Health care for urban poor falls through the gap

While governments and donors focus on health care for those living in rural poverty in developing countries, the residents of the world's slums are being neglected, writes Priya Shetty.

The slums of Mumbai and the favelas of Rio de Janeiro are images of urban poverty so extreme that they are indelibly stamped on the identity of those cities. But urban poverty now goes far beyond these notorious icons.

The world is becoming more urbanised overall (figure). 2008 was a demographic turning point—for the first time, according to the UN Population Fund (UNFPA), more people lived in urban areas than in rural ones. Yet these new urbanites, especially in developing countries, are overwhelming cities that were never designed to have so many inhabitants, and therefore simply do not have the infrastructure to cope.

These people struggle on a daily basis with poor housing, a lack of basic services such as electricity and water, and extreme overcrowding that often leads to infectious disease epidemics. They do not have the capacity to afford health care that wealthy city dwellers access but neither do they benefit from health programmes run by non-governmental organisations (NGOs) or governments in the way that rural areas do. In short, they fall through the cracks, living in the hinterlands of health care.

Developing nations and foreign donors have ignored the problem to an extraordinary degree. Governments such as China and Vietnam have responded to growing urbanisation by instituting draconian measures to stop migration from villages to cities. Donors, meanwhile, have continued to focus on the rural poor, in part because these populations are easier to target through vertical health programmes.

But the problem of extreme urban poverty is becoming harder to wish away. The UN says that most of the world's future population growth will be in cities in low-income and middle-income countries. Asia and Africa are projected to double their urban populations from 1·7 billion in 2000 to 3·4 billion in 2030, according to the 2007 UNFPA report: *State of the world's population: unleashing the potential of urban growth*.

The urban poor rarely fare better than their rural counterparts when it comes to health. Infant mortality and childhood vaccination rates are about the same in both populations. If anything, the health of the urban poor can be even worse than that of rural populations. According to the Urban Health Resource Centre in India, slum children are even more likely than rural children to be malnourished. Overcrowding makes outbreaks of respiratory diseases such as tuberculosis much more likely. For instance, in impoverished parts of the city of Karachi in Pakistan, tuberculosis prevalence is twice the national average. Running water and sewage systems are non-existent in most slums. WHO says that in urban areas, almost 137 million people have no access to safe drinking water, and more than 600 million do not have adequate sanitation.

> **"...1 billion Indian babies are born in slums every year with little or no medical assistance."**

Even though the health needs of the urban poor are high, they have virtually no access to health care. This is partly because of the "ineffective outreach and weak referral system of the urban public health system", says Indrajit Hazarika, senior lecturer at the Indian Institute of Public Health, Delhi. "Social exclusion and lack of information and assistance restricts the use of private facilities by poor people. More importantly, lack of economic resources inhibits the use of private facilities. These make the urban poor more vulnerable and worse off than their rural counterparts."

One main reason for the lack of access to health care is that slum populations are not considered to be a part of urban society. Since slums are usually illegal structures, local governments tend not to acknowledge their existence except when they are demolishing them, and no money is invested in counting or mapping. This situation means that the inhabitants of slums are unable to get social benefits such as subsidised health care. Women's health is especially neglected—1 billion Indian babies are born in slums every year with little or no medical assistance.

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Mapping the urban poor is also challenging because slums are still largely undefined. After analysing USAID's Demographic Health Survey, Anthony Kolb, urban health adviser at USAID, found that the definition of a slum is fairly nebulous. Hazarika agrees. In hugely overcrowded cities such as Mumbai, for instance, where housing is some of the most costly in the world, living in decrepit, "slumlike" housing does not always connote extreme poverty or disadvantage, he says.

The use of aggregate data on health indicators also complicates the issue because the disparity between the health needs and access to care between poor and rich people can be extreme. "To get beyond that

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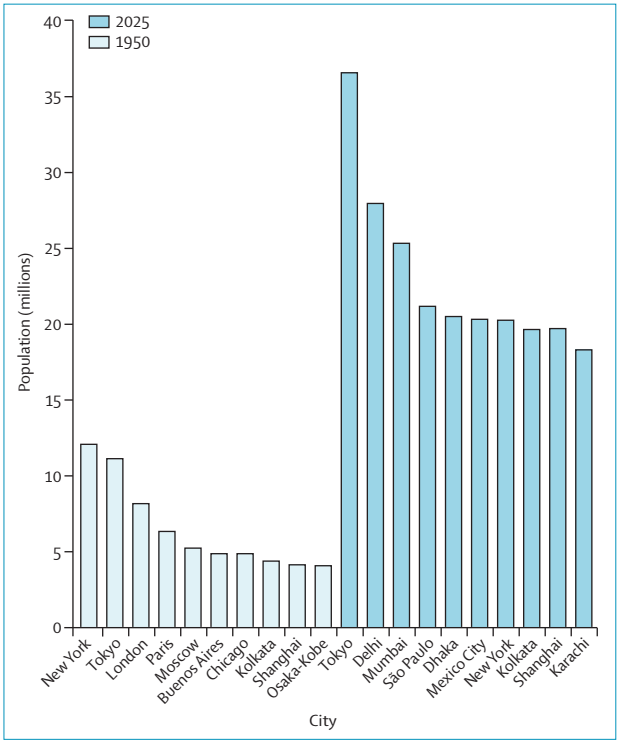

***Figure*: Top ten cities with the largest populations in 1950 compared with those projected for 2025**
Source: UN Department of Economic and Social Affairs.

simplistic analysis one must use a combination of sample survey information that considers a wealth measure, and use creative mapping techniques to describe the often interesting geographic aspects of urban poverty, eg, slum mapping", Kolb tells *The Lancet*.

Some developing countries are now starting to realise the urgency of this problem. In Bangladesh, for instance, government agencies are using mapping technologies to identify the distribution of slums across cities.

Progress is extremely slow and halting, however. For instance, the Indian Government set up the National Rural Health Mission in 2005 to prevent and treat disease in rural areas, and, some experts say, to make rural life easier so that people would not migrate into cities. The country was due to launch a National Urban Health Mission, but last year this plan was shelved indeterminately. In theory, the two missions will now be combined, and a joint National Health Mission launched, but this will not happen until after 2012.

When developing governments do finally engage with this issue, they will face two major challenges: the best way to improve housing, and the most effective way to increase access to health care. Upgrading existing slums can be difficult. Often, they are tightly and haphazardly clustered together, so putting in electricity lines or water pipes is almost impossible. Yet relocating residents is not straightforward either because some slum communities have existed for years which gives their inhabitants a sense of "identity and belonging and community ties", says Peter Williams, founder of Archive, an NGO that works on the link between housing and health. Archive tends to favour upgrading, but Williams says that often, those in political and economic power push hard for relocation when communities occupy land that has a high commercial value.

The challenge of providing health care is enormous, and the best way to go about it is contentious. Given that slum communities are at constant risk of eviction and relocation, providing a continuous health service can be problematic. When slum populations are growing so fast, it is not economically feasible to provide handouts, nor could any government ever build enough hospitals to service these populations, says Williams. In any case, he points out, there is an inherent futility to giving someone a course of tuberculosis drugs then sending them right back to the terrible housing conditions that puts them at constant risk of reinfection. Instead, Williams advocates training up local community health workers who can travel in the slums to provide basic health care and education.

Meanwhile, Hazarika says that "mere provision for home-based or facility-based care is unlikely to solve the problem. An important intermediate step would be to bring poor people under a social security net, to provide financial assistance and facilitate their access to health services." USAID consultant Anthony Kolb agrees. Urban life is typically much more cash dependent than rural life. "As a result", he says, "addressing the affordability of health care access in urban areas is typically a much higher priority or more appropriate approach than focusing on physical accessibility".

Health policy makers clearly have major challenges ahead, and will need to work extremely closely with departments of housing and education, for example, if they are to make any headway. But there needs to be a major shift in policy makers' attitudes to urbanisation, says George Martine, author of the 2007 UNFPA report, and now an independent consultant on urbanisation. A recent UN survey showed that policy makers are still futilely trying to obstruct urbanisation, says Martine. Since urbanisation is inevitable, he says, urban planners and policy makers must be prepared to radically rethink the existing infrastructure.

One obvious reason is that advanced planning will be cheaper and easier than dealing with the situation in a few decades time. Martine warns that the failure to plan properly for urban expansion can be catastrophic. Extreme poverty, scarce resources, and social exclusion are often the factors that have fuelled the violence, gang warfare, and drug trafficking that have characterised slums and ghettos in Latin America, says Martine, who is based in Brazil. Although the high rates of urbanisation in Latin America, and Brazil in particular, has led to rapid economic growth, it has left a troubling legacy of social dystopia in many cities where the urban poor are subject to inequity in all aspects of life. Martine warns that "unless African and Asian countries, who are at the beginning of their urban transition, take a more proactive stance [to urban development], this could very easily become part of their future problems".

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