Health Exchange

Urban health: a 21st Century crisis

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Rapid urbanisation is leading to major health crises around the world. Many people living in urban slums are unable to access any primary health care services. In emergencies, this situation deteriorates and, with little or no health infrastructure, outbreaks of disease are to be expected. How can humanitarian actors deal with this? Ronak Patel and Fredrick Burkle from the Harvard Humanitarian Initiative, argue that one way is for humanitarian organisations to learn from existing grassroots responses to urban health.

(http://healthexchangenews.files.wordpress.com/2011/06/urbanisation.jpg)
Contradictions of globalisation.
Photo: Viviane Moos/CORBIS

Urbanisation itself is not a problem. Urbanisation is necessary for the wealth and economy of most nations. The problem is the speed and scale of urbanisation. By 2008, 50 percent of the world's population lived in urban settings, a figure originally predicted to happen a decade or more later.

Rapid urbanisation becomes unsustainable when populations expand beyond the capacity of their public health infrastructure. Rapidly growing megacities (over 10 million people), and metacities (urban and former suburban populations) differ in their capacity depending on region, resources, propensity for disaster, population number and density. What they all have in common is their falling ability to protect and maintain the public health of their populations.

Large slum populations now account for over 60 percent of the urban population and in urban slums, basic primary and preventive health care is often non-existent.

Learning from the grassroots in urban settings

There is little representation from the larger and established humanitarian community in urban contexts. However, limiting the humanitarian community's role to responding only after a natural disaster strikes (for example, an earthquake) is misguided. Cholera outbreaks in a public health infrastructure-depleted Haiti should not be a surprise to anyone.

Several successful examples of grassroots solutions could guide humanitarian actors' responses to health in emergency urban contexts. Water and sanitation projects are vital. It is not unusual in urban slums, to walk ten minutes to find one latrine that serves 150-200 people and requires a usage fee. The absence of privacy and security for women allows for rape at epidemic levels. Women and children, the most vulnerable, bare the brunt of these effects – infant mortality, diarrhoeal illness, malnutrition and stunting are all increasing. Incremental slum upgrading has shown success in places like Brazil and India, with improvements to water, sanitation and shelter services. Many projects have developed slum level infrastructure, from communal taps and latrines to household level point of use provision.

The Shack/Slum Dwellers Internationalreports success with self-organising community groups who finance toilet blocks and housing upgrades, and garner the attention and cooperation of previously resistant local governments. Programmes that partner with the local government are the most likely to succeed, because they create buy-in for the planning needed to build appropriate scale infrastructure. A project initiated by the Self-Employed Women's Association in India, with cooperation from the municipal government, used microfinance to help slum communities upgrade their households with piped water, underground sewage, individual toilets, storm-water drains, better lighting and stone paved roads. These initiatives have led to significant health gains, which have allowed all households to repay the microcredit loan, presumably through the savings in lower health costs and increased productivity.

In the favelas of Sao Paulo in Brazil, local governments set up self-help schemes to provide electricity, clean water and permanent housing. Similar programmes in Colombia have begun to address the environmental consequences of rapid urbanisation. Megacities determine their own climate mainly from heat islands that form when urban land coverage is overtaken by asphalt and concrete. This leads to a decrease in sustainable rainfall. Residents in the slums of Colombia have taken advantage of programmes to help fund the creation of green spaces and recreational areas for their communities. This has a positive effect on the environment, social

cohesion and health.

In Dhaka, Bangladesh slum communities have developed their own interventions to mitigate their vulnerability to cyclical flooding with interventions ranging from diversifying their income streams, to structural changes to their dwellings. Programmes in India's megacities have adapted the rural model of community health workers and traditional birth attendants to urban slums, with relatively low-cost female providers making home visits to provide basic health services and education, while circumventing the security risk that many women face when accessing care.

The urban population is dominated by poor and illiterate young people. By 2030, 60 percent will be under the age 18, with rates even higher in slums (WHO 2010). Here employment is limited and youth, poverty and the prevalence of weaponry fuel high crime rates. The Colombian NGO Profamilia targets these youth with outreach and education programmes centered on reproductive health as well as dedicated medical care. Through peer educators, the organisation both empowers local youth to become a transformative force in their communities and deliver health education. This Profamila Joven programme reaches a critical population at a critical time stemming the spread of sexually transmitted diseases including HIV, building social cohesion and inculcating gender equality for greater harmony now and into the future.

Lessons Learned

Humanitarian actors, including large international organisations, can learn from these local successes and must play a role in supporting and initiating similar programmes and policies. Most importantly, there is a significant amount of local knowledge contained within these communities and understanding successful methods of coping, resilience and positive deviance holds a wealth of insight for humanitarian practitioners.

The public health community has learned, through decades of research and practice, how to develop effective interventions for common health problems. Protecting the public health of urban populations will require operational research to turn these interventions into effective programmes. As the above programmes show, strategic planning and partnerships with local policy-makers are the best way to ensure sustainable and scalable interventions rather than one-off projects. The human capital contained within these environments is enormous and the most successful and innovative programmes have taken advantage of this resource by empowering slum-dwellers. Slum dwellers can participate in projects and research and become agents of change themselves. Community members that adapt new interventions to suit their own needs can become role models for the rest of the community.

The Overseas Development Institute has begun to consolidate the knowledge base of larger humanitarian organisations working in urban settings. The Inter-Agency Standing Committee Urban Task Force on Meet Humanitarian Challenges in Urban Areas (MCHUA) has been working to identify gaps in knowledge. Finally, several large NGO's have launched inter-organisational working groups to share experience and knowledge. The humanitarian

community needs to pay more attention to the crisis developing in urban areas. Evidence-based, long-term strategies and sustainable programmes and projects are the way forward, informed by learning from the effective grassroots efforts already taking place is critical.

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