BHEW

Equity Dialogue

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KNOWLEDGE BASE

Vulnerable:
To be vulnerable to others is to be in a position of being hurt or ignored, as well as helped, by them. The word vulnerable is derived from the Latin verb vulnerare ("to wound") and the noun vulnus ("wound").

Aday, LA
At risk in America: The health and health care needs of vulnerable populations in
the United States

QUOTATION

A global human society based on poverty for many and prosperity for a few, characterized by islands of wealth surrounded by a sea of poverty, is unsustainable.

South African President Thabo Mbeki at the opening of the World Summit for Sustainable Development 2002.

An alternative source of income for the poor in rural Bangladesh
Photograph by: Asem Ansari

Health intervention and health equity: Evidence from Matlab, Bangladesh

Abdur Razzaque, Peter Kim Streatfield, Karar Zunaid Ahsan

The study addresses issues of prevailing health inequalities using the Health and Demographic Surveillance System (HDSS) data of the ICDDR,B, Centre for Health and Population Research. Two population based birth cohorts, which were 10 years apart (1983-85 and 1993-95), were selected for analysis from two adjacent areas (ICDDR,B service and government service areas) in Matlab. The HDSS system registered 20,665 and 16,925 births for the cohorts of 1983-85 and 1993-95 respectively. These births were followed for five years for survival and migration status. The children of the birth cohorts were matched by socioeconomic status.

In this study socioeconomic status has been measured in terms of household assets (radio, watch, etc.), structure of homestead (wall and roof), and access to some selected basic services (water, sanitation). Economic status of the household was measured by constructing an asset score. Appropriate data on socioeconomic status was collected through the household questionnaire administered during 1982 and 1996 censuses.

Table 1. Mortality rates (per 1000) by wealth, study area and age

Wealth	ICDDR,B-service			Government-service		
	Infant	1-4 yr	Under 5	Infant	1-4 yr	Under 5
Cohort 83-85						
Poorest	103.8	53.5	157.3	131.4	80.4	211.8
Richest	93.0	25.1	118.1	106.2	46.4	152.6
Poorest:Richest	1.12	2.13	1.33	1.24	1.73	1.39
Cohort 93-95						
Poorest	67.1	20.6	81.7	97.7	39.1	136.8
Richest	43.7	10.9	54.6	63.4	17.3	80.7
Poorest:Richest	1.54	1.89	1.61	1.54	2.26	1.70

Source: HDSS, ICDDR,B

Inequity from the wealth perspective

Improvements in child survival have occurred in Matlab, dramatically so for children under 5 years of age, in both service areas as well as in both socioeconomic groups. However, in both areas the difference in under 5 mortality by socioeconomic status exists in both cohorts and has increased in the recent cohort (poor-rich mortality ratio- ICDDR,B 1.33 to 1.61; government service 1.39 to 1.70). In the ICDDR,B area, the increase in the poor- rich ratio of under 5 mortality was mainly because of the increase in poor-rich ratio for infant mortality (1.12 to 1.54), as the poor-rich ratio for 1-4 years mortality (2.13 to 1.89) has declined slightly. In the government service area, the increase in the poor-rich gap of under 5 mortality is explained by the increase in the poor-rich ratio of both 1-4 year (1.73 to 2.26) and infant mortality (1.24 to 1.54).

Table 2 documents under 5 mortality rates by cause, wealth index and study area. The poor had higher mortality rates than the rich for all causes except for accidental deaths in the government area in the earlier cohort and pneumonia deaths in the ICDDR,B area in the recent cohort. Mortality rates declined in both service areas and for both socioeconomic groups, with the exceptions of accidental deaths in the ICDDR,B area and accidental and pneumonia deaths in the poorest section of the government service area. However, in the recent cohort, the poor-rich gap increased for all causes of death in both areas with a few exceptions (for pneumonia in the ICDDR,B area and diarrhoea in the government area). The socioeconomic disparity was more apparent in the government area in the earlier cohort while it was more in the ICDDR,B area in the recent cohort. It is of interest that deaths for pneumonia have increased among the poorest section in the government service area. In the recent cohort, the mortality rate for infection has dropped significantly in both areas for both socioeconomic groups, but the inequality in socioeconomic status has increased.

Inequity from sex perspective

The sex bias in child mortality seems to have disappeared in Matlab. As documented in Table 3, the boy-girl mortality difference exists in the earlier cohort but has disappeared in the recent cohort for the ICDDR,B-service (ratio changed from 0.9 to 1.0) and the government-service (ratio changed from 0.85 to 1.05) areas . The elimination of the boy-girl difference of under 5 mortality can be explained by the reduction in boy-girl difference of 1-4 years mortality (ratio changed from 0.53 to 0.84 in the ICDDR,B-service area and 0.56 to 0.89 in the government-service area). However, it is of interest that during infancy more boys die than girls (ratio changed from 1.09 to 1.05 in ICDDR,B-service and 1.04 to 1.11 in government-service areas).

Table 2. Mortality rates (per 1000) by cause of death, wealth index and study area

Cause of death	ICDDR,B-service			Government-service		
	Poorest	Richest	Poorest:Richest	Poorest	Richest	Poorest:Richest
Cohort 83-85						
Diarrhoea	33.3	24.0	1.39	49.5	28.4	1.74
Pneumonia	15.4	14.5	1.07	16.5	13.5	1.24
Infection	43.2	31.9	1.36	66.0	46.3	1.43
Accident	9.3	6.2	1.49	7.4	8.8	0.85
Others	49.4	40.5	1.22	65.5	52.1	1.26
Cohort 93-95						
Diarrhoea	14.1	6.2	2.28	22.4	13.2	1.69
Pneumonia	8.9	11.0	0.81	26.1	9.7	2.68
Infection	2.2	0.7	3.23	2.1	0.7	3.09
Accident	13.4	6.9	1.94	11.2	8.3	1.34
Others	48.4	28.9	1.67	73.5	47.2	1.54

Source: HDSS, ICDDR,B

Table 3. Mortality rates (per 1000) by sex, study area and age

Sex	ICDDR,B-service			Government-service		
	Infant	1-4 yr	Under 5	Infant	1-4 yr	Under 5
Cohort 83-85						
Boy	108.8	26.0	134.8	119.0	42.2	161.2
Girl	100.1	48.8	148.9	113.9	76.0	139.9
Boy:Girl	1.09	0.53	0.91	1.04	0.56	0.85
Cohort 93-95						
Boy	60.1	16.0	76.1	89.8	25.0	114.8
Girl	59.1	19.1	76.2	81.1	28.1	109.2
Boy:Girl	1.05	0.84	1.00	1.11	0.89	1.05

Source: HDSS, ICDDR,B

Nothing is going to stop me now: Obstacles perceived by low income women as they become self sufficient

Brown SG, Barbosa G

Public Health Nurs. 2001; 18:364-72.

Abstract:

As low income women struggle to become self sufficient, they encounter many obstacles. The literature identifies physical and mental health problems, inadequate childcare, inadequate occupational skills, lack of transportation, criminal histories, and limited educational abilities as major barriers to be overcome in this transition. Qualitative data collected from low income women attending Alternatives for Women, an occupational skills and health information training centre which was developed and implemented by a nurse, refutes several of the previously identified obstacles. Inadequate childcare and transportation were not seen as barriers to success by the program participants, but were viewed as socially acceptable reasons for not working. Eight obstacles were identified by the program participants as being the real reasons for their lack of success. The identified obstacles included the following: lack of self esteem, especially relating to school; "bad" relationships with men; lack of support from family and friends; limited life options; lack of training for nonwelfare recipients; lack of quality programs; criminal histories; and fear of success.

A case history

This issue and subsequent issues present narratives of people who have experienced poverty and are deprived of basic human needs. These stories are reflections of tragic consequences or maybe encouraging accounts of poverty. The purpose behind the stories is to promote a better perception of the many dimensions of poverty and the problems associated with it. We hope that these stories may provide insights into the different problems of impoverishment, which may help to highlight relevant practices and policies that might help the poor.

Empowerment of women

Selina was born to an extremely poor family in Hironkandi village of Gopalganj district. She was growing up in the midst of absolute poverty. When Selina reached the age of 13 her father could no longer support her. Her father arranged her marriage with Munnu Molla from the same village in 1990. Selina's life continued in poverty. She gave birth to her first child, a son, at the age of 14. As the family grew the hardship they faced became excessive. Munnu Molla left their home in search of work in Dhaka. Occasionally he would come home to take care of his wife and child but his income was hardly enough to provide for his family. As time passed and she gave birth to two more children it became nearly impossible to maintain the family with the sole income of Munnu Molla. Selina had no choice but to start work as a domestic aid.

Eventually Selina had the opportunity to apply for a loan from BRAC to start her own business. BRAC approved her loan and provided her with three days of basic training on cage rearing. She received 54 poultry birds and other necessities for her poultry cage. When the birds started to lay eggs Selina was able to pay for her daily necessities. Eventually her husband was able to return from Dhaka to be with his family. Selina was able to save from her income and buy two goats for TK 1200. She also managed to save some money (Tk 2000), which she gave to her husband for his bamboo trading business. Selina now has a substantial savings of TK 7025 with BRAC.

Selina has experienced financial development and improvement in social and health status. As the BRAC programme includes social and health awareness education, she has learnt about the consequences of early marriage, divorce, dowry and the positive impact of marriage registration. She has learnt about the importance of Vitamin A, safe water, and water borne diseases. She knows about the use of slab latrines and washing hands. At times of illness she is aware of the availability of proper health services.

Reaching the poor with effective health, nutrition & population services: What works, what doesn't and why; 2004

A conference "Reaching the poor with effective Health, Nutrition & Population Services: What Works, What Doesn't and Why" was held in Washington DC on Feb 18-20; 2004. The conference was organized by the World Bank in collaboration with the Gates Foundation and the Dutch and Swedish governments. The conference was a part of the "Reaching the poor program" which includes approximately 20 case studies covering some 50 interventions in Africa, Asia, Eastern Europe and Latin America. The conference included presentations on these case studies and similar findings. Recommendations for policy and workshops on methods and data were included for the participants. Many of the results were disconcerting as in some cases overall government health spending was found to favor the rich and thus to increase disparities in health. This was found true for many initiatives undertaken for the purpose of benefiting the poor. Yet there were many promising exceptions. For instance, in Cambodia governmental contracting with non governmental organizations (NGOs) for operating district health systems resulted in a propoor patient mix. Provision of subsidies to meet hospital expenditures to the poor also had a positive impact. Bednets provided through social marketing programs in Tanzania and through programs of immunization for measles in Ghana and Zambia were found to reduce health disparity. In Argentina and Peru the food distribution programme was found to favor the poor. This was also true for Hong Kong where government health spending was strongly in favor of the poor.

Social inequalities in health by individual and household measures of social position in a cohort of healthy people

Chandola T, Bartley M, Wiggins R, Schofield P

J Epidemiol Community Health 2003, 57: 56-62.

Abstract:

STUDY OBJECTIVE: It is increasingly recognised that different dimensions of social inequality may be linked to health by different pathways. Furthermore, factors operating at the individual level such as employment conditions may affect health in a different way from household level factors. The paper examines the associations between self rated health and four measures of social position-occupational class, household social advantage, personal and household income. DESIGN: Multilevel logistic regression models were used to predict self rated health using longitudinal data from the British Household panel survey (BHPS) with respondents nested within households. Separate analyses were carried out for economically active and inactive respondents. SETTING: Interview based surveys of adults living within households that are representative of British households. PARTICIPANTS: Adult respondents from the BHPS. MAIN RESULTS: Occupational class has relatively strong effects on the self rated health of the economically active, although household level factors also seem to influence their health. Household social advantage has relatively strong effects on the self rated health of the economically inactive. CONCLUSIONS: The paper found evidence in support of the view that different dimensions of social inequality have different pathways to self rated health. There are unexplained similarities in health between household members, which require further investigation.

The Equity Dialogue is a joint initiative of the Bangladesh Health Equity Watch and the Poverty and Health Programme of ICDDR,B. Bangladesh Health Equity Watch is a collaborative initiative of four organizations that share a common concern for equitable health and development in Bangladesh. The organizations are the Bangladesh Bureau of Statistics (BBS), Bangladesh Institute of Development Studies (BIDS), BRAC and ICDDR,B. The Rockefeller Foundation currently funds the project. The goal of the Poverty and Health Programme of ICDDR,B is to generate relevant knowledge to improve the health of the poor to reduce poverty. The project is presently being funded by the Department for International Development (DfID).
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