Editorial: Why is urban health so poor even in many successful cities?

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Urban health issues still do not get the attention they deserve in discussions of development or environment. Successful “development” is so intimately related to health – to measures that directly or indirectly help individuals, households or communities avoid or prevent disease, injury and inadequate food intake. Beyond an absence of disease or injury, “development” means the achievement of living and working conditions that underpin well-being. Environmental management is also intimately related to health, again in these two senses, either preventing or minimizing air-borne, food-borne or water-related diseases and the effects of chemical pollutants and physical hazards, and ensuring good living and working environments that can contribute to well-being. Yet because so many of the measures that promote health and well-being fall to organizations that are not health agencies or do not understand their role as it relates to “health”, so little gets done. There are few measures with greater potential to transform well-being than a well-directed, participatory upgrading programme for “slums” or informal settlements for example, yet this is not seen as a health intervention.

Indicators related to health are among the most powerful measures of the success of development and environmental management – for nations, for cities, for groups within cities. With regard to such measures as life expectancy at birth or infant, child and maternal mortality, cities around the world can be among the healthiest places – or among the most life-threatening and health-threatening. There can also be enormous differentials in health indicators within cities. There are neighbourhoods within (say) Mumbai or Nairobi with health indicators that compare favourably with those in cities in high-income nations – but in each of these cities, around half the population lives in informal settlements and, in most such settlements, the indicators are dire.

Urban health issues also do not get the attention they deserve in discussions of urban poverty and poverty reduction. Most official measures of poverty still include no direct consideration of health or of most of the key determinants of health. They attempt to define the income households need for adequate food consumption – but most do not assess the income needed to rent, buy or build safe, healthy housing and the associated infrastructure and services that are key determinants of health (for instance, safe sufficient water, good sanitation and readily available affordable health care). Most national and city governments give a low priority to addressing the social determinants of health.

This editorial focuses on four health issues that are highlighted by papers herein – the failure of national and urban governments to address health (and its determinants); the inequalities within cities and between cities with regard to good health; the question of whether and where there is an urban penalty for health; and the measures that city governments can take to address health issues. Readers interested in urban health issues should also note that prior to this issue, Environment and Urbanization has published 86 papers with the word “health” in their abstract. There have been two previous special issues on urban health (Vol 5, No 2 (1993) and Vol 11, No 1 (1999)); and most other issues have dealt with key determinants of health, including Vol 15, No 2 (2003) on water, sanitation and drainage, Vol 16, No 2 (2004) on violence and security and Vol 19, No 1 (2007) on reducing risks from disasters and climate change.

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What happens to urban health where there is no government?

Where There Is No Doctor by David Werner is one of the most influential books on health. It gives advice on how to treat illnesses and injuries when no doctor is available, and was written for rural populations. But what advice can be given with regard to urban health in settlements where, in effect, there is no government? Where there may be doctors and health services, but much of the urban population has no access to them? Within urban areas, much of what is necessary to promote good health falls within the statutory responsibilities of local government. As Tord Kjellstrom and Susan Mercado noted in their paper published in 2008:

“….urbanization can and should be beneficial for health. In general, nations with high life expectancies and low infant mortality rates are those where city governments address the key social determinants of health. Better housing and living conditions, access to safe water and good sanitation, efficient waste management systems, safer working environments and neighbourhoods, food security and access to services such as education, health, welfare, public transportation and child care are examples of social determinants of health that can be addressed through good urban governance.”

It also falls to local government to implement building and land use regulations that should have health concerns at their centre – to ensure safe buildings and avoid urban development on unsafe sites. But in most of the informal settlements around the world that house around 900 million urban dwellers, few if any of these responsibilities are met.

Various papers in this issue deal with the failure of national and city governments to ensure provision for what is so basic to health: safe and sufficient water piped to each dwelling; a toilet in each dwelling that is effective in disposing of human wastes and thus reducing risks of faecal contamination; drainage that prevents flooding; and health care and emergency services that work and that serve everyone, especially those in the lower-income parts of town (including those in informal settlements). It is difficult to understand the reasons for the scale of this failure. It is not from a lack of documentation; as the guide to the literature notes, it was in 1977 that Samir Basta published his famous paper highlighting the very high infant mortality rates in informal settlements. It cannot simply be a lack of resources, as a high proportion of the population of many successful cities still lacks these basic services and amenities.

For instance, as Susan Chaplin’s paper discusses, so much of urban India (the second largest urban population in the world after China) still lacks sanitation more than 60 years after Independence. In part, this is the legacy of the colonial city and its administration, characterized by inequitable access to sanitation services, a failure to manage urban growth and the proliferation of slums, and the inadequate funding of urban governments. But it is also embedded in the post-colonial state, which, instead of being an instrument for development, has been dominated by coalitions of interests that allow the middle class to monopolize what sanitation services the state has provided. With the economic success enjoyed by so many cities in India, allied to decentralization reforms and democratic structures, one would have expected a rapid increase in the proportion of the populations with (say) adequate water, sanitation, drainage and health care – as has been evident in many Latin American nations. But the urban poor, despite their numbers and their political participation, have not been able to exert sufficient pressure to force governments to effectively implement policies designed to improve their living conditions. The consequence is that public health and environmental policies have frequently become exercises in crisis intervention rather than preventive measures that benefit the health and well-being of the whole urban population.

The paper by Siddarth Agarwal provides evidence of this lack of attention to the health of the urban poor. For instance, in 2004–2005, the


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The under-five mortality rate of the poorest urban quartile in many states in India was two to three times that of the rest of the urban population. The evidence also points to considerable differences between states in this regard. The poorest urban quartile in Uttar Pradesh, for instance, had an under-five mortality rate more than double that of the poorest urban quartile in Maharashtra.

For the poorest quartile of India’s urban population:

- 60 per cent of children were not completely immunized;
- 54 per cent of children were stunted and 47 per cent were underweight;
- only half of births were assisted by health personnel;
- less than one-fifth have water piped into their homes; and
- less than half use a flush or pit toilet to dispose of their excreta.

One aspect of this lack of attention to urban health has been the use of inappropriate definitions regarding provision for water and sanitation. What is needed in any urban environment is adequately treated water that is piped into each dwelling and is available 24 hours a day. But in most nations, the data available on provision for water in urban areas do not measure this. And urban (and rural) dwellers are classified as having “improved drinking water” even if they only have access to public standpipes and taps, boreholes or protected dug wells within a kilometre of the user’s dwelling. They are classified as having “improved sanitation facilities” even if all they have are simple pit latrines with a slab; so the definition of “improved sanitation” is far below the standard needed in urban areas to reduce the risk of human contact with faecal matter. An issue raised in past issues of this journal needs emphasizing again – these definitions are being used to assess progress towards meeting the Millennium Development Goals, but with such low standards of provision, they do not measure who has access to “safe drinking water” and who has access to safe, convenient sanitation.

The paper by Deepa Joshi, Ben Fawcett and Fouzia Mannan discusses this issue of standards.

As a resident of a slum in Dhaka says: “Don’t teach us what is sanitation and hygiene.” So many programmes that claim to address sanitation (and may even move households into the “improved” sanitation category in official statistics) do not provide sanitation to a standard that ensures the key health benefits. Or they demand personal investments in situations of highly insecure tenure, or teach “hygiene practices” that relate neither to local beliefs nor to the ground realities of a complex urban poverty. A study focused on Chittagong, Dhaka, Nairobi and Hyderabad shows how excreta disposal systems, packaged and delivered as low-cost “safe sanitation”, fail to match the sanitation needs of a very diverse group of urban men, women and children. As this paper notes, it is of little surprise that the delivered systems remain unused and are not sustained beyond the life of the projects.

**Inequality**

The findings presented in Siddarth Agarwal’s paper noted above concentrate on the scale of health disadvantages experienced by the poorest quartile of India’s urban population and the large disparities in provision of health care, water and sanitation and in housing conditions in the urban population of seven states, between the poorest quartile and the rest of the population. The paper by Carolyn Stephens revisits the issues of urban health and social inequalities – a topic that was the focus of a special issue of *Environment and Urbanization* in 1997, for which she was guest editor. This paper suggests a need for more precision in understanding inequalities and acting on them. It discusses how measurement and policy response are influenced by whether the focus is on absolute or relative poverty. Stephens notes that many authors fail to clarify the difference between a differential, an unequal and an unjust distribution of services or resources, or health outcomes. The paper discusses which aspects of inequality can and cannot be addressed through conventional local government interventions (for instance, in upgrading informal settlements or public transport, or water pricing). To change urban inequalities at root, we need to recognize and address the unjust distributions of power and control of resources that underpin them.

The short paper by Caroline Moser raises an issue that has been recognized but perhaps
not acted upon, namely the large burden of disease among low-income urban dwellers that comes from non-communicable diseases and injuries.\(^5\) This paper reports on the difficulties facing a community leader in Guayaquil, whom the author has known for more than 30 years, in getting and affording treatment for breast cancer. It serves as a reminder that low-income households in low- and middle-income nations face many of the same health risks from non-communicable diseases as higher-income groups, but cannot get appropriate treatment from public health care and cannot afford private treatment.

**Urban bias or urban penalty?**

The papers reviewed above certainly point to a large health penalty among the low-income urban population when compared to the rest of the urban population. Alice Sverdlik’s review of the literature on health in informal settlements draws examples from studies in many urban settings that indicate that urban health inequalities begin at birth, are reproduced over a lifetime (often reinforced by undernutrition), and may be recreated through vulnerabilities to the “double burden” of communicable and non-communicable diseases. Here, the focus is on health differentials within urban populations.

This review also discusses recent literature on the “urban penalty” related to some aspects of health or health care when urban populations are compared to rural populations. There has long been an assumption among many development specialists that urban dwellers benefit from “urban bias” in the policies and practices of governments when compared to rural residents – although for most low- and middle-income nations, little or no evidence has been presented to support this. It has also long been difficult for those who work in informal settlements or with urban poor groups, confronted by the very poor living conditions, very large health burdens and the animosity of governments (that is often reflected in evictions), to see these people as privileged by government policies and resource allocations. Aggregate statistics often show urban populations with better health outcomes than rural populations (for example, in infant, child and maternal mortality rates or the proportion of children under height and underweight). What is surprising for many nations is how little health advantage the urban population actually has as measured by these indicators, despite the fact that the concentration of high-income people in urban areas pulls up urban averages. The review of the literature points to papers that show little or no health benefits to urban dwellers when urban and rural dwellers with comparable incomes or asset bases are compared. The issue here is a need for much more detailed, disaggregated, location-specific knowledge of health burdens and their underpinnings – and this is not provided by the surveys so widely used to inform development policy. Where local government is competent, capable and willing to work in informal settlements, health is probably better for low-income groups than in rural areas because of the economies of scale and proximity in so many interventions to improve living conditions and provide infrastructure and services. But where local government is incompetent, incapable and unwilling to work with those living in informal settlements (and this is the reality for a very large section of the world’s urban population), there may well be an urban health penalty. Without effective local governance, concentrating people, enterprises, motor vehicles and all their wastes produces very unhealthy conditions. We need more proponents of good health and its underpinnings who prioritize this in rural and urban areas – not the current division into rural and urban proponents, each carefully selecting only the (limited) range of statistics that apparently support their cause.

**Motivating city governments to act on health**

The paper by Sana Chehimi, Larry Cohen and Erica Valdivinos discusses the role of community prevention in improving overall health and supporting health equity. Seen in other terms, this seeks to address some of the underlying determinants of health. It highlights the extent to which improved health and greater health equity depend on community-level identification of the underlying causes of

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5. See also the review of the literature on health in informal settlements in this issue.
illness and injury, and on partnerships within each community among all relevant sectors to address them. Housing and living environments also shape behaviour, making it easier or harder to engage in health-promoting behaviour. Community prevention can address relevant factors in this – including safety, affordable good food, reliable transport, opportunities for play and recreation, and access to meaningful education and employment. The paper presents guidelines for action on various levels – from strengthening individual knowledge and skills through community education; educating providers and leaders (in all sectors); fostering coalitions and networks; changing organizational practice (within government, health institutions and workplaces, among others); to influencing policy and legislation. It also provides guidance on the ways in which different sectors see particular health problems and solutions and the partners, training and funding needed to address them. This allows the development of a matrix, so the contributions of different sectors to any health problem and the areas of overlap in prevention become clear.

The paper on “Municipality, space and the social determinants of health” is unusual in being written by a mayor who is currently in office. Mayor Llorca’s paper emphasizes his government’s efforts to place health at the centre of his social and political agenda and to build a strong movement for public health at the local level. It represents an effort to bring back the old links between health and municipalities that the sanitation movement in the nineteenth century led in urban areas during the early stages of industrialization and the beginnings of the era of mass consumption. But, as he argues, a healthy city is one where all the key social actors (the authorities and local, private and public organizations) commit themselves to a process involving economic and social progress, respect for the environment and a strengthening of collective health, with the aim of improving people’s quality of life. The paper stresses the importance of a municipal health plan that makes clear the roles of all sectors in contributing to this. It also clarifies how good urban spatial planning can shape the health of the people by addressing some of the key determinants of health:

- opportunities for active and healthy lifestyles (especially regular exercise);
- access to affordable and good quality housing;
- opportunities for social cohesion and social support networks;
- access to job opportunities; and
- access to high quality educational, cultural, recreational, commercial, health and outdoor provision.

The paper by Yongmei Zhang and Bingqin Li examines how awards and competitions are often used in China to motivate public servants to address health issues or service improvements. The paper suggests that apart from improving performance, awards and competitions are good at motivating user participation and spreading good practice. But it also notes how the design of the schemes used in China tends to prioritize disproportionately the winning mentality, and sometimes causes high costs and social tension.

Youth and the city

This issue has four papers focusing on the youth theme of the October 2010 issue. They were discussed in the editorial in that issue but a brief reminder is in order here. Two of the papers describe very specific initiatives that have provided support for urban youth. Aquila Ismael’s paper describes the Technical Training Resource Centre (TTRC) in Karachi, which provides training for young people in skills critical to upgrading housing and infrastructure provision in the kaatchi abadis (informal settlements); and Jack Makau’s paper discusses the loose federation of young people’s groups in Nairobi, Mwamko wa Vijana, that has supported the entrepreneurship of its young members but has also encouraged their impressive mentorship of younger children in a wide range of activities. These initiatives are quite different but have two important points in common: both actually evolved through the efforts of young people themselves; and they also both had a vital connection to an established organization (the Orangi Pilot Project–Research and Training Institute in the Karachi case, and the Kenyan slum dwellers’ federation, Muungano wa Wanavijiji, in the Nairobi case). This highlights the important ways in which
existing organizations that focus on community
development more generally can sponsor
and support the emergence of young people's
organized efforts on their own behalf.

The paper by Camilo Darsie de Souza and
Sabrine de Jesus Ferraz Faller draws on research
conducted in Porto Alegre, Brazil, and discusses the
challenges faced by deaf young people as they try
to find social space and an accepted identity for
themselves within the diversity and complexity
of the contemporary city. Richard Mabala's paper,
building on his years of experience working with
young people in East Africa, is a critical reflection
on initiatives undertaken with or for youth. He
discusses a typology of common perceptions or
myths about young people that tend to shape
responses, often in less than productive ways, and
suggests some guidelines that can contribute to
more constructive engagement and to their effective
participation in dealing with their own lives.

Climate change and cities

The paper by Daniel Hoornweg, Lorraine Sugar
and Claudia Lorena Trejos Gómez highlights
the very large differences between cities in their
greenhouse gas emissions per inhabitant – for
instance, the variation in average per capita
emissions for cities, which ranges from more
than 15 tonnes of carbon dioxide equivalent
(Sydney, Calgary, Stuttgart and several major US
cities) to less than half a tonne (various cities
in Nepal, India and Bangladesh). There is also a
ten-fold difference in per capita emissions within
Toronto when comparing different districts.

The paper by Tania López-Marrero and Petra
Tschakert examines what supports or undermines
community resilience to floods in a flood-prone
municipality in Puerto Rico. It suggests that
enhancing resilience in these communities requires:

• support for social learning by building on
  existing knowledge;
• stressing the importance of developing a
diverse set of flood management options; and
• promoting effective linkages and collabora-
  tions between community members and
  emergency managers to encourage collective
  flood management.

The paper by Justus Kithiia and Anna Lyth
deals with an issue that is too little discussed –
the importance of well-planned and protected
urban green landscapes, including wildscapes
and green spaces, in climate change adaptation
and mitigation. Protecting such spaces can be
among the cheapest and most effective ways to
reduce flood risks – yet this is a topic that has
had little attention in urban centres in low-
income nations. The paper discusses the Lafarge
Ecosystems Programme in Mombasa, Kenya,
and shows how a well-managed system of green
landscapes in resource-poor urban areas can
generate net social benefits under a range of
future scenarios.

Feedback

The paper by Benjamin Bradlow, Joel Bolnick
and Clifford Shearing considers why the housing
subsidy programme in South Africa, one of the
most generously funded housing programmes for
low-income groups, has had so little impact on
poverty reduction. Most government funding went
to contractors to build new units “for the poor”;
it was assumed that these would replace homes in
informal settlements that the poor had developed
themselves, and there was little government
interest in supporting urban poor groups to build
new housing themselves or upgrade existing
housing. But most of the contractor-built housing
was too small, of poor quality and in locations far
from livelihoods and services. The authors suggest
that the formal institutions of government have
to learn how to support and work with the poor if
housing conditions are to improve.

The paper by Robert Buckley, on social
inclusion in Mumbai, questions the accuracy
and validity of the criticisms made by Ananya
Roy regarding the approach to community
development of a Mumbai-based NGO, SPARC,
and its partner grassroots federations. Roy has
suggested that the focus on sanitation rather
than on land tenure is an appeal to middle-
class values about cleanliness, and that support
for relocating those who lived right next to the
railway tracks made them agents of the state.
When viewed through a demand-responsive
economic perspective, SPARC’s support for
community toilets was in response to what grassroots organizations asked for, and these also have high returns. Similarly, SPARC’s support for resettlement for those living alongside the railway tracks was for those who were going to be moved, and this support allowed them to have far more influence on where, when and how the resettlement took place. Here too, the high returns from faster, safer trains meant cost savings that were higher than the costs of providing good quality accommodation for those who had to move.

The paper by Timothy Gbenga Nubi and Chidinma Ajoku examines the effectiveness of land administration in Lagos, with a particular focus on the practicality and impact of the 30-day “governor’s consent” and “certificates of occupancy” procurement regime. This regime was introduced to facilitate land documentation and registration for housing delivery in the state. However, despite reducing the time required for processing and granting certificates of occupancy, this has not resulted in significantly increased applications nor has it had a significant effect on housing delivery in the state.

REFERENCES


Werner, David with Carol Thuman and Jane Maxwell (1992), Where There Is No Doctor; A Village Health Care Handbook, Hesperian, Berkeley, 512 pages.