INDICATORS OF POVERTY AND SOCIAL EXCLUSION PROJECT

Findings from the Indicators of Poverty and Social Exclusion Project: Health and a Safe Environment

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Key Report 4

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Contents

1. Introduction

This project is being carried out by the Centre for the Analysis of South African Social Policy (CASASP), which is based in the Department of Social Policy and Social Work, University of Oxford. The project is part of the South African Department of Social Development's (DSD's) Social Policy Analysis Programme which is itself part of a wider programme sponsored by DFID Southern Africa – 'Strengthening Analytical Capacity for Evidence-Based Decision-Making' (SACED).

Poverty research in developing countries has traditionally focused narrowly on income, and often on subsistence income. This conventional approach which is based on money-metric definitions and measurement of poverty, whilst relevant, does not capture the multi-dimensional nature of poverty. Research in developed countries had a similar focus until the 1970's when a paradigm shift occurred towards concepts such as multiple deprivation and, later, social exclusion. Policy makers in South Africa, a country categorised as a middle income developing country and still suffering from deep poverty and inequality resulting from the legacy of apartheid, still tend to define poverty in narrow income terms. The wider goal of this project is to build a strong conceptual and evidence base upon which a more complete understanding of the nature of poverty and deprivation in South Africa can be built.

The IPSE project addresses the following issues:

- What definitions of poverty and social exclusion are appropriate in contemporary South Africa?
- How can such definitions be operationalised so as to create measures and indicators that will usefully inform policy-making?
- What is the extent of poverty and social exclusion in South Africa using a consensual definition?
- What does a consensual definition of poverty/social exclusion imply for policies to alleviate poverty and generate a more inclusive society?
- How does a consensual definition of poverty/social exclusion relate to subsistence-based income poverty lines?

The IPSE project has three broad stages. These are:

Qualitative Stage: A detailed description of the qualitative stage of this project is available in Ratcliffe *et al.* (2005). In brief, though, fifty focus groups were conducted as part of the IPSE project. They were held in nine of South Africa's eleven official languages; six of the nine provinces; with groups covering a range of incomes; and each of the Black African, Coloured, Indian and White population groups. A full list of places where the focus groups took place is included in **Appendix 1**. Participants discussed what they considered essential or necessities that everyone in South Africa should have, be able to do or have access to; what they thought about exclusion for certain spheres of society, and who, if anyone, was excluded; their views on poverty and the poor in South Africa; and their aspirations for the future. The question schedule for the focus groups is

contained in Ratcliffe *et al.* (2005). The aim of the qualitative phase of the project was, first, to inform the survey stage and second, to provide a valuable data set in its own right for analysis of people's views about necessities.

Survey Stage: Building on the insights coming out of the qualitative stage of the project a module was designed and incorporated into the 2005 South African Social Attitudes Survey (SASAS) – a nationally representative sample survey. The module was devised primarily to define poverty and social exclusion democratically. Questions included in SASAS have been used to generate a list of 'Socially Perceived Necessities' (Mack and Lansley, 1985) which are the basis for a set of poverty/social exclusion indicators. Additional survey questions will be incorporated into SASAS 2006 to measure the extent of poverty and social exclusion in terms of this set of democratically defined indicators.

The IPSE module in SASAS 2005 comprised 56 questions: 37 about possessions, 4 about activities, 9 about the neighbourhood and 6 about relationships with friends and family. The quantitative analysis therefore focuses on these 56 items which were all asked about in a similar way. People were asked to say whether they think each item or activity *is essential for everyone to have in order to enjoy an acceptable standard of living in South Africa today*. They were given four options as responses: 'essential' if they regarded the item or activity as essential in this way; 'desirable' if they regarded the item or activity as desirable but not essential; and 'neither' if they regarded the item or activity as neither essential nor desirable. A fourth and final category was 'don't know'. The first two of the four possible responses enable the respondents to distinguish between items that they think everyone should have, and those which they think it would be merely nice (but not essential) for everyone to have. The third category 'neither' allows respondents to state that the item or activity falls into neither of these categories (i.e. it is neither essential nor desirable).

The items in the IPSE component of the module were specifically selected to relate to a range of different standards of living. So, for example, some items were included that, though not essential for survival, might be seen by some groups as essential 'badges of inclusion'. For practical reasons, the list of 56 items was shorter than it could have been and the findings are therefore indicative rather than exhaustive. Thus for example a flush toilet was included, as was a bath and shower, but piped water to the dwelling was not included as this would be covered by default by the other two items. It was also necessary not to repeat issues that were covered elsewhere in the Survey and hence there was no question in the IPSE module as to whether having a job was a necessity as this was already prominent in other parts of the survey. A list of the responses to the 56 items is shown in **Appendix 2**.

Analysis Stage: The data generated by the SASAS module are being analysed to provide a detailed, multidimensional picture of poverty and social exclusion in South Africa. This stage of the project is ongoing.

Aim of this report

Good health and a safe living environment are fundamental indicators of well-being. They are also important domains of a multi-dimensional model of poverty. This report explores the perceptions of South Africans, measured both qualitatively and quantitatively, on key aspects of their living environment in terms of what they regard as essential for an acceptable standard of living. The report does not cover issues regarding housing as these are addressed in a separate report (Magasela *et al.*, 2006).

This report aims to outline some of the qualitative and quantitative findings in relation to health and a safe environment. The report will use the qualitative stage of the IPSE project, and will supplement information with quantitative findings from SASAS 2005, where items were included.

The report briefly reviews key South African policy documents relating to health and a safe environment, and then looks at national indicators, challenges and progress within these areas. This provides a context for findings from the focus groups and the SASAS 2005 module.

2. Health and a safe environment in South Africa

2.1 Health and a safe environment: the international context

Concerns about health, personal safety, transport and the environment take place within a worldwide context. International evidence has recently highlighted the centrality of health and personal safety in developmental goals of reducing poverty and promoting social inclusion. The Millenium Development Goals (United Nations, 2003), to which the South African government has committed, includes indicators of the proportion of the population using solid fuels, the proportion of the population with sustainable access to an improved water source and the proportion of population with access to improved sanitation. Further indicators for Africa include basic social services (basic education, primary health care, nutrition, safe water and sanitation), and the proportion of the population with access to affordable essential drugs on a sustainable basis.

The World Development Report 2004 (The World Bank, 2004) emphasizes the importance 'not just of faster economic growth and the flow of sources, but of the ability to translate those resources into basic services, especially in health, education, water, and sanitation. Too often, the delivery of services falls far short of what could be achieved, especially for the poor.' The World Development Report 2006 further stresses the need for access to healthcare, justice systems and infrastructure (The World Bank, 2006). The most recent World Health Report (World Health Organisation, 2006) focuses on shortages of health workers, particularly in Sub-Saharan Africa, and the 2006 Human Development Report (UNDP, 2006) is titled 'Power, poverty and the global water crisis', and focuses on sustainable sanitation and clean water supplies. This focus in the global literature reflects an increasing perception of the importance of health and the living environment, and a move beyond concerns centred around income poverty.

2.2 Health and a safe environment in South Africa: the Constitution and key documents

These research finding are products of a specific time in South African policy. They reflect and respond to the introduction of government intervention strategies to improve infrastructural and neighbourhood services in relation to health and a safe environment. Both government and participants' responses must be discussed within the context of the South African Constitution (Republic of South Africa, 1996a), and other key policy documents such as the White Paper on Reconstruction and Development (Office of the President, 1994) and the Accelerated and Shared Growth Initiative (ASGISA) (The Presidency, 2006). By reviewing relevant parts of the Constitution relating to the living environment, and presenting an overview of state policies on the living environment, we present a background against which focus group participants' views can be judged to be in line with or different from what the state sees as critical areas of intervention in

ensuring a quality living environment for all. In a sense the focus group discussions are a test of the match and correspondence between state policies and the expressed views of South African citizens on the living environment.

The Constitution contains specific commitments relating to an acceptable and quality living environment for all South Africans, both at the national and neighbourhood levels. For example the Constitution stipulates obligations on the state to promote and fulfill rights to health care services, education and police services. These obligations translate to the need to provide proper facilities (buildings and personnel) in neighbourhoods. Individual department policies, such as the building of clinics, schools, libraries, and access roads in rural areas, indicate these constitutional requirements.

One of the central commitments expressed in the Preamble of South Africa's Constitution is to 'improve the quality of life of all citizens and free the potential of each person'[1]. This commitment places a range of responsibilities on South African society, primarily through the state and its intervention policies and strategies. Part of the responsibility deriving from this commitment is to ensure that neighbourhoods in South Africa (whether rural or urban, formal or informal, low or high income) are of such standard and quality that the objective of improving the quality of life of all South Africans is not compromised. The living environment in South Africa must be such that facilities and amenities provide opportunity for each person to free their potential. A healthy, habitable living environment with essential services such as sanitation, health care facilities and adequate policing are examples of the most critical interventions in this regard.

Human dignity is a 'foundational value' of South African society[2]. The attainment of human dignity in the South African context is linked to the realisation and enjoyment of social and economic rights contained in the Bill of Rights[3]. Some of the social and economic rights relate directly to ensuring that South Africans live in quality physical environments. The issue of a quality living environment, particularly regarding social services and amenities, was raised strongly in the focus groups.

The Bill of Rights enshrines a number of rights which, when considered together, direct state policies towards achieving quality living environments. On the environment, the Bill of Rights states that 'everyone has the right to an environment that is not harmful to their health or well-being'[4]. On health services, 'everyone has the right to have access to health care services'[5]. On police services, the Constitution states that 'the objects of the police service are to prevent, combat, and investigate crime, to maintain public order, to protect and secure inhabitants of the Republic and their property, and to uphold and

[1] Constitution of the Republic of South Africa, May 1996, Act 108 of 1996, Preamble.
[2] see Chapter 1 'Founding Provisions' in Constitution of the Republic of South Africa, May 1996, Act 108 of 1996.
[3] See former Chief Justice A. Chaskalson in The Third Bram Fischer Lecture '*Human Dignity as a Foundational Value of our Constitutional Order'*, South African Journal of Human Rights, 2000, Vol 16 and Liebenberg S 'The interpretation of socio-economic rights' in Chaskalson M *et al Constitutional Law of South Africa*, 2nd ed, 2003.
[4] Section 24 of Constitution of the Republic of South Africa, May 1996, Act 108 of 1996.
[5] Section 27 of Constitution of the Republic of South Africa, May 1996, Act 108 of 1996.

enforce the law'[6]. As will be seen in later sections of this report, the issue of crime and the safety and security of persons and property featured prominently in views expressed by focus group participants. The Constitution places obligations on the South African state as the state 'must respect, protect, promote and fulfil the rights in the Bill of Rights'[7] including rights relating to the living environment mentioned above.

The link between human dignity and social and economic rights, and by extension a quality living environment in line with the commitment to improve the quality of life of all South Africans, has been argued by commentators on the South African Constitution. In the words of former Chief Justice of the Constitutional Court, 'South Africa's socio-economic rights in the Bill of Rights are 'rooted in respect for human dignity… for how can there be dignity in a life lived without access to housing, health care, food, water or in the case of persons unable to support themselves, without appropriate assistance?'[8].

The Constitutional Court argued for this connection of essential services and human dignity in the Soobramoney versus Minister of Health (KwaZulu-Natal) judgement. In this case the Court was of the view that;
We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty… Many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring[9].

The White Paper on Reconstruction and Development (Office of the President, 1994) outlines 'an infrastructural programme that will provide access to modern and effective services such as electricity, water, telecommunications, transport, health, education and training for all our people' (p8, 1.3.6).

It identifies a range of basic needs to be fulfilled, including 'job creation…water and sanitation, energy supplies, transport, nutrition, health care, the environment, social welfare and security' (p9 1.4.3). Specific goals relating to the living environment include rural water provision (p43, 1.1) and 'ensuring availability of free health services' to under-6s and pre-and post-natal care. There is a clear commitment made to the development of community resources, as seen in the planned Urban Renewal Projects: 'integrated provision of infrastructure, housing, community facilities, job creation, environment and recreation facilities' (p.43, 2.4).

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[6] Section 205 of Constitution of the Republic of South Africa, May 1996, Act 108 of 1996.
[7] Chapter 2, Bill of Rights, Section 7 of Constitution of the Republic of South Africa, May 1996, Act 108 of 1996.
[8] Former Chief Justice A. Chaskalson in The Third Bram Fischer Lecture '*Human Dignity as a Foundational Value of our Constitutional Order'*, South African Journal of Human Rights, 2000, Vol 16.
[9] Constitutional Court of the Republic of South Africa, *T Soobramoney versus Minister of Health (KwaZulu-Natal),* November 1997, paragraph 8.

The more recent ASGISA document (The Presidency, 2006) reports increased government expenditure on infrastructure such as electricity, provincial and local roads, bulk water infrastructure and water supply networks, energy distribution, schools and clinics, police stations, courts and correctional facilities (p4). These, and other policy documents, show a government commitment to improving provision of services aimed at ensuring health and a safe environment in South Africa.

2.3 Parameters of this report

There are many aspects which affect the health and safety of a community's living environment. These range from macro influences such as climate change, to personal and household factors such as prevention of child accidents and use of paraffin stoves. This report focuses on a particular set of areas related to health and personal safety: guided by the concerns of focus group participants. These are largely concerns at the individual and neighbourhood levels: healthcare services, environmental safety, emergency services, security and transport.

3. Context and project findings in relation to health and a safe environment

For each topic within this report a brief outline of relevant context in terms of national policy will be provided, before the findings for each of the topics are presented relating to the focus group stage and the 2005 South African Social Attitudes Survey stage.

3.1 Analysis strategy

Qualitative data: Focus group transcriptions were analysed using content analysis, and used both qualitative and quantitative operations on the text (Weber, 1985). Firstly, all 50 focus groups were read through, and broad themes were derived. Secondly, all focus groups were re-read, and significant statements relating to each theme extracted (Colaizzi, 1978). Meanings were formulated in order to produce clusters of themes. Themes were compared within and across categories to establish consistency (Glaser & Strauss, 1967) and referred back to original focus group transcripts in order to validate them. Priority was given to factors endorsed by high numbers of participants, and with high agreement between focus groups.

*Quantitative data***:** The IPSE questions were located in the Poverty and Social Exclusion (PSE) module within version 1 of the South African Social Attitudes Survey 2005 (SASAS 2005). A total of 2,850 interviews were successfully completed for Version 1 of SASAS 2005 which represents a response rate of 86.3%. There were very few missing responses in the PSE module: (range: 0.1% - 1.0%; mean: 0.3%). Similarly, there were very few 'do not know' values (range: 0 - 1.5%; mean: 0.3%).

Cronbach's Coefficient Alpha is a technique which can be used to test the reliability of the set of items that have been identified as 'essentials' . For the 38 items that were defined as essential by 50% or more of the population, the scale reliability coefficient (alpha) was calculated to be 0.9045.[10] This score measures the correlation of our set of 38 items with all other hypothetical 38-item sets of 'essentials'. The square root of the coefficient (alpha) is the estimated correlation of our set of 38 questions with a set of errorless true scores: this was calculated to be 0.9510. The 38 'essentials' that have been identified can therefore be considered to be a highly reliable set of deprivation measures (Nunnally, 1981). They correlate very highly not only with another reliable set of 38 deprivation measures (0.9045), but also with a set of errorless measures of deprivation (0.9510). The coefficient alpha is higher than was achieved in a similar recent study in the UK (Gordon and Pantazis, 1997: 17).

As well as considering overall responses, responses were compared for men, women, people in urban and rural areas, people in different age groups, the four main population

[10] The 38 items were first made into binary variables (where 1= 'essential') and standardised.

groups, people above and below a subjective poverty line[11], and people above and below an income threshold of 200% of mean equivalised household income. Responses for these different subgroups are mentioned in the sections below where relevant.

3.2 Healthcare

Healthcare policy: a brief overview

Pre-1994 healthcare policy: Healthcare policy during apartheid was characterized by inequalities in healthcare spending between racial groups (Williams, 2000), and use of health policies to maintain apartheid systems (Price, 1986). Provision of healthcare for black Africans, both within and outside the Bantustans, was geared towards providing a black labour force, and controlling patterns of migration.

Post – 1994 healthcare policy and legislation: The right to health care services is provided for in three sections of the South African Constitution (S.27). These state the right of universal access to health care services including reproductive healthcare, and medical services for detained persons and prisoners. Further, the constitution states that 'no one may be refused emergency medical treatment'. Children's rights are enshrined in section 28 (1)(c) of the Bill of Rights and provides for "basic health care services" for children'. Whilst healthcare for children is clearly a key concern, findings relating directly to child health will be addressed in Key Report 5: Children's Necessities.

Health-related legislation currently in use includes a range of pre-1994 legislation such as the Medicines and Related Substances Act (101 of 1965) and the Health Professions Act (56 of 1974). Post-apartheid legislation has included the National Health Act (61 of 2003), which requires equitable provision of healthcare, within the limits of available resources. However, to date only some of the sections of this Act have been brought into effect. Further legislation includes the Choice on Termination of Pregnancy Act (92 of 1996) and the Mental Health Care Act (17 of 2002), which seeks to introduce Review Boards for all institutions dealing with mental health. More recently, the Traditional Health Practitioners Act (25 of 2004) has sought to improve integration and accountability of differing forms of healthcare within South Africa. Forthcoming legislation includes the Nursing Act (33 of 2005) (yet to be promulgated) which regulates education, training, research and the Nursing Council, and the Health Professions Amendment Bill (Bill 10 of 2006), which provides for ministerial nomination of members of the professional boards. The Department of Health's National Human Resources Plan for Health aims to address the serious shortages of health personnel, but is currently in early stages of enactment.

Constitutional judgements: Key constitutional court judgments relating to healthcare include Grootboom (1996) and The Minister of Health and others v Treatment Action

[11] People are defined as subjectively poor in this report if they said that their household had an income that was less than the income that they defined as necessary for the household to be able to make ends meet.

Campaign and others (no.2), which required provision of neviropine to pregnant women attending public health clinics. Debate continues regarding adjudication on pricing of medicines and dispensing fees by pharmacies (Gray & Pillay, 2006).

Challenges and achievements: The document 'Towards a ten-year review' (The Presidency, 2003), reports an increase in public health expenditure from 1994 until 2002, although a static per capita expenditure. The introduction of free healthcare for women and children under 6, and the national clinic building programme, have improved immunization status from 63% to 72% nationally. However, per capita Primary Healthcare visits are still under the WHO recommended number, and child stunting, wasting and infant mortality have all risen. TB and AIDS treatment rollouts remain below targets.

The most recent available indicators regarding healthcare are provided by the South African Health Review, published annually by the Health Systems Trust (Ijumba & Padarath, 2006). This document reports slow implementation of the National Health Act and the Mental Health Act, but 'favourable progressive public health spending' and notable growth in district health services, including HIV, primary healthcare and emergency services (p11).

South Africa's healthcare system must be seen within the context of the enormous challenges presented. For example, 30.2% of antenatal attendees were HIV+ in 2005 (Department of Health, 2005), and TB prevalence amongst women of 43.5% in 2004, is further complicated by the emergence of drug-resistant strains. The HIV epidemic, in particular, contextualizes many health indicators, such as a rise in infant mortality from 28.8 per 1000 live births in 2001, to 38.1 in 2004 (Statistics SA, 2006).

Key challenges remain of access to healthcare in rural areas (Tanser, Hosegood, Benzler, & Solarsh, 2001), scarcity of healthcare personnel (Castro-Leal, Dayton, Demery, & Mehra, 1999), and variable infrastructural resourcing of healthcare facilties (Duse, da Silva, & Zietsman, 2003). Prevention of HIV/AIDS and care of AIDS-unwell patients remain controversial policy areas (Sidley, 2006).

Access to healthcare

Access to healthcare ranked as the most important item in SASAS 2005: 91% of all respondents said that it is essential to have 'someone to look after you when you are very ill'. This view was shared equally by men and women, and by the young (those aged 16-25) and old (those aged 65 and over) but was slightly higher for people in rural areas (94%) than in urban areas (90%).

In the qualitative stage of the project, access to healthcare services was also a key concern of participants, and was raised in all focus groups. Lack of physical access was described, due to distance from healthcare facilities:

> ‘People in rural areas who are very far from hospitals. You find there is a cholera epidemic and they die because hospitals are very far.’
> (African, Low Income, Urban, Informal, Zulu, Male, Clermont, Kwa-Zulu Natal)

Lack of access was also a concern for people in poor urban areas where transport was limited or unaffordable:

> ‘There are no clinics. Those that exist do not have medicines. We would like to have more clinics.’
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male)

The SASAS 2005 module revealed how important it was for people to be able to visit relatives in hospital or other institutions: 74% of respondents said that it was essential to be able to visit friends or family in hospital or other institutions. Responses between men and women, and between people in urban and rural areas were very similar, but this issue was particularly important for Black African (77%) and White respondents (70%).

In the focus groups, the need for emergency healthcare was also highlighted:

> ‘Clinics must not be closed on weekends…They must be open for 24 hours’
> (Luganda, KZN, African Middle Income, urban, formal, Zulu, male).

and overburdened services were reflected in lengthy waiting times:

> ‘Many times you need help from the clinic, but they turn you away and they will tell you to come the next day because the clinic is too full.’
> (Phillipi, Western Cape. Coloured, Low Income, Urban, Formal, Afrikaans, Female)

Two groups in particular were perceived to be excluded from access to healthcare. Disabled people experience difficulties in traveling to clinics, and focus groups suggested discrimination for this group and those who suffer from mental health problems:

> ‘There are people who are disabled, but they are chased away by the nurses’
> (Winnie-Mandela, Tembisa, Gauteng, African, Low Income, Urban, Informal)

Inaffordability of healthcare was stressed in the majority of focus groups; this included both medical appointments and medication:

> ‘Oohh. those who cannot afford cannot go to a hospital’
> (Winnie-Mandela, Tembisa, Gauteng, African, Low Income, Urban, Informal, Sepidi, Male.)

Affordability of healthcare was considered in the SASAS 2005 module when people were asked whether it was essential for people who are sick to be able to afford all medicines prescribed to them by their doctor: 81% of people said that this was essential. This view was shared by men and women, and people in urban and rural areas. However, there were differences between population groups in response to this question: 81% of Black African and 83% of White respondents defined this as essential, compared with a lower 74% for Coloured respondents and a much higher 92% for Indian/Asian respondents.

Facilities in healthcare

Focus groups, particularly those in the poorer areas, highlighted lack of facilities in state healthcare

> 'According to the present situation, one must first go to the clinic before going to the hospital. In both clinics and hospitals there is no help because there are no medicines. You receive the same tablets. This forces one to visit the private doctors who charge R120-00 and if one can't afford this amount s/he may end up dying.
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

> 'Hospitals are lacking many things like equipment, appropriate medicine and even doctors often leave our countries.'
> (MALIBU (EERSTERIVER), Western Cape, Coloured, Middle Income, Urban, Formal, Afrikaans, Male.)

The skills drain of healthcare staff was felt to be a key problem, with participants describing 'miserable doctors', 'frustrated doctors', 'poor provincial medical services' (FG 05. Gauteng. White, High income, Urban, Formal, Afrikaans, Males.)

Specialised services

Focus groups highlighted HIV/AIDS services as a particular concern. These ranged from a stated need for anti-retrovirals (particularly nevirapine to prevent mother-to-child-transmission) and material requirements for home-based care

> 'The Government should supply us with gloves so that we can be able to offer first aid to those in need. These are necessary to avoid HIV/Aids infection whilst giving aid.'
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

to preventative education

> 'We have a new epidemic, HIV/AIDS. We need more awareness programmes about that. They help you with TB, but not with HIV/AIDS…more educators or peer educators must be made available to give more information.'
> (OCEAN VIEW, Western Cape, Coloured, High Income, Urban, Formal, Afrikaans, Male)

Focus group responses showed a perception of health as wider than purely medical assistance, and included social services and mental health provision

> 'Counselors counsel the rape victims, children and AIDS sufferers.'
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa Females)

as well as pharmacists, dentists, social workers and public health officers

'Social services are also there for children that have learning problems and also people that have children that have drug problems where they will refer or transfer children. They are also there to assist parents to help their children.'
(Heideveld, Western Cape, Coloured, Middle Income, Urban, Formal, Afrikaans, Female.)

'I think that one of the reasons for our suffering is due to the absence of health officers. When I lived in Queenstown there used to be health officers who would educate members of community on health matters. People residing in urban areas eat bad diets. They eat a lot of fried food which makes them sick whereas their rural counterparts eat lots of vegetable. This is because of the lack of health education.'
(Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male)

In the SASAS 2005 module, 72% of respondents said that it was essential to have someone to talk to if they were feeling sad or depressed. Amongst the different population groups, 75% of Black African people said that this was essential – the highest for the four main population groups. A much higher percentage of people below the income threshold (200% mean equivalised household income) – 73% - stated that this was essential than those falling above this threshold (63%).

3.3 Emergency services

Emergency services policy: a brief overview

Pre-1994 Emergency Services Policy: Ambulance services have traditionally been provided by provincial government departments, as have emergency social services, fire and police emergency response services. Apartheid-era provision of emergency services was comparable to that of health sector services, with distinct and poor-quality provision to non-white and especially homeland areas.

Post-1994 Policy and Legislation: Emergency services continue to be underfunded (Poggiolini, 2004), but have been supplemented by private-sector providers such as Netcare911 and a huge number of private security firms. Volunteer and non-governmental-sector provision has included emergency social services such as Rape Crisis and Child Welfare South Africa, and volunteer staffing of fire services. However, private and voluntary-sector provision is unable to ensure equitable and universal services.

The Rural Doctors Association draft Rural Health Strategy (Rural Doctors Association for South Africa, 2006), envisages aims for 2009 as including 24 hour provision of emergency services, and ambulance response time of less than one hour for any fixed facility. Legislation for the differing types of emergency services largely fall under the relevant departments (health, social development and SAPS), although policy documents

do combine services in planning for disaster management (Republic of South Africa, 2002).

Challenges and achievements: Emergency services are likely to be further stretched. The HIV/AIDS epidemic, high urban crime rates and increasing awareness of child abuse (Dawes, 2002), all affect a largely poor population. Limited provision of primary and preventative services (such as lack of free access to hospital care), lead to higher numbers requiring emergency provision. Events such as the spate of fires in the Western Cape in 2005-2006, which highlighted poorly resourced fire services, may place further demands on provincial departments.

Emergency services

Provision of emergency services was raised in many focus groups, and included all income and population groups. Scarcity and costliness of ambulances was seen as a health risk

> Participant: 'There should be more ambulances; it is not right to wait for one particular ambulance, because the sick person could even die while waiting'
> Participant: 'Helicopters should reach places where the ambulance can't in the rural areas'
> (Mzamohle- Gonubie, Eastern Cape, African, Low Income, urban, informal, Xhosa, females**)**

Social services were largely perceived as part of emergency health provision. Participants especially focused on crisis situations such as rape and child abuse

> 'Also open door businesses where people can go. Say a trauma centre if somebody were raped or if a child is in emergency. They must know where to go.'
> (OCEAN VIEW, Western Cape, Coloured, High Income, Urban, Formal, Afrikaans, Male.)

Fire services were also mentioned as a necessity:

> 'Access to fire departments…Especially here in squatter camps, there is a frequency of our houses burning down.'
> (Phillipi, Western Cape. Coloured, Low Income, Urban, Formal, Afrikaans, Female)

Police responses to emergency calls were also raised in the focus groups:

> We experience quite a number of problems. People may come and steal your furniture e.g. your wardrobe whilst you are away. Your property will be missing. When you phone the police, they promise to come immediately. Your call them at 1 p.m and they arrive at 3 p.m. or else they tell you that all the police vans are on patrol. You may have to wait.
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

Broader issues relating to the police are discussed in the next section.

Though it didn't contain specific questions about emergency services (apart from the question about police presence on the streets which is discussed in the next section), the SASAS 2005 module did reveal how important is was for people to feel that they were equipped to deal with emergencies *themselves*. For example, 72% of people said that it was essential to have someone who could transport you in a vehicle if you needed to travel in an emergency. Whether people had the emergency services or personal means of transport in mind is not known, but it is likely that many respondents had the latter in mind, and responses for this item were slightly higher in rural areas (75%) than in urban areas (70%).

3.4 Safety and security

Safety and security policy: a brief overview

Pre-1994 security policy: Apartheid era policing was largely focused on containing the 'internal threat' of non-white groups. Police-community relations were marked by high levels of police brutality, outbreaks of violence and mutual mistrust (Shaw, 2002).

Post-1994 security policy: Initial measures aimed at ensuring a peaceful transition to democracy included the National Peace Accord, which established norms for political parties, police, soldiers and the new national defense force. During the transition period, police services were demilitarized into a 'community policing service', and measures for accountability, human rights and addressing racial inequalities were introduced. It is testament to the peaceful nature of the transition, that safety and security concerns described in focus groups did not include fears of political violence or civil uprising.

Instead, the 'war on crime' has become the major challenge. The 1995 National Crime Prevention Strategy has led to strong reactive approaches towards crime. The 1998 White Paper on safety and security focused on crime prevention and police effectiveness. It emphasized 'regular patrols of high crime areas', street-level law enforcement including preventative patrols, directed patrols and high density policing. The National Crime Combating Strategy (2000) has led to further 'zero tolerance' strategies, such as 'Operation Crackdown', involving search operations and roadblocks (Dixon, 2000). It has also included the identification of exceptionally high-crime areas as 'crime combating zones'. These are areas where more than 50% of the serious, violent and organised crimes such as hijackings, attacks on farms and smallholdings, and bank robberies occur. Organised Crime Project Teams have been established in order to focus on identifying and 'neutralising' syndicates of gangs.

Key legislation has included the Child Justice Bill (2002), which proposes the development of a rights-based child justice system, and the introduction of Restorative Justice in youth offending. The Compulsory HIV-Testing of Alleged Sexual Offenders

Bill, (2003) and the Criminal Law (Sexual Offences) Amendment Bill (2003), aim to provide greater protection for victims of sexual offences.

Challenges and achievements: The post-apartheid government has carried out 'an ambitious, extensive and systematic process of reform' in security (Cawthra, 2005). This took place in the context of transition from authoritarian to democratic government, and also in the context of rising rates of poverty. However, gaps between policy and practice have led to sometimes fragmentary progress. Cawthra (2005) reports that 'levels of police repression and human rights abuses appear to have levelled out at approximately those of major US cities: while far from perfect, this is a far cry from the situation ten years ago and better than in most developing countries.'

However, crime levels (both reported and unreported) remain extremely high (South African Police Services, 2004). Particularly concerning are levels of violent and sexual crime, and the growth of organized crime syndicates. Whilst focus group respondents focused largely on external threats to safety and security, domestic crimes such as child abuse, known-offender rape and domestic violence are also at alarmingly high levels.

Responses to crime have included community and vigilante movements. These present clear problems for law enforcement, but have also been found to contribute to increased sense of community security (Leggett, 2004). The justice system has also had to adapt to the proliferation of private security provision. Non-state policing provides a significant proportion of safety and security services (Baker, 2002), with an annual turnover of R12 billion (Pillay, 2002). The extent of private security provision has led to debate surrounding the role of the police. For example, should state resources be concentrated on poor areas, leaving wealthier areas to be policed by private firms? (Minnaar & Ngoveni, 2004). Further challenges include accountability of security guards and firms, and the minimal training requirements for armed security personnel.

Attitudes to safety and security

Personal safety, safety of family members, and safety of possessions from crime, were issues raised by all focus groups: 'I think that we are all very anxious nowadays.' (Gauteng. White, High income, Urban, Formal, Afrikaans, Males). Security was seen as a highly important prerequisite for functioning society:

> Participant: 'Yes. I think it is important, the most important. Security. It creates an environment that you can do certain things. Where you can function. '
> (Gauteng. White, High income, Urban, Formal, Afrikaans, Males.)

Fear of crime was perceived as directly impacting on social inclusion:

> 'May I say something about friends as well. In the past we used to have a lot of friends, not that we don't now but because of crime you find that you don't really go out and socialise as much as you used to. You don't go and see your friend because of the accident situation, because of the crime situation. In the past we

used to freely go party, and go visiting people, now you're not safe in your own home.'
(Chatsworth, Durban, KZN, Indian, High Income, urban, formal, English, Female.)

Specific concerns raised included rape, robbery and abduction of children, and participants described a poor sense of personal safety both inside and outside their homes,

'In some areas it is difficult to walk around because some people get raped.'
(Mzamohle Informal Settlement (Gonubie), Eastern Cape, African, Low Income, Urban, Informal, Xhosa, Male.)

'Security is one of the biggest aspects because while you could be sitting in your own lounge watching TV or reading a newspaper you could be robbed in the privacy of your home. Happens everyday...'
(Chatsworth, Durban, KZN, Indian, Middle Income, urban, formal, English, Male.)

'To go into the streets in town is generally too dangerous.'
(Chatsworth, Durban, KZN, Indian, High Income, urban, formal, English, Female.)

People's responses to crime

A number of potential responses to the problem of crime were mentioned by participants. Many participants perceived crime as directly related to unemployment

'But if people had jobs there would be less crime. If people had enough money they wouldn't need to steal. So, it comes back to employment.'
(Chatsworth, Durban, KZN, Indian, High Income, urban, formal, English, Female.)

Harsher punishment for criminals, and specifically capital punishment, were also suggested:

Participant: 'Yes, if you want to get crime down you need punishment has to be reinstituted. For instance there is no capital punishment here.'
Participant: 'Death penalty maybe or stricter regimes in prisons because if you look at the prison situation in south Africa a criminal is given a TV and given 3 meals a day its quite comfortable inside there. So, punishment for criminals should be exposed to the public so that they know if they get caught committing a crime they will be punished.'
(Chatsworth, Durban, KZN, Indian, High Income, urban, formal, English, Male.

Police, and policing, were seen as crucial responses to crime. Participants expressed desire for greater numbers of police and police stations: 'Obviously it would be more police' (Durban, KZN, Indian, High Income, urban, formal, English, Male.)

> ‘Police Station, To protect us from criminals, reduce crime, feel safe to walk late, protects us from domestic violence’
> (Winnie Mandela, Gauteng. African, Low Income, Urban, Informal, Sepedi, Female.)

The need for more ‘visible policing’ was also raised:

> ‘People living in affluent neighborhoods are much safer. Police patrols are more visible in these areas.’
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

The need for more ‘visible policing’ was also evident in responses to the 2005 SASAS module: 77% of respondents said that it was essential to have police on the streets in the local area. Responses were the same (77%) for men and women, but a higher percentage of urban respondents defined this as essential (79%) compared with people in rural areas (a still high 73%). Indian/Asian respondents voted highest for this item (90%), but the other population groups were similar, with 78% of Black African respondents, 73% of Coloured respondents and 74% of White respondents defining it as essential.

However, there was variation in perceptions of the role of police in the focus groups. Whilst many participants saw policing as a positive service, some participants also raised the issue of police corruption.

Several focus group participants perceived a need for police to work in conjunction with the community in preventing crime: ‘Start police forums and involve tribal leaders in handling reported crime’ (Lokaleng village (Mafikeng) North West, African, Rural, Former Homeland, Low Income, Tswana Males)

> ‘I wish that the police will facilitate community policing forums charged with policing our communities.’
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

Participants’ described a responsibility of the community as a whole to respond to crime:

> ‘Where everyone stand together in one community to prevent crime’
> (SCOTTSVILLE, Western Cape, Coloured, Low Income, Urban, Formal, Afrikaans, Male).
>
> There should be cooperation between people and police…When Community Policing Forums (CPF) were formed people tend not to cooperate.
> (Mzamohle Informal Settlement (Gonubie), Eastern Cape, African, Low Income, Urban, Informal, Xhosa, Male.)

but responses also reflected tensions and difficulties in such arrangements

> ‘the Department of Safety and Security has tried to train community policing sectors but when we apprehend wrong-doers we are told that some of them are underage and they are released. This, when the culprit has committed numerous crimes in his/her community. Upon release, the culprit targets the members of the community policing committee. This gives an impression that the police are not

assisting in conflict resolution but are actually fuelling conflict in our communities.'
(Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

Personal responsibility for safety was also stressed. Participants' perceived necessities included burglar bars, alarm systems and especially dogs

Participant: Electric- fence, which makes the yard even more secured from the hooligans.
Participant: The other thing of great importance that plays an important role is the dog, which alerts you once an intruder has entered your space.
(Winnie Mandela, Gauteng. African, Low Income, Urban, Informal, Sepedi, Female.)

As discussed in the Housing report, although people emphasised the importance of burglar bars for the house (64% of people defined them as essential), only 42% of people defined a burglar alarm system for the house as essential, and 31% defined an armed response service for the house as essential. A much higher proportion of people defined a fence or wall around the property as essential (71%) and amongst the four main population groups this was highest for Black African respondents (73%).

Firearms were a divisive topic in the focus groups, with some participants seeing a gun as a necessity for self-defence

'You can buy firearm and pay fees at the gym that can make you to be able to defend yourself.'
(Mzamohle Informal Settlement (Gonubie), Eastern Cape, African, Low Income, Urban, Informal, Xhosa, Male.)

whilst others emphasized the danger of gun ownership, and saw a need for greater monitoring

'South Africa must be cleaned and freed from illegal guns that criminals use to rob banks, shops and highjack cars.'
(Gauteng. African, Middle Income, Urban, Formal, Sesotho, Male)

Participant: 'Censorship on gun issuing and licensing'
Participant: 'Close monitoring of gun owners'
(Gugulethu, Western Cape. African, Low Income, Urban, Formal, Xhosa, Male)

Cell phones and telephones were mentioned as important in personal security

'A phone is necessary especially when there are intruders and you are alone. You can make use of the phone to inform others about what is happening'
(Lokaleng village (Mafikeng) North West, African, Rural, Former Homeland, Low Income, Tswana Females)

Participant: Phone because once you are attacked you can be able to call the police; friends and family to ask for help including neighbours
(Winnie Mandela, Gauteng. African, Low Income, Urban, Informal, Sepedi, Female.)

The importance of cell phones and telephones emerged in the 2005 SASAS module too, with 64% of people defining a landline as essential, and 63% defining a cell phone as essential.

In the focus groups, electric street lighting was mentioned frequently for safety purposes:

> Electricity is important for safety as well. When the street and a house is lit criminals cannot do as they please.
> (Winnie-Mandela, Tembisa, Gauteng, African, Low Income, Urban, Informal, Sepidi, Male.)

Street lighting also emerged as being extremely important in the 2005 SASAS module: a very high 91% of people said that street lighting was essential (the third highest item overall). Though highest for urban respondents (93%) it was also very high for rural respondents (86%). Comparing population groups, 88% of Coloured respondents, 90% of Black African respondents, 92% of White respondents and 98% of Indian/Asian respondents defined street lighting as essential.

3.5 Safe transport

Transport policy: a brief overview

Pre-1994 transport policy: Many of the transport difficulties faced by South Africa today are based in apartheid spatial engineering policies. These aimed to maintain control over transportation of labour from Bantustans to urban areas, and to restrict black populations to residential townships on the metropolitan fringe, necessitating long trips to work and other destinations (Orcutt, 2007). This was described in the Reconstruction and Development Programme (2.9.1)

> The policy of apartheid has…burdened the workforce with enormous travel distances to their places of employment and commercial centres, and thus with excessive costs. Apartheid transport policy deprived the majority of people of a say in transport matters, and has led to the payment of huge travel subsidies; exposed commuters to vast walking distances and insecure rail travel; failed to regulate the kombi-taxi industry adequately; largely ignored the country's outrageous road safety record; paid little attention to the environmental impact of transport projects, and facilitated transport decision-making bodies that are unwieldy, unfocused, unaccountable and bureaucratic.'

In the 1980s, the Kombi-taxi industry was encouraged as a substitute for reduced public transport, and Kombis now constitute up to 50% of urban transport. However, poor regulation has resulted in chaotic service, lack of safety standards or accountability, unregulated fares and 'taxi wars' between rival companies.

Post-1994 transport policy: The RDP white paper (Office of the President, 1994) highlights the key role of transport in reducing poverty and especially rural deprivation.

Policy objectives included large-scale infrastructural spending on roads and public transport. The White Paper on National Transport Policy (Republic of South Africa, 1996b) aimed to improve public transport infrastructure and maintain environmentally friendly principles. In 2000, the government outlined plans for increased spending on public transport, identifying 2.8 million citizens, and 13% of the urban population as 'stranded'. Identified problems include unaffordable public transport and location of townships (Department of Transport, 2000). However, post-apartheid transport legislation has largely concentrated on road transport (such as the Road Accident Fund Amendment Act no.19 of 2005) and air and sea transport (such as the South African Airways Unallocatable Debt Act, No. 7 of 2000).

Challenges and achievements: Patchy provision of public transport and roads, particularly in rural areas, have been identified as a continuing obstacle to improved economic development (Standish & Boting, 2004) and pedestrian safety (Ribbens, 1995). Particular concern has arisen around the need for reduction of illegal taxis and taxi conflicts (Dickson, 2005).
'For many cities, the lack of an effective public transport system is a major impediment to local economic growth, job creation, new investment and the expansion of the tourism industry.' (McKenzie, 2004)

Current transport strategies appear to vary widely between provinces and major cities. For example, Cape Town has plans to introduce parking and road levies, and to increase rail capacity, whilst Johannesburg continues low investment in public transport and highway expansion. However, advances have been made in areas such as de-monopolisation of bus services in metropolitan areas, and a new focus on environmental concerns in transport policy. It is clear that the importance of transport as a prerequisite for poverty reduction should not be underestimated.

Transport

Transport was a recurring theme throughout focus groups (especially lower-income groups), and related to a range of areas, including economic opportunities, access to services and social activities. This report will focus on aspects of transport which are relevant to health and a safe environment. Focus groups living in informal settlements and rural areas frequently highlighted the necessity of roads and bridges

> Facilitator: You mentioned roads. Why do you think roads are essential?
> Participant: So that cars can reach where we stay.
> (Dududu, KZN, African, Low Income, Rural, Zulu Females)

Road quality was also often raised, particularly in poor urban areas

> Road maintenance…We mean the roads must be tarred so that when ambulances and police cars are coming here, they can reach the place quickly. The streets must be fixed.
> (Winnie-Mandela, Tembisa, Gauteng, African, Low Income, Urban, Informal, Sepidi, Male.)

In the SASAS 2005 module, tarred roads were the in the top ten items regarded by people as essential, with 'tarred roads close to the house' being defined as essential by 85% of respondents. 86% of urban respondents defined this as essential, and this was almost matched by rural respondents (82%). The same percentage of Black African and White respondents defined this as essential (85%), compared with 79% for Coloured respondents and 91% for Indian/Asian respondents.

Public transport was a frequent theme, with participants expressing wishes for more accessible and reliable, and particularly for safer, public transport

> People are also not safe when using public transport because of the poor condition of these cars.
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

For some participants, ownership of a car within the household was seen as essential, in light of unreliable or unsafe public transport

> 'I think each family must have a car because public transport is bad in this country. You cannot go anywhere after 7pm'
> (BramFischerville, Soweto, Gauteng, African, Low Income, Urban, Formal, Sesotho Female.)

In the SASAS 2005 module, 56% of respondents defined a car as essential for an acceptable standard of living. Responses varied widely by population group, ranging from 37% of Coloured respondents, to 55% of Black African respondents, to 61% of Indian/Asian respondents, to 75% of White respondents. Sixty-five percent of all those aged 16-24 defined a car as essential. Responses by area were similar, with 56% of urban people and 55% of rural people defining a car as essential. As might be expected, responses differed by income: 70% of those above the 200% mean equivalised household income defined a car as essential, compared to 53% of people below this threshold.

However, some participants in informal areas expressed fears of unsafe motorists

> 'Poor people have no rights. For example here where we stay, the small children play outside. The motorists don't care and they drive so fast. They are supposed to drive 20 km/h, but they drive 80 km/h. They will drive carefully in other decent areas, but not here by us.'
> (Phillipi, Western Cape. Coloured, Low Income, Urban, Formal, Afrikaans, Female.)

3.6 Environmental safety

Environmental safety policy: a brief overview

Environmental safety encompasses a wide range of short-and long-term issues, including carbon levels, air pollution and water safety. For the purposes of this review, we are exploring only a narrow area of environmental safety policy: the difficulties immediately

affecting the respondents of our focus groups. For a more comprehensive review, please see the 1999 State of the Environment Report (Department of Environmental Affairs and Tourism, 1999), which is in the process of being updated, and will be published as the State of the Environment Report 2005. This will include areas such as coastal ecosystems, biodiversity and environmental governance.

Pre-1994 environmental safety policy: Apartheid under-regulation of industrial activity resulted in high levels of environmental degradation, including desertification, acid rain and soil erosion (McDonald, 2000). More immediately, by 1994 12 million shack-dwellers did not have access to clean drinking water and 21 million did not have access to sanitation (African National Congress, 1994). Industrial dumping of toxic waste and pollution of rivers was frequently concentrated near African townships (Durning, 1990). This, and lack of basic municipal services, resulted in breeding of rats and disease in waste heaps, high levels of cholera, tuberculosis and diarrhoea. Lack of electricity resulted in indoor cooking with fuels such as charcoal and wood, leading to respiratory diseases.

Post-1994 environmental policy: Much of post-apartheid environmental policy has aimed at redressing the imbalance in provision of basic municipal services such as electricity, sanitation and waste removal. The 1996 Green Paper on an Environmental Policy for South Africa (Department of Environmental Affairs and Tourism, 1996) focused on redressing the direct consequences of apartheid inequalities regarding pollution, waste control and human settlement-level environmental concerns.

More recent legislation has moved towards wider 'green' concerns, and has included the National Environmental Management: Biodiversity Act no.10 of 2004 (Republic of South Africa, 2004b), and the National Environment Management: Air Quality Act (Republic of South Africa, 2004a). Current bills include the National Environmental Management: Waste Management Bill (2006).

Challenges and achievements: 'Towards a ten-year review' reports a rise in proportion of households with access to clean water, from 60% in 1986 to 85% in 2001, and a rise in access to sanitation from 49% in 1994 to 63% in 2003 (The Presidency, 2003). Progress has been made, but not at levels necessary to ensure full access to services. A recent analysis of access to electricity, water and sanitation services compared 1996 and 2001 Census data, and concluded

'It is apparent, nonetheless, that at the national level, improvements have been made in all indicators over the five-year period. For most indicators the gains are less than five percentage points, or one percentage point per annum'(Leibbrandt, Poswell, Naidoo, Welch, & Woolard, 2004).

Refuse, pollution and safe fuel

Focus groups expressed high levels of dissatisfaction with 'crowded unclean squatter settlements' (BramFischerville, Soweto, Gauteng, African, Low Income, Urban, Formal, Sesotho Female). This reflects a sense of the importance of pride in the neighbourhood: 'I

think our townships can be very nice places if people made flower gardens' (Gauteng. African, Middle Income, Urban, Formal, Sesotho, Male).

Participants expressed a number of health-related concerns associated with environmental safety. This included industrial pollution:

> 'In urban areas the houses are in or close to danger zones. If there are factories like clothing- and shoe factories where mechanical materials are set free and influence the people's health.'
> (Kaapzicht Farm, Western Cape, Coloured, Low Income, Farm-workers, Afrikaans Male)

In the SASAS 2005 module, 65% of respondents defined 'a neighbourhood without smoke or smog in the air' as essential. Responses varied by area, with 69% of urban respondents defining this as essential, compared to 59% of rural respondents. The greatest difference for this item was by subjective poverty: 73% of people defined this as essential if they were not subjectively poor, compared with only 55% of people who were subjectively poor. This does not necessarily mean that clean air is not important for people who are subjectively poor, but could rather mean that clean air is seen more as a luxury by those who are struggling to make ends meet.

In urban areas, inadequate refuse removal was a key concern:

> 'Municipality don't go into squatter camps, people in squatter camps dump their waste just next to where they live. They can easily be infected with diseases because of the rubbish'
> (Winnie-Mandela, Tembisa, Gauteng, African, Low Income, Urban, Informal, Sepidi, Male.)

> 'Where I stay there are neither toilets, streets nor water. Our municipality provides with refuse bags but our environment remains unhealthy.'
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

Refuse was particularly concerning as a health risk to children in a context of limited play space

> 'I have tried to get the municipality to clear the dumping site for 3 months. This dumping site poses a serious health risk to children playing there. They play with used syringes, using these as toy-guns.'
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

> To protect our children from germs, because children play in the rubbish, they put it into their mouths and this causes illness.
> (Phillipi, Western Cape. Coloured, Low Income, Urban, Formal, Afrikaans, Female.)

In the SASAS 2005 module 74% of people said that 'a neighbourhood without rubbish/refuse/garbage in the streets' was essential. This was a particular concern for

people living in urban areas (79% defined it as essential) but was also important in rural areas (65%).

Limited provision of electricity to poor areas was seen as leading to use of alternatives which constitute an environmental hazard

> In places where there is no electricity people use dangerous things such as firewood, stoves and candles
> (Mzamohle- Gonubie, Eastern Cape, African, Low Income, urban, informal, Xhosa, females)
> 'We live in informal settlements where you may find fuel like paraffin. A child may drink paraffin or even get burnt from the stove.'
> (Mdantsane, Eastern Cape, African, Low Income, Urban, Formal, Xhosa, Male.)

Mains electricity in the house was defined as essential by 90% of all SASAS 2005 respondents (the fourth highest item overall), and this scored highly across the board.

Clean water and sanitation

Provision of safe water was highlighted in many (particularly rural) focus groups:

> 'There should be clean water, especially in the rural areas.'
> (FORT BEAUFORT, Eastern Cape. African, Low income, Rural, Xhosa Males.)
>
> 'Water must be safe guarded so that germs for example- dangerous diseases like malaria fever do not get into the water.'
> (KAAPZICHT FARM, Western Cape, Coloured, Low Income, Farm-workers, Afrikaans Male.)
>
> 'A dam in our village is not well looked after, hence it is dangerous for our children. The government must help us to get clean water. Furthermore, the dam needs to be fenced because it has become dangerous for our livestock.
> (Lokaleng village (Mafikeng) North West, African, Rural, Former Homeland, Low Income, Tswana Males).

Provision of safe, clean toilets were mentioned in many of the lower-income focus groups, in relation to health hazards of insufficient sanitation:

> 'Even if we stay in shacks, they can at least make it comfortable, for example the toilets, the children get sick because we need to work with the "poo" ourselves, this causes germs. It is necessary to have clean toilets. Toilets that can flush.'
> (Phillipi, Western Cape. Coloured, Low Income, Urban, Formal, Afrikaans, Female.)
>
> Participant: 'Children fall into pit latrines.'
> Participant: 'In squatter settlements when it rains the pit latrines get flooded and I tell you it's not a pleasant sight.'
> (Gauteng. African, Domestic Workers, Urban, Informal, Sesotho, Female)

> ‘Every one must have toilets that flush including the rural areas, people in rural areas do not have flush toilets and tap water and they are vulnerable to diseases such as cholera’
> (Mzamohle- Gonubie, Eastern Cape, African, Low Income, urban, informal, Xhosa, females**)**

As was seen in the Housing report, 69% of respondents defined a bath or shower in the house as essential, and 85% of respondents defined a flush toilet in the house as essential.

4. Concluding remarks

This report contains qualitative and quantitative findings from the IPSE project relating to good health and a safe living environment. Using the 2005 SASAS module it was possible to explore a nationally representative picture of people's views about necessities in terms of these issues, and differences in responses between different subgroups.

On many aspects of health and a safe environment, there was a high level of agreement amongst and between focus groups. The importance of healthcare provision and healthcare staff were repeatedly emphasised, and included a broad sense of social and educational health services. Emergency services were a frequent concern.

Focus groups across cultural and socio-economic groups agreed on the importance of personal security in the light of neighbourhood-level threats. Suggested responses to crime differed, with police, security firms, and personal responses to security. Similarly, focus group views differed regarding car ownership, although there was a strong sense of necessity for improved public transport and for tarred roads.

Environmental safety at the neighbourhood level was highlighted by many of the focus group participants, and showed understanding of the health consequences of environmental degradation. The importance of street lighting, mains electricity, adequate sanitation and access to clean water was made very clearly in the groups, and these concerns are reflected in responses to the questions in the SASAS module.

These findings provide information about what South Africans regard as being essential for an acceptable standard of living.

The next themed report will focus on adults' views about necessities for children in present day South Africa.

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Appendix 1: The focus group locations and profiles

A total of 52 focus groups were undertaken, four of which were eliminated during the quality control process. The remaining 48 focus groups took place in the following places in South Africa:
Gauteng - Melville, Winnie Mandela, Diepsloot, Braam Fischerville (Soweto), Chiawelo (Soweto).
Eastern Cape - Mzomhle (Gonubie), Mdantsane, Umthatha, Fort Beaufort.
Western Cape - Scottsville, Phillipi, Malibu (Eersteriver), Heideveld, Ocean View, Milnerton, Khayelitsha, Gugulethu.
KwaZulu-Natal - Phoenix, Chatsworth, Dududu (Port Shepstone), Seven Oaks (Greytown), Clermont, Luganda, Umlazi.
Limpopo - Thohoyandou, Duthini (Thohoyandou), iTsani (Thohoyandou), Mavambe (Giyani), Mchipisi (Giyani).
North West - Lokaleng (Mafikeng)

Table A1: Profile of the 48 focus groups

Description of FG	Number of FGs
Urban	35
Rural	13
Female	21
Male	25
Mixed	2
African	34
Coloured	7
Indian	5
White	2
High Income	5
Middle Income	11
Low Income	32
IsiZulu	8
Venda	4
Tsonga	2
Xhosa	12
Afrikaans	8
English	6
Tswana	2
Sepedi	2
Sesotho	4
Total	**48**

Appendix 2: Summary of SASAS 2005 results

In the table below, the 38 items that were defined as 'essential' by more than half of the respondents are highlighted in bold.

Table A2: Percentage of people defining an item as 'essential'

Item	% of All saying essential
Someone to look after you if you are very ill	91
A house that is strong enough to stand up to the weather e.g. rain, wind etc.	91
Street lighting	90
Mains electricity in the house	90
A fridge	89
Clothing sufficient to keep you warm and dry	85
Separate bedrooms for adults and children	85
Tarred roads close to the house	85
A flush toilet in the house	84
For parents or other carers to be able to buy complete school uniform for children without hardship	83
Having an adult from the household at home at all times when children under ten from the household are at home	83
Ability to pay or contribute to funerals/funeral insurance/burial society	81
A place of worship (church/mosque/synagogue) in the local area	81
People who are sick are able to afford all medicines prescribed by their doctor	81
Somewhere for children to play safely outside of the house	78
A radio	77
Having police on the streets in the local area	77
Regular savings for emergencies	74
A neighbourhood without rubbish/refuse/garbage in the streets	74
Being able to visit friends and family in hospital or other institutions	74
Electric cooker	74
Television/ TV	72
Someone to transport you in a vehicle if you needed to travel in an emergency	72
Someone to talk to if you are feeling upset or depressed	72
A fence or wall around the property	71
A bath or shower in the house	69
A large supermarket in the local area	67
A neighbourhood without smoke or smog in the air	65
Burglar bars in the house	64
A landline phone	64
Some new (not second-hand or handed-down) clothes	63
A cell phone	63
Someone who you think could find you paid employment if you were without it	61
Someone to lend you money in an emergency	59
Meat or fish or vegetarian equivalent every day	59
A garden	56

A car	56
A sofa/lounge suite	52
Special meal at Christmas or equivalent festival	49
A lock-up garage for vehicles	47
A small amount of money to spend on yourself not on your family each week	46
Going to town/to a large supermarket for the day	45
For parents or other carers to be able to afford toys for children to play with	45
A burglar alarm system for the house	42
Having enough money to give presents on special occasions such as birthdays, weddings, funerals	42
A wheelbarrow	41
Washing machine	38
A family take-away or bring-home meal once a month	38
A holiday away from home for one week a year, not visiting relatives	37
An armed response service for the house	31
A cinema in the local area	30
A DVD player	29
A computer in the home	28
Money to buy a magazine	20
Satellite Television/DSTV	19
A domestic worker	18

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