

Measuring child poverty and health

A New International Study

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Young Lives 
An International Study of Childhood Poverty

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I. Introduction: a new child cohort study

The health community is well versed in the advantages of longitudinal studies, which produce time series data rather than snapshot cross-sectional studies. Seeking the holy grail of ‘causality’ rather than mere ‘associations’, prospective cohort studies move us one step forward (see the classic text on judgement of cause–effect relationships in Hennekens and Burling (1987)).

However, in health research in developing countries there are few cohort studies because they are very expensive, technically challenging, and because there is limited capacity for implementing them in resource constrained environments. Two events have generated sufficient support for a major new cohort study. Firstly, various governments, including the UK, agreed to work towards international development targets (IDTs) which included the aim to halve the proportion of people living in extreme income poverty by 2015. The commitment to targets requires some sort of baseline and better understanding of how individuals experience poverty dynamically, e.g. moving in and out of poverty. Secondly, the millennium generated general interest in children born in the year 2000 and curiosity as to how they will develop in the new century. In 2001 a major new prospective cohort study was launched which will follow up children born into poverty (plus a small number of non-poor for comparative purposes) in Ethiopia, Vietnam, Peru, and the state of Andhra Pradesh in India¹. Two thousand poor children in each country will be re-visited every three years until they are 15. Entitled ‘Young Lives: an international study of childhood poverty’, the project (www.younglives.org.uk) will strengthen research capacity in the selected developing countries and aims to be replicable in other countries interested in implementing a child cohort study.

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2. Why measure childhood poverty?

Child poverty is important of itself: children make up a large proportion of developing country populations (a third to half are under 15). It is also important more indirectly because future individual and national well-being will depend on the quality of life of current children (White, Leavy and Masters 2002). Children are a particularly vulnerable group among the poor because their welfare hinges on the resources of their parents. Children in poverty are at higher risk of a host of developmental problems. They are far more likely to be of low birth weight due to poor health status of the mother and inadequate prenatal care; they have higher rates of childhood morbidity and mortality; and they continue to be exposed to unsafe environments and conditions that pose additional risks (Bradley and Whiteside-Mansell 1997). In addition, child poverty has the unique feature that short-run deprivation can have long-run consequences (for example, in terms of causing chronic adult morbidity or even premature death).

3. Measuring childhood poverty in a multidimensional way

Childhood poverty needs to be measured in a multidimensional way because poverty itself is multidimensional. Poverty used to be viewed as lack of income only. This view has now been replaced with an acceptance that poverty encompasses not only material deprivation (as measured by income or consumption) but also low achievements in education and health. Increasingly, the definition of poverty is broadened further to include vulnerability and exposure to risk (see for example, the World Bank's 2000/2001 World Development Report: *Attacking Poverty 2001*). Vulnerability is the risk of falling into poverty or deeper into poverty. Asset ownership can protect people against such risk, so studies of vulnerability often use a concept of various assets: human, physical, social, financial and natural capital. It is worth noting that for studies of child welfare it is particularly important not to limit research to income poverty, because various empirical investigations show that this is rarely the sole cause of poor children's risks of illness, school problems or other negative outcomes (Sherman 1997; Ashiabi 2000). For example, Korenman, Miller and Sjaastad (1995) found that about half the effect of chronic poverty on children's literacy was attributed to non-financial disadvantage, such as low literacy of mothers.

Any multidimensional concept has problems. In terms of measuring poverty and comparing different places or times, how do we deal with these different components? What if an individual is 'income poor' but not 'health poor'? Even poverty experts at the World Bank accept that there are 'no easy answers' (World Bank 2001: 19) to this problem and no one composite index (like the Human Development Index which combines life expectancy, educational attainment and real GDP per capita (UNDP 1997)) is recommended. However, modern best practice should focus on deprivation in different dimensions and highlight multiple deprivations.

What relevance does this have for measuring childhood poverty? Clearly most aspects of poverty mentioned above can be measured for the households of the child (if the child has a conventional home). But many of the measures (e.g. different sorts of capital) are rarely applied

in a child-centric way. For example, intra-household behaviour may mean that the household is not 'poor' in terms of various assets (including food), but unequal allocation within the households means that some children (e.g. girls) may be asset poor (not have access to education or sufficient food, etc.). Thus, household poverty should not be used as a proxy for childhood poverty, although data deficiencies and the expense of collecting child-specific measures often leave no option. Furthermore, a multidimensional measure of poverty allows the incorporation of child-specific indicators (considered below). So, while still using multidimensional measures of household poverty we ideally need a multidimensional measure of childhood poverty.

Recent research provides clues as to what to include in child-centric measures. Both the World Bank's (1999) *Voices of the Poor* study and UNICEF's (1999) *Voices of Children and Adolescents in Latin America and the Caribbean* identify indicators of well-being which are important to children. They include: perception of peace in society, perceived family harmony, perception of the health of their environment, quality of food, access to schooling, ability to play in safety and the degree to which they are 'looked down on' by others. In addition to including such child-centric, subjective measures of well-being, a useful multidimensional measure of childhood poverty needs to include traditional, objective outcome measures of child well-being (in order to make comparisons with other studies and to have an impact on policy makers). These traditional indicators include nutritional status, physical and mental morbidity, developmental stage for age, and life skills (including numeracy and literacy).

4. The way forward

The Young Lives project has a conceptual framework that uses all of the outcome measures mentioned above and examines risk factors at the household and community level. Clearly, only some of the above dimensions are applicable to children of certain ages. In 2002 the caregivers of the index children of the Young Lives project will be interviewed. The only outcome measures at this early age (less than two) will be nutritional status, measured by anthropometrics, developmental milestones, and physical morbidity measured using the WHO-recommended 14-day recall of illnesses with clear symptoms; in this case diarrhoea and injury. The Young Lives project will track and re-visit 2,000 children in each of the four countries every three years. As the children grow older more outcome measures will be added. For example, for children aged six and over, their mental health will be measured using the 'Strengths and Difficulties Questionnaire' developed by the UK Institute of Psychiatry and already applied in numerous developing countries. The number of 'developmental stage for age' questions will increase as the child gets older. When children can articulate their perception of well-being (from approximately seven years), this dimension will be added.

The initial plan is to follow children up until they are 15. As the type of outcome indicators necessarily change over time and many are age-specific this study cannot monitor trends (e.g. is the nutritional status of five-year-olds worsening over a ten year period?) unless an additional cohort is recruited in the second round (sweep) of surveying. Funding will be sought for this.

In addition to the outcome measures, explanatory variables such as household livelihood and assets, wealth indices, use of education and health services, care-giving, etc. will be measured to explain variation. The broader policy context will be monitored so that associations with policy trends and shocks can be identified. In order to maximise the policy relevance of the study, sampling will be non-random and purposive, with 20 geographical clusters of 100 children selected in each country according to their likely exposure to development and/or policy trends and potential shocks (e.g. an area dependent on cash-crop production; a slum area regularly

threatened with eviction; a flood zone; remote rural ethnic minorities). There will also be specific mini-projects to explore particular issues in-depth such as children's constructions of security, community, etc. These latter projects will mainly use qualitative methods and the results will be integrated into the analysis to illuminate quantitative findings.

The longitudinal nature of this study will reveal causal pathways in children's health and well-being. It is intended that such findings on causality will have a policy impact that in turn can change and improve young people's lives.

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