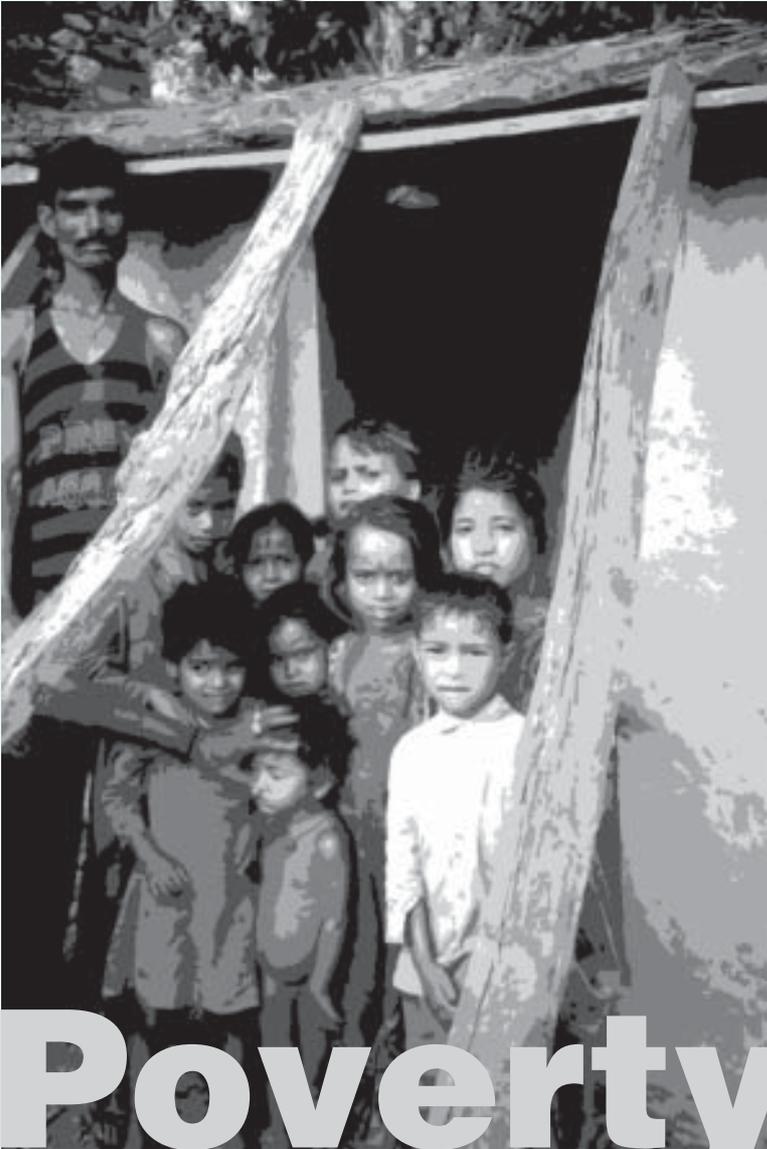


Poverty & health



Caroline Jacoby

That poverty and ill health are inextricably linked is clear. They are both a cause and a consequence of each other. Illness plunges people into poverty and poverty makes people ill. Being a part of this vicious cycle is the norm for many of the world's poorest people. This newsletter highlights examples of programmes where people are working to break the cycle.

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Poverty & health

Poverty, disability and health – an overview

Definitions of poverty

Conventionally, poverty has been defined by levels of income. Those living on less than \$1US per day – about 20 per cent of the world's population – are considered to be living in 'absolute poverty'.¹

However, poverty is not just a lack of money to buy basic necessities. It means not being able to go to school, not having a job, not being able to visit a doctor when illness strikes and not being treated with respect by medical staff. It means not having access to a life-saving vaccine, not having access to appropriate health care information, living one day at a time in fear of the future and being subjected to other people's decisions. It can leave people feeling out of control, feeling isolated, socially excluded, powerless and unrepresented.

Poverty and health

People's health is severely affected by poverty. In poorer countries, life expectancy is significantly lower than in richer ones, infant and child mortality is higher and a woman's chances of dying in childbirth are greater. The world's biggest killer diseases – HIV/AIDS, tuberculosis (TB) and malaria – run rife in poorer countries, killing over six million people every year. Many people in poorer countries die, or are impaired by, diseases that are preventable and treatable with vaccines and drugs, such as antiretrovirals for the containment of HIV.

The vicious cycle

The factors that make people susceptible to illness – lack of nutritious food, clean water and sanitation facilities, and poor or overcrowded housing – are caused by poverty. This is exacerbated even more when combined with the inability to afford treatment. Often

sickness means the family breadwinner cannot work, leaving the family with no money to pay for food. This pushes them into further impoverishment. Family assets may have to be sold, debts incurred and children taken out of school and sent to work or to beg on the streets. Once children are removed from school, it is difficult for them to acquire the skills or knowledge that could help pull them out of poverty. They become trapped in the cycle, as their parents were before them.

In these stressful situations, traditional social and family networks tend to break down or weaken, making any form of collective action very difficult. People stand little chance of ever having a voice or any power to control their lives.

Poverty and disability

The World Health Organization (WHO) estimates that there may be more than 500 million people, or 7–10 per cent of the world's population, disabled by impairments that are preventable and treatable. Over 80 per cent of these people live in developing countries.² If the aim of the internationally agreed UN Millennium Development Goals – to halve the number of people living on US\$1 dollar per day by 2015 – is to be met then disabled people have to be included in the struggle to combat poverty.

Poverty and disability are closely intertwined and, therefore, must be tackled together. People living with poverty are more likely than others to be disabled because they are often hidden away and neglected or stigmatised and are the last to have



Jamice M Tolj

Girl and boy in Rwanda

access to food and basic resources. They are less likely to go to school or gain employment and most likely to die prematurely.

There is a range of social factors that cause disability. These include barriers in the physical environment, and social attitudes and structures. These factors all affect disabled people's ability to contribute to, and participate in, society on equal terms. Disabled people have a right to lead productive and satisfying lives. Reaching out and engaging with disabled people is essential for policies and services to be effective.

Poverty and HIV/AIDS

The statistics about HIV/AIDS are staggering. Over 24 million people had died of AIDS-related diseases by December 2002. Today, more than 42 million people around the world are living with HIV/AIDS, over 29 million of whom live in sub-Saharan Africa.³ More than 13 million children under the age of 15 have lost one or both parents to HIV/AIDS and UNICEF estimates that this number will increase to 25 million by 2010.⁴ What is particularly worrying is that over half of all new HIV infections in the world affect young people between the ages of 15 and 24.⁵ With no parents and no money children are increasingly being forced to use sex as a currency in order to obtain basic necessities.

The size of the problem can instil a sense of hopelessness and inevitability. But the spread of the disease is stoppable if people have access to good health care, information, education and awareness raising.

Poverty and changing attitudes

The World Bank's *Dying for Change* report (2002) was produced to highlight the relationship between poverty and poor health from the perspective of the poor. The views of around 60,000 poor people were recorded

giving an indication of the types of problem that people living with poverty face in trying to gain access to health care.

Problems cited in *Dying for Change* included:

- low quality of service
- staff shortages and absenteeism
- lack of medicines and equipment
- difficulties in obtaining and understanding documentation
- lack of basic necessities (eg water)
- cost of treatment, particularly when without income while waiting to be treated

The report concluded that the poor had the same health care needs as everyone else, needing access to

institutions that were honest, accountable, treated them fairly, institutions that listened to them and showed them respect.

¹ 'Overview', World Development Report 2000/01: Attacking Poverty. World Bank. Oxford University Press, 2001, p3

² WHO Director-General Urges Comprehensive Agenda on Disability. WHO Press Release WHO/68. 3 December 1999.

³ AIDS Epidemic Update. UNAIDS/WHO. December 2002, p6

⁴ Children on the Brink 2002: A Joint Report on Orphan Estimates and Program Strategies. UNAIDS/UNICEF/USAID. July 2002, p6

⁵ Young People and HIV/AIDS: Opportunity in Crisis. UNICEF/UNAIDS/WHO. 2002, p5

The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

In 2002 alone, 3.1 million people died of AIDS, 2 million from TB and 1 million from malaria. As well as untold human suffering, these diseases cause catastrophic social and economic damage. While effective interventions already exist to help prevent and treat these diseases, they remain out of reach for most people in the developing world, particularly the poor and those living in rural areas. It is clear that a dramatic increase in resources to fight these diseases, and to target help where it is most needed, is a matter of urgency.

The Global Fund was created in 2001 by UN Secretary General Kofi Annan to respond to these three pandemics. The target was to raise around US\$12 billion to fund prevention strategies and treatment, through donations from corporations, foundations, individuals and national governments.

The Fund gives priority to funding proposals from countries and regions with the greatest need, based on highest burden of disease and fewest financial resources.

To date, 160 programmes in 85 countries have received some form of assistance from the Fund. However, there is much more to be done. Available funds have fallen far short of the proposed US\$12 billion per year. Unless more money is raised on an ongoing basis, there are fears that the Fund will be wound up.

More information on the Global Fund can be found at

www.globalfundatm.org



The inclusion of disabled children at school, Bangladesh

Poverty and disability

In the past, disabled people were often excluded by many organisations from the planning and implementation of community-based rehabilitation programmes. It has now been recognised that disabled people need to be included in mainstream development programmes in order to stand any chance of breaking from the cycle of poverty.

In response to this need the Centre for Disability in Development (CDD) in Bangladesh developed Community Approaches to Handicap (CAHD). CAHD aims to help development organisations to include disabled people in their activities.

CAHD starts with an organisation's current work and understanding of communities. With minor changes and training of community development workers in the principles of CAHD, disabled people can be helped very quickly.

Rather than focusing on specific groups the CAHD approach concentrates on all types of community groups, including those not normally included in development programmes such as landowners and the middle classes. CAHD recognises that disability can affect anyone and therefore measures must be developed with a wider view, including issues faced not only by disabled people but by all people.

CAHD is now being developed internationally with the support of Handicap International and Christoffel Blinden Mission. In addition to Bangladesh there are currently pilot programmes in Nepal, India and the Philippines.

CAHD aims

CAHD aims to raise awareness of:

- disabled people's need to obtain the appropriate rehabilitation services
- the need to seek solutions to ensure the inclusion of disabled people in the planning, implementation and evaluation of development projects
- the importance of changing prevailing attitudes, such as ignorance, fear and prejudice, towards disabled people in their community.

Recognising that one organisation could not meet all these aims, one of CAHD's core functions is to network with other organisations to provide all the skills required.

CAHD in practice

Rehabilitation

Mainstreaming disabled people into their community cannot be effective unless basic rehabilitation is provided. This requires the provision of therapy, supportive devices and equipment in order to prevent their impairment worsening and to ensure that they can be functional and mobile. The CAHD approach works to improve access to referral services for specialist treatment as well as to develop links and transfer options between basic home therapy service delivery and referral services at hospitals.

Changing attitudes

CAHD also works to challenge the attitudes of both people and organisations. Negative attitudes can create barriers that result in the exclusion of disabled people from their communities.

Sharing information and experiences with disabled people in workshops and meetings, allows communities to gain knowledge of disability and impairment and understand the value of including disabled people in community life. Changing attitudes is a long-term commitment but research shows that people are willing to change their attitudes and practices when a change can be shown to be of advantage to themselves, their family and their community.

CAHD also works to change the practices and policies of organisations and government structures through the training of management staff and other means.

Inclusion

Disabled people must have equal rights to access to education, health care facilities, employment opportunities, social activities and physical access to buildings in order to help them improve their quality of life. Once the attitudes of people



Rehabilitation of a child with cerebral palsy, Bangladesh

Participatory Learning Appraisal (PLA)

a tried and tested tool of problem analysis, planning and evaluation used by community development agencies can be used with CAHD. The PLA approach, both the methods and underlying values, include marginalised people successfully. With a little adaptation to commonly practised PLA, a new disability dimension can be added, as done in India by Amar Jyoti. PLA can then give disabled people a voice in community development decision-making and it leads to significantly improved community awareness of the needs of disabled people. The International Institute for Environment and Development and Healthlink Worldwide are preparing an issue of *PLA Notes* on PLA and disability. If you have any practical experience with this, please contact Heather Payne at Healthlink Worldwide, payne.h@healthlink.org.uk

and organisations change and disabled people are included they will be able to play an active role in the social, economic and political life of the community. National and international organisations need to work with disabled people to advocate for legislation, policy and regulations for the recognition of the rights of the disabled person, as well as to seek practical solutions to address the difficulties of comprehensive inclusion.

Tanjina Aktar's story shows how CAHD helped one disabled child be more active and involved in her community.

CASE STUDY

Tanjina's story

Tanjina Aktar is eight years old and lives in East Jamsing, a village near Dhaka in Bangladesh. She is the oldest child of Nurul and Begum Islam. Tanjina has a baby brother and a sister, Irine, who is five. They are a poor family and are dependent on Nurul's income from construction work. Begum is a housewife.

When she was born both Tanjina and her mother were malnourished. At the age of two Tanjina had an infection that caused a fever. Her parents took her to the doctor who cured the fever but afterwards Tanjina could not walk or talk. Her parents said her legs seemed 'abnormal' but they could not afford to take their daughter to a hospital where she could receive specialist treatment. Tanjina became a burden to her family and they felt there was nothing they could do for her. The children in the village were also cruel to her.

In November 2000, a Community Handicap and Disability Resource Person (CHDRP), Francis Halder, who had been trained in CAHD by CDD, visited Tanjina's community and was told about her. He registered her as one of his clients and made a thorough

assessment of her situation. Tanjina was diagnosed with cerebral palsy.

Halder started providing primary rehabilitation therapy for Tanjina. This has helped to control her limb movement and she is now able to stand and walk with the aid of a crutch. Tanjina can now do many of the basic day-to-day tasks such as feeding and dressing herself. Halder also began counselling her family and neighbours and organised regular community meetings where disability issues and attitudes were discussed openly. This, coupled with the rehabilitation therapy, has successfully motivated both her family and her community to involve Tanjina in community life, such as playing with the other children. The next step will be for Tanjina to start at the local school.

Tanjina's mother also became a beneficiary of an income-generating micro-credit scheme and she is now rearing a milking cow and trading on a small scale.

These comprehensive support services have helped Tanjina and her family; they have improved Tanjina's mobility and daily living skills and improved both family and community attitudes towards her. Had she not received this help she may have experienced further neglect and died at a young age.

Poverty and HIV /AIDS

Breaking out of prostitution

Kenya Voluntary Women Rehabilitation Centre (K-VOWRC) is a project based in Nairobi, Kenya, which is helping young girls find an alternative to commercial sex work

For many young girls in the city, prostitution is their only means of obtaining money. Many have moved there in search of a better life only to find themselves unable to find work. They start working as prostitutes out of necessity in order to have enough money to buy basic essentials like food. K-VOWRC's studies show that prostitution among children aged between 10 and 18 is increasing at an alarming rate. A rising number of orphans whose parents died from HIV/AIDS has led children to turn to prostitution as a means of providing for their siblings and grandparents.

Nekesa is 17 and grew up in a rural part of Western Kenya where life was very difficult. Her mother did not have enough money to send her to school and often the family had little or nothing to eat. When she was 15 her mother sent her to join her older sister in Nairobi in the hope that she would find

employment. On arrival Nekesa found that her sister did not have a job or anywhere to live. She did not even have enough money for the bus fare home. In order to survive Nekesa became involved in sex work. She knew nothing about HIV/AIDS or ways to protect herself from it. 'I was ignorant,' she says. 'I did not know about condoms.' Her clients would often take advantage of her naivety and not pay her. They also often beat her.

One day, a friend took her to K-VOWRC and she's never looked back. She was accepted into their rehabilitation programme and began a tailoring course at Ujuzi Tailoring School in Nairobi's eastern neighbourhood.

Through K-VOWRC Nekesa also learned more about HIV/AIDS and how to protect herself. Her sister found a cleaning job and, with this money and the small sum of money K-VOWRC provided to Nekesa

during her training, the pair has been able to pay their rent.

Although she is not sure what the future holds, Nekesa says, 'Since K-VOWRC, I have stopped commercial sex work. I have a better future and something to look forward to. I will be able to get a job and have an income.'

Nekesa's story is all too familiar in Nairobi. However, K-VOWRC provides some glimmer of hope. The project, started in 1992 by Professor Elizabeth Ngugi, aims to help young girls like Nekesa leave sex work and develop alternative sources of income to reduce and eventually eliminate their financial dependence on prostitution.

The girls go to the centres voluntarily in search of a better alternative to sex work. They receive a small amount of money to live on, transport costs and food, as well as a work training placement with a local business such as hairdressing, dressmaking or basic mechanic and repair work. For the younger girls, many of whom are teenage mothers, the centre also provides a home. Some are also supported to go back to school and continue their education.

A key part of the work the project does is to educate the girls about the spread of HIV/AIDS and provide counselling. K-VOWRC provides them with enough information to make an informed choice about whether or not they continue in prostitution. Many, like Nekesa, choose not to go back.

K-VOWRC is just one community-based organisation that is trying to empower young women to break out of the cycle of poverty, ill health and death.



Young Ghanaian girl developing a small bakery business

Poverty and changing attitudes

Reviews of health services continually show that the relationship between health care providers and their clients greatly affects how service users feel about the facilities they use. When relationships are poor, services are used less and clients are at risk of not obtaining treatment that could make them well.

It is unlikely that health care workers deliberately set out to treat patients badly, so there must be reasons why the provider – client relationship is often so negative. Health workers want to improve the quality of care they give but are often hampered by structural problems such as a lack of equipment or drugs, bad management and non-payment of salaries.

Health Workers for Change is a manual containing a series of workshops, devised by the Women's Health Project at the University of Witwatersrand in South Africa.

The workshops take health workers through a process of identifying their problems and finding solutions to these problems. They help health workers to look at their jobs and the way they do them in an open, non-threatening environment, without linking any discussion or topic to an individual. This is done through role play, poetry reading, storytelling and questionnaire development. The workshops are participant-led and are a contrast to interventions by outsiders. They are easily adaptable to local scenarios.

The workshops create a space in which health workers can explore issues of their daily working lives and are an opportunity to see things from the perspectives of their clients. They give health workers a chance to air their frustrations in

their job openly, without being blamed or victimised. Participants are empowered to develop problem-solving skills and encouraged to take initiatives for change.

Following the workshops clients reported that quality of care had improved. Health workers were

more attentive towards their clients and staff had taken action to increase the efficiency of their service. Clients said that time spent in the health centres was better utilised and their relationships with the service providers had improved.

The People's Health Movement

What is the People's Health Movement?

The People's Health Movement (PHM) is an international movement that is dedicated to changing the current health care delivery system, a system that is failing to serve the health needs of most of the world's poorest people. The movement is committed to providing people with a voice in what happens next in health, helping people in their long-term struggle to find sustainable solutions to their health problems, and campaigning for the importance of primary health care.

How did the movement start?

The PHM grew out of the first People's Health Assembly which was held in December 2000 in Dhaka, Bangladesh. Attended by over 1,400 participants from 92 countries, the Assembly gave people who had rarely been heard before the chance to share their experience of poverty and ill health.

The Assembly also endorsed the People's Charter for Health. The five basic principles of the Charter are:

- Health is a human right for all irrespective of race, gender, age or class
- Universal primary health care should be the basis for formulating health policies
- Governments have a responsibility to provide all of their citizens with access to quality health care
- All health and social policies should involve the participation of people and people's organisations
- Health should be a priority at every level of policy making.

How to get involved

Through the PHM you can be part of a worldwide effort to improve the situation in health care. Log on to their website at www.phmovement.org to find out how.

Laurent Du Villier for Handicap International



A micro-project in Bangladesh

Resources

Overview

The *Dying for Change* report can be found at www.worldbank.org/poverty/voices/reports

Global Fund

For more information on the Global Fund visit www.globalfundatm.org Another resource for information about the Fund is the Break the Silence e-mail listserv, an independently-run international forum on health and development policy issues. To subscribe, send a blank e-mail to: join-break-the-silence@hdnet.org

People's Health Assembly websites: www.phmovement.org www.TheMillionSignatureCampaign.org

Poverty and disability:

- A booklet, *Understanding Community Approaches to Handicap in Development (CAHD)*, can be downloaded from www.handicap-international.org.uk/site/resources/pub.asp

- For more information on CAHD training, contact the Centre for Disability and Development (CDD), D-55, Talbag, Savar, Dhaka, Bangladesh E-mail: cdd@bangla.net

- An article on CAHD, featured in *Disability Dialogue*, Issue 1, January—April 2000 can be downloaded from the Healthlink Worldwide website at www.healthlink.org.uk/pubs/intnews.html#cbr

- *Participatory research for older people: a sourcebook*, provides comprehensive guidelines for older people's participation in research. Email your order to: publications@helpage.org

Poverty and changing attitudes

To obtain a copy of the Health Workers For Change manual, e-mail your name and postal address to: tdr@who.int or write to TDR Communications, WHO, 20 Avenue Appia, 1211 Geneva 27, Switzerland

HIV/AIDS

www.aids.org
www.unaids.org
www.who.int
www.unicef.org

Healthlink Worldwide newsletters - Available from the Healthlink Worldwide website at <http://www.healthlink.org.uk/pubs/intnews.html>

AIDS Action, Issues 43–50 Aimed at health workers and educators working at the primary level, this newsletter provides practical information on a wide range of care and prevention issues concerning HIV, AIDS and sexually transmitted infections.

Child Health Dialogue, Issues 14–20 A forum for the exchange of information about the prevention and treatment of key childhood diseases, as well as providing practical advice on related health education.

- *Poverty and health* is a combined issue of the Healthlink Worldwide newsletters *Aids Action*, *Child Health Dialogue* and *Disability Dialogue*. Healthlink Worldwide no longer produces printed editions of its newsletters. However, this and other newsletters are available online at the Healthlink Worldwide website, www.healthlink.org.uk. Additionally, source material that partner organisations worldwide can adapt for use in their newsletters will become available from the website in 2003.

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About Healthlink Worldwide

- Healthlink Worldwide works to improve the health of poor and vulnerable communities by strengthening the provision, use and impact of information.

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Health Action, Issues 23—26

A forum for health managers, planners and health workers to exchange experiences in implementing programmes.

Disability Dialogue, Issues 1–3 – Practical information for disabled people, service providers and policy makers, including the promotion of social inclusion of disabled people through community-based rehabilitation (CBR) and other social action.