

Moving from the 'why' to the 'how': reflections on humanitarian response in urban settings

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Given the rising numbers of crises in urban settings, Médecins Sans Frontières (MSF) is currently shifting its focus from 'why' it should intervene to 'how' it should intervene effectively in these contexts. Beyond communities affected by natural disasters and epidemics, MSF has chosen to target populations in urban settings that are affected by violence or by marginalisation and neglect: these groups appear to suffer the greatest number of severe threats to their health and well-being. Recent reflection within MSF has identified a number of key operational challenges to confront in order to respond efficiently to the needs of these populations. These include: appropriate assessments; measurable indicators of vulnerability and impact; pertinent operational approaches and medical strategies; adapted security management; and responsible closure of activities. This paper summarises the main lessons learned from working in urban settings with the principal aim of mutual sharing and understanding.

Keywords: humanitarian interventions, operational challenges, urban settings

Interventions in urban settings: rationale

Médecins Sans Frontières (MSF) has built up slowly valuable operational experience in urban settings. While consensus is increasing within the organisation that such environments are an appropriate focus for humanitarian work, there is also acknowledgement that their complexities pose many fundamental questions for a humanitarian actor like MSF. Given the rising numbers of crises in urban settings, MSF is currently shifting its focus from 'why' it should intervene to 'how' it should intervene in these contexts effectively.

Beyond communities affected by natural disasters and epidemics, MSF has chosen to target populations in urban settings that are affected by violence or by marginalisation and neglect: these groups appear to suffer the greatest number of severe threats to their health and well-being. Recent reflection within MSF has identified a number of key operational challenges to confront in order to respond effectively to the needs of these populations. These include: appropriate assessments; measurable indicators of vulnerability and impact; pertinent operational approaches and medical strategies; adapted security management; and responsible closure of activities.

This paper is based on a series of internal MSF inputs and reflections, including a comparative review of both current and past MSF experience of urban projects, interviews with MSF personnel involved in urban projects, discussions with MSF support

departments, an examination of several internal lessons learned documents, and evaluations of urban projects (across different MSF sections). While taking note of the ongoing learning process, it summarises the current reflection within MSF, drawing on wide and expanding experience gained in urban settings. Challenges and lessons of relevance to other humanitarian actors and researchers are highlighted, as well as areas requiring further research.¹

The city as a humanitarian crisis setting

More than one-half of the world's population currently lives in cities, a trend that is on the rise (WHO and UN-HABITAT, 2010).² Cities usually are seen as places of opportunities. Yet, they also can be places of high inequality, in terms of income and livelihood opportunities, education, and access to proper housing and shelter, health services, drinkable water, sanitation, and even physical safety (IASC, 2011). In extreme situations, cities can become theatres of violence, where armed groups and criminal gangs fight for control of territory and other resources. In poor and dense settlements, extreme inequality and exclusion, deprivation, and neglect typically result in acute and chronic situations. Furthermore, given the poorly constructed fabric of many cities and the low incomes of many urban dwellers, city living places many people at increased risk of natural hazards (O'Donnell, Smart and Ramalingam, 2009; IFRC, 2010).

MSF's interventions on behalf of victims of violence and/or victims of neglect and marginalisation generally focus on areas that are resource-poor and where local authorities have limited capacity or willingness to respond. In addition to the scale of needs, other variables usually compound and create scenarios that justify interventions in urban settings:

- Situations of warfare or non-conflict endemic violence within the urban setting with severe consequences for the population in terms of physical and mental health (such as fighting in Baghdad, Iraq, and Mogadishu, Somalia; gang violence in Port-au-Prince, Haiti—before the earthquake; and criminal/narcotics violence in Rio de Janeiro, Brazil).³
- Acute health needs (such as pathologies with high prevalence and gravity, resulting in high levels of morbidity and mortality) also can manifest themselves in situations where authorities deliberately neglect and/or marginalise certain groups within the population, thus making them more vulnerable in terms of their health needs (for example, internally displaced persons (IDPs), refugees and migrants in several African cities, and communities affected by a neglected disease such as Chagas in Cochabamba, Bolivia, people living with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in Bulawayo, Zimbabwe, and child malnutrition in Dhaka, Bangladesh).
- Emergency situations such as natural disasters (for instance, the Haiti earthquake of 12 January 2010) or disease outbreaks (such as Cholera in Lusaka, Zambia).

This paper concentrates on the first two (at times overlapping) scenarios: situations of violence in urban settings; and situations of marginalisation or neglect. Either scenario generates extreme suffering and vulnerability, often creating a vicious cycle that leads to more violence and other hazards, placing particular urban populations in dire humanitarian situations.

The presence of MSF in such settings is conditional on its added value: trying to address existing gaps in health care provision in a given context. This is linked to MSF's medical/humanitarian action—that is, providing health-related services to the most vulnerable people by following the principles of neutral and independent humanitarian action. It is important to note that the decision to work in an urban setting is not dependent on the urban nature of such a setting, but rather on the gravity of the health and humanitarian needs to be found there. In sum, medical humanitarian needs ascertained as present within scenarios of marginalisation, natural disasters, neglect, violence, and warfare represent the basic framework for an intervention in an urban setting. Other considerations such as organisational capacity, previous presence in a country, prospective added value, and discretionary elements are also important in deciding whether or not to deploy to certain locations.

Humanitarian needs

Levels of violence in particular areas of some cities can cause inhabitants enormous suffering (Lucchi, 2010). The most frequent expressions of this violence are threats, armed robberies, assaults, beatings, kidnappings, and murders, all of which can have direct and indirect medical consequences. Besides loss of life, the direct medical consequences of violence include physical and mental trauma (the consequences of shoot-outs in inhabited neighbourhoods, or ramifications of sexual violence, for example). Indirect medical consequences, meanwhile, sometimes result from aggravating factors such as displacement, the breakdown of the social fabric, the separation of families, and the collapse of social and health services and law and order. The deleterious impact on living conditions also produces subsequent suffering and disease, ranging, potentially, from diarrhoea, epidemics, intestinal infections, malaria, malnutrition, and respiratory tract infections, to nutritional problems and sexually transmitted infections (STIs). Furthermore, people may resort to alcohol and drugs to escape their problems. In addition, chronic non-communicable conditions and diseases, such as diabetes, heart disease, and hypertension, are potentially more abundant in urban settings and may require extra attention (WHO, 2008). Due to a lack of access to and the availability of health care, chronic illnesses also can become acute and emergencies can go unattended (Riley et al., 2007). Violence also affects the provision of health care: governmental health structures are not always able to cope with all of the various medical demands produced by violence. The entire health system may collapse due to violent events, and health care professionals may choose to stay away from certain areas of the city for fear of violence.

Cities frequently also become the destination for those who have been forcibly displaced from the countryside or for victims of violence seeking refuge and safety.

Migrants and displaced populations often are exposed to forced labour, low quality of food, overcrowding, poor living conditions and hygiene, sexual exploitation, and violence by new informal actors, criminal gangs, and security forces. As such, these populations are particularly vulnerable to many of the serious medical consequences mentioned above. This new influx of people also puts additional strains on existing urban resources and available services (Bangerter, 2010, p. 399).

Even in the absence of acute violence, discrimination, exclusion, extreme living conditions, neglect, and a lack of proper infrastructure (such as clean drinking water, functioning health centres, and sewage system) and resources in the slum communities also may be the cause of certain humanitarian needs (IFRC, 2010, p. 96). Particularly vulnerable communities might not have the resources to access diagnostic services and treatment for certain diseases (for instance, Chagas disease, HIV/AIDS, and tuberculosis (TB)). In these circumstances, neglect also has severe health consequences and might be justification for an intervention (MSF, 2011).

From 'why' to 'how'

With experience in urban settings still relatively recent, defining the most appropriate operational strategies is still a learning process, which often raises new and difficult challenges and dilemmas. The following section addresses some of the key issues warranting attention from the inaugural phase of an intervention to its closure.

Needs assessments

Needs assessments in urban contexts have proven more complex than those in closed or rural settings because they necessitate work in a large, complicated environment with a loosely defined, dispersed population that may or may not want to be identified and assisted (such as undocumented migrants in Djibouti or in Johannesburg, South Africa). In addition, access to certain areas might be restricted because of insecurity, or a crisis might be protracted but not reaching acute thresholds. In some instances (for example, Lagos, Nigeria), the multitude and overlap of health issues and emergencies, coupled with potentially a very large target population, can make it difficult to find a clear intervention focus.

Specific assessment tools for urban settings do not exist within MSF as yet. The classic rapid assessment formats utilised by humanitarian agencies in conflict emergencies are inadequate for the subtleties of urban settings because they are designed to be carried out quickly, with potential security constraints, frequently in camp settings, and are performed by one or two generalists (MSF, 1997).⁴ Furthermore, employing the classic measurement of magnitude of humanitarian consequences as a basis for decision-making in urban contexts may not be the most appropriate strategy; more nuanced approaches, using new and adapted tools, appear to be necessary (Spiegel et al., 2010).

Another problem in evaluating the most available health data and statistics in these settings is that the data tend to be aggregated information for the entire urban population. This generalised information is difficult to break down to gain a better understanding of specific groups or areas (Patel and Burke, 2009, p. 242). It is important therefore to be aware of the limitations of available data and to work towards acquiring more focused, detailed information on particular populations or neighbourhoods, in order to avoid simplistic assumptions about the population's needs. In addition, the classic categories of vulnerability in conflict zones (such as the disabled, the elderly, and women and children) may not be appropriate in urban settings because these groups and others are subject to many more variables, such as economic problems, physical space, and social cohesion (The Sphere Project, 2011). Acquiring this data may require additional investigation and collaboration with academic institutions or others that may have the ability, experience, and skills to analyse the many demographic characteristics of an urban setting (Ramos and Lemgruber, 2004).

Adapting existing tools to urban and to open settings points towards a mixed methodology assessment that uses both quantitative (such as health statistics, medical consultation data, and population surveys) and qualitative (such as focus group data, health-seeking behaviour analysis, and informant interviews) information. Such assessments should generate an understanding of the needs of the populations felt to be most at risk, including the 'host' population (Koscalova and Lucchi, 2010). Urban settings also demand more diverse assessment teams, including, potentially, anthropological, medical, and political expertise. For example, in Johannesburg, the MSF assessment team investigating the lack of access to health care by Zimbabwean migrants included a lawyer tasked with analysing and advising on legal issues related to migration and the implications of any intervention.

A proper needs assessment must create a clear understanding of the violence and/or neglect and its health consequences for the overall population. A suitable assessment framework for urban settings is needed—one that is able to paint an accurate portrait of the specific groups at risk, as well as a detailed analysis of the context in which all of this is occurring: from the health system to the cultural, economic, legal, political, and social realities and constraints of the setting. Specific attention should be paid to the wide variety of actors usually present in such contexts, and their numerous interests and responsibilities and resources. Only a proper and comprehensive assessment will enable the design of interventions appropriately focused on meeting the most critical unmet medical needs of the target population.

Operational strategy

Once a needs assessment has been completed and the necessary information acquired, an adapted operational strategy can be developed. This should include objectives with specific, defined indicators and ways to verify this information over time. An MSF intervention would involve a core medical component and varying complementary arrangements, such as the delivery of food, shelter, and essential non-food items and the setting up of water and sanitation facilities. The operational strategy should

also include clear outlines for advocacy, communication, networking, and security management, as well as evaluation and monitoring. The different elements and the challenges posed in urban settings are outlined below. This study argues in favour of operational strategies that can be adapted over time and that include a flexible, ‘learning’ approach that permits certain successful aspects to be strengthened and expanded, based on experience, feedback and initial results.

Medical strategies

Medical strategies in response to the needs of victims of violence or of neglected populations vary. The typical MSF medical strategy for a comprehensive response to violence (reducing mortality and morbidity) usually includes care for victims of sexual violence, mental health, surgery and trauma response, mother and child health, and primary health care activities. The response will also include outreach activities including community health workers, information, education and communication (IEC) programmes, and mobile clinics.

However, the diversity of contexts and the uniqueness of each setting—in terms of medical humanitarian needs and available health care provision—have demonstrated that it is not possible to create a standard ‘package’ for an urban intervention. In some resource-poor and violent urban areas, such as in Cité Soleil (a neighbourhood of Port-au-Prince), one approach has been to implement a much more extensive package of activities, including a full range of medical care, as outlined above. An alternative approach in a relatively resource-rich context such as Rio de Janeiro was more limited, strictly providing emergency response (triage and stabilisation) and mental health support inside known violent areas where services are limited due to problems of access. This is important because focusing solely on emergency response to violent trauma may be the most obvious strategy to reduce morbidity and mortality, but potentially many more people might be facing indirect consequences of violence and require more primary health care assistance, including in terms of mental health. Another more specific response to violence implemented by MSF was exclusively medical treatment for sexual violence as well as mental health support, as in Guatemala City, Guatemala.

In poor urban settings, diseases such as HIV/AIDS and (multi-drug-resistant) TB can be quite common. The MSF medical strategies to assist neglected or marginalised populations (in contexts not affected by violence) therefore often focus on those affected by specific illnesses or neglected diseases, such as HIV patients in Bulawayo or Chagas patients in Cochabamba or a community/public health approach with a focus on weaknesses in the health system that affect certain communities disproportionately, such as primary health care for slum dwellers in Lagos.

Each of these examples of medical response packages implies making choices vis-à-vis inclusion and exclusion criteria for services offered and categories of patients able to access services. This is particularly crucial in urban settings as opposed to rural or closed camps: if no strict admission criteria are identified, easy accessibility associated with free health care services would attract an unmanageable number of patients,

putting a huge strain on the resources of the humanitarian actor and undermining the quality of the intervention (Lucchi, 2010).

There is serious debate within MSF on what should be the level of engagement with existing health systems in these locations. In all of the urban areas where MSF has chosen to intervene, there is some level of health care provision available to the general population, and often this is a developed multi-level system—from primary to tertiary level care—involving public and private services. In most of these settings, there are existing specialised Ministry of Health (MoH) structures that offer possibilities for patient referral. Their strengthened presence in many urban settings underscores the importance and the opportunity for humanitarian organisations to work in partnership with them rather than in isolation. In almost all of the reviewed interventions, MSF has chosen to engage and works with or within the existing health care system, in order to address existing gaps in the provision of health care, while ensuring ownership, avoiding duplication, and defining its own added value. At the same time, one should note that the very same health system also can create intentional or unintentional barriers to care, such as certain patient groups not being granted access to free health care, or a lack of good quality care in referral structures, compelling action on such barriers to provoke change in the system. These are potential areas of concern that necessitate in-depth analysis when trying to develop an appropriate intervention strategy.⁵

It is essential to find ways to engage with populations and remain flexible, adaptive, and responsive to their needs. Beyond specific medical offerings and engagement with the health system, many of the challenges of providing assistance in urban settings have to do with access to specific vulnerable groups and all the activities that complement or facilitate medical interventions. With this in mind, it is important to highlight the role of outreach and interaction with communities at risk in urban settings within the medical strategy, be it through community health workers, IEC teams, mobile clinics, or social workers (Pardeshi and Kakrani, 2006). Although urban settings allow for potentially easier physical access to certain locations, actual access to specific vulnerable groups and identification of victims of violence or neglect within the larger general population remain challenging. For example, communities may be less structured and less organised than in rural settings (for instance, a lack of key traditional leaders or community-level organisational structures), and community members may be less accustomed to interacting with community workers. Many individual victims might be scared to access health services for fear of the perpetrators of violence often living in the same community, or because, as was the case in Guatemala City, they lack the knowledge and the experience of seeking out medical treatment following a sexual assault. They are also deterred by the stigma and taboo associated with what has happened to them, reducing their willingness to seek treatment. For these reasons, it is very important that the community trusts the health staff and understands its work as well as its limitations. In this regard, simple messages explaining the medical consequences of violence and/or other serious health threats facing the local population, as well as information on the treatment available

(often life-saving), should be a key part of project implementation (Rio Navarro and Queen, 2011).

Health workers at the community level also can gather information on recent incidences of violence and/or on marginalised or forgotten community members and look to counsel them and offer referrals to existing services. In Johannesburg, small MSF local outreach teams identified and supplied basic services in primary concentration places of newly-arrived migrants from Zimbabwe, such as abandoned buildings, a bus station, and a church. In addition, outreach workers can help with improving knowledge of the causes of defaulting⁶ in urban contexts and with addressing coverage of nutrition programmes and follow up on defaulters (as was done in Djibouti).⁷

At times, solutions can be found to community needs, such as opening clinics in the evening to facilitate access by people working during the day. Furthermore, social workers can play a vital role in networking with other organisations, sharing information with beneficiaries, monitoring referrals, and following up with patients—an essential project component in Soacha/Bogota, Colombia, and in Johannesburg. Existing experience serves to highlight the importance of capitalising on, and developing an optimal approach to, mobilising and working with communities in urban contexts.

The key to developing medical strategies in urban settings is to ensure that the strategy addresses an existing gap according to evaluated health needs, the capacity and performance of the existing health system, and barriers to access, and that it is adapted to local health-seeking behaviour (Koscalova and Lucchi, 2010). Flexibility of response, outreach, and interaction with different communities are necessary components of any medical strategy in urban settings.

Water and sanitation

Any humanitarian intervention, especially one focused on medical care (like those of MSF), will never be capable of solving, or willing to solve, all of the waste and environmental hazard issues of typical resource-poor urban settings; many of these problems are structural and lie beyond MSF's humanitarian role. Yet, if there are critical health consequences due to acute water and sanitation conditions in an urban setting, humanitarian agencies could set a small-scale example of good practice, which other actors can replicate or implement on a larger scale.

Preventative measures include constructing waste areas and a wastewater system, drilling boreholes, and digging wells. Most of the challenges of doing so in urban settings—most recently (in 2010) in Monrovia, Liberia, and Hajipur, India—are linked to a lack of available space to separate properly sanitation structures, volumes of waste and wastewater greater than the area allocated for them, and poor hygiene practices. On some occasions, it is necessary to transport waste to other places to remove the burden from the health structure.

Water and sanitation measures also may be part of an emergency response, as with cholera outbreaks in Lusaka and Port-au-Prince in 2010, among many other examples. Common challenges to cholera response are the lack of available space for setting up treatment centres in congested neighbourhoods and the irrational fears of community

members who often oppose the construction of treatment facilities in their neighbourhoods. Educating and changing the hygiene practices of the population during these emergencies are critical, especially in congested slums—and they remain a challenge in each new emergency.

Both for prevention and emergency response, working with local communities and local authorities, as well as understanding power relations and governance networks within slums, have proven key to the success and good management of water and sanitation interventions (Humanitarian Futures Programme, 2009). Local communities can offer valuable support in engaging with vulnerable groups, providing local candidates for employment, and identifying suitable sites for interventions. This proximity to local communities and authorities can also facilitate IEC work within communities with poor sanitation to improve hygiene practices and help to reduce certain morbidities in the community.

Building networks

There is growing consensus and evidence that an important component of a response in an urban setting is working in a network. One of the unique characteristics of most urban contexts is the wide range of actors that are present and focusing on similar or complementary issues to those of MSF. These actors may be working at the local level, the national level, or both simultaneously. To establish an effective intervention, engaging with and understanding formal and traditional structures is necessary, as well as comprehending and working with policymakers at different levels. Partnerships with local authorities and other entities—such as churches, civil society groups, and NGOs—are more common in urban settings and provide ways of avoiding a completely substitutive role (Haroff-Tavel, 2010, p. 340). These actors and the networks also assist with understanding the context, developing an accurate analysis of needs, monitoring results and impacts, and providing a better overall response to affected populations (including advocacy and medical strategy). In addition, these networks are a key element of decisions taken by a humanitarian actor to exit a given setting and of any handover strategy.

In some instances, it is essential to consider expanding the range of collaboration in an urban setting to enable patients (or community members) to make their own choices—by supplying them with information about agencies, institutions, and organisations with the specific or enhanced capacity to protect or support them. By developing links with legal departments, social security services and other structures that offer (legal or physical) protection, these groups can help to support victims of violent acts or those who are under direct threat (Lucchi, 2010, p. 18).

The work of MSF in Soacha/Bogota and Sincelejo, Colombia, is a good example of networking leading to greater impact. A large group of organisations is working in Colombia on different elements of support for IDPs. An MSF social worker is tasked with networking with all of the institutions (governmental and non-governmental) involved in assisting IDPs in the city, including: governmental organisations providing direct assistance as well as those providing assistance with human rights, justice,

and legal matters; church organisations providing clothes and food assistance; local municipal government organisations providing temporary housing services; and NGOs providing family planning and reproductive health services as well as vocational training. With this network in place, MSF has the opportunity to refer patients to specialised health services. In this context, the team has organised trainings and other types of support for many of these institutions to improve the quality and quantity of relevant referrals (both ways) and has lobbied for IDPs to be issued with the 'Carta provisional de atención en salud a los Desplazados',⁸ a document granting them free health care services (primary and specialised) during the verification phase by the authorities (usually 45 days).⁹

With regard to a more direct public health aspect, it is also important to train associations or local organisations in health education and to supply support materials to enable these groups to engage further in 'peer education' within their communities. Owing to the multitude of actors working in urban settings and the many different levels at which they can be found (macro to micro), networking is a complex operational task. The prioritisation of this networking task and dedicating enough resources to build an effective network should be encouraged for all urban interventions in the start-up phase (Davis, 2011a). In Lagos, the delegation of this task to two people (field coordinator and deputy head of mission) has helped the project to expand its network and to be more effective.

Clearly, networking is a crucial complementary approach to interventions in urban settings. It must be planned and managed appropriately and ultimately must match operational objectives and positioning.

Security management

Security management is an important priority in urban settings. In some urban contexts, the daily stability and the lack of an obvious open conflict can mislead staff into believing that they are not vulnerable or do not face many threats. However, the nature of the target population and the focus of work on violence and/or neglect clearly place an agency and its beneficiaries in vulnerable situations with many risks to their safety and security. The difference with urban contexts is essentially that the geographic area is limited and more condensed (often highly overpopulated), and rumours can spread and situations can change extremely rapidly. This demands the creation of an adapted risk assessment for each location (HPN, 2010, p. 27). A coherent security strategy must be developed and security guidelines, procedures, and protocols implemented. In violent contexts, an agency will most certainly face classic security threats and must be prepared with a relevant response. In Cité Soleil, for instance, MSF structures were (indirectly) hit by stray bullets and there was a need to organise convoys to move staff in and out of the area. Security analysis and subsequent security management must also consider the risks confronting beneficiaries, a major issue during food distributions in post-earthquake Port-au-Prince. It is vital to evaluate and to ensure that assistance activities do not expose any individual or group to an increased risk or vulnerability solely because of attempts to seek treatment from an agency.

Beyond standard security measures, there is also important work to do in relation to perception and acceptance activities linked to armed groups, individual citizens, and other important actors in the surrounding community. On a programmatic level, agencies such as MSF must consider how the medical approach and strategy affect perceptions and how in turn they may affect security. If an agency chooses to intervene in only one area that is the main source of violence but is controlled by a single armed group, this may call into question its impartiality and neutrality, for example. In such a situation, the humanitarian actor would need to consider establishing other types of activities in other areas of the city (which also respond to specific needs) in order to generate an understanding that it does not favour one armed or political group or focus only on the needs of one population or community (MSF–OCBA, 2010).

Many security problems arise from misperceptions and poor implementation of acceptance and proximity strategies. Positive perception and acceptance can lead to expanded access and proximity, such as in Port-au-Prince in December 2010, where youths engaging in post-election violence systematically opened their impromptu roadblocks throughout the city to allow MSF vehicles to pass unharmed. A key tool to control perceptions and improve acceptance is operational communications directed towards 'stakeholders' such as armed groups, the community, government authorities, and leaders. Experienced local and international staff members need to be involved in building and transmitting messages in the communities that provide background on the agency and explain what it is doing there and how it can assist them. In addition, it is important to integrate the feedback from communities and their perceptions into the approaches to be used (HPN, 2010, p.160).

The most complicated security management task in urban settings, involving the greatest amount of work, has been engaging with armed groups of a different size and scope than typically exist in a classic conflict between two states or between two established armed groups. Some armed actors in an urban setting may be loosely organised, of a relatively small size, and/or have narrow criminal objectives yet operate in a brutal violent and unpredictable manner. They may perpetrate violence solely as a means to ensure continued control over and the success of their illicit enterprises. These armed actors wish to remain invisible or beyond the reach of mainstream actors and are able to hide easily in a vast, complex urban environment. Without political, social, or other motivations for their actions, it can be difficult to find ways to engage and negotiate access with them given their suspicions of other actors and their likely willingness to resort to violence quickly if they feel threatened. How can a humanitarian actor negotiate with these entities?

Official state actors may also strongly reject (or forbid) contact with 'criminal' groups to avoid legitimising them or according them certain powers or status (Rodgers and Muggah, 2009, p. 308; Hauck and Peterke, 2010, p. 414). If there has been no contact or network established with all armed and potentially threatening actors, it may be impossible to secure adequate security guarantees to operate, or to resolve serious incidents in a positive way if they do occur. Contact with these groups is

essential to ensure unobstructed access to medical activities for the population and the ability to move and function freely within the communities (Bangertner, 2010, p. 400).

In urban areas such as Cité Soleil, Port-au-Prince, and Rio de Janeiro, MSF has faced many situations of ‘protecting’ patients who became vulnerable when they left their areas of origin to seek treatment or to be a referral patient (MSF–OCBA, 2010). To the end of ensuring an acceptable level of security guarantees from all actors, it is essential to have some type of regular contact or meetings with all actors, from the community to the state level to armed groups, whatever their official status in the society.

Advocacy

In a narrow humanitarian sense (and certainly so for MSF), advocacy is meant to provoke change in practices or in situations affecting patients or communities by highlighting their suffering, exclusion, or neglect and the resulting health consequences. Advocacy messages are based on experience in the field (the witnessed scenario, from medical data and testimonies from patients). It is the proximity of humanitarian actors to patients and their circumstance that allows them to gather reliable data and establish the credibility needed to engage in advocacy-related activities.

Advocacy objectives can vary from introducing new medical protocols of care, to the extension of health services to neglected areas, all the way to support for an enlarged and improved assistance strategy by international donors in a particular setting. Advocacy can also aim to increase the protection of certain vulnerable populations by raising awareness of the suffering of violence-affected or neglected populations while still addressing the underlying causes of suffering (Lucchi, 2010). Depending on the goals, advocacy targets can be local civil authorities, national health authorities, state governments, and/or the international community depending on the issue and situation.

Examples of advocacy in an urban context linked to MSF’s response to violence (such as in Port-au Prince and Rio de Janeiro) have focused on demonstrating that it is necessary and possible to bring health care to *favelas* or slums. Advocacy activities in these settings intend to flag the human suffering of community members, the significant medical needs, and possible models of care in these violent areas. In cases of violence with identifiable and verifiable causes, MSF also attempts to condemn it openly and raise awareness of the health consequences it provokes among the population.

In contexts where MSF has responded to the needs of marginalised or neglected populations, advocacy usually concentrates on improving overall access to health care by the affected populations. MSF will draw attention to the lack of resources, the need for more investment by different health actors, and the clear responsibility of local and national government authorities to resolve the underlying problems. For example, in Cochabamba, where MSF was treating patients affected by Chagas disease, MSF advocated at the local level for more resources for treatment and at the international level for more investment in diagnosis and treatment. Likewise, in 2009, MSF advocated for free access to health care for Zimbabwean migrants in South Africa, regardless of their legal status.

Advocacy in urban settings can benefit from the presence of a multitude of actors that can serve as a multiplier force in spreading the message of concern. While maintaining its neutrality and independence, MSF has attempted to incorporate other influential actors and to utilise existing networks in pursuit of its advocacy objectives. In these situations, it can be more effective to work with the existing system and networks and alongside other actors that are part of that system. In Johannesburg, for instance, MSF worked through a network of local activists to push for free access to health care for migrants by sharing information with legal groups to ensure the enforcement of the South African Constitution, which grants everybody free access to health care, regardless of their legal status in the country. In addition, having witnessed serious abuses against unaccompanied minors, MSF set up a special counselling service and advocated strongly with the authorities and the United Nations Children's Fund (UNICEF¹) to ensure minors had health care, legal documents, protection, shelter, and other basic rights.

With regard to sustainability, an option is to facilitate the creation and support of civil society activist groups and to build their capacity to work effectively and independently. In Lagos, MSF supported the Treatment Action Movement to increase awareness of the need for free access to comprehensive HIV/AIDS care and to reduce discrimination and stigmatisation of people living with HIV/AIDS. In this way, when MSF departs from a country, it can leave behind structures to monitor health systems and to advocate for their further improvement (Davis, 2011b).

In summary, there is a case for advocacy strategies to be made a central component of project activities in urban settings (as in any other environment), and integrated directly into such activities from the onset, to impact broadly and more effectively on the overall contextual problem (cause) that extends beyond just the medical consequences confronting patients (symptom).

Monitoring

The importance of a good monitoring process, integrated into the project management cycle, as many humanitarian actors are aware, cannot be stressed enough. A regular review of the effect that activities are having on the most vulnerable groups (target population) typically is central to the monitoring process.

In urban settings, though, a problem is that mortality can be inadequate as a prime indicator to monitor the magnitude of the crisis and the effectiveness of the assistance. Studies have shown that, in protracted situations, using an emergency threshold to establish a benchmark for the crisis might not be appropriate (Checchi and Roberts, 2005). These indicators often show only moderate elevation of mortality, but it is protracted and spread out over a large population. In these situations, the excess death tolls might better reflect the magnitude of the crisis while evolution of mortality rates might indicate the trend (Salama et al., 2004). It is essential therefore to search for alternative ways to measure and monitor mortality and to identify and use alternative indicators. Agencies should consider more subtle, sensitive indicators of a population's

health, such as levels of food security and access to health care and other essentials, to monitor best the magnitude and the evolution of crises when the measurement of mortality is not practical.

A community-based network can play a key role in monitoring and measuring achievements. For example, a surveillance system or other indicators that can monitor the evolution of a crisis over time could be implemented using community outreach workers based in the community (Pardeshi and Kakrani, 2006). This practice would necessitate considerable simplification of the indicators to be collected and a continuous supervision effort, but it may generate a more realistic and insightful understanding of the effectiveness of activities implemented (Koskalova and Lucchi, 2010). User-friendly data-gathering mechanisms need to be developed in order to collect all of the required project information. Monitoring should also include a regular review and analysis of the phenomena taking place (violence and/or neglect), updates on its context, and its continued health-related consequences for the overall population. This information should be reviewed, assessed, and, most importantly, used periodically to inform the impact, quality, and relevance of projects (Rio Navarro and Queen, 2011).

Exit strategies

Violence in urban contexts can be a chronic problem, with peak as well as quieter moments—the violence in Port au Prince declined dramatically during the 2010 World Cup—but in most instances the possibility of it stopping completely is unrealistic. For neglected or marginalised populations, the likelihood of them receiving more or better assistance might be more realistic, but it will take time. This raises a crucial question: what should be the time commitment for a humanitarian actor in these settings?

A realistic exit strategy will focus on increasing the capacity of the existing system to respond to the needs of vulnerable groups or communities. With these more strategic objectives in mind, most projects in urban settings rely heavily on a handover strategy with the MoH (or at times with other NGOs).

To this end, MSF project strategies include activities aimed at capacity-building, reaching agreement on medical protocols, drug lists, and a gradual sharing of responsibility for and the management of certain components with the MoH, leading to the progressive disengagement of MSF. In most settings, exit strategies are meant to facilitate the transition from emergency response to longer-term development (towards the strengthening of the health system). In some instances, to facilitate the handover, and to avoid a complete collapse of services where a reduction of capacity and funding is likely, MSF could take decisions on how to minimise the cost/resource-heavy approach and to integrate better with existing partners, particularly the MoH, at the earliest stage.

A new approach of pragmatic decision-making can emerge to define ‘good-enough’ quality given the limitations of the context and handover partner (Pett, 2011). For

example, it has been necessary for MSF to decrease gradually the scope of its medical input, either in terms of medical components in a given health-care centre (such as Lagos—still ongoing) or in terms of the number of beds in a given hospital (such as the maternity hospital in Monrovia—a case of successful multi-year handover). MSF's intervention in Kibera (Nairobi), Kenya, is a good example of integration of the exit strategy into overall planning and its influence on daily activities. Given that MSF planned to transfer project activities at some point to the Kenyan MoH, a level of collaboration and a gradual handover needed to be built into the project. Over the life of the project, MSF and the Kenyan authorities held regular monthly meetings to track progress and to discuss ongoing work, including elements of capacity-building and support for the MoH, both to help ensure success and to prepare for the departure of MSF.¹⁰

It is clear that interventions in urban settings have a different timeline and expected duration than a classic emergency response. Although planning for longer-term interventions, including multi-year plans of action and budgets, should occur, it is rarely the case right now (Bangerter, 2010, p. 405). Most urban projects still rely on classic short-term emergency planning that tends to lead to a more limited vision of the future and creates a certain level of project instability. It is recommended that one define exit strategies early in the project lifecycle. Clear expected outcomes would then influence planning in the long term across annual planning cycles, maintaining a coherent overall operational strategy.

Conclusion

Urban settings are justified contexts for interventions by humanitarian organisations such as MSF. The health consequences of violence, marginalisation, and/or neglect for vulnerable populations are significant. Given that urban settings are the future location for many humanitarian interventions, it is important to continue nurturing an attitude of reflection, innovation, and flexibility in order to establish the most effective operational response possible. MSF is slowly building up its experience in such environments, while often struggling to strengthen and improve its response, to define intervention criteria, and to adapt implementation strategies. Sharing such challenges, dilemmas, and experience with the rest of the humanitarian community can help to foster mutual learning and can lead to improved action, benefitting the populations that humanitarian organisations together are trying to support.

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Endnotes

¹ The urban projects that this paper draws on are: Bosasso (Somalia), Bulawayo (Zimbabwe), Cairo (Egypt), Cochabamba (Bolivia), Dhaka (Bangladesh), Djibouti (Djibouti), Guatemala City (Guatemala), Hajipur (India), Johannesburg (South Africa), Lagos (Nigeria), Lusaka (Zambia), Mogadishu (Somalia), Monrovia (Liberia), Nairobi (Kenya), Port-au-Prince (Haiti—covering two projects in Martissant and Cite Soleil areas), Rabat (Morocco), Rio de Janeiro (Brazil), Sanaa (Yemen), Sincelejo (Colombia), Soacha/Bogota (Colombia), and Tegucigalpa (Honduras).

² There is no universally accepted definition of ‘urban’. Each state makes its own distinction between urban and rural areas for the country in question. Generally, however, cities are held to have some common characteristics:

- the degree of concentration of the population;
- the economic base (normally, the proportion of the labour force employed in non-agricultural activities);
- the availability of electricity and/or piped water in living quarters; and
- ease of access to medical care, schools, and recreation facilities (IASC, 2011).

³ Violence is an important issue in many urban contexts where MSF is working. For the sake of clarity, the organisation only addresses the consequences of violence by providing assistance to direct and indirect victims, rather than trying to mitigate it by tackling its causes (a rather important activity for which the organisation has neither the mandate nor the expertise).

⁴ An example of this contextual challenge can be demonstrated by the interpretation of acute malnutrition prevalence rates in urban contexts, which are quite different from prevalence rates in rural areas due to the higher population density in an urban setting.

⁵ The presence of private health providers in urban settings, and MSF interaction with them, also needs careful consideration, but the issue—and relevant practice and policy—is complex and rather new, and hence unresolved as yet.

⁶ That is, patients who do not complete their treatment, especially when regular follow-up at a health facility is required.

⁷ There is an erroneous belief that, in urban contexts, the coverage of nutrition programmes should be higher because the population lives closer to health facilities. The reality is that coverage can be low, mainly because the causes of malnutrition are more likely to be related to economic issues and the low purchasing power of vulnerable communities: mothers may have to choose between bringing their malnourished children to supplementary feeding centres and possibly losing income by missing opportunities of daily work (Maxwell et al., 2000).

⁸ ‘Temporary health-care provision card for IDPs’.

⁹ Information from 2008.

¹⁰ MSF recognises the operational and ethical dilemmas that arise from such conceptual issues, including a potential loss of independence and quality of the medical offering when partnering with other actors, and chooses to confront them through continuous debate in the field, to ensure context-specific solutions.

References

- Bangerter, O. (2010) 'Territorial gangs and their consequences for humanitarian players'. *International Review of the Red Cross*. 92(878). pp. 387–406.
- Checchi, F. and L. Roberts (2005) *Interpreting and Using Mortality Data in Humanitarian Emergencies. A Primer for Non-epidemiologists*. HPN Network Paper 52. <http://www.odihpn.org/documents/network/papero52.pdf> (accessed on 2 August 2011).
- Davis, G. (2011a) *Lessons Learned: MSFE, Lagos Urban Settings Intervention*. Internal document. Médecins Sans Frontières, Lagos.
- Davis, G. (2011b) *Urban Interventions Reflections*. Internal document. Médecins Sans Frontières, Lagos.
- Haroff-Tavel, M. (2010) 'Violence and humanitarian action in urban areas: new challenges, new approaches'. *International Review of the Red Cross*. 92(878). pp. 329–350.
- Hauck, P. and S. Peterke (2010) 'Organized crime and gang violence in national and international law'. *International Review of the Red Cross*. 92(878). pp. 407–436.
- HPN (Humanitarian Practice Network) (2010) *Operational Security Management in Violent Environments*. Good Practice Review 8. Overseas Development Institute, London.
- Humanitarian Futures Programme (2009) *Humanitarian Crisis Drivers of the Future: Urban Catastrophes. The Wat/San Dimension*. <http://www.humanitarianfutures.org/sites/default/files/WatSan%20Report.pdf> (accessed on 3 August 2011).
- IASC (Inter Agency Standing Committee) (2011) *Strategy, Meeting Humanitarian Challenges in Urban Areas*. <http://www.humanitarianinfo.org/iasc/pageloder.aspx?page=content-subsidi-common-default&sb=74> (accessed on 2 August 2011).
- IFRC (International Federation of Red Cross and Red Crescent Societies) (2010) *World Disasters Report: Focus on Urban Risk*. http://www.preventionweb.net/files/15465_wdr2010full1.pdf (accessed on 16 June 2011).
- Koscalova, A. and E. Lucchi (2010) *Evaluation Report on the MSF Response to Displacement in Open Settings*. Internal document. Médecins Sans Frontières, Vienna.
- Lucchi, E. (2010) 'Between war and peace: humanitarian assistance in violent urban settings'. *Disasters*. 34(4). pp. 973–995.
- Maxwell, D. et al. (2000) *Urban Livelihoods and Food and Nutrition Security in Greater Accra, Ghana*. Research Report 112. <http://www.ifpri.org/sites/default/files/pubs/pubs/abstract/112/rr112.pdf> (accessed on 3 August 2011).
- MSF (Médecins Sans Frontières) (1997) *Refugee Health: An Approach to Emergency Situations*. MSF, Geneva.
- MSF (2011) *Urban Survivors*. <http://www.urbansurvivors.org> (accessed on 4 November 2011).
- MSF–OCBA (Operational Centre Barcelona–Athens) (2010) *Review of Responses to Crises in Urban Contexts*. Internal document. MSF–OCBA, Barcelona.
- O'Donnell, I., K. Smart and B. Ramalingam (2009) *Responding to Urban Disasters: Learning from Previous Relief and Recovery Operations*. ALNAP Lessons. <http://www.alnap.org/pool/files/alnap-provention-lessons-urban.pdf> (accessed on 29 March 2012).
- Pardeshi, G. and V. Kakrani (2006) 'Challenges and options for the delivery of primary health care in disadvantaged urban areas'. *Indian Journal of Community Medicine*. 31(3). p. 132.
- Patel, R. and T. Burke (2009) 'Urbanization: An Emerging Humanitarian Disaster'. *The New England Journal of Medicine*. 361(8). pp. 741–743.
- Pett, L. (2011) *Making an Exit: Advice on Successful Handover of an MSF Project*. Internal document. Médecins Sans Frontières, London.
- Ramos, S. and J. Lemgruber (2004) 'Criminalidade e respostas brasileiras a violencia'. *Observatorio da Cidadania 2004*. <http://xoomer.virgilio.it/leonildoc/pdf/criminalidade-cor.pdf> (accessed on 23 April 2010). pp. 45–52.

- Riley, L., A. I Ko, A. Unger and M. Reis (2007) 'Slum health: diseases of neglected populations'. *BMC International Health and Human Rights*. 7(2). <http://www.biomedcentral.com/1472-698X/7/2> (accessed on 16 June 2011)
- Rio Navarro, J. and K. Queen (2011) *Lessons Learned – MSF's Projects Working on Violence in Urban Settings*. Internal document. Médecins Sans Frontières, Geneva.
- Rodgers, D. and R. Muggah (2009) 'Gangs as non-state armed groups: the Central American case'. *Contemporary Security Policy*. 30(2). pp. 301–307.
- Salama, P., P. Spiegel, L. Talley and R. Waldman (2004) 'Lessons learned from complex emergencies over the past decade'. *The Lancet*. 364 (9447). pp. 1801–1813.
- Spiegel, P., F. Checchi, S. Colombo and E. Paik (2010) 'Health-care needs of people affected by conflict. Future trends and changing frameworks'. *The Lancet*. 375(9719). p. 982.
- The Sphere Project (2011) *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. http://www.sphereproject.org/component/option,com_docman/task,cat_view/gid,17/Itemid,203/lang,english/ (accessed on 25 May 2011).
- WHO (World Health Organization) (2008) *Our Cities, Our Health, Our Future*. http://www.who.int/social_determinants/resources/knus_final_report_052008.pdf (accessed on 16 June 2011).
- WHO and United Nations Human Settlements Programme (UN-HABITAT) (2010) *Hidden Cities: Unmasking and Overcoming Health Inequities in Urban Settings*. http://www.hidden-cities.org/downloads/WHO_UN-HABITAT_Hidden_Cities_Web.pdf (accessed on 25 May 2011).