given that urban values and urban culture are becoming ever more pervasive in the modern world and that the city has developed as a leading force in rural areas as well, the problems of urbanization have a much wider impact than that felt in the city itself. As the city gradually engulfs the countryside and urban society permeates rural, so the problems of the urban young will become the problems of a much wider group of young people.

This book has been written in response to the pressing need to assess the personal and social consequences of city life for the young. It explores evidence from a range of countries of the circumstances of young people in cities and discusses some of the major issues of child and youth welfare. It also examines the trends in social planning in relation to the urban young and suggests the introduction, where appropriate, of new, innovative policy and programme responses to the problems of young people.

1. Growing up Urban

Jo Boyden in "Children of Our Cities"

Growing up poor

Worldwide the children of the urban rich grow up with the benefits of education, recreation, good health and nutrition. They also have space, privacy and material well-being. By contrast, poor children experience multiple deprivations. Their attendance at school is sporadic and they face far greater obstacles in their education than do rich pupils. Many are forced to work rather than go to school and have no time for play. Their health and nutrition is poor and their physical development impaired. But the poor also form the major proportion of victims of abuse and neglect, whether within the home, at school or at the workplace. They are more likely than rich children to fall foul of the authorities and to become homeless.

Economic recession in recent years has hit both the North and the South. In the cities of the market economy countries of the North, poverty is on the increase. Economic growth is restricted mainly to commerce, services and the highly technical industries. Given that the requirement in these sectors is for a small, highly skilled labour force, the long-term prospects for an increase in employment are extremely poor. Industrial decline, brought about by the collapse of the old manufacturing industries such as textiles and ship building, and the demise of the more modern ones, such as steel and cars, is widespread. A fall in demand for manufactured products and the increased use of labour-displacing technologies have meant that a large number of urban areas in the North — especially the inner cities — that were once thriving economically now experience high levels of unemployment and low incomes (Harrison, 1985; Habitat, 1987). Some jobs have been lured away to greenfield sites, but many have gone altogether, leaving up to one-third of the people in some cities unemployed.

The overall trend in the market economy countries of the North is one in which growth is mainly in the smaller towns rather than the larger cities and metropolitan areas. Some cities in Britain, West Germany and Italy are experiencing population decline (Habitat, 1987). The majority of adults in the inner cities of the North are semi and unskilled manual workers who, with their extremely poor employment prospects, are unable to provide properly for their families. Many such areas also serve as ghettos for ethnic or religious
minorities. Indeed, ethnic minorities make up the major proportion of people in many cities in France, West Germany, the Netherlands and Britain. In some urban areas in West Germany, for example, up to 25 per cent of all children belong to 'guest worker' families (Habitat, 1987). And nearly one quarter of the population — mainly middle-class whites — left New York City between 1950 and the mid-1970s for the suburbs and outlying towns, to be replaced by poor members of ethnic minorities (Habitat, 1987).

Low wages and high unemployment in many northern cities run parallel with sharp increases in the cost of living. Northern Ireland, for example, is one of the most deprived regions in Europe, with lower wages, higher living costs and a worse unemployment rate than anywhere else in the UK (Evason, 1985). In 1983 nearly one-quarter of all Northern Ireland's children were in families dependent on supplementary benefit and one in twelve lived in homes dependent on family income supplement. Male unemployment reaches over 48 per cent in some districts and three items — food, fuel and housing — account for more than 75 per cent of the incomes of the majority of the poor. A higher proportion of income in Northern Ireland is made up of benefits than in any other area in the UK, meaning that the poor in this region are vulnerable not only to unemployment, but also to cuts in public expenditure.

Growing up poor in the cities of the North means growing up dependent on the State. But welfare payments are hardly generous. Retirement pensions, supplementary income, unemployment and other benefits tend to be set at a bare minimum, making it impossible for most families to lift themselves out of the cycle of deprivation.

In the South, however, urban slum dwellers do not receive even minimal benefits. Growing up poor in the cities of the South means living in perpetual hunger and insecurity without the support of the State. In the South, urban expansion and poverty are largely a result of poor resource distribution, population growth and decline in production in the countryside. The crisis in rural areas has led to a steady flow of migrants to cities. Since the 1950s many of the cities of the South have experienced dramatic increases in the supply of labour without corresponding expansion in employment. Industrial manufacturing and formal sector employment is generally extremely restricted. Even in areas where migration is no longer a major factor, rates of urbanization remain high because of natural growth in population.

Unemployment figures are, however, only a partial measure of poverty because they do not indicate income levels or the cost of living. By taking all these factors into account, it is possible to see how severe urban poverty can be in the South. In Mexico City, for example, the official unemployment rate in 1984 was only 8 per cent, but nearly half of the city's population existed on less than US$4 daily (Evason, 1985). Similarly, Indian cities have low official unemployment rates — often under two per cent — but a recent World Bank study of Madras found that 98 per cent of the population had an annual average income of less than US$125 (Evason, 1985). Overall, International Labour Office estimates for the early 1970s indicated that between one-fifth and one-quarter of the urban working population in the South was without regular employment (Bairoch, 1973).

World recession has meant a decline in demand for the raw materials exported by the primary producers of the South. With the collapse of prices on international markets, many countries have fallen into severe debt. Public sector spending has been cut back and crucial urban services withdrawn.

In the absence of a properly funded welfare state and with low rates of formal employment, the urban poor must either create their own jobs or work under contractual arrangements which offer no long-term security or social benefits. Income distribution in cities is extremely uneven.

According to the World Bank, the contrast between rich and poor is particularly stark in the cities of Asia, where unemployment is more widespread in urban areas than in the countryside. Globally, a high percentage of poor urban families experience severe seasonal or daily fluctuations in income. Workers in occupations such as those tied to agricultural production cycles, the tourist trade or construction are especially vulnerable. Street work, which is the only source of income for many families, is extremely competitive and volatile, with very low levels of capitalization and virtually no access to credit.

A roof over one's head

There is no guarantee of a roof over one's head in the metropolis. The prices of construction materials and marketable land in cities worldwide are extremely high — beyond the reach of low-income families. In rich and poor countries alike, land speculation and commercial development combined with population increase, lack of public sector building and poor planning result in shortages of low-cost housing. Tourist hotels, banks, office blocks and luxury apartment buildings are constructed at the expense of homes for the poor. In the more rapidly expanding urban centres like Bombay, even families with steady employment in industry or local government are forced by the housing shortage to live on the street.

In wealthy communities housing is given top priority, and is considered a necessity not a luxury. And it amounts to a great deal more than mere shelter; it also includes access to employment, public and domestic amenities and social services. It is, moreover, legally underpinned by a property title or rental contract. Even in poor cities the children of the rich live in sumptuous houses or apartment blocks that stand out in sharp contrast to the shabby tenements or makeshift shacks that house the majority. They live distant from the noisy, polluted industrial areas of the cities in quiet and pleasant residential neighbourhoods that the poor normally enter only to provide services. Their homes are maintained by cooks, domestic servants and gardeners and are frequently close to parks and modern shopping centres, on seashores or in wide, well-swept streets lined with trees. Even in cities experiencing serious shortages of essential items, such as food, the rich can cover their needs and where slum dwellers often face water rationing, wealthy families have luxuriant gardens.
sustained by the daily use of sprinklers.

The children of the urban poor live in very different conditions. For example, the poorest families in cities are generally concentrated in the areas least suited to human habitation and where population densities are extremely high. Dr Pandey of the Tata Institute of Social Studies in Bombay graphically describes the problems of urban congestion and poor resource distribution that affect so many young people living in the city (Pandey, 1983). According to him, Bombay produces 70 per cent of India’s engineering goods and dyes, 60 per cent of its yarn, 45 per cent of its chemicals and 30 per cent of its cloth, among other industrial products. It would seem that the city is rich: together with its rural hinterland it accounts for 35 per cent of India’s wealth in terms of both income and capital.

Yet one of Bombay’s slums — Dharavi — is reputed to be the largest in Asia. Here families live in hovels surrounded by rubbish, without electricity, clean water, or toilet and cooking facilities. In fact more than 50 per cent of Bombay’s population lives in slums covering a mere 17 per cent of the total residential area. Even the streets occupy more space than the slums — perhaps as much as 25 per cent of the city’s surface area. In short, the 60,000 or so cars and taxis on Bombay’s streets are better served and occupy more space than the 250,000 pavement dwellers. Similar, and sometimes even worse, conditions exist in many other cities throughout the world.

Crowding is widespread in poor communities, especially in the inner city. It presents a danger to children, causing unsanitary housing, and severe health and sanitation problems. In India more than half of urban households occupy a single room, with an average occupancy per room of 4.4 persons (Gilbert and Gugler, 1983). Densities of over 1,000 persons per hectare are common in the slums of Calcutta and Dhaka and the squatter settlements of Ahmedabad, Delhi, Manila and Seoul. The central areas of Hong Kong are said to have the highest ratio of low-income families per available hectare in the world. In 1976, the average residential density was calculated at 1860 persons per hectare, with certain areas reaching up to 4000 (Yuen and Lo, 1976).

In the inner city, expansion of the living space is frequently only made possible by squatting on vacant lots, constructing additional rooms on roofs or converting uninhabited buildings. As the overspill is housed on new floors or balconies overhanging the street, the risk of collapse grows. Tenements in areas subject to extreme weather conditions, such as monsoons, or earthquakes, are frequently destroyed, leaving thousands homeless. In the mid-20th century the influx of refugees from mainland China into Hong Kong gave rise to appalling congestion:

Many of the refugees crowded into tenement buildings... that were subdivided into minimal rooms, cubicles and even more bed spaces... in addition. Flat roof spaces were let and many families found sleeping room on the pavements and elsewhere. The code plan for the 1961 census of Hong Kong included designations for cocklofts, staircases, passages, hawker stalls, caves, tunnels, and sewers. (Dwyer, 1976, p. 156)

Some of the poorest inner-city slums in the Middle East, Latin America and Asia are now well over 30 years old. And in that time their buildings have hardly been maintained at all. Inner-city tenements usually have services such as lighting and sewers, but these are more often than not grossly over-utilized and in an extremely dilapidated state. Many landlords divide their properties into minute units and rent them to the maximum possible number of families. In Seoul, the extreme shortage of cheap housing has led to the development of 'beehive' buildings where landlords sub-divide buildings into rooms of five square metres or less and rent them to young industrial workers (Hardoy and Sittenfeld, 1989). Many inner-city homes are damp, dark, poorly ventilated and often unsafe. Countless inner-city children worldwide have been killed or maimed by falling masonry or fires caused by faulty wiring and many have become seriously ill from drinking water contaminated by overflowing sewers and other environmental hazards.

In the North, now that most of the jobs are located on the outskirts of cities and the city centres have become impoverished, housing in these areas can be as bleak as its counterpart in the South. Indeed, the term 'slum' came into use in the wake of the industrial revolution when Europe's urban poor were first separated from the wider population and housed in distinct residential districts (Goldfield and Brownell, 1979).

In the North the city centre still provides income and employment for many families, making this the prime motive for seeking housing in the inner city, together with the high cost and delays in transportation to the suburbs. But in the South those families unable to find accommodation in central areas and neglected by inadequate public housing schemes are forced to resort to buildings their own homes in unserviced zones on the outskirts of the city, a long way from employment sources. In 1986 more than 600 million human beings — approximately 45 per cent of the global urban population — lived in squatter settlements (UNFPA, 1986). Indeed, the favelas of Rio de Janeiro, the barongbarongs of Manila and the pueblos jovenes of Lima and similar shanties elsewhere are perhaps the single most characteristic feature of rapid and unplanned urbanization in the South.

In Calcutta 3.5 million people live in 3000 shanty towns (Macpherson, 1982). More than a third of Kuala Lumpur's population and half the population of Luaka live in illegal squatter housing. Slum and squatter inhabitants together make up 50 per cent of the population in Dhaka. 51 per cent in San Salvador and 55 per cent in Port Sudan. Shelter is makeshift. Building materials are lightweight and impermanent, often scavenged from rubbish tips or demolition sites. Recycled materials like cardboard, plastic sheets, bamboo, wooden boxes, flattened tin cans, car tyres, or bedsteads are commonly used for construction. In the most extreme cases — such as with India's countless pavement dwellers — squatter families do not even possess a shelter but sleep out in the open.

Squatters are very vulnerable to persecution either by landlords or the authorities. Over the years numerous government have cleared slums without making provisions for the people made homeless. For example, Sang Kye
Dong, an area of squatter housing in Seoul, was designated for redevelopment in the mid-1980s and local residents were faced with eviction (Asian Coalition for Housing Rights, 1989). In a ten-month period from 1986 to 1987 the 400 residents—half of whom were children and young people—were attacked eighteen times and their water pipes and electricity connections were destroyed. Eventually, on 14 April 1987, over 3000 people with a convoy of 77 trucks entered the area to forcibly remove the residents and their belongings. Similarly, in Nairobi, where the poor build their homes on rented land, numerous examples exist of landlords simply burning homes down to bring in new tenants who are able to pay higher rents. A woman from Bogotá tells us about the time she and her family were evicted from their home:

One day Tono went out to get work. He was in First street when he saw a group of people with planks and things, and he asked what was going on. They told him it was an invasion; that this was to claim land and build a house for the people who didn’t have one. So we went and built a little hut with four planks. But then the 8th of April 1967 came; the army arrived and knocked down the house and all the furniture was lost. It was the worst day of our lives... imagine, there we were with all the children and the bullets and gas thrown by those officers. I heard one officer say to another, “hurry up, get more gas, it’s running out,” and we were dying because we couldn’t breathe... the horses walked over our huts and destroyed everything. (Muñoz and Pachon, 1980, p. 82)

In central Bombay, pavement dwellers are moved on average a hundred times a year by the police (Nirmala Niketan, 1982). Eviction can result in the break-up of communities and the loss of essential support systems such as shared childcare for the family. At the very least, treasured household possessions may be lost. But eviction is also likely to be accompanied by indiscriminate violence, of which children are frequent victims. Repeated eviction can then often cause severe emotional trauma among children.

The dirty, dangerous city

In low-income areas in both the home and the surrounding neighbourhood the child is exposed to danger. The International Institute for Environment and Development points out that empirical studies in poor urban neighbourhoods in the Third World demonstrate that probably the highest causes of child death or morbidity is accidents:

Families of six or more people live in one tiny room. In such cramped conditions, there is little possibility of protecting children from burns or scalds from fires or cooking or heating stoves or of safely storing kerosene or other potentially dangerous substances away from children’s reach. Meanwhile, outside the house, the open spaces where they play are rarely protected from traffic... The only open space close by is often contaminated with rotting garbage, with stagnant water and with excreta. (Hardoy and Satterthwaite, 1986, p. 6)

Squatter settlements usually spring up on unclaimed land, often unstable, and thus especially dangerous to children. In Guayaquil in Ecuador, and Iquitos in Peru, houses are built on flaming stilts and spread out over rivers or swamps; they are connected by narrow wooden catwalks that, being wet all the year round, regularly rot and collapse. In Kuala Lumpur, houses are built on low ground subject to flooding. In other cities they may be found in low-lying marshes or ravines, alongside storm drains or over disused mines. In Mexico City, people make their homes on municipal rubbish tips where they work. Sometimes squatter houses straddle the edges of busy highways or railway lines—where numerous children are killed or maimed in accidents—and in Cairo thousands have been built in the city cemetery.

Cities generate more pollution than rural settlements. For example, noise pollution is a serious problem in many cities. Tests in a school classroom in Bangkok showed that noise from traffic, construction and industry reached 76 to 95 decibels (Phanumvanit and Liengcharensit, 1989). The OECD recommendation is that outdoor noise levels should not exceed 65 decibels for people’s well-being indoors. The burning of fuel for heat and power is a major cause of atmospheric pollution in cities. Death from lung cancer is four to seven times higher in China’s cities than for the nation as a whole, owing to air pollution from consumption of fossil fuels (Habitat, 1987). Industry and motor vehicles discharge vast quantities of toxic gases into the atmosphere. Gastrointestinal and respiratory problems are common in most cities. Water is often heavily polluted and high noise levels produce anxiety and stress. Some of these forms of pollution—notably lead poisoning—can be more harmful to children than to adults. Cubatao, in Brazil, is known as the Valley of Death because the concentration of heavy industry results in very high levels of still births, tuberculosis, pneumonia, bronchitis and asthma.

Many poor communities lie close to industrial zones or on municipal rubbish tips where soils are toxic and air pollution severe. It was not by chance that the great majority of the 2800 people killed and 40,000 more disabled by the accidental release of methyl isocyanate in Bhopal in 1984 were poor people living in slums around the Union Carbide plant (Centre for Science and Environment, India 1989). In UNICEF’s Action for Children (1986) Tom Weber reported on living conditions on Mexico City’s rubbish dump, where homes have been built on top of the smouldering mounds of rubbish. One of the women he interviewed talked about how her son was killed on the dump.

One day my boy fell in a fire-hole in front of the house and his legs were burned off; he died... When the winds blow, fire jumps out of the earth and runs crazy over the mountain... June, July, August, September are very bad months. The wind fans the dump into an ocean of fire. Many children drown in it. (Weber, 1986, p. 6.)
Environmental damage resulting from urban and industrial development also affects the surrounding areas. Manufacturing in Alexandria accounts for about 40 per cent of Egypt’s industrial activity (Harnan, 1989). The metropolitan area generates approximately 4500 tons per day of solid industrial waste. In the past decade fish production in Lake Maryut has declined by about 80 per cent because of the direct discharge into it of industrial and domestic effluents. The combination of altitude, rains and limited winds with the development of some 60 industries and unchecked urban growth, make Mexico City one of the most polluted areas in the world (Scheinberg, 1989). The Valley of Mexico, in which the city lies, has suffered severe biological and environmental degradation; 73 per cent of the forest area and 99 per cent of the lake area has been lost, leading to widespread soil erosion, and around 700 hectares of land annually are incorporated within the city.

While many of the environmental hazards that result in high levels of mortality and morbidity among urban children occur also in rural areas, certain problems, such as air pollution, are worse in cities. Also, population densities in urban communities increase the dangers. In congested areas diseases relating to poor environmental conditions, nutrition and personal hygiene are common. Contagious diseases such as measles and whooping cough are also rampant. But overall, the social, personal and health consequence of high density housing in cities is unclear and the evidence is sometimes contradictory.

In a review of social and psychological research into the effects of crowding, Palen found that it was not linked in any way with human pathologies such as epidemics, crime, moral degradation or loss of community (Palen, 1981). On the other hand, population per residential area has been found to be positively related not only to the incidence of infectious disease but also to the rates of admission to mental hospitals in Honolulu (Booth, 1976). Similarly, research in 125 geographic areas in the Netherlands found that population per square mile was positively related to admission to both general and mental hospitals and to the age adjusted death rate (Booth, 1976). Overcrowding has also been found to correlate positively with juvenile court appearances and the numbers of youths receiving public assistance (Booth, 1976). It is likely, though, that the incidence of disease is affected less by population density than by biological and social factors. The most vulnerable populations are often found where population density is highest (Harpham, Lusty and Vaughan, 1988).

The concentration of physical infrastructure services such as piped water and sanitation in urban areas disguises some major deficiencies in their distribution within cities. While wealthy families often have individual water connections, the poor rely on a series of makeshift arrangements. The luckier ones have access to communal standpipes. Many, though, purchase water from street peddlers and store it in uncovered barrels which are easily contaminated or become a breeding ground for mosquitoes. Often pavement dwellers rely on tapping fire hydrants at night. Others buy water at exorbitant prices from nearby tenements, shops or factories. Shortages of safe piped water are a major health hazard in cities.

The inadequate disposal of domestic waste — waste water, solids, and particularly human excreta — is another major factor affecting child well-being in cities (UNICEF, 1984). Low sewerage connection rates, drainage and runoff from storms, periodic flooding and soil erosion, exacerbate the sewage problem (Harpham, Lusty and Vaughan, 1988). Solid waste from the kitchen is commonly thrown onto the street or into storm drains or sewers. This causes frequent blockages. During the rainy season especially, waste water overflows and floods streets and sometimes even houses. Many poor people in cities have no toilet facilities at all. Of India’s 3,119 towns and cities, only 209 have a partial or full sewerage system (Centre for Science and Environment, India 1989). Indeed, sewage treatment covers less than one-third of the urban population in India and untreated sewage everywhere flows into rivers. According to one estimate, two-thirds of all illnesses in the country are related to waterborne diseases such as typhoid, infective hepatitis, cholera, diarrhoea and dysentery.

Defecation in the open, on railway lines, pavements, rubbish tips, the borders of wide roads and river banks, is commonplace. Even where adequate latrines are provided, children may be prohibited entry and expected to defecate in the most public of places. Many families have dry latrines set against a wall in the yard or in the dwelling itself. The contents frequently spill out. Children play in the backyards or on the streets risk being contaminated by excrement. Open drains and faeces, urine and rubbish on pavements and streets attract flies, spreading disease further.

Accommodating the young: policy issues

Governments are often accused of demonstrating urban bias in physical infrastructural and social planning. The greater concentrations of affluent families and services in cities give the impression that, overall, the urban population is far better off and better catered for than the rural. This is largely because most assessments of comparative levels of wealth between urban and rural communities are based on averages for the city as a whole. A very different picture emerges when conditions in individual low-income urban neighbourhoods are examined. In most cities there are marked contrasts between different neighbourhoods in terms of the size of dwelling, the number of occupants per dwelling, the percentage of homes with water, electricity and other services, employment, income, health, nutrition, rates of population increase and literacy levels among adults. Planning and resource allocation both within cities and between the city and the countryside can only be effective if proper account is taken of these differences.

Government responsibility towards the urban young is twofold. There needs, on the one hand, to be a guarantee of far greater protection against the physical and social risks of the city. On the other hand, much higher priority must be given to the development and promotion of children and young people in cities.
The urban world presents many hazards for the young. This is especially true in the South where urbanization is rapid and largely unplanned and where services are patchy and poorly developed. Some of the hazards, such as overcrowding and poor sanitation, are old and familiar and some, like industrial pollution, are newer and less well documented. A more consistent effort is needed globally to identify with greater precision the hazards of urbanization and to assess their consequences, particularly for the young. These consequences need to be evaluated in terms of emotional, physical and social welfare, as well as physical and intellectual development.

Even in the North, where urban planning may be sophisticated and urban poverty is neither so intense nor so widespread, planners cannot afford to be complacent. Northern cities have their fair share of pollution, deprived and alienated inner-city populations and floundering social services. But the high rates of urban growth and the concentrations of young people in urban populations in the South, especially, will place an ever-increasing burden on national budgets. The young require more services than adults — they generally need more health care, for example. They also require a number of specialist services, such as education and vocational training and, in cases of family breakdown, substitute care. But to what extent are increases in the population of urban young globally matched by increases in services? There is probably no city in the world that can claim to have kept up with these demographic developments by providing adequate services for its children and youth.

It is not just that the young have greater or different needs from adults, but young people actually compete with adults to obtain access to urban facilities. Adults require streets for mobility between the different zones of the city: children require streets for play and teenagers require them for social exchange. Equally, primary schools, pre-school facilities or mother and baby clinics compete for funding with homes for the aged or hospitals. Adventure playgrounds compete for space with theatres and restaurants. In this competition it is usually adults who win. After all, it is they who make the decisions and allocate the resources.

It is obvious that a large and growing proportion of children and young people in cities are in jeopardy. But government response to their plight is poor. The distribution of resources within cities, whether by area, social class or age group, is extremely uneven. Also, there is little coordination between the various agencies of government. This means that many children and young people are not provided for in social policy, physical planning and service allocation. Governments need to evaluate the efficiency of public sector spending as it affects the young. City authorities and statutory bodies should look at ways in which young people, according to their age and capacity, may be able to participate more directly in decision-making processes as a means of ensuring that they take higher priority in planning and provision and that they are served by the public sector in a manner appropriate to their needs. The young require more space and more facilities. They also require a voice in the political arenas which crucially affect their lives.

2. Growing up with Family

Images of family

It is not only the physical environment of the city that differs from rural communities. There are also fundamental social differences. For example, cities are likely to be far more heterogeneous in terms of ethnicity, religion and socio-economic status, and, above all, to differ in the structure and organization of the family.

Large extended family units — once common in Europe and still widespread in many rural areas in the South — have become less frequent in the majority of cities. They have been replaced by smaller, nuclear families. For many people the nuclear family is the most important symbol of modernization. It emerged in the urban context largely because in industrial societies the foundation for productive work in the family was eroded (Qvortrup, 1985). Moreover, workers needed to be able to move about freely to look for jobs. Extended family ties impeded mobility. A man’s wages in the city were not sufficient to support a large number of dependants and the nuclear family was more viable economically than the extended family. Rural to urban migration in many countries has reinforced this pattern. Census data show, for example, that 80 per cent of migrants to cities in India settle in nuclear families rather than the traditional joint families (De Souza, 1983).

Urban-industrial development also resulted in the emergence of new roles within and attitudes towards the family (Sommerville, 1982). The home became a place of retreat. It provided psychological support for wage labourers alienated from their work and forced to spend their days in grim noisy factories. But more importantly, in the 19th and 19th centuries among the more affluent middle classes in Europe women were increasingly thought to be in need of protection against an alien urban world (Winn, 1984). They were perceived as weak and dependent and their children even more so. The notion of the special bond between mother and child became increasingly prevalent (Schepers-Hughes, 1989). The urban-industrial ideal — perpetuated mostly by the wealthy — was the isolation of women and children in the home and their seclusion from work (Zelizer, 1985; Sommerville, 1982).

Changes on the domestic front initiated by the urban rich have taken place
5. The Child's Health

Unhealthy urbanites

In the poor urban communities of the Third World between one-quarter and one-third of children die before they reach five years of age (Pryer and Crook, 1988). Of those who are born alive, between 10 per cent and 25 per cent are likely to die within the first year of life. Countless urban children worldwide could avoid suffering from serious health problems if better information and technologies were available. But they would also need to live in a cleaner environment and have safer water supplies and more food. Millions of urban children lack essential services and live in conditions extremely damaging to their health. Yet large multi-storied hospitals dominate the skylines of cities in both the North and the South, and a great deal of money is spent on urban health by governments everywhere. Moreover, doctors and other highly trained medical staff prefer to live in large towns and cities — with their readily available facilities for work and leisure — rather than the countryside. Urban children, therefore, to be far healthier than their rural counterparts.

Indeed, urban health is generally thought to be better than rural health; overall statistics would seem to confirm the picture. As a result, most of the health initiatives in the South in the last decade have focused on rural populations (Harpham, Lusty and Vaughan, 1988). However, statistics can be very misleading. Overall averages may indicate that people in cities are healthier than those living in rural areas, but squatters and slum tenants — the city's unofficial population — are often not included in the figures (Harpham, Vaughan and Rifkin, 1985). Moreover, statistics are usually based on data drawn from hospitals and other curative facilities, even though the majority of poor people do not have access to them (Gish, 1970; Nelson, 1978). Most urban health facilities are distant from poor communities and many are private. In Manila, for example, in the 1970s there was only one hospital bed for every 4,000 slum dwellers, while for the rest of the population there was one for every 300 people (Basta, 1977). The urban poor may not be able to afford the transport needed to reach hospital, and if they manage to get there, doctors' fees may well be out of their reach. Even if they receive treatment, they will be unable to afford the kinds of food necessary for maintaining their health. Often they do not have sufficient funds to complete the treatment properly.

Only relatively recently have health experts become aware of the pressing need to look more critically at the real differences in health between poor and rich communities within the city. As Rossi Espagnet of the World Health Organization says:

The study of intra-urban differentials is in its infancy. People seldom realize that there are urban groups whose health conditions are in several ways worse than those of corresponding rural groups. Seldom do there exist in rural areas the appalling conditions of extreme misery, destitution, environmental degradation and moral disruption that affect huge populations in the many large and intermediate cities of the developing world. (Rossi-Espagnet, 1984, p. 42)

Harpham, Lusty and Vaughan, however, point out that concern about urban health should not shift attention from the enormous problems of rural areas so much as emphasize the inequality in health in cities and the special difficulties resulting from the rapid rates of urbanization and environmental degradation (Harpham, Lusty and Vaughan, 1988). They highlight three groups of factors that are detrimental to the health of urban populations. The first includes those problems directly associated with poverty, such as low incomes and inadequate diet, which prevail in both rural and urban areas. The second relates to the physical environment and to the conditions which are especially characteristic of the urban world. These include factors such as inadequate sanitation, blocked and overflowing drains, inadequate water supply, overcrowding, uncollected rubbish, contamination of food, congested traffic, smoke and pollution from manufacturing, processing and distilling plants, inadequate recreational facilities, poor housing and a general increased exposure to infectious diseases. The third group of factors results from social and psychological instability and insecurity in city slums, where there is a lack of support networks and the incidence of single-parent households and isolated nuclear families is particularly high. These latter factors result in health problems such as depression, anxiety and substance addiction. "The urban poor suffer health problems of 'underdevelopment', such as malnutrition and infectious diseases, and those of industrialization, such as the chronic and social diseases" (Harpham, Lusty and Vaughan, 1988, p. 55).

The health of children from different socio-economic backgrounds has been assessed in Ibadan, Nigeria and compared with that of a group of rural children (Oludayisi, 1975). Overall, the health of the poorest of the urban children and those in the countryside was very similar, being consistently worse than among the wealthier groups. However, some of the urban children suffered far more serious health problems than the rural group. Equally the average annual incidence of tuberculosis infection was lower in the rural Ivory Coast than in Abidjan (Coulombly, 1981). When mortality rates among children under five in both rural and urban areas in six countries in Latin America were compared, it was found that only in Bolivia and El Salvador were rural children at greater risk than urban (Puffer and Serrano, 1973).
Feeding the city

Poor nutrition in cities is giving increasing cause for concern. A report sponsored by the World Bank states that the incidence of malnutrition is accelerating more rapidly in cities than in rural areas (Austin, 1980). The underlying causes of urban malnutrition are very similar to those of rural, but the effects can be very different and sometimes urban malnutrition is more severe than in the countryside.

There is widespread malnutrition among children in the 0-5 age group, who are thought to suffer most, since nutritional status is very closely linked to health and mortality in the very young. The Pan-American Health Organization, using data drawn from ten countries, found in 1973 that in 57 per cent of children under five, nutritional deficiency was the most important health problem underlying, or associated with, death (Pryer and Crook, 1988). This was especially true of deaths resulting from diarrhoea and measles. Malnutrition lowers the resistance to infectious disease, and repeated bouts of ill-health and disease affect the appetite, digestion and absorption of food, increasing malnutrition further. Comparisons of rural and urban areas in the Philippines, India and Brazil showed that overall averages for mortality among new-borns and infants in their first year of life were higher in the countryside than in cities (Pryer and Crook, 1988). But in many instances death rates were far worse in the poorest urban communities than in the rural areas. A 1978 survey in the Punjab in India showed that children whose weight was less than 80 per cent of that expected for their age were ten times more likely to die than children whose weight was above this figure (Pryer and Crook, 1988). In Bangladesh, 75 per cent of children admitted to hospital with severe malnutrition were dead within three months of their discharge (Wray, 1985).

In a global study of urban nutrition by Jane Pryer and Nigel Crook, a number of major trends have been revealed (Pryer and Crook, 1988). Data from cities in Morocco, India and Peru showed that socio-economic status correlated closely with food intake. And surveys in thirteen major cities in India showed that the food intake of the urban poor was no better than that of the rural poor. Perhaps most worrying is the fact that in many cities malnutrition among children was found to be on the increase (Rossi-Espagnet, 1984). This is certainly the case in, for instance, São Paulo's favelas. In Lima, 50 per cent of children under five were found to be suffering from malnutrition, and in the late 1980s the consumption of proteins and calories probably dropped by 31 per cent and 53 per cent respectively (Creed, 1985). Recent data from Ethiopia show an overall increase in the number of children who are below 80 per cent weight for their age, with more urban than rural children being in this condition (Goyder, 1985). In a study of a shanty settlement in Kibera on in Sri Lanka, undertaken by the Save the Children Fund, 33 per cent of children under six showed signs of chronic malnutrition — with 6 per cent demonstrating acute malnutrition (Peryea, 1988).

Poverty is a major causal factor in poor nutrition in cities. Where food is expensive. This is due in part to the prevalence of processed as opposed to fresh products and the lack of cultivable land for direct production. People living in accommodation with inadequate cooking facilities, those who are too busy to shop or cook, and those living in cities where the cost of fuel is high, may be forced to rely on processed foods. Others rely on fast-food outlets. In urban Indonesia and the Philippines, household spend on average 25 per cent of their food budget on snacks bought from street vendors (Pryer and Crook, 1988). Food sold in the street is normally subject to government controls and is often unhealthy, being prepared with stale fats and dirty water and re-heated several times (Asgill Children, 1978). Urban populations are extremely vulnerable to changes of food prices. Furthermore, people who migrate to towns and cities are sometimes unable to find the staple foods they have been used to in their home area. Many are not aware of the relative nutritional value of the foods available in the city or, if they are, cannot afford a healthier diet.

Advertising can be very powerful and persuasive in the city; it tempts the poor to buy prestige, often imported, foods in attractive packaging which they can ill afford.

In Zambia, 54 per cent of the severely malnourished children admitted to hospital had been given imported soft drinks instead of milk (Lappe and Collins, 1977). Some companies target children specifically. Giant posters
advertising Coca-Cola, aimed primarily at the young, line city streets throughout the world (Medawar, 1979). Street children and young workers, who spend little time under adult guidance, are especially tempted to spend their earnings on ice cream, sweets and soft drinks.

Advertising also urges mothers to use infant formulas rather than to breastfeed their babies (Greiner, 1975). This can seriously affect rates of morbidity and mortality. In the slum district of Cite Simone in Haiti, it has been found that infants who were bottlefed from birth were four times as likely to die as those who had been exclusively breastfed (Wray, 1985). Milk powders are expensive and parents may over-dilute the feed in order to make the powder go further. In a study of 100 malnourished children in Jamaica, the total earnings of 93 per cent of the families was so low that to bottlefeed a child adequately would require half their income (Jeliffe, 1975). This cost did not even take into account the bottles, teats or fuel required to sterilize the equipment. Another danger with bottlefeeding is that the water used may be polluted. Of course, without adequate supplies of water and fuel it is impossible to sterilize bottles and teats properly.

The pressures and difficulties of city life often make breastfeeding impossible. In the city, mothers may not be allowed to take their babies to work. They may be left at home with younger children or with untrained childminders who do not know how to feed them properly. Early weaning may be introduced, beginning the route to protein/calorie malnutrition and reducing the infant’s resistance to disease. In one Addis Ababa slum, the need for mothers to work led them to introduce bottlefeeding to their infants early, placing them at risk (Goyder, 1985). In accordance with tradition, clear bottles would be covered with dirty rags to protect the child from the evil eye. There was little water or fuel and so bottles were not sterilized.

Environmentally unsound

Poor health among urban children is exacerbated by the environment in which they live. We have seen some of the factors affecting the health of the young in cities: blocked and overflowing drains; inadequate sanitation; uncollected rubbish; polluted water supplies; stagnant water lying in puddles or receptacles. Other factors include crowded, decaying buildings, congested traffic, air pollution from manufacturing, processing and distilling plants and inadequate recreational facilities. Journalist David Blundy describes a part of Cairo where the poor make a living by sifting through garbage:

The children are all filthy. Many of them look sick and suffer from coughs, watering eyes and sores. Most of them have constant stomach illness. Sayed said that the most common illness was infection after the children cut themselves on the glass and metal in the garbage. A girl had a long cut on her forearm. It was festering and covered with dirt. She brushed it with her hand every few seconds to get rid of the flies that settled in the wound. Sayed said

that the doctors do not come to Bani El Bakara and the hospital is a long way by donkey and cart. (Blundy, 1986)

A high proportion of morbidity and mortality among children in poor urban areas is associated with water-borne diseases such as cholera, typhoid, hepatitis, dysentery and diarrhoea. Equally, a shortage of water, in reducing personal hygiene, increases the likelihood of faecal-oral transmission of disease.

Diarrhoeal diseases arise not only from polluted water, but also from poverty and malnutrition. Such diseases are major causes of child morbidity and mortality in urban slums and squatter settlements in the South. Gastroenteritis, for example, is a leading cause of childhood deaths in cities in the South. In Cite Simone, 67 per cent of infant mortality was due to diarrhoea and 63 per cent of that mortality occurred in infants with severe malnutrition (Wray, 1985). Among 1,819 infants with diarrhoeal disease in Panama City, 45 per cent came from the slums and 22 per cent from the shanties (Kouray and Vasquez, 1979). On the other hand, zero infection rates were reported for those living in higher quality housing. In Sao Paulo, infant deaths from enteritis and diarrhoea are twice as high in the peripheral areas of the city as in the centre (Ihsa, 1977).

We have seen that malnutrition is also linked to diarrhoeal disease because it drains the body of essential nutrients. Infants and young children who are bottlefed are at particular risk of contracting diarrhoeal diseases because of the widespread use of unclean or contaminated water and dirty bottles. But as children grow older, they often play in rubbish, waste waters, ditches and gutters. Faeces and other contaminated materials are transmitted directly to the mouth.

Upper respiratory infections, pneumonia and related diseases are as common in children in some cities as diarrhoeal diseases. Pollution and poor housing are important contributory factors in this case (Giggs, 1979). Malnutrition combined with the toxic effects of the environment make a child especially vulnerable to illness and even death. Asthma is on the increase in urban areas globally and this is believed to be linked to pollution (BBC Radio 4 news, 1986). Other diseases prevalent in overcrowded, insanitary conditions, such as tuberculosis, measles, whooping cough and malaria, are on the increase in cities in the South.

Worms, skin infections and eye diseases are also prevalent in urban areas. Studies of Colombo, Sri Lanka, have shown that 70 per cent of children from disadvantaged communities are infected with worms as a result of poor environment and sanitation (Pries, 1985). In Singapore, 75 per cent of squatters suffered from hookworm, ascaris, and trichuris, compared with 32 per cent of flat dwellers (Kleevens, 1966). In Bombay, in one slum the overall prevalence of leprosy was 22 per 1,000 compared with 6 per 1,000 for the city as a whole (Gananpati et al, 1976).

Overpopulation is known to adversely affect child health and rates of survival. There are few indications that population is decreasing in poor cities,
in spite of expectations by economists and development specialists that modernization would result in a decline in fertility. The World Fertility Survey interviewed 330,000 women in 42 countries in the South and in 20 countries in the North between 1974 and 1982 and found that in some countries women in major urban centres had higher fertility than those in smaller towns (World Fertility Survey, 1984). Families in extremely poor urban communities in many instances have as many — or even larger numbers of — children as those in the countryside. This may be a result of a reduction in the incidence of breastfeeding in cities; breastfeeding tends to prevent conception. Children born less than two years after the preceding birth are less likely to live up to their fifth birthday than those born between two and three years after. The larger the number of children, the poorer the mother’s health and therefore the greater the risk to the child. Fetal development is directly affected by maternal health. Birth weight is decreasing in some low-income urban areas and poor maternal health is thought to be a major contributory factor (Harpham, personal communication).

Another environmental danger for children in cities is the high risk of involvement in accidents. Medical records and statistics worldwide represent only a small percentage of the injuries to children due to accidents that actually take place, since many are never reported or dealt with by the health services. High accident rates could be due to heavy traffic, unprotected play areas, unrepaird walkways, dangerous or poorly maintained machinery at the workplace, or sub-standard housing.

Many accidents take place when children are left unattended in streets or in the home and when they are working in sweatshops, restaurants, foundries and factories. Cities worldwide harbour countless latchkey children who are the frequent victims of domestic accidents. Infants and younger children may be tied to heavy objects such as beds or tables to stop them from coming to harm. Sometimes they are strangled or cut by the very cords that secure them or else pull the furniture to which they are attached on top of them. Unattended children are frequently involved in domestic fires caused by overturned stoves. They may also be burnt by boiling water or cut by kitchen utensils. Many children are locked out of the house when parents leave for work precisely to avoid damage to the home. They are left roaming the streets, exposed to exploitation or abuse. They are also at risk of being involved as pedestrians in traffic accidents. Children under five or six years old are especially vulnerable. Research from West Germany suggests that this age group cannot discern from the sound of the engine which direction a car is coming from (Ward, 1978). Nor can they adequately judge the distance or speed of moving vehicles.

Death from accidents in the North have become easier to detect because of the decline in wealthy countries of traditional childhood killer diseases. An examination of the statistics over the past few years shows that one-third of all child deaths in Britain are caused by accidents (Constantinides, personal communication). In the borough of Haringey, London, it has been found that there are strong links between the cause of death and poverty. Accidents such as poisoning, burns and scalding are more prevalent among poorer families than wealthier groups. A high percentage of child deaths in the borough are caused by homicide. Accidents in cities may account for high rates of disablement. In addition, disablement in cities in the South may be increasing with the prevalence of measles, polio and other diseases that cause deafness, blindness, brain damage and paralysis.

Quite apart from the physical dangers of city life, poor urban children are said to be exposed to the stress of overcrowding, insecurity and family instability (Pollit, 1974; Llanos Zuloaga, 1970; Bello, 1983). Parents are absent from the home for long periods during the day and families are subjected to many hardships, with frequent evictions, unemployment and irregular incomes. The rates of substance abuse among urban adults are high and this affects children in many ways — mostly because it is closely linked with domestic violence. One estimate suggests that 5-15 per cent of all children between 3 and 15 are affected by persistent and socially handicapping mental conditions (Zaki-Hasan, 1979). The majority of these are in poor countries. A World Health Organization (WHO) study estimated that the rate of mental disorders among children attending clinics ranged between 13 per cent and 18 per cent in rural areas and between 25 and 30 per cent in urban slums in the South (Zaki-Hasan, 1979).

**AIDS and the urban child**

We have already seen how high risk behaviours among urban adolescents make them vulnerable to HIV infection and AIDS, but in some countries the AIDS pandemic also poses the newest and perhaps greatest health threat to urban infants and young children. While still less important in mortality and morbidity in the very young than diseases such as malaria, measles and tuberculosis, the World Health Organization predicts that 250,000 HIV-infected infants will be born in Africa alone by 1992 (Black, 1990). Moreover, it is expected that the spread of HIV and AIDS will result in an increase in a range of other serious childhood diseases.

The geographical scope of the AIDS pandemic is expanding rapidly, as it reaches countries and regions previously unaffected. So far the major impact worldwide is in urban areas. This is especially true of the severely affected countries of Central and East Africa. But with the growing ease of communications and movement of people between town and village, AIDS is likely to become more evenly spread between urban and rural communities. Men who migrate to cities for work, for example, may carry the virus back to rural women.

Overall, children are likely to comprise an increasing percentage of HIV and AIDS patients worldwide in the future. Already about 10 per cent of AIDS cases reported to the Caribbean Epidemiology Centre are children under five years old (Saito, 1989). In Botswana 28 per cent and in Uganda 16 per cent of all AIDS sufferers are children under 5 (Martin and Ngatiri, 1990).

All these infants and children die very young. Infected babies are particularly
at risk of developing AIDS because their immune systems are both immature, quickly falling prey to the virus, and overtaxed, due to their first exposure to infections. Poor living conditions, poor nutrition and prevalence of infectious diseases are thought to reduce the time lag between infection and death in babies, making early death more common in the underdeveloped countries of the South than the industrialized North. WHO estimates are that overall one-quarter of children born infected will probably die before the age of one and four-fifths before the age of 5 (Black, 1990).

Life expectancy at birth may fall by about 6 years in many Sub-Saharan cities and infant and child mortality could be as much as 30 per cent greater than would otherwise have been expected during the next few decades (Chin, 1990). In Haiti it was found that infants born to seropositive mothers were significantly more likely to be premature, of low birth weight and malnourished at 3 and 6 months of age than those born to seronegative women (Halsey, Boulou et al. nd).

Indeed, transmission from the mother is the main cause of paediatric AIDS and HIV infection. Between 25 and 40 per cent of infants born to HIV-infected women will in turn be antibody positive. The mother’s health during pregnancy is an important factor influencing transmission to the infant. The baby is far more likely to become infected if the mother suffers HIV-related illnesses during pregnancy (Panos, 1989). In such cases the risk to the new-born could increase to 50 per cent (Marias and Radlett, 1989). The rates of mother to infant transmission vary geographically, being higher in Africa than the United States and lower still in Europe (Boylan and Stein, 1989). This could be connected with the proportion of women in the population in a more advanced state of disease, or the debilitating effects of malaria, tuberculosis, poor nutrition and other serious health problems common in Africa. It could, on the other hand, be due to variations in genetic susceptibility.

The greatest risk occurs in utero, when the virus can be transmitted across the placenta during embryonal or foetal development (Boylan and Stein, 1989). There is also a significant risk during birth, when the baby can be infected in the birth canal by the mother’s blood or bodily secretions. Other modes of transmission, including contaminated blood transfusions, infected blood products or breast milk, and sexual abuse, play a comparatively minor part in paediatric cases (Preble, 1990). However, patterns of transmission vary globally. In industrialized countries, where procedures for screening blood are now rigorous, transfusions are no longer a risk. However, in the South many countries do not have the resources to maintain such high standards and transfusions remain a route of transmission, all the more so because of the greater need of transfusions in early childhood in poor countries.

Given the strong link between HIV and AIDS in women and risk to children, the incidence of paediatric cases is highest in communities where large numbers of sexually active women of childbearing age are seropositive. This applies to urban communities in Central and East Africa and the Caribbean more than anywhere else in the world. The World Health Organization’s Global Programme on AIDS reported in 1990 that up to 30 per cent of sexually active adults between the ages of 20 and 40 years are believed to be already infected with HIV in some urban communities of Sub-Saharan Africa (WHO, 1990). In these areas equal numbers of males and females are infected. Similar trends have been noted for the Caribbean, where there is also evidence of a rapid increase in infection in women in this age group in recent years. Thus, whereas women comprised 14 per cent of the reported cases in Haiti in 1983, this had risen to 40 per cent two years later (UN Economic and Social Council, 1989).

Nearly one in three pregnant women attending antenatal clinics in Kigali, Ruanda, where female prostitution is an important source of income among the poor, are HIV infected (Wilson Carswell, 1990).

By contrast, in the United States, Western Europe, Australia and New Zealand 90 per cent of cases are homosexual males or injecting drug users and overall prevalence is far lower, at just 1 per cent (Kapila, 1989). The pattern for Latin America is in evolution from one of transmission through homosexual sex and intravenous drug use to one of heterosexual transmission, with a corresponding increase among sexually active women. Eastern Europe, North Africa, the Middle East, Asia and the Pacific (excluding Australia and New Zealand) have to date reported relatively few cases of HIV infection or AIDS. Of the known cases in these latter regions, most have had contact with people from areas where the incidence is high.

Paediatric AIDS and HIV infection is generally less publicized than seroprevalence among adults. This is partly because children are ‘practically invisible both socially and economically’ (Wilson Carswell, 1990, p. 7). But it is also because the symptoms of HIV infection in the very young are non-specific and could indicate other illnesses, many of which are common among children in the most affected areas. Typically, the infant fails to gain, or begins to lose, weight at about 6 months (Wilson Carswell, 1990). It often develops one of a number of common infections, with fever, diarrhoea or respiratory problems and responds poorly to conventional treatment. Diagnosis is hindered because many mothers treat their children outside formal health services. Others remove their children from hospitals or clinics when there are no signs of improvement, having lost faith in the treatment. Even in formal services, the underlying HIV infection may not be tested for. Besides, babies can carry the mother’s HIV antibodies until 18 months or so without necessarily being infected themselves and most simple HIV tests cannot distinguish between the two circumstances (WHO, 1989b).

Quite apart from the direct threat of HIV and AIDS to children’s lives, there is the threat of orphanhood and resulting destitution. The mother’s death can be particularly serious because in many countries women are the main providers of subsistence. Projections that the disease may kill as many as 9.9 million adults of reproductive age in 10 Central and East African countries in the 1990s indicate that up to 5.5 million children could in this way be orphaned (Preble, 1990). If these projections become reality, this means that orphans will form between 6 and 11 per cent of the population under 15 years in these countries, a situation that is bound to have far-reaching human consequences.

But with under-reporting and failures in diagnosis, the statistics give only a
partial picture. Moreover, given that:

infection occurs primarily in adults during their most productive years (20–49 years) and among urban populations, the full economic and social consequences are not reflected by the mortality rate. (UN Economic and Social Council, 1989, p. 6)

The toll on adult health and life has many implications for children. At the very least, it means that children find themselves caring for sick parents and maintaining family businesses. AIDS disrupts the whole family; old people, for example, who might otherwise have expected to be able to depend on their offspring must instead assume parenting roles for the second time in their lives. Local economies in some countries are failing and labour is short in key organizations and sectors.

Traditionally, orphans in Africa are taken in by the extended family, but since the onset of AIDS, family and community resources have been severely undermined, with the result that large numbers of children are left in orphanages, hospitals and other institutions. Countless others end up joining the homeless population on the city streets. Of course, a high percentage of the AIDS orphans globally are themselves ill. In Port-au-Prince, Haiti, over half of children under 18 months in orphanages are seropositive (Black, 1990). Due to ignorance about how AIDS is spread, many of these children are rejected by the extended family out of fear that they may pass the infection on (Hampton, 1990). The poorer sections of society and poorer countries of the world are the most vulnerable (Panos, 1990). Underdevelopment profoundly influences the distribution and spread of HIV and AIDS. Access to education and information is a major problem in poor communities, especially where levels of literacy are low. Also, whereas condoms may be widely available and affordable to the majority in many wealthy countries, they are extremely expensive and hard to obtain for most in the South. In Africa, particularly, the lack of health provision is another contributory factor, in that the problem of untreated sexually transmitted diseases which facilitate the transmission of HIV and AIDS is widespread. Moreover, women traditionally have less access to health services than men and may be unaware of their serostatus. Women frequently only discover that they are infected during ante-natal care. Even in countries where terminations are permitted, many women attend ante-natal clinics for the first time too late in the pregnancy to undergo the procedure. Even when women attend during the early weeks of pregnancy, the delay in confirming serostatus can make termination impossible.

Large numbers of pregnant women and their partners are reluctant to consent to having an antibody test and large numbers would not consider a termination anyway. Decisions affecting reproduction are highly personal and influenced by a range of complex issues. It has been suggested that perhaps one major reason for the lack of success in preventing mother-to-infant transmission may be the failure to recognize fully the women's own needs and priorities (Panos, 1989). And since many of the children born to infected mothers will be healthy, it could be argued that it is an invasion of privacy to forbid or prevent these women from becoming pregnant.

Women often feel that with the risk of transmission to the foetus being at its greatest in 4 in 10, the likelihood of the infant failing prey to HIV and AIDS is still far less than the chance of succumbing to one of the many other health hazards in poor communities (Black, 1990). Infected women must balance the danger of passing the virus on against the chance that if they do not bear children, their husbands may leave them and family reject them. A survey of pregnant women attending ante-natal clinics in Brazzaville, Congo, found that most thought HIV antibody testing should be part of routine ante-natal screening (Mariasy and Radlet, 1989). However, a high percentage admitted that, even if they discovered they were antibody positive, this would not affect their decision whether or not to become pregnant.

Another problem is that in many areas attitudes towards sexual fidelity and fertility can act as a very real constraint on the practice of safer sex. In Sub-Saharan Africa, for example, there is a widespread reluctance to use condoms outside commercial forms of sex. Sexually transmitted diseases are explained by witchcraft and extra-human forces rather than contagion (Caldwell, Caldwell and Quiggin, 1989). These same explanations could also apply to AIDS. Social pressures on women to produce large numbers of children are very strong. Lineage ties are powerful, with the emphasis on high levels of fertility as the means of perpetuating the line (Caldwell, Caldwell and Quiggin, 1989). Children born outside marriage are not rejected but valued as they also add to lineage strength. Marriage bonds are weak and the family unit consists of the mother and her children. Because marriage does not establish the basic unit of society, social concern with extramarital or premarital sex is not strong. Divorce and polygamy are common and also many couples practise post-partum sexual abstinence. Moreover, men are frequently absent from the home for long periods, working as migrant labourers, truck-drivers or itinerant traders. All these factors together mean that sex with substitute partners is common, as is commercial prostitution in some communities.

Seropositive women are often unfairly blamed as transmitters of HIV and especially for bringing the affliction into the family (Black, 1990). When they fall ill and as they grow steadily weaker, they are deeply troubled by fears for their children's health and survival and may be unable to make proper provision for their future. They may be unsure about whether or not to breast feed and may experience feelings of profound guilt about children infected during pregnancy or at birth. They may not know whether to have their seropositive infants immunized against other major diseases. Many also have to cope with the burden of keeping secret the presence of the virus in the family or the social stigma of this knowledge being public and the family being disowned, rejected or persecuted by neighbours, relatives and others (Panos, 1990).

Discrimination against infected children has resulted in a number of countries in their being barred from attending schools and day-care facilities.
In the United States parents have had to fight school authorities and have won court injunctions enforcing their children’s right to attend. The psychological, social and economic pressures on families living with HIV and AIDS are extreme, resulting frequently not in increased unity and mutual support between members, but blame, recrimination, separation or abandonment. Throughout the world children experience these problems and pressures as a result of AIDS, in addition to living with disease and death.

The hidden years

Health specialists working in poor countries are mainly concerned with children between the ages of 0 and 5. This is because levels of morbidity and mortality among infants and younger children are extremely high. Once a child reaches the age of about 6 the chance of survival seems to improve. However, this pattern does not always apply. In a recent survey carried out in Somalia for example, it was found that 5-12 year olds were more vulnerable to malnutrition than younger children (Pratt, personal communication). The assumption was that parents were depriving their older children of food in order to protect and secure the survival of the younger ones. In general, there is very little information concerning this older age group. This is partly because a large proportion of poor children over five years of age are not in school and are therefore not included in health surveys. But more importantly, older children are widely neglected by health services globally.

Work has a major impact on the health of children over five. Undoubtedly there are some health benefits to be gained from work. Child labour may be a necessary means of ensuring a reasonable level of nutrition for all the family. Children working in restaurants or kitchens may be given food; by earning an income they may be ensured of the means to buy food. Psychologically, the work or street group can provide children with security. But, given the kinds of conditions under which most children work, the negative effects on health tend to far outweigh the positive.

Child workers are subject to a whole range of industrial diseases, including silicosis, pneumoconiosis, asthma, bronchitis, pulmonary tuberculosis, bony lesions, deformities and eyesight problems. Some are treated brutally by their employers. Others suffer from excessive fatigue through working long hours with no recreation or labour saving devices. The time allowed for meals is often entirely inadequate. All this can lead to stunted growth, malnutrition, anaemia and undesirable changes in the endocrine and nervous systems.

Children working in India’s match industry are exposed for 12 hours or more a day to the noxious fumes of phosphorus and other chemicals, and always face the danger of fire and explosions (Economist Development Report, 1986). A number of children involved in Lima’s firework industry and in quarrying in Bogotá have been killed in explosions (Salazar, 1988). According to government statistics published in 1970, of the victims of industrial accidents in Italy, 8 per cent are children and adolescents (Boudhiba, 1982). And from an enquiry conducted by the National Centre for Labour Law Studies in the Campania region of Italy, it emerged that 12 per cent of 518 child workers under 14 years of age had suffered accidents at work (Naidu and Kamini, 1985).

Children who work with machines and those employed in the manufacture of chemicals or explosives often have severely impaired eyesight. Some suffer from corneal ulcers as a result of foreign bodies falling into the eye. Equally, hammering metal with metal, or stone with metal, presents a grave risk. Eye problems are especially prevalent in the polishing and diamond-cutting industry. Thousands of girls between the ages of 12 and 15 in Kao-Hsiung, in southern Taiwan, are engaged in joining computer wires under microscopes, wearing jumpers and implanting hair on dolls’ heads (Boudhiba, 1982). Many develop seriously impaired eyesight within 5-8 years of commencing work.

Working children often experience malnutrition, anaemia, fatigue and excessive physical stress, all of which make them especially susceptible to infectious diseases, and damage their development. Among child cigarette makers in Madhya Pradesh, in India, there is a very high incidence of anaemia and chronic bronchitis. One study in Japan demonstrates a difference of 4 cm in height between children who began work before the age of 14 and those who began after 18, whereas their heights had been comparable when they were 12.

Children working in brick kilns, asbestos factories or mines for long periods develop silicosis, asbestosis and pneumoconiosis. In foundries and machine shops children are exposed to ash, clay and grease. In some industries children are exposed to radiation, which is thought to cause leukaemia and sterility. Working long hours exposes children to increased risk of accidents from falling or tripping and from machinery. They may be forced to carry heavy loads, such as bales of carpets, or large containers. The bone structure becomes damaged, the spine affected.

Garbage separation is possibly one of the most dangerous occupations in which children are found working. As Tom Weber notes, Mexico City’s dump provides employment for many children:

It is an enclave of robotized trash people who are forever digging, scraping, tearing, pulling and rooting their way through mountains of rubbish for anything of value — anything that can be eaten or worn, used for shelter or re-cycling. The carrion, swill, garbage, contaminated industrial waste and stinking hospital offal make it a most lucrative business. (Weber, 1986, p. 6)

A study of child domestics in Nairobi revealed that they lacked freedom of movement and that their employers continually and mercilessly emphasized their menial status (Oinyango and Kayango-Male, 1982). The children were overworked and forced to undertake tedious, exhausting tasks. Employers demanded total obedience, and controlled the children with beatings and insults. These young domestics experienced no emotional warmth and were expected to behave as adults. Expressions of developmental needs by the children were viewed by employers as symptomatic of disobedience. All the children were underpaid. There were a number of cases of severe psychological
disturbance. Some of the girls were withdrawn, unable to interact with other people. They were reluctant to eat in public and refused to speak. There were other symptoms, such as bed-wetting, frequent nightmares and a phobic fear of employers. Most of the children were self-deprecating, and experienced feelings of worthlessness.

Helping children to health: policy issues

Urban and industrial development in the second half of the 20th century has presented major problems for health planning and policy. The urban-industrial complex has given rise to a range of new health dangers, many of which have still to be fully identified and most of which affect the young more than any other group. In addition, industry has placed unprecedented demands on public services because it requires a healthy and efficient labour force. The WHO's global strategy of Health for All by the year 2000 refers explicitly to the impact of urbanization on health. Yet there remain many serious obstacles to the guarantee of good health among the city dwellers of the world.

The problem with traditional health policy in most countries is the strong emphasis on curative treatment rather than the promotion of the general good health of the population. In the South this approach has sometimes been adopted at the expense of environmental services such as clean water supplies, sanitation and housing standards and immunization against infectious and epidemic diseases (Hardiman, 1986). It is in curative medicine that the heavy investment — in terms of finance, expertise and professional status — has been traditionally made. And the general public has now become convinced that what they require is ever more dramatic advances in medical science and specialist interventions to cure major health problems. But historical evidence would suggest that medical science is moving in the wrong direction. The decrease in the number of deaths in cities in the United States and Western Europe during the 19th century was the result of improved nutritional standards rather than the introduction of new technologies (Wray, 1985).

The building of more hospitals and clinics and the provision of more medical personnel — although necessary in many places — will not in themselves improve the health of children in poor urban areas.

In recent years there has been a gradual shift in emphasis away from curative services towards primary healthcare, which focuses on preventive and promotional measures. This is partly because of financial constraints on health services, but mainly because of the recognition that the whole community should be involved in healthcare, and that effective health provision depends on attention to priorities such as clean water, environment and education. Primary healthcare has received strong support from Inter-governmental agencies such as WHO and UNICEF and non-governmental bodies like Oxfam and Save the Children Fund. In primary healthcare programmes, the home, as opposed to the specialized health facility, is the focal point for preventive and promotional work and is backed by a supportive referral network. The

transition from cure to prevention, from secondary to primary healthcare, can be costly for government. It may mean dismantling existing structures and developing entirely new systems of delivery. It may also mean overcoming opposition from practitioners who have staked their reputations and careers on curative medicine.

Considerable effort has been put into developing effective strategies for the delivery of primary healthcare. But because of the general belief that urban populations are healthier than those in rural areas, the delivery systems have largely been based on models of rural epidemiology and rural social organization. Health specialists tend to have in mind 'village health workers' or 'barefoot doctors' and homogenous, undifferentiated rural communities when developing services (Harpham, Vaughan and Rifkin, 1985). But there are other problems with urban healthcare: in small rural communities it is easier to achieve complete coverage of the population than in the sprawling slums and shanties of the city.

Although primary healthcare is now a widely accepted approach in cities, it cannot be entirely successful until planners and policy-makers have a clearer picture of the health problems that exist there. This requires the more careful recording and analysis of statistics by settlement, district, class, age and gender so that those most at risk can be reached effectively. The present emphasis on mothers and young children in primary healthcare, for example, may lead to the neglect of other needy groups. Older children, especially if they work rather than attend school, may not benefit from health provision.

Since the 1980s it has become increasingly clear that the greatest challenge to health services — and indeed other services such as the legal and social — in many cities in the near future will be the spread of AIDS:

The range of physical and psychosocial problems experienced by people with HIV and HIV-related diseases is such that they often require constant medical, custodial and psychosocial care. (WHO, 1989d, p. 3)

Care of the patient is only one of many priorities, because family and community members may also need counselling and economic support. Indeed, the challenge and threat of AIDS demands a varied response at all levels, from the local community, voluntary sector and statutory bodies. Legal aid may be sought by people who experience discrimination violating their civil rights (Panos, 1990). Workers' organizations may be called in to protect members who are HIV positive from dismissal or similar action by employers. And governments will have to fund and organize education and information campaigns to stop the spread of the disease.

The World Health Organization has alerted the international community to the global scope of the pandemic and to the need for coordinated effort at the international level in support of concerted action at the national level to combat its spread. In 1987 the Organization established a special intervention now called the Global Programme on AIDS. This programme has developed and is responsible for promoting, monitoring and evaluating the global
strategy for the prevention and control of AIDS. It has three overall objectives: to prevent infection with HIV; to reduce the personal and social impact of HIV infection; and to unify national and international efforts against AIDS. The programme has backed education initiatives, research and public information campaigns throughout the world. It also works with governments in policy development.

But there are no easy solutions to the problem of control and prevention. Despite serious practical and ethical doubts about their value, some governments favour compulsory measures to identify people who are seropositive and prevent them as far as possible from transmitting the virus to others (Panos, 1990). These involve the screening of individuals or population groups, the use of the law to regulate behaviour and isolating those who carry the virus from the wider population. One problem is that groups singled out in this way tend to react by avoiding situations where compulsory procedures may be enforced. Mandatory blood testing among groups consistently engaging in high-risk behaviours has been instituted in some countries, though, and prostitutes are tested regularly in Australia, Guatemala, Israel and South Korea (Panos, 1990).

Despite the cost and, more importantly, the ethical problem of depriving people who have committed no crime of their liberty, Cuba has implemented nationwide screening accompanied by mass isolation of all infected people for an indefinite period until a cure for AIDS is found. Other countries, among them Sweden, practise selective isolation of seropositive people who knowingly place others at risk. But even this approach is problematic, given that many people — juvenile prostitutes in poor communities for example — have no control over their lives and may be forced to engage in risk behaviours for survival.

The complex measures needed to contain the AIDS pandemic, including the screening of blood supplies, administering blood testing programmes and conducting extensive prevention campaigns, are expensive both in human and financial terms (Smith and Macdonald, 1987). Some of these interventions cannot practically be implemented in the countries where the incidence of HIV/AIDS is very high. Even without seeking actively to identify people who are seropositive and helping them minimize the risk to others, the maintenance of uncontaminated blood supplies and patient care alone threaten to overwhelm health services in a number of countries.

The danger is that, as the number of people with the disease grows, scarce resources will be diverted from services dealing with other serious health problems to AIDS. But, also, investment is needed in the implementation of new preventive measure and research into a cure. Maternal and child health services will have to be expanded to provide education, screening, counselling and, where legal, terminations. Family planning centres can also play an important role in education on safer sex and mother-to-infant transmission. All health services involved in prevention and care will need to increase their community outreach and provide support for voluntary endeavour and home-based provision.

We have seen that poverty is clearly a major cause of poor health. A wider distribution of resources and income, and, therefore, employment generation, should be seen as fundamental elements in effective health policy. The need for increased income is especially great in urban areas, where production for home consumption is severely restricted and food has to be purchased. Unfortunately, in many cities, the only measure aimed at supporting domestic incomes is the manipulation of rural/urban terms of trade to control the prices of staple foods. The trouble is that control of prices is normally only achieved by introducing burdensome State subsidies or by penalizing rural producers. Cheap food for city dwellers often results in the collapse of rural production nationally, forcing government to import basic products from abroad.

A clean and safe environment is another crucial component in health status. The urban environment can be far more hazardous for child health than the rural. This is another area in which public policy is usually extremely weak. Powerful industrial interests and lobbies resist government attempts to reduce air and water pollution in cities. Multinational corporations wishing to avert legislative reform on environmental pollution need merely to threaten to move their factories abroad; few governments trying to contend with high levels of urban unemployment will want to risk upsetting the vested interests of major international companies. In the light of the Bhopal disaster, it is evident that the international community should play a far more active role than at present in the setting and pressing for enforcement of industrial standards, especially in the South.

The sheer pace of urbanization, combined with the lack of public sector investment in physical infrastructure, means that governments are not keeping up with the escalating environmental needs of city populations. A high percentage of squatter settlements, for example, are forced to rely on self-help strategies or private firms for the provision of clean water and other services. In many cases, they obtain services only by tapping illegally existing facilities. Far more resources than are allocated at present are needed to provide safe piped drinking water, efficient storm water drainage and sewage disposal and treatment in cities. This would involve not only releasing more public sector funds for improved services, but also intervening more directly in urban planning so as to ensure that measures for a safer and cleaner environment are introduced.

Popular education also plays an important role in health. Education is the main weapon against AIDS. It involves informing about and teaching preventive measures such as good nutrition, immunization and personal hygiene, as well as advising on the appropriate action to take in case of illness and the curative services available. However, health education can be used by government to deflect public concern away from the more crucial factors influencing health. Obviously, health education in isolation will be ineffective, and it has impact only when accompanied by measures to reduce poverty and improve services. In the case of infants and young children, health education is normally channelled through parents, especially mothers. Mothers are seen as the key agents in the improvement of
environmental conditions and the dissemination of health information within the family and the community. One of the dangers inherent in focusing on mothers and children is that an additional burden of responsibility is placed on urban women, who are already overworked and under stress.

On the whole, little is done to inform children directly about health matters. This means that generations of children are growing up without understanding how diet and lifestyle affect health. Moreover, family structure and roles undergo many changes with urbanization. It should not be assumed that the strong mother-child bond predominates in all cities. Channeling information and education through parents will not help children who live without adult support or care. It will not help those children within the family who are unwanted or abused. Nor will it help the many working children whose occupation presents a direct risk to their health. WHO recognizes that

in Primary Health Care the individual, the family and the community are the basis of the health system with the Primary Health Care worker as the central worker. Yet many children either do not have families or are abused and neglected by them. Their status in the community and their legal status may be very low and often, even when there are Primary Health Care workers, they are not communicating with these groups of children. (Pitt and Shah, 1981, p. 14)

Action

The one initiative that does recognize how children, when informed of health issues, can contribute to the improvement of health is the 'Child to Child' programme, developed by the Institute of Child Health in London. This programme now extends to rural and urban communities in numerous countries throughout the world. It aims to teach and encourage children of school age to concern themselves with the health, welfare and general development of their pre-school brothers and sisters and of other younger children in the community. School-age children have proved to be extremely good at detecting health problems and taking responsibility for the health status of other, younger children. They can be trained to identify early symptoms of disease and to make sure that infants benefit from immunization and other preventive measures. They can disseminate at home vital information on nutrition and health learnt at school, influencing adults to change their attitudes and practices.

In Davao City, in the Philippines, children are trained in a community-based health programme to become health scouts (Ideas Forum, 1985/1, no. 20). They learn how to bath their younger siblings and give them oral rehydration salts when they have bouts of diarrhoea. They are also encouraged to take action to prevent common accidents in the home and to monitor the hygiene of their brothers and sisters. In Kilwes, a town in Kenya, the older pupils in twenty primary schools are learning how to care for disabled children. Through role play they discover the difficulties experienced by disabled children and are taught how to play with them and to help them take exercise. Some of the schools in the town are compiling lists of local disabled children and others are arranging screening sessions for the detection and assessment of disability.

It is the de-professionalization of services and use of community resources for the prevention of disease and promotion of good health that above all characterizes primary healthcare. The use of auxiliaries and volunteers in AIDS education and patient support programmes has proved extremely effective in a number of countries. One of the greatest needs of seropositive children, for example, is to have access to child care rather than health care services and these are best provided by the community. In cases where the parents or guardians have died or are themselves too sick to care for children, the priority is to find foster parents locally. Care of sero-positive children who might have long periods of serious illness and will probably die is both stressful and demanding. It requires a special commitment and understanding on the part of care-givers that cannot necessarily be found through the normal channels of paid professionals. Often the people involved in these programmes are themselves seropositive or have experienced HIV-related illness or AIDS in someone close to them and therefore have a deeper rapport with the patient.

The Leake and Watts AIDS Foster Home Project in New York State places seropositive children with people prepared to care for and nurse them. Foster parents are chosen after a careful screening process. Many are from minority communities because a large percentage of the children are blacks or hispanics and the policy is to place them with people of their own cultural background as far as possible. Foster parents need to be firm advocates for the child, as well as educators of other people in their social network. Most of those in the Leake and Watts programme are people who have themselves experienced adversity and few live in conventional nuclear family settings.

Providing support of various kinds for foster parents is extremely important. In the Leake and Watts programme they receive financial aid from the placement agency to cover basic needs, medical expenses and certain extras such as paid child care to allow them to break the daily routine. TASHO in Kampala, which offers counselling and information on AIDS in addition to medical care and support, also helps find friends and relatives to foster children. The agency explains to potential foster parents how AIDS is spread and, together with Save the Children Fund, gives them food, clothing and financial help to enable the children to go to school. Foster families can feel isolated because of necessary constraints of confidentiality. In the Leath project in Scotland foster parents are permitted to tell a close and trusted friend about their situation and this individual can act as their personal counsellor and supporter (Russell, 1987). A system of respite care for the carers has also been developed along the lines of schemes for the families of disabled children using a pool of local people. The Leathian children also use ordinary children's services, paediatric outpatient departments and day care facilities in the local community.

Families living with AIDS often require extensive emotional support and