Easton, Delia. "The Urban Poor." Encyclopedia of Medical Anthropology. Vol. 1. New York, NY: Springer, 2003. 207-13. Print.

The Urban Poor

Health Issues

Delia Easton

Introduction

Health outcomes are inextricably linked to poverty (Farmer, Conners, & Simmons, 1996), and as a result anthropologists studying urban populations have devoted considerable attention to understanding and representing the health conditions of the urban poor. Anthropological portrayals of the poor have altered over time. Despite earlier social science research documenting the disturbing health outcomes among the urban poor (e.g., Engels, 1892; Liebow, 1967; Spradley, 1970), there was relatively little ethnographic research that integrated theory from both urban and medical anthropology prior to the 1980s (Foster & Kemper, 1996). Even then, wary of misrepresenting the poor through reductionist stereotypes, anthropologists have often evaded focused analysis of urban poverty (Bourgois, 1995). The intent of this entry is to both summarize the health challenges faced by people living in urban poverty and briefly trace theoretical approaches to the urban poor.

Anthropologists have variously referred to poor urban areas as "ghettos" (e.g., Hannerz, 1969) "urban slums" (Whyte, 1943), "squatter settlements" (Glasser, 1994), or "inner-cities" (Singer, 1994; Wallace et al., 1994). The nuanced meaning of each of the above terms, and the appropriateness of each to describe poor urban populations, has been previously discussed and debated (Hannerz, 1969, 1980), and will not be covered here. For the purposes of this entry, I will use the term used to describe the locale by the authors at the time of their research, with the caveat that each term clearly reflects the historical and political setting of the research. For lack of a better general term, I will use "urban poor" to refer to those most often vulnerable to disease in urban settings.[1] The review will also look at what anthropology has brought to the study of the health of the urban poor, and what it can potentially contribute in the future. Physical, cultural, and medical anthropologists have all contributed to aspects of understanding how the processes of urbanization, industrialization, and globalization affect health among the poor worldwide. Because of shared topics of research and approaches to understanding health, there is an obvious overlap between epidemiological, medical anthropological, and public health studies on health among the urban poor. If relevant to the topic, formative work in fields other than anthropology is noted.

Threats to Health among the Urban Poor

The topic of health among urban poor is a critical global issue since approximately one third of the world's poor live in cities (McDade & Adair, 2001). At least 80% of urban areas are in underdeveloped areas of the world that often lack adequate infrastructures (Kendall et al., 1991), meaning that there are too few or sufficiently developed public health care, sanitation, and transportation systems in these areas to provide people with basic living necessities and consistent health care. Health among the urban poor in the United States and other developed countries is in some ways distinct from health in poor urban areas in the developing world. Yet the experiences of the urban poor in industrialized and developing countries have commonalities, particularly in regards to morbidity and mortality rates. For example, Fullilove, Green, and Fullilove (1999) cite research demonstrating that survival rates among inner city men over the age of 40 in the United States are lower than those of similarly aged men in Bangladesh. In this section, I will briefly synthesize findings on compromised health and disease among the urban poor. The following health issues are not all specific to urban health, but considered in concert with other biological, cultural, and structural variables, are salient to the holistic picture of health among the urban poor.

The population density found most often in closely inhabited urban centers and settlements is a critical condition for epidemics such as the plague, measles, influenza, poliomyelitis, tuberculosis, and the HIV/AIDS pandemic to thrive, spread, and exist at endemic levels (Armelagos, Ryan, & Leatherman, 1990). The devastating spread of HIV/AIDS through both urban and rural areas of the world has been further facilitated by factors including migration for employment, and the interconnection between sex work, and high-mobility occupations such as truck driving (e.g., Decosas & Padian, 2002; Voeten, Egesah, Ondiege, Varkevisser, & Habbema, 2002). Large-scale societies with high birth rates permit a rapid production and replacement of disease hosts (Schell, 1996). Because of the dense concentration of people in urban centers, sanitation has been a past problem for now-industrialized countries, and remains a persistent problem for less developed countries. Although all urban dwellers are exposed to environmental pollutants and toxins (Schell, 1996), the poor do not always have the option of living in asbestos-free or lead-free housing. The most obvious result of burgeoning populations in urban areas worldwide is the lack of habitable, economically priced shelter, forcing the poor into overcrowded conditions (Bashem, 1978). Overcrowding has been linked to health problems stemming from inadequate sanitation services, the rapid spread of communicable disease, and stress. Research done among African Americans in the United States has demonstrated that stress levels, high among poor groups experiencing the effects of racism, have a noticeably negative effect on health (Dressler, 1990, 1993).

Homelessness

Homelessness is not a problem exclusive to urban areas, but the poor living in cities are especially vulnerable to being left without shelter. Overcrowding, inadequate housing, unemployment, policies directed against the poor and working class, gentrification, and, in the United States, the de-institutionalization of mental hospitals in the 1970s have all been cited as factors contributing to urban homelessness (Baer, Singer, & Susser, 1997; Glasser, 1994; Hopper, 1988). In particular, poor urban youth are at risk for homelessness. Facing sexual or physical abuse, inadequate family resources, or rejection because of sexual identity, some youth may choose to or be forced to leave home (Clatts, Davis, Sotheran, & Atillasoy, 1998; Glasser, 1994). In developing countries, the number of homeless people in urban areas has grown exponentially in the last few decades: the result of forced rural to urban migration due to the increasing precariousness of subsistence farming (Baer et al., 1997), and to population increases in rural areas (McDade & Adair, 2001). Often homeless people in developing and industrialized countries occupy settlements or squatter settlements, which lack adequate sanitation, infrastructure, or basic health care systems (Baer et al., 1997; Rubenstein & Lane, 1990). Being homeless, or having inadequate shelter has been linked to heightened vulnerability to infectious disease, especially HIV and tuberculosis, alcoholism, malnutrition, and exposure to violence (Clatts & Davis, 1999; Farmer et al., 1996). Lacking shelter, food, resources, or all three, homeless people may resort to activities such as theft, robbery, selling illicit drugs, or sex trading for survival (Bourgois, 1995; Clatts et al., 1998; Clatts & Davis, 1999; Glasser, 1994; Schoepf, 1992; Waterston, 1993).

Violence

Exposure to violence is another widely acknowledged problem for the poor living in urban settings, especially the homeless (Glasser, 1994). Researchers have conceptualized the proliferation of violence in cities as the result of: (1) clashes between ethnic and social boundaries (Merry, 1981, 1996); (2) rapid social disintegration (Wallace, 1990); (3) the result of familial stigma and the misuse of state power (Glasser, 1994; Hecht, 1998); (4) gender power differences and homophobia (Asencio, 1999); and (5) as the byproduct of the inherent danger of operating in an underground economy (Bourgois, 1995, 1998). Violence is also closely associated with illicit substance use and alcoholism (Singer, 1994; Wallace, 1990), both of which are linked to HIV risk directly through the sharing of contaminated needles (Singer, 1996), trading sex for drugs (Sterk, Elifson, & German, 2000), and indirectly through decreases in inhibition (Stall, Heurtin-Roberts, McKusick, Hoff, & Wanner-Lang, 1990).

Malnutrition

Malnutrition is a threat for both rural and urban dwellers worldwide (Schell, 1996). As already noted, malnutrition is one of many issues in the web of health problems facing the urban poor and homeless. Although the inability to purchase basic foodstuffs is a critical factor in

malnutrition, the availability of nutritious, economically priced food is also a factor. In many U.S. cities, for example, grocery stores are scarce in poor neighborhoods and public transportation systems are highly inadequate. The result of these combination of factors is that residents of these communities are compelled to shop for groceries at bodegas or convenience stores, which have very limited selection and high prices. Himmelgreen et al. (2000) note that in the United States, food insecurity—the limited or uncertain availability of nutritious food—is most experienced in the inner city, in households with children, among the homeless, and among African Americans and Latinos.

Infectious Disease

Infectious disease is a focal point of urban medical anthropological literature in developing countries, and international health research. The poor in urban areas of developed countries and developing countries, often malnourished or with compromised immune systems, are vulnerable to infectious disease because of inadequate shelter, sanitation, and inaccess to basic heath care or lack of health insurance. For example, despite heightened attention, education, and improvements in sanitation, acute diarrhea remains a health threat, and a leading cause of death for young children worldwide (Kendall, 1991). Children with inadequate or no housing are especially at risk for diarrheal disease because of the unavailability of clean water and sanitation services (Glasser, 1994). Describing her ethnographic work in Brazilian favelas, Scheper-Hughes (1984, 1985) argues that rates of infant mortality are so common, and resources so scarce, that mothers have developed emotional strategies for coping with the awareness that some of their children may die. For example, mothers may not name their children immediately to prevent bonding to a child who may not survive, or they may favor children perceived as hardier and thus more likely to survive to the detriment of weaker more vulnerable children. Nation and Rebhun (1988) argue that mothers were far from inured to the death of children, but simply did not have the economic means of obtaining adequate health care for their children. The structural constraints influencing infant mortality are addressed in detail by Scheper-Hughes (1992). Tuberculosis, medically manageable with access to adequate health care, is often fatal to the poor in both rural and urban areas of the developing world (Farmer, 1999).

Increasingly, the impact of globalization, rapid sociocultural change, and increased mobility has proven ideal conditions for the global spread of relatively "new" diseases, such as HIV/AIDS (Jochelson, Mothibeli, & Leger, 1991). Increased mobility through air travel and the development of highways and local roads resulted in the rapid transmission of HIV worldwide (Armelagos et al., 1990). Despite some improvements to the infrastructures of developing countries, overall the rural and urban poor are still highly vulnerable to disease. Migration patterns based on availability of employment illustrate that the health of the rural poor is now fundamentally linked to the health of the urban poor. This heightened mobility—though at one level increasing job opportunities for the unemployed, and theoretically, access to health care—is disruptive to local economies and family structure. In addition, structural adjustment programs in developing countries, predicated on the export of locally produced goods and the increasing importation of corporate products, has often resulted in the decreased availability of health care, social services, and HIV-prevention tools such as condoms (Parker, Easton, & Klein, 2000). In the United States, undocumented immigrants may resort to underground or street economies for survival (Baer et al., 1997). Street youth, homeless men, and women trying to support themselves or their children sometimes resort to trading sex or selling drugs—high-risk activities for HIV (Clatts et al., 1998; Clatts & Davis, 1999; Schoepf, 1992; Schoepf, Engundu, Wa Nkera, Ntsomo, & Schoepf, 1991; Susser & Stein, 2000).

Recounting data from over 12 years of fieldwork in Yabucoa, Puerto Rico, Susser and Kreniske (1997) describe how some Puerto Rican migrants looking for greater financial opportunity may experience urban U.S. living when they have no relatives for emotional or financial support. Unable to find profitable work, some migrants began using drugs, and sometimes supporting drug use through commercial sex work. Clearly, HIV can be rapidly transmitted among these migrants, both on the mainland and upon return trips to Puerto Rico.

Anthropological Theory and Urban Poverty: Ways of Representing the Urban Poor

Paradigmatic shifts in urban anthropology have influenced representations of the urban poor. Urban anthropology is

considered to have its early roots in the Chicago school in the 1920s and 1930s (Merry, 1996). Elijah Anderson's work typifies research done from an urban ecological perspective (Low, 1999). During the 1950s, research on slum clearance was conducted in London and Laos through the Institute of Community Studies (Low, 1999). Drawing on theories of kinship and social networks, Stack's US-based research among urban African Americans demonstrates that extended kinship networks and social reciprocity are practical adaptations to scarcity of resources, high unemployment rates, and overall poverty (Stack, 1974). Social networks can be viewed as a form of social capital for the urban poor. Stack is careful to point out that the African American community was fully aware of middle-class values and aspirations, but congruent lifestyles were unattainable to them. Their poverty was not a chosen, self-perpetuating state, but a result of real social economic constraints

The concept of the "culture of poverty" is worth noting here because of the impact it has had on discussions of urban poverty in the 1970s and 1980s, and because of its enormous influence on social policy. Oscar Lewis concentrated his ethnographic work on Mexican, Puerto Rican, and Latin American populations in the 1950s and 1960s toward understanding how poverty is perpetuated within certain communities. This question was most concretely addressed in his 1968 work, *La Vida*, a richly detailed description of Puerto Rican Barrios in New York and San Juan after World War II. Lewis contended that, in populations such as Puerto Ricans and urban Mexicans, exposure to poverty and oppression inevitably resulted in the acquisition of largely self-destructive learned behaviors that perpetuate impoverishment. Waterston (1993) contends that the notion of a "culture of poverty" was an idea that first surfaced around the time of the Irish immigration of the 1840s and 1850s, as speculation was made about the cultural origins of "deviant" behavior among immigrants. Nonetheless, Lewis, who is most closely associated with the culture of poverty construct, theorized that poverty is a cultural trait developed over time in response to oppressive life circumstances. Although Lewis theorized that the culture of poverty also had some protective aspects to it, such as creating a greater sense of inter-connectedness among those joined in poverty, his construct has been widely criticized for its reductionism and the negative impact it has had on public policy to this day (Goode & Eames, 1996). The theory of the culture of poverty assumes a middle-class notion of deviant culture, and conflates class with ethnicity (Goode & Eames, 1996). Later historians have suggested that the notion of the culture of poverty later resurfaced as Wilson's "underclass" (Marks, 1991). Countering criticism, Wilson later re-termed the underclass the "urban poor" (Susser, 1999).

In the 1980s, urban anthropology gradually oriented itself less toward micro-level analyses, and away from Lewis's psychologically grounded theory of poverty, and more toward research exploring political, economic, and historical structures of urban living (Low, 1999; Sanjak, 1990). Examples include Hannerz's (1969) ethnography of an African American ghetto in Washington, DC, illustrating intra-group variation and offering an alternative view to the relatively monolithic culture of poverty (Good & Eames, 1996). Similarly, Susser's detailed ethnographic account shows how working class families in a Brooklyn neighborhood actively respond to the limited economic possibilities available to them (Susser, 1982). At the same time, reflecting a broader trend in anthropology overall, medical anthropologists writing about health and the urban poor began to offer alternatives to primarily relativistic, ahistorical, and apolitical traditions (Morsy, 1990). Schensul and Borerro (1982), for example, describe the death of a Puerto Rican infant in an urban U.S. hospital because of language and cultural differences, the critical event determining the formation of a health organization devoted to advocating for the health of the city's urban Latinos. Urban ethnographies focusing on poverty in the 1990s represent the urban poor as inhabiting discretely bounded areas of cities, where commonalities of class, ethnicity, and the absence of political voice form a unified spatial identity (Low, 1999). In these ethnographies, the urban poor take on a distinct social identity through their locale in the city. In Brazil, Hecht (1998) and Scheper-Hughes (1992) also describe similarly youth and communities effectively segregated through poverty and violence. In the United States considerable anthropological attention has also been devoted to the societal marginalization of drug users (Baer et al., 1997; Singer, 1996; Waterston, 1993). For example, crack-cocaine dealers occupy a marginal and deteriorated area of Harlem, with few or no avenues for supporting themselves in the mainstream economy (Bourgois, 1995, 1996).

Integrating Local and Global Anthropological Perspectives on the Health of the Urban Poor

Structural Violence

Farmer and colleagues argue that the poor, through their experience of social inequality, discrimination, and limited choice endure a structural violence that concretely manifests on a local level (Farmer, 1999; Farmer et al., 1996). Central to the concept of structural violence is an evaluation of how disease is linked to social inequality, class, and ethnicity. Dressler's (1993) research, for example, demonstrates that skin color is significantly associated with hypertension mediated socially through experiences of racism and not genetically. Singer argues that the high rates of drug use among urban minorities reflects an attempt to alleviate the depression and low self-esteem engendered by the frustration of enduring perpetual racism and poverty (Baer et al., 1997; Singer, 1994).

Urban Syndemics

The idea of structural violence is premised, in part, on Wallace's analysis of the multiple layers of societal and structural factors that place individuals at risk for HIV (Wallace, 1988, 1990). Capturing a wider trend in urban areas with systemic implications for poverty and health, Wallace recounts how urban deterioration in the Bronx, loss of municipal and public health sector funds, in conjunction with widespread fires, combined to result in an environment conducive to the rapid spread of HIV. Singer (1994) first described what he termed "syndemics" of the urban poor. Syndemics, fully explained by Baer, Singer, and Susser (1997) below, are intertwined and mutually reinforcing health issues and social conditions of the urban poor:

> Health in the inner-city is a product of a particular set of closely interrelated endemic and epidemic diseases, all of which are strongly influenced by a broader set of political-economic and social factors, including high rates of unemployment, poverty, homelessness, and residential overcrowding, substandard nutrition, environmental toxins, and related health risks, infrastructural deterioration and loss of housing stock, forced geographic mobility, family breakup and disruption of social support networks, youth gangs and drug-related violence, and health care inequality. (Baer et al., 1997, p. 174)

Singer illustrated this idea by describing the substance abuse, violence, and AIDS (SAVA) syndemic, a constellation of experiences, symptoms, and behaviors among study participants that appeared to be synergistically linked: substance use, experience of abuse or violence, and current infection with HIV/AIDS.

The concept of syndemics is useful for understanding how sociocultural, historical, and geographic realities in urban areas interact with and compound the adverse consequences of disease. Fullilove, Green, & Fullilove, (1999a) describe the inevitable increase of violence, addictive disorders, and HIV rates in urban U.S. areas following the high unemployment rates, increase in drug trade, and urban flight of the 1970s and 1980s. Similarly, the forced migration of rural dwellers to urban areas in large parts of Africa, Latin America, and Asia subsequent to loss of viable work, economic development programs, and political flux has resulted in overcrowding, challenges to already inadequate infrastructures, and the rapid transmission of HIV in parts of Africa, South America, and Asia (Farmer et al., 1995; Parker, 1995; Romero-Daza & Himmelgreen, 1998; Sabatier, 1996). The lack of basic sanitation alone in squatter settlements that surround large cities in as much as 20–50% of the developing world (Rubenstein & Lane, 1990) is a considerable barrier to health and overall survival. Dehydration from diarrheal disease, for example, is a direct result of inadequate sanitation and contaminated water supply sources. Feasible and sustainable interventions for reducing rates of infectious disease among the urban poor must be geared not only toward individual behavior, but toward the reality of the multiple and concurrent health threats in impoverished urban areas and the systemic, structural, and institutional components of disease (Manderson, 1998).

Conclusion

Clearly, anthropology has much to bring to the task of comprehending and effectively addressing health problems related to urban poverty. Anthropological research has effectively represented and portrayed the sociocultural, biological, and structural components of health and disease for the urban poor. Rich ethnographic descriptions illuminate the complexities of the daily struggles of the urban poor, while capturing the historical processes and political and economic roots of their vulnerability to

unnecessarily high rates of morbidity and mortality. The concept of urban syndemics permits an understanding of the compounding and mutually interactive effects of poverty and exposure to multiple health threats. An integrated anthropological analysis of individual experience, local level knowledge, and broader societal and structural factors clarifies exactly how disease devastates the urban poor. It also demonstrates the immense challenges to providing effective and sustainable health care, affordable treatment, and health therapy to the urban poor worldwide. Continued rigorous anthropological research on urban poverty that documents the micro- and macro-determinants of health and disease is necessary:

(1) to advocate for the urban poor
(2) facilitate their empowerment, and
(3) influence policy change

NOTE

1. Susser, however, cautions that a limitation of the term "urban poor" is its implication that the poor are separate and not an integral component of dynamic economic systems.

REFERENCES

Armelagos, G., Ryan, M., & Leatherman, T. (1990). Evolution of infectious disease—a biocultural analysis of AIDS. *American Journal of Human Biology, 2*(4), 353–363.

Asencio, M. (1999). Machos and sluts: Gender, sexuality, and violence among a cohort of Puerto Rican adolescents. *Medical Anthropology Quarterly, 13*(1), 107–126.

Baer, H. A., Singer, M., & Susser, I. (1997). *Medical anthropology and the world system*. Westport, CT: Bergin & Garvey.

Basham, R. (1978). *Urban anthropology: The cross-cultural study of complex societies*. Palo Alto, CA: Mayfield.

Bourgois, P. (1995). *In search of respect: Selling crack in El Barrio*. New York: Cambridge University Press.

Bourgois, P. (1996). Office work and the crack alternative among Puerto Rican drug dealers in East Harlem. In G. Gmelch & W. P. Zenner (Eds.), *Urban life, readings in urban anthropology* (pp. 418–431). Prospect Heights, IL: Waveland Press.

Bourgois, P. (1999). The moral economies of homeless heroin addicts: Confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments. *Substance Use and Misuse, 33*(11), 2323–2351.

Clatts, M. C., Davis, W. R., Sotheran, J. L., & Atillasoy, A. (1998). Correlates and distribution of HIV risk behaviors among homeless youth in New York City: Implications for prevention and policy. *Child Welfare, 77*(2), 195–207.

Clatts, M. C., & Davis. W. R. (1999). A demographic and behavioral profile of homeless youth in NYC: Implications for AIDS outreach and prevention. *Medical Anthropology Quarterly, 13*(3), 365–374.

Decosas, J., & Padian, N. (2002). The profile and context of the epidemics of sexually transmitted infections including HIV in Zimbabwe. *Sexually Transmitted Infections, 78*(1), 140–146.

Dressler, W. (1990). Culture, stress and disease. In T. M. Johnson & C. F. Sargent (Eds.), *Medical anthropology: Contemporary theory and method* (pp. 248–268). New York: Praeger.

Dressler, W. (1993). Health in the African-American community: Accounting for health inequalities. *Medical Anthropology Quarterly, 7*(4), 325–345.

Eames, E., & Goode, J. (1996). Coping with poverty: A cross-cultural view of the behavior of the poor. In G. Gmelch & W. P. Zenner (Eds.), *Urban life, readings in urban anthropology* (pp. 378–392). Prospect Heights, IL: Waveland Press.

Engels, F. (1892). *The condition of the working-class in England in 1844*. London: Swan Sonnenschein & Co.

Farmer, P. (1995). Culture, poverty, and the dynamics of HIV transmission in rural Haiti. In: H. Brummelhuis and G. Herdt (Eds.): Culture and Sexual Risk: Anthropological Perspectives on AIDS. New York: Gordon: 3–28.

Farmer, P. (1999). *Infections and inequalities: The modern plagues*. Berkeley: University of California Press.

Farmer, P. E., Conners, M., & Simmons, M. (Eds.). (1996). *Women, poverty, and AIDS: Sex, drugs, and structural violence*. Monroe, ME: Common Courage Press.

Farmer, P., Lindenbaum, S., & DelVeccio-Good, M. J. (1993). Women, poverty and AIDS: An introduction. *Culture, Medicine, and Psychiatry, 17*, 387–397.

Foster, G. M., & Kemper, R. V. (1996). Fieldwork in cities. In G. Gmelch & W. P. Zenner (Eds.), *Urban life, readings in urban anthropology* (pp. 135–150). Prospect Heights, IL: Waveland Press.

Fullilove, M., Green, L., & Fullilove, R. (1999a). Building momentum: An ethnographic study of inner-city redevelopment. *American Journal of Public Health, 86*(6), 840–844.

Fullilove, R. E., Fullilove, M. T., Northridge, M. E., Ganz, M. L., Basset M. T., McLean D. E., et al. (1999b). Risk factors for excess mortality in Harlem: Findings from the Harlem Household Survey. *American Journal of Preventive Medicine, 16*(3S), 22–28.

Glasser, I. (1994). *Homelessness in global perspective*. New York: G.K. Hall.

Goode, J., & Eames, E. (1996). An anthropological critique of the culture of poverty. In G. Gmelch & W. P. Zenner (Eds.), *Urban life, readings in urban anthropology* (pp. 405–417). Prospect Heights, IL: Waveland Press.

Hannerz, U. (1969). *Soulside*. New York: Columbia University Press.

Hannerz, U. (1980). *Exploring the city: Inquiries toward an urban anthropology*. New York: Columbia University Press.

Hecht, T. (1998). *At home in the street: Street children of Northeast Brazil*. Cambridge, U.K.: Cambridge University Press.

Himmelgreen, D., Perez-Escamilla, R., Segura-Millan, S., Peng, Y., Gonzalez, A., Singer, M., et al. (2000). Food insecurity among low income Hispanics in Hartford, CT: Implications for the public health policy. *Human Organization, 59*(3), 334–342.

Hopper, K. (1988). More than passing strange: homelessness and mental illness in New York City. American Ethnologist, *15*(1): 155–167.

Jochelson, K., Mothibeli M., and J. P. Leger. (1991). Human immunodeficiency virus and migrant labor in South Africa. International Journal of Health Services: Planning, Administration, Evaluation 2191: 157–173.

Kendall, C., Hudelson, P., Leontsini, E., Winch, P., Lloyd, L., & Cruz, F. (1991). Urbanization, Dengue, and the health transition: Anthropological contributions to international health. *Medical Anthropology Quarterly, 5*(3), 257–268.

Liebow, E. (1967). *Tally's corner*. Boston: Little, Brown.

Low, S. (1999). Introduction. Theorizing the city. In S. M. Low (Ed.), *Theorizing the city: The new urban anthropology reader* (pp. 1–36). New Brunswick, NJ: Rutgers University Press.

Manderson, L. (1998). Applying medical anthropology in the control of infectious disease. *Tropical Medicine and International Health, 3*(12), 1020–1027.

Marks, C. (1991). The urban underclass. *Annual Review of Sociology, 17*, 445–466.

McDade, T. W., & Adair, L. S. (2001). Defining the "urban" in urbanizations and health: A factor analysis approach. *Social Science and Medicine, 53*, 55–70.

Merry, S. E. (1981). *Urban danger: Life in a neighborhood of strangers*. Philadelphia, PA: Temple University Press.

Merry, S. E. (1996). Urban danger: Life in a neighborhood of strangers. In G. Gmelch & W. P. Zenner (Eds.), *Urban life, readings in urban anthropology* (pp. 47–59). Prospect Heights, IL: Waveland Press.

Morsy, S. (1990). Political economy in medical anthropology. In T. M. Johnson & C. F. Sargent (Eds.), *Medical anthropology: Contemporary theory and method* (pp. 26–46). New York: Praeger.

Nation, M., & Rebhun, L. (1988). Angels with wet wings won't fly. *Culture, Medicine and Psychiatry*, *12*(2), 141–200.

Parker, R. (1995). The social and cultural construction of sexual risk, or how to have (sex) research in an epidemic. In: H. Brummelhuis and G. Herdt (Eds.): Culture and Sexual Risk: Anthropological Perspectives on AIDS. New York: Gordon: 257–269.

Parker, R., Easton, D., & Klein, C. (2000). Structural barriers and facilitators in HIV prevention: A review of international research. In E. Sumartojo & M. Laga (Eds.), *AIDS: Structural factors in HIV prevention, 14*(Suppl. 1), S22–S32.

Romero-Daza, N., & Himmelgreen, D. (1998). More than your money for labor: Migration and the political economy of AIDS. In M. Singer (Ed.), *The political economy of AIDS* (pp. 185–204). New York: Baywood.

Rubenstein, R. A., & Lane, S. D. (1990). International health and development. In T. M. Johnson & C. F. Sargent (Eds.), *Medical anthropology: Contemporary theory and method* (pp. 367–390). New York: Praeger.

Sabatier, R. (1996). Migrants and AIDS: Themes of vulnerability and resistance. In M. Haour-Knipe & R. Rector (Eds.), *Crossing borders: Migration, ethnicity and AIDS* (pp. 87–101). London: Taylor & Francis.

Sanjek, R. (1990). Urban anthropology in the 1980s: A worldview. *Annual Review of Anthropology, 19*, 151–186.

Schell, L. M. (1996). Cities and human health. In G. Gmelch & W. P. Zenner (Eds.), *Urban life, readings in urban anthropology* (pp. 135–150). Prospect Heights, IL: Waveland Press.

Schensul, S. and M. Borrero. (1982). Introduction: The Hispanic Health Council. Urban Anthropology, *11*(1): 1–8

Scheper-Hughes, N. (1984). Infant mortality and infant care: cultural and economic constraints on nurturing in Northeast Brazil. Social Science and Medicine 1995: 535–546.

Scheper-Hughes, N. (1985). Culture, scarcity, and maternal thinking: maternal detachment and infant survival in a Brazilian shantytown. Ethos 13(4): 291–317.

Scheper-Hughes, N. (1992). *Death without weeping: The violence of everyday life in* Brazil. Berkeley: University of California Press.

Schoepf, B. G. (1992). Gender relations and development: Political economy and culture. In A. Seidman, & F. Anang (Eds.), *Twenty-First century Africa: Toward a new vision of self-sustaining development* (pp. 203–241). Trenton, NJ: Africa World Press.

Schoepf, B. G., Engundu, W., Wa Nkera, R., Ntsomo, R., & Schoepf, C. (1991). Gender, power, and risk of AIDS in Zaire. In M. Turshen (Ed.), *Women and health in Africa*. Trenton, NJ: Africa World Press.

Singer, M. (1994). AIDS and the health crisis of the U.S. urban poor: The perspective of critical medical anthropology. *Social Science and Medicine, 39*(7), 931–948.

Singer, M. (1996). A dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA syndemic. *Free Inquiry, 24*(2), 99–110.

Spradley, J. (1970). You Owe Yourself a Drunk: An Ethnography of Urban Nomads. Boston: Little Brown.

Stack, C. B. (1974). *All our kin: Strategies for survival in a black community*. New York: Harper & Row.

Stall, R., Heurtin-Roberts, S., McKusick, L., Hoff, C., & Wanner-Lang, S. (1990). Sexual risk for HIV transmission among singles-bar patrons in San Francisco. In R. Vlack & W. F. Skinner (Eds.), *AIDS and the social sciences: Common threads* (pp. 100–123). Lexington: University of Kentucky Press.

Sterk, C. E., Elifson, K. W., & German, D. (2000). Female crack users and their sexual relationships: The role of sex-for-crack exchanges. *The Journal of Sex Research, 37*(4), 354–360.

Susser, I. (1982). *Norman street: Poverty and politics in an urban neighborhood*. New York: Oxford University Press.

Susser, I. (1999). Creating family forms: The exclusion of men and teenage boys from families in the New York City shelter system. In S. M. Low (Ed.), *Theorizing the city: The new urban anthropology reader* (pp. 67–82). New Brunswick, NJ: Rutgers University Press.

Susser, I., & Kreniske, J. (1997). Community organizing around HIV prevention in rural Puerto Rico. In G. C. Bond, J. Kreniske, I. Susser, & J. Vincent (Eds.), *AIDS in Africa and the Caribbean*, (pp. 51–64). Boulder, CO: Westview Press.

Susser, I., & Stein, Z. (2000). Culture, sexuality, and women's agency in the prevention of HIV/AIDS in Southern Africa. *American Journal of Public Health, 90*(7), 1042–1048.

Voeten, H., Egesah, O., Ondiege, M., Varkevisser, C., & Habbema, J. D. (2002). Clients of female sex workers in Nyanza Province, Kenya: A core group in STD/HIV transmission. *Sexually Transmitted Infections, 29*(8), 444–452.

Wallace, R. (1988). A synergism of plagues: "Planned shrinkage," contagious housing destruction and AIDS in the Bronx. *Environmental Research, 47*, 1–33.

Wallace, R. (1990). Urban desertification, public health and public order: Planned shrinkage, violent death, substance abuse and AIDS in the Bronx. *Social Science and Medicine, 31*(7), 801–813.

Wallace, R., Fullilove, M, Fullilove, R., Gould P., and D. Wallace (1994). Will AIDS be contained within U.S. minority populations? Social Science and Medicine *39*(8): 1051–1062.

Waterston, A. (1993). *Street addicts in the political economy*. Philadelphia, PA: Temple University Press.

Whyte, W. F. (1943). *Street corner society*. Chicago: University of Chicago Press.