Poverty and perinatal health

Close to 1.5 billion people in the world live in extreme poverty, a situation which is particularly stark in the developing world, where 80% of them live. Poor people have little or no access to qualified health services and education, and do not participate in the decisions critical to their day-to-day lives.

Poverty cannot be defined solely in terms of lack of income. A person, a family, even a nation is not deemed poor only because of low economic resources. Little or no access to health services, lack of access to safe water and adequate nutrition, illiteracy or low educational level and a distorted perception of rights and needs are also essential components of poverty.

There is a two-way link between poverty and health. Illness impairs learning ability and quality of life, has a negative impact on productivity, and drains family savings. Poor people are more exposed to environmental risks (poor sanitation, unhealthy food, violence, and natural disasters) and less prepared to cope with them.

Because they are also less informed about the benefits of healthy lifestyles, and have less access to them as well as to quality health care, they are at greater risk of illness and disability.

It is a fact of life that those who live in extreme poverty are five times more likely to die before five years of age, and two and a half times more likely to die between 15 and 59 years than those in higher income groups. The same dramatic differences can be found with respect to maternal mortality levels and incidence of preventable diseases.

The impact of poverty on health is largely mediated by nutrition and is expressed throughout life. However, nutrition and health are only somewhat responsive to mere economic growth. Those living in poverty and suffering from malnutrition have an increased propensity to a host of diseases, a lower learning capacity, and an increased exposure and vulnerability to environmental risks. Poor children frequently lack stimuli critical to growth and development.

Poverty has a woman’s face; of the world’s 1.3 billion poorest, only 30% are male. Poor women are often caught in a damaging cycle of malnutrition and disease. This plight stems directly from women’s place in the home and in society: it often also reflects gender bias in health care. We often find poor women at the back of the waiting line.

For 90% of the pregnancies and deliveries in our world, the reality is very different. A young woman in Ethiopia, for example, goes into the reproductive phase of her life with a one-in-ten chance that she will die as a result of pregnancy or delivery. That is not only shocking – it is totally unacceptable.

But, there is something else. There were 132 million births in the year 2000, 90% of them took place in developing countries. Maternal, infant and child mortality illustrate the largest gaps between the rich and the poor in today’s world. There are between 7 and 8 million perinatal deaths, but we do not know exactly how many are stillbirths and how many are early neonatal deaths. In many cases, births of infants who die soon after birth are neither recorded nor counted.

Although exact medical causes in countries may differ, the problem is simple: the common denominator for those deaths is the lack of appropriate and quality services, confounded by poverty. The WHO and UNICEF estimate that 15% of babies weigh <2500 g at birth. In some countries, a full one-third of all babies born are below this weight. Yet, probably only 1/3 of infants are weighed at birth and it is among those births without weight statistics we are likely to find the poorest.

Millions of babies died and a sizable fraction of them die from AIDS—shocking data from the 2005 AIDS update. In developing countries, 2062 per thousand die of disease and hunger before the age of five, and most often from neonatal causes, respiratory infection and diarrhea. In 2004, 4.9 million adults and children were newly infected with HIV and 3.1 million adult and child deaths happened in the same year. Fortunately, there is increased use of contraceptives but unfortunately not in Africa, and in about half of the developing countries, access to family planning is poor or very poor.

Every year more than 600,000 women die in pregnancy, during child birth, or from unsafe abortions, and 99% of these occur in developing countries. This incidence did not change during the last 10 years. Even more distressing than the absolute number is the fact that the vast majority of these deaths are preventable.

Importance of education

Poverty is one of the most influential factors for illness, and illness – in a vicious cycle – can lead to poverty. Education has proven to be a critical strategy to break this cycle.
Level of education in relation to health is particularly important among women. In addition, education for women is closely associated with later marriage and smaller family size. Experience in several countries demonstrated the power of education to increase the nutritional levels and the health status of the poor. In urban India, for example, it has been found that the mortality rate among children of educated women is almost half than that of children of uneducated women. In the Philippines, it has been demonstrated that primary education among mothers reduces the risks of child mortality by half, and secondary education reduces that risk by a factor of three.

Several strategies can be used to improve the access of mothers and children to educational opportunities as a way of improving their health status. At the national level, governments, particularly in developing countries, have to establish education – including the education of the parents – as a priority, and to provide necessary resources and support.

At the international level, lending institutions have to implement debt-reduction policies for those countries willing to provide increased resources for basic education.

Emphasis on education can provide substantial benefits in the health status of populations even before reducing the economic gap between the rich and the poor.

How do we respond?

Why the world continues to allow 30,000 children to die each day of poverty?

Ultimately what is killing girls is not precisely malnutrition or malaria, but indifference. And that, in turn, arises from our insularity, our inexperience in traveling and living in poor countries, so that we have difficulty empathizing with people like African children. We often hear comments like: “It’s tragic over there, but we’ve got our own problems that we have to solve first.” Nobody who has held the hand of a starving African child could be that dismissive.

Part of the problem is that, for example, most of the universities in the developed world do an execrable job preparing students for global citizenship. Although a majority of the world’s population lives on <$2 a day, however, the vast majority of Western students graduate without ever gaining any insight into how that global majority lives. According to a Roper/National Geographic poll, 38 percent of Americans aged 18–24 years consider speaking another language to be “not too important”. Sixty-three percent of those young Americans cannot find Iraq on a map of the Middle East, and 89% do not correspond regularly with anyone outside the United States.

We should stimulate our students to spend their summer holiday not in Paris or London, but to travel through Chinese or African villages. Universities should give course credit for such experiences – and offer extra credit for students who catch intestinal worms. Doing so, we will galvanize them to care about these issues. Then they will learn more than they ever would from an equivalent period in the classroom. And then they shall gain not only the occasional intestinal parasite but also an understanding of why we should fight to save poor children in Africa.

Furthermore, most people in the west feel rather ambivalent about Africa. When faced with the continent’s poverty, our instinctive reaction is to want to help. But our incomplete knowledge of the historical, political and economic factors that have weighed Africa down means that we do not know whether or not our puny individual efforts will ever do any good. The thrust of the argument can be easily summarized: the West provides too little aid, and that the help it does provide is not all that efficient at helping Africa. Indeed, about 75% of aid to Africa is spent through pre-determined projects rather than going directly into national budgets and too much money is spent on expatriate workers: the world bank estimates that there are around 100,000 “technical experts” funded by donors in Africa. Worst of all, too many aid decisions in the West are motivated by political maneuvering and selfish national interests. This means that only about $4 in every $10 of global aid goes to low-income countries. The USA comes in for strong criticism on most of these fronts; and the UK fares only moderately better.

Africa fails to develop because many high value-added activities do not take place there. For example, Germany remains the world’s fourth largest exporter of coffee, despite not growing a bean. Africa produces the raw materials, while the rest of the world adds the processing, marketing and distribution to end up with a larger slice of the economic pie.

It is clear that Africa should do better in a more globalized economy. But we are concerned that citizens in the West have become alienated and apathetic consumers who, consequently, do not care about the creation of a financially fair world. Such an argument makes it seem like the last few years never happened: the anti-African-poverty campaigns in Europe and the US since 2005, the live eight concerts or the writings of Jeffrey Sachs and Martin Wolf.

How can we help?

How can we change? Yet, progress is painfully slow.

For most of us here today, the work-day is far removed from issues confronting poor women in Cambodia or Cameroon. But there are ways in which our actions can help these women in the long run.
One is research. The development of research partnerships between developing and industrialized countries will not only help to combat the global inequity of health but will also be of enormous mutual benefit for all.

Another issue is spreading knowledge, through articles, through personal contact, through dialogue with other countries’ health professionals and governments. Pregnancy, childbirth and being a newborn are not diseases – they are special periods in human life when the risk of death or disability can be very high. This must be understood clearly by all: from medical, nursing and midwifery schools, from research funding bodies to industry and governments. Not understanding or knowing well the normal can lead to abuse of technology and iatrogenic complications. Excellent examples are Matres Mundi and the Ian Donald School with their global humanitarian and educational activities described elsewhere in detail. Obviously, global problems can be solved by global efforts. Even a modest personal contribution to this global tragedy will be our moral duty!

This will help to promote the idea that today’s men and women are able to find mutual support, understanding and encouragement in diversity as the best way to grow as people in a more equitable and supportive society, where no one is excluded.

References


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