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An Assessment of Association between Financial Constraint and Protection Gap With Respect to International Health Assistance among Internally Displaced Persons

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Abstract

The major objective of this research study was to study the present state of health related protection gap among internally displaced persons (IDPs). A sample size of 234 respondents was selected through lottery method of simple random sampling to ascertain respondent's attitudes towards phenomena under investigation through Likert scale as measurement tool. Both uni-variate and bi-variate analyses were carried out to determine outcomes. Health-related protection gap (dependent variable) as associated with financial constraint (independent variable) was assessed by using Chi-square test. The study established that health-related protection gap had a highly significant association with access to employment, getting assistance from non-governmental organizations, IDPs lagged behind non-displaced persons in economic development, household monthly income, NGOs financial assistance, low income as a cause of low quality of life, lack of income as barrier to maintain good health and weak health condition produce reluctance in income generation. It was concluded that poor economic status and unemployment prevailed in IDPs camps. The displaced people depended on charities or assistance from government or NGOs. Such assistance always fell short of the needs of people therefore; IDPs were prone to health hazard. The health related protection gap, therefore was high for financially needy people. Study proposes and recommends integration of efforts by governmental organization, NGOs and local communities in providing of health and financial support to such deprived groups.

Keywords: Financial constraint, Health-related protection gap, internally displaced persons

Introduction

Internally displaced persons has been defined by the international committee of the Red Cross and some well-known non-government organization (NGOs) as "persons or groups of persons who have been forced or obliged to flee or leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and

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who have not crossed an internationally recognized state border" (Cohen & Deng, 1998).

Rise in number of IDPs is a major concern for international community. During the year 1997 some 17 million IDPs were estimated at global level. During the year 2011-12 some 28.8 million IDPs were reported by the Geneva-based Internal Displacement Monitoring Center (IDMC). It was found that 15.5 million of IDPs were looked after by the UN refugee agency by the end of 2012; in addition, collective numbers of Refugees belong to UNHCR. Due to violation of human right and global level of violence, IDPs were thwarted by conflict similar to refugees (IDMC, 2012).

In Pakistan, during August-September 2010, a significant displacement was seen after the disastrous flooding that hit the country affecting almost 20 million people, and forcing over 7 million, people to flee their habitual homes. The displaced persons were forced to live in IDPs camp where they suffered from multiplicity of problems, including provision of health care facilities, ramified into huge user fees, unsafe environment, a far distances or costly transport fares to get to clinics and hospital etc. Older people and people with bodily disabilities, women and girls had additional problems during such mobilizations (Abbas & Qazi, 2009); these included poor facilities to travel, physical disability and social taboos(for females) to travel alone or get a checkup by a male doctor. Sexual and gender based violence in form of sexual assaults and rape stepped back IDPs, especially females, fearing of further humiliation, risk of further aggression and stigmatization. Access to treatment helped to conduct awareness campaigns and to lemmatize mental illness related to sensitive health problems (UNHCR, 2010). IDPs had low resources to pay for their treatment. In such situations, they suffered extortion or mistreatment, and may have been forced into prostitution or forced sex as return for medical supplies (DRC, 2007).

Poverty is the root cause that prevents IDPs to have a proper access to health facilities. Adult IDPs have a little exposure to vocational training and ways to make money. Affected people from rural areas, especially suffer because they find themselves in altogether a new environment of urban society, where these rural families do not earn enough money to make their livelihood expenditure for daily life like water, food, fuel transport and basic thing other than food like toilet paper, sanitary napkins, detergent, toothpaste and soap (WFP, 2000).

Most IDPs are helpless as compared to the settled portion of population according to definition of socio-economic assimilation; the major reasons are less number of opportunities to generate a respectable income and a prolonged displacement. By the passage of time IDPs get into the habit to secure external sources of help for their lazy life style. This dependency affects theirself-respectand finding a job (Woolcock, 1998).

The exploitation of IDPs in labor market clearly shows the prevailed obstacles and the familiar mindset of this society. IDPs living in camps have a worse life then those who mix with the local population and get jobs. The ratio of IDPs joblessness to those who are part of host community is three times more (Petrasek, 1995).

Many factors gave birth to number of risks for example excessive poverty, lack of ability to provide for one's own and his family, economic deficiencies and financial dependence on others. The poor economic condition of IDPs was the result of their lack of approach to the prolific resources i.e. training, education, credit, land and property (UNICEF, 2005).

The economic conditions and health are interlinked and the relationship has two consequences i.e., on one hand, poor economic condition harbors poor quality of life and the deficiency of money restrains health benefits, on the other hand(Zoidze & Djibuti, 2004). Absence of universal backing, in law and health over-burdens IDPs. In such sorts of circumstances, IDPs generally depend on their financial status and social cash flow –the difference between opening and closing balance during a month to choose whether to go to IDPs camps or take asylum somewhere else. In numerous removal circumstances in Khyber Pakhtunkhwa (KPK), Pakistan, the wealthiest IDPs fled to significant urban areas, including urban areas outside the contention territory; the more defenseless were displaced inside their regions of starting point or to neighboring rustic ranges; and the most helpless went to camps (FDMA, 2013).

Justification of the Study

In KPK, particularly Federally Administrated Tribal Area (FATA) a conflict endemic area with periodic outbreaks of violence since 2002 (Fishman, 2010). The North Waziristan Agency (NWA) IDPs situation has worsened when government start recently operation against miscreants. Most people of NWA were displaced, with higher socially ranked managed to settle in better living facilities, however, the poor class is left with no option except to reside in IDPs camp. Due to economic and political reasons, these camps are paid little attention by governmental organizations and NGOs resulting

in poor living facilities including basic facilities of food, shelter and health, if present, the facilities are unequally distributed.

This study is designed to focus on to explore the health needs of IDPs in these camps, the socioeconomic dynamic in access to health facilities, and prevailing mechanics among IDPs overcome the health issues inside the camp.

Objectives of the Study

This paper aims at finding the association between financial constraints faced by internally displaced persons (IDPs) and health -related protection gap

Study Hypothesis

To find out the association between financial constraints faced by internally displaced persons (IDPs) and health-related protection gap, Chi-square test was used for this purpose. The hypothesis for this study is given below.

Hypothesis

Ho = There is no association between financial constraints faced by internally displaced persons (IDPs) and health-related protection gap.

H1 = There is an association between financial constraints faced by internally displaced persons (IDPs) and health-related protection gap.

Methodology:

Procedure: Prior permission from the administrative of cantt was sought for data collection. Permission was obtained from the respective authors based on the measures used in this research. Due to security threats, nobody was allowed to go inside the IDPs camp. Researcher was permitted to collect data from the participants. The researcher obtained consent from the participants of the study. All the data was collected from male members. Also, the researcher informed participants about the nature of the research and gave them guarantee about the confidentiality of information they were going to provide. This they performed by giving them written consent forms. Due to the cultural norms of purdah and prestige in tribal society, women were not allowed to be interviewed. Participants who agreed to participate in the research were requested to be given the interview. All the questionnaires were completed by the male participants and were given to the researcher. Response rate was 86 %. However, it took approximately 40-45 minutes.

Research design:

The present study, based on time horizon, was a cross sectional study which is also called “one short” study. It helps to obtain all the pictures that were prevailing at the time of study. This design is suitable for the

determination of existing phenomena, problem or attitude by taking a cross-section of the population (Babie, 1989).

Universe of the Study:

The study was conducted in IDPs Bakkakhel camp established in Banuu district. The camp was inhabited by 900 IDPs families that were displaced from various part of insurgency effected area.

Sample Size and Sampling:

For a population of 900 IDPs, a sample size of 234 respondents suffices (Sekaran, 2003). A comprehensive interview scheduled based on Likert scale was constructed and served in collecting the relevant information. Consequently, the data was presented in the percentages along with ascertaining the relationship between independent variables, namely the (financial constraint) with the Health-related protection gap (Dependent Variable). It is obtained by indexing and cross-tabulating them to ascertain the relationship through the application x^2-test statistics. The list of all households residing in the camp was obtained from camp administration. The sample was drawn from the population by using lottery method of simple random sampling. Also, primary data was collected at household level from the household heads.

Data Collection and Analysis:

A conceptual framework (Table-1) comprising of one independent variable (financial constraints) and dependent variable (health related protection gap) was devised. A list of questions/attitudinal statements was pooled from existing literature to measure the variables at hand. These questions were vetted by a team of experts in the field and three level Likert scales were constructed to measure both variables. Questions related to above variables were translated into local vernacular and asked accordingly from the selected respondents.

Uni and bi-variate analysis techniques were used to analyze data. At uni-variate level simple frequencies and percentages were used. However, for bi-variate analysis the following procedure was used.

The variable of health related protection gap was measured by taking attitudinal response of respondents on 12 item likert scale. Reliability test (Cronebach's alpha test) for the 12 items was run to test the internal consistency and connectivity of scale items. Alpha value came out to be 0.781 which showed that the items used for measurement of health related protection gap are internally consistent and the scale can be reliably used to measurement of variable at hand. The dependent variable (health related

protection gap), therefore, was indexed to reach to a summary attitude towards health related protection gap. The respondents that were deprived on half of more items of the scale were rated as they don't have health related protection. Subsequently, both independent and dependent variables were cross tabulated to measure their association. As the data was collected on three level likert scale, a sub category of ordinal scale, for which Chi-square test is appropriate for testing the association among variables at bi-variate level, as outlined by Tai (1978) at bi-variate level was used.

Results

Perception of the respondents regarding financial constraint

Perception of the respondents regarding financial constraint is shown in Table 2. The frequencies and percentage distribution show that majority 60.1% respondents had no access for employment, while 20.1% of them had access to employment, and 9.8 % did not know about it. This result supported by Woolcock (1998), who found that by the passage of time IDPs got habitual to a complete external source of help combine with their lazy life style. This habit of dependency affected the self-respect of an IDP individual for whom finding jobs is even difficult. In addition, high proportion 73.5% respondents perceived that they get assistance from NGOs, while 19.2% had opinion that they did not get assistance and 7.2% were uncertain about getting assistance from NGOs. This result is also supported by IDMC (2012) that found that majority of IDPs in camp received assistance like shelter, food, cash and other form of protection and assistance from NGOs.

Furthermore 75.2%respondents had the opinion that IDPs economic development is too much lagged behind than those from non IDPs and 16.2% respondents viewed that IDPs economic state is not too much lagged behind than those from non IDPs, while 8.5% did not know about it. This result is supported by Salama, Spiegel & Brennan (2001) who viewed that at present most IDPs seek to better lodging and living conditions and consider that this would incredibly enhance their prosperity and livelihood chances. At present the greater part of IDPs' living conditions are still poorer than the general population. While access to public services equivalent or preferred among IDPs over non-IDPs, the previous consider that the nature of the services needs change. Nonetheless, those IDPs living in new settlements are as a rule fulfilled by their expectations for everyday comforts. Social life is a source of trust for IDPs and a capable asset for prosperity and overcoming powerlessness. In spite of IDPs feel that their social capital in the more

extensive society is undermined by their social minimization and slander contrasted with non-IDP group. Majority 77.4% respondents perceived that their monthly income did not fulfill their household needs and 16.2% respondents viewed that their monthly incomes fulfill their household needs while 6.4% had given no response. These finding supported by UNICEF (2005) who pointed out that many factors gave birth to number of risks for example excessive poverty, lack of ability to provide for one's own and his family, economic deficiencies and financial dependence on other. The poor economic condition of IDPs was the result of their lack of approach to the prolific resources i.e. training, education, credit, land and property.

Moreover a high proportion 77.4% respondent regarded that NGOs financial assistance did not fulfill their family need, and 14.1% respondents disagreed, and 8.5% were uncertain, although IDPs get assistance from government and NGOs but these assistance were not sufficient to their family needs. These results supported by Woolcock (1998) who found that the majority of most of the IDPs is helpless as compared to the settled portion of population according to definition of socio-economic assimilation; the major reasons are less number of opportunities to generate a respectable income and a prolonged displacement and insufficient assistance. Similarly, a majority of 76.1% respondents perceived that low income is the cause of low quality of life and 14.5% respondents negated it, while 9.4% were uncertain. In addition 76.5% respondents assumed that lack of income sustainability is barrier for maintain good health and 15.4% were disagreed while 8.1% did not know. Similarly 72.6% respondents perceived that women are more economically vulnerable as compared to men, while 20.7% viewed that women are not economically vulnerable as compared to men and 7.5% did not know. However 75.6% respondents assumed that weak health conditions produce reluctant in income generation, 15.8 % disagreed and 8.5 % were not sure. These finding are supported by Zoidze and Djibuti (2004). They found that the economic conditions and health are interlinked. This type of relationship has two consequences i.e. on one hand poor economic condition brings bottom level of life and the deficiency of money to sustain health. On the other hand poor health condition restraints men to go up in life because of the expenditure to maintain a good health. Likewise, a high proportion 63.7% of respondent were not assisted by their relatives and friends, while 26.5% receive assistance and 9.8% did not know. This result is supported by Murphy (2007), who found that the procurement of help and support among removal by relatives, companions and tribesmen termed as social

capital is a capacity of trust, social standards, investment and it assume of a critical part in recovery.

It is summarized that IDPs are most vulnerable group. They were lagged behind the normal citizen in economic run and were dependent on assistance from external agencies for sustaining life. However, such assistance was always insufficient to meet their needs. Weak social groups like women were worse affected in this respect and mostly deprived from basic facilities.

Association between financial constraints and health related protection gap

IDPs are considered marginalized group of people. They have limited access of opportunities. They cannot get employment in the study area. The miseries due to poverty are multiplied many fold due to internal displacement and life in camp. Health hazard and psychological stresses further aggravate the situation. Association of perception of respondents about financial constrains and health related protection gap is given in table 3.

This result show that a highly significant (p = .000) association was found between access to employment and health related protection gap. Employment is a first step to economic earning and meeting the basic needs like health. Unemployment means low earning and poor access to health. The same is the evident from this result. This result is supported by Woolcock (1998), who found that by the passage of time IDPs got habitual to a complete external source of help combine with their lazy life style. This habit of dependency affected the self-respect of an IDP individual for whom finding job is even difficult. In addition, a significant association (p = .000) was established between getting assistance of NGOs and health related protection gap. Those having fear access to assistance services are safer in health related issues. The result explore that mostly IDPs get the assistance in the form of food items or non-food items. This results supported by IDMC (2012), who found that majority of IDPs in camp received assistance like shelter, food, cash and other form of protection and assistance from NGOs.

Moreover a highly significant (p=.000) association between IDPs economic development is too much lagged behind those from non-displaced persons and health-related protection gap was found. It reveals that majority of IDPs has worse conditions in camp. They have no access to better health care facilities. Therefore, they are lagged behind non displaced persons. This result is supported by Salama et al (2001), who viewed that at present, most IDPs seek to better lodging and living conditions and consider that this would incredibly enhance their prosperity and livelihood chances. At present, the greater part of IDPs' living conditions are still more poor than the general population. While access to public services equivalent or preferred among IDPs over non-IDPs, the previous consider that the nature of the services needs change. Nonetheless, those IDPs living in new settlements are as a rule fulfilled by their expectations for everyday comforts. Social life is a source of trust for IDPs and a capable asset for prosperity and overcoming powerlessness. In spite of IDPs feel that their social capital in the more extensive society is undermined by their social minimization and slander contrasted with non-IDP group. Likewise a highly significant (p=.000) association was seen between household monthly income and health related protection gap. The result describes that the financially vulnerability increases with low income. Therefore, poor people are more prone to health hazards then others. This result supported by UNICEF (2005), who pointed out that many factors gave birth to number of risks for example excessive poverty, lack of ability to provide for one’s own and his family, economic deficiencies and financial dependence on other. The poor economic condition of IDPs was the result of their lack of approach to the prolific resources i.e. training, education, credit, land and property. In addition, a highly significant (p=.000) association between health related protection gap and NGOs financial assistance was established. Financial assistance from NGOs is negligible and insufficient for normal life; therefore, the health needs are not always met through. This result is supported by Woolcock (1998), who found that the majority of IDPs are helpless as compared to the settled portion of population according to definition of socio-economic assimilation. The major reasons are less number of opportunities to generate a respectable income and a prolonged displacement and insufficient assistance.

Furthermore, a highly significant (p=.000) association between low income cause of low quality of life and health related protection gap was found. The data

describes that health and income are interrelated to each other. Those IDPs who are wealthy can pay high fee of doctor. While poor IDPs generally have worse health status. Similarly, a highly significant (*p*=.000) association was found between lack of income as barrier to maintain good health and health related protection gap. The result shows that the poor health is both a cause and effect of poverty. It increases the poverty due to working capacity constraint. Moreover, a highly significant (*p*=.000) association was reported between weak health condition produce reluctance in income generation and health related protection gap. The result indicates that the weak health condition is the hurdle in income generation among IDPs as persons with poor health are reluctant to participate in economic activities. These finding are supported by Zoidze & Djibuti (2004), they found that the economic condition and health are interlinked. This type of relationship has two consequences i.e., on one hand; poor economic condition brings bottom level of life and the deficiency of money to sustain health, on the other hand poor health condition restraints men to go up in life because of the expenditure to maintain a good health.

Likewise, a significant association was established (*p*=.000) between women are economically vulnerable as compared to man and health related protection gap. It indicates that women were considered more vulnerable group in IDPs camp due to their financial dependence on men, and cannot make their own decisions. Often women were economically vulnerable as compared to men. This result supported by UNHCR (2010). It was viewed that during the displacement women are particularly more vulnerable to economic dependency and exploitation, both because of traditional child-raising and household roles and because they normally have no more access to services than men. Similarly, a highly significant (*p*=.000) association between receiving assistance from relatives/friends and health related protection gap was found. During the displacement provision of help and assistance of friends and relatives play significant role in physical and psychological recovery. This result is supported by Murphy (2007), who found that the economic condition and health are interlinked. This type of relationship has two consequences i.e., on one hand, poor economic condition brings bottom level of life and the deficiency of money to sustain health, on the other hand poor health condition restrains men to go up in life because of the expenditure to maintain a good health

It can be concluded that poor economic status and unemployment prevail in IDP camps. The displaced people depend on charities or assistance from government or non-government organization, such assistance is always short of needs of the masses. Therefore people are strangled in health hazard. The health related protection gap, therefore, is highly for financially constrained people.

Discussions

It is universally accepted that war victim's health needs are more in line with mental problems like depression, anxiety, sleeplessness (Joop& De Jong, 2002). During armed conflict the emotional immaturity results in post-traumatic stress for children in account their little tolerance of violence (Kim, Torbay, & Lawry, 2007). The liability to violence, distance from family members and the destruction of homes and livelihood can also increase mental illness problems, such as sadness, nervousness, post-traumatic stress disorders and psychosomatic illnesses which can reduce a person's standard of life and destroy the power to fight against diseases (Mooney, 2005). In camps, IDPs are kept socially excluded and are not even given psychological help and psychiatric treatment that is given in refugee camp. Social rituals like marriages and birthdays are kept behind their back which is the large source of happiness and entertainment. This unhygienic mental and social position of IDPs combined with total negligence of physical and mental health facilities which results is over thinking about the dear ones that are crushed or lost hence, leads in mental disorders (Roberts et al, 2009). IDPs were given facilities regarding health care during the first few days but with the passage of time to maintain health care facilities diminish very quickly. Furthermore the facilities provided to them regarding health were not capable to overcome the needs and priorities of the IDPs. It is admitted everywhere that war stricken health needs were more similar with mental problems like tension, restlessness and sleeplessness (Hamid& Musa, 2010). The financial condition and health are interdependent. IDPs have no access to employment. They have poor physical health and mental health. They couldn't access to medical care, narrowly escaping death and being seriously injured (Latif & Musarat, 2012). Independence and status diminish slowly and gradually as a result of displacement for a long time, bad state of livelihood, unsecure and circumscribed movement. The needs for mental sickness have been addressed very meagerly up till now which may include

faulty nutrition, loss and violence based trauma, although these psychological factors are much more important than anything. People that are still displaced as well as many resettled families pass their life in between the fear of past and the worry for future (Deborah & Raoul, 2002). Over the long term as their fundamental requirements for security i.e, clean water, food, and safe house get to be non life undermining, the misfortunes experienced by IDPs are regularly ignored or disregarded. This happens despite continuous health and social needs coming from their separation (e.g., loss of support, financial position, training, accommodation and human services) (Anderson, 2009).During the displacement women are more vulnerable. They are dependent on men. Friends and relatives play very important role in physical and psychological recovery. The issues of mental stress emerged to be the most common where IDPs in camp were more affected as compared to IDPs living in host community. It was present among all age groups and in both the sexes however, people in older ages were affected the most at both localities. Most common signs of mental stress among children, youth and mature age people were the same namely feeling down, depression, constant crying, anxiety and hopelessness while in elderly it accounted for loss of appetite, over thinking and sleeplessness. Alarmingly mental health care was completely absent from both localities and IDPs were mostly dependent on religious healing for sake of mental health relief. The most common illnesses for death among children were asphyxia, diarrhea and measles where women died mostly due to pregnancy related problems. The security check posts proved to be the main reason for these deaths as the movement of IDPs from camp to health care facility was stopped by them. Health care availability was less frequent and inappropriate at IDPs camps. IDPs living in camps were mostly dependent on mobile clinics for their health needs fulfillment and were least satisfied with it. Mother and childcare facilities like antenatal, post natal care and birth assistance were not frequently available to pregnant women IDPs living camps. By concluding the argument, it is evident that in absence of international protection, higher level of social capital and economic status facilitated many of IDPs bear the load of health problems due to inadequacy and absence of health care facilities.

Implications

The study focused only on health and employment related issues faced by IDPS in the study area. Therefore, further research is required to find out their social and psychological hindrances as well as its negative impacts upon their children and household dwellers. The study results suggest that the government and other humanitarian organizations shall play a pivotal role in ameliorating the exacerbated conditions of IDPS, in order to diminish further negative outcomes upon the victims and their families.

Conclusion

It is concluded that poor economic status and unemployment prevail in IDP camps. The displaced people depend on charities or assistance from government or NGOs, such assistance is always short of needs of the masses therefore people are strangled in health hazard. The health related protection gap, therefore is high for financially constrained people.

Recommendations

1. Reducing financial constraint of IDPs by providing adequate support in cash and kind in a decent way besides creating employment opportunities for decent earning.
2. Encouraging social and financial support from host communities and relatives enable IDPs to with stand socio-economic and health related stresses.
3. Integration of efforts from GOs and NGOs for creating health services packages for IDPs based on their complete exemption from all health services fees inside camp and host community.

Table-1 Conceptual framework

Independent variable	Dependent variable
Financial constraint	Health related protection gap

Table 2 ***Frequencies and Percentage Distribution of Respondents regarding financial constraint*** **(N = 234)**

No	Questions	Yes (%)	No (%)	Don't Know

				(%)
1	You have access for employment	47 (20.1)	164 (70.8)	23 (9.8)
2	You get assistance from NGOs	172 (73.5)	45 (19.2)	17 (7.2)
3	IDPs economic development is too much lagged behind than those from non-displaced people	176 (75.2)	38 (16.2)	20 (8.5)
4	Your monthly income fulfill your household need	38 (16.2)	181 (77.4)	15 (6.4)
5	NGOs financial assistance is sufficient for your family need	33 (14.1)	181 (77.4)	20 (8.5)
6	Low income causes low quality of life	178 (76.1)	34 (14.5)	22 (9.4)
7	Lack of income sustainability is a barrier for maintaining good health	179 (76.5)	36 (15.4)	19 (8.1)
8	Women are more economically vulnerable as compared to men	170 (72.6)	47 (20.8)	17 (7.5)
9	Weak health condition produce reluctant in income generation	177 (75.6)	37 (15.8)	20 (8.5)
10	You receive assistance from friends/relatives	62 (26.5)	149 (63.7)	23 (9.8)

Table 3*Association between financial constraint and health related protection gap*

Financial constraint	**Perception**	**Health related protection gap**			**Total**	**Chi-Square (P-Value)**
		Yes	**No**	**Don't Know**		
You have access for employment	**Yes**	29(12.4)	16(6.8)	2(0.9)	47(20.1)	χ2=136.278 (0.000)
	No	31(13.2)	132(56.4.)	1(0.4)	164(70.1)	
	Don't know	4(1.7)	6(2.6)	13 (5.6)	23(9.8)	

You get assistance from NGOs	**Yes**	39(16.7)	132(56.4)	1(0.4)	172(73.5)	χ2=136.456 (0.000)
	No	23(9.8)	17(7.3)	2(0.9)	42(17.9)	
	Don't know	2(0.9)	5(2.1)	13(5.6)	20(8.5)	
IDPs economic development is too much lagged behind than those from non-displaced people	**Yes**	39(16.7)	137(58.5)	0(0.00)	176(75.2)	χ2=167.764 (0.000)
	No	24(10.3)	12(5.1)	2(0.9)	38(16.2)	
	Don't know	1(0.4)	5(2.1)	14(6.0)	20(8.5)	
Your monthly income fulfill your household need	**Yes**	25(10.7)	7(3.0)	3(1.3)	35(15.0)	χ2=155.017 (0.000)
	No	38(16.2)	142(60.7)	1(0.4)	181(77.4)	
	Don't know	1(0.4)	5(2.1)	12(5.1)	18(7.7)	
NGOs financial assistance is sufficient for your family need	**Yes**	23(9.8)	7(3.0)	3(1.3)	33(14.1)	χ2=156.575 (0.000)
	No	40(17.1)	141(60.3)	0(0.00)	181(77.4)	
	Don't know	1(0.4)	6(2.6)	13(5.6)	20(8.5)	
Low income causes low quality of life	**Yes**	41(17.5)	137(58.5)	0(0.00)	178(16.1)	χ2=115.965 (0.000)
	No	21(9.0)	11(4.7)	5(2.1)	37(15.8)	
	Don't know	2(0.9)	6(2.6)	11(4.7)	19(8.1)	
Lack of	**Yes**	39(16.	140(59.	0(0.0	179(76.	χ2=131.4

income sustainability is a barrier for maintaining good health		7)	8)	0)	5)	20 (0.000)
	No	24(10.3)	7(3.0)	5(2.1)	36(15.4)	
	Don't know	1(0.4)	7(3.0)	11(4.7)	19(8.1)	
Weak health conditions produce reluctant in income generation	**Yes**	38(16.2)	139(59.4)	0(0.00)	177(75.6)	$\chi 2$=156.836 (0.000)
	No	24(10.3)	9(3.8)	1(1.3)	37(15.8)	
	Don't know	2(0.9)	6(2.6)	12(5.1)	20(8.5)	
Women are more economically vulnerable as compared to men	**Yes**	38(16.2)	139(59.4)	0(0.00)	177(75.6)	$\chi 2$=137.028 (0.000)
	No	25(10.7)	9(3.8)	3(1.7)	37(15.8)	
	Don't know	1(0.4)	6(2.6)	13(5.6)	20(8.5)	
You receive assistance from friends/relatives	**Yes**	22(9.4)	38(16.2)	2(0.9)	62(26.5)	$\chi 2$=84.837 (0.000)
	No	40(17.1)	107(45.7)	2(0.9)	149(63.7)	
	Don't know	2(0.9)	9(3.8)	12(5.1)	23(9.8)	

*Number in table represent frequencies and number in parenthesis represent percentage proportion of respondents.

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