Most analyses of differentials and trends in health and mortality find the anticipated relationship between measured outcomes and a range of socio-economic status variables including education, income status of employment and wealth. Such analyses are generally national-level studies based on cross-sectional data – for most low income countries, DHS, MICS or similar sample household surveys (Rutstein 2000; Mahy 2003). Such sample-based analyses are unable to analyse local-level variations in health and mortality outcomes because of their limited sample sizes and the rarity of some events – deaths to adults aged 20-60 years old, for example.

Recent more intensive longitudinal studies are pointing to new inequalities in health and mortality outcomes that do not mirror the national- or population-level analyses (Garenne 2010). Many of the studies in the INDEPTH network highlight the importance of small-scale, inter-village variations and point to the often ambiguous association of the wealth variable, for example, with child and adult health outcomes (Binka, Nazzar et al. 1995). Even with this new richness from such studies, we have to realize that most INDEPTH sites are in rural areas with the exception of studies in South Africa and in the Nairobi slums.

From a multi-year longitudinal study of health and mortality in Accra called the Women’s Health Study of Accra (WHSA), we have been able to produce much finer grained analyses of health and mortality differentials within an urban area (Weeks, Hill et al. 2006; Douptcheva and Hill 2011). In this paper, we show several surprising results.

First, in some of the communities designated as ‘slums’ by UN Habitat, child mortality and adult morbidity are surprisingly good. Such areas, insanitary and chaotic as they may seem, are providing low cost accommodation for the residents. Using a range of strategies, the residents have found ways to protect themselves and their children despite the crowded and unclean living conditions. The socio-demographic profile of the population, shaped heavily by migration, modifies the risk profile even for those poorer than the mean for the whole neighbourhood (Fink, Weeks et al. 2012).

Secondly, the anticipated differentials in both self-reported and objectively measured dimensions of adult health are very narrow and often in the opposite direction anticipated in relation to socio-economic status. There are strong effects of age which seem to outweigh the impact of the SES variables (Darko, Adanu et al. 2012).
Thirdly, there is evidence of pronounced neighbourhood effects where even for those poorer than the mean for the whole neighbourhood, place of residence can mitigate some of the otherwise adverse health outcomes associated with poverty. There is in addition evidence of spatial clustering of similar kinds of health outcome independent of many of the individual and household-level characteristics even for those poorer than the mean for the whole neighbourhood (Weeks, Getis et al. 2010).

These empirical facts present a challenge to conventional theory on the determinants of health outcomes and premature mortality (Fotso, Madise et al. 2012). Clearly, migration and the strong selection processes associated with movement of individuals and households plays a very significant role. The role of individual agency emerges from the studies in striking ways. The effects of this aspect of behaviour are plainer in urban places where access to services is more uniform than in rural areas where distance and other problems of access play a more significant role in determining the pattern of health service use. The paper concludes with some discussion of the value of the Capability Approach as an improvement of the classically epidemiological approach to understanding health outcomes and differentials.

REFERENCES


