Impact of Urbanization on Health

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Introduction

Among the significant demographic trends that have taken place in the world during the past thirty years we can consider increasing levels of urbanization.

In 1950, the proportion of total world population of 2.5 billion that lived in urban areas was 29.4%; by 1980, this proportion had reached 39.9%. According to the estimate of the United Nations Department of International Economic and Social Affairs slightly more than half on the world expected population of 6.1 billion by the year 2000, will be residing in urban areas and this proportion will reach nearly 2/3 of the projected world population of almost 8.2 billion by the year 2025.

Of course we should agree on the definition of urban areas and on the term of urbanization. The United Nations has recommended that countries regard all places with more than 20.000 inhabitants living close together as urban. In fact, nations compile the statistics on the basis of many different standards. For instance the United States uses « urban place » to mean any locality where more than 2,500 people live.

Whatever the numerical definition, it is clear that the course of human history has been marked by a process of accelerated urbanization. Although the Australian Archaeologist V. Gordon Childe equated civilisation with urbanism, other social scientists distinguished between the cultural phenomena characteristic of urban areas and those of the most civilised society.

Tyde identified the formal criteria that, according to his system, indicate the arrival of urban civilization: increase of settlements size, concentration of wealth, large scale public works, writing, representation art, knowledge of exact sciences, foreign trade, full time specialist in nonsubsistence activities, class stratified society, and political organization based on residence rather than kinship.

He thought the underlined causes of the urban revolution as the cumulative growth of technology, and increasing availability of food surpluses as capital.

Other scientists suggested different criteria, but there is a general agreement among scholars that one of the necessary, but not sufficient, preconditions for the urban revolution is the potential for production of storable food surpluses.

Urbanization in Somalia

As far as Somalia is concerned, following the previous cited sources, the percentage of the urban population which was 12.7% in 1950 will be 63.9% in the year 2025. Today Somali urban population represent 34.1% of the total population. The cities of Somalia are not large. Mogadishu the capital city has a population of about 700.000.

Other major cities are Hargeiza, Kisimayu and Merca.

All of them are very old cities; this is characteristic of Somalia.

Truly most of the cities of the other surrounding countries, like Kenya whose capital city Nairobi grew to serve primarily european and governamental interests, only later became the target of cultural and political migrations. Until fairly recently the majority of African town dwellers were but temporarily migrants who after a period of employment returned to their rural homes and their favourite way of life.

Many towns are originally arab inspired coastal towns which have been during the centuries important trading centres.

But they grew only recently, very quickly, and to some extent, very irregularly, and this is especially true for the capital city Mogadishu.

The population density in Somalia is about 9/sqkm. But actually in urban areas and especially in the capital city, this density is much higher because of the shortage of houses and this is one of the most important aspects of urbanization that has a great impact on health.

We can see all the different types of Somali houses: *aqal, mundul, harish, baraks, bloketti* (brick houses).

About the in-house density I have no figures, but the impression is that it is higher than in rural areas.

Life and Morbidity Measures

In order to measure the impact of urbanization on health we have to take some indicators.

Longevity and mortality figures are good indicators of health status. Life expectancy at birth in Somalia is estimated to be 43 years: the breakdown shows the following figures: 45 years in urban population and 40 years in rural population.

In 1977 infant mortality rate was 192.5‰ in rural comunities and 138.3‰ in urban populations with a significant difference in favour of the latter.

A study of crude mortality rate carried out some years ago in Pakistan showed a significantly higher mortality rate among rural populations in comparison with urban ones.

Similar studies conducted in some european countries (e.g. United Kingdom, Holland, Denmark) give a quite different picture. Mortality rates are higher in urban population than in rural communities.

According to a study carried on among the Rotterdam (urban) population in 1976 the crude mortality rate is directly related to migrations and density and especially in-house density.

Morbidity data. Unfortunately other useful indicators are not sufficiently and adequately available but we can consider some very well known situations that could give us some good information.

Malaria is still a big health problem in Somalia. Since some years it can be considered practically eradicated from the capital city of Mogadishu.

This seems to be the result of a joint effort both of preventive and curative levels by Health Autorities and on the other hand of a lack of adequate breeding sites of the vectors. There is not enough clean water in the city for an adequate growth of mosquitos.

Schistosomiasis which is one of the major health problems is practically absent from Mogadishu for understandable reasons.

The access to health service is obviously much easier for the urban population.

After some time, on the other hand, we have seen in a few years, entirely new villages growing up in suburban areas.

The problems of safe water supply and excreta disposal are becoming bigger and bigger.

There are some indications that urban areas, very large cities in particular, tend to promote the development of schizophrenia and industrial societies seem to spawn this disorder more than do agricultural settings. We have no figures as far as Somalia is concerned, but we have to be aware of the problem. Actually mental patients are usually better cared for in rural settlements than in urban areas.

Food Supplies and Nutrition

Combined surveys of household which have been done in different years in some Mogadishu districts about food consumption and anthropometric measurements of children under five, put in evidence similar results in the different districts which can be summarized as follows;

— daily protein intake sufficient
— fat intake very high (38% of total calories intake)
— vitamin A very deficient
— vitamin B very deficient (50% of the normal requirements)
— vitamin C satisfactory only in the high educated groups
— calcium: adequate only in the highest income group
— caloric intake: sufficient.

In the urban population in Mogadishu the diet, although sufficient in calorie values, is very unbalanced. Education does have effect on the intake of vitamin C and Calcium, reflecting more use of fruits and milk. The higher income levels are mainly characterized by a higher protein consumption, reflecting that they can afford to buy more meat.

Protein deficiency doesn't seem to be an acute problem either for urban or rural areas. However an adequate procapite protein intake as a whole does not mean that there is no problem of protein consumption in the population. And especially in younger age groups protein malnutrition is widespread. Support for this clinical impression may be given by additional observation of the growth and development of children from 0 to 3 years.

According to different surveys and different authors too, curves of weight for-age are normal or nearly normal according to Harvard standards up to 6 or 8 months and they show a marked drop in growth, between 80th and 90th percentile of Harvard standards, after 8 months up to 22 to 26 months.

These results are very similar to those found in rural population.

Attitude toward Health Problems

Studies carried out on the impact on health of the urbanization, from the point of view of the attitudes toward mutual interactions between modern medicine and traditional health care, by different authors, have given similar results.

Health problems, expressed as psychiatric or psychosomatic ones represented almost half of the disease treated in the villages by traditional healers as compared to 20% in Mogadishu. Treatment of various organic symptoms was more frequent in the city than in the villages.

Treatment with religious acts represented almost half of all treatments in the city while the corresponding figure was less than 30% in the villages.

Traditional dancing and herbal medicine were more practised as treatment in the villages than in the city.

Knowledge about isolation for common infections was higher in city than in the villages. People in the city had more often experienced patients isolated for common infections than people living in the villages.

Attitudes toward the practices of the healer were also explored in some studies. The results revealed that 96% of the population in the villages had positive attitudes toward the traditional healer. While 72% was the corresponding figure in the city. Only a few of the interviewed in the villages classified the activities of the healer as useless while 13% of the city respondents thought it was useless and even dangerous.

Khat and alcool consumption show a significant difference between urban and rural population.

Conclusion

Urbanization, in modern terms, in Somalia is very recent. It is still an ongoing phenomenon.

Actually there is a very close and strict relation between urban and rural people and interchange is the rule. Somali are basically nomads and even urban people can be considered still nomadic and not yet settled down people.

As it happens in many developing countries, urbanization in Somalia seems so far to have a positive impact on health. This was the rule also for European countries after the industrial revolution until a few decades ago.

Problems of overcrowding and urbanization in general have to be approached. Problems of enviromental hygiene (water supply, excreta and waste disposal, adequate housing) have to be studied and their solution has to be planned in view of a very near future.

But another aspect cannot be neglected. I am mentioning the chemical pollution both at the domestic and industrial level. That is a big problem which so far has not been sufficiently taken into account. Research both at the enviromental and human level on these aspects should be carried out, in order to prevent new diseases and to promote human health.

Urban air pollution is the most noticeable one. We have no figures about Mogadishu's atmosphere pollution; but according to our personal experience it is relatively higher than it is in London or Rome at the moment.

As I mentioned above, today in Europe we have the opposite situation. Can the european experience be used in order to prevent the negative aspects of urbanization in Somalia?