

DYING FOR CHANGE

Poor people's experience of health and ill-health

Foreword

In his 2001 address to the World Health Assembly, UN Secretary General Kofi Annan said: “The biggest enemy of health in the developing world is poverty”. Globally, there is a stark relationship between poverty and poor health: in the Least Developed Countries, life expectancy is just 49 years, and one in ten children do not reach their first birthday. In high-income countries, by contrast, the average life span is 77 years and the infant mortality rate is six per 1000 live births.

Poverty creates ill-health because it forces people to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. Poverty creates hunger, which in turn leaves people vulnerable to disease. Poverty denies people access to reliable health services and affordable medicines, and causes children to miss out on routine vaccinations. Poverty creates illiteracy, leaving people poorly informed about health risks and forced into dangerous jobs that harm their health.

The World Bank study *Voices of the Poor*, which gathered the views of more than 60,000 poor people across the globe, highlights many of these issues. *Voices of the Poor* looks broadly at poverty, its determinants and consequences. Health and ill-health emerged as central concerns of those consulted, prompting WHO and the World Bank to collaborate on a separate publication that would highlight the relationship between poverty and poor health from the perspective of poor people. *Dying for Change* is the result. It aims to illuminate from a human, qualitative perspective what many quantitative studies have already recorded: how poverty creates ill-health, and how ill-health leads to poverty. It also highlights the link between good health and economic survival. Poor people everywhere say how much they value good health. A fit, strong body is an asset that allows poor adults to work and poor children to learn. A sick, weak body is a liability, both to the individual and those who must support them.

In particular, poor families are concerned about the health of their breadwinner – when he or she dies, or needs expensive medical treatment, the costs can be devastating. The family may be thrown into a cycle of poverty from which it cannot escape.

One of the strongest messages to emerge from the study is that poor people are angry and frustrated at their exclusion. They understand why they are ill and why they are poor, and often have ideas about what can be done. But the majority are ignored and marginalized by those with power, including health service authorities.

In 2000 world leaders issued the Millennium Declaration, pledging to halve the numbers of people living in extreme poverty by 2015. If we are to succeed in this task, we must include, involve and listen to poor people and their representatives. The poor have long recognized the link between good health and development. But until recently, this link has been neglected in mainstream development thinking.

As good health is crucial to protect the family from poverty, so better health is central to poverty reduction. Improving the health of the poor must become a priority, not only for public health but also for other sectors of development — economic, environmental and social. As Kofi Annan said: “We shall not finally defeat AIDS, tuberculosis, malaria or any of the other infectious diseases that plague the developing world until we have also won the battle for safe drinking water, sanitation and basic health care ... The best cure for all these ills is economic growth and broad-based development”.

Ann Kern
Executive Director
Sustainable Development and Healthy
Environments
World Health Organization

Jo Ritzen
Vice President and Network Head
Human Development
World Bank

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Introduction

For me, a good life is to be healthy.

An old man, Dibdibe Wajutu Peasant Association,
Ethiopia

Dying for Change reports on the health aspects of *Voices of the Poor (I)*, an extensive World Bank study of people's perspectives and experiences of poverty. The aim of this report is to present and summarize the views and testimonies that relate to health. We hope this will provide insights for health policy-makers into the reality of poor people's lives and the impact of ill-health upon them.

Voices of the Poor, upon which *Dying for Change* is based, is the result of a wide-ranging qualitative study involving interviews and small group discussions with more than 60,000 poor women and men from 60 countries, including a review of 81 Participatory Poverty Assessments¹. While the studies are not nationally representative, we believe that when so many people describe their lives, problems, needs and priorities, we are obliged to listen to what they say.

Health emerged as a key issue in the interviews and discussions, often to the surprise of the World Bank researchers involved, since no probing questions on health or disease were included in the study's research guides. We believe that this reflects the centrality of health to poor people's lives.

A number of valuable lessons emerged from the study, which we attempt to summarize in the second part of this document. Three should be mentioned here. First, poor people view and value their health in a holistic sense, as a balance of physical, psychological and community well-being. This view, consistent with the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", is remarkably consistent across age, gender, nationality and culture. Second, people overwhelmingly link disease and ill-health to poverty. Poor people define poverty in the conventional way – lack of income – but also as instability, worry, shame, sickness, humiliation and powerlessness. All these manifestations have consequences for health. Third, good health is not only valued in its own right, but also because it is crucial to economic survival.

Outline

Part I of this publication distils what poor people said about health. It is divided into four sections. In the first, *Poor places kill*, poor people describe how their health is threatened by the hazards of poverty. These include what health professionals would call the "social and economic determinants" of ill-health, i.e., hunger, lack of water, energy and sanitation, and poor housing conditions.

¹ Participatory Poverty Assessments are qualitative studies that use participatory methods to explore poverty and its causes from the perspective of poor people and other stakeholders.

The second, *No right to speak*, looks at health in the context of gender and age. What specific health concerns do poor women have? How do they differ from men's concerns? What do old people fear? Children's unique perspective is only touched upon, as children did not participate extensively in *Voices of the Poor*. In the third section, *Health is number one*, poor people describe their experience of ill-health and its consequences. The final section, *Worse than dogs*, looks at poor people's experience of health services.

Part II focuses on the implications of poor people's testimonies for health policies. These reflections are those of WHO, based on *Voices of the Poor* and the overall experience of the organization, rather than conclusions drawn by poor people themselves.

For reasons of simplicity, those who participated in the study are often referred to as "the poor" or "poor people". It is recognized that this is a crude term that conceals the diversity of people's experience.

Voices of the Poor

*Voices of the Poor*² was undertaken to inform the *World Bank Development Report 2000/1*, subtitled *Attacking Poverty*, and other World Bank activities. The material is published in three volumes. The first volume, *Can Anyone Hear Us?*, is an analysis of the World Bank's participatory assessments in 50 countries during the 1990s, which included more than 40,000 people. The second volume, *Crying out for Change*, was specifically commissioned to gather poor people's views. Some 20,000 poor people in 23 countries took part. The third volume, *From Many Lands* (forthcoming), will contain country case studies and conclusions about regional patterns.

Voices of the Poor is a qualitative study. The foreword to *Can Anyone Hear Us?* explains: "Using participatory and qualitative research methods, the study presents very directly, through poor people's own voices, the realities of their lives". The study sample ranged from 85 communities in Tanzania to 10 communities purposively selected in other cases. For example, when the text states "in Russia", it means in the communities visited. The predominant means of data collection was through small group discussions. More information on the research methods used can be found in the appendices of the published volumes.

² The project was led by Deepa Narayan, Senior Advisor, Poverty Reduction and Economic Management, World Bank. It resulted in 25 publications, all available online (see References). The volumes on which this analysis is based are: *Voices of the Poor: Can Anyone Hear Us?* by Deepa Narayan, with Raj Patel, Kai Schafft, Anne Rademacher and Sarah Koch-Schulte, March 2000; *Voices of the Poor: Crying out for Change*, by Deepa Narayan, Robert Chambers, Meera K. Shah and Patti Petesch, September 2000; and advance extracts from *Voices of the Poor: From Many Lands*, edited by Deepa Narayan and Patti Petesch, September 2001.

PART I : Health, ill-health and poverty

We are all poor here, because we have no school and no health center. If a woman has a difficult delivery, a traditional cloth is tied between two sticks and we carry her for seven kilometers to the health center. You know how long it takes to walk like that? There is nobody who can help here, that's why we are all poor here.
Togo, 1996

Part One looks at what poor people involved in the *Voices of the Poor* study had to say about health. Because health touches on and is determined by so many aspects of people's lives, this information is scattered throughout the original study. The framework below – which covers the determinants of health, gender and age, the impact of ill-health, and health systems – was developed solely for this publication.

In *Voices of the Poor* information on health appears in the form of direct quotes, the comments of researchers and interviewers, and the analysis of its authors. Often, the three are interwoven. Therefore summarizing, and extracting material on health, is a difficult process. Inevitably, the specific context of the interviews has been lost and it is likely that some important lessons have been missed.

A. *Poor places kill* – the social and economic determinants of ill-health

Poor places keep people poor. And poor places also kill.
Crying out for Change

The discussions and interviews in *Voices of the Poor* reveal that poor people understand, very clearly, the link between their living conditions and ill-health. This section looks in more detail at some of the risk factors that poor people identify as the causes of disease and illness.

Fire of hunger

They [the children] sometimes get sick for no reason. Sometimes it is because of lack of food. We are poor. We have no money to buy or to feed ourselves...

A woman, Voluntad de Dios, Ecuador

Lack of food is the most frequently mentioned want. Hunger and malnutrition are seen as underlying causes of many diseases. They cause weakness and exhaustion, and make people more susceptible to infections. Many people say they eat only once a day and sometimes have nothing for days on end. The poorest people rely on what they can find growing wild or by catching fish and shellfish. In towns, hunger is less dramatic or obvious than it is in rural areas, but poor people in Jamaica say that it is even more prevalent there than in the countryside.

Hunger is highly seasonal, in both rural and urban areas. In rural areas, the “hungry season” is determined by the agricultural cycle. In urban areas, it often corresponds to the rainy season, when there are fewer jobs in construction and vending.

A group of women in Nigeria report that they are so weakened by hunger, they do not have enough breast milk to feed their babies. In Ethiopia there are expressions like “burning hunger” and “fire of hunger”. Parents worry constantly about providing enough food for their children.

You’re never sure what you are drinking

I am tired of going to the municipality [about the water contamination] and insisting that they do something. Of course we are ill.

A Bulgarian man

If two out of three children become ill and vomit... it is due to the water; even though you can add chlorine, you’re never sure what you are drinking.

Women, Argentina

Poor people speak about the lack of safe water as an acute deprivation and cause of ill-health.

In all regions, people describe their daily struggles to get water for human use, but shortages are most widespread in Africa. Problems of distance, quantity, quality and safety of supply are mentioned, but also environmental hazards like flooding, siltation and pollution. For example, in Jamaica inputs into banana farming are said to contaminate local water supplies.

Inadequate maintenance of wells, pipe-lines and bore-holes is also an issue. In Kwalala, Malawi, people report serious problems if bore-hole pumps break down in the rainy season. They know that taking water from the lake is risky, because it is contaminated with wastes from the highlands, but say that they have no choice.

Lack of water for irrigation is identified as a major problem for rural communities, threatening livelihoods and household food security.

Fetching water is not only time-consuming and hard work, but can cause injuries, especially to women. Indian women say they trek two kilometers to fetch water, and face dangers such as “boulders, slipping out of the rock joints... wild animals... wolves, and hyenas”.

A plague of flies

Just look how the kids are playing in the street with so much dirt. The water in the streets brings infections, and it is because of a lack of a sewage system...

A woman, Barrio las Pascuas, Bolivia

Sanitation problems are acute in many communities, particularly in urban areas. In Bangladesh, for example, poor people point out the scarcity of latrines, and say that long queues often form outside toilets.

Worries about health risks, particularly for children, and bad smells from open sewage canals, are particularly striking in the reports from Latin America. Sewage is said to “run openly in the roads” and endangers children playing in the street.

The hazards of uncollected rubbish and waste are also mentioned frequently by poor people in urban Latin America. At Isla Trinitaria in Ecuador, a group of women describe how they live in cane houses on a pier above garbage-filled water. They talk of “a plague of flies” and “illnesses caused by pollution”. In some settlements at Nova California in Brazil, residents complain of foul-smelling garbage “causing all types of diseases affecting the community and especially children”.

In Indonesia, several urban slums are in low-lying areas with poor drainage. The river brings in silt and garbage from the city. It floods during heavy rains, often causing skin and eye diseases, harvest failures and damage to houses.

Draughty, humid, leaking

Everything is contaminated, land, water, plants, and people.

Community member, Ecuador

It's draughty, humid, leaking. Just try live here in winter. Our children have fallen ill. And the adults too. There are bugs, cockroaches, what have you. It's cold.

Roma men and women, Bulgaria

Poor people almost always live in poor housing or shelters, and often in dangerous or unstable areas. Many live in huts or hovels made of temporary and unstable material – examples include adobe in Egypt, mud, thatch and bamboo in Vietnam, and “reeds... ruined zinc” in Ecuador.

Many identify such housing as a risk to their physical safety and health, and say better housing is a pressing priority. In many countries, poor people mention that it is hard to keep vermin and dangerous animals out of their houses. Others complain that living in crowded conditions encourages disease.

Fire is a frequently reported hazard, particularly in slum areas where shelters are often built close together and of combustible materials. People in Russia say that

electric wiring, which has not been replaced for 50 years, is a fire risk. Elsewhere in Russia they say that dust from a nearby chemical factory causes cancer and other illnesses.

When children waste and die

Poor people often identify ill-health with a particular season. In cold climates winter is the difficult time, while in tropical areas people fear the rainy season. In Ghana, people say “the rainy season is the time when children most waste and die”, and when diseases such as malaria, Guinea-worm disease, diarrhea, skin and eye diseases and snakebites are rampant.

No one needs us

For a poor person everything is terrible illness, humiliation, shame. We are cripples; we are afraid of everything; we depend on everyone. No one needs us.

Blind woman, Tiraspol, Moldova, 1997

Not every disabled person can afford the procedures to qualify for disability payments.

Moldova, 1997

Disability among the very poor is very common. Directly and indirectly, disability is often caused by poverty. For example, a child may not be immunized because its illiterate mother does not receive information about a free vaccination program, or someone may be permanently injured by doing a dangerous job.

The disability becomes disabling when there is no access to support, information and services. This can be aggravated by discrimination and exclusion. From Bulgaria comes the report that disabled and blind people are considered “incapable of anything”. In many countries, the authorities are said to obstruct disabled people’s access to disability allowance.

Typically, the types of specialist health care that disabled people need do not exist. Where they are available, their high cost may effectively exclude poor people, or force them to interrupt treatment.

I look for a job every day

They can’t take the tension, have no job, must support three kids, so they take the rope and that’s it.

Kalofer, Bulgaria

I look for a job every day. But some days I am ashamed of going outside. Everybody will look at me and will know that I have no job and that is why I am roaming like a street dog...I am always sad, I do not speak loud, I have headaches and I become nervous – from depression.

A Bulgarian man

Adequate and secure livelihoods are a central concern of poor people. Both in rural and urban areas poor people have to work long hours to make ends meet, often in dangerous jobs. They are driven into livelihood activities that are not only dangerous but also illegal and anti-social, including theft, drug dealing, sex work, child labor and trafficking.

More and more poor people, particularly men, have no job at all. Almost universally, male discussion groups speak of frustration, anger, and humiliation, stemming from the misery of joblessness and the inability to provide for their families. This anxiety is particularly visible in reports from Eastern Europe and Central Asia. In Kalofer, Bulgaria, a town with 4,200 inhabitants, four men in their thirties had committed suicide in the four months before the interviews.

B. *No right to speak* – Age, gender and health

Voices of the Poor suggests that “good health” and “well-being” mean different things to women and men, old and young. Men stress material assets and time to relax, while women emphasize “having enough”, having peace in the family, being able to provide for their children, and having good relations with neighbors and friends.³ Young people fear sickness in those they depend on – particularly their parents – rather than their own ill-health, while old people are more concerned with loneliness and isolation.

Gender differences also affect men’s and women’s experience of ill-health, and their access to health services. For example, women are more likely than men to suffer from exhaustion, while men may tend to have drug or alcohol problems (see pages ? and ?). Men are more likely to access formal health care, while women tend to rely on traditional or other alternative health services, because they are cheaper and more socially acceptable.

Men and women also tend to have different roles in health care provision. Women are typically the providers of health care, while men are more frequently involved in making financial decisions around health care and in financing and transporting sick relatives to clinics and hospitals.

Women’s unequal access to health care is a reflection of their lack of power in society. *Voices of the Poor* reports that women are typically excluded from decision-making in the community and at other levels. In Indonesia, poor women are said to have “no right to speak” at community gatherings: “If poor women protest, their voice will not be heard, or even worse, they would be chastised for speaking in public”.

³ However, *Voices of the Poor* concludes that it is hard to generalise about these differences as gender roles and priorities are rapidly changing in many parts of the world.

When women are sick...

When women are sick, there is no one to look after them. When men are sick, they can be looked after by women.

South Africa, 1998

It is widely accepted that men are entitled to formal health care, and the resources needed to secure it, before women. Typically, women defer treatment of their own illnesses in order to get care for their families.

Access to care may also be influenced by social norms affecting women's mobility. In Pakistan, for example, it is reported that women and children are unwilling to travel alone. In Balochistan, Pakistan, women say they are not "allowed" to travel to hospital without their husbands. Similarly in Yemen, women do not go alone to health services unless they are near by, and in any case, they must first seek approval from their husbands or a male member of the community.

Women's social status and self-esteem may also affect their access to health care. In another case in Pakistan, a woman said she did not want to go to hospital because, being illiterate, she felt unable to describe her condition to hospital staff in ways that they would understand.

Women have taken charge of everything

Most men now abandon their homes. Women now work the fields... Women have taken charge of everything. They pay heavily and endure this life.

Discussion group, Ecuador

Poverty means working for more than 18 hours a day, but still not earning enough to feed myself, my husband and two children.

A woman, Cambodia

In ever increasing numbers, in all parts of the world, women are shouldering the double burden of paid and household work. Many women are constantly exhausted as a result. Researchers in Vietnam say the women they interviewed were "quite clearly overworked", and this led to increased health problems. Women have little time to rest, reflect, enjoy a social life or take part in community activities. Women's overwork may also result in the neglect of their children.

Many women support themselves and their families by working in the informal sector, in domestic work, petty trade and vending. There are frequent reports of sexual harassment and abuse, particularly by domestic workers.

Households headed by women – widows, deserted and divorced women and single mothers – are particularly vulnerable. In many cultures, especially in Africa and

Asia, these women report stigmatization and constant discrimination. Practices like the burning of widows are now illegal. But widowhood is still a devastating shock, both to widows and their children. Many discussion groups report that widows and single mothers are victims of disrespect and violence.

Voices of the Poor suggests that activities specifically aimed at building awareness of gender inequity and improving gender relations have sometimes had an impact. In Argentina, Bulgaria, Ecuador, Jamaica and the Kyrgyz Republic there are reports of changes, and of men who help at home. In Indonesia, men under 35 are helping out more with housework and child care when their wives work in factories or overseas, but not when they do casual work.

Violence never ends

Here there is battering all over the place. Women hit men, men hit women, and both hit children.

Novo Horizonte, Brazil

'What did you do to get raped?' [The police] ask all sorts of questions without giving any help.

South Africa

Domestic violence against women is frequent in all countries covered by the study, and is mentioned in 90 per cent of communities. Since this subject is so often taboo, it is notable that it was discussed at all. In groups in Ethiopia and the Kyrgyz Republic it was impossible to mention the subject, and in Bangladesh discussions were held in hushed voices.

Abused women suffer not only from physical injury, such as broken bones and bruises, but also from psychological stress, shame, isolation and depression. In some cases abuse has led to suicide. Abused women are often too scared and defeated to seek help, either from the police or health services. Men's reactions to their own violence are little reported.

Roughly 30 per cent of discussion groups said physical violence had decreased over the last decade. Most of these groups were in Latin America and the Caribbean, some in Asia. Women in these areas display greater awareness of their rights and decreasing tolerance of abusive behavior. They report several responses to violence: fleeing to safe houses, filing complaints, counseling, and leaving abusive marriages. Women link the reduction in violence to the work of NGOs and to their own increasing economic power. However, women's work can also trigger male violence: men may resent women working or feel neglected when they are away from the home.

Another 30 per cent of groups could not agree on trends. In Eastern Europe, Central Asia and Brazil there were reports of increased violence.

Regardless of trends, the overall prevalence of domestic violence and physical abuse was reported to be high. It was most often linked to economic pressures and to changing gender roles and relations. Alcohol and drug addiction, gambling, polygamy and promiscuity were also mentioned. In Brazil and Argentina, alcoholism and drug abuse were frequently mentioned in connection with domestic violence.

Some men mistreat their families physically, verbally, and psychologically to the point of sending the family member to the hospital, and [even causing] death. [Men]... who have experienced violence in their childhood... think they have to deal with things in a similar way at their homes; therefore, violence never ends.

A woman, Isla Trinitaria, Ecuador

Generations to come

There are children that don't get the affection they need from their parents. You can see sadness from the lack of love on their little faces. Instead they get beatings and verbal abuse.

A woman, Isla Trinitaria, Ecuador

In some families you can see there is sexual abuse against the girls; they are beaten, marked, many times burned. I think those things are the result of frustrations.

Isla Trinitaria, Ecuador

We do not think that life will become any better for our children and even for generations to come.

Discussion group, Malawi

Very few children took part in the *Voices of the Poor*. However, where children's voices are recorded, they are striking.

In Ho Chi Minh City, Vietnam, poor children were asked about their fears and dislikes. They were not specifically asked about health, yet illness and its consequences are often mentioned in their responses. Girls' fears include having no money for medicines, having nobody to look after them when their parents are sick, and drug addiction. Boys speak about teachers getting ill, accidents, drug addiction, HIV/AIDS, and sickness in the family. Both boys and girls mention the fact that their neighborhood is dirty and polluted and that housing is poor. Other fears include drunken men beating up their wives and children, quarrelling, divorce and debts.

Interviews with adults in other countries reveal how children are beaten and feel unsafe in their homes. Young people in Sacadura Cabral, Brazil, relate stories of fathers coming home drunk or drugged to beat or rape them. Children sometimes react by running away. They may end up as street children, where they are exposed to violence, abuse and disease.

Dangerous child labor, child trafficking, child prostitution and drug abuse among children is reported in many countries.

Now there are nine-year-olds taking drugs. Their parents see them so drugged up that they cannot do anything, so they just protect the other children.

A woman, Argentina

A lonely crisis

I am old and I can't work, therefore I am poor. Even my land is old and tired, so whatever little I manage to work does not give me enough.

An old man, Togo, 1996

In many cultures, old people are treated with respect, and continue to play an important role in the household. But, says *Voices of the Poor*, “old age is increasingly a painful and lonely crisis for many people”. Reports from Egypt, Jamaica, Somalia and other places show that old people are often abandoned by their children, who seek a better life in town. In many places poor parents refuse to become burdens on their equally poor, adult children. “We are nearly dead now; we do not have any desire for ourselves; we just hope our children will not be poor” (Vietnam, 1999).

In countries badly affected by HIV/AIDS an opposite pattern is emerging: elderly parents are being forced to take on responsibility for children dying from HIV/AIDS, and care of their young grandchildren. These new families B of grandparents and young grandchildren B are typically very poor.

In countries where old people have relied on state pensions, financial crises have left the aged poor extremely vulnerable, unable to afford medicines or food. They rely on charity or are forced to beg.

C. *Health is number one – ill-health and its consequences*

Let hunger be ranked first because if you are hungry you cannot work! No, health is number one, because if you are ill you cannot work!

Discussion group of women and men, Musanya Village, Zambia

Poor people most frequently describe ill-health and “ill-being” in multidimensional terms, not only as disease but also as hunger, pain, exhaustion, exclusion, isolation, bad relations within the family and with other people, insecurity, fear, powerlessness and anger.

Specific diseases and conditions are mentioned, but only rarely (see *We all suffer*, below). It is much more common for poor people to talk about the devastating consequences of ill-health rather than particular illnesses.

Conversely, good health is identified as a central component of a good quality of life. In the descriptions of well-being, three different types can be identified: *material well-being*, often expressed as having “enough”; *bodily well-being*, i.e., to be strong, healthy and good-looking; and *social well-being*, which includes having children and caring for them, self-respect, security and confidence in the future, freedom of choice and action, and being able to help others.

Our life comes to a halt

We face a calamity when my husband falls ill. Our life comes to a halt until he recovers and goes back to work.

A woman, Egypt

Poor people cannot improve their health status because they live day by day, and if they get sick they are in trouble because they have to borrow money and pay interest.

A woman, Tra Vinh, Vietnam

Sickness of the family breadwinner is something that poor people particularly fear. It means food and income suddenly stop. Paying for treatment brings more impoverishment – assets may have to be sold and debts incurred. A downward spiral of poverty begins: food becomes scarce, causing malnutrition, and children are withdrawn from school and sent to work. If a working adult dies, then the ratio of dependents to adults increases. If he or she is permanently disabled, then another dependent is created.

Illness as a cause of destitution was cited often throughout the study. Of the 15 causes of a downward slide into poverty mentioned by interviewees, this was the most frequently mentioned - ahead of losing a job, which took second place. The poor are more likely to be exposed to health risks, because their work is physically demanding and often dangerous. But they are least likely to be able to afford health care when they are injured or fall ill. Researchers from Bedsa, Egypt, write: “The poor always say that their strength or health is their main capital”. Illness can quickly turn this asset into a liability.

We all suffer

Poverty snatched away my wife from me. When she got sick, I tried my best to cure her with tebel [holy water] and woukabi [spirits], for these were the only things a poor person could afford. However, God took her away. My son, too, was killed by malaria. Now I am alone.

An old man, Ethiopia

The health problems people report to researchers include: injuries such as broken limbs and burns, poisoning from chemicals and pollution, parasites from contaminated water, skin infections and mental disorders. Diseases mentioned by name include pneumonia, bronchitis, tuberculosis, HIV/AIDS, asthma, diarrhea, typhoid and malaria.

HIV/AIDS is discussed in Argentina, Jamaica, Thailand, Vietnam and many African countries, where people talk about its devastating consequences. Its impact is, by far, most marked in Malawi and Zambia, where poor people repeatedly raise and discuss the subject. In Zambia, a group of young people made a causal diagram that linked poverty to prostitution, to HIV/AIDS and related diseases.

Many suffer ill-health as a result of war and conflict. A middle-aged man from Bosnia says: “The rise in the number of people with heart complaints, high blood pressure and depression has become normal for us. There is not a person in Tombak who does not suffer from at least one of these illnesses. All of this has been brought on by poverty and war.” A woman from Glogova says: “We all suffer from two illnesses: high blood pressure and nerves.”

My heart aches

I want to commit suicide, I want to run out... because to see the kids crying and I do not have one sucre (penny) to give them some bread... life is so sad.

A mother, Isla Trinitaria, Ecuador

Mental health problems – stress, anxiety, depression and lack of self-esteem – are among the effects of poverty commonly identified by discussion groups. They are mentioned by groups in every region. In Tabe Ere, Ghana, women say that poverty creates so much pressure and anxiety that it can lead to insanity. Ghanaians point to madness as a likely consequence of poverty.

In Eastern Europe and Central Asia in particular, the stress of sudden poverty has led to psychological problems. In Bosnia and Herzegovina, every community visited by *Voices of the Poor* researchers reported “psychological ill-health”. Poverty has forced families to reduce their consumption dramatically – to eat cheaper food, to cut what they spend on health care and to rely increasingly on home and traditional remedies. People say that they are unable to uphold social norms B for example, providing hospitality to strangers B and that this makes them feel depressed and worthless.

There are families who don't eat or drink in three days. People die of hunger... Ayagan was a good guy. He could not provide food for his family; his children cried, and then he shot himself.

An elderly man, Uzbekistan

It helps me forget my problems

There are a lot of people in this village who drink vodka in the morning, and then go and do something bad, commit crime.

A woman, Ak Kiya, Kyrgyz Republic

When I don't know how my children are going to eat tomorrow, I tend to get drunk whenever I can. It helps me forget my problems.

A man, Gabon, 1997

When I give money for bread, my heart aches, but when it is for heroin – I feel so nice, my soul feels so pleasant, I feel great. But then I wake up in poverty, and it is horrible.

A 30-year-old heroin user, Bulgaria

Poor people see alcohol and drug use as a major consequence of poverty. Groups in many places mention a pattern of male drunkenness, scarce money spent on alcohol and drugs, and domestic violence.

In Latin America and the Caribbean in particular, ill-health linked to disease, alcohol and drug abuse is the most frequently mentioned impact of poverty. Drug abuse is mentioned in urban areas of Latin America and in Bangkok and Ho Chi Min City. It is also frequently reported in Bulgaria, Kyrgyz Republic, Russia and Uzbekistan. The addicts themselves are miserable and so are their families, worried about their addicted children.

Alcohol abuse is especially prevalent among men. A cause-and-impact diagram, resulting from several group discussions in Kuphhera, Malawi, shows how men's beer drinking often leads to promiscuity, disease and eventually to death. In Eastern and Central Asia, alcohol abuse is steadily rising.

D. *Worse than dogs* – poor people's experience of health services

Informants stress, over and over again, that health care services are vital to their survival and livelihood. However, the significance that the poor attach to health services is muted by their widespread disappointment – in some cases anger – at the bad quality of service and the difficulties of accessing care. These difficulties include the direct cost of doctors' fees, medicines and bribes, and the indirect cost of transport to health services and time lost waiting for treatment. Abusive treatment by staff is a further disincentive to seeking care. Each of these is explored in more detail below.

When formal health care services are unavailable, people turn to traditional medicine. In most cases, they say that they would rather be treated by modern health care providers, but often traditional services are all they can access or afford. As mentioned in part B, women are more likely than men to use traditional medicine.

When access to care is constrained, illness is likely to persist or worsen. Crucially, this may stop people working and force them to sell assets and fall into debt, leading to a cycle of dependency and poverty. One report from Egypt illustrates the pattern: “The poorer group in the community cannot afford to treat themselves. This causes them to feel tired, or illness eventually disables them. At the end, illness and inability to afford medical treatment decreases the ability to work in poorer households”.

How would you get a sick person out of here?

If anybody takes sick in the community it costs a lot to go all the way around; and if you are not careful, the people can die before they reach the hospital.

A woman, Little Bay, Jamaica

While you are healthy it is OK, but if you get a snakebite that is not simple, you have to go to Los Juries and hope to God it's not a stormy day with much rain. How would you get a sick person out of here? Walking is impossible, a vehicle would not get out...the ill person would die!

A young woman, Los Jurías, Argentina

Typically, health services are scarce in the areas where poor people live, forcing them to travel long distances to seek care. Poor roads and high transport costs can make this difficult, expensive and time-consuming. Particularly in rural areas, people stress the difficulty of handling emergencies and the lack of local health centers.

We have to wait

When we go to hospitals we know we will have to wait beyond the expected time... There comes somebody who is 'higher' than us and jumps the queue without much fuss.

Discussion group, Padre Jordano, Brazil

You go to the hospital, you have to get a number, you go to the guard, the nurses are chatting. You have to wait until they fancy giving you a number... 'Is the doctor here?' 'No, the doctor isn't here.' They lie.

A 25-year-old woman, Los Juries, Argentina

One of the greatest barriers to health care for the poor is the time it takes to get treatment. For many, time is a resource, since time away from work may mean lost income.

Once they have arrived at the health center, people may have to wait hours before being seen. Some say the length of time spent waiting is a strain, and can itself cause illness.

There are no medicines

We do not go to the hospital because it is necessary to bring our own bed linen, dishes, sometimes even a bed.

A young woman, Muynak, Uzbekistan

You go and they don't attend you. There are no medicines. It's a disaster.

A young man, Los Juries, Argentina

We don't have influence over the hospital because they don't take our advice.

Poor people in Mtamba, Malawi

In many countries, poor people believe that clinics and hospitals are *the* most important state institutions. Even so, health services (along with other state services) are routinely criticized as inefficient. In Egypt, poor men and women say that the rural hospital is the worst service provider: “They have their noses up in the air and neglect us”. In general, local staff are appreciated more than those in distant clinics and hospitals.

The most frequent complaints are of a low quality of service, staff shortage and absenteeism, and lack of medicines and equipment. In many countries even basic necessities, such as clean water, are lacking.

A further problem, often mentioned, is the need for documents such as health cards and food ration cards. They are hard to obtain, difficult to keep safe, and for some people, impossible to read and understand.

We don't have the money to get cured

We are not allowed to get sick anymore because we have to pay for medication... with what?

An old man, Zenica, Bosnia and Herzegovina

We get sick and we don't have the money to get cured. We don't have medicines because they are expensive... Everything is so expensive.

Women, Juncal, Ecuador

The high costs associated with health care are repeatedly mentioned. People say that these costs can be devastating, combined with loss of income during illness.

Corrupt health staff is a common allegation. They may demand unofficial “fees” or expect small “gifts” in return for ordinary services, such as registering, examination by a nurse or doctor, tests and being given medicine. They may ask a sick person to make unnecessary repeat visits to the health clinic or hospital.

Usually official fees must be paid in cash and in advance. There are many examples of poor people saying that they use other health care providers, such as traditional healers or private practitioners, because they have more flexible terms of payment, and accept late payments, installments and payment in kind. They are also said to be kinder and easier to access in terms of time and distance.

An angry nurse

Rude, humiliating and inappropriate treatment are common complaints. A man from Tanzania says: “We would rather treat ourselves than go to the hospital where an angry nurse might inject us with the wrong drug”. Elsewhere in Tanzania, men, women and young people say over and over again that they are treated “worse than dogs”. Before they have a chance to describe their symptoms, they “are yelled at, told they smell bad, and [that they are] lazy and good-for-nothing...”

In La Calera, Ecuador, a young man says: “In the hospital they don’t provide good care to the indigenous people like they ought to. Because of their illiteracy they treat them badly... they give us other medicines that are not for the health problem we have”. In Vietnam, people prefer the medical care provided by the border medical guards to that available at the health station. They explain: “People don’t go to the medical station because the professional skills of the health workers are low.”

The behavior of health staff, though not excusable, often reflects their very difficult working conditions. A nurse from Bulgaria comments: “There are elderly people who spend half the week in the hospital. They just refuse to understand that there are also other people who are ill... as if we can change something. There is no money for free drugs. I cannot feel [good] when there are people abandoned... and me not being able to do anything.”

No one helps anyone

No one helps anyone, the hungry lives for himself and the satiated lives for himself.

Zawyet Sultan, Egypt

When food was in abundance, relatives used to share it. In these days of hunger not even relatives would help you by giving you some food.

A young man, Nchimishi, Zambia

In poor communities, the lack of formal health services often forces people to turn to traditional or social networks. These networks provide crucial support – emotional and practical – and also facilitate access to formal services. The importance of social solidarity is especially evident in the event of sudden illness and disease, natural disasters and accidents.

Voices of the Poor states that in many countries traditional networks and coping mechanisms are extremely stressed. Poor people speak of a loss of community and a decline in traditional hospitality, the result of increasing urbanization, crime, corruption, violence and insecurity. This leads to loneliness and isolation, which in turn creates mental stress and illness. The most vulnerable – children, the elderly, widows, ethnic minorities, the disabled, and people with HIV/AIDS – find themselves excluded, cut off from information, health services, education and economic opportunities. This in turn creates poverty, which often perpetuates from generation to generation.

When social solidarity breaks down, collective action is difficult. Poor people everywhere mention important local organizations, e.g., the funeral society, the rotating credit group and farmers groups. But these organizations seldom grow beyond the neighborhood or develop into social movements. One notable exception is neighborhood associations in Brazil, praised by poor people for presenting the community's needs to public agencies and the city government. The associations help residents in their day-to-day lives and during crises such as ill-health, lack of food and poor housing.

To summarize

Poor people want institutions that are honest, accountable, treat them fairly and show respect. Men and women from Novo Horizonte, Brazil, ask that staff “be there; treat us with good manners; have patience; listen to people; try to understand the needs of the people; give attention; don't always say ‘come back later’; say honestly if you can or cannot solve the problem; work with love; do not treat us with ignorance, respect the community's problems; be there on time; give equal treatment, do not discriminate; solve the problem”.

PART II : Reflections and implications

Voices of the Poor confirms, from a family and community perspective, what we already know from macro-economic data: that poverty and ill-health are inseparable; that the principle causes of ill-health fall within the domain of public health; and that health systems in developing countries are failing the poor.

How can the health of the poor be improved? Part II discusses the implications of what poor people said in Part I. It is structured around the three areas mentioned above, and a fourth that covers health concerns that disproportionately affect poor people. These tentative conclusions reflect the *Voices of the Poor*, but they are also based on WHO's knowledge and expertise. They are, therefore, the conclusions of WHO, not the suggestions of poor people. Part II begins by looking at the importance of poor people's participation in efforts to improve their health.

Focusing on the needs of the poor is essential. Overall improvements in health status, or efforts to reform health services, will not necessarily benefit the poor – they face specific health problems and specific barriers to accessing care, and therefore require targeted interventions. Research by WHO suggests that in many developing countries neither health policies nor broader development strategies are explicitly designed to address the health needs of the poor (2)⁴. The result is that the poor continue to shoulder a disproportionate burden of ill-health and to be excluded from health care. This in turn perpetuates inequality between the poor and the better off.

The strategies presented here are deliberately broad and non-prescriptive. This is for two reasons. Firstly, WHO believes that to a large extent health policy must be determined by the local context. Secondly, very little hard evidence exists on what works to protect, restore and maintain the health of the poor. Some work has been done by WHO (3) and the World Bank (4), and that has been drawn on here, but in general the technical detail of policy is missing. Perhaps the most important conclusion of this document is that the learning has to be done through action and innovation in the field.

Participation

Poor people have the right to participate in processes that affect their lives. *Voices of the Poor* shows clearly that this right is realizable B poor people are fully capable of analyzing their problems and suggesting solutions. Poor people frequently complain that they are not consulted and not respected, leaving them powerless and voiceless.

Strategies are needed to involve poor people and their representatives in the design, implementation, monitoring and evaluation of policies and programs that affect health. These will not only provide valuable information about the problems facing poor people, thereby helping to ensure that projects are appropriate, but also, and more fundamentally, they will help to empower the poor and alleviate feelings of shame and isolation – themselves causes of ill-health.

“Poor people” cannot be treated as a homogenous group. Gender, age, culture and ethnicity all affect health needs, perceptions of health and ill-health, and access to and experience of health services. Therefore, participation processes should be tailored to meet the needs of different groups, in particular women, indigenous people and the poorest of the poor.

Another important finding to emerge from *Voices of the Poor* is that poor people’s values, networks and support mechanisms are being eroded by the strain of increasing poverty and urbanization. This affects the way that poor people cope with health. In order to facilitate participation – and support the mechanisms

⁴ Preliminary findings from a WHO study of national policies on health and poverty reduction found that the majority of health policies have no explicit concern for poverty. The majority are concerned with improving overall health gains, without concern for the distribution of those gains.

through which people handle ill-health – ways should be sought to support and strengthen poor people's groups and networks.

Improving the health of the poor

1. Understanding health within a broad development framework

Poverty and ill-health are inseparable. In 127 case studies in *Voices of the Poor* which examine why families have fallen into poverty, ill-health emerges as the single most common trigger for the downward slide. Individual testimonies reflect this finding – ill-health is perceived both as a cause of increased poverty and as an obstacle to escaping it.

Illness can reduce household savings, lower learning ability, reduce productivity and lead to a diminished quality of life, thereby creating or perpetuating poverty. The poor, in turn, are exposed to greater personal and environmental risks, are less well nourished, have less information, and are less able to access health care. They are therefore more at risk of both illness and disability.

The other side of the coin – that improving health can prevent or offer a route out of poverty – has been given less attention. Evidence now shows that better health translates into greater, and more equitably distributed, wealth by building human and social capital and increasing productivity. A healthy workforce not only produces more, but also saves more. Healthy children are better able to learn. Healthy families tend to have fewer children, and better birth spacing.

The inextricable links between health and poverty suggests that health (and other social objectives) should be placed at the center of the policy-making process, rather than seen as by-products to improvements in overall economic performance. This requires, among other things, that spending on health and other social sectors should be recognized as an investment. Policies – such as social safety nets – are also needed to protect the poor both from the impoverishing effects of ill-health, and from economic “shocks” which can deepen poverty and in turn worsen health status. These shocks include loss of income due to unemployment, loss of assets (for example, because of a natural disaster) and currency devaluation.

Most fundamentally, it is important to ensure that the benefits of economic growth are delivered equitably – there can be no real progress on poverty reduction, or improvement in health outcomes, unless economic and social inequities are tackled.

One important element of putting health at the center of development processes is improving cross-sectoral action between health and other sectors, including (but not limited to) education, finance, labor, trade, agriculture and environment. Limited resources may mean that health ministries need to priorities, that is, to work first and foremost with those sectors that have the greatest impact on health in their country. In many countries, the capacity of ministries of health to analyze

cross-sectoral links and to take cross-sectoral initiatives is low, and may need to be strengthened.

2. Revitalizing public health

In identifying the causes of their ill-health, poor people point to issues traditionally covered by public health – poor nutrition (in particular), dirty water, poor sanitation, inadequate housing and pollution. These issues require urgent attention – in low-income countries, just 46 per cent of people have access to sanitation facilities (5), and one in three children under five in the developing world (nearly 182 million) are stunted as a result of poor nutrition.

Poor people also identify a number of other causes of illness which extend beyond the customary domain of public health. These include unemployment, exhaustion from overwork, domestic violence, isolation (particularly for old people) and the breakdown of social networks.

While the link between economic poverty and poor health is indisputable, it is possible to make significant improvements in the health of the poor without raising per capita income. This requires improvements in (and improved access to) basic public services, such as clean water, sufficient and safe food, decent housing and adequate sanitation, and improved education for girls and women.

In many countries, public health is in disarray. It is typically under-funded and poorly staffed, and wrongly regarded as marginally important compared to health care delivery services. In practice – and partly because of the way that aid is delivered – public health programs have evolved into a number of uncoordinated vertical programs, each working individually and without an overall understanding of the country's public health needs.

Health ministries are best placed to take the lead in advocating improvements in public health services. Information on how poverty-focused investments in basic services can improve health will greatly aid this process.

Efforts to revitalize public health must not lose sight of the importance of focusing on poverty. Traditionally, public health has aimed to improve the health of the majority, without regard to whether benefits are reaching the poorest sectors of society. The goal of modern public health should be to improve the health of whole populations, *with a focus on the poorest groups*. In other words, to address the inequity in health status between rich and poor.

3. Making sure that health systems serve the poor and protect them from impoverishment

More often than not, health services fail those who need them most – the poor. Poor people have nowhere to turn when faced with serious illnesses. The most

frequent complaints are that services are far away, access to care is prohibitively expensive, and health staff are rude and unprofessional. Women face particular difficulties – they are often less able to travel and have the least resources for accessing care.

WHO's experience suggests that poor people will be effectively excluded from health care unless services are geographically accessible, of decent quality, fairly financed and responsive.

Most basically of all, services must exist in the places where poor people live. Many countries already recognize that they need to expand health services in poor communities, for example, through outreach services. What is needed is a reallocation of resources to favor peripheral areas over urban ones, and basic health care over tertiary care.

Health services must also be affordable. Poor people already pay a lot, both in fees and for the indirect costs of health care, including unofficial "fees" (corruption), transport, medicines and loss of income. *Voices of the Poor* suggests that there are many cases where free services do not benefit the poor; for example, because of corruption which results in free medicines being sold, and doctors diverting patients to private practice. However, other studies show that even very small charges deter poor people from using health services.

The challenge is to create health services that are affordable both for the poor and the state. There is a great need for innovation in financing mechanisms to provide poor people with financial protection against catastrophic illnesses and injury, and to ensure that no obstacles block their timely access to services. Approaches must aim to draw on and build community solidarity, for example, by allowing for payments in kind and payments when resources are available (such as at harvest time). Micro-insurance schemes, such as those run by SEWA (Self-Employed Women's Association) in India, provide important experience to build on. As a basic principle, fees should never cause further impoverishment.

Ensuring that the poor have access to health care requires that health systems are financed by pre-payment schemes. This is the norm in high-income countries, but in low-income countries out-of-pocket spending can account for 40 per cent of total health financing (6). Out-of-pocket spending clearly disadvantages the poor, who are most likely to be ill and injured, and least able to afford health care. The type of pre-payment scheme must be determined by local conditions. A general taxation scheme is most desirable, as this involves the greatest pooling of risk, but this is institutionally very demanding and can be unworkable in countries with large informal economies. Social insurance, voluntary private insurance schemes, and community insurance schemes are alternatives used in poor countries.

As well as being accessible and affordable, health services must be of decent quality. This means not only offering a good standard of care, but also reducing waiting times, making medicines available, and treating patients with respect.

One of the most important findings to emerge from *Voices of the Poor* is that the attitudes of health staff to the poor are frequently appalling, and this is a deterrent to seeking care. This is a problem often neglected by health policy. Strategies to tackle it must include improving staff capabilities, motivation and working conditions; for example, by improving the selection of staff, improving training, and, crucially, ensuring that decent salaries are paid on time. Providing incentives – such as a hardship allowance – will also help to improve the availability of quality staff in poor areas. Co-management of health services with communities can also provide incentives to shift the behavior of health care providers.

Specifically, it is also important to improve staff attitudes towards poor people and their treatment; for example, by promoting listening skills, and instilling in staff the idea that poor people have a right to health care and to be treated with dignity. Systems to monitor staff behavior, and channels through which poor people can complain, may also be appropriate in many countries.

Implementation of all these strategies must take into account the specific and special needs of women, in particular, and sub-groups of the poor such as indigenous people. Indigenous people are typically discriminated against by health staff, who may not understand their culture or even their language. Women may be reluctant to seek care from male doctors.

Equally, strategies to improve health services are much more likely to be successful if poor people are involved. Processes to decentralize the management of health services – underway in many countries – provide an excellent opportunity for this. Policies such as co-management and community-based monitoring of health services can greatly improve their effectiveness, as well as their responsiveness to poor people's needs.

4. Focusing on poor people's health problems

WHO research suggests that a small number of conditions affect poor people disproportionately. These include communicable diseases (specifically TB, HIV/AIDS and malaria), childhood illnesses (e.g., measles, polio), and reproductive health problems.

While *Voices of the Poor* does not tend to detail the specific illnesses of the poor, it makes clear that bodily afflictions and illnesses are a major concern among poor people. This insecurity around bodily well-being adds to poor people's mental anguish and stress. When talking about ill-health, both men and women also focus on mental and psychological ill-health – such as the mental stress caused by poverty, powerlessness and discrimination.

Voices of the Poor points to a serious gap in our understanding of poor people's mental health problems, particularly in developing countries⁵. Even less is known

⁵ WHO's Department of Mental Health and Substance Dependence has recognised the importance of the link between mental illness and poverty and one of the four topic areas for discussion at the ministerial round tables in the World Health Assembly in May 2001 was devoted to a discussion on 'Mental Health and Socio-economic Factors',

about how to treat such problems: almost all research on the efficacy of mental health treatments – either pharmacological or psycho-social – is based in developed countries, and little work has been done to test the applicability or appropriateness of such treatments to developing countries.

Strategies are needed to ensure that the health services and interventions offered to poor communities are comprehensive, and maintain a balance between addressing physical and mental health problems. Individual interventions and programs to tackle specific diseases should be integrated as much as possible, both with each other and with health systems, to avoid unsustainable “vertical” programs.

CONCLUSION

There is growing recognition in both international and national health policy of the centrality of health to economic and social development and poverty reduction. Indeed – many of the conclusions and suggestions made above are reflected the health policies and plans of developing country governments and developed country donors. But in all but a handful of cases this recognition is not being translated into practice.

Action is needed. Detailed, cross-sectoral policies on how to improve the health of the poor need to be developed. Poor people’s participation in policy development and implementation must remain central. And poor countries and international donors must mobilize the necessary resources to deliver improved health. Governments around the world must respond to the demands of poor people, who are crying out for better health – and dying for change.

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(WHO/NMH/MSD/WHA/01.3). However, in general it recognised that the relationship between poverty and ill-health needs further research and discussion.