



Responding to inequalities in health in urban areas in east and southern Africa

BRIEF 5: WHAT DOES THE EVIDENCE INDICATE FOR ADVANCING URBAN HEALTH AND WELLBEING?



Introduction:

A lens on urban health inequalities

By 2050, urban populations will increase to 62% in Africa. The World Health Organisation (WHO) and UN Habitat in their 2010 report “Hidden Cities” note that this growth constitutes one of the most important global health issues of the 21st century. Cities concentrate opportunities, jobs and services, but they also concentrate risks and hazards for health. How fairly are these risks and opportunities distributed across different population groups but also across generations? How well are African cities promoting current and future wellbeing? How far are health systems responding to and planning for these changes?

Training and Research Support Centre (TARSC) as cluster lead of the “Equity Watch” work in EQUINET explored these questions in 2016-18, for east and southern African (ESA) countries. We implemented a multi-methods approach to gather and analyse diverse forms of evidence and experience on inequalities in health and its determinants within urban areas. We explored current and possible responses to these urban conditions, from the health sector and the health promoting interventions of other sectors and of communities. We aimed to build a holistic understanding of the social distribution of health in urban areas and the distribution of opportunities for and practices promoting health and wellbeing from different perspectives and disciplines.

We thus integrated many forms of evidence, including a review of literature, analysis of quantitative indicators, internet searches of evidence on practices and thematic content analysis.

We included cycles of participatory review and validation by young people from diverse urban settings and socio-economic groups in Harare and Lusaka.

These methods were applied with an intention to draw on different disciplines, concepts and variables from different sectors and on the lived experience and perceptions of the youth directly affected by different urban conditions.

Separate publications and briefs present findings from the work. This brief reports on the combined findings and their implications for improving equity in urban health and wellbeing.



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Key findings from documented evidence

The findings reported in this brief can be found in full in 'Responding to inequalities in health in urban areas: Report of multi-method research in east and southern Africa', EQUINET Discussion paper 117, EQUINET, Harare

Our review of the literature in [EQUINET Discussion paper 106](#), reported also in [Brief 1](#), suggested that a policy perception of an urban advantage is no longer valid for many health outcomes and determinants in ESA countries. A focus on urban–rural differentials thus seems to be no longer sufficient for addressing inequalities in health, especially those emerging from disadvantage and rising poverty *within* urban areas.

The review identified that urbanisation in ESA countries is associated with rising and often conspicuous wealth in some groups and increasing levels of public access to online information and social media. At the same time it is also associated with many socio-economic deficits, often in close proximity to wealth. Many urban residents experience poor living conditions, unemployment, income and social insecurity, crime and different forms of violence, social isolation and exclusion. While health services are generally available and geographically accessible, there are cost, quality and acceptability barriers that lead to the poorest groups of people making less use of services.

Recent migrants, residents of informal settlements and those living in informal housing and 'backyard shacks' or as lodgers in formal areas thus have a vastly different experience of urban life than wealthier, more secure groups. These conditions pose particular challenges for people at different ages and stages of life, such as for adolescents or elderly people.

The literature presents a series of fragments of different and often disconnected facets of risk, health and care within urban areas. It appears to chase, lag behind or miss the rapid, diverse and multifactorial changes taking place in urban areas. There is limited direct voice of those experiencing the changes and limited report of the features of urban and social assets that promote wellbeing.



We chose to focus on urban youth to further explore these issues, not only given young people's exposure to current and future urban health risks, but also given their role addressing those risks.

As described in Discussion paper 117 and in [Brief 1](#), we found that holistic, integrated and affirmative approaches have the potential to overcome such deficits and to address and rebalance the multiple social, economic and environmental determinants of these different health outcomes.

'Wellbeing' – also termed 'buen vivir' – is a concept that has value in integrating, exploring and acting on the psychosocial, social, time use, political, material, economic, service, governance and ecological determinants of health equity in urban areas. Indeed, the WHO Constitution makes explicit reference to wellbeing as the affirmative dimension of health in its first principle "Health is a state of complete physical, mental and social *wellbeing* and not merely the absence of disease or infirmity". A focus on wellbeing reaches beyond the control of negative outcomes to promote positive strategies and appreciate the role of individual and collective assets. It integrates both objective and subjective dimensions and pays attention to current impacts as well as future consequences that develop cumulatively over time.

Despite the potential a concept of wellbeing offers to understanding urban health equity and its drivers, our analysis of available data from across ESA countries highlighted that, in contrast to other regions, there is limited data collected in the region on many dimensions of wellbeing. The data are also predominantly focused on negative indicators. This is further discussed in [EQUINET Discussion paper 114](#) and in [Brief 2](#).

Key findings from the participatory review

Our participatory validation with urban youth involved a total of sixty-three young people from six different levels of socio-economic security in Harare and Lusaka. These six groups were identified as representing a spectrum of key socio-economic groups in the city with higher levels of youth populations, viz:

- At higher levels of security: (1) youth living in low density, higher income suburbs, and (2) youth in formal employment (although noting that these too may be insecure).
- At medium levels of security: (3) youth in tertiary education.
- At lowest levels of security: (4) young people in informal settlement (5) unemployed youth, and (6) youth in informal jobs.

Key findings from wellbeing and health-promoting interventions

As a form of appreciative inquiry, we searched specific practices being applied to address these issues in other countries globally and reported these practices in an 'ideas book'. Examples from them are described in the synthesis paper and in [Brief 4](#). The practices we found highlighted some common features:

- They address a range of material, economic, social and personal dimensions of wellbeing, with cross cutting benefits.
- They build relationships between young people, bring their voice into planning and connect them with local authorities, services and different professionals and community leaders.
- They strengthen capacities of and communication between youth across the different city zones, increasing their understanding of each other's needs and supporting solidarity between them.
- They bring innovative practice within familiar settings, using various methods to organise and raise the visibility of community evidence. They provide informal spaces that complement formal participatory processes and build innovation around local ideas, practices and resources.
- They often give more prominence to social dimensions, providing for community interactions, to engage people's creativity and curiosity, where people can contribute ideas and interventions.
- They facilitate co-operation across communities and with services, including to organise public resources.



In discussing these innovations, young people from Harare and Lusaka in 2018 endorsed that a range of informal approaches are needed to create spaces where they can share information and introduce such innovations in their own settings, including in peer-to-peer strategies, youth hubs, innovation festivals and online surveys. While formal mechanisms like the junior parliament or the local government junior council were seen to be useful and partnerships with state institutions essential to develop solutions to priority problems, it was perceived that formal mechanisms needed to link with and enable these informal spaces and processes to reach and engage with young people across the city and to build their self-confidence to solve problems.



How we identified these young people, the participatory approaches used and the findings are described in more detail in the synthesis paper, in [Brief 3](#) and in individual reports of the work in [Harare](#) and [Lusaka](#).

All six groups of young people in Harare and Lusaka had a more narrow definition of health than of wellbeing. They saw health services as largely treating disease, while having secure incomes, education, participation in government decisions and shelter were seen to be very important for their wellbeing.

Mental wellbeing was also prioritised in both cities, with young people facing stress from their situations. They reported relying on peers, rather than on services for psychological support.

They saw these issues become more challenging in the future, envisaging that as the city grew, it would become more competitive and overcrowded, demanding even more on young people's capacities for innovation and entrepreneurship, threatening natural resources and green spaces, and with a diminishing, rather than an increasing level of social solidarity as urban populations grow.

Access to education and a relevant curriculum; job and enterprise creation, the creative and green economy; access to shelter and non-violent enabling community environments; information and communication and participatory government were all seen to be important areas for intervention to improve both current and future health and wellbeing.

While the young people felt that these interventions could be affected by urban planning, they perceived that they could not easily access these planning processes, or that when they did participate their views were not taken seriously.

Applying a wellbeing lens in addressing urban health equity

The issues raised in the literature review, the data analysis and the participatory review and the approaches being applied in urban areas internationally point to learning and insights on acting on urban health equity through the holistic lens of wellbeing.

Our current dominant approach of understanding health equity in relation to the distribution of morbidity and various deficits in immediate, proximal determinants of health appears to be necessary but not sufficient to understand, explain and proactively advance health equity in urban areas.

This is particularly the case when health services have become increasingly biomedical and focused on disease. It is especially so for youth, as while they may appear to be in 'good health' in terms of freedom from disease, they face a number of physical, mental and social challenges that have immediate and long term effects on their health and wellbeing.

Holistic, integrated and affirmative approaches have the potential to overcome such deficits and to address and rebalance the multiple determinants of health.

Recent 'health in all policies' approaches seek to address this by embedding health in the work of other sectors. However, the outcomes may still be motivated, perceived, defined and measured in terms of reducing immediate risks to ill health, limiting ownership of other sectors of these outcomes and application of bottom-up, participatory approaches. They may focus on individual measures for particular sectors, which while necessary, may not adequately encourage the cross-sectoral collaboration needed for sustained and significant changes for urban health, particularly given the pace and complexity of urbanisation.

We propose 'wellbeing' as providing a holistic, integrated, affirmative and shared outcome.

Many countries have gravitated to this concept. Some have done so in criticising the equation of development with economic growth at the cost of social inequality and the degeneration of nature, and in seeking a more balanced relationship between socio-political, material, ecological and economic conditions, for current and future generations as a common good.

We argue that the concept has value in exploring and advancing health equity in urban areas. It is not 'owned' by any particular sector, and avoids the siloing of outcomes. Its focus reaches beyond the control of negative outcomes to promotion of positive strategies and assets at individual and collective levels.

It integrates both objective and subjective dimensions and current and future consequences that develop and emerge cumulatively over time. From our experience of the participatory youth validation, 'wellbeing' is (currently) a more accessible concept in its use, not (yet) owned or mystified by a technical community. Using it enabled us to put youth at the centre of assessment, taking into account their lived experience and perceptions of their lives and future as active participants.

The gaps we found in the assessment of urban wellbeing suggest that beyond applying a more comprehensive concept of wellbeing, our routine measurement, within and across countries, should measure and disaggregate evidence on positive and negative determinants and outcomes and on people's perceptions of their conditions and services. Particularly for local urban planning, it should blend routine information with participatory assessment within different areas and groups in the city. The participatory validation with young people in Harare and Lusaka showed the new evidence this provides. While the literature generally focused on wealth and area gradients in health and its determinants, what the youth reported did not always follow these gradients. They also raised areas such as mental stress that they reported to be having a significant effect on their wellbeing, but to be largely ignored by services.



We thus propose changes in the way we think about and analyse urban health equity:

1. To embed analysis of health equity within the wider concept of wellbeing, as a shared outcome more likely to be owned and understood by different sectors and communities, integrating the range and interaction of both assets and risks in the psychosocial, material, economic, environmental determinants that affect current and future health equity.
2. Beyond current areas of focus, to pay more attention to enterprise creation, the creative and green economy, shelter, internet access, psychosocial wellbeing and participatory democracy as relevant for current and future urban wellbeing.
3. To develop, measure and use in urban planning and in monitoring state performance a wider set of parameters that cover the psychosocial, spiritual, cultural; physical; education and culture; living conditions and services; time use; economic; environmental; governance and citizenship dimensions of current and future wellbeing.
4. To integrate participatory methods to draw out, understand and use in planning the diversity of lived experience and perceptions that affect variations in urban health and wellbeing.

Analysing equity in urban wellbeing

The disconnected facets and fragments that we piece together to analyse urban health is further reflected in systems and services that are themselves segmented and silo'ed, and better equipped to focus on technical aspects than the social factors and relations that influence their effectiveness and uptake. In a context where data has increasing influence in planning, deficits in evidence can distort local plans and lead to poor recognition of conditions and experiences important for health equity. WHO and UN Habitat (2016) suggest that we need to reclaim a more multidimensional understanding of equity as a measure of good urban government.

In part this implies gathering and disaggregating evidence on social inequalities within urban areas and between social groups in ESA countries.

Applying a concept of wellbeing can also help to lever a more holistic analysis by stimulating new ways of defining and measuring progress. Countries in other regions have begun to do this such as in:

- The WHO Global Health Observatory urban health observatories.
- The WHO Urban Health Equity Assessment and Response Tool (Urban HEART) and the InDepth Urban Health and Demographic Surveillance Sites in Africa.
- Integrating psychosocial, political, economic, service, governance and ecological indicators, including in composite indices such the Happiness Index and the Quality of Life Index.
- The involvement of citizens in the selection and measurement of parameters, such as the Better Life initiative and Urban HEART.

As noted earlier, there is much more limited evidence of such data being gathered or used in ESA countries, although the development of indicators for the Sustainable Development Goals (SDGs) may partially address this.

At the same time, measured data have limitations in understanding these multidimensional and sometimes fast moving urban contexts.

This calls for methods that draw more directly and systematically on the lived experience of different groups of urban residents. The participatory validation in Harare and Lusaka provided evidence and weightings for areas of wellbeing not well reflected in current data, including employment security in youth, support for entrepreneurship and the creative economy, security of shelter, access to green spaces and affordable publicly subsidised social media, and support for mental wellbeing.

Further, in contrast to the more negative focus on risk factors and problems in published papers and data, a wellbeing perspective led us to evidence on positive innovations in urban areas, building on and strengthening local assets and relations. Adding the voice of those directly affected enriched the analysis, understanding and response.

We thus propose that we deepen how we assess and plan for urban health equity and wellbeing:

1. By identifying and measuring both positive and negative indicators across ESA countries for the range of wellbeing parameters, measuring risks and assets and positive and negative outcomes, drawing on wellbeing indicators used in other regions globally.
2. By complementing quantitative data from routine information and surveys with participatory, qualitative assessments and the voice of those directly affected, particularly for within-area assessment and planning.



Implications for urban primary health care

There is a growing recognition of the need for more effective responses to urban health challenges, to deliver on both the right to health and people's 'right to the city'.

A 'healthy city' has been defined as one that enables people to have equitable access to economic opportunities and services; that empowers people to achieve their potential and that nurtures natural environments.

These intentions and a holistic understanding of wellbeing have resonance with comprehensive Primary Health Care (PHC).

The innovative responses we found for promoting urban youth wellbeing have features that may inform what a reinvigorated urban PHC may involve in practice:

1. **Facilitating recognition, visibility and voice of active residents and citizens**, appears to be critical, not only to formally recognize people's (changing) conditions, but also to ensure that the evidence and agency of diverse social groups in urban areas, including marginalised or excluded groups, are brought into the mechanisms, spaces and processes used in urban planning and services.

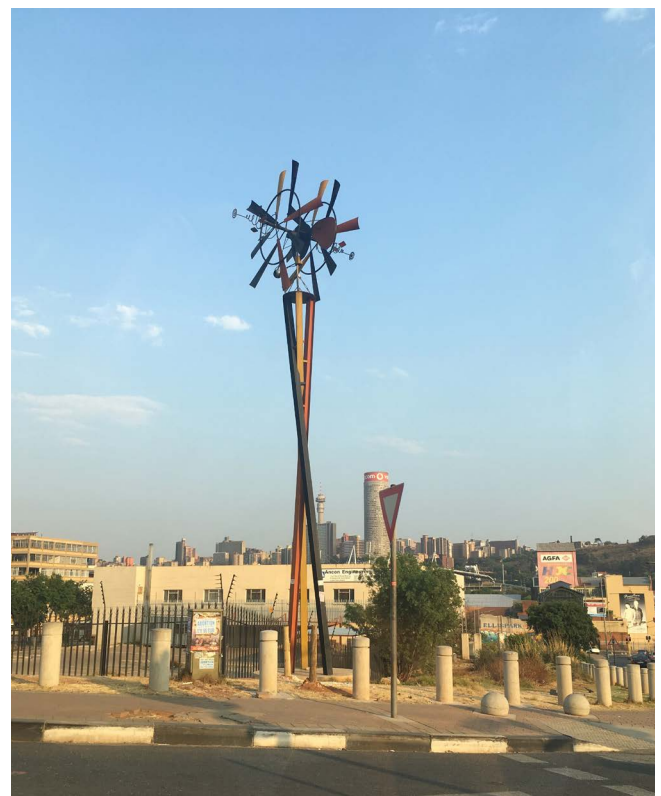
This implies a shift from an urban PHC that is singularly preoccupied with managing negative outcomes and that sees people particularly in terms of the specific diseases they come with, to greater use of participatory and asset based approaches that identify the strengths and capacities within and priorities of communities and that builds interventions on these assets.

It suggests having a register of the catchment population and integrated services for individual, family and community mental, physical and social health that plan proactively for family and population health, enhancing continuity of care and linking primary care and other services and payment systems to support the health of the whole community.

2. **Addressing different dimensions of wellbeing, including social dimensions, at the same time or place**, in place based approaches that bring different disciplines, sectors and actors together in a shared framework, often community driven, in comprehensive place-based strategies outside health care facilities, such as in markets and schools.

Public spaces are important sites for generating integrated approaches, such as by 'co-locating' different services to support access, co-ordination across services, shared staff training, shared work practices and team approaches.

3. **Embedding ideas, innovation and collaboration within familiar settings**. Many of the approaches used to promote wellbeing generate creative formal and informal spaces and processes to nurture new practices and relationships within familiar urban settings. They shift from preoccupations with competitive advantage to valuing and nurturing ecosystems for collaboration.





Doing this implies a shift in the often top-down approaches of health systems to engage the community and primary care levels as knowledge producers (and not just a knowledge implementers or reproducers), including for their role as contributors to wider urban democracy.

4. **Stimulating and building relationships, trust and collaboration**, within social groups and with local authorities, urban services, administrative and technical personnel, artists and different types of community leaders.

Young people pointed to the potential for PHC practice to support this through: health authorities participating in local council dialogue with existing urban youth forums on programmes and budgets; bringing community evidence into decision making; facilitating voice of groups not usually heard and using e-governance, online forums and social media.

They saw urban PHC as providing competent services, but not stopping there. It would also involve competent health teams going into the community to meet people in their own forums and spaces and working with community members as voices, watchdogs and social advocates for health.

5. **Using online and social media** for people to report issues, get information and provide feedback, to support participatory planning; for online mapping and surveys; for crowdfunding; to generate and model ideas and to facilitate accountability on key services.

PHC services may provide free Wi-Fi access, as Lusaka does in youth corners, but the health sector could also join in advocacy for reduced data costs and for free Wi-Fi in all public services.

6. **Bringing investment and using innovative financing approaches.** Primary care, as the more pro-poor level of the health system, demands adequate funding without cost barriers at point of care.

Adequate domestic funding of public sector urban PHC would appear to be a necessary basis for leveraging other resources. These may come from a wide range of sources such as crowdfunding, seed funding, innovation challenge competitions, angel investors and 'matchmaking' private funders. They complement and do not substitute the public sector duty to fund PHC.

These features of urban PHC potentially position the health sector as a key contributor to a healthy city. It raises concern therefore that the literature presented evidence of the opposite taking place, with report of urban PHC initiatives struggling and facing shortfalls, weak links between local primary care services and public and community health; declining investment in public health capacities, weakening public health authority and a persistence of 'sectoral silos'.

Despite the potential for 'win-wins' for various sectors in achieving mutual goals in areas such as transport; food systems; energy use; clean water and waste management; shelter, green spaces, local enterprise and the creative economy, health sectors have faced difficulties in initiating, co-ordinating or sustaining intersectoral action for health. Facing such challenges in a context of underfunding, a focus on 'the core business' of personal care services may further limit thinking on the services and approaches needed to improve current and future health in our cities.

Rural PHC was incubated in a moment of change in our region. It emerged from the confluence of new thinking in the 1976 Alma Ata conference and the political, democratic and nation building imperatives of the liberation struggles as a source of new ideas and practice in the health sector. It was implemented by states with support from rural communities. The significant inequities between the opportunity for and experience of improved health in urban areas call for similarly new ideas and practice for *urban* PHC, framed by a shared aspiration for wellbeing, rooted in urban communities and supported by states.



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