BUILDING HEALTHY CITIES

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

Comparative Urban Studies Project

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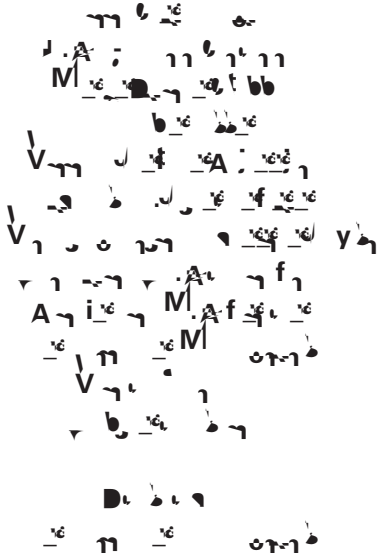

Cover Photograph: Mothers and Children at a Health Clinic, Kampala, Uganda

WOODROW WILSON INTERNATIONAL CENTER FOR SCHOLARS
LEE H. HAMILTON, DIRECTOR

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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 interna-

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

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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, Mar a Elena Ducci's paper on Chile provides us with a success story. Despite being a develop-

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

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

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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,

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 wi388[(aF4)s wTrxJT uitevp(the)03EaTJrirte 0

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.

"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 employ-

"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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CHAPTER 2

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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 communiti g lev9-29adgniticia9(r)29lti omm ann

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 D

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

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.

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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 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

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Pontificia Universidad Cat. lica, Chile

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	21 9T55 194.112 mApro					

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-

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).

María Elena Ducci

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

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 (Clasificaci„n 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 Promoci. ,n 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 2 1 Tf-s5

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PART II

HEALTH DELIVERY SYSTEMS

CHAPTER 4

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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 inade-
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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

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

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

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

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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	4418580			

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.

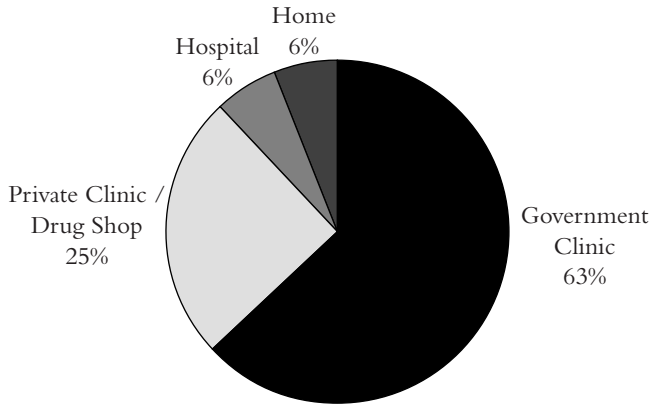
Table 4. Health Facilities by Ownership in Kampala District

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

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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 (Men dez 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

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 inhabit-

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 S

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

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
	Type of Facility and Usage by Population Density								
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.

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

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 nt volual posictu

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

Equally frustrated and desperately poor individuals peddle illicit alcohol

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

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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 1998:192a mon3abilitils397(skillS306(wies of(anmmedand social Mujinj

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 land-

Wendy Prosser

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.

> 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

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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,

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

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

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

> 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 peri0.teug the colp scalingsye b uit

> 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).

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.

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

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, nongovern-

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CHAPTER 8

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The contribution of the urban migrant population to the health

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

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

(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.

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 . . . per-

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 services,trvernme

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).

ment policies and processes and their consequent development programs.

PART IV

THE ROLE OF URBAN GOVERNANCE

CHAPTER 9

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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.

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

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

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 GTJT arsmsix

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 (MohT:spect-0.0003 Tcy.012

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 decentral-

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).

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

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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CHAPTER 11

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RICHAR

Richard Stren

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

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 th

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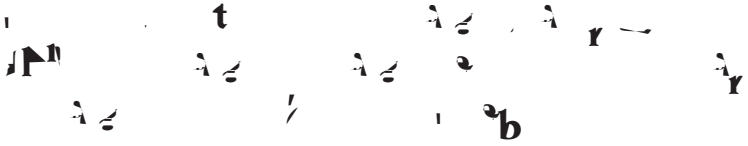

Kampala, Uganda
July 2-3, 2001

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
Mar a Elena Ducci, Pontificia Universidad Cat. lica, 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