Chronic Poverty and Development Policy

Cape Town's African poor

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Contents

1. Introduction **1**

2. Methodology **2**

3. Employment **2**

4. Money **4**

5. Hunger **7**

6. Morbidity **10**

7. Conclusion **13**

Endnotes **14**

References **14**

List of tables

Table 1: Comparing educational levels to the likelihood of obtaining paid jobs **4**

Table 2: Sources of income **5**

Table 3: Survival strategies during times of hunger **8**

List of figures

Figure 1: Main categories of monthly expenses **6**

1. Introduction

The typical 'face of poverty' in South Africa is no longer that of a rural woman engaged in subsistence agricultural production. Poverty today also refers to the large number of unemployed men who wait daily in vain on street corners for a casual job, women suffering from among the highest rates of HIV/Aids infection in the world, large numbers of children living in areas with among the highest crime and murder rates in the world, and poor black communities which continue to be excluded from the economic riches of our country. We can no longer ignore the problem of urban poverty.

A large part of Cape Town's less affluent population live on the Cape Flats, which was relatively unpopulated until the 1960s. Since then, two waves of settlement took place: the period after the 1960s saw the forceful resettlement of so-called 'Coloured' people through apartheid socio-spatial engineering, and in the 1980s a then illegal process of large-scale African migration from the impoverished areas of the Eastern Cape began (see Hindson 1987; Tomlinson & Addleson 1987). Numerous studies (see Swilling et al. 1991, for example) demonstrate how the combined effects of social engineering, spatial planning and rural-urban migration have contributed to urban sprawl, the expansion of racialised economic geographies, and the creation of an apartheid city. At present, the townships of Khayelitsha and Greater Nyanga are home to three quarters of a million people.

The uniqueness of Cape Town's urban sprawl is not restricted to its recent and rapid population growth, but also lies in the fact that it reflects a nexus of extremes (DBSA 1998; O'Leary et al. 1998). Cape Town has a strong and relatively varied economy with a monocentric structure, characteristic of South African cities. In a typical centre-periphery fashion, it represents a polarised city centre where affluent suburbs and economic activity present a contrast to the overcrowded, impoverished township periphery (Myonjo & Theron 2003a; 2003b). Whereas the majority of white and wealthy black people live opulent lifestyles, the majority of those on the Cape Flats live in abject poverty. This paper seeks to gain a greater understanding of the socio-economic realities and livelihood challenges facing the residents of Khayelitsha and Greater Nyanga.

2. Methodology

The Cape Town African Urban Poor (CTAUP)[1] study was conducted in Khayelitsha and Greater Nyanga, where the majority of Cape Town's African population resides. A Household Livelihood Survey (HLS) was used as the research instrument. Particular attention was paid to:

- livelihood assets, needs and strategies
- health status and assets (including anthropometrical measurements), and
- food security and nutritional status issues.

The HLS was undertaken from August to November 2002, randomly sampling 624 households for the purpose of a representative sample. The average number of persons per household was 4.6. The sample included 1 668 adults and 1 216 children, resulting in a total of 2 884 respondents. In-depth focus group discussions and unstructured interviews were also conducted during 2002.

3. Employment

Current research in South Africa indicates that transitions in and out of poverty relate to changes in employment status, particularly wage labour (Aliber 2003). The employment status of a household is a determinant of whether it remains in, escapes from, or falls into poverty. In this context, transitory poverty correlates with employment stability. Unemployment figures in the case study are high, with more than half of all households (52%) generating no income from wages at all, and almost two thirds (64%) of adults being unemployed. Overall, 23% of adults earn a permanent salary, 8% are occasionally employed and 5% are self-employed. Factory work constitutes a main portion of wage labour (13%), followed by general skilled work (9%) and domestic work (6%). Men are more likely to obtain paid jobs than females, with 52% of males and 72% of females having no paid work. Youth unemployment is particularly elevated: two thirds (67%) of individuals between 18 and 25 years are neither employed nor enrolled for further education. This figure decreases somewhat in the 26-to-30-year age group to 57%. Wage labour is the most important source of total household income. This is reflected in the average total income of R1 463 per month in households with some form of wage labour,

compared to the average income of R502 per month in households without wage employment. Even so, two thirds (67%) of wage earners do not earn enough to push their household above the poverty line, making them the 'chronic working poor', and half of the breadwinners (52%) receive less than R1 000 per month.

In addition to the fact that they earn low wages in general, the income of those households with employment is unstable and precarious. For example, in 32% of households the main breadwinner had lost his or her job at some point during the previous year, and 31% of households had suffered the permanent loss of a full-time job during the previous five years.

In order to understand the employment context in the case study, it is important to consider factors that might contribute to unemployment, such as spatial isolation, education and language. In this regard, 40% of main breadwinners take more than an hour to reach their work place. Train transportation is the most common means of accessing work (42%), followed by transportation by taxi (17%) and bus (15%). For 60% of breadwinners, a return journey to their work exceeds R20 per trip. Apart from the direct costs involved in transportation, its hidden costs reflect the multiple dimensions of poverty that need to be calculated as well, including ineffective means of transport and loss of time, social instability, and reduced access to potential jobs and commercial opportunities.

As generally assumed, the educational level of an individual is linked to his or her employment opportunities and ability to obtain a paid job. The majority of adult residents in the case study (94%) are literate, and most received between 6 and 10 years of schooling, with one third speaking exclusively Xhosa (that is, no English and/or Afrikaans).

However, only one fifth of respondents had completed matric (the South African final school certificate), and tertiary qualifications (including trade certificates) are rare. Furthermore, the level of education does not seem to make a difference in terms of *individual* residents obtaining paid jobs. In fact, residents with 11 to 12 years of schooling were less successful in obtaining wage labour than those with one to five years of primary education. The percentage of likelihood to obtain paid employment in relation to educational level is summarised in Table 1 on the following page.

The findings indicate that an educational level of between one and 12 years does not make a difference in the likelihood of residents obtaining paid jobs. However, when the data was analysed in terms of employment and educational level *within*

Table 1: Comparing educational levels to the likelihood of obtaining paid jobs	
Ranking	**Percentage likelihood of paid employment**
1	Tertiary qualification – **40.9%**
2	Standard 6–8 (8–10 yrs) – **40.4%**
3	Standard 4–5 (6–7 yrs) – **37.8%**
4	Standard 3 or lower (1–5 yrs) – **36.7%**
5	Standard 9–10 (11–12 yrs) – **33.9%**
6	No education – **31.2%**

one household (that is, both employment and the highest educational level were recorded, but the main breadwinner did not necessarily have the highest level of education), there was a significant positive correlation ($p = 0.05$) between years of schooling and wage. Those households with more years of schooling were more likely to have paid jobs with higher incomes. The greatest correlation between education and wage existed where the schooling of household members exceeded Standard 8. In addition, households were more likely to earn a higher income and wages if household members could speak English, and particularly if they spoke both English and Afrikaans.

These findings suggest that the educational levels prevailing *within* a household and the languages spoken by its members, particularly English and Afrikaans, influence people's chances of obtaining and maintaining paid jobs, implying a close-knit social system within households.

Since income levels are low and the nature of employment precarious, it is unlikely that even those people holding jobs could escape poverty in the long term. For this reason, an understanding of the sources of income and money is warranted.

4. Money

The HLS suggests that most households depend on multiple sources of income. Combining all sources of income, more than three quarters of households represented in the case study (76%) fall below the official poverty line of R352 per adult (equivalent) per month, at

an average of R212 per person (that is, R976 per household with 4.6 adult equivalents). Moreover, 33% of households have less than R100 per month per household member, and in 50% of all households the monthly income amounts to less than R185 per month per adult equivalent. Only 7% of households generate a monthly income exceeding R600 per adult equivalent. The main sources of income are shown in Table 2 (in descending order).

Table 2: Sources of income

Source	Average per household	Percentage of total
Wages	R555.71	58.4%
Social grants	R166.47	17.5%
Temporary employment	R82.06	8.6%
Self-employment (non-agriculture)	R75.12	7.9%
Other	R15.56	1.6%
Pension from employer	R12.98	1.4%
Remittances	R12.88	1.4%
Money from special friend	R12.60	1.3%
Self-employment (agriculture)	R8.55	0.9%
Rent	R6.08	0.6%
Seasonal work	R3.20	0.3%

Whilst wages constitute the most important source, namely nearly 60% of income, social grants represent the second most important source, accounting for 17% of income. Grants make a significant difference (p = 0.000) to the middle third income group earning between R500 and R1000 per month, with 55% of households receiving one or more social grants. The top third income group (above R1000) relies less on state social assistance, with 38% of households receiving grants. The lowest income group earns less than R500 a month and also seems to have the least possibility of obtaining grants (31% of households), even less so than the top income group. Language skills and educational level within households did not appear to impact on the possibility of receiving a grant.

Apart from temporary work and self-employment, other sources of income are limited, amounting to less than 8% of the

total income. The majority of households (83%) did not have any savings, whilst the savings of two thirds of households of the remaining 17% amounted to less than R1000. Respondents reported the following reasons for saving money (in order of the most recurrent reasons): buying food, paying school fees, health and medical care, and paying debts. Despite low income levels, 62% of all households invested in burial insurance, and 9% of households held life insurance.

Expenses incurred by households need to be measured both in terms of the amount spent, and in relation to income. Food represented the single largest expense, accounting for 39% of total monthly expenses. Next to food, the other largest monthly expenses included energy (10%), health (9%), clothes and furniture (8%), debt (5%), maintenance (5%), insurance (5%), and support for others (4%) (see Figure 1).

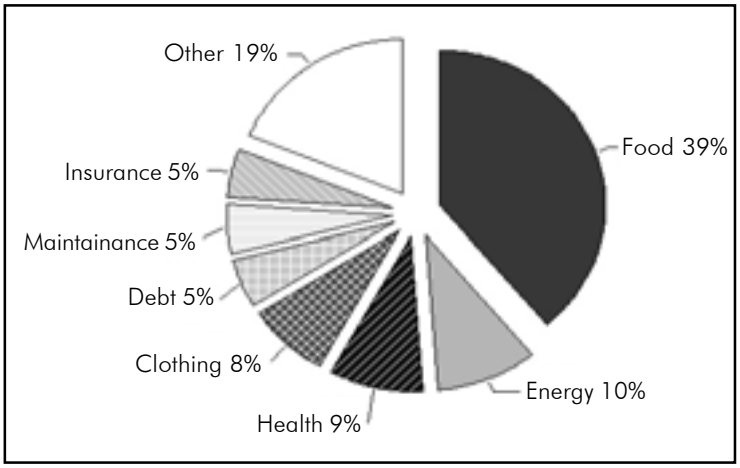

Figure 1: Main categories of monthly expenses

Fifty-six percent of households incurred debt, tending to incur debt primarily from hire purchase companies (26%), friends (12%), family (12%) and community members (19%). Based on an estimated median of the predetermined categories of debt, an approximate average figure for total household debt was calculated to be R1 872. Consistent with findings on savings and expenses, the most important reasons for debt were reported as follows: to buy food, to pay for schooling and medical expenses, and to pay off other debts. More specifically, debt was significantly higher in households with permanent employment (62%), than in households without a steady wage income (50%). There was a significant positive correlation between income and debt (p = 0.000), with the top earners holding the greatest debt.

Most of the higher income groups received a wage, and a positive correlation was evident between wage and education, and wage and language skills. Hence, a similar correlation between income and education/language was to be expected. Those households where members had more years of schooling and spoke English as well as Afrikaans generated a significantly

higher average *wage* per month than those where this was not the case. For example, the average monthly wage where members spoke neither English nor Afrikaans was R417, compared to R640 in households where members spoke both English and Afrikaans. The difference in *income* was even more profound, since households where nobody spoke English or Afrikaans generated an average monthly income of R767. Households with English and/or Afrikaans language skills produced R1 102 per month. This suggests that extended education and language skills increase the chances of obtaining a higher overall income, even if it is not the breadwinner him- or herself who possesses these skills.

The study shows that there is little cushioning for extraordinary expenses, particularly in the light of unstable income sources. It is also apparent from the *relative* debts which many of the households hold that borrowing and loans appear to be a short-term solution for many households that are seriously challenged to make ends meet. A lack of money in these poor areas has to be viewed in the context of food price hikes, and an expanding monetisation of services (health, education, transport), goods and housing. These impoverished communities are excluded from the economic mainstream due to their inability to secure stable employment. This coincides with their increased incorporation into the cash economy. These dual developments not only result in increased monetary impoverishment, but specifically impact on food security (hunger) and health issues (morbidity).

5. Hunger

Hunger is the most extreme expression of poverty, as the most basic bodily needs are not met. Internationally, a high proportion of the poor experience extended periods of hunger, as they are caught in a vicious cycle of chronic and severe poverty, a poverty deprivation trap (Burkey 1993:12–17; Chambers 1991:111). In the case study, a total of 70% of households had been excluded from access to sufficient food during the previous year. When enquiring about food security in the previous year, 81% of households indicated that there had been too little food available. Moreover, an average of 43% of households experience a food shortage at any given time of the year. The reported survival strategies in times of food shortage are summarised in Table 3.

Table 3: Survival strategies during times of hunger	
Coping strategy	**Percentage**
Could not do anything	40%
Borrowed / begged for food	33%
Borrowed money / asked for credit from food sellers	32%
Worked for food	13%
Collected from rubbish dumps / bins	2%
Other	16%

While 40% of households indicated that they could not address the food crisis, closer investigation revealed that non-English-/ non-Afrikaans-speaking households were less resourceful in terms of survival strategies (46% said they "could do nothing") compared to those with English and/or Afrikaans language skills (31% said they "could do nothing"). An even stronger positive correlation emerged between educational level and survival strategies ($p = 0.000$): the higher the educational level within a household, the more likely members were to address the food crisis actively and effectively. Access to a permanent salary also increased the likelihood of resourcefulness, with 70% of households employing various strategies to secure food (including loans and debt), compared to 51% of households that were unemployed.

When households compared their food security to that of the previous year, 54% of respondents felt that they were currently worse off, 27% maintained that their situation was about the same, and only 18% of households believed that their food security situation had improved over the previous year. Furthermore, 55% of all households indicated that their general food consumption had been *less* during the year of the survey compared to the previous year. Thus, based on the overall subjective perceptions in the case study, the extent of hunger appears to have increased over the preceding year.

Since three quarters of household incomes (76%) fell below the poverty line, it is not surprising that more than 80% of households experience insufficient amounts of food, and 70% reported hunger. Statistically, there was a negative and significant correlation between hunger and income level

(p = 0.000). Whilst income and food security are related, money is not the sole means of obtaining food. Home food gardening (that is, urban agricultural practices) and livestock farming are two potentially effective means to achieve food security that are not necessarily dependent on a monthly income. However, only 3% of households engaged in home food gardening (grains and vegetables), and do so solely for their own use and not for trading or selling. Similarly, livestock ownership is rare amongst households, with poultry representing the highest percentage of livestock held (11%).

In the small number of households engaged in urban agricultural activities, there was no indication that home food gardening and livestock farming reduced the vulnerability of households to hunger. These findings indicate that home food gardening and livestock farming are not effective sources for generating food security at present. The reasons for its ineffectiveness may lie in a vicious cycle consisting of spatial constraints, infertile soil and continued migration from rural areas, resulting in further overpopulation in urban areas (particularly in small towns) (Burkey 1993:11–25).

Food security needs to be analysed not only in terms of quantity but also quality, since households that have sufficient amounts of food may still be victims of undernourishment and malnutrition because the food lacks essential nutrients, vitamins and minerals. It is alarming that more than half of all the households (54%) rarely or never consume meat or eggs, 47% rarely or never eat fruit, and 34% rarely or never eat vegetables. The apparent decrease in food security and the reported increase in the frequency of hunger indicate that living conditions are deteriorating for large numbers of people in the case study.

Since the majority of poor people are dependent on their physical strength as a source of livelihood, the effects of lack of food security on poor health result in a devastating vicious cycle. Not only might food insecurity compound already poor health conditions, it might also be a causative factor in maintaining poverty levels. Whilst poor nutrition creates long-term health risks, it also exacerbates existing health problems, including HIV/Aids. As worldwide research indicates (Topouzis 2000), food insecurity can lead to devastating 'underinvestment' at crucial times in the human life cycle, and can permanently reduce people's capabilities. For example, inadequate child nutrition creates long-term health problems, including higher medical costs, mental retardation, poorer educational performance, and lower labour productivity, and is likely to impact negatively on overall life expectancy (Nel & Steyn 2002).

Increased direct access to household food production needs to complement the food relief programmes. Supportive home food gardening measures as a means to promoting food production in urban areas include:

- Optimum utilisation of existing public land (especially municipal commonage) and/or already existing potential garden space around houses
- Management of these gardens in partnership with local authorities and local communities, through integrated development planning, public-private and public-community partnerships, local economic development programmes and projects
- Development of community-based technical support services, incorporating indigenous knowledge systems
- Long-term subsidisation of cultivation expenses
- Appropriate skills development in schools and through adult learning programmes
- Promotion (for example in the media) of home food gardening as an important asset and capability-generating component of household survival strategies
- Deepening access to and improvement of water supply.

6. Morbidity

Poor health is a noted characteristic of impoverished communities due to the risks to which poor people are exposed. These include, in another 'vicious cycle', malnutrition, poor hygiene and sanitation, natural disasters and morbidity. More than one third of the case study respondents (37%) claimed that their health was poor, 11% reported health problems, and 36% did not access medical treatment when needed. However, there was no indication that hunger impacts directly on health status. For example, no evidence was found that hunger per se caused ill health amongst household members.

The case study demonstrates that there are several factors that affect both health and mortality. This is reflected in the two main causes of death, which are HIV/Aids and TB, or HIV/Aids and TB combined.[2] The age standardised mortality rate per 100 000 for HIV/Aids is highest in Nyanga (146) and Khayelitsha (103), and lowest in South Peninsula (10) and Blaauwberg (23)

(Scott et al. 2003). HIV/Aids-related death is a major cause of chronic poverty. Conversely, chronic poverty renders poor households more susceptible to HIV/Aids exposure and thus infection. HIV/Aids is not a single unicausal epidemic, and policy interventions need to be multipronged. The case study shows that the basic information on HIV/Aids prevention does not seem to be sufficiently clear or accessible to poor people, despite the implementation of extensive public awareness campaigns. There is a need for basic, yet specific and applied education and information regarding HIV/Aids, its transmission and prevention. In addition, it is critically important to extend the social safety net and roll out effective treatment regimes. There remains significant room for government to improve its performance in all these areas.

In the light of HIV/Aids mortality and the low and high impact projections by Calitz (2000a; 2000b), it is important to investigate the extent of people's understanding and knowledge base of the epidemic. The study reveals that 86% of people interviewed stated that they knew the causes of HIV/Aids infection, while 75% held the view that HIV/Aids could not be cured at present. However, when more specific questions were asked, it became apparent that many respondents did not have an understanding of HIV/Aids. For example:

- 23% of people considered sex with healthy-looking people to be safe (that is, no risk of HIV infection), and 14% did not know whether this was true or false
- 34% of people thought that HIV-positive people could not look or feel healthy, and 16% did not know whether this was true or false
- 34% of people believed that HIV/Aids could be cured at present if treated early enough, and 24% did not know whether this was true or false.

This lack of basic knowledge exists against the backdrop of a very high prevalence of HIV-positive adults. Antenatal surveys conducted in 2001 revealed a 22% infection rate in Khayelitsha and a 17% infection rate in Nyanga (Western Cape Provincial Government Records 2001). The Aids epidemic is expected to lower the life expectancy of black Cape Town residents to 40 years, decreasing by 15 years in six years' time.[3] In addition to contributing to the direct causes of morbidity as the ultimate symptom of chronic poverty, the case study identified three additional and related contributing factors, namely malnutrition, poor hygiene and sanitation, and general risk factors.

Firstly, inadequate diet resulting in malnutrition poses a health risk to impoverished urban communities. Malnutrition

not only manifests in wasting due to starving or insufficient amounts of food, but also in other forms, including obesity. Obese individuals in impoverished areas are often undernourished and compensate with large amounts of cheap, unhealthy food that is easily available (for example high-fat, refined-carbohydrate food with low fibre and protein content). Obesity amongst women emerges as a problem in the case study, frequently leading to high blood pressure and diabetes. Based on the Body Mass Index (BMI) scores of those women interviewed, 70% of women are overweight (with 24% overweight and 46% obese), and only 28% fell within the normal weight range. A further aggravating factor appears to be the sedentary lifestyle many women lead due to crime and lack of physical activity. Interestingly, those few households that engaged in home food gardening showed a 56% lower frequency of serious illness amongst members than those that did not. This finding indicates that home food gardens might provide an important food source that positively impacts on general health status and bolsters resistance to illness and infection.

Secondly, access to clean water and adequate sanitation are indicative of the overall hygiene level within a community and the expected risk of infections and illnesses. In this study, 59% of households derived water from water taps outside their shelter, whilst the rest used public taps. Similarly, 60% of households had access to a flush toilet, whilst other residents used pit latrines (13%) and bucket toilets (11%). Only 17% of households had a toilet inside their home, with the majority of households sharing outside toilets. Thirty percent of households reported difficulties in accessing a communal toilet, and 10% had no access to toilets. In addition, despite the presence of facilities for washing hands near toilets in 66% of households, only 24% had soap for washing hands after using the toilet. Overall, the hygiene status appears to be fairly poor, increasing the risk of infection from preventable diseases.

Thirdly, there are some general risk factors. At least two thirds of homes were found to be susceptible to water damage, and the majority of shelters were at risk from fire and wind damage. Despite the high percentage of households that had access to electricity (81%), paraffin is the most frequently used fuel for heating and cooking because it is considered to be cheaper than electricity. Besides the negative health and environmental consequences, this practice also increases the risk of accidents and fire. For example, according to a 2001 Markinor study an average of 11 children die each day in South Africa because of accidental paraffin consumption (Pfaff 2001),

and of the 118 000 children per annum who accidentally drink paraffin, 55 000 are hospitalised with chemical pneumonia (Ridyard 2002). In addition, the study indicated that annually 46 000 fires in South African homes are related to paraffin accidents, resulting in an estimated R1,3 billion worth of property damage.

Due to a nexus of poor living conditions related to shelter, sanitation and water, geographic isolation, insufficient access to electricity, low income and low educational levels, the problems related to ill health and morbidity are exacerbated. The cumulative effect of high rates of obesity amongst women (a major contributor to high blood pressure and diabetes), in conjunction with high levels of HIV/Aids, TB and assaults, increases the vulnerability of these communities to becoming trapped in a chronic poverty spiral.

Health promotion needs to address malnutrition by improving the nutritional status of obtainable foods through, for example, a public food distribution system designed to increase food quantity and accessibility, and expanding food fortification and nutrient supplementation. The lack of clean water and adequate sanitation also impacts negatively on health issues, and this needs to be improved urgently. Finally, the use of paraffin is a major health hazard, imposing very heavy financial costs on the state, and its use as a major source of fuel should be discouraged. Instead, electricity should be made more accessible and affordable.

7. Conclusion

This case study illustrates the complex realities facing the poor and, on a different level, policy makers and government. The Cape Town urban poor have few assets, experience social isolation and exclusion, earn low levels of income, are exposed to hazardous living conditions, poor nutrition, high rates of HIV/Aids infection, social breakdown and a general lack of infrastructure essential for social development. These factors undermine the poor's ability to escape from poverty through their own efforts, and confine them to long-term poverty traps. Substantial social investment, increased access to assets, and incorporation into the mainstream economy are needed to incorporate the majority of the poor, particularly the most vulnerable – the chronically poor – into the socio-economically active sphere of presentday Cape Town.

Endnotes

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2. Data from Western Cape Provincial Government records, 2001.
3. These figures were projected by the Cape Town City Health Department in May 2003.

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