

The purpose of this brief is twofold:
a) to describe how health interplays with the four dimensions of poverty in Sida's conceptual framework, i.e., resources, opportunities and choice, power and voice, and human security; and the four development contexts and,
b) to provide guidance on how to integrate health into the multidimensional poverty analysis (MDPA). The brief can also be used when e.g., appraising the relevance of a contribution, or to guide an evaluation and a policy dialogue on the links between health and poverty eradication.

HEALTH AND POVERTY

Poverty is both a cause and a consequence of poor health. Poverty increases the risks of poor health. Poor health, in turn, entraps communities into poverty. Infectious and neglected tropical diseases kill and weaken millions of the poorest and people in risk of poverty each year.¹

People living in poverty might be forced to dwell in harmful environments, with e.g., inferior housing quality, lack of or limited access to safe and clean water and adequate sanitation, and/or access to nutritious food. These are all risk factors for ill-health. Poverty in itself might also be a barrier for people to access health care when needed because of limited financial resources and high costs for seeking health care, and other factors e.g., lack of information on appropriate health-promoting practices and fear of stigma and discrimination.

BOX 1: IMPLICATIONS OF HEALTH

Good health is the basis for job productivity, capacity to learn at school, and capacity to grow intellectually, physically and emotionally, and is thus a crucial precondition for poverty reduction. Societies which are burdened by disease tend to experience a multiplicity of severe impediments to economic growth². Diseases, including pandemics such as COVID-19, reduce the annual incomes of societies and the lifetime incomes of individuals, which may have negative effects on development programs and on overall development strategies. Building on good knowledge about the interrelation between development and health and applying this aspect to a development program and to multidimensional poverty analysis is crucial to minimize the negative effect and to ensure more sustainable development.

Considerable progress in poverty reduction and global health has been made over the last decades. Life expectancy – which is the most commonly used measure to describe a population's health – has increased drastically over the last couple of centuries. Between 2000 and 2016 it increased by 5.5 years.³

However, there are still huge differences that have to be addressed: at least half of the world's population still does not have full coverage of essential health services and according to WHO an estimated 100 million people have fallen below the poverty line⁴ as a result of out-of-pocket health care spending.⁵

More than ever, health needs to connect social, economic and environmental well-being, linking the present to the future – with a particular focus on the most vulnerable countries and communities, and people who are at risk of being left behind.

1 <https://www.healthpovertyaction.org/news-events/key-facts-poverty-and-poor-health/>.

2 Bloom D.E. and Sachs J.D. Geography, Demography and Economic Growth in Africa. Brookings Paper on Economic Activity, No. 2, pp.207-295, 1998. See also, www.cid.harvard.edu

3 https://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/

4 Measured in 2010. Poverty defined at the international US\$ 1.90-a-day poverty line measured in terms of 2011 purchasing power parity (PPP).

5 World Health Statistics 2019 Monitoring Health for the SDGs https://www.who.int/gho/publications/world_health_statistics/2019/en/

Sida's model for multidimensional poverty analysis (MDPA)⁶ helps to understand **who** is poor (target group), **how** poverty is experienced in the above-mentioned four dimensions and **why** this situation has come about.

In order to answer the question **who** is poor, the poverty analysis through a health lens takes its starting point from both those who suffer from and are affected by ill-health.

In order to understand and to alleviate poverty, there is a need to understand the different dimensions of poverty and the related interlinkages: 1) resources, 2) opportunities & choice, 3) power & voice, 4) human security (see box 2). To understand the causes of poverty, the opportunities to move out of poverty, and the main risks that could aggravate poverty, it is important to understand the context in which a person lives: Political & institutional context; Economic & social context; Conflict/Peaceful context; Environmental context.



Source: Sida (2017) Dimensions of Poverty – Sida's Conceptual Framework.

The aim of this brief is to give guidance on how health relates to multidimensional poverty, and can be helpful when making an analysis of multidimensional poverty. The brief can also be used when e.g., appraising the relevance of a contribution, or to guide an evaluation and a policy dialogue on the links between health and poverty eradication.

BOX 2: THE FOUR DIMENSIONS OF POVERTY:

Being poor in terms of **resources** means not having access to or power over resources that can be used to sustain a decent living standard and improve one's life. Resources can be both material and non-material: a decent income or physical and human capital, such as being educated or having professional skills, being healthy, having agricultural tools or a cart to transport goods.

Being poor in terms of **opportunities and choice** concerns what possibility you have to develop and/or use your resources so as to move out of poverty. Access to productive employment, education, health clinics, infrastructure, energy, markets and information affect the choices available and opportunities to escape from poverty.

Being poor in **power and voice** relates to people's ability to articulate their concerns, needs and rights in an informed way, and to take part in decision-making affecting these concerns inside the household, in local communities and at the national level. Discrimination and violation of human rights are important aspects when analysing this dimension. Power is a relational concept that allows us to better understand socio-cultural hierarchies and relations of which gender is one. Others include age, caste, class, religion, ethnicity and sexual identity. Reinforcing forms of discrimination based on sociocultural relations may increase an individual's poverty in this sense

Being poor in terms of **human security** means that physical, sexual, and/or psychological violence and insecurity are constraints to different groups' and individuals' possibilities to exercise their human rights and to find paths out of poverty.

According to Sida, a person living in poverty is resource poor and poor in one or several other dimensions.

RESOURCES – ILL HEALTH AND POVERTY

Resources

There is a strong interlinkage between health and possessing and/or having access to or power over resources that can be used to sustain a decent living standard, meet basic needs and improve one's life. Resources can be both material and non-material. Being healthy is thereby one resource in itself.

Social determinants of health, e.g., education, living conditions and gender norms, affect people's health and their access to services. Critical factors, e.g., infant mortality and maternal and fertility rates, are directly related to the literacy rate of women, which in turn are related to their social and economic status.⁷

Sudden ill-health can push families into an irretrievable downward spiral of dependency due to increased medical expenses and income losses, which may exacerbate and deepen poverty. Many poor households may need to resort to negative coping strategies

⁶ Dimensions of Poverty Sida's Conceptual Framework, 2017 <https://www.sida.se/English/partners/methods-materials/poverty-toolbox/>

⁷ Saurabh S, Sarkar S, and Pandey D.K. Female literacy rate is a better of prediction of birth rate and infant mortality. Journal of Family Medicine and Primary Care. Vol.2, No.4 pp.349-353, 2013. Doi 10.4103/2249-4863.123889.

to compensate for the lost income by selling assets and resorting to unsustainable use of available natural resources. Costs of seeking health care is not only limited to out-of-pocket spending on care, but include also transportation costs, opportunity costs, and informal payments to providers.

In particular, noncommunicable diseases (NCDs) can lead to increased burdens on individuals, families and communities, including impoverishment from long-term treatment and care costs, and to a loss of productivity that threatens household income and leads to productivity loss for individuals and their families, making NCDs a contributing factor to poverty and hunger.⁸

Women and girls are most at risk of falling into poverty because of the burden of caring is often designated to female family members. This means that they may have to e.g., give up their education or that they end up in an abusive situation, such as sexual exploitation, in order to help meet household costs.

Resource poverty is further a great risk factor for acquiring diseases. Resource poverty creates conditions that perpetuate the spread of infectious diseases and prevents affected populations from obtaining adequate access to prevention and care. Communicable diseases such as malaria, HIV, tuberculosis, and neglected tropical diseases account for the main burden of the diseases in many low and middle-income countries (LMICs).⁹ In addition, non-communicable diseases (NCD) such as heart and cardiovascular diseases, cancer, mental disorders and diabetes, are on the rise.

Air pollution (indoors and outdoors) has become a health threat in LMICs that leads to premature death from heart disease, stroke, and cancer, as well as acute lower respiratory infections. The disease and disability caused by environmental pollution have great economic costs, and these costs can undercut trajectories of national development.¹⁰

Children and women are disproportionately affected by communicable diseases. The leading cause of death among children up to the age of 5 are pneumonia, diarrheal diseases and malaria. Poor households might not have sufficient financial resources for

letting their children be part of a vaccination program. WHO estimates that every year 1.5 million children under the age of 5 die from infectious diseases that could have been prevented by vaccination.¹¹

Moreover, around 45% of deaths among children under 5 years of age are linked to undernutrition, with the majority of cases in LMICs¹². The consequences of undernutrition can lead to poor cognition and educational performance and an increased risk of nutrition-related chronic diseases in adult life.

Women in LMICs continue to die mostly from AIDS and maternal causes. Over 90% of all maternal deaths occur in LMICs, most of them from preventable causes related to pregnancy and childbirth. Each year between 4.7% and 13.2% of maternal deaths can be attributed to unsafe abortion.¹³

HIV remains a major public health threat. Poverty can increase vulnerability to HIV infection. Certain groups such as men who have sex with men, transgender people, women & girls etc, are more at risk for HIV infection. Young women aged 15–24 years are twice as likely to be living with HIV compared to men¹⁴. The unequal socioeconomic status of women affects their ability to prevent or mitigate the effects of HIV. The majority of new HIV infections for children in western and central Africa are due to the low coverage of antiretroviral therapy among pregnant women living with HIV.¹⁵

Sexual and reproductive health is a lifetime concern for both women and men, from infancy to old age. Evidence shows that reproductive health in any of these life stages has a profound effect on a person's health later in life.¹⁶ However, at least 225 million women in LMICs have an unmet need for modern contraception, nearly half of the adolescent pregnancies (21 million) in LMICs are unintended and almost all of the around 25 million unsafe abortions that occur globally are in LMICs. Another challenge is the limited access to comprehensive sexuality education. Over time, mental illness has become more important causes of death. Mental health disproportionately affects women due to e.g., intimate partner violence, socioeconomic disadvantage, low income and income inequality, and low or subordinate social status and rank. Despite evidence to support a range

8 <https://www.who.int/global-coordination-mechanism/ncd-themes/poverty-development/en/>

9 The Burden of Disease Among the World's Poor 2020, A report by the World Infection Fund in collaboration with the Swedish International Development Cooperation Agency

10 <https://pubmed.ncbi.nlm.nih.gov/27325064/>

11 Ibid.

12 <https://www.who.int/news-room/fact-sheets/detail/malnutrition>

13 Women's, Children's and Adolescents' Health: Trends in the SDG Era

14 The Burden of Disease Among the World's Poor

15 The Burden of Disease Among the World's Poor

16 <https://www.unfpa.org/sexual-reproductive-health>

of cost-effective mental health services 75% of those who are in need do not have access to any kind of care.¹⁷

Even though women disproportionately suffer from ill-health, men have lower life expectancy (69.8 years for men compared to 75.3 years for women) which is related to health practices, and the social and cultural influences that shape them. The leading health-risk behaviors that account for a major share of men's ill-health are directly related to masculinity norms. These health behaviors are e.g., poor diet, tobacco and alcohol use, occupational hazards, unsafe sex, and drug use. They account for more than half of all male deaths and about 70 percent of male morbidity globally. In addition, men are less prone to seek health care. However, there are some positive masculinity norms, e.g., men who are more involved as fathers and caregivers are more likely to have better health.¹⁸

When an illness and issues related to reproductive health are surrounded by fear and stigma, the negative impacts can be even more severe for those affected and face poverty. Stigma and discrimination are barriers to effective and equitable healthcare. They keep individuals from seeking out services that can improve their health, or, in some cases, save their lives which – in turn – have negative effects on their ability to work and thus make their living. This is, e.g., the case for people living with HIV, individuals with disability and mental illness, people who are suffering from drug abuse and teenage pregnancy. For example, a pregnant teenager is significantly more likely to be poor than her peer, with poorer nutrition and general health that will have a strong impact on her educational and working performance.

Other groups in risk of poverty are elderly people. The numbers of elderly poor in developing countries are increasing and elderly people are overrepresented among the chronically poor. As most elderly people live and share resources with younger family members and lack any pension, this can create dependency. For example, in Moldova elderly people stand out as poorly integrated in the social and economic life. Elderly people with low incomes have for instance less access to health care¹⁹.

OPPORTUNITIES AND CHOICE – INEQUALITY AND LIMITED ACCESS



Being poor in terms of opportunities and choices refers to one's possibilities to develop and/or use the resources to move out of poverty. Access to health service including commodities, and information on health are examples affecting the choices available and opportunities to escape from poverty.

Despite improvements in health, substantial proportions of people living in poverty suffer disproportionately from burden of disease and limited access to means of prevention and health service.

People in poverty have limited human assets (knowledge and education), safe water and sanitation, and affordable nutritious food. This may lead to long-term negative effects on health and learning, impacting employability and human capabilities.

People living in poverty are often less likely to access health information and timely health care due to e.g., geographic accessibility (distance or travel time to health services); availability (hours of operation and waiting times that meet demands); financial affordability (cost of health services); acceptability (responsiveness of health services); and, poor quality of services.

Women, children and adolescents particularly in rural areas, are disproportionately affected by lack of access to means of prevention and quality health services. Over 800 women die every day from preventable causes related to pregnancy and childbirth.²⁰ Most of [childbirths](#) in LMICs occur without skilled birth attendance, risking both the life of the mother and the child. In 2018, 2.5 million neonatal deaths and 5.3 million under-5 deaths²¹ were estimated mainly because of low coverage of effective interventions to provide quality care within existing health systems.²²

Women's and girls' opportunities and choices when it comes to health might be hampered due to discriminatory norms including coerced sex, sexual violence and harmful practices, such as female genital mutilation/cutting and child, early and forced marriage. These practices, in turn, can make them more vulnerable and unable to protect themselves from unwanted

17 Assessing Development Assistance for Mental Health in Developing Countries: 2007–2013

18 Masculine Norms and Men's Health, Promundo

19 Multidimensional Poverty Analysis Moldova, 2018, Swedish Embassy in Moldova [Link to report in Poverty Toolbox](#)

20 <https://www.unfpa.org/maternal-health>

21 Women's, Children's and Adolescents' Health: Trends in the SDG Era

22 The Burden of Disease Among the World's Poor

pregnancy and HIV including other sexually transmitted infections as well as from complications related to pregnancy and childbirth.

Poor-quality care is associated with a greater share of excess mortality than lack of access to health services.²³ Drawing on data from 54 LMICs, 38% of the health facilities lack access to even rudimentary levels of water, 19% lack sanitation and 35% do not have water and soap for handwashing.²⁴ While it is difficult to ascertain how many deaths are directly resultant from poor sanitation, a WHO study in 2012 calculated that for every U.S. dollar (\$1) invested in sanitation, there was a return of 5.5 USD in lower health costs, more productivity, and fewer premature deaths.²⁵ Access to safe and clean water and sanitation hygiene (WASH) also contributes to reducing the risk of infectious diseases and overuse of antibiotics. Antibiotic resistance is strongly associated with the increasing number of diseases including new diseases, and overuse of antibiotics. Antibiotic resistance leads to higher medical costs, prolonged hospital stays, and increased mortality.

Health service expenditures are often skewed away from the needs of the poorest and can leave them dependent on the more accessible but lower quality and often expensive private service providers. Evidence shows that people living in poverty spend a disproportionate share of their income on health care than those belonging to middle income or wealthier groups. About 925 million people spend more than 10% of their household income on healthcare and 200 million people spend more than 25% of their income on health, which pushes 100 million people into poverty every year.²⁶

In Kosovo high out of pocket expenses for healthcare and other health expenditures have been identified to increase the poverty headcount with 15 percent.²⁷

POWER AND VOICE – DISCRIMINATION AND LACK OF EXERCISING RIGHTS

Power & voice

Being poor in terms of power and voice relates to people's ability to articulate their concerns, needs and rights in an informed way, and to take part in decision-making affecting these concerns.

Lack of power and voice could link to health and poverty when people cannot advocate for certain rights such as the right to health care and health security. The latter is vital to control the outbreak of epidemic and endemic diseases.

Health is closely related to dignity and the enjoyment of basic human rights. Discrimination and/or lack of enabling laws can adversely affect physical, mental and social wellbeing of citizens, in particular among women and girls and other vulnerable groups.

Disadvantage and discrimination may exclude certain groups from accessing quality care and/or heightened exposure to human rights abuses in health care settings such as coercive or forced treatment and procedures. Especially vulnerable persons include e.g., people living with disabilities and/or mental disorder, indigenous populations, elderly, women living with HIV, people in prostitution, people who use drugs, internally displaced persons and undocumented migrants, transgender and intersex people.

The situation may be exacerbated when different forms of discrimination and other factors intersect. For instance, women living with disabilities, HIV, fistula and other diseases strongly associated with stigma and discrimination, are facing multiple forms of discrimination, barriers and marginalization in addition to gender discrimination.

Many women and girls living in poverty face restricted or no access to information and services about their sexual and reproductive health and rights due to discrimination, stigma, restrictive laws and policies, and entrenched traditions, which might have a negative impact on their health. An example is the high number of teenage pregnancy, approximately 12 million girls aged 15–19 years give birth each year in LMICs.²⁸

23 Women's, Children's and Adolescents' Health: Trends in the SDG Era

24 Water, sanitation and hygiene in health care facilities
Status in low- and middle-income countries and way forward

25 The Burden of Disease Among the World's Poor

26 The 2019 UHC Global monitoring report

27 Multidimensional Poverty Analysis Kosovo 2017 p. 8 see report: <https://www.sida.se/English/partners/methods-materials/poverty-toolbox/>

28 <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>

HUMAN SECURITY – GENDER BASED VIOLENCE AND INCREASED INEQUALITIES



Being poor in terms of human security means that physical, sexual, and/or psychological violence and insecurity are constraints to different groups' and individuals' possibilities to exercise their human rights and to find paths out of poverty.

Human security is impacted by issues related to sexual and gender-based violence (in the household and in society at large), physical and psychological violence against people with disability, the denial of health service to LGBTQ people or SRH services to women and girls.

It is estimated that 35 percent of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives.²⁹ Due to their lack of income and resources, those who experience domestic or intimate partner violence have fewer options to leave violent relationships.³⁰ Women who have experienced partner violence report higher rates of depression, having an abortion and acquiring HIV, compared to women who have not been abused.³¹

Another form of violence is female genital mutilation (FGM) which is recognized internationally as a violation of the human rights of girls and women. FGM reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against females. FGM is nearly always carried out on minors and is a violation of the rights of children. More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated.³²

Lack of human security exacerbates the risk of ill-health as it is a barrier for poor people to seek health care and other kind of support. In Uganda, for example, survivors of GBV often do not seek assistance, both for fear of social stigma and exclusion, but also as due to lack of awareness of associated risks such as unwanted pregnancies, HIV and other sexually

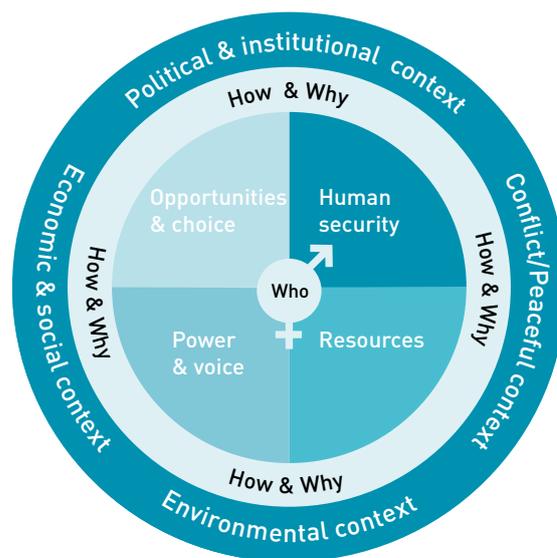
transmitted infections (STIs).³³ This argument holds also for a woman and for an adolescent girl seeking safe abortion services in many countries.

Men and boys can also be victims of sexual abuse and exploitation and those living in poverty are most at risk. Young men may be less likely to report and/or find it more difficult to disclose abuse and exploitation than young women due to social stigma.³⁴ The absence of reporting mechanisms and shelters, especially for men, boys and the LGBTQ community, is a major challenge. The poorest communities and those living in conflict and fragile contexts are mostly affected.

Apart from causing physical damage, violence could also lead to psychological damage among people living in conflict areas, which exacerbates health inequalities, particularly for women, children and adolescents.

ANALYSING POVERTY AND HEALTH IN DIFFERENT CONTEXTS

How health impacts on the different dimensions of poverty has been discussed in the previous section. Moving further from a descriptive study to an analysis of the root causes of poverty, there is a need to analyze the development context to understand why some people are poor. The health dynamics in relation to the context analysis will be further explored in the following section.



Source: Sida (2017) Dimensions of Poverty – Sida's Conceptual Framework.

²⁹ <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

³⁰ Women and girls living in poverty are more vulnerable to sexual exploitation, including trafficking. And those who experience domestic or intimate partner violence have fewer options to leave violent relationships, due to their lack of income and resources.

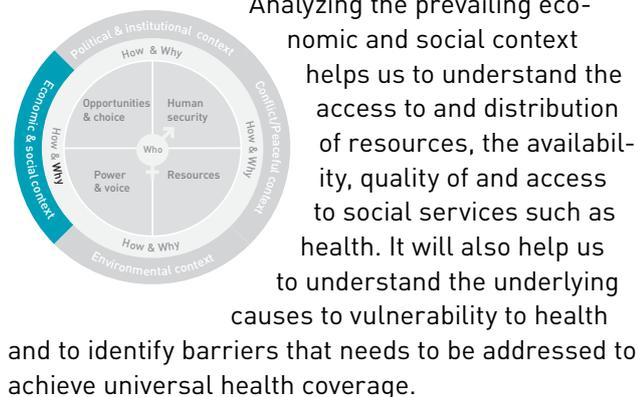
³¹ <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

³² <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>

³³ Multidimensional Poverty Analysis Uganda, 2017, Swedish Embassy in Kampala (p.48)

³⁴ <http://www.stop-cse.org/sexual-exploitation-boys-young-men/>

ECONOMIC AND SOCIAL CONTEXT



Lack of universal access to quality, affordable health services endangers countries' long-term economic prospects. LMICs account for 90% of the global burden of disease but for only 12% of global spending on health.³⁵ The primary source of health financing is often from the international community and the households (out-of-pockets). For example, in DRC the health sector would collapse and access to basic services for the most vulnerable would be even more compromised without significant international support. The government budget's allocation to health is insignificant (4%), used to pay salaries and not for any investments.³⁶

The health systems in LMICs also suffer from insufficient human resources, limited institutional capacity and infrastructure. There is a huge shortage of health staff and investing in human resources is urgently needed. Also, more attention should be paid to the labor market dynamics to achieve a balance between supply and demand within the health system.

Over 70% of the health workforce comprise of women with inadequate pay and benefits as well as poor working conditions. This is frequently mentioned in developing countries as the most pressing problem facing the health workforce and their performance³⁷.

The increasing burden of noncommunicable diseases in LMICs is a double burden for the already weak health systems. Conflicts and humanitarian crisis increase the pressure on the health system due to

increase in violence, injures and other health related issues.

Emergency responses to health related shocks, such as the COVID-19 outbreak (see box 3), often means that resources for maternal health – including sexual and reproductive health services – may be diverted to deal with the outbreak. This contributes to a rise in maternal and newborn mortality, increased unmet need for contraception, and increased number of unsafe abortions and sexually transmitted infections.³⁸ The health care systems in many countries are weak and have operated at maximum capacity even prior to the COVID-19 outbreak, which implies that 'flattening the curve' to match the capacity of the health care apparatus will not be a realistic option for less-developed countries. Even scarce resources are likely to be transferred to treatment of COVID-19, which weakens the provision of health services overall.

BOX 3: COVID-19 AND POVERTY

Health shocks might have tremendous impacts on poverty. The COVID-19 pandemic is having severe impacts on the progress made during the last twenty years. The impacts of the pandemic disproportionately affect the already poor in countries with weak health systems. The disruption of essential services as a consequence of COVID-19 response are having a major indirect effect on child, adolescent and maternal health and SRHR. Thus, building resilient systems and adopting preventing measures are crucial for peoples' health status and for preventing deeper poverty.

Corruption, e.g., bribes, thefts and unethical drug promotion, is a pervasive problem that weakens the daily functioning of health systems – including provision of quality care and medical products. During outbreaks, such as COVID-19, corruption may worsen as we see an increase in supply and demand in health systems, which is a perfect situation for corrupt actors to take advantage of. However, extra measures and resources channeled to target outbreaks, might provide an opportunity to strengthen parts of the health care provision, as some contra-Corona virus measures, such as hand-washing and social distancing, are beneficial for a wide range of diseases.

Social structures that are exclusionary and inequitable could keep people in poverty and low health status. When analyzing health system performance, dimension such as equity, quality, responsiveness, efficiency should be taken in to account. These will

35 <https://bmc-musculoskeletal-disorders.biomedcentral.com/articles/10.1186/s12891-017-1624-z>

36 Multidimensional poverty analysis for the Democratic Republic of Congo 2018, Swedish Embassy in Kinshasa

37 World Health Report. Health Systems: Improving Performance, pp. 73-90, 2000. See also Das A, Gopalan S.S. and Chandramohan D. Effects of pay for performance to improve quality of maternal and child care in low-and-middle-income countries: a systematic review, BMC Public Health Vol. 16, No. 32, pp.1-11, 2016.

38 https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_A_Gender_Lens_Guidance_Note.pdf

help us to understand what is required for improving health systems, service delivery, health financing and governance (power and voice). However, there is no one-size-fit-all approach to strengthening health systems. The mix of policies and approaches will need to reflect country contexts and participatory processes such as leaving no one behind (commitment to equity, non-discrimination and a human rights-based approach); transparency and accountability for results (access and availability for citizens to budget information); evidence-based national health strategies and leadership as the foundations for strengthening health systems; and, making health systems ‘everybody’s business’ – with engagement of citizens, communities, civil society, and private sector.

POLITICAL AND INSTITUTIONAL CONTEXT



There is a strong link between health and the political and institutional context. Lack of financial resources and political will, concerning health including SRHR and human rights, have negative effects on peoples’ access to health services, products and information.

Discriminatory social institutions e.g., laws, social norms and practices restrict marginalized and vulnerable people such as women and adolescents, people with disabilities and/or mental health to access information and receiving essential health care, which in turn have a negative development outcome.³⁹

The Universal Declaration of Human Rights (UDHR) is a milestone document in the history of human rights. The UDHR remains as relevant today as it was on the day in 1948 that it was proclaimed and adopted by the United Nations General Assembly. The UDHR promises to all the economic, social, political, cultural and civic rights that underpin a life free from want and fear. They are the inalienable entitlements of all people, at all times, and in all places — regardless sex, age, gender and transgender identity or expression, sexual orientation, disability, ethnicity, and religion or other belief.

The International Health Regulations (IHR), published in 2005, are a legally binding instrument of international law that aims to a) assist countries to work together to save lives and livelihoods endangered by the international spread of diseases and other health risks and b) avoid unnecessary interference with international trade and travel. IHR is an important document because it is not limited to specific diseases but apply to new and ever-changing public health risks.

The International Conference on Population and Development (ICPD) Program of Action, adopted in 1994, lays out a far-sighted plan for advancing human well-being that places the human rights of individuals in the center. The ICPD emphasizes the value of investing in women and girls, both as an end in itself and as key to improving the quality of life for everyone. The importance of sexual and reproductive health is also affirmed in the ICPD – including family planning, as a precondition for women’s empowerment. The ICPD calls for an end to gender-based violence and harmful traditional practices, including female genital mutilation.

In 2019, a renewed high-level political declaration on universal health coverage (UHC) was adopted. It is an important document that highlights the importance of assuring strong primary health care – the provision of essential health services at the community level – and strengthening health systems. The resolution includes a strong focus on women, children and adolescent health – including sexual and reproductive health as a key component of UHC.

The lack of rule of law, corruption and political oppression also affects inequalities and make it more difficult for vulnerable groups to move out of poverty. For example, women, including adolescents, with unintended pregnancies, often resort to unsafe abortion when they cannot access safe abortion. Barriers to accessing safe abortion include, for example, restrictive laws, poor availability of services, high cost and stigma. As a consequence of COVID-19 measures, such as lockdowns and disruptions in service delivery are on the rise.

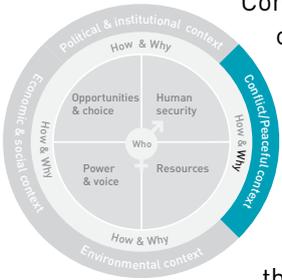
Sexual and reproductive health and rights are key to women’s ability to take charge of their own lives. The quickly changing political contexts of recent years have influenced the SRHR discourse, access to rights, funding, services and lived experiences. Due to the current political and ideological attack on the SRHR

³⁹ https://www.researchgate.net/publication/271826265_Tackling_the_root_causes_of_gender_inequality

agenda – which is linked to the backlash against gender equality – there is a decrease in access to SRH-services and in turn increased number of unsafe abortion and maternal mortality rate in many LMICs.

The lack of rule of law may also cause increased corruption within the health sector and/or affect health staffs' motivation and ability to provide quality care. In Moldova – for example – unofficial payments or bribes to staff is normal procedure to get access to services, even for people who have health insurance. Between 40% to 90% of the primary health care facilities do not have the basic equipment to carry out the services.⁴⁰

PEACE AND CONFLICT CONTEXT



Conflict and violence are obstacles to wellness. Nearly a quarter of the global population – currently live in settings affected by conflict, displacement and natural disasters. Combined with weak national health systems, these settings make it difficult to deliver basic health services where they are most needed and would make the biggest difference. As a result, these settings also have high burden of disease and death.

Displaced households and/or households with widows, orphans, elderly and disabled individuals are most at risk of falling into poverty as a result of conflict. Households that are already poor, risk falling further into poverty. Material damage on e.g., housing and land are obvious consequences impacting particularly the poorest and most vulnerable (e.g., children and persons with disabilities) because it reduces access to food and income to purchase necessities such as health service and medicine.

Crises often exacerbate existing violence against women and girls, and present additional forms of violence against girls and women. In addition, more than half of maternal deaths occur in fragile and humanitarian settings. The risk of maternal death – the probability that a woman dying from a maternal cause – is 1 in 4900 in developed countries, versus 1 in 54 in countries designated as fragile states.⁴¹

In armed conflict, GBV can become so widespread and systematic that it is considered a weapon of war. During armed conflict, the upholding of basic human rights frequently fails due to the collapse in the protection of civilians and involvement of civil society.

The effects of terror and conflict further amplify peoples' vulnerability to ill-health and the mortality rates due to ill-health are higher in countries chronically affected by conflict than elsewhere. These countries have significantly lower coverage of reproductive and maternal health services and childhood vaccinations than other countries. In South Sudan, for example, maternal mortality in 2017 was as high as 1150 per 100,000 live births.⁴² Men's and boys' health are also affected by conflict situation. For example, poor men are reporting being stressed and depressed because of not being able to live up to the role as the provider and protector.⁴³

Conflict, political instability as well as climate change entail also opportunities for the spread of infectious diseases. For example, displacement of communities can exacerbate transmission and/or introduce disease to new areas. Disruption of supply chains and emigration lead to shortages of medication, reagents and trained medical personnel, as well as a breakdown in routine health services such as vaccination. Another possible impact is that some norms and behaviors that are risky for women's and girls' health are exacerbates. Parents may marry off their daughters at an early age in return for dowry or bridal wealth as a coping mechanism. This reduces the age of sexual debut, which in turn increases, e.g., the risk of contracting HIV and teenage pregnancy.

COVID-19 has resulted in increased violence against women and girls, child abuse and harmful practices. These are consequences of the lockdown measures, and lack of access for survivors to safety and health services.

40 Multidimensional poverty analysis, Moldova 2018, Swedish Embassy in Chisinau, p. 16

41 <https://www.who.int/reproductivehealth/news/srhr-refugees-migrant/en/>

42 The Burden of Disease Among the World's Poor

43 Development trends, increasing engagement of men and boys for gender equality.

ENVIRONMENTAL CONTEXT



The human-induced negative impact on the environment results in death, diseases and injuries, impacting the quality of life, reducing productivity, and weighing down the health systems. The burden is unevenly distributed and effects poor

people, already living in poor conditions, even worse since they depend more directly on natural resources and services.

Pollution is the world's largest environmental cause of disease and premature death and nearly 92% of pollution-related deaths occur in LMICs.⁴⁴ This includes environmental threats at work, home and broader community/living environment. In many LMICs, e.g., laws are weak or not applied, vehicle emission standards are less stringent and coal power stations more prevalent. In the big cities of developing countries, it's the poorest who live in cramped informal settlements, often near rubbish dumps, who feel the full force of air pollution. Poverty can also compound the damaging health effects of air pollution, by limiting access to information, treatment and other health care resources.

Lack of safe drinking water and sanitation has a negative effect on living standards, as they increase morbidity due to different diseases. In turn, this can be induced by climate shocks and stresses such as floods and droughts. Small changes in temperature can also have the potential to increase the frequency of diseases and new diseases. Lack of sanitation and increased number of diseases increase the risk of antimicrobial resistance (AMR). Environmental impacts and climate change will thus have great implications, and put pressure, on the health system.

⁴⁴ [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(17\)32345-0.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)32345-0.pdf)

The interface between humans, animals, and the environments can also be a source of diseases impacting public health and the social and economic well-being of the world population. Zoonoses (diseases or infections naturally transmissible from vertebrate animals to humans) comprise a large percentage of all newly identified infectious diseases as well as existing infectious diseases which may contribute to increase in antimicrobial resistance.⁴⁵

TOOLS FOR INTEGRATING HEALTH ANALYSIS INTO THE MULTIDIMENSIONAL POVERTY ANALYSIS

Analyzing the links between health and poverty is an integral part of the multidimensional poverty analysis that aims to identify constraints for people living in poverty and their path out of poverty.

Below is some supplementary guidance for integrating the health perspective into the dimensions of poverty:

Sida's [Poverty Toolbox](#) provides tools and guidance for conducting multidimensional poverty analysis, including [Guiding Questions](#) and a [Menu of Indicators](#) provides practical advice and access to data source on economic development and poverty. A special brief on [Covid-19 and Dimensions of Poverty](#) highlights the impact of the COVID-19 pandemic on poverty. In addition a brief on [Gender Equality and Dimensions of Poverty](#) highlights the connections between gender inequality and dimensions of poverty.

Other useful tools are found on [WHO Social Determinants to Health](#).

⁴⁵ <https://www.who.int/zoonoses/en/>