Health and Wellbeing in the Lives of the Extreme Poor

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The Extreme Poverty Research Group (EPRG) develops and disseminates knowledge about the nature of extreme poverty and the effectiveness of measures to address it. It initiates and oversees research and brings together a mix of thinkers and practitioners to actively feed knowledge into practice through interventions taking place in real time. It is an evolving forum for the shiree family to both design and share research findings.

The data used in this publication comes from the Economic Empowerment of the Poorest Programme (www.shiree.org), an initiative established by the Department for International Development (DFID) and the Government of Bangladesh (GoB) to help 1 million people lift themselves out of extreme poverty. The views expressed here are entirely those of the author(s).

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INTRODUCTION

It is widely recognised that ill health is one of the most serious life challenges that individuals and households face. It is equally recognised that ill health, either directly or indirectly, is a major drain on an individual or household's resources, and has been identified as one of the main reasons people fall into or remain in poverty. Examining the relation between poverty and health is therefore critical to understanding the potential impact of development interventions on people's overall well-being. By way of an introduction to this paper, we would like to trace out some key ideas which together constitute a point of departure for thinking about the significance of health in understanding livelihoods.

First, health is both means and ends; *instrumental to* as well as *constitutive of* wellbeing. Development professionals are more familiar with the former idea but less so with the idea of health as being constitutive of wellbeing. Health has long been a central element in the notion of basic needs. And while many needs can be understood as relative to cultural and social contexts, Doyal and Gough in their *Theory of Human Need* (1991) identify two needs which are universal across time as well as space: health and autonomy. Their argument is that to live well in whatever cultural context, people have to possess a minimum level of good health. Health therefore is a universal prerequisite for successful and critical participation in one's form of life. The authors accept that both health and autonomy (i.e. irreducible human needs) can be delivered through more relative 'needs satisfiers', which often appear to us as the needs themselves, such as food, shelter, and clothing. Furthermore, both of these universal human needs can be understood as inputs into functionings and capabilities in the forms of physical energies, mental states and social room for agency (i.e. autonomy). Arguably, as our analysis will show below, the idea of 'security' as an objective need could be added to form a trio of interdependent universal human needs. Thus health is best seen as a form of security as well as a proxy for it; and security is understood as both an input and outcome of autonomy.

Second, the argument linking poor health and poverty is by now irrefutable. Poverty has a very high cost for health. It makes people sick and in some cases, irreversibly so. It also reduces people's ability to deal with the consequences of ill health because resources tend to be few and entitlements weak. At the same time, to complete a vicious 'poverty cul de sac', being able to forge a decent livelihood requires good health. As a result, health is always more precarious, less certain, more insecurely present among the poor. Narayan *et al* (2000) summarised the significance of health and poverty in their seminal work on the *Voices of the Poor* when they noted that health was one of main concerns of the poor precisely because of its ability to quickly drag people into poverty: "loss of income coupled with the cost of treatment and the transformation of a wage earner into a dependent—make injury and illness common triggers of impoverishment" (Narayan et al, 2000: 89).

Third, the link between poverty and ill health is particularly germane to the context of Bangladesh. Although Bangladesh has made good progress in key health indicators notably in relation to the MDG 4 target (under-5 mortality rates) and the MDG 5 target

(maternal mortality ratio) (Countdown 2012, NIPRT 2012), the country still faces formidable health related challenges. Food insecurity remains a critical and volatile issue in Bangladesh and although the number of people suffering from malnutrition has decreased recently, it remains very high. Over 41 million people or 27 % of the total population are still considered malnourished; while 41% of children under five in Bangladesh are stunted, 16% are wasted, and 36% are underweight. Crucially, there are twice as many stunted children in the poorest quintile of the population than in the richest quintile (NIPRT 2012). Such conditions, especially at an early age, have long term impacts. They normally lead to continuous ill health, chronic morbidity and shortened life expectancy throughout adulthood. These conditions are also transferred inter-generationally, and gender discrimination means that they affect girls and women more than boys and men (UNICEF 2012). Ill health therefore is a common occurrence among the poorest in Bangladesh and a major factor associated with movements into poverty (Sen 2003, Kabeer 2009). Recent work on poverty dynamics in Bangladesh provides an even more alarming and stark scenario. Davis (2011) found that as many as 75% of the households used in his research identified illness and injury as the primary cause of impoverishment in their lives. To put this into perspective, the second reason reported as the main cause of impoverishment was dowry and wedding expenses. This however occurred only in 39% of cases. Furthermore, according to Davis, the prevalence of ill health and its negative impact on livelihoods is disproportionately higher among the chronically poor, as opposed to the poor.

CHRONIC ILLNESS AND EXTREME POVERTY

In Shiree's CMS3 March 2010 survey, 36.9% of households (n=336) suffered from chronic illness. Our definition of chronic illness was purposefully very broad[1] and therefore it is important to recognise the variable nature of health problems faced by the extreme poor. Respondents suffering from a range of illnesses including dengue fever, TB, diarrhoea, diabetes, cancer and arthritis will have described themselves as 'chronically ill' and yet in terms of risk to life, prognosis, cost of treatment and many other factors, their illnesses are very different. In this paper, our focus therefore is not on particular types of illnesses but on their impact on extreme poverty dynamics. The flowing case illustrates the typical consequences of chronic illness for the extreme poor.

Illness makes Khalil Howlader's life very difficult

When Khalil Howlader's first daughter was four months old, she suffered severe bouts of fever and diarrhoea. At that time Khalil had to sell his rickshaw van for 1,700 Taka. After selling his van, he began working as a day labour in the cement factory, and when he had time, he would pull a rented van to earn some extra cash. Khalil also joined a co-operative society started up by the shop owners of the local market in 2001, and stayed in it for one year. In the end however he had to leave the society because he could not pay the weekly instalments. He had no disposable income since all his money was being used to support his family.

[1] In the questionnaire, chronic illness referred to any illness that had occurred over the previous three months

Eventually the work at the factory took its toll on Khalil's health. He began to suffer from severe and recurrent chest pains and eventually was no longer able to work. He was forced to leave his job. Over the next two years, the chest pains intensified and he was incapable of carrying out basis tasks. Naturally, noone wanted to give him work and he became labelled as someone who was always sick. So just at the time when Khalil was least employable, his health needs were at their highest. This dragged his family into a situation of severe deprivation.

In tracking changes of chronic illness status, we compare data on the 336 households collected in March 2012 (round 1) and March 2011 (round 4). We classify the households into four groups: those with no chronic illness in rounds 1 and 4 (No/No); households with no chronic illness in round 1 but with chronic illness in round 4 (No/Yes); households with chronic illness in round 1 but free from chronic illness in round 4 (Yes/No); and households with chronic illness in both rounds 1 and 4 (Yes/Yes).

A significant reduction (36.9% to 10.7%) of chronic illness was found between rounds 1 and 4 (Tables 1 and 2) and among different types of household members (i.e head of household, any adult household member, children between 5 and 15 years of age). Children under 5 years of age did not show a significant reduction due to the small sample size.

Table 1 Prevalence of chronic illness in Rounds 1 and 4

	R1 (%)	R4 (%)	P
Head	91 (27.1)	25 (7.4)	<0.001
All adults	118 (35.1)	35 (10.4)	<0.001
Children 5-15 yrs	12 (3.6)	3 (0.9)	0.019
<5 yrs children	5 (1.5)	1 (0.3)	ns*
Total	124 (36.9)	36 (10.7)	<0.001

*Fisher's exact test

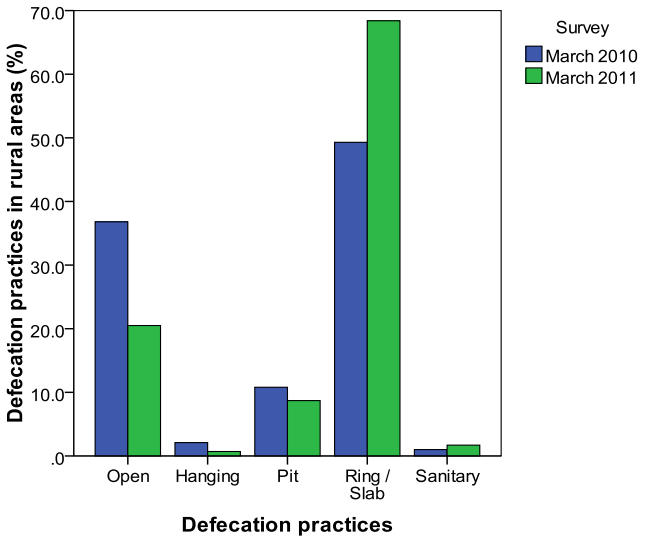
Table 2 Type of household who suffered from chronic illness in Rounds 1 and 4

Chronic illness R1	No	No	Yes	Yes	McNemar
R4	No	Yes	No	Yes	p
Head	231 (68.8)	14 (4.2)	80 (23.8)	11 (3.3)	<0.001
All adults	203 (60.4)	15 (4.5)	98 (29.2)	20 (6.0)	<0.001
Children 5-15 yrs	321 (95.5)	3 (0.9)	12 (3.6)	0 (0)	0.035
<5 yrs children	330 (98.2)	1 (0.3)	5 (1.5)	0 (0)	ns
Total	196 (58.3)	16 (4.8)	104 (31.0)	20 (6.0)	<0.001

One of the most obvious explanations for the major decline in morbidity and chronic illness is an improvement in better hygiene practices and health interventions. Analysis of the data from the CMS3 March 2010 survey for example found poor sanitation (defecation in open spaces) was associated with an increased risk of anaemia (open defection 36.6% anaemic, latrine use 26.3% anaemic, p=0.04). Many of the shiree supported interventions had an explicit health focus in their interventions such as

health counselling, primary health assistance and notably, the introduction of latrines. Post intervention results are very positive with a significant reduction in open defection and an increase in ring/slab latrines use in rural areas (Figure 1) being observed.

Figure 1: Defecation Practices 2010-2011



Another obvious explanation which might trigger improvements in health is better quality and increased food intake. According to the CMS3 2010 survey, extreme poor households had very low animal protein intake and low staple food intake (rice and potatoes). Two thirds of households ate only 1 or 2 meals a day. Female headed households were more likely to eat smaller portions (86%) than male headed (60.4%), and 75% of female heads were undernourished or anaemic (compared to 63% in male headed households). We will discuss diets and nutrition in more detail below. For the moment, it is important to locate the significance of food intake in poverty traps. Poor intake of food is directly related to lowered immunity to disease, which increases the chance of prolonged illness (diarrhoea, infections, colds and fever etc.). Chronic illness, as Khalil's case clearly shows, directly affects people's working ability - to work regularly and for full days, or to accept higher paying but more physically demanding work. A fall in employment and wages reduces income and this in almost all cases of extreme poverty, results in a reduction of food intake both in terms of quantity and quality. The opposite dynamic is also true. Improved diets help improve people's appetite, energy, and immunity to disease. These enhance the ability to work and thereby wrest people from one type of extreme poverty trap. Drawing on insights from CSM3 and CMS5, we illustrate what we consider to be the dominant pattern of poverty dynamics triggered by chronic illness in diagram 1 and diagram 2 below[2].

[2] The diagrams were developed by da Corta while carrying out preliminary fieldwork (da Corta and Salam 2011)

Diagram 1: Illness, work and malnutrition poverty trap

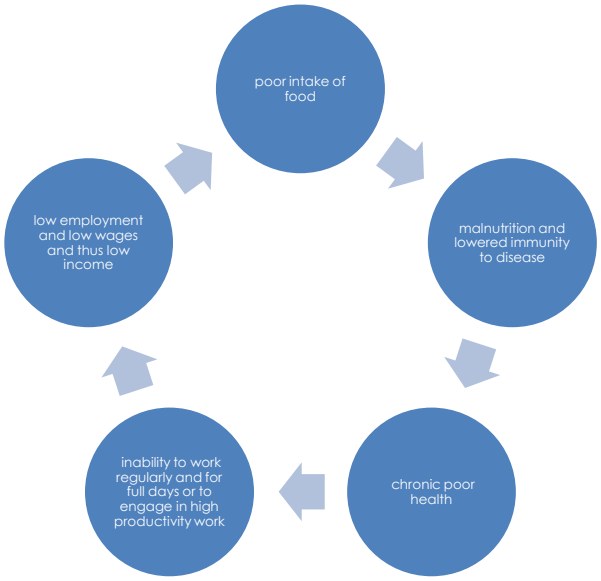
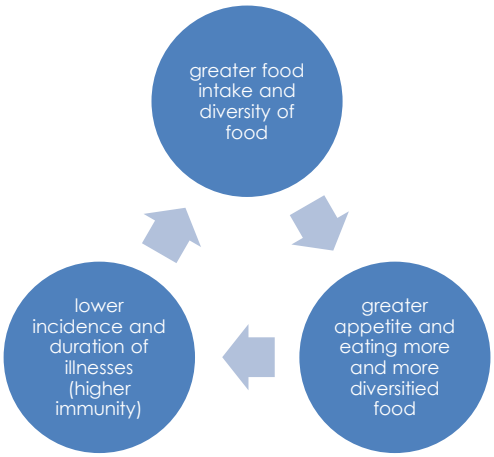


Diagram 2: Illness, work and malnutrition poverty trap



PHYSICAL HEALTH, BASIC INCOMES, LIVELIHOOD SECURITY

The extreme poor in Bangladesh, as in other countries in the world, rely far more upon manual labour (paid or unpaid) for their basic incomes as well as subsistence and reproduction requirements within the family. In agrarian and pastoral societies, agricultural and livestock management requires long hours, often in extreme climates, of heavy physical work either on their own farms and grazing lands, or as tenants or employees, with remuneration in kind. Under relatively low technological conditions, consistent with high rates of absolute surplus value, productivity is low along with

rewards which are barely enough for daily subsistence. This leaves no room for savings and stores.

In Bangladesh, the vast majority of extreme poor households still work in the agricultural sector, and display a higher dependence upon the male adult even if women are centrally involved in practically all stages of agricultural production. Women in Bangladesh do double and triple days and their work is grossly underreported and under-valued. However the idea that the male is the main earner of the family, remains strong. There are a number of reasons for this. First, men are usually paid more than women even for the same work. Second, men are usually paid in cash while women are often remunerated in kind. Third, men have more opportunities, via migration or non-agricultural jobs, to expand their income earning capacity. Finally, even when men are not the key cash income earner, they will nevertheless still be the key source of social and cultural protection for women and the household. The latter is particularly evident in urban contexts where women often have more regular and higher incomes (mainly from employment in the garments sector or from domestic services) and yet quite often turn to males (husbands or otherwise) when household protection or representation is required. Related to this, even when women are the main earners in the household, they still need to carry out their domestic responsibilities as mothers, wives and carers. The idea of men as the main breadwinner may not therefore always be actually true (see da Corta in this report) but it still impacts on people's everyday behaviour and actions.

To use the language of 'single point of business failure', the health of key workers in poor families in both rural and urban contexts, is a necessary condition for family survival. Morbidity and chronic ill health are easily contracted by key workers since they are often the more spatially mobile and of course often have to work in what are quite physical and demanding work environments. This puts the whole family at risk. Beckerian behaviour applies in order to offset such risk, but often at the expense of the health of others, especially women and girls in the family. Given labour market insecurities in a non-rights based context, morbid labour is the first to be discarded or rewards are reduced, with cumulative negative effects upon the whole family. The case of Khalil clearly demonstrates this dynamic.

The significance of being able to secure a basic income and the risk posed to this by ill health is demonstrated in our analysis of the CMS3 data. Households in which any adult (Figure 3) or household member (Figure 4) did not suffer from chronic illness in rounds 1 or 4 (i.e. No/No) worked twice as long as other cases where household members reported chronic illness ($p=0.006$ and 0.030, respectively). If we then compare households which did not report chronic illness in either rounds (i.e. No/No) with those who reported chronic illness in both rounds (i.e. Yes/Yes) we find significant differences in the mean number of days worked. No/No households heads worked 73.6 days compared to the 43.1 days worked by Yes/Yes household heads ($p=0.001$); 'all adults' in No/No households worked 73.0 days compared to the 51.8 days worked by 'all adults' in Yes/Yes households ($p=0.015$); and finally, all No/No household members worked 72.5 days compared to the 51.8 days worked in the Yes/Yes households ($p=0.022$). Further indication of how chronic illness affects working capacity is shown in the data concerning child labour. Households in which children between 5 and 15 years of age recovered from chronic illness (i.e. Yes/No) worked significantly longer (overall mean of

85.0 days) than similar aged children in No/No households (overall mean of 31.9 days), and No/Yes households (overall mean of 25.7 days) (p<0.001).

Figure 2 Chronic Illness of Adults and Mean total working days (over previous 30 days)

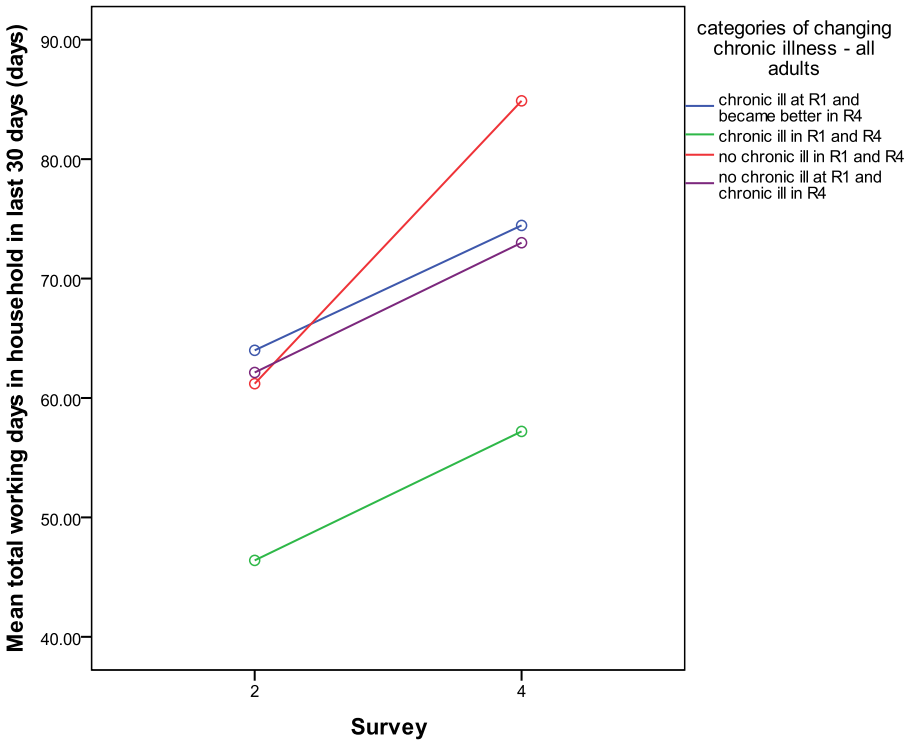
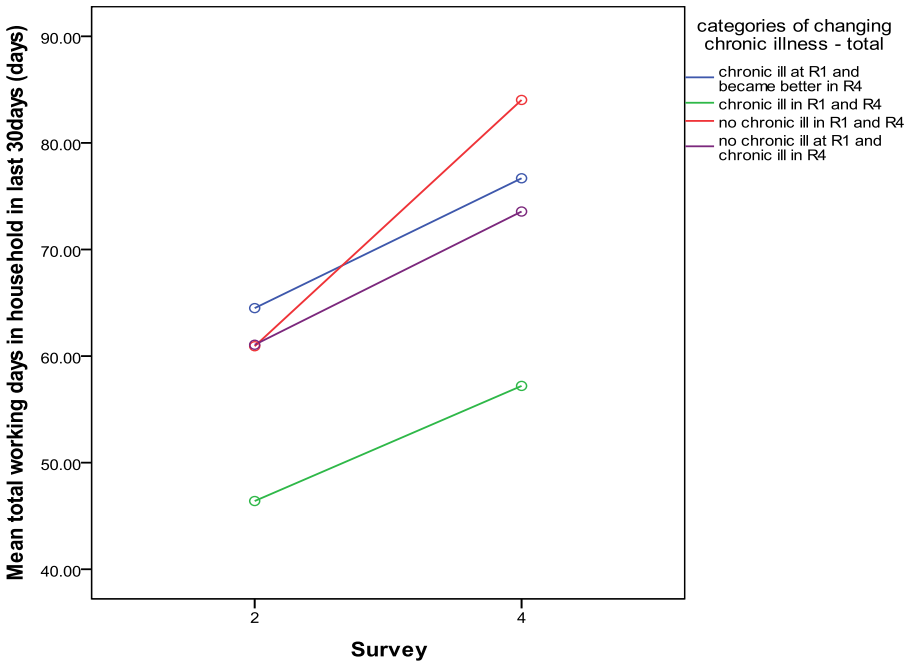


Figure 3 Chronic Illness of all household members and mean total working days (over previous 30 days)



NUTRITION AND EXTREME POVERTY

In another paper, Devine and Wood (2014) rehearsed the argument that the category of extreme poor is qualitatively different from that of 'the poor'. There are several important differences between the categories of 'poor' and 'extreme poor', but many of these differences lie in or are directly linked to the nutritional domain (Kabeer 2009, Lipton 1988). This was confirmed during early discussions with households selected for our tracking studies (CMS5). In the vast majority of cases, changes in wellbeing status were almost always associated with changes in diets. Hunger, food deprivation and chronic malnutrition are the most immediate but also ruthless manifestations of extreme poverty, marking the bodies of the extreme poor in indelible script. This is supported by Kabeer's (2009) argument, developed from her longitudinal analysis of poor households, that food insecurity is actually a stronger and more valid proxy for extreme poverty than income which is used more frequently by development practitioners and analysts.

An adequate diet is a function of quantity and balanced quality. Continuous extreme poor nutrition has different effects for the two genders at different ages: physical growth, stamina and strength, brain development, immunity, cell regeneration, eyesight, vulnerability to diseases and pandemics, successful pregnancy, breast feeding and post-natal recovery, and onset and forms of old age deterioration. All these factors affect morbidity, infant mortality, and life expectancy with implications for the real meaning of dependency ratios (i.e. beyond the mere numerical ratios) in terms of obligations and resource use (such as expenditure on healthcare across consultations, medicines and care).

Extreme poor families experience periodic and continuous failure in both the quantity and quality of their nutritional intake. In general terms this is an entitlement failure, manifested as weak effective demand, but chronically rather than stochastically as in Amartya Sen's analysis of famines. For Sen (1982), famines entailed mass entitlement failure due to the rapidity of change in the relative value of commodities and assets, and the covariance of market behaviour to offset the initial collapse of normal food supplies, driving down the exchange value of non-food assets for food. Chronically weak effective demand arises from a conjuncture of negatively reinforcing variables in which morbidity itself is a factor since extreme poorly educated families rely upon physical labour whether on their own land or that of others. Extreme poor health leads to ongoing extreme poor health via inadequate nutrition entitlements.

According to the 2010 CMS3 baseline survey, there was extremely low animal protein intake across households, and very few families consumed meat, poultry, fruits or milk. Moreover, staple food intake (rice and potatoes) was very low with two thirds of families eating less than 3 meals per day. Female headed households were more likely to eat smaller portions (86%) than male headed (60.4%), and a higher proportion were undernourished or anaemic (75% compared to 63% prevalence in male heads). Finally, 84.8% of children below the age of 5 were stunted, wasted, underweight or anaemic. While these numbers confirm conditions of severe deprivation, the prevalence and force of chronic under-nutrition manifested itself vividly during the initial period of targeting beneficiaries:

Targeting in the Barind Tract [3]

When Netz first targeted the extreme poor people in the harsh Barind tract they found severely malnourished people with haemoglobin counts so low they had to be taken immediately to hospital. When asked to describe their diets before the intervention, especially during the two lean periods of March to May, and September to October, extremely poor women said they ordinarily consumed one 'panta' meal as their main meal every day. They often gave their meals to their husbands on the basis that they had to do manual work. Women complained of the following symptoms: headaches, weakness, gastric problems and gas – all triggered by the fact that their stomachs were empty. They also pointed out that the weakest were particularly vulnerable. Thus "pregnant women suffered the most" and "kids started leaving thin stools and had swollen bellies". Naturally, there was no money for treatment or care.

Despite feeling unwell and not eating, the women reported that if work was available they would immediately take it out of desperation. They have to make careful calculations as taking on paid work, carries risk. If they manage to keep working till lunch time without being ill, they at least get half a day's wage. However if they don't make it till lunch time, they are sent away with no pay. You never know if you will last the half day but it is still worth the risk. Almost everyone had had days when they failed to make it to lunch. Mungli Hasada for example continued to faint every time she started work and so always ended up losing her promised wage. She complained that frequent starvation gave her chronic gastric illness, and as soon as she started physical work, she found that she had no strength. She also complained of quarrels with her husband over food and other spending. Money was tight in the house and Mungli had asked her husband to skip meals like her so that they could use some money to get her grandson medical treatment. Her husband refused saying he needed to spend money on food and to eat in order to work.

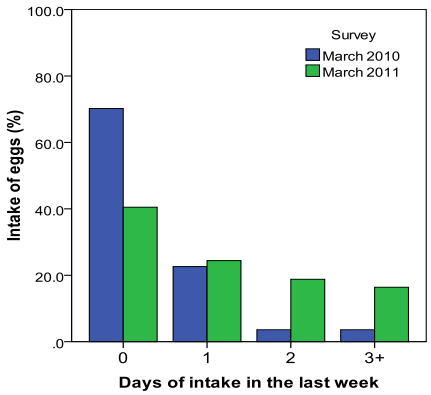
Outside of the lean periods, the quantity of food consumed would increase but not its diversity. So in effect families were eating more rice, sometimes adding chilli as a condiment. Occasionally during the rainy season, women scavenge for snails and crabs, and in some areas, they collect and cook green leafy plants from the forest.

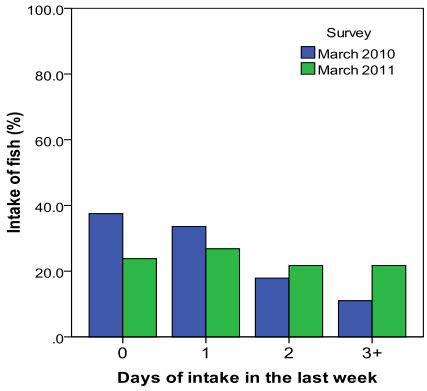
Dietary diversity is significant because it is a strong indicator of food security. When we compare CMS3 data from rounds 1 and 4, we observe very important and positive differences in the consumption of eggs, fish and poultry, all of which indicate marked improvement in nutritional quality (Figure 4). In the total sample, the mean food diversity based on seven food groups (grains, roots and tubers, legumes and nuts, dairy products, flesh foods, eggs, vitamin A rich fruits and vegetables and other fruit and vegetables) increased from 4.3 in survey 1 to 4.8 in survey 4 (Figure 5). The overall

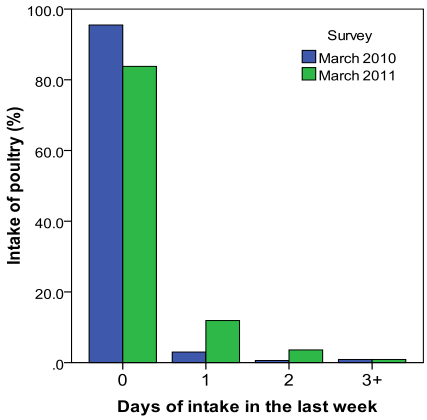
[3] This case study was written up by Lucia Da Corta following focus group discussions with extreme poor households.

improvement in food security is also reflected in households resorting less to food coping strategies[4]. Between surveys 1 and 4, the mean food coping strategies fell from 3.3 to 2.2.

Figure 4 Number of days in the last week in which household members consumed particular foods

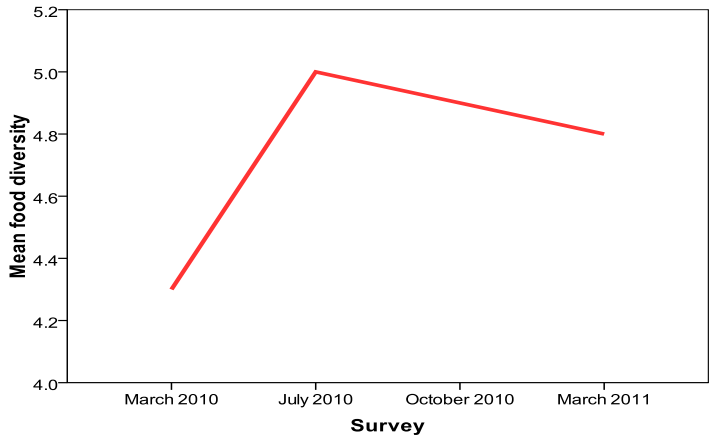






[4] A number of food coping strategies were asked about including reduced food intake, borrowing money to buy food and sending family member elsewhere to eat.

Figure 5 Changes of mean food diversity (March 2010 – 2011)



The above data suggests that the asset transfer programmes supported by Shiree have had a positive impact on the nutritional status of extreme poor households. It seems to confirm that assets have given people a stronger material base from which to begin to improve their livelihoods and, as indicated above, this has translated quite quickly into improved diets. However meaningful improvements in health take time, require continued investments and are always under threat. Negative changes in people's material circumstances therefore translate very quickly into unhealthy survival strategies, notably reduced food intake and poorer nutritional content. Paradoxically, calories and nutrition are easy targets for the extreme poor and are quickly 'traded off' when conditions get worse. 'Trading off' health is one of the most common ways in which the extreme poor literally absorb into their everyday experience the worst effects of their poverty.

A comparison of CMS3 data from 2010 and 2011 provides further compelling evidence of the prevalence and patterns of nutritional tradeoffs. Households in which the head did not suffer from chronic illness in rounds 1 or 4 (No/No) spent more money on food than those households where the head became chronically ill in round 4 (No/Yes) (overall mean Tk 1,890.3 and 1,054.7 respectively, p=0.004). Households in which the head of household recovered from chronic illness in round 4 (Yes/No) spent more money on food than those households in which the head became chronically ill in round 4 (No/Yes) (overall mean Tk 1739.6 and. 1153.7 respectively, p=0.035). The message is very consistent and clear: ill health leads to reduced food expenditure. Our CMS5 data (household tracking studies) are also replete with stories of households caught up in nutritional trade-off traps. Typically, a household member becomes ill, household production is reduced, more energy and resources are invested in health care and food intake is sacrificed. As chronic health persists, households have to make difficult judgements about trade-offs and sacrifices including the strategy of not seeking health care and of course, as the case of the Barind Tract women demonstrates, not eating. As we will see below, this 'typical pattern' does not affect all members of the household in quite the same way.

ILL HEALTH, CAPABILITIES AND THREATS TO DEPEDENCY

Over the last two decades, the evolving discourse around 'capabilities' has taken us beyond the previous, narrower, human capital arguments towards a broader range of functionings as a defining characteristic of development and progress, or poverty reduction more specifically. Of course, health featured strongly in the human capital

arguments alongside education. But these human capital arguments were input/supply conceptions, and mainly linked to economic abilities with less concern for broader outcomes. While the capabilities discourse has its limitations, it offers an important notion of active citizenship as a prerequisite for wellbeing alongside an ability to express effective demand. In other words the concept of capabilities draws attention to the importance of engaging with the institutional landscape through which survival has to be pursued. The problem for extreme poor people seeking to fulfil these conditions of development is their entrapment in a variety of dependencies. Much in line with moral economy (Scott 1976) dynamics of informal helping, these dependencies often provide important material and social support, as well as facilitate access to external opportunities, services and amenities. On the other hand these dependencies come at a price, and can be exploitative, undermine capabilities and reduce remuneration for work. Extreme poor health, chronic or stochastic, undermines capabilities both directly and indirectly: directly in the obvious sense of impaired functionings; indirectly in that dealing with extreme poor health absorbs immediate material resources (doctors' fees, costs of medicines, securing care), carries opportunity costs with knock-on effects for the capabilities of others in the household, and uses up obligations and favours provided by whatever networks and social resources are available. When these networks fail, the chances of life improvements are significantly reduced. Thus a different health related poverty trap emerges: the loss of health can put pressure on networks of support which eventually are depleted. However without the same networks of support, treatment and care options are significantly reduced.

Taslima left alone

Taslima had been in paid employment until the birth of her first child. After a few years however her husband moved out of the house, leaving her with debts, the children and no job. Initially women neighbours helped her by finding cheaper accommodation and arranging small jobs for her. Taslima then fell ill. Again help was initially forthcoming – food items were purchased on credit, the children were looked after by neighbours, house bills were deferred, and some medicine was even purchased for her by friends. As the illness persisted however, the help decreased. When her eldest child became ill, the landlord (her aunt) told Taslima to leave as she had become too much of a burden. Fights and quarrels ensued and Taslima spent a year moving to accommodations which were cheaper but also always less safe and hygienic. As a consequence, her health deteriorated further as did that of her children. Her debts also increased. Locally, she had become known as a liability for as one neighbour put it "no one will help her now because she never pays anything back". Taslima stood at the entrance to the door of her latest house as we talked to her. Her three children sat on the ground, close to her feet. She was in a defiant mood "I don't want anyone's help, it is not worth it". The defiance however barely covered the fact that she was profoundly vulnerable and completely helpless. Just before we had arrived, Taslima had been told to move out of her house again. She did not know where to go.

SOCIAL DISTRIBUTION OF HEALTH

The capabilities context for understanding the significance of health has in Bangladesh, like most other societies, gender as well as age dimensions. While male leaders of households attract resources to the cost of other household members, women with ill-health, perhaps arising from repeated pregnancies, are more likely to be marginalised and excluded, and sometimes even displaced (see Da Corta in this report). Again calories and nutrition are often traded in the hope that security and safety are reciprocated. In one of our focus group discussions organised with extreme poor beneficiaries to explore issues of nutrition and food, we began to look at household feeding priorities in cases of pregnancy (da Corta and Salam 2010). The host NGO had been actively advocating, through its programme, more food and periods of rest for pregnant and lactating mothers, and had identified their main challenge as persuading husbands and mother-in-laws of the importance of prioritising pregnant women's nutritional needs. However the NGO continually ran against problems. In its working area, female abandonment and domestic abuse (verbal and physical) were not uncommon especially during the early stages of marriage. Women themselves therefore tended to prioritise the needs of their husbands and mother-in-laws in an attempt to ward off the risk of being thrown out of the household. The women in the focus group discussion admitted that husbands sometimes were helpful and would give their wives some of the food off their own plates. However, in most cases, wives would return the food to their husbands – calories which could be used for mother and baby traded in for long term survival in marriage, stronger future relations with the in-laws, and in some instances, a reduction in domestic abuse. This de facto collusion in the inequality of diet and nutrition allocation reflects a systematic weaker capability, in the sense of claims and entitlements, of women even within their own families

We have already alluded in this report to the important reductions in poverty and in extreme poverty over the past two decades in Bangladesh (Devine and Wood, as well as Ali in this report). The HIES report is understandably quite upbeat these achievements, claiming

> the standard of living of the population in general has improved very significantly in recent years. This is reflected in reduced incidence of poverty with stability in the distribution of income and expenditure; increased nutrition from more diversified food consumption basked; and higher level of living in terms of non-food indicators' (BBS 2011: ii)

However a closer examination[5] precisely of core health indicators warns us that this upbeat assessment needs to be treated with some caution. Despite therefore progress in reducing the number of citizens below both upper and lower official poverty lines, Bangladesh has the highest number of undernourished women in the world (Finucane *et al*., 2011) and has the third highest proportion of under 5s suffering undernutrition. In this regard, Bangladesh ranks just above landlocked and war-torn countries of Africa. Unfortunately, Bangladesh's official data on poverty do not simultaneously disaggregate by gender and poverty status across a range of socio-economic and health indicators.

[5] The analysis on the Indian HDR was first developed by Da Corta.

This is a serious weakness which prevents the monitoring of progress in women's welfare and the development of appropriate policy responses particularly in relation to extreme poor women's welfare. By contrast, the most recent Indian Human Development Report, published in 2011, does disaggregate by gender as well as by socially marginalised scheduled caste (SC), schedule tribe (ST) and Muslim households. This report offers a cautionary tale for those attempting to deduce trends among extreme poor Bangladeshi women from aggregated national data on women and children. Thus in India the rapid fall in poverty levels over the past decade has not been met by a corresponding improvement in nutrition rates among women and children from socially excluded groupings (SC, ST and Muslim). Although the percentage of women overall in India with a BMI of less than 18.5 fell slightly (from 36% to 33%) over the period from 1998/99 to 2005/6, the percentage of women with a BMI of less than 18.5 among the poorest groupings (proxied by SC, ST and Muslim households) remained unchanged or even increased. Malnutrition of SC and ST women remained unchanged over the same period (at 41% for SCs and 46% for STs) and the incidence of malnutrition among Muslim women increased from 34% to 35%. Moreover, the report notes an increasing trend of anaemia among SC, ST and Muslim women (Mehrotra and Gandhi, 2012:62, Mehotra et al 2011:131-5). As noted above, underweight and anaemic women are more likely to give birth to underweight children and the 2011 HDR confirms this, showing that India has the highest percent of underweight children under five in the world (standing at 43.5%), and that the percentage of wasted children has actually increased over the 1998/9 to 2005/6 period.

The general point therefore is clear. The high and rising figures for women's and children's undernutrition in socially excluded groupings has occurred despite the rapid growth in aggregate income in India and despite concerted central government attempts to combat malnutrition (for example the government has since 2004 been trying to universalise its Integrated Child Development Service). The warning for discussions on poverty reduction in Bangladesh is that the problem of underweight women and children in particular is highly intractable and yet often overlooked. This is borne out in national statistics. According therefore to the 2010 HIES, 17.5% of the population live below the lower poverty line (itself a measure of under-consumption) and therefore are considered extreme poor. Yet the absolute figures reported for under-nutrition are much higher: 30% of women between the ages of 15 and 49 in Bangladesh are chronically malnourished, and have a BMI of less than 18.5; and 43.1% of children under 5 years of age are underweight. This suggests that the figure of 17.5% may significantly underestimate the number of those living in conditions of extreme poverty even if they don't live below the official poverty line. Indeed if we look at nutrition alone, it is likely that women and children under 5 living in non-extreme poor and even non-poor households may to all extent and purposes, be living 'extremely poor' lives.

In terms of the social distribution of (ill) health, age discrimination may be more complicated and we know far less about it. However there is emerging evidence from our CMS5 data (qualitative tracking studies) that age discrimination is becoming increasingly important in determining the allocation or distribution of welfare benefits. Certainly the gender/age combination can explain the neglect of young girls in extreme poor families, especially in cases of high dowry expectations or, as the previous section

illustrated, when young brides are vulnerable in their new marital homes (see Da Corta in this report). At the other end of the life cycle, we find increasing cases of elderly parents being forced to fend for themselves even when they reside with their families. One of the ironies of this is that the Government has welfare programmes set up precisely to support the elderly in need. Access to these programmes however for the extreme poor is exceptionally low and irregular, forcing the elderly to seek help from their families who are also struggling or, as we have found frequently, to turn to begging.

Momtaz – alone in her own house

Momtaz is over 80 years of age and has been a widow for around 20 years. Most days she begs in neighboring villages in order to get food. She started begging when her husband became ill and could not continue as an agricultural labourer. Although begging was demeaning and hard work, in those days Momtaz usually received enough help to eat at least once a day. About 10 years ago, Momtaz started suffering from different illnesses and now needs regular medicine for a problem with her eye. She has asked her Chairman for help but has never received any benefits from local government even though she knows she has some form of entitlement. She still lives in the house she shared with her husband, together with her eldest son and his family. He helps when he can but not on a daily basis as he has to look after his own family. Occasionally, Momtaz still moves around begging. However these days she does not receive as much from begging. She blames this on her lack of mobility and weakness but also points out that there are far more women begging and she cannot compete with them. When her son can not help, she goes without food. As she gets older and weaker, the number of times she goes to bed without having eaten all day, seems to increase.

The broad conclusion here is that the social management of health access within families and communities determines the distribution of capabilities by social status, gender and age, reflecting deep-seated social practices of resource allocation. The poorer the family, the more difficult the choices that have to be made, and the more tested are the priorities for overall family survival. This is not a point about wilfully bad, misogynist male behaviour, but more about the Faustian dilemma visited upon the extreme poor with no room for manoeuvre to be inclusive (Wood 2001, 2003). The capabilities discourse therefore also operates within the family, with individuals having agency and families being sites of negotiation and contestation, as well as intergenerational bargains. In this following section, we will explore this further.

CARE AND FAMILY REPRODUCTION

It is impossible to understand the interface between health and extreme poverty without looking at public health dimensions. This leads us to reflect upon the behaviour and performance of wider health related agents and institutions. There are a range of public and private, formal and informal services through which people in Bangladesh seek care and treatment. Not surprisingly, private options are not generally used by the extreme poor even if, especially in urban slum areas, poorer people are often forced to look for treatment privately because public services are considered inaccessible and not very helpful. However the extreme poor also report, very consistently, that many of the governmental or public services where people are entitled to seek care, are equally

beyond their reach. The reasons for this are quite familiar. First, for many living in more remote areas even getting to health centres requires time, entails significant transportation costs and calls upon the time and resources of other family members who have to accompany those seeking treatment. Second, reports that government facilities require unofficial payments are rife. The amount to be paid depends on the type of illness, the kind of treatment required and the number of 'middlemen' in place to broker access. In general however, extreme poor households claim that payments, both in terms of amount and number of payments, are increasing over time. Third, quite often patients go to hospitals and begin paying for consultations only to find that the right kind of medicine or equipment is not available. This then forces them to seek the medicine in the open market, often from the same medical staff who treated them in the hospital. Fourth, the extreme poor often state that hospital staff do not treat them properly simply because they are poor. In some places, we also heard reports of better-off people managing to secure medicines and services from hospitals even when they are not sick.

Extreme poor families, almost by definition, have weak entitlements and therefore it is not surprising that they are excluded or feel they can not access pubic health and care services. Under such weak entitlement conditions, they are therefore forced to rely strongly upon their own families in the first instance, possibly supported by wider kin and community. However this support draws on moral economy expectations and obligations (Scott 1976) and as such is always discretionary, non-rights based and insecure. The case of Momtaz clearly illustrates the inherent problem of these arrangements - support within the family can quickly erode especially when resources are scarce.

In this way, families come to internalise the provision of their own welfare, thus strengthening the link between biological reproduction and survival. There are several imperatives at play here: the provision of future labour,; upward intergenerational transfers in terms of future income and care services; performance of social functions expected within the community, especially regarding any common property management; political protection of the family.[6] These imperatives structure both desirable size and gender compositions of families. These decisions are also fundamentally affected by conditions of high infant mortality. With infant mortality rates higher for extreme poorer families, pregnancies are likely to be more frequent as discount rates are higher. There is, therefore, always the likelihood of over-insurance. This means that young women, often with significantly poorer nutritional entitlements within their affinal family, experience more gynaecological problems during pregnancy (a higher incidence of miscarriages and bleeding), at birth and afterwards. While they are likely to be attended by other women in extended families, extreme poorer families are often more nucleated and care is therefore not as guaranteed.

In families who have de facto over-insured by having larger families than actually desired (or required) for survival, the health needs of the resultant children is difficult to service, often entailing gendered choices between the entitlements of siblings. Within

[6] These latter two imperatives are often classified as 'social reproduction'.

the home, early diseases are not adequately offset by breast feeding, with malnourished nursing mothers unable to cope (da Corta and Salam 2011). Once the immediate health needs of children are ignored, the impacts are far reaching and extremely difficult to recover from. Children are much more likely to be of low birth weight and to remain malnourished throughout their lives if their mothers were malnourished during adolescence, and prior to and during pregnancy (UNICEF, 2012 and Mehrotra et al, 2011:132). The weight of this statement is brought home forcibly when we look at key health indicators of children below 5 years of age from our CMS3 data. In 2010, a total of 84.8% of children of extreme poor households were stunted, wasted, underweight or anaemic. The table below disaggregates this figure and also shows how below 5 year old children from extreme poor households are significantly worse off than the national averages.

Table 3: Stunting, Wasting and Underweight in < 5 Year Olds

	Shiree CMS 3 (March 2010)	BDHS 2011
% < 5 year old stunted	48.9	41
% < 5 year old wasted	22.8	16
% < 5 year old underweight	45.9	36

As we have already mentioned, scarcity and insecurity often lead to entitlement trade-offs. In a pattern similar to Becker's (1981) New Household Economics, families are seen to make internally 'rational' decisions about the allocation of key resources (such as food, education, health care and other forms of investment) to those members likely to deliver the highest return on investment. For this reason, the symbolic and culturally embedded indicator of the male as the main source of income and wealth in families, whether through agnatic land (i.e. means of production) inheritance and usufruct in patrilineal descent systems, or through paid forms of employment outside the family, is so central to understanding the provision of health especially when managed within households. As we have argued above, even when men may not necessarily be the de facto main earners in extreme poor families, their needs are still more likely to be prioritised because decisions around resource allocation have become institutionalised in patriarchal societies like Bangladesh as intrinsic gender discrimination. Asset as well as other sacrifices, material or otherwise, are therefore made first for adult male earners, and then for younger males followed by girls, wives, mothers-in-law, and finally grandmothers. The prevalence of this age/gendered hierarchy is so strong that even in circumstances where women might have superior access to more regular and higher paid employment, young males are still favoured with superior resources over their female siblings, and working wives still service their unemployed male partners. The principle of a hierarchy of entitlement therefore prevails.

This privileging of adult males in terms of access to healthcare is manifested in several ways. Health expenditure in terms of doctor's fees, frequency of visits, hospital referrals and treatment, and medicines are biased towards adult male earners. Also such expenditure is sustained over longer periods, sometimes years; and again this is less likely to occur for other family members. In addition to expenditure, family level care and support is much more evident in instances where the adult male earner is ill. This of course reflects familial love and affection but also a more structural political economy problem which from the outset, forces families to internalise care, and then to 'choose' to prioritise the care of adult males, especially working ones. Female compliance should not be taken as female sanctioning. Deep rooted gender discrimination, forcefully manifested in virtually all aspects of a women's life, makes the choice anything but a free one.

When women become ill, healthcare considerations often move in a different direction as the criteria used to assess the costs and benefits of seeking health care also change. The sufferings of women are often neglected or certainly de-prioritised because of perceived high opportunity costs either in the form of diverting scarce household resources or in terms of domestic duties forgone. The latter should not be underestimated. Domestic work and responsibility are not usually up for negotiation and rarely shared by male partners even in cases of illness. Indeed if poor health is likely to result in a dereliction of domestic responsibilities, women face the risk of being abandoned or sent away (see Da Corta in this report). Faced with this, women may 'choose' to ignore their health needs. Ironically therefore, 'choosing' not to seek health treatment and care is understood as a way of ensuring a more secure future. The case of Abdul and his family illustrates the complexity and messiness of the micro decisions which underpin household decisions on health priorities. The case also draws attention to the unforgiving consequences of decisions

Hard health choices

Abdul is an agricultural labourer with three young children. His eldest daughter was born poorly and Abdul and his wife had managed for years to use some of their earnings to pay for treatment. They never found out what was wrong with her except that she had trouble breathing and was always weak. Medicine helped but never cured the daughter. Following the birth of their third child, Abdul's wife fell ill and she could no longer take on physically demanding labour jobs. In 2009, Abdul also fell victim to a gastro-intestinal problem and was not fit enough to work in the field. He sold some of his assets in order to go to the local hospital for treatment. He was told to take medicine on a daily basis. With no income and mounting health bills, he moved his family to a cheaper (and less healthy) homestead location, and then stopped paying for his daughter's medicine. In his mind the daughter's medicine was not working and therefore dispensable. With medication, his health is improving slowly but his daughter has become even weaker and starting to have more illnesses. During our discussions with his wife (and not in front of Abdul), one of the female neighbours told us that the wife had stopped taking medicine and was using the money to pay for her daughter's care. She had not told her husband because she was frightened of his reaction.

CONCLUSION

Health is both constitutive and instrumental to wellbeing. For the extreme poor, ill health represents one of the most powerful livelihood threats and carries a wide range of deleterious impacts which can persist through generations. The loss of working age labour poses a particular risk to extreme poor families since it very quickly triggers off a chain of coping strategies resulting normally in asset depletion, increased debt and food reductions. Coupled with increased expenditure on medication and treatment as well as demands (financial and time) on other household members for care and support, these strategies – especially if prolonged over time – worsen the condition of poverty.

The bulk of ill-health related care among the extreme poor in Bangladesh is borne by households themselves with some support from wider kin and community. This internalisation of welfare provision reflects both the inadequacy of healthcare provision for the extreme poor as well as the fact that by definition, the extreme poor have exceptionally weak entitlements. Any discussion of the significance of (ill) health in the lives of the extreme poor therefore needs to engage with this broader and complex institutional context. Put in very brief terms: those most in need of health care are those who find themselves least able to access public or private health services. In policy terms, there is no doubt that work has to be done to make sure that public health sector facilities respond more effectively to the health needs of the extreme poor. This however is unlikely to happen in a short timeframe. Therefore more emphasis has to be put into finding simpler, more affordable and localised alternatives.

According to official statistics, Bangladesh has made considerable progress in terms of reducing poverty and extreme poverty. However when we look at core health indicators, the overall assessment is less optimistic. The number of people malnourished in Bangladesh is considerably high, as is the number of children who are stunted, wasted or underweight. Crucially, the poorest in society are disproportionately affected by ill health. Our data confirms this, demonstrating that over one third of extreme poor households have members with illnesses that can be considered chronic.

In internalising the management and provision of health care, individuals and families have to engage in a range of complex compensating measures involving various forms of trade-offs and sacrifices. The most recurrent sacrifice takes the form of food denial. Calories and nutritional inputs are easy target and quite often traded to avoid other choices or sacrifices. However, although a relatively easy target, the impact of reducing the quantity and quality of food is particularly damaging for present and future generations. At the same time, the forced management of health care within households where resources are scarce encourages a privileging of some people's entitlements over others. Institutionalised and deep rooted gender discrimination puts men at the top of the entitlement hierarchy and as a result, the heath needs of women, the elderly and children are given less priority. This is a second level of 'internalising' health care and responsibility.

The final point from this paper is rather more optimistic and draws on the finding that post intervention, significant positive changes in the health status of the extreme poor were observed. Chronic ill health may be a stubborn characteristic of extreme poverty (Kabeer 2009) but improvements in key areas such as hygiene practices and food intake are possible and have positive impacts in other areas of poor people's lives. If we accept that most of the features which distinguish extreme poverty from the poor lie in the health/nutrition domain, then these improvements, if followed up over time, offer real and realistic hope in terms of sustainably reducing extreme poverty levels.

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