

ORIGINAL ARTICLE

Characterization and Local Perceptions of Poverty Among Rural Households in Northern Zambia

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ABSTRACT

Background: Poverty has been linked with poor health outcomes in world health reports and cited by many scholars and leading health economists and public health specialist as a cause for poor health seeking behaviours especially for the rural poor. Poverty and ill-health are so closely intertwined that it is possible to use the words interchangeably, and still mean the same thing. Poverty has been defined as “a state of relative equilibrium of body form and function which results from its successful dynamic adjustments to forces tending to disturb it. It is not a passive interplay between body and forces impinging upon it but an active response of body forces working towards readjustment”¹³. Poverty on the other hand has been defined as a “lack of access to income, employment, and normal internal entitlements for the citizens to such things as freely determined consumption of goods and services, shelter and other basic needs of life”⁹.

The poverty and ill-health situation has grown grimmer for Africa and some Asian countries. The last decade has seen an emergence of new and a resurgence of old infections with a virulence and velocity hard to compare. East Asia and Sub-Saharan Africa have been at the receiving end of most the consequences of poverty and the ill health that result exacerbated by the HIV and AIDS pandemic.

It has been suggested that attacking poverty is the answer to better health. Many agree with this notion of improving health. The million dollar question has however remained how to proceed with the war against poverty. Experts and scholars have done commendable work studying, defining and designing solutions for poverty. That much has been achieved in these lines, again there is no denying. Success in reducing poverty has however remained elusive, especially in sub-Saharan Africa. World Health Organisation (WHO) in its World Health Report for 2005, admits failure in improvement of most health indicators in sub-Saharan Africa and more so for Zambia.

Methods: The participatory action research (PAR) was conducted in Chikoti village in Luwingu area among 212 households, Kungu village in Kasama with 236 households, Mpepo village in Mpika with 220 households and Ilondola village with 360 households. The study investigated the relationship between poverty and ill-health and how the rural poor respond to this discourse.

Results: The communities demonstrated a clear understanding of their own environment and were able to define factors which make them vulnerable to poverty and inversely to poor health. The study communities were able to distinctly define their own poverty levels and identify the categories of community members into the poverty status that is: managing poor, moderately poor and the extremely

poor according to their local conditions and in their own local language.

Conclusion: It is clear from the study findings that the rural communities do perceive poverty to affect all of the community members equally regardless of age or education levels. The study participants also demonstrated that they understood the vulnerability of women and children to poverty and its effects. It was also observed that poverty stricken communities often give preference to food than health, introducing ill-health due to negligence.

INTRODUCTION

Poverty has been linked with poor health outcomes in world health reports^{1,2,3} and cited by many scholars and leading health economists and public health specialist as a cause for poor health seeking behaviours especially for the rural poor^{10,11,12}. Poverty and ill-health are so closely intertwined that it is possible to use the words interchangeably, and still mean the same thing. The situation has grown grimmer for Africa and some Asian countries. The last decade has seen an emergence of new and a resurgence of old infections with a virulence and velocity hard to compare. East Asia and Sub-Saharan Africa have been at the receiving end of most the consequences of poverty and the ill health that result exacerbated by the HIV and AIDS pandemic.

It has been suggested that attacking poverty is the answer to better health^{1, 2, 6, 10, and 11}. Many agree with this notion of improving health. The million dollar question has however remained how to proceed with the war against poverty. Experts and scholars have done commendable work studying, defining and designing solutions for poverty. That much has been achieved in these lines, again there is no denying. Success in reducing poverty has however remained elusive, especially in sub-Saharan Africa. World Health Organisation (WHO) in its World Health Report for 2005,^{18,19} admits failure in improvement of most health indicators in sub-Saharan Africa and

more so for Zambia. It is important to note that it has been over 10 years down the line since The World Bank declared they would invest in health to make services work for the poor¹. It is highly likely that the cause of this un-necessary failure is as a result of poverty reduction solutions being worked out and solutions synthesised by a groups of elite experts in lands of plenty and corridors of power, (both locally and internationally) where poverty is a subject to be learnt, probably never to be experienced. Hungry mouths and empty bellies are often seen among people who are affected by poverty. These prefer to look for subsistence for their hunger rather than health which is at a long distance, time consuming and unsatisfactory.

METHODOLOGY

This was a cohort study involving participants in the selected localities over a period of three years. The intervention was communally managed income generating projects funded by Community Response to AIDS (CRAIDS), Programme against Malnutrition (PAM) and the farmer input support programme supported by government through the department of community development. Participatory Action Research (PAR) was the main research tool as the aim was to translate the already existing tactile knowledge among the community members into quantifiable, observable and measurable outputs which could be used to improve on the day today livelihood activities within the research areas and beyond.

SAMPLE SIZE

Using the Pocock formula, the sample size for the study was determined to be 332 households. Adjusting for 90% response rate then, n=370. This meant recruiting an average of 93 households from each of the 4 research site. At the start of the study a total of 384 household were recruited, 14 households more than the calculated target sample. This was to provide for dropouts given the long period over which the study was to be undertaken.

Study Sites:

These were four (4) large villages in four (4) districts of Northern Zambia. These sites were purposefully but carefully chosen because they were receiving financial support, material or technical support in running income generating activities. All the sites were off the tarmac and had similar general social economic dispositions.

Participatory Action Research (Par) Process

Phase 1. Initial Exploration Work

Literature review was conducted in the study districts. District documents such as district investment plans, district health information reports, poverty reduction strategy papers and district situation analysis were reviewed. Baseline data collection on local indicators on poverty such as number of meals per day, type of fuel used for cooking, type and size of housing, valued household assets, affordability of post basic education and other social services such as clean water and health service. Baseline data on local health indicators such as common illness, nutrition, water & sanitation, vulnerable groups and social behaviour was reviewed from the local health facilities and the district health offices to get an idea of the common ailments in the study areas.

PHASE 2. Discovery Process

The researcher and community agreed on the study goals and expected outcomes to ensure that there was no undue over expectations from the community. Definitions and perceptions of poverty, ill-health and wellness as working definition were also agreed upon at this point. The local teachers and retired civil servants helped in the translation of the local language (Bemba) definitions into English to ensure that the meaning of words and phrases retained the original meaning or were as close as possible.

PHASE 3. Prototyping

This was the active phase that involved identification of study communities that were already involved in income generating activities (IGAs) and various health promotion activities. The study was conducted in Kungu village of Misamfu area of Kasama and Mpepo Village in Mpika. Both locations were involved in IGAs implemented by Community Response to AIDS (CRAIDS) project. In Chinsali the illondola area was funded by Programme Against Malnutrition (PAM) which falls under the ministry of community development (MCD). In Luwingu the Chikoti community had agricultural related IGAs funded by KARA Counseling. Income generating initiatives and related training was offered to the participating households except for the Luwingu community.

Ethical clearance was obtained from the Bio-Medical Ethics Committee of the University of Zambia in Lusaka.

STUDY RESULTS

CHARACTERISATION OF STUDY PARTICIPANTS

Table 1: Household head by type

Household head	N	%
Male	95	24.7
Female	121	31.5
Widower	30	7.8
Widow	52	13.5
Boy Child	25	6.5
Girl Child	15	3.9
Chronically Ill	46	12.0
Total	384	100.0

The majority of the study households were women headed if we sum the married, widowed and girls 188 (49%) representing nearly half of all the study households. The study also had some chronically ill household heads about 46 (12%). The table also

demonstrates that the study had very few child headed households. 40 (10.4%) households were headed by minors below the age of 17. This sums up a combined total of 274 households which are prone to poverty and ill-health, due to minority, gender imbalance and poor economic opportunities.

Table 2: Household heads by age

Age	n	%
= 17	48	12.5
18 - 25	29	7.6
26 - 35	45	11.7
36 - 45	67	17.4
46 - 55	66	12.2
>55	129	36.6
Total	384	100.0

The study had a relatively small child headed households at 48 (12.5%) while the majority of the rest of the households were headed by adults ranging from 18 years to over 55 (87.5%). Majority of the adult participants were over 45 years at 129 (48.8%). This demonstrates that the older people in the rural areas are more likely to be poor and vulnerable to poverty and ill health. It is fascinating to note that the younger generation ranging from 25-45 are not the majority heads of the households. Had they been there, the economic situation would have been far better than what was observed. Therefore it is very evident that the young people are indulging in ill-planned unproductive activities failing to contribute to economic activities but falling prey to ill-health.

Table 3: Household head by education level

Education	n	%
No Education	111	28.9
Primary	153	39.8
Secondary	104	27.1
Tertiary	16	4.2
Total	384	100.0

Majority of the study household heads had little or no education at all 264 (68.7%) while 104 (27.1%) had

reached secondary school and only 16(4.2%) had reached tertiary education level. Most of the developing countries and the financial institutes have concluded that poor education is poor economy.

Definitions of Poverty as Perceived by the Local Study Communities.

During phase one of PAR, the study communities defined the factors or indicators of poverty in the three categories of extreme poverty, moderately poor and the managing poor as shown in table 1-3. The study communities defined the factors in a local language (Bemba) which was then translated into English with the help of the local resource persons such as teachers and agriculture extension officers.

Table 4: Characteristics of the Extreme poor

English	Bemba
Extreme poor	<i>Abapine nkonko</i>
<ul style="list-style-type: none"> o No source of food of their own. o No house of their own o No field of their own o No children of their own o No clothes o No blankets o Depend on begging 	<ul style="list-style-type: none"> o <i>Tabakwata ifyakulya ifyabo</i> o <i>Tabakwata inganda iyabo</i> o <i>Tabakwata ibala iliyabo</i> o <i>Tabakwata abana abaabo</i> o <i>Tabakwata ifyakufwala</i> o <i>Bafimbana umulilo</i> o <i>Bakalombalomba</i>

It was clear that the local communities had their own terms and conditions that they used to define extreme poverty in their local language and local perceptions as shown in table 1. The common characteristic of this group was that they had nothing of their own and their survival depended on the good will of other community members.

Table 5: Characteristics of the Moderately Poor

English	Bemba
Moderately poor	<i>Aba pinā panono</i>
<ul style="list-style-type: none"> o Eat once per -day o Have a small house(1- 2 rooms) o Have a small field o Have no fertilisers o Have no domestic animals o Can't take their children basic schools o Have no smart clothes o No blankets 	<ul style="list-style-type: none"> o <i>Balya limo pabushiku</i> o <i>Bakwata akayanda akanono</i> o <i>Bakwata akalibala akanono</i> o <i>Tabakwata umufundo</i> o <i>Tabakwata ifitekwa</i> o <i>Teti batwale abana kumasukulu</i> o <i>Bakwata ifisamu</i> o <i>Bafimbana umulilo</i>

It was also clear that the local communities had their own terms and conditions that they used to define the moderately poverty in their local language and local perceptions as shown in table 2. The common feature of this group was that they had little or nothing of the means of livelihood and could only manage to survive. To a large extent this group also depended greatly on help from government social safety nets, friends, relatives, children or well wishers. Communities depending on local languages, failing to understand the national “lingua-franker” which happens to be English, are often found to be poor, poverty stricken and prone to poor health.

Table 6: Characteristics of the Managing Poor

English	Bemba
The managing poor	<i>Abapina eefilya</i>
<ul style="list-style-type: none"> ○ Have one large meal per day ○ Have a reasonable field ○ Can afford some fertiliser ○ Have some domestic animals (Chickens or goats) ○ Have a small village shop ○ Have a bicycle ○ Have a reasonable house ○ Have working children 	<ul style="list-style-type: none"> ○ <i>Balya limo, nomba balekuta</i> ○ <i>Balikwata ibala ilyalinga</i> ○ <i>Balakwata u tumufundo</i> ○ <i>Balikwata iftekwa (inkoko ne mbushi)</i> ○ <i>Balikwata incinga</i> ○ <i>Balikwata inganda iikuluko</i> ○ <i>Abana Balabomba</i>

It was also clear that the local communities had terms and conditions that they use to define the managing poor described in table 3 above. The common factor in this group was that they had some kind of means of unsustainable means of production. The redeeming factor for this group was that they needed to have children who were educated or working in “town” as this was the source of their continued supplements of food, money, fertilizer, clothes and other household utility goods such as bicycles and furniture.

Perceptions of vulnerability to poverty by study households

The household heads were asked to assess their own households using the parameters of poverty agreed by the community. The tables below show the results of the study participant's perceptions at the end of the start of the study.

Table 7: Self Assessment of poverty levels by household heads

Age	Self Assessed Poverty Levels							
	Extremely Poor		Moderately Poor		Poor		Total	
	n	%	N	%	n	%	n	%
	21	12.0	18	15.3	9	9.9	48	12.5
18 - 25	14	8.0	3	2.5	12	13.2	29	7.6
26 - 35	21	12.0	16	13.6	8	8.8	45	11.7
36 - 45	35	20.0	19	16.1	13	14.3	67	17.4
46 - 55	27	15.4	24	20.3	15	16.5	66	17.2

X²=12.88 p=0.230

The study results demonstrated that there was no significant relationship between poverty and age range (p=0.230). All household in the study assessed themselves in the various poverty categories without any age advantage at all

Table 8: Household head self assessed poverty levels

Education level	Self Assessed Poverty Levels							
	Extremely Poor		Moderately Poor		Poor		Total	
	n	%	n	%	n	%	n	%
No Education	55	31.4	33	28.0	23	25.3	111	28.9
Primary	71	40.6	50	42.4	32	35.2	153	39.8
Secondary	44	25.1	30	25.4	30	33.0	104	27.1
Tertiary	5	2.9	5	4.2	6	6.6	16	4.2
Total	175	100.0	118	100.0	91	100.0	384	100.0

X²=5.08 p=0.533

The study results found that there was no significant relationship in the study household heads perceptions of their poverty levels especially for those with little or no education (p=0.533).

Table 9: Household head self assessed poverty levels

Household head	Self Assessed Poverty Levels							
	Extremely Poor		Moderately Poor		Poor		Total	
	n	%	N	%	n	%	n	%
Male	30	17.1	32	21.7	33	36.3	95	24.7
Female	46	26.3	36	30.5	39	42.9	121	31.5
Widower	14	8.0	9	7.6	7	7.7	30	7.8
Widow	29	16.6	19	16.1	4	4.4	52	13.5
Boy Child	12	6.9	9	7.6	4	4.4	25	6.5
Girl Child	7	4.0	7	5.9	1	1.1	15	3.9
Chronically ill	37	21.1	6	5.1	3	3.3	46	12.0
Total	175	100.0	118	100.0	91	100.0	384	100.0

X²=48.54 p<0.001

The study results demonstrated a very strong relationship between poverty levels and the type of household head. Overall nearly half (56.8%) of the female headed households were perceived to be moderately poor to extremely poor.

DICUSSIONS OF FINDINGS

It is clear from the study findings that the rural communities do perceive poverty to affect all of the community members equally regardless of age or education levels. This is more so if the factors of productions such as finances, farm implements and inputs, road infrastructure and markets are under-developed and difficult to access where they exist. The communities also demonstrated a clear understanding of their own environment and were able to define factors that make them vulnerable to poverty and inversely to poor health. The study participants also demonstrated that they understood the vulnerability of women and children to poverty and its effects.

The findings in this study have helped to clarify the poverty and ill-health environment in which the rural poor operate. This environment can be demonstrated in a diagrammatic expression of a triad as shown below. The basis for people's response to poverty and ill-health starts with the cultural and traditional beliefs, fears and aspirations. The negative or positive response to poverty and ill-health was to a large extent dependant on the enabling or un-enabling environment created by the government's policies and programmes aimed at reducing rural poverty and enhancing health seeking behaviours. The government's policies and programmes are also dependant on the scientific and conventional evidence on which basis government draws policies and programmes that respond to the evidence. In the event that the evidence upon which the planning is based is squid, it is most likely that the policies and programmes have little or no chance of success.

This is usually the case with establishing compelling evidence around culture, traditions and beliefs as these are not scientifically easy to demonstrate or

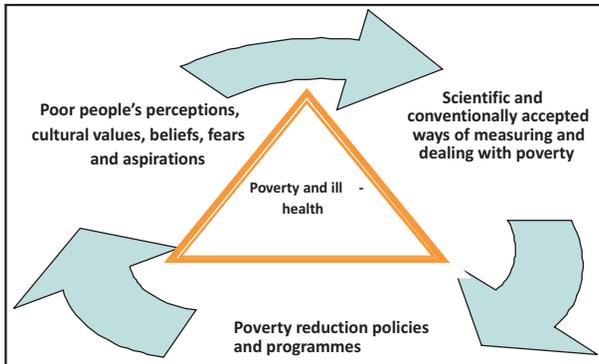
prove (ref). It is often however forgotten that it is the culture and traditions that determine the bulk of people's way of life. What is found around them determines what they eat, how they socialise, what they fear and how they protect themselves from the negative effects of the environment and what they use as remedy to ill-health. It is also their culture and traditions that will determine what they believe in, what they will learn and use and how they react to new knowledge and information. Their fears and aspirations will also determine how they cope with negatives shocks of the environment such as adverse weather, new diseases and new living conditions especially those brought about by technological advancements.

It is therefore important that these aspects of people's way of life are well considered by the learned technocrats in charge of developing policies and programmes for poverty reduction and promotion of good health on behalf of the rural poor. In most cases this is not the case as the peoples cultural and traditional environment does not form part of the conventional evidence gathering processes on which planning, implementation and monitoring of such policies and programmes are based^{36, 37, and 38}.

The people's perceptions, cultural values, beliefs, fears and aspirations for poverty reduction and good health are usually ignored by the learned know it all technocrats during the planning, implementation and evaluation processes of such programmes. The people are usually discounted as ignorant, illiterate and not capable of comprehending the complex methodologies involved in most scientific models for measuring poverty and designing health programmes^{17, 18, 19, 20, 23, 24}.

The diagrammatic figure below helps to demonstrate the triad of poverty and ill-health environment in which the rural poor struggle to survive.

Figure1: Diagrammatic demonstration of the environment of poverty and ill-health for the rural poor.



Government policies and programmes aimed at poverty reduction and health improvement are usually an adaptation of blue prints from multilateral and influential international organizations who finance and monitor progress using their home grown monitoring and evaluation tools which have little or no contextual reference to the views and perceptions of the rural poor^{17,18,19,26,27,46}.

The scientific and conventionally known and acceptable ways of measuring and dealing with poverty are complex and usually difficult varying far and wide^{16,17,18,19}. This is further worsened by the fact that these complex methodologies used in measuring and understanding poverty can only be understood and practiced by specially trained technocrats such as economists. Learned scholars such as social-economists have usually agreed that there is no standard ways of measuring poverty conventionally as economies and the factors of production and the weight of currencies differ from regions to region and country to country^{23, 24,29,30,31}.

Ironically, technocrats both local and international have however continued trying to define poverty and design solutions without the participation of the locals who own and understand their local determinants of poverty and ill-health. These socially and economically excluded rural poor people demonstrated through the results of this study that they can be a source of essential missing jig-saw-puzzle of defining determinants and designing solutions to poverty and ill-health. In this

particular study in Northern Zambia, the rural poor communities demonstrated their capacity to measure local poverty and ill-health while categorising the affected households according to their local conditions, cultural and traditional way of life. Going by the evidence gathered in this study it is therefore prudent to rely more on the people's perceptions as these would reflect the true value of what people perceive to be a problem and when the perceived problem is resolved, they will evidently be relieved. More often than not government's efforts at poverty reduction and health promotion are not appreciated by the rural poor people because of the lack of consultations and consensus with the recipient communities or simply because the new developments do not answer to the people's needs, fears and aspirations in relation to their cultural and traditional way of life.

CONCLUSION AND RECOMMENDATIONS

It is clearly evident from the findings of the study (table 8) that most of them were dependant on local languages would deprive them of the vital understanding of the government programmes against poverty and poor health. Majority of the households are women (188, chronically ill 46, and child-headed households 40) are major contributors to poverty and poor health which is a vicious circle. The government policies and programmes do not appear to have had any effect on these people since independence.

It is therefore recommended that government policies and programmes be community oriented based on community participation and their decision making. When communities are decision makers they begin to understand the value of ownership and possession. Lastly but not the least, the household surveys have clearly demonstrated that majority of the heads of the households did not come from the age group between 25 to 40 years of age. These are the younger generations who can lend a strong hand to improve the economy, industry and political will. Unfortunately, they are prone, to irresponsible and unprotected life styles more which subjects them to

ill-health, disease and absenteeism. There is an urgent need for the policy makers to protect this age group by giving them opportunities such as good education, protected and progressive life styles. This will result in bridging the gap between the rural and urban communities and inversely impacting positively on the current rural urban migration tendencies.

ACKNOWLEDGMENTS

The author wished to acknowledge the two supervisors, for technical Prof. S.K Baboo and Prof. S. Siziya for their support and guidance throughout the study period. I also wish to thank Mr Johnny Banda for technical support in Statistical analysis of data and Mr Stephen Mukalula and Richard Kaela for the data entry.

I also wish to thank the District Health official and their counterparts at the councils for Kasama, Mpika, Luwingu and Chinsali for the assistance and support rendered to me during the process of project site identification and selection.

I also would like to acknowledge the support and cooperation of all the four village headmen and their communities of Illondola, Chikoti, Kungu and Mpepo villages. Special thanks also to the teachers and the retired Civil servants who helped translate and facilitate the discovery process of the participatory action research. I am also grateful to the district coordinators of Programme against Malnutrition (PAM) under the ministry of community development and Community Response to AIDS (CRAIDS) allowing me to use their funded community groups as the intervention for the study

REFERENCES

1. World Bank (2001) The World Annual Report: world Free of Poverty. Available at <http://www.worldbank.org/annualreport/2001/overview.htm>. Accessed on 23/03/2012.
2. Cattell V. (2001) Poor People, Poor Places, and Poor Health: The mediating role of social networks and social capital. Journal of Social

- Science and Medicine .Vol. 54 (1501-15160. Available at World Wide Web: <http://www.elsevier.com/locate/socscimed>. Accessed on 05/03/2012.
3. Walsh J.A and Warren S (1979) Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries. The New England Journal of Medicine vol.301 (18) 967-974. <http://www.ais.up.ac.za/med/pcm870/interimstrategy.PDF>. Accessed on 05/03/2012.
4. Zambia 2000 Census of Population and Housing (2004) p137. Vol.6: Northern Province Analytical Report. Central Statistics Office. Lusaka. 1-162
5. Milimo J.T, Shilito T and Brock K (2001) The Poor of Zambia Speak: Who Would Ever Listen to the Poor? Zambia Social Investment Fund, Venus Stationary Limited, Lusaka.
6. Waitzkin H. (2003) p526. Report of the WHO Commission on Macroeconomics and Health: A Summary and critique. The Lancet. Vol: 361 (523-526) www.thelancet.com. Accessed on 15/05/2012
7. Government of the Republic of Zambia (2002) Zambia Poverty Reduction Strategic Paper 2002-2004. Ministry of Finance and National Planning. Lusaka, Zambia.
8. Government of the Republic of Zambia (2007) Zambia Demographic Health Survey report. Central statistics Office, Lusaka.
9. GRZ/UNDP (2002) Local Government and Poverty Reduction: Zambia Country Paper. Maputo. Mozambique.
10. Maurice K (1990) Health is a Sustainable State: Viewpoint. The Lancet Vol: 336 (664-667). www.thelancet.com. Accessed on 15/05/2012 .
11. Navarro V. (2000) Assessment of the World Health Report: Viewpoint. The Lancet. Vol:356 (1598-1601). www.thelancet.com. Accessed on 15/05/2012
12. Ezzati M., Lopez A.D., Rogers A., Hoorn V.S. and Murry J.L.C. (2002) Interpreting the Global Burden of Disease: Commentary. The Lancet Vol: 360 (1342 - 1360) www.thelancet.com. Accessed on 15/05/2012 .
13. Park K (2005) Preventive and Social Medicine. M/s Banarsidas Bhanot Publishers, Jabalpur, India.
14. Francis Teal (2001) Education, incomes, poverty and inequality in Ghana in the 1990s.

- Centre for the Study of African Economies, Department of Economics, University of Oxford. <http://www.csae.ox.ac.uk/conferences/2002-UPaGiSSA/papers/Teal-csae2002.pdf>. Accessed on 15/05/2012
15. Rebecca Dodd and Lise Munck (2008) World Bank and World Health Organization Report. Dying for Change, Poor people's experience of health and ill-health (Accessed at: www.who.int/hdp/publications/dying_change.pdf). Accessed on 15/05/2012.
 16. WHO Regional Office for Europe. (2010) Rural poverty and health systems in the WHO European Region. Copenhagen. www.euro.who.int/data/assets/pdf-file. Accessed on 02/03/2012.
 17. World Health Organization, Organization for Economic Co-operation and Development and World Bank. (2-4 September 2008) Effective aid, better health: Report prepared for the Accra High Level Forum on aid effectiveness. Accra, Ghana. <http://www.oecd.org/dataoecd/62/7/41212222.pdf>. Accessed on 15/05/2012.
 18. Kathy Cahill et al. (Selected Papers 2003–2005) High Level Forum on the Health Millennium Development Goals. WHO and the World Bank. www.hlfhealthmdgs.org/Documents/WHOCOnferenceReportENG.pdf. Accessed on 15/03/2012
 19. World Health organization (2008). Human Rights, Health and Poverty Reduction Strategies. Health and Human Rights Publications Series Issue No 5 December 2008. http://www.whqlibdoc.who.int/hq/2008/WHO_HR_PUB_08.05_eng.pdf. Accessed on 15/03/2012.
 20. Jonathan Henry Haughton, Shahidur R. Khandker (2009). What Is Poverty and Why Measure It? The World Bank <http://www.publications.worldbank.org>. Accessed on 18/02/12
 21. World Health organization(2007). Scaling Up for Better Health in Cambodia. A Country Case Study for the World Health Organization in follow-up to the High-Level Forum on the Health Millennium Development Goals. Ministry of Health, Cambodia. Accessed on 18/02/12
 22. Jonathan Henry Haughton, Shahidur R. Khandker (2009). Measuring Poverty. The World Bank <http://www.publications.worldbank.org>. Accessed on 18/02/12
 23. Food and Agriculture Organization of the United Nations (2010) The State of Food Insecurity in the World Addressing food insecurity in protracted crises. <http://www.fao.org/worldfoodsituation/wfs-home>. Accessed on 18/02/12
 24. Food and Agriculture Organization of the United Nations / United Nations Industrial Development Organization.(2010) African Agribusiness and Agro-industries Development Initiative. <http://www.fao.org/worldfoodsituation/wfs-home>. Accessed on 18/02/12
 25. Rodolfo Quirós (2006) Agricultural Value Chain Finance. Summary of the conference “Agricultural Value Chain Finance” Costa Rica - May 16 - 18, 2006. http://www.ruralfinance.org/fileadmin/templates/rflc/documents/1197886385023_Agricultural_Value_Chain.pdf Accessed on 18/02/12
 26. Food and Agriculture Organization of the United Nations, (2007) Agro-industrial supply chain management: Concepts and Applications. Available at <http://www.fao.org>. Accessed on 18/02/12
 27. World Economic Forum (2009) The Next Billions: Business Strategies to Enhance Food Value Chains and Empower the Poor. <https://members.weforum.org/pdf/BSSFP/NextBillionsBusinessStrategiesEnhanceFoodValueChains.pdf> Accessed on 15/05/2012
 28. The United Nations (2010) the Millennium Development Goals Report 2010. New York. <http://www.un.org/millenniumgoals/pdf/MDG.pdf> Accessed on 15/05/2012
 29. United Nations Development Programme (2002). Conceptual Shifts for Sound Planning Towards an Integrated Approach to HIV/AIDS and Poverty. Available at <http://www.sahara.org.za>. Accessed on 15/05/2012
 30. L S Tladi (2006). Poverty and HIV/AIDS in South Africa: an empirical contribution. Available at <http://www.sahara.org.za>. Accessed on 18/02/2012.

31. World Health Organisation (2008) commission on Social Determinants of Health. Closing the Gap; Health equity through action on the social determinates of health. Available at http://www.who.int/social_determinants/thecommission/finalreport/en/index.html Accessed on 20/03/2012
32. International Monetary Fund (2001). Rural poverty in Developing Countries; Implications for Public Policy. Available at <http://www.imf.org/external/pubs>. Accessed on 15/03/2012
33. World health Organization (2005) Building UNFPA/WHO capacity to work with National Health Development Planning Processes in support of reproductive health. Report of a technical consultation. Geneva, Switzerland. http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf. Accessed on 15/05/2012.
34. Ronelle Burger (2005). Poverty, Inequality and Health in Sub-Sahara Africa: Evidence from the Demographic and Health Surveys. A paper presented during the 4th PEP Research Network General Meeting, June 13-17th. Colombo, Sri Lanka. http://www.pep-net.org/fileadmin/medias/pdf/files_events/4th_colombo/PMMA/Burger-pa.pdf. Accessed on 15/05/2012.
35. GRZ/MACO (2009) Report on Proposed Reforms for the Zambian Fertilizer Support Programme. Available at: http://www.aec.msu.edu/fs2/zambia/FSP_Review_Report_feb_09.pdf. Accessed on 14/05/2012
36. Eroarome Martin Aregheore (Accessed on 30/04/11) Zambia Country Pasture/Forage Resource profile. Available at: <http://www.fao.org/ag/AGP/AGPC/doc/Counprof/zambia/zambia.htm> Accessed on 14/05/2012
37. FAO (1996) Report of the World Food Summit. Available at: <http://www.fao.org/docrep/003/w3548e/w3548e00.htm>. Accessed on 14/05/2012
38. IMF (2001) Rural Poverty in Developing Countries Implications for Public Policy. Available at: <http://www.imf.org/external/pubs/ft/issues/issues26/index.htm>. Accessed on 12/05/2012
39. Anup Shah (2010). Structural Adjustment- a Major Cause of Poverty. Available at: <http://www.globalissues.org/article/3/structural-adjustment-a-major-cause-of-poverty>. Accessed on 12/05/2012
40. FAO (2005), pp49-50. Microfinance and forest-based small-scale enterprises. Available at: <http://www.fao.org/docrep/008/a0226e/a0226e07.htm>. Accessed on 12/05/2012
41. International Fund for Agricultural Development (IFAD) (2010), Rural Poverty Report 2011, p 10. <http://www.ifad.org/rpr2011/report/e/overview.pdf>. Accessed on 15/05/2012.
42. Emmanuel Mali (2010) The Volatility of the Exchange Rate: A Case of the Zambian Kwacha By Emmanuel Mali - 29 June, 2010. The Volatility of the Exchange Rate; Case of Zambian Kwacha (A Discussion Paper) http://www.eaz.org.zm/newsletter.php?newsletter_id=66. Accessed on 10.05.2011.
43. World Development Indicator Data base. <http://www.nationmaster.com/graph/economy-gdp-economy-gdp&date=1964> Accessed on 10.05.2011.
44. Patricia A. Wilson (1996), pp618, 621-2, Empowerment: Community Economic Development from the Inside Out. Urban Studies, Vol. 33, Nos 4- 5, 617- 630, 1996. <http://soa.utexas.edu/people/docs/wilson/Empowermentarticle.pdf>. Accessed on 10.05.2011.
45. Fraser et al. (2006), pp 125-6. Bottom up and top down: Analysis of participatory processes for sustainability indicator identification as a pathway to community empowerment and sustainable environmental management. Journal of Environmental Management. Vol.78, 114-127. http://ecosistemas.uchile.cl/antar/wp-content/uploads/2008/07/bachmann_etal2007.pdf. Accessed on 15/05/2012
46. DeWalt et al, (2004), pp 1232-4. Literacy and Health Outcomes: Systematic Review. Journal of General Internal Medicine; Vol. 19:1228-1239. <http://onlinelibrary.wiley.com>. Accessed on 10.05.2011.
47. DeWalt DA, Hink A (2009) pp271-2. Health literacy and child health outcomes: a systematic review of the literature. Pediatrics, Vol.124: Suppl 3:S265-74. <http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf>. Accessed on 15/05/2012.

48. Sanders LM et al, (2009) pp135-6. Literacy and child health: a systematic review. Arch Paediatrics and Adolescent Medicine. Vol:163 (2):131-40. [http://www.ub.gu.se/sok/sfx/pubmed/index.xml?atitle=Literacy and child health: a systematic review](http://www.ub.gu.se/sok/sfx/pubmed/index.xml?atitle=Literacy%20and%20child%20health%3A%20a%20systematic%20review). Accessed 15/05/2012.
49. Picot J et al, (2009) pp 225,235-8. The clinical effectiveness and cost-effectiveness of bariatric (weight loss) surgery for obesity: a systematic review and economic evaluation. Health Technology Assessment. Vol:13 (41):1-190, 215-357, iii-iv. <http://www.curehunter.com/public/pubmed>. Accessed on 15/05/2012
50. Shepherd J et al, (2010) pp125-8. The effectiveness and cost-effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19: a systematic review and economic evaluation. Health Technology Assessment. Vol:14 (7):1-206, iii-iv. <http://www.ncbi.nlm.nih.gov/pubmed/20178696>. Accessed on 15/05/2012