POVERTY AND ITS IMPACT ON HEALTH: CASE STUDY OF TALUKA MANJHAND

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ABSTRACT

Present study is designed to analyze relationship between poverty and health. It has been rightly said that poverty is a mother of all social evils. Poverty is a major social problem of Pakistan. It has adverse effects on health. For the study of this problem a survey method was used to collect data. A questionnaire was administrative in 35 villages of Taluka Manjhand. The related literature is carefully reviewed and incorporated in this paper. Results and conclusions are drawn from primary data which are presented in frequency and percentage based tables and diagrams are used to make data more understandable. On the basis of conclusion some suggestions are forwarded to improve the situation.

Keywords: Poverty, Health and Hygiene, Environment, Development.

INTRODUCTION

More than a billion people in the world do not have access to safe drinking water, a basic necessity of life. In Pakistan alone, 38.5 million people lack access to safe drinking water and 50.7 million people lack access to improved sanitation, Water borne diseases are responsible for 60% of the total number of child mortality cases in Pakistan, with diarrheal diseases causing deaths of 200,000 under-five years' children, every year. Unsafe drinking water is shown to lead to poverty through time spent by women and girls to fetch 'drinkable' water from long distances. The combination of unsafe water consumption and poor hygiene practices require treatments for water borne illnesses, decreased working days, and also contribute to lowering of educational achievement due to reduced school attendance by children.

Like all other developing or less developed countries of world Pakistan is faced with the social evils of poverty, ill health status, high mother mortality rate and high infant mortality rates.

In Pakistan 58.7 million people are living below the poverty line 33% of that is living in Sindh (Daily *Times*, 20 November, 2014). According to World Bank Report 2013 in Pakistan 60% of population is living in below poverty line.

CONCEPT OF POVERTY AND ILL-HEALTH

Concept of poverty is defined in number of ways. There are various approaches which have been used to define poverty. According to Calori-based approach one who is unable to take certain amount of calories can be considered as proper. The required amount of calories is 2350 minimum number of calories in take per person per day. That is minimum level of nutrition intake that one must have to live a healthy life in Pakistan.

Second definition of poverty at international level is 2 dollar a day (200 rupees), but PLSM survey report 2012-2013 indicates that in Pakistan population is living 1.25 dollar a day, which means below the poverty line. With this trend this is very hard for Pakistan to achieve millennium development goal by 2015. High mother mortality rate, infant mortality rate and low literacy rate in Pakistan are showing very horrible picture of country (Daily *Times*, November 20, 2014).

The concept of Health is defined as a state of mental and physical well-being of body.

According to World Health Organization's definition of health, it is a state of complete physical, mental, social well-being and not merely absence of disease or infirmity.

Pakistan Demographic and Health Survey Report 2012-13 has uncovered the facts about Pakistan are as under:

Fertility rate:	3.8
Crude death rate:	25.7
Infant Mortality rate:	74 deaths per 1000 live births
Vaccination immunization (EPI):	92% Polio, 65% DPT, 61% measles, (48% in rural and 66% urban)
Assistance to doctor during delivery	44% rural, and 71% urban mothers

OBJECTIVES OF THE STUDY

Main objective of this research paper is to analyze the relationship between poverty and ill-health. Specific objectives are listed below:

- To know the extent of poverty in villages of Majhand taluka.
- To analyze the health of people in villages of Majhand taluka, and,
- To explore the link between poverty and health of people.

HYPOTHESIS

- Poverty causes low health status.

RESEARCH METHODOLOGY

Survey research is designed. Universe of study is selected 2 union councils Majhand taluka District Jamshoro. The 35 villages were selected randomly from the list of villages. In order to give equal chance of representation samples were taken from each village based on number of people and houses in village. Structured questionnaire was administrated to collect primary data.

Data is presented in simple frequency & percentage based tables along with diagrams.

SURVEY OF LITERATURE

UNDP Report 2012-13 on poverty reveals the facts that more than half of the population of Pakistan is destined with condition of poverty. Pakistan's budget allocation on social sector, especially on health is not enough that is0.8% of total GDP. (*The Express Tribune*, March 29, 2013).

Poverty and poor health status are intertwined, poverty causes poor health status and poor health begets poverty, poor are unable to afford the healthy nutrition and medicines. Healthy population is essential for the development of nation (Grant, 2005).

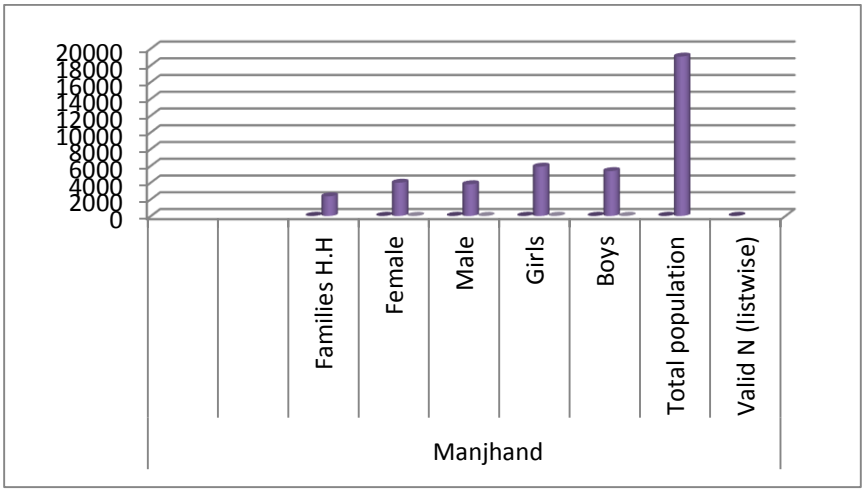
Poverty causes ill health at individual as well as at community level. Low income families confirm ill health status, especially long lived poverty conditions have hazardous impacts on health (Phipps, 2003).

Children belonging to low income families comparatively have more incidences of ill health and mortality because low income mothers give birth to low birth weight infants. Where there is poverty there is also less educated mothers, low nutrition intake and faulty infrastructure. Environmental and social conditions of a person or community are directly linked to their social class (Barbara Starfield, M.D., & M.P.H., 1992).

In all the developing countries poverty is major hurdle in the way of improving issue of health. Doctor's team can do nothing until the issue of poverty is not resolved. World health organization's reports reveal the fact that countries having increasing trend of poverty assures the increasing trend of mortality rate. Children are not vaccinated, mother mostly die in delivery cases because of not having access to hospitals.

TABLE-1
STATISTICAL ANALYSIS OF POPULATION

Union Council Manjhand	N	Sum	%
Families H.H	35	2349	
Female	35	3980	21
Male	35	3799	20
Girls	35	5896	31
Boys	35	5368	28
Total population	35	19043	
Valid N (list-wise)	35		



Source: Field Work.

Above table and diagram shows demographic features of universe studies. Total population was 19043 in 35 villages. 2349 number of households, total number of females 3980, total number of males 3799, total number of boys 5368 , total number of girls 5896.

TABLE-2
POVERTY

Descriptive Statistics				
Union council		N	Sum	Mean
Manjhand	Ultra poor	13	90	6.92
	Valid N (list-wise)	13		

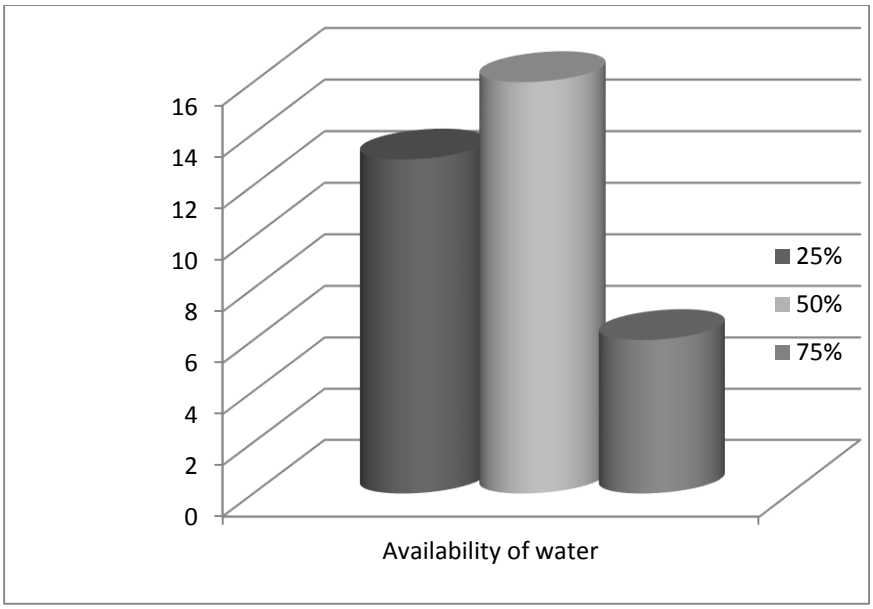
Source: Field Work.

Table indicates the poverty in Manjhand; it can be analyzed from the facts that in Union Council, Manjhand each 6th person is ultra-poor out of total population.

TABLE-3
WATER AVAILABILITY

Union Council			Frequency	Percent
Manjhand	Valid	25%	13	37.1
		50%	16	45.7
		75%	6	17.1
		Total	35	100.0

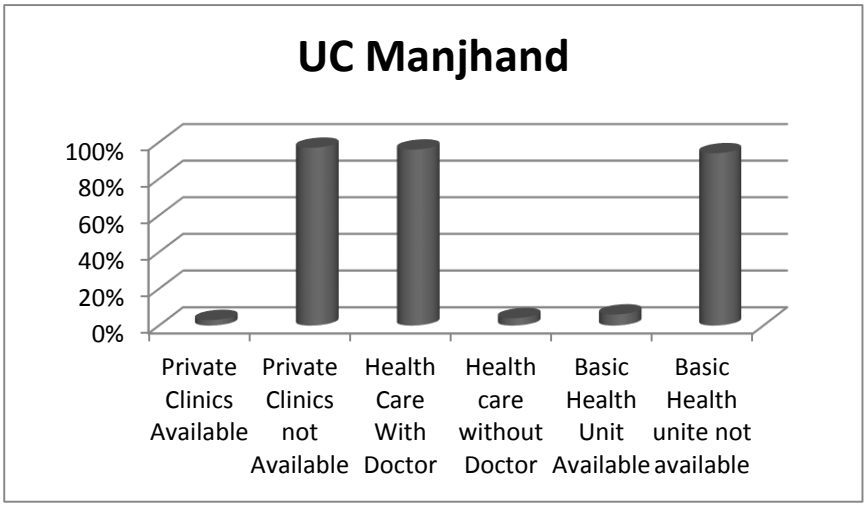
Source: Field Work.



Above table and diagram denotes that in Union Council Manjhad, 37% of the total population has access to 25% water, 45% of village's population has access to 50% water and 17% of the total population has access to 75% water. It is concluded that there is also low access to clean and drinkable water to population.

TABLE-4
HEALTH STATUS

Health Facilities	Union Council Manjhand
Private Clinics Available	3%
Private Clinics not Available	97%
Health Care With Doctor	96%
Health care without Doctor	4%
Basic Health Unit Available	6%
Basic Health unite not available	94%

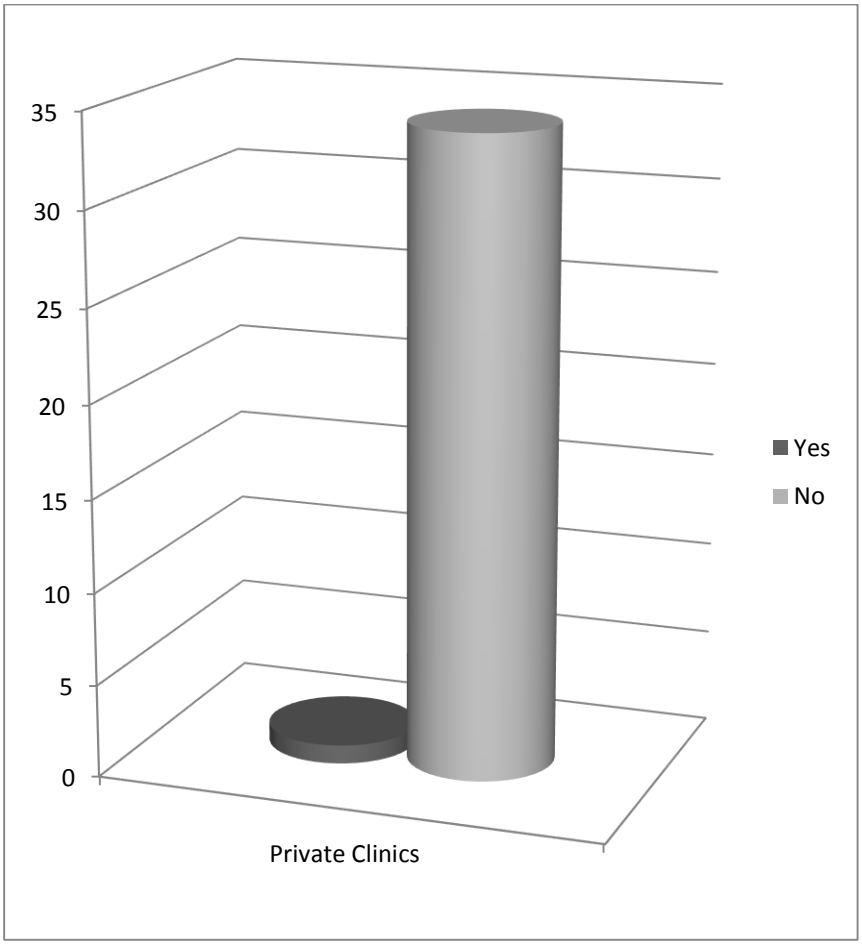


Source: Field Work.

Above table and diagram elucidates the availability of health services to population in Manjhand, and results are 3% private clinics are available and 97% private clinics are not available; health care with doctor 96% and health care without doctor 4%; basic health units available 4% and basic health units not available 96%.

TABLE-5
PRIVATE CLINIC

Union Council			Frequency	Percent
Manjhand	Valid	Yes	1	2.9
		No	34	97.1
		Total	35	100.0

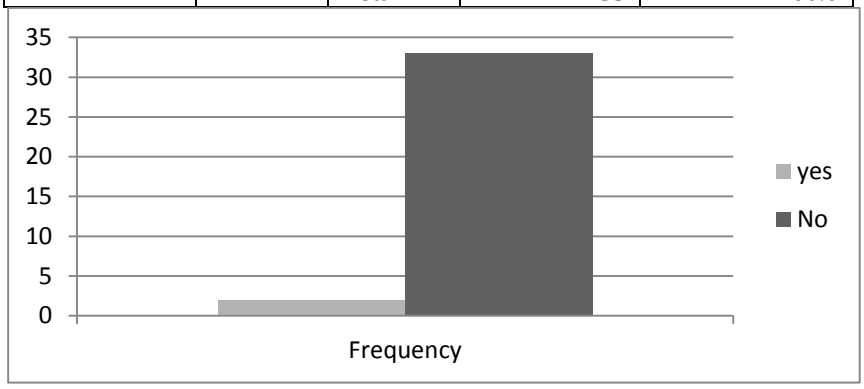


Source: Field Work.

Table and diagram shows the availability of private clinics that is 2.9% and private clinics not available are 97.1%.

TABLE-6
PRIMARY HEALTH CARE WITH DOCTOR

Union Council			Frequency	Percent
Manjhand	Valid	Yes	2	5.7
		No	33	94.3
		Total	35	100.0

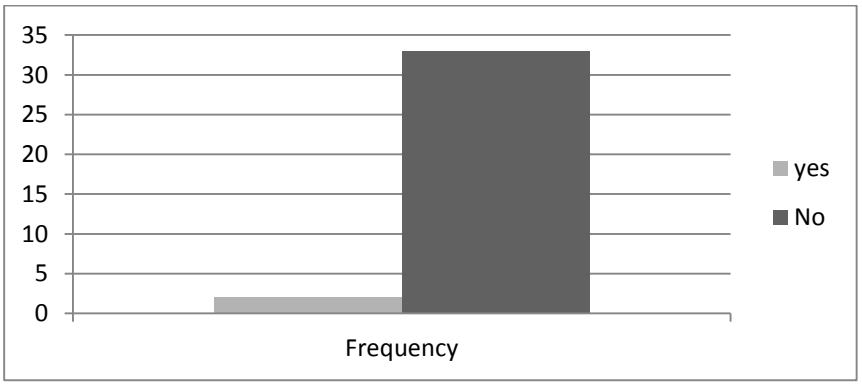


Source: Field Work.

Table indicates that people in take help of doctors for their primary health care in Majhand 5.7% and those who do not consult doctor are 94.3%.

TABLE-7
BASIC HEALTH UNIT

Union council			Frequency	Percent
Manjhand	Valid	Yes	2	5.7
		No	33	94.3
		Total	35	100.0



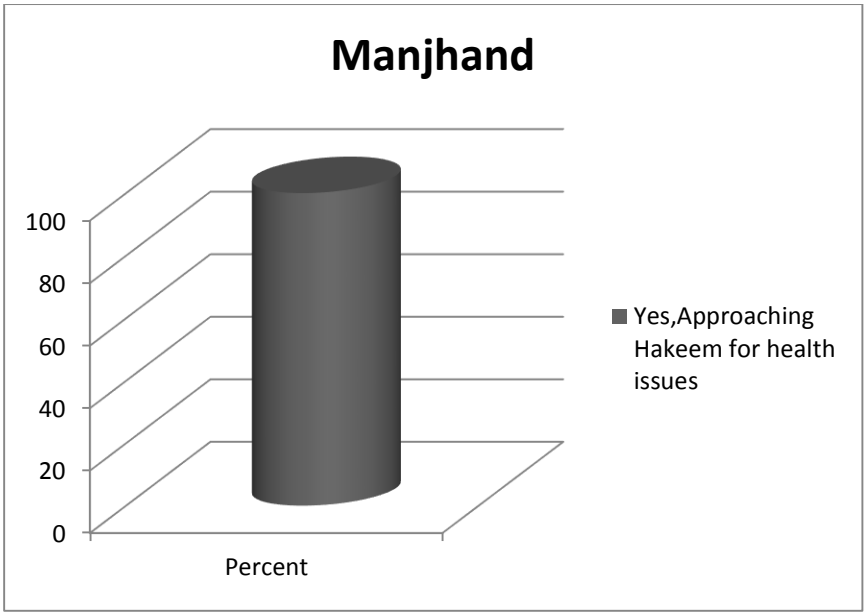
Source: Field Work.

This table indicates availability of basic health units, 5.7% population have availability of basic health units, whereas majority of population that is 94.3% do not have this facility.

TABLE-8

CONSULTATION WITH HAKEEM IN HEALTH ISSUES

Union council		**Frequency**	**Percent**
Manjhand	Valid No	35	100.0



Source: Field Work.

Table indicates traditional use of Hakeem for health issues in Manjhand and it is observed that all the population is approaching Hakeem for health issues.

DISCUSSIONS

Study indicates that in Union Council Manjhand of Jamshoro District and Sindh Province every 6th person is living below the poverty line. Only 17% people have access to the drinking water. There is a gap between the availability of water and population. The study shows that 50% drinking water is available for 45.7% of total number of people. This trend clearly shows that drinking water is not available to sufficient number of people. Basic health care centers and private clinics are also not available in sufficient number. It is found that the majority of people go for health care consultation with Hakeems. Poverty and ill-health status are intertwined. Low budget allocation on social sector and non-

availability of health facilities at community level causes ill health status among people. Studies conducted by Grant, 2005 *et.al.*, Phipps, 2003 *et.al.*, confirms the similar trends.

CONCLUSION

Macro level as well as micro level analysis of data on poverty and poor health statuses has revealed a close connection between both variables. Non availability of clean water, lack of medical facilities, illiteracy is resulted from mass poverty and generates ill health. In researched areas people do not have access to clean water, have less infrastructural facilities, health units are not available, and people mostly take local medication(Hakeem)and suffers from ill health. At micro level people are unable to afford the travelling expenses, private doctor's fees and medicines and suffer from ill health. Healthy nutrition is must for healthy life, and poor due to poverty are unable to take healthy diet.

Study concludes that in Sindh and research area Manjhand due to mass poverty people suffer from ill health. Until or unless issue of poverty is not resolved many other social evils and health status cannot be improved.

SUGGESTIONS

- In order to control poverty and to improve health conditions, government needs to allocate more funds for social sector, especially for health and education. Besides, new jobs should be created, and industrialization should be promoted to deal with the issue of poverty and unemployment.
- Health units should be established in villages so that small communities can benefit. People cannot afford expensive on long journeys. Thus, they should be provided with medical facilities in their villages.
- Staff should be appointed purely on merit basis.
- Basic medication should be free in health units. Basic health units should be provided with latest equipment and necessary facilities.

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