

## Health policies and families in poverty: A brief consideration of past, present and future policy initiatives

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While the health of mothers and children has long been of concern to national and international development authorities, as well as non-governmental organizations (NGOs) the lack of a meaningful programmatic focus on the family led to a lack of attention to the health and development needs of *families* living in poverty. Even though the quality of life of many families has greatly improved over the last several decades, as the current economic crisis has spread to developed and developing countries the fragility of progress has been exposed. Hope for progress among the 26% living in poverty<sup>1</sup> may be deferred or threatened as health system deteriorate, food security declines, environments deteriorate and personal security of families is threatened by multiple sources of violence. Many of those among the 1.9 billion in 1981 “who would have escaped” poverty by now<sup>1</sup>, have already inherited the stigmata of poverty from a malnourished mother. As infants suffering from intra-uterine growth retardation are born into poor families they would have had a higher risk of mortality at birth, while those who survived to adulthood, *if they prospered*, have a much higher risk than normal weight infants in suffering from diabetes, hypertension and heart disease. As a consequence countries, such as India, are now experiencing the double burdens of the diseases of poverty and the diseases of prosperity which in large part may have its roots in poverty!

The earliest governmental policies affecting the health and well-being of families were often the consequence of perceived needs in the course of social and economic change, great loss of life in military conflicts and the fears of specific diseases. The policies that emerged were not always “evidence based” nor in the best interests of the family or its members. Nor were they focused on families *per se*, but rather on laws and regulations concerning quarantine and exclusion. These first local or national policies relevant to health were related to movements of populations beginning in the Middle Ages in response to the Black Death (plague), and were subsequently applied to such conditions as leprosy, yellow fever, syphilis, cholera, tuberculosis and trachoma. (Table 1) Individual families were temporarily quarantined at home when specific diseases were diagnosed in a family member. The appearance of signs and symptoms of such diseases as trachoma, tuberculosis, “insanity” or “feeble mindedness” among immigrants in the 19<sup>th</sup> and early 20<sup>th</sup> century were sufficient basis for exclusion of individual family member.

While the origins international policies on health followed the historical memory of the great epidemics of earlier centuries, studies of the cholera epidemic in London by John Snow in 1854 established the scientific foundation for the methods of epidemiology which has become one of the main tools for establishing health policy.

Pro-natal population policies in many European countries can be traced to both the political and military need to re-establish a large healthy adult population after the decimating wars of the 19<sup>th</sup> and early 20<sup>th</sup> century in Europe. At the same time concern for child health emerged as a consequence of the Industrial Revolution and an emerging child welfare movement that was concerned with the abuses of child labour, and the apparent increase in abandoned and orphaned children. Infant and young child mortality suddenly increased to high levels at a younger age in cities in North America, and the industrializing areas of Europe during the 19<sup>th</sup> century following a steady slow decline or stable levels. Part of this increase appeared to be associated with the large numbers of women with children who had recently entered the urban labour market. Infant and child nutritional status deteriorated in part due to working women being

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<sup>1</sup> The old international poverty line of \$1.08 a day in 1993 Purchasing Power Parity (PPP) prices has been updated to a new international poverty line of \$1.25 a day in 2005 PPP prices. Using this new data, a World Bank paper by Martin Ravallion and Shaohua Chen finds that poverty levels across the globe have declined, with 1.4 billion people (one in four) in the developing world living below US\$1.25 a day in 2005, down from 1.9 billion (one in two) in 1981. In other words, global poverty rates fell from 52% in 1981 to 26% in 2005.

unable to breastfeed their infants or provide safe nutritious food to their young children as a consequence of the hours and circumstances of their work. For example, in one Italian town with good data, while the overall infant mortality rate had fallen to 100/1,000 live births in 1900, among women working in the emerging textile factories in 1903- unable to breastfeed and providing animal milk to their infants - it was 682/1,000 live births. With the development of commercial pasteurization machines in the mid 1890s local health and welfare authorities in England, France, Germany and North America were able to organize milk distribution centers in the first decade of the 20<sup>th</sup> century. These centers subsequently expanded to serve as sources of health education in the care of infants and children, nutrition monitoring, and childhood immunization when they became available several decades later in North America, and, after the Second World War, in Europe. Even in the developed countries there is at least a 10 year interval between the establishment of the scientific basis for a policy and the formulation and implementation of the policies.

The empirical and scientific foundations of obstetrics can be traced in part to Soranus of Ephesus (98-138 CE), a Greek physician who practiced in Rome. He described the qualities of the ideal midwife; emphasized and provided a clinically relevant rationale for the psychological and physical needs of the parturient woman, signs of imminent labor and delivery and the management of labour; and elaborated on the essential care of the newborn, including the need for cleansing with warm water, resuscitation, the cleansing of the eyes with olive oil to wash off the thickest moisture – a sign of *ophthalmia neonatorum* which was a major cause of blindness in children, and the many aspects of breastfeeding and infant feeding. Most of his teachings were “lost” in the Middle Ages, in part as a result of widespread prejudices and superstition with respect to the nature and position of women. In most cultures child birth was assisted by either an older experienced woman in the family or the community. Those with the greatest experience – and possibly the more favourable outcomes - were recognized as (traditional) birth attendants. Some common complications could be dealt with based on experience, but on the whole other complications and even death, were considered part of the normal risks of child birth. However, Swedish authorities, having noted in 1751 that of the 651 women dying in childbirth, at least 400 could have been prevented by having more midwives, started a campaign to increase the numbers and improve the training of physicians and midwives; founded the first lying-in hospital in 1775; improved the skills of home deliveries by midwives in 1829 when they were licensed to use forceps and other obstetric instruments; and introduced antiseptic techniques in the lying-in hospitals in the late 1870s, and required it, by law, for midwives in rural districts in 1881. During this period non-septic maternal mortality was reduced from 414 to 122 per 100,000 live births. It was many decades before these policies were widely and fully implemented in other countries.

The historical origins of the health systems of the developing world were often rooted in the economic interests and approaches of the colonial powers, and depended largely on whether colonial interests were based on agriculture, estate labor, mining or manufacturing. Economic concerns dictated the need to protect the colonial staff, their families and the local labor force, such as those working on commercial farms, rubber tree plantations, tea estates, etc. In some instances the family may have been present and contributed to the work force, such as on the tea estates. The protection of the work force was among the primary motivation for the development of the health system and/or the control of specific diseases, such as malaria. However, in settings economically dependent on migrant labor – whether by voluntary, co-opted or forced by taxation<sup>2</sup> or legislation, there was no support to the health of families left behind in rural areas. The men, having entered the cash economy, but separated for varying periods of time from their wives and family, found themselves in circumstances not always conducive to healthy life-style behaviour. The Francophone countries established networks for the

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<sup>2</sup> Glen Grey Act in 1894: South Africa a cheap labour force was ensured by requiring African men to pay an annual “labour tax” of ten shillings *in cash* “unless they could prove that during three months of each year they had been in service or in employment beyond the borders of the district.

“grand campaigns” against specific diseases. The colonial infrastructure for health care was largely therapeutic and centralized and based either on government or missionary supported hospitals, which at times included training of nurse-midwives and medical assistants. In most instances these included care during pregnancy and a small number of deliveries, and the promotion of child nutrition.

For society and the family to ensure a healthy and effective adult, the mother and child diad must be safely supported and sustained through pregnancy, birth and until the child becomes independently mobile. In humans, with the particularly long dependency period, the mother-child bond becomes the basic bond in our system of social relationships, with many of the health care functions inherent in this bond. While some families are to an extent self-sustaining - particularly in the case of the large extended families still seen in many developing countries - poverty and social exclusion seriously compromise the capacity of families to meet the basic needs of its members for health, nutrition, shelter, physical and emotional caring, and the safety and development of its individual members. Such families are also more vulnerable, or unable to protect its members from experiencing physical or psychological exploitation or abuse. Even as policies and programs may exist to support such families, rural residence, poverty and social exclusion may make them inaccessible. In much the developing world the majority of the hungry and the poor are farmers and their families, living in rural areas where access to basic services, education, health and safe water supplies are limited, often of poor quality, and far more inaccessible than those for their urban counterparts.

With the advent of the World Health Organization many of the international health policies and technical support to countries were directed at disease specific control and/or eradication based on the availability of antimicrobials such as penicillin for yaws and syphilis, streptomycin for tuberculosis, household spraying with DDT to prevent malaria transmission, and vaccination for smallpox. Insofar as these diseases were common in poor communities poor families benefited. But other than yaws – a disease eliminated by one dose of a long acting penicillin, and smallpox was eradicated by everyone at risk receiving a single vaccination., the challenge of the high mortality associated with the malaria and respiratory and diarrheal diseases in children require continuous efforts, and at times, new approaches. However, a “vertical” disease-specific approach to tuberculosis control proved insufficiently effective in resource-poor settings, and the global efforts to “eradicate malaria,” although initially promising, were thwarted by the parasite acquiring a resistance to the anti-malarial drugs and the banning of DDT. Also, As progress was made donor countries decreased their financial support when it should have been increased, and DDT became a banned insecticide.

As WHO noted, there are only a few conditions that benefitted from a “vertical” one-disease, or single technology approach. The unsuccessful “vertical” campaigns were being incorporated into the major international health policy of the 1950s and 1960s, namely the development and strengthening of “Basic Health Services,” which was defined as “a network of coordinated peripheral and intermediate health units with a central administration capable of performing effectively a selected group of functions.” But, even the concept and policy of promoting basic health services<sup>3</sup> was flawed, as Dr. Halfdan Mahler, Assistant Director-General at that time noted, “when such services were needed, countries could not afford them, and when they could afford them they no longer needed them.” While the general health services were soon deemed essential. But the general health services in most developing countries were beyond the reach of the poor, and particularly the large majority of poor families in the rural areas.

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<sup>3</sup> Basic health services were defined as a network of coordinated peripheral and intermediate health units with a central administration capable of performing effectively a select group of functions essential to the health of an area, and assuring the availability of competent professional and auxiliary personnel to perform these functions.

Policies in the health sector cannot be separated from those in other sectors, particularly those being advocated for agriculture where the dynamics of family relationships and responsibilities may be modified. In a joint WHO-UNICEF-country program assessment mission to a southern African country we noted marked highly significant differences in the prevalence of young child malnutrition by province which the national authorities could not explain. Inquiry to other government ministries provided the answer. Half of the provinces were planting a high-yield maize crop as part of an agricultural development program. The others were raising their traditional maize. The high level of malnutrition was in the high-yield provinces! The high-yield greatly increased the total yield of maize, providing the family with a cash income, but “shelf-life” of that maize was only 9 months. For the remaining 3 months the family had to go to the commercial markets to buy food for the family – a task performed by the men in the family! Among the agricultural policies currently being proposed for some areas of sub-Saharan Africa is a call for increasing the off-farm income of the family. While off-farm income has increased the economic situation of many families who remain on the land such as in much of southern Africa, in different settings there is a down size to this approach insofar as it may require an absentee parent, with the life-style influences and the risks of HIV/AIDS.

The Millennium development goals related to health can be traced back to WHO-UNICEF collaboration in preparing their common goals for the Fourth UN Development Decade when the goals were formulated on the basis of analyzing research and experiences in communities and countries throughout the world. While goals are not policies, the means by which countries achieve those goals do represent policy. For example, the goal for the reduction of maternal mortality were based on the national experiences of Jamaica and Sri Lanka, where over a period of several decades maternal mortality was reduced by 50% every ten years. The policies that went into that achievement included a system based on trained midwives in rural and urban areas, maintaining the number of midwives, “obstetric beds” and their location according to the population growth.

Health policies have been either system/institutional based or technology based. National authorities and international agencies have pursued both approaches. What has been more important is that either approach needs to be “evidence based”. A family life-cycle approach provides a framework for the examination of the relevance of policies addressing the health needs of families. As noted in Table 2, policy needs will vary with the different stages in the family life-cycle, but also with the environment, resources and institutions available to the family by which their nutritional and health needs may be met. The belief-based policies usually derive from a larger social-cultural belief system that may or may not have been empirical in origin, and may or may not be scientifically relevant, but may be an important element of current cultural or religious systems, and thereby cannot be ignored. The technical appropriateness of health policies have been validated based on the application of the scientific method to the needs of the family as they relate to the families need for food, water, shelter and the safe disposal of waste. They are also applicable at all stages of the family life cycle, including *inter alia* physical and social maturity for marriage, as defined both culturally but also physiologically, pregnancy and birth practices, and infant and child nutrition.

The impact of poverty on the health of families may also arise from the health impact of health and nutrition of the previous generation or the *in utero* malnutrition experienced of one or both parents. They arise often as a consequence of deep seated historical or epidemiological circumstances that cross generation of families, even as some families are able to escape from poverty, its consequences or stigmata may remain.

Primary Health Care (PHC) became the policy and program thrust of WHO and UNICEF based on the report and subsequent resolutions of the governing bodies of each. PHC was described as:

“a practical approach to making essential health care universally accessible to individuals and *families* in the community in an acceptable and affordable way and with their full participation. ...Family members are often the main providers of health care. In most societies, *women* play an important role in promoting health,

particularly in view of their central position in the family; this means that they can contribute significantly to primary health care, especially in ensuring the application of preventive measures. . . .Other family members also make major contributions. *Young people* can be educated to have a good understanding of what health means, how to achieve it, and how to contribute to development. They can be very effective in taking these messages to their homes and interpreting new ideas to their families, as well as being useful in practical work, for example in the fields of first aid and basic sanitation. *Old people* can also be given many tasks which contribute to the health of the community and which at the same time improve their own health by giving them a social purpose. It is important to encourage *men*, too, to take a greater interest in health . . .”<sup>4</sup>

Historically, the impact of poverty on the health of families has been mediated singularly or in combination with: a lack of food security and malnutrition; poor housing and sanitation, and unsafe water supply; the epidemiology of infectious and contagious disease; reproductive patterns associated with age of marriage and child bearing and unregulated fertility; and, harmful traditional practices affecting the health and well being of women and children. But the poverty of families is also associated *inter-alia* with illiteracy, discrimination against women and specific ethnic groups, unemployment, substance abuse; corruption, usury and inherited debt; and, child labor. Meeting annually<sup>5</sup> in the years preceding the International Year of the Family in 1994, the representatives of the organizations and agencies of the United Nations system and a number of NGOs concerned with the family, noted that to a great extent we were all particularly concerned with the same families. These were families that were disadvantaged at many levels and unable to adequately meet their own needs. Rather than labeling these families as being “at risk” the agencies concluded that these were families that would benefit from a range of capacity building efforts supported by the collaborative efforts of several sectors as represented in the UN system, i.e., health, education, agricultural development, etc. A proposal to give effect to this approach was presented to, but rejected by the Administrative Coordinating Committee of the UN.

Even as international authorities recognize the relationship of poverty to health, poverty is largely measured in terms of individuals, not families, despite the recognition that the basic health needs of the poor are family based i.e., safe and adequate food, clean water and sanitation. There have been several approaches in defining poverty among families and individuals. Conceptually the association of poverty with poor health and nutrition is widely accepted, but until the last several decades, not always with precision in definition or measurement, nor adapted to stages of and/or local circumstances. The current definition of poverty used for international comparisons by the World Bank is the “percentage of the population living on less than \$1.25 a day at 2005 international prices.” This is derived from the concept of purchasing power parity (PPP) for an essential “food package to meet nutritional needs” based hundreds of surveys on local costs. Neither family size nor structure enters into this indicator.

The other major source of information on poverty can be found in the Demographic and Health Surveys (DHS), as well as the UNICEF supported national Multiple Indicator Cluster Surveys (MICS), have estimated national *household* wealth quintiles for urban and rural areas based on the nature of the housing, sanitary facilities and water source, as well as household linked possessions – essentially a figure relative to each country and not necessarily fully comparable to the poverty line based on consumption equivalents. The DHS have the advantage of providing family perspective in terms of family size, relationships, presence or absence of one or both parents, orphanhood and foster-hood. However, comparisons between countries are relative and do not necessarily comparative with the World Bank’s measure of poverty based on individuals!

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<sup>4</sup> Primary Health Care, Report of the International Conference on Primary Health Care, Alma Ata 1978, WHO and UNICEF.

<sup>5</sup> The *Ad Hoc* Inter-Agency Meeting on the International Year of the Family

**Table 1. An historical overview and current examples of health policy development**

<b>Policy - era</b>	<b>Applied by</b>	<b>Conditions</b>	<b>Associated policies</b>
Quarantine for infectious diseases -plague (Venice 14 <sup>th</sup> century)	Local authorities at ports	Initially plague, concept expanded to include leprosy, syphilis, yellow fever, cholera, smallpox. Later expanded to common infectious disease control for diphtheria, scarlet fever, etc.	Burning of clothes, bedding; fumigation of premises; vaccination
Asepsis (19 <sup>th</sup> century) hand washing	Physicians and nurses – incorporated into training, & hospital policy	Puerperal sepsis following delivery	Development and use of disinfectants
Training midwives for Safe child birth (18 <sup>th</sup> century)	Licensing Swedish midwives after training to use obstetric instruments	Complications during delivery & high mortality in child birth	Requirement to use aseptic techniques; in 20 <sup>th</sup> century Jamaica & Sri Lanka reduce Maternal Mortality every 10 years
Vaccination	1853 United Kingdom	Requirement for children	
Pasteurization of milk (19 <sup>th</sup> )	Milk distribution centers	Infant mortality due to milk borne infection	(Later became MCH clinics)
Control of specific contagious diseases – mainly of children	Local health authorities – pre-antibiotics	diphtheria; pertussis; scarlet fever, etc.	Quarantine and later fumigation of household – Bathing & cleanliness
Immunization of children (diphtheria; pertussis; tetanus; BCG in 1920s)	National & local health authorities	Not widely provided in Europe until after WWII	School entrance requirement; WHO Expanded Program on Immunization
Emergency relief for children and families at the end of WWII 1943-47	UNRRA	provision of food, fuel, clothing, shelter and other basic necessities, medical and other essential services	
Ibid 1947+	UNICEF	provide emergency food and healthcare to children in countries that had been devastated by <a href="#">WW II</a> .	Initial support for the construction of plants for powdered milk; later joined with WHO on infant and young child feeding policies
International Health authority for health policy and development	WHO 1948	Epidemic disease control: Yaws eradication; malaria control & “eradication”; small pox eradication	UNICEF/WHO Joint Committee on Health Policy
Basic Health Services	WHO policy 1950s-1978	Disease specific eradication/control, MCH and family planning, Expanded Program of Immunization, etc	Training health workers & developing management systems
Modern contraceptive technology development	Non-governmental organisations early 20 <sup>th</sup> Century; UN trust fund for population in 1967, becoming UNFPA in 1969	Global population research, development & support to national FP programs; expanded to other areas of reproductive health	Coordination and collaboration with other UN agencies
Primary Health Care (Alma Ata Declaration)	WHO-UNICEF policy 1979+	Involvement of communities, women in the eight essential elements of PHC	Health system financing

International Code of Marketing Breast-Milk Substitutes	WHO (1981) & national authorities, infant-food manufacturers, NGOs	Exclusive breast-feeding 4-6 months; no advertising, free samples, etc.	WHO-UNICEF designation of Baby Friendly Hospital
Frame work Convention on Tobacco Control	WHO2003: 172 countries and EU have become Parties to the convention; regular reporting	Aimed at reducing the annual 6 million tobacco related deaths, including 600,000 non-smokers	Bans advertising & sale to minors; high tobacco taxes; health warnings on packs

**Table 2. Needs and constraints exacerbated among families in poverty**

<b>Family life cycle stage</b>	<b>Needs</b>	<b>Cultural/social economic needs/ constraints</b>	<b>Policy and service requirements</b>
Marriage	Biological and social maturity of the man and woman	Dowry, bride price & resources to establish a household, or arrangements in existing household	Age of marriage laws; elimination or cultural shift in dowry/bride price practices
Family Planning	Ability to time, space and limit pregnancies to optimize both maternal and child health; pre-pregnancy nutrition	Expectation <i>for women</i> to establish fertility! Family planning services with a variety of contraceptive methods and, as appropriate, infertility diagnosis & treatment ; equitable food distribution, iron supplementation	Easy access & minimum/no cost for a variety of FP methods. Regardless of legal status, decriminalization of consequences of unsafe abortion. Iron fortification of common foods.
Pregnancy	Monitoring & screening pregnancy by trained person; identification of risk & facilities for referral	Traditional birth attendants; Risk criteria for referral	Nutrition, vitamin & trace elements supplementation according to local needs
Delivery	Delivery by trained attendant; essential obstetric care with accessible back-up facilities and personnel	Traditional practices: place, position and person performing delivery; Risk in own home (e.g. Nepal); doula	Training of traditional birth attendants; creation of maternity house; affordable transport; funds for supplies
Early infancy & childhood	Breast-feeding and appropriate infant and young child food & feeding practices; immunization;	Working women	Implementation of the International Code of Marketing of Breast-Milk Substitutes; Breast-feeding “friendly” workplace
Pre-school child	women’s literacy; father or other adult male family member supporting care	Internal or international long term absence of one parent	Include women’s literacy programs and reading to children in the MCH/FP clinics (“immunization” against ignorance)
School Age child & adolescents	ibid	Cultural attitudes on human sexuality; dynamics of peer relationships; access to primary and secondary education	Age appropriate school curricula on human development and sexuality; teacher training of child and adolescent development
Overall Family needs and intra familial life style	Healthy food patterns; safe in-door cooking; clean water; safe waste disposal; avoidance of substance abuse; intra-family	Historical culture patterns constraining women’s role in the family and larger community; cultural, religious, tribal or other	Inter-sectoral coordination of poverty relevant policies; elimination of harmful traditional practices affecting women and children; use of locally recruited and

	<p>communication &amp; problem solving; and conflict resolution; recognition of adolescent needs &amp; problems; adherence to beneficial traditional family based practices</p>	<p>conflicts between family groups in the community: domestic violence; access to other services and institutions ; other sector policies conflicting with health policies</p>	<p>trained health promoters; map households and categorize in relation to health needs and identify families in need of support with respect to violence, substance abuse, etc.</p>
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