaam City are common to other cities and municipalities in Tanzania. A critical analysis of these problems revealed that they were not necessarily technical, but more the result of weaknesses in the institutional, legislative, and organizational framework of the sector. Hence, the solution to these problems required reorganization of the sector. Recognizing the need for institutional reform, the government of Tanzania initiated the Health Sector Reform Program (HSRP) in 1996, which is implemented alongside poverty reduction strategies to maximize effectiveness.

Under the HSRP, the government places special emphasis on reducing morbidity, improving nutrition, and strengthening access to health servic-

es, and particularly primary health care. Some specific national targets to be achieved by year 2003, and which are relevant to maternal and child health, are to lower the infant mortality rate from 99 per 1000 to 85 per 1000; reduce under-five mortality from 158 to 127 per 1000; lower maternal mortality from 529 to 450 per 100,000; and reduce malaria-related fatality for under-five children from 12.8 percent to 10 percent.

As part of the implementation of the HSRP, the Dar es Salaam City Commission established the Dar es Salaam Urban Health Project, which has the responsibility of steering the implementation of the sector reform in the city. The reform process has witnessed implementation of major programs including the Tanzania First Health Rehabilitation Project, of which Dar es Salaam City forms a major component. The project, to be implemented over four years (April 2001 – December 2004), focuses on problems related to primary health care. Among the specific project components to be implemented in Dar es Salaam City are the extension of 32 dispensaries, to provide adequate space for MCH services, and the construction of maternity wards and delivery buildings at three municipal government hospitals – Temeke, Ilala, and Mwananyamala. Also, there would be one new health center and 21 new dispensaries constructed, all of which are intended to provide adequate space and modern facilities for MCH services. Dar es Salaam City authorities are also involved in the implementation of the wider Healthy Cities Program under the auspices of the World Health Organization (WHO).

Some of the specific targets in relation to MCH in Dar es Salaam City are: to increase attendance of pregnant women at MCH clinics before 20 weeks of pregnancy by 50% of the 1998 figures; to reduce the death of women from childbirth by 10% of the 1998 figure (from 280 deaths/100,000); to increase the rate of immunization by 20%, from 70% to 90% by the year 2005; to reduce the child mortality rate at birth by 10% of the 1998 figures; and to increase the number of mothers delivering at health centers from 30 to 50% by the year 2002.

The Way Forward – What Options are Available?

A World Bank report, "Tanzania at the Turn of the Century: From Reforms to Sustained Growth and Poverty Reduction" (30 April 2001), noted that gross domestic investment, which had increased from about 13

percent of GDP in 1964 to 30 percent in 1991, declined sharply to 18 percent in 1997, due mainly to a fall in public investment as a result of reducing overall government spending and privatization. In this regard, it will be more relevant in the process of reforming the urban health sector with the aim of improving the service delivery mechanisms (including MCH), to seek full involvement of communities as well as the private sector.

As consumers, communities can play a significant role in ensuring efficient cost recovery, thereby sustaining investments in the sector. As "informal" service providers (such as traditional birth attendants or TBAs), they can supplement the role of formal service providers and can build useful partnerships with the public and private sectors, particularly in addressing the service needs of low-income settlements (slums, squatters, and so on). Communities can also play an important role in improving the efficiency of service provision and management in the sector.

The most effective way of ensuring community participation is through broad-based partnerships where, for example, responsible municipal authorities share information and consult with communities in all aspects of service provision; and, municipal authorities provide the necessary legal, institutional, and technical support to communities. An enabling environment is required to provide a viable framework for partnership. Among others, gender-sensitive policy frameworks are necessary to ensure the needs of women, especially in relation to MCH services.

More important is the full participation of urban women in promoting maternal and child care/health. Emphasizing the care of babies and toddlers means focusing also on women whose physical and emotional conditions influence their pregnancies and their babies' development. Increased health care skills among urban women will increase their utilization of the available services (prenatal care, immunization, contraceptive use, and so forth), and this will result in positive reproductive and health outcomes. This implies that there is a need to strengthen health education of urban women, on the one hand, and empower them economically on the other.

As mentioned above, the involvement of the private sector is crucial if municipal authorities are to meet the health challenges that confront them. In the context of private sector partnerships, priorities should include, although not exclusively, policy issues, relating to urban health

sector financing strategies, private sector participation, and protection of vulnerable groups (poor urban women, etc.), as well as implementation issues, relating to the creation of an enabling environment for private sector partnerships and financing. Depending on the risk level, the costs to be incurred, and profits to be made, the different possible types of involvement of the private sector have to be identified and best options practiced.

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Appendix 1. Details of health services available in Dar es Salaam City - 1999

Municipality	Hospital				Health Center				Dispensary				Total facilities	MCH clinics	MCH clinic & family planning
	G	V	PR	PV	G	V	PR	PV	G	V	PR	PV			
Ilala	2	0	5	5	1	0	0	5	17	4	5	127	171	64	43
Kinondoni	1	0	8	9	2	0	1	2	21	2	0	189	235	73	72
Temeke	1	0	1	1	1	0	0	0	19	0	3	86	112	57	57
Total	4	0	14	15	4	0	1	7	57	6	8	402	518	194	172

Source: Dar es Salaam City Commission, Health Department, 1999. Abreviations:G – Government, V – Voluntary, PR – Parastatal, PV – Private

Appendix 2. Number of health personnel in Dar es Salaam City – 1999

Municipality	Total	Medical Officers	Asst. Med. Officers	Clinical Officers	Asst. Clinical Officers	Nursing Officers	Nurse Midwifery	Nurse Assistants	MCH Attendants
Ilala	693	15	17	168	25	146	175	79	68
Kinondoni	1134	47	10	150	60	406	335	37	89
Temeke	757	14	7	198	29	82	126	191	110
Total	2584	76	34	516	114	634	636	307	267

Source: Dar es Salaam City Commission, Health Department, 1999.

Appendix 3. First attendance to MCH clinics by pregnant women in Dar es Salaam City – 1999

Municipality	Expected Attendees	No. at First attendance		Number of women with Serious Risks				
		<20 Weeks	>20 Weeks	<18 YRS	>35 YRS	≥5 PRG	Anemia	Others
Ilala	22,356	23,623	35,917	800	964	988	11,901	1,608
Kinondoni	246,735	–	31,518	–	–	–	–	–
Temeke	27,183	10,092	17,959	454	1,070	724	438	1,709
Total	296,274	33,715	85,394	1,254	2,034	1,712	12,339	3,317

Source: Dar es Salaam City Commission, Health Department, 1999.

Appendix 4. Family planning services in Dar es Salaam City – 1999

Municipality	Expected Clients	Actual Clients	Drugs	Loop	Injection	Condoms	Traditional Methods	Others
Ilala	111,783	64,406	19,087	434	26,048	18,641	196	–
Kinondoni	246,735	101,211	43,741	423	53,850	3,197	-	–
Temeke	135,915	122,371	79,605	423	31,591	841	30	9,881
Total	494,433	287,988	142,433	1,280	111,489	22,679	226	10,077

Source: Dar es Salaam City Commission, Health Department, 1999

Appendix 5. Deaths of mothers during delivery and causes, Dar es Salaam City – 1999

Description	Municipality			Total
	Kinondoni	Ilala	Temeke	
Total mothers who delivered	1,044	222,764	19,576	243,384
Deaths of delivering mothers	2	74	4	80
Causes: Ruptured uterus	0	4	1	5
PPH	1	21	0	22
APH	0	2	0	2
Puperal Sepis/spticaensix	0	4	0	4
EPH Gestosis	0	0	0	0
Eclampsia	0	18	1	19
Relapsing fever	0	0	0	0
Anemia	1	14	1	16
Obstructed labor	0	0	0	0
Malaria	0	4	0	4
HIV/AIDS	0	0	0	0
Others	0	7	1	8

Source: Dar es Salaam City Commission, Health Department, 1999.
Note: Statistics shown are for reported cases only.

Appendix 6. Immunization and provision of Vitamin A to children < 1 yrs, Dar es Salaam City, 1999

Municipality	Expected No. of children	BCG	OPV '0'	OPV '3'	DPT 3	Measles	Vitamin A
Ilala	22,356	45,601	12,450	11,781	14,615	10,541	8,361
Kinondoni	63,045	50,860	–	47,968	48,580	49,856	12,551
Temeke	27,183	22,116	–	16,044	20,845	18,509	8,888
Total	112,584	118,577	12,450	75,793	84,040	78,906	29,800

Source: Dar es Salaam City Commission, Health Department, 1999.

CHAPTER 3

A Successful Health Story: The Rationale for Chile's Achievements

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A notable situation

A comparison of Chile with some developing and developed countries shows that Chileans are closer to populations in the latter group on some health indicators (see Table 1). In spite of facing a great scarcity of resources and limitations on improving their social policies, as with all developing countries, and in spite of the meager resources destined for the health sector, Chile and Cuba have both been able to substantially improve their health levels. The situation in the three African countries included in the table (Tanzania, Uganda, and Zambia) show a large gap,

Table 1. Basic indicators for some developed and developing countries

Country	Total Population	Annual Growth (%)	% of Population Over 60 Years		Fertility Rates		Life Expectancy at Birth (years)	
	1999	1990-99	1990	1999	1990	1999	Male	Female
Chile	15.019	1.5	9.0	10.0	2.6	2.4	73.4	79.9
Cuba	11.160	0.5	11.7	13.4	1.7	1.8	73.5	77.4
Sweden	8.892	0.4	22.8	22.3	2.8	1.6	77.1	81.9
Uganda	21.143	2.8	4.0	3.2	7.1	7.0	41.9	42.4
Tanzania	32.793	2.8	4.1	4.1	6.1	5.3	44.4	45.6
U.S.A.	276.218	0.9	16.6	16.4	2.0	2.0	73.8	79.7
Zambia	8.976	2.4	3.9	3.4	6.2	5.4	38.0	39.0

Source: Annex Table 2: Basic Indicators for All Member States (WHO 2000).

Table 2. General and infant mortality in Chile, 1940–1997

Year	General Mortality (1)	Infant Mortality (2)
1940	21.3	193.0
1950	14.8	136.0
1960	12.3	120.0
1970	8.9	79.0
1980	6.6	32.0
1985	6.1	19.5
1990	6.0	16.0
1995	5.5	11.1
1997	5.4	10.0

(1) Per 1000 people, (2) Per 1000 live births
Source: MINSAL (1999)

according to which the populations in those countries live some thirty years less than those in Chile and Cuba.

In spite of facing a great scarcity of resources and limitations on improving their social policies, as with all developing countries, and in spite of the meager resources destined for the health sector, Chile and Cuba have both been able to substantially improve their health levels.

In the 1950s, the prevalent pathologies in Chile were child malnutrition, acute diarrhoea and dehydration, respiratory illnesses, common infections, parasites, and so forth. Health interventions, therefore, focused on these pathologies, with a strong orientation toward national health care, with the result that both general mortality and infant mortality have decreased constantly since then (see Table 2). Especially notable is the decline in the latter, which to a large extent explains the increase in life expectancy, which rose from 41 years at the beginning of the 1940s to 75 years by the year 2000 (Medina 1989; MINSAL 1988, 1990, 1999).

Advances in health indices over the last decades cause Chile to stand out in Latin America (along with Cuba and Costa Rica) for its comparatively favorable health environment. Chile has experienced an epidemiological transition, which has brought it closer to the situation of developed countries, wherein chronic diseases, cancer, and accidents now rate among the principal causes of morbidity and mortality. However, the large differences between the health care received by rich and poor peo-

Table 3. Population with access to water and sanitation and per-capita GNP in selected Latin American countries

Country	Potable water 1990-1995 (%)	Sanitation 1990-1995 (%)	Per-capita GNP 1994*
Costa Rica	92	97	2,400
Colombia	87	63	1,670
Chile	85	83	3,520
Mexico	83	50	4,180
Argentina	71	68	8,110
Nicaragua	58	60	340
Bolivia	55	55	770
Haiti	28	24	230

* Current international dollars, 1994
Source: World Bank (1996)

ple, as well as the difficulties that challenge attempts to continue improving health care delivery to the poorest segments of Chile's population, are central themes on the current political agenda and remain among the most urgent concerns of the population.

Some reasons that explain the gains achieved

One of the most important elements that stimulated the improvement in health levels was expanding the provision of potable water and sanitation services, which decreased the incidence of diarrhoea and other infectious diseases. Chile extended both services to a greater extent than other countries in the region with higher income levels, such as Mexico and Argentina (see Table 3).[1] In 1998, 95.4 percent of houses had access to potable water and 84.2 percent had access to sanitation (MIDEPLAN 1998).

Table 4. Malnutrition index, 1975–1993*

Year	% malnourished children 0–5 years old
1975	15.5
1980	11.5
1985	8.7
1989	8.3
1993	5.0

*Information before 1975 does not exist. (TABLE SEMPÉ: table utilized until mid-nineties to asses children's nutritional state. SEMPÉ is the French doctor who designed this table)
Source: MINSAL, 1988, 1990, 1997.

Table 5. Percentage of vaccinated children by type of vaccination, 1980–1996

Year	B.C.G.	D.P.T.	3rd Dose Polio
1980	93.4	90.0	82.4
1985	96.4	98.3	98.6
1989	97.5	96.4	96.3

Source: MINSAL (1988, 1999).

Table 6. Medical attention at childbirth, 1955–1998

Year	% total births
1955	57.8
1960	66.9
1965	74.3
1970	81.1
1975	87.4
1980	91.4
1985	97.4
1989	98.8
1998	99.6

Source: MINSAL (1988).

Progress was also the result of a sustained effort over more than four decades on the part of the Servicio Nacional de Salud (National Health Service), which focused on mother and child health and the development of a series of "regular" programs dedicated to professional care (during childbirth, prenatal care, well-child care, and responsible parenting), as well as permanent national activities, such as those that provide vaccinations and free milk and food for children under age 6. Tables 4, 5, and 6 show the decline in child malnutrition in the country, vaccination coverage statistics, and the rise in medical attention at childbirth.

Once these programs, which particularly benefit the poorest of the poor, were consolidated, their good organization and wide coverage ensured that economic level would stop being a major factor in infant mortality, which it had been until the 1960s (Kaempffer and Medina 2000). Another factor that has had a great impact on the decrease in health problems has been the improvement of education levels, especially of females. Statistics show that better educated mothers have fewer children and their children get sick less often (Romero, Bedregal, and Bastías 1994).

According to former Minister of Health Dr. Jorge Jiménez de la Jara (2000), successful strategies in the management of maternal-child health focus on an integral conception of health and health care, a health team with especially delegated functions, ongoing research and training, and continuous evaluation of the actions taken and instruments used. This

Table 7. Factors affecting infant mortality in Chile, 1998

Factors		Rate per 1,000	Index
Total infant mortality		10.3	100
Birth order:	First	10.2	99
	Fourth	12.7	123
	Seventh	20.0	194
Mother's age:	< 15 years	17.1	166
	30 to 34 years	9.4	91
	45 years and older	30.0	291
Years of study:	None	26.5	295
	4 to 6	16.5	160
	10 to 12	10.3	100
	13 or more	6.0	58
Residence:	Urban	10.0	97
	Rural	12.9	125
Child legitimacy:	Legitimate	10.0	97
	Illegitimate	11.9	116
Maternal economic activity:	Active	10.1	98
	Inactive	11.1	108

Source: Kaempffer and Medina (2000).

integral conception recognizes the linkages between both poverty and an unhealthy environment and morbidity and mortality, and helps to develop programs and interventions for working with poor communities, both urban and rural. The growth of professional and integrated medical groups has also permitted a gradual delegation of functions to non-medical workers and has widened the coverage capacity of the programs:

> The pediatric nurse has been essential to national health care and in hospitals; the midwife has been central in the extension of health care coverage to mothers; the nutritionist has been central to that which concerns malnutrition and balanced diets. The trained assistant also has been incorporated as a human resource, in both urban and rural settings, especially in well-child care and the solution of minor problems. (Jiménez 2000:51)

Finally, research and ongoing evaluations of procedures and instruments used have allowed for the adaptation and improvement of programs (Kaempffer and Medina 2000); for example, Table 7 shows the results of a study of the factors that influence infant mortality, among which are the age of the mother and her level of education.[2]

The current situation

The basic health problems in Chile today are cancer, chronic diseases (diabetes and hypertension), accidents, and obesity. As seen in Table 8, two of the principal causes of death (circulatory and respiratory diseases) are directly related to lifestyle. Another problem that seems to be transforming itself into a national health concern is the increase in obesity, especially among sectors with fewer resources and mainly among women, as is shown in Table 9.

The cost of treatment and the equipment necessary to combat most of the prevalent health problems is so high that it seems impossible to make significant advances toward their solution. The alternative that is considered the key to confronting the current situation lies within the strategy

Table 8. Ten principal causes of death, Chile, 1997

Causes of death	%	Rate per 100,000 people
Circulatory system diseases	26.4	141.8
Malignant tumors	21.7	116.3
Respiratory system diseases	12.7	68.3
Traumas & poisoning	10.6	56.6
Digestive system diseases	7.5	40.1
Signs, symptoms, & poorly defined causes	4.7	25.4
Endocrine gland, nutrition, & metabolism-related diseases	3.3	17.6
Infectious diseases & parasites	3.1	16.9
Reproductive system diseases	2.2	11.6
Mental illness	2.0	10.8
Other causes	5.8	31.3
Total	100.0	536.7

Source: MINSAL (1999), classification according to CIE 10 (Clasificación Internacional de Enfermedades).

Table 9. Prevalence of obesity* in adults, according to sex and socioeconomic level, 1988 and 1992

Sex	Socioeconomic level	1988 (%)	1992 (%)
Men	Total	15.4	20.5
	Upper class	10.7	22.9
	Middle class	15.4	18.4
	Lower class	13.2	20.0
Women	Total	26.5	39.9
	Upper class	14.1	20.5
	Middle class	21.1	41.9
	Lower class	29.3	49.7

*Obesity defined by Body Mass Index of 27.8 in men and 27.3 in women.
Source: Berrios et al. (1996)

initiated by the World Health Organization in the 1970s, which tries to change the emphasis from assistance and treatment to prevention and promotion. The goal is to make communities responsible for their health and to develop a new model of family medicine, education, and integration of people into this process.

Chile has broad experience in the application of preventive programs, which have been incorporated into those that the population now considers natural rights, and are expressed in the national culture; for example, the success of vaccination campaigns (see Table 5).

The idea of promotion raises interest in the quality of life and offers a more integral focus on health. Promotion started to develop seriously in the country only in the 1990s, enhanced by the creation of a health promotion unit in the Ministerio de Salud in 1997. In 1998, the Consejo Nacional para la Promoción de la Salud (National Council for Health Promotion), called "VIDA CHILE," was established as a multidisciplinary entity with participation of diverse sectors, such as health, education, work, and environment. Thus, a national policy of promotion and prevention was defined that is bringing to life new programs and actions that seek to maintain the population in good health.

Four national health priorities have been identified as most susceptible to being impacted positively by specific prevention and promotion actions—cardiovascular diseases, accidents, cancer, and mental health. It was determined that the most efficacious ways to impact these areas were to promote

healthy diets, significantly decrease the use of tobacco and alcohol, and promote physical activity. Fostering such promotion is driven by MINSAL, under its general framework, but each region and community decides which programs and actions it prefers to focus on. Promotion also has the objective of incorporating efforts at the local level through communities' participation in the execution of promotion programs.

Merging old and new knowledge

Within this new model, centered on family health, promotion, and prevention, some attention might be placed on the value of traditional and alternative medicine. Growing demand for this type of service has been observed in developed countries of the North, particularly among more educated sectors of the populations, and focused especially on the prevention of health problems and the maintenance of good health. This is not a general tendency in Chile at this time, nor is it an openly accepted current in the traditional Western medicine sector.

Great potential exists in the Third World for the recovery and development of traditional healing systems, many of which are still used, usually clandestinely. Although the theme of alternative or traditional medicine is not discussed openly in Chile, it carries weight in countries with more indigenous cultures and traditions, such as Mexico in Latin America and the majority (if not all) of the African and Asian countries. Without claiming that traditional modalities can substitute for the advances made by modern Western medicine, some alternative systems can function as effective instruments of promotion and prevention and can complement Western systems, supporting the progress made so far. They can also be seen as a good opportunity to revalue local cultures and develop self-esteem, identity, and pride among populations of the developing world.

To achieve this integration between traditional and modern health care systems, it is necessary to approach these themes with a more "scientific" focus and develop research that permits differentiation between therapies that have positive effects and those that are the product of ignorance and charlatanism. This theme is of special relevance to the poorest countries where prevention and promotion reinforced by alternative health care systems could help to offset high treatment costs.

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Notes

1. According to the World Bank Atlas classification of countries according to levels of wealth, Chile, Argentina, and Mexico are considered countries with medium-high levels of income; World Bank (1996, 2000-01).

2. Active national programs of the Ministerio de Salud in 2001 include the programs for: broadening immunizations; healthy vision; trauma; TB; cardiovascular ailments; cancer; pharmacies; acute respiratory infections; mental health; nutrition; alcohol, tobacco, and drugs; women, children, adolescents, adults, and older adults. It also adapts its programs and actions depending on needs, for example, seasonal needs. The campaign for winter health care organized for 2001 included a plan to improve primary attention, vaccinations against influenza and rubella, and prevention of cholera, Hepatitis A, and Hanta Virus.

PART II

HEALTH DELIVERY SYSTEMS

CHAPTER 4

Health Delivery Systems: Kampala City, Uganda

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Health is one of the main concerns of poor urban people and the delivery of health services directly affects the health status of individuals. Other closely related determinants include socioeconomic factors, geographical and environmental factors, political aspects, and sociocultural aspects. Despite the efforts of governments to directly fight poverty, the percentage of the population living in absolute poverty in Uganda (46 percent) is still rather astounding (MFPED 1998). When one considers that 11.3 percent of Uganda's population lives in urban areas, the fact that urban health problems continue to grow as the impoverished urban population increases should come as no surprise, especially among the most vulnerable sector of the population—women and children.

The provision of health services in Uganda is constrained by inadequate budgetary resources — less than 1 percent of GDP — and heavily biased in favor of curative services. Current health indicators (MFPED 1996) show high rates of maternal mortality (506/100,000), infant mortality (97/1,000), and total fertility (6.9 children per woman). Poor urban households have less access to safe water and spend up to 40 percent of their earnings on water. Malnutrition and anemia are also rampant in slum areas (NCC/UNICEF 1993). Immunization rates have gone down to 38 percent from 47 percent in the last five years and it is feared that infant mortality is also increasing.

Uganda has adopted a Primary Health Care (PHC) strategy and decentralized health services to the district and sub-district level. The government hierarchy of PHC consists of health centers (I to IV)[1] and a district hospital. It is estimated that the government provides about 40 percent of

care, nongovernmental organization (NGO) units make up 25 percent, and the rapidly proliferating private sector (clinics and drug shops) provide 35 percent (MOH 1993).[2] Although cost sharing in government health units was introduced in the early 1990s, it has since been abandoned.

This paper covers a brief background of Kampala City, the main health problems faced by its residents, available health services, poor people's health-seeking behavior, coping mechanisms of the urban poor, and health aspirations of the urban poor. Most of the examples are drawn from two studies carried out in two separate slum areas of Kampala — "Access to Health and Education: The Poor in Uganda" (Katwe slum; Jitta and Ndidde 1998a) and *Kampala Women Getting By: Wellbeing in the Time of AIDS* (Kamwokya and Katanga slum areas; Wallman 1996).

Health Situation in Kampala District

Kampala, the capital city of Uganda, is administratively subdivided into five divisions, each one serving as a sub-county and with relative autonomy in revenue collection, planning, and delivery of social services, including health services. Kampala's night/residential population is 902,899, 40 percent of the total country's urban population, and its annual population growth rate is 4.8 percent, twice the national growth rate (2.5 percent). Migration contributes 70 percent to this population growth compared to 31 percent by natural growth (KCC/World Bank 1993).

The city has many slums/unplanned areas, which are relatively small, located in swamps, and densely populated, in which living conditions are extremely poor. In 1996, the Katwe II community had a population of 8,225 with a density of 15,519 persons per square kilometer (Jitta and Ndidde 1998a). Poor housing, characterized by mud-and-wattle houses, is common. In the Kamokya community, 73 percent of the houses were of one room with a mean household size of four persons and more than three people sleeping in one room (Wallman 1996). Most Kampala residents depend on the informal sector for their livelihood, trade in particular, and there are high levels of unemployment, particularly among the youth. More than a quarter of households are female-headed.

The urban poor have no access to safe water: 94 percent in Katwe community reported their water to be unsafe. A large proportion of

families buy water at a high cost (50 Uganda Shillings per 20 liters of water), limiting the amount a family can buy to 40 liters a day, considered inadequate for healthy living. The great volume of waste washed down by the rainwater contaminates protected wells in the city. Pit latrines, many unhygienic, are used, but many households use plastic bags for fecal disposal, which they throw in the open drains and at garbage dumping places. Mountains of uncollected garbage cause a terrible stench, provide a perfect breeding place for pests, and cause serious environmental pollution.

Uganda in general has poor health indicators and a heavy burden of disease, where 75 percent of life years are lost as a result of premature death due to preventable disease (MOH 2000). Morbidity and mortality patterns in Kampala are similar to the national picture, the main causes of death being malaria, diarrhoea, and respiratory infections in children, and malaria and HIV/AIDS in adults. The poor recognize the major causes of ill health, as well as their seasonal variations (see Appendix, Table 1). In Kamwokya, 83 percent of respondents identified malaria and 71 percent identified AIDS as the most common illnesses among adults (Wallman 1996:98), while 92 percent of Katwe residents reported malaria as a leading illness in children and 67 percent of households reported AIDS in adults (Jitta and Ndidde 1998a**;** see Appendix: Table 2). Residents attributed high malaria prevalence to environmental factors such as stagnant water, poor sanitation, and poor housing in the slum areas.

Human resources in the health sector remain inadequate in Uganda. Overall, the doctor/population ratio is 1:18,700, trained nurses/population is 1:4,300, and midwife/child-bearing women is 1:1,800 (MOH 1997). Eighty-two percent of the medical officers and allied health professionals, 79 percent of registered nurses, and 63 percent of enrolled nurses work only in hospitals (MOH, 1993). However, Kampala public health units are generally better staffed with professional health workers as compared to the rest of the country (MOH 2000; see Appendix Table 3).

Funding of Health Care Services

Public health units are under-funded from the Health Department of Kampala City Council (KCC), which receives funds from the central government and parent districts. For example, the Kampala Health

Committee Chairperson had indicated that the City had received only about US$ 52,000 in 1996-7, as urban authorities tend to rate health lower than education, roads, and councilors' sitting allowances. Also, in 1998, only 10 percent of the health budget was approved and only 1 percent of the total budget was received. At the division level, health departments are responsible for funding basic public health services. Table 6 shows budget estimates for the Kampala division (Makindye Sub-county) for health for 1996-7. User fees collected at health centers (about US$ 800 per month) were used for recurrent expenditure, while KCC Health Department covered salaries and wages. Specific programs paid for vector control and drug supplementation. Specific funding, equipment, and vehicles were provided by the National Essential Drug Management Program and NGO public health center projects (Jitta and Ndidde 1998b).

Health Service Delivery in the City

The health care system in the city consists of both public and private health facilities. Generally, residents of Kampala have greater access to health facilities than the national average, with 49 percent of the population living within 5 kilometers of the nearest health unit, and many less than 1 kilometer. In addition, Kampala contains roughly 10 percent of the total number of hospitals in the country, the total reaching only 101 units (MOH 2000). There are several smaller public units and health centers, but KCC, the city authority, does not have a district hospital. It uses Mulago Hospital, the national tertiary referral training hospital. There are also mission and private hospitals, several private clinics, pharmacies and drug shops (some may be unregistered), many of which are owned by health providers who also work in hospitals or public health units (see Appendix, Table 4), but access to these centers is limited. In addition, in most cases, they are staffed and run by unqualified attendants. Most KCC and private facilities are open for at least twelve hours; large hospitals remain open twenty-four hours.

Most facilities, both private and public, focus mainly on curative services, in part due to the high morbidity and mortality rates that accelerate demand for such services. These include but are not limited to the treatment of major diseases, including malaria, pneumonia, and sexually

transmitted diseases (STDs). Public health facilities, however, provide a wider range of services. KCC health centers were commended in particular for their services in the treatment of STDs. More sophisticated specialized services are mainly offered in big hospitals (Jitta and Ndidde 1998a; Wallman 1996).

Private clinics offer curative services to the majority of people and only few of these provide preventive services, such as immunization and reproductive health services to their clients. Drug shops, though not very distinct from clinics, offer consultations, but are mainly utilized for purchasing drugs. A range of preventive services include prenatal services provided mostly by clinics, big hospitals, and a few private health centers; postnatal services provided by KCC clinics and hospitals; maternity services provided by KCC clinics, hospitals, private maternity centers, and traditional birth attendants (TBAs); and health education and immunization in public facilities. NGOs fund and run health projects offering preventive and health promotion services, including improvement of water, sanitation, and training community health workers (CHWs).

Parallel health care services form an important part of the health care system in Kampala. These include traditional healers (herbalists and diviners) and TBAs. Some of these offer service openly while others provide herbs secretly. Parallel care is particularly utilized for illnesses that are believed not to be resolved in biomedical units; for example, mental health, epilepsy, HIV/AIDS and related conditions, misfortunes and suspected witchcraft (Jitta and Ndidde 1998a, Wallman, 1996). TBAs and CHWs have been trained and work in many parts of the city. In Kawempe division, a public health center (PHC) project funded by the Save the Children Fund has trained more than 80 TBAs and 21 CHWs (Kawempe Health Centre 1999). TBAs are especially appreciated by the community because of their expertise and the personal attention they give to clients at low cost.

Constraints on Health Care

Cost of health care was reported to constrain access to health services by most urban dwellers. In the Katwe and Kamokya communities, respondents reported inability to afford the cost of health care, particularly with regard to private care units. The biggest problem is if a patient needs hos-

pital admission and/or specialized services and investigations such as an X ray. Most city residents said that only cash payment is accepted, credit being given in very rare emergency cases and when the provider knows the patient. Alternative providers were more inclined to accept partial payment or payment in kind. The cheapest source of treatment reported is home, that is, by buying drugs or herbs form herbalists. Most households reported paying about US $2 for a malaria episode if a health unit is visited (the daily poor household income estimated at about US $1.5). Traditional healers charge more than public units, while private clinics charged highest, US $6.5 (Jitta and Ndidde 1998a).

Health-Seeking Behavior and Coping Strategies

Consumers mainly judge quality of care on the basis of availability of drugs, staff training, and staff attitudes to patients. Mothers perceived paying units to be the ones with better quality of care probably due to better staff attitudes and availability of drugs, but also prompt services and cleanliness. Shortage of drugs was a major reason for not utilizing services at Mulago Hospital. Private clinics were commended for their confidentiality, but KCC facilities were the best for treatment of STDs. Maternal child health services in government facilities had the best ratings—prenatal services (81% households), maternity services (76%), and immunization services (92%). The hospital's ranking was higher because they offer specialized care and have trained providers (Jitta and Ndidde 1998a).

Kampala residents practice medical pluralism; biomedicine is popular but is combined with traditional means of care. Economic implications and social factors determine the choice of therapy; the poor attend public health units more frequently. Residents of Katwe go to the distant Mulago rather than closer Nsambya Hospital if admission is anticipated. Advice from relatives and friends and knowing someone in a health unit may significantly determine choice of where to seek care (Wallman 1996). The majority of cases were treated at home either with non-medical remedies and/or with medicines purchased without prescriptions or advice from drug shops, pharmacies or clinics (see Figure 2).

Coping mechanisms are embedded in the people's health-seeking behavior. Due to the need to cut individual costs on health care, home treatment is the most common form of coping with medical ailments. For common

complaints, many women know and use herbal treatments obtained from drug shops (Wallman, 1996). During financial hardship, many opt to buy only the amount for which they have enough money in hand; it is also not uncommon for people to share drugs, particularly for children to use remnants of previously acquired drugs. Other coping strategies include borrowing money, visiting health units where health providers can offer credit, and sacrificing other household needs, such as food.

Poor People's Aspirations for Health Services

According to the survey conducted among poor residents of Katwe II (Jitta and Ndidde 1998a), most communities did not want to pay for care in government health units, but said that if they had to pay, the quality of health care had to be improved. Ninety-five of the respondents said that people should not have to pay for health care in government health facilities. They wished to have flexibility when paying for health care.

At the Household Level

Individual families should keep their surroundings clean, use toilets, burn their garbage, and endeavor to participate in public health activities in the community. Family planning services should be promoted to allow better child spacing and reduce family size. Resource allocation within the family should take into consideration nutrition, health care, and education of children as priorities. Women felt they should be more involved in the decision-making process for family financial management, and that nutrition education should be given to the whole family as men mostly control the family resources.

At the Community Level

Local councils should establish health days in each zone to focus on removing garbage, digging and clearing drains, and cleaning up the environment to reduce disease risk. The PRA discussion recommended that landlords should provide latrines/bathrooms for all tenants, more water taps should be installed in the community, and profits made by the LC could be used to further develop the area. The Health Committee should sensitize communities to improve health practices and reduce preventable diseases, including HIV/AIDS in the area.

Health Units

Medical personnel should attend to patients promptly, show more compassion to the sick, and respond to emergencies faster and more efficiently. Drug management should be improved to ensure more equitable distribution of drugs to patients. Technical capabilities of medical staff should be improved with in-service training to equip the staff with adequate skills for new technical procedures; and the number of trained staff should be increased. The standard of nursing needs to be improved, especially in government hospitals.

Kampala City Council Authorities

More technically trained medical staff should attend to mothers; staff remuneration should be improved to reduce unofficial payments in government units. Health providers felt that more drugs and essential equipment should be provided to the units to improve overall services. Private clinics wanted more contact and supervision from the medical office in the area, to ensure uniform quality care in the city. Proper drainage and sewerage systems, together with the provision of clean water and improved environment, were greatly recommended for Kampala.

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NOTES

1. Grading of health units in Uganda: I = sub-dispensary, II = dispensary, III = health center, IV = sub-district health unit.

2. It should be noted that these proportions are rough and do not reflect parallel care services of traditional healers.

Appendix

Table 1. Top Six Illnesses Diagnosed in Kampala Public Health Units by Month (2000)

Month	Pneumonia	Diarrhoea	Dental	Intestinal Worms	Malaria	Skin Diseases	Trauma	Total
January	1,208	469	491	248	6,172	343	199	9,130
February	1,427	742	782	392	3,365	624	536	7,868
March	941	460	591	273	2,670	418	237	5,590
April	1,660	973	370	223	3,524	466	410	7,626
May	1,797	618	589	358	5,747	580	410	10,099
June	1,058	448	371	284	3,482	415	357	6,415
July	3,134	573	725	378	5,293	579	453	11,135
August	2,107	758	587	688	7,100	753	449	12,442
September	1,740	679	1,304	497	5,030	620	516	10,386
October	1,271	741	785	752	4,060	448	461	8,518
November	525	148	402	137	1,495	155	146	3,008
December	224	103	128	113	1,230	91	114	2,003
Total	17,092	6,712	7,125	4,343	49,168	5,492	4,288	94,220

Source: Kampala City Council – Health Management Information System Office.

Table 2. Top Ten Diseases as Perceived by Katwe Community (n=42 households)

Disease condition	% Households reported children	% Households reported Women	% Households reported Men
Malaria	92	76	72
ARI	88	68	68
Diarrhoea	40	24	20
Measles	40	0	0
Worms	20	15	5
HIV/AIDS	16	32	35
STDs	8	28	45
Accidents	20	12	18
Skin conditions	5	7	13
Others	24	9	9

Source: Jitta and Ndidde (1998a)

Table 3. Staffing at Mulago, Butabika Hospitals, and Kawempe Health Centre

Category	Mulago	Butabika	Kawempe
Medical Doctors	210	13	1
Medical assistants	35	13	2
Nursing officers	210	39	1
Double training Nurse/midwife	143	0	2
Enrolled midwives	120	0	8
Enrolled Nurses	198	40	0
Asst. Health visitors	n/a	n/a	2
Clinical clerk	n/a	n/a	1
Nursing Aides	n/a	n/a	3
Total	916	105	20

Source: Kawempe Health Centre 1999; MOH 1991.

Table 4. Health Facilities by Ownership in Kampala District

Type	Division				
	Central	Kawempe	Nakawa	Makindye	Rubaga
Government Hospitals	2	1	2	0	0
Private/ Mission Hospitals	2	0	0	2	2
Local Gov't Health Centre	1	2	2	2	2
Other Private Clinics, drug shops, pharmacies	216	243	238	256	317

Source: Kampala City Council – Health Management Information System Office.

Table 5. Total Cost of Care (including drugs) at Different Health Facilities

Service	Public Health Care	Private Clinic	TH/TB
Malaria	2,000/- (US$ 2)	6,500/-(US$ 6.5)	5,000/- (US$ 5)
STD	2,000/- (US$ 2)	5,000/- (US$ 5)	5,000/- (US$ 5)
ANC	2,000/- (US$ 2) (Registration)	2,000/- (US$ 2)	3,000/- (US$ 3)
Maternity	5,000/- (US$ 5)	20,000/- (US$ 20)	10,000/- (US$ 10)
Postnatal	1,500/- (US$1.5)	3,000/- (US$ 3)	–
Immunization	00	00	–
Family Planning	1,000/- (US$ 1)	2,000/- (US$ 2)	–
Dental Extraction	3,000/- (US$ 3)	5,000/- (US$ 5)	–

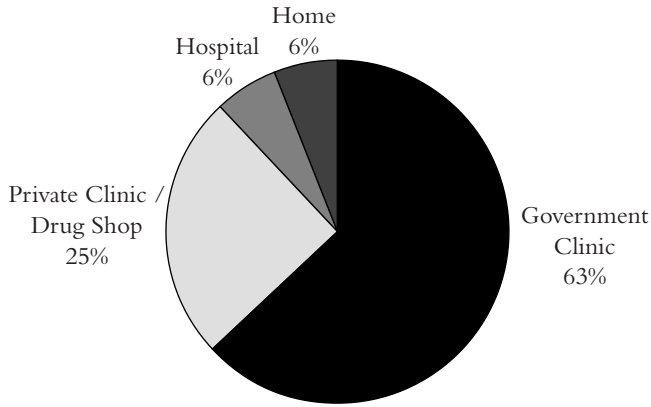
Source: Jitta and Ndidde 1998a.

Table 6. Health Budget at Sub-county Level — Kampala District

Budget Item	Amount (US $)
Office Equipment and Furniture	5,070
Stationery	1,936
Water protection	12,830
Health education	9,950
Drainage equipment	2,000
Vector control	15,037
Insecticide	26,950
Disease control (Bilharzia)	5,484
Disease control (Sleeping Sickness)	16,110
Construction of Health Center	2,006
Staff transport	18,490
Contingency	11,490
Total	127,353

Source: Jitta and Ndidde 1998a.

Figure 1. Place of Treatment



Source: Jitta and Ndidde 1998a

CHAPTER 5

Urbanization and Health Services Delivery in Kenya: Challenges for the City of Nairobi

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In Kenya, as in most other developing countries, public and private medical services are unevenly distributed. The reasons for the uneven distribution have to do with both market forces as well as non-market factors. By and large, market forces are responsible for much of the observed spatial variations in the supply of private medical services. The reasons for the inequity in the provision of public health services are largely rooted in the past, and relate to the ad hoc development of state intervention in health care delivery. Rather than plan the allocation of health care resources, the government has relied on the historically established health care delivery infrastructure, which was biased toward the urban areas. Indeed, historically, and especially since the late 1970s, the philosophy of primary health care has guided health policy and planning in most developing countries. The focus has largely been on the rural areas, and rarely have issues relating to the problems of rapidly growing cities been addressed. Generally, most countries' national health budgets tended to be (and many today are still) pro-urban, largely because most hospitals, which provide rather expensive care, tend to be located in the urban areas. Consequently, when examining issues of equity in health care at the national level, it was often argued that the rural areas deserved special consideration if this pro-urban bias was to be rectified. In recent times, however, it has been recognized that there is an equally urgent need to develop primary health care in urban areas as there is in rural areas (Harpman 1994). Indeed, medical services are often at the center of concerns about inequalities in the provision of urban services.

Due to rapid urbanization, urban populations in most countries have long surpassed the carrying capacities envisioned at the point of urban development, especially in the poor and developing economies. As a result, cities in these countries are faced with overutilization of the available social services, especially in education and health, which are basic and fundamental for human development and quality of life (Menédez 1991). The rapid rates of urbanization and the associated growth of poor urban populations have prompted health policymakers and planners to raise questions about the appropriate way in which to develop the urban health care delivery system.

This paper highlights the challenges facing Nairobi as a rapidly growing urban center in Kenya, with special emphasis on health service delivery to the poor. A socioeconomic and demographic profile of Nairobi is given, followed by an epidemiological profile. An overview of the organizational structure of the city's health services is outlined and the distribution and utilization of health service facilities is described. I conclude with a brief discussion of the key challenges and opportunities resulting from the rapid population growth in Nairobi.

Demographic and Socioeconomic Profile of Nairobi

Kenya, like many other developing countries, has experienced relatively rapid urbanization in the last century. The urban population increased from 748,000 in 1942 (the census year before independence in 1964) to 10 million in 1999—a more than thirteen-fold increase in approximately fifty years. The urban population as a proportion of total population rose from 9 percent in 1962 to about 35 percent in 1999, with the sharpest rise occurring between the census years 1989 and 1999.

The city of Nairobi was established in 1901 when the Kenya-Uganda Railway reached its present location, then a small depot for caravan trade (DSA, 1992). Since then it has continually experienced rapid growth, both in terms of population and physical expansion. The physical area expanded from 3.84 km^2 in 1910 to today's total area of 684 km^2. In 1901, the total population of Nairobi was just 8,000. By 1999, the census revealed Nairobi's population to be 2.2 million. In 1962, 46 percent of the urban population was residing in Nairobi and although by 1999, this proportion had fallen to just 23 percent, Nairobi is still the largest urban center in Kenya.

Table 1: Nairobi: Population Densities by Division

		Population Density in:			
Division	**Area (km^2)**	**1969**	**1979**	**1989**	**1999**
Central	10.6	8,247	11,642	14,107	22,164
Huruma ⋆ *b*	1.4	—	—	—	64,340
Mathare ⋆	1.5	818	2,040	4,000	46,002
Dagoretti	38.7	1,294	2,681	4,531	6,215
Embakasi	208.3	63	254	711	2,088
Kasarani *a, b*	85.7	—	—	—	3,955
Kibera	223.4	821	2,391	—	1,284
Kibera (slum) ⋆ *b*	1.7	—	—	—	49,228
Makadara	20.1	5,300	5,259	8,211	9,823
Pumwani	11.7	13,438	11,341	10,571	17,263
Westlands	97.6	714	1,061	1,312	2,127

⋆ Slum areas isolated from the Divisions in which they are to be found.

a. Earlier data not available due to boundary changes.

b. Data shown only for 1999.

Source: Compiled from Government of Kenya, Population Census Reports, 1999.

The annual population growth rate was about 6.9 percent between 1948 and 1962. Subsequent population growth rates were 5.55 percent (1963-69), 4.76 percent (1969-79), 4.7 percent (1979-89) and 4.8 (1989-99). While about two thirds of Nairobi's annual population growth comes from natural increase, the remaining third results from net migration.

An estimated 40 percent of Nairobi's population lives in one of its several slums. The three largest are Kibera (Kibera District), Huruma, and Mathare (Central District); the remaining slums are located mainly in Eastlands. Table 1 shows population densities in the city by division. To highlight the population density in the three major slums, they have been isolated from their respective divisions.

The aggregated divisional population figures hide the high population densities prevailing in many of the city's slum areas and low-income areas in the Eastlands (Makadara and Pumwani). The main slum areas, listed in order of total population, are found in sub-locations of Kibera, Mathare, Huruma, Korogocho, Kawangware, Kangemi, and Kariobangi. All the slum areas have population densities much higher than the city average. The 1992 strategic health plan for Nairobi estimated that about 31 per-

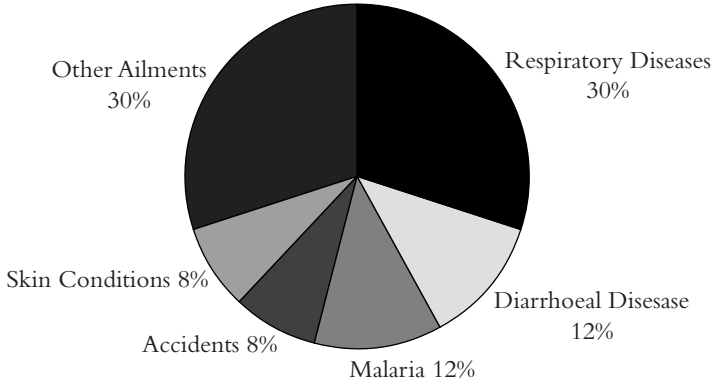
cent of the Nairobi's population is crammed into 2 percent of its inhabitable area (DSA 1992). Yet, despite the overcrowding in these areas, populations there continue to grow faster than in the rest of the city. The majority of migrants into the city settle in these low-income areas where housing costs are relatively low, and where friends and relatives from their village are likely to be residing.

An Epidemiological Profile of Nairobi

There is currently no reliable epidemiological data for the city of Nairobi. However, the team that prepared a strategic plan for the Nairobi area under the auspices of the Kenya Health Rehabilitation Project collected morbidity data from a random sample of health facilities in the city. There were also data from the Nairobi City Council and Ministry of Health (MOH) statistics (DSA 1992). The team analyzed data from the MOH Health Management Information System (HMIS) and from an earlier study by REACH (1988). From these three sources, an aggregate summary of Nairobi's epidemiological profile was obtained. This is shown in Figure 1.

The epidemiological profile of the city is dominated by diseases associated with poverty – mostly respiratory and diarrhoeal – which constitute 42 percent of the disease burden in the city. Malaria follows at 12 percent, and skin conditions and accidents each account for 8 percent. The large segments of the poor who live in the slum areas, where the conditions are appalling, largely explain this profile. The slums are mostly unplanned and lack sanita-

Figure 1. An epidemiological picture of Nairobi



tion and sewerage facilities. Accommodations are overcrowded and water for drinking and cooking is both scarce and often contaminated. These conditions are a recipe for the spread of air- and water-borne diseases.

Organizational Structure of Nairobi's Health Services

Nairobi has a wide range of health facilities–both public and private–that range from single purpose clinics, integrated service centers, and private medical clinics to Kenyatta National Hospital, the national referral hospi-

Table 2. Inventory of Health Facilities in Nairobi 1988

Health facility	NCC	MOH	Gov't Parastatal	Mission NGO	Private	Total
Hospitals	1	5	1	1	6	14
Health Centers with maternity beds	9	–	–	–	–	9
Health Centers without beds	14	–	–	–	–	14
Maternity units / Nursing homes	–	–	–	2	9	11
Dispensaries	–	30	8	17	17	72
Clinics	25	–	–	–	4	29
Total	49	35	9	20	36	149

Source: REACH (1988)

Table 3. Inventory of Health Facilities in Nairobi 2001

Health facility	NCC	MOH	Gov't Parastatal	Mission NGO	Private	Total
Hospitals	1	5	1	2	7	16
Health Centers	28	5	–	–	3	36
Maternity units / Nursing homes	3	1	–	2	4	10
Dispensaries	7	44	8	23	68	150
Clinics	33	13	2	10	64	122
Total	72	68	11	37	146	334

Source: Ministry of Health, Health Management Information Systems, June 2001.

tal. Health facilities include hospitals, health centers, maternity homes, dispensaries, and clinics. The private sector runs the largest number of the health facilities, followed by the Nairobi City Council, the Ministry of Health, nongovernmental organizations (NGOs, missions), and other government ministries (in that order). Tables 2 and 3 summarize the inventory of health facilities in Nairobi by operating agency in 1988 and in 2001, respectively.

Thus, in 1988, when the total number of health facilities equaled 154, there was an average of one facility for every 9,740 people in the city. Today, more than ten years later, there has been a doubling of health facilities in Nairobi; much of the increase has been due to a proliferation of private facilities, most of which charge fees for their services. Therefore, despite population growth, the average population per facility in the city has gone down to 6,436.

Distribution and Patterns of Health Services Utilization in Nairobi

Health services are considered to be of such fundamental importance to human well-being that their distribution should be determined solely on need, rather than by considerations such as income or other "enabling" factors. It is for this reason that in many countries there is governmental involvement in the financing and provision of health services delivery. Nonetheless, variations in access to care are still apparent, not least between people living in different areas. Rural communities, for example, have been identified as lacking in their fair share of health care services. Differences in service availability imply variations in access to medical care, and lead to differences in the rates of utilization of medical services.

There is a dearth of information concerning access to and utilization of health services in Nairobi. This section provides an overview of the access to/utilization of health services there, bringing out the relative disadvantage of the urban poor. Information on the spatial distribution of the health facilities and the patterns of utilization relies much on the Nairobi Area Study report (REACH 1988) and the 1992 Strategic Health Plan for the Nairobi Area (DSA 1992).

Table 4. Distribution of health facilities by division in Nairobi as of June 2001

	Type of Facility and Usage by Population Density								
Division	Population 1999	Hospitals	Population per Hospital	Helath Centers	Population per Health Center	Dispensaries	Population per Dispensary	All Health Facilities[b]	Population per Health Facility
Central	234,942	1	234,942	4	58,736	61	3,852	109	2,155
Dagoretti	240,509	0	—	4	60,172	5	48,101	10	24,051
Embakasi	434,884	1	434,884	5	86,977	6	72,481	20	21,744
Kasarani	338,925	2	169,463	7	48,418	15	22,595	34	22,595
Kibera	286,739	5	57,348	5	57,348	23	12,467	47	6,100
Makadara	197,434	1	197,434	5	39,489	15	13,162	37	5,336
Pumwani	202,211	1	202,211	0	—	10	20,221	21	9,629
Westlands	207,610	5	41,522	3	69,203	15	13,840	42	4,943
Nairobi	2,143,254	16	133,953	33[a]	64,947	150	14,288	320[c]	6,417[d]

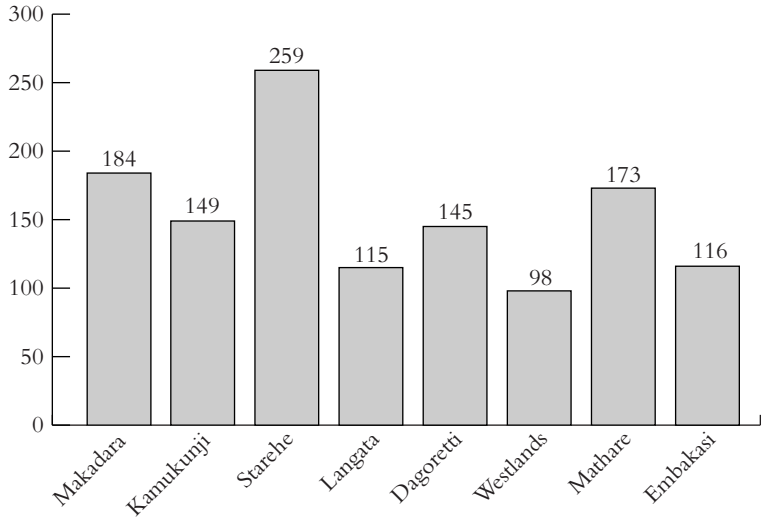
Notes: [a] It was not possible to identify the location of three privately operated health centers from the available records.
[b] Includes other health facilities like health clinics and maternity homes.
[c] The total does not tally with that on Table 3 because the location of 14 privately operated facilities could not be ascertained.
[d] Computed using the total of 334 facilities as in Table 3.

Source: Compiled from data from Ministry of Health, Health Management Information Systems.

The table shows that facilities are unevenly distributed among the city's divisions. With respect to hospitals, for example, Dagoretti has none and Embakasi has one, while Kibera and Westlands each have five. Yet, due to densities, the population per hospital in Kibera division is about 57,000, while it is only 42,000 in Westlands division. Five of the seven divisions (excluding Dagoretti) have populations per hospital way above the Nairobi average of 134,000. Health centers are not as unevenly distributed: although Pumwani division lacks a single health center, only Westlands and Embakasi have populations per health center way above the Nairobi average of 65,000. Dispensaries are largely concentrated in the Central division, bringing the population per dispensary to a low of about 4,000. This figure is rather deceptive as most of these are private and largely situated in the central business district. The division includes two of the city's largest slum areas—Huruma and Mathare—which have virtually no facilities located in them. A similar situation can be seen with respect to Kibera slum, in Kibera division. Overall, Dagoretti, Embakasi, and Kasarani divisions are the most disadvantaged in terms of population per facility – facilities in those divisions serve more than three times the average population per facility in Nairobi. Excluding Central Nairobi, which is favored by the concentration of private facilities largely within the central business district, the best-served divisions are Westlands, Makadara, Kibera, and Pumwani, in that order.

Besides the existence of facilities within a geographic area, another measure of access is the rate of utilization of the facilities. No current data exist on utilization by *type* of facility in the city, but the 1992 strategic health plan for the Nairobi Area (DSA 1992) did report on the utilization of facilities as a whole. The plan reported that nearly one half of the total patient volume visiting Nairobi City Council (NCC) facilities offering curative services were seen in health centers. But the NCC dispensaries experienced the largest workloads – each seeing an average of 53,000 patients per year – 25 percent higher than that of the health centers without beds, and 70 percent higher than that for health centers with beds. The dispensaries were seeing about 190 patients per day, compared to 152 and 123 for health centers without beds and with beds, respectively. The plan reported a 57 percent decline in the utilization of curative services in the NCC curative facilities between 1987 and 1990. A decline (of about 18 percent) in the utilization of preventive and promotive health services

Figure 2. Average daily curative services: visits per facility by division – 1990



was also reported. However, it must be noted that if the growth in the population were held constant throughout the period, the visits for all services would have increased by 15 percent.

The figure shows that Starehe division (corresponding largely to the present Central division excluding Mathare) had the highest number of visits per facility per day, followed by Makadara and Mathare. The report noted that the high utilization figures for Starehe were largely because there were only two facilities in the division, which are not only close to downtown, but also open 24 hours every day. The high utilization rates for facilities in Kamukunji (corresponding largely to the present Central division including Mathare) were attributed to the number of people working in the area as well as accessibility via public transport. Mathare, which also had high utilization rates, was then the largest division by population. The inhabitants were (and still are) predominantly low-income earners.

The Nairobi Area strategic plan also reported an alternative utilization indicator, which combined the total population and patient volume – the number of visits per resident per year; Table 5 summarizes that picture. Again, Starehe had the highest utilization rate, and Langata had the lowest rate at 0.36.

Table 5. Comparative utilization of NCC curative services by division, 1990

Division	Number of Facilities	Population	Total Facility Visits	Visits per Facility per Year	Visits per Resident per Year
Makadara	4	160,000	205,047	51,262	1.28
Kamukunji	3	150,000	111,945	37,315	0.75
Starehe	2	70,000	159,303	79,652	2.28
Langata	3	240,000	86,669	28,890	0.36
Dagoretti	3	150,000	124,278	41,426	0.83
Westlands	4	130,000	98,565	24,641	0.76
Mathare	5	310,000	226,352	45,270	0.73
Embakasi	3	170,000	99,620	33,207	0.59
Nairobi	27	1,380,000	1,111,779	41,177	0.81

Source: DSA (1992), Table 5.5D.

Discussion

About a quarter of Nairobi's population is crammed into 2 percent of the city's inhabitable area – in the city slums. As the population continues to swell, so does the number of the urban poor, however defined. According to Welfare Monitoring Survey III (Government of Kenya 2000), overall poverty in the city (by head count ratio, using absolute food poverty[1]) increased from 26 percent in 1992 to 50 percent in 1997. There is now wide agreement that indicators of quality of life should measure economic development not only in improvements in indicators such as per-capita income but also in terms of health and nutrition. Good health and nutrition are important factors in the provision of a regular supply of labor, an advantage for countries with surplus labor, since it avoids the disruptions caused by sickness and resulting absenteeism. Poor health and nutrition reduce labor productivity and impair the population's ability to learn, thus undermining investments in training and education. The increase in the number of slum dwellers and the concurrent increase in poverty are clearly linked and do not point to any advances in human welfare along these dimensions in the city.

There is no doubt that many dwellers in the city of Nairobi are already exposed to major threats to their health and well-being. These people

have to contend with overcrowding, bad sanitation, and contaminated water, if any at all. The result is the prevalence of numerous poverty-related diseases. One might expect that since Nairobi is the most urban area in the country that it might have a slightly different epidemiological pattern compared to rural areas. Yet, the high proportion of urban residents considered to be living in absolute poverty overwhelms the effects of epidemiological transition. High levels of traditional health problems, evidenced by malnutrition, rampant infectious diseases, and high maternal, perinatal, infant and child mortality rates, become the norm. The scarcity and contamination of water supplies and the general lack of sanitation and appropriate sewerage disposal make diarrhoea one of the most important health problems in the city. As one of the five leading causes of morbidity in children in Nairobi, diarrhoea mostly affects children below five years of age because their immature bodies have low resistance. The incidence of diarrhoea is higher in the high and very high-density areas. Surveys by the African Medical Research Foundation (AMREF) in the Kibera, Soweto, Lunga Lunga, and Mukuru slums/estates found a diarrhoea episode rate of 3.5 to 4.5 per child per annum (quoted in DSA, 1992).

Infectious diseases such as acute respiratory infections can impact nutritional status, while overcrowding, both indoors as well as outdoors, means that transmission rates of infections can be high. From a public health as well as an economic perspective, there is need to improve the health status of the slum dwellers using an environmental health approach focused on the physical infrastructure for water.

Besides the illnesses associated with a traditional health profile of developing areas, certain health problems are now emerging, largely within the poor communities in the city, that are typical of industrialized societies. In terms of the epidemiological profile of Nairobi presented above, these problems are subsumed under "Other Ailments" in Figure 1. They include hypertension, mental illnesses, drug and alcohol abuse, sexually transmitted illnesses (including HIV/AIDS), accidents (traffic and industrial), and violence. The conditions under which many work and live are frighteningly oppressive and conducive to hypertension and mental illness. Mathare Mental Hospital, the country's largest mental asylum, is located in one of the big slums. Pockets of commercial sex workers are also found in the slums. Many fall into this trade as a last resort for survival. Alcohol and drug abuse are also high, and with them, come crime.

Equally frustrated and desperately poor individuals peddle illicit alcohol and drugs, with often disastrous consequences: toward the end of 2000, an episode in one slum area left over 130 dead and scores blind because of the unhygienic conditions under which homemade alcoholic brews were prepared.

The main outcome of poverty due to rapid urbanization is poor health, whether caused by illnesses whose origin is largely due to poverty or due to industrialization-related causes. Overall, the health delivery system has not been able to cope with the increased demand for health services. The population growth rate outstrips the growth in urban health services and the economic growth rate. As a result, the service delivery system performance has been dismal in the provision of health services to the urban poor.

Conclusion

The phenomenal increase in the population of the city of Nairobi has brought problems with it, especially in the area of health services provision. The health service delivery system in Kenya, as in any other developing country, faces many constraints – financial, logistical, political, and administrative – that have led to the dismal performance of the service. This, coupled with rapid urbanization, could prove a disastrous recipe for poor health for the majority of the urban poor, who are the majority in terms of numbers but who receive inferior health care. The poor work in risky occupations, use risky transport systems, lack an adequate water supply, and often have no access to proper health facilities. Studies done in Kenya tend to place emphasis on the general socioeconomic situation in the country; however, few, if any, have addressed the problems of the urban poor. This paper shows there is a dearth of research in some vital areas relating to the provision of health services to the poor in the urban areas in the country. There is not much information, for example, on how much the urban poor pay for a wide range of services, including health services, and the quality of services they receive in the face of overutilization occasioned by the vast numbers. There are also gaps in research in certain areas in terms of the physical environment and its effect upon health. There is need to do comparative studies to show which policy initiatives will ensure that those in greatest need in the urban area – the urban poor – have increased access to health services.

Health policy development also needs to address the issue of the respective roles of the Ministry of Health and the municipal health services, which fall under the aegis of the Ministry of Local Government. This often creates friction in terms of service provision, but it is the poor, who cannot afford the cost of care in private facilities, who suffer because of such skirmishes.

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Notes

1. Absolute food poverty encompasses both food and non-food basic requirements.

CHAPTER 6

The Role of NGOs in Health Service Delivery

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Urban regions and the social problems found in them are beginning to receive more attention from the development community as the theory of "urban bias" is unraveling and development practitioners are realizing that cities have many of the same problems as rural areas. Rising poverty and rapid growth in urban populations are straining physical infrastructure and increasing income inequality, thus exacerbating the health problems of the urban poor. Certain characteristics of international nongovernmental organizations (NGOs), such as flexibility, innovation, and community focus, have enabled them to be successful in addressing urban health problems. This piece investigates how NGOs can maximize community benefit by incorporating three key factors in delivering health care services: (1) using an intersectoral approach combining projects from many disciplines; (2) creating selective collaborations with other international NGOs, local organizations, and governments; and (3) fostering community participation and cooperation in program delivery. Even though many successful programs include these aspects in day-to-day efforts, this changing field of development demands that NGOs use their adaptability, creativity, and the ability to learn from others to increase the impact they have on urban populations.

The Cost of Urbanization

Over the past century, the world has witnessed an urban explosion that strains the infrastructure and social systems of urban areas, especially in developing countries. This phenomenon is widely documented and therefore will not be repeated here. The basic assumption, though, is that

"growing cities [in the developing world] are characterized by a deteriorating environment and physical infrastructure, a lack of basic services, an increased exposure to environmental contamination and rising poverty levels" (Maxwell, Levin, Armar-Klemesu, Ruel, Morris, and Ahiadeke 2000:91).

These urbanization issues must be considered within the larger context of a world that is facing globalization, shifting political paradigms, and creating new economic and social constraints. Multiparty states are replacing many of the one-party states of the past, and governments are moving toward economic and political liberalization. Unfortunately, more conflicts are occurring within nations, as opposed to between, with increased suffering among the countries' nonmilitary populations. These conflicts often determine who will become migrants or refugees and send millions fleeing to urban areas. According to Turner and Hulme, "the capacities of different nations to adapt to the rapid economic changes of a globalized economy vary enormously and, to date, it appears that the poorest countries will bear the highest costs" (1997:226). Many of these costs involve the health of the urban poor and can be mitigated by interventions such as job creation, skills development, sanitation, and social marketing of health education. International nongovernmental organizations are in a position to provide interventions that address some of the dramatic changes occurring in urban areas of developing countries.

The Role of International NGOs

NGOs have become important players in promoting and facilitating development in low-income countries. Research and experience show that certain characteristics of NGOs make them adept at addressing the health problems of the urban poor. NGOs typically have an ability to address the areas of greatest need; have a motivational force; are innovative, flexible, and independent; and are often low-cost operations (Cohen and Deng 1998:192; Gilson, Sen, Mohammed, and Mujinja 1994:23; Gellert 1996:21-23; Matthias and Green 1994:11). They tend to have a stronghold in the community already and can easily tap into existing urban public groups, promoting local involvement. In addition, NGOs typically work worldwide and, as such, have a broader base of experiences and knowledge from which to learn about successful and problematic

programs in different parts of the world. Although all of these qualities may not be present in every NGO, successful development programs tend to exhibit many of these characteristics.

Addressing the specific needs of the urban poor presents special challenges for NGOs. NGOs can successfully implement health programs in the most low-income areas of a city, but the question still remains if the most disadvantaged are benefiting from the programs. One study found clustering of similar housing types within urban neighborhoods but no clustering of nutritional status (Morris, Levin, Armar-Klemesu, and Maxwell 1999:2016). Households can be categorized by socioeconomic status by neighborhood, but true health problems do not concentrate in one neighborhood or another. This complicates the interventions an NGO may wish to implement, as a large-scale project targeting an intervention for a specific neighborhood may exclude the health problems of the truly needy.

To counteract these challenges to health strategies, NGOs should draw on their strengths and experiences to include the following three features in future health projects:

Using an intersectoral approach. For these purposes, an intersectoral approach recognizes that the health of the urban poor depends on more than just access to health care and, therefore, incorporates all sectors and disciplines into addressing health problems by providing services for factors that influence health, such as the physical environment, an individual's income level, education level, behavior, and practices. Education has been found to be associated with better health and hygiene practices, resulting in better nutritional status (Maxwell et al. 2000). Increased income is also linked to improved health, and studies suggest that poor environmental conditions may be mitigated by good home hygiene practices, which can be learned through health education (Morris et al. 1999:2018). The point is that an NGO cannot provide only health care services without taking into consideration the availability of other resources in the community and other factors affecting health. Other researchers recommend an intersectoral, interdisciplinary approach to development (Werna, Harpham, Blue, and Goldstein 1998).

An NGO is not expected to provide all necessary services for an area, but some programs can be combined to address certain problems. An important

problem identified by the urban poor is lack of access to credit. Microfinance institutions are addressing this problem by providing small loans in order for borrowers to start or expand a business. Several organizations, such as Freedom from Hunger (www.freefromhunger.org) and the Cambodian RACHA (www.racha.org.kh), have taken an intersectoral approach and have helped improve the economic and health situation of women and their families in rural areas through microcredit and health education promotion, and the same model can be adapted in urban areas. "Programs aimed at enhancing mothers' ability to earn an income or to improve environmental sanitation would be broadly acceptable as interventions whose real aim is to improve child nutrition" (Maxwell et al. 2000:137). Whatever the approach of an NGO, it must be complementary to other available programs and services, which leads to the need for collaboration.

Developing selective collaborations with governments, local organizations, and other international NGOs. To create an intersectoral approach and provide all needed services to the urban poor, NGOs must work with local and national government entities, other international NGOs, and local organizations. Lack of coordination can create "inadequate geographical and sectoral coverage, duplication, competition and ineffective use of resources" (Cohen and Deng, 1998:192). The development community has talked about the importance of collaboration for years, in the form of everyone across the board sharing all information and working together. But this has shown to be inadequate to the task of consistently impacting health service to the urban poor. A more directed proactive method would bring about better results. Selective collaboration implies that NGOs, as well as other players in the field of health service delivery, understand the role they play in the community and the responsibilities of other organizations in other sectors. NGOs need to understand the entire landscape in which they operate, their role in it, and their position in relation to other service providers. Having this information enables organizations to more readily approach others with a collaborative effort by knowing whom to approach and what to work on together. NGOs should identify their programmatic strengths and the niche they fill in development and within a particular community. Then, NGOs can build on these factors to provide effective services that complement the other activities in the community.

As valuable as service coordination is and as logical as it seems, history has demonstrated collaborations are time consuming, are laden with process, and can be ineffective. To improve alliances, Gilson et al. (1994:23) argue that coalitions of all partners (international NGOs, government agencies, and local organizations) should clarify the role of each collaborator, strengthen capacity to implement their responsibilities, and build mutual trust and willingness to coordinate their responsibilities better. These activities can be put into the framework of selective collaboration and its three spheres of importance: act, cooperate, and refer. The spheres represent where an organization lies in the service delivery landscape according to other organizations.

"Act" is what an organization does well and the services it provides. This central organization in the "act" sphere works one-on-one with organizations in the "cooperate" sphere, which provide a service for the beneficiaries of the central organization that the central organization does not necessarily have the capacity to provide. Both organizations receive a benefit from this type of relationship, either by recruitment of program beneficiaries or because programs complement each other. The organizations that fall into the last sphere of importance, "refer," may not directly tie into the work that the central organization is doing, but the central organization must at least be aware of them on the landscape of service delivery in order to refer their beneficiaries if necessary.

An example of selective collaboration is Project LOOK (www.projectlook.org) in Seattle, Washington. It started in 1991 by providing afterschool academic help for targeted high-risk students, mostly migrants, in low-income urban neighborhoods. This is Project LOOK's "act": academic help and tutoring, which they provide very well. Students' academic achievement more than doubled in the first year of the project. However, they realized that academic help alone is ineffective in helping the children to succeed without also supporting the needs of their families and their health needs. Therefore, Project LOOK expanded its program by adding family advocates who identify family needs in addition to the academic help already being provided. Project LOOK now "cooperates" with other organizations to have them provide services such as business development training and health education. The programs in the "cooperate" sphere complement what Project LOOK is already doing, and the organizational structures of the two programs work well together.

Existing programs and projects can provide for other family problems identified by the family advocates. Programs such as emergency food and help with immigration laws fall into the "refer" sphere of Project LOOK. These programs have a system in place to address these specific needs of the participants of Project LOOK. Because Project LOOK cannot offer all the services that their beneficiaries need, they have developed partnerships with other organizations that can provide them more effectively. With selective collaboration, Project LOOK identified its strengths and created links to other organizations that can be most beneficial to the project's participants. The final aspect of this approach, then, is involving the project's participants and the local community.

Fostering community participation and cooperation. The assumption here is that the goal of NGO activities in urban areas is to create sustainable programs that benefit the most needy of the urban poor. Because health problems are not clustered in urban areas, NGOs must identify specific problems and constraints of each neighborhood, including factors that affect health, such as environmental conditions and residents' socioeconomic status. Community participation can identify local problems as well as garner community involvement in addressing those problems. Participatory rural appraisal (PRA) is a tool that includes the community in naming problems, recognizing solutions, and empowering community members to implement interventions themselves and has become a cornerstone for development. The three basic components are a facilitative attitude, open methods, and a partnership of everyone involved (Chambers 1997:104-106). The PRA process and results can change the attitudes of community groups based on the information gathered. Highly flexible and adaptable, it has been documented successfully in both rural and urban areas (Drinkwater 1994; Reusen and Johnson 1994; Shah 1995). Additionally, the necessary skills to conduct PRA are easily transferable to local staff and community members. (More can be read about PRA tools in Clark University [1991]).

Despite the numerous benefits of PRA, Chambers criticizes this popular practice for becoming too popular, too fast: "The label has spread without substance" (1997:211). The behavior of outside facilitators has detracted from the ideal PRA empowering method, rushing through explanations and becoming too rigid in its adaptation. Donors are

demanding community participation, so NGOs are using PRA, motivated by funding instead of the intended motivation of community input and empowerment (ibid.). By keeping the three components of PRA in the forefront of development, however, NGOs have counteracted criticisms of PRA and have successfully used it in different forms to involve community members and local staff personnel to gain insights into development opportunities. Bergdall and Powell (1997) document a truly successful PRA project in Ethiopia, which involved problem identification and community mobilization to improve the community livelihood with little outside assistance; another example from Cambodia attests to the adaptability of PRA to identify health problems in the community and to build capacity of local staff (Kelly and Prosser 2001).

The aspect of skill transfer of PRA techniques and other management capacities is a major method of creating sustainable development programs. "Many realize that the failure to utilize and strengthen local capacities increases the vulnerability of beneficiary populations" (Cohen and Deng 1998:192). Health improvements throughout the world have been achieved by giving people the knowledge and ability to do things for themselves. Building the capacity of local organizations enables them to create and manage necessary programs to address health problems in the community without depending on outside sources. In order for NGOs to maximize their program activities, they need to incorporate skills transfer into their organizational structures accordingly.

Challenges

This paper examines past applications of approaches to health care service delivery in order to learn from them. The concepts of an intersectoral approach, collaboration, and community participation have appeared in literature for many years. The 1848 Public Health Act in England, the Alma Ata in 1978, and the Healthy Cities Project in 1987 all call to work with the community to seek sustainability by promoting intersectoral collaboration for health and supportive environments that focus on all settings that affect health, including work, home, and school (Werna et al. 1998:9-14). The fact that these same three elements have surfaced time and again in program planning but that the world is still riddled with poor health is telling of the current health care approaches.

Criticisms of these approaches and NGO roles in facilitating them substantiate the fact that health care delivery can still be improved. NGOs have been criticized for creating dependence in communities by providing services that the public sector should be providing. NGOs are dependent upon donors, which can dictate what services they provide. In addition, because they are accountable to donors and not the local government per se, critics argue that NGOs operate at the local level with no regard for, or support of, national health plans or policies. Also, NGOs find it difficult to collaborate with other organizations, which can be detrimental to this three-pronged approach. "Many [NGOs] have not developed the capacity to identify or respond to the needs that fall outside their traditional areas of involvement. One consequence is that the needs of [beneficiaries] that go beyond their areas of expertise may fail to be assessed or addressed in situations of poor coordination" (Cohen and Deng 1998:192). With this commentary in mind, collaboration continuously being promoted, and the still-prevalent need for health care improvement, NGOs have some challenging decisions to make in order to change the way they work with the community, other organizations, and government agencies to deliver health care.

Final Thoughts

Only by learning from past experiences and reviewing the criticisms of current efforts can NGOs improve upon health service delivery for the urban poor. Critiques can be lessened by using a truly participative approach to involve the community and by using selective collaboration of groups involved in service provision. Because development takes place in a changing, uncertain world, Turner and Hulme recommend that NGOs take a flexible, adaptive approach, based on "learning, experimentation, creativity and access to local knowledge" (1997:145).

This effort calls for using three fundamentals of service delivery to address the health needs of the urban poor: intersectoral method, selective collaboration, and community participation. Stefanini sums up this approach best:

> NGOs should aim to play a facilitating, catalytic role in order to develop the available human and institutional potential. To do this they will need to acquire new skills and attitudes, especially manage-

> rial and organizational competence, and a really participatory style of management. To enhance local sustainability, NGOs should work with rather than substitute for the functions of the state. This means working within the government structure to build capacity and implement effective government policies. (1995:46)

Interventions for health improvements cannot be isolated from other efforts. The best approach an NGO can take is to identify what they do best and complement it with other organizations and programs to work toward meeting all of the needs of an urban community. Community participation and transferring skills are simple keys to increase the success of meeting basic human needs and making programs sustainable. By focusing on a few elementary efforts when delivering health service to the urban poor, concerted impact and lasting improvements in the lives of people at risk are, indeed, possible.

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PART III

RESPONSES OF THE POOR AND URBAN MIGRANTS

CHAPTER 7

Migrants and Public Health in Uganda: From "Pathogens" to Agents of Public Health Care Development

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In one of her many essays on colonialism and the politics of health service delivery in Africa, Maryinez Lyons picks on how the present speculation on the "origin of AIDS" in Uganda is reminiscent of the old attitude that disease is often inflicted upon a population by outsiders. According to her, the history of the Banyarwanda migrant laborers provides a rich example of borders, population movements, and public health issues. It also provides an example, over time, of the pathologization of an entire group of people. From nearly the beginning of their arrival in large numbers, "the Banyarwanda were perceived to be a threat to the health of Ugandan subjects" (Lyons 1995:2-3). This observation encapsulates the central contradiction of migrant labor, capitalism, and public health concerns in Uganda, and provides the starting point of the argument that, rather than merely being the "pathogens" that they are taken to be, there is a reciprocal relationship between the history of migrant labor in Uganda and the prioritization of public health development in the country.

Uganda was effectively colonized in 1884 when it became a Protectorate. However, prior to this, several communities in the concomitant areas had variously experimented with early mercantile capitalism. Colonial conquest and accumulation hinged on migrant labor valued for being cheap and likely to avoid the risk of exploiting indigenous labor, which could cause revolts and undermine government. Hence, capitalism in Uganda depended on migrant labor from Sudan, Rwanda, Kenya, Zaire, and other neighboring countries. However, meek as they may have been, one of the axes of discord between migrant labor and capital in

Uganda related to struggles for access to better public health care. These struggles by migrants and the poor placed improving public health care (PHC) services on the agenda of the state right from colonial days. This essay asserts that the contribution of migrants to the development of public health in Uganda evolved from the introduction of capitalist relations of production and the ensuing struggles of poor migrants and other urban poor communities for better economic and social conditions.

Conceptualization of Migrants

Much of the past debate on migration theory centered on the extent to which different actors have leverage with regard to decisions about migration. Neoclassical models present the decision as dependent upon the individual's perception of the costs and benefits of migrating. Structural models, on the other hand, suggest that labor migration systems were established to serve the interests of capitalism and the individuals involved had little choice in the matter (Bakewell 1999). This essay would suggest a middle ground akin to Gidden's structural theory where analysis accommodates both agency and structure to present a more comprehensive picture of issues. That being the case, migrants will be viewed as social actors working with some room for personal choice, while also being constrained by the wider social context in which they exist. According to Arjan de Haan, most "debates pay too little attention to the contribution of migration to poverty reduction; policies tend to ignore migration, or have the implicit" or explicit aim to reduce migration (2000: preface, i). Past literature often presents migrants as "predators" on the limited modern enclaves of society, even when those very enclaves, be they cities or the infrastructure within them, were built on migrant labor. Migrants are also often seen as "disseminators" of disease—*pathogens*—to their host societies; for example, migrants have been blamed for both the tuberculosis concerns in South Africa, and more recently, for the health problems of Somali refugees in the Nordics, as well.

However, contemporary literature on labor conditions and refugees has begun to yield information on the contribution of migrants to poverty eradication and development in both their origin and host areas. This change in perspective to account for reciprocal relationships between migration and development has implications for development policy and

raises some salient issues with regard to migrants. First and foremost, they tend to migrate to increase personal or community welfare (whether they move together or retain links with their roots). Second, migrants are in most cases not a net burden, but instead they often tend to improve the welfare in the areas of destination. Third, migration from areas of scarcity to those of plenty helps to reduce global inequality. Fourth, most migrants are conscious actors and not objects of pity. Their actions are buttressed in complex networks of class, religion, kin, and so on. Even recent studies on the impact of voluntary repatriation of refugees find that they resent UNHCR's assumption that home is the place of origin to which all migrants intend to return (Bakewell 1999; Crisp 2000). Fifth, migration is embedded in social norms and structures, and in turn reinforces such societal perceptions (de Haan 2000).

The challenge, then, is to define "who is a migrant," because the definition continues to be contentious. With the lack of a conventionally accepted and uniform definition, an operational one has been coined for purposes of this paper: migrants are considered to be persons who undertake a more or less permanent change of residence that entails a change in the total round of social and economic undertakings. Migration, and therefore those who partake in it, is multidimensional, resulting from a great variety of forces. According to Morrison (1983) and Ammassari (1994), the four main perspectives to migration issues relate to (1) the scale, (2) the temporal, (3) the cultural, and (4) the historical. In this paper, particularly for lack of substantial empirical data, a historical dimension is adopted that relies on credible secondary sources that allow the historical analysis of the interface of urbanization, poverty, migrants, and public health in Uganda with the aim of highlighting the historical contribution of migrants to public health development.

Colonialism, Urbanization, and Migration

Colonial states like Uganda have been labeled "soft states" because the incomplete development of capitalist forces leads to poor delivery of services and underdeveloped infrastructure. According to Myrdal (1970), soft states, among other things, manifest patterns of inefficient management systems, less effective exercise of control, sanctions, and corruption. In sum, the soft state reinforces inequality. This follows for urbanization in

Uganda, which developed to provide administrative posts and collection centers for natural resources plundered from the interior by the colonial government. The weaknesses of the soft state were reflected in the development and management of urban centers in Africa as a whole, with negative consequences for health and wealth distribution among urbanites.

As Allan Gilbert and Josef Gugler (1982) put it, the Third World city was "the instrument of conquest," built to house the colonial master and elite but exclude the majority of the African population. In it, modern services (such as health, education, recreation, trade, and industry) were intended for the "conqueror" and not the "conquered." Concerns over rural-urban migration were largely based on the conception of cities as safe havens from the squalor of the countryside; that "virgin" populations in cities were at risk of diseases brought by unclean, infested, and unhealthy rural migrants who had to be kept at bay. For example, in most of the major cities and towns of Uganda, the affluent sections were ringed off from the poor African settlements by buffer zones (mainly golf courses and wetlands). African women, in particular, were for a long time barred from migrating to urban areas regardless of their status as mothers, wives, or workers.

The exclusive city was based on a residualist approach to the development of urban social services, such as health and housing. The deliberate policy of creating exclusive cities was ubiquitous to the whole of anglophone Africa, as a commentary on the Town Planning Act of 1917 in Nigeria below suggests:

> Colonial social policy took a residualist approach. . . . An outcome of the concentration of social services and other forms of amenities in these colonial centres was the emergence of cities with origins in colonization and the growth of uneven, unequal spatial and socioeconomic development. This law classified Nigerian cities and towns into first-, second-, and third- class towns. White towns on one hand, and native towns, on the other. This classification then determined structures and the provision of infrastructures such as electricity and pipe-borne water. The social services and administration of these towns depended on this classification; the native town suffered almost absolute neglect. (Aina 1999:75-76)

The result of the concentration of social and economic amenities in cities prevailed in Uganda as well: immigration of populations seeking to benefit from urban services was inevitable.

The history of migrant labor to Uganda took the form of population movements from the northwest — bringing immigrants from the West Nile District and the adjoining areas of Congo and Sudan, and the southwest — bringing in migrant labor from Kigezi, Ankole, Rwanda, Burundi, and Tanzania. Most of these migrants were destined for the sugarcane plantations in central (Buganda) and eastern (Busoga) Uganda. However, other migrants, especially those from the southwest, settled for labor on private coffee farms mainly in Masaka, Buganda (see Rutabajuka 1989). The interface between labor and capital was one of exploitation, and the new forms of labor organization and rural agricultural production needed during the colonial period disrupted many African social systems profoundly (Lyons 1992, 1995).

However, because immigration could not be controlled, there emerged an historical discrepancy between the urban population and available public health amenities in Uganda. The urban poor—most of them migrants—found their source of livelihood in market exchange. Since the market fails to provide any security, and the poor are not in a position to accumulate savings, they survive by complementing market exchange with a system based on resources of kinship and friendship, which follows the rules of reciprocity—a mode of exchange among equals, embedded in a fabric of continuing social relationship (Lomnitz 1977). However, the reality today is that rapid urbanization in developing countries like Uganda has tended to absorb a disproportionately higher share of the countries scarce health resources, and high rural-urban migration continues to exert more pressure for increased health services to cope with the ever-expanding population.

Migrants' Contributions to Public Health Development

In a bid to avoid investing substantial resources in developing social services in the colony, the colonial administration applied all measures at its disposal, including coercion, to encourage or control migration depending on the demand for labor at the time. In the majority of cases, public

health concerns only became an issue when there was surplus labor that needed to be dispensed with (Rutabajuka 1989; Mamdani 1976; Ahluwalia 1995). Therefore, migration (be it across borders, urban-rural or vice versa) was largely a product of capitalism and consequent urbanization. Even the identity of migrants (whether in terms of gender, tribe, religion, and class, among others) also depended on the labor policies of the capitalist state; concern was initially with indigenous labor, followed by migrant labor, followed yet again with rural labor reserves, when adverse conditions in rural areas threatened to curtail the reproduction of labor.

According to Lyons (1995), colonial medical officers, initially worried about the spread of sleeping sickness, soon warned about the spread of other diseases. Certain tribes became identified as possible health hazards. Over time, there evolved a colonial discourse on "tribal traits"—the Baganda were clever and clean, the Bakiga were dense and unruly, and the Banyarwanda were dirty and diseased. In 1935, a member of the colonial Legislative Council described how "Hundreds of half-starved natives from foreign neighbouring territories, many of them diseased, can be seen daily wending their weary way on foot along the Uganda roads, travelling three and four hundred miles in search of work. Our hospitals are full of these men" (cited in Lyons 1995:11).

Their health compromised by weather and the horrible experiences of trekking for work, migrants faced poor working conditions as well:

> At work places (shambas) migrants were not housed and the employers did not care where the laborers slept. . . . But where the laborer found other migrants from his area of origin, he would share their hut with them. . . . Under the migratory system the laborer was paid a 'bachelor wage' which was meant to cater for himself alone. On the Masaka coffee shambas, the migrants were not given food by their employers. …Health care was the responsibility of the laborers as the employers did not provide medical treatment to the workers when they fell sick. . . . Hence they relied on treatment with herbs, which were crushed, mixed with water and drank. (Rutabajuka 1989:25-28)

Lyons (1995) noted that in spite of the poor conditions the migrants were subjected to, the colonial authorities continued to regard the migrants

themselves as an unhealthy influence on the local population. However, these poor conditions, and the stigmatization that went with them, forced migrants to adopt various forms of struggle to force their employers to cater to their social and economic needs. Throughout the 1930s, this ranged from absenteeism, doing shoddy work, and physical confrontations to desertion of bad employers (Rutabajuka 1989). These struggles brought to the fore the limitations in social service provision and, especially, the inadequacy of public health care services in Uganda at the time.

The J. R. McD. Elliot survey of working conditions in the Protectorate in 1937 was one of the landmarks toward improvements in public health care service delivery in Uganda. Following the recommendations of the report, rough camps were thrown up in which exhausted men could recuperate and the sick get medication. Specifically to address health concerns of migrant populations, there were repeated suggestions to establish a chain of camps at crossing points along the borders with Tanzania and Rwanda in which unfit or unwell men could be "conditioned" before traveling further into Uganda (Lyons 1995; Rutabajuka 1989). Thereafter, from the 1940s to the post-independence period, there were deliberate attempts to improve the distribution and quality of health care services at the disposal of both urban and rural populations, hence increasing the access of the poor to them.

The structure and role of the working class, and the tensions in its relationship with capitalism have been crucial to political and economic development in modern societies. However, according to Brett (1993), the limited proletarianization undermined collective labor in Uganda, thus inhibiting the development of a radical working class movement. This resulted from the extreme suppression of any form of dissent to the colonial administration's policies:

> The authority of the colonial system was virtually unquestioned from the First World War to the end of the Second. However new opposition movements began to emerge in the forties based on local groups opposed to their exclusion from the modern institutions created by colonialism itself. . . . In April 1949 there was a major revolt involving workers and farmers, mainly induced by low prices and resentment against expatriate monopolies. . . . In 1953 the East African Royal Commission advocated policies to reverse the tendency to suppress

> African entrepreneurship … These changes created openings for African advancement. (Brett 1993:23-24)

The process of redressing past social and economic imbalances continued into the post-independence era with donors supporting planning and large state-dominated enterprises in industry, agriculture, and social services. These developments went ahead with the Africanization of the civil service, and the scaling up of investments in the banking, insurance, roads, transport, and communication sectors, as well as in education and health. These policies greatly extended opportunities for African advancement. The health sector was among those that can be credited for high performance, in terms of growth, in the 1960s:

> Mulago, the national teaching and referral hospital, was completed by the British immediately before Independence and twenty more district hospitals were built over the next decade. Both Catholic and Anglican Churches had run hospitals and local health centres in Kampala and up-country during the colonial period, and they were allowed to retain their control over these. (Brett 1993:25)

Nevertheless, the postcolonial governments did little to channel resources to the poor. Thus, even in the 1960s most people did not benefit from independence, and the hand hoe remained the fulcrum of export agriculture; the poor had limited access to the modern sector and remained alienated from the state. Increasing discontent and the recourse to the army to contain it led to the political events that culminated in the 1971 coup that ushered in General Iddi Amin Dada and the economic regression, human rights abuses, and institutional decay that came to characterize Uganda up to today.

However, the negative attitude toward migrants as a source of poor health continued into the 1960s and there is evidence that such sentiments remain entrenched in popular consciousness today, especially in areas that thrived on migrant labor, such as Masaka District. A typical example is found in statements from a 1964 government report:

> Uganda has experienced a rather hard period during the year 1963/4 due to her neighbours in the North, on the West, and in the

> Southwest being in internal trouble. A vigilant eye had to be kept for the possibility of refugees coming from the Sudan, the Congo and Rwanda, bringing with them infectious diseases. Therefore all medical authorities on the boundaries concerned have always been alert to deal with any emergencies. (Government of Uganda 1965:44)

The patterns of immigration to Uganda remained the same even after independence until the 1970s, when the effects of economic decline began to bite. Thus, the sources of migrants remained the same (see above), with the addition of considerable immigration from the Nyanza Province of Kenya. In response, the post-independence government provided transit labor camps in which sleeping facilities were provided for 80,638 immigrants in 1964 alone, approximately 20,000 above the average for the two years 1962 and 1963. Besides these temporary measures, effort was made to improve the health and other social amenities in refugee settlements, such as the one in Nakapiripirit, in Moroto District, which was considered a model camp. However, the above figures did not reflect the total number of people entering the country in search of employment, as improved means of transport made it possible for many of them to avoid having to stop at the labor camps for the night (Government of Uganda 1965:43-44).

Contemporary Dynamics of Migrants and Public Health

Projections estimate that by 2010, 40 to 60 percent of Africa's population will be living in urban areas yet there is little evidence that constructive steps are being taken to plan for this colossal scale of urbanization in Uganda. With the economic decay and political mismanagement that characterized the 1970s, proper urban governance is still a new craft; for example, a basic asset that eluded urban governors in Uganda was the command of reliable planning data. Urban civil servants lacked logistics and motivation to take interest in and document important developments like urban immigration, let alone how it was impacting urban development and/or vice versa. In other words, urban administrations still exude what Stren (2001:10) called the "seeing like a state" problem, in that they have failed to deal with the complexities and nuances of localities. These

and other factors obscured the visibility of the plight of the urban poor in general and the migrants within them in particular.

Because of the concentration of health services in urban centers, Uganda has one of the poorest health access figures; accessibility to health care in Uganda has been limited to approximately 49% of the population living within five kilometers of a health facility (Saito 2001:1). Overall, health infrastructure distribution is poor, and where health units exist, they are poorly equipped with human and medical resources to serve their communities; rural areas are even worse off in this regard. In most of the districts of Uganda, both urban and rural cost-sharing in public health utilities has been reported to be hindering access to health care for those who cannot afford to pay.

A participatory poverty assessment of the poor's perceptions of the quality and delivery of social services in Uganda found unanimity in the complaints that health service delivery is among the worst.[1] The poor find it extremely difficult to afford the rather high cost-sharing fees. Other factors inhibiting access to public health include long distances to health units (especially in rural areas), poor quality of available health services, limited health infrastructure, human resources factors, inadequate and irregular medical supplies, and so forth (Tumusiime 2001:31). In addition, many health units do not provide a full range of services. Even the geographical coverage of health facilities does not reflect actual needs: in Uganda, over 50 percent of the hospitals are situated in urban areas, while most health centers are located near trading centers. Most of the private clinics are also located within or close to urban centers; for example, there are more than four hundred private clinics operating in Kampala City alone.

A Case Study of Kampala

According to the 1991 Population Census figures, Kampala remained the major destination of urban migrants. The high rates of in-migration to Kampala are shown in Table 1.

Kampala commands approximately three times the immigrants than the rest of the districts in the country. However, this increased immigration is taking place in the context of limited health facilities and general urban economic decline, considering that the city was not planned to provide social services even for its present population. The urban popula-

Table 1. Migration Ratios of In-Migrants by Sex

Sex	Kampala District Ratio Value	Rank[2]	Uganda Ratio
Male	57.09	34	17.09
Female	57.79	34	18.24
Total	57.45	34	17.68
Sex Ratio	93.1	16	90.1

Source: Compiled from 1991 Population and Housing Census - Kampala District Profile.

tion, accounting for 11.3 percent of the total population, is concentrated in Kampala, where 41 percent of the Ugandan population lives. As the population of the city continues to grow rapidly, the available public health care amenities remain inelastic. Table 2 shows that Kampala City has only 43 health units to serve a population of over 800,000; and of these, perhaps only 11 are well-equipped.

The 1991 census report noted that the rapid increase of the urban population was bound to create pressure on urban infrastructure, such as water supply, housing, transport, and educational and health amenities (Republic of Uganda 1998), a clear example that urbanization does not necessarily mean access to better health care, particularly when it is taking place in the context of economic decline (Stephens 1996). The biggest challenge in planning for health services in cities like Kampala is the rapid population growth in the face of the sluggish growth in health budgets.[3] Economic interests of migrants aside, the population factor is also aggravated by the influx of patients from the periphery of Kampala City simply because health facilities are concentrated in the city. Worse still, the health facilities are largely located in the central business district, which has the lowest residential populations, while those areas with high population densities that house the urban poor, such as slums, are conspicuous for the absence of health and other social services.

Table 2. Population vs. Health Services in Kampala City

Population	866,500
Hospital	14
Health Care/Maternity Dispensary	11
Maternity Unit	3
Dispensary/Sub-dispensary	15
Total Unit (6)	43
Population per bed Unit 1/6= (7)	20,151

Source: Compiled from statistics of the Ministry of Health Planning Department.

Responses of the Urban Poor and Other Groups

The poor continue to struggle to access modern services. In Uganda today, communities of urban poor have resorted to informal networks of health provisioning that range from small credit schemes to support poor colleagues' treatment in clinics to exchange of herbal and other traditional medicines, including magic. This has in recent times led the Ministry of Health to formally recognize the role of traditional medicine in mitigating lacunae in public health service delivery. The Ministry of Health and Makerere University are currently carrying out joint medical research on the treatment of ailments such as AIDS by traditional healers.

Because of the magnitude of the HIV/AIDS pandemic, Uganda is witnessing a proliferation of community and national-based health care associations. Major players, like The AIDS Support Organization (TASO) and the National Community of Women Living with Aids in Uganda, emerged out of urban community initiatives. There has been a proliferation of "burial groups/societies" in response to the challenges of managing the rate of mortality caused by AIDS, which has particularly affected the urban poor. Such groups are mostly found in slums where the urban poor live. Those who fail to cope with AIDS care in the city are forced to migrate, either to a different town or to the rural areas. Above all, poverty and HIV/AIDS exacerbate each other; migrants are prone to engage in risky sex after being removed from traditional cultural and social networks, therefore furthering the spread of HIV/AIDS (Opolot 2001:9). In other words, AIDS plays a key role in migration patterns today, placing it at the center of the public health care demands.

Besides work-, kin-, and neighborhood-based groups in the city, increasingly common today are women's associations geared to improving the social and economic welfare of members' households. Together they exchange credit (that may have been internally or externally mobilized) to invest in developmental projects. Given that women bear the bigger burden of health care, the health conditions of members come first in their budgetary allocation of pooled resources, however meager.

However, on top of the initiatives of the poor there has also been a rapid growth in the number of urban health service organizations keen on contributing to the management of AIDS, cholera, malaria, meningitis, and other diseases. The role of Rotary, Lions, and other clubs is noted in

this regard, as well as numerous charities, such as the Gatsby Charity in the areas of urban sanitation and supporting the ailing poor to access unaffordable treatment. On a broader scale, nongovernmental organizations and other nonprofit foundations led by the Church, have a dominant stake in developing and managing Uganda's health sector.

Finally, the Kampala City Council (KCC), despite its limited resources and administrative limitations, has scaled up its investments in developing and improving the quality of public health services. The remaining challenge lies in targeting public health care service developments in or closer to poor neighborhoods. The concentration of health facilities in the central business district has to be discouraged as it excludes those who live and desire such services on the fringes of the city. However, pro-poor health delivery targeting requires concerted research effort. Improved access to credible research results could enable KCC to improve pro-poor infrastructure development even within concerns over limited budgets.

Conclusion and Recommendations

Policies are needed for taking stock of and supporting the social demands of migrants. Those forms of migration that occur in very exploitative circumstances (for example, forceful transfer of girls to cities for sex work or child labor in general) should be stopped even if those who send them consider it a source of alternative means of livelihood. It is, therefore, essential to distinguish "worst forms" of migrant labor from those that provide essential contributions to livelihood (de Haan 2001:25). The escalation of AIDS, and its attribution to migrants, implies that neglecting the plight of poor migrants is bound to have a disastrous impact on their access to urban health services and in the process have negative consequences for other urbanites as well.

At stake here is the whole question of equitable development that entails becoming critical of the manner in which urban authorities, and indeed governments at large, distribute urban resources with a view to attacking urban management models that exclude minorities, migrants or the poor (see, among others, de Haan 2000; Kanbur and Squire 1999; Achor 1997; Gilbert and Gugler 1982; Stren 1975). In recent times, the advocacy of the UNCHS Habitat II has been crucial in networking urban scholars, administrators, and civil society at large to build consensus

around the need to develop inclusive cities. Inclusive cities enshrine a principle of urbanization that is sensitive to the plight of the urban poor (Toepfer 2000:7-8; Stren 2001:10-11; Moor 2000:7-9). Planning inclusive cities implies reorienting policy toward guiding urbanization other than preventing it. The call is made for urban governance that acknowledges that more holistic, inclusive, and participatory policies, strategies, and actions are required to make the world's cities and communities safer, healthier, and more equitable (Gebre-Egziabher 2000:4). However, as Stren (2001:11) has noted, inclusive governance is most difficult to achieve in large cities, where it may be hamstrung by both local and higher level political influences. This could be the challenge facing such planning in cities like Kampala, but there is room for continued experimentation with the model.

There is need for comprehensive planning for the better health of cities in Uganda, and this cannot be left to urban authorities or the poor alone but has to involve the active participation of government, nongovernmental organizations, and donors. Rapid urbanization implies that planning for health services has to be stepped up if adequate health care at acceptable levels of quality is to be provided for urban dwellers. Underlying this requirement is the call for a holistic approach to service delivery. In other words, improving health systems in urban areas is contingent upon the resolution of a diverse range of absent or poorly delivered services that includes improving quality and access to housing; improving sewerage, garbage, sanitation, and urban environmental management; improving quality of and access to water; improving urban transport and communication systems; and improving quality of and access to health and education services.

As this is catered to, it is important to ensure that our cities become more inclusive through participatory development processes. In other words, the urban poor and other minorities should be active stakeholders in defining and implementing the "dream" healthy city.

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NOTES

1. The Uganda Participatory Poverty Assessment Process (UPPAP) conducted the Participatory Poverty Assessment (PPA) in nine pilot districts in the country: Moyo, Bushenyi, Kisoro, Kampala, Kumi, Kotido, Kapchorwa, Kalangala, and Kabarole.

2. The table shows that overall, Kampala has a higher than national average in-migration ratio with the population of women slightly higher than that of men. The ranking shows that out of the 45 districts in the country in 1991, Kampala had thirty-four more chances to be the recipient of new immigrants than the other 44 districts put together.

3. Ikiara (1992:153-154) made similar comments on Nairobi.

CHAPTER 8

Self-Help Intiatives of Urban Migrants: A Case of TASO – Uganda

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The contribution of the urban migrant population to the health system can be understood in terms of their continuous struggle to resolve the predicament of the poorer and more vulnerable sections of urban communities. The success of their struggle is evaluated by their ability to satisfy unmet health needs, the level of community participation, the degree of utilization of the provided health services, and the extent that equitable benefits are derived from the provided services.

This paper explores one of the most common means through which local populations in Uganda have acted to satisfy their own needs, namely self-help groups that rely heavily on foreign funding. The AIDS Support Organization (TASO) Uganda is one such initiative, whose contribution is examined in this paper in an effort to determine its role in improving the country's health system, which is currently overburdened as a result of the HIV/AIDS pandemic.

The Context

The National Resistance Movement (NRM) government, on assumption of power in 1986, was confronted with three major challenges within the health sector: the poor health status of the population, inadequate funding support for health care, and poor health infrastructure. With the collapse of public health services, the decline of the national capacity to coordinate and direct health activities, and the serious need for human aid as a result of internal conflict and economic decline, international relief agencies, particularly nongovernmental organizations (NGOs), took the forefront of health provision in Uganda.

The 1980s, therefore, registered two significant changes: there was a marked shift in the key actors within the health delivery system, from central and local government structures to international health actors; and the nature of health care provision changed. In the absence of an overarching health strategy, an increasing dominance of selective vertical programs characterized health care provision, engendering the proliferation of different donor-funded, project-based interventions. These interventions were basically linked to the internal policies of the various international agencies, effectively creating a series of un-integrated "micro-policy" environments and interventions that largely reflected the values, ideologies, objectives, and priorities of the agencies. The policies were, therefore, defined vertically in terms of the type of intervention, and geographically, within the confines of small project areas, with little, if any, integration with national policy.

Recognizing that government efforts to improve health were unlikely to rely on increases in public spending financed by debt or taxes or on reallocation being socially or economically justified, the NRM government adopted this health care strategy and reinforced it by supporting the rapid expansion of the selected vertical programs throughout the country. Subsequent reforms within the health care sector were premised on this fact. Underlying this selective strategy was the assumption that the platform for more integrated primary health care (PHC) services would be provided.

The 1990s marked the government's commitment to address the infrastructure and material resource crisis that it had inherited. Priority was given to developing and implementing policies on health financing and infrastructural development. With strong donor influence and guidance from the Health Policy Review Commission (HPRC), which, in 1987, had made an extensive analysis of the health sector situation of Uganda, the government undertook infrastructural development through a two-pronged strategy that sought to rehabilitate the existing health system and to further develop PHC services. Reorientation of the health care system to PHC was seen as one of the major ways of overcoming the health challenges.

The 1992 Three-Year Health Plan was an epitome of these concerns. The plan laid out five major policy recommendations: no further expansion of health care infrastructure would be done; priority should be given

to restoring the functional capacity of existing facilities; the health system should be reoriented to PHC; a basic health care package approach, determined by local needs and available resources, should be used; and a user-charge policy should be promoted as one way of financing health care in Uganda.

Reorientation of the health system to PHC focuses on ensuring application of cost-effective interventions for health promotion and disease prevention throughout the entire range of health care delivery institutions. As a means to pursue a cost-effective approach, the government drew on a strategy that focused on manpower development in the medium term and a five priority program—including immunization, water and sanitation, food and nutrition, control of malaria and other communicable diseases, and health education, an activity that is considered critical in all aspects of PHC.

The financing approach that was adopted reduces government responsibility for paying for the kind of health services that provide few benefits to the users of the service (Okuonzi and Macrae 1996). It proposes that the financing and provision of the private type of health services, which benefit mainly the direct consumer and are largely curative, should be shifted to a combination of the NGO and private sectors, which were recognized to be financially more self-sufficient. The underlying assumption is that the shift would increase the public resources available for the type of health services that are public goods, in this case, largely preventive programs that accrue to communities as a whole, not just to individuals and families. As such, the government would withdraw from paying for mostly curative care, which would otherwise be paid for by direct beneficiaries. It follows that such withdrawal would increase public resources available for government provision of basic curative and referral services to the poor, who currently have only limited access to services of this nature.

In fact, however, the reinforcement of selective vertical programs has tended to overshadow other aspects of health care provision. Little thought is given to the social aspects of health and how they relate to other aspects. Inequalities, particularly between social groups and social strata, are intensified. The "urban biased" nature of resource allocation initiated by the colonial system designed to meet the health care needs of the few and reinforced by the paradigm of "development from above"

(top-down development planning) has not only increased geographical disparities, but also intra-sectoral inequalities.

According to the Ministry of Health, the new policy direction signifies a shift from direct service provision by the government to strengthening partnerships and facilitating other health actors like the community and private sectors. However, withdrawal of government expenditures of public resources from paying for curative services for all does not necessarily engender increased government attention to provision of basic curative and referral services to the poor. Indeed, existing data indicate a limited utilization of the formal health care system (GOU 1996). According to the statistics provided by the Ministry of Health, only 21 percent of those with recent illnesses visited a government facility; 31 percent visited either NGO or other private facilities, and 48 percent utilized the informal sector.

According to the World Bank (1995), approximately two thirds of the total health expenditures are privately financed, implying that, increasingly, most households have found it inevitable to meet their own health needs in the absence of adequate health provision by the government. Although the government provides a greater number of health facilities, the NGO sector has a greater capacity utilization and staff productivity, due mainly to differences in staff motivation. However, the pattern of private investments in health does not differ significantly from the government's pattern of selective resource allocation. There is a concentration of private investment in urban areas as a result of the comparative advantages of these areas— more attractive physical infrastructure, locational proximity, accumulation of administrative and political power, and the more reliable market required by profit-making health care organizations. Within the urban sites, however, resource allocation, instead of reflecting efficiency and equity criteria, usually tends to be the result of converging interests of the more powerful and articulate urban classes (Amin 1974; Lipton 1977; Ammasari 1994).

The AIDS Support Organization (TASO) Uganda, Limited

TASO is arguably the largest organized community response to HIV/AIDS in Uganda, operating in eight urban sites. By 1999, TASO had registered 57,924 clients (persons living with HIV/AIDS) of whom

66 percent were female and 10.8 percent were children below the age of 15 (Ssebbajja and Nvule Musoke 1999). TASO provides counseling, AIDS information, medical care, material assistance, and educational support to its registered clients and their affected families.

TASO has its origins in a small group of people who began meeting in one another's homes in Kampala in October 1986. The group was comprised of individuals who had migrated to Kampala from rural areas in search of better socioeconomic opportunities. The group included a truck driver, two soldiers, a veterinary assistant, an office boy, an accountant, a physiotherapist, a nurse, a schoolteacher, and a social scientist (Hampton 1991:3-4). At the time, the country was lacking the capacity to effectively deal with the health needs of the population that were resulting from the growing HIV/AIDS scourge, in addition to other health concerns. According to the founding director, in an inspiring account that she wrote after the loss of her husband to AIDS:

> There really wasn't much support here in Uganda, except from both sides of the family. But even they didn't fully understand what was happening. They could give emotional support but we were short of medicines and material support. There was stigmatisation from friends and neighbours. (Kaleeba 1992:5)

The government's reaction in 1983, when the first AIDS cases were reported was far from desirable:

> We already had enough problems with the war and the poor state of the economy, without trying to deal with AIDS as well. . . . The attitude was: forget about AIDS, deal with the issues that you can do something about. After all, if people in the USA cannot cure AIDS then what is the point of saying we have AIDS too. . . . Instruction from the Ministry of Health was not to talk about AIDS, because this would create a scare which couldn't be dealt with then. (Kaleeba 1992:5)

On its part, the NRM government was quick to respond to the epidemic by focusing exclusively on HIV prevention through building its capacity to provide information and education, ensuring a safe environ-

ment, specifically in the health care facilities, and enhancing communication and monitoring systems. Here, the priority need for its population was identified as information to prevent HIV transmission.

Bearing in mind the pressing needs of the affected Kampala population, and following her personal experience with a more supportive health care system in the United Kingdom, Noerine Kaleeba, with fifteen other group members, developed a different health care model. For these TASO founders, the government's strategy was inadequate; for them, AIDS was not simply a medical condition. It was a condition that was threatening their quality of life. It, therefore, required being tackled in a physio-psycho-social totality:

> As we reached out to other people who were infected, we found that a lot of the time they didn't have food or medicines or transport to the hospital. Helping to meet these needs stand out as an important aspect of starting an organization (Kaleeba 1992:42).

> When we began we were just a group of lunatic people, some of whom had AIDS. We met to talk, to cry, to pray, to share, to let off steam. Soon we realised we needed to do more than that, especially in relation to medicine and clinical care, professional support, and welfare support (Kaleeba 1992:46).

Issues such as food, security, nutrition, income, livelihood, and shelter had to be factored in. The affected population's rights to provision of basic needs and responsibilities to prevent further HIV spread deserved as much attention as did the inadequate health infrastructure. Prevention of further HIV transmission also meant responding to the needs of the people living with HIV and AIDS. To translate these ideas into reality, more so when there were no precedents for such groups in Africa, the group required a supportive environment:

> No office, no transport and no funds. But what they did have was initiative, vision and a deep commitment to practical action on behalf of people with HIV and AIDS, who were neglected by the health services and ostracised by the rest of society. … this combination . . . persuaded two British organizations — ActionAid and World in Need — to provide TASO with the funds to get started" (Hampton 1991:4).[1]

The open and constructive attitude of the government played a significant role in the growth and development of TASO: "One cannot rely on government funding, but the government's blessing is necessary. . . . We have been very fortunate. Uganda's National AIDS Control Program is run by creative and adaptable people, with a helpful attitude" (Kaleeba in Hampton 1991: 5, 43). TASO's efforts, which became complementary to those of the government, helped to reconstruct the language in order to draw the attention of the population to the epidemic and its effects. Hitherto there had been no message for those people who were already infected. People with HIV and AIDS were seen as being as good as dead. Public health messages were essentially saying: "Beware of AIDS, AIDS kills" (Kaleeba 1992:79).

TASO wanted to say that people living with HIV/AIDS were still useful to society, and the quality of whatever life they were left with needed to be enhanced. Its messages were targeting two audiences. TASO was appealing to HIV infected persons to live responsibly, to recognize their responsibility to society, to keep healthy and remain actively involved in economic and social activities within society. The message to the "others," that is, the rest of society, was that they should support people with HIV infection to help them fulfill their obligations (Hampton 1991; Kaleeba 1992).

Attention was thus specifically drawn to the popular perceptions of AIDS that were imbued with moral probity, calling for strategies that would understand HIV/AIDS in its entirety. This local initiative saw the need to develop a widespread non-biomedical approach to health, recognizing the communities' perception of the human body, which played a part in the way knowledge is constructed. More thought was given to the social aspects of health and how both the social and technical sides of health fit together.

Additional areas of complementarity included increasing medical treatment and drug access, fostering greater HIV/AIDS awareness, strengthening the referral system, enhancing community capacity through training and logistical support, and advocating for improved accountability of health workers to their clientele. TASO also supported community efforts to alleviate the socioeconomic consequences of AIDS. Although TASO recognized that AIDS care needs to be integrated into existing health and social services, they also realized that providing some specialized services, including clinical care, could not be avoided. It is in this context that TASO was keen to supplement governmental and nongovernmental medical initiatives.

Policy Concerns

TASO is attempting to reconceptualize health from being merely an absence of disease to a condition that deals with every aspect of life; there are several implications of such a broad conceptualization. First, health services need to be integrated to incorporate the numerous non-health related activities and sectors. A well-functioning health care system is one that is sensitive to the context of the health problem. It must provide comprehensive care by attending to both the immediate illness(es) and the underlying causes. It must ensure continuity of care, implying sustained interaction, if necessary, that has a long-lasting impact on health. It must also provide integrated health care; this caters to the ability to perform several specific tasks concurrently.

Second, a broader conceptualization of health confirms that a different orientation of health care services, from predominantly curative to include preventive and promotive aspects of health, is inevitable. Efforts should be directed to developing comprehensive and integrated health initiatives that respond to the health needs of a population that is obviously socially differentiated. Health providers would also have to consider involving the communities as active participants in health care and not simply recipients and users of services. Emphasis would, therefore, move away from professional health providers to local resource persons. Here, participation is viewed as a means to strengthen the relative position of the poor and marginal groups in society.

Brett (1993), however, cautions the proponents of community participation in the development process against the tendency to promote and utilize the participatory approach as an obligatory rule of organizational conduct. He observes that using one approach to solve organizational problems may lead to the agencies' failure to take into account variables that affect performance and, therefore, fail to fit into local conditions. The performance of different kinds of agencies in Uganda has, therefore, been influenced by the differing needs and conditions. Brett argues that the manner in which services need to be run is dependent on three major factors—the need for access, the nature of the relevant technologies, and the scale of operations. Therefore, the choice of the form of social control—market or democratic—should be influenced by these factors (Patel and de Beer 1990; Brett 1993).

From the Ugandan experience, it is important to distinguish between two kinds of self-help initiatives. One type is that which is community initiated and depends on external support to improve the quality of life of the intended beneficiaries through disease prevention and health promotion, but taking into account the communities' values, objectives, and priorities. The other type, which is more common, is based in communities and operates on democratic principles, using the "Western" approach in response to the needs, incentives, or pressures of external agencies. These include the Community Based Health Care Associations (CBHCA), Church-based mother's unions, and income-generating projects developed by the Local Councils. The latter groups tend to be the result of pressure from the political establishment and the desire for external support. The strategy and structures dominated by external objectives and organizational methodologies tend to have little, if anything, in common with "traditional" pre-Western organizational forms and clearly conflict with the desire to use the group approach as a way of increasing local autonomy and eliminating dependence.

In the latter type, it can be observed that the notion that the community is being provided with opportunities to participate in planning and implementing its own development is symptomatic of top-down thinking and assumes that the people in the community are not already engaged actively as subjects of their own development. The community is assigned a role that has already been defined for them by someone else, which implies that development failures can be attributed to external domination, and raises concern as to whether these "democratic" organizational forms are the best way of achieving the set objectives.

Concluding Remarks

Migrants and other vulnerable groups in urban sites have a significant role to play in meeting the needs of growing cities amidst resource paucity. Specifically, through self-help initiatives that are almost entirely funded by international donors, urban migrants have mobilized themselves to attend to the effects of the development policies that governments have designed in close alliance with international funding agencies. For a more meaningful contribution, however, there is need for the vulnerable groups to move beyond dealing with these effects only and question the develop-

ment policies and processes and their consequent development programs. These groups have a potential to provide a different approach to the health and development concerns of the urban community. Their challenge is to forge an alliance with those who can influence policy in their favor, paying attention to issues of legitimacy, equity, and universality.

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Notes

1. For TASO to accomplish its mission, international donors have had to heavily finance its activities. Donors include bilateral agencies, such as USAID, ODA/DFID, and DANIDA, and international organizations, such as WHO, ActionAid, Food for the Hungry, and many others.

PART IV

THE ROLE OF URBAN GOVERNANCE

CHAPTER 9

Urban Governance and Health in East Africa

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Governance and health issues in East African cities are inextricably linked to the distribution of power and resources in socioeconomic structures facing physical, infrastructural, and fiscal constraints. Yet, these links are often obscured by the deep disciplinary gaps between health scientists posing weighty epidemiological questions and political scientists grappling with more modest concerns of participation. When the two disciplines speak to each other, however, the technical issues of health and service delivery illuminate the larger contexts of leadership, decision-making, and resource allocation.

East African cities have grown from the push and pull of population movements in search of modernity and the promise of opportunities, but their governance structures have frayed under enormous pressures that defy orderly urban planning. Although health is an essential component of the urban sector, its viability is predicated on growing national economies and vibrant political structures. Scenarios for strengthening the health of cities thus need to be conscious of the real limits of treating health outside the whole array of economic and political issues that undergird the management of cities.

This paper focuses on some themes that inform debates about health and urban governance. First, cities comprise both pockets of poverty and enclaves of affluence that stem from severe socioeconomic inequalities. Second, the progressive weakening of East African economies over the years has greatly impacted the ability of cities to be self-sustaining entities that provide broad public services. The economic decline has, in turn,

engendered additional pressures on existing services not just from the urban poor, but also from an increasingly impoverished middle class. Third, the social fragmentation in cities impedes collective action around fundamental governance issues. East African cities are agglomerations of estates, neighborhoods, and slums, without the essential foundations for citizenship (common political membership) that might enhance their collective power to make demands and deal with the underlying causes of their health problems. The lack of collective action is exacerbated by the fact that these cities are the locus and focus of power in contexts where national elites are less secure and where the mechanisms of participation and accountability are still new and weak. As cities remain closer to centers of power, weak elites need to keep tight reins on them, depriving them of vistas to evolve autonomous organizational power that might allow them to meet the needs of their multiple constituencies.

The Health Profile and Context

The unassailable assumption in the literature on urban health is that the living conditions of the urban poor are a function of environmental and socioeconomic disparities. Access to housing, water supply, and sanitary facilities are some of the significant environmental factors that influence the health of inhabitants. Urban inequalities consign the poor to live in poor physical environments, with overcrowded housing, inadequate water supplies, poor sanitation and waste disposal, and high levels of pollution and other hazardous substances. When wealth and income are factored into the equation, these inequalities determine, for the majority of urban dwellers, access, affordability, and delivery of health services (Todd 1995; Lampis 1995; Satterthwaite 1995).

The broad picture of urbanization in East Africa is a familiar one of rapid population movements putting strains on the physical and social environment. Increasing rates of urbanization have stimulated ever-increasing rates in the number of urban poor (WHO 1993; Ruel et al. 1999). Of vital impact on health are the patterns of urban settlements. Most of the new urban migrants are concentrated in peri-urban settlements, squatter settlements, slums, temporary settlements, and illegal settlements, areas where there are no health services, schools, or employment opportunities (Bartlett et al. 1999:94-97). In addition, these are

areas prone to industrial gases, effluent and solid waste, and garbage disposal dumps, predictable sources of the majority of urban diseases. As Wang'ombe (1995:859) explains: "These settlements are found in parts of cities that are not designated for human settlements, unless certain developments occur first, such as construction of drainage systems, water supply, roads, and power. However, these settlements precede infrastructural developments because of population pressure due to rural-urban migration."

Urban planning in the post-independence era assumed that slums and other inhospitable settlements were social irritants awaiting modernization or demolition, but over the years, they have become a permanent feature of the urban landscape. The allure of donor-funded housing programs, such as the site-and-service schemes in East African cities in the 1980s, waned as these settlements graduated into slums in the 1990s. As they have become centers of the vibrant informal sectors of urban economies, slums and unplanned settlements constitute the sites and sources of livelihood for a majority of urban dwellers. But they are replete with diseases of poverty, as demonstrated by the annual outbreaks of cholera during the rainy seasons in the slum settlements of Nairobi, Dar es Salaam, and Kampala. Malaria is a major health hazard in these areas, stemming from the stagnant water pools and lack of drainage systems. In a word, inadequate sanitation, uncollected waste, proximity to industrial plants, open drainage systems, and polluted rivers expose the poor to infectious and parasitic diseases (Brockerhoff and Brennan 1998).

The continued deterioration of the environment surrounding urban poor settlements points to the links between the environment and urban health crises. But such crises also have a fiscal component. East African cities for a long time operated as quasi-autonomous entities within the local government ministries. This autonomy gave them some latitude to set health policy by providing public health services and clinical services, often with technical assistance from the ministries of health. Public health mandates enabled cities to provide essential public goods such as clean water and disease control, while ownership of hospitals and health centers by municipalities allowed them to provide free clinical services. The private sector, for the most part, supplemented cities as organizers of health delivery systems notably in the provision of private health services (Wang'ombe 1995:859-60; World Bank 1993; McPake 1993).

The fiscal crisis assumed two dimensions. First, since the sources of financing for city health services emanated from central governments through grants and budgetary allocations, the economic deterioration had a marked impact on urban health. Health ministries that once played essential roles in operating and paying for some of the health facilities could no longer sustain these roles, thanks to the structural adjustment policies that hollowed out the African public sector (Gilson and Mills 1995; Alubo 1990).

Second, the other major source of financing—urban taxes and fees levied by cities—faced a similar secular deterioration as the urban population increased without appreciable increases in the tax base. Slum dwellers do not pay urban taxes; their landlords should, but they do not. This has inevitably put even more pressure on the urban middle classes who suffer double taxation, first, to the government, and second, to urban authorities. As East African cities reel under the burden of meager allocation of government grants in the health sector as compared to rural areas, they have resorted to raising taxes to meet the shortfalls (Wang'ombe 1995:860-61; Hutchinson et al. 1999). No wonder that urban middle classes, who should ideally be friends of the poor in the task of remaking city governance structures, remain their perpetual class enemies.

The decimation of the public health sector via cost-sharing measures relegated cities to secondary roles in health delivery, roles that were filled subsequently by the private sector, nongovernmental organizations (NGOs), and international aid agencies. A 1989 study of eighty NGOs in Nairobi (cited in Stren, Halfani, and Malombe 1994:185) shows that NGOs provide a range of basic health services, such as childcare, nutritional counseling, and family planning. In addition, most of the major hospitals in Nairobi are run by NGOs. The contribution of NGOs to disease control, water availability, and health provision is important, but it conceals the long-term problem of insulating local authorities from their primary responsibilities of providing public goods. Although city authorities face real resource constraints as compared to governments, private providers, and voluntary organizations, ceding essential functions to these entities diminishes their long-term capacity to reestablish systems of accountability and reciprocities with their urban constituencies.

The Governance Profile and Context

Issues of poverty and health in urban settings are now popularly framed in terms of political disempowerment and social exclusion, hence the centrality of institutions of participation and interest aggregation (Friedman 1992; Stephens and Harpham 1992; Harpham and Tanner 1995). The dual crisis of governance and health translates into the multiplicity of socioeconomic and organizational impediments to effective governance. Although East African cities, with their heavy concentration of populations, should form fertile grounds for political mobilization, income disparities and social fragmentation still preclude effective claims of citizenship. Moreover, despite the emergence of alternative structures of political organizations around neighborhoods and functional realms, their capability remains underutilized without significant changes in the political contexts anchored in genuine decentralization and orderly planning.

For most of the post-independence era, state centralization meant that governments kept a close watch on a potentially restless urban population with the consequence that bureaucratization of urban governance emasculated participatory institutions (Mabogunje 1990; Stren, Halfani, and Malombe 1994). When the core of the bureaucratic machines began to decay (and with the related collapse of urban planning), East African cities entered an anarchic phase of urban development, a legacy they are now grappling with. Where participation would have engendered a culture of citizenship and problem solving, bureaucratization and state control fostered dependence and, increasingly, despair. Weakening the power of cities rendered them increasingly dependent on revenue and budgetary support from central governments that had become saddled with fiscal crises.

Contemporary urban governance reveals two contradictory trends. First, the liberalization reforms of the 1990s wrought political change, but there has not been a perceptible impact on the ability of cities to deal with problems on their own terms. The public and bureaucrat realms of cities are still circumscribed by the long and draconian arms of the states through local government and other ministries. As Halfani (1997:141) has shown, the various legislation Tanzania enacted to strengthen the reestablishment of urban authorities conferred a "virtual monopoly of governance powers to the state institutions."

After years of control by a government-appointed City Commission, the Nairobi City Council returned to electoral politics in 1992, yet central government dominance remains. Similarly, although Kampala has had vigorous mayoral elections won largely by regime opponents, the structure of governance has been stultified by central control. Moreover, despite the remarkable record of decentralization in Uganda, the central state retains considerable power to intervene in city administration. Maxwell (1999:1940) speaks to the widespread dilemma of decentralization for urban governance:

> The move toward decentralization and devolution in theory strengthens municipal governments, and their capacity to deal with problems. But it also puts increased demands on already-strained capacities, and often with little more than token budgetary support from central governments. But, even with the devolution of political authority from central to local government, questions remain about the access of the urban poor to local political processes.

Second, urban informalization has spawned political forms of survival, self-help, and localism (Goetz and Clarke 1993; Swilling 1997; Halfani 1997:122). As the informal economies have virtually swamped the formal ones in East Africa's cities, they have begun to evolve internal governance that insulates the poor and marginalized from the ravages of feeble urban authorities. The potential of informal organizations in improving the political efficacy of the urban poor should, however, not be exaggerated. The whole array of informal activities in production and services operates in precarious environments that are less congenial to coherent collective action. Although middle classes wearing the organizational labels of "civil society" are critical in articulating the grievances of the urban poor, their imprint on building new institutions remains thin.

How can cities reconcile the two contrasting trends in the governance realm? Resuscitating a semblance of the division of labor between the public authority and community action presents an institutional opportunity that East African cities can seize in the light of the traumas of the last decades. Political authority that underpins city governance needs to be strengthened in its broad institutional dimensions, in particular the legal structures governing property rights and representative bodies that foster participation.

Informal political and community organizations have flourished where public authorities are weak or absent, affording chances for the redefinition of roles between state and society at micro levels. These organizations, however, require legitimation and support from resurgent formal urban authorities; this would force a robust debate about the content of democracy and institutional reciprocities. Through recognition and legitimation of informal organizations, cities would recapture some of their previous structures of tax collection and boost their revenue base. An expanding tax base would assist in the resurrection of the decrepit infrastructure and services that constitute health hazards. A broad-based tax system would also restore a modicum of equity in burden-sharing that is necessary for political coalition-making.

A brief description of cases from Nairobi and Dar es Salaam underscores both the potential and pitfalls of forging novel participatory mechanisms and the enormity of reconstructing East African cities. There are about 260 welfare associations centered in Nairobi City residential neighborhoods that seek to overcome the failure of the city to provide basic services. Even though the Nairobi City Council hardly delivers any services, it still levies taxes and charges that fall disproportionately on the middle classes in formal employment. These self-help associations are desperately seeking to curb rising insecurity and reconstruct essential services. Their mandates have grown to encompass mobilization against those who construct illegal structures, grab public land, run shady businesses, and pollute the environment (Onyango 2001).

Even though they are not legally established, city authorities tolerate these associations, but their main source of opposition comes from strong interest groups (often linked to the state and powerful business groups) that have thrived on decades of disorder. Consequently, some leaders of these associations have been murdered and most live under constant threats from countervailing groups. These associations exist in a legal limbo, which guarantees that they will remain stunted in their ability as alternative vehicles and voices for participation. Community action cannot exist in the absence of benign and transparent city authorities. Some leaders have proposed that given their strategic roles, the city needs to amend its by-laws to accommodate these associations (Thuku 2001; Onyango 2001).

While local communities struggle to find means of engaging Nairobi and other major Kenyan cities on questions of governance, the leadership of these cities remains hostage to the antiquated Local Government Act that

makes them mere appendages of the central government. Thus, inasmuch as local communities seek coherent local governments, they have a long way to go as long as these institutions lack autonomy and are part of insecure national political structures. Two years into a job as mayor of Kenya's second largest city, Mombasa, the mayor was hounded out of office in 1999 by a group of councilors linked to the central government. His reform agenda to correct the deterioration of social services, restore fiscal health, and resurrect the tourist industry ran against what one observer described as a "Mafia-type gang of extremely wealthy individuals who have no respect for public lands or laws as they compete to gobble up all the open spaces" (Mutonya 1999). Similarly, barely a year after declaring that "the council affairs are being run in the most efficient manner," Nairobi's mayor resigned in ignominy in August 2001, citing frustration at the failure of the central government to help in public service delivery and lack of effective power (Omari 2001).

Years of decay of urban governance in Dar es Salaam have affected a host of services and infrastructure to the extent that reconstruction can only proceed at a heavy price for urban residents: water and sewage systems to ensure a healthy city need rehabilitation, but the poor have constructed illegal settlements in the vicinity; infrastructure such as roads need to be widened or expanded, but they are now sites of booming informal businesses. Recently, the government leased the Dar es Salaam Water and Sewerage Authority (Dawasa) to a private company to rehabilitate the water supply that caters to the city's more than three million residents. This has forced thousands of residents to lose their homes and commercial houses that were built oblivious to the underground water pipelines. Similarly, the city undertook a major demolition of property along a 70-km stretch to give way for road expansion. The people who were uprooted were not compensated because, the government argued, it had already compensated the original owners of the land in the early 1970s. Unscrupulous former landowners and City Council officials resold the land to unsuspecting people, hence the legal quagmire (Rwambali 2001).

Conclusion

The governance deficit in East African cities affects health in direct ways. Healthy cities are founded on thriving urban and national economies, but oftentimes health in poor countries is sacrificed on the altar of wealth-

creation. In reality, health is a wealth issue because it is anchored in the larger contexts of poverty, illiteracy, hazardous environments, and social inequity. Governments routinely confront questions about the right balance between wealth and health through resource allocation, planning, and investment patterns. The nature and structure of government at both macro and micro levels thus matters for establishing priorities and trade-offs. If political participation is one way out of the governance crisis that underlies urban inequalities, how do cities overcome the reality of fragmented communities? How can distributive questions be mediated in governance structures that are participatory and representative?

The rejuvenation of East African cities poses interesting questions of actors and structures, public and community power, urban planning and participation. Tentative institutions of urban governance have gradually started to fill the vacuum created by years of inchoate urban planning. The success of these efforts is predicated equally on successful restructuring of national politics to allow wider latitude to urban governments. East Africa needs to learn from most of Francophone West Africa where there have been more sustained attempts to develop democratic and decentralized city governance structures (Bartlett et al. 1999:236-39).

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CHAPTER 10

Building Healthy Cities and Improving Health Systems for the Urban Poor in South Africa

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The Legacy of Apartheid

South Africa's apartheid system repressed the social, economic and political lives of the majority of its citizens. It was a form of "racial capitalism" that included both paternalism and a disregard for subaltern interests and aspirations. Most people lacked basic government services like housing, health care, water, sanitation, and electricity. Black people were excluded from national and provincial government, and black municipalities had no power or democratic base; they were administrative agents of the white provincial governments. In the eyes of the apartheid government, black urban poor did not exist. Anybody living on urban fringes without permission was there illegally and was forcibly returned to the rural homelands. Whites benefited under job reservation laws, and once Nationalist Party power was entrenched, poor whites were almost unheard of.

The apartheid health system was one of the world's most unequal, fragmented and wasteful. Fourteen racially differentiated health departments—ten for each Bantustan, three for the white, colored, and Indian populations, and one general affairs department—administered and duplicated services. Four provincial departments as well as 382 local authorities were also responsible for health issues. Even after desegregation in 1990, hospitals were still controlled by these segregated health departments. None of them catered to the black urban poor because, in theory, there were no black urban poor.

Apartheid ideology claimed to uphold Western and Christian values, and encouraged a positivist view that conservative Western knowledge

systems were superior. This led to education and health systems that were imposed, top-down, authoritarian, and disdainful of alternative ways of learning and healing. The present dispensation faces the problem of de-entrenching the knowledge and practices left behind after generations of this form of governance. The new policy discourse aims to empower previously disadvantaged people by addressing relations of power and knowledge, using a process of consultation through the devolution of power to local government.

This paper explores some of the contradictions inherent in both democratically changing social reality, and delivering practical changes in areas such as employment, housing, sanitation, health, and education. The focus is on building healthy cities that democratically accommodate the needs of the previously neglected urban poor. Foucault's (1980) theoretical linking of knowledge production and the operation of power provides a useful framework for looking at a process of changing social reality. Relations of power are specific to different societies, being organized through relations of class, race, gender, religion, sexual preference, and age, among others. However, alternative perceptions and forms of knowledge can challenge dominant knowledge systems (Weedon 1987). Within this actor-orientated paradigm, the emphasis is on enabling poor individuals, households, and communities to help themselves, with policies aimed at meeting basic needs and enhancing human development and empowerment.

What Do We Mean by the Urban Poor?

In mid-2000, South Africa's estimated population was 43.68 million (SAIRR 2000/2001:47), with 36.2 percent of economically active citizens unemployed—40.9 percent of the latter in urban areas (SAIRR 2000/2001:378-79). This suggests that a significant portion of South Africans could be categorized as the "urban poor." However, there is a growing consensus—spearheaded by the work of Nobel prize winner Amartya Sen—that aside from lack of income, poverty includes the inability to reach a minimum standard of living and well-being as a result of deprivation of resources, opportunities, and choices. Many South Africans' continued poverty is intrinsically linked to the systematic entrenchment of discrimination during apartheid (SANGOCO 2001:76).

Migrant labor was central to the political economy of South Africa for more than a century, and apartheid was in some ways the rationalized policy of labor migration. The policy restricted the movement of entire families to urban areas, and male circular migration was predominant. Although apartheid's demise has changed the pressures and demands for labor, it remains unclear how these changes will affect future forms and patterns of labor migration. Current estimates are that more than 2.5 million legal, and many more illegal, migrants—from rural areas within South Africa and from neighboring countries—work in South Africa's mines, factories, and farms (Lurie 2000:343).

Contemporary South African migration includes a significant shift of people from rural areas to informal settlements on the urban peripheries. Government's response to this major problem has been to make forced removals a feature of life in South Africa once again. For example, in the Alexandra renewal project, the euphemism for removal is the "de-densification of appropriate land." People who have built houses illegally in Alexandra are now being moved to outlying areas. Government argues that this is "not dumping people but assisting them. We are moving them from an area that is hazardous to their health and providing them with a piece of land. The previous government didn't do that." However, the people who are being moved to Diepsloot are angry because they have no access to electricity and running water as they had in Alexandra (*Sunday Independent* 2001).

The urban poor include growing numbers of street children and orphans. The Health Systems Trust estimates that AIDS will orphan more than two million children by 2005 (SAIRR 2000/2001). Managing this development alone will require the joint efforts and resources of a number of government departments such as welfare, education, water affairs, and housing.

The Transformation of Local Government

The Municipal System

After South Africa's first democratic elections were held, its system of governance changed radically. At the time of change, political parties and analysts agreed that strong provincial governance was critical for effective service delivery. The outcome was constitutionally guaranteed autonomous provincial governance, and municipalities becoming directly

responsible for the provision of services to the urban poor. The wall-to-wall entities created by the Municipal Demarcation Act of 1998, with powers and responsibilities to deliver health services, replaced a mixed-up system of municipal, local, rural, and homeland councils. There are three municipal categories: metropolitan (unicities), district, and local. Several local municipalities make up one district municipality (Nicholson 2001).

This system is expected to increase municipal powers, responsibilities, and accountability. For example, local government now takes responsibility for providing health services. The transformed local governments have greater political status in the attempt to address the empowerment of previously disadvantaged people. However, there is still no solution to long-standing problems, such as lack of adequate finance, capacity, and skilled administrators.

Primary Health Care

The new national devolutionary approach to public health is based on principles of primary health care within a district health system, replacing apartheid's emphasis on a curative biomedical approach using hospital-based care, medicine, and advanced technology. The new approach attempts to employ principles of consultation and local empowerment by giving more power and responsibility to municipalities. Resources must be distributed equitably, meaning that those areas with the least resources should be given the most assistance. Communities should meet their different needs by being involved in the planning, provision, and monitoring of health services. A greater emphasis should be placed on services that help prevent disease and promote good health—a shift away from curative services. Technology must be appropriate to the level of health care; for example, this would mean ensuring that all clinics have refrigerators for the storage of vaccines before equipping them with high-tech facilities. There should be a multisectoral approach to health. In the primary health care approach, the provision of nutrition, education, clean water, and shelter become central to health care delivery. So, for example, the departments of water affairs and education are important role players within the health system (Nicholson 2001:26).

This offers communities a more developmental approach to health, in which they are not merely passive recipients; resources and finances shift away from high-tech tertiary hospitals to primary level services; and specialist doctors would play a more supportive role to nurses in clinics. The development of professional nurses who can manage clinics is key to this system.

Health Delivery: The District Health System

With the demarcation of municipal boundaries completed, the boundaries of the 180 health districts must be aligned with the new municipalities. For the district health system to work effectively, it is important to get the size of the district right. It should be large enough to contain the full range of health services, including a district hospital, but small enough to allow efficient service delivery and community involvement. The urban poor are often migrants, making planning and effective delivery a serious challenge. Many are "squatting" illegally on nonresidential land on which there is no proper provision for sanitation and water. The shifting nature of these communities also makes it difficult to implement the principle of giving them any real say over their own health care.

Challenges in Implementing the System

Financing Local Government

Introducing the new health system is not without its problems, and its integration with the new local government system is by no means complete. Many South African municipalities are in a serious financial crisis. By mid-June 1999 an estimated 633 of the 843 local authorities had debts in excess of R9.3 billion, which, together with serious capacity problems, impacted on their ability to deliver services (*Reconstruct* 1999). Part of the plan for financing local government was that wealthy communities within the new municipalities would finance the development of poorer communities. With a few exceptions, this has rarely worked because of the huge disparities in service provision inherited from apartheid. At the time of this writing, residents in the Ethekwini (Durban) unicity are protesting over massive tax increases imposed without consultation. There are many taxes and service-fee defaulters, and a number of municipalities have suffered from bad financial management. In some of the poorest areas, local government has little chance of raising revenue. It is still not clear how municipalities will be financed, but many may remain dependent on national revenues for some time (Nicholson 2001).

Financing the Primary Health Care System

The reallocation of resources to the primary health care system means that hospitals throughout South Africa have suffered. In July 1999, a provincial

commission of inquiry in Gauteng investigated hospital care practices at several provincial hospitals (Chris Hani Baragwanath, Sebokeng Academic, Natalspruit, and Tembisa) after complaints from both health workers and patients. Financial constraints were identified as the core problem. The commission noted that public hospitals lack capacity and infrastructure for coping with growing demand. Hospital managers cited the provision of free primary health care and treatment of children under five, as well as the demand for abortion, as causes of greater stress on the system. The HIV/AIDS epidemic is also putting undue pressure on available resources for health delivery (SAIRR 2000/2001:237-38).

However, as clinics become better staffed and better equipped, they can begin to take the pressure off the hospitals. A spokesman for the KwaZulu-Natal Department of Health reported that the number of unbooked mothers[1] delivering in hospitals dropped by 80 percent in 2000, and that while maternal mortality rates dropped significantly at clinics, they increased in hospitals, indicating that the referral system is starting to work. Unfortunately, the AIDS epidemic has significantly affected the new system, making it difficult to assess how well it is working (interview with D. McGlew, Director of communications, 2001).

The Relationship between Provincial and Local Government

The devolution of power to local government calls for a clearer distinction between provincial and municipal powers. The powers of provinces in relation to delivering health services are fairly deeply entrenched. The KwaZulu-Natal provincial Department of Health has direct control of 62 hospitals and 500 clinics, all funded and run separately from the unicity and district municipal clinics. The long-term aim is for municipalities to provide all delivery, and for the province to build capacity, monitor the delivery of health services, and provide strategic and policy direction. However, there has been no decision on how to manage the staffing and financial implications of this change; for example, the transfer of health workers becomes complicated, because the provinces and municipalities offer different conditions of service.

The National Government's Shift toward Centralization

One response to a lack of capacity and delivery at the local level has been for the state to take more control over the provinces, a debate within both

party and government that has intensified during Thabo Mbeki's presidency. A recurring feature in the debate on the devolution of provincial powers has been whether national government had given the provinces enough powers to bolster their capacity and ability to deliver. Some argue that provinces act largely as implementing agencies for central government, which sets the direction in health, education, and welfare. This tends to stifle the development of talent and energy at the provincial and local levels, and central government is accused of undermining its own principles of grassroots capacity building and participation (SANGOCO 2001:12-14).

The Role of Traditional Leaders

A major issue during the negotiations preceding the 1994 elections was how to reconcile traditional institutions with the new democratic order. At the local and district level in rural areas the *amakhosi* (traditional leaders) were accorded ex-officio status. However, legislative inertia surrounding the precise roles and functions of traditional authorities has largely reduced constitutional bodies for traditional leaders to ceremonial entities. Traditional leaders have voiced serious concerns about the transformation of local government, mobilizing against the changes expected to follow local government elections in 2000. Some compromises were reached, but the impasse between government and traditional leaders remains.

These difficulties are inherent when transforming to democracy from a hierarchical, authoritarian system of governance. Traditional leaders played a political and administrative role in the former homelands and self-governing territories, and colonial and apartheid legislation conferred on them the standing of local bureaucrats. However, pre-colonial institutions were themselves inherently patriarchal and hierarchical, with leaders claiming inherited rights to rule. It remains to be seen how much support will be given to traditional leaders who resist the new discourse of representative elective, democratic governance.

The Role of Traditional Healers

Traditional healers' holistic and cosmological emphasis on health has played a significant role in resisting the biomedical health model. Widely held and espoused in both rural and urban areas, traditional medicine is pivotal to indigenous social structure and religion. Practitioners are thus highly resistant to change, having maintained individual and social equi-

librium for generations. Traditional healers are an example of Foucault's thesis about the production of knowledge, its relation to power, and the ability to resist alternative forms of knowledge.

In South Africa, biomedical practitioners still tend to scorn traditional medicine, advising people against healers' advice and medicines. Others seem to have reconciled these two systems, however, and recently government has taken significant steps to recognize the contribution of alternative healers toward health delivery for several reasons: first, they are often more accessible; second, they live and work in the community; and, third, although they are not cheap, they are a source of comfort and care for many. On the other hand, some practices, such as sharing razor blades, are clearly dangerous in the context of the HIV/AIDS epidemic, and healers need to be persuaded to change in this regard.

The HIV/AIDS Epidemic

Like most of sub-Saharan Africa, South Africa has been hard hit by HIV/AIDS. The government's responses suggest that HIV/AIDS education programs have paid insufficient attention to the linkage outlined by Foucault between knowledge production, social practice, and ways of being. In spite of concerted education and communication campaigns, the epidemic has not been contained. Sectors of the South African population have either consciously or unconsciously resisted valid biomedical explanations of HIV/AIDS and ways of preventing infection. Local government responses to the epidemic are unsatisfactory, suggesting some kind of resistance to information about the disease. In his HIV/AIDS impact report to the Durban unicity council (*Natal Mercury* 2001), Mr. Bheki Nene noted that the council's responses to the epidemic have been uncoordinated, fragmented, ad hoc, and sectorally focused. Many sectors had only recently responded to the impact of the disease, while others were yet to respond. The report recommended that an AIDS coordinating committee should head the implementation of a council action plan.

Campaigns to overcome this resistance have to employ methodologies that accommodate the participants' belief systems, and which also promote community participation in planning, providing, and monitoring health services. However, Winifred Bikaako (2001) cautions against uncritical use of Western-style participatory principles and practices. External objectives and organizational methodologies often dominate

these methodologies, and do not necessarily increase local autonomy or eliminate dependence. Although traditional "pre-Western" organizational forms, often hierarchical in structure, clearly conflict with group approaches, they remain part of the social reality to be changed.

Conclusion

South Africa's new health system is decentralized, emphasizing primary health care delivered at the district level. The approach is equity driven, to cater to both the urban and rural poor. However, there are challenges to implementing the approach, and provinces and local governments need to cooperate with commitment and integrity for the system to fall into place.

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Notes

1. Unbooked mothers are women who delivered children without any previous record of attending an ante-natal clinic or a hospital.

CHAPTER 11

Health and Urban Governance in Developing Countries: Some Development Issues

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A New Vision of Development

In his brilliant book, *Development as Freedom*, the Nobel-prize economist Amartya Sen explains how, when substantive freedoms connect with one another in an integrated process, a high or improving state of development is the result. Among these important freedoms are not only the freedoms to earn income (and thus be free of the terrible restrictions that go with poverty) and to express oneself politically, but also the freedom to obtain decent education and health care (Sen 1999). In Sen's argument, countries with "support-led" growth (but often low levels of absolute economic wealth), as opposed to countries in which there are high levels of economic growth and wealth (with low levels of public services and supports in terms of health, education, and social security), have good prospects for development. This is because their people have a much higher life expectancy. Indeed, the UNDP "human development" index, which has become an alternative to GDP as a measure of progress for over a decade, explicitly includes a proxy for the quality of health care in its three-item scale (including education, life expectancy, and income). As Gary Becker (another Nobel prize winner in economics) has effectively shown, investments by firms or states in health care for their employees and citizens can have real (and measurable) impacts on productivity, and thus, wealth and development (Becker 1993).

These insights by major, high-profile economists in the area of human capital have helped bring us an approach to development that relates less to quantifiable measures of income and physical investments, and more to a combination of economic and social assets. In one of its most recent

World Development reports, the World Bank stresses the importance of reducing the vulnerability of low-income households in poor countries by strengthening their human capital and social assets; supporting local participation; removing obstacles to economic activity based on gender, ethnicity, race, and social status; and sheltering them from economic shocks, violence, and major dislocations (World Bank 2001:chap. 2). Among the key elements in the Bank's complex recipe for success is the empowerment of the poor, an objective which includes both making state institutions responsive to poor people, and providing for the removal of social barriers. These objectives, at the urban level, involve institutions of *governance*.

The Challenge of Adequate Health Services in African Cities

This emerging vision of the prerequisites for development—a vision based on concepts of human capital, social support, and risk—is particularly relevant for the subject of health care in African cities. First, this vision focuses on the potential for improved productivity among the most vulnerable members of any society, notably the poor (urban and rural), women, minorities, and marginal ethnic and racial groups. In a typical city in sub-Saharan Africa, this range of groups may represent upwards of 50 percent of the population. Given the cumulative features of poverty, marginality, and vulnerability to ecological and political disasters, not to mention the scourge of HIV/AIDS in African cities (where the incidence among the population is many times higher than in rural areas), it seems prudent to consider the assets that the poor *have*, rather than what they do not have. In the "asset vulnerability" approach developed by Caroline Moser, a sociologist formerly working with the World Bank, emphasis is placed on identifying areas such as social and human capital, housing, and social and economic infrastructure that help the poor and vulnerable survive (Moser 1998). Once these assets are identified, they can be strengthened, rather than replaced with completely different structures. The delivery of health care services to the poor, through a variety of methods and approaches, is extremely important to their ability to insert themselves productively in the urban economy. In a way, this approach, for urban development, is similar to the approach to slum upgrading, which

replaced the building of housing estates and sites-and-services schemes several decades ago. The idea is to invest *in situ* as much as possible, rather than attempt through bureaucratic-intensive schemes, to create New Jerusalems in a city. In any case, of all the major continental areas in the developing world, Africa has perhaps been the least successful in launching centrally initiated planning and development schemes in its sprawling cities.

Although it is difficult to measure the effect of health status on economic productivity, recent studies using Latin American data provide some instructive leads. Based on data from a national household survey in Peru in 1995, and using as the major health indicator the number of reported days of illness, Rafael Cortez (2000) shows that poor health is very costly both for individuals and for organizations. Based on his calculations, one less day of reported illness in a month increases the wage rate by 3.4 percent for urban women, and 4.7 percent for urban men. The urban poor are more plagued by ill health than the non-poor, since their access to medical care is not as good, their nutrition is generally more limited, and they work longer hours. Other studies suggest, but do not conclusively demonstrate, that poor health for individuals in informal (rather than formal) employment is a much greater burden, since in informal sector work, other workers are not readily available to provide substitute activities lost to absence. For public policy, efforts to improve urban health care in Latin America—following the human capital model—tend to focus "on community characteristics that can be modified through collective actions. These characteristics include…population density, transportation, sanitation, or access to potable water. They might also include local population traits that affect behaviors and generate externalities, such as education" (Savedoff and Schultz 2000:30).

A second reason why the new, asset enhancement approach to local development is important to Africa is that the existing level of formal services and infrastructure facilities for urban residents is extremely low. Indeed, on an aggregate level, urban services for Africans are the lowest in the world. At the same time, African cities—particularly in Eastern Africa—are among the fastest growing. This picture of very low levels of urban services badly lagging behind rapidly increasing demand can be illustrated by a variety of statistical measures of urban service delivery. Based on a UNCHS database that includes 237 cities all over the world, a

major difference can be seen between the industrialized north and cities in the "developing" areas of the south (Table 1). In terms of water, sewerage, electricity, and telephone connections, the proportion of urban households receiving urban services is much lower in the developing world. By region, however, there is a clear gradation in terms of each of these services from an absolute low in Africa, through Asia and Latin America, to a high level in the industrialized north. The poorest countries (in this case those located in Africa) claim the lowest level of urban services, no matter what the service being measured. A similar gradation of urban service levels—from the lowest in the poorest cities of Africa to the highest in the industrialized north—obtains for virtually all other major urban services: waste disposal, expenditure on roads per person, education, and health services (UNCHS 1999). The introduction to a major recent comparative study of waste management in African cities makes the following observation:

> The rapid rate of uncontrolled and unplanned urbanization in the developing nations of Africa has brought environmental degradation. Indeed, one of the most pressing concerns of urbanization in the developing world, especially in Africa, has been the problem of solid-, liquid-, and toxic-waste management. Recent events in major urban centres in Africa have shown that the problem of waste management has become a monster that has aborted most efforts made by city authorities, state and federal governments, and professionals alike. A visit to any African city today will reveal … heaps of uncontrolled garbage, roadsides littered with refuse, streams blocked with junk, disposal sites constituting a health hazard to residential areas, and inappropriately disposed toxic wastes. (Onibokun 1999:2-3)

In the specific case of health statistics, the UNCHS database shows that African cities lag behind cities in all other regions. Thus, in the 87 cities representing Africa in the database, there are an average of 954 persons per hospital bed, compared to 566 for Asia Pacific (which includes China), 288 for Latin America and the Caribbean, and 132 in the industrialized north. Child mortality (under 5 years) is also higher in African cities, in this case showing at a rate of more than twice the level in the Asia Pacific region (UNCHS1999, Socioeconomic development tables).

Table 1. Percentage of Urban Households Connected to Utility Services by Region

Region	Water Connections	Sewerage Connections	Electricity Connections	Telephone Connections
Africa	37.6%	12.7%	42.4%	11.6%
Asia (Pacific)	63.2%	38.5%	86.1%	26.0%
Latin America and the Caribbean	76.8%	62.5%	91.6%	41.2%
Industrialized	99.4%	97.8%	99.4%	89.1%

Source: UNCHS (1999)

In this instance, the rate in Africa is thirty times higher than that reported for cities in industrialized countries.

One of the main reasons urban services are so minimal in many developing country cities is an acute shortage of local resources. With per-capita revenue figures at such levels as $13.20 in Nairobi, $2.60 in Lagos, $17.10 in Delhi, $27.70 in Dhaka, or $31 in Abidjan, only the most elementary municipal activities and local services can be supported. Latin American revenue figures are somewhat higher—again, depending on the wealth of the country in question—but in rapidly urbanizing countries such as Bolivia (where the revenue per capita in La Paz is $108) or Guatemala (where Guatemala City shows per-capita revenue of $26; UNCHS 1999), services and infrastructure cannot even come close to keeping up with population growth. When services (such as water or electricity) are either partially or fully privatized, the new owners have difficulty in raising rates in order to finance new infrastructural investment. Cities in the north (such as Toronto with $2,087, New York with $5,829, or Amsterdam with $4,559) have a much larger pool of local resources out of which to finance needed infrastructure. Although the individual returns may be somewhat unreliable, the UNCHS survey indicates that in 1993 the average per capita revenue received by municipal governments in Africa was $15.20, in Asia (Pacific) $248.60, in Latin America and the Caribbean $252.20, and in the industrialized world $2,763.30. The ratio between the lowest and the highest region is in the order of 1:182, much higher than that between per-capita income in sub-Saharan Africa and the "high income" countries, where it is 1:51 (World Bank 2000:275).

Policy Directions: A Governance Approach

African cities—particularly those in Eastern Africa—are growing faster than cities in most other parts of the developing world. At the same time, because of basic conditions of poverty, they have almost no resources to deal with a whole variety of services and infrastructure that are virtually taken for granted in cities in more developed regions. Health services are no exception. But if health conditions are not improved, the productivity of African cities will fall even further, to the point where, as the main engines of their economies, these cities will be totally unable to function in the new globalizing world of trade and competition.

What should be the policy response to this dilemma? In much of the rest of the developing world, health services, like primary education, land-use planning, and other services, are being decentralized from the national to the local level. But new institutions of governance have accompanied this decentralization. In Brazil, for example—a country with great extremes of wealth and poverty—the new Constitution (promulgated in 1988) moves primary health care responsibility from the state to the local level. In Brazil, however, a lot of effort has gone into finding the appropriate financial and social support at the municipal level for the administration and coordination of such services. One innovation (described in the Constitution) is the establishment of community "boards" or councils for health, environment, education, and the like. These boards contain representatives of community and non-governmental organization (NGO) groups involved in the issues in question, non-elected professionals, and other activists who are engaged in health, education, and environmental matters. The boards act as close advisers to elected municipal councilors when budgetary and policy issues are being discussed and decided. Somewhat the same story has occurred in the Philippines, a country that passed a far-reaching Local Government Code in 1991. The interesting element in the Philippines case, however, is the extent to which the central government (through the Ministry of Health) had developed relations with NGOs, volunteer health workers, and other community organizations at the local level before devolution was legally mandated in 1991. Once this took place, many of the structures and relationships were in place for the munici-

palities and cities and their local chief executives to formally take responsibility for primary health care. Problems still exist, but the transition from a centralized to a decentralized system did not have to happen overnight (Bautista 1998).

How can or should this devolution take place in Africa? Should larger cities and towns have the responsibility for primary health care and health-related services, rather than central ministries (as is the case in most countries)? One strong argument *against* such devolution is the very weak financial situation of most municipalities in Africa, and their limited ability to manage a complex range of local services. Given the fact that it is politically and economically difficult to privatize primary health services in Africa on a large scale, how can primary health be managed more effectively in the interest of local communities? There are at least two answers to this question.

First, there are undoubtedly many informal ways in which poor and marginal people obtain health services without traversing formal clinics and doctors' offices. These may include traditional medicine, informal purchases of drugs and medications, or just learning through social contacts and family about better nutrition and preventive health practices. Improving people's ability to deal informally with their own and their families' health is as much a question of education and human and social capital as it is of the construction of formal clinics and the hiring of nurses and doctors.

The second point is, following the Brazilian and Philippine examples, that any decentralization or engagement of national ministries at the local level needs to involve local people—both elected and non-elected, both professionals and nonprofessionals—in the dialogue on these questions. This line of reform accords well with our new understanding of "governance," as the relationship between government and civil society and its major stakeholders. The more local people are genuinely involved, the more they will accept jointly agreed solutions to provide taxes and fees for local health services, and the more the quality and incidence of these services will reflect their needs. In the end, the successful delivery of health services is as much a governance question as it is a technical question. How, and how effectively these services are being delivered in Uganda is undoubtedly a very important question for all of us.

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APPENDIX

Agenda—Building Healthy Cities: Improving the Health of Urban Migrants and the Urban Poor in Africa

Kampala, Uganda
July 2-3, 2001

JULY 2

9:30 a.m. **Welcome**
Bazaara Nyangabyaki, Centre for Basic Research

9:45 a.m. **Opening Remarks:**
Minister of Health
USAID Representative

10: 15 a.m. **Objectives of the Meeting**
Samson Opolot, Centre for Basic Research
Gilbert Khadiagala, Woodrow Wilson Center

10:45 a.m. **Panel I: Maternal and Child Health**
Michael White, Brown University
María Elena Ducci, Pontificia Universidad Católica, Chile
Roselyn Nderingo, Green Growth Research & Development, Tanzania
Commentator: Nasarius Assimwe, Makerere University

1:45 p.m. **Panel II: Health Delivery Systems**
Dr. Jessica Jitta, Child Health and Development Centre
Wendy Prosser, independent consultant
Benjamin Nganda, University of Nairobi

JULY 3

9:00 a.m. **Panel III: Migrants' Contributions to Health Systems**

Samson Opolot, Centre for Basic Research
Winnie Kajura-Bikaako, ACORD/Centre for Basic Research
F. Nii-Amoo Dodoo, University of Maryland
Commentator: Dr. Peter Simon Rutabajuka, Centre for Basic Research, Kampala

11:15 a.m. **Panel IV: Health and Urban Governance**

Richard Stren, University of Toronto, Canada
Gilbert Khadiagala, Woodrow Wilson Center
Lynn Dalrymple, University of Natal, Durban
Commentator: Dr. Suzzie Muwanga, Makerere University