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Poverty Diagnostic Model

Oliver Mtapuri
Turfloop Graduate School of Leadership, University of Limpopo, Edupark,
Block B, P.O. Box 759, 0787 Fauna Park, Polokwane, South Africa

Abstract: The study approaches the poverty problem by using the individual as the unit of analysis and by drawing on the Health Belief Model commonly used in the health sciences. The argument in this study is that the mere absence of resources provides insufficient grounds for the description of an individual as poor since it takes no note of that person's needs and wants. The question posed is then how to best achieve livelihood outcomes? In this, it follows two approaches from the literature on health economics; these assess the process by which individuals decide how to react to health issues, i.e., whether or not to seek treatment and change behaviour. The process is outlined in an eight stage process; these stages being further interpreted by a note on belief formation. The Poverty Diagnostic Model is the major contribution of this study.

Key words: Poverty, Health Belief Model, perceptions, livelihoods, capabilities, diagnostic, environment, factors, values, attitudes

INTRODUCTION

In order to get closer to a scientific, multidimensional understanding of poverty, this study introduces a new model which builds upon the models commonly used in the health sciences. It is distinguishable from the models in the health sector in terms of its focus. While health models focus on health problems, this model focuses on poverty and poverty perceptions. The proposed poverty diagnostic model modifies and customises these for use in development studies in general and poverty analysis in particular.

This modification and customisation is important in that researchers are now able to use this tool to interrogate what the poor feel about their poverty what factors enable exit from poverty or perhaps understand what factors keep them locked in poverty by asking the poor on a one-on-one basis by way of counselling and mentoring sessions. The introduction of this tool into social science research is the major contribution of this study.

MATERIALS AND METHODS

This study is a desk study and made use of literature drawn from the health sciences. It draws upon the Health Belief Model and postulates a new model for poverty diagnosis Poverty diagnostic model. According to Glanz and Rimer (2005):

> The Health Belief Model (HBM) was one of the first theories of health behavior and remains one of the most widely recognized in the field. It was developed in the 1950s by a group of US public health service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease. For example, the public health service was sending mobile X-ray units out to neighborhoods to offer free chest X-rays (screening for tuberculosis). Despite the fact that this service was offered without charge in a variety of convenient locations, the program was of limited success. The question was, Why?

Health Belief Model (HBM): The Health Belief Model (HBM) describes perceptions concerning the threat or susceptibility and severity of a health problem, the benefits of avoiding that threat and the factors that influence the decision to act (Glanz and Rimer, 2005). Broadly, the HBM asserts that there are six constructs that influence people's decisions:

- Believe they are susceptible to the condition (perceived susceptibility)
- Believe the condition has serious consequences (perceived severity)
- Believe that taking action would reduce their susceptibility to the condition or its severity (perceived benefits)

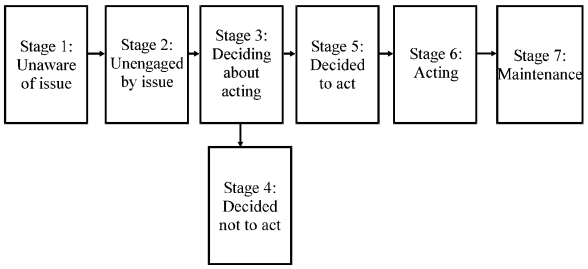

Fig. 1: Precaution Adoption Process Model

- Believe costs of taking action (perceived barriers) are outweighed by the benefits
- Are exposed to factors that prompt action (cue to action)
- Are confident in their ability to successfully perform an action (self-efficacy)

These are constructs that motivate people to seek or not seek treatment against their diseases or ailments.

Precaution Adoption Process Model (PAPM): This model has seven stages which range from lack of awareness to maintenance of behaviour. These stages are shown in Fig. 1.

The theory postulates that a person may be completely unaware of a hazard/disease. That person may become aware of it but remains unengaged (Stage 2). In Stage 3, the person considers deciding to act on the issue. Then, they either decide not to act, Stage 4 or 5, the person decides to act. Stages 6 and 7 are characterised by action and the subsequent maintenance of a behaviour. According to this model, a person cannot revert to Stages 1 and 2 while in other stages there is room to regress. The model recognises that people who are unaware of an issue or unengaged and therefore less concerned by it face different barriers from those whom have decided to act (Glanz and Rimer, 2005).

This model states that people can decide or decide not to act against their ailments/habits. When they decide to act, for example to quit smoking, they can do so and be able to quit smoking and maintain a non-smoking habit.

RESULTS

The Poverty Diagnostic Model (PDM): Understanding the causes and consequences of poverty involves looking beyond the statistics to examine the processes and events that expose people to poverty, the conditions that prevent their escape and thus lead to its entrenchment and the consequences of poverty for those forced to experience it (Saunders, 2004).

The PDM looks at the individual as the unit of analysis and change. In developing this model, the overriding consideration or questions were: does, for instance, culture/ethnicity/norms matter in shaping poverty perceptions? If yes, what else? If not what then shapes perceptions of poverty? Poverty also invokes and conjures vulnerability meaning a poor person's susceptibility to more poverty as a consequence of social, economic, cultural, legal and political factors.

Furthermore, culture may engender a spirit of subservience, obedience, deontology (accept things as given without questioning them) while the legal and political environments may well be oppressive, cruel, repressive, suppressive, stifling and unfair. The legal and political environments may also be libertarian, democratic, tolerant, laissez-faire, liberal and egalitarian. All these impact on poverty in many ways including breeding stigma which manifests itself in shame, humiliation, embarrassment, disgrace, blame, fault, blameworthiness and dishonour (as expressed by the poor themselves). Oyen (2002, 2003) sees as negative the stereotypical portrayal of poor people as lazy, dirty, criminal, sinful, producing too many children, greedy for social support. To some extent this model will allow us to move away from the stigma that portrays poor people as such. Thus, the perceptions of the poor about their status also has to be elaborately identified, defined and described. It should be borne in mind that perceptions, in turn are influenced by circumstances.

The literature shows that poverty is influenced by factors which are both self inflicted and inflicted by other agents; various factors impact poverty positively by decreasing it or negatively by increasing it; shocks of all kinds impact on these factors at all levels and in turn impact poverty. And some of these forces are mutually reinforcing, some are causes of poverty and some result from poverty. Reardon and Vosti (1995) point out that with typologies we begin by examining the asset portfolio of the rural poor, asking the question: poor in what? That is what this model attempts to help unpack. Thus, the PDM consists of the following components:

- Identification and description of internal and external forces at the macro-(global/national), meso-(community) and micro-(family/individual) levels through data collection and analysis
- Develop livelihood interventions/strategies
- Implement the eight stage action model
- Aim to achieve specific livelihood outcomes

Researcher shall distinguish here between internal and external forces. Internal forces are those forces arising from social factors such as education, skills, experience,

beliefs, status, marital status, family composition, living conditions and social services as well as factors of a relational nature in social systems such as marriage, divorce, friendship, parenting, kinship and networks. These factors synergise, harmonise, collude, conspire, dissipate, diffuse, exaggerate, over and understate poverty both in unison and in disunity to produce undesirable poverty outcomes of destitution, helplessness, hunger and starvation which are invariably associated with poverty.

External/exogenous factors are factors that are outside the influence of the individual as a unit. These factors include social, political, demographic, economic/markets, historical, technological, geographical, infrastructural, cultural/ethnic (standards and norms), legal, environmental, asset and natural endowments, international forces and so forth. These forces are those that are beyond ones control as an individual or even a household, community or social grouping. Based on the premise that physical environment, economic, social and other factors may create poverty stimuli before people begin to interact with the environment, researchers want to understand where and when these factors interface before affecting the individual. Furthermore, in developing this model, the question was: Do the social, economic and physical environment create a stimulus for poverty? Or does poverty represent these forces in disequilibrium? Alternatively because poverty is the antithesis of wealth does wealth therefore represent a balance of these forces?

In poverty analysis, some people believe there are things beyond their control as a result of fate/destiny/ancestors/superstition. Therefore, it becomes pertinent to ask the poor whether being in poverty (or being out of it) is within their control. Values, beliefs, observation, norms, standards, intentions, information, experience, skills and abilities, attitudes, views and opinions, cognition, motivations, behaviour, patronage, capabilities (as postulated by Sen) and gender relations also have an effect on poverty. These cut across at the individual, community (norms and standards) to the macro levels (e.g., patronage). Gorin and Arnold (1998) note that the emphasis on community is explicitly political in that the community becomes a mediating structure between the domain of the everyday life of the individuals (micro-level) and the larger social/political/economic context within which individuals live (macro-level). Researcher argue here, given the foregoing that families and communities show nuances and norms that are of interest in order to characterise poverty's manifestations and help us contextualise it.

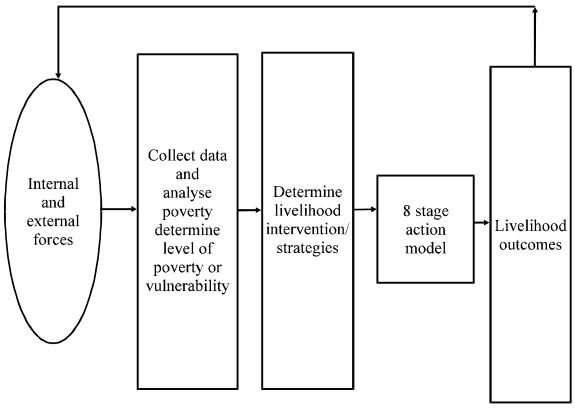

Fig. 2: Poverty diagnostic model

The outcome of the interactions and interplay of these factors results in re-cycled and the formation of new configurations such as the inclusion of capacities and capabilities because these can support or inhibit growth at the individual, family and community levels necessitating adaptations to achieve functionings. Arnold and Janssen (1998) define functionality (as opposed to functionings) as the ability to carry out a given task and assert that when this is impaired it becomes necessary to adjust to the environment to be able to fulfill functions. The diagrammatic presentation of the poverty diagnostic model is shown in Fig. 2.

This model presents the interplay of both internal and external factors whose impacts need to be understood to achieve desired livelihood outcomes. To do so, one needs to firstly, collect data and analyse it to be able to determine the level of poverty or vulnerability within a given space. Secondly, determine the livelihood interventions/strategies that are context specific and with potential to make a positive impact on the individual or community depending on the target of the intervention. The eight stage action model is then executed by stakeholders such governments, non-governmental organisations, the private sector and any role player concerned with poverty.

At any point in the eight stage action model there will be groups of people who will require different actions and interventions (Fig. 3).

The eight stage model attempts to position people into typologies. At Stage 1 you engage the community, families or individuals on the issue and create community structures for poverty diagnosis, counselling and mentoring. At Stage 2 you separate those who are engaged/concerned about their poverty and those who are unengaged by poverty. At this stage you are trying to identify those who are no longer bothered by their poor

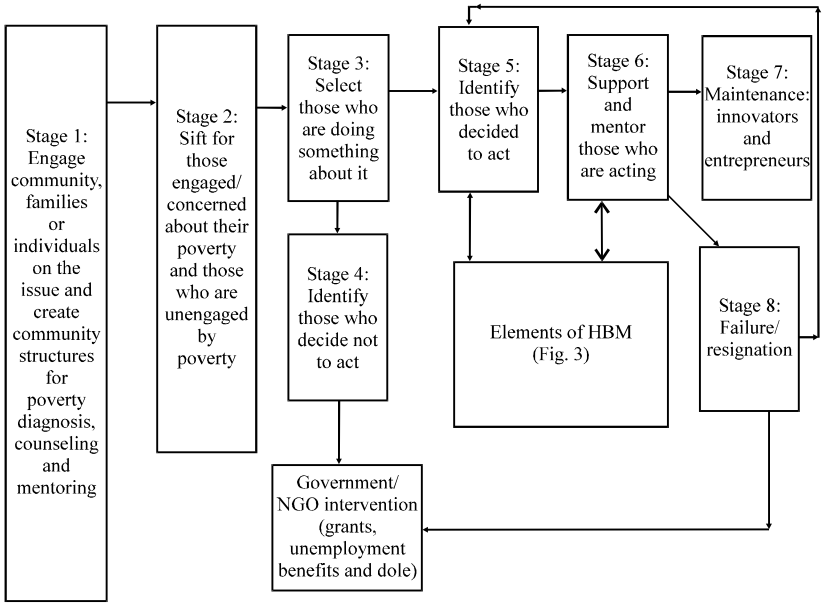

Fig. 3: Eight stage action model

situation to the extent that they just accept it or have given up. In other words, those who even knowing their poor status are indifferent and are unengaged. At Stage 3, you identify those who are deciding to do something about their predicament. Among these would be those who decide not to act (Stage 4) and those who decide to act (Stage 5).

The interventions, termed level 1 interventions, for those in Stage 5 and 6 would take the form of: poverty alleviation; poverty prevention; risk reduction: social responsibility; empowerment; poverty elimination and combinations of these. Those who graduate to Stage 7, the strategies, termed level 2 strategies would involve: (health) wealth promotion; (health) wealth protection and surveillance and data systems. Through the identification of certain transition points, the unique needs, behaviours and motivations of certain populations can be targeted (Arnold and Janssen, 1998). In Stages 5 and 6, elements of the Health Belief Model as well as the stages of change become important.

In implementing the PDM, those who succeed can pursue level 2 interventions. In Stage 8, among those who fail, sift for those who want to try again. These can then be located in Stage 5 with new programmes and incentives. Stage 4 identifies those candidates for Government and other agents support, for example, Non-Governmental Organisations (NGOs) through grants, unemployment benefits, pensions, relief aid, dole and so forth. This category may or may not include orphans and the elderly. Taking HBM as a value-expectancy theory, Janz, Champion and Strecher iterpreted it as follows: the desire to avoid illness or not to get well (value) and the belief that a specific health action available to a person would prevent (or ameliorate) illness (expectation). Thus, researchers can recast this to poverty analysis as follows: the desire to avoid poverty (value) and the belief that a specific action available to a person would prevent (or ameliorate) poverty (expectation). Researchers thus find potential utility in the Health Belief Model in the realm of poverty analysis. In implementing the PDM it becomes imperative to carry out diagnosis with periodic check-ups as is done in the medical field in order to identify and help the laggards.

Using this model, there is need for tailor-making strategies for starters, doubters and laggards. This would be an attempt to take into account people who take their poverty as fait accompli resulting from their fate or destiny. In many ways it would be necessary to disabuse people of such notions and throw light on existing opportunities. People acquire certain knowledge, attitudes, habits, beliefs, values and skills through life experiences which engender some normative and subjective beliefs for action. At this action stage, these beliefs must be taken into account especially in the eight stage action model.

DISCUSSION

Poverty, it appears, is a result of the mode of transactions between the individual and his/her

environment against a backdrop of different ordinances governing that interaction from context to context. Because poverty is multi-dimensional, attack on it must use multiple approaches undergirded by a mutually beneficial coalescence of forces in the transactions between the individual/family/community and the environment. In that sense, person environment relationships become important and assume new meaning.

Principally, the desire to understand the etiology or causal agents of poverty undergirds the desire to build this framework. From a policy point of view, the PDM helps to strategise the form and content of the targeted interventions. From a purely scientific point of view, it helps to articulate assumptions and hypotheses from which to generate new knowledge and enrich the scientific enterprise and ultimately the poor (as beneficiaries of the research product), policy (through informed interventions) and society (increase in knowledge and a better standard of living).

Thus, the PDM may herald systematic, theory-based research on poverty containing the following qualities: adaptability to different contexts, hence, context-sensitive; local norms compliant; flexible; all embracing and accommodative in that it accommodates diversity within a group; supportive with a perceptive fit; maintains macro-micro linkages (micro is represented by an individual or family and macro as represented by a group, community or whole population); dynamic and user-friendly and allowing for greater disaggregation of information.

The model can help in the management of poverty programmes aimed at reducing vulnerability and poverty within poor communities. The use of the PDM will inform the decision to overhaul either behaviours or perceptions for the good of the individual and society as a whole. Theory can highlight and flag symptoms of problems and cause-effect relations. It helps, for instance within the policy framework to assist practitioners and politicians with what they need to know before developing interventions informed by a deeper understanding of the underlying problems. It also helps in the identification of indicators to be monitored and evaluated and particularly with regard to how and where these interventions should be directed.

The model helps in the analysis of norms that influence people's livelihood strategies. Using indigenous knowledge bases, the model can be used to craft coping and adaptive strategies by uncovering people's priorities and ensuring that they are addressed. The model allows individuals/communities to look at the people's strengths as well as their weaknesses. Through poverty diagnosis which will be done as is in the health sector where doctors look at/examine the symptoms to reach to the source of the problem, people can be given a window through which they can break out of the cycle of poverty.

Thus, the model is capable of taking into account the issues of gender, HIV/AIDS, food security, income and expenditure, asset holdings, ethnicity, socio-economic status, duties and entitlements, environment, aesthetics including those of a psychological and spiritual nature as the assessment is done at the individual level. Perhaps this model may well lead to the elucidation of the role of, for example, age, culture, gender in development in general and poverty in particular and importantly to portray a unique picture of that development at the individual, family and community levels. There are benefits that accrue to the individual by leaping out of poverty such as the prospects of a better life for self and community characterised by a higher standard of living for all. As such, it is necessary to instil the belief in people that it is better to improve one's lot than to remain in poverty.

In this study, researcher provide another lens through which poverty can be understood by postulating a new model for the analysis of poverty with a focus on the micro-level, individual and community descriptors/factors. Thus, models can be useful in order to target certain behavioural outcomes and change specific perceptions. For example, how ignorance and lack of knowledge and information as well as cultural taboos can be addressed if these prove to be a hindrance to removing people from poverty. What the model does is to tap on other social science disciplines such as psychology, health and sociology. The PDM may require psychologists to work in the realm of poverty with a new thrust and new form and content to go to the root causes of poverty and perhaps engender, nurture and develop the required responses. Further research needs to be carried out to unpack further and understand the structural determinants of poverty.

CONCLUSION

The issue presented is that some people accept their poverty while others seek to escape it. The policy maker's problem is how to best respond to these two groups. The study proposes that the poverty diagnostic model can provide a basis for coherent policy design.

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