The Health of Urban Populations in Developing Countries

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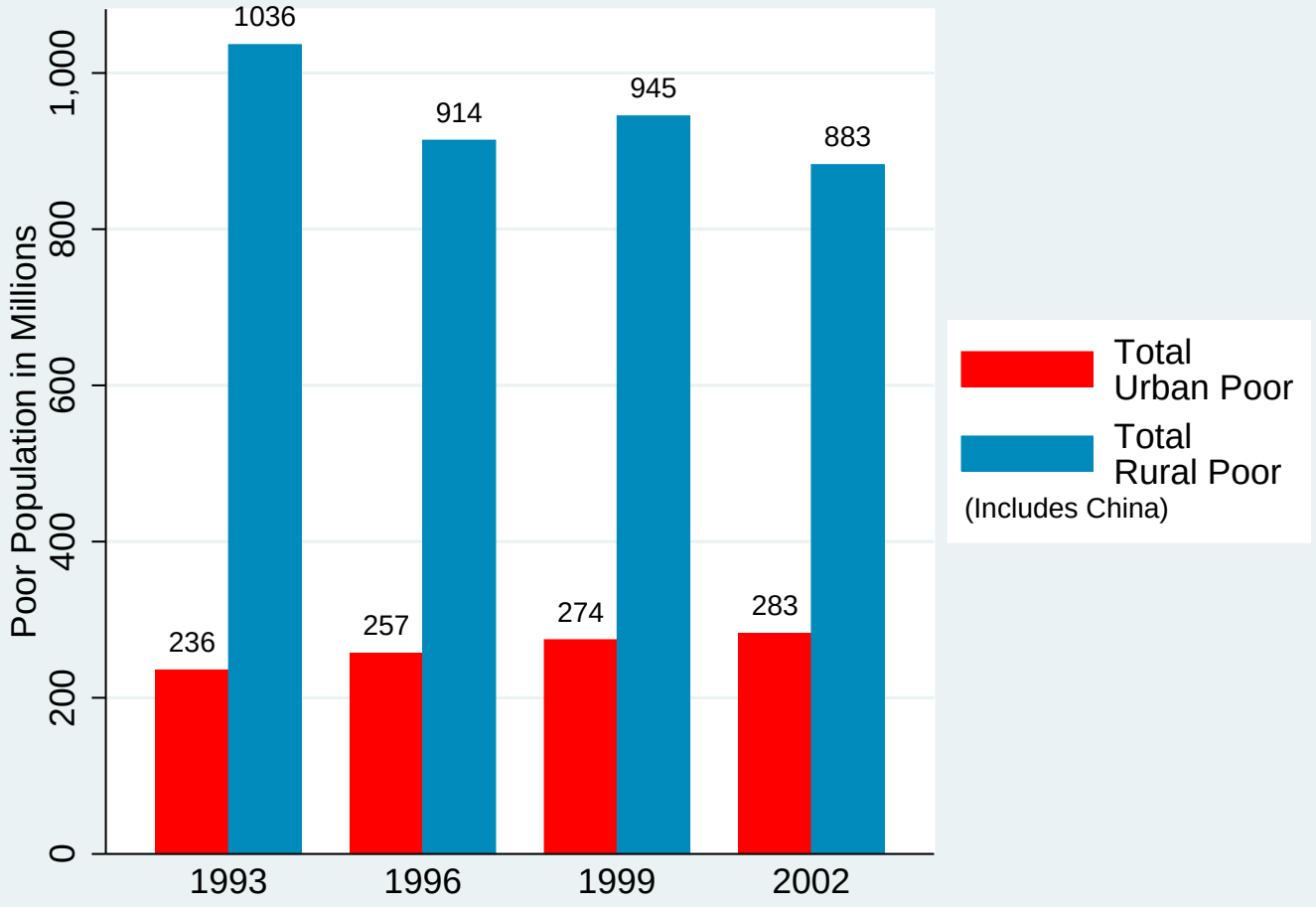
Outline

Urban Population and Poverty: Definitional Problems

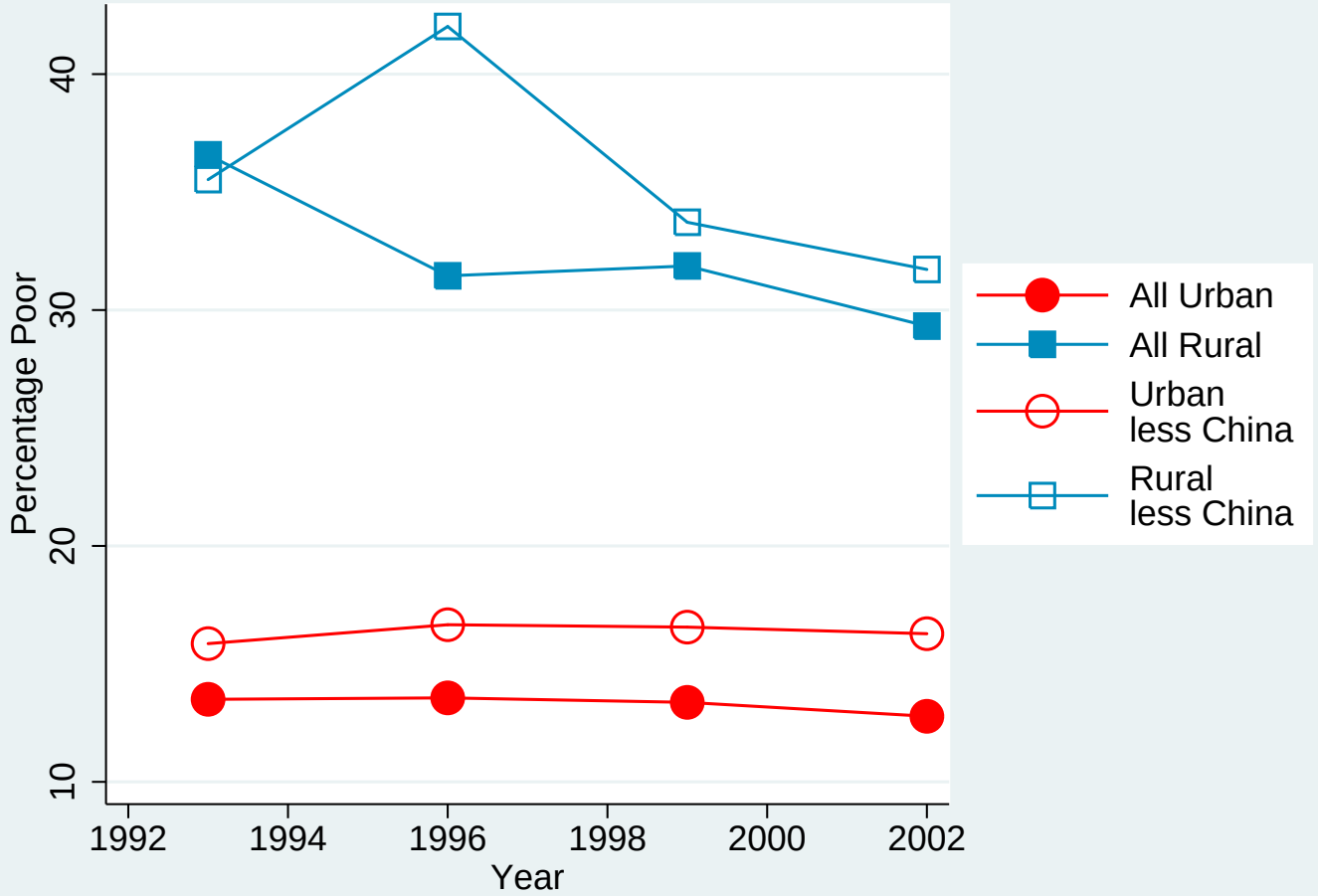
- It is well known that developing countries differ greatly in their city and urban definitions—inducing non-comparability over countries, over time, and even across cities in a given country at a point in time.
- It is less well known that similar problems plague definitions of poverty, even those based on the "$1-a-day" basic needs measure employed by the World Bank.
- These definitional problems interact:

LDC Urban and Rural Poverty Totals ($1.08 version)



Source: Ravallion et al. (2007).

LDC Poverty "Headcounts"—Note China Effect



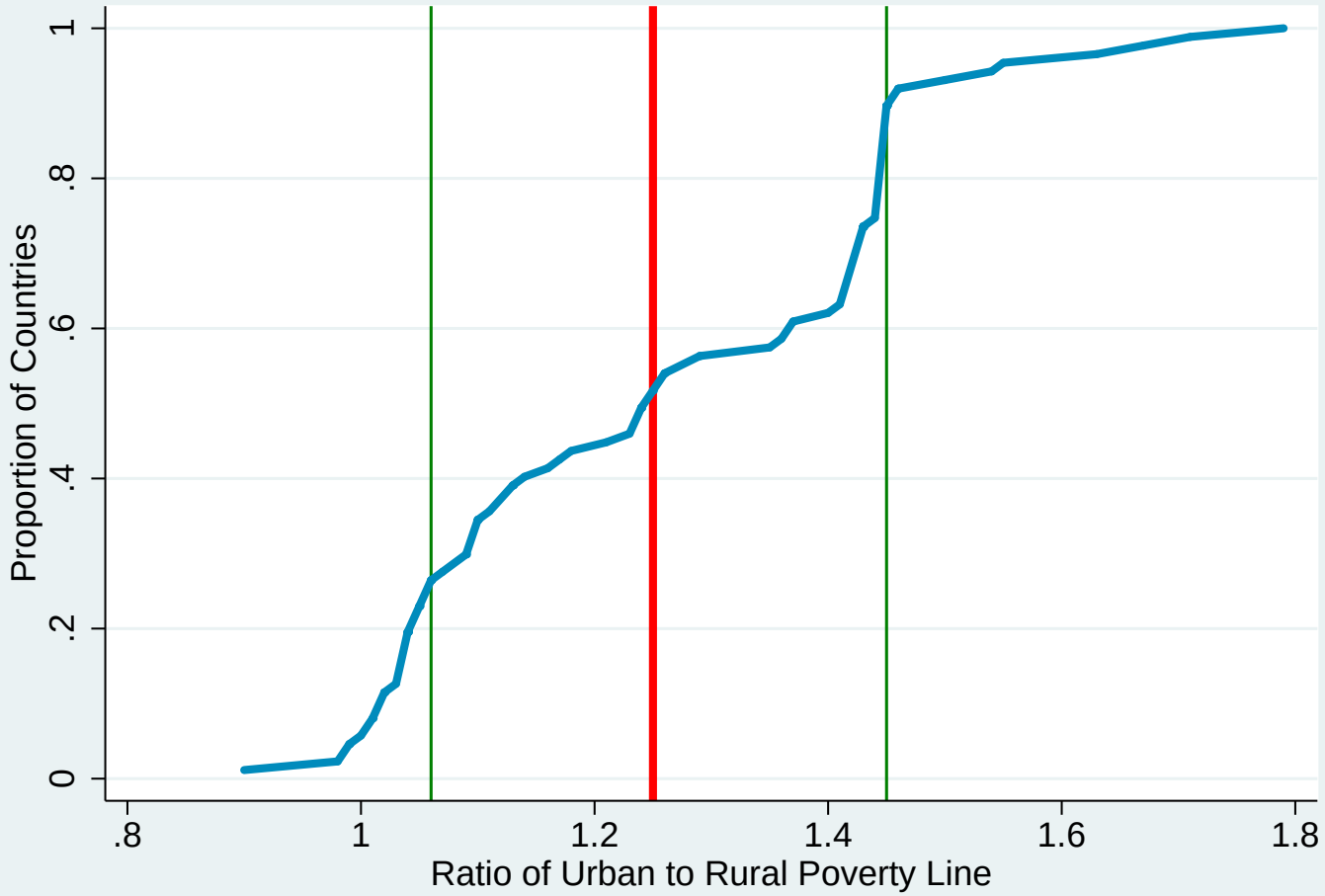
Source: Ravallion et al. (2007)

Monetized Measures of Poverty

Are Prices Facing the Urban Poor Effectively Measured?

- Urban poor face different prices for basic foods than urban non-poor
- Is sufficient allowance made for non-food essential expenditures (rents, time and money costs of daily commutes)?
- Poor may need to purchase services (drinking water) provided by public sector to better-off neighborhoods.
- Variation across neighborhoods within cities
- Variations across cities of different size.

Ratio of Urban to Rural Poverty Lines: Sufficient?



Source: Ravallion et al. (2007)

Health: Looking Beneath the Averages

- On average, modern-day urban residents enjoy better health than rural villagers (apart from HIV/AIDS)
- But urban averages mask substantial within-city inequality
- Urban poor often face health risks like those of rural villagers. Similar gaps in knowledge of prevention and treatment. Access to health services more difficult for urban poor than commonly realized
- Among urban poor, those living in "slums" can face risks well in excess of rural risks

Urban Health System: Distinctive Aspects

- The urban system is much more monetized than the rural system—those lacking cash are effectively excluded from the formal health sector (private and public)
- Subsidies exists for the poor for some services, but are often a patchwork and require the poor to spend much time searching for the subsidized providers, goods, and services. A subsidy existing on paper may be no subsidy at all.
- We should not presume that urban health services, once accessed, are even of minimally acceptable quality.
- We know of rural-urban imbalances in public health personnel; but less is known of imbalances between poor and better-off neighborhoods, or between larger and smaller cities.

Biases in Our Knowledge of Urban Health

Much of what we know (outside Latin America) is drawn from demographic sample surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys):

- Limited information on adult morbidity and mortality
- Laypeople's cause-of-death reports, and also reports of symptoms, are not always reliable in medical terms
- Increasing use of bio-marker data (e.g., anemia)
- Increasing use of own or proxy reporting on intimate-partner violence, accidents, injuries.

Inadequate Measurement of Living Standards

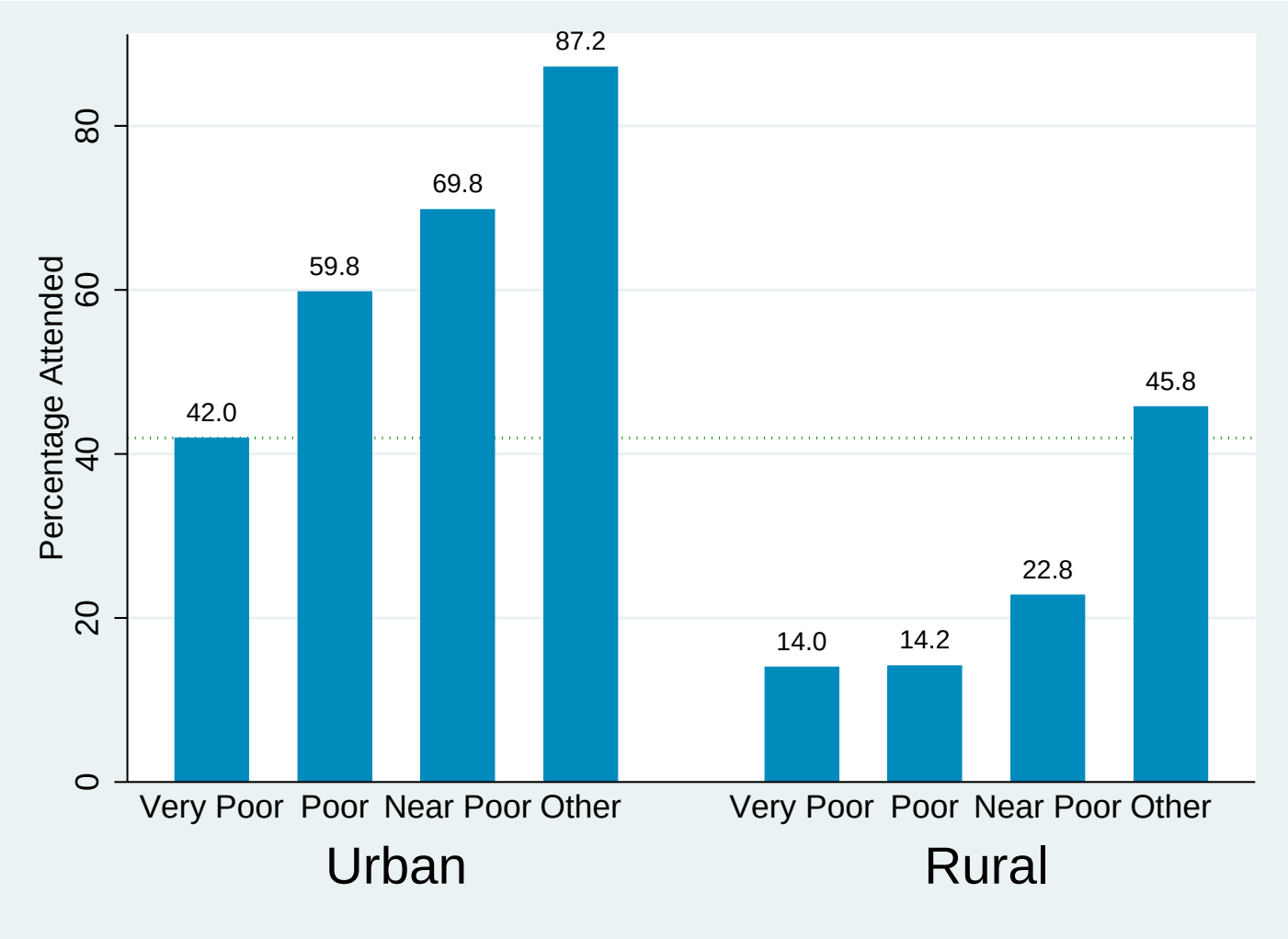
- Survey samples too small for city-specific measurement
- Demographic surveys seldom provide location of respondents—not even the name of the city is given in the DHS and the MICS!
- No reliable information on consumption expenditures or incomes
- Proxy measures of living standards based on ownership of consumer durables, public services, producer durables
- Difficult to distinguish "slums" from other neighborhoods with survey data alone

A Sketch of Urban Health

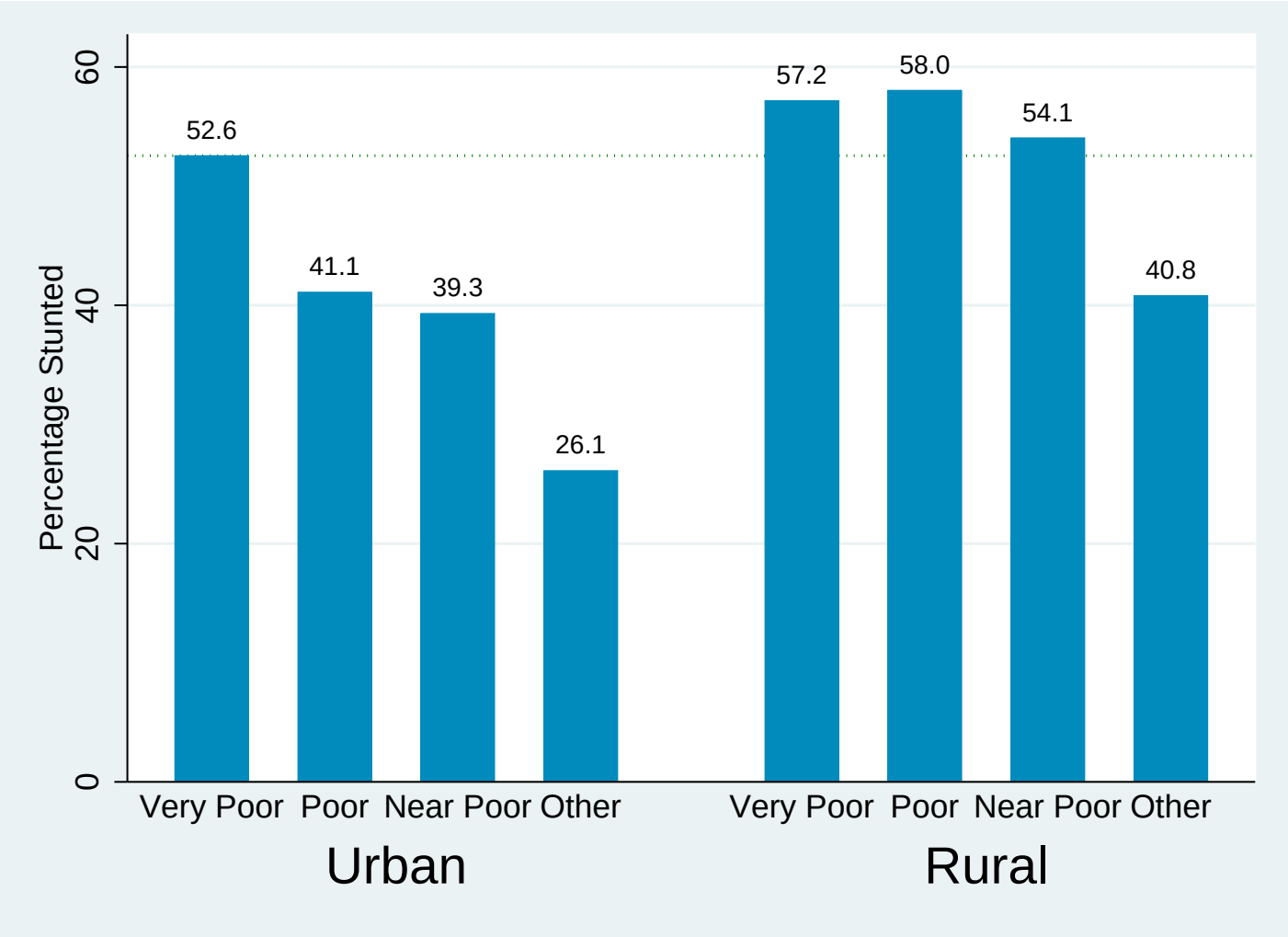
A sample of results from the DHS program (160 surveys now available):

- In what follows, we use MIMIC factor analysis of consumer durables, producer durables, age and education of household head, provision of electricity to generate relative measures of living standards
- Urban households ranked relative to other urban households; rural households ranked relative to other rural households.
- Descriptive categories: "Very poor" households are lowest 15 percent of households; "Poor" range from 16–25 percent; "Near-Poor" from 26–50 percent; and "Other" are the remaining households in the 51–100 percentile range.

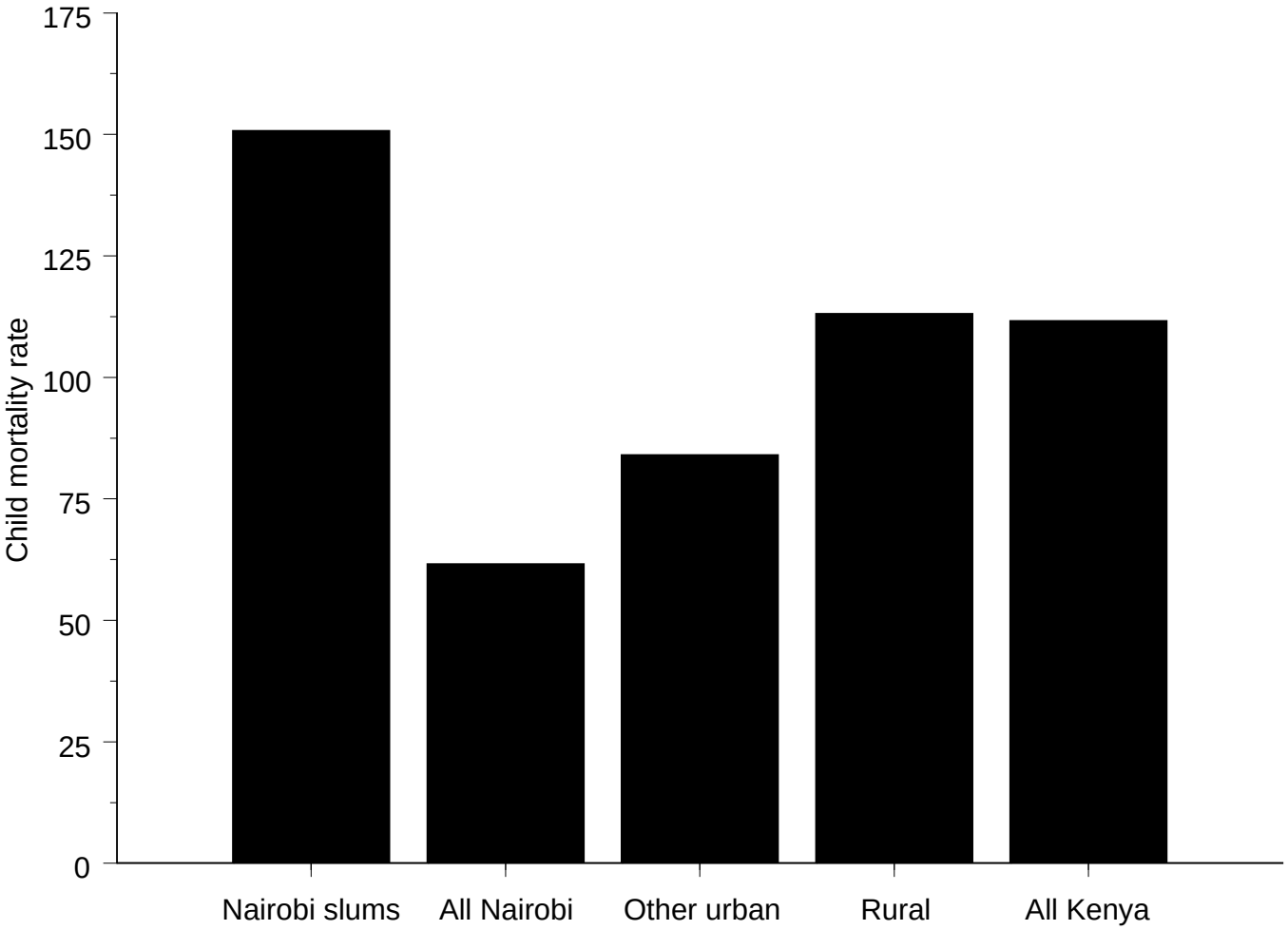
Attendance at Delivery: Urban and Rural India



Child Malnutrition: Urban and Rural India



Spatial Concentration of Poverty: Child Mortality in Nairobi's Slums

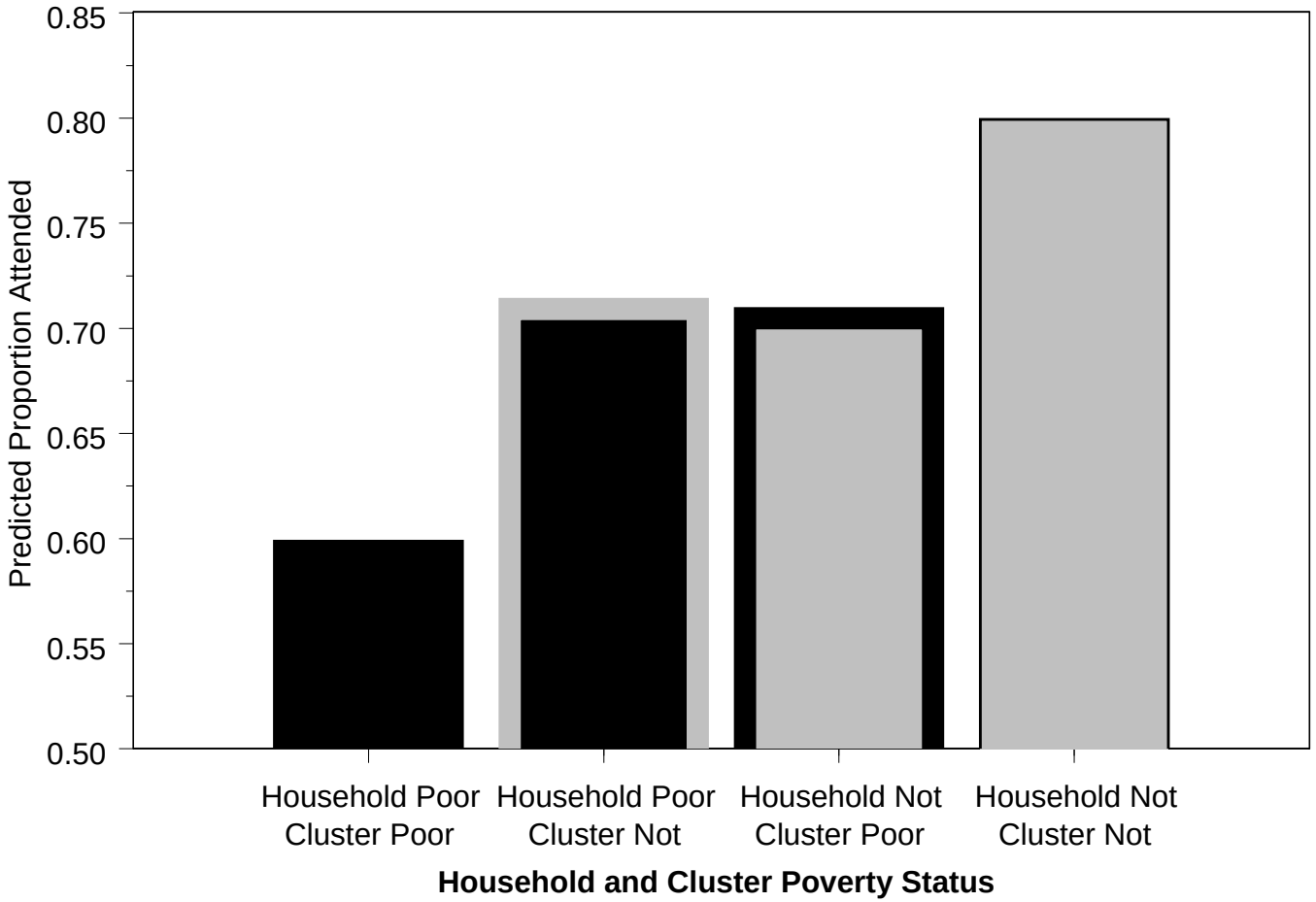


Composition? Neighborhood Effects? Social Epidemiology?

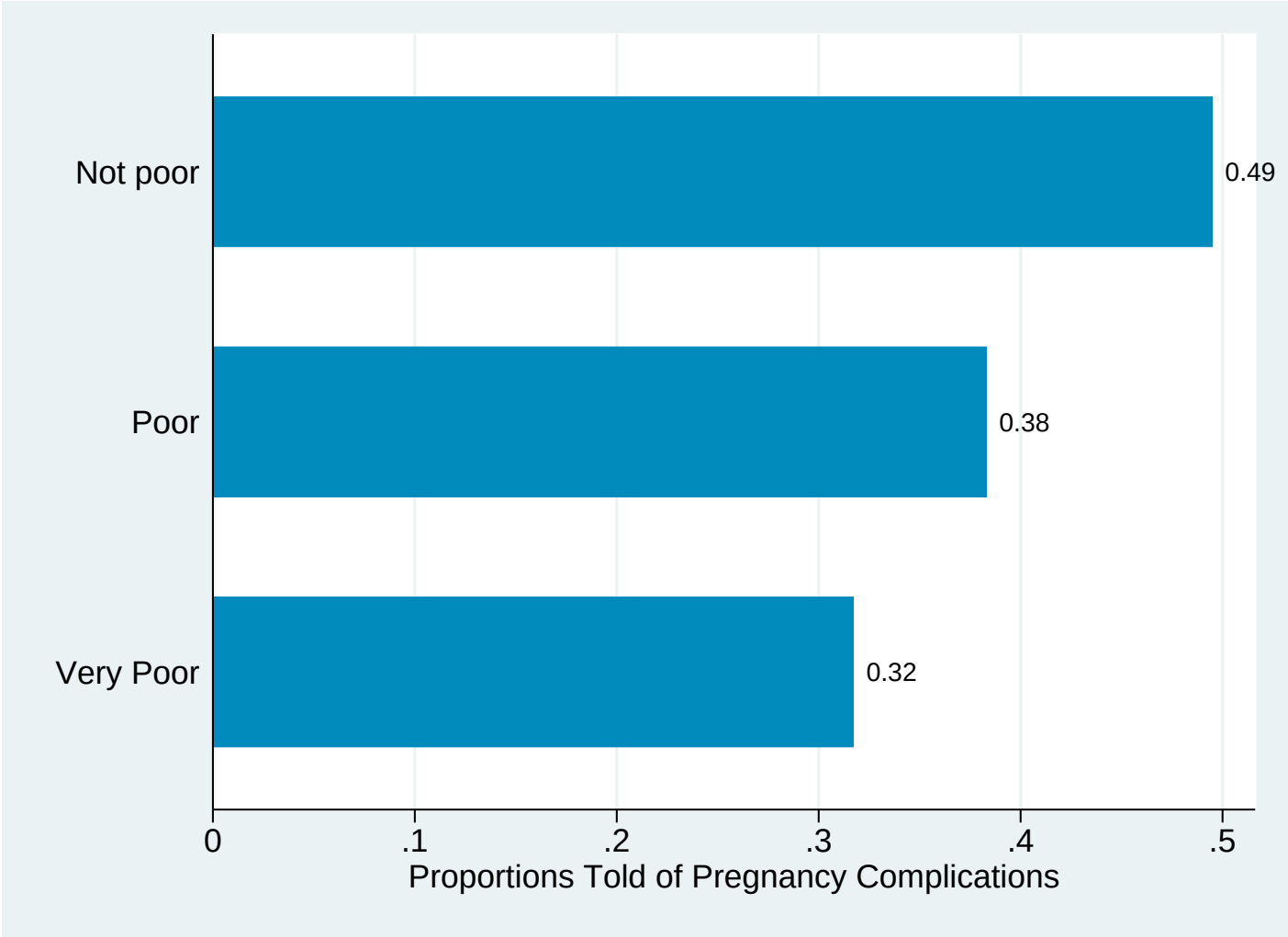
How to interpret elevated risk in slums?

- Poor children more likely to die; slums composed of poor households
- Externalities I: In addition, spatial concentration of poverty heightens risks due to contaigon
- Externalities II: The poor lack knowledge of prevention and cure; if not segregated in poor communities, they might learn from social network connections to better-educated, better-off
- Externalities III: Concentration of poverty in slums reduces interest on part of public health sector, politicians, bureaucrats

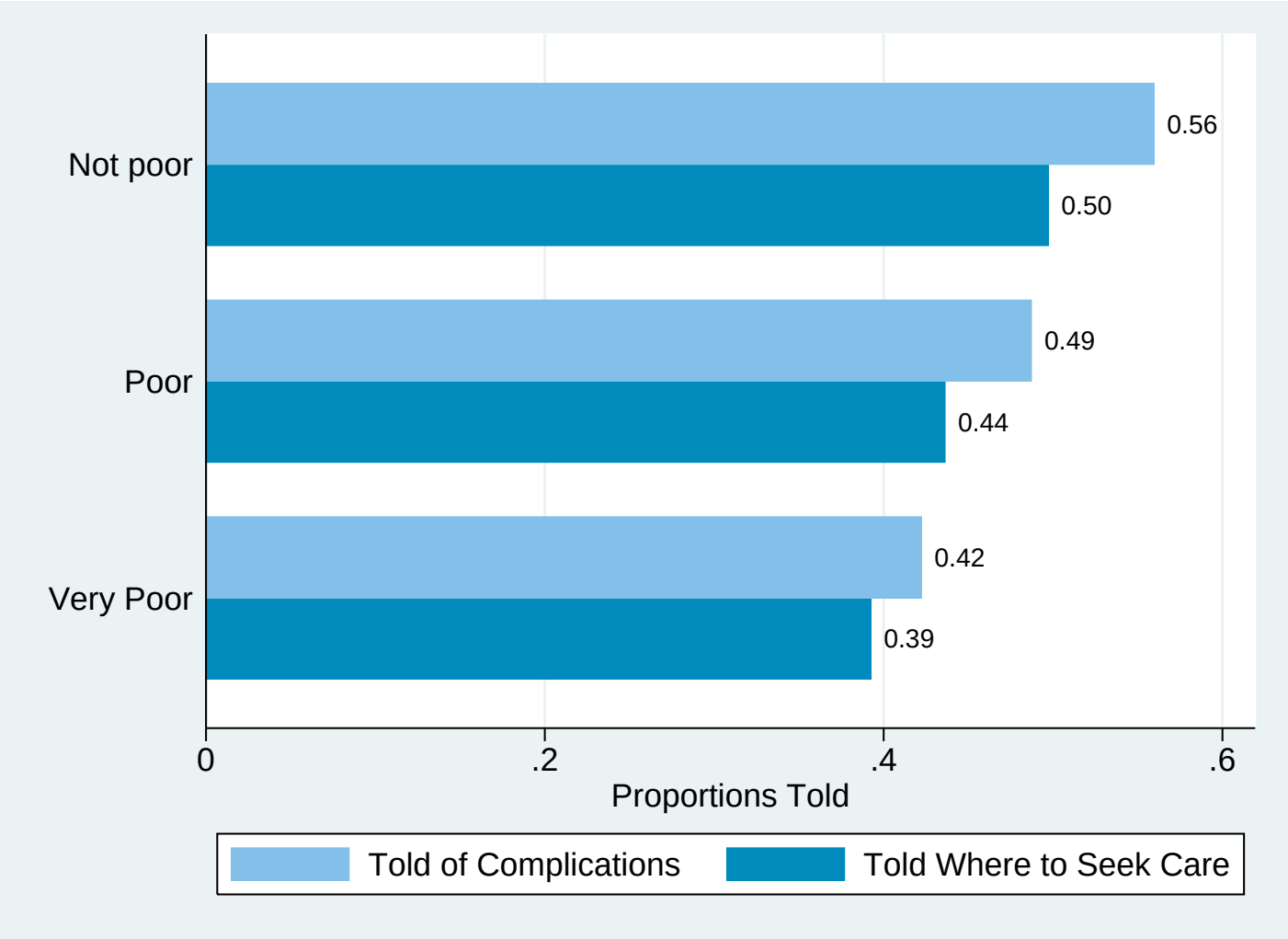
Evidence of Neighborhood Effects in Birth Attendance?



Quality of Health Care: Prenatal Care in Urban India



Quality of Health Care: Prenatal Care in Urban Philippines



The Das–Hammer (2007) Studies of Quality in Delhi

- Public and private providers easily accessible in poor and less-poor neighborhoods alike
- But both types of providers score low on (vignette-based) health knowledge
- When observed interacting with patients, score even lower.
- The public sector does not assign its better providers to poorer urban neighborhoods!
- All this amounts to "Money for Nothing"

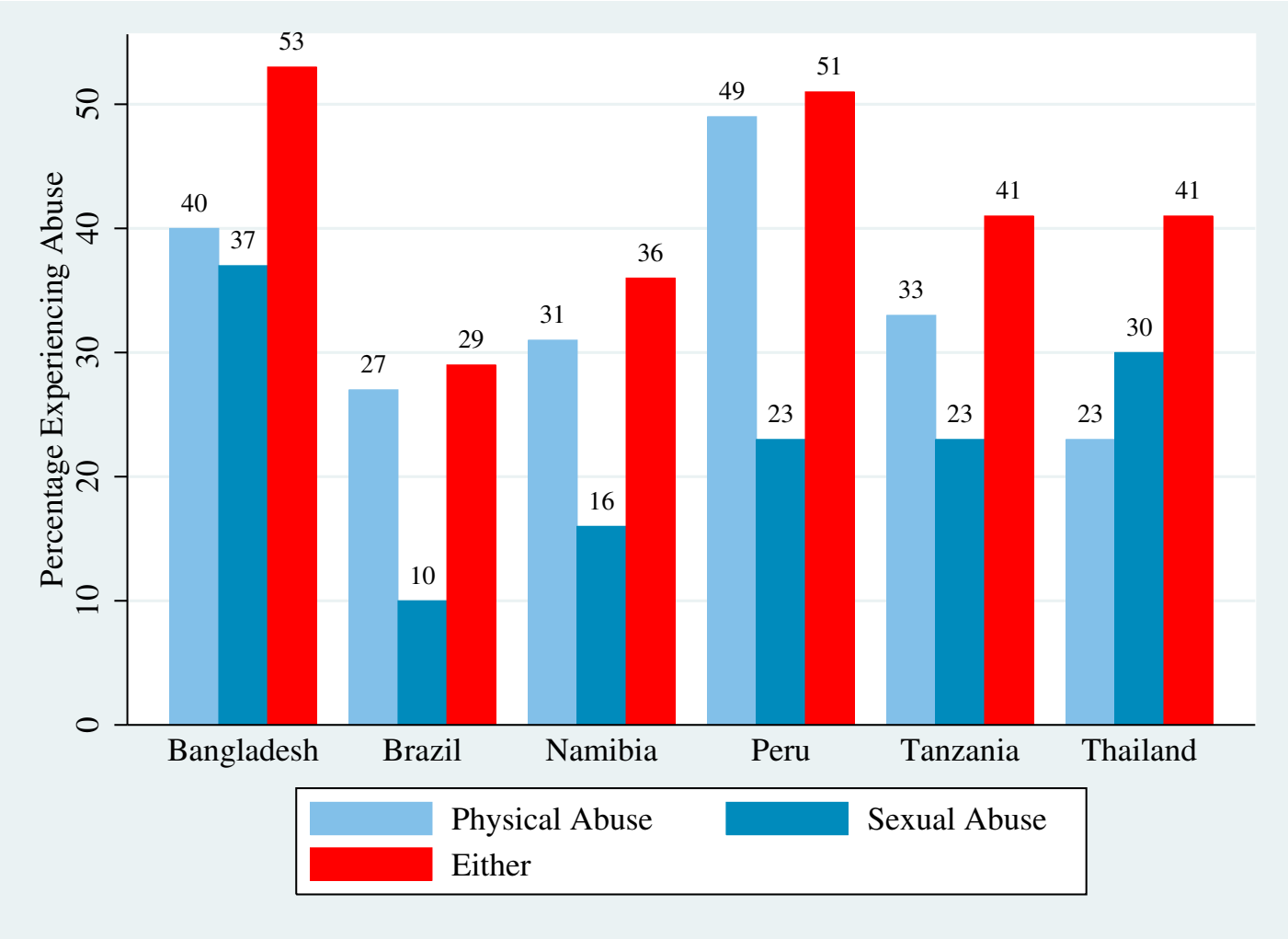
What Health Issues are Being Overlooked?

- Mental health
- Intimate-partner violence and alcohol abuse; crime
- Traffic-related accidents and deaths
- Urban tuberculosis
- Health threats from outdoor and indoor air pollution
- Upcoming risks from climate change: increases in frequency of floods, heat waves, other extreme events

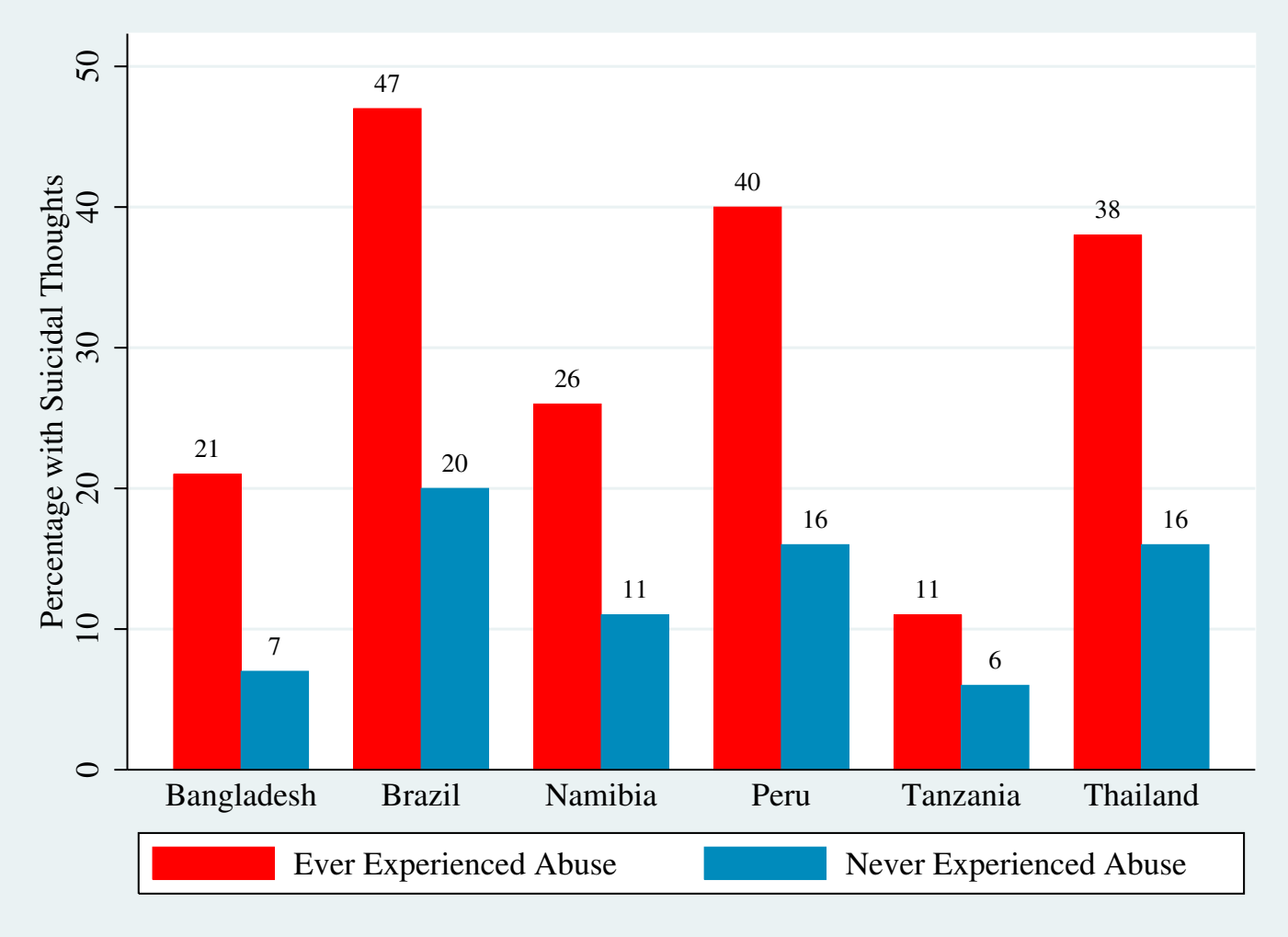
Why Mental Health?

- Not so much because of burden of psychiatric needs. . .
- Low-level depression, paralyzing fatigue, anxieties, fearfulness—not difficult to assess (work of Trudy Harpham, WHO short form)
- In study after study, women exhibit more mental ill-health than men, and adolescent girls more than adolescent boys
- For poor women, mental ill-health saps sense of self-efficacy needed to seek out health care for themselves and their families in difficult environments.

Intimate-Partner Violence: The WHO (2005) Study



Women Having Suicidal Thoughts, by Experience of Violence



Mental Health: The Subjective Experience of Inequity

- Individuals evaluate their own circumstances by comparing them with the observable circumstances of others. When consistently unfavorable, comparisons may provoke feelings of resentment and injustice, producing stress, anger, anxiety, paralysis.
- Important dimensions, from U.S. literature on discrimination and racism:
  - Fair treatment or fair outcome?
  - About me or about people like me, my group?
  - Futile or implies need to redouble effort?
- This has not been studied systematically for LDCs

Social Comparisons, Mental Health, Efficacy

In the view of Wilkinson (1996),

> *It is the social feelings which matter, not exposure to a supposedly toxic material environment. The material environment is merely the indelible mark and constant reminder of one's failure, of the atrophy of any sense of having a place in a community, and of one's social exclusion and devaluation as a human being.*

Repeated exposure to social inequities could erode feelings of social confidence and weaken the sense of personal efficacy needed to assert claims on health resources.

Much of U.S literature examines whether relative deprivation interpreted in personal or group terms. Tyler and Lind (2002):

> *If people feel that they are not doing well relative to other people, they [may] react in individualistic ways. If they think change is possible, they might go to school or work harder. If they think change is not possible, they might drink or use drugs. In either case, they respond to feelings of deprivation by taking individual actions. . . . In contrast, if people feel that their group is deprived relative to other groups, they are more likely to become involved in actions that focus on changing the situation of their group. It is of particular interest if they engage in collective behavior . . . .*

Self-efficacy in health

Would seem especially important for women:

- Women bear much of the burden of safe-guarding the health of their families
- Women also sustain much community organizational life
- Women (in study after study) are more afflicted by anxieties, stress, and depression than men.
- Contributing factors: Men engaging in domestic violence, alcoholism—the result of debilitating social comparisons? Women's efficacy restricted by lack of autonomy, mobility.

But what is really known about these connections?

And on that depressing note . . . THANK YOU!