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The Impact of Poverty on Health in Urbanising Communities

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ABSTRACT

South Africa, in a similar way to other developing countries, is experiencing rapid urbanisation, resulting in the growth of slums and squatter settlements where people live under appalling conditions of poverty and deprivation. People in these settlements live in substandard housing with inadequate water supply, sanitation and other basic necessities. Associated with this lack of services is an increase in disease and ill-health of these growing peri-urban populations. This paper draws attention to the relationship between poverty and health in the peri-urban environments. The discussion clearly indicates that the principal causes of ill-health and social maladjustment which include infections, inadequate nutrition, and faulty childrearing practices are products of poverty, ignorance and lack of resources. The effects of poverty on women and children's health is explored; and the new government's policy for dealing with poverty is highlighted.

Introduction

At the beginning of the 19th century, only three per cent of the world's population lived in towns. By 2030, more than half of the world's population of about 10,000 million people will be trying to survive in cities, mainly in the urban fringes. It is estimated that of this 10,000 million people, more than 8,000 million will be living in developing countries (Stambouli, 1991) Thus, urban problems in developing countries have become more acute in recent years as more people flock to cities, putting severe pressure on the urban infrastructure and physical environment. The direct result of this urban expansion has been a tremendous increase in 'shanty' towns or 'squatter' settlements where living conditions and hygiene are appalling. The most widely observed and acutely felt urban problem in developing countries is the large number of poor and unemployed people in the cities. These countries account for two-thirds of the total (world) population and well over three-fourths of the population living in poverty. It is forecast that by the end of the 20th century, the urban poor may represent a quarter of humanity (Harpham; Lusty & Vaughan,

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1988). Commenting on the dimensions of Third World poverty, Ahluwalia, *et al* (1979: 306) concluded that: *"...almost 40 percent of the population of the developing countries live in absolute poverty defined in terms of income levels that are insufficient to provide adequate nutrition"*. In South Africa about forty-five percent of the population, of which approximately 3,5 million are children, live in poverty (Editor: Barometer, 1991). Yet the urban poor are largely unseen and unheard. The majority of the poor avoid official contacts and investigations because they distrust the motives of the inquirers. The relatively affluent people simply do not see or hear the poor who are their neighbours because they do not share the same experiences.

The urban poor are caught in a web of insecurity, low income, environmental hazards and unsatisfied human needs. They face unsanitary living conditions, malnourishment, exposure to infectious organisms and toxic chemicals, and lack of health services. Worsening environmental conditions in many areas threaten to reverse whatever minimal gains have been made in public health (Harpham; Lusty & Vaughan, 1988; Gilbert & Gugler, 1992; WHO, 1991). Hardoy, *et al* (1990:4) estimates that *"...at least 600 million people living in urban areas of the Third World live in what might be termed life- and health- threatening homes and neighbourhoods"*.

The health of the urban poor combines the problems of rural poverty (malnutrition, infectious diseases) with those of urban development (environmental pollution, violence, sexually transmitted diseases, and many others). On the other hand, the poorest of the urban poor seem to endure at one and the same time the effects of poverty and the worst by-products of industrialisation and urbanisation (Maxwell, 1991; Hardoy, *et al*, 1990; Harpham & Stephens, 1991). A review of literature on urbanisation trends in developing countries shows that the urban poor have a different health profile from other groups, both in terms of mortality and morbidity. A number of these studies indicate that intra-urban differentials in health have increased substantially over the past 5 years (Rossi-Espagnet, 1983; Harpham & Stephens, 1991 [WHO, 1984]). This is clearly illustrated in the following examples. In Manila the infant mortality rate (IMR) for the whole city was 76 per 1,000 against 210 per 1,000 in Tondo, a squatter settlement. In Quito, IMR rate in upper-class districts was 5 per 1,000, while for children of manual workers in the squatter area the IMR was 129 per 1,000.

South Africa is in no better position. While statistics for whites show similar values for those of upper-middle income countries with regard to health indicators (life expectancy and infant mortality rate), the pattern of disease for the majority of South Africans is similar to those found in other developing countries (Zwarenstein & Bradshaw, 1989; Jacobs, 1991; Yach, *et al*, 1989; Gie, *et al*, 1993).

In the discussion below, the concept of poverty as well as the relationship between poverty and health is considered. A closer look is taken at poverty and health in South Africa with emphasis on women and children. The national policy framework for dealing with poverty is also considered.

Definition of Poverty

While Tolley & Thomas (1987) tend to measure poverty in terms of income and economic development, Harpham; Lusty & Vaughan (1988) are of the opinion that the measurement of poverty is difficult and may prove deceptive, especially if income is the sole criterion. Because income statistics tend to be unreliable and the majority of poor people may be unemployed and not have access to an income, a better picture can be obtained by using non-monetary criteria. While the 'poverty line' may have administrative uses, it has no absolute validity as the percentage of a population above or below that line can be large or small depending on the assumptions and concepts used. Thus, the distribution of income values serves as a better indicator as it provides a better approach and permits the selection of a poverty line appropriate for a specific purpose.

Ferge& Miller (1987:15), on the other hand, see poverty as a self-evident phenomenon of everyday reality which is difficult to grasp in a scientifically manageable way. According to this author poverty may be defined in absolute or relative terms. Defined in absolute terms, poverty means the inability of individuals or families to maintain, through lack of adequate resources, a socially minimal or acceptable level of living. In the relative sense, poverty is one aspect of social inequality. It means that part of the population lacks the resources which assume full social membership in the given society, or at least which would assure living conditions customary in a given society. From these definitions it is clear that poverty in the absolute sense may be considerably reduced or even overcome if all sections of the poor could profit from economic growth, while the reduction of poverty in the relative sense is related not only to an increase in resources, but also to structural changes in the allocation of resources. In the latter sense, poverty is not only a condition of economic insufficiency but also of social and political exclusion. This is true for South Africa where the apartheid policies have had a profound impact on the nature of services provided. On the whole the areas of operation in service provision were dictated by a system which promoted advancement of the interests of whites at the expense of the black majority, leading to a marked erosion in their health status and quality of life. With a per capita gross national product (GNP) of more than R8,500, South Africa is classified as an upper middle class income country which could afford to feed, house, educate and provide health care for all its all its citizens, yet statistics show that about forty-five percent of the population, of which approximately 3,5 million are children live in poverty (Barometer, 1991).

The Impact of Poverty on Health

The poor urban environment affects various sectors of the community in different ways. Included in these are the youth, unemployed or underemployed men, the urban workers and the elderly. Due to lack of parental supervision, the urban young poor who constitute a high proportion of the urban population often end up as drop-out with limited skills necessary for competition in the job market. Coupled with inevitable stresses and strains of adolescence, this situation often results in low self-esteem and sometimes depression. Other common problems of the urban poor include unwanted pregnancies, illegal abortions, sexually transmitted diseases, malnutrition, psychological disturbances, substance abuse and dependence, suicide, violence and accidents. Unemployment and lack of opportunities is a constant threat to the stability of poor urban men and their families. A number of studies have shown a link between unemployment of the father and the severity of child abuse as well as an elevated stress among the wives. Unemployed men have also been found to be aggressive and to indulge in alcohol and other addictive substances resulting in abusive and violent behaviour (Hammarstrom, 1994). Most poor urban dwellers end up in poorly and insecurely paid jobs, often lacking occupational health and other welfare services. More and more old people who are moving to the cities, either to follow their children or to find employment, end up struggling for survival in squatter settlements, without adequate psychosocial and economic support from family or community. All too often, their overall situation is deplorable as they are seen begging on street corners or doing a multitude of odd jobs for survival.

The urban environment is particularly cruel to women and their children, particularly infants and young children. In South Africa, as in most communities in third world countries, mothers and children make up over two-thirds of the population, while one-fifth of the population is under fifteen years. Likewise it is among these vulnerable groups that disease and death take their toll. The impact of poverty on women and children's health is reviewed below.

Urban poverty and children

While great progress has been made in promoting the health of children in South Africa, it has become evident that in most black communities, poverty, ignorance and disease still go hand-in-hand and medical services are either still rudimentary or are lacking. Minimum sanitary facilities that the affluent, privileged communities take for granted, a reliable supply of safe drinking water and arrangements for safe disposal of human waste are frequently non-existent. Family diets generally provide less than the accepted minimum allowances of protective foods necessary to maintain health and fight off disease. In the squatter camps surrounding towns

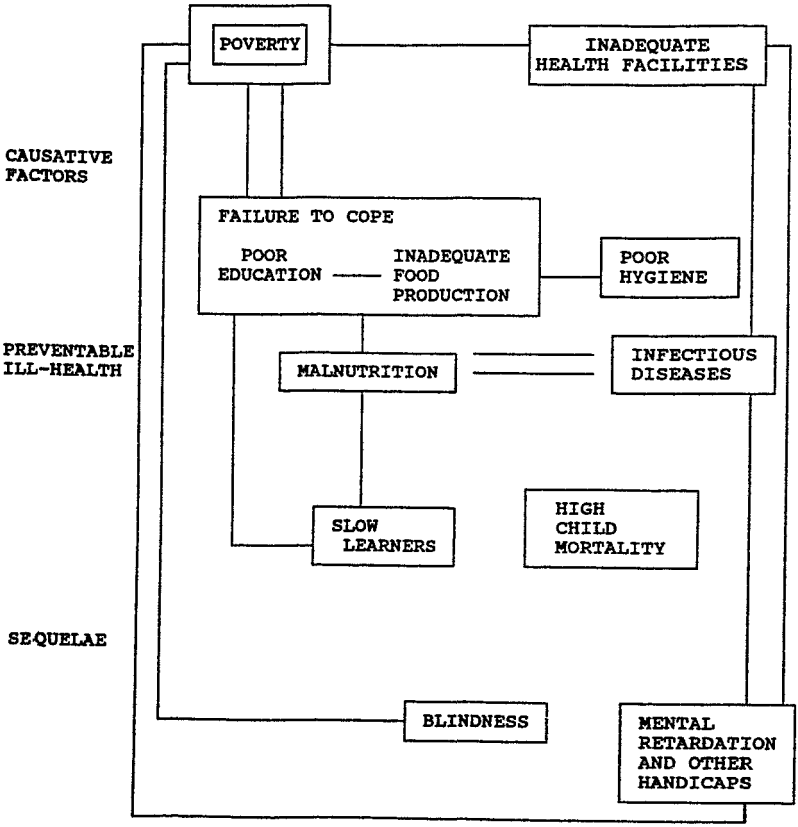
and cities, the health conditions are even worse, for overcrowding facilitates the spread of infectious diseases. Many of these diseases are poverty-related. These diseases include malnutrition, low birthweight, as well as indoor pollution from domestic fuel combustion and tobacco use. Instead of electricity, most households resort to fuels such as wood, coal and paraffin for heating, cooking and lighting purposes. The design and construction materials used in informal housing, such as plastic, wood, etc, do not allow for adequate ventilation. Indoor air pollution associated with combustion of fuels may exceed outdoor pollution resulting in high levels of acute respiratory infections (Samet, *et al*, 1987; Von Schirnding, *et al*, 1991). Women and children are at particular risk as they spend a lot of time in the home.

In view of the causal relationship between poverty and disease, the children who grow up where such conditions prevail are the principal sufferers. Proper prenatal care is often lacking, and until recently, in most peri-urban and rural areas, a large number of children are still delivered by traditional birth attendants, as they are the only affordable and accessible source of maternal health care (Ntoane, 1991; Jacobs, 1991). Infant mortality is high and most preventable diseases are still rife. Since their control depends on correcting the unfavourable environment, up to now it has been almost impossible to address this situation. In 1992, Dr Rina Venter, the Minister of Health and Population Development, told Parliament that although there were no available figures for neonatal deaths in 1989, in 1987 an average of approximately 50% of black and "coloured" deaths resulted from prematurity and low birth weight. Similarly, the infant mortality rates (deaths per 1,000 live births in the first year) were estimated at 63 for Africans with the corresponding figure of 9 for whites. 2,242 cases of marasmus and 7,470 cases of kwashiokor were also reported in 1987. Furthermore, the Minister pointed out that the incidence of such diseases were probably higher than the stated figure for 1989. An official of the Department, Mr Vugarellis, reported that in view of the high incidence of measles (13,629 notified cases and 290 deaths) in 1989, the Department of National Health and Population Development would launch an intensive immunisation campaign against the disease. In March 1990 it was reported that Transkei was experiencing a measles epidemic, and that one in four children who contracted the disease died (Cooper, *et al*, 1990). The statistics, according to Epidemiological Comments of April 1989, also confirm that the high infant mortality rates result from preventable diseases: intestinal infections (32,3%), respiratory disease (18,9 %), nutritional disease (12,3%), respiratory disease (18,9%), nutritional disease (12,2%) and viral diseases (11,1%), adding up to 74,5% of all known cases.

Sutter (1982:66) is of the opinion that patterns of ill-health and subsequent disability found in most black communities in South Africa are similar to those found in other developing countries in terms of the socioeconomic situation and limited resources, inadequate accessibility to and use of health facilities, malnutri-

tion, poor hygiene and disease. She states that *"...many children fail to survive and many who do survive are left permanently disabled or retarded by malnutrition and communicable diseases"*. Figure 1 demonstrates the cycle of poverty in developing countries.

Figure 1: Cycle of Poverty and Disease in Developing Countries



Adapted from E. Sutter (1982) **Rehabilitation in South Africa**, Volume 26: 3, pp 65 - 70.

Poverty and women's health

In discussing poverty and health, a point that deserves special emphasis is that poverty is very much a women's issue, at least in part because of women's double roles. Women with young children are much more likely than men to be poor, and their burdens are usually greater as they must care for children and the household and also earn a living. Poor women have needs and make contributions that are different to those of poor men; thus their problems require different solutions (Pietila & Vickers, 1990; Perales & Young, 1988).

Women make up more than 50% of the world's population, yet their position is inferior to that of men. Women from lower socioeconomic backgrounds have even less power than do other women. Because of the lower social and legal status accorded to them, poor women are usually less educated, have fewer opportunities, poorer health care and less control over their lives. Poor women also have less access to land, capital and technology and this lack of access leads to greatly diminished efficiency of production both outside and inside the house. Less education entails cost to society, not only because of the loss of women's potential for higher productivity in the labour market, but also because women as mothers make the first investment in the nutrition, health and education of children and these investments are critical to the country's future economic growth.

The pattern of ill-health extends to poor women, not only in the form of high maternal mortality, but also in the form of high morbidity. According to WHO (1980; 1992), the maternal mortality rate reaches as high as 1,000 per 100,000 live births in developing countries, compared with 5 to 30 per 100,000 in industrialised countries. Likewise, UNICEF reports that about 500,000 women die from conditions related to pregnancy and childbirth (UNICEF, 1981; 1991). These statistics are too important to ignore. Poverty reflects many unfavourable associations with childbirth which affect infant survival. Poor women are said to suffer from what is termed 'maternal depletion', as a result of early mating, continuous cycles of pregnancy and inadequate diets, often made worse by food prejudices, and uninterrupted overwork leading to anaemia or general malnutrition with premature ageing and early death (Williams, *et al*, 1985; Travis, 1976; Ntoane, 1991). Jacobs (1991) points out that in South Africa, the maternal mortality is further aggravated by the suffering of women who, having little control over their health and limited access to abortion as a means of reproductive control, are forced to seek backstreet abortions with disastrous outcomes. The recent estimates indicate that between 125-200,000 maternal deaths occur every year due to unsafe induced abortions (WHO, 1992; Sundstrom, 1993).

Poverty lays a particularly heavy burden on black women in South Africa, because of their dual roles in the economy. Often women work inside and outside the home. At home they are usually responsible for house chores, food preparation

and child care. For poor rural and peri-urban women, home production can also include such gruelling chores as gathering firewood and carrying water; plowing and harvesting; building houses, grinding and milling grains and caring for animals (Ntoane, 1991; Wilson and Ramphele, 1989). Poor women also tend to have more children which adds considerably to their chores.

Many of these women are physically depleted from these chores and have very little time to care for these children, a situation which leads to child abuse and neglect.

Consideration of the health status of poor women will be incomplete without mention of an ever-increasing rate of sexually transmitted diseases. These are often not treated timeously because of fear of being prejudiced and stigmatised, even though these are generally passed on from husbands, particularly those who are migrant workers. With the spread of the epidemic AIDS, the lives of these poor women and their newborns are in even more danger (Ntoane, 1991; Rees, 1991).

Another area of inquiry which has not received the attention it merits concerns women's issues related to the workplace. The available information suggests that poor women are exposed to workplace hazards such as lead or solvents which may affect their fertility, lead to foetal damage, miscarriage or abortion and childhood cancer. Research is urgently needed in order to provide the basis for intervention in this important area.

African culture has disappeared from the big cities which, in addition, lack the social services available to city dwellers in the industrialised countries. Due to the harsh reality of the urban environment, the extended family with its protective structure is often replaced by the nuclear family unit. Another consequence of the rampant urbanisation is the general weakening of traditional family structures resulting in an increase in the number of female-headed households (Tulchin, 1986). According to Todaro (1986) South Africa is one of the countries in which about 40% of households are headed by women. This finding was also confirmed in recent studies conducted in the country (Cooper, *et al* 1992). Their poverty is only the most obvious symptom of how the urban environment can be disadvantageous to women. Considering that about 45% of the population in South Africa (of which 3,4 million are children) live in poverty, this situation is lamentable as it exposes a significant number of children to poverty-related diseases (Barometer, 1991). It often occurs that employed mothers leave for work before their children wake up in the morning and find them sleeping when they return, either because of their long working hours or public transport delays. These children are often on their own, unattended, without proper nutrition or supervision of either school attendance or homework. This situation is responsible for high rates of truancy, for children becoming dropouts, for illiteracy, juvenile delinquency and substance abuse. An alarming increase in numbers of "street children" attests to this situation.

Investigations show that street children the world over share a common aetiology – poverty, unemployment, family upheaval and violence, overcrowding, alcohol abuse among parents and school failure (Cockburn, 1991). It is estimated that Africa alone has five million street children. These children live among prostitutes, derelicts and drug-pushers on the streets. Very simply put, these children are the victims of urbanisation.

Mass poverty is the single most powerful circumstance inhibiting human, social and economic development, and a long list of problems, such as those mentioned above, are, in fact, the products of poverty. Society in general and the family in particular, stand to benefit if women's physical, mental and social being are improved. Any efforts aimed at coming near to achieving health for all by the year 2000, should address the adverse effects of poverty which militate against favourable maternal health, as well as the general health and optimal growth of the majority of South African children. Clearly the solution requires a political approach at the highest government levels, with women participating in the establishment of priorities and the implementation of programmes. This includes understanding the environment of the poor and an examination of the socio-political process necessary for the improvement of that environment. The new government's Reconstruction and Development Programme (RDP) promises to be such a tool. Its mission statement clearly states that mass poverty is the single greatest burden of South Africa and that its alleviation should be the first priority of the new government. In the section below, a closer look at the RDP, its objectives and some of the specific strategies for dealing with poverty are considered.

The Reconstruction and Development Programme

The RDP is a policy framework which seeks to mobilise the people and resources of the country towards the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future (African National Congress {ANC}, 1994). It promotes the idea that poverty is a social problem rather than a problem of personal failure, and that it requires a strategy that necessitates a broad attack on the fundamental causative conditions. This strategy advances the interests of disadvantaged groups, emphasises redistribution of power and influence, encourages enhancement of coping mechanisms of target populations and aims to strengthen community participation and integration. It aims at finding ways of working with people in extreme poverty that will enhance their independence instead of reinforcing their dependence. The strategy for meeting basic needs rests on the following four pillars:

(1) Creating opportunities for all South Africans to develop to their full potential.
(2) Boosting production and household income through job creation, productivity and efficiency, improving conditions of employment, and creating opportunities for all to sustain themselves.
(3) Improving living conditions through better access to basic physical and social services, health care, and education and training for urban and rural communities.
(4) Establishing a social security system and other safety nets to protect the poor, the disabled, the elderly and other vulnerable groups.

It is encouraging to note that the RDP specifically identifies women and children as sectors of society that require special attention. The new health policy is already providing free health care services for mothers and children under the age of six. The efforts to improve women's health extend to reproductive rights. The aim is to ensure that reproductive health care services promote people's right to privacy and dignity – which includes a woman's right to choose whether or not to have an early termination of pregnancy. Institutions, and other oppressive practices and laws that discriminate against women are being revised and brought in line with national policy. These measures will go a long way in ensuring that the health of children is taken care of. This attention to optimal growth and development in childhood represents an investment in future health and in national productivity.

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