

## C4 Urbanisation

More than half of the world's population now live in urban areas. At the end of the nineteenth century less than 3 per cent of the world's population lived in towns and cities (Weber 2007), and in 1950 Africa and Asia were still almost wholly rural. The pace of urbanisation in the past twenty years has been especially high in the poor regions of the world where the growth of informal settlements has brought with it attendant problems of environmental health (UN Habitat 2006). These informal settlements, generally called 'slums'<sup>1</sup> in UN literature, are characterised by poverty and precarious living and working conditions (Kjellstrom et al. 2007). In a context of intensely competitive demand for land in cities, the residents of these settlements often have little or no claim on city or national governments.

Three associated trends are worth noting. First, the cities of developing countries will absorb 95 per cent of all urban growth over the next two decades, and by 2030 will be home to almost 4 billion people, or 80 per cent of the world's urban population. Second is the increased urban–urban migration and the reclassification of many rural areas to urban,<sup>2</sup> both of which contribute to the urbanisation in Africa, Asia and Latin America. Third is the seemingly contradictory trend of, on the one hand, the increasing number of 'metacities' and 'megacities', with conurbations of over 20 and 10 million people respectively, and, on the other hand, the population growth of medium-sized cities, of fewer than 500,000 inhabitants.<sup>3</sup> Already more than half of the world's urban population live in cities of fewer than 500,000 inhabitants and almost one-fifth live in cities of between 1 and 5 million inhabitants (UN Habitat 2006).

The above trends are significant in understanding the phenomenon of urbanisation, even though countries employ different definitions of 'urban'

IMAGE C4.1 **Rio**

which may also change over time (Satterthwaite 2006; Vlahov et al. 2007). Many question the very concept of a rural–urban divide, noting that ‘village communities’ exist within cities and that urban societies exist in rural areas (Pacione 2005; Pahl 1965).

This chapter examines the associated health and environmental problems caused by the rapid growth of cities and the challenges of rapid urbanisation, including urban poverty and the attendant growing inequities now seen within as well as between many cities of the world.

### **Understanding the nature and context of urbanisation**

The current nature of urbanisation can only be understood within the macro-political and social contexts of individual countries and overall global trends. For example, what are *the process and causes* of urbanisation, particularly with reference to the political economy and the impact of capitalism on rural areas?

First, the most important driving factor of global urbanisation is natural population growth in existing urban settings. However, rural-to-urban migration is an important factor in some contexts. As described in Chapter

C3, agricultural sector policies in Asia and Africa which have reinforced colonial patterns of agricultural production and stimulated the growth of export-oriented crops at the expense of food crops have dramatically increased rural poverty. This process also takes place in Latin America, in particular in Brazil. Moreover, in Asian countries the Green Revolution plays a role. Deforestation, mining and hydroelectric projects have also contributed to landlessness and the forced displacement of millions of people, leading to even deeper levels of rural poverty. Consequently, people have been pushed from rural areas and pulled into cities, in search of better sources of livelihood.

The poverty of recent migrants is aggravated by the losses of subsistence farming opportunities and the supportive kinship ties that exist in rural areas. Migrants are particularly affected by social and economic exclusion and often have no access to health care, education or decision-making.

Changes brought about by economic globalisation include the weakened ability of governments and nation-states either to influence or to control the external forces that impact on local economic and health development. Many cities are drawn into the dominant chain of global economic activity and have become focal points for foreign direct investment, while productive capacity is often restricted to a limited number of cities. 'Global' cities such as Bangalore and Johannesburg combine rapid economic growth – which benefits an affluent minority – with rapid urbanisation of poverty, environmental degradation and a weakened social fabric.

An accompanying change is the accelerated *informalisation* of the urban economy, coupled with *de-industrialisation* (UN Habitat 2004), leading to increasing underemployment (ILO 2005).<sup>4</sup>

These social and economic changes affect workers, but also impact on the governance of cities, as public authorities are unable to obtain the revenues required to provide public services. Also worth noting is the weakening of national and local public institutions, relative to the arrival of powerful multinational, external private-sector companies, following the advent of neoliberal policies in the 1980s and 1990s.

Other new challenges posed to the global community are the effects of migration and industrialisation, notably due to climate change and several aspects of environmental degradation. Security analysts fear that the tidal wave of forced migration will not only fuel existing conflicts, but create new ones in some of the poorest and most deprived parts of the world. Furthermore, as noted in Chapter B3, most of these refugees will become internally displaced peoples who will end up in the informal settlements and 'slums' of cities and remain largely invisible to the people of the rich world.

### The health implications of urbanisation

In a context of limited financial resources and weak institutional capacity, urban services and infrastructure development have not kept pace with urban population growth in many cities of developing countries. Public institutions have failed to anticipate, adapt and manage urbanisation and its impact on population health, and an increasing proportion of people are expected to be without adequate housing, water supply, drainage and sanitation facilities (see Chapter C5). Furthermore, information systems in many least developed countries often do not capture the living conditions, environment and health status of populations living in unplanned and informal urban settlements and these remain outside official government records.

Disaggregated data reveal urban informal settlements as areas of concentrated disadvantage. When data are not disaggregated and one standard is applied across urban and rural divides, the peculiar situation and needs of the urban poor are hidden. But where disaggregated data exist, they reveal startlingly high intra-urban inequalities related to socio-economic status and living conditions. One study of twenty-three countries highlighted that inequalities are generally greater within urban areas when compared with rural areas, except in countries where rural economies are structured around plantation agriculture (Mitlin 2003).

Urban dwellers who live in these settlements contend with three groups of factors which combine to keep them perpetually at health risk. First are the direct effects of poverty: low income, limited education and unequal access to food. Second are man-made conditions of the living environment: poor housing, overcrowding, pollution and increased exposure to infectious diseases. In informal settlements, the ratio of population to water and sanitation facilities, if available, is quite high. Even the minimum standard of one standing tap to 200 persons proves highly inadequate. Third are social and psychological problems due to the lack of social support systems, urban violence and the impact of social exclusion.

The urbanisation and feminisation of poverty have a direct bearing on the progress and well-being of women and girls. An additional concern is meeting the challenges of physical and psychological development faced by adolescent boys and girls in informal settlements (see Box C4.1). These manifest in unwanted pregnancies, sexually transmitted diseases, illegal and unsafe abortion, sexual exploitation, early marriages, malnutrition, drugs, substance abuse, violence and trauma. Youth violence is one of the most severe public health problems in many cities of the world and it could be an even more important burden of health in the future. In Cali, Colombia,

**BOX C4.1 Health risk of street children**

Tanzania is one of the countries with the highest number of urban street children. According to recent estimates there are 3,000 street children in Dar es Salaam. Most come from rural areas and have either left or been abandoned by their families. Living on or off the street is a survival strategy for children orphaned by AIDS when their family or community cannot support them. A study into the effects of street life on children's health showed that the unhealthy urban environment has a major impact (Lugalla and Mbwambo 1999). While boys can find some casual work in the informal sector, girls often end up as commercial sex workers and face a much greater risk of becoming HIV-infected. In Mwanza, 80 per cent of the street girls had suffered an STI at least once, compared with 30 per cent of the boys (Rajani and Kudrati 1996; Williams 2007).

homicide rates of up to 200 per 100,000 inhabitants have been recorded in the most deprived neighbourhoods (Rodriguez 2006).

Climate change is expected to affect, in particular, cities in developing countries; within those settings, the urban poor are most at risk (Campbell-Landrum and Corvalan 2007).

**A critical review of the Healthy Cities initiative**

Addressing the health needs and increasing health inequities of urban populations in the context of economic globalisation, persistent and high unemployment, economic stagnation, climate change and weak national and local public institutions demands a radical reorientation of public health systems, policies and processes. Fundamentally, there is a need to break out of the common single-sector approach and the patterns of narrow focus of single-issue programmes<sup>5</sup> that are designed in isolation of the local context and without proactive efforts to engage with and to develop capacity of community-based organisations, particularly those living in poor and informal settlements, in empowering initiatives. There is a need for a systemic approach to build effective public policies that improve living conditions and the environment and reduce health inequities.

The Healthy Cities and Municipalities Movement (HCMM) was initiated by the World Health Organization (WHO) in Europe in 1987, and subsequently taken up in other regions, and in others developed differently without its explicit identification as a 'healthy setting or healthy city'.

The HCMM was an important development because of its focus on the role of political leaders, intersectoral collaboration and participatory governance in policymaking and programme development, rather than a response that decontextualises health and medicalises its response. Indeed, it has been used in many countries as a platform for legitimising and supporting community-based civil society initiatives, often in collaboration with local governments and health systems (Perez Montiel and Barten 1999). Also explicit was recognition of the need to challenge power relations between public-sector providers and the people they serve. The HCMM was not conceived of only to improve health; it also aimed to tackle the power imbalance between the public and government; between people and bureaucrats; and between the poor and professionals. The HCMM also placed emphasis on equity and social justice.

The collective experiences of HCMM have provided valuable lessons, both positive and negative. Among the strengths have been the value of an area-based approach to population health rather than the traditional vertical, issue and disease-based approach; the recognition that shared ownership across official institutions and community-based organisations has to be actively developed, with capacity-building required by both communities and the professionals engaged in the initiatives; and that successful initiatives were sustained by a strong social vision by community members (Baum et al. 2006; Mendez and Akerman 2002). Also important was the recognition that health cuts across different policy sectors, which led to the development of mutually beneficial links with other global initiatives focusing on the improvement of the environment and quality of life in cities. These include Local Agenda 21, Habitat and the Initiative Local Facility for Urban Environment (LIFE). Among the many benefits of the collaborations has been the heightened profile in health within these initiatives, along with the strengthened urban planning and environmental profile of the HCMM.

The constraints and inherent contradictions, however, have meant that despite the progressive rhetoric and frameworks, the HCMM as a whole has been unable to achieve its intended radical agenda. Instead of power-sharing, the traditional power imbalance between the sectors have been maintained (Mendez and Akerman 2002; Ziglio et al. 2000), with the authorities dominating the priorities, the processes and the extent of engagement (Stern and Green 2005). This has been manifest in several ways. Technical solutions have replaced the ideal of addressing fundamental contextual and power-related issues, and flexible and innovative local partnerships have been stifled by hierarchical and vertically structured bureaucracies (Harpham and Boateng 1997; Pickin et al. 2002).

Control over civil society organisations (CSOs) by national governments and/or donors has also predominated in some countries, with priorities and funding favouring selective, vertical programmes that focus on single issues rather than ‘bottom up’ participatory and intersectoral initiatives and comprehensive approaches at all levels. In addition, in many instances CSOs have become delivery agents for donor-funded programmes, causing the energy for social and political mobilisation to be dissipated, directed towards competing for funds or controlled by the donors.

Perhaps the starkest contradictions are the attempts to develop HCMM initiatives within a context of neoliberal reforms, such as privatisation and outsourcing in many cities. On the one hand, HCMM was promoting social development and community participation, while on the other policies were promoting the market and converting ‘community members’ into ‘individual consumers’. Also contradictory is the local HCMM focus on equity, at a time when globalisation is making it increasingly difficult for local actors to address many of the fundamental driving forces of poverty and inequality. Many of the HCMMs have been developed in a context of structural adjustment programmes (SAPS) and, in many cases, political upheaval and the near collapse of public health systems.

The HCMM has nevertheless been an important landmark. The framework provided by the HCMM, along with its principles now echoed in the Commission on Social Determinants of Health, provide an opportunity and a challenge for progressive civil society to build on the rhetoric to strengthen their role, relevance and impact.

### **Governance and health issues in cities: water and sanitation**

The tensions and contradictions inherent in the HCMM become clearer as we examine the provision of safe water and sanitation for the poorest and most vulnerable people living in cities of developing countries.<sup>6</sup>

Inadequate supply of drinking water and sanitation at the household level remains the most critical and widespread water-related problem in low-income urban settlements. Despite this, financial allocations to the water sector as a whole are shrinking. Unreliable coverage data and limited transparency in governance further inhibit effective planning for utilities by governments and communities.

The low priority and low level of resources accorded to sanitation are further exacerbated by poor coordination, unclear roles and responsibilities, and conflicting policy, legal and regulatory frameworks. For instance, sanitation is the responsibility of several government departments, which operate conflicting policies and regulatory regimes. Because targets are

**BOX C4.2 People-centred drinking water and sanitation services in Venezuela**

The desire to re-establish citizen involvement in the management of water services led the Venezuelan water sector to discuss and debate the communal management of Hidrocapital, the water company of the capital, Caracas. Following on from this, the authorities adopted the development of 'Water Technical Roundtables' and 'Water Communal Councils', designed to harness the knowledge and skills of the community to help solve the problems of the water sector. They facilitated 'community mapping' which harnessed the knowledge of community members about the location of the various installations of the water service network; the diagnosis of problems; and the formulation of repair and maintenance plans.

Water Communal Councils provide a platform for communities, Water Technical Roundtables, representatives of the Hidrocapital and elected local government officials to exchange information, discuss and debate. They are open to all citizens and meet at a regular time and in a well-known place. They help to prioritise needs on the basis of inputs from all sections of society; organise a work programme agenda to which both the water company and the community commit; and exert social control over the public company.

Within five years, there has been a transformation of the water and sanitation sector, not least of which is the public water companies meeting with citizens, and the increasing number of communities that are managing their own water resources.

*Source:* Rodríguez 2005.

often set at the aggregate level, issues of exclusion and inequity and of sustainability and long-term functionality are not addressed.

Revamping the operations of public utilities is critical to fulfilling the water and sanitation Millennium Development Goals (MDGs), especially for the urban impoverished population. Public utilities currently provide as much as 95 per cent of coverage for up to 35–45 per cent of urban residents served by a piped network supply. Even during the height of the privatisation era in the 1990s, private-sector investment in water and sanitation was only 5 per cent of all private investments in infrastructure.<sup>7</sup> According to the World Development Movement, only 1 per cent of promised private sector investment in water globally since 1990 was targeted at sub-Saharan Africa.

However, public utilities have not taken the measures to improve and extend provision in urban areas. Governments, international finance institutions and donors must now move away from debating the pros and cons of privatisation towards determining how public-sector utilities can turn around their performance, promote 'public-public partnerships' and help utilities in developing countries improve services through peer support and collaboration (see Box C4.2).

The recognition of non-state providers (NSPs) or small-scale service providers (SSSPs), including community-managed systems, as the dominant providers for the poor in slums and peri-urban settlements is also pertinent. NSPs serve between 30 and 60 per cent of urban residents through a variety of formal and informal arrangements. However, the sector currently lacks the governance and regulation required to secure the necessary standards of water cleanliness at affordable prices.

#### ***Participatory governance***

Participatory governance is an important tool of development, which is gaining an increasing acceptance in all sectors. In some policy contexts community involvement in water and sanitation and alliances between government and civil society organisations are contributing to achieving best practices and sustainability. Examples of best practices abound globally.

#### ***Partnership and resource mobilisation***

Several donors have shown commitment to the concept of public-private 'partnerships'. In line with this concept, the UN outlined the concept of Water Operators Partnerships (WOP). UN-HABITAT's Water and Sanitation Trust Fund uses 'partnership' as the key strategy for leveraging more funds and expertise for the water and sanitation sector. With modest sums, the agency is partnering with development banks and other international finance institutions to leverage more funds in grants and these are being followed up with increased investment loans. Through such partnerships, a synergy is built to ensure sustainability.

#### ***The role of civil society in water governance***

Many past efforts to sustain improved water and sanitation services in urban centres have failed as supportive capacity-building was not clearly thought out in the planning design stages of the systems, in local or regional institutions. The resultant lack of human resources and capacity to operate and maintain the existing systems is one of several reasons that has led to the poor performance in the water and sanitation services in urban areas, especially in the slums.

**BOX C4.3 Partnership for pro-equity water supply and sanitation, Madhya Pradesh**

'The Slums Environmental Sanitation Initiative (SESI) was set up as a pilot project in October 2005 and was to be executed in four project cities in a tri-partite partnership model.' The project brought together resources and expertise from the UN-HABITAT, WaterAid India and its local non-governmental organisation (NGO) partners and the four municipal corporations of Bhopal, Gwalior, Jabalpur and Indore for the benefit of 20,000 households, with each city identifying poverty pockets of 5,000 households which lack water and sanitation infrastructure. The project creates awareness among the people about the use of sanitation facilities in informal settlements.

Based on a situational analysis, the SESI projects are being implemented in these areas. The local partner NGOs play pivotal roles in mobilisation of the residents to form Community Water Supply and Sanitation Committees (CWASC), some of which are now registered as legal entities. The Community toilet has separate toilets for men and women, disabled and the elderly. There are also child-friendly toilets for boys and girls as well as bathing facilities for men and women.

Already, sixteen poverty pockets within the participating four cities have become the first open defecation-free 'slums' in India. Recently, the government of Madhya Pradesh State has drafted the State Sanitation Policy.

*Source: Water for Asian Cities 2007.*

Also there are many dynamic NGOs and community-based organisations at the local level that have developed and sustained innovative initiatives, but there are few linkages with city-level government, meaning that good practices are seldom replicated or properly evaluated with respect to their impact on local government systems. UN-Water for Cities programmes add value to the services delivery sector by developing the capacities of civil society organisations through technical cooperation and demonstration of community-oriented water supply and sanitation. These investments enhance the possibility for an acceptable degree of ownership, which to a good extent ensures a higher rate of return on investments by international finance institutions (IFIs) and assures sustainability and a credible level of output from facilities.

**Recommended policy responses for reducing inequities<sup>8</sup>**

- *Political commitment* is critical to addressing urban health inequities. This includes ensuring that all enjoy the right to the city and that health equity initiatives target and engage those most in need.
- *A systems approach* which acknowledges the relationship between urban and rural development and the influence of supra-local factors and need for action on local, national and global determinants is required.
- *Effective or healthy governance*. It is impossible to address the social determinants of health inequities in isolation from the broader remit of management of national development, or from the wider macro-policy level environment of decision-making.
- *Develop capacities of CSOs* for meaningful participation at all levels.
- *Develop a local knowledge base* that captures the reality of informal settlements.
- *Strengthen relevant existing initiatives* and processes.
- *Equip local government* with sufficient means and resources. Decentralisation has been recommended as a tool to strengthen local authorities for more effective service delivery, but the devolution of functional responsibilities has presented local governments with a major challenge, compounded by adverse economic and political conditions. Municipalities need to be strengthened to achieve a match between their newly acquired responsibilities to provide services and to fund capital improvements, and a higher degree of control over their revenue sources.

There is clearly an important role for public health advocates to play at the interface between essential services, urban planners, water and sanitation providers and education. There is also a need to develop the capacities of community-based, civil society organisations and local governments to ensure effective public policies that address social exclusion and reduce urban health inequities.

**Conclusion**

The complexity and magnitude of the problems of the urban social and physical environment posed by the current trends of urbanisation, migration, climate change, conflict and uneven development are immense. Although the MDGs have acknowledged the need to reduce urban poverty, the implications of the urban context for policy and for the achievement of all MDGs are not sufficiently understood. The renewed interest in Primary Health Care (PHC) and the WHO Commission on the Social Determinants of Health provide a new opportunity.

It is clear that improvements in health and health equity demand not only changes in the physical and social environment of cities, but also approaches that take into account wider socio-economic and contextual factors. The creation of more and better employment and social protection is a crucial challenge. Health systems have an important role to play, particularly at primary care level, where the interaction with communities is facilitated and the linkage between health and living conditions cannot be neglected. Disaggregated information on the (potential) health impact of policies and decisions taken by other sectors and governance levels is important. Comprehensive PHC can play an important role in developing the capacities of civil society and community-based organisations in order to ensure meaningful participation, to influence policymaking processes and to guarantee the right to the city for all.

While it is important to acknowledge how bottom-up participatory processes can contribute to sustainable health plans and healthy urban settings, there is also a need for local actors to address the supra-local and global factors that impact on cities and the distribution of power and resources. Duhl (1984), in his seminal paper on 'Healthy Cities', argued for the need to conceive of the city as *a whole*. Barten et al. (2006), in their recent analysis of the need to address social determinants of health to reduce urban health inequity, argue that it is necessary not only to conceive of the urban setting as a whole, but also to take a *national and global perspective* on the social, economic and political determinants of urban health inequity.

## Notes

1. The identification of an area as a 'slum' contributes to stigma and discrimination against its residents. Also, the labelling of 'slums' excludes even more deprived areas.
2. Reclassification can be due to increased population or the redefinition of an urban area. Several countries face this dilemma following population growth or political pressures.
3. It is almost impossible to determine the cut-off for a city as different criteria are applied by countries. These classifications are therefore more for illustration than the rule.
4. This is a situation where qualified labour engages in less lucrative or less skilled jobs (such as petty trading) following a retrenchment or lack of job opportunities.
5. These focus mainly on effects instead of addressing the political, social, economic and environmental determinants.
6. For a detailed discussion on the social and health consequences of water and sanitation shortages, see Chapter C5. Also see *Global Health Watch 2005–2006* for a discussion on the privatisation of water and sanitation.
7. *International Herald Tribune*, [www.ihf.com/articles/2006/03/20/news/water.php](http://www.ihf.com/articles/2006/03/20/news/water.php).
8. Taking into account the impact of climate change.

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