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Meeting the Health Needs of the Urban Poor in African Informal Settlements: Best Practices and Lessons Learned

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Cover photo: *Train Tracks, Viwandani Slum, Nairobi, Kenya*

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Slums are not "the problem." Rather, they are the spatial manifestations of urban poverty, social exclusion, and inappropriate government policies.

Indeed, slum settlements represent an active, grassroots attempt by the desperately poor to take care of themselves.

(Sclar and Northridge, *AJPH* 2003)

PREFACE

BACKGROUND TO THIS REPORT

In mid-2007, Jhpiego was contacted by the Urban Institute to provide technical assistance in Ghana to help evaluate and advise the Community-based Health Planning and Services (CHPS) program. CHPS aims to extend coverage of basic and primary health care services to all Ghanaians to help overcome major health concerns. CHPS was originally designed to function in the rural areas, and has yet to be fully adapted to any urban setting.

In 2004, USAID/Ghana awarded a \$12-million, five-year cooperative agreement entitled CHPS-TA to assist Ghana Health Service in scaling up CHPS in 30 rural districts as well as helping pilot CHPS in two poor urban communities in Accra and Tema. To support this innovation, USAID/Washington mobilized a team of experts¹ to provide technical assistance to the Tema CHPS urban pilot.

This report was produced to provide background to the technical assistance team, and has been reproduced here to reach a wider audience.

¹ The team that traveled to Ghana was composed of Louise Palmer, Research Associate at The Urban Institute (lpalmer@ui.urban.org), Susan Igras, Consultant and Senior Program Advisor at CARE (igras@care.org) and Jane Otai, Community Liaison Officer at Jhpiego-Kenya (jotai@jhpigo.net). Also traveling with the team was Anthony Kolb (akolb@usaid.gov), Urban Health Advisor, USAID/Washington.

MEETING THE HEALTH NEEDS OF THE URBAN POOR IN AFRICAN INFORMAL SETTLEMENTS: BEST PRACTICES AND LESSONS LEARNED

INTRODUCTION

Recent demographic studies suggest that an “estimated 72 percent of the urban population of Africa now lives in slums” (Cohen 2006), and that two-thirds of all people will live in urban areas within the next 50 years, with 95% of that growth occurring in developing countries (World Economic Forum 2007). Given this demographic and population shift, there is a need to understand the impact that urbanization has on health care and vice versa; document promising models of public health interventions; and renew the call for all participating actors to share knowledge in the field of urban health to better inform future programs.

There are immense health care needs in informal settlements, commonly referred to as urban slums. This is immediately evident from a first-person perspective: upon visiting a slum, it is hard to ignore the impact that the lack of resources (sanitation, waste disposal, access to water, food) has on health. Additionally, a limited number of targeted research studies of public health interventions within densely-populated areas have been conducted; these supplement our understanding of health care needs in the urban slums. What is less clear, however, is how the sum of all health needs affects individuals and communities with respect to health status, health-seeking behavior and access to health care, and what the urban health programming response should be.

In preparing this report, a thorough search of the literature revealed a dearth of information on data and program reviews regarding the health of the urban poor in the developing world. Numerous studies, dating as far back as 15 years, have reported that there is not nearly enough documentation on access to health care in the urban slums (David et al. 2007; Solo, Perez and Joyce 1993), but little has changed to build a knowledge base about urban health programming. While much may have been done by local and international projects to identify and address urban health needs, only a few have documented their experiences; moreover, almost all are experiences from Asia and Latin America, and most are incomplete and/or uncritical about their successes and failures. Projects that have been implemented in African urban slums tend to have been small in scale, of short time spans and, in many cases, implemented by organizations with a limited capacity to evaluate their interventions or publish their findings.

The aim of this report is to review the available documentation describing experiences in health programming in informal settlements and to summarize challenges, lessons learned and promising approaches to program implementation. This report first describes the context of health in informal settlements and then discusses specific health projects and lessons to be learned for future programming initiatives.

Our findings show that with thoughtful planning, resources and inclusive programming, great strides can be made in improving the health status of communities in informal settlements in Africa and beyond. Rigorous evaluation is also required to identify and validate best (or better) practices learned through project implementation, particularly in Africa.

METHODOLOGY

The basis of this review was formed by articles, commentaries, program tools and other materials compiled by the authors, who actively work in the urban slums, over the years. Building upon this knowledge, a review of literary journals, abstracts, program briefs, PowerPoint presentations and other “gray” literature was conducted. Additionally, Google™ was used as a primary search engine to identify additional literature that was not captured in the authors’ personal files.

URBAN SLUMS DEFINED

“While their physical forms vary by place and over time, slums are uniformly characterized by inadequate provision of basic infrastructure and public services necessary to sustain health, such as water, sanitation, and drainage” (Sclar and Northridge 2003).



Alleyway, Viwandani Slum, Nairobi, Kenya

Urban slums are communities that are characterized by one or more of the following shortcomings: insecurity of land tenure, poor structural housing conditions, deficient access to safe drinking water and sanitation, and severe overcrowding. Slums are built in areas where no development has taken place, owing either to unstable land (hillsides as in the case of many Latin American cities, or flood plains), or proximity to garbage dumps or industrial areas (Korogocho and Viwandani, two Nairobi slums, are examples of these particular conditions). Slums often crowd train tracks or pipelines. Most lack accessible roads and government-run facilities (such as health facilities)

and services (such as garbage collection) (Environmental Health Project Strategic Report 12, 2004, hereinafter “EHP 2004”).

Urban slums are often described in terms of their physical appearance, while the dignity and unique strengths of slum communities are sometimes overlooked. As reported by Nwangwu (1998), slum residents can be eager to share information about themselves, their living circumstances and their organizational structures, and are usually not shy about laying out their troubles. Nwangwu commented further, “Remarkably, they [do] not regard themselves as poor” (1998).

Nwangwu’s research suggests that certain slum communities are able to retain their dignity and self-determination by mobilizing resources to build roads, schools, health centers and sanitation blocks, and establishing rules governing their use. Where such capacity is lacking, some programs use community mobilization and capacity-building techniques to create community action groups. As discussed below, the ability to rally support among stakeholders to act collectively for the benefit of the whole community is an essential element of a strong urban health program (Nwangwu 1998).

While slum communities are typically “at-risk” populations, they should not automatically be treated differently from any other community.² Like many populations worldwide, slum dwellers

² One exception is that urban slums experience higher rates of migration in and out as compared to other communities (Zulu et al. 2006).

take pride in their cultures and aspire to community ownership. For example, in Korogocho, it is commonly held that while a man may not have the money to own a home or buy food or water, he can gain respect in the community through his family and his children. Thus, it is important to look beyond the physical conditions of the urban slums and to recognize the great social wealth they have to offer.

THE CONTEXT OF HEALTH IN INFORMAL SETTLEMENTS

“Poor health outcomes of slum dwellers ultimately result from factors outside of the health care system.... Ideally, health interventions should...link security of tenure, provision of basic services such as water, sanitation, etc. and livelihood opportunities to the provision of health services so that informal settlements can be transformed into viable, safe and healthy communities” (David et al. 2007).

The relatively few statistics that have been published on the health status of residents in informal settlements demonstrate the need for intervention to avert further preventable deaths and suffering. The child mortality rate in the Nairobi slums has been placed at over two times the rate for Nairobi in general: 151 deaths per 1,000 births compared to 61/1,000 for children under five years of age (see **Appendix A** for selected, representative statistical information). However, little substantive research has been published about the root causes of these alarming statistics, and even less has been documented about how to effectively address them. Because of the lack of available literature, this report draws heavily on the experience of a few organizations³ as well as the authors’ own experience of program implementation in the urban slums, to provide an overview of the context of health in informal settlements, including the challenges of accessing and using quality health services. Where available, further examples from available literature supplement these ideas.

While program experiences differ, and communities face unique challenges and opportunities, the following broad themes consistently reappear in the discussion of the factors that affect health services in the urban slum setting: (i) ownership; (ii) dignity and recognition; (iii) community involvement; (iv) equal access; (v) recognition of power relations within the informal settlements and between the settlements and the larger community; and (vi) structural barriers to improving provision of health care to the urban slums. While these themes are not addressed in all case examples described in the literature, their significance to program success (largely because of their importance to the communities) warrants their mention and consideration in program design and evaluation.

³ While more complete program descriptions can be found on pages 20–28 of this report, several organizations and government bodies have spent the past several years collaborating on a variety of community-driven health initiatives in the slums of Nairobi, Kenya. These organizations are: The African Population Health Research Center (APHRC), the City Council of Nairobi (CCN), International Technology Development Group (ITDG), Jhpiego and Program for Appropriate Technology in Health (PATH).

At the Facility Level

Urban slums often lack public services, including government-run health services. However, in areas where public health facilities operate in or near slums, it is important to consider the challenges they face and their impact on service quality. Broadly, these challenges include: (i) lack of training; (ii) supply shortages; (iii) staff shortages, turnover and morale; (iv) lack of community interest in the health facility and/or animosity towards facility-based health care providers; and (v) poor attitude of health workers toward community members. Effective program design requires an understanding of how these factors interact and, ultimately, how they affect the quality of health care provision at the local level.

In the urban slum context, it is important to consider not only the supply of formal health care, but the many nongovernmental actors who also shape the conditions of service provision. Lay health care providers, including traditional healers and unqualified pharmacists, are a major health care resource for slum dwellers because of low cost, accessibility, longstanding cultural beliefs and distrust of the official health system. Additionally, there are numerous local organizations that provide health care services to the urban poor. While some of these individuals and organizations are reputable, many do not have sufficient tools or training, and provide slum dwellers with a lower standard of care. Program planners should not ignore the prominence of the private sector in health care provision to the urban poor (some estimates suggest that at least 50% of health services in urban settings are delivered by these groups) (EHP 2004).

At the Community Level

A variety of factors contributes to the health status of slum communities and the availability and use of good quality health services. Broadly, these factors can be categorized either as environmental health challenges or as challenges related to meeting the numerous needs of slum residents. Due to the interconnectedness of these factors, the failure to address one challenge exacerbates the other and worsens the overall plight of the health of the urban poor.

A common thread among the “social” factors is the burden placed on women to ensure that their families’ health care needs are met, despite the barriers to health and welfare that life in urban slums presents.

Health-Seeking Behavior

An important factor that drives uptake of health care services in the urban slums is a lack of client demand. Many would-be clients do not seek available services for the following reasons: (i) accessing medical care may not be their top priority; (ii) they may not know that services (affordable or not) are available to them; or (iii) they may not know where or how to access services (and may be afraid to ask), even if they know that they need medical help. An effective program design can address these behavioral and sociological dimensions of health-seeking behavior by mobilizing the community to actively seek health care and raising awareness about the range of available services.

Family Structure

Urban slums are often populated by migrants who have left their families and communities behind in their home villages to take advantage of the more highly compensated and readily available work opportunities in the urban areas. Because these migrants often arrive in informal settlements without extended family or other close personal contacts, the social support network

for slum dwellers is often weak. Alcohol, drugs and an increasingly “macho” culture (especially among young men) may further contribute to the disintegration of traditional family structures in the urban slums.

Many slum households are headed by single women (untraditional in many parts of Africa, particularly East Africa) or teenage children. Given that “[u]rban poor women are often main breadwinners, [a] maternal death or severe illness puts the family, especially the children, at risk of malnutrition and death” (EHP 2004). Jhpiego’s experience has been that male involvement in health initiatives (creating men’s support groups, for example) and supporting women’s groups—which often exist in the communities—are promising ways to build up a support network in the urban slums.

Sexual Norms

Dodoo, Zulu and Ezeh (2006) found that the urban poor are “significantly more likely than their rural counterparts to have an early sexual debut and a greater incidence of multiple sexual partnerships. The disadvantage of the urban poor is accentuated for married women: those in Nairobi’s slums are at least three times as likely to have multiple sexual partners as their rural counterparts” (Dodoo, Zulu and Ezeh. 2006). The implications of these findings suggest that slum residents are at a higher risk of having unplanned pregnancies (and subsequently seeking unsafe abortions), and have a higher chance of contracting sexually transmitted diseases, particularly HIV, or of having pregnancy- or labor-related complications (Dodoo, Zulu and Ezeh 2006). Community-led health awareness campaigns, peer education and condom distribution/ education programs are of vital importance to address these needs.

Money

As everywhere, economic realities are closely tied to the availability and quality of health care, as well as access to and use of services, in the urban slums. Alongside the inability to pay for health services, poverty limits the procurement of other goods and services that directly affect health: food, water and waste disposal. In times of economic hardship, mothers often engage in illicit activities, such as prostitution and brewing, to care for their families. Recognizing that income generation is a priority for slum residents, USAID suggests that “health improvement efforts would be most effective if associated with livelihood improvement and local empowerment strategies” (EHP 2004).

Ethnicity

Urban slums are often made up of different ethnic groups living in close proximity to one another. When ethnic tensions exist between these groups, they may create barriers to community mobilization efforts, including efforts to improve the quality of health care. Segregated communities may be hesitant to share health facilities and pose a challenge to creating the comprehensive support network that is necessary for the long-term sustainability of a program. While resolving historical ethnic rivalries is beyond the scope of a health intervention, it is important to identify and incorporate cultural beliefs and tensions into program design.

Policy Framework and Governance Structures

A number of barriers in policy and governance impede improvements in the living conditions in informal settlements.

First, urban development policies may not consider the poorest urban communities. Without a policy framework that encourages and enables productive collaboration with the urban poor, actions taken by government stakeholders tend to be less effective (CARE International 2006). A second related factor is the lack of government oversight in urban planning. To hold government agencies accountable for their treatment of the urban poor, advocates and community members must have open lines of communication with government officials and service providers. One such mechanism is holding community forums where local government officials can discuss problems and identify solutions that are amenable to all stakeholders, including community members (Burris et al. 2007; CARE International 2006).

However, even in cases where both adequate policy frameworks and oversight mechanisms are in place, it can still be challenging to bring all relevant stakeholders together to address issues of health care. The often illegal (or quasi-legal) status of residents strips them of a voice to advocate for water, sanitation and other services. Additionally, urban slums are often built on land belonging to wealthy individuals or government officials, creating a power structure that denies slum dwellers security in the ownership of their homes, prevents discussion about their rights as residents and contributes to the overall poor health of their communities. Working with communities in a participatory way may be a new concept to governments and providers, and may require training for all involved. Finally, the migratory nature of some informal settlements can be a barrier to community cohesion and the natural existence of community-wide advocacy groups.

Environmental Factors

Sanitation, Solid Waste and Toilets

Waste disposal poses a major problem for slum residents, with negative implications for their health. “Solid waste services are...rare in poor urban settings since most slums do not benefit from municipal services. As a result, residents live among mountains of garbage and the associated vermin. Burning of trash causes air pollution, and in some communities, scavenged hospital or medical waste poses a particularly dangerous health hazard” (EHP 2004). However, it should be noted that in the slum of Korogocho, the dumping site is a source of livelihood for many residents.



Korogocho Slum, Nairobi, Kenya

Additionally, as toilets are often privately owned and/or pay-per-use, many residents resort to defecating in the open or in plastic bags. As a result, human waste can be found in plastic bags or out in the open on the streets of the urban slums. These areas need well-managed, officially licensed and community-supported toilets. Additionally, urban health programs must identify ways to foster infection prevention practices among slum residents, particularly hand-washing and toilet use.

Food and Nutrition

Access to food, whatever the nutritional content, is a major challenge for slum dwellers. Weeds, porridge and starches (fufu, maize meal, and taro root) often provide the basis for slum residents' nutritional subsistence. Some even cheaper alternatives include street food and fast food, which is processed, unhygienic (often carrying cholera, typhoid and other diarrheal diseases), and lacking in nutritional value (EHP 2004). In Korogocho, cow, fish and chicken intestines from factories find their way into the community as cheap protein. Given that 26% of children die as a result of diarrhea each year in the urban slums, food safety is a major force affecting health care.

Water

Provision of clean water poses a major challenge to slum dwellers. Cairncross (1990) found that many low-income households spend 10–20% of their income on water; however, even these expenditures do not guarantee that the water is available or clean. Although the health benefits of access to clean water have been well-documented, the authors have observed that many communities do not see water purification as a priority or as cost-efficient (Nwangwu 1998).

People's health status in urban slums is determined by multiple, intersecting factors including income, food, water, security, sanitation and waste disposal, family structure, political and policy frameworks, and availability of quality health services. As such, program planners must ensure that all of these areas are addressed to truly make an impact. The following section analyzes some promising program approaches found in the literature to improve informal settlement residents' access to and use of quality environmental health services, aimed at ultimately improving overall well-being.

LESSONS LEARNED AND PROMISING PRACTICES

As discussed previously, there is a notable dearth of program descriptions and project reports on health interventions that have been conducted in urban slums in developing countries. There are, however, targeted studies that have been published on particular health issues, and several papers have been written that provide assessments of health needs and/or offer guidance to project planners as they consider program implementation, specifically to address health in the urban slum setting. There are also many resources available that discuss good program design and management, including some that specifically talk about community engagement. None, to the knowledge of the authors, details considerations of program design, program startup, community penetration and buy-in, monitoring and evaluation, and sustainability specifically in the slum context.

Despite the lack of reports that detail successes and lessons learned, several reports and papers—both in the peer-reviewed and the “gray” literature—provide some overarching guiding principles and key considerations for successful program implementation in the urban slums (David et al. 2007; Solo, Perez and Joyce 1993; USAID/EHP 2004). Specifically, many sources recommend that program designers:

- Work through existing networks of nongovernmental organizations, faith-based organizations, community-based organizations (CBOs) and community champions, whose involvement is critical for community buy-in and success. Recognize that no single project can change everything. A successful intervention addresses specific problems, focuses on the most vulnerable urban populations and sets realistic, measurable goals.

- Collect data. Program evaluations and research are necessary to measure success and build the knowledge base for future programs.
- Establish relationships with community champions who have access to, and the respect of, both the urban poor and decision-makers. Where champions do not exist, develop this capacity within the community. Through local leadership, communities can be empowered with a strong voice in the decision-making process, both at the project level and beyond.
- Engage all stakeholders. Champions of the community or of the poor, as well as those who play a role in local power relations, must buy in to the program and stay active in its implementation. Mechanisms must be in place for good communication and coordination among all stakeholders.
- Plan for sustainability from the start. Activities after program support ends must be included in program design.

In addition to these broad, theoretical guidelines, there are a few substantive project descriptions available for review. These include:

- The Nairobi Urban Health Poverty Project (NUHPP) in Nairobi, Kenya
- Jhpiego's subsequent work in the urban slums with African Population Health Research Centre (APHRC), Program for Appropriate Technology in Health (PATH) and the City Council of Nairobi (CCN)
- Examples described by the Population Reference Bureau (PRB)
- Case studies from the Environmental Health Project

See **Appendix B** for full program details/descriptions.

Successful start-up and design of all health programs rely on many key factors. Four lessons are particularly relevant for successful health programming in the urban slums: (i) Communities must be involved in the identification of problems, understand and buy into the project, and ultimately own the project; (ii) Despite their good intentions, donors and grant administrators can actually cause harm; (iii) Implementers, especially during start-up, must manage expectations to avoid disappointment and/or disillusionment with the project; and (iv) A successful project should incorporate a governance approach to ensure community participation and dialogue among stakeholders.

Community Involvement for Buy-In, Project Design and Ownership

Recognizing and tapping into the remarkable potential in [slum] communities can augment public health infrastructure at the community level. When seen in this light, poor urban settings become “slums of opportunity and potential” rather than “slums of despair” (David et al. 2007).

In slum communities characterized by high population density, underdeveloped infrastructure and weak governance, improving the quality of services at health facilities alone is not sufficient for improving health status. In order to make a real impact upon its target population, a project must incorporate community input, trust, understanding, buy-in and ownership into its design.

Community Buy-In

Slum communities, like all communities, may not be immediately accepting or trusting of newcomers. The NUHPP experienced this first-hand. At the onset of the project, community stakeholders were skeptical of the consortium's intentions. They recognized the true value of NUHPP only after observing consistent improvement in the quality of services over the course of

several years and benefiting from access to legal counsel and support groups. The positive foundation established by NUHPP made it much easier for Jhpiego, APHRC, PATH and the CCN⁴ to work effectively in later stages of urban health programming in Nairobi.

**Case Example: Exchange Visits to Motivate and Mobilize Communities into Action
Nairobi, Kenya**

Exchange visits are a powerful tool that can help to spread knowledge and expertise in development issues. They can also mobilize residents of urban slums to act on their own behalf. One successful example of this strategy can be found in the Nairobi Urban Health Equity Gauge Project (NUHEG), under the leadership of the APHRC.

APHRC worked with two urban slum communities in Nairobi—Korogocho and Viwandani—where poor sanitation caused widespread diarrhea, infections, scabies and malaria, contributing to a mortality rate of 153/1,000 per annum for children less than five years of age. Although the communities were aware of these health risks, they relied on the government to take care of their sanitation needs, and became resigned to their situation when city officials failed to step in.

To show the residents of Korogocho and Viwandani that they had the capacity to change their own environment and to ensure that their children did not die of preventable diseases, APHRC sent them on an exchange visit to two other Nairobi slums, Kiambio and Pumwani. Although these communities had begun under the same conditions as Korogocho and Viwandani, the residents of Kiambio and Pumwani took community development into their own hands and demanded that local officials organize regular garbage collection, repair roads and contribute to the overall improvement of the community. Additionally, local leaders in Kiambio and Pumwani established a school, an ambulance service and a mobile health clinic; all were funded and maintained by collection of a small fee from each member of the community. Invigorated by the initiative of the residents of Kiambio and Pumwani, the Korogocho and Viwandani communities organized themselves to take action to improve their communities as well. Sweeping, unblocking drainage systems and cleaning up garbage were a few of the new community initiatives. Ultimately, this exchange visit improved environmental health and sanitation in both Korogocho and Viwandani.

Project Design

As part of NUHPP, Jhpiego introduced the concept of Performance and Quality Improvement (PQI) to community health. Through this process, Jhpiego worked with communities to identify problems and guided them in developing their own solutions, thus giving them a stake in the success or failure of the health interventions. This not only built the capacity of local leaders to solve problems, but also energized communities to assert their role in improving health.

⁴ Please see **Appendix C** for full details about these organizations.

Performance and Quality Improvement (PQI)

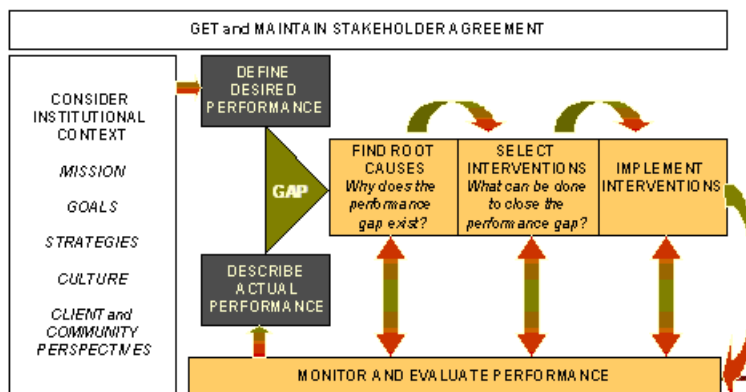
"Involving the urban poor is...instrumental in enhancing implementation effectiveness of urban public policies and programmes..." (David et al. 2007).

The Performance and Quality Improvement Approach (PQI) is a very simple, practical and non-proscriptive tool for helping communities assess their needs and develop solutions. It offers an intuitive approach rooted in participatory research, which has been effectively incorporated into several health interventions in slum settings, particularly in Nigeria (Nwangwu 1998). Rather than offering a preformed package of solutions, PQI encourages clinics, communities and households to consider: (i) What is the situation? (ii) What are the gaps at each step in the continuum of care? (iii) What are the key issues? and (iv) How can we fill the gaps?

The PQI process was used to design both the NUHPP and Jhpiego/APHRC initiatives. It was particularly successful in engaging health providers at Lunga Lunga and Kariobangi health facilities in Nairobi in a conversation with the community about the problems they faced and potential solutions going forward. The health facility staff cited lack of training, equipment, supervision and cooperation from the community as causes for the low motivation and negative attitudes toward patients among clinic staff. Community members claimed that they responded to poor treatment from the clinic by seeking services elsewhere, particularly from traditional birth attendants and herbalists. But given the opportunity to come together and discuss their grievances, health providers and community leaders came to an understanding: providers pledged to treat patients with respect and dignity, while community leaders promised to cooperate with providers and assist them with their needs. This open communication and understanding has greatly improved service provision in the community: health providers have become more motivated to help patients, and clients have become more satisfied with the help they have received.

Moving beyond the design phase, the PQI process that was used in Nairobi sought to: (i) strengthen the capacity of facility-based health providers to deliver higher quality services to slum-dwelling clients; (ii) work hand-in-hand with community members to ensure that their expectations about service quality were met; and (iii) educate community members about self-care and care-seeking best practices, as well as the full range of resources available to them.

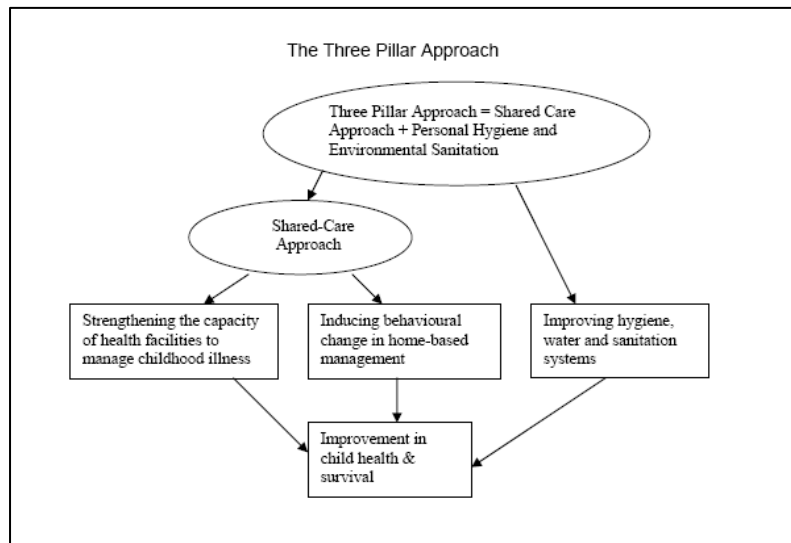
The Performance Improvement Process



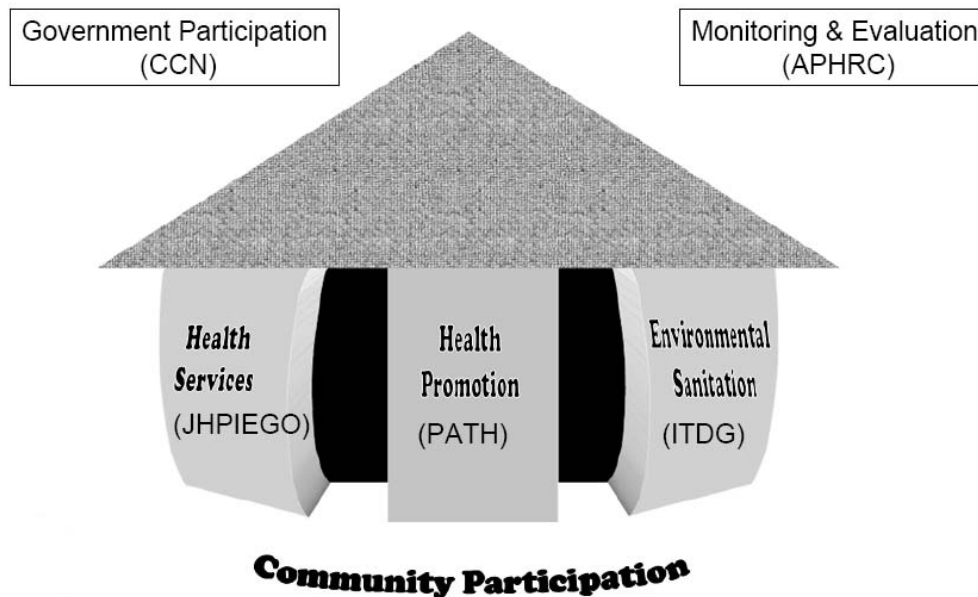
The Three Pillar Approach

The Three Pillar Approach builds on the Shared Care model that has yielded positive results in rural areas, with one key variation: the Three Pillar Approach has a major focus on personal hygiene and environmental sanitation, which are critical problems in poor urban areas. The design of the Three Pillar Approach recognizes that most infectious and communicable diseases rampant in urban slum areas can be contained through prevention activities at both the household and community levels. These include the promotion of personal hygiene and environmental sanitation, appropriate home-based management of childhood illness, and timely utilization of health care facilities. The Three Pillar Approach can be achieved only through a multi-dimensional program that is based on adequate understanding of the local situations. The approach is not a methodology, but a framework for understanding the critical components of designing urban health programs.

Below: An illustration of the Three Pillar Approach. By effectively working with health facilities, promoting health practices among urban slums residents and focusing on environmental health, the quality of health can be improved.



Below: The Three Pillar Approach as it relates to the NUHPP framework specifically.



Community Ownership

All stakeholders must ultimately own the project for it to be effective in the long term. A good illustration of this principle is the successful cooperation between the government of San Salvador and slum community “town councils” detailed in **Appendix C**. Through this program, the city government donated materials and technical assistance to slum communities so that they could undertake gradual improvements by stages. When one component of the project, such as an improvement in the sanitation system, was successfully completed, the government invested more resources in the community toward further improvements. Thus, just as recent microfinance efforts have linked “pay to performance,” the San Salvador slum community project linked “performance to reward” (Solo, Perez and Joyce 1993). Incorporating community ownership into the program design was not only economically efficient; it allowed slum dwellers to feel a sense of dignity and pride in actively bringing about community improvements.

Case Example: Community Involvement and Buy-In to Resolve the Problem of Limited Space Korogocho, Kenya

Because informal settlements tend to be overcrowded and unplanned, it can be a challenge to find the space to construct basic amenities. As such, program planners must understand and resolve conflicts of land ownership before moving forward with construction.

The issue of space played a role in the implementation of the (NUHPP), which included constructing toilet blocks for public use and increasing water points throughout the slum of Korogocho. Space was not seen as a challenge during the planning phase; in fact, there were several empty spaces that seemed ideal for the new amenities. However, before the project could get off the ground, the village elders and chief created insurmountable hurdles that prevented planners from using the available spaces, and the district commissioner could do nothing to change their minds.

Unable to attain land through official channels, the project turned to community-based groups. A women's group and a youth group volunteered to give their land for the facilities on the condition that they would be responsible for maintenance, and six toilets were successfully constructed. Thus, community buy-in and involvement proved instrumental to program success, even without assistance from formal leadership.

Donor Participation

Often the constraints originate in the definitions and policies set by the same international donor agencies wishing to help the urban poor” (Solo, Perez and Joyce 1993).

A prerequisite for successful community buy-in and ownership is concurrence between the donor's agenda and the stakeholders' agenda. While there are numerous explanations for project failure, two main explanations for why communities do not benefit from projects emerge from the literature review: (i) the donor has made incorrect assumptions about how the community would react to the project; and (ii) the donor has imposed rigid guidelines for use of the donated money. Thus, it is critical for donors to understand the circumstances on the ground and the specific needs of the community, and to adjust their financial guidelines accordingly.

Assumptions

A common pitfall among project planners is automatically assuming that expensive, state-of-the-art improvements are necessary, without consulting community leaders and assessing the circumstances on the ground to ascertain that such improvements are appropriate and sustainable. Three examples of this assumption were found in the program reviews. In the first, in Cartagena, Colombia, a low-lying swamp was in need of a sewage system. Sanitation engineers proposed a traditional system, despite the potential for the pipes to sink and for leakage into the water system to occur. The community wanted to install a septic system instead, but planners objected on the grounds that it was not the “gold standard.” In the end, the community's desires were honored and the system has worked well.

In the second case, urban planners in Concepción, Chile, could not connect the high-altitude hillside to the city's central water system because of the high pressure needed to push water up such a steep incline. However, since Concepción averages 300 rainy days per year, a simple water catchment system would have supplied ample water to the hillside communities, and perhaps even provided additional water to lower-lying communities. The water catchment system was ruled out on the grounds that it was “backward,” thus denying the whole hillside the needed infrastructure for construction and development.

In the final case, a slum community of Nairobi was targeted for housing and water upgrades. Formerly run-down homes were upgraded to multi-story buildings with water connections and terraces. However, rather than improving the living standards of slum dwellers, the renovation had the effect of gentrifying the community so that its former residents could no longer afford to live in their homes. They moved into nearby gulches, claiming that “no one would try to take the gulches from them” (Solo, Perez and Joyce 1993).

To ensure community buy-in, ownership and long-term sustainability of the project, donors must be aware of the community’s specific interests and circumstances, not just what they deem to be “best” for the community.

Guidelines

Rigid guidelines for the allocation of donors’ funds can exclude creative solutions and community input from project design. In Jhpiego’s experience in the slums of Nairobi, donor guidelines have posed a challenge for implementation in two instances. In the first case, community leaders requested money to fund the construction of facilities to house new pediatric wards in the clinics as well as private places for meetings of HIV support groups. But because donor guidelines were not clear about using grant money to build structures, it was challenging to meet the community’s request.

In the second case, Jhpiego identified community health advocates to assist with the project. The health advocates requested stipends to support their work, as was customary among organizations operating in the area, but because donor guidelines did not support such payments, it became challenging to motivate these advocates to support the project.

Managing Expectations

“[T]he project must not be too ambitious to start with, since failure leads to disillusionment.... The celebration of...success, no matter how little, will imbue [the community] with more courage and confidence to embark on another project” (Nwangwu 1998).

No single project can be all things to all stakeholders. One of the challenges of community ownership of projects, perhaps more so in the urban slums than elsewhere, is the sheer enormity of needs that communities may identify during the process of generating ownership and buy-in. Donors may feel overwhelmed by the magnitude of challenges facing slum communities and target their money elsewhere to avoid disappointment or perceived failure. Communities may become disenchanted with the project or lose confidence in the donor and project implementers if they feel their needs are not being met.

For instance, under NUHPP, community leaders stated up front that they expected a large amount of money as stakeholders in the project. When funds were not forthcoming, they felt shortchanged and protested against NUHPP. In order to gain more funding, stakeholders exaggerated the prices of materials. When they failed to get the contracts, they made it difficult for NUHPP to complete the task. Through discussions and extensive deliberations, however, NUHPP staff and community leaders reached an agreement that allowed the project to move forward with the community’s blessing.

In order to minimize the challenges faced by NUHPP, project planners and stakeholders must agree upon specific goals and establish a common set of realistic expectations prior to project implementation.

Urban Policy and Governance

“Urban health promotion is not simply a matter of the right interventions, or even the necessary resources. Urban (and indeed global) health depends to an important extent on governance, the institutions and processes through which societies manage the course of events” (Burris et al. 2007).

A governance approach aims to create forums for dialogue and participation in community issues among all key stakeholders with a role in creating and maintaining healthy communities. Typically, the desired outcomes are: (i) stakeholders with defined roles and responsibilities *vis-à-vis* the problem; (ii) increased capacity among community members to advocate for changes to meet their needs; (iii) increased capacity among providers and local authorities to respond to community needs; (iv) mechanisms for holding stakeholders accountable; and (v) functioning communication systems for continued dialogue and problem-solving. There are several emerging examples of how a governance approach has solved problems typically associated with “hardware” (for example, broken water pipes, or simply a lack of adequate services). An additional advantage of the government approach is that it incorporates not only government agencies and providers, but also communities.

Two Governance Examples from CARE

Zambia: A community-local government jointly managed committee

CARE International. 2006. *Cities on the Brink: Urban Poverty in the 21st Century*.
www.careinternational.org.uk/urban

Community water taps in a poor settlement in Lusaka had been out of service for years and residents had lost faith that their water fees translated into improving local water needs.

Rather than a quick but costly fix to the problem by mending the pipes, CARE assisted the community and local government officials to create a jointly managed committee. The committee together decided upon a system for managing the water system and collecting fees. As women played an important role in daily household water needs and supply, the project ensured that they had significant participation in the process.

This collaborative approach reinstated trust between the two groups and provided an example to all involved about what can be achieved through a participatory governance approach.

Ghana: The Urban Basic Access to Social Services Project (UBASS)

CARE Kumasi. 2006. *UBASS Project: Some Success Stories*.

Contact Bright Wireko-Brobby at CARE-Kumasi.

The UBASS governance project worked with existing community civil society organizations (CSOs), such as carpenters' and hairdressers' associations, and with local government authorities (including service providers) to improve citizen access to basic urban social and health services. The UBASS project recognized that there is often a wide gap between authorities who plan and implement public services and those living in the poorest communities. Bridging this gap using a governance approach became the objective of the project.

To achieve this objective, the project brought together the CSOs to form an overarching Association of Civil Society Organizations (ACISO). UBASS worked in three communities with one ACISO per community. Project workers then trained ACISO members in communication and advocacy skills necessary to interact with local authorities to express community needs. Similarly, the project worked with local authorities to sensitize them to the governance approach of working in participation with communities to solve problems.

A key component of the project was the bringing together of the ACISO (and other community members) with the local authorities at a community forum. Such meetings provide an opportunity for authorities to listen to the community's needs, and for the community to better understand how they can access services and influence local authority decisions about service provision. Importantly, when facilitated well, these meetings become an opportunity for the community and local authorities or service providers to find ways of collaborating to meet the community needs. Indeed, during the project, an ACISO successfully worked with the local water company manager to reinstate water supply, which had stopped four years previously as a result of ongoing construction work.

The governance approach in Kumasi has resulted in sustained community action through the ACISOs after the project ended. ACISOs continue to meet and discuss community issues around service provision. One ACISO successfully applied for and received a small grant to implement TB prevention activities in their community, and other projects are being designed to improve the disposal of solid waste.

Program Interventions

As well as helping communities to identify their needs, the PQI process used in the NUHPP and Jhpiego/APRHC projects assisted communities in designing appropriate interventions, as displayed below.

COMPONENT	NEED	INTERVENTION	RESULT
Service Delivery	Training among clinic staff	Health care staff were trained in ART, counseling and testing, infection prevention and control, focused antenatal care, pediatric HIV	Clinics improved in service quality. Service providers more knowledgeable in managing cases in the clinics, increased uptake of services.
Service Delivery	Lack of staff meetings to review cases and discuss issues among staff	Trained on importance of staff meeting to review work progress and plans for coming week	Staff meetings held weekly and issues resolved amicably.
Service Delivery	Community did not trust clinic staff	Community groups and health facility staff brought together in Village Health Committees to build trust, discuss issues and work together	Quality of health care markedly improved (according to focus group discussions, exit interviews and objective measures). Community now talks of "our clinic."
Service Delivery	Community members and health facility staff did not know where community-based services were located	Created community maps and community directory of all available health and spiritual services	Communities now "own" the maps and directories and can direct themselves to services. Facility-based health providers can now refer clients to community services when appropriate.
Service Delivery	Health facilities in disarray	Communities volunteered to help clean and paint health facilities	Facilities are now in better shape and community feels a sense of ownership of the cleanliness of health facilities.
Service Delivery and Community Capacity	Stigma a major barrier for HIV-positive persons to access services	Community awareness campaigns initiated to address stigma, clinic staff sensitized on stigma issues (utilizing the "Whole Site Approach" in which all clinic staff, including cleaners, guards, etc., are trained) to encourage HIV-positive individuals to feel comfortable coming to the clinic for services	Clients more satisfied; support groups initiated in the community for psychosocial support; men more involved in stigma reduction; schools supporting orphans and vulnerable children and those affected by HIV; anti-stigma signs in health facilities; community mapping has made it easier to find HIV services offered without asking.
Service Delivery	Children born with HIV not getting health attention	Trained service providers in pediatric HIV	Children receiving health care in slum health facilities

COMPONENT	NEED	INTERVENTION	RESULT
Service Delivery	Poor waste disposal at health facility	Construction of incinerators and training health providers on maintenance	Improved waste disposal at health facility.
Community Capacity	Communities had no income to pay for health services	Community trained in micro-enterprise and business management	Small businesses have begun and microfinance institutions are interested in lending more support via loans.
Community Capacity	Community did not have access to nutritious food	Community gardens were developed—one at the health facility and another in the slum itself (using gunny bags)	Leafy vegetables are now available for community garden participants.
Community Capacity	Community members did not understand HIV medication nor the importance of adherence	Trainings were done for community groups to increase awareness of the importance of antiretrovirals in HIV management and to increase adherence rates	Increased demand for ART—by more than 50% in one clinic—and (anecdotal) improvements in adherence rates.
Community Capacity	Sexual assault a major problem, especially for the old and the sick	Self-defense group engaged to conduct anti-rape training for women and young boys. Rape prevention messaging disseminated through local community groups	New intervention; results have yet to be fully evaluated.
Community Capacity	Sexual risk-taking common among community members	Safe sex peer education workshops conducted	Understanding about the role condoms play has increased.
Community Capacity	Community awareness of HIV transmission low, myths and misconceptions pervasive	Peer educators/magnet theatre training conducted to pass on correct messages	Community understanding of HIV aspects improved.

SUSTAINABILITY AND THE WAY FORWARD

The success of health programs in urban slums relies on generating stakeholder buy-in and ownership from the start. This approach not only guarantees that the project will address the target community's priorities in the short term, but also engages local government authorities and health care providers in ensuring sustainable, self-sufficient improvement in the long term.

Both the NUHPP and Jhpiego/APHRC programs trained staff at the CCN in disease management, water provision and sanitation, and community engagement, and in doing so, gradually built the capacity of CCN staff to manage the initiative after project funding had ended. The initiatives engaged in supportive supervision activities where project staff mentored managers at CCN and coached them on proper supervision skills and best practices. This effort proved especially helpful at the health facilities: with the skill of supportive supervision, CCN staff could ensure that high-quality services were being provided at the health facilities while maintaining positive relations with clinic staff.

CONCLUSION

For development organizations, the way forward lies in building a knowledge base of best practices. All actors working to improve the health of the urban poor must carefully document the methods and outcomes of their interventions and disseminate this information rather than simply talking about projects anecdotally.

While the challenges related to improving health care in urban slums are often systemic and structural, modest gains can be made through targeted interventions that incorporate community ownership, government involvement and the management of expectations among stakeholders. Paramount to success is the acknowledgment that no project can solve all problems; instead, success should be measured by its impact on the specific needs of a target group.

APPENDIX A: SELECTED NAIROBI STATISTICS

Analysis of the Nairobi Urban Health and Demographic Surveillance System (NUHDSS) data shows that:

- The infant mortality rate (IMR) in Korogocho, a slum of Nairobi, Kenya, in 2003 was 130/1,000 live births (Kyobutungi et al. 2006) compared to 67/1,000 for Nairobi as a whole, 79/1000 for rural Kenya, and 96/1000 for the lowest national wealth quintile (Central Bureau of Statistics, Ministry of Health and ORC Macro 2004).
- The under five mortality followed a similar trend with 192/1,000, 95/1,000, 117/1,000 and 149/1,000 respectively.
- The most common causes of childhood mortality from January 2003 to December 2004 were acute respiratory infections and diarrhea accounting for 26% and 21% of deaths among under fives respectively (Kyobutungi et al. 2006).

APPENDIX B: Jhpiego PROJECT DESCRIPTIONS

1. NAIROBI URBAN HEALTH AND POVERTY PARTNERSHIP (NUHPP)

Project Dates: January–December 2005

Brief description: The NUHPP partnership was established to demonstrate, on a pilot project basis, the variety of interventions that would need to be addressed to make an impact on the health of two slum communities in Nairobi, Kenya: Korogocho and Viwandani.

Partners: The NUHPP partnership began with support from the Rockefeller Foundation in a week-long session at the Rockefeller Foundation's Bellagio Conference Center in Bellagio, Italy. The Rockefeller Foundation in Nairobi, Kenya, was interested in addressing the health of the urban poor, and so gathered the partners that would eventually make up the NUHPP partnership to devise a plan of partnership and action. In brief, the partners were:

- APHRC: lead partner, responsible for monitoring and evaluation; (<http://www.aphrc.org/>)
- Jhpiego: responsible for health facility upgrade interventions; (<http://www.jhpiego.org/>)
- ITDG: responsible for water, environmental sanitation and livelihood interventions; (since renamed: Practical Action)
- PATH: responsible for behavior change communication interventions; and (<http://www.path.org/>)
- City Council of Nairobi (CCN): responsible for coordinating and facilitating interventions and applying lessons learned into the local government policy framework. (no Web site available)

Project Intent: The intent of the project was to design and execute interventions in multiple aspects of health in order to: (i) tackle the major determinants of child morbidity and mortality through the Integrated Management of Childhood Illnesses (IMCI) strategy; (ii) show improvement in environmental sanitation in the community; and (iii) show behavior change with respect to health through behavior change communication (BCC).

Funding: Funding for this partnership came from a variety of sources. While seed funding came from the Rockefeller Foundation, the amount of money proved to be inadequate to complete all of the interventions that the partnership hoped to accomplish. As a result, other donors contributed: The Embassy of Finland in Kenya, The William and Flora Hewlett Foundation and the European Union all provided financial support. Total funding for the two-year NUHPP partnership was expected to be \$1,400,000 but ended up being far less.

2. MAKING COMPREHENSIVE CARE FOR HIV A REALITY IN AFRICAN URBAN SLUMS

Project Dates: July 2005–July 2007

Brief description: Building on the success of NUHPP, Jhpiego was awarded additional funding to continue strengthening improvements among the facilities and community groups in Korogocho and Viwandani slums in Nairobi, Kenya.

Partners: Jhpiego acted as the lead partner in the consortium. APHRC was retained to help provide monitoring and evaluation of program activities, and PATH continued with its work in behavior change communication. The City Council of Nairobi continued to play a vital role in government and community relations.

Project Intent: The project was intended to continue the work begun under NUHPP, taking its lead from the community and addressing the issues that they—in conjunction with Jhpiego and its partners—perceived as most urgent and pressing to improve the status of their own health care.

Funding: This project had a defined and secure funding stream of \$350,000 for the two-year period.

Two new projects have just begun in the same two slums where Jhpiego and APHRC are working:

3. COMPREHENSIVE CARE FOR HIV AT THE HOUSEHOLD LEVEL IN AFRICAN INFORMAL SETTLEMENTS: CONSOLIDATING THE GAINS

Project Dates: December 2007–March 2008

Brief description: APHRC and Jhpiego were awarded additional funding to continue improvements among the facilities and community groups in Korogocho and Viwandani slums in Nairobi, Kenya, and to consolidate the gains made in previous projects.

Partners: APHRC acts as the lead partner in the consortium. Jhpiego continues its role of implementation. The City Council of Nairobi continued to play a vital role in government and community relations. The Trust for Indigenous Culture and Health (TICAH) will play a role in community nutrition.

Project Intent: The project is intended to continue the work begun under NUHPP and subsequent funding, taking its lead from the community and addressing the issues that they perceive as most urgent and pressing to improve the status of their own health care.

Funding: This project has a defined and secure funding stream of \$700,000 for the year-long period.

4. EXPANDING REPRODUCTIVE HEALTHCARE IN AFRICAN INFORMAL SETTLEMENTS

Project Dates: December 2007–January 2009

Brief description: Jhpiego was awarded funding from the Wallace Global Fund to build on its successes under NUHPP and subsequent funding from the Rockefeller Foundation to address the unmet needs for reproductive health and family planning in the urban slums of in Korogocho and Viwandani slums in Nairobi, Kenya.

Partners: Jhpiego is the lead partner on this project. The City Council of Nairobi continued to play a vital role in government and community relations.

Project Intent: The project, utilizing the PQI model used during previous initiatives, will aim to improve the provision of reproductive health in the urban slums, especially for HIV-positive persons.

Funding: This project has a defined and secure funding stream of \$245,000 for the two-year period.

APPENDIX C: PROJECT EXAMPLES FROM THE LITERATURE⁵

It has been mentioned that project descriptions of other urban health initiatives in the slums were not widely available. However, the following project descriptions, taken from a report by Solo, Perez and Joyce (1993), have proven useful in the preparation of this report.

1. A PROGRESSIVE APPROACH TO MANAGING URBAN GROWTH: THE TIJUANA EXAMPLE

The term “explosive urban growth” hardly begins to describe what has been occurring in Mexico’s border towns in recent years. In Tijuana, poor families have settled on the banks of the river, which runs through the center of town, building ingenious retaining walls with old truck and car tires filled with sand and cement. In the early 1980s, aware of the dangers of both floods and landslides, the city tried in vain to remove the squatters. Eventually, the rain-swelled river accomplished the major eradication job that the city could not, with tragic consequences.

No sooner were the first communities washed away when new residents came to settle on the site of the disaster. At that point, the Secretariat for Human Settlements and Public Works (SAHOP) realized that unless viable alternatives were made available, the throng of new families-immigrants without fixed jobs or savings, who were simply too poor to qualify for the traditional state-provided low-income housing-would repeat the mistakes of the past.

By instituting a new policy, SAHOP was able to sell lots of unserviced, unoccupied *ejidos*, or farmland held in public domain. In doing so, it went against local tradition and law. SAHOP marked off streets, sidewalks, house lots, and public areas with white lime, and sold off the house lots with the assurance that they would receive services someday. Families were given one month to pay the full cost-which represented the government cost of expropriation, including indemnification and legal fees-and two months to occupy the site. Buyers not living on-site within the required time lost the right to the lot. Since the land was technically still in the process of expropriation by the national government, SAHOP sold “options to buy with permission to occupy” rather than outright titles. And the state governor personally guaranteed the outcome of the purchase and sale agreements.

The system worked remarkably well. SAHOP sold off 100 lots per week and houses went up at a similar rate. No one moved back to the old site of the river banks. Families pitched in to pave roads, plant trees, and do as much of the public works as possible. Water came from trucks. People relied on latrines. But the site plan allowed for wide and accessible streets, making future service installation more feasible. The city was able to begin construction of an aqueduct and sewer system about a year after each site was occupied. The families were then more financially stable and had a greater ability to pay for the services.

The Tijuana experience suggests several lessons:

- People can pay for the full cost of the land. The cost of unserviced land is not a major barrier if land is legally available.
- Both the city and its residents stand to gain from programs that accommodate new growth, and the savings in avoiding disasters on mountainsides and along river banks is probably incalculable.
- With government support and encouragement, families are willing to assist with the vital work of urban development.
- Incremental infrastructure improvements based on demand and affordability can be a feasible mechanism for reaching the urban poor.

⁵ Source: Solo TM, Perez E and Joyce S. 1993. *Constraints in Providing Water and Sanitation Services to the Urban Poor*. Water and Sanitation for Health Project Technical Report No. 85. U.S. Agency for International Development: Washington, D.C.

The Tijuana model, which takes after the U.S. Homesteading Act, is certainly more productive than one that attempts to control or ignore urban growth.

2. CONVENTIONAL VERSUS UNCONVENTIONAL TECHNOLOGIES

Cartagena, Colombia

In this low-lying swamp community of 100,000, a study was conducted to determine an "intermediate technology" to improve sanitation, a goal that presupposed that no other system could replace a conventional sewer in the long term. But the study resulted in the development of a special technology that has proved even more effective than a conventional sewer system, at about one-third the cost-not only for swamp areas, but indeed, for any low-density urban area. The new system replaced the large-diameter pipes of the conventional system, which sink or warp in swamp areas, with an unconventional system that filters out sewage solids into septic tanks and moves off the liquids in small-diameter pipes. The septic tanks require cleaning every six years.

While local residents were easy to convince as to the feasibility of the new system, planners and engineers from the local government agency were not so enthusiastic. Despite a water table 25 inches below ground, highly impermeable soils, and land levels well below the city sewer mains, the officials kept insisting that a conventional sewer system be installed, despite its tendency to sink and the necessity of pumping the sewage uphill to the city sewer mains. One of the chief arguments the planners and engineers made was that existing construction codes did not allow for the lower standards of the new technology (i.e., it was illegal). Fundamentally, though, it was the lack of familiarity with the proposed new technology (a technique not discussed in most engineering schools) that created the most resistance. In the end, the new system was applied as a pilot and has functioned well for more than 10 years.

Concepción, Chile

In the areas surrounding the city of Concepción, Chile, planners ruled out the hillsides as permissible construction areas on the grounds that the city water pressure was insufficient to reach above a certain level. As a result, they eradicated poor communities huddled above the city. The irony is that Concepción averages 300 rainy days per year-enough pure potable water to supply New York City. Yet planners and engineers completely discarded the catchment of rainwater as "backward," even though such a solution can service any area at low cost.

3. GENTRIFICATION AND EIRR: A CASE IN KENYA

In Kenya, one urban project targeted low-income populations with new housing and urban-upgrading components. Although the project ran into many problems-site conditions, land tenure, and cost recovery to name a few-the sum of the costs came to far less than the sum of the benefits, because the sale and rental price of the land soared after its improvement.

Thanks to the project, however, the former slum became a home for the elite, not low-income families. The upgraded areas included three-story, ultra-modern villas with gardens in tiers. The original targets of the project, the poor, were run out of their neighborhoods and into gulches outside the city. They felt safer there, they said, because nobody would try to take the gulches from them. They failed to realize, of course, that the gulches with their difficult terrain would probably never get water and sewers. In terms of EIRR, the project was an all-out success. In terms of bringing water to the poor, it failed miserably.

4. A SUCCESSFUL URBAN-UPGRADING APPROACH IN SAN SALVADOR

During the mid-1980s, the mayor of San Salvador instituted a model slum-upgrading program that operated in *all* of his city's slums. It presumed a certain continuity in urban upgrading, viewing improvement as an ongoing process, and not one to be resolved within the framework and schedule of a project. The program defined "upgrading" in terms of stages of improvements. As a first stage of improvement, the program made all slum dwellers members of a major sports facility in the city and by establishing local neighborhood councils in each slum. Thereafter, a system of step-by-step rewards for progress was established whereby the city donated materials and technical assistance for a series of amenities, from a community center to a piped water and septic tank system. If the community complied in construction and maintenance, it was rewarded with materials and assistance for the next stage of improvement.

5. THE NECESSARY CONTRADICTIONS OF "COMMUNITY-LED" HEALTH PROMOTION: A CASE STUDY OF HIV PREVENTION IN AN INDIAN RED LIGHT DISTRICT

One of India's best known community-led interventions is the Sonagachi Project in Kolkata. This project, which focuses on India's sex workers, began in India's largest red light district, where an estimated 5000 (mainly female) sex workers live and work. The project involved components of HIV prevention and community development, using a "3 Rs" approach: Respect, Recognition, and Reliance. The set of activities has effectively improved health. The argument in the paper listed here is that the success of the interventions is due, at least in part to the effective management of local power relations.

The authors assert that while it may be ideal that the community takes over the running of a participatory project, such work depends upon significant skills and powers, which cannot be assumed to exist in historically marginalized communities. Lessons learned include:

- Very substantial efforts and a long timeframe are required to build participants' capacities for activities including demonstrating accountability to funding agencies, management, and negotiation.
- The planning of a participatory project should include explicit consideration of how relationships with potential adversaries are to be managed, rather than denying their existence.
- Project designs should provide for opportunities to monitor and critically reflect on the nature of the project's engagement with powerful groups.
- Project evaluators should not use idealized standards of community leadership, but by whether practical steps to actively manage, monitor, and change relationships with powerful groups have been taken.

6. THE MAKING CITIES WORK/GREAT CAIRO HEALTHY NEIGHBORHOOD PROGRAM (CHNP)

Project Dates: October 2003–August 2004

Brief Description: The Making Cities Work Project was carried out in Ezbet el Nawar, Egypt, an informal slum neighborhood located on the border between Cairo and Qalyubeya. The first phase of the project included an engineering assessment of Ezbet el Nawar's sewage and water systems, analyses of 75 water samples from private wells and the municipal filtered water system, and an environmental health survey of 510 local households. After gathering information, project implementers brought community stakeholders into the process of developing a local plan of action and took measures to ensure the long-term sustainability of improvements. These measures included conducting a three-day training workshop for the Local Unit staff on how to operate and maintain a water treatment plant; hosting and publicizing a hygiene education program for 250 women on Egyptian Mother's Day; and helping the local government to codify regulations for sewage collection and water treatment.

Partners: USAID Making Cities Work Program, The Experimental Center for Recycling and Environmental Development (ECRED) in Ezbet el Nawar, Egypt.

Project Intent: “To design, promote, and implement affordable, feasible and replicable improvements in household and community sanitation, drinking water, and other environmental health technologies.”

Funding: USAID

7. THE ACF KINSHASA MARKETS AND WATER AND SANITATION PROJECT

Project Dates: October 2000–January 2002

Brief Description: Treating the open-air markets of Kinshasa as virtual communities, project implementers worked with local contractors, CBOs, and 30,000 market vendors and their households to implement three important changes in the community: 1) to build community management capacity and improve hygiene practices; 2) to improve sanitation facilities; and 3) to increase the availability of safe drinking water. ACF conducted interviews with vendors and clients to understand the community’s environmental health needs, used local contractors to install new facilities, and empowered the vendors to monitor the new facilities as well as to administer a local health education program.

Partners: Action Contre le Faim (ACF) (Action Against Hunger), USAID

Project Intent: To reduce public health hazards by improving sanitary conditions in Kinshasa’s seven open-air markets.

Funding: USAID

8. THE IRC KANANGA WATER SUPPLY AND HYGIENE EDUCATION PROJECT

Project Dates: October 2000–January 2002

Brief Description: This project promoted better health and hygiene practices by using a community survey followed by an education and training campaign. It increased the quantity and improved the quality of household water by mobilizing local labor to build four reservoirs/fountains and 75 individual safe water-supply sources. Additionally, the IRC Kananga project improved the sustainability of water supply facilities by training 76 water committees in the proper financial management and maintenance of the water sources.

Partners: International Rescue Committee (IRC), Association pour le développement integral en milieu rural (ADIR), Institut national pour le développement et études sociales (INADES), the Archdiocese of Kananga, and 12 Kananga-based NGOs.

Project Intent: To improve access to safe, potable water for 20% of the population (around 150,000 people) and to educate 50% of the population about better hygiene practices.

Funding: USAID

9. THE IRC BARUMBU ENVIRONMENTAL HEALTH PILOT PROJECT

Project Dates: October 2000–January 2002

Brief Description: The IRC Barumbu Project used four strategies to meet its objectives: 1) building the capacity of the community to address and identify its own needs; 2) improving wastewater management and drainage; 3) increasing sanitation facility use; and 4) to improving domestic and community hygiene practices.

Partners: International Rescue Committee (IRC), Cellule de base pour l'assainissement de Barumbu (CEBAB)

Project Intent: To reduce the incidence of diarrheal diseases by working with the community to eliminate environmental causes, and to identify and test creative solutions for addressing urban environmental health/sanitation problems.

Funding: USAID

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