The Place of the Urban Poor in the Cairo Programme of Action and the Millennium Development Goals

Mark R. Montgomery

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Mark Montgomery is Professor of Economics, State University of New York at Stony Brook, and Senior Associate, Policy Research Division, Population Council. E-mail: mmontgomery@popcouncil.org In preparing this summary paper, I have drawn from material presented elsewhere in greater depth: Montgomery and Ezeh (2005a,b), Montgomery and Hewett (2004), and Panel on Urban Population Dynamics (2003).

1 Introduction

Over the next thirty years, the world's population is expected to grow by nearly one-third, but this growth will be highly concentrated in the urban areas of poor, developing countries (United Nations 2002). Of the anticipated 2 billion persons to be added to the world's total by the year 2030, fully 1.9 billion are expected to reside in the cities and towns of Africa, Asia, and Latin America. Rural population totals, by contrast, are likely to undergo little net change over the period and relatively small changes are also expected for the urban populations of rich countries. (See Figure 1.) This urban transformation is also evident in national percentages. Whereas in 1950 less than 20 percent of the population of poor countries lived in cities and towns, by 2030 the figure will likely have risen to nearly 60 percent. Within a few years, according to these forecasts, it will no longer be possible to speak of the developing world as if it were mainly composed of rural villages. As the urban transition unfolds in the coming decades, researchers and policy-makers concerned with poverty and reproductive health must increasingly set their concerns in urban contexts.

That poor countries are urbanizing has long been known. In its influential series *World Urbanization Prospects*, the United Nations Population Division has regularly issued updates of estimated urban population totals and percentages, and readjusted its urban projections in light of newly available data. Whatever the differences in details, this series of reports has consistently foreseen the arrival of an era in which developing countries become, for the first time, more urban than rural. At least twenty years of such reports were available to the framers of the1994 ICPD Programme of Action, the document which powerfully articulated the rationale and set out the guiding principles for an emphasis on poverty and reproductive health. But the Programme of Action was assembled without much by way of specific reference to the spatial contexts—whether urban or rural—that shape poverty, influence reproductive health risks, and determine access to services. The dimensions of emphasis in this document were rather those of gender, education, and (to a lesser degree) age; the intellectual argument it developed was couched largely in terms of the human rights and basic needs of all developing-country citizens irrespective of their places of residence.

Even so, upon close reading the Programme of Action can be seen to recognize and lay stress on a number of issues that, when taken in combination, provide ample justification for considering the influence of urban and rural contexts on reproductive health. HIV/AIDS and sexually transmitted disease figure among the Programme's central health concerns, and although these are by no means confined to urban areas, they are represented all too prominently in the urban profile of disease. Access to contraception and other reproductive health services is also a main

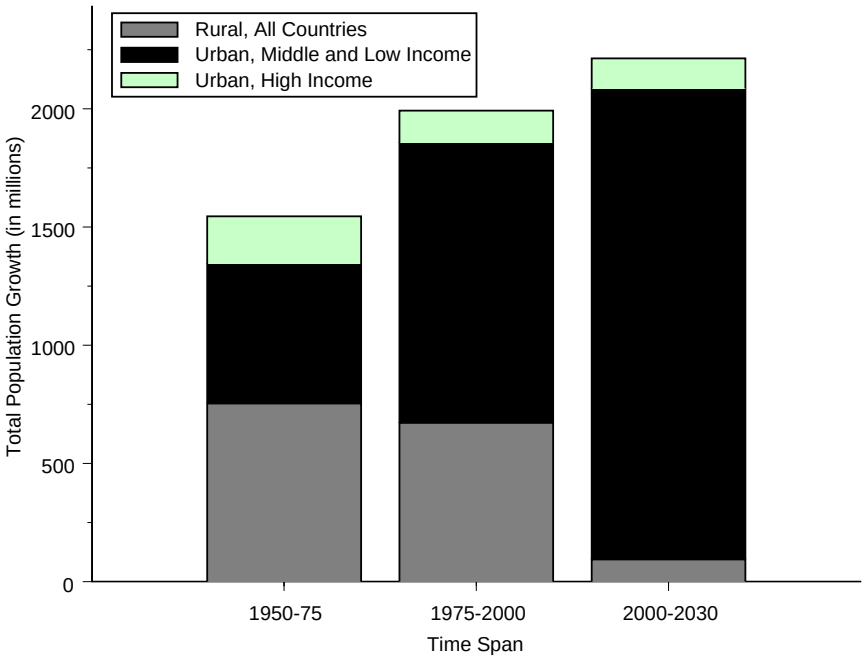


Figure 1 Estimated and projected world population growth 1950–2030, for all rural populations, developing-country urban population, and developed-country urban population. Source: United Nations (2002); Panel on Urban Population Dynamics (2003).

area of emphasis in the Programme of Action. It is now well understood that rural areas have often lacked adequate access to such services; less well-understood, however, is that poor urban residents may also lack the information and means necessary to secure effective access. The Programme of Action gives a great deal of attention to the roles of the private for-profit sector, non-governmental organizations, and civil society in the promotion of reproductive health and gender equity. These are of particular interest in the urban health care arena, which is populated by multiple types of service providers, with private providers generally more prominent among them than is the case in rural areas. Moreover, as the national governments of developing countries continue to decentralize their responsibilities in service delivery and revenue-raising to regional and municipal tiers of government—the scope and rapidity of the past decade's remarkable transformation of political economy were probably only dimly foreseen in 1994—the private and non-governmental providers are likely to assume an even greater role in urban health service provision. Finally, the centrality of poverty and inequality in

determining access to education and health, perhaps the fundamental theme of the Programme of Action, opens the door to an exploration of the full implications of urban poverty.

The Millennium Development agenda shares with the ICPD Programme a concern for poverty, education, and basic human needs; it is distinctive in, among other things, adopting a broader range of health and development concerns and is also distinctive in the degree to which targets and measures are quantified. The MDGs depart from the Cairo Programme in reserving a prominent place for the urban poor: the United Nations Millennium Declaration specifies, in Target 11, the ambition of achieving by 2020 "significant improvement in the lives of at least 100 million slum dwellers" under the broader goal of ensuring environmental sustainability.[1] According to the most recent estimates (UN-Habitat 2003), which are shown by region in Figure 2, there are some 870 million slum dwellers in the developing world, accounting for 43 percent of its urban residents. Set against this 870 million total, the ambitions of Target 11 would appear modest indeed, especially so in view of the substantial further population growth anticipated for urban areas. Nevertheless, because development agencies and researchers have long put their emphasis on rural poverty, Target 11 serves as a pointed reminder of the fact that poor people are also to be found in cities.

The way in which Target 11 has been phrased may tend to suggest that the terms "urban poor" and "slum-dwellers" are synonymous. Indeed, it is common for debates on urban poverty in the developing world to be framed wholly in terms of the living conditions of slum dwellers. But there is, as yet, surprisingly little knowledge of the relationship between urban poverty overall and the living standards of slum populations. It is not known, for example, what proportion of the developing-country urban poor live in slums, nor what proportion of slum dwellers can be counted as poor in terms of income and other socioeconomic criteria. UN-Habitat (2003: xxvi) draws attention to the socioeconomic diversity that marks many slum populations: "[S]lum dwellers are not a homogeneous population, and some people of reasonable income live within or on the edges of slum communities.... In many cities, there are more poor people outside the slums than within them." Although the Habitat report does not develop this point further, it places the issue of slum heterogeneity squarely on the research agenda.

Although UN-Habitat and its research partners are making steady progress, no consensus has yet been achieved on how "slums" are to be defined. The spatial concentration of poverty would seem to be an essential element of any slum defini-

[1] See www.un.org/millenniumgoals for further information on the Millennium Declaration and its associated goals, specific targets, and research programs. A number of the MDG targets refer to health issues that are of concern in urban areas, but make no explicit mention of urban health as a distinct area of interest.

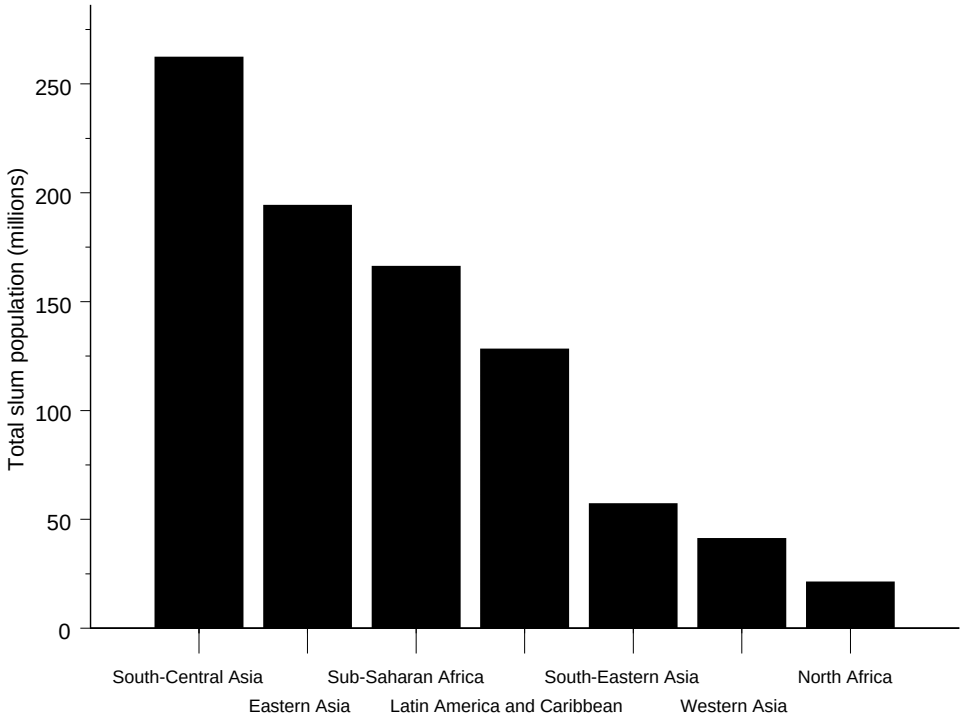


Figure 2 Estimated total populations living in slums, by region of the developing world. Source: UN-Habitat (2003)

tion, but current efforts at systematizing such definitions (UN-Habitat (2003) uses indicators of access to safe drinking water, adequate sanitation, electricity, and security of housing tenure) have been focused on households, and have not much examined the concentrations of poverty or affluence in the neighborhoods that surround households. In short, not enough research has yet been conducted in the cities of developing countries to identify with any confidence the health implications of spatially concentrated poverty and neighborhood disadvantage.

Section 2 of what follows will draw upon several recent reviews and research reports to document the empirical associations between urban poverty and health. (Unfortunately, in this brief note I can do no more than introduce the issues and give a general sketch of magnitudes.) The distinction between household and neighborhood poverty cannot be explored in depth with existing studies, but I will present suggestive evidence that may serve to spark interest in more thorough analyses.

With some of the urban health differentials by poverty having been documented, Section 3, which draws from the recent U.S. National Academy of Sci-

ences report (Panel on Urban Population Dynamics 2003), then outlines several dimensions in which urban contexts differ from rural in terms of reproductive health programs and service delivery. It is remarkable how little research attention has been paid to the specifically urban aspects of reproductive health programs. The problem is not that these programs are mainly rural; especially in the areas of sexually transmitted diseases (STDs) and HIV/AIDS, many programs are situated in cities and address health issues that are of special concern to urban populations. Rather, the problem is that the conceptual frameworks that inform program design and evaluation do not appear to have been thoroughly appraised from an urban perspective. The service providers who work in cities may well be attentive to urban possibilities and constraints, but the research literature has conspicuously failed to provide them with concepts and guidelines tailored to their environments.

2 Urban poverty and health: A quantitative sketch

On average, as the Panel on Urban Population Dynamics (2003) has shown, city populations in developing countries exhibit lower levels of child mortality than are found in rural populations, and similar urban–rural differences are evident across a range of health indicators. But urban averages can obscure striking within-city differentials in health—the urban poor often face health risks that are nearly as bad as those seen in the countryside, and sometimes the risks are decidedly worse. Figure 3 illustrates this. In the slums of Nairobi, rates of child mortality substantially exceed those found elsewhere in the city; they are high enough even to exceed rural Kenyan mortality. If urban populations do have an advantage in health relative to rural populations, then it seems that this advantage must be very unequally shared.

Of course, such urban disadvantages were once widely apparent in the West—in the nineteenth century, it was not uncommon for mortality rates in urban slums to far exceed those of the countryside. Confining attention to the portions of Figure 3 that refer to urban Kenya, we recognize significant differences in health *within* the urban population. These intra-urban inequities have received curiously little attention from demographic researchers, but of course they will be taking on greater weight in all poverty calculations as developing countries continue to urbanize. Because the Nairobi slum populations of Figure 3 exhibit the poorest health in urban Kenya, there is a suggestion that the spatial concentration of poverty found in these slums must apply health penalties beyond those applied by household poverty alone. But the figure does not distinguish poor households living in slums from poor households living elsewhere, and it can give no clear testimony as to the effects of spatially concentrated poverty.

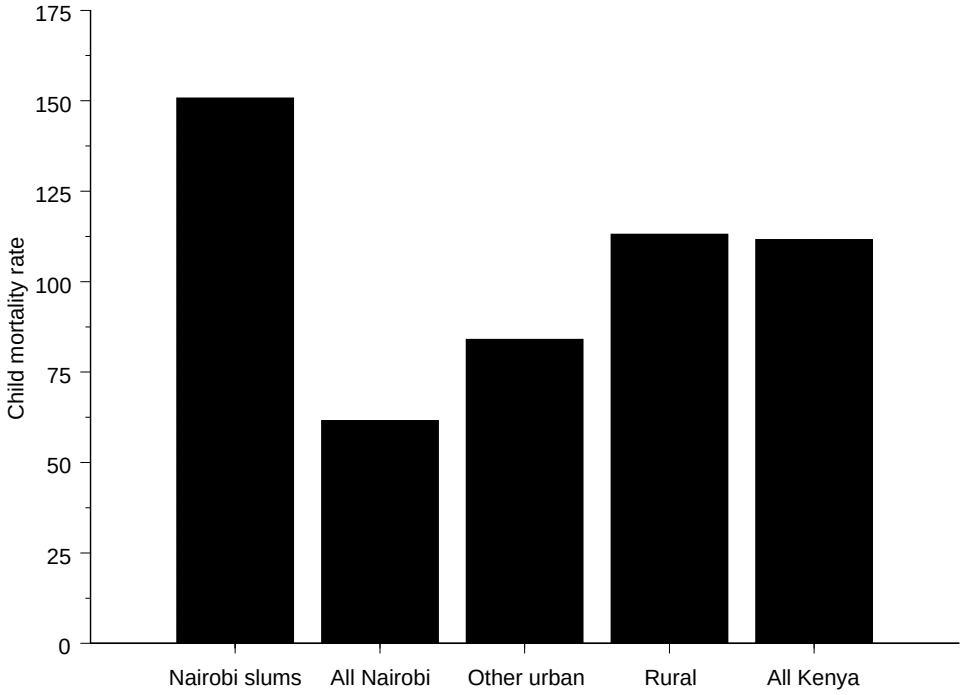


Figure 3 Comparison of child mortality rates ($_5q_0$) in the Nairobi slums sample with rates for Nairobi, other cities, rural areas, and Kenya. Source: African Population and Health Research Center (2002).

There is enough here, however, to indicate that urban averages may mask significant differentials in health that exist within diverse urban populations, and may thus obscure the health penalties facing the urban poor and the double penalty that (we conjecture) faces those urban poor who live in neighborhoods of concentrated disadvantage. In the sub-sections that follow, we will document poverty-related health differentials in several important areas of urban reproductive health. In one of these—having to do with birth attendance—we are able to separate the influence of household poverty from that of neighborhood poverty, and will show that both types of poverty are likely to make a difference to the reproductive health of urban residents.

Unmet needs for contraception

An unmet need for contraception is said to exist when a woman in a sexual union (and at risk of conception) says that she would prefer to have no more children, or

none soon, yet does not use modern contraception to bring these desires into effect. In the Cairo Programme, the level of unmet need is presented as a key indicator of reproductive health overall (see United Nations (1999: paragraph 58)).

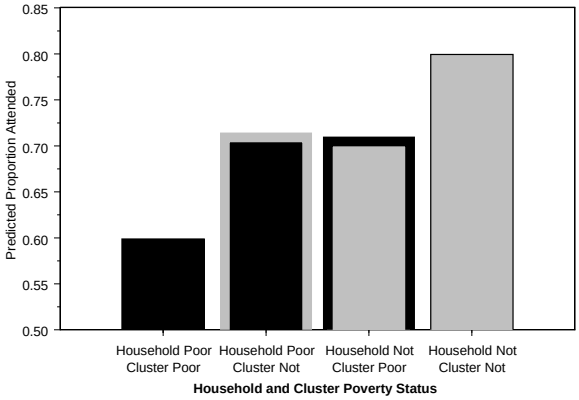
Unmet needs are often interpreted as evidence of lack of access to family planning services of acceptable quality. However, it is also recognized that other family decision-makers (e.g., the husband or partner) may not share the woman's desires for birth spacing or limitation, and that this divergence of views may be responsible for the apparent unmet need. Little research has examined urban–rural differences in unmet need. If urban women enjoy easier access to contraceptive services, as is often alleged, one would expect this advantage to be manifested in lower levels of urban unmet need. But urban women will also tend to have a greater demand for birth limitation, and in principle this could cause urban levels of unmet need to be higher than rural.

Table 1 provides evidence on this score from a large set of Demographic and Health Surveys, in which urban women are divided into those who are relatively poor (as indicated by a score on a socioeconomic index) and other women. As can be seen in the table, rural levels of unmet need tend to be higher than urban levels, though the differences are not always large. The urban (relative) poor have, in their turn, higher levels of unmet need than do other urban women. Montgomery and Hewett (2004) have re-analyzed levels of unmet need for the urban sub-samples of these DHS surveys, and the results (reported in Table 1) show that relative poverty is an important influence on urban unmet need.

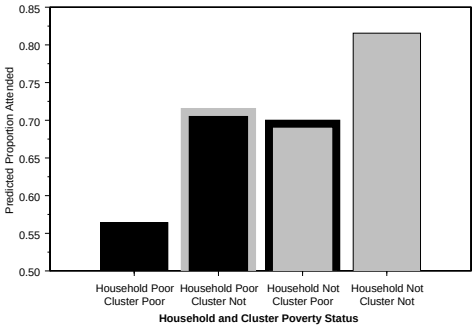
Birth attendance

The Cairo Programme and the MDGs stress the importance of reducing maternal mortality, singling out the need to ensure that women are assisted by skilled personnel at the time of labor and childbirth. (See United Nations [1999: paragraph 64] for the Cairo Programme.) The urban–rural differences in birth attendance are striking; but equally striking are the differences *within* urban areas by poverty status. These differences are summarized in Table 2, taken from Panel on Urban Population Dynamics (2003), and in Figure 4, which shows the effects of both household and neighborhood poverty on the likelihood of birth attendance for urban women.

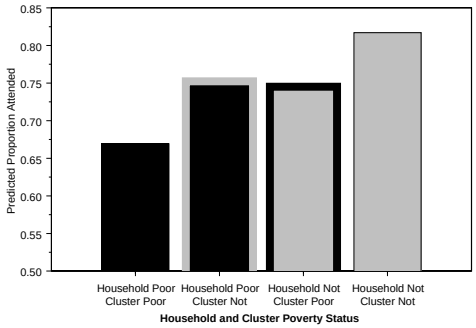
Figure 4 summarizes the results for all Demographic and Health surveys in this analysis (Figure 4a) and separately for the sub-Saharan and Latin American surveys. The bars in the figure represent probabilities of birth attendance for poor urban women in poor sampling clusters (a proxy for neighborhood), nonpoor women in these poor clusters, and similarly for poor and nonpoor women in the nonpoor clusters. As can be seen, the least-protected women reside in poor households in



(a) All surveys with household and cluster factors significant ($n = 38$).



(b) Sub-Saharan Africa surveys ($n = 13$).



(c) Latin American surveys ($n = 11$).

Figure 4 Predicted proportion of births attended, by household and cluster poverty. Results for surveys in which both household and cluster factor scores are significant. Source: Montgomery and Hewett (2004)

poor clusters, and the best-protected are the women in non-poor households in non-poor clusters. But poor women in non-poor clusters are about as well protected (in terms of birth attendance) as the non-poor women in poor clusters. It seems that there may be social or medical resources accessible in the better-off urban clusters that offer substantial benefits to poor households.

Maternal mortality

Maternal mortality risks provide an especially revealing perspective on urban reproductive health. Because it is difficult to predict whether life-threatening problems will emerge in the course of a woman's pregnancy, delivery, and the aftermath, maternal mortality risks depend crucially upon having fast access to emergency care. It might be thought that cities, which offer many more transport options than do rural areas, would exhibit much lower levels of maternal mortality. The cases in which the expected urban advantage does not emerge are therefore instructive about the circumstances of the urban poor.

Fikree et al. (1997) compared maternal mortality rates in the low-income communities of Karachi with rates in six rural districts elsewhere in Pakistan. Estimates of maternal mortality ratios (MMRs), together with their confidence bands, are shown in Figure 5. Although the MMR estimate for the Karachi slums is the lowest among all these sites, the rural estimates are significantly higher than Karachi's only for the remote districts of Loralai and Khuzdar. It appears that Karachi's slum-dwellers suffer from maternal health disadvantages not unlike those that afflict Pakistan's rural dwellers.

Why did the urban health advantage not prove greater in this case? In the poor communities of Karachi, some 68 percent of births are delivered at home, and 59 percent are attended by traditional birth attendants (TBAs). Yet rural women are even more likely to deliver at home and to have family members or TBAs in attendance. Another study of Karachi slums (Fikree et al. 1994) identifies the core of the problem: When acute pregnancy and delivery complications arise in these slums, there can be critical delays in locating male decision makers and obtaining their consent to hospital care. Much as in rural Pakistan, it has not been customary in these slum communities for husbands or other men to be present at the time of childbirth. Delays in initiating the search for care are compounded by the tendency for poor Karachi families to pursue local care first, going from place to place in the neighborhood before making an effort to reach the modern health facilities located outside the neighborhood. Fikree et al. (2004) illustrates these care-seeking patterns in a study of postpartum morbidities in the Karachi slums.

Mayank et al. (2001), who studied poor urban women in a New Delhi slum, found that women and their families possess strikingly little information about the

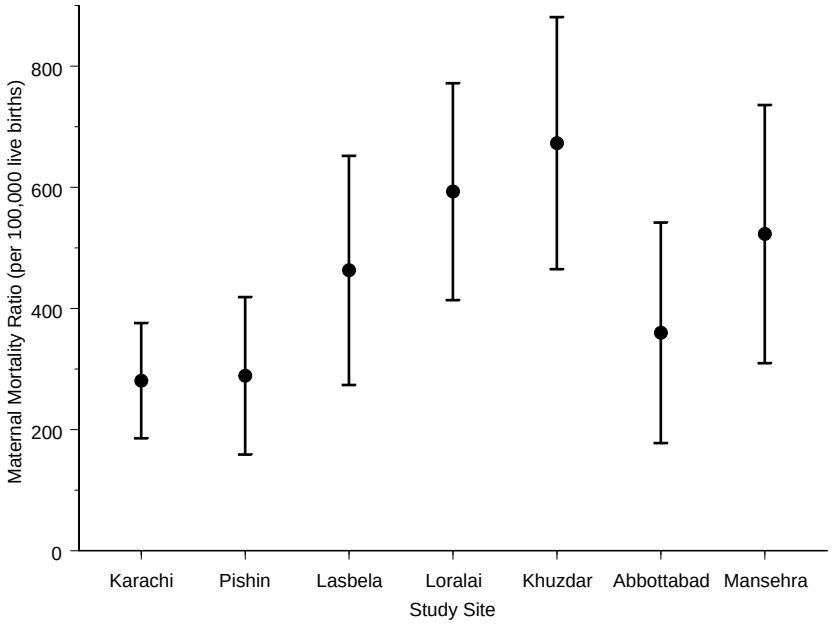


Figure 5 Maternal mortality ratios in the Karachi slums and six rural sites in Pakistan. Source: Fikree et al. (1997).

risks of pregnancy and birth, and on their part, local antenatal clinics do little to fill the gap. The maternal mortality rate in this urban sample was estimated at 645 deaths per 100,000, a rate not much different from that prevailing in rural India. A number of pregnant urban women suffered from potentially serious ailments—over two-thirds were clinically diagnosed as anemic, and 12 percent were found to be seriously anemic. Yet relatively few women understood that high fevers and swelling of the face, hands, or feet might be symptoms of conditions that could endanger their pregnancy. In this urban community, antenatal care is provided free of charge in the local health clinic, and the vast majority of women made use of this care. However, the quality of the care the women received is grossly inadequate; for example, fewer than 10 percent of women attending the local clinic were given any advice about the danger signs of pregnancy.

HIV/AIDS

An enormous body of literature is now available on the social epidemiology of HIV/AIDS in both developing and developed countries. Even in the early years of the epidemic, researchers recognized the social factors involved in the spread of the virus, and emphasized the importance of social and sexual networks in shaping its transmission dynamics (Morris 1993). Friedman and Aral (2001) give a succinct and valuable introduction to the use of social network concepts and methods in the study of HIV/AIDS, other sexually-transmitted diseases, and their linkages to networks of drug users and similarly high-risk behavioral groups.

Despite the quantities of research underway on HIV/AIDS, much remains to be learned about its social components. Indeed, although HIV/AIDS is commonly thought to be more prevalent in urban than rural areas, the scientific basis for this belief is surprisingly thin (UNAIDS 2004: 31). As noted by UNAIDS, in only a few developing countries are community-based studies of prevalence available that can quantify the urban–rural differences.[2] Figure 6 presents recent findings from several nationally representative community-based studies in which prevalence is estimated from blood samples taken in connection with household-level demographic surveys. In these three cases—Mali, Kenya, and Zambia—urban prevalence rates are clearly much higher than rural rates. Where HIV/AIDS is concerned, therefore, one sees little evidence of the "urban advantage" that is expected in other domains of health, and as the epidemic proceeds in southern Africa, and begins to affect large populations in India and China, an erosion of urban health advantages in these countries may also begin to take place. However, circular and urban-to-rural migration is a factor that is contributing to the spread of disease in rural areas (UNAIDS 2004: 33), and many observers foresee an upcoming era of rising rural incidence and prevalence.

[2]Country profiles are available at http://www.census.gov/ipc/www/hivaidsn.html, but these profiles are worked up from the reports of selected clinics and various sentinel sites, which do not necessarily yield statistically representative portraits for urban or rural populations.

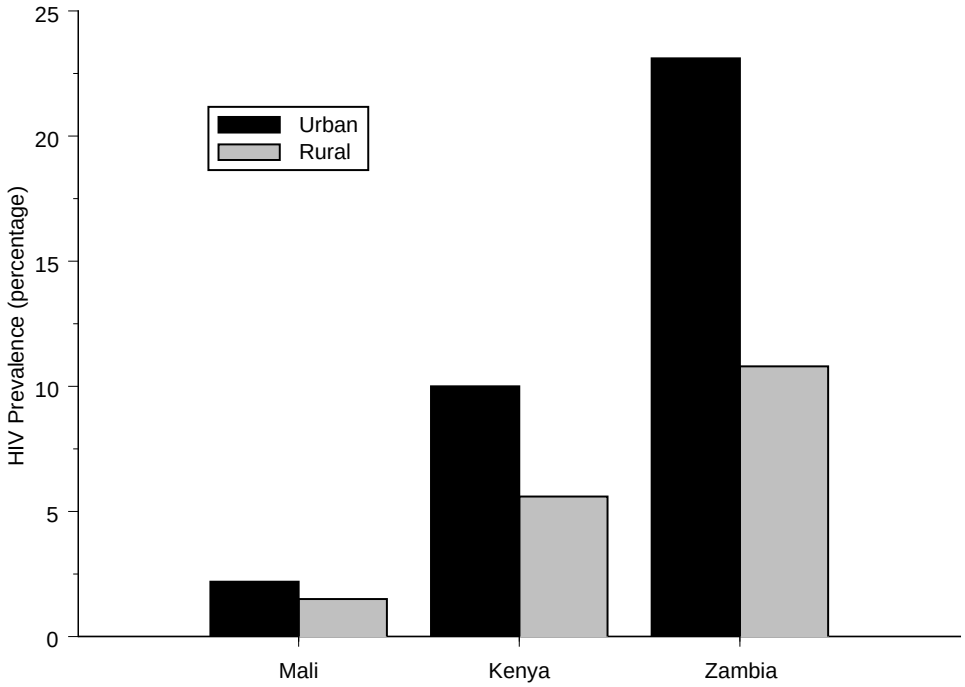


Figure 6 Estimates of urban and rural prevalence of HIV from the Demographic and Health Surveys: Mali, 2001; Kenya, 2003; and Zambia, 2001–2002. Sources: Mali Ministère de la Santé (2002); Kenya Central Bureau of Statistics (2003); Zambia Central Statistical Office (2003).

3 The Urban Program and Services Environment

We close this note with a brief outline of key urban–rural differences in health programs and service delivery. The services and reproductive health programs found in cities offer some resources that can be of use in spacing and limiting births, other resources meant to ensure safe conditions at delivery and swift assistance should complications arise, and still others that provide protection against sexually transmitted and related diseases. Rural areas also have services and programs of this general kind. What, then, are the important urban–rural differences in the program environment?

Many of the studies that touch on these issues are found in what might be called a "gray literature," that is, in project reports and memoranda. These materials must reflect a great deal of specific expertise and experience in reproductive health that could be drawn upon in a comprehensive review. To date, however, researchers have not collated and organized this knowledge in a way that distills its lessons for program design, service delivery, and evaluation. The National Academy study (Panel on Urban Population Dynamics 2003) identified seven distinctive features of urban service environments that deserve further consideration.

First, the diverse composition of cities and the absence of certain social controls on behavior that are exercised in rural villages may raise the profile of some reproductive health problems. Urban sexual networks, the role of prostitution, subpopulations of drug users, and communities of migrants separated from their families all can increase the risks of STDs and HIV/AIDS. In city life, adolescents can elude the watchful eyes and discipline of family elders and neighbors and find themselves at risk of violence, pregnancy, and disease. Urban socioeconomic composition is also expressed in the levels of demand for preventive services, such as contraception, and at least on average, city residents have greater abilities to pay for preventive and curative care.

Second, as noted earlier, many countries are undertaking ambitious programs of governmental decentralization, and these political reforms are introducing new municipal, state, and regional units of government (Panel on Urban Population Dynamics 2003). In the era before these reforms were initiated, responsibility for the delivery of family planning and reproductive health services generally rested with national ministries, which held the requisite funds and technical expertise. Decentralization has introduced many uncertainties. As vertically organized delivery systems give way to more complex forms involving multiple units of government, what becomes of the expertise and funds previously concentrated in the national ministries? Are national staff relocated and reassigned, or are municipal and regional units of government asked to acquire their own staff to oversee service delivery (Aitken 1999)? What sorts of transfers from upper to lower tiers of

government will sustain the reproductive health care system? How is information about health to be returned from the local to the national level to guide resource allocation?

These would appear to be highly complex matters, and it is surprising that they have attracted relatively little research attention to date. Scattered case studies are available—interesting recent results for the Philippines are discussed in Schwartz et al. (2000, 2002)—but nothing akin to a comprehensive review has been published. Of course, decentralization is still new, and it is often difficult to distinguish between the reforms being proposed and those actually being implemented. In principle, at least, the developments at the municipal and local levels might generate opportunities for local governments to engage indirectly in service delivery through monitoring and contractual relationships with the local private sector and nongovernmental organizations.

Third, as noted earlier, the private sector is a distinctive and prominent presence in urban reproductive health, and indeed, in urban health care more generally. The urban private sector is highly heterogeneous, offering an array of expertise that ranges from traditional healers to chemist shops to highly trained surgeons. Fee-for-service arrangements take on greater importance in the private sector, and service pricing raises questions of equity and ability to pay.[3] In some countries, private providers interact with their clients through health insurance mechanisms, especially when patients are in the employ of the public-sector or "formal-sector" private firms. Rural areas generally lack the scale, diversified economies, and concentrations of resources needed to support much private-sector activity in health. Some drugs and supplies can be purchased in rural markets, and traditional forms of health care are much in evidence, but on the whole it is the public sector that must provide rural villages with modern forms of care.

Fourth, the question of access to services takes on a different cast in urban areas. As was seen in the discussion of maternal mortality, in urban settings, it is inadequate—and potentially misleading—to conceive of access as being measured by the physical distance to services. The greater density and variety of urban transport can greatly reduce the time it takes to reach services by comparison with access time in rural areas. Much less time is likely required to locate emergency care, such as that needed in cases of hemorrhage and other complications of childbirth, than is the case in most villages. However, time costs can still loom large in discouraging preventive and nonemergency forms of care. These costs should not be underestimated, particularly when services are located far from main transport routes and the clusters of residence and employment for the urban poor. Moreover,

[3] Public-sector services, even if ostensibly free, often require patients to pay for drugs and supplies or to make side payments.

delays in obtaining care are not just a matter of time and transport. In poor city neighborhoods, as we have seen for Karachi and New Delhi, there can be as little knowledge of reproductive health as in remote rural villages. In both settings, delays in seeking health care can arise from the need to consult with men and family elders and obtain from them the funds needed to purchase care.

Fifth, the quality aspect of service delivery merits comment. It is a common assumption that urban reproductive health services are of higher quality than rural services. Careful comparisons have not always supported this view. Some aspects of quality have been found to differ—for instance, urban clinics are more likely than their rural counterparts to have electricity—but in terms of the interactions between staff and clients, the information exchanged, and the availability of essential supplies, the situations of urban and rural clinics can be much the same.

Sixth, the roles that may be played in service delivery by communities and community organizations no doubt differ a great deal between cities and rural villages. Urban neighborhoods can be defined according to social criteria, involving notions of belonging, inclusion, and exclusion that may be difficult for outsiders to discern. The social capital of urban communities—the matrix of formal and informal associations that can provide support, information, and a means of linking individuals to services—would also appear to have a distinctive character. Some service delivery systems that were developed for rural populations, such as community-based distribution networks, may need to be substantially adapted to serve urban populations (Tsui et al. 1997).

Strategies for communicating about reproductive health that work well in rural villages may also need to be adjusted to the circumstances of urban life. Cities are characterized by a diversity and multiplicity of information. In large cities, information emanates from so many sources that a potential user of contraception may well find herself overwhelmed and unable to discern the quality of any single source. Individuals may have to rely on their social networks and local associations for guidance to services. The localized networks of the urban poor may not offer them many leads, and the poor may not learn of new reproductive health services and initiatives unless special efforts are made to reach them.

Seventh, urban–rural differences in the costs of service provision need to be considered (Tsui et al. 1997). Presumably the spatial concentration of urban residents would have the effect of reducing the per-unit costs of some types of service provision (such as the supply of clean water), although economies of scale and scope in provision of health information and the supply of health care do not appear to have been documented. Other cost factors may also favor urban areas. It is difficult to persuade highly skilled health personnel to locate in remote rural villages absent a substantial wage premium. Professionals with school-age children are generally reluctant to sacrifice their urban educational opportunities and often

can do no more than take a tour of duty in the countryside. Rural health services requiring this sort of labor must pay higher real wages and cope with higher rates of turnover. Health services that depend on electricity and piped water may well be costlier to organize in rural areas. On the other hand, there may be offsetting savings stemming from the lower costs of rural land and housing, and of course the relative spatial dispersion of rural dwellers may lessen disease transmission and in this way reduce rural costs.

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Table 1 Predicted Unmet Need for Ever-Married Women Aged 25–29 by Residence and, for Urban Areas, Poverty Status

DHS Surveys in Region	All Rural	Urban Poor	Urban Nonpoor	Statistical Significance: Urban Poor vs. Urban Nonpoor	Statistical Significance: Urban Poor vs. Rural[a]
North Africa	0.27	0.16	0.12	2 of 3	3 of 3
Sub-Saharan Africa	0.34	0.31	0.24	12 of 30	26 of 30
Southeast Asia	0.22	0.23	0.16	5 of 5	5 of 5
South, Central, West Asia	0.24	0.22	0.15	4 of 9	7 of 9
Latin America	0.25	0.16	0.10	10 of 13	13 of 13
Total	0.29	0.25	0.19	33 of 60	54 of 60

Source: Panel on Urban Population Dynamics (2003).

[a] Significant difference (at the 0.05 level) in the predicted values of unmet need for the urban poor and rural residents. Of the 54 surveys with significant differences between the urban poor and rural residents, 39 showed lower levels of unmet need among the urban poor (the difference is 7.5 percentage points in the average survey), and some 15 showed that the urban poor have significantly higher levels of unmet need (an average difference of 5.3 percentage points). The level of unmet need for the urban poor exceeded that for rural women in no surveys in North Africa; 9 surveys in Sub-Saharan Africa; 3 in East and Southeast Asia; 2 in South, Central, and West Asia; and 1 in Latin America. The difference exceeded 3 percentage points in the surveys for Burkina Faso (1993), Côte d'Ivoire (1994), Ghana (1993), Mozambique (1997), Rwanda (1992), Senegal (1992 and 1997) and Zambia (1992).

Table 2 Differences by poverty status in unmet need for modern contraception, using socioeconomic factor scores

Region	Socioeconomic score negative and significant	Effect of household socioeconomic score			
		Absolute difference[a]		Relative to mean[b]	
		All	Significant	All	Significant
North Africa	3 of 4	4.0	4.9	18.9	22.0
Sub-Saharan Africa	31 of 42	9.5	11.5	22.9	28.1
Southeast Asia	5 of 6	4.5	5.7	17.3	24.8
South and Central Asia	6 of 12	5.2	7.1	22.7	26.6
West Asia	3 of 4	3.9	4.8	22.5	28.0
Latin America	16 of 16	6.3	6.3	31.1	31.1
TOTAL	64 of 84	7.4	8.7	23.8	28.1

Source: Montgomery and Hewett (2004)

[a] Expressed in percentage points. The difference is between predicted unmet need among households at the 25th percentile of the urban household factor score distribution and unmet need among households at the 75th percentile. The 25th percentile households are termed "relatively poor" in this analysis, whereas those at the 75th percentile are termed "relatively affluent".

[b] Expressed in percentage of mean unmet need in the urban samples.

Table 3 Differences by poverty status in urban birth attendance by a doctor, nurse, or trained midwife, using confirmatory-factor scores

Region	Socioeconomic score positive and significant[a]	Effect of household socioeconomic score:			
		Absolute difference[b]		Relative to mean[c]	
		All	Significant	All	Significant
North Africa	4 of 4	7.1	7.1	11.6	11.6
Sub-Saharan Africa	31 of 39	10.7	12.9	18.7	20.2
Southeast Asia	4 of 5	10.8	14.3	14.9	19.5
South and Central Asia	8 of 8	18.8	18.8	47.6	47.6
West Asia	3 of 4	4.4	5.3	7.6	9.4
Latin America	13 of 16	7.9	9.4	13.8	16.4
TOTAL	63 of 76	10.4	12.3	19.5	21.8

Source: Montgomery and Hewett (2004).

[a] This column may be compared with results for women's education. Women's education exerts a positive and significant influence on birth attendance in 4 of 4 surveys in North Africa, 24 of 39 in sub-Saharan Africa, 4 of 5 in Southeast Asia, 8 of 8 in South and Central Asia, 4 of 4 in West Asia, and 14 of 16 in Latin America. Husband's education is positive and significant in 3 of 4 surveys in North Africa, 10 of 36 in sub-Saharan Africa, 3 of 5 in Southeast Asia, 3 of 8 in South and Central Asia, 2 of 4 in West Asia, and 6 of 16 in Latin America.

[b] Expressed in percentage points. The difference is between predicted birth attendance among households at the 75th percentile of the urban household factor score distribution and birth attendance among households at the 25th percentile. The 25th percentile households are termed "relatively poor" in this analysis, whereas those at the 75th percentile are termed "relatively affluent".

[c] The difference between the 75th and 25th percentiles, expressed in percentages of women with all births attended in the urban samples.

Table 4 Among Those Aware of AIDS, Knowledge That Using Condoms and Limiting Sexual Partners can Reduce the Risk of AIDS, by Residence and, for Urban Areas, Poverty Status

DHS Surveys in Region	All Rural	Urban Poor	Urban Nonpoor
Sub-Saharan Africa	0.57	0.64	0.73
Southeast Asia	0.22	0.25	0.39
South, Central, West Asia	0.63	0.69	0.71
Latin America	0.54	0.66	0.81
Total	0.54	0.62	0.72

Source: Panel on Urban Population Dynamics (2003)