Poverty, Health and Development

Nabil M Kronfol MD, DrPH
President Lebanese Healthcare Management Association

Introduction

The Alma Ata Declaration of 1978 expressed the need for urgent and unified actions by all governments, health workers and communities to protect and promote the health of all people. The declaration emphasized: equity in access to health services, economic and social development, the community's right and duty to participate in health, access to primary health care (PHC) and intersectoral collaboration for health development[1].

Women are often the key to improving a population's health, and this is especially true in the Eastern Mediterranean region. Projects that empower women and provide basic needs are transforming poor communities. Many of the inequalities in health, both within and between countries, are due to inequalities in the social conditions in which people live and work[2]. These social determinants have an important effect on health status and general wellbeing. Tackling these underlying causes of poor health can contribute to improving health and health equity[3].

The World Health Organization has given this approach added impetus by the creation of the Commission on Social Determinants of Health. Over the past two decades the basic development needs program, a component of the community based initiatives program in the WHO Eastern Mediterranean region, has developed and implemented community based initiatives to improve health in poor populations through actions on social determinants. The basic needs development programs, which enhance the status of women and their role in the health of families, are an important part of this work[4].

Women and Development

The low status of women in the Eastern Mediterranean region is one of the key underlying social determinants of health. Sex differences in access to health care and poor health indicators for women and girls in several countries have resulted in differences in mortality and morbidity between male and female infants[5], differences in the quality of care for male and female children[6], high maternal mortality (estimated at 1600 deaths per 100 000 live births in Afghanistan and Somalia)[7], limited prenatal and postnatal care and lack of skilled attendants at birth[8], higher prevalence of mental illness among women than men[9],[10], and high rates of suicide and attempted suicide among women of reproductive age[11].

Gender determinants that have an adverse effect on the health of girls and women include low valuation of girls compared with boys and of women compared with men; social structure and beliefs that tolerate violence against women and children; limited autonomy for women in making choices about treatment for their children or themselves; and considerations of family honor that are associated with early marriage for girls and female genital mutilation.

Poverty in Lebanon

A Country Study released in 2008, based on a full national report, draws a profile of poverty in Lebanon based on money-metric poverty measurements of household expenditures. The report provides a comprehensive overview of the characteristics of the poor and estimates the extent of poverty and the degree of inequality in the country. It finds that nearly 28% of the Lebanese population can be considered poor and 8% extremely poor.

However, the most important finding of the report is that regional disparities are striking. For example, whereas poverty rates are insignificant in the capital, Beirut, they are very high in the Northern city of Tripoli (Bab El Tabbaneh) and in the province of Akkar. In general, the North governorate has been lagging behind the rest of the country and thus its poverty rate has become high.
Levels of poverty are above-average in the South but are not as severe as expected. There are three other major results that have notable implications for a poverty-reduction program in Lebanon.
First, with few exceptions, measures of human deprivation, such as that provided by an Unsatisfied Basic Needs methodology, are generally commensurate with those for money-metric measures based on household expenditures. Second, the projected cost of halving extreme poverty is very modest, namely, a mere fraction of the cost of the country's large external debt obligations. However, such a cost would rise dramatically if inequality were to worsen (i.e., if future growth were anti-poor). Also, the cost of reducing overall poverty would be substantially higher.

Third, the poor are heavily concentrated among the unemployed and among unskilled workers, with the latter concentrated in sectors such as agriculture and construction. This places a priority on a broad-based, inclusive pattern of economic growth that could stimulate employment in such sectors.

Based on such findings, the report concentrates on providing general policy recommendations on issues of directing public expenditures to poor households. One of its major recommendations is to concentrate on channeling resources to poor regions below the governorate level, such as to "four strata" where two-thirds of the poor in Lebanon are concentrated. However, the report notes that macroeconomic policies, particularly fiscal policies, will have to be redesigned to mobilize the resources necessary to finance the increases in public expenditures on the social safety nets and public investment in social services that should be part of a major poverty-reduction program.

Poverty in the Eastern Mediterranean Region

To test the hypothesis that poverty is associated with infant mortality in the Eastern Mediterranean countries and to measure the strength of the association, a bibliographic search was conducted by the author from the department of Health Education and Training Primary Health Care Administration, Qassim, Saudi Arabia[12]. Nine studies,

[1] Declaration of Alma-Ata. International conference on primary health care, Alma- Ata, USSR, 6–12 September 1978. Geneva, World Health Organization, 1978.
[2] Irwin A, Valentine N, Brown C, Loewenson R, Solar O, Brown H, et al. The Commission on Social Determinants of Health: tackling the social roots of health inequities. PloS Medicine 2006; 3(6):e106.
[3] Feachem RGA. Poverty and inequity: a proper focus for the new century. Bull World Health Organ 2000;78:1-2.
[4] M Assai, S Siddiqi, S Watts; "Tackling social determinants of health through community based initiatives"; BMJ Volume 333, October 21 2006
[5] Fikree FF, Pasha O. Role of gender in health disparity: the South Asian context. BMJ 2004;328:823-6.
[6] Yount KM. Provider bias in the treatment of diarrhea among boys and girls attending public facilities in Minia, Egypt. Soc Sci Med 2003;56:753-68.
[7] WHO Regional Office for the Eastern Mediterranean. Social and health indicators for countries of the Eastern Mediterranean. Cairo: EMRO, 2006.
[8] League of Arab States, Republic of Yemen Ministry of Health and Population, Central Statistical Organization Yemen. Yemen family health survey: principal report 2003. Sanaa: CSO, 2005.
[9] Noorbala AA, Bagheri Yadzi SA, Yasamy MT, Mohammad K. Mental health survey of the adult population in Iran. Br J Psychiatry 2004;184:70-3.
[10] Maziak W, Asfar T, Mzayek F, Fouad FM, Kilzieh N. Sociodemographic correlates of psychiatric morbidity among low-income women in Aleppo, Syria, Soc Sci Med 2002;54:1419-27.
[11] Mohammadi MR, Ghanizadeh A, Rahgozart M, Noorbala AA, Malekafzali H, Davidian H, et al. Suicidal attempt and psychiatric disorders in Iran. Suicide Life Threat Behav 2005;35:309-16
[12] Jahan S. Poverty and infant mortality in the Eastern Mediterranean region: a meta-analysis."; J Epidemiol Community Health. 2008 Aug; 62(8):745-51.

conducted in the Eastern Mediterranean region, fulfilled the inclusion criteria. Poverty was associated with an increased risk of infant death. There was a significantly increased risk of infant death among illiterate mothers compared with literate mothers. This meta-analysis indicates that there is a significantly increased mortality risk in infants born in poor households. The results suggest that policies aimed at poverty alleviation and female literacy will substantially contribute to a decrease in infant mortality.

The Basic Development needs

The basic development needs programs help to enable women by giving them the opportunity to earn money through loans and training. The programs also include measures to improve health and wellbeing such as health services, nutrition, safe water, sanitation, and shelter. The programs strongly emphasize community involvement and intersectoral collaboration, facilitated by WHO linkages with ministries of health. Intersectoral coordination encourages government departments to work together, mobilises communities and involves them in the development process. Intervention sites are identified in response to a request from the local residents.

The two major challenges for these programs are sustainability of the existing projects and scaling them up to national level. The programs cannot be sustained without the support of local governments and civil society.

Basic development needs programs are community based initiatives that can tackle poverty, ill health, and social determinants of health, enhancing the status of women is of special relevance for programs in the Eastern Mediterranean region

Community Based Initiatives

During the past few decades, the health sector has confirmed its catalytic role for health promotion, devising appropriate initiatives for improving health and quality of life of the community. This effort has been promoted in the Eastern Mediterranean Region (EMR) of the World Health Organization (WHO) since 1988 through Community-Based Initiatives (CBI), which have provided opportunities to integrate health interventions in local development processes.
The CBI approach addresses the major determinants of health within a broad perspective of development, and creates access to essential social services for optimum level of equity at the grass roots level through the active involvement of the community and intersectoral collaboration[13].

The CBI is an integrated, bottom-up, socioeconomic development concept, which is based on full community involvement, supported through intersectoral collaboration.[14] It is a self-sustained, people-oriented strategy that addresses the diverse basic needs of the community and recognizes health as a social cohesion factor. CBI offers the added value of overcoming inequity, which has positive implications for health. The most salient aspects of this approach are the organization, mobilization and enhancement of community capabilities and involvement in micro-development through social and income generating schemes.[15] The ultimate objective of the program is to reach the goal of the Alma Ata declaration, “Health for All”.

The EMR countries are implementing different programs under the umbrella of CBI: Healthy Villages, Healthy Cities, Basic Development Needs (BDN) and Gender in Health and Development.
The program focuses on fostering community action in poor areas and addressing inequities in health. The major strategies of the CBI program are:
• Empowering community and intersectoral collaboration;
• Addressing the needs of women, children and youth;
• Strengthening health, nutrition and environmental

[13] Assai M, Siddiqi S, Watts S. Tackling social determinants of health through community- based initiatives. British medical journal, 2006, 333(7573):854–6.
[14] Guidelines and tools for management of basic development needs. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2000
[15] Assai M. Community-based initiatives and their relation to poverty reduction and Health development in the EMR. Eastern Mediterranean health journal, 2007, 13(6):1242–9

conditions;
• Improving economic status to reach self-sufficiency at the local level;
• Targeting poor and underprivileged communities;
• Encouraging networking;
• Partnership with nongovernmental organizations, universities and potential donors;
• Linking various health-related programs.
The experience of CBI in countries of the EMR provides a useful model for other regions in implementing grass roots level interventions that address social determinants of health. CBI is particularly effective in overcoming gender discrimination and in providing a social environment that supports women’s development[16].

Conclusion

Economic variables must be taken into account in any attempt to develop social health protection systems. However, such variables should not blind us to the importance of social protection as a civic right and as an effective way to improve the well-being of the population, with a resulting positive effect on the economy. Building or reforming social health protection systems involves a complex combination of political, social and technical factors and strategies. Reforms often call for major changes in resource allocation and in the distribution of power and thus evoke fear and resistance among small but powerful segments of society[17].

[16] Mohammad Assai Ardakani and Humayun Rizwan; “Community ownership and intersectoral action for health as key principles for achieving “Health for All”; Eastern Mediterranean Health Journal, Vol. 14, Special Issue
[17] Driss Zine-Eddine El-Idrissi, Kaddar Miloud & Sabri Belgacem; “Constraints and obstacles to social health protection in the Maghreb: the cases of Algeria and Morocco”; Bulletin of the World Health Organization | November 2008, 86 (11)