A Compendium on Health of Urban Poor in Africa

Abstract of select Papers and Reports

Urban Health Resource Center, New Delhi
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1. To Mitigate, Resist, or Undo: Addressing Structural Influences on the Health of Urban Populations

Arline T. Geronimus, ScD

Abstract

Young to middle-aged residents of impoverished urban areas suffer extraordinary rates of excess mortality, to which deaths from chronic disease contribute heavily. Understanding of urban health disadvantages and attempts to reverse them will be incomplete if the structural factors that produced modern minority ghettos in central cities are not taken into account. Dynamic conceptions of the role of race/ethnicity in producing health inequalities must encompass (1) social relationships between majority and minority populations that privilege the majority population and (2) the autonomous institutions within minority populations that members develop and sustain to mitigate, resist, or undo the adverse effects of discrimination. Broad social and economic policies that intensify poverty or undermine autonomous protections can reap dire consequences for health. Following from this structural analysis and previous research, guiding principles for action and suggestions for continued research are proposed. Without taking poverty and race/ethnicity into account, public health professionals who hope to redress the health problems of urban life risk exaggerating the returns that can be expected of public health campaigns or overlooking important approaches for mounting successful interventions. (Am J Public Health. 2000;90:867–872)

2. Maternal health in resource-poor urban settings: how does women's autonomy influence the utilization of obstetric care services?

Jean-Christophe Fotso, Alex C Ezeh and Hildah Essendi
African Population and Health Research Center (APHRC), Nairobi, Kenya

Abstract

Background

Despite various international efforts initiated to improve maternal health, more than half a million women worldwide die each year as a result of complications arising from pregnancy and childbirth. This research was guided by the following questions: 1) How does women's autonomy influence the choice of place of delivery in resource-poor urban settings? 2) Does its effect vary by household wealth? and 3) To what extent does women's autonomy mediate the relationship between women's education and use of health facility for delivery?

Methods

The data used is from a maternal health study carried out in the slums of Nairobi, Kenya. A total of 1,927 women (out of 2,482) who had a pregnancy outcome in 2004–2005 were selected and interviewed. Seventeen variable items on autonomy were used to construct women's decision-making,
freedom of movement, and overall autonomy. Further, all health facilities serving the study population were assessed with regard to the number, training and competency of obstetric staff; services offered; physical infrastructure; and availability, adequacy and functional status of supplies and other essential equipment for safe delivery, among others. A total of 25 facilities were surveyed.

Results
While household wealth, education and demographic and health covariates had strong relationships with place of delivery, the effects of women's overall autonomy, decision-making and freedom of movement were rather weak. Among middle to least poor households, all three measures of women's autonomy were associated with place of delivery, and in the expected direction; whereas among the poorest women, they were strong and counter-intuitive. Finally, the study showed that autonomy may not be a major mediator of the link between education and use of health services for delivery.

Conclusion
The paper argues in favor of broad actions to increase women's autonomy both as an end and as a means to facilitate improved reproductive health outcomes. It also supports the call for more appropriate data that could further support this line of action. It highlights the need for efforts to improve households' livelihoods and increase girls' schooling to alter perceptions of the value of skilled maternal health care.

3. Maternal and Child Health among the Urban Poor in Nairobi, Kenya

Monica Magadi
Centre for Research in Social Policy (CRSP), Department of Social Sciences, Loughborough University

Abstract
This paper examines maternal and child health in the Nairobi slums using information on 1219 births which occurred in the past three years before the Nairobi Cross-sectional Slum Survey (NCSS) of 2000. The specific objectives are to compare maternal and child health indicators in the Nairobi slums with the rest of the Kenyan population, and to identify socio-economic and demographic factors associated with poor maternal and child health in the Nairobi slums. The results show that overall, the quality of antenatal care in the slums is comparable to the rest of the Kenyan population. With respect to professional delivery care, the Nairobi slums are worse off than the rest of Nairobi or other urban areas in Kenya, but seem better off compared to the rural communities. It is with respect to child health indicators that the slum residents in Nairobi show the greatest disadvantage, in comparison with the rest of the Kenyan population. Children in the slums are considerably less likely to be fully immunized and more likely to experience fever and diarrhea than their counterparts living elsewhere in Kenya. In general, lower educational attainment and belonging to the Luo ethnic group are consistently associated with poorer maternal and child health outcomes in the Nairobi slums.
4. Social Indicators in the Urban Context: Urban Poverty and Health Study in Sub-Saharan Africa *Rationale, Methodology and Instruments

by Gora Mboup

This document is intended to provide a systematic approach to carrying out surveys which aim to better understand poverty and health outcomes in urban slums and to monitor the progress in reaching targets set by Millennium Development Goals (MDG) which aims at improving the lives of 100 million slum dwellers worldwide by the year 2020, and for laying down a base from which to measure change in the next decade and beyond.

5. Poverty Reduction Among the Urban Poor in ACCRA, Ghana – A Comparative Study of the Roles of Two Community Based Organizations (CBOs).

By Dr. Alex B. Asiedu
Department of Geography and Resource Devt.
University of Ghana, P.O. Box LG59, Legon, Accra, Ghana.

ABSTRACT

This case study is on participants’ evaluation of a poverty reduction programme that is under implementation by two Community-Based Organizations (CBOs) within a suburb of Accra, Ghana’s capital city. Specifically, the study focused on assessment of participants’ views on the causes and dimensions of poverty as well as the impacts of certain on-going projects aimed at alleviating of poverty in the community. The study further sought to isolate the factors that explain participants’ satisfaction with these projects and also analyzed their views on future sustainability of the projects. It was realized that respondents’ views on poverty were quite divergent, embodying some of the very well known notions of the concept. Furthermore, socio-economic variables were found to dominate the factors accounting for satisfaction with project execution. Majority of the respondents also expressed confidence on the projects’ future sustainability, even in the absence of governmental and other forms of support.
6. Provision and Use of Maternal Health Services among Urban Poor Women in Kenya: What Do We Know and What Can We Do?

Jean Christophe Fotso, Alex Ezeh and Rose Oronje

Abstract
In sub-Saharan Africa, the unprecedented population growth that started in the second half of the twentieth century has evolved into unparalleled urbanization and an increasing proportion of urban dwellers living in slums and shanty towns, making it imperative to pay greater attention to the health problems of the urban poor. In particular, urgent efforts need to focus on maternal health. Despite the lack of reliable trend data on maternal mortality, some investigators now believe that progress in maternal health has been very slow in sub-Saharan Africa. This study uses a unique combination of health facility- and individual-level data collected in the slums of Nairobi, Kenya to: (1) describe the provision of obstetric care in the Nairobi informal settlements; (2) describe the patterns of antenatal and delivery care, notably in terms of timing, frequency, and quality of care; and (3) draw policy implications aimed at improving maternal health among the rapidly growing urban poor populations. It shows that the study area is deprived of public health services, a finding which supports the view that low-income urban residents in developing countries face significant obstacles in accessing health care. This study also shows that despite the high prevalence of antenatal care (ANC), the proportion of women who made the recommended number of visits or who initiated the visit in the first trimester of pregnancy remains low compared to Nairobi as a whole and, more importantly, compared to rural populations. Bivariate analyses show that household wealth, education, parity, and place of residence were closely associated with frequency and timing of ANC and with place of delivery. Finally, there is a strong linkage between use of antenatal care and place of delivery. The findings of this study call for urgent attention by Kenya’s Ministry of Health and local authorities to the void of quality health services in poor urban communities and the need to provide focused and sustained health education geared towards promoting use of obstetric services.
Objectives

To document and compare the magnitude of inequities in child malnutrition across urban and rural areas, and to investigate the extent to which within-urban disparities in child malnutrition are accounted for by the characteristics of communities, households and individuals.

Methods

The most recent data sets available from the Demographic and Health Surveys (DHS) of 15 countries in sub-Saharan Africa (SSA) are used. The selection criteria were set to ensure that the number of countries, their geographical spread across Western/Central and Eastern/Southern Africa, and their socioeconomic diversities, constitute a good yardstick for the region and allow us to draw some generalizations. A household wealth index is constructed in each country and area (urban, rural), and the odds ratio between its uppermost and lowermost category, derived from multilevel logistic models, is used as a measure of socioeconomic inequalities. Control variables include mother’s and father’s education, community socioeconomic status (SES) designed to represent the broad socio-economic ecology of the neighborhoods in which families live, and relevant mother- and child-level covariates.

Results

Across countries in SSA, though socioeconomic inequalities in stunting do exist in both urban and rural areas, they are significantly larger in urban areas. Intra-urban differences in child malnutrition are larger than overall urban-rural differentials in child malnutrition, and there seem to be no visible relationships between within-urban inequities in child health on the one hand, and urban population growth, urban malnutrition, or overall rural-urban differentials in malnutrition, on the other. Finally, maternal and father’s education, community SES and other measurable covariates at the mother and child levels only explain a slight part of the within-urban differences in child malnutrition.

Conclusion

The urban advantage in health masks enormous disparities between the poor and the non-poor in urban areas of SSA. Specific policies geared at preferentially improving the health and nutrition of the urban poor should be implemented, so that while targeting the best attainable average level of health, reducing gaps between population groups is also on target. To successfully monitor the gaps between urban poor and non-poor, existing data collection
programs such as the DHS and other nationally representative surveys should be re-designed to capture the changing patterns of the spatial distribution of population.

8. To Mitigate, Resist, or Undo: Addressing Structural Influences on the Health of Urban Populations

Young to middle-aged residents of impoverished urban areas suffer extraordinary rates of excess mortality, to which deaths from chronic disease contribute heavily. Understanding of urban health disadvantages and attempts to reverse them will be incomplete if the structural factors that produced modern minority ghettos in central cities are not taken into account.

Dynamic conceptions of the role of race/ethnicity in producing health inequalities must encompass (1) social relationships between majority and minority populations that privilege the majority population and (2) the autonomous institutions within minority populations that members develop and sustain to mitigate, resist, or undo the adverse effects of discrimination.

Broad social and economic policies that intensify poverty or undermine autonomous protections can reap dire consequences for health. Following from this structural analysis and previous research, guiding principles for action and suggestions for continued research are proposed. Without taking poverty and race/ethnicity into account, public health professionals who hope to redress the health problems of urban life risk exaggerating the returns that can be expected of public health campaigns or overlooking important approaches for mounting successful interventions. (Am J Public Health. 2000;90:867–872)


Antai D. Division of Epidemiology, Institute of Environmental Medicine, Karolinska Institute, Stockholm, Sweden. theangelstrust.nigeria@gmail.com

BACKGROUND: Vaccine-preventable diseases are responsible for severe rates of morbidity and mortality in Africa. Despite the availability of appropriate vaccines for routine use on infants, vaccine-preventable diseases are highly endemic throughout sub-Saharan Africa. Widespread disparities in the coverage of immunization programmes persist between and within rural and urban areas, regions and communities in Nigeria. This study assessed the individual- and community-level explanatory factors associated with child immunization differentials between migrant and non-migrant groups.

METHODS: The proportion of children that received each of the eight vaccines in the routine immunization schedule in Nigeria was estimated. Multilevel multivariable regression analysis was performed using a nationally representative sample of 6029 children from 2735 mothers.
aged 15-49 years and nested within 365 communities. Odds ratios with 95% confidence intervals were used to express measures of association between the characteristics. Variance partition coefficients and Wald statistic i.e. the ratio of the estimate to its standard error were used to express measures of variation.

RESULTS: Individual- and community contexts are strongly associated with the likelihood of receiving full immunization among migrant groups. The likelihood of full immunization was higher for children of rural non-migrant mothers compared to children of rural-urban migrant mothers. Findings provide support for the traditional migration perspectives, and show that individual-level characteristics, such as, migrant disruption (migration itself), selectivity (demographic and socio-economic characteristics), and adaptation (health care utilization), as well as community-level characteristics (region of residence, and proportion of mothers who had hospital delivery) are important in explaining the differentials in full immunization among the children.

CONCLUSION: Migration is an important determinant of child immunization uptake. This study stresses the need for community-level efforts at increasing female education, measures aimed at alleviating poverty for residents in urban and remote rural areas, and improving the equitable distribution of maternal and child health services.

*Health Place.* 2010 May;16(3):573-80.


Goebel A, Dodson B, Hill T. Queen’s University, Kingston, Ontario, Canada. goebela@queensu.ca

Basic services have improved in many urban areas of South Africa, which should improve health and well-being. However, poverty and ill-health persist and are unequally distributed by race, class and place. This paper explores conditions of the most marginalized group, female-headed households, in a case study of Msunduzi Municipality (formerly Pietermaritzburg). Data from two household surveys conducted in 2006 show important patterns regarding the incidences of and coping strategies around, illnesses and deaths. While some positive environmental health outcomes are apparent, considerable stresses face households in relation to HIV/AIDS related deaths, poverty, and lack of health services. The insights of both urban environmental health and feminist geography assist in explaining the gendered and spatialized patterns of health in post-apartheid urban South Africa.

*10 J Urban Health.* 2010 May 7.
11. **Menstrual Pattern, Sexual Behaviors, and Contraceptive Use among Postpartum Women in Nairobi Urban Slums.**

Ndugwa RP, Cleland J, Madise NJ, Fotso JC, Zulu EM. London School of Hygiene and Tropical Medicine, London, UK, robert.ndugwa@lshtm.ac.uk.

Postpartum months provide a challenging period for poor women. This study examined patterns of menstrual resumption, sexual behaviors and contraceptive use among urban poor postpartum women. Women were eligible for this study if they had a birth after the period September 2006 and were residents of two Nairobi slums of Korogocho and Viwandani. The two communities are under continuous demographic surveillance. A monthly calendar type questionnaire was administered retrospectively to cover the period since birth to the interview date and data on sexual behavior, menstrual resumption, breastfeeding patterns, and contraception were collected. The results show that sexual resumption occurs earlier than menses and postpartum contraceptive use. Out of all postpartum months where women were exposed to the risk of another pregnancy, about 28% were months where no contraceptive method was used. Menstrual resumption acts as a trigger for initiating contraceptive use with a peak of contraceptive initiation occurring shortly after the first month when menses are reported. There was no variation in contraceptive method choice between women who initiate use before and after menstrual resumption. Overall, poor postpartum women in marginalized areas such as slums experience an appreciable risk of unintended pregnancy. Postnatal visits and other subsequent health system contacts provide opportunities for reaching postpartum women with a need for family planning services.


12. **Informal urban settlements and cholera risk in Dar es Salaam, Tanzania.**

Penrose K, de Castro MC, Werema J, Ryan ET. Department of Global Health and Population, Harvard School of Public Health, Boston, Massachusetts, United States of America. kpenrose@post.harvard.edu

BACKGROUND: As a result of poor economic opportunities and an increasing shortage of affordable housing, much of the spatial growth in many of the world’s fastest-growing cities is a result of the expansion of informal settlements where residents live without security of tenure and with limited access to basic infrastructure. Although inadequate water and sanitation facilities, crowding and other poor living conditions can have a significant impact on the spread of infectious diseases, analyses relating these diseases to ongoing global urbanization, especially at the neighborhood and household level in informal settlements, have been infrequent. To begin to address this deficiency, we analyzed urban environmental data and the burden of cholera in Dar es Salaam, Tanzania.
METHODOLOGY/PRINCIPAL FINDINGS: Cholera incidence was examined in relation to the percentage of a ward’s residents who were informal, the percentage of a ward’s informal residents without an improved water source, the percentage of a ward’s informal residents without improved sanitation, distance to the nearest cholera treatment facility, population density, median asset index score in informal areas, and presence or absence of major roads. We found that cholera incidence was most closely associated with informal housing, population density, and the income level of informal residents. Using data available in this study, our model would suggest nearly a one percent increase in cholera incidence for every percentage point increase in informal residents, approximately a two percent increase in cholera incidence for every increase in population density of 1000 people per km(2) in Dar es Salaam in 2006, and close to a fifty percent decrease in cholera incidence in wards where informal residents had minimally improved income levels, as measured by ownership of a radio or CD player on average, in comparison to wards where informal residents did not own any items about which they were asked. In this study, the range of access to improved sanitation and improved water sources was quite narrow at the ward level, limiting our ability to discern relationships between these variables and cholera incidence. Analysis at the individual household level for these variables would be of interest.

CONCLUSIONS/SIGNIFICANCE: Our results suggest that ongoing global urbanization coupled with urban poverty will be associated with increased risks for certain infectious diseases, such as cholera, underscoring the need for improved infrastructure and planning as the world’s urban population continues to expand.

13. Peri-urban dynamics and regional planning in Africa: Implications for building healthy cities


Innocent Chirisa. Department of Rural and Urban Planning, University of Zimbabwe.

Much as peri-urban zones in Africa are places of possible disaster outbreaks in terms of disease outbreaks and other social hazards due to their general lack of planning and institutional integration, they can act as cradles for building health cities. This is so for many practical reasons poised in the sustainable development framework – the prevalence of horticultural activities; their attractiveness to investment by the moneyed classes of society in the areas of housing, commerce and other big-time ventures; and attention by regional planners in their quest for tapping on the wealth of the rural-urban linkages. This article captures these various dynamic activities and developments in the peri-urban zones of some African countries towards building a case for building healthy cities in the sustainable development framework. The key questions addressed in the article are:

- (a) To what extent are Africa peri-urban zones areas of possible disease outbreaks owing to the increased migration trends in different countries?
• (b) What regional planning measures to be put in place so that the sustainability of peri-
urban areas of the selected cities and towns to curb incidences of waterborne, airborne and other pandemic diseases?
• (c) What housing options must be put in place towards addressing the slum conditions in these quintessential areas? (d) What is the contribution of developers and investors in the place making of peri-urban settlements?

In addressing these questions, the comparison of the different factors are key in determining whether or not the question of spatial scale matter; technologies to be employed and how best a stewardship approach will help in consensus-building by the different stakeholders so that harmonious places in the form of healthy and stable peri-urban African settlements are fostered. The case study approach was chosen in order to depict spatially relevant details and dynamics that link the subject of peri-urban interfaces and their implications for regional planning in Africa.

14. Poverty, living conditions, and infrastructure access: a comparison of slums in Dakar, Johannesburg, and Nairobi, 2010

In this paper the authors compare indicators of development, infrastructure, and living conditions in the slums of Dakar, Nairobi, and Johannesburg using data from 2004 World Bank surveys. Contrary to the notion that most African cities face similar slum problems, find that slums in the three cities differ dramatically from each other on nearly every indicator examined.

Particularly striking is the weak correlation of measures of income and human capital with infrastructure access and quality of living conditions. For example, residents of Dakar’s slums have low levels of education and high levels of poverty but fairly decent living conditions. By contrast, most of Nairobi’s slum residents have jobs and comparatively high levels of education, but living conditions are but extremely bad. And in Johannesburg, education and unemployment levels are high, but living conditions are not as bad as in Nairobi.

These findings suggest that reduction in income poverty and improvements in human development do not automatically translate into improved infrastructure access or living conditions. Since not all slum residents are poor, living conditions also vary within slums depending on poverty status. Compared to their non-poor neighbors, the poorest residents of Nairobi or Dakar are less likely to use water (although connection rates are similar) or have access to basic infrastructure (such as electricity or a mobile phone).

Neighborhood location is also a powerful explanatory variable for electricity and water connections, even after controlling for household characteristics and poverty. Finally, tenants are less likely than homeowners to have water and electricity connections.

1. AIDS. 2010 Jul;24 Suppl 2:S39-44.

Nada KH, Suliman el DA. Population Council, West Asia and North Africa Regional Office, Maadi, Cairo, Egypt.

OBJECTIVES: To measure the prevalence of HIV/AIDS risk behaviors and related factors in a large, probability-based sample of boys and girls aged 12-17 years living on the streets of Egypt’s largest urban centers of Greater Cairo and Alexandria.

METHODS: Time-location sampling (TLS) was used to recruit a cross-sectional sample of street children. Procedures entailed using key informants and field observation to create a sampling frame of locations at predetermined time intervals of the day, where street children congregate in the two cities, selecting a random sample of time-locations from the complete list, and intercepting children in the selected time-locations to assess eligibility and conduct interviews. Interviews gathered basic demographic information, life events on the street (including violence, abuse, forced sex), sexual and drug use behaviors, and HIV/AIDS knowledge.

RESULTS: A total of 857 street children were enrolled in the two cities, with an age, sex, and time-location composition matching the sampling frame. The majority of these children had faced harassment or abuse (93%) typically by police and other street children, had used drugs (62%), and, among the older adolescents, were sexually active (67%). Among the sexually active 15-17-year-olds, most reported multiple partners (54%) and never using condoms (52%). Most girls (53% in Greater Cairo and 90% in Alexandria) had experienced sexual abuse. The majority of street children experienced more than one of these risks. Overlaps with populations at highest risk for HIV were substantial, namely men who have sex with men, commercial sex workers, and injection drug users.

CONCLUSION: Our study using a randomized TLS approach produced a rigorous, diverse, probability-based sample of street children and documented very high levels of multiple concurrent risks. Our findings strongly advocate for multiple services including those addressing HIV and STI prevention and care, substance use, shelters, and sensitization of authorities to the plight of street children in Egypt.


Garenne M.
The health of children improved dramatically worldwide during the 20th century, although with major contrasts between developed and developing countries, and urban and rural areas. The quantitative evidence on urban child health from a broad historical and comparative perspective is briefly reviewed here. Before the sanitary revolution, urban mortality tended to be higher than rural mortality. However, after World War I, improvements in water, sanitation, hygiene, nutrition and child care resulted in lower urban child mortality in Europe. Despite a similar mortality decline, urban mortality in developing countries since World War II has been generally lower than rural mortality, probably because of better medical care, higher socio-economic status and better nutrition in urban areas. However, higher urban mortality has recently been seen in the slums of large cities in developing countries as a result of extreme poverty, family disintegration, lack of hygiene, sanitation and medical care, low nutritional status, emerging diseases (HIV/AIDS and tuberculosis) and other health hazards (environmental hazards, accidents, violence). These emerging threats need to be addressed by appropriate policies and programmes.

17. Abortions rife in Kenyan slums

NAIROBI, Kenya, Aug 2 – With just one day to go to the Constitution referendum, a new report by a human rights watchdog shows that 92 percent of women in Kenyan slums have procured an abortion at least once in their lifetime.

The report by the Kenya Human Rights Commission (KHRC) comes at a time when the Constitution debate has reached its peak with the church opposing the proposed Constitution over the abortion clause.

“Despite the fact that the respondents were exposed to high risks of complications, most of them did not bother to undergo a follow up in a hospital,” KHRC Acting Deputy Executive Director Tom Kagwe said on Monday.

Mr Kagwe said 80 percent of the abortions were through perforation of the cervix to induce premature labour, 15 percent used herbs while the other five percent used medical personnel.

“Whether or not the debate on abortion will inform people (on the way to vote in the referendum) it is clear that even before 4th of August unsafe abortion has been procured and even after that people will still secure unsafe abortion countrywide,” he said.

The study was done among 65 women between March and April last year in Korogocho slums.