

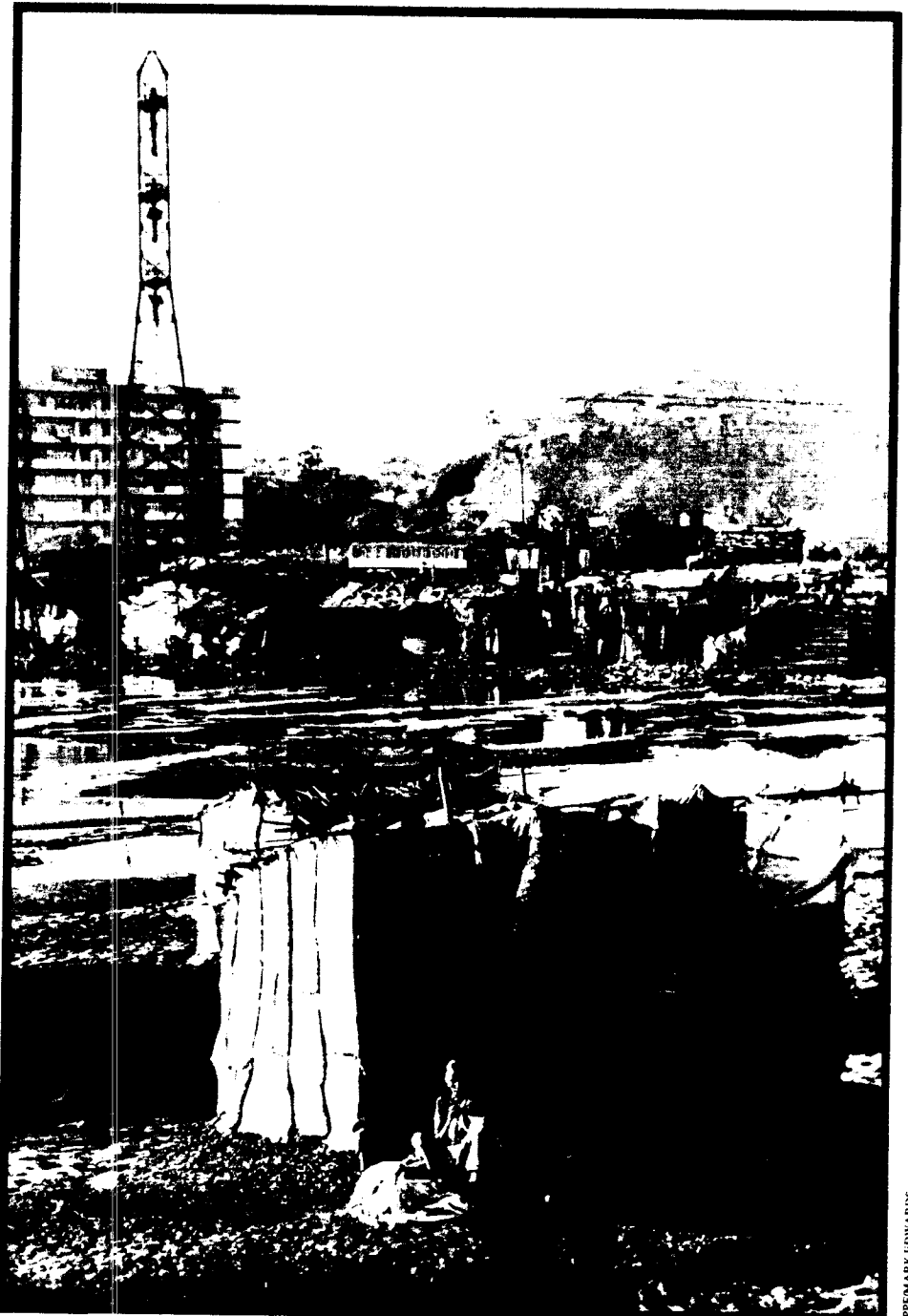
Health and habitat: the urban dimension

While the number of people living in cities is on the increase and the proportion of those living in slums and shanty towns in developing countries is already between 30 and 60 per cent, preventive health care and family planning for the urban poor is frequently neglected. Here, John Briscoe and Michael Porter, both World Bank specialists, urge a more comprehensive approach which links fertility concerns with other social and environmental improvements.

In one unheated room three metres by five, with only a bed and a meagre selection of cooking utensils, a couple struggle to bring up their five children. They eke out pitiful supplies of contaminated water bought at exorbitant prices from water vendors and dump their waste, water and garbage outside the door of their shack. All the family defecates on any convenient patch of ground nearby. This is how millions live in the urban slums of the developing world.

The numbers living under such conditions is rising rapidly. Although in 1975 only one out of six people lived in urban areas, by the year 2000 half the world's people will live in cities. Of the urban dwellers in developing countries, large numbers – between 30 per cent and 60 per cent – live in slums, with the proportion rising rapidly.

Poor city dwellers have to face both the traditional health problems as well as newer hazards. First, because their diets are poor and they live in overcrowded, unsanitary conditions, they suffer high rates of malnutrition and infectious diseases – particularly diarrhoeal and respiratory infections. Second, because they are also exposed to the worst environmental conditions and stresses associated with industrialization, they are also beginning to suffer from higher rates of such chronic diseases as cardiovascular com-



A shanty settlement in Bombay, bypassed by main services and surrounded by stagnant water.

plaints and cancer.

Considering the size of these populations, remarkably little systematic data is available on the health of poor urban people. Though data

from most developing countries shows that health in the cities is better than health in the countryside, it is slowly being recognized that city averages give little insight into the health of slum dwellers. This is either because their situation is masked by the superior health status of middle and upper-income groups. Haiti is representative

IPPEMARK EDWARDS



WENDY WALLACE

Migrating to escape drought, squatters settled on this barren land outside Omdurman, Sudan, where fuel and water have to be fetched from afar.

of many such countries. In the slums of Port au Prince more than 20 per cent of children die before their first birthday, a mortality rate twice that of Haitians living in rural areas and several times higher than the rate for rich urban dwellers.

How can the health of the urban poor be improved? Improving health services in low-income areas is one obvious necessity. The emphasis on primary health care over the past decade has largely missed the urban poor and only recently has attention

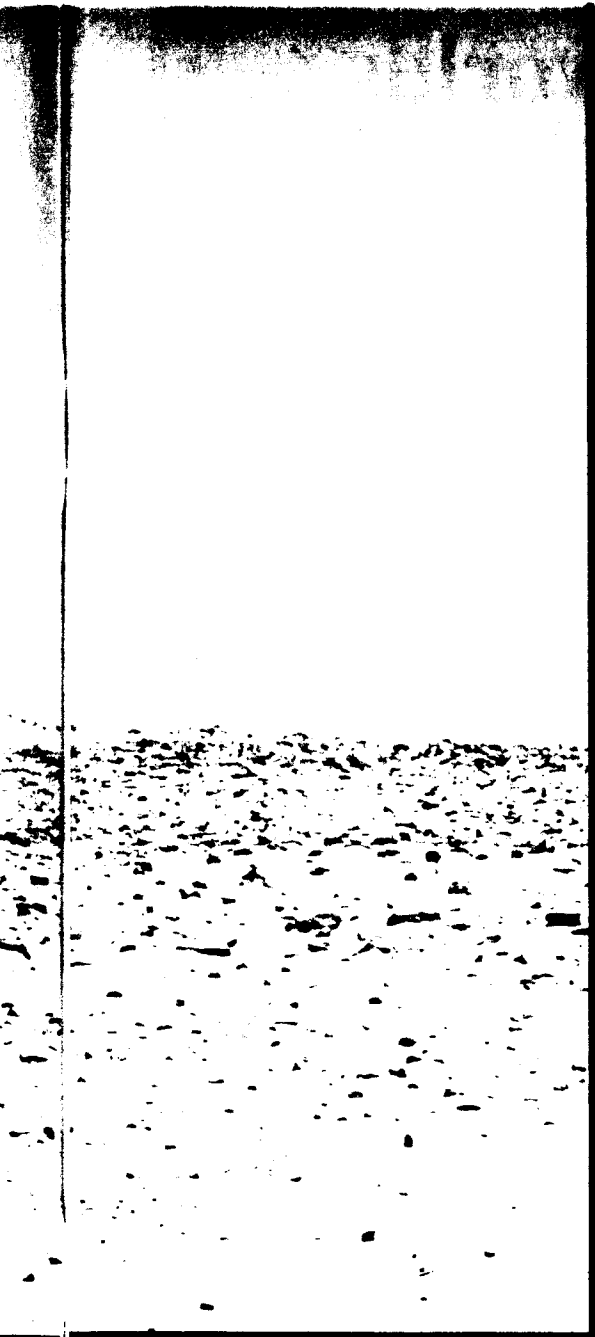
been directed to their plight. As health service resources located in cities have expanded there appears to have been a mistaken assumption that all urban health needs have been met. However, efforts have started to extend the basic health services to slum dwellers. With the rich resources available in cities, it is now a question of mobilizing the efforts of governments, the private sector and the community itself, to overcome the inadequacies in health services for the urban poor.

Important as such improvements are, however, the contribution of modern medical services to overcoming poor environmental conditions is limited. To find an answer it is appropriate to recall how the first

industrial cities met their problems.

In 19th century Europe, because of inadequate housing, ventilation, water supply, sewerage and drainage, life expectancy was much lower in cities than in the country. The decline in mortality rates in the late 19th and early 20th centuries owed relatively little to medical practice and discoveries. The great social reformers saw the root causes of ill health in the environmental conditions under which people lived. As a result, improvements in housing, water supply, excreta disposal, drainage and air quality became the sine qua non for improving health in cities.

Since these achievements, concerns with social epidemiology have become



sanitation services are improved. Only recently have broader-ranging investigations of the effect of housing quality on health been undertaken. Well-conducted studies in low-income areas of two Middle Eastern cities show that improved dwelling quality is strongly associated with reduced mortality.

However, many critical questions concerning the relative impact of components of urban improvement programmes on health remain unanswered. For instance, it remains a matter of conjecture, from a health perspective, what level of investment is required in water and sanitation to gain a benefit – is it a high level or will a more modest investment gain the same objective?

Current high rates of urban growth, unparalleled in human history, adversely affect all aspects of urban development and health, creating demands for houses, jobs and amenities beyond immediate solution. About half of this rapid urban growth stems from natural increase and this proportion is increasing, ensuring that urbanization will continue at a rapid rate even if migration to the cities decreases. Whatever their origin, the cost of accommodating these new urban dwellers is very high – in Bombay, for example, the per capita cost of providing basic living conditions is estimated to be \$2,000. Even modest reductions in population growth will have a significant impact on the capital investment necessary for better living conditions and health.

Acceptance of family planning by the urban populace is a matter of crucial concern and programmes promoting family planning have to form part of overall urban development. Like mortality rates, fertility and contraceptive prevalence rates (CPR) are consistently better in urban as compared with rural areas, as a result of higher incomes and female literacy rates, easier access to contraception and the effects of modernization. However, the spread between urban and rural rates varies widely between countries. In Indonesia urban prevalence rates are barely better than those in rural areas, while in Nepal the urban rate is 39 per cent compared with 3 per cent in the countryside. Continuation rates of effective contraception are also higher in cities, but surprisingly, the overall use of inefficient methods of contraception show no urban/rural differential, although there are wide variations between countries.

tion may be higher in urban areas, it has become apparent that there are different levels of contraceptive acceptance in different sections of the urban community. The problem encountered as a result of the aggregation of health data also applies to family planning data, masking the need to focus on the low-income sections of the city, where contraceptive acceptance is generally lower.

Unfortunately, little data is available which deals with intra-community differences, and it is not always consistent. Slum areas of Rio de Janeiro have surprisingly high levels of effective contraceptive use, while in Bombay with an overall CPR of about 42 per cent, some slum areas have a rate as low as 14 per cent. High parity and low contraceptive use take their toll in poor maternal and child health. Strengthening family planning and maternal and child health programmes in urban low-income areas is an urgent priority.

The task ahead is daunting. A start has been made, but much more has yet to be done. The plight of the slum dwellers in developing countries is poorly understood and requires more information about their attitudes, priorities, and health and family planning practices.

Despite fragmentary information, experience in how to deal with poor urban communities is accumulating. But what is missing is the sense of urgency and an awareness of the scale of change currently being experienced. This is particularly acute in the health and population field where the focus for the past two decades has been rural, while the major demographic trend of our time has occurred relatively unnoticed.

Action is needed, a scaling up from isolated initiatives to a more comprehensive programme linking health and fertility concerns with those of providing more houses, water, sanitation, jobs and education. More insight into their inter-relationships is essential to derive better solutions. It is a daunting task – one requiring information, understanding, resource commitment but perhaps most of all imagination, flair and leadership.

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largely superseded by a narrower, biomedical perception of disease etiology. As a result, our understanding of the relationship between habitat and health remains partial and often contradictory. As human numbers accelerate beyond anything imaginable in the last century and difficult investment decisions have to be faced, the subject of the relationship between environment and health has re-emerged as a critical issue.

The most intensively studied component of the habitat-health relationship is that of the effect of water supply and sanitation services on diarrhoeal diseases. A review of this literature confirms a broad and usually substantial beneficial effect on mor-