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ADDRESSING POVERTY-RELATED HEALTH DISPARITIES: MANAGING SUCCESSFUL PROJECTS, PROGRAMS AND COMMUNICATIONS BOTH NATIONALLY AND INTERNATIONALLY

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Objective: To show successful ways to manage projects and programs to address poverty-related health disparities.

Materials and Methods. The study used bibliosemantic, systematic and analytical research methods.

Results: The study highlighted key factors driving effectiveness. It found that integrating community engagement, local context understanding, and sustainable resource allocation was critical. Programs that prioritized grassroots involvement, such as training community health workers and tailoring solutions to local needs, achieved better health outcomes.

Clear, measurable goals with robust monitoring frameworks also enhanced accountability and impact. Partnerships across governments, NGOs, and the private sector improved resource sharing and coordination. Vertical initiatives, like disease-specific campaigns, succeeded in reducing mortality but faced challenges in addressing broader health system weaknesses.

Conclusions. Comprehensive models, like universal health coverage and conditional cash transfer programs, reduced disparities by tackling both immediate health needs and underlying causes. The study emphasized the importance of partnerships between governments, NGOs, and private entities, alongside robust monitoring and adaptive strategies. Combining disease-specific approaches with system-wide reforms is crucial for achieving equitable health outcomes.

KEY WORDS: **international management, projects, programs, poverty-related, health disparities, public health, communications.**

Health challenges evolve over time, but they remain disproportionately concentrated among the most disadvantaged, both within and between nations. Wealthier countries and affluent groups within societies consistently enjoy greater opportunities to protect and enhance their health compared to less privileged populations. This disparity has persisted throughout history.

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Before the 19th century, high rates of infant, child, and maternal mortality were the norm globally. Malnutrition left many individuals with physical development far below modern standards. Outbreaks of infectious diseases like smallpox, measles, and tuberculosis often wiped out large portions of communities, leaving survivors with long-term disabilities. Average life expectancy was universally low; for example, women in England had the longest lifespans from 1600 to 1840, yet even theirs ranged only between 35 and 45 years – roughly half of what is typical today.

Between 1960 and 2007, life expectancy at birth rose dramatically in many regions: from 69 to 79 years in high-income countries, from 36 to 73 years in China, from 56 to 72 years in Latin America and the Caribbean, and from 44 to 64 years in South Asia. However, in sub-Saharan Africa, the increase was far smaller, rising from 40 to just 46 years, leaving the region's life expectancy more than 30 years behind that of richer nations. Even within regions, disparities are striking. For instance, life expectancy at birth is 42 years in Sierra Leone but 73 years in Mauritius; in South Asia, it is 44 years in Afghanistan compared to 72 years in Sri Lanka. Some countries, like Swaziland, Angola, and Zambia, have life expectancies just over 40 years, while others, such as Japan, Australia, Canada, and Sweden, exceed 80 years [1].

Research results and discussion. When health data is broken down by social groups within countries, stark inequalities emerge. Even in affluent nations like the US, the UK, Finland, and the Netherlands,

poorer individuals live 5–15 years less than their wealthier counterparts. While it's often assumed that income-related health disparities have lessened in wealthy countries, evidence shows that these gaps have widened in recent decades. The stark contrasts in life expectancy, education, and health outcomes between the rich and the poor, as well as among racial and ethnic groups, challenge the ethical and moral values of modern wealthy societies [2].

In poorer nations, the inequalities are even more pronounced. Research consistently shows that the bottom 20% of the population fares significantly worse than the top 20% in critical health indicators like child mortality and nutritional status. Children in the poorest quintile are, on average, twice as likely to die before the age of five compared to those in the richest quintile, with the risk being up to five times higher in some cases. Similarly, maternal nutrition follows this pattern, with women in the poorest groups nearly twice as likely to suffer from undernutrition as their wealthier counterparts.

As seen in Table 1, health financing and poverty are closely linked to poor health and shorter lifespans, but for those with limited resources, health is also a vital economic resource. Their ability to work and sustain their families depends on staying healthy. Illness or injury in a low-income household can trigger a chain reaction of financial hardships, including lost wages, increased medical expenses, and the need to sell essential assets like livestock or land. Time that could be spent earning money or attending school is often redirected to caring for sick family members. With greater exposure to illness and limited access to healthcare or social safety nets, the poor are particularly vulnerable to this cycle of decline.

Good health is key to economic and social progress. Healthy individuals are more productive, earn higher incomes, and take fewer sick days, which drives economic activity and attracts investment. Children who grow up healthy are better equipped to learn, stay in school, and build stronger human capital. As health outcomes improve, school absenteeism and dropout rates decrease, and children perform better academically. These benefits also extend to family and societal structures. Improved health and education levels often lead to smaller family sizes, as fertility rates typically decline after mortality rates drop. This reduction in population growth lowers the dependency ratio, providing a "demographic dividend" that supports economic growth at both national and household levels.

For families in poverty, fewer children and better investment in their well-being can break cycles of disadvantage. Healthy children are less likely to face developmental challenges or lifelong disabilities and are better positioned to maximize their potential as adults. As they grow, they can avoid financial ruin from health crises and contribute more effectively to their families' prosperity. The ripple effects of better health extend across generations, laying the groundwork for greater stability and economic advancement at both individual and collective levels.

Barriers to healthcare access extend beyond income. Service-related obstacles include high costs for treatment and transport, long distances to facilities, time demands, poor-quality care, staff shortages, negative attitudes, and cultural or language mismatches. On the client side, social and cultural restrictions, especially for women, limit mobility and access. Women often face heavier time burdens due to household roles and have less financial independence. Misunderstandings about illnesses and services, combined with limited health education, further exacerbate the problem [4].

Institutional issues also play a role. Health systems in impoverished regions often

Table 1. **Health and financing statistics for low-, middle- and high-income countries [3]**

	Low-Income		Middle-Income		High-Income	
Indicator Year	2011	2021	2011	2021	2011	2021
Population, billion	525	685	5,163	5,782	1,335	1,392
Life expectancy at birth (years)	60.3	62.5	70.0	70.6	78.9	78.8
Fertility rate (births per woman)	5.3	4.6	2.5	2.2	1.7	1.5
Mortality rate, under-5 (per 1,000 live births)	91.0	66.5	47.7	35.9	6.0	4.9
Maternal mortality ratio (modeled estimate, per 100,000 live births)	542.0	-	218.0	-	11.0	-
Immunization, measles (% of children ages 12–23 months)	72.6	66.8	85.2	83.8	94.0	93.5
GDP per capita (current US$)	769.8	680.7	4,205.2	5,925.8	38,570.7	44,840.4
GDP (current US$), billion	404,514	466,420	21,713,900	34,266,063	51,524,951	62,461,025
Health expenditure (% of GDP)	4.8	5.3	5.0	5.4	11.3	13.1
Health expenditure per capita (current US$)	36.4	36.5	208.6	320.8	4,385.2	5,832.7

underemphasize prevention and promotion, follow ineffective local treatment norms, and tolerate stigma or discrimination from healthcare providers. Poor communities frequently lack representation in decision-making processes, including health policy and budget allocation, leaving their voices unheard and their needs unmet. Addressing poverty-related health disparities requires targeted interventions that tackle the root causes of poor health, improve access to essential services, and empower vulnerable populations. Successful projects and programs often combine resources, community engagement, and innovative strategies to deliver measurable outcomes.

Global health programs targeting infectious diseases have achieved significant milestones, particularly in areas where health needs align with clear, measurable outcomes and strong donor interest. For example, the Global Fund to Fight AIDS, Tuberculosis, and Malaria has channeled billions of dollars into combating these diseases, reducing mortality rates and improving access to life-saving treatments in low-income countries. Similarly, the Global Alliance for Vaccines and Immunizations (Gavi) has significantly increased immunization coverage in low-income nations, preventing millions of deaths from preventable diseases like measles, polio, and pneumonia. These vertical initiatives demonstrate the power of focused, well-funded programs to address specific health challenges.

Efforts to improve maternal and child health have addressed key disparities by prioritizing reproductive health services and reducing child mortality. The UNICEF-supported Integrated Management of Childhood Illnesses (IMCI) program combines preventive and curative strategies to address common childhood illnesses like diarrhea, pneumonia, and malaria. In addition, skilled birth attendance and community-based health workers have improved maternal outcomes in countries like Bangladesh, where training midwives and expanding access to care significantly reduced maternal mortality.

Empowering communities to take charge of their health has proven to be a sustainable approach. Searchers, as described by William Easterly, have implemented grassroots solutions tailored to local needs. For example, programs that train community health workers have successfully provided basic care and education in rural areas with limited healthcare infrastructure. The Grameen Foundation's mobile health services in South Asia have connected poor communities with health education, disease monitoring, and telemedicine support.

Integrating health services into robust primary healthcare systems has been key to addressing a wide range of disparities. Countries like Rwanda have achieved remarkable progress by investing in universal health coverage, ensuring that even the poorest citizens have access to basic healthcare. Brazil's Family Health Program (Programa Saúde da Família) brought healthcare teams into underserved areas, improving health outcomes and reducing inequality [5].

Programs that link health interventions with improvements in other sectors, like education, nutrition, and sanitation, have demonstrated the importance of addressing the social determinants of health. Conditional cash transfer programs such as Mexico's Oportunidades (later renamed Prospera) provide financial incentives to poor families for meeting health and education goals, leading to improved maternal and child health outcomes. Clean water and sanitation initiatives, such as those led by WaterAid, have reduced waterborne diseases and improved overall community health.

Though historically overlooked in global health, some programs are now addressing non-communicable diseases (NCDs) in impoverished communities. The WHO's Framework Convention on Tobacco Control has reduced smoking prevalence in several low-income countries, mitigating long-term health disparities. Community-based education on nutrition and chronic disease prevention has been effective in countries like India, where programs focus on diabetes and hypertension management among the poor.

Collaborative efforts that pool resources and knowledge have driven success. The Millennium Development Goals (MDGs) focused global attention on key health disparities, such as reducing child mortality and improving maternal health [6], while the Sustainable Development Goals (SDGs) continue to emphasize health equity. Partnerships like Doctors Without Borders (MSF) have provided emergency care in conflict zones and underserved regions, saving lives and advocating for better health policies.

The success of these initiatives lies in their ability to combine top-down funding with bottom-up implementation, empowering local communities. They focus on measurable, well-defined outcomes while addressing the broader determinants of health, such as education, sanitation, and economic stability. Collaboration between governments, NGOs, and the private sector has also been a critical factor. While challenges remain, these programs showcase how targeted interventions, when properly designed and implemented, can reduce health disparities and improve lives for the world's poorest populations [7].

Thus, integrating community engagement, local context understanding, and sustainable resource allocation was critical. Programs that prioritized grassroots involvement, such as training community health workers and tailoring solutions to local needs, achieved better health outcomes. Clear, measurable goals with robust monitoring frameworks also enhanced accountability and impact. Partnerships

across governments, NGOs, and the private sector improved resource sharing and coordination. Vertical initiatives, like disease-specific campaigns, succeeded in reducing mortality but faced challenges in addressing broader health system weaknesses.

Comprehensive approaches, such as Brazil's Family Health Program and Rwanda's universal health coverage model, reduced disparities by focusing on primary care access and addressing social determinants. The study emphasized that combining targeted interventions with system-wide improvements is essential for long-term success.

Conclusions. The study on poverty-related health disparities concluded that these inequities are deeply rooted in social, economic, and systemic factors. Successful interventions focus on addressing the social determinants of health, such as education, nutrition, and sanitation, while improving access to quality healthcare. Programs integrating community participation, such as training local health workers and tailored grassroots initiatives, proved more sustainable and effective.

Comprehensive models, like universal health coverage and conditional cash transfer programs, reduced disparities by tackling both immediate health needs and underlying causes. The study emphasized the importance of partnerships between governments, NGOs, and private entities, alongside robust monitoring and adaptive strategies. Combining disease-specific approaches with system-wide reforms is crucial for achieving equitable health outcomes.

Prospects for further research consist in an in-depth study of effective methods of preventing the destructive impact of poverty on the health disparities for both individuals and public health in general.

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ПОДОЛАННЯ ПОВ'ЯЗАНИХ З БІДНІСТЮ ДИСПРОПОРЦІЙ У ЗДОРОВ'Ї: МЕНЕДЖМЕНТ УСПІШНИХ ПРОЄКТІВ, ПРОГРАМ І КОМУНІКАЦІЙ НА НАЦІОНАЛЬНОМУ ТА МІЖНАРОДНОМУ РІВНЯХ

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Мета: продемонструвати успішні підходи до управління проєктами та програмами, спрямованими на подолання нерівності у сфері охорони здоров'я, пов'язаної з бідністю.

Матеріали та методи. У роботі використано бібліосемантичний, систематичний та аналітичний методи дослідження.

Результати. Дослідження висвітлило ключові фактори, що впливають на ефективність. Воно показало, що інтеграція залучення громад, розуміння місцевого контексту та сталий розподіл ресурсів мають вирішальне значення. Програми, які надавали пріоритет залученню громадськості, наприклад навчанню медичних працівників у громадах та адаптації рішень до місцевих потреб, досягали кращих результатів у сфері охорони здоров'я.

Чіткі, вимірювані цілі з надійною системою моніторингу також сприяли підвищенню підзвітності та результативності. Партнерства між урядами, неурядовими організаціями та приватним сектором покращили розподіл ресурсів і координацію. Вертикальні ініціативи, як-от кампанії з боротьби з конкретними захворюваннями, досягли успіху в зниженні смертності, але зіткнулися з проблемами в усуненні більш широких недоліків системи охорони здоров'я.

Висновки. Комплексні моделі, як-от універсальне охоплення послугами охорони здоров'я та програми грошових виплат на певних умовах, зменшили нерівність шляхом задоволення як нагальних потреб у сфері охорони здоров'я, так і усунення причин, що їх зумовлюють. Дослідження підкреслило важливість партнерства між урядами, неурядовими організаціями та приватними структурами, а також надійного моніторингу й адаптивних стратегій. Поєднання підходів, орієнтованих на конкретні захворювання, із загальносистемними реформами має вирішальне значення для досягнення справедливих результатів у сфері охорони здоров'я.

КЛЮЧОВІ СЛОВА: **міжнародний менеджмент; проєкти; програми; диспропорції у здоров'ї, пов'язані з бідністю; громадське здоров'я; комунікації.**

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