Review Article

The Negative Impact of Poverty on the Health of Women and Children

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Abstract

This article is based on "The Negative Impact of Poverty on the Health of Women and Children" and discusses the association between poverty and poor health. Poverty is high on the international development agenda. World conferences and summits have paid attention to the increasing levels of poverty of billions of the world's peoples. The poor die in young age and they usually suffer from communicable diseases, maternal and perinatal conditions, and nutritional deficiencies. They are not only at risk from diseases of the poor but they also suffer from lifestyle health problems that are often found among affluent communities. Unfortunately, in many communities, the most affected are women and children.

Keywords: Poverty; Health; Women; Children

Introduction

Poverty is about not having enough to meet basic needs. [1] The World Bank describes poverty as hunger, lack of shelter, not having access to school and lack of medical care. [2] The World Bank estimates that in 2012, 896 million people were living on less than $1.90 per day. [2] Most of the poor are in the developing countries including Zambia where about 82% of the population lives in abject poverty. [3] The World Health Organization [4] states that poverty creates ill-health because it forces people to live in dirty environments. In a poverty-stricken country, the poor suffer from ill health. [5]

Poverty and debt relief

The burden on the poorest countries has invited attention in recent years. Currently, the 52 poorest countries of which 37 are in Africa, owe a total of 376 billion. [6] These countries pay the same amount in debt service as they spend on health and education combined. It has been estimated that if funds were diverted back into health and education from debt payment, lives of about 7 million children a year could be saved. [6] Zambia still spends more on interest payments to the World Bank and International Monetary Fund (IMF) than on health and education for its citizens. In 2001, Zambia spent $158 million on debt service repayments, compared to $24 million for health and $33 million for education. [6] It is against this background that International organisations are much concerned with the impact of poverty and macro-economic policies on health. The United Nations International Children's Fund (UNICEF) and other agencies concerned with children's health proposed a modification of the programme to protect essential health functions-structural adjustment with a human face. In response to the concern about the impact of macro-economic policies the WHO set up a commission on macroeconomics and health which has conducted a series of studies on how concrete health interventions can lead to economic growth and reduce inequity in developing countries. It recommended a set of measures designed to maximize the poverty reduction and economic development.

Multi-lateral debt relief

Millennium Development Goals (MDGs), the Heavily Indebted Poor Countries Initiative (HIPC) and Multi-Lateral Debt (MDR) initiatives.

The Economics Online (2016) gives the following information on the Multi-Lateral Debt Relief

In 1996, the IMF and World Bank launched the Heavily Indebted Poor Countries Initiative (HIPCI). By 2015, 41 countries were classified as HIPCs - 33 in Africa, 4 in Latin America, 3 in Asia and 1 in the Middle East. The overall objective of the HIPCI is to reduce debts to sustainable levels, enabling resources to be reallocated towards poverty reduction. About 45% of the funding is got from the IMF and other multilateral institutions, and the remaining amount, from bilateral creditors. The total cost of this assistance was estimated to be about $75 billion in 2014.

To focus efforts towards the reduction of poverty, the United Nations (UN) launched its Millennium Development Goals (MDGs) in 2000, which included setting the following targets:

- Eradicate extreme poverty and hunger.
- Achieve universal primary education.
- Promote gender equality and empower women.
- Reduce child mortality.
- Improve maternal health.

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- Combat HIV and AIDS, malaria and other diseases.
- Ensure environmental sustainability.
- Develop a global partnership for development.

To hasten the achievement of these goals, in 2005 the G8 countries signed the Gleneagles Agreement which agreed on a package of debt relief, mainly for Africa. [7] This agreement involved three multi-lateral organizations – the IMF, World Bank and the African Development Fund (ADF). The package, targeted at HIPCs, was dependent upon African governments continuing to introduce democratic reforms and to improve standards of governance (especially increased transparency and accountability). The package is formally known as the Multilateral Debt Relief Initiative, and involves providing 100% debt relief for a number of heavily indebted countries where traditional debt relief would not make debts sustainable. [7]

Poverty in Zambia

According to the Living Conditions Monitoring Survey (2010), 60 percent of Zambians are classified as poor. [8] In the Zambian context, poverty can be defined as lack of access to income, employment opportunities, and entitlements, including freely determined consumption of goods and services, shelter, and other basic needs. As of 2010, poverty continued to be more prevalent among rural than urban residents (78 percent and 28 percent, respectively). [8]

The country's economy deteriorated in the mid-1970s after a sharp decline in copper prices and a sharp increase in oil prices. The creation of import substitution parastatals with the goal of minimising the country's dependency on copper exports and diversifying the economy did not achieve the desired results. In the midst of a stagnating economy, Zambia began to implement vigorous Structural Adjustment Programmes which failed to substantially alter the economy and led to increased levels of poverty for the majority of Zambians. [8]

The structural adjustment programmes (SAPs) compounded debt. The SAPs is associated with adverse effects on the ability of women to benefit from growth, due to their concentration in a limited number of economic sectors, their limited mobility and their responsibilities for unpaid care work (Assaad and Amtz). [9] Since the introduction of SAP a lot of companies have closed down, and most people have lost their jobs and lack stable means of earning a living. The prices of all the necessities continue to rise and are beyond the reach of the majority of Zambians as there are no food subsidies. Furthermore, the unreliable donor support and natural disasters such as drought have also contributed further to deterioration of the country's economy. [10] The drought has immensely affected the country's agricultural sector, and the small-scale farmers are unable to grow food to feed themselves. To avert the hunger situation, the Government had to mobilise funds to purchase and distribute relief food to drought-stricken areas. These diverted funds are necessary for developmental projects.

The Zambia Demographic and Health Survey (ZDHS) [8] states that women constitute a large number of those living in poverty in Zambia and that women-headed households are the most hit by poverty. There are several reasons why women-headed households are poor, and these include among others low educational status, unemployment and inability to pursue challenging formal sectors, which offer higher salaries. The ZDHS further states that in Zambia, 591 maternal deaths are approximately at 100,000 live births meanwhile the infant, neonatal and under-five mortality rates are at 70, 34, and 119 per 1,000 live births, respectively. These mortality rates are unacceptably high. The leading causes of deaths in children are malaria, respiratory infections, diarrhoea, malnutrition, and anaemia. Apart from these, HIV and AIDS are increasingly contributing to morbidity and mortality in children. On the other hand, malnutrition is on the increase, attributed to the worsening poverty levels and growing food insecurity, as well as suboptimal infant and young child feeding practices. According to available statistics, 70 percent of the population is food insecure, and 45 percent of children are stunted. Additionally, fifteen percent of children are underweight, and five percent wasted. These rates are among the highest in the region. Besides that, there is a general critical deficiency of micro-nutrients (iodine, iron, and vitamin A), among both children and expecting mothers. [8]

Other reasons for the higher poverty levels in women-headed households include inadequate access to land coupled with lack of land title due to divorce and inheritance customs. Women are further discriminated against in accessing credit markets. [11] Where women are household heads, the incidence of malnutrition and infant mortality rates is higher than when men head the households. [12,13] Furthermore, female household heads earn much less than men, and there is a significant linkage between female family headship and poverty. [14]

The health care system equally has its challenges. Cuts in the health budget have resulted in low-quality health care, shortages of medical supplies and equipment, lack of drugs in hospitals and health centres and poor maintenance of hospitals and other health facilities. [15] Traditionally, women have responsibilities in health care and child rearing; therefore the social service responsibilities and expenses have become a burden on women who are already poor. [16]

Discussion

Effects of poverty on the health of women and children

The greatest burden of health risks is borne by the disadvantaged in societies especially women and children who are often poor, have very little formal education and low occupations. [17] Women and children often suffer from lack of protein and energy, the adverse health effects which are frequently worsened by deficiencies in micronutrients particularly iodine, iron, vitamin A and Zinc. [18] Globally, among women of reproductive age, maternal mortality is the second leading cause of death, and women face a 1 in 180 chance of dying from maternal causes. [19] The WHO further states that the proportion of children under five years old who were underweight declined by 11 percentage points between 1990 and 2014, from 25% to 14%. While Africa has experienced the smallest relative decrease, with underweight prevalence of 16% in 2014 down from 23% in 1990, in Asia for the same period it reduced from 32% to 18% and in Latin

America and the Caribbean from 8% to 3%. This means Asia is likely to, and Latin America and the Caribbean will meet the MDG, while Africa is expected to fall short, reaching about only half of the targeted reduction. Even if Asia overall might meet the MDG, to halve the 1990 rate of underweight, rates continue to be high in Southern Asia (28%). This combined with the large population means that more than half of all underweight children live in Southern Asia (51 million out of the global estimate of 95 million in 2014). [19]

The problem of underweight is most prevalent among children under five years especially in the weaning and post-weaning periods of 18-24 months. [20] Underweight children are at increased risk of deaths from infectious illnesses such as diarrhoea and pneumonia. [21,22] The effects of inadequate nutrition on the immune system are many, and infectious diseases also occur more frequently and severe in underweight children. [23] A child's risk of dying from malnutrition is not limited to those children with the most severe malnourishment. There is a continuum of risks such that even mild under-nutrition places a child at increased risk.

Low-birth-weight contributes to infant mortality. [24] Besides, low birth-weight babies who survive may suffer from growth retardation and other infections during childhood, adolescence and adulthood. Growth-retarded women are likely to carry on the cycle of malnutrition by giving birth to low birth-weight babies. [25] In areas where food is scarce, menarche can be delayed, and lactational amenorrhoea is prolonged. During times of food shortage, the food intake for women decreases as they always eat last after ensuring that everybody else has eaten resulting in malnutrition. [26] Their daily calorie intake is frequently not sufficient to cover their heavy physical workload. Besides, frequent child bearing makes extra metabolic demands on them. Most women in developing countries have chronic malnutrition often dating back to childhood and exacerbated by pregnancy. A malnourished pregnant woman has higher chances of giving birth to a low birth weight infant. [27]

Ideally, women should have a caloric intake that covers their energy expenditure and physiological needs as well as specific nutrients such as folic acid and iron when pregnant and lactating, this is not so for women in developing countries where a malnourished mother can lose as much as 7 kilograms after a year of lactation. In most cases, these women are anaemic as a result of iron deficiency. Anaemia has serious health consequences and can lead to heart failure and maternal death due to blood loss during delivery. Goitre is also prevalent especially among pregnant women and young girls due to iodine deficiency. Furthermore, women dispose off all excreta; consequently, they are exposed to infectious diseases, which result in increased utilisation of calories and loss of protein and other nutrients exacerbating maternal malnutrition. [28]

Health effects of malnutrition

The results of malnutrition could hardly be more serious: about 45% of child deaths in 2011 were as a result of malnutrition (including foetal growth restriction, suboptimal breast feeding, stunting, wasting, and deficiencies of vitamin A and zinc). [29] In 2013 the growth of around 161 million children aged under five was stunted by chronic malnutrition, leading to hampered cognitive and physical development, poor health, and an increased risk of degenerative diseases [30]. In the same year, 51 million children were stunted (having low weight for height) because of acute under nutrition; severe wasting increases the risk of morbidity, particularly from infectious illnesses such as diarrhoea, pneumonia, and measles, and is responsible for about two million deaths a year. [30]

Meanwhile, deficiencies of Vitamin A and Zinc cause many deaths (157 000 and 116 000 child deaths, respectively, in 2011) [29] and iodine and iron deficiencies, coupled with stunting, leads to children not achieving their full capacity. Iron and calcium deficiencies increase the risks associated with pregnancy, particularly maternal mortality. [29] Similarly, overweight and obesity in children and adults have been increasing at a faster rate in all regions of the world, and half a billion adults were affected by obesity in 2010. Dietary risk factors, together with inadequate physical activity, were responsible for 10% of the global burden of disease and disability in 2010. [31]

Poverty leads to inadequate food intake in children resulting in malnutrition. Some children under five years suffer from malnutrition evidenced by stunted growth. According to the Zambia Demographic and Health Survey, 40 percent of children under age five are stunted, and 17 percent are severely stunted. Analysis by age groups further shows that stunting is highest (54 percent) in children aged 18-23 months and lowest (14 percent) in children less than six months of age. Severe stunting shows a similar pattern, with the highest proportion of children aged 18-23 months (25 percent). Mothers' nutritional status, as measured by their body mass index, influences the level of stunting in their children. Stunting is most likely (50 percent) among children whose mothers are thin (Body Mass Index (BMI) of less than 18.5) and least likely (32 percent) among children whose mothers are overweight or obese (BMI of 25 or above. [8]

Malnutrition is responsible for millions of deaths annually in low and middle-income countries, not only directly but also in combination with or as a result of multiple infections. [32,33] This is because a low nutritional status predisposes a child to infections. When the immunological position of a malnourished individual is impaired, the course of infection becomes more severe hence the increase in mortality from infectious diseases. [33] Due to poverty, childcare becomes complicated as parents have inadequate resources to take care of their children's needs. [34] Mothers have to work or sell some merchandise in the streets to earn a living and children are left at home under the care of their older siblings without proper meals.

Poverty is a disease that saps people's energy, de-humanises them and creates a sense of helplessness and is frequently associated with the unhealthy environment. [35] The effects of poverty are most often interrelated so that one problem rarely occurs alone, for instance, poor sanitation makes it easier to spread around old and new diseases, and hunger and lack of water make people more vulnerable to them. [36] Impoverished communities often suffer from discrimination and end up being caught in cycles of poverty. Another complicating factor is the

high prevalence of HIV as there is a relationship between HIV and poverty. Studies have revealed that poverty contributes to the spread of HIV and AIDS. [37]

How can nurses contribute to poverty reduction?

Nurses have an important role to play in poverty alleviation in that they are grass-root workers who deal with the poor in the community in both urban and rural areas. One of the measures that nurses can take is to educate the community about the value of education. Education can help to improve health-related practices such as improvement in health-seeking behavior. [1] Child early and forced marriage if curbed can help to reduce poverty levels as women can be empowered to work and provide for themselves instead of marrying early. [2] Some of the poor people attend health centres when they are ill, and this is a tremendous opportunity to help educate them and to help them take appropriate measures to reduce poverty. It is essential that all Nurses understand the implication of poverty on the health of women and children and this should be done by organizing orientation workshops by the policy makers and health managers.

Nurses can advocate for government policies like the state Earned Income Tax Incentives for children and families where there is refund of tax credits to low income parents paying child support; providing support to families with challenges such as mental health illness, substance abuse or domestic violence by providing individual support, peer support and mentoring. [3]

Advocating for equal pay to the policy makers in situations where women are paid less for the same job as men would help to improve the living standards of the families. [4] The other things that nurses can do to reduce the impact of poverty include advocacy for better living conditions for the poor and educating communities on engaging in income generating activities such as gardening, knitting, sewing while providing maternal and child health services.

Conclusion

Poverty is a global, national and local concern but its effects at the local level are more devastating. Poverty causes diseases, which in turn breeds poverty. A healthy person is better able to secure his/her well-being, and that of her family and the reverse is true. Although the causes of poverty are complex, its reduction still needs to be given priority; hence the International organizations and Governments have put forth a long list of suggestions and plans to try to reduce poverty. Among them are social insurance programmes, improved education, cancelling debts developing nations owe to industrialized countries, removing import barriers so that nations with a large percentage of the poor can sell their products more easily and low-income housing for the poor.

Furthermore, in the year 2000, the United Nations General Assembly set goals to be achieved by 2015. These included the elimination of extreme poverty and hunger as well as gross inequality of income within countries. Solutions to poverty reduction should address political, social and other factors that create poverty. Poverty alleviation at country level requires community participation at grass root levels and intersectoral collaboration in the implementation of poverty alleviation programs. Community participation offers sustainability, increases levels of self-esteem and reliance. Poverty alleviation will lead to improvements in the health status of women and children and ultimately their standard of living.

Conflict of Interests

All authors disclose that there was no conflict of interest.

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