INTERNATIONAL NURSES DAY 2004

NURSES: WORKING WITH THE POOR;
AGAINST POVERTY

Information and Action Tool Kit
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Message from ICN</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Chapter One – Understanding Poverty</td>
<td>5</td>
</tr>
<tr>
<td>Chapter Two – Listening to the Voices of the Poor: Poverty Profiling and Analysis</td>
<td>11</td>
</tr>
<tr>
<td>Chapter Three – Poverty and Health: A Deadly Link</td>
<td>17</td>
</tr>
<tr>
<td>Chapter Four – Addressing Health and Poverty Concerns: Breaking the Link</td>
<td>23</td>
</tr>
<tr>
<td>Chapter Five – Pro-poor Health Policies: A Framework for Action</td>
<td>27</td>
</tr>
<tr>
<td>Annex 1 – Action Items: Action Against Poverty – For Health</td>
<td>37</td>
</tr>
<tr>
<td>Annex 2 – Millennium Development Goals</td>
<td>39</td>
</tr>
<tr>
<td>Annex 3 – Press Release on Poorer People Live Shorter Lives and are Sick More Often than the Well-off; Nurses take aim at poverty and the link with poor health</td>
<td>41</td>
</tr>
<tr>
<td>Annex 4 – Facts and Figures: the Real Story</td>
<td>43</td>
</tr>
<tr>
<td>Annex 5 – Position Statement on Nursing and Development</td>
<td>45</td>
</tr>
<tr>
<td>Annex 6 – Position Statement on Publicly Funded Accessible Health Services</td>
<td>47</td>
</tr>
<tr>
<td>Annex 7 – Position Statement on Universal Access to Clean Water</td>
<td>49</td>
</tr>
</tbody>
</table>
Dear Colleagues,

Poverty is the greatest misery we face today. This is why ICN has chosen to focus on poverty for this year’s IND theme. Some 1.2 billion people are living in extreme poverty; that is, on less than $1 a day. This means they lack the basic necessities for a healthy life -- adequate food, water, clothing, shelter and health care. Additionally, up to 2.8 billion people are living on less than $2 a day.

Poverty and poor health go hand-in-hand, with the poor sharing an unequal burden of ill health. The poorest 1.2 billion people bear two-thirds of the world’s communicable disease, maternal and perinatal mortality, and nutritional deficiencies. The particular cruelty of poverty is its vicious circle, whereby people do not have access to health, education and other means to increase their income and to improve their health status. Yet without good health, a person’s potential to escape from poverty is severely weakened.

What can we as nurses do? We know that investing in education, health care and sound social policy can improve health outcomes. We also know that health is an asset, thus promoting and protecting it must be a key concern. This means that we must be sure we are educated about the determinants of health, about empowerment, and about working with communities and vulnerable groups to address their unique needs.

We can work to ensure the poor are treated with respect, and work to influence policies and programmes, ensuring they are designed with the poor and most vulnerable in mind. We can lobby for fair labour standards, safe work places, equal rights for women (who represent 70 per cent of the most poor), and lobby to ensure equity of access to health services.

Nurses are the most trusted of health professions. We can do much to work with and on behalf of poor people. We work with them to ensure that their voices are heard, that they are included in decisions concerning them, and that the inequalities of access, employment, services, gender, ethnicity and race are addressed. Working side-by-side with clients, service providers, community leaders, policy makers and politicians we can do our part to reduce the plague of poverty.

Sincerely,

Christine Hancock
President

Judith A. Oulton
Chief Executive Officer
Introduction

Nurses know that good health is a precondition for sustainable economic and social development. They know that when people are unable to meet their basic needs due to poverty, they become susceptible to diseases and suffer high mortality rates.

Health affects every aspect of a person’s behaviour. Whether you feel full of energy or are weak, tired or in pain can determine if you are able to contribute to family and community. Poor health in a significant percentage of a society’s population is a major obstacle to social and economic development. Actions that nurses take to promote health, prevent disease, alleviate suffering, and aid healing and rehabilitation can help people lead healthy and productive lives.

With this year’s International Nurses’ Day theme and tool kit, the International Council of Nurses aims to increase nurses’ awareness about the links between poverty and health and suggest multisectoral actions to reduce poverty and improve health.
Poverty is a complex and pervasive problem throughout the world. More than half of the developing and transitioning world lives in poverty, with about 1.2 billion people or 23 percent of the total population living on US$1 or less per day. An additional 1.6 billion people make do with between US$1 and $2 per day.¹

All humans have certain basic needs. These include physical requirements such as clean water, food, energy to live; psychosocial and spiritual relations; environmental protection, adequate shelter and security; and opportunities for personal growth and care including access to basic education and health services.²

Individuals living in poverty struggle to meet even these most basic human needs. With this struggle comes a loss of dignity often described as the most injurious and debilitating characteristic of poverty.³

Poverty has Many Faces

Poverty has many faces and dimensions. A person can be considered poor because of low income, unmet basic needs, or both. Poverty is a condition that extends beyond lack of income and goes hand in hand with lack of power, humiliation, and a sense of exclusion from access to goods and social services. Defining poverty solely as an income level, or as an inability to acquire basic food and shelter, limits our ability to understand its true characteristics and make effective interventions for improvement. Poverty is a human condition, a way of life that affects all interactions a person has with the surrounding world. Extreme poverty is characterised by lack of material resources, as well as a lack of capability, choice, security, power, and the ability to enjoy the natural rights of being human.⁴

Guidelines prepared by the Organisation for Economic Cooperation and Development and the World Health Organization (OECD/WHO) on poverty and health define five core dimensions that reflect the deprivation of human capabilities.⁵
To implement interventions that make a difference in the lives of the poor, it is important to understand the many dimensions of poverty. For example, measures to improve gender equality are essential for reducing poverty in all its aspects.

Poverty Lines

Poverty lines are a useful and practical tool for measuring poverty. A poverty line uses indicators to separate the poor from the non-poor, based on a country’s definition of poverty. A poverty line is established according to the income or consumption needed to maintain minimum nutritional requirements and other necessities. For example, people considered to be living below the poverty line in a certain country may be those who earn below the average annual income. In another country, people whose calorie intake falls below the recommended daily requirement may be considered to be below the poverty line.

The World Bank defines global poverty according to the poverty standard in poor countries, using the US$1 a day mark (in local currency) as the poverty line.

Caution must be exercised in interpreting poverty lines. For example, should a family with an income above the poverty line but lacking access to basic health services and education or safe drinking water be considered non-poor? A money-based interpretation of poverty may not rank this family as poor, but a multidimensional interpretation would classify it as impoverished.

Types of Poverty

Poverty exists in many forms. While the different types share common characteristics, each has its own causes and effects and thus must be considered individually when developing intervention strategies.

- **Absolute or Extreme Poverty** – The deprivation of elements needed to sustain life and health: adequate food, safe water, shelter, land, employment, and security. People living in this category are most likely to repeatedly return to poverty despite societal improvements. This type of poverty is currently the main focus of the international agenda, highlighting the global divide between the rich and the poor.

- **Relative Poverty** – The deprivation of opportunities, material items, and self-respect viewed as normal in the community to which one belongs. For example, one may have basic food and shelter, but lack the same access that others have to education and health services. Such inequality within a country can divide society, provoke instability, and impede national growth by diminishing the productivity of the poor.
Inherited Poverty – Poor parents pass on their status to their children, thus feeding the seemingly unending poverty cycle.12

Instant Poverty – Poverty caused by sudden hazards or circumstances like drought, earthquakes, typhoons, bankruptcy, war, and refugee movements.13

Vulnerable Populations

Certain groups of people are at high risk for falling into the downward spiral of poverty. They are also more likely to experience the most severe hardships related to poverty. Women, indigenous populations, minority and socially excluded groups, refugees or displaced persons, the mentally or physically disabled, and people living with HIV/AIDS are among the groups particularly affected by poverty.

Visiting Nurses of Moldova are a Lifeline to Many

The Visiting Nurses Programme of the Moldova Red Cross Society offers comprehensive basic and medical assistance to the country’s most vulnerable groups. Moldova, one of the newly independent countries of Eastern Europe, has suffered a tremendous increase in poverty and misery since the post-Soviet period. Most of the population live below the poverty line, with retired and disabled people the hardest hit.

The Visiting Nurses Programme was created to provide medical and social assistance to these groups, whose allowances are too small to cover even basic needs, including medicines and treatment. The salaries of the nurses themselves are very low, only US$23 per month, but despite this they are very devoted to their work. The programme continues to seek funding to maintain the activities of its core 30 visiting nurses, but with such great need still apparent, the hope is to expand to 100 nurses who will be able to assist a total of 2,000 beneficiaries, extending this lifeline of support and care to more of these lonely, impoverished people.
The Feminisation of Poverty

In most countries poverty has a female face: about 70 percent of the 1.2 billion people living in poverty are female. In many countries, the number of women in poverty has risen significantly over that of men over the last two decades. Women are twice as likely as men to be illiterate and significantly more likely to suffer from poverty-related health conditions such as iron deficiency anaemia and protein-energy malnutrition.\textsuperscript{14}

Several factors contribute to gender disparity. Though women are increasingly entering the labour force, they generally have greater difficulty finding employment, have harder school-to-work transitions, and 30 to 40 percent lower wages than men.\textsuperscript{15,16} Despite the tremendous growth of dual-income families and single-parent households, societal perceptions have changed little and women still bear primary responsibility for maintaining the home. To balance the demands of family and work, women tend to move in and out of the labour force, thus reducing their opportunities for career advancement and retirement benefits.\textsuperscript{17}

Youth Unemployment and Poverty: A Vicious Cycle

Young people who are able to find productive employment, secure steady incomes, and successfully begin family lives are key to the reduction of absolute poverty. About 100 million youths enter the global workforce each year, a trend that is bound to maintain itself or grow, as more than 1 billion of the world’s population is currently between the ages of 15 and 25. Unfortunately, they suffer high unemployment rates, constituting about 41 percent of the total 180 million unemployed in the world. In most developing countries, young men and women must choose between informal work and no work and may face long hours, low wages, and dangerous working conditions.\textsuperscript{18} Youth unemployment not only perpetuates the intergenerational cycle of poverty but also contributes to higher levels of crime, substance abuse, violence, and political extremism. In some countries, belonging to an armed militant group is virtually the only paid occupation available to men. The sex industry is often a last resort for women and also perpetuates the cycle of poverty.\textsuperscript{19}

The Elderly: A Traditionally Vulnerable Population

Maintaining a viable income in the later years of life is an issue with which many struggle. In many developing countries, retirement is a luxury that few can afford. Approximately 40 percent of individuals over 64 years in Africa and 25 percent in Asia are still in the workforce, employed mostly in agriculture.\textsuperscript{20} Individuals who have sustained themselves mainly through informal employment are at particular high risk for poverty because such employment provides inconsistent incomes and poor coverage under social security schemes.
Other factors, including cutbacks on social security and healthcare in some countries and the HIV/AIDS epidemic, have combined to diminish the supply of resources and support systems available to older individuals. HIV/AIDS has had a particularly substantial impact in many of the least developed countries. Not only are older persons assuming more responsibility to care for themselves, they are forced to expend their own resources to care for ill or orphaned children and grandchildren.\(^2\)
Growing Concern about Poverty

Illiteracy, ill health, gender inequality, and environmental degradation are some of the main aspects of poverty that have created growing concerns about human deprivation. Alarmed by increasing levels of poverty, the international community has made an unprecedented agreement on the Millennium Development Goals (MDGs) for reducing poverty. Each goal is to be achieved by 2015.

<table>
<thead>
<tr>
<th>Millennium Development Goals and Targets</th>
<th>Indicators for Monitoring Progress</th>
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<tbody>
<tr>
<td><strong>Goal 1: Eradicate extreme poverty and hunger</strong></td>
<td><strong>Goal 2: Achieve universal primary education</strong></td>
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<tr>
<td><strong>Target 1:</strong> Reduce by half the proportion of people living on less than a dollar a day.</td>
<td><strong>Target 3:</strong> Ensure that all boys and girls complete a full course of primary schooling.</td>
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<tr>
<td><strong>Target 2:</strong> Reduce by half the proportion of people who suffer from hunger.</td>
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<tr>
<td>- Proportion of population below $1 (PPP) per day.</td>
<td>- Prevalence of underweight children under 5 years of age.</td>
</tr>
<tr>
<td>- Poverty gap ratio (incidence X depth of poverty).</td>
<td>- Proportion of population below minimum level of dietary energy consumption.</td>
</tr>
<tr>
<td>- Share of poorest quintile in national consumption.</td>
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**Goal 3: Promote gender equality and empower women**

**Target 4:** Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015.

- Net enrolment in primary education.
- Proportion of pupils starting grade 1 who reach grade 5.
- Literacy rate of 15-24-year olds.

**Goal 4: Reduce child mortality**

**Target 5:** Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

- Under-five mortality rate.
- Infant mortality rate.
- Proportion of one-year-old children immunised against measles.

**Goal 5: Improve maternal health**

**Target 6:** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

- Maternal mortality ratio.
- Proportion of births attended by skilled health personnel.
### Goal 6: Combat HIV/AIDS, malaria and other diseases

| Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS. | - HIV prevalence among 15/24 year-old pregnant women.  
- Condom use rate of the contraceptive prevalence rate.  
- Number of children orphaned by HIV/AIDS. |
|---------------------------|---------------------------------------------------------------|

| Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. | - Prevalence and death rates associated with malaria.  
- Proportion of population in malaria risk areas using effective measures for malaria prevention and treatment.  
- Prevalence and death rates associated with TB.  
- Proportion of TB cases detected and cured under directly observed treatment, short-course (DOTS). |
|---------------------------|-----------------------------------------------------------------|

### Goal 8: Develop a Global Partnership for Development

<table>
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<tr>
<th>Target 17: In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.</th>
<th>- Proportion of population with access to affordable, essential drugs on sustainable basis.</th>
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</table>


Understanding the dynamics of poverty and health requires a poverty profiling and analysis. Listening to the voices of the poor is an important aspect of understanding the situation and taking action. According to Feuerstein, a nurse author and development worker, a poverty profile is an analytical tool for rapidly and systematically identifying the poor, where they live, and what causes and characterises their poverty. It is a simple, practical, and low-cost method for gathering baseline information to guide action against poverty and in support of health. Key questions in a poverty profile include:

- **Demography, dependency, and vulnerability**: who and where are the poor and what are their characteristics?
- **Economy, labour, and employment**: what are the socio-economic and employment characteristics of poor and vulnerable groups?
- **Land, agriculture, and livestock**: how does access to productive land and agriculture affect the poor?
- **Organisational strengths for popular participation**: are the poor able to mobilize against poverty?
- **Food security and nutrition**: how can the poor avoid hunger and malnutrition, which undermines efforts to move out of poverty?
- **Education and communications**: what access are the poor getting to literacy and numeracy, and to modern communication systems?
- **Vital health indicators and basic health information**: what factors characterise the health and well-being of the poor?
- **Health expenditure, infrastructure, and human resources**: what services are available for the poor and can they access them?
- **Safe motherhood and newborn and childcare**: what factors undermine the chances of poor women and young children?
- **Environmental degradation and pollution**: what are the main environmental factors affecting the poor?

Based on the analysis, priority problems and needs are identified. Appropriate strategies are devised and main responsibilities along with a time frame for activities
are agreed with the people involved. Short and long term objectives, health indicators, and resource and support needs are defined.

Data sources for poverty profiling

Surveys: There are two major sources of data on poverty: household surveys and community surveys. Household surveys can provide important data about individuals and households such as location, household composition, income, consumption levels, employment, occupational status, educational levels, nutritional and health status. Similarly, community surveys provide a picture of the facilities, services, and characteristics of community resources available to the poor, also showing if these resources and services are utilised. Community surveys can use institutional records from health and educational facilities to analyse how they are used and identify barriers and possible ways of addressing them.

Household and community surveys can be used to construct an index of deprivation. A simple index of deprivation can be designed in collaboration with poor people in the community. For example, communities can decide that any family that has lost both parents to AIDS, single parent families with young children, those who are widowed or orphaned, that have young children who are not fully immunised, and children who are not going to school can be ranked high on the scale of deprivation. It is important to note that the main source of information on poverty should be the people themselves.

Other sources of existing information: Data from departments of employment and social welfare are also useful in determining socio-economic status and poverty levels. A variety of reports and publications produced by government, universities, UN agencies, and non-governmental organisations (NGOs) in addition to maps, press reports, and other sources will provide information on poverty at national or district levels.

Translating Public Health into Community Well-Being

An experienced public health nurse and health visitor, Jenny has worked in a socially deprived area of the United Kingdom’s West Midlands for years. To respond to the multiple health needs and poor mortality and morbidity record in her community, she initiated a community development project. She knew that many of the health problems were not simply due to individual behaviour and "lifestyles", but were the result of poverty and life circumstances. As a nurse, she found she was trusted and had access to lives and homes that social workers or the police did not.

Local stakeholders identified the lack of community-based facilities for families with young children, including a high proportion headed by single parents, as a major problem. Based on her small-scale research into the concerns of single parents, Jenny demonstrated to health managers the need to develop more family services. From this flowed a commitment and some limited resources from a few employers. Jenny used these to develop a range of projects including family learning activities, “drop in” health sessions, and English language classes for women. Other community members later took on the day-to-day running of these activities, indicating a sense of ownership and ensuring sustainability.

She also began breakfast clubs at the local primary school that allowed children to arrive early and have breakfast together. These not only improved the children's nutritional status, but led to increased attendance at school. Teachers reported that the children had greater concentration and could better apply themselves to learning. Her projects were so successful that Jenny was later asked to join the regional public health management team.
Working with the poor to analyse their situation

Families and communities can be involved in participatory poverty assessments to determine the level of deprivation in their neighbourhood or communities. These can include:

Well-being and wealth ranking: Community members can rank households who dress poorly, are led by women who are widowed or divorced, children who are orphaned, breadwinners who are unemployed, imprisoned, etc.

Social mapping: A group of people can talk about their problems and needs such as lack of food, caring for orphaned grandchildren, difficulty in paying school fees, or lack of money to buy medicines.

Ranking exercises: A group of women can record how treatment is obtained for common illnesses such as tuberculosis, HIV/AIDS, skin conditions etc. as well as any barriers to treatment and waiting times at health facilities.

Timelines: People identify prevailing situations such as drought or flood; or changes in government agricultural policies, access to credit, or prices of essential items that have led to an increase in poverty and hunger.

Resource mapping: A map of the area is drawn highlighting locations of different natural resources e.g. forests, fertile farmland, and areas where good fishing or endangered animals can be found. Sites prone to flooding and lands too poor for cultivation can also be marked.

A more comprehensive poverty assessment tool is summarised below.
<table>
<thead>
<tr>
<th>Issues to look at</th>
<th>Methods to use</th>
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<tbody>
<tr>
<td>Perceptions and indicators of wealth, well-being, and poverty.</td>
<td>Well-being and wealth ranking.</td>
</tr>
<tr>
<td>Perceptions of changes in welfare, terms of trade, access to income, and employment.</td>
<td>Timelines, trend analysis.</td>
</tr>
<tr>
<td>Access/use of services (health, education, credit), perceptions of services and changes.</td>
<td>Semi-structured interviews, trend analysis of health, education, etc.</td>
</tr>
<tr>
<td>Seasonal stress, food security, health, income, expenditure, occupation.</td>
<td>Seasonal calendar, family needs.</td>
</tr>
<tr>
<td>Assets of poor households, e.g. common property services, natural resources.</td>
<td>Resource mapping, focus groups.</td>
</tr>
<tr>
<td>Survival strategies in times of crisis.</td>
<td>Livelihood analysis, semi-structured interviews.</td>
</tr>
<tr>
<td>Perceptions of consumption levels of food, clothing, well-being.</td>
<td>Well-being grouping, social-mapping, interviews.</td>
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<tr>
<td>Local self-help institutions and support for poor (e.g. churches, traders associations).</td>
<td>Institutional mapping, interviews.</td>
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<tr>
<td>Community “safety nets” for the poor.</td>
<td>Institutional mapping, interviews.</td>
</tr>
<tr>
<td>Role of community institutions in service and infrastructure provision.</td>
<td>Interviews, institutional mapping.</td>
</tr>
<tr>
<td>Responsibilities and obligations within households (food, school fees).</td>
<td>Semi-structured interviews.</td>
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</tbody>
</table>

Adapted from *Research on Poverty and Health 1995/6; Participatory Poverty Assessment in Africa*: World Bank.

The process of compiling a poverty profile is the first step in understanding the effects of poverty on health.
Poverty and health are interlinked in four ways:

- Ill-health leads to poverty;
- Poverty leads to ill-health;
- Good health is linked to higher income;
- Higher income is linked to good health.

Poor health reduces productivity and interferes with the ability to make a living, while poverty increases the risk of contracting diseases that interfere with earning income. When a poor person becomes ill or injured, the entire household can suffer due to lost income and healthcare costs and be trapped in a downward spiral of poverty and illness. Conversely, good health increases a person’s productivity and immunity to disease, creating conditions that prevent poverty or help one to get out of poverty.

People living in poverty or low-income settings are likely to suffer greater ill health or die younger than other groups. For example, those living in absolute poverty are five times more likely to die before reaching the age of five, and two and a half times more likely to die between the ages of 15 and 59, than those in higher income groups. HIV/AIDS, malaria, tuberculosis, diarrhoeal diseases, malnutrition, and maternal mortality all disproportionately affect the poor, often making them poorer.

As shown in the diagram below, poverty and health are interlinked.

**Figure 1. The Interrelationship of Poverty and Health**

<table>
<thead>
<tr>
<th>Ill health is both a cause and consequence of poverty</th>
<th>Better health can prevent or offer a route out of poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness can reduce household savings, lower learning ability, reduce productivity, and diminish quality of life.</td>
<td>Increases productivity, leading to greater and more evenly distributed wealth.</td>
</tr>
<tr>
<td>Poverty puts individuals at greater risk for environmental hazards, malnourishment, and lack of access to adequate healthcare.</td>
<td>Healthy adult breadwinners are more able to work and provide for their families.</td>
</tr>
<tr>
<td>ILL HEALTH</td>
<td>POVERTY</td>
</tr>
<tr>
<td>POVERTY</td>
<td>ILL HEALTH</td>
</tr>
</tbody>
</table>

Student nurses Kate and Jennifer are led along the Spokane River on a cold October morning. Martha from Outreach is their guide and she calls out to Gypsy, who is resting under a shower curtain duct-taped to a tarp in a thicket of thorn trees. He's battling emphysema and has been short of breath lately. Allowing the nurses to examine him, Gypsy peels off his coat and starts unbuttoning his flannel shirt, revealing scars on his chest. "I think maybe you better take my blood pressure. I had a triple heart bypass up in Montana," he reports. Kate finds that it is high, 160 over 100 and tells him he needs to visit the clinic the next day to get some new blood pressure medication. They give him some juice and power bars, noticing that a half carton of eggs seem to be the only food around. They promise to check back the following week and bring the blankets he needs.

Every student at Washington State University who graduates with a nursing baccalaureate is required to take a semester of community health nursing. For some in Spokane, that means a semester of working with a needy downtown population—among them the poor, homeless, mentally ill, drug- and alcohol-addicted, and abused.

The programme succeeds in raising awareness about the relationship between health and poverty. Jennifer admits she was shocked by this part of her training: "I didn't know there were this many homeless people in Spokane and had no idea where they were. You could be walking by a trail to where they sleep, and never know it. I actually recognize people now. Instead of 'Oh there's a homeless person over there,' it's like 'hey there's Gary.' They have names now."

Statistics

The numbers related to health and poverty are dramatic:

- More than a billion of the world’s six billion people cannot fulfil their basic needs for food, water, sanitation, health care, housing, and education.
- 1.1 billion people worldwide are malnourished.
- An estimated 1.2 billion people live on less than US$1 a day.
- Life expectancy at birth in the least developed countries is less than 50 years, in comparison to 77 years in industrialised countries.
- 799 million in developing countries and 41 million in developed and transitioning countries are undernourished.
- Preventable diseases cause the deaths of 30,000 children per day globally.
- The lifetime risk of dying during pregnancy in Sub Saharan Africa, where almost half the population lives in absolute poverty, is one in 12, compared to one in 4,000 in Europe.

Major Problems Related to Poverty

Poverty is associated with major conditions that deplete poor people and render them vulnerable to diseases and poor productivity. Major health conditions include:

Malnutrition: When people are not able to obtain adequate amounts of food that provide the range of the nutrients needed to sustain health, they become more susceptible to disease and disability and thus, poverty. While many of the world’s industrialized countries are facing epidemics of obesity, under nutrition remains a
major problem in the developing world. About 49 percent of the 10.7 million deaths annually among children under five years of age in all developing countries are associated with malnutrition.30

The health effects of malnutrition are widespread. Table 2 presents a summary of some of these effects across the lifespan.

Table 2: Disorders of Nutrition Across the Lifespan

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Common Nutritional Disorders</th>
<th>Main Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embryo/foetus</td>
<td>Intrauterine growth retardation</td>
<td>Low birth weight (LBW)</td>
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<td></td>
<td>Iodine deficiency disorders (IDD)</td>
<td>Brain damage</td>
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<td></td>
<td>Folate deficiency</td>
<td>Neural tube defects</td>
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<td></td>
<td></td>
<td>Stillbirths</td>
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<tr>
<td>Neonate</td>
<td>LBW</td>
<td>Growth retardation</td>
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<td></td>
<td>IDD</td>
<td>Developmental retardation</td>
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<td></td>
<td></td>
<td>Brain damage</td>
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<td></td>
<td></td>
<td>Early anaemia</td>
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<tr>
<td>Infant &amp; young child</td>
<td>Protein-energy malnutrition (PEM)</td>
<td>Continuing malnutrition</td>
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<tr>
<td></td>
<td>IDD</td>
<td>Developmental retardation</td>
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<tr>
<td></td>
<td>Vitamin A deficiency (VAD)</td>
<td>Increased risk of infection</td>
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<tr>
<td></td>
<td>Iron deficiency &amp; anaemia (ID&amp;A)</td>
<td>High risk of death</td>
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<td>Goitre</td>
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<td>Blindness</td>
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<td></td>
<td>Anaemia</td>
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<tr>
<td>Adolescent</td>
<td>PEM, IDD, ID&amp;A</td>
<td>Delayed growth spurt</td>
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<td></td>
<td>Folate deficiency</td>
<td>Stunted height</td>
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<td>Calcium deficiency</td>
<td>Delayed /retarded intellectual development</td>
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<td>Increased risk of infection</td>
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<td>Blindness</td>
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<td>Anaemia</td>
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<td>Inadequate bone mineralization</td>
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<tr>
<td>Pregnant &amp; lactating women</td>
<td>PEM, IDD, VAD, ID&amp;A</td>
<td>Insufficient weight gain in pregnancy</td>
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<td>Folate deficiency</td>
<td>Maternal anaemia</td>
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<td>Calcium deficiency</td>
<td>Maternal mortality</td>
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<td>Increased risk of infection</td>
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<td></td>
<td>Night blindness</td>
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<td>LBW &amp; high risk of foetal death</td>
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<td>Adults</td>
<td>PEM, ID&amp;A</td>
<td>Thinness</td>
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<td>Lethargy</td>
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<td>Anaemia</td>
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<td>Older persons</td>
<td>PEM, ID&amp;A</td>
<td>Spine/hip fractures, accidents</td>
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<td></td>
<td>Osteoporosis</td>
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Nurses Help At-Risk New Mothers Cope

As a registered, public health nurse with the Nurse-Family Partnership (NFP) programme, Rita visits the homes of first-time, low-income mothers, many of whom are still teenagers. She works intensively with these mothers to improve maternal, prenatal, and early childhood health and well being, with the expectation that her intervention will help achieve long-term improvements in the lives of at-risk families. When Rita visits each family, she focuses on the mother’s personal health, the quality of her caregiving for her child, and the parents’ own development. She begins visiting while the mother is still pregnant, (before the 28th week, ideally between the 12th and 20th week) and continues through the first two years of the child’s life. Rita also investigates and works with the mother’s existing support system, including family members, fathers when appropriate, and friends, to help families access other health and human services they may need.

A recent study of the programmes’ outcomes showed that the visits made by Rita and the other nurses have resulted in a reduction of pre-term and low-birth-weight babies, improved parenting and home environments, reduced quickly recurring and unintended pregnancies, increased participation in the workforce, and reduced incidence of conduct disorders, involvement in crime, and delinquency.

It is obvious that consequences of malnutrition can be a major barrier to health and productive living. Poor people often face difficulty in finding adequate amounts of food to sustain optimal health. The production of cash crops for sale, seasonality of natural hazards such as droughts or floods, the high cost of animal protein, limited household funds for food, and unfair food allocation within households are important determinants of malnutrition.

Lack of Clean Water and Sanitation: Poor people live in unhealthy environments that affect the quality of their lives and their health. More than a billion people in the world do not have access to clean drinking water and over 2.4 billion lack access to proper sanitation facilities. Inadequate sanitation leads to diseases that can trigger the downward spiral of poverty. Approximately two million children die every year—6,000 a day—from such infections.  

Lack of clean water is a barrier to women’s education as they spend time and energy fetching water over long distances. Children’s education is also interrupted, as they too are often involved in collecting water. The lack of educational opportunities, lost productivity, and cost of health care sustains the vicious cycle of disease and poverty for billions of people.

Poor Access to Care: Quality health care depends not only on the availability of services, but on their appropriateness and acceptability to meet the needs of the populations they are designed to serve. Inadequate primary, secondary, and tertiary health care leads to the development and worsening of numerous treatable conditions. The following are some examples of health consequences resulting from poor access to care:

- Lack of culturally appropriate health education surrounding human sexuality contributes to unwanted pregnancies, unsafe abortions, and transmission of sexually transmitted diseases including HIV.
- The absence of quality prenatal care puts both mother and baby at higher risk for complications including malnutrition, birth defects, premature delivery, and difficulties during delivery, abortion, infection, and death.
- Lack of medical treatment at all levels leads to the progression and spread of treatable diseases such as HIV/AIDS, TB, and malaria and other conditions.
Major Infectious Diseases: HIV/AIDS, malaria, and TB are three infectious “diseases of poverty” that disproportionately affect the poorest populations of the world and have an impoverishing impact on households.

HIV/AIDS has reached catastrophic proportions in many parts of the world, causing devastation of individuals, communities, and societies. Each day 14,000 people are newly infected with the virus and some three million die annually. More than half of this population is under 25 years of age and in their prime productive years. Poverty is a major factor in HIV infection, with some girls in the world’s poorest countries exchanging sex for money towards school fees or to help their families.

In some countries in Sub Saharan Africa, up to 35 percent of the adult population is infected and most die prematurely from AIDS-related conditions. Life expectancy has fallen dramatically to below 50 years. Rates of HIV/AIDS infection are also growing rapidly in Central Asia and Eastern Europe.

As the disease spreads, individuals and families faced with significant caretaking and financial burdens are at greater risk of falling deeper into the spiral of poverty. Studies in Burkina Faso, Rwanda, and Uganda calculated that AIDS will increase the percentage of people living in extreme poverty from 45 percent in 2000 to 51 percent in 2015. The estimated 14 million AIDS orphans are vulnerable to poverty and homelessness. As countries lose their young, productive people to AIDS, households fall into deep poverty.

Caring for Isolated AIDS Patients in South Africa

Nurse Mpho Sebanyoni was so worried by the plight of AIDS patients in South Africa that she quit her well-paid hospital job to care for them. Her friends called her “mad” for quitting her secure post to become a nomadic AIDS carer. Walking up to 25 km per day from village to village, Mpho cares for the sick, teaching their relatives and friends how to look after them and educating them about AIDS.

“I started working in this way because I worried about the young people who were discharged from hospital with no one to care for them… When I first started, I came across some horrific cases.”

In one instance, a family had left a 27-year old relative to die alone in a bicycle shed. Mpho cared for him for his last three months, dressing his wounds, clothing him, and getting him blankets to keep warm. In another family, a sick grandmother who could hardly move was expected to care for seven grandchildren whose parents had died from AIDS. They are now all cared for now by a UK charity that provides communities with resources for orphaned children.

Mpho also created a home-care based project servicing 78 surrounding villages. Over 30 volunteers now assist her in training family members in home care of AIDS patients. In recognition of her work, Mpho was named South African Woman of the Year.

“No other disease [than HIV/AIDS] has so dramatically highlighted the current disparities and inequities in healthcare access, economic opportunity, and the protection of basic human rights.”

WHO (2003), Global Health Sector Strategy for HIV/AIDS, p. 3.
Malaria is a major cause of morbidity and mortality with serious impact on lost productivity. Children who survive infection often suffer from learning disabilities and brain damage that excludes them from schooling and increases their vulnerability to poverty. As malaria becomes more and more resistant to drugs, and the disease-carrying mosquitoes more resistant to insecticides, it is likely to become an even more serious threat to human development leading to increased poverty.  

In Africa today, malaria is understood to be both a disease of poverty and a cause of poverty.”

WHO (2003), Malaria in Africa, Malaria Fact Sheet, p. 1.

Tuberculosis (TB) is perhaps the greatest infectious killer of all times. Every year TB infects 100 million people, eight million of whom develop active TB. Every year TB kills about two million people—many of them adults who are in their most active and productive years. The global problem of TB is complicated by the spread of HIV/AIDS, the increased international movement of persons, and the implementation of poorly managed TB control programmes. In economic terms TB is a disease of poverty that traps the world’s poorest in a vicious cycle of disease and impoverishment.

Mental Disorders and Poverty: A review of research studies in six countries showed a significant relationship between a high prevalence of mental illness and poverty. Factors associated with mental illness were low educational levels, low income, lack of material possessions, lack of employment, and housing difficulties. Street children, drug users, internal migrants, persons who have been displaced, and individuals living with HIV/AIDS are at particularly high risk of suffering the impact of poverty and mental disorders. Mental illness is an example of the vicious cycle between health and poverty.

While poverty itself can be a contributing factor in declining mental health, mental illness results in numerous economic and social costs including:

- Lost productivity from:
  - Premature deaths caused by suicide (generally equivalent to and in some countries greater than the number of deaths from road traffic accidents);
  - People with mental illness who are unable to work;
  - The need to care for mentally-ill persons;
  - Direct and indirect financial burden for families.

- Unemployment, crime, stigma, and alienation in young people whose childhood mental problems were not adequately addressed to enable them to benefit fully from education.

- Costs of accidents caused by people who are psychologically disturbed; this is especially dangerous in professions such as train driver, airline pilot, factory worker, etc.

Poverty, Human Rights, and Health: Poverty remains one of the most important human rights challenges. Protection of the basic rights that all humans have to food and nutrition, health, education, and freedom from discrimination leads to decreased vulnerability to ill-health and poverty. Conversely, human rights violations such as violence against women and children, torture, slavery, and harmful traditional practices result in poor health and poor productivity associated with poverty. Understanding the health effects of poverty provides a basis for taking actions to address the links between poverty and health.
Health is central to overall human development and poverty reduction. To improve the health of poor people, a pro-poor health approach needs to be adopted and supported. Scaling up financial resources for health should be a priority. Through poverty profiles and analyses it is possible to identify actions against poverty and for health. As the Commission on Macroeconomics and Health (CMH) of the WHO has shown, improved health outcomes are a prerequisite for poor countries to break out of the cycle of poverty.\footnote{39}

Health inequalities are widening, which means that we are not reaching the poor with essential services. It is important to address health and poverty concerns because:

- It promotes the efficiency of efforts to ensure better outcomes both in health and poverty reduction.
- It is a matter of equity and social justice.
- It is a matter of human rights.

Cathy: “Street Nurse” to the Homeless

Travelling tirelessly around the city of Toronto, homeless activist Cathy is known as a “street nurse”. Her career began 20 years ago working for two prominent physicians in a downtown bank tower, but only working on the streets exposed her to the depth the homeless problem in her own city. “It is obscene that as a nurse in Canada, my specialty is homelessness,” said Cathy, who, along with the Toronto Disaster Relief Committee, has unveiled an underworld of homelessness beneath this country’s prosperous facade. “Lately I’ve been asking myself, ‘Am I still doing nursing?’ I now spend more time standing in front of groups making speeches, organizing vigils to respond to homeless deaths, and lobbying the federal government . . . as opposed to, for example, (treating) diabetes.” Cathy observes: “Homeless deaths are not simply about freezing to death, just as death by bullet is not the only cause of death in war. Housing is a prerequisite for health and it is purely and simply the lack of housing that creates the ill health I see every day.” Her success in raising awareness about the health effects of homelessness was recently recognized with a national award for compassionate social justice advocacy.

What can be done?

In its Policy Background Paper on Nursing and Development, ICN recommends actions to address the issue of health and poverty.\footnote{40}

- Advocate policies that give priority to the health needs of the poor and other at-risk groups.
- Promote educational preparation and nursing practice that meet the health needs of poor and at-risk populations.
- Emphasise in policy statements that improving the health of the poor also contributes to economic growth and development.
Support the development of models for local health systems that reach those most in need of health care.

Because health and poverty are interlinked, nurses and national nurses associations (NNAs) must work with policy makers and development groups to put health on the poverty agenda, and put poverty on the health agenda. This will involve a multisectoral approach that views investments in health as beneficial to poverty reduction and vice versa. This approach embraces and addresses the multiple determinants of health such as employment and income, housing, food security, access to education, water and sanitation, and lifestyle factors. Though nurses work in the health sector, they can become partners in putting health on the agenda of other sectors. Nurses can put health on the poverty agenda by:

- Lobbying to increase resource flows to the health sector, particularly coverage of poor people.
- Becoming informed about Poverty Reduction Strategy Papers (PRSPs) to formulate pro-poor health approaches and detailed health sector programmes.
- Following-up on the three health-related Millennium Development Goals (MDGs) that should be met by 2015: reducing child deaths, maternal mortality, and the spread of HIV/AIDS, TB, and malaria. Nurses and NNAs should also be involved in multisectoral approaches to address the other MDG goals listed in Table 2.
- Becoming involved in country coordinating committees of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) that disperses funds to countries hardest hit by HIV/AIDS, malaria and TB to combat these diseases.
- Calling for the Ministry of Health and other sectors to implement the recommendations of the Commission on Macroeconomics and Health (CMH): for scaling up of investment in health and for expanding close-to-client health services.
- Promoting an understanding that health is central to development.
- Linking with other sectors to address multiple determinants of health and poverty reduction such as education, water and sanitation, agriculture, labour and social protection, etc.

To link actions against poverty and for health, nurses and NNAs need to establish partnerships with other sectors to put poverty on the health agenda. This requires integrating poverty concerns into the work of health professionals and health policy makers so that the impact of health interventions on poverty is understood and appreciated. Initiatives that can be taken include:

- Lobbying to increase access to care and target investments for:
  - Health conditions that disproportionately affect the poor (TB, malaria, HIV, infant and child mortality, maternal health, malnutrition).
  - Regions or areas where the poor are concentrated.
  - Types of services that are likely to disproportionately benefit the poor (primary health care; public health interventions; preventive, health promoting care rather than curative).
  - Levels of service that are likely to disproportionately benefit the poor (primary rather than secondary or tertiary).
  - Targeting the poor within programmes.

- Advocacy to remove financial barriers to access to care, through:
- Strengthening social safety nets through social health insurance and social assistance programmes.
- Mobilizing resources for financing health services according to means and ability to pay.
- Introducing targeted subsidies and fee exemptions.
- Applying risk pooling and fund sharing principles where appropriate.
- Replacing direct out-of-pocket payments with various forms of pre-payment.

- Analysis of the problem of low demand and low use of services among the poor by:
  - Identifying and addressing social, linguistic, and other non-financial barriers.
  - Improving the quality of care.
  - Increasing the awareness, sensitivity, and skills of providers.
  - Enhancing awareness and information among the poor.

- Monitoring and evaluation of access to care by:
  - Disaggregating information and analysis by socio-economic status, income, sex, ethnicity, rural-urban residence, employment status (formal/informal), etc.
  - Identifying the incidence of benefits: are the poor benefiting from services? Why or why not?

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**Nurses Respond to Effects of Rural Poverty in Schoolchildren**

Minutes after the doors open at the middle school where she works, kids file into the closet-size waiting room of nurse Gwen. There are children with jaws swollen by infections from tooth decay, diabetic children who need to check their blood sugar, and asthmatic students waiting for a burst of medicine from inhalers. Grimmer realities of life also visit Gwen's examination room. There are pregnant 13- and 14-year-olds who need prenatal care and others suffering from sexually transmitted diseases. Nurses like Gwen understand that poverty restricts the educational opportunities of the children she sees. Unable to meet basic needs, their families encounter tremendous difficulties in fostering the development of their children. Their daily struggles include inability to pay for safe, quality childcare; lack of access to affordable health coverage; inadequate housing; and lack of reliable transportation. So Gwen and other school nurses are out there on the front lines every day, strengthening the children’s chances of a good education by improving their health status. She has often been the first and only consistent source of health services for many uninsured school-aged children.

Aware that families who need assistance the most are often the least aware of available benefits, the nurses make special efforts to conduct effective outreach and referrals to state programmes and affordable health care coverage. In turn, aware of the nurses' contributions, the state legislature is working to increase their number throughout the school system.

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In order to put health on the poverty agenda and poverty on the health agenda, nurses and NNAs need to become health activists. Their expertise in health and illness and sharing their experiences of caring for poor people provides nurses with good credibility to contribute to the national debate on actions against poverty and for health.
While the health care needs of the poor are greater than those of the non-poor, their access to health services is lower, due to a variety of financial and non-financial barriers. One of these barriers is the perceived low quality of care they may receive. There is some evidence that the health care providers are not sufficiently aware of or sensitive to the health care needs and preferences of the poor; rude and disrespectful treatment by health care providers is widespread.\textsuperscript{42} The poor face barriers in health-seeking behaviour and access to care, including:\textsuperscript{43}

- Physical, such as distance of health facilities;
- Actual or perceived poor quality of services;
- Financial related to the following costs:
  - Direct costs (fees for services, costs of tests and drugs, etc.);
  - Indirect costs (transport, food);
  - Opportunity costs (lost wages, time spent, other household expenses curtailed);
- Knowledge- or awareness-related barriers;
- Social, cultural barriers (social, cultural, or linguistic distance from health care providers).

The World Bank has identified four ways services are failing the poor. First, while governments devote about a third of their budget to health and education, they do not necessarily reach poor people. Public spending on health and education generally benefits richer people. For example in India the richest fifth receive three times the curative health care subsidy of the poorest.\textsuperscript{44}

Second, even when public spending can be reallocated to be pro-poor, the money doesn’t always reach the frontline service provider such as smaller schools and clinics in remote parts of the country. Third, even if the share allocated to remote areas is increased, teachers, doctors, and nurses often work in a system where corruption is rife, incentives for service delivery are weak, and absenteeism is not monitored. For example, a survey of primary health care facilities in Bangladesh found the absenteeism rate among doctors to be 74 percent.\textsuperscript{45} Even when present, some service providers treat poor people badly.

Not addressing the causes of lack of demand for health care is the fourth way services fail poor people. Poor people often do not send their children to school or take them to a clinic. This can be attributed to poor health facilities, cultural factors, or social distances between poor people and service providers. In Bolivia 60 percent of children who died before age five had not seen a formal health provider during their illness. Even when services are free, poor families often cannot afford the time it takes to travel, be it 7.99 km to the nearest primary school in Mali or the 22.9 km to the nearest medical facility in Cameroon.\textsuperscript{46}
Culturally Sensitive Nurses Straddle the Border

All sorts of undesirable health records are being broken at the US-Mexican border, home to nine million people. These include highest teen pregnancy rate, highest obesity rate, highest diabetes rate, and highest rate of car crash injuries caused by not wearing seatbelts.

About 3.4 million people here fall below 200 percent of the poverty level. More than a third are trapped in substandard living conditions requiring special assistance. The vast majority cannot afford health insurance, so do not seek preventative medical care and have difficulty understanding why they need to look after their blood pressure or cholesterol levels when they do not feel ill. To complicate matters further, the economic disparity between Mexico and the US compels more than 800,000 people to cross the 2,000-mile-long border every day.

Rudy is one of the culturally and linguistically competent nurses playing a key role in reducing the serious health inequities faced by U.S.-Mexican border populations. A family nurse practitioner with a medical centre on the Arizona/Mexican border, he is also president of the local chapter of the Hispanic nurses association. “As nurses,” he explains, “we see their health problems every day: heat exhaustion, hypothermia, and poisoning. They get so thirsty crossing the desert that they’ll drink anything, including antifreeze. If they make it to the ER, we send them to dialysis.”

“The worst disease at the border is poverty,” Rudy emphasizes, “It results in unemployment, teen pregnancy, lack of quality housing, domestic violence, diabetes, cancer and more.”

Robert, an Hispanic nurse in a Texas border town clinic, loves his work: “Here, you get to know how the people live and what kind of resources they have. You get to meet their families, and to understand the patients as people.”

Pro-poor Health Systems

A pro-poor health approach gives priority to promoting, protecting, and improving the health of poor people. As the ICN Policy Statement affirms:

“The International Council of Nurses and its member national nurses' associations advocate for the development of national health care systems that provide a range of essential health services accessible to all the population, as determined within the country in both preventive and curative care.

Where such services are not publicly funded, ICN believes that governments have a responsibility to ensure accessible health services to vulnerable groups.”

Health systems have to focus on services that address the principal health needs of poor people, reach vulnerable groups more equitably, and improve their health. In taking a pro-poor approach, health systems may:

Focus on human resource strategies: Globally health systems face a shortage of health professionals, unsupervised personnel, high attrition rates, low salaries, and poor working conditions. In many countries, the fact that health workers are themselves poor leads to absenteeism, lack of motivation, and poor quality services. Nurses and national nurses associations can be part of government initiatives to:

- Analyse the skill mix of health workers; review the scope of nurses, midwives, medical assistants, and others to reach out to vulnerable and poor people.
• Reorient training to focus on health promotion and preventive and outreach services.
• Provide financial and non-financial incentives including adequate pay, accommodation, protection from workplace violence, and continuous education.
• Create job opportunities and incentives for work in remote and underserved areas.
• Increase access to information and communication technology for health personnel to improve standards of training and continuing education.

**Strengthen health services:** Addressing the diseases particularly associated with poverty and the priority health needs of the poor will reduce the burden of communicable and chronic diseases. Weak and collapsing health systems are inadequately prepared to address the health needs of society in general and needs of the poor in particular. Nurses and national nurses associations can be active partners with governments, development agencies, NGOs, and others to:

• Increase access to maternal and child health services including antenatal care, skilled care during labour and delivery, and emergency care.
• Promote healthy lifestyles and prevent chronic conditions such as diabetes, respiratory problems, mental health and psychosocial problems, injuries, and tobacco and alcohol-related diseases.
• Prevent communicable diseases such as upper respiratory infections, HIV/AIDS, TB, malaria, diarrhoea, and malnutrition that disproportionately affect poor people.
• Set priorities that reflect the health needs of poor people and involve them in identifying their needs.
• Analyse health care data to determine health status, health service needs, and health service use by poor and vulnerable people.
• Target vulnerable and underserved populations such as remote rural populations, refugees, and displaced people.
• Ensure availability of medicines and equipment in health services.
• Improve staff morale and capacity to provide quality care.
• Improve the attitude and behaviour of health personnel, particularly toward poor people.
Nurses' Teaching and Care Lead to Better Health in a Poor Peruvian Community

Led by two professors, a team of nine senior nursing students from a Philadelphia university made a trip to a remote Peruvian village. Their goal was to educate the families about health issues to improve their standards of health and living. While they found that acute care of many illnesses was impossible, simpler measures were very effective. These included education on nutrition, disease prevention, immunizations, sanitation, hygiene, and food preparation. Classes were taught in the Heimlich Maneuver and in women's health issues including breast self-examination.

The nurses divided their day between visiting homes in the morning and teaching classes in the afternoons. In the homes, they checked blood pressure, dressed wounds, and assisted victims of stroke, diabetes, heart defects, and cancer by explaining how to take their medication and when to visit doctors. The nurses found that poverty hindered many families from seeing doctors and refilling their prescriptions. One young nurse realized that what the community really needed from them was “encouragement and care.” She observed that the classes “were instrumental in helping members of the community better care for themselves by improving their daily living routines.”

Karen, one of the students, reflected upon her return that she had witnessed “a wisdom inherent in another culture, tremendous human resilience, and resourcefulness. Those we taught and cared for taught us so much more in return, lessons that cannot be learned in classrooms or in books.” The team felt that their intervention laid the foundation for better health and helped the community move forward.

Support equitable health financing mechanisms: On-going health care reform and cost-containment measures such as user fees, cost-sharing, and privatisation of health services raise concerns about equity and access to health care of all people, particularly the poor. Health financing mechanisms should not be a barrier to access to health care by the poor or add to their financial burden and impoverishment. Publicly funded or subsidised health services, prepayment systems, and health insurance contributions lessen out-of-pocket payments at the time of illness and ensure equitable access to health for all people. Nurses and national nurses associations need to be involved with governments, development agencies, NGOs and others in efforts to:

- Lobby for equitable financial strategies that protect everyone, particularly poor people, from being excluded from health services or from heavy financial burden.
- Increase access to health care by groups with limited ability to pay user fees or insurance contributions, such as women with less access to income.
- Develop different mechanisms that restrict out-of-pocket payments at the time of illness.
- Support community financing schemes and voluntary insurance with the active participation of poor people.
- Monitor the impact of cost-sharing approaches such as user fees, and other revenue generation schemes on the use of health services by poor people.
- Lobby for free primary health care services to poor people.
- Identify highly vulnerable groups and communities that should have access to health services.
- Identify priority diseases and conditions that cause a heavy burden of ill-health, loss of productivity, and death.
- Develop policies and procedures for exemption of poor people from payments for hospitalisation.
Table 3: Examples of main types of policies and laws that relate to health across the life cycle of the poor.

<table>
<thead>
<tr>
<th>Poverty-related Policies and Laws Affecting Health Across the Life Cycle</th>
<th>Purpose of policy</th>
<th>Example of law</th>
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<tbody>
<tr>
<td><strong>Stage 1: Pre-conception and contraception</strong></td>
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<tr>
<td>1. Provide appropriate contraceptive methods for poor/vulnerable women.</td>
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<td>Contraceptives to be provided free/at low cost to the poor.</td>
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<td><strong>Stage 2: Pregnancy and early fetal growth</strong></td>
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<td>1. Establish minimum age for marriage.</td>
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<td>Legal marriage for girls, 18 and for boys 20 years.</td>
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<td>2. Define minimal antenatal care for poor women.</td>
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<td>Eligible women are entitled to three free antenatal visits.</td>
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<td>3. Regulate volunteer health workers e.g. traditional birth attendants (TBAs).</td>
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<td>TBAs permitted to conduct home deliveries after training.</td>
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<td><strong>Stage 3: Childbirth and welfare of mother and newborn</strong></td>
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<tr>
<td>1. Increase poor women’s access to skilled birth assistants.</td>
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<tr>
<td>Produce minimum number of skilled assistants for home delivery.</td>
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<td>2. Reduce maternal and newborn death rate.</td>
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<td>Compulsory investigations of maternal/newborn deaths.</td>
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<td>3. Forbid FGM.</td>
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<tr>
<td>FGM is a punishable offence.</td>
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<td>4. Promote only breastfeeding for first six months.</td>
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<td>Restrict formula feeds.</td>
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<td><strong>Stage 4: Infancy</strong></td>
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<td>1. Increase access to child health services, e.g. growth monitoring, immunisation.</td>
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<td>Free services for children under years.</td>
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<tr>
<td>2. Prevention of malnutrition in children living in drought-affected areas.</td>
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<td>Provide free supplementary feeding.</td>
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<td>3. Eliminate discrimination against the girl child.</td>
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<td>Monitor abortion of female foetuses and newborn deaths.</td>
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<td>Stage 5: Childhood</td>
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<tr>
<td>2. Prevention of diarrhoeal diseases.</td>
<td>Enforce food hygiene, improve access to clean water supply.</td>
<td></td>
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<tr>
<td>Child labour.</td>
<td>Enforce labour laws against child labour.</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Stage 6: Adolescence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase access to reproductive health services, e.g. contraception, sex education, prevention of HIV/AIDS and other STDs.</td>
<td>Provide youth friendly services, school health, drop-in centres, peer education, etc.</td>
</tr>
<tr>
<td>2. Prevent abuse of tobacco, alcohol, drugs, other substances of abuse.</td>
<td>Prohibit advertising, sales of and tobacco, alcohol, etc.</td>
</tr>
<tr>
<td>3. Prevent road traffic injuries and deaths.</td>
<td>Enforce minimum age for driving licences.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 7: Adults</th>
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<tbody>
<tr>
<td>1. Prevent diseases related to poor sanitation and lack of safe water.</td>
<td>Improve sanitation and access to safe water supply. Subsidy on staple food, food-for-work, land rights for women.</td>
</tr>
<tr>
<td>3. Increase access to reproductive health services including family planning for low-income groups.</td>
<td>Provision of legal aid, shelter.</td>
</tr>
<tr>
<td>4. Prevent domestic violence against women.</td>
<td>Legal and educational measures.</td>
</tr>
<tr>
<td>5. Fight stigma against people living with HIV/AIDS.</td>
<td></td>
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<tr>
<th>Stage 8: Older people</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase access to sheltered housing options for older people.</td>
<td>Provision of shelters, income subsidy for older people.</td>
</tr>
<tr>
<td>2. Increase food security for older people who are refugees.</td>
<td>Food subsidy, food-for-work.</td>
</tr>
<tr>
<td>3. Support older people who care for children orphaned by AIDS.</td>
<td>Home and community care Income support, etc.</td>
</tr>
</tbody>
</table>

Conclusion

Poverty and health are interlinked. In understanding the effects of poverty on health and poor health on poverty, nurses and NNAs can work with multiple sectors to break the link. Actions taken by nurses and others to improve health contribute to poverty reduction. Similarly actions taken to reduce poverty have positive impacts on health outcomes. A proper understanding of poverty requires analysis and profiling of the determinants. It is also important to understand the health effects of poverty. While poverty is growing globally, there seems to be a renewed interest to address it and its effects. The agreement on the Millennium Development Goals (MDS), the WHO Macroeconomics and Health Commission, and the World Summit on Sustainable Development are signs that the will to reduce poverty is growing.

In developing pro-poor health systems and policies, it is important to identify and prioritise the sectors that have a major impact on health and poverty reduction. Education and health are fundamental to poverty reduction and are prominent in the Millennium Development Goals. Primary education, particularly for females, is strongly related to improved health care of children, families, and communities. Food security is related to nutrition and health. Access to water and sanitation are essential for reducing infectious diseases. Prevention of violence and injuries are effective public health measures to reduce the burden of death. Actions in these and other sectors are at the heart of improving health and reducing the spiral of poverty.
TOOL KIT

FOR

WORKING WITH THE POOR
Action Against Poverty – For Health

- Apply pressure to your local, regional and national governments for investment in education and models for local health care systems that reach those most in need of health care.

- Raise awareness among nurses about the importance of advocating on behalf of the poor and treating them with respect and by developing and publishing a policy statement.

- Promote educational preparation and nursing practice that meets the health needs of poor and at risk populations.

- Work to ensure that nursing education, including continuing education, includes information about the determinants of health, about empowerment, and about working with communities and vulnerable groups to address their unique needs.

- Speak out. Publish a press release on poverty (see sample) with statistics (see sample) on International Nurses Day.

- Publicise the Millennium Development Goals (MDGs) widely among the association membership.

- Launch a pro-poor health campaign to give priority to promoting, protecting and improving the health of poor people.

- Follow-up action in support of the MDGs in the three health goals that should be met by 2015: reducing child deaths, maternal mortality and spread of HIV/AIDS, TB and malaria.

- Establish partnerships with other sectors to put poverty on the health agenda and specifically to address the other MDG goals listed in Table 2.

- Get involved in the country coordinating committees of the Global Fund to Fight AIDS, Tuberculosis, Malaria (GFATM) that disperses funds to countries hardest hit by HIV/AIDS, malaria and TB to combat these diseases.

- Make submissions to the Ministry of Health and other sectors to implement the recommendations of the Commission on Macroeconomics and Health (CMH): for scaling up of investment in health and for expanding close-to-client health services.

- Advocate to promote understanding of health as central to development.
<table>
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<tr>
<th>Health-related Millennium Development Goals</th>
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<tbody>
<tr>
<td>Goals and Targets of the Millennium Declaration</td>
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<tr>
<td><strong>Goal 4: Reduce child mortality</strong></td>
</tr>
</tbody>
</table>
| **Target 5:** Reduce by two-thirds, between 1990 and 2015, the under five mortality rate. | - Under-five mortality rate.  
- Infant mortality rate.  
- Proportion of one-year-old children immunised against measles. |
| **Goal 5: Improve maternal health** | |
| **Target 6:** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. | - Maternal mortality ratio.  
- Proportion of births attended by skilled health personnel. |
| **Goal 6: Combat HIV/AIDS, malaria and other diseases** | |
| **Target 7:** Have halted by 2015 and begun to reverse the spread of HIV/AIDS. | - HIV prevalence among 15/24 year-old pregnant women.  
- Condom use rate of the contraceptive prevalence rate.  
- Number of children orphaned by HIV/AIDS. |
| **Target 8:** Have halted by 2015 and begun to reverse the Incidence of malaria and other major diseases. | - Prevalence and death rates associated with malaria.  
- Proportion of population in malaria risk areas using effective measures for malaria prevention and treatment.  
- Prevalence and death rates associated with TB.  
- Proportion of TB cases detected and cured under directly observed treatment, short-course (DOTS). |
| **Goal 8: Develop a Global Partnership for Development** | |
| **Target 17:** In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries. | - Proportion of population with access to affordable, essential drugs on sustainable basis. |

SAMPLE PRESS RELEASE
Poorer People Live Shorter Lives and are Sick More Often than the Well-off
Nurses take aim at poverty and the link with poor health

Geneva 12 May 2004 — On the occasion of International Nurses Day, nurses worldwide are drawing attention to the links between poverty and health and calling for multi-sectoral action to reduce poverty and improve health. Poverty is a complex and pervasive problem throughout the world. More than half of the developing and transitioning world lives in poverty, with about 1.2 billion people or 23 percent of the world’s population living on US$1 or less per day. An additional 1.6 billion people make do with between US$1 to $2 per day.1

In most countries poverty has a female face, as about 70 percent of the 1.2 billion people living in poverty are female. In many countries, poverty of women has risen significantly over that of men over the last two decades. Women are twice as likely as men to be illiterate and significantly more likely to suffer from poverty-related health conditions such as iron deficiency anaemia and protein-energy malnutrition.2

“Poverty is the greatest misery we face today. As nurses, everyday we encounter people that are unable to meet their basic needs due to poverty and we see how this makes them more susceptible to disease and early death”, stated Christine Hancock, President of the International Council of Nurses. “The particular cruelty of poverty is its vicious circle, whereby people do not have access to health, education and other means to increase their income and to improve their health status. Yet without good health, a person’s potential to escape from poverty is severely weakened.”

Nurses are calling for investment in education, health care and sound social policy to improve health outcomes. In their campaign to reduce poverty and its negative impact on health, they will be advocating for equity of access to health services, fair labour standards, safe work places and equal rights for women.

As the most trusted of health professions, nurses can work effectively with and on behalf of poor people to ensure that their voices are heard, that they are included in decisions concerning them, and that the inequalities of access, employment, services, gender, ethnicity and race are addressed.

Editor’s note

The International Council of Nurses (ICN) is a federation of 125 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses since 1899, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

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Email: carrwalk@icn.ch - Web site www.icn.ch
## Facts and Figures: The Real Story of Poverty and Health

### 1 billion
More than a billion of the world’s six billion people cannot fulfil their basic needs for food, water, sanitation, health care, housing, and education.

### 1.2 billion
The number of people in the developing and transitioning world living on US$1 or less per day.

### 1.1 billion
The number of people worldwide who are malnourished.

### 70 %
Of the 1.2 billion people living in poverty, 70 percent are female.

### 41 %
Of the total 180 million unemployed in the world, 41 percent are between the ages of 15 and 25.

### 5 X
Children living in poverty are five times more likely to die before reaching the age of five.

### 2.5
Those living in poverty are 2.5 times more likely to die between the ages of 15 and 59 than those in higher income groups.

### 1 in 12
Lifetime risk of dying during pregnancy in Sub Saharan Africa, compared with one in 4,000 in Europe.

### Under 50
Life expectancy at birth in the least developed countries, compared with a 77-year life expectancy in industrialized countries.

### 49 %
Of the 10.7 million deaths annually among children under five years of age in all developing countries, 49 percent are associated with malnutrition.

### 2 million
Approximately two million children die every year—6,000 a day—from infections caused by poor sanitation.

### 115 million
The number of children who do not attend school; of them, three-fifths are girls.

### 42 million
Around the world, 42 million people are living with HIV/AIDS, 39 million in developing countries.

### 10 %
Only 10 percent of global spending on medical research and development is directed at the diseases of the poorest 90 percent of the world’s people.

### 54
Number of countries that were poorer in 2003 than they were in 1990.
Nursing and Development

ICN Position:

As an advocate for healthy communities and sustainable development, ICN collaborates with nursing, health care and other organisations to identify health needs of populations at risk. ICN works strategically to enable nurses and others to develop and achieve goals for nursing and health care that take into account local needs, local socio-political, demographic and economic conditions and constraints, and the local cultural context.

ICN invests its resources to produce the maximum beneficial effect for health outcomes, and the development of nursing and health care. It supports local, cost-effective approaches to health systems development, including the just treatment and security of nurses and health professionals. Within nursing, ICN’s emphasis is on strengthening national nurses’ associations so as to enhance self-reliance and foster their ability to help others.

ICN values the ‘cascade’ approach in development, where the expectation is that, in return for assistance, partners will help others in a like manner. This also involves taking responsibility and creating conditions for local development within a framework that emphasises the principles of justice, equity, non-discrimination, transparency and flexibility.

ICN supports development strategies and policies that:

- Increase resources and at the same time provide adequate prosperity to improve health and well being and reduce health inequalities, and provide equitable, cost-effective, access to health care.

- Strengthen women and children’s capacity to exercise more control over their lives and living conditions.

- Encourage interdisciplinary and inter-sectoral collaboration.

- Protect the natural environment.

- Support infrastructure development in nursing and health.

- Help groups to help themselves and others.
Background:

ICN’s vision is a healthy world where access to health is a basic human right. ICN works with governments, national and international organisations in helping populations to attain a level of health that will permit them to lead a socially and economically productive life.

ICN views development as creating conditions that allow populations to meet the needs of the present without compromising the ability of future generations to meet their needs. For us, sustainable development is concerned with providing a framework whereby groups, communities and individuals have access to resources and opportunities, and exercise their rights, using them to create infrastructures that promote healthy communities.

Strengthening the nursing profession is key to improving world health. In fulfilling its mandate to represent nursing world-wide, advance the profession and shape health policy, ICN strives to base its programmes and initiatives on its values of visionary leadership, inclusiveness, flexibility, partnership, and achievement.

Adopted in 2000

The International Council of nurses is a federation of 125 national nurses’ associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

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Publicly Funded Accessible Health Services

ICN Position:

The International Council of Nurses and its member national nurses' associations advocate for the development of national health care systems that provide a range of essential health services accessible to all the population, as determined within the country in both preventive and curative care.

Where such services are not publicly funded, ICN believes that governments have a responsibility to ensure accessible health services to vulnerable groups.

Essential and accessible health services should be determined by each country's health needs. They should balance efficiency and cost-effectiveness with quality, striving to achieve this balance within the resources available.

ICN supports efforts by national nurses associations to influence health and public policy that is based on the health priorities for the nation, equity, accessibility of essential services, efficiency (including productivity), cost-effectiveness, and quality care.

ICN promotes educational preparation in management and leadership development that prepares nurses for a broad range of roles and responsibilities. ICN supports efforts by national nurses associations to ensure that government policy for publicly funded health services does not downgrade the level of nursing education required by the complex demands of these services.

ICN and its member associations support and promote the principles of primary health care as a means of helping promote availability of and accessibility to essential health services at a cost that communities and nations can afford.

To ensure accessible, cost-effective and quality services, appropriate regulatory principles, standards and mechanisms need to be established and be applied equally to both private and public health services.
Nursing education systems should ensure curricula are regularly updated to meet the needs of the changing environment, that they are appropriately implemented, and that ongoing education needs are addressed.

A healthy nation is a vital national resource. A prime goal of each nation must be to achieve the best health status possible for the population within the resources available.

ICN and member associations need to maintain effective networks with relevant stakeholders to help ensure resource allocation and availability of services is based on needs and priorities, promotes primary health care, and considers quality considerations as well as costs.

This goal is made more difficult because of:

- Increased demand for health services (due to factors such as the changing nature and amount of health problems, aging populations and rising public expectations);
- Rising health care costs often associated with insufficient resources and with an increased emphasis on costly applications of advanced technology;
- Inadequate use of available resources because of inefficiencies in the planning and priority setting, utilization and management of health care systems.

Health system reform in many countries is trying to address these problems. This has implications for both private and public components of health systems.

**Adopted in 1995**

**Last reviewed in 2001**

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**Related ICN Position:**

- Promoting the Value and Cost Effectiveness of Nursing

**ICN Publications:**

- Cost Effectiveness in Health Care Services - Guidelines for National Nurses’ Associations and Others, Geneva, ICN, 1993
- Costing Nursing Services, Geneva ICN, 1993

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Universal Access to Clean Water

ICN Position:

ICN believes that the right to water is non-negotiable. Secure access to safe water is a universal need and fundamental human right; an essential resource to meet basic human needs, and to sustain livelihoods and development. Water is a public good and ICN opposes privatisation of water services and resources.

ICN also believes that with commitment and political will by governments and others, clean and safe water can be made accessible to all people at low cost using appropriate technology.

ICN supports the target set in the UN Millennium Development Goals that aim to halve by 2015 the proportion of people without sustainable access to safe drinking water. Access is a key aspect of effective poverty alleviation strategies.

ICN calls on nurses and National Nurses Associations (NNAs) to:

- Work with representatives of other sectors such as local government and water resources to lobby for clean and safe water supply.
- Urge their governments to provide safe and accessible water to the whole population.
- Lobby for a pro-poor and gender sensitive approach based on understanding of the roles of women and men in water management, so that women and men can participate equally to increase access to clean water.

Further ICN calls on nurses and NNAs to work with national and international bodies concerned with water supply to:

- Heighten vigilance and ensure safety of water supplies from intentional attacks, using biological, chemical or other harmful agents.
- Lobby for sound regulatory policies that ensure universal access to clean water, and
- Monitor the public health impact of deregulation and privatisation of water supply, especially on vulnerable populations.

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Background

Nurses work with individuals, families and communities to promote health, to prevent illness, to restore health and to alleviate suffering. Nursing’s mission to achieve these goals would be frustrated without access of the population to clean and safe water supply.

Rapid population growth, industrialization, urbanization, agricultural intensification and water-intensive lifestyles are resulting in global water crisis. About 20 per cent of the population lacks access to safe drinking water, while 50 per cent lack access to a safe sanitation system.

More than 3 million people die each year from water-related diseases such as diarrhoea; and millions suffer from diseases such as dysentery and trachoma. Disease due to poor sanitation and hygiene cause the deaths of 2 million children every year.

Due environmental degradation and pollution, sources of water supply are threatened with contamination by sewage and harmful bacteria, chemicals such as nitrates; heavy metals such as lead, mercury, and arsenic; and persistent organic compounds.

The lack of clean water supply poses a serious threat to public health. It also adds to the heavy burden of women in some countries, who often travel long distances to fetch water on their back, with serious health consequences. Despite the back-breaking task to collect water, such water is often contaminated with animal, human, or industrial waste and other contaminants with harmful consequences to health.

There is growing concern that sources of water supply can be targeted for attack by bacteriological, chemical or other agents with the intention to cause harm to large populations.

Global trends toward deregulation and privatisation of water supply represent serious barriers to universal access to clean and safe water.

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3 www.unep.org
Adopted in 1995
Revised in 2002

Related ICN Positions:
- Reducing environmental and lifestyle-related health hazards
- Towards elimination of weapons of war and conflict
- Nurses and primary health care
- Nurses and human rights

ICN Publications:
- Fact Sheet on Safe Household Water: Preventing Disease, Saving Lives

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