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Struggling for Health in the City

An anthropological inquiry of health, vulnerability and resilience in Dar es Salaam, Tanzania

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Introduction

Staying healthy in Dar es Salaam is a daily struggle. Like many other cities in developing countries,[1] the *de facto* capital of Tanzania has rapidly grown over the past decades. This urban growth, however, was not accompanied by economic growth. On the contrary, the country went through a deep economic crisis in the 1980s, followed by a Structural Adjustment Program in the 1990s, initiating rapid economic and political reforms. Rural poverty has driven people to the city and keeps them there, although most of them can barely earn a livelihood. What does health mean for people living under such conditions, and what do they do to maintain it? These questions form the core of this study.

Urban health research

Urban health problems are, of course, neither new nor restricted to Dar es Salaam. In the 1980s, a growing number of researchers working in cities of developing countries became concerned about the combined impact of the worldwide economic recession and rapid urban growth on people's health (Harpham et al. 1988, Salem and Jeannée 1989, Tabibzadeh et al. 1989). They have shown that these developments have outstripped the capacity of city

1 Throughout this text we use the somewhat old-fashioned term "developing country" as a convenient abbreviation. We prefer it to other terms like the Third World or the South, although we are aware that each of these terms has its deficiencies.

administrations and led to a veritable crisis in many cities (WHO 1993). This crisis manifested itself in a fall of living standards, a deterioration in both the quality and quantity of services and a decline of the quality of the built and natural environment (UNCHS 1996: 89), also in African cities like Dar es Salaam (Stren and White 1989).

The proportion of urban dwellers has steadily increased from 30 percent in 1950 to 47 percent in 2000 and will probably reach 60 percent in 2030 (UN 2004). If this growth rate continues, there will be as many city dwellers in the world as people living in rural areas by 2007. More than two thirds of the world's urban population live in cities of developing countries.

Urbanization does not necessarily pose a threat to health, as the experience in many cities of rich countries shows. If, however, rapid urban growth combines with economic decline and mismanagement, city administrations are no longer able to protect city dwellers from natural and man-made hazards, including negative effects of globalization (Satterthwaite 1993, Harpham and Tanner 1995, Atkinson et al. 1996, GTZ 2001, Harpham and Molyneux 2001, McGranahan et al. 2001). What we observe today is, in fact, an "urbanization of poverty" (UN-Habitat 2003a).

Epidemiological approaches

The theory and methodology of classic social epidemiology have guided most research on urban health. Investigators relied on quantitative methods to describe the extent, nature and distribution of health problems in urban populations and to measure the health impact of various factors. Priority areas were the often great health differentials within and across cities, the synergy of risks, the double burden of infectious and non-communicable disease due to a more general epidemiological, health or risk

transition[2], and health problems related to difficulties in the delivery or utilization of health care and social services. Over the past decade, knowledge on urban health problems, especially in the four priority areas just mentioned, has greatly increased, and urban health has been put on the agenda of multilateral, bilateral and non-governmental organizations working in international health and development (Milbert et al. 1999). The Sustainable Cities Program of the United Nations Development Program and the Healthy Cities Program of the World Health Organization, for instance, have a strong focus on health (Harpham 1996, Pugh 1996, Werna et al. 1998), and both of them have become active in Dar es Salaam.

To highlight key issues in urban health research, we give a brief summary of a multi-country study carried out in Ghana, Indonesia and Brazil, more precisely in the cities of Accra, Jakarta and São Paulo (Songsore and McGranahan 1993, McGranahan and Songsore 1996, McGranahan et al. 1996). The aim of this study was to examine health differentials within and across these cities with a particular focus on the impact of environmental factors on diarrhea and acute respiratory infection in young children. Its findings document that conditions are worst in Accra, the smallest and poorest of the cities surveyed, and best in São Paulo, the largest and wealthiest. This means that the environment of a smaller city may be just as unhealthy as that of a mega-city, if inadequate household water supplies, bad sanitation, insect infestation, indoor air pollution and local accumulation of solid waste are common (McGranahan and Songsore 1996: 137).

2 The term "epidemiological transition" was originally defined by Omran (1971) to refer to the phenomenon of shifts in the relative importance of different diseases, basically a shift from infectious and parasitic diseases through receding pandemic and towards chronic, degenerative and man-made diseases. In developing countries and their cities, this health transition is delayed (Philipps 1993), especially among the poor (Heuveline et al. 2002). Recent reports promote the closely related concept of risk transition (WHO 2002).

Not surprisingly, the situation was found to be worst in poor neighborhoods of all three cities where centralized household services such as piped water, sewerage connections, electricity and door-to-door garbage collection hardly exist (McGranahan et al. 1996: 124). In these poor neighborhoods, local environmental problems are not only more severe, they also tend to reinforce each other to create a complex of interrelated environmental hazards. The synergy of risks increases, if members of different households have to share water sources, sanitary facilities and waste disposal services.

Even within poor neighborhoods, differences in environmental and health conditions have been established. In Accra, for instance, where the majority of the population is poor, if measured against international standards, and economic contrasts are muted, the study identified extremely diverse household conditions in terms of environment and ill-health (McGranahan and Songsore 1996: 148). In households with no or only one of the risk factors assessed by the study, the prevalence of diarrhea was also nil. As the number of risk factors increased, so did the prevalence of diarrhea. The same trend has been found for acute respiratory disease.

A crucial insight of the study is that more affluent households were able to shift both the intellectual and practical burden of environmental management to the government or a private service provider (McGranahan et al. 1996: 123–124). It can be inferred, in other words, that poor households have to carry a heavier burden in terms of environmental management than affluent households. They have to find their own solutions in terms of getting water, emptying septic tanks and disposing garbage, and this is not only a practical but also an intellectual challenge.

Many more studies could, of course, be cited, but this example is particularly suited to provide a background against which we can outline the theoretical approach of our study. Up to now, most urban health research has been informed by a view of health defined by experts and has concentrated on conceptual links between health, urban environment and poverty, conceptual links which were created by the theory and logic of the researcher. What health means to people who live in a particular locality, what links they create between health and other aspects of their reality, and what they do in their daily life to stay healthy are topics which have not yet been sufficiently examined in this literature. We do not simply refer to a distinction between "etic" and "emic" positions popular in the anthropology of the 1970s. At the centre of our analytical interest are individual persons as social actors who interpret experiences of everyday life and thereby construct and reconstruct meanings and values in interactions with others, and in particular social and cultural contexts (Hannerz 1992).

Our approach is guided by the theory and methodology of anthropology which, above all, seek to gain a better understanding of people and the meaningful world they create in different social, environmental and historical contexts. Drawing on the work of Michel Foucault (1963), Pierre Bourdieu (1977) and Anthony Giddens (1984) and their concepts of "agency" and "practice", we go beyond social constructivism and integrate a view of people as individual subjects and social actors with an analysis of cultural phenomena, social conditions and structural constraints. Such an approach, we argue, is particularly useful for the study of health and illness in heterogeneous and rapidly changing urban settings, where structural conditions force people to find their own ways of sustaining and restoring health. In an era of globalization, and especially in localities constrained by poverty, people have to use their reflective capacities as they con-

front new situations, contingencies, and uncertainties that interrupt the daily routine. We thus use a perspective that is resource- rather than deficit-oriented, not because of a calculated optimism, but in order to open a space for the consideration of people as actors, not victims, who shape their lives even under difficult circumstances.

In the field of urban health research, the need for such an approach has become increasingly recognized, particularly due to difficulties encountered in interventions. Tanner and Harpham (1995: 216), for instance, point out that technical solutions and standardized intervention packages alone cannot alleviate health problems. In fact, the best technological solutions help little, if they do not reach or are not accepted by the people and do not build on their resources. For this reason, Rapid Assessment Procedures[3] and Participatory Approaches[4] have become rather popular.

Following up on the multi-country study outlined above, researchers in Accra, for instance, used rapid assessment methodology to develop "proxy" indicators for routine monitoring of the environmental health situation in different neighborhoods (Songsore et al. 1998). In addition, the research team employed a combination of qualitative and quantitative methods to investigate the gender division of labor in and around the home and to assess gender and age differentials in environmental risks and resulting health effects (Songsore and McGranahan 1998). The

3 Rapid Assessment Procedures have been developed in order to make anthropological methods more useful for health research (see e.g. Manderson and Aaby 1992, Vlassoff and Tanner 1992, Obrist van Eeuwijk 1996). Among the first to provide guidelines for rapid appraisal in urban health research were Annett and Rifkin (1988).

4 Several books and papers discuss main issues and experiences in applying participatory approaches to health research (Vlassoff and Tanner 1992, Koning 1994, Koning and Martin 1996), urban studies (Mitlin and Thompson 1995) and urban health research (Guène et al. 1999, N'Diaye 1999, Odermatt et al. 1999).

findings of the qualitative component in the latter study indicate that male household heads are the key decision-makers in terms of allocation of resources to support environmental improvement, while women bear the burden of environmental management within the home. This creates tensions in the home which are further exacerbated by changes in the economic context resulting in a redefinition of gender relations. Moreover, the study found that the household is a socio-spatial construct of considerable importance in everyday environmental management, and so are networks of solidarity and other social and economic exchanges beyond the household.

The findings of this and of similar studies document that qualitative research brings to light the complex cultural, social and economic processes involved in environmental management essential for health on the household level. Based on such evidence, Harpham (1996: 5) suggests that future research should provide more insights into the social aspects of daily life and the experience of health and ill-health in the city, and Atkinson (1996) calls for an incorporation of "people-centered", "meaning-centered" and "power-centered approaches". What we need is a better understanding of the inner working of urban communities (Harpham and Molyneux 2001: 131).

The approach presented in our study claims middle ground between positivist and participatory epistemological stances (Obrist et al. 2003a). It is firmly grounded in ethnographic research in Dar es Salaam, an East African City in many ways similar to Accra in West Africa, and contributes to this innovative strand of urban health research. It develops an approach to study health practice with a focus on households, thus situating itself at the intersection of two major fields in the anthropology of complex societies: medical anthropology with its main concern for experiences, meanings and practices relating to health (Feierman and Janzen 1992, Good 1994, Nichter and Lock 2002) and urban anthropology with core interest in people's organization of daily life as individuals and members of households and social networks

(Sanjek 1990, Hannerz 1992, Gmelch and Zenner 1996). At the same time, our study draws on the somewhat disparate literatures of sociology, psychology, gender and development studies.

Overview of chapters

Chapter 1 argues that "health" on the household level is a fascinating new field for anthropological inquiry. Grounded in ethnographic field research as well as cultural and social theory, we combine approaches of medical anthropology and urban anthropology and link them with current debates in international health development. Health means different things to different people. We critically review various definitions and explain how we understand the concept in this study. Our focus is on health practice in everyday life, on social actors and moral subjects, who appropriate global meanings while facing the structural constraints of an African city. Emphasizing domestic health and vulnerability on the household level, we examine agency and resilience focusing on women from a gender perspective. We present our framework and outline, the study site and methodology.

The second chapter employs a historical perspective to identify the main forces shaping health risks and response options on the level of the city and the neighborhood. Particular attention is given to the urban health crisis of the 1980s and the fundamental political and economic reforms of the 1990s. We discuss the impact of the crisis and the reforms on the life of the city residents, abstract main features of urban social organization from previous research on survival strategies and fill gaps with new empirical data.

Chapter 3 narrows the focus on the household level and shifts attention from urban health risks to response options. It investigates health conceptions and their applications in everyday life

from the perspectives of middle-aged women who belong to the lower middle class of Dar es Salaam.

The next two chapters examine the social dimensions of responses to urban health risks, especially internal household dynamics and connections with wider social networks. A detailed analysis of a gendered division of responsibilities in health practices enables us to identify social experiences as well as individual agency as women search for socially acceptable decisions and courses of action. We also critically assess meanings of support and the significance of reciprocity in a context of changing gender and generational relations.

Chapter 6 centers on the interplay of urban risks and response options from the point of view of individual women. Applying the health practice framework introduced in the first chapter and bringing together the different strands of analysis and argument developed in the subsequent chapters we assess how women put response options to more or less effective use. This allows us to group women according to degrees of vulnerability and to take a closer look at the dynamics of vulnerability in concrete case studies.

In the final discussion, we highlight the contribution of this study to different strands of research and outline implications for policies and interventions. Our qualitative study of vulnerability to urban health risks in Dar es Salaam provides a close-up view of patterns and differentials in women's health practice as they struggle to reach at least minimal standards of health while confronted with environmental hazards, commoditization, social fragmentation and, above all, the specific contingencies and uncertainties characterizing "informal cities" in rapid change. In this sense our findings have high inner validity for this particular locality. Generalizations based on ethnographic studies are, of course, difficult but our main findings tie in well with recent and on-going studies on vulnerability and resilience to poverty in Dar es Salaam and Tanzania.