RJPSSs June 2019, Vol. XLV, No.1, ISSN: (P) *0048-7325 (e) 2454-7026*, Impact Factor 6.763 (SJIF)

# A Study on Poverty and Health in India

**Dr.Gouri Manik Manasa**

*Assistant Professor, Dept of Social Work, Vijayanagara Sri Krishnadevaraya University, Ballari, Karnataka*

*Email: drmansa_social@yahoo.com*

***Abstract***

*Poverty and health the poor suffer worse health and die younger. They have higher than average child and maternal mortality, higher levels of disease, more limited access to health care and social protection, and gender inequality disadvantages further the health of poor women and girls. For poor people especially, health is also a crucially important economic asset. Their livelihoods depend on it. When a poor or socially vulnerable person becomes ill or injured, the entire household can become trapped in a downward spiral of lost income and high health care costs. The cascading effects may include diverting time from generating an income or from schooling to care for the sick; they may also force the sale of assets required for livelihoods. Poor people are more vulnerable to this downward spiral as they are more prone to disease and have more limited access to health care and social insurance. The DAC Guidelines on Poverty Reduction present a practical definition of poverty, placing it in a broader framework of causes and appropriate policy actions. The five core dimensions of poverty reflect the deprivation of human capabilities: economic (income, livelihoods, decent work), human (health, education), political (empowerment, rights, voice), socio-cultural (status, dignity) and protective (insecurity, risk, vulnerability). Gender inequality is a major determinant of poverty and ill health. Poor women and girls are worse off, in relation to assets and entitlements, within the household and in society. Socio-cultural beliefs about the roles of men and women contribute to this inequality. Poor women and girls may experience even deeper disadvantage in access to resources for health, such as cash and financing schemes, services, and "voice". Some categories of women and children are especially vulnerable for example elderly widows, unsupported female and child-headed households, and street children. Women are also major producers of health care through their roles as household managers and carers. But the health, including the reproductive health, of poor women and girls suffers from inadequate nutrition, heavy workloads and neglect of basic health care, factors aggravated by exposure to sexual abuse and interpersonal violence. All have a serious effect on human development and the formation of human capital. Action on gender inequalities is therefore an essential element of a pro-poor approach to health.*

**Keywords:** children, women, health,poverty, poor, development, India.

Reference to this paper should be made as follows:

**Received: 12.03.2019**
**Approved: 16.06.2019**

**Dr.Gouri Manik Manasa ,**
*A Study on Poverty and Health in India ,*

*RJPSSs 2019, Vol. XLV, No. 1, pp. 19-27*

*Article No.3*
**Online available at:**
http://
rjpsss.anubooks.com/

## Introduction

Health is now higher on the international agenda than ever before, and concern for thehealth of poor people is becoming a central issue in development. The nations of the worldhave agreed that enjoying the highest attainable standard of health is one of thefundamental rights of every human being without distinction of race, religion, political belief and economic or social condition.**1 Beyond its intrinsic value for individuals, improvingand protecting health is also central to overall human development and to the reduction of poverty.**

The Millennium Development Goals (MDGs), derived from the UN Millennium Declaration,commit countries to halving extreme income poverty and to achieving improvements inhealth by 2015.**2 three of the eight goals are health-related, calling for a two-thirds reduction in child mortality, a three-quarters reduction in maternal mortality, and a halt to the spread of HIV/AIDS, malaria and tuberculosis**. In addition the eighth goal, redeveloping a global partnership for development, calls for developing countries to haveaccess to affordable essential drugs..

## Poverty and health

The poor suffer worse health and die younger. They have higher than average child and maternal mortality, higher levels of disease, more limited access to health care and social protection, and gender inequality disadvantages further the health of poor women and girls. For poor people especially, health is also a crucially important economic asset. Their livelihoods depend on it. When a poor or socially vulnerable person becomes ill or injured, the entire household can become trapped in a downward spiral of lost income and high health care costs. The cascading effects may include diverting time from generatingan income or from schooling to care for the sick; they may also force the sale of assets required for livelihoods. Poor people are more vulnerable to this downward spiral as they are more prone to disease and have more limited access to health care and social insurance Gender inequality is a major determinant of poverty and ill health. Poor women and girls are worse off, in relation to assets and entitlements, within the household and in society. Socio-cultural beliefs about the roles of men and women contribute to this inequality. Poor women and girls may experience even deeper disadvantage in access to resources for health, such as cash and financing schemes, services, and "voice". Some categories of women and children are especially vulnerable – for example elderly widows,unsupported female- and child-headed households, and street children. Women are also major producers of health care through their roles as household managers

and cares. But the health, including the reproductive health, of poor women and girls suffers from inadequate nutrition, heavy workloads and neglect of basic health care, factors aggravatedby exposure to sexual abuse and interpersonal violence. All have a serious effect on human development and the formation of human capital. Action on gender inequalities is therefore an essential element of a pro-poor approach to health.

**Research Methodology:**

This is a descriptive research paper, where secondary information produced by different authors and researchers has been used. For obtaining necessary information, various books, journals as well as websites have been explored by the researcher which has been mentioned in the reference section.

**Objectives;**

- To assess the poverty and health for women and children.
- To assess the block ward peoples condition and problems
- To assess the policy for women and children

**Programs That Mitigate the Effects of Poverty on Children;**

poverty can increase children's exposure to a wide array of problems including inferior housing, insufficient food and poor-quality diets, deficient health care, inadequate parenting, and poor-quality childcare, and result in delayed physical, cognitive, and socioemotional growth. A wide array of assistance programs and policies aid low-income households with children by providing either cash assistance payments or inkind benefits to meet specific needs. This article reviews the effectiveness of several in-kind assistance programs in mitigating the impact of poverty on children. In addition, a number of programs, discussed in the article byRobert Plotnick in this journal issue, attempt to reduce the prevalence of poverty through increased earnings, public cash transfers and tax credits, and private cash support from absent parents. The programs selected for this review comprise only part of a public safety net for children and their families and include large federally funded programs known to have effects on children, either because they are targeted directly to children or because benefits to low-income households with children account for a significant component of program expenditures.In general, the programs selected for review are also those designedto reduce the negative effects of poverty in such fundamental areas as food,Shelter, and health care.

**The Special Supplemental Food Program for Women, Infants, and Children (WIC)**

The Special Supplemental Food Program for Women, Infants, and Children

(WIC) started as a two-year pilot program in 1972 in response to growing concern about evidence ofmalnutrition and related health problems among low-income pregnant women and children. Over the years, WIC has expanded and now serves almost seven million women and children per month. WIC focuses on the special nutritional needs of low-income pregnant women, infants, and children, based on the assumption that insufficient nutrition during these criticaldevelopment periods may result in adverse health outcomes. Million women and children per month. WIC participants must satisfy the eligibility conditions listed in Table 1. The WIC program provides three main benefits to participants: (1) vouchers for specific supplemental foods; (2) nutrition education;and (3) referrals to health care and social service providers. The foods target specific nutrients—protein, vitamins A and C, calcium, and iron. Nutrition education in the WIC program focuses on the relationshipbetween nutrition and health, assists participants to make positive changes in eating habits, and considers ethnic, cultural, and geographic food preferences. WIC providers also advise clients about types of health care,accessible locations of health care, and the utility of health care, However, WIC is expected to beonly supplemental to the FSP and is not an entitlement program. Participation in WIC is limited by federal funding levels, which have never been adequate to serve all eligible applicants. Federal regulations specifythat a waiting list of eligible applicants be maintained. As program openings becomeavailable, a priority system, which gives priority to pregnant and breast-feeding women and infants over children, fills these openings from the waiting list.

**Integrating poverty and gender into health programmes-Module on nutrition;**

Health and nutrition indicators. It is veryimportant for programme planners to selectappropriate indicators during the programmeplanning process. To obtain a more completepicture of the nutritional situation in the country,and to identify the most vulnerable and at-riskgroups, it is suggested that indicators, wherepossible and reasonable, be disaggregated by sex,income level, rural-urban residence, and ethnicity.

- Infant mortality rate
- Under-five mortality rate
- Percentage of newborn infants with LBW
- Percentage of mothers attending antenatalclinics who have gained at least 6 kg duringpregnancy
- Percentage of children stunted (under 5 yearsold)
- Percentage of children severely underweight
- Percentage of children moderatelyunderweight

- Percentage of children in growth promotionprogrammes gaining sufficient weight (as perage) (over specified amount of time)
- Micronutrient indicators (specific cut-offand deficiency signs to be determined byeach project)
- Percentage of targeted population with irondeficiency by age
- Percentage with signs of night blindness (orBitot spots) vitamin A deficiency by age
- Percentage with signs of iodine deficiency byage
- Percentage of affected population receivingsupplementation (as relevant, ferrous sulfate,vitamin A, iodine oil solution)
- Percentage of mothers with low BMI
- Percentage of mothers with low BMIreceiving nutrition counseling and/orsupplementary foods
- Percentage of 0–6 month olds exclusivelybreastfed
- Percentage of mothers who introducedcomplementary foods to their child before 9months (out of all mothers interviewed withchildren 6 to 23 months old)
- Percentage of school-age children,adolescents and adults with overnutrition
- Number of meals received per child perschool year
- Percentage of children who received a mealeach day

**National health policy -2017;**

The policy proposes a potentially achievable target of raising public health expenditure to 2.5% of the GDP in a time bound manner. It envisages that the resource allocation to States will be linked with State development indicators, absorptive capacity and financial indicators. The States would be incentivized for incremental State resources for public health expenditure. General taxation will remain the predominant means for financing care. The Government could consider imposing taxes on specific commodities- such as the taxes on tobacco, alcohol and foods having negative impact on health, taxes on extractive industries and pollution cuss. Funds available under Corporate Social Responsibility would also be leveraged for well-focused programmes aiming to address health goals.

- **Preventive and Promotive Health**

The policy articulates to institutionalize inter-scrotal coordination at national and sub-national levels to optimize health outcomes, through constitution of

bodies that have representation from relevant non-health ministries. This is in line with the emergent international "Health in All" approach as complement to Health for All. The policy prerequisite is for an empowered public health cadre to address social determinants of health effectively, by enforcing regulatory provisions.

Ø **The policy identifies coordinated action on seven priority areas for improving the environment for health:**

- o TheSwachh Bharat Abhiyan
- o Balanced, healthy diets and regular exercises.
- o Addressing tobacco, alcohol and substance abuse
- o Yatri Suraksha – preventing deaths due to rail and road traffic accidents
- o Nirbhaya Nari –action against gender violence
- o Reduced stress and improved safety in the work place
- o Reducing indoor and outdoor air pollution

The policy also articulates the need for the development of strategies and institutional mechanisms in each of these seven areas, to create Swasth Nagrik Abhiyan –a social movement for health. It recommends setting indicators, their targets as also mechanisms for achievement in each of these areas. The policy recognizes and builds upon preventive and promotive care as an under-recognized reality that has a two-way continuity with curative care, provided by health agencies at same or at higher levels.

**Improving the health of the world's poorest people;**

In developing countries, millions of people suffer from avoidable health problems—such as infectiousdiseases, malnutrition, and complications of childbirth—simply because they are poor. Wide differences in health status between poorer and better- off people are often avoidable and unfair, reflecting different socioeconomic constraints and opportunities rather than different individualchoices. And while governments have made strides in improving public health over the last severaldecades, many initiatives to improve the health of the poorest people have been unsuccessful.In recent years, new research has become available on health inequalities in developing countries. These studies shed light on how the world's poorest people are faring, demonstrating for the most part how persistent and pervasive health inequalities are. Other research has assesseda variety of approaches to reducing health inequalities, including reforms in the way health care isfinanced and organized,

improvements in thequality and accessibility of services, and broadercommunity development.

**Approaches That Benefit the Poor;**

Researchers generally agree that effective responsesto health disparities can be found in many sectors,including health, education, finance, environment,agriculture, transportation, labor, and othersectors. A range of interventions, if carefully designed, can work toward reducing inequalitiesin health and health care.

- **Enacting Pro-Growth and Pro-Poor Policies**

  Often, rising incomes means growing inequalities, as the rich benefit more from technologicalchange than the poor. To counter this effect, policiesthat promote economic growth should beaccompanied by social policies in areas such aseducation, labor, and primary health care, and byspecial measures to ensure that the benefits of programs

  Flow to the poor.

- **Investing in Education**

  Education (especially universal primary education)helps reduce health inequalities because it enablespeople to obtain safer, better jobs, have betterhealth literacy, take preventive health care measures,avoid riskier health behaviors, and demandmore and better-quality health services.

- **Directing More Health Benefits Toward the Poor**

  Because the poor tend to use health services lessthan the rich, public health programs may use"targeting" strategies to direct more benefitstoward the poor. These strategies may identifywho is poor and therefore eligible for certain benefits,or they may direct programs toward certainareas where poorer people live, or address specifichealth problems that the poor tend to suffer.Programs using multiple approaches may be mosteffective.10 In places where governments chargeuser fees for public health services, the ability toadminister waivers or sliding-scale fees is critical tothe success of directing benefits toward the poor.

- **Promoting Primary and Essential Health Care**

  he "essential services" approach means providinga basic package of cost-effective healthServices to everyone. Though financed by thegovernment, private-sector health providers maydeliver the services.

- **Increasing the Availability and Quality ofHealth Services**

A common prescription for health systems is todirect more resources toward primary-level facilitiesand care, to increase and strengthen these servicesso that more people in neglected areas can benefit.

- **Developing Public-Private Partnerships**

  Since many nongovernmental organizations(NGOs)already work closely with the poor, governmentsmay opt to support them to deliver health servicesto poor and vulnerable segments of society.

- **Mobilizing Community Resources**

  Recent projects in India and Ghana have mobilizedcommunity resources in innovative ways toimprove the health of the poor. These approacheshave included intensive training of communitybasedhealth workers, the involvement of traditionalleaders, and local delivery of services. Some rich poor divide in access to information, technology, and high-quality health care threatens to leave the global poor even further behind.

**Conclusion**

Support for effective national health systems is critical to shift more responsibility to partner countries to design andimplement their health policies and programmes. Capacity building should go beyond the health sector. It requires viewing pro-poor health approaches in a larger context of political and economic restructuring, fiscal policy, administrative reform and the strengthening of participation and democratic systems. All these areas if investments in health and poverty reduction are to be sustainable.

**References**

1. Constitution of the World Health Organization (1948) date; 11-10-2018 time 11:00am
2. WHO (2001), *Macroeconomics and Health: Investing in Health for Economic Development,* Report of theCommission on Macroeconomics and Health, WHO, Geneva date: 12-10-2018 time:12:00 pm .
3. Ohls, J., and Beebout, H. **The Food Stamp Program: Design tradeoffs, policy, and impacts**. Washington, DC: Urban Institute Press, 1993, pp **-10-15 .**
4. *Center on Budget and Policy Priorities.* The depth of the food stamp cuts in the final welfare bill. Washington, DC: Center on Budget and Policy Priorities, 1996, pp **5-8**.

5. Trippe, C., and Sykes, J. Food Stamp Program participation rates: January 1992. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis and Evaluation, October 1994, pp- **8-15.**
6. Du S. *et al*. A new stage of the nutrition transition in China. *Public Health Nutrition*, 2002, 5(1A), **16–17.**
7. Adam Wagstaff, *"Poverty and Health Sector Inequalities,"* Bulletin of the World Health Organization 80, no. 2 (2002): pp- **9**.
8. World Health Organization (WHO), The World Health Report 2000—Health Systems: Improving Performance (Geneva:WHO, 2000), accessed online at www.who.int/whr2001/2001/archives/2000/en/contents.htm, on June 3, 2003. Date: 10-10-2018 time: 3:45 pm
9. WHO, *"Macroeconomics and Health: Investing in Healthfor Economic Development*," Report of the Commission onMacroeconomics and Health (Geneva: WHO, 2001). Date: 15-10-2018 time: 11:00 am