TECHNICAL DISCUSSIONS ON STRATEGIES FOR HEALTH FOR ALL IN THE FACE OF RAPID URBANIZATION

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CITIES AND THE POPULATION ISSUE

WORLD HEALTH ORGANIZATION GENEVA
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WORLD HEALTH ORGANIZATION
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The increasing proportion of people living in cities and towns through the process of urbanization is one of the main features of world development. By the year 2000, 51.1 per cent of 6.3 billion people in the world will be living in urban areas (United Nations, 1991). About 46 per cent of urban dwellers at present are in large cities of 500,000 and above and a fifth live in mega-cities of a million or more. In general, the rate of growth in large cities is much faster than the total population growth so that in the twenty-first century, social planners anticipate that urban problems will become more serious than they are now.

Cities in developing countries are growing because of natural increase (excess of births over deaths), in-migration and reclassification of urban areas. In earlier stages of development, migration to cities was the dominant influence on urban growth. In later stages, however, natural increase has become the main reason for urban population growth. In many developing countries, the decline in fertility expected because urbanites have higher literacy and education, better income and employment, improved status of women and improved access to the mass media has not occurred, at least to the degree required to make a significant difference in overall rates. Reclassification, or the process of designating formerly rural areas as urban because of changes in their socioeconomic characteristics, has not been a very important element in urban growth except in certain countries (UNFPA, 1986).

Migration and natural increase, as important factors in urban population growth are closely interlinked. Studies have shown that the relatively young age of migrants to cities generally results in greater contribution to natural population increase because migrants have fewer deaths and more births (Stolnitz, 1984). There is also an apparent time lag between migration to cities and internalization of fertility reducing behaviour. Recent migrants to cities tend to continue having high fertility rates for decades before their values and fertility behaviour change, particularly when access to family planning information and services is limited.

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1 There is, as yet, no universally accepted definition of what constitutes an urban area. The United Nations uses national definitions which generally include population size (from 2,000 to 20,000 inhabitants), administrative or political status (a city or municipal charter) or socioeconomic characteristics associated with urban life (per cent of work force in non-agriculture callings, availability of urban services such as a high school, hospital, etc.)
2. Urbanization and Health

Statistics show that urban residents in developing countries generally have higher income, higher educational attainment, better access to social and welfare services and better health status than people in rural areas. Various social indicators bear this out. Infant mortality rates (IMR) in rural areas of 96 low and middle-income countries studied by the World Bank, for example, were almost double those in urban areas. In India, the IMR in rural areas was 105 per 1,000 live births, compared to 57 in urban areas. In Peru, IMR was 101 per 1,000 in rural areas and 54 in urban areas. Similarly, IMR for rural areas in the Ivory Coast was 121 per 1,000 compared to an urban IMR of 70 (World Bank, 1990).

Although income, health, social welfare and other services in urban areas are better, the poor and underprivileged in cities and towns tend to have worse social and health conditions. This is especially true in urban slum and squatter areas where urban poverty is in such sharp contrast with the affluence and conspicuous consumption of city elites. Slum and squatter communities in developing country cities house from a third to more than half of the city population. In such communities, people live in appalling overcrowded conditions, lack sanitation, have no potable water, and do not have access to suitable employment. The communities of the poor are also often illegal, subject to floods and chemical pollution, and beset with criminality and other social ills.

Statistical averages, therefore, generally mask the poor health conditions among the urban poor. Low income, poor environmental conditions, poor nutrition and lack of adequate access to health, family planning and social services combine to make the health conditions of many urban poor people precarious.
3. Urbanization and Fertility

Despite the conditions cited above, migration of rural folks to cities and towns continues unabated in developing countries because of the real or perceived difference between economic and social conditions existing in rural and urban areas (UNFPA, 1986). The average annual growth rate of urban population in South Asia was 4.0 per cent in 1980-1988; in Sub-Saharan Africa, it was 6.2 per cent. In the last decade, demographers have noted a slight slackening of growth of mega-cities of 5 million and above all over the world. However, this may be partly attributed to the sprawl of human settlement beyond metropolitan area boundaries, an artifact of data gathering methods rather than a real slowing of population growth.

The continued growth of very large cities has been debated among economists and policy makers alike. One school of thought contends that agglomeration economies and economies of scale make large cities more efficient in generating economic development. Another school argues, however, that short-term economic gains in large cities are sooner or later overcome by diseconomies as polarization between urban centres and rural areas creates discontent and greater social inequalities. It must also be pointed out that societal problems inevitably hurt the lowest income groups in cities as they generally lack the means to escape them (Oberoi, 1989).

The growth of cities and towns is mainly due to natural increase and internal migration. With very few exceptions, past attempts in developing countries to curb migration to cities have not succeeded too well. Fertility regulation measures, therefore, are the main instruments available to policy makers in their efforts to limit urban population growth (UNFPA, 1980).

The measures needed to regulate fertility in urban areas and elsewhere are well known. First, there must be an explicit population policy formulated and adopted by the authorities. Implementation of this policy is enhanced by the setting up of specific qualitative and quantitative targets based on scientific projections of demographic patterns and realistic assessment of public and private sector capabilities. Second, the population policy must be conveyed to the people through effective information, education and communication (IEC) channels formulated in a coherent strategy. Third, there must be effective and efficient institutions to adequately respond to the demand for health and family planning services created by the IEC strategy. This takes the form of a population infrastructure composed of public, private and non-governmental sector structures that may include public hospitals and clinics, private facilities, community-based institutions, social marketing efforts, etc. Fourth, and finally, there must be planning, implementation and managerial capabilities to make sure that the human, technological and material resources needed for the population programme are made available in the right places, in the correct quantities and at the right time.

3.1 Population policy

Most developing countries do not have a separate population policy for urban and rural areas. In the latest United Nations survey of
population policies, 49.1 per cent of 108 governments considered the growth rate of the population unsatisfactory (too high) and, therefore, adopted policies and programmes designed to limit population growth. Interestingly enough, 70.4 per cent of the governments surveyed considered the distribution of their population over national space unacceptable, thereby indicating the need to control rapid urban growth. About 45.4 per cent of the government said population distribution needed major changes and 25.0 per cent said minor changes were required. Despite this dissatisfaction over population distribution policies, very few governments have adopted explicit measures to curb rural-urban migration although family planning interventions in urban areas have tended to receive national and local support. (United Nations, 1990, p. 23,29).

Most fertility regulation policies and programmes in urban areas tend to be integrated with health activities. Traditionally, family planning operations are combined with maternal and child health programmes. In some countries where the need to curb population growth is considered of the highest priority, a separate population commission may be vertically set up side by side with the health structure. While such vertical family planning interventions might have achieved some success in some countries, they have been generally found to be quite expensive and difficult to manage as duplication of functions with health and other ministries, competition for the services of health personnel, and problems of inter-agency coordination have contributed to waste in the use of scarce resources.

In quite a number of countries, duplication and waste has been avoided by lodging population policies and programme co-ordination at the highest level of governmental decision-making. This has taken the form of creating National Population Commissions at the Cabinet or Presidential level where the top level structure is mainly a policy formulation and co-ordination body. At the city level, similar co-ordination structures may be replicated. Provided the implementation of family planning programmes is not vertically carried out, separate from the health and other service-delivery structures, problems might be avoided.

### 3.2 Communication of population policy

A comprehensive communication strategy is needed if the population policy is to be effectively disseminated among urban citizens in a sufficient manner that attitudes and behaviour related to fertility are affected. Population messages might be conveyed through various channels: the mass media, the school system, through a network of public officials, community leaders and influential persons, through service providers in the various urban government bureaucracies, etc. In some instances, a separate IEC unit in a population agency might concentrate solely on publicity campaigns seeking to create higher demand for family planning services. If the attempts of this unit are not reinforced by well-trained service providers who know how to convey population messages through counselling and advice, the communication may be rendered ineffective.
Population communication might also be helped a great deal by the support of urban community leaders and influential persons. In many developing country cities, urban citizens are well organized into community and neighborhood associations designed to achieve mutual help and common action. This is true even in slum and squatter communities where residents, relying on rural-based cooperative structures, have the potential for popular participation. Where such structures for community action are directly involved in population communication, they generally contribute to programme success.

### 3.3 Organization of the population and health system

As previously mentioned, an integrated population and health system has been found to be most effective in making programme efforts successful. Such a health system might be composed of hospitals, clinics, dispensaries and mobile units run by the city government; a network of private hospitals, clinics and individual health practitioners; non-governmental clinics and health facilities run by charitable, religious, civic and other organizations; and facilities providing health and family planning services operated by special groups such as labour unions, factories, government employee associations, etc. Because of the great variety of such entities in urban areas, it is most important that explicit population and health policies and programmes are adhered to by all of them.

A special concern of public authorities in many developing countries is the high concentration of such structures and facilities in urban areas. Typically, governmental expenditures for health are three times higher in urban than in rural areas. Private sector health interventions are even more biased toward urban areas because those who can afford to pay for health services are in cities. Thus, in Peru, two-thirds of all medical doctors live in the capital city of Lima, where 27 per cent of the population lives. In Senegal, 70 per cent of all physicians and pharmacists, 60 per cent of all midwives and 40 per cent of nurses are concentrated in the Dakar-Cap Vert region, where fewer than 30 per cent of the population live.

Another matter for serious concern is the heavy concentration of health spending in developing countries on curative care. It has been estimated that about 70 to 85 per cent of total health spending in developing countries, both public and private, goes to curative care. Only 5 to 10 per cent of health funds are devoted to community services such as health education, mosquito control, eradication of vermin and pests, etc., while another 10 to 20 per cent is spent on preventive measures. Within the curative sector, hospitals often account for more than 80 per cent of total health costs. Most of these hospitals are located in urban areas.

An immediate effect of this imbalance in allocation of health services is the continued attractiveness of cities to rural people. Even in countries committed to rural primary health care, people needing medical and health services in rural areas ignore the local clinics and go...
directly to urban medical facilities. In countries where transportation means are inadequate, this tendency of rural people to go to cities increases the risks to sick people as it may take hours or even days before medical care can be provided. The trend also leads to a vicious circle of continued neglect of health facilities in rural areas, as people go to cities for health care anyway.

The factors related to providing health and population services in urban areas mentioned above, are very much needed if the rapid growth of cities and towns in developing countries is to be curtailed. It is heartening to note, however, that compared to conditions existing in rural areas, those in cities and towns are more amenable to effective fertility regulation. To begin with, the pre-conditions for fertility regulation are better in urban areas. Urban residents, in general, have higher literacy rates, better education, higher income, and better access to the mass media - factors that tend to be positively correlated with lower fertility. Compared to their rural counterparts, urban women also tend to have higher literacy and education; they are more likely to work in the formal sector and have better access to health and family planning services. In general, therefore, urban women tend to have lower fertility rates than rural women.

The positive conditions noted above should not be construed to mean that population and health measures in urban areas in developing countries are not beset with problems. In many countries, population and health conditions in cities and towns still suffer from many shortcomings. Some of the major problems are as follows.
4. Special Health and Population Problems

4.1 Migrants

In most developing countries, in-migration typically accounts for a third to half of annual urban population growth. Rural-urban migrants, according to a number of socio-cultural studies, tend to have higher fertility rates than native urbanites. Despite the fact that the migrants might have higher literacy and educational achievement rates than the people they left in the villages, they still retain many of the rural values that place a premium on high fertility.

Temporary or cyclical migrants to urban areas avail of health and population services in cities without getting integrated into urban social structures. As previously mentioned, such migrants are usually prompted to seek urban services because of the poor or non-existent services where they are. This tendency, of course, overburdens urban facilities. At the same time, it discourages the government from improving rural facilities.

4.2 Women in urban areas

The social and economic conditions of women in developing countries put them in a disadvantaged position but such conditions may tend to be exacerbated in urban areas. A number of studies of rural-urban migration have shown that women tend to have a secondary role in the decision-making process leading to migration. This is especially the case when migration is related to marriage, the desire to keep the family together, or where the woman comes as a dependant.

A particularly alarming trend in many large cities in developing countries is the rapid growth of female-headed households due to teenage pregnancies, abandonment by the husband or partner, separation and divorce. Such female-headed households tend to be at the bottom of the socio-economic ladder because women find it too difficult to combine full-time employment with looking after their children and the household. In many urban areas, the "safety net" provided by kinship or the extended family has been severely eroded. Even in Bangladesh and India, where the care of widows is one of the main duties of children, the rapid increase of elderly abandoned women is a critical problem in urban areas.

Although education of girls has been proven to be one of the most important factors in fertility regulation, the level of educational attainment for girls still lags seriously behind that of boys, even in urban areas. For example, in India, urban literacy rates are twice as high as rural rates but female literacy rates consistently remain much lower. In Pakistan, 63 per cent of boys in relevant age groups are enrolled in elementary school but only 32 per cent of the girls are. In rural areas of Pakistan, enrolment rates for girls are as low as 20 per cent. The low educational levels for girls are particularly serious because it has been shown that education is directly associated with health and fertility conditions. It has been estimated by the World Bank that an extra year of mother's education is associated with a 9 per cent decrease in the mortality of their children aged below five years of age. Higher education, also, is directly correlated with lower fertility rates among women.
4.3 Youth

Young people in urban areas, like women, tend to be disadvantaged as far as their access to health and population services are concerned. It has been mentioned that one of the main effects of rapid urbanization is the breaking down of family ties and the unravelling of the safety net that used to look after the young. The United Nations estimates that by the year 2000, half of the world's population will be under 25. (United Nations, 1991). There will be over half a billion of young people within the age bracket 15-19, who need family life education and, where necessary, family planning services. A substantial number of them will be living in urban areas in developing countries.

A particularly difficult problem in developing country cities is the high rate of teenage pregnancy, high rates of sexually transmitted diseases among the young, and the lack of public and private sector structures to deal with these problems. In some urban societies, sex education for adolescents remains unknown because of social taboos and religious beliefs. Unmarried young adults are generally denied access to contraceptives in many developing country cities. The usual policy for teenage girls who “get into trouble” is expulsion from school, punishment by parents, public censure, or, if the girl is “lucky” an early marriage. In some cases, the unwanted pregnancy is terminated illegally through back alley abortion clinics. It is worthwhile mentioning, that three-fourths of maternal deaths in developing countries are due to five main causes, and unsafe abortions is one of these (the other causes are haemorrhage, infection, toxemia and obstructed labour). The rate of maternal deaths among women aged 15-19 is twice as high as it is among those aged 20-24. The first child of a teenage mother is 80 per cent more likely to die than the second or third child of a woman aged 20-24. (Sadik, 1990).

4.4 Community participation

In most developing countries, the public sector is often unable to deliver health and family planning services to the people because of lack of resources. The full participation of the community, therefore, is needed in such forms as providing physical facilities, volunteer labour, and contributions in cash or in kind. Community leaders are important communicators of health and family planning ideas. They can mobilize the people in immunization campaigns, sanitation programmes, community clean-up drives, family planning campaigns, etc.

Despite the known importance of community participation, however, organizing communities among the urban poor is beset with difficulties. This is particularly true in communities of new migrants and very old slum areas. In the former, the migrants usually do not know each other well, they may form warring factions and may refuse to cooperate not only with each other but with the Government as well. Where new squatter settlements have illegal or uncertain tenure, the bulk of organizational resources are focused on achieving more secure status rather than attaining
health and social services. In very old slum areas, apathy and a feeling of personal helplessness might prevail because only the people who cannot achieve upward mobility have been left behind and the enterprising and able people had left the community. Under such circumstances, community organization is extremely difficult to achieve.

The fact is, however, that without community participation, most health and family planning programmes in developing country cities are doomed to failure. City and national governments usually do not have the financial resources to provide adequate health and family planning services. They can barely meet the bill for salaries and wages, basic drugs and commodities and other necessities. Communication programmes, mobilization campaigns, and drives for health and sanitation improvement all require full citizen participation. Because of the poverty of the people, they cannot avail themselves of the services of private health providers and they have to count on the government. The government, in turn, must depend on the people to complement its efforts and to achieve some measure of local self-reliance.

In low income urban communities, more improvements in the health status of people could be achieved by preventive rather than curative approaches. For example, improved drainage or filling up of low-lying areas where stagnant water becomes the breeding place for mosquitoes is important for the prevention of malaria or dengue fever. Effective removal of garbage and human waste is necessary for preventing infectious diseases such as cholera, typhoid, parasites and diarrhoea. Extending clean water to poor urban communities is a necessity for any health and sanitation measure. All these interventions require full community participation. The health infrastructure should have the human resources and organizational capabilities to mobilize the people in the communities if it is to cope with urban health problems.

Community participation is also a prerequisite to effective family planning. Information, education and communication programmes are most effective if mediated through community leaders and people of influence. Contraceptive distribution is more efficient if done through local distributors, who are trained in counselling, are trusted by the people, and are motivated to carry out their tasks. Organization of family planning campaigns is best carried out through armies of volunteers who disseminate information, provide services or carry out referral functions for matters beyond their capabilities. Even the marketing of contraceptives becomes more cost-effective if based on community-based systems.

4.5 Inter-agency coordination

Experience has shown that fertility control in developing country cities is best achieved through integrated programmes where family planning is considered a natural element in the total health system. In a number of countries, governments have set up vertical family planning programmes. Such programmes have shown some initial success but, in the long run, many of them have proven to be quite expensive. Duplication and competition between the health
and family planning structures, a usual feature of such vertical systems, may make them ineffective in the long run.

Lack of coordination might even exist within one health and family planning structure if proper planning is not done. For example, some urban health systems have independent units to take care of publicity and health education that are not closely linked with service delivery structures. Such publicity and health education units see their role primarily as increasing the demand for health and family planning services. They may use the mass media quite effectively but ignore the communication opportunities provided by the service delivery workers themselves, especially those working directly with the people in small communities. The service delivery workers, in turn, lacking training in communication, fail to take advantage of their face-to-face interactions with the people to inform, counsel and train in the fields of health and family planning.
As the world faces the prospect of being half urban by the turn of the century, limiting the growth of large cities and extending health and family planning services to urban citizens have become important policy concerns. Although internal migration has contributed significantly to urban growth in developing countries in the past, natural increase has now become the more important element in urban growth. Family planning, therefore, is needed in developing country cities and towns.

Urban statistics may show that people who live in cities and towns have better health and economic conditions than their rural counterparts but such statistics mask the widespread poverty and poor health situations existing in urban slum and squatter communities. In many countries, the urban poor live under unsanitary and dangerous conditions, lacking water, drainage, garbage and waste collection and access to medical facilities. Their appalling plight is often highlighted by the contrast with the affluence and conspicuous consumption of those around them. Ironically, the perceived difference between rural and urban areas continues to attract more migrants to urban areas. Past attempts to control such in-migration have generally been unsuccessful.

Reducing the growth of urban populations requires effective family planning policies and programmes. Controlling fertility in urban areas is linked with several factors such as increased income, better employment, literacy and education (especially of women), better nutrition, access to health services, better availability of contraceptives, and more effective collaboration between the health system and communities and people. Special groups such as young people, women, and the underserved and underprivileged have to be reached by health and social services, including family planning. Inter-agency coordination is most important in achieving success in health and family planning. The full cooperation of the people in their local communities is also a prerequisite to programme success.


