

Knowledge gap nr 3. Slum health care

A health policy issue of rising consequence, slum health care is still inadequately studied. Official statistics tend to conflate strikingly-different urban realities. The resulting averages suggest an urban advantage, whereas the health status of slum dwellers is often worse than in the countryside. The opaqueness of derelict slums deters most analyses. To national authorities, aid agencies and researchers alike, close-by slums may remain inaccessible and unreadable. In this way, large populations may become visible to authorities only when epidemics or riots strike. The Ebola epidemic in West Africa has eloquently demonstrated the vulnerability of slums, and the ineptness of official responses.

“The proliferation of informal drug sellers and itinerant doctors within slum areas can be interpreted as a supply-side response to demand for accessible services. Outside of the regulatory framework, and with minimal financial investment, these providers are able to offer extended hours of services, and can set up and relocate easily as per the needs of the poor urban populations they serve. By contrast, static primary care clinics within slum areas are very few in number..”. “..so little is known about the underlying business strategies that make the private sector viable in slum settlements. [...] the informal private sector is responding to a lucrative market opportunity.” (Adams, Islam and Ahmed, 2015).

In many cases, the conflicts ravaging the countryside have displaced rural populations towards large cities. Over time, these supposedly-temporary settlers have become permanent ones. Whole rural societies have been subjected to an accelerated, traumatic urbanisation. In the Middle East, most displaced people live dispersed in cities, reconfiguring in this way the urban fabric. *“The humanitarian response in middle-income countries often intersects with the rising needs of urban poor. Fueled by increased population mobility, humanitarians are increasingly forced to respond to violence and exclusion from basic services in urban centres” (Whittall, 2014).*

Under-governed urban slums pose extraordinary obstacles to orthodox healthcare provision: insecurity, cramped spaces, poor transport, absent utilities, local rackets, diffidence towards outside initiatives, reluctance of health workers to be deployed there, all combine to asphyxiate health service development. Unsurprisingly, no standard urban healthcare delivery model seems adequate in such messy, hostile environments. With swelling urban populations, no prospect of a reversal in urbanisation trends, and negligible chances that atrophied state authorities manage to gain access to and control of these unruly spaces, health care for impoverished urban settlers can only expand organically, largely financed by households.

Slums are spontaneous if problematic laboratories, where a lot of experimentation takes place for better or worse. Given their increasing economic, demographic and political weight, these over-crowded spaces will condition broader healthcare developments, most likely diverging from expected or desired outcomes. Renewed efforts to penetrate these blurred, uninviting, multi-faceted environments are badly needed.

QUESTIONS

1. Which political, economic and cultural barriers impede the provision of better health care in slums? Would action-oriented research reduce such barriers?

2. *Slums are conspicuously absent in most health policy documents, which tend to portray the healthcare arena as uniform, hence to be served by the same delivery model. What measures might help policy makers to better reflect diverse health needs and responses?*

3. *What measures would be realistically needed to make slums less vulnerable to health stressors?*

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