URBANIZATION AND PRIMARY HEALTH CARE (With special reference to the situation in African countries)

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Introduction

Ladies and gentlemen, I would firstly like to warmly thank you for inviting me to be a speaker at your workshop. I would also like to take this opportunity of thanking OXFAM UK for generously supporting my visit here.

Urbanization is one of the most important future developments which will have repercussions upon health. The most important development trend in developing countries at the present time is the rapidly growing number of people living in cities. That includes African cities.

In discussing urbanization and primary health care with special reference to Africa I want to ask three questions. Firstly, what do we know about urbanization in Africa ? Secondly, what do we know about the health of the urban poor - those who live in slum, squatter settlements and shanty towns ? And finally, what do we know about urban primary health care ?

What do we know about urbanization in Africa ?

Although less urbanized than Asia and Latin America, Sub-Saharan Africa, apart from Pacific Islands, is projected to have the largest percentage increase in urban population during the quarter century starting 1975. Africa's urban population will nearly double from 136 million to 361 million people by the turn of the century. By that time 43 percent of Africa's people will live in cities. This is compared to just 6 percent in 1930, and 30 percent in 1980. Although Africa is the world's least urbanized region, it has the world's most rapid urbanization rate. Urban population growth averaged more than 5 percent in the 1970 and is expected to continue at that pace for the remainder of the century, with cities like Lagos growing at 14 percent per year and Maputo, 8 percent per year.

The giant cities expected in Africa by the year 2000 will be Cairo with 13 million people, Kinshasa with 8 million and Addis Ababa, Nairobi, Lagos, and Jos with aroud 5 million. However, some caveats should be given when discussing urbanization. Different countries use different definitions of what is urban, and extrapolations are often from old data. For example, extrapolations from the last Nigerian census of 1963 show Lagos to have a population of 1.2 million in 1980 while U.N. revised figures suggest 2.8 million and recent national demographic household surveys point to a figure between 4 and 5 million. However, the general trend and implications are not doubted.

Another point to note is that natural increase within the city often is an equally important cause of urbanization as is in-migration from rural areas. Although I do not want to go into a discussion of the causes of urbanization, it is interesting to note that in global terms 61 percent of urbanization is due to natural increase within the cities and only 39 percent from in-migration.

The most important outcome of this urbanization is the growth in numbers of the urban poor. In most East African cities, for example, the proportion living in poverty in the slums and squatter settlements is estimated at between 30 and 40 percent and is growing. In 1981, Addis Ababa had the doubtful privilege of containing the highest proportion (79%) of slums and squatters to city population anywhere in the world. These populations live in crowded, unsanitary conditions which lead to health problems.

What do we know about the health problems of the urban poor ?

We know that the urban poor have a wide range of health problems. It has been suggested that :

The urban poor are at the interface between underdevelopment and industrialization and their disease patterns reflect the problems of both. From the first they carry a heavy burden of infectious diseases and malnutrition, while from the second they suffer the typical spectrum of chronic and social diseases (Rossi-Espagnet of the World Health Organization).

In other words the urban poor get the worst of both worlds. However, trying to obtain good data on the health status of the urban poor is difficult. City health statistics usually tend to look much better than rural ones. This is often either because the slum or squatter inhabitants do not appear in the statistics (they are often not official residents of the city in many cases), or because their inclusion is obscured by the enormous difference that exists between their status and that of the middle and high income groups in the city. Thus, a very misleading average becomes the basis of that city's statistics. Properly compiled and disaggregated information reveals a quite different and more truthful picture. There is an urgent need for good disaggregated data which points to intra- urban differentials and also for studies which pin point at risk groups within low-income urban groups.

During the last two years I have been searching for such data and have reviewed the

results in various publications. In summary it is possible to categorize the health problems of the urban poor into those which are a direct result of poverty, those which can be called psycho-social problems and those which are associated with the environment (see figure 1).

The dream : health in the city

Poverty

Direct problems of poverty	*Environmental problems*	*Psycho-social problems*
Unemployment	Inadequate water &	Stress
Low income	sanitation	Alienation
Limited education	Overcrowding	Instability
↓	Poor housing	Insecurity
Inadequate diet	Lack of land to grow food	↓
Lack of breast feeding	Lack of rubbish disposal	Depression
Prostitution	Traffic	Smoking
	Hazardous industries	Alcoholism
	↓	Abandoned children
	Infectious diseases	
	Pollution	
	Accidents	
	Consumption of junk foods	

Figure 1 - For many, poverty forms a barrier to the dream of a health life in the city

Some of these health problems are not found in rural areas while others like malnutrition, for example, are often worse in poor urban areas than in rural areas. Studies which address comparisons between the health of urban poor and rural populations have usually found that there were more severely malnourished children in low income urban than in rural populations. The reasons for this are complex. Many rural families, especially in Africa, own a small piece of land where they can grow part of their food, or where harvest surpluses are available. This is generally not possible for the poor in the overcrowded cities. In the cities, although salaries are higher, so also are costs, with the result that the poor have a smaller proportion of their income for food. Furthermore, in the highly competitive situation of the city, women often work full or part-time, usually in the informal sector, to complement the family income or as the only family support. Under such circumstances women many typically have less time for food preparation and they may resort to early unhygienic weaning. They may have to leave their infants in the custody of young children unable to prepare weaning food properly. They may have to dilute and divide a limited milk supply among many and many fall easy prey to advertisements for breast milk substitutes. Most of the health problems of the urban poor are a result of poverty. And most of them cannot be solved by specialized high-tech medicine but by primary health care as outlined at Alma Ata in 1978.

What do we know about urban primary health care ?

Most policies, programmes and litterature relating to primary health care (PHC) are based on a rural epidemiology, a rural social structure and a rural administrative framework. We are only slowly learning about the issues that need to be considered in urban primary health care. They include :

• The fact that urban poor populations are often very mobile and hetergeneous. What defines a community in these circumstances ? Successful urban PHC programmes have often used a functional definition of community rather than a spatial definition eg. based on workers, religion, social activities, women's groups etc. What mechanisms are needed to activate poor urban communities ?

• The fact that the urban poor are already dependent upon sophisticated, curative health services through the hospitals, private practitioners and pharmacists. This makes it difficult for community health workers, who emphasize preventive health care, to achieve credibility. PHC is often perceived as second-class care for second-class citizens.

• The fact that urban community health workers (CHWs) often drop out because they are living in a cash economy and cannot afford to do voluntary work. With no land to tend how do you pay urban CHWs in kind ?

• The fact that lack of land tenure security makes most urban poor populations reluctant to begin environmental improvements.

• The fact that the poorest of the poor are particularly difficult to reach in the city. The landless, homeless, jobless and street children must be the main beneficiaries of PHC.

• The fact that the multitude of agencies at work in the urban environment makes inter-sectoral action a priority objective. Often the municipality or town council has provided an inter-sectoral forum into which other ministries (health, sanitation, social work, housing, education, etc.) can make inputs.

We now have a wide range of case studies which have been collected with the initiative of institutions like UNICEF, WHO, OXFAM UK and the London School of Hygiene and Tropical Medicine which illustrate the above issues. There is also a growing network of people involved in urban PHC which is serviced by a quarterly newsletter called URBIS (this is financed by OXFAM UK). At the moment people are often raising more questions than answers about urban PHC. This is welcome sign that urban PHC is being recognised as a subject which needs to be tackled right now. I hope that the questions and answers produced at this workshop will usefully feed into urban primary health care policy in Dakar and other African cities.