

Tackling Health Inequalities in Global Health

Case study presentation : Poverty

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Case study 1

Amina is a 46-year-old woman living in Johannesburg, South Africa. She is a single mother of three children and works six days a week as a cashier in a shopping centre. Her household income covers rent, transport and basic food, but there is very little money left at the end of the month.

Amina was recently diagnosed with type 2 diabetes and hypertension. At the clinic, she was advised to lose weight, eat more fresh vegetables and whole foods, and exercise for at least 30 minutes several times a week.

Amina understands the recommendations and would like to follow them. However, fresh food is often more expensive than the processed foods she usually buys for the family, and some foods recommended by the nurse do not keep well in her small shared refrigerator. She leaves home early in the morning and returns late, so she often buys inexpensive ready-made food near her workplace.

Her job involves sitting or standing in the same place for long periods. After work, she still has housework and childcare responsibilities. She does not feel safe exercising outside after dark and cannot afford a gym membership.

During a follow-up appointment, a healthcare professional tells her that controlling her diabetes will depend mainly on whether she is willing to “change her lifestyle”. Amina leaves the consultation feeling that she is being blamed for her illness

Questions for case study 1

1. What factors in Amina's situation influence her diabetes and hypertension?
Try to distinguish individual, household, community and structural factors.
2. To what extent can Amina's diet and physical activity be described as “choices”?
3. What makes it difficult for Amina to follow the advice to eat healthier and exercise more? Which of these barriers are linked to her living or working conditions?

Case study 2

Marcus is a 15-year-old boy living with his mother and younger sister in a low-income neighbourhood of Baltimore, USA. His mother works irregular shifts in two part-time jobs. The family has enough income to meet some basic needs, but rent consumes a large proportion of the household budget.

Their apartment has recurrent problems with damp and mold. Marcus has asthma, and his symptoms are often worse at home. During the past year, he has missed several days of school because of asthma attacks and because he sometimes has to care for his younger sister when his mother is working.

His mother occasionally delays buying medication until payday because of other household expenses.

Marcus's school has fewer extracurricular opportunities than schools in wealthier parts of the city. His neighbourhood also experiences violence, and his mother does not want him spending much time outdoors in the evening. Marcus often feels stressed about money, his mother's work situation and safety in his neighbourhood.

Twenty minutes away, adolescents of the same age grow up in much wealthier neighbourhoods. Their families generally have larger homes, greater access to educational opportunities, safer places for recreation and more financial security.

Marcus sometimes sees these differences on social media and when travelling across the city. He says that people often tell him that “everyone has the same opportunities if they work hard enough”, but he does not feel that this reflects his experience.

Questions for case study 2

1. Would you describe Marcus as poor? Does your answer change depending on whether you use an absolute or relative definition of poverty?
2. Define absolute and relative poverty
3. Identify the different pathways through which Marcus's socioeconomic situation may affect his health. Which are material and which are psychosocial?

Case study 3

Carmen is a 29 year old woman living in Orlando, Florida. She is from Venezuela, where she was forced to flee following national economic collapse. Carmen applied for asylum in the U.S. in 2021, however, her case is still backlogged in the immigration court system. She applied for a work permit while she waits, but her application has been pending for over a year.

Carmen was trained as a civil engineer in Venezuela, but since moving to the U.S., she is not able to work legally. She moved alone with no social support, and her only source of income is occasionally cleaning for a non-profit, but they have to pay her in gift cards because they cannot legally put her on the payroll. The other women on the cleaning team are U.S. citizens who receive a regular wage and health insurance through their jobs. Carmen has no bank account and no record of income in the U.S.

She lives at the local women's shelter, where she has been for almost a full year. She survives on one hot meal a day served at the shelter, and otherwise she buys non-perishable food that she can store under her bed, since she doesn't have access to a refrigerator. By the standards of many people around the world, her basic needs for food and shelter are met, but she has no private space, no phone plan, and no way to contact her friends and family.

Carmen increasingly struggles to sleep at night. She has become more anxious and depressed, and she has intermittent chest pain, especially when she walks long distances. She worries that if her health gets worse, she will not be well enough to work as an engineer again, even once her papers come through. Carmen knows that she cannot afford physical or mental health care, and since she doesn't speak very much English, she worries that her concerns would not be understood.

This year, the county health department announced that deaths from heart disease in the country have fallen steadily over the past decade, and it launched a free heart screening campaign. The screenings are advertised only in English, booked online, and require a Florida ID. Carmen has not heard about them. When a university research team surveyed local households about health and income, the shelter was not included, because it is not counted as a household.

Questions for case study 3

1. Carmen does the same cleaning work as her colleagues but is paid in gift cards with no insurance. Is this a problem of poverty, inequality, or inequity? How does this change the solutions you would propose?
2. The county reports falling heart disease deaths and has launched a free screening campaign. How can the county's health be improving while Carmen's chest pain goes unexamined? How could the county's goal change so it could account for someone like her?
3. Carmen has no payroll record, no bank account, and was left out of the household survey. What are the consequences of her being invisible in the data, and what would need to change for people in her situation to be counted?

Case study 4

Sandro is a 48 year old man who grew up in Vernier, outside of Geneva. He left school at 16 and has worked as a baggage handler at the GVA airport for over twenty years, mostly on night and early morning shifts. He started smoking at 15 when almost everyone in his group of friends smoked, and now smokes about a pack a day. He says the cigarette break is the only real pause he gets during a shift.

Because of his schedule, Sandro usually eats from the vending machines at work or picks up fast food on the way home. He doesn't sleep well during the day and rarely exercises. To keep his monthly health insurance premium more affordable, he chooses the highest deductible allowed, 2500 francs. He tries to avoid going to the doctor for anything that doesn't seem urgent.

Last year, after feeling tired and thirsty for months, he saw a doctor and was diagnosed with type 2 diabetes and high blood pressure. The doctor told him that he needs to stop smoking, change his diet, and exercise. Sandro understands the risks and has tried to quit smoking twice but went back within weeks.

His coworker Nadia is 46, she earns the same salary and works the same shifts. She has never smoked, packs her own meals and walks to work. Her health is good. Their manager has mentioned that Sandro "only has himself to blame," since Nadia manages fine in exactly the same job.

Questions for case study 4

1. In the Gwatkin article, a health difference which results from a lifestyle “in full awareness of the risks” may not be inequitable. Does Sandro meet that description? Did he have full awareness when he started smoking at 15?
2. Sandro chose the highest deductible - is this free choice? How is it different from choosing to smoke?
3. Which parts of Sandro’s situation did he choose? Where should the line be drawn?
4. Does the example of Nadia prove that Sandro’s poor health is his own responsibility? Does comparing groups rather than individuals change how fairness is judged?

Key concepts

- Individual responsibility vs structural determinants (Manderson & Jewitt)
- Absolute vs relative deprivation (Sen - Marmot)
- Material vs psychosocial explanations (Davidson)
- Stigma of poverty (Davidson)
- Health poverty vs. inequality vs. equity approach (Gwatkin)
- The data gap (Gwatkin)
- Capabilities approach (Marmot)
- NCDs -> NCDPs (Manderson and Jewitt)
- Agency + privilege is suggested when we say “diseases of lifestyle” - but many people do meet these qualifications. (Manderson and Jewitt)