

Healthy urban: An agenda of the day

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The term Urban was first used in 1619 and came from a Latin word 'Urbanus' meaning city (1). There is no single universal definition of urban since this tends to vary from country to country. The definition of urban however may vary in time, delineation of administrative and political boundary, population size and density and economic function (2).

In 2014, global estimate shows that 54% of the world population resides in urban setting (3). This proportion is projected to expand to 66% by 2050. The pace at which urbanization grows is unprecedented especially in developing countries. It is projected that population in urban areas of low income countries will grow from 1.9 billion in 2000 to 3.9 billion in 2030 (4). Urbanization is recognized to offer opportunities as well as bring challenges to human health and wellbeing. By offering opportunities, urbanization is considered as a hub of economic and social transformations with better literacy and education, life expectancy, improved housing and sanitation, access to services, participation in public affairs, better living conditions, better food security and better health indicators (5). Nonetheless, such narrative appears to mask the realities of disadvantaged urban poor who do not share the same level of joy regarding access to opportunities (6).

Posing challenges, children and women in informal settlements of SSA including Ethiopia sustains poor health indicators as compared to those in rural settings (7). Communicable diseases such as HIV/AIDS and tuberculosis, and non-communicable diseases like diabetes and cardiovascular disease are major health threats in Africa and this is particularly so in rapidly increasing urban settings of Sub-Saharan Africa (8).

To date, evidences suggest that over a third of the urban population in many low and middle-

income countries live in slums areas (9,10). Many people in such settings live in neighborhoods with little or no provision of education and health services, poor safe water supplies, poor sanitation and waste management and poor nutritional status (11, 12). This is against the imperative of Sustainable Development Goals (SDGs) which echoes the attainment universal health coverage (UHC). The commitment to universal health coverage and SDGs aims to improve the living conditions and health of urban residents (5). Equity, inclusiveness and accountability in health and development are the key focuses of interventions to improve the wellbeing of all urban residents (13). This calls for urban leadership to broaden responsibilities to take up demographic issues, pollution, slums, infectious and communicable diseases such as HIV/AIDS and tuberculosis, non-communicable diseases as well as aging population and migration as an agenda. This requires investment in infrastructure, job creation and expansion of social services (5).

As it stands now however, urban residents are believed to sustain vulnerability to infectious diseases, chronic non-communicable diseases, injuries, road accidents, violence and crime (4,14). Such vulnerability is not evenly distributed where disparities or inequities in health outcome indicators between urban settings remains apparent. This is particularly so in Ethiopia (15). Urban poverty as defined in terms of poor access to social services, crime safety, security, social segregation and social alienation is widespread at informal settlements and its residents are vulnerable to the challenges (16). Equally important is the challenge posed by urban health data which is aggregated with averages neglecting disparities within residents in urban setting between rich and poor, young and old, men and women, migrants and long-term residents. Recent

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evidence from Ethiopia revealed that most the population in the urban slums (80.4%) use unimproved sanitation facilities while 8.2% practice open defecation (17).

WHO has long recognized the challenges of urbanization to global and country specific development agenda. As part of its Social Determinants of Health initiative, WHO has given due attention to urbanization as it may positively or negatively affect places where people grow, live, work and age (18) and creates opportunities for inequities in services including health (6). One of the major concerns to track urban settings and determinants of health is the lack of disaggregated evidence. In order to address such challenges, global network of researchers for Urban Health (Knowledge Network on Urban Settings - KNUS) was formed to collate and synthesize evidence on broad policy and program interventions for healthy urbanization (19). In as much as dealing with urban health problems is sine qua non to dealing with wide range of problems all stakeholders are expected to collect and collate evidences that should be triangulated to provide benchmark for urban planning and intervention. KNUS is designed to engage all those that are operating in urban setting to carry out equity assessment and response tool on a regular basis to monitor and act on health inequity in programming and intervention (6). The assessment is guided by a tool "Urban Health Equity Assessment and Response Tool" (Urban HEART) which draws on the Social Determinants of Health framework and was introduced in 2010 (20). It guides the process of local and national stakeholders to identify, prioritize, and track inequities in health in urban settings targeting 12 selected indicators including infant mortality, tuberculosis, diabetes, road traffic injuries, safe water, improved sanitation, primary education, full immunization, skilled birth attendance, smoking, unemployment, and government expenditure on health. Piloted in 17 cities from nine countries across the world, the assessment has suggested: countries may review equity indicators, provide guidance on validating routinely collected health data and link data on equity with interventions and engagement of all

concerned stakeholders including community. This requires provision of local and national policy and strategies and commitment to use findings in national and global reports (20).

The relative emphasis on this global initiative is to shade light on the fact that: i) urban health evidences are aggregated in developing countries and more importantly in Sub-Saharan Africa shadowing the realities of urban poor; ii) urban poor are not homogeneous making vulnerability within and between urban settings apparent and iii) addressing urban health problems remains the responsibility of diverse sectors (4).

Ethiopia with conservative estimate of its urban population projected to grow from 15.2 million in 2012 to 42.3 million in 2037 with a growth rate of 3.8% a year (21) is fast urbanizing. Such growth will undoubtedly pose challenges if corresponding social, economic and physical development is not well aligned to meeting the health needs of urban residents (22).

Recent initiatives by FMOH and USAID supported JSI JSI's Strengthening Ethiopia's Urban Health Program has paid attention to urban health as a broad agenda pushing its boundary from what has been introduced as urban health extension in 2009 (23). Broad advocacy forums through urban health think-tanks, media and scientific forums have laid the foundation for urban health as the responsibility of every stakeholder. However, framing this with defined roles and responsibilities as well as accountabilities for stakeholders requires policy direction on the one hand and commitment of all stakeholders on the other.

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