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Equity Dialogue

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Table of Contents

QUOTATION

The poverty of our century is unlike that of any other. It is not, as poverty was before, the result of natural scarcity, but of a set of priorities imposed upon the rest of the world by the rich. Consequently, the modern poor are not pitied...but written off as trash. The twentieth-century consumer economy has produced the first culture for which a beggar is a reminder of nothing.
John Berger, contemporary British author, critic.
The Soul and the Operator, Expressen, 1999

KNOWLEDGE BASE

Measurement

Measurement is the determination of the size or magnitude of something. Measurement is not limited to physical quantities, but can extend to quantifying almost anything imaginable. Examples of measurement range from degrees of uncertainty, to the consumer confidence, to the rate of increase in the fall in the price of beanie babies. It is important to know, however, that different kinds of quantity should be measured with different levels of measurement.
In scientific research, measurement is essential. It includes the process of collecting data which can be used to make claims about learning. Measurement is also used to evaluate the effectiveness of a program or product (known as an evaluand).
Source: Encyclopedia, nationmaster.com

Child labour

Child labour is an emerging problem for the world and Bangladesh. It is most prevalent in the developing regions of the world. Especially the South Asian region is home to many of the world's millions of child workers. There are 3.2 million children working as child labourers, accounting for 7.5 percent of the total children aged 5-17 years, and 43 percent of the total economically active children (working children). The highest category of child labour belongs to the age group 10-14 years, where 2.2 million child labourers are found in this category. By definition and in accordance with the ILO convention No. 138 (Minimum Age), children aged below 12 years working for any number of hours and those aged between 12-14 years working for 14 hours or more per week are considered "Child Labour".

Child worker in a metal industry *Photograph by: Jesmin Akter*

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Pro-poor health policies in Poverty Reduction Strategies

Laterveer L, Niessen LW, Yazbeck AS.
Health Policy Plan. 2003 Jun;18(2):138-45.

Abstract:
Since 1999, the International Monetary Fund and World Bank have required low-income countries soliciting for debt relief and financial support to prepare a Poverty Reduction Strategy Paper (PRSP). The objective of this study is to arrive at a systematic assessment of the extent to which the first batch of interim PRSPs actually addresses the health of the poor and vulnerable. A literature study was used to design and test a semi-quantitative approach to assess the pro-poor focus of health policies in national documents. The approach was applied to the existing interim proposals for 23 Highly Indebted Poor Countries. Results show that a majority of proposals lack country-specific data on the distribution and composition of the burden of disease, a clear identification of health system constraints and an assessment of the impact of health services on the population. More importantly, they make little effort to analyze these issues in relation to the poor. Furthermore, only a small group explicitly includes the interests of the poor in health policy design. Attention to policies aiming at enhancing equity in public health spending is even more limited. Few papers that include expenditure proposals also show pro-poor focused health budgets. We conclude that our systematic assessment of a new international development policy instrument, PRSP, raises strong concerns about the attributed role of health in development and the limited emphasis on the poor, the supposed primary beneficiaries of this instrument. There is a need and an opportunity for the international development community to provide assistance and inputs as poor countries shift their policy thinking from an interim stage to fully developed national policies. This paper presents a menu of analytical and policy options that can be pursued.

GEGA conference in South Africa: Building global and national coalitions for action in health equity

The Global Equity Gauge Alliance (GEGA) held a conference on 'Building Global and National Coalitions for Action in Health Equity' at the Tropicana Hotel in Durban, South Africa from June 13-14, 2004. Participants from the thirteen country gauges, researchers and activists from many collaborating institutions across the world, representatives from international human rights and donor agencies and government dignitaries from a number of African countries attended the meeting.

The topics discussed included the 'Global Health Watch', an alternative World Health Report to be written by NGOs, academics and campaigners from around the world; Applying the Equity Gauge strategy in different country settings; GEGA's focus at the national level; and Building regional processes to support global and national coalitions in Latin America, Africa, Asia and developed countries. The sessions on 'Global issues and global responses' discussed: The global politics and economics of health, Privatisation and commercialization of health services, Poverty reduction strategies. The sessions on 'Strategies to support implementation of solutions and reduce inequalities' included the topics: Building networks and working with the media, Intersectoral and upstream interventions, Action research at the local level, Developing participatory processes for building an evidence base; and the session topics on 'Strategies to support implementation of solutions and reduce inequalities' were: Human rights and health rights for monitoring and advocacy, Working with government and linking ministries, Influencing other policy levels: Local to national and national to global, and Evidence for advocacy.

Poverty Reduction Strategy Papers (PRSPs) and prospects of attaining health related MDGs in Sub Saharan Africa and South Asia

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In September 1999, World Bank and IMF initiated a new framework to achieve sustainable poverty reduction in low-income countries. This framework required low-income countries to formulate nationally owned, participatory poverty reduction strategies (PRSs)-embodied in the Poverty Reduction Strategy Papers (PRSPs). These PRSPs serve as the focal point for development assistance and the basis for concessional lending and debt relief under the enhanced Heavily Indebted Poor Countries (HIPC) initiative. It shows country-level operational framework for progressing toward the Millennium Development Goals (MDGs) and is an important entryway for tackling poverty-health challenges. As health has a vital role in both MDGs and PRSPS this paper reviews the economic and health condition of some South Asian and Sub-Saharan African countries[1] and examines the prospects of attaining the MDGs.

Most of the countries of South Asia and Sub-Saharan Africa have weak agrarian economies where economic growth is sluggish due to resource constraints and poor governance. With the exception of India and Tanzania, per capita GDP growth has been very slow in the selected countries. In Nigeria, Kenya, Zimbabwe and Zambia, per capita growth over the period of 1990-2002 was negative. Furthermore, inequality prevails in all of these countries where the poorest 20% receive less than 10% of the national income.

Social Sector Spending and Debt

Public expenditure on health, as a proportion of GDP, was 2.5 % in Sub-Saharan Africa compared to a mere 1.0 % in South Asia. In only 4 of the 12 selected countries, public expenditure on health as a proportion of GDP, was more than 3 percent- Malawi dominates with 3.6 percent followed by Zambia and Zimbabwe (UNDP 2002). Nevertheless, political and social conflicts and burden of debt servicing are absorbing a substantial share of the GDP in most of these countries.

Child Malnutrition

About half of the preschool children in South Asia (47 %) are moderately or severely underweight compared to roughly one-third (31 %) in Sub-Saharan Africa. Prevalence of underweight children declined in South Asia from 53 to 47 percent while it increased slightly in Sub-Saharan Africa from 30 to 31 percent over the period of 1990-2001 (World Bank 2004).

In Bangladesh, Nepal and India roughly half of the children were underweight in 2001, while only 13% were underweight in

[1]Selected on the basis of child mortality, geographic location and availability of statistics. Analysis of this study is based on data from various reports of UNDP, World Bank and Millennium Data Files of UN.

Zimbabwe and approximately, one out of every three were so in Burkina Faso and Nigeria. Prevalence of underweight children declined in most of the countries (particularly in Bangladesh (27%) and India (26%)) but increased in Zimbabwe (13%) and Zambia (11%) over the reference period. If the current trend continues, only Bangladesh and India are likely to attain the target of reducing the prevalence of underweight children by half by 2015 whereas Zimbabwe, Zambia, Tanzania and Burkina Faso are highly unlikely to attain this target.

Child Mortality

More than 10 million children die in the world every year before they reach the age of five and 99 percent of these deaths occur in developing countries. The leading causes of more than 70 percent of these deaths are acute respiratory infections, diarrhea, measles and malaria. The reduction in under five mortality rate was substantial in South-Central Asia (from 125 to 95 per 1000 live births) compared to Sub-Saharan Africa (from 176 to172 per 1000 life births) over the reference period of 1990-2001. Inter-country comparison shows predominance of Burkina Faso with the highest under-5 mortality rate (207) compared to the least in Bangladesh (73). Apart from significant reductions in Bangladesh (49%) and Nepal (40%), other countries made very slow progress over the reference period of 1990-2002. Mortality rates rose alarmingly in Zimbabwe (54%) and Kenya (26%). If the current trend prevails only Bangladesh and Nepal are likely to achieve the target of reducing under- 5 mortality by two-thirds between 1990 and 2015. Zimbabwe, Kenya, Tanzania and Zambia are very unlikely[2] to attain the target.

Maternal Mortality

Every year, approximately 500,000 women die in the world due to pregnancy and childbirth related complications and 99 percent of these deaths are in the developing world. In 2001, 520 and 920 women per 100,000 live births died in South Asia and Sub-Saharan Africa respectively compared to 400 globally. In Bangladesh, Nepal and Ghana maternal mortality ratio (MMR) has decreased by 55, 51 and 27 percent respectively over the reference period of 1990-2000. In contrast, the situation for maternal mortality has increased alarmingly in Malawi (221%) followed by Tanzania (95%), Zimbabwe (93%), Kenya (54%) and Pakistan (47%). If the present trend continues, only Bangladesh and Nepal are likely to achieve the target of reducing maternal mortality by three quarters by 2015.

Conclusion & Recommendations

It is very unlikely that most of the selected countries will achieve the health related MDGs. A substantial share of public expenditure should be allocated for improvement and expansion of health care services. These expenditures should be pro-poor in order to reduce inequality in health. Enhancement of basic health care for the poor can be attained by increasing access to safe water, better sanitation facilities, and by improving quality and management of health care services. Improved maternal and reproductive health, immunization of children, development of community infrastructure to increase access to health care combined with international donor support will ensure the achievement of MDGs.

Figure1. Average annual per capita GDP growth rate (1990-2002)

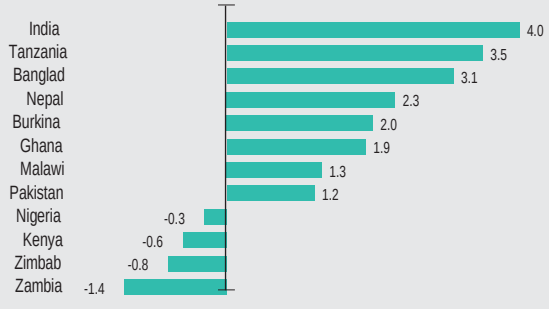


Figure 2. Prevalence of Underweight Children

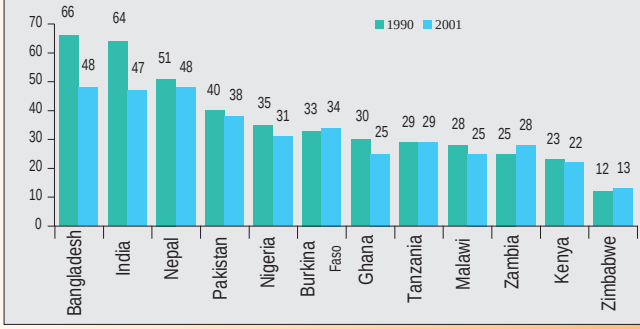


Figure 3. Percentage change in under 5 mortality rates(1990-2002)

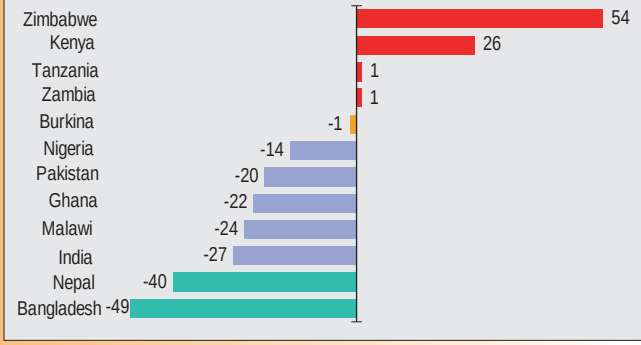
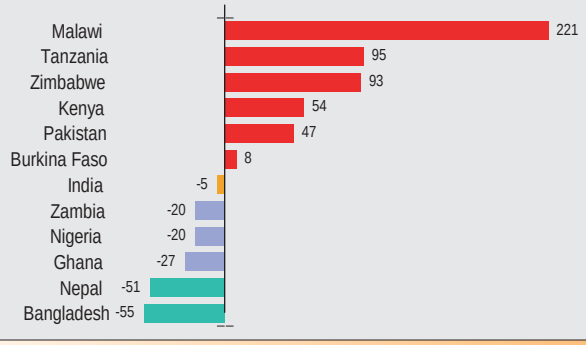


Figure 4. Maternal Mortality Ratio (1990-2002)



[2]Countries are classified on the basis of progress made over the past decade and prospects to achieve a target. Red bars countries are very unlikely, yellow bars are unlikely, blue bars are possible while countries with green bars are likely to achieve the target (for figures 1, 3 and 4).

Case history of Miss X

The following is the case history of a participant attending the 'Misplaced Childhood Drop-in Cente' which focuses on the child sex workers of the streets of Dhaka City.

Miss "X" was married like many other Bangladeshi girls at the very early age of 12 or 13. Her husband was almost as old as her father. She found it difficult and demeaning to cope with the unwanted sexual advances of her husband. Eventually she divorced him and returned to her father's house. As her father was extremely poor she had to fend for herself by working at a garments' factory. At work a girl who was actually a pimp befriended her. The pimp lured her with promises of a decent lifestyle, food, shelter, security and the opportunity to treat her existing gynecological problems to join the oldest profession and become a commercial street sex worker.

After some time, she managed to save some money but became dependent on drugs (ganja), smoking and alcoholism as a means to cope with her new profession. In the meantime she fell in love with a boy from the streets, and eventually married him. After her marriage the boy tried to force her to give him all her savings. Disillusioned once more, she left him and went back to being a commercial sex worker.

When she left her second husband she was pregnant and also emotionally devastated. She became dependent on drugs again. Due to her physical condition she was unable to work regularly. As a consequence she spent all her savings and often had to starve. In the seventh month of her pregnancy, she visited the INCIDIN office for the first time. She became very friendly with the staff of the center and was given frequent counseling sessions to make her understand the hazards of addiction and its effects on herself and her unborn child. The INCIDIN office referred her to CTRDW, a local shelter home for street based pregnant mothers. The behaviour she received at the shelter was hostile and antagonistic. Thus, she left the shelter to give birth to her baby on the streets with the assistance of some friends and neighbours. For one and a half months she suffered without proper treatment from severe post partum bleeding, lost quite a bit of weight and became very weak.

Eventually she left her son with her mother in the village and came back to Dhaka. Once again she had no other choice but to go back to the streets to provide for herself and her son. She was forced to live with a local leader, a "mastaan" of the street, with whom she got pregnant in spite of the precautions she had taken. Now she is in the advanced stage of her pregnancy. The mental anguish and financial hardship she is being subjected to is agonizing. pregnancy as before has prevented her from working and this time due to her lack of financial security her first-born is suffering as well. She has attempted to get rid of her unborn child several times and has subjected herself to self-abusive behavior. Sessions of psychosocial counseling has helped her to stop abusing herself but she still intends to give away her child for adoption after birth.

In all ages and almost everywhere around the world women are extremely vulnerable. A right to live the life they choose can be ensured with proper opportunities, knowledge and support from different organizations.

Lessons from the margins of globalization: Appreciating the Cuban health paradox

Spiegel JM, Yassi A.
Bulletin of World Health Organisation. 2000;78(1):3-18.

Abstract:
It is widely recognized that Cuba, despite poor economic performance, has achieved and sustained health indices comparable to those in developed countries--the Cuban Paradox. There has been, however, remarkably little scholarship evaluating how this has been accomplished, especially during a period of extreme economic hardship. Cuba's exclusion from the mainstream of "globalization," moreover, allows us to gain insights into the population health impact of policies that have accompanied globalization. Cuba's experience challenges the conventional assumption that generating wealth is the fundamental precondition for improving health. As peoples around the world search for cost-effective ways to improve well-being, they might want to learn how alternative public policy approaches, such as those used in Cuba, may be effective. We therefore reviewed the literature on the health-wealth relationship in this globalizing era; then systematically examined public policy in Cuba, not only for health services (financing, vertical and horizontal integration, prevention and primary-care focus, inter-sectoral linkages, etc.) but for non-medical determinants of health as well. These included education, housing, nutrition, employment, etc. plus the community mobilization and social cohesion that the Cuban system has generated. It appears that the active implementation of public policy affecting a wide variety of health determinants explains the Cuban paradox, and that the international community can learn from Cuba's experience. The prospect for healthy public policy can thus exist within, rather than only on the margins of globalization. The importance of monitoring how Cuba sustains such policies as it faces growing challenges in this globalizing era is increasingly worth observing.

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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