Responding to inequalities in health in urban areas in east and southern Africa

BRIEF 1: WHAT DOES THE LITERATURE TELL US?

Introduction: A lens on urban health inequalities

By 2050, urban populations will increase to 62% in Africa. The World Health Organisation (WHO) and UN Habitat in their 2010 report "Hidden Cities" note that this growth constitutes one of the most important global health issues of the 21st century. Cities concentrate opportunities, jobs and services, but they also concentrate risks and hazards for health (WHO and UN Habitat 2010). How fairly are these risks and opportunities distributed across different population groups but also across generations? How well are African cities promoting current and future wellbeing? How far are health systems responding to and planning for these changes?

TARSC as cluster lead of the "Equity Watch" work in EQUINET explored these questions in 2016-7, for east and southern African (ESA) countries. We implemented a multi-methods approach to gather and analyse diverse forms of evidence and experience on inequalities in health and its determinants *within* urban areas.

We also explored current and possible responses to these urban conditions, from the health sector and the health promoting interventions of other sectors and of communities. We aimed to build a holistic understanding of the social distribution of health in urban areas and the responses and actions that promote urban health equity. This included building an understanding of the distribution of opportunities for and practices promoting health and wellbeing from different perspectives and disciplines. We thus integrated many forms of evidence, including a review of literature, analysis of quantitative indicators, internet searches of evidence on practices, thematic content analysis and participatory validation by those more directly involved and affected. In this latter element, TARSC co-operated with youth from different suburbs in Harare and the Civic Forum on Human Development (CFHD).

This brief reports what we found from a review of published literature.

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Implementing a review of published literature

The methods, findings and an annotated bibliography of the literature can be found in full in Loewenson R, Masotya M (2015) Responding to inequalities in health in urban areas: A review and annotated bibliography, EQUINET Discussion paper 106, TARSC, EQUINET, Harare.

An annotated bibliography was compiled in 2015 from a review of published papers on the pattern of and responses to urban inequalities in health in ESA countries. It was implemented through an online search of papers drawn from English language literature post 2005 accessed from online libraries. An initial review of the 1060 abstracts yielded 118 papers, and after reading the full papers 105 were included. The annotated bibliography provides information on each paper, and a review was compiled on the findings on urban health in ESA countries.

Notably only a quarter of papers sourced discussed interventions to address inequalities, and even fewer community responses to urban inequalities in health. The papers particularly covered two countries, Kenya and South Africa, with evidence largely from ad hoc quantitative surveys. There was limited presentation of direct experiences and perceptions of those affected. Generalising from the findings of this search is thus done with caution.

A follow up search and review was implemented in 2016 of evidence on holistic paradigms for exploring urban health to identify conceptual approaches that may apply in the follow up work. Searches of the same online libraries yielded 59 papers in English and Spanish, together with 23 papers documenting the indicators used to measure wellbeing in these approaches. The approaches applied and dimensions of wellbeing identified were reviewed and the findings are outlined in this brief. The papers were also used to compile a matrix of indicators for these different dimensions of wellbeing used in the analysis of data outlined in Brief 2.

Documented urban health inequalities in ESA countries

The annotated bibliography presented evidence on patterns of and responses to urban inequalities in health in ESA countries, and the specific sources for the findings below are detailed in that document (Loewenson and Masotya 2015). This brief summarises the findings. The literature indicated that for ESA countries, while urbanisation is associated with rising and often conspicuous wealth in some groups and with increasing levels of public access to online information and social media, it also involves many dimensions of urban stress, often in close proximity to wealth, ie:

- Poor living conditions for many urban residents, including substandard and overcrowded housing, water, sanitation systems, unhealthy cooking fuels and technologies, ground water contamination and solid waste, air and water pollution; traffic and related injury.
- Employment and income insecurity, with high shares of income spent on high priced food and other basic needs; consumption of poor quality food and harmful use of alcohol, tobacco and other drugs; and
- Social insecurity, crime and different forms of violence co-existing with isolation, exclusion and power imbalances across different age and social groups.

The review found that while health services are generally available and geographically accessible, there are cost, quality and acceptability barriers that lead to inverse care, with poorest groups using services less. This is disrupting the continuity of care necessary for common chronic and sexual and reproductive health conditions. These gaps could however be closed through how services are organized and delivered.

The literature pointed to broad trends, but included less evidence on social inequalities in health *within* urban areas in ESA countries. Much of the published evidence on within urban area inequalities came from DSS sites located in two settings only: Nairobi urban 'slums' and South Africa, where household data is more available. From these DSS sites and from ad hoc surveys, while mother's education and wealth are commonly measured determinants of *within* urban area health inequalities, other social features were also found to be associated, including:

a. High mobility and different waves of *inward migration*, with greater insecurity, weaker social support and higher HIV risk noted in more recent migrants into cities.

b. Different *forms of residency*, not only in terms of informal settlements but also for groups living in informal housing and 'backyard shacks' or as lodgers in formal areas.

c. Living in *different areas* in the city, both for those living in peripheries and slums, and those in high density suburbs historically sited in less healthy environments, where residents face new risks of epidemic disease from failed water systems and use of shallow wells.

d. *Different age groups and stages of the life-course*, including in terms of the sexual and reproductive, dietary, social and environmental risks faced by adolescents transitioning to adulthood, the risk of chronic conditions in adults and the physical and social risks of elderly people; and

e. *Different levels of formal recognition*, with those in informal settlements and employment often excluded from past or current investment in services and infrastructure.

The picture presented in the literature is not a coherent one- it is rather a series of fragments of different and often disconnected facets of risk, health and care within urban areas. There is limited direct voice of those experiencing the changing conditions. There is also very limited report of the features of urbanisation that *promote* wellbeing.

Some papers point to these wellbeing promoting features, with:

- urban agriculture supporting food security,
- schools and other facilities promoting sports and other health promoting activities for children;
- community health workers and supportive families enabling service uptake; and
- increased levels of social power and autonomy in women, supporting improved reproductive health.

However, there is limited evidence of how such heath promoting influences are distributed across different groups of migrants, residents, zones, age groups and formal/ informal settlements, despite these social features having relevance for health inequalities within urban areas, as noted above.

This social distribution of health outcomes suggests a need for health services and health promoting responses that are appropriate and accessible to the wide diversity of people serviced, across different areas, residences, gender, stages of life, wealth, time since migration, employment security, social power and inclusion. These services should be provided in ways that tap into the resources, capacities and assets that exist within urban areas, and that build coherence and continuity with communities and with other sectors.

The literature was, however, more focused on the challenges than on the solutions. While this was the case, some papers reported practices that were health promoting, in:

- Regulating practices that are harmful to health;
- Promoting appropriate technologies for urban agriculture, food security, environments and energy;
- Addressing deficits in urban sanitation and safe water;
- Using solar power for water disinfection, rainwater harvesting, cooking technologies, and
- The outreach into communities of social and other services.

In the health sector, the papers confirmed the relevance of primary health care and community- based approaches, including those involving community health workers (CHWs), participatory assessments and social media. The papers pointed to urban sites that merit greater attention in promoting public health, such as market places.

The documented health interventions suggested, however, that there are weak links between primary care services and urban public health. Generally, it appeared that there are 'sectoral silos', with limited collaborative interaction or measures to build synergies across sectors. Some approaches also segmented poorer groups in small risk pools in community based schemes, without confronting the wider imbalances in resources, power, or in sectoral practices and planning.

Local councils were commonly documented to be facilitators of co-ordinated responses, and public sector (state) investment was reported to play a key role in levering community-oriented private sector innovation. The papers thus pointed to the importance of an adequately resourced public health capacity in the state to encourage and ensure the role of other sectors, including in terms of the legal obligations in public health and other law. They also note that *public health laws* needed to be updated to take into account urban realities and to achieve a better balance between competing goals that each affect health: such as between ensuring safe microbial levels in waste water used in urban agriculture and ensuring adequate food.

Many of the papers recommended *community involvement* in policy and actions to address these urban health determinants. However, few papers presented interventions that implemented and tested these recommendations, with almost no exploration of the *community assets, capacities, roles and perceptions* that inform, shape and sustain health actions, or their impact on social cohesion, solidarity, segmentation and exclusion across cities.

The paucity of papers on this, at least in the published health literature, suggests the need for further exploration of the assets for health in urban communities, and the health promoting (and harming) ways communities are addressing the drivers raised earlier of social inequality in urban health. Such assets may include the peer-to-peer, informal support networks, the information sharing and connectedness gained through social media and other socially grounded approaches to promoting health.

Generally, the literature on urban health in ESA countries appears to chase, lag behind or miss the rapid, diverse and multifactorial changes taking place in urban areas.

Participatory approaches that include the direct voice of those experiencing urban life could help to address this gap, such as with adolescents in transition to adulthood from different parts of the city; different strata of market women; informal producers; recent migrants; or lodgers/ backyard dwellers. Many of these groups are not geographically circumscribed. They move through, are found in and interact in diverse ways with many parts of the city, and not just the poorest areas.

Holistic approaches to urban wellbeing

The search and review described earlier yielded evidence of various holistic paradigms for exploring urban health equity, particularly those that seek to overcome the fragmentation of determinants and sectoral inputs that influence health and that seek to advance health, rather than simply control disease.

Cities are major sites of expression of alternative visions of development. As noted in the annotated bibliography, they present within a small area extremes of inequality in wealth, resources and consumption and are sites of intensive flow of traded commodities and waste that generate challenges to public health, wellbeing and environments. They manifest a diversity of deficits in basic needs, imbalances between material, social and ecological wellbeing with widely differing experiences for different social groups.

This context seems to call for a more holistic vision of wellbeing. The UN Habitat refers to *'inclusive cities'*, to overcome structural segregations within development discourse, to overcome the separation of living spaces for rich and poor, close gaps in access to quality basic services, to provide space for all population groups to partake in urban social and cultural expressions, and to strengthen social inclusion in and social accountability of local government (Habitat undated, Habitat 2015).

Others challenge the development discourse further. Argentinian author Atilio Boron (2015) points to wider debates over development amongst some states and social movements. These debates have rejected a linear notion of development driven by technical imperatives, particularly given the significant structural asymmetries, social deficits and inequality in the global economy. They have sought to identify alternative relationships between society, economy and environment/nature to address universal rights and the strengthening of human capacities, to build a more harmonious relationship with nature, to balance the liberating qualities of work and leisure, to reconstruct the public sector and to build a democracy that is "representative, participative and deliberative in a democratic, pluralist and secular state" (Boron 2015, online).

Grassroots initiatives, resistance struggles, and movements for social transformation have in some settings integrated local knowledge and ways of thinking in taking up these debates.

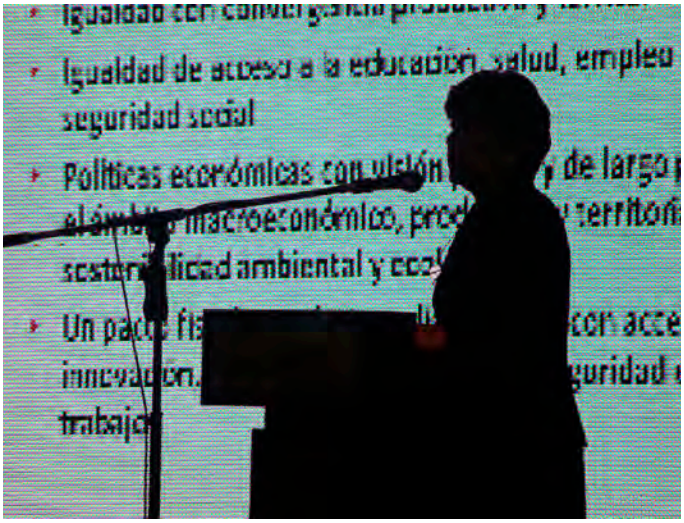
For example, the 'Ecological Swaraj' in India, expresses a link between local culture and a response to current challenges to build "a holistic vision of human wellbeing that encompasses physical, material, socio-cultural, intellectual, and spiritual dimensions"... and that..."... puts collectives and communities at the center of governance and the economy. Based on the twin fulcrums of ecological sustainability and human equity, the paradigm offers a systemic approach to social transformation, resting on political, economic, socio-cultural and ecological pillars..." (Kothari 2014 p1).

This thinking links alternative world views to a confrontation with key global challenges. It is reflected, for example, in linking principles of mutual care and reciprocity to environmental challenges, found in Eco-ubuntu (Tutu undated) and in Bhutan's focus on Gross National Happiness (GNH) as a national socio-economic goal (GNH Centre Bhutan 2016).

These paradigms that assess the development of a society through the complementarity and reinforcing interaction of its psychological, physical, spiritual and ecological wellbeing appear to more directly integrate equity as a principle. They envisage community vitality and wellbeing as something that "cannot exist while others suffer", that also comes from "living in harmony with nature, and realizing our innate wisdom..." (GNH Centre Bhutan 2016 online).

The 'Buen vivir' paradigm is a further holistic approach that explicitly seeks to challenge drivers of social deficits and inequality, and that has wide application, including at state and constitutional level. The term in Spanish can be translated as "living well," but has a wider distinctive meaning in Latin America. 'Buen vivir' is applied in several Latin American countries seeking to depart from "development alternatives" that provide only partial adjustments to major challenges to wellbeing. Drawing on contributions from indigenous cultures, social movements and political institutions and making linkages between multiple knowledge systems, it challenges the conceptual basis of development, its ways of understanding nature and society, its institutions, and its discursive defences (Gudynas 2011a, 2011b).

Buen Vivir critiques the equation of progress in contemporary development with economic growth, when this is at the cost of intense exploitation of nature and significant social inequality. It focuses on basic needs, wellbeing and quality of life (material, social and spiritual) of the individual and community, and beyond many social determinant approaches, integrates social rights of current and future generations, as a collective or common good and in a balance with nature. It introduces biocentrism, raising the importance not only of human beings, but of life as a whole, in which a citizen not only has rights, but also obligations and responsibilities. Material life is just one part of life and cannot just be reduced to the accumulation of things and objects. The paradigm in application thus seeks to transform production towards creating wellbeing, jobs and value added and to generate wealth in a manner that does not sacrifice the wealth of future generations, as for example is discussed in Ecuador (Perez 2014). Buen vivir provides no prescriptive formula and must be constructed for each historical, social and environmental context, positioning politics, rather than economics, at the centre of development strategies.



These paradigms suggest changing the question somewhat in addressing urban health equity.

Asking the question as "what are the determinants of health in urban areas (and how can the health sector intervene on them)?" implies a linear, deterministic focus, placing health as a singular consequence of segmented economic and other determinants that have their own competing goals and outcomes.

More holistic paradigms, such as those outlined here, may lead one rather to ask the diverse urban people in focus:

How do you perceive your wellbeing?
What balance between material, economic, social, spiritual elements and your natural environments would produce wellbeing for your community, at the widest social level, and for both current and future generations?
What community assets exist for this?

Within this the health sector may be able to see how to share its own role in relation to others.

Further, given that alternatives may be emerging more from local innovation than 'top down' practice in some settings, particularly those that make people more aware of and confident in their capacity to produce change, the question may be asked:

What can we learn from local innovations within urban areas that point to approaches for achieving wellbeing?

Apply a wellbeing lens to urban health in ESA countries

The dimensions of a more holistic framework and the questions above provide entry points for further exploring and responding to urban health equity in ESA countries, including through the lived experience and perceptions of different urban social groups of their wellbeing and of how to improve it.

The evidence presented in this brief clearly indicates that closing inequalities in health in urban areas cannot be a task solely for the health sector. A more holistic wellbeing framework offers the opportunity to engage all sectors that play a role. With its focus on the complementarity and reinforcing interaction of different dimensions of wellbeing, it may also more directly integrate equity as a principle. In so doing it may point to entry points and measures for a more solidarity driven, city wide and cross sectoral approach to promoting urban health equity.

The findings from the literature on health inequalities in ESA countries and on these multiple dimensions of wellbeing suggest a range of possible areas and conditions that have relevance to urban wellbeing and within which to explore health promoting practice in the region, including:

1: Urban ecosystems - Green and natural environment – including

- recreational and public spaces;
- waste recycling, circular metabolism (recycling waste back into productive use) safe water and sanitation;
- urban design, spatial planning, use of urban space and overcoming structural segregation;
- resources and roles of local authority, community, commerce, professionals.

2: Urban economy, income security and employment - including:

- access to modern technology, inclusive innovation;
- production and marketing activities and chains;
- urban agriculture, community gardens, land zoning, waste water treatment and use, food security;
- control of harmful exposures and risk environments;
- employment in the creative economy;
- valuing young people's time and input.

3: Urban living and community conditions - including:

- recognition of citizenship and rights of residency of social groups;
- housing and shelter, and 'regeneration';
- access to health services, including community health workers;
- access to schools and support for return to school in dropouts;
- forms, accessibility and safety of transport and physical activity;
- control of harmful foods, control/harm reduction for tobacco, drugs, alcohol.

4: Urban socio-political systems and conditions - including:

- social and cultural integration, inclusion, active citizenship;
- rural, cross border connections;
- control of violence and of risk of sexual abuse;
- autonomy in sexual/reproductive roles;
- balance of individual and social interests, roles;
- Information, IT and social media;
- Inclusion in local decision making.

This list is indicative.

The next briefs in this series present the findings from subsequent work on how these and other areas are reflected in quantitative indicators of wellbeing in ESA countries, how they are perceived by diverse social groups of youth in the capital city of one ESA country, and what innovations are being applied in cities to generate the synergies between social, economic and ecological wellbeing implied by these more holistic, equity focused approaches.

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