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Prevalence of Urban Poor and Its Health Related Factors in the State of Selangor, Malaysia

[1]MS Sherina*, [1]L Rampal, [1]AR Hejar, [2]A Rozali & [1]A Mohd Yunus

[1]Department of Community Health, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia.
[2]Health Services Division, Ministry of Defense Malaysia

ABSTRACT

The objectives of this study were to determine the prevalence of the urban poor and its health related factors in Selangor. This cross-sectional study was conducted in the community of Selangor. Data was collected from January 2006 to June 2006. Three out of nine districts were selected to be involved in the study, which were Klang, Kuala Langat and Petaling. A Multistage Stratified Proportionate Systematic Random Sampling was used for this study. The sampling was carried out by the Statistics Department of Malaysia. The survey frame was based on the information gathered from the Population and Housing Census in year 2000. The respondents were interviewed by trained research assistants using a structured pre-tested standardized questionnaire prepared in Malay and English languages. A monthly income of RM706 and less was used to define urban poor based on the guidelines given by the Economy Planning Unit of Malaysia (2004). SPSS 16.0 version was used to analyze the data. Out of 2535 respondents interviewed in this study, 2491 respondents answered the questionnaire completely (response rate 98.3%). Out of 2491 respondents, 202 (8.1%) had a monthly income of RM706 and less. Analysis of the urban poor respondents found that majority were aged between 18 to 40 years old (55.9%), and 29.7% had diagnosed medical illnesses, where hypertension, diabetes and asthma were the most common illnesses at 12.4%, 10.9% and 5.0% respectively. About 10% of the urban poor respondents had physical disabilities such as blurring of vision (7.9%), hearing problems (1.0%) and other disabilities (1.0%).

Keywords: Urban poor, prevalence, health-related-factors, Selangor

INTRODUCTION

Malaysia has been facing rapid urbanization and population growth. The increasing trend of urbanization in Malaysia is accompanied by the concentration of people in the metropolitan as well as large urban areas.[1] The process of such urbanization has produced many negative impacts on the socioeconomic and environmental well-being of the urban poor; particularly those who are living in squatters accommodation and low-cost flats.[2]

In Malaysia, the prevalence of absolute poverty has traditionally been determined by reference to a threshold poverty line income (PLI). This PLI is based on what is considered to be the minimum consumption requirements of a household for food, clothing, and other non-food items, such as rent, fuel, and power. The proportion of all households living below this threshold is the proportion living in poverty – that is the poverty rate. The PLI for Selangor was RM529 in 2002 and was increased to RM706 in 2004.[3]

Although the overall prevalence of urban poverty in Malaysia is low compared with that of rural poverty, it must be noted that the PLI used in measuring poverty prevalence in urban areas is similar to that of rural areas, i.e. RM529 per month in Peninsular Malaysia, RM690 in Sabah and RM600 in Sarawak.[3] Thus, if one uses different PLI for urban areas, say 20-30 per cent higher from that of rural areas, reflecting the higher cost of living in the urban areas, one will find higher incidence of urban poverty. Consequently, if we consider other socioeconomic variables such as housing conditions, amenities, in measuring the incidence of urban poverty in addition to income, the extent and magnitude of urban poverty may be more serious.[1]

According to World Bank, poverty is defined in terms of a person's income or the amount of goods they are able to consume. The World Bank has set the international poverty line at an expenditure level of $1 for every person a day. Another standard definition of absolute poverty is "a condition of life so characterized by malnutrition, illiteracy, and disease as to be beneath any reasonable definition of human decency".[4] This definition concentrates on what it means to be in a state of poverty – to lack food, to be uneducated, and to lack access to basic health care. Poverty and health are inextricably linked, where more illnesses (both communicable and non-communicable) are associated with poverty. There is in fact a two way relationship between poverty and ill-health, with illness often further impoverishing the

*Corresponding author: *sherina@putra.upm.edu.my*

poor. Illness prevents people from working, affects their productivity and lowers their income. The costs of obtaining health care can also be substantial, both in terms of time off from work and in terms of money spent on services.[5] It was estimated that between 1990 and 1994, 21% of previously non-poor households in Bangladesh slipped into poverty as a result of health-related causes.[6]

Even though PLI is usually based on households and not individuals [3], this study presents its results for both individuals and households. This is because the objectives of this study were to determine the prevalence of urban poor, and also the health factors of the urban poor in Selangor, which need to be identified individually. The findings of this study can be used to improve the lives of the poverty groups in terms of health related factors in the urban areas.

METHODOLOGY

This was a cross-sectional study conducted in the community of Selangor. Data was collected from January 2006 to June 2006. Out of the nine districts in Selangor, three districts Klang, Kuala Langat and Petaling were selected in the study.

A Multistage Stratified Proportionate Systematic Random Sampling was used for this study. The sampling was carried out by the Statistics Department of Malaysia. The survey frame was based on the information gathered from the Population and Housing Census in year 2000. The state was stratified into the following four sub-stratums namely, metropolitan areas (75,000 population and above), urban large (10,000 to 74,999), urban small (1,000 to 9,999) and rural (the rest of the areas). Further selection was made based on artificially created, contiguous geographical areas called Enumeration Blocks (EBs). An EB consists of 80-120 households and has specified boundaries. Only population residing in non-institutional households was covered, and only Malaysian citizens were included in this study.

For the purpose of this study, only EBs in urban areas of Selangor were identified. Both urban large and urban small areas were included, but not metropolitan and rural areas. There was no difference in PLI levels between the urban small and urban large areas, as the definition for urban poor is the same for all areas in Selangor (based on the Economy Planning Unit's definition for PLI in 2004).[3] Selection of sample within the EBs was based on the number of households in the stratum. The sample size calculated for this study was 823 households (based on the EPI INFO STATCALC calculation at 99.9% confidence interval and 5% expected prevalence of urban poor households). Based on an estimate that the response rate of households might only be 70%, an additional 247 (30%) households were sampled. A total of 1070 households were selected using a table of random numbers, with each household estimated to have at least 1 to 2 adult respondents. All adults aged 18 years and above of the selected households were included in the study.

The respondents were interviewed by trained research assistants using a structured pre-tested standardized questionnaire in both Malay and English languages. The interviewer obtained verbal consent before administering the interview and the information was immediately and directly transcribed into the questionnaire. The questionnaire included questions on socio-demography such as age, sex, race, religion, marital status, school attendance, education level, employment status and total monthly income. Questions assessing health related factors included questions on health problems, medically diagnosed chronic and mental illnesses (personal and family), history of smoking, and physical disabilities. Questions on utilization of health services included questions on types of health services utilized, usage of government clinics or hospital in the last 6 months, knowledge on the services of the nearest government clinic and expenditure on medical treatment for the past 6 months.

This study was approved by the Ethical Committees of the Malaysian Ministry of Health, and the Faculty of Medicine and Health Sciences, University Putra Malaysia. Statistical Package for Social Sciences (SPSS 16.0) was used to analyze the data.

RESULTS

Out of the 1070 households sampled, 1056 had respondents fulfilling the selection criteria (Malaysian citizens aged 18 years and above) who were willing to participate in the study. A total of 2535 respondents from the 1056 households were identified to be interviewed in this study. However, only 2491 respondents who were interviewed answered the questionnaires completely, while 44 of the respondents did not complete the interview section giving a response rate of 98.3%. The reasons given for not completing the interview were having to go to work and too busy with housework. Each household had one to three respondents who participated in the study.

Table 1 shows the household monthly income of the respondents. Out of 2491 respondents, 202 (8.1%) had a monthly income of RM706 and less, and 1238 (49.7%) had a monthly household income of RM1500 and less. The 202 respondents were from 88 households which were all located in urban small areas of Selangor.

Table 2 shows the sociodemographic profile of the urban poor respondents with PLI RM706 and below. Majority of the respondents were in the age category of 18 to 40 years old (55.9%). About 41.6% of the respondents were males,

whereas others were females (58.4%). Most of the respondents were Malays (55.9%), Muslims (55.9%), and married (65.8%), attended school (91.1%) and had secondary education (57.1%), with the highest certificate in SPM/SPMV/MCE (28.7%). However, half of the respondents were unemployed (50.0%).

Table 1. Household monthly income by respondents (n = 2491) and households (n=1056)

Characteristics	Respondents (%)	Households (%)
By PLI RM706/month		
Above RM706	2289 (91.9)	968 (91.7)
RM706 and below	202 (8.1)	88 (8.3)
By PLI RM1500/month		
Above RM1500	1253 (50.3)	644 (61.0)
RM1500 and below	1238 (49.7)	412 (39.0)

Table 2. Socio demographic profile of the urban poor respondents (n = 202)

Profile of the respondents	n	%
Age (years)		
18-40	113	56.0
41-59	71	35.1
60 and above	18	8.9
Gender		
Female	118	58.4
Male	84	41.6
Race		
Malay	113	55.9
Indian	74	36.6
Others	8	4.0
Chinese	7	3.5
Religion		
Muslim	113	55.9
Hindu	76	37.6
Buddha	6	3.0
None	4	2.0
Christian	3	1.5

Continuation
Table 2. Socio demographic profile of the urban poor respondents (n = 202)

Profile of the respondents	n	%
Marital Status		
Married	133	65.9
Single	52	25.7
Widowed	15	7.4
Divorced	2	1.0
Attended School		
Yes	184	91.1
No	18	8.9
Education Level (n=184)		
Primary	64	34.8
Secondary	105	57.1
Tertiary	15	8.1
Highest Certificate (n=173)		
UPSR	56	27.7
PMR/SRP/LCE	44	21.8
SPM/SPMV/MCE	58	28.7
STPM/HSC	5	2.5
Certificate/Diploma	6	3.0
Bachelor Degree	4	2.0
Employment		
Unemployed	101	50.0
Non-Government	59	29.2
Government	19	9.4
Self Employed	18	8.9
Others (Labourer)	5	2.5

Table 3 shows the health related factors of the urban poor respondents. About 29.7% of them had health problems, where hypertension, diabetes and asthma were the most common chronic medical illnesses at 12.4%, 10.9% and 5.0% respectively. As for the family members of the respondents, hypertension was also the commonest chronic illness (21.8%), followed by diabetes (18.8%), asthma (7.9%) and ischaemic heart disease (7.9%). Most of the respondents in this study did not smoke (74.9%), and did not have any diagnosed mental illness (91.6%). Almost 10% of the respondents had physical disabilities such as blurring of vision (7.9%), hearing problems (1.0%) and other disabilities (1.0%).

Table 4 shows the utilization of health services among the urban poor respondents. A majority of the respondents sought treatment at government clinics (88.6%), and 62.4% sought treatment at these government clinics during the past 6 months. Most respondents had knowledge about the services of the nearest government clinic to their houses (95.0%), and received either free medical treatment or at a nominal fee of RM 1 (43.6%). However, most respondents had never received treatment at any Hospital Emergency Unit during the last 6 months (96.5%).

Table 3. Health related factors of the urban poor respondents (n = 202)

Profile of the respondents	n	%
Diagnosed Health Problem		
No	138	68.3
Yes	60	29.7
Don't know	4	2.0
Medically Diagnosed Chronic Illness *(can tick more than one answer)*		
Hypertension	25	12.4
Diabetes	22	10.9
Asthma	10	5.0
Ischaemic Heart Disease	7	3.5
Arthritis	5	2.5
Cancer	4	2.0
Stroke	1	0.5
Known Family Chronic Illness *(can tick more than one answer)*		
Hypertension	44	21.8
Diabetes	38	18.8
Asthma	16	7.9
Ischaemic Heart Disease	16	7.9
Stroke	8	4.0
Cancer	4	2.0
Arthritis	3	1.5
Smoking		
No	140	74.9
Yes	40	21.4
Quit	7	3.7
Diagnosed Mental Illness		
No	185	91.6
Do not know	15	7.4
Yes	2	1.0
Known Family Mental Illness		
No	183	90.6
Do not know	15	7.4
Yes	4	2.0

Continuation

Table 3. Health related factors of the urban poor respondents (n = 202)

Profile of the respondents	n	%
Physical Disability		
Blurring of vision	16	7.9
Hearing Problems	2	1.0
Other Disabilities	2	1.0
Blind	0	0.0
Deaf	0	0.0
Mute (unable to speak)	0	0.0
Paralysis (upper and / or lower limbs)	0	0.0
Mental Retardation	0	0.0
Congenital Diseases	0	0.0

Table 4. Utilization of health services among the urban poor respondents (n = 202)

Profile of the respondents	n	%
Health Services utilized *(can tick more than one answer)*		
Government Clinic	179	88.6
Private Clinic	64	31.7
Government Hospital	59	29.2
Self Treatment	4	2.0
Private Hospital	1	0.5
Traditional	0	0.0
Received treatment at the government clinic past 6 months		
Yes	126	62.4
No	76	37.6
Knowledge on services provided by the nearest government clinic to house.		
Do know	192	95.0
Do not know	10	5.0
Medical treatment expenditure for the past 6 months		
Free / nominal fee of RM 1	88	43.6
Do not know	84	41.6
Do know	30	14.9
Received treatment at Hospital Emergency Unit past 6 months		
No	195	96.5
Yes	7	3.5

DISCUSSION

Prevalence of urban poor

Urban poverty is a multidimensional phenomenon, and the poor suffer from various deprivations, e.g., lack of opportunities to employment, inadequate housing and social protection, and lack of access to health, education and personal security.[6]

This study found that the prevalence of urban poor was 8.1% for individuals and 8.3% for households. In comparing this figure to other figures worldwide, it must be kept in mind that there are various estimates of the proportion of urban poor populations and also, different definitions have been used. One global estimate suggested that 27.7 per cent of the developing world's urban population lived below official poverty lines. Regional variation for urban poor was also considerable: sub-Saharan Africa, 41.6 per cent; Asia, 23 per cent; Latin America, 26.5 per cent; and the Middle East and North Africa, 34.2 per cent. According to the state of world population series, urban poverty has been increasing faster than rural poverty.[6]

Malaysia's poverty rate has declined dramatically over the past three and a half decades. About half of Malaysian households lived below the poverty line in 1970, falling to 16.5 per cent in 1990 and to just 5.1 per cent in 2002. The prevalence of urban poverty declined from 3.3 per cent in 1999 to 2.5 per cent in 2004. Although the urban poverty rate is very low, rapid urbanization that has occurred over the decades means that the number of the urban poor is now considered significant.[3] The redefinition of urban areas in 1991, whereby about 6 per cent of the total poor in built-up areas that were previously defined as rural were classified as urban, has contributed to the rise in urban poor. As such, the number of poor households in urban areas in Malaysia rose significantly from about 77,900 in 1993 to 99,300 in 1995 primarily due to this redefinition.[7]

However, even this may be an underestimate: official poverty lines are often set unrealistically low, below the levels required to meet basic needs, and standard income-based definitions do not usually take into account the higher cost of living in the cities. In this study, if an alternative measure of household income of RM1500/month was used as the PLI, the prevalence of urban poor for households would have been much higher (39.0%) as compared to the national PLI of RM 706/month (8.3%) found in this study.

Socio demographic profile of the urban poor

A person's age and gender have remarkable influence on their likelihood of experiencing poverty. In this study, 55.9% of the respondents who were found to be poor were from the age of 18 to 40 years. This study also found that 58.4% of the urban poor respondents were females. A study in Canada reported that the young and the elderly were more likely to experience poverty. As well, women in every age group were more likely to live in poverty than men.[8]

There are three main ethnic communities in Malaysia, which are Malays, Chinese and Indians. In this study, the prevalence of urban poor was highest among Malays (55.9%) compared to Indians (36.6%) and Chinese (3.5%). Previous studies in Sabah and Sarawak have showed that Bumiputera (Malays and other indigenous groups) were experiencing higher levels of poverty than the Chinese since 1990.[9] The report by the Economic Planning Unit in 2003 also stated that the poverty rates for the Bumiputera, Chinese and Indians were 7.3%, 1.5% and 1.9% respectively.[3] It showed that poverty was higher among the Bumiputera than the other communities. Meanwhile, a national survey in America on poverty by race and ethnicity showed that Blacks, Hispanics and Native Americans, each have poverty rates almost twice as high as Asians and almost three times as high as Whites.[10]

Majority of the urban poor respondents in this study were married (65.8%). This finding defers with the national survey in America, where families with a female head of household had a poverty rate of 29.9% and comprised the majority of the poor families. Poverty rates were also higher among families with female households with no husbands present (26.5%), followed by male households with no wives present (12.1%).[10]

This study also found that most of the respondents (57.1%) had secondary education, 34.8% had primary education and 8.9% had never attended school. Half of the respondents in this study were also unemployed (50.0%). Poverty in urban areas has been strongly linked to the low levels of education and unemployment. High poverty rates have been linked to low levels of educational attainment. Low levels of formal education have been linked to employment in low wage earning jobs. Low wages have been linked to subsistence living. Education - especially basic (primary and lower-secondary) education - helps reduce poverty by increasing the productivity of the poor, by reducing fertility and improving health, and by equipping people with the skills they need to participate fully in economy and society.[10]

A variety of studies in diverse settings have shown that unemployment is two to three times greater among the poor than among the middle or higher income groups and correspondingly higher among the very poor compared to the relatively poor.[11] It is not merely that employment prevents poverty, but that poverty restricts access to skills, attitudes and opportunities for further advancement. A study by Johari and Kiong (1991) of urban poor in Sabah found the following: urban poor were found in all ethnic groups; the urban poor were wage earners and concentrated in low wage sectors, they had low levels of education, as well as limited access to employment opportunities, social facilities and services.[9]

Health related factors of the urban poor

It should also be noted that many of the population groups, which suffer a heavy load of ill health, disease and malnutrition, are poverty groups. This study found that most of the respondents suffered from two major chronic illnesses; hypertension (12.4%) and diabetes (10.9%). Diabetes is recognized as one of the most common disease in Malaysia. The National Health Morbidity Surveys showed that the prevalence of diabetes in Malaysia increased from 6.3% in 1986 to 8.3% in 1996,[12] and further increased to 11.6% in 2006.[13]

A recent study by Anand et al conducted in 2003 to 2004 in urban slums of Faridabad district, Haryana found that there was a high prevalence of hypertension (blood pressure ≥ 149 / 90, or on an antihypertensive drug) among the urban poor; 17.2% in men and 15.8% in women.[14]

Another important illness among the urban poor in this study was asthma (5.0%). Mielck et al (1996) found that poverty and severe asthma were associated in Germany. The authors concluded that the lack of basic sanitation and inadequate housing among the poor and low socioeconomic class probably contributed to respiratory problems such as asthma.[15]

This study also found that 21.4% of the respondents were currently smoking. The study by Anand et al found that the prevalence of smoking among men was 36.5% and 7% among women in their study among respondents in urban slums. This study concluded that there was a high prevalence of risk factors, such as smoking for non-communicable diseases among the urban poor community. The authors expressed concern that there was a likelihood of a high future burden of non-communicable diseases such as hypertension and diabetes among the urban poor.[14]

Utilization of health services among the urban poor

Preliminary studies have shown that among the urban poor, there are increased health problems and increased need for health care services.[8, 16, 17] This study found that majority of the urban poor preferred to seek treatment at government clinics (88.6%) as compared to private clinics. One of the reasons was that a majority of them received free treatment or were only asked to pay a nominal fee of RM 1 at these government clinics (43.6%). Almost all respondents in this study had knowledge on the services provided by the nearest government clinic to their house (95.0%).

Health professionals have a key part to play in eradicating poverty. Firstly, they need to make sure that interventions within the health sector benefit the poor; such as ensuring government health expenditure proportionately serves the poor in both urban and rural areas, and ensuring that there is no prejudice among the health professionals in treating the poor. One of the commonest complaints from poor people using health services was that health professionals treated them with disrespect and offered them substandard treatment.[5]

The fact that the Malaysian government provides free treatment or just a nominal fee of RM 1 in government clinics is a good factor in promoting the use of health services in the government sector among the urban poor. A study by Russell and Gilson among the urban poor in Sri Lanka found that free health care services in Sri Lanka protected the majority of poor households against high out of pocket payments for treatment at the time of illness. This protection against even relatively low fees was an important poverty reduction measure because, even a small direct cost could cause impoverishment among the poor.[18]

CONCLUSION

The prevalence of urban poor in Selangor was 8.1% for individuals and 8.3% for households. The prevalence of urban poor was highest among the Malays, those who were married, with secondary education and unemployed. Among the major chronic illness, there was a high prevalence of hypertension and diabetes among the urban poor population and a very high percentage of them sought treatment at government clinics.

The findings of this study show that there are many areas to be explored among the urban poor population, such as unemployment and management of chronic illnesses. These people need adequate support to help them improve their lives in our community.

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