Mission of the Centre for Basic Research

To generate and disseminate knowledge by conducting basic and applied research of social, economic and political significance to Uganda in particular and Africa in general, so as to influence policy, raise consciousness and improve quality of life.

Building Healthy Cities: Improving the Health of Urban Migrants and the Urban Poor in Africa

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Workshop Report No.14/2002

Table of Contents

Introductory Remarks by Dr. Bazaara Nyangabyaki, Executive Director, Centre for Basic Research

In his introductory remarks, Dr. Bazaara Nyangabyaki welcomed all the participants, and especially the international participants, to the workshop. He gave a brief overview of CBR and said that it was established as an educational trust and later registered as a non-profit-making NGO which carries out basic research in various fields. He also noted that CBR had hosted a number of networks.

On the issue of health, Dr. Bazaara noted that modern medicine was started by missionaries who then expanded the hospitals and dispensaries. All this health infrastructure later declined in the 1970s due to neglect and mismanagement under the dictatorial regime of the time. Then the SAPs came in the 1980s, which emphasized the reduction of government spending on health and education and the introduction of cost-sharing.

He further noted that with the coming of new diseases like HIVAIDS, the costs of drugs were very high and yet there were many poor people who could not afford. The most vulnerable people in our context were the migrants. He, therefore, questioned how they survived, and emphasized that this needed to be explored. Dr. Bazaara also noted that Uganda had a history, of migrants and their access to health services. He, therefore, hoped that by, the end of the workshop, participants would have learnt a lot and would bring out research policy issues.

Finally, he thanked Wodrow Wilson Centre and Centre for- Basic Research for organizing the workshop and wished all the participants fruitful deliberations.

Remarks by Prof. Gilbert M. Khadiagala, Wodrow Wilson Centre (WCC)

Prof. Khadiagala noted that it was a pleasure for them to be in Kampala and added this was the first collaborative project with CBR. He thanked all those involved in the preparations. He noted that WWC was founded of President Wodrow Wilson with an aim to foster knowledge and research, and had a big development component. He informed the participants that the projects at the centre ranged from cold war, environmental and security programmes. He added that the Africa project was new at the centre with a goal to educate the Americans about Africa, and bring scholars and academicians together.

Prof. Khadiagala also noted that they were in Africa to focus on building healthier cities. He said that he was looking forward to the deliberations and thanked USAID for funding the workshop.

Opening Remarks by the Mayor of Kampala City,
His Worship John Sebaana Kizito

In his opening remarks, Mr. Sebaana Kizito welcomed all the participants to Kampala and was happy that Kampala had been chosen as the venue for the workshop since health was taken as important in the city. He said that it was fortunate that the Ugandan Government had acknowledged the gravity of the HIV/AIDS problem and preventive measures had been taken. He added that Kampala City Council was closely behind the government in the fight against AIDS.

He observed that a lot of people lived in Kampala City with a population that was a bit more that 10% of the country's total population. Mr. Sebaana Kizito further noted that the city had 11 clinics fully facilitated with medical staff to ensure good services to the citizens.

He thanked the participants for taking this issue seriously and said that discussing it would provide some solutions for the city authorities. He noted that he was looking forward to many ideas being raised, which would be implemented if funds were made available. He wished all the participants a good stay in the city and pledged that he was willing and ready to discuss more issues at a personal level. He then declared the workshop open.

Panel I: Maternal and Child Health

Migration, Urbanization and Health *by Dr. Michael Vv7zite*

Dr. White noted that urbanization was part of the solution of health problems, and went on to give reasons for the need of urbanization and health. He argued that urbanization was involved in demographic and health transitions. He also noted that there was an increase in the percentage of the world's population and the less developed countries were experiencing a bigger increase, and hence the need to link urbanization with health. He further showed trends on how health varied between the rural and urban areas.

Why Urbanization and Health?

- Urbanization is involved in the migration and health transitions.
- Urbanization is both a site and a process.
- They also have service delivery options.

Why Migration and Health?

- Migration feeds urban growth with 40-60%, and the percentage becomes larger if urban growth is by natural increase
- Migrants are different e.g. some are highly motivated and are always moving from one settlement to another.
- Migration and social networks (deterioration of social capital) how they transform themselves and what social mechanisms of how to treat themselves.

LDC Urbanization: What is different and what is not?

- Urban living takes place at a greater scale during this transition.
- Urbanization rate is similar to the historical one.
- Natural increase plays a bigger role for the LDCs' populations.
- Absolute city population increments are larger.
- There is a larger youth bulge because these are the age groups that move
- To the urban areas in search of opportunities

Urbanization and HIV/AIDS

- Urban HIV+ rates usually exceed the rural ones.
- Migrant labour is often implicated in the transmission.
- AIDS knowledge is higher in the urban areas.

In conclusion, he noted that urban areas led transition with lower fertility, better child outcomes, more health knowledge, health environment shifts. He also noted that migrants presented dual outcomes as innovators and were disconnected from original social networks. Therefore, there was need to recognize service delivery, and be more accommodative to the migrants who should not be essentialised as poor.

Improving and Increasing Access to Maternal and Child Health Services to Urban Migrants and the Poor in Africa: The Case of Dar-es-Salaam City, Tanzania *by Roselyne R.M. Nderingo*

The presenter observed that Africa was witnessing an unprecedented pace of urbanization whose rising levels contributed to the wealth of nations but also enormous pressure on the scarce resources available. This also put pressure on governments to establish effective social service delivery mechanisms including health services. She further noted that meeting the urban health challenge for Africa's burgeoning cities would definitely require concerted efforts of all actors and stakeholders in society, government, the private sector and the international

donor community and the communities themselves. Traditional roles had to change and new alliances had to be forged to harness the diverse resources of civil society.

She emphasized that both central governments and local authorities had a role to play in creating an enabling environment for this partnership to flourish. She, however, said that in Africa, the existing legislation left no room for such partnerships in the health sector.

Nderingo argued that the necessary reviews and reforms in legislation should provide room for all stakeholders to effectively participate in the development of the health sector. Where appropriate, the state may readjust its role by withdrawing, from being the main service provider and instead concentrate on putting in place comprehensive urban sector development policies that cover all the sectors.

She further emphasized the issue of community participation which she said had special advantages. This, she said, did not only ensure that the community was provided with what it wanted rather than what the government thought it needed, but also provided the community with a sense of belonging and ownership. This inevitably resulted in better care for the investment and a greater willingness to pay for the services. The women of the community, in particular, who were the direct beneficiaries of Maternal and Child Health services, could be important agents of change.

Nderingo gave a brief overview of the health situation in Tanzania which she said emphasize equity in the distribution of health services and viewed access to services as a basic human right. She noted that the government provided more than 60% of health services and non-governmental organizations provided the remainder. She, however, observed that debt repayment which cost more than 40% of the total government's revenue that made health situation worse since the government could not allocate sufficient resources for putting in place effective and efficient health service delivery mechanisms to cover all urban and rural areas. However, under the Heavily Indebted Poor Countries debt relief initiative, Tanzania had been relieved of a debt amounting to US $ 54.6 million in April 2001.

She also made a critical analysis of other problems facing the health sector in Tanzania, and revealed that they were not necessarily technical but more attributable to weaknesses in the institutional, legislative and organizational framework of the health sector itself. Hence the solution to these problems required re-organization of the sector. Recognising the need for institutional reform, the government initiated the Health Sector Reform Programme in 1996 which was being implemented under the Ministry of Health alongside poverty reduction strategies. It emphasized decentralization from national to regional and district levels.

In the case of Maternal and Child Health (MCH), Nderingo noted that the government conducted the Tanzania Reproductive and Child Health Survey

which was designed to provide information on levels and trends of fertility, family planning knowledge and use, infant and child mortality, and indicators of maternal and child health and nutrition. The study revealed that although the proportion of Tanzanian mothers who received antenatal care from a doctor, nurse, midwife or medical aide had remained steady at just over 90% since 1991-92, there had been a shift to the less trained health aides. The proportion of pregnant women receiving at least one tetanus toxoid injection had declined from 92% in 1996 to 83% in 1999. The survey also showed a decline in the proportion of births that occurred in a health facility - from 153% in 1991 - 92 to 47% in 1996 and 44% in 1999. Less than one in five of those who delivered at home went to a health facility for postnatal check-up within a month after delivery.

The results of the survey also showed no appreciable change in the nutrition status of children in Tanzania. Over 40% of children under five showed evidence of chronic malnutrition or stunting, while 5% were acutely malnourished.

Nderingo further noted that the number of health facilities available in Dar-es-Salaam City was too insufficient to meet the demand of the fast-growing urban population. It was also evident that there was an acute shortage of qualified and experienced manpower. Available data from the Dar-es-Salaam City medical office indicated that the health facility-patient ratio was 1:5,397. The same report showed that the doctor-patient ratio in the city was 1:18,637. Also, the shortage of financial resources to cover costs for proper operation and maintenance had resulted in the inadequate supply of drugs, injections, vaccines as well as the vital utensils and supplies required in MCH clinics.

She also cited long distances, poor communication facilities and the high cost of transportation as affecting attendance to MCH clinics by women. The general situation demonstrated the fact that there was still an urgent need to develop and implement appropriate urban health policies and strategies that would increase access to health facilities and services to the fast-growing urban population and particularly the poor urban migrants. In this regard, therefore, some specific targets in relation to MCH in Dar-es-Salaam were:

- To increase attendance of pregnant women at MCH clinics before 20 weeks of pregnancy by 50% of 1998.
- To reduce the deaths of women at delivery by 10% from 280 deaths 1000 in the year 1998.
- To increase the rate of immunisation by 20% - from 70 - 90% in the year 2005.
- To reduce child mortality rate at birth by 10% by 1998.
- To increase the number of mothers delivering at health centres from 30 to 50% by the year 2002.

She concluded by exploring the available options and argued that there was need to seek full involvement of the community and the private Sector in the process of reforming the urban health sector with the aim of improving the service delivery mechanisms (including MCH). As consumers, communities could play a significant role ensuring efficient cost recovery, thereby sustaining investment in the sector. As informal service providers (such as Traditional Birth Attendants) they could supplement the role formal service providers and build useful partnerships with the public and private sectors, particularly in addressing the service needs of low-income earners.

Nderingo noted that the most effective way of ensuring community participation was through broad-based partnerships where, for example, responsible municipal authorities shared information and consulted with communities in all aspects of service provision; and that municipal authorities provided the necessary legal, institutional and technical support to communities. An enabling environment was required to provide a viable framework for partnership. Among others, gender-sensitive policy frameworks were necessary to ensure the needs of women, especially in relation MCH services.

More important, she observed, was the full participation of urban women in promoting maternal and child care/health is crucial. Increased health skills among urban women would increase their access and utilization of the available services resulting into positive reproductive and health outcomes. Therefore, there was need to strengthen heath education and economic empowerment among the urban women.

She further mentioned the involvement of the private sector, which she said was very crucial, if municipal authorities were to meet the health challenges. In the context of the private sector partnerships, the priority issues should then include, although not exclusively, policy issues relating to urban health sector financing strategies, private sector participation, and protection of vulnerable groups; as well as implementing issues relating to the creation of an enabling environment for private sector partnerships and financing.

CHILE: The Rationale for Health Achievements *by Dr. Maria Elena Ducci*

Dr. Ducci noted that Chile had undergone an epidemiological transition reaching, at the beginning of the millennium, a situation close to the developed countries with chronic illnesses, cancer and accidents as the main causes of mortality.

She noted that it was important to call to attention the cases as Cuba and Chile, which despite the extreme resource shortages and limitations to develop their social policies like most developing countries, had been able to improve substantially their levels of health.

Dr. Ducci explained the better health levels of Chile and noted that Chile had been changing the water and sanitation problem, with 85% of the population accessing water and 83% sanitation services which accounted for the improving health levels in the country. She also observed that the country focused on maternal and childcare especially nutrition and pregnancy control. Childcare was mainly clone through the provision of free milk on condition that these children were taken to the health facilities. She said that medical attention for child birth was about 99%, malnutrition index was becoming lower and lower at 5% from over 50%, and immunization coverage was over 90%.

She attributed these levels to the high level of education in the country, noting that the relationship between health and education was very clear. She argued that Chile had had public health development since the 1950s when most facilities were public but currently more and more were being privatized. On this note, she emphasized need to directly; relate health with the environment, giving privilege to the poor i.e. centring on the poor communities.

Dr. Ducci observed that the main health problems in Chile were related to cancer, high blood pressure and obesity whose costs of treatment were very high. She argued that the clue, therefore, was to focus on prevention and promotion as tools for improved health in LDCs. She gave an example of a new model of medicine being developed, i.e. family medicine, which was more related to improving the environment though the results were slow.

In this regard, she cited the example of Cuba which had had a huge economic problem but a very high health level because of the concept of family doctors. She noted that LDCs should not wait to develop before tackling their health problems, emphasized community approaches that had been notable in the Cuban and Chilean experiences.

Discussion

Dr. Micheal White's Paper

A participant inquired about what experiences there were with the recent trend of unaccompanied children. How were they being provided for in terms of health given their vulnerability, and how was their right to health ensured? He was also asked to comment on the relationship between human settlements and environmental conditions, and the cases where the migrants kept moving in and out. How could the community-based services be provided?

In his response, Dr. White said that the issue of unaccompanied children had been around but little or no documentation had been made. He said that these were mainly driven by economic, social and economic disruptions. He called upon researchers to delve into this area so as to help authorities make good policies.

On the relationship between human settlements and environmental conditions, he argued that improved economic conditions increased personal conditions. He also said that there was need for public sector involvement whereby local institutions would educate individuals about environmental hazards.

As regards migrant family movements, it was suggested that temporary workers be hired in order to make the services very flexible.

He noted that there was a general need for resources to accomplish most tasks, and emphasized community participation and health promotion.

Roselyne R.M. Nderingo's Paper

Dr. Bazaara noted that there was need for the author to put the analysis in a historical context so as to enable the readers to see the position of the urban poor in Tanzania. He asked what policy changes there had been in the Tanzanian context.

It was noted that one of the municipalities (Ilala Municipality) had a very high level of condom use. Prof. Dodoo, therefore, asked what reasons accounted for the high use levels in the area compared to other municipalities. Participants also asked what provisions there were to address the early childhood issues of migrants' children.

Nderingo, in her response, noted that the government of Tanzania emphasized promoting the health sector and encouraged the cities and towns to make interventions that were relevant to, their situations. She also mentioned that the government had endeavoured to implement the Health Sector Strategic Plan. She noted that Dar-es-Salaam considered urban migrants as a challenge and had made a project to contain the bigger part of the population by 2006.

Concerning the high levels of condom use in Ilala, Nderigo said that it was the second largest municipality with average middle class residents who were mostly the educated folks. She argued that this status mainly contributed to the condom use levels.

She also noted that most women migrants were very poor, with low or even non-existent incomes and, therefore, nutrition was very, low. She said that over 40% of children in Tanzania were malnourished and MCH services were free, but access in terms of distance and availability of drugs were still the main problems.

Dr. Maria Elena Ducci's paper

It was recommended that there was need to pay more attention to the local sources of medicine much as they were retained. Dr. Ducci argued that Cuba had been involved in a lot of research but did not talk about drug

manufacturing. She said that if they were manufacturing the drugs, then it was possible that the drugs were being sold.

She also emphasized that traditional medicine did not compete with western medicine but could be used by LDCs to promote health following the Cuban example. It was also necessary to consider the use of ambulatory clinics (mobile clinics).

Panel II: Health Delivery Systems

The Role of NGOs in Health Service Delivery *by Dr. Wendy Prosser*

In her presentation, Dr. Prosser noted that urban regions and the social problems found in them were beginning to receive attention from the development community; as the theory of "urban bias" was unravelling and development practitioners were realizing that cities had many of the same problems as rural areas. Rising poverty and rapid growth in urban populations were straining physical infrastructure and increasing income inequality, all exacerbating the health problems of the poor. The paper investigated how NGOs could maximize community benefit by incorporating three key factors in delivering health care services:

- Using an intersectoral approach combining projects from many disciplines.
- Creating selective collaborations with other international NGOs, local organisations and Government.
- Fostering community participation and cooperation in programme delivery.

Even though many successful programmes included these-aspects in day-to-day efforts, this changing field of development demanded that NGOs use their adaptability, creativity and the ability to learn from others to increase the impact they had on urban populations.

She further argued that over the past century, the world had witnessed an urban explosion, which strained the infrastructure and social systems of urban areas, especially in developing countries. These urbanization issues had to be considered within the larger context of a world that was facing globalization, shifting political paradigms, and creating new economic and social constraints. Conflicts then arose which would determine who would be migrants, refugees and those fleeing to urban areas. Many of these costs involved the health of the urban poor and could be mitigated by interventions such as job creation, skills development, sanitation and social marketing of health education. International non-governmental organisations were in a position to provide interventions that

addressed some of the dramatic changes occurring in urban areas of developing, countries.

On the role NGOs, she noted that they had become important players in promoting and facilitating development in low-income countries. Research and experience showed that certain characteristics of NGOs made them adept at addressing health problems of the urban pool. Addressing the specific needs of the urban poor presents special challenges for NGOs. NGOs could successfully implement health programmes in the most low-income areas of a city, but the question still remained if the most disadvantaged were benefiting from the programme.

To counteract these challenges to health strategies, she argued that NGOs should draw on their strengths and experiences to include three features in future health projects:

1. Using an intersectoral approach: For these purposes, an intersectoral approach recognizes that the health of the urban poor depends on more than just access to health care and, therefore, incorporates all sectors and disciplines into addressing, the health problems by providing services for the factors which influence health such as, the physical environment, an individual's income level, education level, behaviour and practices. The point is that NGOs cannot provide only health care services without taking into considering the availability of other resources in the community and other factors affecting health. An NGO is not expected to provide all the necessary services for an area, but some programmes can be combined to address certain problems. Whatever the approach of an NGO, it must be complementary to other available programmes and services which leads to the need for collaboration.

2. Developing selective collaboration with government, local organizations, and other international NGOs: To create an intersectoral approach and provide all the needed services to the urban poor, NGOs must work with local and national government entities, other international NGOs and local organisations. Lack of coordination can create "inadequate geographical and sectoral coverage, duplication, competition and - ineffective use of resources". The development community has talked about the importance of collaboration for years, in the form of everyone across the board sharing all information and working together. But this has shown to be inadequate to the task of consistently impacting health services to the urban pool. A more directed, pro-active method would bring, about better results.

3. Selective collaboration implies NGOs, as well as other players in the field of health service deliver; understand the role they play in the community

and the responsibilities of other organizations in other sectors. NGOs need to understand the entire landscape in which they operate their role in it, and their position in relation to other service providers. Having this information enables the organisation to more readily approach others by knowing whom to approach and what to work on together. NGOs should identify their programmatic strengths and the niche they fill in development and within a particular community. Then NGOs can build on these factors to provide effective services that complement the other activities in the community.

As valuable as service coordination is and as logical as it seems, history has demonstrated collaborations are time-consuming, are laden with process and can be ineffective. To improve alliances, Dr. Prosser alluded to Gilson et. al that coalitions of all partners (international NGOs, government agencies and local organisations) should clarify the role of each collaborator, strengthen capacity to implement their responsibilities and build mutual trust and willingness to coordinate their responsibilities better. Umbrella groups can provide this coordinating effort and become the information resource centre, but it is most effective if one organisation spearheads the endeavour. A useful tool in identifying possible partners is political mapping, Organisations use this simple tool to identify other organisations in the geographical area, political influences that may be counterproductive or helpful to their development efforts, and citizen groups (both supportive and uncooperative). This tool can be tailored to specific urban areas or to specific issues. Using this tool and evaluating the results places the NGO and its work in the broader context within the local situation and identifies important players and the local community.

4. Fostering community participation and cooperation: The assumption here is that the goal of NGO activities in urban areas is to create sustainable programmes the benefit the neediest of the urban poor. Coalition building assists in achieving this goal of sustainability as well as community participation and capacity building. Community participation can identify local problems, as well as garner community involvement in addressing those problems. Participator Rural Appraisal (PRA) is a tool which includes the community in naming, problems, recognizing solutions and empowering community members to implement interventions themselves, and has become a cornerstone for development. The three basic components are a facilitative attitude open methods and a partnership for everyone involved. The aspect of skills transfer of PRA techniques and other management capacities is a major method of creating sustainable development programmes.

On challenges, Dr. Prosser noted that the paper did not describe any new approaches to improving health care for the urban poor, but examined past applications of existing approaches to health care service delivery in order to learn from them. Criticisms of these approaches and NGOs' roles in facilitating them substantiated the fact that health care delivery could still be improved. NGOs had been criticized for creating dependence in communities by providing services that the public sector should be providing. NGOs were dependent upon donors, who could dictate what services they provided. In addition, because they are accountable to donors and not to the local government *per se,* critics argued that NGOs operated at the local level with no regard to, or support of, national health plans or policies. Also, NGOs found it difficult to collaborate with other organisations which could be detrimental to this three-pronged approach. All in all, collaboration being promoted, and in view of the prevalent need for health care improvement, NGOs had some challenging decisions to make in order to change the way they worked with the community, other organisations, and government agencies to deliver health care.

She concluded that only by learning from past experiences and reviewing the criticisms of the current efforts could NGOs improve upon health service delivery for the urban poor. Critiques could be mitigated by using a truly participative approach to involve the community and by using Selective Collaboration of groups involved in service provision. Interventions for health improvements could not be isolated from other efforts. The best approach an NGO could take was to identify what it did best and complement it with other organisations and programmes to work towards meeting all of the needs of an urban community. Community participation and transferring skills were simple keys to increasing the success of meeting basic human needs and making programmes sustainable. By focusing on a few elementary efforts when delivering health services to the urban poor, concerted impact and lasting improvements in the lives of people at risk was, indeed, possible.

Urbanization and Health Service Delivery in Kenya: Challenges for the City of Nairobi *by Dr. Benjamin M. Nganda*

Dr. Nganda began by giving a historical background of the philosophy of primary health care and how it had guided health policy and planning in most developing countries. He noted that the focus had largely been on the rural areas of these countries. Rarely had issues relating to the problems of rapidly-growing cities been addressed. Generally, most countries' national health budgets tended to be pro-urban, largely because most hospitals, which provided rather expensive care, tended to be located in the urban areas. Consequently, when examining the issue of equity in health care at the national level, it was often argued that the rural areas deserved special consideration if this pro-urban bias was to be rectified. Iii recent times, however, it had been recognised that there

was an urgent need to develop primary health care in urban areas as there was in rural areas.

With the ever-increasing rapid urbanization, urban populations in most countries had long surpassed the carrying capacities envisioned at the point of urban development, especially in the poor and developing countries. As a result, cities in these countries were faced with over-utilization of the social services available, especially in education and health which were basic and fundamental for human development and quality of life. The rapid rates of urbanisation and the associated growth of poor urban populations had prompted health policy-makers and planers to raise questions about the appropriate way in which to develop the urban health care delivery system.

Dr. Nganda then went on to highlight the challenges facing Nairobi as a rapidly growing urban centre. The urban population, according to the 1999 population census, stood at approximately 10 million; and about 22% of the urban population was residing in Nairobi, the largest urban centre in Kenya. About two thirds of Nairobi's annual population growth came from natural increase, the rest from net migration. High population densities were experienced in the low-income areas of Eastland and in uncontrolled or illegal structures in the slum areas. An estimated 40% of Nairobi's population lives in slums. All the slum areas had population densities much higher than the city average. The 1992 Strategic Health Plan for Nairobi estimated that about 31% of Nairobi's population was crammed into 2% of its inhabitable areas. Yet, despite the overcrowding in these areas, populations in these areas continued to grow faster than in the rest of the city. The majority of migrants into the city settled in these low-income areas where housing costs were relatively low. Their friends and the relatives from the village were also likely to be residing there.

Concerning, the organizational structure of Nairobi's health services, Dr. Nganda argued that there was a wide range of facilities, both public and private. They ranged from single-purpose clinics, integrated service centres, private medical clinics to the national referral hospitals. The Nairobi City Council ran the largest number of health facilities, followed by the private sector, the Ministry of Health, other Government ministries and a variety of Non Governmental Organisations in that order as shown in Table 1.

Table 1

Inventory of Health Facilities in Nairobi 2001

Health facility	NCC	MOH	Other ministries	Mission NGOs	Private	Total
Hospitals	1	5	1	1	8	16
Health centres with matern1ty beds	9	-	-	-	-	9
Health centres without beds	19	-	-	-	-	24
Maternity Units/nursing homes	1	-	-	2	9	12
Dispensaries	7	44	8	23	67	149
Clinics	25	13	-	-	4	42
Total	**62**	**67**	**9**	**26**	**88**	**252**

NCC - Nairobi City Council
MoH - Ministry of Health

However, he said that many of the city dwellers in the city of Nairobi were already exposed to major threats to their health and well-being. They had to contend with appalling overcrowding, bad sanitation, and, where they get it, contaminated water. The result was a plethora of diseases associated with poverty. Being the main urban area in the country, one would expect to find a slightly different epidemiological pattern compared to the rural areas.

High levels of traditional health problems evidenced by high maternal, peri-natal, infant and child mortality rates and malnutrition and infectious diseases became the norm. Infectious diseases as acute as respiratory infections could impact on nutritional status, while overcrowding both indoors and outdoors meant the transmission rates could be high. From a public health as

well as economic perspective, there was need to improve the health status of the slum dwellers using, an environmental health approach focused on the physical infrastructure for water.

Besides the illnesses associated with traditional health profile of developing areas, certain health problems were now emerging, largely within poor communities in the city, that were typical of industrialized societies. They included hypertension, mental illness, drug and alcohol abuse, sexually transmitted diseases (including HIV/AIDS), accidents (traffic and industrial) and violence. The conditions under which many lived were frighteningly oppressive and conducive to hypertension and mental illnesses. All in all, he observed, the health delivery system had not been able to cope with the increased demand for health services and economic growth rate. As a result, the service delivery system performance had been dismal in the provision of health services to the urban poor.

He also observed that the phenomenal increase of population in the city had brought problems with it, especially, in the area of health service provision. The system faced financial, logistical, political and administrative constraints, which had led to the dismal performance of tile service. This, coupled with rapid urbanization, could prove a disastrous recipe for poor health for the majority of the urban poor, who were the majority in terms of numbers of those who received inferior health care. These very people worked in risky occupations, used risky transport systems, lacked adequate clean water supply and often had no access to adequate health facilities.

He concluded that there was a dearth of research in, some vital areas relating to the provision of health services to the poor in the urban areas in the country. There was not much information, for example, on what the poor in the urban areas paid for a wider range of services in the face of over-utilisation occasioned by the vast numbers. There were also gaps in research in certain areas in terms of the physical environment and its effect upon health. There was, therefore, need to do comparative studies to show which policy initiatives would ensure that those in the greatest need in the urban areas the urban poor who currently had the poorest access to health services - had access to these services.

Health Delivery Systems: Kampala City, Uganda *by Dr. Jessica Jitta*

Dr. Jitta observed that health was one of the main concerns of poor urban people and that the delivery of health services directly affected the health status of the individuals. Urban health problems continued to grow as the urban impoverished population increased, especially among the most vulnerable population, children and women. The provision of health services in Uganda was constrained by inadequate budgetary resources - less than 1% of GDP and was heavily biased in favour of curative services. She also observed that Uganda had adopted Primary Health Care strategy and decentralized health services to

district and sub-district level. It was estimated that government provided about 40% of care, NGO units 25% and the rapidly proliferating private sector (clinics and drug shops) provided 35% (MOH, 1993). These proportions were rough and did not reflect parallel care services. Cost-sharing in government health units had been introduced from early 1990s but had recently been scrapped.

She further gave a brief background of Kampala City which she said was administratively divided into five divisions, each serving as a sub-county and with relative autonomy in revenue collection, planning and delivery of social services including health. Kampala residential population was 902,899 ie 40% of the total country urban population, and its annual growth rate was 4.8%, twice the national growth rate (2.5%) (Kampala Urban Study, 1993). The city had many slums/unplanned areas, which were relatively small and located in swamps and densely populated.

Health situation in Kampala

Uganda in general had poor health indicators and a heavy burden of disease where 75% of life years were lost due to premature death brought about by preventable diseases. Morbidity and mortality patterns in Kampala were similar to the national picture, mainly malaria, diarrhoea and respiratory infections in children and malaria and HIV/AIDS in adults. The poor people recognised the major causes of ill health as well as their seasonal variations. The health care systems in the city consisted of both the public and the private health facilities. Generally, Kampala residents had greater access to health facilities than the national average of 49% of the population living within 5km of the nearest health unit.

Human resources in the health sector remained inadequate in the country. Overall, the doctor/population ratio was 1:18,700 while that of trained nurse was 1: 4,300 and mid-wife/child bearing women was 1:1,800. 82% of the medical offices and allied health professionals, 79% of registered nurses and 63% of enrolled nurses were in hospitals (MoH, 1993). Kampala public health units were general1y better staffed with professional health workers compared to the rest of the country.

Most facilities, both private and public, focused mainly on curative services, in part due to the high morbidity and mortality rate that accelerated the demand for such services. Users, however, showed preferences for specific health services: for example; KCC health services were commended in particular for their services in the treatment of STDs (Jitta and Ndide, 1998). Private clinics offered curative services to the majority of the people and only a few of these provided preventive services such as immunisation and reproductive health services to their clients. Drug shops, though not very distinct from clinics, were mainly utilized for purchasing of drugs but also offered consultations.

Parallel health care services formed an important part of the health care system in Kampala. These included traditional healers (herbalists and diviners) and Traditional Birth Attendants. Traditional Birth Attendants and Community Health Workers had been trained and worked in many parts of the city. They were appreciated by the community because of their expertise and personal attention they gave to clients at a lower cost.

As far as access to health services were concerned, most residents lived in less than 5km radius to the nearest health unit. Private clinics and drug shops used most frequently were located within the communities. Medical personnel owned these clinics but, in most cases, unqualified attendants run them.

The cost of health care was reported to constrain access to health services by most urban dwellers. The biggest problem was when a patient needed hospital admission and/or specialized services and investigations e.g. X-rays. Alternative providers were more inclined to accept partial payment.

The quality of health services was judged on the basis of availability of drugs, staff training and staff attitudes to the patients. Mothers perceived paying units to be with better quality of care probably due to better staff attitudes and also promptness and cleanliness (Jitta and Ndidde, 1998).

Health-seeking behaviour and source of treatment

Kampala residents practised medical pluralism; blomedicine was popular but was combined with traditional means of care. Economic Implications and social factors determined the choice of therapy, the poor attended public health units more frequently. Advice from relatives and friends and knowing someone in a health unit might significantly determine the choice of where to seek care.

Funding of health care services

Users and donors dominated financing, health services in Uganda. Public health units were under funding from the health department of Kampala City Council (KCC). KCC health department received funds from the central government and parent districts. In 1998, 10% of the health budget was approved and only 1% of the total budget was received. User fees collected at the health centres (about US $800) a month was used for recurrent expenditure while KCC covered salaries and wages. Specific programmes paid for vector control and supplementation of drugs. Specific funding, equipment and vehicles were provided by Essential Drug Management Programme and NGO Primary Health Care projects (Jitta and Ndidde, 1998).

Coping Strategies

Coping mechanisms were embedded in the people's health-seeking behaviour, Home treatment was the commonest form of coping as households attempted to cut on the costs of health care. During periods of financial hardships, many opted to buy under-doses, while others shared drugs, particularly among children. Other coping strategies included borrowing money, and visiting, health units where health providers could offer credit. Dr. Jitta further noted that the study revealed that the poor people had their own aspirations for health services, which included the following:

- 95% of the respondents said that people should not pay for health care in government health facilities.
- At household level, individual families should keep their surroundings clean and endeavour to participate in public health activities. Women felt that they should be involved more in decision.-making processes for family financial management.
- At community level, local councils should establish health days in each zone to focus on clearing garbage, drainage to reduce disease risk. Health committees should sensitise communities to improve health practices and reduce preventable diseases in the area.
- Medical personnel should attend to patients promptly and show more compassion to the sick, attending emergencies more efficiently and faster. Drug management should be improved to ensure more equitable distribution of drugs to patients. Technical capabilities of medical staff should be improved with in-service training to equip staff with adequate skills.
- Staff remuneration should be improved to reduce unofficial payments in government health units and more drugs and essential equipment availed in the units to improve overall services.

Discussion

Dr. Wendy Prosser's paper

NGOs were mainly driven by donors who dictated what should be done; and the difficulty with collaboration was that there was a tendency of competition especially where there was a tender system. Did anyone think NGOs could do more than just being a voice e.g capacity building?

In Uganda, there was a tendency for government to regulate NGOs. What was the relationship between the state and civil society? Was it necessary for a partner to regulate or control another?

There was a strong desire for individualism among NGOs especially escalated by the donors. Donors were very much driven by individual points of view and political objectives; and this -which called for building meaningful linkages and the art of sharing. There was, therefore, need to institutionalise the NGOs away from the donors.

It was noted that donor funds were not available to NGOs which were funding their own issues.

Dr. Nganda's paper

A participant questioned whether the link between urbanisation and the spread of HIV/AIDS and other STDs was automatic. Weren't there places where there was urbanisation and the rate of the spread of STDS was tile same or even less. What policy could be drawn from here?

Dr. Jessica Jitta's paper

It was noted that the composition of the people in question came from disturbed areas and, therefore, it was difficult for them to cope because of psychological problems. How much capacity were NGOs investing in the poor people?

On the need to recognise the use of traditional services, there was need to be selective about what kind of services they offered, and inform the users about what ailments got alternative treatment and those that did not.

A participant observed that Uganda lacked an urban policy, and cited the example of Kampala City which was still considered as a district. The dynamics of the urban setting were not taken care of, especially in terms of funding.

It was also observed that most successful programmes were religious based. Was there a way in which the initiatives of the religious organizations could be copied since most of them combined both the spiritual and the modern aspects? Was there a way this form of collaboration for these two could be combined?

Responses from the presenters

Dr. Wendy Prosser

She observed that donors were now moving more to funding partnerships and NGOs could still carry out very good work if they collaborated. Selective collaboration was a different way of collaboration which could be very workable.

On the regulation of civil society, she noted that the sphere of importance had to be emphasized and, therefore, work in that framework to avoid any form of clashing or duplication.

She further noted that most NGOs targeted the poorest of the poor, but the challenge was how to identify them. She also emphasized the need to establish link and partnerships.

Dr. Jessica Jitta

She noted that most of the migrants came with a lot of psychological trauma but there was a place informally gazetted for the first arrivals that later moved to other dwellings after they got used to slum life.

Traditional alternatives needed to be studied further to understand how they could be used, but they could not be stopped. Therefore, there was need to recognize the complimentality they provided for the medical services.

Dr. Nganda

On the relationship between prostitution and urbanization, he noted that the two were related and that this experience was not unique to Nairobi City.

The cost of care of sexually transmitted diseases was very high which led to further spread of the diseases.

Participants observed that there was a strong need to educate the donors on what the communities needed and what was relevant in terms of interventions.

Panel III: Migrants' Contribution to Health Systems

Migrants and Public Health in Uganda: From 'Pathogens' to Agents of Public Health Care Development *by Samson James Opolot*

"Present speculation on the origin of AIDS' iii Uganda reminds LIS of the old attitude that disease is often inflicted upon a population by outsiders. The history of the Banyarwanda migrant labourers provides a rich example of borders, population movement and public health issues. It also provides all example over time of the pathologisation of an entire group of people. From nearly the beginning of their arrival in large numbers, the Banyarwanda were perceived to be a threat to the health of the Ugandan Subjects" (Lyons, 1995, 2-3).

Opolot began with the above quotation, noting that it encapsulated the central contradiction between migrant labour, capitalism and public health concerns in Uganda. He said that the contribution of migrants to the development of public health in Uganda evolved from the introduction of capitalist relations of production and the ensuing struggles of the migrants, and the poor in general, for better economic and social conditions of work. These struggles by migrants and the poor placed improving public health care services on the agenda of the state right from colonial days.

Much of the debate in migration theory had centred on the context to which different actors had room to manoeuvre in decisions about migration. At one extreme, neo-classical models presented, the migration decision as resting with the individuals based on their analyses of the costs and benefits of moving. At the other, structuralist models suggested that labour migration systems were established to serve the interests of capitalism and the individual has little choice in the matter (Bakewell, 1999). However, migrants should be viewed as social actors working with some room for manoeuvre while constrained by the wider social context in which they exist.

Some studies on the conditions of labour and refugees had begun to yield a new crop of literature that emphasized the contribution of migrants to poverty eradication and development. This literature, among other things, raised some salient issues with regard to migrants. Migrants tended to migrate to increase personal/community welfare (whether they moved together or retained links with their roots). Second, migrants were not a net burden but tended to improve the welfare in the areas of destination. Third, migration from areas of scarcity to those of plenty helped to reduce global inequality. Fourth, migrants were conscious actors and not objects of pity.

He then historically analyzed the interface between urbanization, poverty, migrants and public health in Uganda with the aim of highlighting the contribution of migrants to public health development.

Colonialism, Urbanization and Migration

Colonial states like Uganda had been labelled as 'soft states' because of the incomplete development of capitalist forces. According to Myrdal (1970), soft states manifested patterns of inefficient management systems, less effective exercise of control, sanctions and corruption. In sum, the soft state reinforced inequality. Urbanization in Uganda (developed to provide administrative posts and collection centres for agricultural and other resources plundered from the interior by the colonial government. The weaknesses of the soft state were reflected in the management of urbanization in Uganda and Africa as a whole with negative consequences for health and wealth distribution among the majority of urbanites.

As Gilbert and Gulger (1981) put it, the third world city was the 'instrument of conquest'. It was built to house the colonial master and the elite but exclude the majority of the African population. In it, modern services e.g. health, education, recreation, trade and industry, were intended for the 'conqueror' and not the 'conquered'. Largely, concerns over rural-urban migration were based on the conception of cities as 'safe havens' from the squalor of the countryside. It was held to be true that 'virgin' populations in cities were at risk of disease brought by unclean, infested and unhealthy rural migrants who had to be kept at bay. African women, ill particular, were for a long time barred

from migrating to urban areas regardless of their status as mothers, wives or workers. The exclusive city was based on a residualist approach to the development of urban social services such as health and housing.

The history of migrant labour to Uganda took the form of population movements from the North-West bringing immigrants from West Nile district and the adjoining areas of Congo and Sudan, and the South-West bringing in migrant labour from Kigezi, Ankole, Rwanda, Burundi and Tanzania. Most of these migrants were destined to the sugarcane plantations in Central (Buganda) and Eastern (Busoga) Uganda. Because migration could not be controlled, there emerged a historical discrepancy between the urban population and available public health amenities in Uganda. For example, Kampala was the most urbanized and densely populated district followed by the second largest town of Jinja at 4,581 and 428 persons per sq. km respectively. However, these two cities had less than adequate facilities to cater for the increasing urban population.

Consequently, the urban poor - most of them migrants - found their ultimate source of livelihood in market exchange, but could not survive individually. The market failed to provide any security and the poor were not in position to accumulate savings. They survived by complimenting market exchange with a system based on resources of kinship and friendship, which followed the rules of reciprocity, a mode of exchange among equals, embedded in, a fabric of continuing social relationships (Lomnitz, 1974). However, the reality today was that rapid urbanization in developing countries like Uganda had tended to absorb a proportionately higher share of the countries' scarce resources. And yet the high rural-urban migration continued to put more pressure for increased health services to cope with the ever-expanding population.

Migrants Contribution to Public Health Development

In a bid to avoid investing substantial resources in developing social services in the colony, the colonial administration applied all measures at its disposal, including coercion, to encourage or control migration depending on the demand for labour at the time. And, in the majority of the cases, public health concerns only became an issue whenever there was surplus labour that needed to be dispensed with (Rutabajuka, 1989; Mamdani, 1976; Ahluwalia, 1995). Therefore, largely, migration was a product of capitalism and consequent urbanization. To confirm this, even the identity of migrants (whether in terms of gender, tribe, religion, and class) also depended on the labour policies of the capitalist state. For example, initially, concern was with indigenous labour, followed by migrant labour, followed yet again with rural labour reserves when adverse conditions in the rural areas threatened to curtail the reproduction of labour.

It was the poor terms of service, and the stigmatization that went with it, that forced migrants to adopt various forms of struggle to force their employers to cater for their social and economic needs. Therefore, migrants did not just succumb without resistance to capital, though this took the form of individualized action. This ranged from absenteeism, physical confrontation, to desertion of bad employers (Rutabajuka, 1989). These struggles brought to the fore the limitations in social service provision and, especially, the inadequacy in public health care services in Uganda at the time. Albeit being largely individualized throughout the 1930s, this agitation culminated into strike actions by farmers and industrial workers in the latter half of the 1940s forcing the colonial administration to invest in developing more public health care infrastructure in the country.

According to Brett (1992), the structure and the role of the working class, and the tensions in its relationship with capitalism had been crucial to political and economic development in modern societies. However, according to him, the limited proletarianisation undermined collective labour in Uganda inhibiting the development of a radical working class movement in Uganda. This resulted from the extreme suppression of any form of dissent to the colonial administration's policies.

The process of redressing past social and economic, Unbalances continued into the post independence era with donors supporting planning and large state-dominated enterprises in industry, agriculture and social services. These developments went ahead with the Africanisation of the civil service, the scaling up of investments in the banking, insurance, roads, transport and communication sectors as well as education and health. These policies greatly extended opportunities for African advancement. The health sector was among those that could be credited for high performance, in terms of growth. Nevertheless, the post colonial governments did little to channel resources to the poor. Thus, even in the sixties, most people did not benefit from independence: the hand hoe remained the fulcrum of export agriculture, the poor had limited access to the modern sector; the poor remained alienated from the state. Increasing discontent and the recourse to the army to contain it led to the political events that culminated in the 1971 coup which ushered in Gen. Iddi Amin Dada and the regression, human rights abuses and institutional decay that came to characterize Uganda up to today.

However, the negative attitude towards migrants as a source of poor health continued into the 1960s; and there is evidence that it remains entrenched in popular consciousness today, especially in the areas that thrived on migrant labour such as Masaka District.

The patterns of immigration in Uganda remained the same even after independence until the 1970s when the effects of economic decline began to bite. In addition, there was considerable immigration from the Nyanza province of Kenya

In response, the post-independence government provided transit labour camps in which sleeping facilities were provided for 80,638 immigrants in 1964 alone - approximately 20,000 above the average for the two years of 1962 and 1963. Besides these temporary measures, effort was made to improve the health and social amenities in refugee settlements. However, the above figures did not reflect the total number of people entering the country, in search of employment as improved means of transport made it possible for many of them to avoid having to stop at the labour camps for a night (Government of Uganda, 19615, 43-44).

Contemporary Dynamics on Migrants and Public Health

Projections showed that by 2010, 40 - 60% of Africa's population would be living in the urban areas yet there was little evidence that constructive steps were being taken to plan for this colossal scale of urbanization in a country like Uganda. With the economic decay and political mismanagement that characterized the 1970s, proper urban governance was still a new craft. For example, a basic asset that eluded the urban governors was the command of reliable planning data. Urban civil servants lacked logistics and motivation to take interest in and document important developments like urban immigration, leave alone how it was impacting urban development and/or vice versa. These and other factors had obscured the visibility of the plight of the urban poor in general and the migrants within them in particular.

In this section, Opolot provided some insights on the contemporary dynamics of migrants, the urban poor and public health in the city of Kampala. According to the 1991 Population Census, Kampala remained the major destination of urban migrants with adverse consequences for health and social service delivery in general. The poor who dominated the ranks of the city's population undoubtedly suffered the brunt of inadequate health services in the city. It was noted that Kampala commanded approximately three times the immigrants to the rest of the districts in Uganda. And more women than men were migrating to the city. However, this increased immigration was taking place in the context of limited health facilities and general urban economic decline considering that the city was not planned for its present population. Generally, the urban population, accounting for 11.3% of the total population, was concentrated in Kampala where 41% of the population lived.

As the population of the city continued to grow rapidly, the public health care amenities had remained inelastic. When specific, health services breakdown was done, it was obvious that services such as maternity health were even more absent in the city. The table below shows that Kampala City has only 43 health units to serve a population of over eight hundred thousand. Yet we contend that this population was grossly underestimated.

Table 2

Population vs Health Services in Kampala City

Population (1)	Hospital	Health care/ maternity dispensary	Maternity unit (3)	Dispensary/ sub-dispensary	Total unit	Population per bed 1/6= (7)
866,500	14	11	3	15	43	20151

Source: Compiled from statistics of Planning Department, Ministry of Health.

The 1991 Census report noted that this rapid increase of the urban population was bound to create pressure on the urban infrastructure like water supply, housing, transport, educational and health amenities (Republic of Uganda, 1998). The biggest challenge in planning for heath services in cities like Kampala was the rapid population growth compared with the sluggish growth in health budgets. The economic interests of migrants aside, the population factor was aggravated by the influx of patients from the periphery of the city, just because health facilities were concentrated in the city. Worse still, the health facilities were largely located in the central business district with the lowest residential populations. Those areas with high population densities such as slums, which housed the urban poor, were conspicuous for the absence of health and other social services.

A participatory poverty assessment conducted in nine pilot districts in the country concerning the poor's perception of the urban quality and delivery of social services in Uganda found unanimity in the complaints that health service delivery was the poorest. The urban poor in Kampala the capital city found it extremely difficult to afford the rather high cost-sharing rates. Other factors inhibiting access to public health included distances to the health units - especially in rural areas, poor quality of aviii1able health services, limited health infrastructure, human resources, inadequate and irregular health supplies (Prosper Tumusime, 2001 in *Uganda Health Bulletin*', Vol. 7).

Geographical coverage of the health facilities did not reflect the actual needs. Consequently, the distribution of these services was not equitable, and their accessibility was poor. In addition, many health units did not provide the full range of public health care services. In Uganda, over 50% of the hospitals were situated in urban areas, while most of the health centres were located near trading centres. Most of the private clinics were also located within or close to the urban centres. For example, there were more than 400 private clinics in Kampala City alone. Besides, the bulk of government health expenditure was

currently devoted to the curative treatment of mostly preventable problems, hence the need and re-orientation of health care delivery in the future to public health care.

Responses of the Poor

Like in the past, the poor did not take abuse of their rights to social services sitting down and resorted to forms of struggle to access the modern services or innovate with traditional alternatives. Today, communities of the poor resorted to informal networks of health provision that ranged from small credit schemes to supporting poor colleagues' treatment in clinics or exchange of herbs including magic. This had in recent times led the Ministry of Health to formally recognize the role of traditional medicine in mitigating the lacunae in public health service delivery in the country. The Ministry of Health and Makerere University were currently carrying out joint medical research for treatment of ailments such as AIDS with traditional healers.

Because of the magnitude of the HIV/AIDS pandemic, Uganda was witnessing a proliferation of community and national-based health care associations. Major players like The AIDS Support Organisation (TASO) and National Community of Women Living with AIDS (NACWOLA) in Uganda emerged out of urban community initiative. Especially among the rural and urban poor, there had been a proliferation of burial groups/societies in response to the challenges of providing care and managing the rate of mortality caused by AIDS which had particularly affected the urban poor. Such groups were mostly found in slums where the urban poor lived. Those who failed to cope with AIDS care in the city were forced to migrate to other towns or rural areas. In other words, AIDS played a key role in migration patterns today, placing it at the centre of the public health care demands of this century.

Besides work, kin and neighbourhood-based groups in the city, increasingly common today were women's associations geared at improving the social and economic welfare of members' households. Together, they exchanged credit (that may have been internally or externally mobilized) to invest in development projects. Given that women bore the bigger burden of health care, the health conditions of members came first in their budgetary allocation of pooled resources, however meagre.

However, on top of the initiatives of the poor there had also been a rapid growth in numbers of urban health service organisations keen on contributing to the management of AIDS, cholera, malaria, and others. The role of Rotary, Lions and other clubs was noted in this regard, as well as the numerous charities such as the Gatsby Charity in the area of urban sanitation and supporting the ailing poor to access unaffordable treatment. On a broader scale, it was common knowledge that non-governmental organisations and other non-profit

foundations led by the church had a dominant stake in developing and managing Uganda's health sector.

Finally, the Kampala City Council, despite its limited resources and the administrative limitations noted at the beginning, was commended for scaling up its investments in developing and improving the quality of public health services. As noted, there remained a challenge in targeting such public health care growth towards the poor because of the limited research conducted by or accessed by KCC that would improve the targeting of the poor in urban infrastructure development. Above all, the limitations of the budget could not be overemphasized.

Opolot came up with the basic recommendation as the need to provide supportive policies for taking stock of and supporting migration. This should, however, not apply to all cases: there were forms of migration that occurred in such exploitative circumstances that the aim should be to stop this and provide alternative means of livelihood to migrants.

Consequently, more than ever, before, urban scholars and managers were increasing1y becoming critical of the distribution of urban resources and, therefore, attacking urban management models that exclude minorities, migrants or the poor.

There was need for comprehensive planning for the better health of cities in Uganda and this could not be left to urban authorities or the poor alone but had to involve the active participation of government, NGOs and donors. Rapid urbanization implied that planning for health services in urban areas had to be stepped up if adequate health at acceptable levels of quality was to be provided to urban dwellers. Underlying this requirement was the call for a holistic approach to service delivery. In other words, improving health systems in urban areas was contingent upon the resolution of a diverse range of absent or poorly delivered services that included:

- Improving quality and access to housing.
- Improving sewerage, garbage, sanitation and urban environment management.
- Improving quality and access to water.
- Improving urban transport and communication system
- Improving quality and access to health and education services.

However, as this was being done, it was important to ensure that our cities became more inclusive through participatory development. The urban poor and other minorities should be stakeholders in defining and implementing the 'dream' healthy city. There was need for inclusive cities where policy was re-oriented towards guiding urbanization other than preventing it, which called for urban governance that acknowledged more holistic, inclusive and participatory

policies, strategies and actions required making the world's cities and comm. unities safer, healthier and more equitable.

Self-Help Initiatives of Urban Migrants: A Case of TASO Uganda
by Winnie Bikako

The paper explores one of the most common means through which local populations in Uganda have acted to satisfy their own means, namely self-help groups that heavily rely on foreign funding. The AIDS Support Organisation (TASO) is one such initiative. The contribution of TASO is discussed from various dimensions that, in the author's view, are significant in improving the country's health system which is currently overburdened as a result of the HIV/ AIDS pandemic.

Bikako, therefore, argued that the contribution of the urban migrant population to the health system could be understood in terms of the migrants' continuous struggles to resolve the predicament of the poorer and vulnerable sections of the urban communities. Its performance was seen in terms of its capacity to satisfy unmet health needs; the level of community participation; a degree of utilization of the provided health services and the extent to which equitable benefits were derived from the provided services.

She further observed that on assumption of power in 1986, the National Resistance Movement government was confronted w1ith three major challenges within the health sector namely: the poor health status of the population, inadequate funding support for health care and poor health infrastructure. These were later to form the basis of change in the entire health policy framework. The eighties, therefore, registered two significant changes. There was a marked shift in the key actors within the health delivery system, from central and local government structures to international health actors. Secondly, the nature of health care provision changed. In the absence of an overarching health strategy, an increasing dominance of selective vertical programmes characterized health care provision, engendering the proliferation of different donor-funded project-based interventions. These interventions were basically linked to the internal policies of the various international agencies; effectively creating a series of unintegrated "micropolicy" environments and interventions that largely reflected the values, ideologies, objectives and priorities of the agencies. The policies were, therefore, defined in terms of the type of intervention, and geographically, within the confines of small project areas, with little, if any, integration with national policy.

The 1990s marked government's commitment to address infrastructure and material resource crisis that it had inherited. Priority was given to developing and implementing policies on health financing and infrastructure development. With strong donor influence and guidance from the Health Policy Review Commission, which M 1987 had made an extensive analysis of the health

sector situation of Uganda, Government undertook infrastructural development through a two-pronged strategy which sought to rehabilitate the existing health system and to further develop Primary Health Care (PHC) services. Reorientation of the health care system to PHC was seen as one of the major ways of overcoming the health challenges.

The 1992 three-year health plan laid out five major policy recommendations:

- No further expansion of health care infrastructure would be done.
- Priority should be given to restoring the functional capacity of existing facilities.
- The health care system should be reoriented to PHC.
- A basic health care package approach, determined by local needs and available resources, should be used.
- A user-charge policy should be promoted as one way of financing health care in Uganda.

Bikako argued that the reinforcement of selective vertical programmes had tended to overshadow other aspects of health care provision. Little thought was given to the social aspects of health and how they related to other aspects. Also, inequalities, particularly between social groups and social strata were intensified. The 'urban biased' nature of resource allocation initiated by the colonial system and reinforced by the paradigm of top-down development planning had not only increased geographical disparities but also intra-sectoral inequalities. Resource allocation, instead of reflecting efficiency and equity criteria, usually tended to be the result of converging interests of the more powerful and articulate urban classes.

The new policy direction signifies a shift from direct service provision by government to strengthening partnership and facilitating other health actors like the community and private sectors. According to the statistics provided by the Ministry of Health, only 21% of those with recent illnesses visited a government facility, while 31% visited either NGO or other private facility, and 48% utilized the informal sector, indicating, that neither government nor the NGO provided adequate primary health care to the majority of the population.

She further argued that private expenditure in the health sector had tended to outweigh government expenditure. According to World Bank, approximately two-thirds of the total health expenditures were privately financed, implying that increasingly most households had found it inevitable to meet their own health needs in the absence of adequate health provision by the government. Although the government had a greater number of health facilities, the non-governmental sector had greater capacity utilization and staff productivity due mainly to differences in staff motivation (World Bank, 1995).

The AIDS Support Organisation (TASO)

Bikako noted that TASO was the largest organised community response to HIV/AIDS in Uganda. It operated in eight urban sites and by 1999 had registered 57,924 clients (persons living with HIV/AIDS) of whom 66% were female and 10.8% were children below the age of 15 (1999 TASO Annual Report). TASO had its origins in a small group of people who began meeting in one another's homes in Kampala in October 1986. The group comprised individuals who had migrated to Kampala in search of better socio-economic opportunities. At the time, the country was lacking the capacity to effectively deal with the health needs of the population that resulted from the growing HIV/AIDS scourge, in addition to other health concerns. According to the founding director, in an inspiring account of her personal experience with HIV/AIDS that she wrote after the loss of her husband to AIDS:

> There really wasn't much support here in Uganda, except from both sides of the family. But even they didn't fully understand what was happening. They could give emotional support but were short of medicines and material support. There was stigmatization from friends and neighbours.

On its part, the National Resistance Movement (NRM) government was quick to respond to the epidemic by focusing exclusively on HIV prevention through building its capacity to provide information and education, ensuring a safe environment, specifically in the health care facilities, and enhancing communication and monitoring systems. Here, the priority need for its population was identified as information to prevent HIV transmission.

Bearing in mind the pressing needs of the affected Kampala population and following her personal experience with a more supportive health care system in the United Kingdom, Noerine Kaleeba (Founder of TASO) with other fifteen group members developed a different health care model. For the TASO founders, the government's strategy was inadequate. For them, AIDS was not simply a medical condition. It was a condition that was threatening their quality of life and, therefore, required being tackled in physio-psycho-socio totality. Issues such as food security, nutrition, income, livelihood and shelter had to be factored in. The affected population's rights to provision of basic needs and responsibilities to prevent further HIV spread deserved as much attention as the inadequate health infrastructure did. Prevention of further HIV transmission also meant responding to the needs of the people living with HIV and AIDS resulting from neglect by the health services and being ostracized by the rest of society.

For TASO to accomplish its mission, international donors have had to heavily finance its activities. Donors include bilateral agencies such as USAID, ODA/DFID, DANIDA and international organisations such as WHO, Action Aid, Food for the Hungry, among others. The founders of TASO also recognized the important role of government in developing self-help initiatives. The open

and constructive attitude of the government played a significant contribution to the growth and development of TASO. TASO's efforts became complementary to those of government. It helped to reconstruct the language that was being used to draw the attention of the population to the epidemic and its effects. Additional areas of complementarity included increasing medical treatment and drug access, creating HIV/AIDS awareness, a referral system and the support of community efforts to alleviate the socio-economic consequences of AIDS enhancing community capacity through training and logistical support, and, advocating for improved accountability of the health workers to their clientele.

Although TASO recognized that AIDS care needed to be integrated into existing health and social services, it realized that providing some specialized services including clinical care could not be avoided. It was in this context that TASO was keen to supplement government and non-governmental medical initiative. Attention was specifically drawn to the popular perceptions of AIDS that were imbedded in moral probity, calling for strategies that would appreciate HIV/AIDS in its entirety. Here was a local initiative that recognized the need to develop a widespread non-biomedical approach to health. It recognized the communities' perception of the human body, which played part in the way knowledge was constructed. More thought was given to the social aspects of health and how both the social and technical sides to health fitted together.

On policy concerns, Bikako argued that TASO attempts to reconceptualize health from being merely an absence of disease to a condition which deals with ever), aspect of life. Implications of such a broader conceptualization are two:

- Health services need to be integrated to incorporate the numerous non-health related activities and sectors. A well-functioning health care system is one that is sensitive to the context of the health problem. It must provide comprehensive care by attending both to the immediate illnesses and the underlying cause. The facility must ensure continuity of care, implying sustaining necessary interaction that has a long-lasting impact on health. It must also provide integrated health care; this caters for the ability to perform several specific tasks concurrently.

- A broader conceptualization of health confirms that a different orientation of health care services, from predominantly curative to include preventive and promotive aspects of health, is inevitable. Efforts should be directed to developing comprehensive and integrated health initiatives that respond to the health needs of a population that is obviously socially differentiated. The providers of health would also have to consider involving the communities as active participants in health care, and not simply recipients and users of services. Emphasis of health care would, therefore, move away from professional health providers to local resource

persons. Here, participation is viewed as a means to strengthen the relative position of the poor and marginal groups in society.

She further argued that from the Ugandan experience, it was important to distinguish between two kinds of self-help initiative; One type was that which was community-initiated and depended on external support to improve the quality of life of the intended beneficiaries through disease prevention and health promotion, taking into account their values, objectives and priorities. The other type, which was more common, was that based on communities and operated on democratic principles using the 'western' approach as a response to the needs, incentives or pressures of external agencies. These included community-based health care associations, church based mothers' unions and income generating activities developed by the local councils. The latter group tended to be a function of pressure from the political establishment and the desire for external support. The strategy and structures, dominated by the external objectives and organizational methodologies, tended to have little, if any, in common with 'traditional' pre-western organizational forms, clearly conflicting with the desire to use the group approach as a way of increasing local autonomy and eliminating dependence.

In the latter type, it could be observed that the notion of the community being provided with opportunities to participate in planning and implementing its own development was, therefore, symptomatic of top-down thinking and assumed that the people in the community were not already engaged actively as subjects of their own development. The community was assigned a role, which had already been defined for them by someone else, implying that development failures could be attributed to external domination. Concern was raised as to whether these democratic organisational forms were the best way of achieving the set objectives.

Bikako conclusively noted that urban migrants and other vulnerable groups within urban sites had a significant role to play in situations of increasing needs of growing cities amidst resource paucity. Specifically, through self-help initiatives that were almost entirely funded by international donors, urban migrants had mobilized themselves to attend to the effects of the development policies that governments in close alliance with international funding agencies had designed. For a more meaningful contribution, however, there was need for the vulnerable groups to move beyond dealing with these effects only and question the development policies and processes with their consequent development programmes. These groups had a potential to provide a different approach to the health and development concerns of the urban community. Their challenge was to forge an alliance with those who could influence policy in their favour. Issues of legitimacy, equity and universality deserved serious policy attention.

The Urban Poor and Health Systems in East Africa: Voices from Nairobi Slums *by Prof. Francis Dodoo*

Prof. Dodoo noted that the paper was based on a study carried out by the African Population and Health Research Centre (APHRC) and it came into being for a number of reasons. Beyond the urban trends and the deprivation of slum residents, the study's initiation could be traced to research findings that reported statements from rural field respondents in two separate studies carried out by the Centre. In both, rural respondents appeared to place blame for the escalation of STIs and HIV/AIDS at the doorstep of their urban peers. The arguments they made included; first, that STI infections were seasonal phenomena in rural areas that coincided with the return of urban residents for Christmas, Easter and other holidays. Second, they argued, all of the media evidence was of urban deaths, the bodies from which then got brought 'home' to the rural areas on weekends for burial.

It then became the interest of APHRC to understand what the sexual networking of urban residents was, what they knew about the risks associated with certain sexual behavior and whether their knowledge had influence on their behavior. For the reasons above, the study focused on Nairobi's slum population and the initial foray involved focus group discussions in four purposively selected slums with a goal of understanding sexual networking behavior of slum residents and how that might relate to the spread of HIV/ AIDS.

The discussion groups were asked to list, discuss and then rank their needs. With little variations across slum, age, and Sex, the most significant general needs turned out to be housing (cost, quality and ownership), employment, toilet availability, and water access. As far as health needs were concerned, slum residents' articulation of their problems included the prevalence of diseases and sicknesses, as well as the lack of medical (and particularly maternity) facilities; there was also considerable concern about the quality and cost of health care in the slums. Not surprisingly, the concern with water sanitation expressed under basic needs reared its head in health need discussions about sanitation and toilets, as well as in the type of diseases that residents complained about.

> Yes, there is no water in the whole of Kibera all the way to Laini Saba. You may find that one tap is here and about one thousand people use that tap and that particular tap does not even bring enough water. You will stay there up to evening waiting for your turn to fetch water. Even if you are buying, it is not available, its not there (Kibera service providers).
>
> When people build houses, they do not care about toilets. The City Council toilets are overstretched. There is only one City Council toilet (Embakasi women, 13-17 years).

> You see, next to the house is a toilet which is not even 15 metres deep. Rats come from there and enter our kitchens walking all over the food" (Kahawa North men, 25-49years).

> All these diseases we have mentioned, most of them are brought about by poor sanitation and drainage. This has to do with the drains blocking. If water gets there, it stagnates. Mosquitoes breed there. Malaria is spread and even typhoid can be spread" (Majengo men, 50+ years).

The lack of water and poor sanitation combined to manifest the nature of diseases and ailments articulated by the residents. With inadequate health facilities and the lack of quality care, convoluted by cost and corruption, slum residents were extremely vulnerable to the vagaries of diseases and illness.

The list of reproductive health needs included STDs and HIV/AIDS, unwanted pregnancies (with much reference made to teenage pregnancies), abortion, and lack of family planning services. The discussion about reproductive health concerns also highlighted the inadequacies of the health care delivery systems. Undoubtedly, appropriate health Services and care constituted a major concern slum residents had. The author noted that they (researchers) were not surprised, however, given the poverty of the slum contexts, that the other overwhelming significant concern of the residents regarded employment and earnings. Indeed, many of the residents saw the lack of decent - paying jobs as the root cause of their problems. The argument heard over and over again was that if they had work that garnered them decent income, they, like the researchers, would not need basic health interventions, as they would be able to make and exercise rational decisions about their competing needs.

> The problem of lack of jobs is the greatest because there are so many other problems that arise from it like rent, education, food, etc. That is why we need jobs" (Kahawa North women, 50+ years).

Prof. Dodoo also noted that another key finding from the research regarded the vulnerability of children and adolescents to the sexual culture of the slums. The interaction of space constraints, social contextual factors and economic difficulties worked to make young residents susceptible to sexual health problems. This was particularly critical in settings where the reproductive health care system was geared towards those aged 15 and above, and even older adolescents were not very keen to use the existing services, because of the nature of interactions they had with service providers who often chastised them for "early" engagement in sex.

One way in which slum poverty manifested itself was in dwellings that were constructed from cardboard, tarpaulin and/or corrugated tin sheets. These homes often consisted of a single room generally in a neighborhood of six feet by nine feet in dimension, sometimes only internally partitioned by a curtain. This room was used as a living room, kitchen, bathroom and bedroom which parents

and children shared. The result was that there was no privacy and children of tender age got to see arid hear sexual activity taking place. Next door neighbours business was also public, given the flimsy materials that separated the dwellings.

> I think there is no privacy in our houses when parents are having sex. You see a child of about 15 sharing the same room and only separated by a curtain. When the parents start having sex, they start wondering what kind of noise the parents are doing, so they will pretend they are asleep when they are actually hearing everything. So next time they will want to try the same things. (Kahawa North males, 18-24 years).

> The major problem here is the house. If people had proper houses, some things would be private. Children would not be trying to imitate what they hear. Because now even children of 9 years are conceiving and giving birth. It is not strange, they do give birth at 9 years of age (Majengo male, 50+ years).

Economic Considerations

The economic down-turn of the city was nowhere more evident than in the slums where the acute lack of jobs forced residents to resort to whatever means they had available to make ends meet. Even those who found jobs were hardly able to get decent-paying ones or continuous or consistent work. Thus in addition to selling second-hand clothes, vegetables, and brewing illicit alcohol, exchanging sex for money became a significant means of subsistence. Multiple partnerships could then be related to the ongoing search for money, women often had to interact with many men to get sufficient money for their subsistence needs. Oftentimes, the sums of money involved were extremely small.

> Mainly women have many sexual partners; some have children and may be they do not have food. They try to go to people and ask them for money and they are told there is no money. They go from one person to another until they get the money (Embakasi female, 13-17 years).

> Money, there is nothing else. But if you understand, you cannot accept that. Now when your problems are solved, you will never know whether you have a disease or not. That time you may not be thinking about the disease because you have problems. That is the problem girls have. So when I have a disease is when I come to regret ... (Embakasi female 18-24 years).

The influence of slum life on children was critical because the young frequently imitated what they saw as prevalent in the social contexts of their communities, and came to deem it norm. It was reported that children even younger than 10 were actively engaged in sexual activity, with little access to information, services or facilities that would protect them from disease spread and pregnancy. The visibility of existing prostitution and the role of substance abuse were highlighted by the following quotes:

> Maybe I stay with them (prostitutes) and they depend on that. It is a business, and if I stay with them, I see them clean and live well; then I will envy them: I will therefore be influenced to start that job" (Embakasi woman, 18-24 years).
>
> And the fact that you see if you walk in the hidden streets here in Majengo you find a woman seated on a stool outside her door. You want to tell me that a small child does not know? ... They are those who sell sex. When a child sees a woman sitting outside her door and then a man goes in there and the woman follows him and they lock the door, maybe I can control it in my house ... I have a wife and two children. My children are small. I could wait until they are asleep. You see something like that! I could use all my tricks. But from the fact that my neighbour is a sex dealer, will I have helped anything? (Majengo female, 13-17 years).

The main findings of the study were that economic and health concerns were seen by slum residents to be the principal bottlenecks to improvements in their health status.

Discussant: Dr. Simon Peter Rutabajuka

Samson Opolot

The discussant noted that the main argument of the paper was that migrants had not been mere agents of disease as historically perceived. He argued that the author should have laid more emphasis on discourses of disease and ways in which these discourses have been used to regulate the flow of labour and how in contemporary terms they were used to control populations which were faced with unemployment.

Agency seemed to lean more to the more powerful, and the contributions of the poor did not seem to go beyond the next neighbour's efforts, which needed to be explained.

Urban governance was singled out as a key solution. However, the author should look at the idea that urban planning was not wholly positive, not predictable and not unproblematic. The author needed to delve more into the ideas on how migrants linked up discourses on disease.

Winifred Bikaako

The paper raised the potential of community mobilization for self-help. However, this initiative and potential needed to be put in a much broader context of what was currently called social policy reform.

She captured the transgression from crisis to the social sector, bringing in NGOs arid the reform towards comoditisation of social services. Context needed to be spelt out more clearly and say more about the informal health sector arid its

provision of health services because it was a key issue raised in the paper. The way the sector linked to the community was very critical in explaining the reform taking place.

The author also raised the issue of incorporating participatory approaches into the debate. This was in recognition that these approaches were mainly concerned with pretences aimed at interpretation of service delivery,

Francis Dodoo

The objectives of the paper were clearly spelt out but the research could say more about the reasons why sexual health was important and why it should be singled out and separated from the health category, particularly in the urban areas.

The discussant also wondered whether the author wanted to make mention of the state and the manner of its interventions. What about the level of regulating slums' social and economic conditions by the state?

Moral questions were posed in the paper, but major, protagonists were left out e.g. the church and NGOs which probably had programmes designed to address the questions like prostitution, drug use and even poverty.

There was need for a history of a demographic problem (historical sociology) to bring out the concerns of demographers and on whose behalf the demographers were intervening in the slums of Nairobi.

Plenary

Opolot's paper

A participant noted that the paper had fallen prey to what it was criticizing. Who were the migrants in the city? It was important to understand the dynamics of colonialism.

On the issue of agency, what did these people (migrants) innovate? There was need to understand them and build on them to reach a particular goal. Of particular interest was the issue of the state which the author had referred to as the "soft state". What was its character in terms of what it could do i.e. controlling the environment in which the migrants lived?

The cost-sharing issue was an empirical question, which had lately been of concern to many people. How had the gender identities and communities responded?

There was need to look at the trends migration had taken i.e. from rural to urban, migrants fleeing war areas, or cattle rustlers and the magnitudes of migration.

The presentation gave the impression that migrants were poor, yet this was an empirical question.

Bikako's paper

There was need to bring out a broad process of the initiatives, how people had adapted beyond TASO given that it was donor-funded. What was the limit of self-help? Could it bring about fundamental changes which would deliver people? There was need to link self-help programmes to the political processes.

Were the initiators of TASO migrants?

Dodoo's paper

The author talked about the existence of multiple sexual partners. While it was easy to establish the existence, what method was used given the sensitivity of the matter in regard to families?

The question of male body prostitution did not feature in the paper. Did it mean it was non-existent in Nairobi?

The politics of space influenced sexuality, socialization and education. Was there a strong relationship where there was no space constraint? There was need to show how poor the slum dwellers were.

There was need to talk about street children, and street families since they were synonymous with slum life.

Responses from the presenters

Samson Opolot

He noted that the basic thing was to conceptualise migrants in terms of identity, class and trends, and to look at the vulnerable position in which they competed for health services.

He also noted that there were different forms of exclusion, and the biggest arose from quality. The rich would always have alternatives whether in terms of numbers or quality.

A depth of analysis of the conceptualization of labour and the state relations could be done while analysis of the character, trends and class of migrants needed an empirical study.

Winnifred Bikako

Most concerns deserved research attention. The paper was trying to move away from considering health as a physical being to viewing it as something that affected the lives of the people in totality.

Francis Dodoo

The author noted that they (researchers) were soliciting the thoughts of the slum dwellers about what their basic health needs were. The study on sexual partners was qualitative and that support mechanisms needed to be developed for the poor people.

On the question of males exploiting women, he noted that it might be dues to the socialization of the boys, and peer pressure. He also informed participants that they did not go into the field with concepts on prostitution.

Panel IV: Health and Urban Governance

Health and Urban Governance in Developing Countries: Some development Issues *by Richard Stren*

Dr. Stren noted that the emerging vision of prerequisites for development – a vision which was based on concepts of human capital, social support and risk – was particularly relevant for the subject of health care in African cities. First of all, this vision focused on the potential for improved productivity among the most vulnerable members of any society, notably the poor (urban and rural), women, minorities, and marginal ethnic and racial groups.

He further argued that the urban poor were more plagued by ill-health than the non-poor since their access to medical care was not as good, their nutrition was generally more limited and they worked longer hours. Other studies demonstrated, though not conclusively, that poor health for individuals in informal (rather than formal) employment was a much greater burden, since in informal work, other workers were not readily available to provide substitute activities lost to absence. For public policy, efforts to improve health care in Latin America – following the human capital model – tended to focus on community characteristics that could be modified through collective actions. These characteristics included population density, transportation, sanitation or access to portable water. They might also include local population traits that affected behaviours and generated externalities such as education (Savedoff and Schultz, 2000),

Another reason why the new, asset-enhancement approach to local development was important to Africa was that the existing level of formal services and infrastructure facilities for urban residents was extremely low. Indeed, on an aggregate level, urban service s for Africans were the lowest in the world. At the same time, African cities, and especially cities in Eastern Africa, were among the fastest growing. This picture of very low levels of urban services badly lagging behind rapidly increasing demand could be illustrated by a variety of statistical measures of urban service delivery.

Still on African cities, he argued that because of the basic conditions of poverty, they almost had no resources to deal with a whole variety of services and infrastructure that were virtually taken for granted in cities in more developed regions. But if health conditions were not improved, the productivity of African cities and their citizens would fall even further to the point where, as the main engines of their economies, these cities would be totally unable to function in the new globalising world of trade and competition.

In much of the rest of the developing world, he argued, health services like education, land-use planning and other services were being decentralized from the national to the local level. But new institutions of governance had accompanied this decentralization. He gave an example of Brazil which moved primary health care from the state to the local level and formed boards, which boards had representatives from the professional, non-professional representatives from the community and NGO groups involved in the same and other activists. The boards acted as advisers to the elected municipal councillors.

He also questioned whether this devolution should take place in Africa and how and whether larger cities rather than central ministries should have the responsibility for primary health care. However, he argued, such devolution was in a very weak financial situation for most African municipalities which limited their ability to manage a complex range of local services. Given the fact that it was politically and economically difficult to privatize primary health care in Africa on a large scale, how could it be managed more effectively in the interest of local communities? There were at least two answers:

- There were undoubtedly many informal ways in which poor and marginal people obtained health services without traversing formal clinics. These might include traditional medicine, informal purchases of drugs and medication or just learning through social contacts and family about better nutrition and preventive health practices. Improving people's ability to deal informally with their own health was as much a question of education and human and social capital as was the construction of formal clinics and hiring of nurses and doctors.
- Following the Brazilian example, any decentralization or engagement of national ministries at the local levels to involve local people - both elected and unelected, professional and unprofessional in the dialogue on these questions. This line of reform accorded well with the new understanding of "governance" as the relationship between government and civil society and its major stakeholders. In the end, the successful delivery of health services was as much a governance question as it was a technical question.

Urban Governance and Health in East Africa *by Prof Gilbert M. Khadiagala*

Prof. Khadiagala in his presentation noted that questions of governance and health in East African cities were inextricably linked to the distribution of power and resources in socioeconomic structures facing physical, infrastructural and fiscal constraints. Yet these links were often obscured by the deep disciplinary gaps between health scientists posing weighty epidemiological questions and political scientists grappling with more modest concerns of participation. When the two disciplines spoke to each other, however, the technical issues of health and service delivery illuminated the larger contexts of leadership, decision-making and resource allocation.

He further noted that East African cities were creatures of population movements in search of modernity and the promise of opportunities, but their governance structures had frayed under enormous pressures that seemed to defy orderly urban planning. Although health was an essential component of the urban sector, its viability was predicated on growing national economies and vibrant political structures. Scenarios for strengthening health systems in cities thus needed to be conscious of the real limits confronting health issues outside the whole array of economic and political issues that undergirded the management of cities.

Prof. Khadiagala focused on themes that informed debates about health and urban governance. First, cities evidenced both pockets of poverty and enclaves of affluence that stemmed from severe socioeconomic inequalities. Second, the progressive weakening of national economies over the years had greatly impacted the ability of cities to be self-sustaining entities that provided the broad public services. The economic decline had, in turn, engendered additional pressures on existing services not just from the urban poor but also from an increasingly impoverished middle class. Third, the social fragmentation extant in cities impeded collective action around fundamental governance issues. East African cities were agglomerations of estates, neighbourhoods, and slums without essential foundations for citizenship (common political membership) that might enhance their collective power to make demands and deal with health problems and their underlying causes.

Compounding the lack of collective action was the fact that these cities were the locus of power in contexts where national elites were less secure and where the mechanisms of participation and accountability were still new and untested. As cities remained closer to centres of power, weak elites needed to keep tight rein on them, depriving them of vistas to evolve autonomous organizational power that might allow them to meet the needs of their multiple constituencies.

On the health profile and context, he argued, the unassailable assumption in the literature on urban health was that the living conditions of the urban poor were a function of environmental and socioeconomic disparities. Access to

housing, water supply and sanitary facilities were some of the significant environmental factors that influenced the health of inhabitants. Urban inequalities consigned the poor to live, in poor physical environments, with overcrowded housing, inadequate water supplies, sanitation and water disposal, and a higher level of pollution and other 1-iazardous substances. When wealth and income became factors in the equation, these inequalities determined, for the majority of urban dwellers, access, affordability and delivery of health services.

He also noted that urban planning in the post-independence era assumed that slums and other inhospitable settlements were social irritants awaiting modernization and demolition, but over the years, these structures had become a permanent feature on the urban landscape. The allure of donor funded housing programmes such as site and service schemes in East African cities in the 1980s waned as these settlements graduated into slums in the 1990s. As they had become centres of the vibrant informal sectors of urban economies, slums and unplanned settlements constituted the sites and sources of livelihood for a majority of urban dwellers. But they were replete with diseases of poverty as demonstrated by the annual outbreaks of cholera during the rainy seasons in the slum settlements of Nairobi, Dar-es-Salaam and Kampala.

The continued deterioration of the urban environment surrounding the urban settlements pointed to the links between the environment and urban health crisis. But this crisis also had a fiscal component. East African cities for a long time operated as quasi-autonomous entities within the local government ministries. This autonomy gave them some latitude to set health policy by providing public health services and clinical services, often with technical assistance from the ministries of health. Public health mandates enabled cities to provide essential public goods such as clean water and disease control, while ownership of hospitals and health centres by municipalities allowed them to provide free clinical services.

Concerning the governance profile, he argued, issues of poverty and health in urban settings were now popularly framed in terms of political disempowerment and social exclusion, hence the centrality of institutions of participation and interest aggregation, Although East African cities with their heavy concentration of populations should form the fertile grounds for political mobilization, income disparities and social fragmentation still precluded effective claims of citizenship. Moreover, despite the emergence of alternative structures of political organizations around neighborhoods and functional realms, their capability would remain underutilized in the absence of significant changes in the political contexts anchored in genuine decentralization and orderly planning.

He observed that resuscitating a semblance of the division of labour between the public and authority and community action presented an institutional opportunity that East African cities could seize in the light of the traumas of the last decades. Political authority that underpinned city governance

needed to be strengthened in its broad institutional dimensions; in particular the legal structures governed property rights and representative bodies that fostered participation. Informal political and community organisations had flourished where public authorities were weak or absent, affording chances for the redefinition of roles, between the state and society at micro levels. These organisations, however, required legitimation and support from resurgent formal urban authorities; this would force a robust debate about the content of democracy and institutional reciprocities.

Finally, he observed that the governance deficit in East African cities affected health in direct ways. Healthy cities were founded on thriving urban and national economies, but oftentimes health in poor countries was sacrificed on the altar of wealth creation. In reality, health was a wealth issue because it was anchored in the larger contexts of poverty, illiteracy, hazardous environments and social equity. Governments routinely confronted questions about the right balance between wealth and health through resource allocation, planning and investment patterns. The nature and structure of government at both micro and macro levels thus mattered for establishing priorities and trade-offs.

Improving Health Systems for the Urban Poor: The South African Experience
by Prof. Lynn Dalymple

Prof. Dalymple in her presentation noted that under apartheid, the health system was one of the most unequal, fragmented and. wasteful in the world. Fourteen different health departments administered and duplicated services on a racial basis. There were 10 bantustan health departments, three own affairs health departments for the whites, the coloured and Indian populations and one general affairs department. There were also provincial health departments as well as 382 local authorities that were responsible for health issues. Hospitals were segregated until 1990; and even when this fell away, they were still controlled by racially segregated health departments. None of these systems catered for the black urban poor because there were considered non-existent.

However, since 1994, when the first democratic elections were held, the system of governance in South Africa had undergone radical changes. The process of transforming local government began with the mass action against apartheid cities in the 1980s. National local government negotiating forums were introduced and transitional local governments set up. The intention of the new system of government was to increase powers, responsibilities and accountabilities of municipalities. However, there were considerable challenges related to introducing this system because the powers of the provinces in relation to delivering health services were fairly deeply entrenched. She gave an example of Kwa-Zulu-Natal province where the provincial department of health had direct control of 62 hospitals and 500 clinics. These were funded and run

separately from the clinics that fell in the unicity and the district municipalities. The long-term aim was for all delivery to take place through the municipalities and for the province to build capacity, monitor the delivery of health services and provide strategic and policy direction.

She also noted that many of the municipalities in South Africa were in a serious financial crisis. Part of the plan was that wealthy communities within the new municipalities would finance the development of the poorer communities. However, with a few exceptions, this had not really worked out. This was because of the huge backlogs in the provision of services left by the apartheid government. Also, there were people who did not pay rates and service charges and there had been poor financial management in the municipalities.

However, a new approach to health care had been established for the country based on the principles of primary health care and a district health plan. This approach was based on the following principles:

- Resources must be distributed equitably. It means that those areas with the least resources must be given more assistance.
- Communities should be involved in the planning, provision and monitoring of health services.
- A greater emphasis should be placed on services that help prevent disease and promote good quality health.
- Technology must be appropriate to the level of health care.
- There should be a multi-sectoral approach to health. In primary health care approach, the provision of nutrition, education, clean water and shelter become central to health care delivery.

Concepts such as health promoting schools epitomized this integrated multi-sectoral approach. Clearly, the school setting provided an ideal opportunity for all members of the school community to work together to provide positive health experiences and an environment conducive to health for scholars, teachers and the community at large.

On the challenges of implementing the system, Prof. Dalymple noted that the introduction of new a system was not without problems. She argued that it needed all the negotiating skills that South Africans were now famous for. The transitional process had been difficult and the re-allocation of resources to the primary health care system meant that the hospitals in South Africa had suffered. As the clinics became better staffed and better equipped, they were beginning to take the pressure off the hospitals. A spokesman of KZN Department of Health reported that the number of unbooked mothers delivering in hospitals dropped by 80% in 2000. Running parallel to the public health service, there was a substantial private health system, especially in metropolitan areas. Generally, access to this system was limited to the wealthy people or people with medical insurance. However, some private hospitals and doctors assisted poor people in

time of crisis. For example, some hospitals had recently announced that they would provide any woman who had been raped with anti-retrovirals.

She further noted that South Africa had a significant population of people who could be categorized as the "urban poor". Recent poverty discourses had indicated a number of approaches to defining poverty in addition to the traditional poverty line.

The migrant labour system was central to the way in which the political economy of South Africa was ordered in the last century and was intimately bound up with the structure and functioning of the system of apartheid. The demise of apartheid and the rise of democracy was changing the pressures and demands for labour but it was not clear how this would affect the forms and patterns of labour migration in the new South Africa.

Migration took many other forms and there was a significant shift of people from the rural areas to the peripheries of the urban areas where informal settlements spring up overnight.

She noted that for the district health system to work effectively, it was important to get the size of the (district right. It should be large enough to contain the full range of health services, including a district hospital, but small enough to allow efficient service delivery and community involvement. The urban poor were often a migrant population and that made planning and catering for their needs a serious challenge. The shifting nature of these communities also meant that it was difficult to implement the principle of giving them any real say over their own health care.

On the responses to HIV/ AIDS, Prof. Dalymple noted that council decided to make the anti-retroviral drug Nevirapine available to pregnant mothers at all health care centres in the unicity. However, the implementation of this strategy would be delayed until a provincial policy had been developed.

Finally, she observed that the new health system that was being introduced into South Africa was a decentralized system with the emphasis on a primary health care approach. The principle of equity was key to the approach and both the urban and rural poor were catered for. However, there were a number of challenges to implementing the approach, and provinces and local governments were required to work together with commitment and integrity before the whole system fell into place.

Discussant: Dr. Suzie Muwanga

Prof. Richard Stren's paper: Health and Urban Governance in Developing Countries: Some Development Issues

The discussant noted that the paper provided a theoretical context to the three papers because it examined a new approach to development that had

increasingly come to focus on new measurements of development and, correspondingly, of poverty - economic and social assets.

The paper provided us with a new thinking for development and provided policy options that centred on systems of governance and greater participation in urban services delivery to ensure coverage and sustainability. This highlighted the importance of governance strictures and particularly the strengthening of social capital. The erosion of social capital was also highlighted in the Uganda Participatory Poverty Assessment report as being an impediment particularly in urban settings where it was difficult to construct community identities and hence use the networks that usually accrued from that for accessing services or fighting poverty. The examples the Brazil offered lessons in how the systems were managed. Decentralization had to be accompanied by concerted efforts on the part of central government to get communities on board, as in the case of Brazil where the community boards were involved in the transition from centralized to decentralized systems.

Prof. Gilbert M. Khadiagala's paper: Urban Governance and Health in East Africa

The paper highlighted the disciplinary gap that had kept the issues of health and governance apart: the need to confront the issue of health in cities within the overall debate on power resources and socio-economic structures. Urbanization in East Africa, mainly a result of population movements in search of opportunities, concentrated in peri-urban poverty and inequality in urban governance and thus became an important factor in facing the problem of health.

The governance of cities was well situated in the political and economic crisis. It had plagued most African countries for the last two or so decades and one witnessed that there was a microcosm of problems that were faced in other sectors like education - for example, where individual self-help strategies replaced beleaguered state structures,

He challenged the assumption that urban health was a function of environmental and socio-economic disparities, Access, affordability, and the delivery of health services, however, was identified as the real issue that consigned the urban poor to live in unhealthy conditions. While the underlying message was a need for changes in the governance structure - there was cautionary note to the paper that suggested that devolution of services was not panacea to poor health conditions existing in the cities -of Nairobi, Dar-es-Salaam and Kampala. The examples of participatory initiatives in the form of associations, clearly as the case of Nairobi demonstrated, revealed that there were interests that gained from the status quo and were, therefore, unwilling to allow truly democratic and decentralized city governance structures to emerge.

The paper perhaps provided a cautionary voice on the limitations and experiences in the urban centres of Nairobi and Dar-es-Salaam with the new self-help initiatives and associations set up to supplement, and in some instances fill, the void left by state services.

Prof. Lynn Dalymple's paper: Improving Health Systems for the Urban Poor: The South African Experience

The discussant noted that the paper highlighted the fragmented health service system based on race where none of the systems catered for the urban poor blacks because, in theory, there were no urban black poor; changes in the health care system approach; developmental approach with greater community participation embodied in primary level health services, and devolution.

The paper provided interesting insights into new approaches being developed in South Africa that really provided a virgin territory in which many lessons gained on governance and transitions from centralized to decentralized systems took place.

Plenary

Participants' discussion generated the following observations and comments:

On Prof. Stren's paper, Dr. Bazaara argued that there was need to tell how government structures were framed in the new law, how decision-making was made and how local governance was constituted, and who would safeguard decentralization.

There was also need to point out the different historical contexts of the successes in the Philippines and Brazil as given the paper, i.e. a comparative historical assessment.

A question was raised concerning Khadiagala's paper on urban planning. A participant cited the example of Uganda where every ministry had its own planning section and the country had decentralized without building capacity. The presenter was then asked what, in his view, were the advantages and disadvantages between decentralization and devolution of powers. Didn't property rates impede on overall urban planning?

Given that the local council system was running parallel to the technocrats and, therefore, there was a danger of conflict between politicians and technocrats, what was the harmonious way of not infringing on the interests of the masses? What was civil society?

A comment was made on Prof. Dalymple's paper that concerning the urban poor definition vis-à-vis collective action, the latter was easier in rich neighbourhoods while it was hard in the poor neighbourhoods. What then were

the coping mechanisms of the poor? Since they were not poor in ideas, what kept them in the perpetual situation?

And what would constitute the most critical issue of health in matters relating to urban governance?

Responses from presenters

Prof. Stren noted that there were different arguments within each country concerning civil society and how it was defined; but it was important to have civil society if one wanted to devolve powers.

On property rates impeding urban planning, he said that they were supplemented, inelastic and changing very easily, and hard to collect due to evasion. He noted that the on1v impediment was that they were not paid and, therefore, the question would be how to ensure that they were paid.

Prof. Khadiagala noted that one could not do urban planning without urban governance. He also questioned how one would improve the livelihoods of the urban poor and also make them citizens of the city. He argued that slums should be national crises, especially concerning where the people lived and what resources they had.

On neighbourhood associations, he noted that they should be looked at as supplementary formal authorities to formal relationships with the city authorities. It was not an ad hoc relationship. He argued that associations served a clear role but should not be celebrated outside government. They were important functional roles but should be legitimated in the local governances.

Prof. Dalymple noted that the municipals were political and the only problem which remained was that of traditional leaders and what their powers in the municipals would be. She also said that the women were oppressed and had no freedom of association.

On safeguarding municipal standards, she inforM12d the participants that it was the provinces that looked after the new system but financing was very difficult.

The health issues were mainly prevention, information, access to primary health care and proper referral systems.

Concluding Remarks

In his concluding remarks, Dr. Andrew Selee of Woodrow Wilson Centre thanked all the presenters, the participants, Centre for Basic Research, the Mayor of Kampala City and USAID for attending the workshop and for the issues that were raised. He observed that the major issue was to improve governance and the lot of the poor. He also noted that the Wodrow Wilson Centre would collaborate with Centre for Basic Research concerning publication of the papers presented in order to provide a lasting form to them.

On his part, Dr. Bazaara, the Executive Director of CBR noted that Kampala City Council needed to invest in knowledge about medicines and also the capacity to harness the knowledge, to act as civil society to force government and think in terms of developing capacity to transform herbs into modern medicine.

He also noted that CBR would like to collaborate with the City Council and, for that matter, government. He enlisted the support of members to focus attention on the problems.

Dr. Bazaara thanked the Wodrow Wilson Centre for the materialization of the workshop and suggested cementing relationships with them by critically examining, the issues of governance in order to become healthier and live a better life.

Closing Remarks by the Mayor of Kampala City
His Worship John Sebaana Kizito

In his closing remarks, Mr. Sebaana Kizito noted that the gathering was very important because it brought together people of different ideologies, experiences and countries, and that the time had been well used to highlight a problem because it led to finding a solution. He applauded the organizers and the funders of the workshop for a job well done.

The Mayor also observed that developing countries shared a lot in common because the standard of economic development was almost the same. It was, therefore, important to come together since most problems were centred on poverty. He observed that Kampala City would be planned better but it lacked funds for this purpose. He, therefore, emphasized the need for participation and consultation with the beneficiaries of urban programmes. He noted that he was intrigued by the Latin American example, especially the use of herbs which were abundant in Uganda. This could be a learning experience for the Ugandans and should not be left hanging. He pledged to continue follow up on the traditional healers as alternative providers of care and to educate doctors on the importance of herbs.

He also noted that Kampala had been honoured to host the meeting, and encouraged the participants to make such meetings more regular and involve more people. Finally, he thanked all the participants for their contributions.

With those remarks, he declared the workshop closed.

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CBR Workshop Reports

1. **Pastoralism, Crisis and Transformation in Karamoja**; Report of a Workshop Organised by CBR and held at the Faculty of Science Makerere University, August 14 - 15, 1992, by Joe Oloka-Onyango, Zie Gariyo and Frank Muhereza; 26p.
2. **Women and Work: Historical Trends**; Report of a Workshop Organised by CBR, and held at the Faculty of Science, Makerere University, September 7-10, 1992, by Expedit Ddungu, James Opyene and Sallie Kayunga; 61p.
3. **Workers' Education;** Report of a CBR Workshop held at the Faculty of Veterinary Medicine, Makerere University, March 19-20, 1993, John Jean Barya, Sallie Simba Kayunga and Ernest Okello-Ogwang; 47p.
4. **Pastoralism and Crisis in Karamoja;** Report of the Second CBR Pastoralism Workshop held at St. Phillips community Centre, Moroto, January 28-29 1994, by Frank Emmanuel Muhereza and Charles Emunyu Ocan; 19p.
5. **Regional, Workshop on Public Interest Environment Law and Community-Based Initiatives for Sustainable Natural Resources Management in East** Africa held at Colline Hotel Mukono, in August, 1996 by Samson Opolot and James Opyene; 37p.
6. Report of a Workshop Organised by CBR on "**A Dialogue on Gender Dimensions of Agricultural Policy in Uganda** held at Fairway Hotel Kampala, May 3-4, 1996, by Samson James Opolot and John Ssenkumba; 58p.
7. **Report on the Proceedings of the NOTU/CBR Seminar: Worker' Social Conditions in Uganda Today** held at held at Pope Paul VI Memorial Community Centre on 22-23 July 1997, by John Ssenkumba and Crispin Kintu; 27p.
8. **Report of the ENRECCA Workshop on "Modernity, Development and Institutional Change: A Dialogue Towards the Next Millennium**" held at Lake View Hotel Mbarara, 21 – 28 February 1998, Charity Kyomugisha; 38p.
9. Report o**f the Workshop on the Survey: "Constitutionalism Project Phase Three**" held at Colline Hotel Mukono, 29-30 January 1996, by John Ssenkumba; 22p.
10. **Lessons of Constitution-Making in Uganda** by Samson James Opolot and Chrispin Kintu Nyago; 29-30 January 1996. 52p.
11. **Report on A One-Day Dissemination Workshop on the Study "Civil Society, Empowerment and Poverty Reduction: A Review Essay** by Bazaara Nyagabyaki and Kintu Nyago Held at Centre for Basic Research on 2 September 1999, 21p.
12. **Peace, Democracy and the Human Rights in Uganda: A String of Fragile Pearls**; held at the Conference Centre, Kampala, on 20th October 1999, by Samson Opolot. 31p.
13. **GWESA Research Methodological Workshop Report**; held at Hotel Triangle, Jinja, on 21-23 July 1999, by Winnie Bikaako and Raphael Musoke. 41p.
14. **Building Healthy Cities: Improving the Health of Urban Migrants and the Urban Poor in Africa**; held at Hotel Africana, Kampala – Uganda, on 2-3 July 2001, by Charity Kyomuigsha. 74p.