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GUIDELINES ON URBAN HEALTH SYSTEM DEVELOPMENT

I. RATIONALE/BACKGROUND

In the Philippines, nearly 60% of the population in 2000 lived in areas classified as urban, and an estimated 28% lived in squatter and slum settlements. Urban Health System Development (UHSD) must help cities address the challenges of rapid urbanization.

Increased congestion, pollution and slum formation with wider inequity across social determinants of health are results of rapid urbanization. Urbanization has also increased risks, hazards and vulnerabilities to health of urban populations including communicable diseases, violence, traffic injuries, obesity, and settlement in unsafe areas.

The rapid rate of urbanization has outpaced the ability of governments to build essential infrastructure for health and social services. Thus, it will require more than the provision and use of health services to improve the health of urban populations.

II. OBJECTIVE

These guidelines outline the basis, purpose and nature of DOH support to the development of Urban Heath System and defines directions and framework for Urban Health System Development (UHSD) in the Philippines.

III. SCOPE

This issuance shall apply to the entire health sector involved in Urban Health System Development (UHSD), including the Department of Health (DOH) its Centers for Health Development (CHD), DOH-retained Hospitals and Attached Agencies, City Governments, national and city Official Development partners (ODA) as a guide for technical assistance to City Health Offices, as they embark on developing and enhancing their Urban Health Systems.

IV. USHD GOALS AND OBJECTIVES

A. Goals

1. **To Improve Health System Outcomes** Urban Health System shall be directed towards achieving the following goals; (i) Better Health Outcomes; (ii) More equitable healthcare financing; and (iii) improved responsiveness and client satisfaction.

2. **To influence social determinants of health** The rapid urbanization in cities makes it difficult for health as well as other sectors like the economic, social service sectors to cope. The DOH must help influence social determinants of health in urban settings, with focused application on urban poor populations particularly those living in slums.

3. **To reduce health inequities** In the urban setting, inequities between the rich and the poor are worse than in rural areas. Urban Health Systems Development seeks to narrow the disparity of health outcome indicators between the rich and the poor.

B. General Objective: To address the Urban Health challenge

C. Specific objectives:

1. To establish awareness on the challenges of Urban Health;
2. To initiate inter-sectoral approach to Urban Health Systems Development; and
3. To guide LGUs to develop sustainable responses to the Urban Health challenge

V. DEFINITION OF TERMS

1. **Urban areas**. The National Statistical Coordination Board (NSCB) Resolution No. 9 s. 2003 provides the following urban criteria: (1) a city/municipality is to be considered as urban in its entirety if it has a population density of at least 4,000; and (2) a barangay in a city or municipality not classified as urban in the first criterion is to be considered as urban if it has a population of at least 7,000 or it is a poblacion or central district of a city or provincial capital;

and defines urban areas as follows:

1. If a barangay has a population size of 5,000 or more, then a barangay is considered urban, or
2. If a barangay has at least one establishment with a minimum of 100 employees, a barangay is consider urban, or
3. If a barangay has 5 or more establishments with a minimum of 10 employees, and 5 or more facilities within the two-kilometer radius from the barangay hall, then a barangay is considered urban.

The National Capital Region is considered as entirely urban.

2. **City Classification (NSCB definition)**

Highly Urbanized Cities — Cities with a minimum population of two hundred thousand (200,000) inhabitants, as certified by the National Statistics Office, and with the latest annual income of at least Fifty Million Pesos (P50,000,000.00) based

on 1991 constant prices, as certified by the city treasurer.

Independent Component Cities — Cities whose charters prohibit their voters from voting for provincial elective officials. Independent component cities shall be independent of the province.

Component Cities — Cities which do not meet the above requirements shall be considered component cities of the province in which they are geographically located. If a component city is located within the boundaries of two (2) or more provinces, such city shall be considered a component of the province of which it used to be a municipality.

3. **Rapid Urbanization.** Urbanization is a social-economic-political cultural phenomenon that occurs in an often unmanaged autonomous process when people individually respond to economic opportunities and social trends in ways that result in collective effects that are primarily defined by greater concentration of human activities and increased density of human settlements.

4. **Urban Health System.** The World Health Organization (WHO) defines "health systems" as encompassing all individuals, groups, organizations, institutions, and mechanisms undertaking actions for the purposes of protecting, restoring or improving health status of the population. Adapting this definition for urban areas, the DOH recognizes "urban health systems" as encompassing all entities and processes operating in urban settings to protect, restore or improve health status.

5. **Social Determinants of Health.** Social determinants of health are those critical characteristics of societies and communities in which people live that have an impact on their health (eg. level of education, water and sanitation, housing, employment, food production). In urban health, the living conditions of people define the set of social determinants important to their health.

6. **Equity in Health.** The World Health Organization Constitution (WHO, 1946) asserted that "the highest standards of health should be within the reach of all, without distinction of race, religion, and political belief, economic or social condition". It implies that ideally, everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance.

7. **Health Inequity.** Health inequity refers to the presence of systematic disparities in health outcomes between groups with different levels of underlying social advantage/disadvantage.

8. **Slum.** Slum is defined by UN Habitat as including a wide range of low-income settlements and/or poor living conditions. It includes diverse kinds of housing used by low-income groups such as tenements, cheap boarding houses, squatter settlements, houses built on illegal subdivisions, which together comprise areas of concentrated disadvantage. Slums are further characterized by the following features: (a) lack of basic services; (b) substandard housing or illegal and inadequate building structures; (c) overcrowding and high density; (d) unhealthy living conditions and hazardous locations; (e) insecure tenure and irregular or informal settlements; (f) poverty and social exclusion (g) aggregate minimum settlement size.

VI. GENERAL PRINCIPLES

1. **Healthy Urbanization.** Healthy urbanization is urbanization that protects and promotes public health rather than threatens or erodes healthy of individuals and communities, urban Health Systems must promote healthy urbanization so that cities develop in ways that achieve better health and avoid risks to ill health under conditions of rapid urbanization.

2. **Inter-sectoral action.** Inter-sectoral action is a comprehensive action to address causes of health inequities that lie largely outside the direct reach of the health care system, especially in a setting where all health and social sectors cannot cope with the rapid rate of urbanization. Urban Health Systems must therefore be designed by inter-sectoral collaboration with people and institutions from outside the health sector to influence a broad range of health determinants and generate responses producing sustainable health outcomes.

3. **Inter-city coordination.** Inter-city coordination between contiguous cities is important because a city, particularly if it is not a Highly Urbanized City may not have all the resources, institutions and capacities to be able to respond to the entire health needs of its constituents, and may thus benefit from resources, institutions and capacities of other cities through inter-city or inter-LGU coordination.

4. **Social cohesion.** Social cohesion is action through core groups. Membership in community groups gives strength for representation before large formal institutions. They develop a stronger voice to be head by policy makers.

5. **Community participation.** Community participation is a process that goes beyond consultation of community members in already formulated plans to involvement of communities in the issues which affect their health and well-being. It makes the community an active participant in initiating solutions to their health concerns instead of merely being passive recipients. Community participation must be integrated in all aspects of the intervention process, including planning, designing, implementing, and sustaining any project/ program.

6. **Empowerment.** Empowerment is enabling individuals and communities to have ultimate control over key decisions involving their wellbeing, Empowerment strategies include building knowledge and purchasing power, and mechanisms to increase client accountability.

VII. COMPONENTS OF UHSD IN THE PHILIPPINES

The following are the developmental components of the UHSD in the country. A. Programs and Strategies

The following programs and strategies shall guide the development of programs for urban areas:

1. **Healthy Cities Initiatives (HCI)**

A Healthy City is one that is continually creating and improving physical