

Improving Access to Health for Women and Girls in Low-income Urban Settlements

The world is becoming increasingly urbanised. Over one third of urban dwellers now reside in low-income urban settlements, where living conditions are often inadequate and there exist multiple barriers to access to health services for women and girls. Based on six case studies and a thematic review examining women’s and girls’ access to health in low-income urban settlements, IDS researchers and partners call for decision-makers to take a broader approach to address the social, structural and economic determinants of health, and to ensure community involvement in interventions with genuine gender inclusivity.

Understanding intra-urban health inequalities

The majority of the world’s population now reside in cities and this trend is set to continue – by 2050 the World Health Organization (WHO) estimates that 70 per cent of the world’s population will be living in urban areas. City living can provide opportunities – for example, increased economic opportunity, anonymity, independence and leisure. And, in some countries, people living in urban areas experience better health, on average, compared to those in rural areas. However, this average masks the marked inequality that exists within urban areas, perpetuated by underlying political, economic and social factors.

Living conditions in low-income urban settlements are often inadequate, with overcrowding, substandard housing, poor access to affordable quality food, insufficient safe recreation spaces, and a lack of amenities, including water, electricity, sanitation and sewerage systems, refuse collection, and public health facilities. For residents of low-income urban settlements, living in such spaces is associated with a lack of engagement in health-related policy and over-exposure to particular health challenges. These include alcohol use; sex work; non-communicable diseases (NCDs) related to poor diet, tobacco and

What is a low-income urban settlement?

The places in a city or town where poor people most often live are called many things – slums, ghettos, colonies, inner city, informal settlements, peri-urban areas, and townships – with stigmas and stereotypes attached. The United Nations identifies five characteristics defining a slum: inadequate access to safe water; inadequate access to sanitation and infrastructure; poor structural quality of housing; overcrowding; and insecure residential status. However, within and across different countries, living standards within these areas can vary. In this briefing, we use the term ‘low-income urban settlements’.

sedentary lifestyles; a high prevalence of infectious diseases such as HIV and TB; and mental health issues arising from the stresses of surviving on the economic margins of large cities with high levels of crime and violence, with fragmented – or no – access to social support.

Unequal gender relations further enhance this inequality. Women in low-income urban settlements are marginalised and excluded from health services and related policy processes according to case studies looking at access to HIV services in Kibera and Majengo in Nairobi, Kenya and at sexual and reproductive health and rights (SRHR) for indigenous women in Shillong, India. Women in

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Shillong often internalised the notion of being second-class citizens and of not having any role in politics and policy. This marginalisation and inequality prevented women from asserting their rights and demanding access to sexual and reproductive health (SRH) knowledge and services.

Historical and/or underlying political factors can entrench intra-urban health inequalities. Apartheid in South Africa legitimised disparity, unfair resource distribution, inferior education and unequal access to health. This legacy still has a profound impact on health, the development and provision of infrastructure for health services, and in health policy formulation. The case study on SRHR and ICTs in South Africa demonstrates that this inequality is echoed through poor access to ICT, with low-income urban settlements experiencing poor network coverage, weak satellite signals, insufficient bandwidth and voice capacity. Underlying this, there are significant factors which limit women's use and access to ICT, including illiteracy. Patterns of inequality cannot be addressed simply through access to technology – special policy measures are needed to support infrastructural and other developments in low-income urban settlements.

Barriers to access of health services

Life for women and girls living in low-income urban settlements is characterised by exclusion, and this is reflected in poor access to basic health care and services. The thematic review and several case studies observed women's poor access to appropriate, efficient and confidential health services. In some cases, it was a **physical lack of access** – health-care services were scarce, difficult to get to, or inappropriate. In Shillong, India, research revealed little SRH service provision in the low-income urban settlements. Similarly, in Kibera and Majengo, Nairobi, women and health-care workers reported a lack of HIV-related health services, stock-outs of essential drugs and faulty equipment, leading to time-consuming referrals.

Even where health services are available and physically accessible, poverty in various forms can hinder women's and girls' access. **Income poverty** can make health care prohibitive. For example, in Shillong, India, despite the close proximity of urban health centres,

some women reported that out-of-pocket expenses put them off seeking health care for themselves.

Time poverty can also be a barrier to access. In Khayelitsha, South Africa, prior to the implementation of a community-based intervention to address the burden of NCDs, people would lose a day's work due to waiting at the clinics all day. One of the successes of the intervention was that Community Health Workers (CHWs) provided services to the community, allowing people to access services in a more timely fashion.

Lack of patient confidentiality and absence of political will also affected access to services. Some women in Kibera and Majengo did not feel that health-care workers respected confidentiality, which prevented them from accessing HIV-related services. Additionally, it was found that ensuring access to and quality of health services was not a priority for some county-level policymakers, who felt it was not their role.

Community, voice and participation

Voice, participation and community engagement are essential to ensuring delivery of appropriate and effective health services for women and girls in low-income urban settlements. There are numerous examples from the case studies where participatory engagement has been integral to improving health services and delivery. The Philani Mentor Mothers Programme – a maternal mental health intervention in low-income urban settlements in Cape Town, South Africa – recruited mentor mothers, acknowledging that resident women with thriving children are best placed to be trained to deliver services to other women in their community. Similarly, in the intervention to address NCDs in Khayelitsha, the community were involved from conception through to delivery. CHWs and the wider community requested the intervention, informed it (through a community mapping exercise) and participated in activities (fun walks, health club, etc.). As part of the Community Led Total Sanitation (CLTS) initiative in Kalyani, India, women living in low-income urban settlements played a lead role in making Kalyani open defecation free (ODF). This was the first time they were included in decision-making processes both at

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home and in the community, and they felt that they had finally found their voice.

Before CLTS was implemented in Kalyani, the municipality played a limited role in the welfare of low-income urban settlements and provided no institutional commitment or resources. However, the municipality chairperson played a key role in driving the process and supporting the community to successfully make their town ODF. As a result of the community's success in improving their sanitation status, the municipality received national recognition and now pays more attention to the needs of those living in the low-income urban settlements. Engagement with and buy-in of local community leaders was an important element that strengthened the impact of the Philani, NCD and CLTS interventions.

Local women were active agents of change in these community interventions. But more often, voices of women living in low-income urban settlements are silenced and there exist many barriers to their participation in high-level health decision-making. In Khasi society in Meghalaya, India, women are excluded from political participation, despite the fact that land inheritance is determined by the maternal line. Women cannot vote or hold office in the traditional governance system, and the traditional women's organisation in the community (*seng kynthei*) has a limited decision-making role. Within the state governance system, women can vote and hold office, but in practice, few women are elected to the legislature. There are limited, if any, procedural mechanisms for community participation in policy development and the prioritisation of health needs. This, coupled with the culture of silence around SRHR in Khasi society, makes it challenging for women to discuss or inform decision-making on SRH.

Where official channels for political engagement do exist and where governments recognise the importance of public participation in informing policy, this does not always translate to women being able to engage in decision-making around issues that affect their health. In Kenya, the new constitution encourages and emphasises public participation, and devolution (introduced in 2013) should support this, with appropriate civic education programmes for citizens. However, so far there has been

low public engagement in decision-making and governance, and, as one health-care professional stated, 'here in Kenya, policies are made by leaders, and not beneficiaries. Leaders make policies that favour them.' Women and girls living in low-income urban settlements face both internal and external barriers to political participation through not knowing how the political systems work, a lack of confidence and knowledge about how to engage policymakers, a lack of time and income, and other competing priorities.

Taking a multisectoral approach

Findings from the thematic review and several of the case studies stress the need for a more cohesive approach, bringing together multiple sectors. One shortcoming of the intervention to address NCDs in Khayelitsha was the focus on individual behaviours or risk factors for NCDs instead of addressing the broader social, cultural, structural and environmental determinants identified in the research. Active involvement of different sectors was required in order to prevent and address the multifactorial risk factors for NCDs.

The case study of the Philani intervention recognised that women living in newly-urbanised areas often lack social support systems, can be exposed to urban violence, and experience social exclusion and a denial of basic reproductive rights. While individual level interventions to improve maternal mental health are essential, the Philani intervention acknowledges that this cannot be done at the expense of addressing structural determinants such as poverty and adverse living conditions.

At the time of the case study on SRHR and ICT in South Africa, there were no policies which addressed both SRH and ICT, despite much activity on ICT innovation and the use of mobile phones for health (mHealth), and little interaction between the government departments of health and communication. However, shortly after publication, South Africa launched an mHealth strategy laying the foundation for the integration and coordination of both public and private sector mHealth initiatives in the country. This recognition of the need to provide multisectoral policy guidance is a positive step in supporting and promoting the integration of ICT for health into existing health systems and programmes.

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Policy recommendations

The six case studies undertaken show that there are on-the-ground particularities, and that there is no blueprint to addressing the health of women and girls in low-income urban settings. However, there are a number of cross-cutting policy recommendations which are important to consider in the development of policies and interventions to address the health of women and girls living in these settings.

Intra-urban health inequalities

It is important to recognise the multifaceted nature of intra-urban inequalities, which impact on the health of women and girls in low-income urban settlements. Poverty, gender, and issues of place all contribute to intra-urban health inequalities and act as barriers to access to health services.

Additionally, the informal nature of some low-income urban settlements means that governments may not officially recognise or take responsibility for services in these areas, in part due to lack of formal addresses and official paperwork. Governments need to treat people living in informal and low-income urban settlements as citizens, acknowledging and realising their rights to basic services, including health.

Barriers to access to health services

Women and girls in low-income urban settlements face layers of exclusion that act as barriers to access to health services, and these layers can have a reinforcing effect on each other. Policymakers, governments, donors and those involved in the implementation of interventions need to acknowledge this and ensure that policies and programmes work towards addressing these barriers. This includes finding creative ways to facilitate access to services and to overcome the constraints to access – including time, health-care costs, lack of transport, etc. This may rely on government partnerships with community-based services and involve decentralised initiatives.

Community, voice and participation

The active involvement of communities, the buy-in of local leaders and the genuine ability of women to engage and participate in decision-making processes are essential to ensuring women's and girls' access to appropriate and effective health services in low-income urban settlements.

Policymakers, governments and others involved in the implementation of interventions should:

- Focus on community involvement in interventions, including engaging men, and should see the urban poor as change agents and not just passive recipients of interventions and policy pronouncements.
- Learn from and build on the many successful community-based approaches that exist. Care should be taken to ensure genuine gender inclusivity and to avoid tokenistic references to women's participation within government and state policy processes.

Multisectoral approach

Ill-health is just one of the challenges poor women and girls face in low-income urban settlements, alongside many other social, economic and structural determinants of health. In order to adequately address the health challenges of women and girls in these urban spaces, it is essential to look beyond the health sector and adopt policy responses that are multisectoral and take a broader approach to addressing the structural determinants of ill-health.

Policymakers, governments, and donors need to ensure that health policies and programmes are seen in conjunction with other sectoral concerns, including water and sanitation, urban planning, gender equality, and nutrition, among others.

Further reading

World Health Organization and United Nations Human Settlements Programme (2010) *Hidden Cities: Unmasking and Overcoming Health Inequities in Urban Settings*, Geneva: World Health Organization

Hawkins, K.; MacGregor, H. and Oronje, R. (2013) *The Health of Women and Girls in Urban Areas with a Focus on Kenya and South Africa: A Review*, IDS Evidence Report 42, Brighton: IDS

Case studies from India, Kenya and South Africa on women's and girls' access to health in low-income urban settlements can be read on Interactions: <http://interactions.eldis.org/urbanisation-and-health>

Credits

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