Title: Bridging the Gap in Urban Health and Poverty Research

Paper Description: Traditional urban research does not capture the multi-dimensional complexity of urban poverty and disease, especially in the developing world. By incorporating qualitative approaches in traditional research methodology, planners can better align methods to local realities.

Author Name & Affiliation: Mojgan Sami, PhD student, University of California, Irvine

Topical Area: Health

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"In the postwar rush to turn planning into an applied social science much was ignored – the city of memory, of desire, of spirit; the importance of place and the art of place-making; the local knowledges written into the stones and memories of communities" (Sandercock and Lyssiotis 2003)

Urban health tends to be perceived as measures ensuring access to fresh food, parks, sidewalks and good air quality. In the last decade, donors such as The California Endowment have initiated place-based plans to "build healthy communities" through participatory action planning[1]. While these endeavors are steps in the right direction, the overall approach to healthy urban development tends to narrowly focus on the physical and built environment, and does not pay adequate attention to the social determinants of health, or what the World Health Organization calls "causes behind the causes" of health (WHO 2008). In part, the challenge lies in the difficulty of understanding the complexity of social reality and the diverse social constructions of health and poverty that exist in multi-cultural cities throughout the world. To control for such complexity, planners tend to favor quantitative, standardized approaches to research whereby they can generalize impacts and solutions to a wider population. However, by overly de-contextualizing urban health research, planners miss the opportunity of obtaining

[1] See http://www.calendow.org/healthycommunities/.

deeper understanding and insight into the age-old problems that have plagued cities from the beginning of the planning profession; namely, inequity and inequality (Hall 2002).

Urban planning and public health (henceforth "urban health") are predominately informed by the modernist, rational conceptualization of the scientific endeavor. Ontologically, they privilege the objectification of "the city" and "the body" in their quest to plan and implement policies and programs most conducive to "urban health." Epistemologically, they privilege distant, context-independent expert knowledge generation that relies on tools and instruments to discover objective facts. Methodologically, they rely on quantitative paradigms of analysis and inferential statistics to determine the "causes" of urban decay, disease and insecurity. The overall goal of these dominant traditions in planning is characterized as "societal guidance" (Friedmann 1987). The planning profession is well aware of the critical, Marxist and feminist critiques of an overly "technical" approach researching social realities. In addition, it has been argued that rationalist planning practices often focus too narrowly on solutions informed by economics without adequately taking anthropological, critical, sociological, and political science perspectives into account (Mercado, Havemann et al. 2007). Such criticism often points to the dangers of environmental determinism in urban health research. While the modernist, rational model of planning that narrowly focuses on economic solutions still informs the dominant culture of planning practice (Porter 2010), alternative paradigms of social science have increasingly influenced planning practice.

Planners have been greatly influenced by the interpretive (communicative, argumentative) turn in social science which characterizes an ontological, epistemological and methodological break with traditional frameworks that sought a "perfectly ordered" society. These breaks shift the objectification of the city and the body towards awareness of the *processes*

of place-making by embracing local knowledges and memories of marginalized communities. This "turn" is based on the phenomeonological interpretation of knowledge to action which builds on the viewpoint that reality is not an objectified existence waiting to be "discovered" by scientific methods, but rather "actively constituted through social, interactive processes" (Healey 2006). Friedmann (1987) characterizes these alternative planning paradigms as those that aim for "social transformation." He characterizes this move away from traditional planning to social transformation as an "epistemological break" (Friedmann 1987; Beard 2003) away from *expert* knowledge from above, towards less hierarchical and collaborative planning processes in (and with) communities. Friedmann refers to this "new" link between knowledge and action as "process knowledge." In fact, his definition of planning, "linking knowledge to action," is perhaps the only definition that has gained traction in the practice of planning. His "epistemological" break is a useful heuristic for urban health research since it provides space for multiple actors/collaborators in the planning process rather than privilege one actor (or donor or expert) over another.

In fact, this epistemological break can be seen in global health research which has recently shifted from a focus on health research to a more nuanced, social ecological approach to research *for* health (WHO 2010). According to WHO, the term "'research for health' reflects the fact that improving health outcomes requires the involvement of many sectors and disciplines. …[It] is research that seeks to understand the impact on health of policies, programmes, processes, actions or events originating in any sector; to assist in developing interventions that will help prevent or mitigate that impact; and to contribute to…health equity and better health for all" (WHO 2010: 22). While the global health community recognizes the importance of cross-sectoral research, it has yet to address the challenges of over-reliance on statistical data in

achieving "better health for all." For example, quantification does not address questions related to deep understanding and may lead to "superficialness and loss of thoroughness" (Mazumdar 2006). In fact, it has been argued that privileging quantitative research methodologies in the field of urban health has led planners to limit their questions to those which yield numeric data (Gaber 1993). As a result, planners may not be asking the "most important" questions that cannot necessarily be answered through statistical software. Thus, planners "may lose touch with certain types of social and economic problems that would be better addressed through qualitative methods" (Gaber 1993:2). Jane Jacobs' 1961 *The Death and Life of Great American Cities* famously condemned planners' bias toward quantitative studies and questioned their indices of blight and deterioration (Jacobs 1993). Jacobs states, "Cities have much more intricate economic and social concerns than automobile traffic" (Jacobs 1993:7). In fact, Jacobs asserts throughout her book that focusing too much on the quantitative approach to urban planning discounts the reality of vibrant, diverse life in American cities.

Traditional urban planning and public health research tends to treat the city as a monolithic entity, and may miss intra-urban differentials embedded in the city's diverse physical, historic, social, economic and political context. Over-reliance on highly standardized, quantitative methods of data collection and analysis risks the danger of reinforcing dominant social constructions of poverty and ill-health which perpetuate long-held disease paradigms that are not in line with contextual realities on the ground. In turn, such methods that aim to be "context neutral" may lead to inaccurate statistics related to living and health conditions (Satterthwaite 2003). Nowhere is this more prevalent than the myth of chronic disease being a product of increasing wealth. Only recently have urban health researchers begun to measure rates of chronic disease in urban slums (Sami 2010; Yajnik and Ganpule-Rao 2010). By

incorporating qualitative components in traditional quantitative methodology, planners can better align research methods to local contexts.

The distinction between "quantitative" and "qualitative" research may be misleading as the debate tends to focus on superficial arguments around the tools and methods of data collection and analysis, rather than on the overall approach to research. The usual tension between quantitative and qualitative research masks the fact that these two approaches to inquiry encompass at least two ontological and epistemological paradigms: positivism and interpretivism (Lin 1998). According to Lin (1998), positivists describe causal relationships, or associations, and interpretivists describe causal mechanisms. For example, a positivist study may demonstrate the link between a mother's education and the health of her infant, but there may be "many plausible stories embedded in that conclusion" (Lin 1998: 165). Lin continues by noting that some of these explanations may be reasonably assessed through quantitative surveys through the addition of a question, "but many others would be difficult to determine without using qualitative methods – intensive, open-ended interviewing, participant observation and document analysis." One epistemological approach is not necessarily "better" than the other, but when combined in urban health research, there is a stronger bridge between the numeric results and underlying social conditions that may explain those results. Lin bridges the quantitative/qualitative divide by noting that qualitative data assists researchers to test the strengths of particular associations whereas quantitative data assists researchers to understand the scope (or spread) of such associations.

Interpretive/qualitative research can be viewed as an *approach* to research that allows the researcher to study the multi-dimensional nature of reality. Such an approach views reality as *filtered* through language, spatial, temporal, social, cultural, historic and disciplinary lenses with

which we "observe" the world (Lofland, Snow et al. 2006). Understanding such filters does not imply that researchers are fabricating reality (Lofland, Snow et al. 2006); rather, they recognize the limitations of objective research which may overvalue existing expert knowledge and undervalue situated, local knowledge (Haraway 1988). An interpretive/qualitative approach to research recognizes the importance of context, and tends to interpret socially constructed meanings through "thick description" of a particular phenomenon of inquiry (Geertz 1973). Such an approach to research enables planners to be more aware of the historic and structural underpinnings of socially constructed realities. For example, Dr. Libby Porter's postcolonial analysis of the challenge to traditional planning institutions in Australia when indigenous groups claimed land rights provides insight into the cultural lens of planning as a profession, and the implications for minority groups in society who may not "see" the world with the same lens (Porter 2010).

Quantitative research focuses on tools and methods of data collection, aiming for generalizability, validity and reliability in research design evaluated through a disciplinary lens borrowed from the hard sciences. The "gold-standard" of quantitative research are randomized control studies (experiments) that aim for isolating the subject/object of inquiry from their natural environment. Rather than aiming to understand the complexities of contextual realities, quantitative researchers seek to control for context. Methods such as random sampling and large sample sizes allow quantitative researchers to make statistical inferences to larger populations. Describing reality through statistical measures dictates a focus on the strength/reliability of procedures and validity of the results. In contrast, qualitative approaches allow the researcher to search for deeper understanding and meaning *in context*. It enables a space for challenging taken-for-granted assumptions about people, places and practices. In

addition, it is open to the contributions of local knowledges that deepen understanding of a particular phenomenon.

Over-reliance on standardized quantitative techniques and tools discounts the important contextual realities that exist in different settings, and limits the types of questions that may be asked in research. For example, a municipal planning authority (MPA) may conduct an annual survey of urban slum indicators with the aim of providing the Ministry of Health (MoH) with scientific and generalizable findings in order to determine budget and service allocations. The MPA may conclude that 80-90% of the slum dwellers have access to sanitation (Satterthwaite 2003). Their results may lead to a *generalizable* and *statistically valid* recommendation to the MoH that financial assistance for slum sanitation upgrading is "not needed." Yet, each year health surveys demonstrate high prevalence of diseases related to lack of adequate sanitation among slum residents. Both the MPA and health surveys are quantitative studies using random sampling and are equally valid and generalizable. The discrepancies between the two studies may warrant a follow-up qualitative study to better understand the contextual realities that are providing divergent results.

A follow up qualitative/interpretive study with key informants may find that "sanitation" had multiple meanings to different sub-populations. For example, one group may understand "access" to sanitation as implying whether they had plastic bags (otherwise known as "flying toilets"). Such a study informs quantitative researchers of the social/contextual realities that must be taken into account so that recommendations are not just statistically valid, but also empirically validated and *socially* valid. Such a qualitative study may assist both planning department staff and policy makers to change their data collection methods in order to make better estimates for service provision and funding in slum conditions. Qualitative research can

provide an opportunity for policy makers to explore social, economic, political, spatial or historic factors that impact interpretations of physical and social reality. Simply "converting" a qualitative study into a quantitative study would not yield such deep insight. One approach is not "better" (or more "scientific") than the other; but depending on the question and context of inquiry, both approaches assist policy makers and planners in both deeper understanding and better estimating the scope of a particular phenomenon. One of the most fundamental characteristics of qualitative research is that "it provides a way of studying human events and activities in their natural settings" because they allow the examination of social phenomenon in their "most complete form" – that is, in the field (Gaber 1993: 3).

Over-reliance on standardized quantitative techniques may also overlook important cultural and environmental realities that exist in different settings. For example, cities in the Asia Pacific region have many unique characteristics that are not apparent in a standardized socio-economic study design (Mazumdar 2002). Traffic congestion in the Asia Pacific region is not perceived in the same manner as traffic congestion in the United States. In the United States, streets are assumed to be part of the transportation infrastructure, but "this is not always the primary function…in Asian cities" (Mazumdar 2006: 38-39). "Behavior of people in the street, the way people use the street, and therefore the very conception of the street, varies. Streets are not for one kind of user, the automobile" (Mazumdar 2006: 39). This is an important fact that an urban health planner relying on traditional transportation statistics may miss. In fact, as the anthropologist Peattie points out, one of the values of non-positivistic methods is its ability to question the assumptions and definitions concerning the nature of society and its problems (Peattie 1990).

It is important to note that qualitative approaches to urban health research may or may not be participatory in nature. While it is beyond the scope of this paper to provide an analysis of participatory processes for urban health research, the popularity of participatory processes requires reflection. Participatory action research (PAR) or community based participatory research (CBPR) that seek to include community residents as "collaborators" (as opposed to objects to be studied) are important to ensuring contextualization of urban health research in local communities. Recently, WHO (2008) called on all government sectors to put "health equity" at the center of all planning and program interventions to ensure the future peace and security of the planet. One way that national and local governments have responded to this call is through increasing health promotion efforts in poverty-reduction strategies. The Ottawa Charter (WHO 1986) defines health promotion as "the process through which individual groups and communities increase control over the determinants of health and thereby improve their health." This "increased control" is often termed "empowerment." Generally, "empowerment" seeks to provide a community with the tools/capacity to increase "control" over decision-making processes and focuses on "participatory" processes and greater political and social involvement in community life as a pathway to "power over" decision-making.

While there is no consensus on the definition of "participation" in policies and interventions, it is generally agreed that "participatory" (bottom-up) processes are "better" than non-participatory processes (top-down) in public policy and planning. Generally, participation is seen as an important predictor variable that drives other important community outcomes (such as health). Public sector planners tend to view participation (or "community involvement") in a hierarchy. They often cite Arnstein's "ladder of participation" to distinguish between "levels" of participation ranging from attending a meeting (low control) to decision-making authority (high

control). Recently, Feldman and Quick have distinguished between "participation" and "inclusion." Unlike Arnstein, their distinction is not hierarchical, but qualitative in nature. Thus, good participation is based on "good representativeness;" which in turn, is often based on a priori knowledge/conditions. Feldman and Quick state, "Attention to the inclusiveness of the practices is…important to achieving representativeness" (Feldman and Quick 2009). Inclusion involves representation as a "consequence" of a deliberative/collaborative process. This does not imply that there is always a consensus. "Inclusive practices that invite mutual responsibility for their people's ability to become legitimate participants….render transparent the work of making a process and its outcomes representative" (Feldman and Quick 2009: 37). Rather than rely on discrete "methods" or "techniques" of participatory processes to enhance inclusion, Feldman and Quick assert that inclusion can be seen as a result of a "pattern of practices" and "how they are enacted." It is the attention to the way these practices and enactments "enable participants to become a *community* of participants" that is critical (Feldman and Quick 2009). In addition to paying increased attention to how participating is enacted in a community, it is critical to evaluate how such participatory processes lead to social transformation. According to social psychologists, "Participation in conditions where material and symbolic obstacles prevent the possibility of real social change can be a hollow exercise. It legitimizes the status quo rather than providing an opportunity for marginalized people to pursue their needs and interests" (Campbell and Jovchelovitch 2000).

Urban poverty is a multi-dimensional, complex phenomenon that is not easily analyzed with traditional quantitative approaches or tokenistic participatory processes. This is especially true in an era where public health and urban planners have reunited their efforts to deal with urban health disparities (Corburn 2009). The danger of continuing to rely solely on

generalizable numeric data is that it only captures one or two dimensions of poverty and disease without necessarily capturing the social realities which embed such indicators. It is important to emphasize that bridging the gap between statistical indicators and complex social realities does not imply the abandonment of numeric data collection and analysis. As noted by Lin (1998), quantitative approaches to research allow planners to understand the spread of a particular phenomenon. What it does imply, is that there is a danger that *purely* quantitative methods may lead to uni-dimensional causes of disease and overlook social constructions of poverty and illness embedded in communities and research practices. Social constructions of poverty and disease are embedded in perceptions and cultural attitudes towards the poor and vulnerable (as well as perceptions and cultural attitudes *of* the poor and vulnerable). These social constructions perpetuate myths around poor populations which impede sustainable solutions in poor urban populations. While it is a fact that many poor urban communities suffer from lack of adequate living conditions leading to vectors causing TB, cholera, etc., the rates of chronic disease are also increasing at alarming rates among the urban poor. Recently, local health practitioners have noted that chronic and non-communicable diseases (NCDs) account for 35 million deaths each year – or 60% of all deaths worldwide—of which 80% occur in low and middle income countries (Sami 2010). Such numbers necessitate a deeper understanding of the causes behind the causes of disease to assist urban health planners in providing sustainable, context-appropriate solutions. By conducting interpretative/qualitative alongside traditional quantitative approaches to research, planners will be able to better align solutions to local contexts in efforts to improve urban health and security for the most vulnerable populations, and ultimately bridge urban health disparities.

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