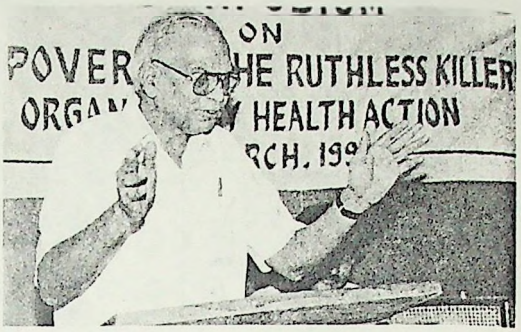
Com H-70.

We never had a strategy !!!

Eradicating poverty



We gave only haphazard attention to poverty and palliative schemes : never a comprehensive strategy to combat poverty.

Prof. P. Venkataramaiah

A very curious thing is that though we knew that poverty existed in India, we don't find a discussion on poverty in Indian context till late 1960's.

All the studies on poverty came into existence in the late 60's and in early 70's.

Why? Is it that the people earlier did not realise that poverty was a major problem in Indian society?

The reason, to my mind was that in the 50's and 60's, we were short of food grains. Perhaps, the planners felt while even those who were already employed did not have enough food grains, what was the point in thinking about unemployment and about those who did not have the purchasing power.

After green revolution

After green revolution, and with the increase in food grain production, I think, for the first time, there was optimism that we had enough food grains in the society and that we could think about the problem of poverty. A lot of studies ensued.

And the poverty estimates were based on calorie requirement. In the rural areas, it was said to be 2400 calories and in urban areas 2100. Poverty estimates were about 50% in the 60s and 70s. Now the poverty estimates vary between 35% to 40%.

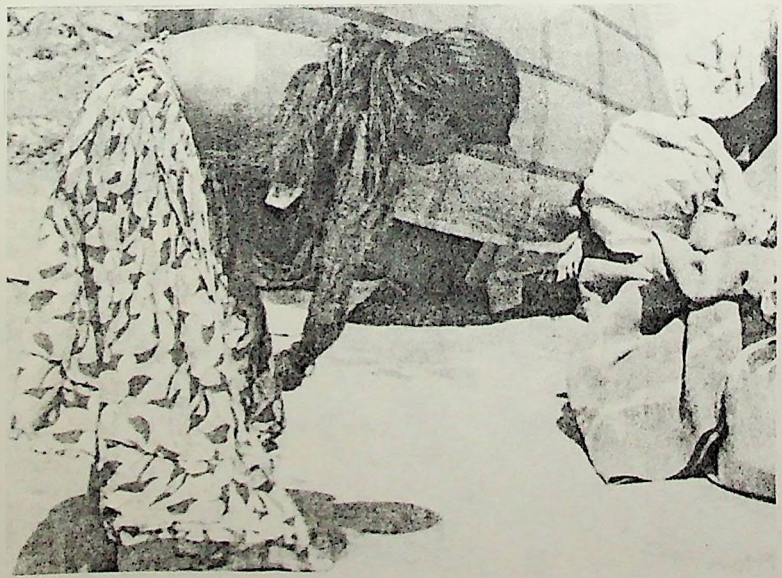
The question of poverty adds an important dimension to the type of developmental policy that we plan to pursue.

Employing the poor?

If the people are not having adequate food, the question is: In what way can they be employed?

And then also the question: Are poor people employable?

Similarly : If they are poor and don't have enough to eat, what then is the type of work they can do?



Thus, a poor man would not be employed and thus he cannot be a part of development process.

Maybe, as a charity or as some palliative measure, some consideration can be shown . But still he remains only outside the developmental process.

This was not explicitly stated anywhere. But this was the type of thinking. Given this scenario, after 70's, a number of measures like the Rural Employment Programme, Rosgar Yojana and Integral Rural Development Programme were devised to see if poverty can be eradicated.

But neither the policy-makers, nor the politicians, nor academicians took the poor as a part of the overall development process.

Poverty and quality of life

We will have also to think of the relevance of poverty to the health status.

Social scientists are aware that we should not confine ourselves to only the economic dimension of poverty. For, the national income or national expenditure does not capture all the aspects of the general welfare of the people.

It is not the question of how much income you get but whether it is reflected in the health status, in longveity.

The quality of life gets reflected in your longevity, reduced infant mortality, literacy level, and so on.

In countries which were following a socialistic pattern, physical quality of life seemed to be much better than what their income-level suggested.

If you take China, for example, on the ranking of income, it comes much below, but on the ranking of quality of life, it comes much above.

If you take Kuwait or some of the Arabic states, incomes are very high there, but quality of life is low.

In Kerala, too, the per capita income is much below that of other states, but the quality of life and health status is much higher.

Quality of life inspite of

Yes, India is poor. Her resources are low and her per capita income cannot be very high; but does it put such a constraint on resources that the quality of life cannot be improved? That is the question.

The question is all the more important now than it was a few years ago. That is, in the context of the various economic reforms in the last few years.

The reformers pleaded that if you left it to the market forces, poverty would decrease.

Now you find large debates on whether poverty has increased after the reforms or has decreased.

Both the schools quote figures convenient to them. But implications are serious.

If you are faced with international prices and Indian incomes you will end up with a situation where you build residences, for non-residents. You know in many places all over Bangalore, Madras and Hyderabad places are allotted to non resident Indians.

Prices and prices

The essence of the new economic policy is that you would have a sort of a price level in this country which is in tune with the price level abroad.

We seem to believe that we must move into a situation where our price system will correspond to the international price system, so that the trade can flow in both directions .

In this, I have a major objection: it is good if prices are made equal; but the price of labour cannot be an exception.

You cannot have an economic system where commodity prices are equal across the borders without factor prices being the same.

The mistake we are doing is in this that we want to have prices for commodities the same but not for factors.

If you are faced with international prices and Indian incomes you will end up with a situation where you build residences for non-residents. You know in many places all over Bangalore, Madras and Hyderabad places are allotted to non resident Indians.

I cannot understand why non-residents need residences and

Real cause of illness

When I was discussing the aspect of poverty with my friend, he said, the main causes or pin-causes for poverty in India is 'U' and 'I'. 'U' stands for underdevelopment and 'I' stands for inequality. As a medical man, when I see a child with diarrohea, I have to treat that child again and again unless and until I extend my horizon to the state of poverty which is the root-cause.

For me, the root-cause is poverty. Even when I see a child wandering in the street and not attending school, I feel the cause is same poverty.

As a conscious citizen, and as a health professional, until and unless I extend the equation of drug-disease-and-office, to the real cause of the health situation in the country, that is poverty, I would have failed in my duty.

***Dr D V Ramana* at the symposium**

Public Distribution System for Poverty Alleviation

Public distribution system (PDS) did not come up as a measure of alleviating poverty. People in Andhra Pradesh and Kerala may feel surprised if I say this, because there the PDS operates in every nook and corner of the State.

Originally, the public distribution system in the nation was drawn for the urban people and not for the rural poor.

It was more a food security measure for the urban areas.

The other purpose was to see to it that industrial wages were restrained to an extent.

The logic: Indian industry was not competitive compared to that of the West and the profits of the Indian Industry had to be ensured.

And Industrial workers were getting organized leading to a reduction in the profit, making the Indian Industry non-competitive in the process. Hence the urban prices for essential commodities had to be kept low lest workers might demand higher wages.

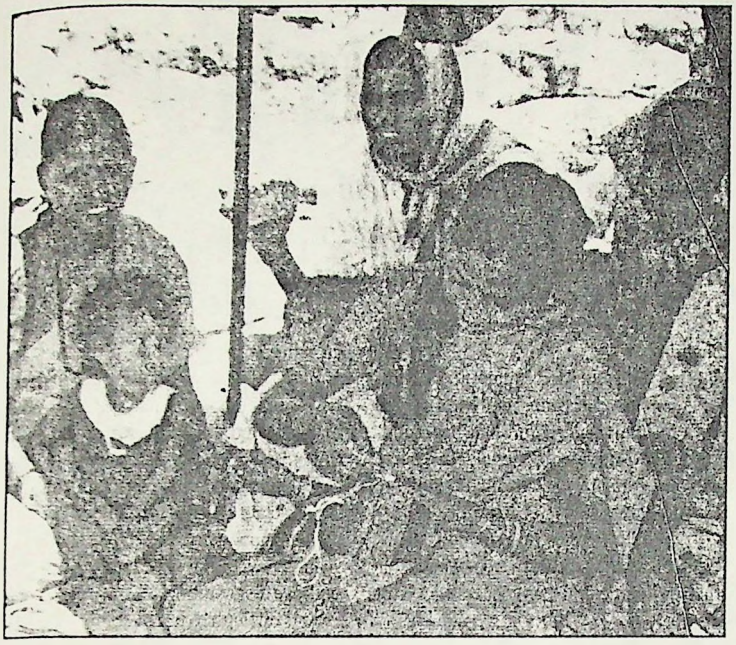
The public distribution system, thus, was not meant as a poverty alleviation measure at all.

Somehow it has wrongly been ingrained in our minds that it is a subsidised scheme for the poor.

Again, Food Corporation of India is doing the function of support prices and not that of procurement after 70's.

The difference between the open market price and the Food Corporation of India (FCI) price has almost vanished. We cannot think of a public distribution system based on the issue prices of FCI as a poverty alleviation measure.

P V



the local residents are to be thrown out.

We end up with this situation because the residents do not have the incomes of non-residents.

Health prices

This has also great implications for health. International drug prices are in tune with the incomes of populations elsewhere, and not in tune with the incomes of our own population.

What then about the health status?

Fortunately, it is not the drug technology that has a major role in improving the health condition of the population as nutrition, sanitation and indigenous systems of medicine.

Employment and poverty

We know when people do not have employment, they are poor.

But I must say also, that we should not confuse unemployment with poverty.

If you look, the State with maximum employment is Bihar. Unemployment is lowest in Bihar and much higher in Kerala, Maharashtra and so on.

Reason: It is only a rich man who can afford not to work.

A poor man cannot. Whatever work he finds, he has to do. Maybe if he is very poor, he will even just sit before your office and sell a few toffees. He purchases for 50 paise and tries to sell at 55 paise and at the end of the day makes Rs.2/- He must at least make that rather than do nothing.

So when I say employment, I mean employment at a level of a reasonable income.

Areawise approach

What is it that we can do if we want to really alleviate poverty in such a situation?

You know we have various schemes like Employment Assurance Scheme, Integrated Rural Development Programme (IRDP), Nehru Rojgar Yojana, etc. Actually a stage has come wherein we put all the money under these various schemes together.

What we must rather do is to take an area, district or a mandal, look at what money is available, and supplement, if necessary, and have an employment-guaranteed scheme.

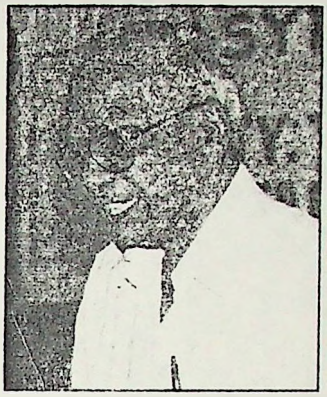
When I say an employment gurantee scheme, an employment with gurantee of a minimum wage.

And this I think is possible and feasible.

This is the way to attack the poverty problem.

(Excerpted from the keynote address by Prof P Venkataramaiah at the symposium on "Poverty : The Ruthless Killer")

Strange Reforms



Very strangely while from the decade of 40's to 70's the State control, state regulation and state participation were considered virtues and the market or the free enterprise and private enterprise were said to have obvious limitations in delivering public goods, the thinking changed from 80's onwards. Then a thinking set in that planning had obvious limitations and that there were virtues to the free market.

Prior to 80s the rate of growth has been 3.5%. From 80 to 90 it was growing at 5.5%. And the decade of 80's had been very good for us as the queue for a large number of goods had come down. For example, scooters, cars and TV because of free availability.

It was not because the policies of 80's were made by a different set of people or by another person. Only there was a shuffling of chairs but not of the people who made the policies. Very strangely, it was the very same people like Dr Singh, Mr Venkataraman, etc.

— *Dr Venkataramaiah* at the symposium

Deceptive Statistics and Deceptive Solutions

H. E., Shri Krishan Kant
Governor of Andhra Pradesh

For example, the statisticians told us that India has record food grain production which was over 191 million tonnes in 1994-95.

They did not care to tell us that this record food grains production yielded only 210 Kg of food grains per person per year, which was not enough to keep body and soul together.

"Millstone"

In most developing countries, poverty is a millstone which could not be cast off despite years of serious effort. Significant sections of the population continued to live in abject poverty and hopelessness, deprived of an assured minimum income, suffering inadequate nutrition level, without health care and education.

Its social consequences were quite manifest.

Child mortality remained high, life-expectancy was low, the resistance to diseases was insufficient, and the number of women dying in child-birth was high.

The sum total was that even when economic development revealed a statistical drop in the levels of poverty, significant sections of the population continued to suffer on account of its widespread prevalence.

The wretchedness of their lives had other fall-outs such as high levels of crime, addiction to drugs and exploitation of women.

"Deepening wretchedness"

That poverty needs to be tackled as the central focus of the economy is unexceptionable.

There is wide divergence of opinion among experts about the methods to find solutions for the problem of poverty.

This issue has assumed even greater importance in the wake of the ongoing world-wide debate on the choice of the economic model for accelerated growth.

Much of the Third-World had languished in the race for gaining expeditious rewards from economic growth.

The international politics and cold war put such strong onus on the politics of national security espoused by the power blocks that many a newly independent state of Asia and Africa and Latin America could never muster requisite resources or even the will-power to choose the right economic course for accelerated growth.

Welfarism became very good politics although it was doubtful if it could be good economics.

The block politics forced the third-world countries to spend disproportionately large sums of money on maintaining armed forces and purchase of expensive defence hardware from the Eastern and Western blocks, leaving very

little to meet such critical infrastructure requirements such as clean drinking water, access to health care, universal education and employment.

Significantly, during the past 50 years of the cold war, a majority of the armed conflicts - wars,civil wars, insurgencies, guerella warfare etc., occurred principally in the Thirdworld countries, where a majority of the world's poor resided.

The politics of the cold war years reduced the Third-World merely to a front to be used, exploited and discarded by the two chief power blocks.

The result was a stunning increase in world-wide poverty during the cold war period and a deepening of the wretchedness of the world's poor.

Statisticians' field-day

The end of the cold war led to a flurry of activities, both in the developed and developing worlds - euphemistically described as North and South - aimed primarily at resolving the problem of poverty.

The statisticians had had a field-day describing what was poverty and then changing the description and then again re-changing it.

But, as always, what the statisticians said was important but what they did not say was even more important.

For example, the statisticians told us that India had a record food grain production which was over 191 million tonnes in 1994-95.

They did not care to tell us that this record food grains production yielded only 210 Kg of food grains per person per year, which was not enough to keep body and soul together.

The statisticians advised us to celebrate the fact that India was exporting food grains, whereas China was importing it.

We were one up after all.

It was left to us to read between the lines and to remind ourselves that if we had an efficient public distribution system, reaching food where it was needed most, we would never have adequate surpluses for export.

Even when there was dramatic reductions in poverty, the off-take of both wheat and rice, the staple food of India's poor, had been declining over the years.

In the year 93-94, the off-take of rice was 8.88 million tonnes as against 9.36 million tonnes in 92-93 and 9.94 million tonnes in 91-92.

Similarly, the off-take of wheat in 93-94 was 5.86 million tonnes as against 7.41 and 8.78 million tonnes in 92-93 and 91-92 respectively.

It may be interesting to assess the reasons for this declining off-take of food grains from the Public Distribution System (PDS), which caters to the needs of the poor, especially in the rural areas.

It is nobody's case that the Indian poor have suddenly become so rich that they have stopped going to the fair price shops to stand in long queues and suffer the uncertainties of supply, and, instead, buy their supplies from the super market.

The low off-take from the PDS is perhaps an index of inadequate purchasing power of the rural poor.

It was left to us to read between the lines and to remind ourselves that if we had an efficient public distribution system, reaching food where it was needed most, we would never have adequate surpluses for export.

Another index

Another significant index is the performance of our agricultural sector in terms of its contribution to the national Gross Domestic Product (GDP).

Over the years, although the contribution of agriculture to GDP has been declining, the number of people dependent on agriculture for their living has remained more or less unchanged.

It is unlikely that their wages have remained unaffected by the progressive decline in agriculture's contribution to national income.

Critical factors

These indicators really point towards the complexity of the problem of poverty.

Very often, the choice of the methodology to compute the levels of pov-

erty results in different statistical outcomes,

An excessive focus on nutrition levels, as is adopted by our Planning Commission, does show declining trends in poverty in purely statistical terms.

In all probability, it will be a correct estimate as well but it may underplay the importance of such critical factors as feeling of security, optimism of outlook, self-confidence of the family etc.

A decline in quality of life can happen even in the midst of plenty and a constantly-rising economic curve.

Aping the west

The tragedy of a majority of the developing countries is that in trying to ape the economic success of the west, they are squandering their own age-old social resources.

Take for example social security.

In the Western countries, billions of dollars are spent in providing social security in terms of old-age pensions, old-age care homes, unemployment bonus, and other varieties of doles.

Contrast this with the systems of families taking care of the aged and infirm prevalent in most countries of Asia.

For almost no cost, a remarkable social security system has come to exist through the sheer force of history for thousands of years.

Our duty is to build further upon it and to profit from it rather than to squander it in a hopeless pursuit of the western Eldorado.

I urge the Symposium to consider whether it serves our purpose to view poverty through the blinkers of statistics as the Westerner does, or we can tap the very great resources available in our socio-cultural environment to overcome the challenge.

It is my belief that we can fight the wretchedness of poverty by strengthening our age-old social institutions and make a significant difference in the lives of a significant number of people.

An individual can feel secure if he is supported by the right social institutions, even in a regime of relatively low wages.

The cost involved in creating institutions providing social security is impossible to be borne by most developing countries.

It is unnecessary as well because most of the developing countries have historically-created social institutions which are a good and adequate security-cover for the poor.

I am not suggesting that this could be the only solution to the complex problem of poverty but I am sure it can suggest a new approach and perhaps a new model which we can commend to the world.

I shall be happy for a debate on this subject.

It is nobody's case that the Indian poor have suddenly become so rich that they have stopped going to the fair price shops to stand in long queues and suffer the uncertainties of supply, and, instead, buy their supplies from the super-market.

(Inaugural address at the symposium on 2 March, 1996 organized by **HEALTH ACTION** *at Secunderabad)*

COMH-70.

Poverty Eradication Is Not Difficult

Prof. P. Venkataramaiah

Most of the diseases in the developing countries are rooted in undernutrition and unhygienic living conditions associated with poverty. The solution to health problems lies in eliminating poverty.

Not only the right to live but also the right to live with dignity is a basic human right.

After nearly five decades of independence, while the percentage of the poor has declined from 55% to 30%, it has grown in terms of absolute numbers.

The recent estimates show that twenty-five crores of our population live under poverty. In the sense that they do not have the minimum calorie requirement.

The irony

With the green revolution and the growth of food grains output, the average per capita food availability is enough to meet the nutrient needs of the population.

But there is not enough purchasing power with some sections of the people to satisfy their basic calorie requirements.

It is a cruel irony that we have a huge buffer-stock of grains of about 35 million tonnes and twenty-five crores of people without enough food.

The economic reforms of the past years have not had any beneficial impact on the poor. If at all, there is a feeling, that has an adverse impact.

Health and poverty

What is the role of poverty in determining the health status of the population? Historically, it is the availability of food that has resulted in the decline of mortality-rates in European countries.

If you look at India, it is felt that it is the advances in the medical sciences that reduced the mortality-rate in the Indian context. That is, with the control of epidemics.

But, whatever control that can happen by eradicating epidemics has already happened.

And the further morbidity that exists in the nation cannot be controlled, or further improvement in mortality cannot be achieved, unless poverty is eliminated and enough nutrition is made available to the population.

Most of the diseases in the developing countries are rooted in undernutrition and unhygienic living conditions associated with poverty. The solution to health problems lies in eleminating poverty.

Not difficult

It is estimated that in the Indian context, the resource required to eliminate poverty is of the order of 10% of our national income or above one lakh crore of rupees.

If you want to limit to the elimination of severe malnourishment and hunger or extreme poverty, it is said that it requires 4% of our national income which comes to forty thousand crores.

And, this is not such a large amount.

If there is a political will, this is something which is within the manageable reach of our economy and our resources.

I think, we should remember that poverty anywhere is a threat to prosperity everywhere.

(Presidential address at the symposium.

Prof P Venkataramaiah is the Director of Centre for Economic and Social Studies (CESS), Hyderabad).

Count On People

And Not On Politicians To Eradicate Poverty

Fr John Vattamattom svd

A few days ago, I happened to be in Allahabad and I visited the Anand Bhavan. The experience touched me deeply.

That was the place where people, like our beloved Father of the Nation and our first Prime Minister and others, took very important decisions. And, when they took such decisions, they had before their eyes the well-being of the people of this country.

Walking around the place that day, I was trying to compare that with the present scenario and I could not help but be moved.

What a difference between the thinking of our leaders then and the thinking of our so-called leaders now!

And, if poverty is the major sickness today, especially in our country, I think all of us, especially our present leaders, are responsibile for that.

We need to look into the various aspects of this very important but very disturbing topic : *Poverty: The Ruthless Killer.*

Actually, the biggest sickness we have in the country and the world today is poverty. Poverty is not simply a state of affairs but a sickness by itself.

We need to question the effectiveness of the type of remedial measures taken by the government, and particularly of its new economic policy and all that.

This, especially with regard to the ordinary people of this country whose number unfortunately is on the increase.

The remedy for the sickness of poverty in this country cannot be found except by people themselves, people coming together.

The peoples' strength is what we can count on. And we have certain examples even in this state of Andhra Pradesh. Especially, the women's initiative in the matter of prohibition and so on.

Unless the people take these things into their own hands the situation will not change.

And, under this present situation, we need not expect much from our political leaders.

Gandhiji's principle of "Antyodaya" has to be held up. And it has to be implemented through all of us.

And people need to come together and take decisions.

And they should say; we have something to say about our own destiny and days.'

Such days will come if all of us work together. HA

(Introductory talk at the symposium.
Fr John Vattamattom svd, is Director-Emeritus,
The Catholic Health Association of India, Secunderabad).

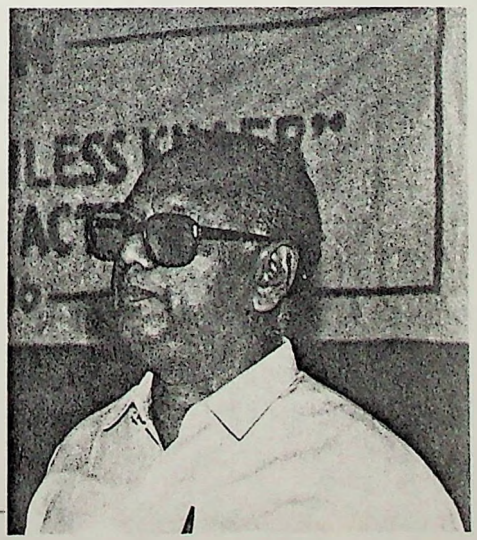
More pieces from the symposium will be published in the subsequent issues.

Under the present situation, we need not expect much from our political leaders.

Gandhiji's principle of "Antyodaya" has to be held up. And it has to be implemented through all of us.

And people need to come together and take decisions.

And they should say; we have something to say about our own destiny and days'.



The Why and How of Massive Poverty

Dr Sr Placida Vennalilvally

Indian economy has grown and is growing due to the modernization green revolution and latest technologies in the agricultural sector.

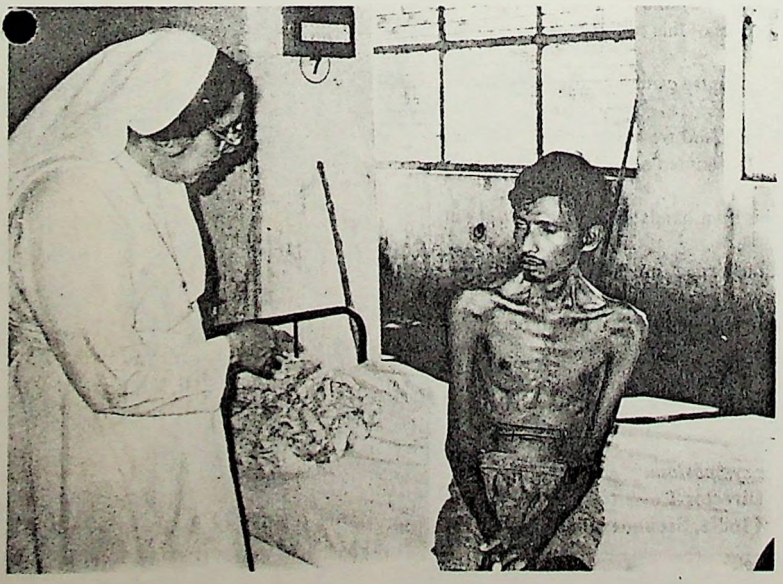
But, this positive progress of the economy is marred by the ugly fact that massive poverty continues to exist.

Poverty is a situation in which an individual fails to earn an income sufficient to buy him/her bare means of subsistence.

It is a severe lack of material and cultural goods which impedes the normal development of individuals.

The number of poor estimated in the rural areas is about 168 million. They are landless labourers, fisherfolk, backward classes and backward tribes.

The urban poor are about 42 million who are immigrants from villages, living in slums and on pavements.



Poverty: the killer

Poverty is the biggest single cause of death, disease and suffering in the world.

Adequate income is basic to adequate diet. Poor people do not have money to purchase food.

The houses of the poor are not only overcrowded but they lack privacy, too. Poverty forces them to live in sub-standard houses which weaken the family solidarity.

Poverty contributes also to mental illness, stress, suicide, family break-up and drug abuse.

The poor are harassed, humiliated and discriminated against at every level.

Unrepresented and powerless

Problems faced by the poor in our society are many; social discrimination, social condemnation and homelessness.

Being unrepresented and powerless, they are always the target of attack and hostility by the powerful, thus lowering

their self-image and creating in them a feeling of inferiority complex.

The demoralising and deterimental effects of poverty are not confined to individual suffering only, but is also a danger to the nation.

As Gandhiji said "The cry of the poor should not remain unheeded."

A limited income restricts people to live with deteriorating houses, inadequate sanitation, crowding and lack of privacy.

The poor are isolated from society. And they move about from place to place. Not by choice but by necessity.

They are ill-equipped to cope with emergencies.

What are the causes?

Hunger and malnutrition of millions of people are the result of the unjust distribution of resources, and production due to the interests of selfish people, corruption in public life, and massive investment in sophisticated weapon-systems leading to the neglect of even the primary needs of the poor.

Economic and political causes of poverty are

- unwise economic policy,
- unequal distribution,
- population growth,
- unemployment,
- unproductive hoarding and
- economic depression.

Unwise policies

There are policies which forcibly reduce agricultural production and policies that further the pauperization of women and children.

Therefore, poverty is the result of not only individual greed but also the way our society and our economy function.

The beneficial effects of growth do not reach large masses of the people due to our development strategies.

Our efforts were not sufficient to absorb the backlog of unemployment and the rising labour force as also to meet the consumption needs of the people.

Another significant factor, which prevented benefiting from growth has been the widening inequalities of incomes.

Total amount of the subsidies meant for the poor too is inadequate. And they do not reach the poor.

Under the ceiling policy, there was much surplus land for distribution. But, in most cases, the owners have parcelled out the ownership among relatives, friends and even servants so that little remain as surplus.

Thus development strategy was neither enough nor effective to alleviate poverty.

Concerted efforts

How do we solve these problems of the poor?

The ideal solution in solving the problem of massive poverty lies in making poverty reduction the core of planning strategy.

We need to provide large employment opportunities and raise the provision for social consumption by the poor. Special measures need to be undertaken for the landless agricultural labourers, artisans, hill area people and tribal population who lack assets and skills to earn and stand on their own feet.

We need to be aware of our social responsibilities and change the consumerist behaviour and combat hedonism and our indifference towards poor.

Let us all, politicians, economists, industrialists, educationists and social workers together crusade against poverty.

We shall thus become builders of a prosperous, democratic and progressive nation, enabling us to create social, economic and political institutions ensuring justice and fullness of life to every man and woman.

The number of poor estimated for the rural areas is about 168 million. They are landless labourers, fisherfolk, backward classes and backward tribes.

The urban poor are about 42 million who are immigrants from villages, living in slums and on pavements.

Com H-70.

POVERTY & HEALTH

Meeting with Ravi 23.01.99 and on 08.02.99

This was the first meeting to discuss the forthcoming WHO workshop on Poverty and Health in South Asia.

The focus is

- What is poverty – what are the various definitions?
- How is it measured?
    1. How is poverty measured
    2. Who are the poorest
    3. What are their conditions
    4. Where are they distributed – Karnataka – BIMAROU – India – S.Asia

- What are the causes of poverty?
    1. At the local level
    2. At the State level
    3. At the National level
    4. At the Regional level
    5. At the Global level

- The effect of poverty on health and vice versa, the effect of health on poverty
    1. How does poverty impact on health
    2. What are the other determinants
    3. How does health (or rather the lack of it) affect poverty
    4. What is the impact of a lack of access to health resources for the poorest.

- What is being done to change poverty
    1. In terms of health inputs
    2. In terms of other inputs

My role is to read up relevant literature on S. Asian experiences so that we can develop a book that will be presented at the workshop.

The focus is on South Asian poverty.
Keep a look out for appropriate publications, individuals, case studies.

WHAT IS POVERTY?

Definitions

Poverty is more than the lack of what is necessary for material well being. It can also mean the denial of opportunities and choices most basic to human development. Human development is *"a process of expanding human choices and enabling people to enjoy long, healthy, creative lives with a decent standard of living and to enjoy dignity. self esteem, the respect of others and the things that people value in life."* [1]

At present the focus is on Nutritional definition of poverty. But it does not take into factors like security, self esteem and quality of life.[2]

Many types of Poverty
Inherited, Instant, Temporary, New Poverty, Relative P~, Absolute P~, Hidden P~, Endemic P~, Overcrowding P~, Terminal P~.
Basic Needs are
Physical needs (food, water, sanitation, sleep)
Environmental needs (shelter, fuel)
Social and spiritual needs (affection, sexual, privacy, human rights)
Personal and Communal assets (access to land, water, forests, grazing, roads, transport, education/health services and productive employment)[3]

---

[1] RM 2
[2] RM 9
[3] RM 16

HOW IS POVERTY MEASURED?

What are the indicators?
Who are affected by it?
What are their conditions?
Where are they?

More than 3 million of New Delhi's 11 million live in slums. Another 3 million fleeing rural poverty are expected by the year 2000 AD[1]

Human Poverty Index – It provides an aggregate human measure of the prevalence of poverty in a community. It measures

1 Survival and longevity: the vulnerabilty to death at a relatively early age. This is represented in the HPI by the percentage of people expected to die before the age of 40.

2 Knowledge: being excluded from the world of reading and communication. This is measured by the percentage of adults who aare illiterate.

3 Decent standard of living, in particular, overall economic provisioning. This is represented by a composite of three variables – the percentage of people with access to health services and to safe water and the percentage of malnourished children under five.

Country	Value
India	35.9%
Pakistan	46%
Myanmar	27.5%
Bangladesh	46.5%
Bhutan	44.9%

Indian statistics

%age without access to safe water (90 – 96)	19%
%age without access to health services (90 – 95)	15%
%age of undernourished children (90 – 97)	53%
%age without access to sanitation	71%
%age of population not reached Class 5 (1995)	38%
%age of pop. Living on an income < US$1 per day	52.5%

There is poverty also in the industrialised countries (100 million below the poverty line, 37 million unemployed, 100 million homeless and 200 million with a life expectancy < 60yrs)[2]

Feminisation of poverty – some of the causes

- Discrimination in nutrition. Increasing food costs will worsen this situation. The average wt of women has remained the same from 1956 to 1992.
- Discrimination in access to health care, esp during child birth
- Susceptibility to infections, e.g. TB, malaria
- Mental trauma leading to suicides, burns.
- Violence against women.[3]

Current scenario of poverty

- 36% of pop. Below poverty line in 93 –94.
- Totally 320 million of which 244 million are in rural areas (30% of rural pop.)
- Incidence of poverty has decreased from 56% (73) to 36% (93).[4]

GOI – Those who consume < 2,435 Kcal per day. This measure was first developed in the 1930s by the Bombay Labour Enquiry Committee to measure poverty in Sholapur. It was subsequently developed by the Planning Commission in 1962.
Only 35% of pop is below the Poverty line.[5]

A poverty line is a tool for measuring poverty and for seperating the poor from the non-poor. It is constructed according to the value of income or consumption necessary to maintain a minimum standard of human nutrition and other basic necessities. E.g. it can be drawn based on a minimum wage or a minimum caloric intake necessary to sustain human life.
Head Count ratio – counts the number of people below a specified poverty line. However, it does not show the various levels of poverty within the groups.
Poverty lines do not generally include other factors which determine quality of life (access to safe water, basic public services).
One definition of poverty line – anybody with < 1.5 acres of land and having to sell their labour for > 90 days a year.
Drawing poverty lines should be different for urban and rural pop. E.g. if an income is taken as the cut off, a specified income can buy more in a rural area compared to an urban area. It has been suggested that a higher poverty line be drawn for urban areas.
The situations of those just above the poverty line may be no better than those below it. As conditions fluctuate they may go below it.
Consumption data is superior to income levels as the latter vary with employment.
The line is usually drawn to reflect consumption/income which will sustain human life. It is also important to find the severity of those below the poverty line. In one situation, most may be just below the poverty line while in another situation, most may be way down. This is called the Poverty Gap index and is measured by
Poverty line – mean income of those below the poverty line
Poverty line
When looking at the PL, disaggregate – rural/urban; M/F; class; also look at the trends (incidence of poverty).[6]

Poverty profiling is an analytical tool for rapidly and systematically identifying more clearly the poor, where they live and what causes and characterises their poverty. This can be done in a participatory way with the people themselves identifying the poor. It can be done at various levels. But the outcome depends on who is doing it. Some tools from PRA can be used, e.g. wealth ranking, semi structured interviews, FGI, etc.
Household and community surveys can also be used to identify the poor. The other possibility is to look into existing records. [7]

---

[1] RM 1
[2] RM 2
[3] RM 6
[4] RM 7
[5] RM 12
[6] RM 16
[7] RM 17

WHO IS POOR?

Poverty profile – landless or small landowners, small scale artisans and traders; female headed households; low wage workers; unemployed; marginalised indigenous populations; nomadic herdsmen and pastoralists; small scale fishermen; refugees and displaced persons. The most vulnerable in a population are those for whom multiple deprivations converge – lack of food, shelter, water, health care, education and employment. In any place the most vulnerable form the bottom half of the pop. Some people tend to move in and out of absolute poverty.
Increasingly women are being hit by poverty. This is because the %age of female headed households are increasing. Also women are being exploited on the job front by being paid less. Increasingly cutbacks in Govet services increases the burden on the woman – e.g. home based care for AIDS patients.[1]

Among the most poorest and the vulnerable in some countries are the indigenous people. Their rights to land, natural resources and lifestyles have been continually eroded whether by the Govt or by the settlers or by MNCs.[2]

Those suffering from inadequate shelter are usually women, children, displaced communities, older people and people with physical and mental disabilities.[3]

---

[1] RM 16
[2] RM 17
[3] RM 18

WHAT ARE THE CAUSES OF POVERTY?

At a local – state – national – regional – global level

4 billion people have been excluded from the consumption revolution. 3/5 of them live without basic sanitation; 1/3 without safe drinking water; 1/5 have no access to health services; 1/5 do not get primary education; 1/5 of the children are undernourished. Some of the reasons for this exclusion are

1 Lack of re-distribution of income
2 Disinclination to shift from a polluting to a cleaner technology
3 The need to promote goods that empower poor producers and
4 The Neglect to shift from consumption to meeting basic needs.

Expanding consumption strains the environment, which can deplete and degrade renewable resources. Consumption is usually by the well of while the effects of the degradation are on the poor.[1]

SEWA believes that poverty is created by those who exploit others and capitalize on their vulnerabilities.[2]

Feminisation of poverty – some of the causes

- Discrimination in nutrition. Increasing food costs will worsen this situation. The average wt of women has remained the same from 1956 to 1992.
- Discrimination in access to health care, esp during child birth
- Susceptibility to infections, e.g. TB, malaria
- Mental trauma leading to suicides, burns.
- Violence against women.[3]

Arms race has led to much diversion resources for defence rather than welfare or infrastructure development (like water, health care, education and employment).[4]

Unjust distribution of resources. Corruption. Arms race. Unwise economic policies. Population growth. Unemployment. Inadequate land redistribution efforts. [5]

Kalahandi in Orissa and Tikamgarh in MP are supposed to be the most backward districts, considering the 'distress deaths'. Yet Kalahandi's per capita rice production is the highest in India. And Tikamgarh is the highest wheat producing district in MP. The distress deaths are not due to lack of food, but the inequitable distribution. In kalahandi, only 25% of the grains produced there is consumed there. Rest is exported to the rest of the country by the merchants. In both these districts, a few very prosperous people profit from the misery of the large majority.

The health budget in India for PHCs is Re 0.50 per person per year. This has remained static since the 1980s. The State's contribution to Health has fallen from 3% of total Budget (in the 1st Five year plan) to 1.05% in the 8th Five Year Plan.[6]

20 main causes of poverty

1 Inequity
2 Unemployment
3 Small landholdings
4 No access to credit
5 Producers get minimal returns – most profits go to middle men
6 Cuts in social sector
7 Little access to modern technology
8 No democracy

9 Non supportive legal system
10 Poor environment
11 Privileges retained by the elite
12 Neglect of traditional systems
13 Ecological degradation leading to disasters
14 Civil war
15 Gender bias
16 Alcoholism
17 Illiteracy
18 No access to health care
19 Lack of water
20 Colonial conditions continue

Rapid urbanisation is one of the main cause for urban poor. In 1900, 10% of the pop were urban with only one city (in China) with a pop >1 million, by 1950 it was 30% with 26 cities with pop > 2 million. The slums are growing at twice the rate of cities, Calcutta's 67% of pop are in slums. Some of the causes of this urbanisation are migration for jobs, displacement and disasters in the rural areas (economic/environmental refugees).[7]

Corrupt practices which prevent the poor from escaping the poverty cycle

- Passing agrarian reforms without implementing it
- Elite hijack funds intended for the poor
- National teaching hospitals absorb most of the health budget
- Leaders ignore unjust practices like bonded labour
- Distortion of welfare programmes, e.g. sick animals given to beneficiaries or poor quality of grain supplied in the PDS
- Informal fees paid to doctors/nurses for treatment
- Drugs and medicines siphoned from the hospitals/HCs
- NGOs use programme funds to further the Director's needs

Tourism and its effect on worsening poverty. Some are prostitution, STD, unwanted pregnancies, inappropriate diets thanks to 'fast foods' displacement.[8]

Lack of access to legal aid and advice. The law enforcement agencies are usually on the side of the rich/oppresor/gangs/elite. (Case study from Yellamalai)[9]

---

[1] RM 2
[2] RM 3
[3] RM 6
[4] RM 9
[5] RM 10
[6] RM 11
[7] RM 17
[8] RM 20
[9] RM 21

CASE STUDIES

ASHA – works in the slums of New Delhi. Has trained Community Health Workers who conduct deliveries at a fraction of the cost of hospital deliveries. These are women who are from the slums and provide MCH care to the mothers and children. They have reduced severe malnutrition from 47% to 4%. Immunisation coverage is at present 97% (as compared to 15% in 1989). The Eligible couple's protection rate has also increased from 8% to 45%. The CHWs are also members of women's groups who lobby Govt to regularise their land holdings.The Govt responded and today 475 families have responded.[1]

SEWA has a twin strategy of development along with struggle. While organizing women, it ensures employement and meeting the women's basic needs. The women have been struggling for the rights of the vendors, for minimum wages, for access to credit, for employement, for social security, for women's control over forests and lands. At the same time it felt the need for building Alternative Economic Organisations like co-operatives and unions. Some of the institutions built are the SEWA Bank with a membership of 81,000 + members and a working capital of Rs 180 million. SEWA believes that

- Strengthening, protecting and promoting employement, especially self – employement, is the most effective way to combat poverty
- Building alternative economic organisations – co-operatives and producer groups – is essential for the poor to emerge from the cycle of poverty.
- A joint action of struggle and development – union and cooperative – has resulted in significant gains for the poorest workers.
- A holistic and integrated approach – which combines work and income security as well as food and social security is essential to break the chain of poverty.
- Critical inputs like access to raw materials, markets, capital, skills, capacity building of workers in management and enabling policies (minimum bureaucracy, access to resources like land water, forests) are needed to develop and strengthen worker owned economic organisations.
- When poor women lead the struggle against poverty, the whole nation prospers.[2]

Fatima Bi of Kalva Village, Kurnool District.[3]

NDDB with its dairy co-operatives has produced income to the tune of Rs 50,000 crores for the women of this country. It tried the same with oilseeds, fruits and vegetables, but thanks to bureaucratic intereference could not proceed as expected.[4]

Page 107[5]

Case studies from Yellamali – KN 5
Case studies in organ sale

---

[1] Rm 1
[2] RM 3
[3] RM 5
[4] RM 14
[5] RM 21

WHAT ARE THE EFFECTS OF POVERTY?

Poverty on health
Ill health on poverty

Child labour is one of the effects of poverty. In S. Asia there are 80 million children in servitude
India – 55 million (41.47 in agricultural occupations, 7.6 million in manufacturing units, 1 million each in brick kiln, stone quarries and construction, 0.14 million in transportation, 1.52 million in trade and commerce and 0.84 million in circus, cinema, begging and rag picking.
Pakistan – 10 million (7.5 million in agriculture, 0.5 million in carpet industry, 2 million in brick kiln, etc.)
Bangladesh – 10 million (9 million in agriculture)
Nepal – 4 million
Sri Lanka & Madives – 1 million
Bhutan – 0.1 million[1]

Effect of poverty on health

- Low Birth Wt
- Unaided delivery leading to increased potential for mortality (matenal and neonatal)
- Increased infections in the infancy leading to high IMR
- Malnutrition and infectious diseases in the childhood leading to stunting
- As they grow their productivity decreases[2]

In 94 – 95 there was "a bumper crop of grains" – 191 million tonnes. But per capita this 210 kgs per person per year, which was not adequate for the needs of the average person. On top of that we exported food grains, thus reducing the availability even further. The uptake of grains in the PDS has been reducing over the years

Year	Rice (Million tons)	Wheat (Million tons)
1991 – 92	9.94	8.78
1992 – 93	9.36	7.41
1993 – 94	8.88	5.86

This low uptake is probably due to the diminishing purchasing power of the poor.[3]
In 1995, India apparently had a buffer stock of 35 million tones, yet 250 million people did not have enough food to eat!

According to a senior administrator, *at least a third of the country is under what we may call low intensity civil war.* Parts of Bihar and AP are virtually ungovernable. Dogged battles are being fought over land, water and forests.[4]

Poverty is not only whether one can afford a bundle of goods but also what prevents one from doing so. Being poor in India means the lacking good health and skills to make the most economic opportunities. Being poor also means a very high chance of being illiterate – 45% of illiterate households are poor. 1/3rd of boys and <1/10th of girls in poor households reach the 8th standard.[5]

The poor have higher mortality figures compared to others – Guatemala – MMR = 243 for remote areas as compared to National average of 106.
Poverty may have different effects depending on the circumstances. Example poor, rural indigenous people may actually have a healthy life because of their lifestyle and access to basic resources like food and water. On this front they may be better off compared to the urban slum inhabitant. On the other hand they may be vulnerable to violence from developers and Forests Depts.[6]

Unemployment leads to reduced food intake, stress on personal and social relationships, reduced access to health services, and increased health damaging life-styles like smoking, alcohol and violence.[7]

Poverty usually leads to reduced intake of food. This is governed by factors like

- Access to land and agriculture
- Food crops Vs cash crops
- Seasonal variation – e.g. pre-harvest
- Preference to "modern foods" and animal foods
- Household expenditure pattern
- Allocation of food within a household

The urban poor usually live in crowded slums. The 'houses' are small and cramped and often dark. The floor is earthen. Safe water and sanitation is usually non-existent. The 'wretched' are the pavement dwellers who don't have the luxury of having a roof above their heads or walls around them. They are at the mercy of the elements. This poor shelter results in water and vector borne diseases. Crowding allows measles and TB to spread rapidly. Lack of ventilation results in pollution from cooking fuel causing respiratory and eye problems.
Very few of the poor have access to safe water and sanitation (give figures). Diseases caused by contaminated water are

1. Diseases caused by the ingestion of contaminated water – e.g. diarrhoea, cholera, typhoid, dysentery, hepatitis, etc.
2. Diseases caused by insect borne vectors – debgue, malaria, filaria
3. Diseases caused by lack of water – scabies, trachoma, lice
4. Diseases caused by parasites in the water – helminthiasis, dracunculosis, amoebic dysentery, etc.

All these diseases cause untold misery, morbidity and mortality among the poor. (give figures)
Lack of potable water has other implications also for the woman

- Fatigue in collecting the water
- Backache, arthritis, slipped disc
- Miscarriage
- Time and energy(12%) can prevent the woman from doing other useful work like non-formal education or child care.
- Inability to grow a kitchen garden or raise small livestock
- Even safe child birth may not be possible

Poverty can affect a person from conception to death. This is given in detail in page 47 – 59.
Some of the common diseases of the poor other than the above are Malaria, TB, worms and mental diseases.[8]

Psychological aspects of poverty

- Mental disorders
- Feeling of inferiority
- Lack of self esteem
- Treated as objects

- Feeling vulnerable and insecure
- Feel less equal to others
- Feel at the mercy of fate and destiny
- Feel lonely, especially if they do not have the family support.
- They feel unable to help dependents
- They are forced to depend on others

Trade in organs

Bonded labour

Lack of family life due to working and living conditions.

Effects of ill-health on poverty. Acute illness and even more chronic illness (HIV) steadily pushes a person into poverty. Also the frustration of inaction can generate powerlessness. Illness undermines the productive capacity leading to a loss of income.[9]

---

[1] RM 4
[2] RM 8
[3] RM 9
[4] RM 11
[5] RM 12
[6] RM 16
[7] RM 17
[8] RM 18
[9] RM 21

WHAT IS BEING DONE/CAN BE DONE TO REDUCE POVERTY

Action on the determinants of poverty
Action to increase health care to the poor

ASHA – works in the slums of New Delhi. Has trained Community Health Workers who conduct deliveries at a fraction of the cost of hospital deliveries. These are women who are from the slums and provide MCH care to the mothers and children. They have reduced severe malnutrition from 47% to 4%. Immunisation coverage is at present 97% (as compared to 15% in 1989). The Eligible couple's protection rate has also increased from 8% to 45%. The CHWs are also members of women's groups who lobby Govt to regularise their land holdings.The Govt responded and today 475 families have responded.[1]

The HDR recommends the poor countries to increase consumption to overcome poverty. They should 'leapfrog' into 'growth pattern' that are pro-environment and pro-poor. This requires a few chosen ingredients, consumption that is to be shared, strengthening, socially responsible and sustainable. Consumption being shared would ensure that basic needs for all are met. Consumption that is stre~ means that it must build the human capabilities. C~ that is soci~ res~ so that it does not compromise the well being of others. C~ which is sus~ means that it will not mortgage the choices of future generations.[2]

SEWA has a twin strategy of development along with struggle. While organising women, it ensures employment and meeting the women's basic needs. The women have been struggling for the rights of the vendors, for minimum wages, for access to credit, for employment, for social security (health care, education, housing), for women's control over forests and lands. At the same time it felt the need for building Alternative Economic Organisations like co-operatives and unions. Some of the institutions built are the SEWA Bank with a membership of 81,000 + members and a working capital of Rs 180 million. SEWA believes that

- Strengthening, protecting and promoting employment, especially self – employment, is the most effective way to combat poverty
- Building alternative economic organisations – co-operatives and producer groups – is essential for the poor to emerge from the cycle of poverty.
- A joint action of struggle and development – union and co-operative – has resulted in significant gains for the poorest workers.
- A holistic and integrated approach – which combines work and income security as well as food and social security, is essential to break the chain of poverty.
- Critical inputs like access to raw materials, markets, capital, skills, capacity building of workers in management and enabling policies (minimum bureaucracy, access to resources like land water, forests) are needed to develop and strengthen worker owned economic organisations.
- When poor women lead the struggle against poverty, the whole nation prospers.[3]

Some of the ways to reduce poverty

- Accelerated growth in agriculture
- Promote the productive use of labor
- Provide basic social services – primary health care, FP, nutrition, primary education,
- Economic growth which is sourced in agriculture, in rural non-agricultural activities and in productive expansion of the informal sector, all of which will have high employment elasticities.[4]

We cannot depend on the politicians, the people must take things into their own hand.

The Government spends 12% on anti-poverty programmes and food subsidy in 1997, it cut back on health and education expenditures in the nineties. Also thanks to poor targeting, the non poor receive the benefits.
Targeted expenditure on health, education, growth enhancing, job oriented investements in infrastructure (roads, water supply, sanitation, irrigation and rural markets). Re-tegreted PDS in UP and Bihar seem to be helping the poor. The other crucial input is land reforms.[5]

In Dharamapuri Dt, a massive IEC programem to increase awareness among the people about health issues has increased the utilisation of the PHCs (OPD and deliveries).[6]

Devolve power and funds down to the Panchayat level

NDDB with its dairy co-operatives has produced income to the tune of Rs 50,000 crores for the women of this country. It tried the same with oilseeds, fruits and vegetables, but thanks to bureaucratic intereference could not proceed as expected.[7]

Globalisation is good for a country, but safety nets have to be provided to protect the vulnerable.[8]

The rural poor need measures which will re-establish the agricultural practices, while at the same time protecting the products and prices.
Urban poor may be helped with food subsidies, subsidies for industry and public sector.[9]

Providing adequate water and sanitation reduces water borne diseases considerably, as well as helminthiasis. Adequate ventilation and prevention of pollution will reduce the load of respiratory infections. Siting the shelter away from vector breeding areas will reduce malaria. filaria and dengue. Some other measures are given on page 43.[10]

Look at the roots of poverty and try to tackle some of the shallow ones first.

- Inequity National policies to curb inequities. Unions to represent the interests of the poor. IGP and C&S prg. Local industries and marketing systems.
- Unemployment Unions to represent the interests of the poor. IGP and C&S prg. Local industries and marketing systems. Food for work, loans for self employment.
- Unequal land holdings Unions of landless. National policies. Subsidised food schemes and PDS. Small industries
- Lack of access to capital IGP and C&S Prg. Keep health costs low.
- Globalisation Unions to demand fair wages and safer working conditions.
- SAP Unions to demand exemption of poor household from user fees. IGP and welfare activites to support the indigent.
- No role in governance Will depend on the National policies.
- Violence Low cost legal aid. Counselling for vicitms.
- Environmental degradation Unions to protect the environment, promote reafforestation, protect water sources, promote sustainable agricultural practices, etc.
- Race & class discrimination Unions to represent their interests. Education, IGP, health and human rights schemes.
- Natural disasters Siting of dwellings on safer locations. Use of better materials for construction of shelters for the poor. Early warning systems for cyclones, typhoons, etc. Emergency back up services available for the victims. Instant relief.
- War and Conflicts NGO initiatives to rebuild wartom societies
- Gender discrimination Education. IGP and C&S P. FP, abortion and delivery services.
- Domestic violence Trg of police, HWs, teachers, local leaders. Access to free legal advice and assistance.

- No access to education/training Innovative school systems to reach the poor, school dropouts, adult learners. IGP to raise funds for school fees. Support children for higher learning.
- No access to health services Mobile services. Exemption of fees. Recruit local volunteers and health staff who will work with the poor.
- No access to water Community managed water systems. Sanitation need to be established.

Livestock is invaluable for the poor.
Appropriate technologies for
food and nutrition (agricultural tools, improved seeds, local methods for composting, processing and preserving food, improved granaries).
shelter (low cost dwellings, community should be involved in the construction),
water and sanitation (rainwater catchments, standpipes, rainwater harvesting.);
MCH (health records, TBAs, ORS,)
First aid (1st aid kits)
Prevention of diseases (bed nets,)
Education[11]

Some policies which can mitigate poverty
Legal age of marriage (to prevent teenage pregnancies)
FP, Maternal and abortion services available, affordable and accessible
Regulation of VHWS, TBAs so that care is accessible
Prohibition of female infanticide
Ensure availablitlity of emergency obstetric services at hospitals
Compulsory registration of births and deaths and investigation of maternal and child deaths
Compulsory service for young medical graduates
Ban on breast milk substitutes
Free services for children
Supplementary feeding in drought prone areas
Monitoring of abortion of female fetuses
Compulsory flouridation
Compulsory certification of hotels and vendors
Strict enforcement of laws on child prostitution
Compulsory education and prohibition of children working in hazarous industries
Services for disabled people
Increased access to Reproductive health services and sexual education
Prohibition on manufacture, advertising and distribution of cigarettes, alcohol, narcotic drugs
Driving laws to prevent RTA
Services for mentally ill
Occupational laws to prevent accidents
Food security for poor
More in page 89-92
NGOs are one answer.
Credit and Savings programme
IGP for women[12]

---

[1] Rm 1
[2] RM 2
[3] RM 3
[4] RM 7
[5] RM 12
[6] RM 13
[7] RM 14

Reference List

1 Marion Lloyd. Urban Poverty. *Health for the Millions* 24 (6):5-7, 1998.

2 Anonymous. Human Development. *Health for the Millions* 24 (6):10-11, 1998.

3 Mirai Chatterjee. Women's struggle against poverty. *Health for the Millions* 24 (6):12-15, 1998.

4 Kailash Satyarthi. Child Labour. *Health for the Millions* 24 (6):28-30, 1998.

5 Anonymous. The Challenge of a Sarpanch. *Health for the Millions* 24 (6):32-32, 1998.

6 Mira Shiva. Feminization of Poverty. *Health for the Millions* 24 (6):33-34, 1998.

7 J. N Godrej. Rural Poverty. *Health for the Millions* 24 (6):35-37, 1998.

8 CM Francis. Poverty the ruthless killer. *Health Action* 9 (4):3-3, 1996.

9 Krishna Kant. Deceptive Statistics and Deceptive Solutions. *Health Action* 9 (4):14-16, 1996.

10 Placida Vennalilvally. The Why and How of Massive Poverty. *Health Action* 9 (4):20-21, 1996.

11

safety from such chronic threats as hunger, disease and repression. It also involves protection from sudden and hurtful disruptions in people's daily lives—in the home, workplace and community.

In poor nations and rich, human life is under threat from crime, accidents and violence. Reported crimes worldwide were increasing by 5% a year in the late 1970s and early 1980s—faster than the growth in population. Recently, however, some countries with disturbingly rampant crime have been witnessing improvements. In the United States incidents of violent crime have fallen three years in a row, and between 1995 and 1996 the number declined from 3 million to 2.7 million, the lowest level since surveying began 24 years ago.

Industrial and traffic accidents also present great risks. In most industrial countries the number one killer of people aged 15–30 is accidental injury. In developing countries traffic injuries account for at least half of accidental deaths, and in Thailand, for example, the death rate due to traffic accidents quintupled between 1962 and 1992, from 4 per 100,000 people to 20.

Another threat to human security: inadequate and illegal housing. More than a billion people live in inadequate shelter, without piped water, electricity, roads or, in most cases, security of tenure. Between 30% and 60% of the people in developing countries live in illegal settlements, and around 100 million are thought to be homeless. Such conditions leave people constantly exposed to overcrowding, chronic diseases, environmental disasters, evictions and other sudden new threats, undermining progress in human development.

Domestic violence—an often hidden but universal scourge—causes physical and persistent mental suffering, disrupts women's lives and blocks their personal growth and participation in society. In Thailand a study shows that more than 50% of married women living in Bangkok's biggest slum are regularly beaten by their husbands. In Santiago, Chile, 80% of women acknowledged being victims of violence in their homes. Every nine seconds in the United States a woman is physically abused by her partner.

Human poverty and deprivation

Despite the remarkable progress in human development, the backlog of human poverty remains pervasive.

Human poverty, a concept introduced in *Human Development Report 1997,* sees impoverishment as multidimensional. More than a lack of what is necessary for material well-being, poverty can also mean the denial of opportunities and choices most basic to human development. To lead a long, healthy, creative life. To have a decent standard of living. To enjoy dignity, self-esteem, the respect of others and the things that people value in life.

Human poverty thus looks at more than a lack of income. Since income is not the sum total of human lives, the lack of it cannot be the sum total of human deprivation.

Since income is not the sum total of human lives, the lack of it cannot be the sum total of human deprivation

Measuring human poverty in developing countries

Human Development Report 1997 introduced the human poverty index (HPI) in an attempt to bring together in a composite index the different dimensions of deprivation in human life. The HPI provides an aggregate human measure of the prevalence of poverty in a community. It is important to keep in mind that the *concept* of human poverty is much bigger than the *measure,* for it is difficult to reflect all dimensions of human poverty in a single quantifiable composite indicator. Lack of political freedom, lack of personal security, inability to participate freely in the life of a community and threats to sustainability can hardly be measured and quantified. The HPI nonetheless draws attention to deprivations in three essential elements of human life already reflected in the HDI—longevity, knowledge and a decent living standard.

What's the difference between the HDI and the HPI? The HDI measures progress in a community or country as a whole. The HPI measures the extent of deprivation, the proportion of people in the community who are left out of progress.

Estimates of the HPI for developing countries (HPI-1) have been worked out for 77 countries with comparable data (see

TABLE 1.7

Human poverty index (HPI-1) for developing countries

Country	Human poverty index (HPI-1) value (%)	HPI-1 rank	HPI-1 rank minus HDI rank[a]	HPI-1 rank minus $1-a-day poverty rank[a]
Trinidad and Tobago	3.3	1	–4	..
Chile	4.1	2	0	–13
Uruguay	4.1	3	–1	..
Singapore	6.5	4	3	..
Costa Rica	6.6	5	2	–15
Jordan	10.0	6	–15	–1
Mexico	10.7	7	–1	–9
Colombia	11.1	8	–1	–4
Panama	11.1	9	3	–13
Jamaica	11.8	10	–9	0
Thailand	11.9	11	1	7
Mauritius	12.1	12	1	..
Mongolia	14.0	13	–15	..
United Arab Emirates	14.5	14	7	..
Ecuador	15.3	15	1	–16
China	17.1	16	–13	–14
Libyan Arab Jamahiriya	17.4	17	5	..
Dominican Rep.	17.4	18	–4	–7
Philippines	17.7	19	–8	–9
Paraguay	19.1	20	–4	..
Indonesia	20.2	21	–4	1
Sri Lanka	20.6	22	–1	8
Syrian Arab Rep.	20.9	23	7	..
Bolivia	21.6	24	–10	7
Honduras	21.8	25	–10	–16
Iran, Islamic Rep. of	22.2	26	11	..
Peru	23.1	27	7	–16
Tunisia	23.3	28	10	13
Zimbabwe	25.2	29	–13	–10
Lesotho	25.7	30	–16	–16
Viet Nam	26.1	31	–5	..
Nicaragua	26.2	32	–6	–10
Botswana	27.0	33	7	–6
Algeria	27.1	34	17	20
Kenya	27.1	35	–13	–11
Myanmar	27.5	36	–7	..
El Salvador	27.8	37	4	..
Oman	28.9	38	25	..
Guatemala	29.3	39	8	–12
Papua New Guinea	29.8	40	–1	..
Namibia	30.0	41	11	..
Iraq	30.1	42	3	..
Cameroon	30.9	43	–1	..
Congo	31.5	44	4	..
Ghana	31.8	45	0	..
Egypt	34.0	46	14	16
India	35.9	47	–3	–11
Zambia	36.9	48	–7	–14
Lao People's Dem. Rep.	39.4	49	2	..
Togo	39.8	50	–4	..
Tanzania, U. Rep. of	39.8	51	–8	14
Cambodia	39.9	52	1	..
Morocco	40.2	53	16	28
Nigeria	40.5	54	2	8
Central African Rep.	40.7	55	–7	..
Dem. Rep. of the Congo	41.1	56	3	..
Uganda	42.1	57	–10	–2
Sudan	42.5	58	–6	..
Guinea-Bissau	42.9	59	–10	–10
Haiti	44.5	60	–6	..
Bhutan	44.9	61	–2	..
Mauritania	45.9	62	4	8
Pakistan	46.0	63	14	24
Côte d'Ivoire	46.4	64	7	20
Bangladesh	46.5	65	9	15
Madagascar	47.7	66	5	–3
Malawi	47.7	67	–1	9
Mozambique	48.5	68	–2	..
Senegal	48.6	69	4	1
Yemen	48.9	70	10	..
Guinea	49.1	71	0	21
Burundi	49.5	72	–1	..
Mali	52.8	73	–1	..
Ethiopia	55.5	74	2	15
Sierra Leone	58.2	75	–2	..
Burkina Faso	58.2	76	1	..
Niger	62.1	77	1	3

Note: HDI and $1-a-day poverty ranks have been recalculated for the universe of 77 countries.

a. A negative figure indicates that the HPI-1 rank is better than the other, a positive the opposite.

Source: Human Development Report Office.

technical note 2). The HPI-1 value reflects the proportion of people affected by the three key deprivations—providing a comparative measure of the prevalence of human poverty. Here's what the HPI-1 reveals (table 1.7):

- The HPI-1 ranges from 3% in Trinidad and Tobago to 62% in Niger.
- Other countries with an HPI-1 of less than 10% are Chile, Uruguay, Singapore and Costa Rica.
- The HPI-1 exceeds 50% in Mali, Ethiopia, Sierra Leone, Burkina Faso and Niger.
- The HPI-1 exceeds 33% in 32 countries, implying that an average of at least a third of the people in these countries suffer from human poverty.

A comparison of HDI and HPI-1 values shows how well—or poorly—the average achievements in a country are distributed. China and Egypt have similar levels of overall human development, but the HPI-1 for China is only 17%, while that for Egypt is 34%. Similarly, Kenya and Pakistan are at par in the HDI, but the HPI-1 for Kenya is less than 30% and that for Pakistan is more than 45%. This reveals that the fruits of

human development are distributed more inequitably in Egypt and Pakistan than in China and Kenya.

The HPI-1 also reveals deprivation that would be masked in the income measure of poverty. Egypt and Pakistan have reduced their income poverty to less than 15%. But human poverty in these countries remains much higher, at 34% and 46%. The HPI-1 also shows progress masked by the income measure of poverty. In Zimbabwe and Nicaragua, for example, income poverty is severe, at nearly 50%. But these countries have made much more progress in reducing human poverty, achieving HPI-1 values of 25% and 26%.

Measuring human poverty in industrial countries

Poverty and deprivation are not only a problem of the developing countries.

- On the basis of an income poverty line of 50% of the median personal disposable income, more than 100 million people are income-poor in OECD countries.
- At least 37 million people are without jobs in OECD countries, often deprived of adequate income and left with a sense of social exclusion from not participating in the life of their communities.
- Unemployment among youth (age 15–24) has reached staggering heights, with 32% of young women and 22% of young men in France unemployed, 39% and 30% in Italy and 49% and 36% in Spain.
- About 8% of the children in OECD countries—including half or more of children of single parents in Australia, Canada, the United Kingdom and the United States—live below the income poverty line of 50% of median disposable personal income.
- Nearly 200 million people are not expected to survive to age 60.
- More than 100 million are homeless, a shockingly high number amid the affluence.

To capture the multiple dimensions of poverty in a composite measure, an HPI for industrial countries (HPI-2) is introduced here, focusing on deprivation in the same three dimensions of human life as the HPI-1, but replacing the measures with ones that better reflect social and economic conditions in these countries. And it adds a fourth dimension—social exclusion—for which the HPI-1 does not include a quantitative measure because no reliable data could be found. For industrial countries appropriate data are available.

The nature of deprivation in human life varies with the social and economic conditions of a community or country. Studies of poverty in the developing countries—with low levels of resources and human development—focus on hunger, epidemics, illiteracy and lack of health services and safe water. These issues are less dominant in industrial countries, where hunger is not as pervasive, primary schooling is nearly universal, most epidemics are well controlled, health services are typically widespread and safe water is easily available. Not surprisingly, typical studies of poverty in the more affluent countries concentrate on social exclusion, a complex and persistent deprivation difficult to eliminate in all countries, industrial and developing alike.

Poverty and deprivation are also major problems in industrial countries

Although the dimensions used in the HPI-1, for developing countries, are equally relevant to industrial countries, the indicators used are not. A second index is needed, using indicators that reflect the way poverty is manifested in industrial countries.

The HPI-2 comprises:

- Deprivation in survival, measured by the percentage of the population likely to die before age 60.
- Deprivation in knowledge, measured by the percentage of the population functionally illiterate—lacking an ability to read and write adequate for the most basic demands of modern society, such as reading instructions on a medicine bottle or reading stories to children.
- Deprivation in economic provisioning, measured by the proportion of people whose disposable personal income is less than 50% of the median, leaving them unable to achieve the standard of living necessary to avoid hardship and to participate in the life of the community.
- Social exclusion, measured by one of its most critical aspects—the percentage of long-term unemployed (those out of work 12 months or more) in the total labour force.

The HPI-2 uses the same measures as the HPI-1 for survival and knowledge,

applying a higher cut-off point. For economic provisioning and exclusion, new measures are used. These require explanation.

Social exclusion takes many forms, varies considerably from one community to another and is difficult to measure. But long-term unemployment, which is consistently monitored in most industrial countries, is a suitable proxy for exclusion. It reflects exclusion from the world of work and the social interaction associated with employment, which is an important part of social exclusion in most communities.

For economic provisioning the HPI-1 uses a combination of malnourishment and lack of access to water and health services, while the HPI-2 uses a headcount measure of income poverty. These divergent approaches were followed for three reasons.

First, the HPI-1 incorporates economic provisioning from both public and private income. Public provisioning is an important source of consumption for poor households, and key deprivations in this area are captured in lack of access to such services as health care and water. Deprivation in private provisioning focuses on food consumption, since by far the largest proportion of personal incomes of the poorest households in the poorest countries goes to food—more than 50%, sometimes more than 80%. For the HPI-2 these would not have been the most suitable measures because in industrial countries food is not the principal component of private income and because most people already have access to such basic public services as water.

Second, deprivation in income is a more appropriate measure for industrial countries because it reflects deprivation in the material means that people require. But the use of a single international poverty line can be misleading—because of variations in what are defined as "essential" commodities. Differences in the prevailing patterns of consumption—of clothing, housing and such means of communication as radios, televisions and telephones—mean that

TABLE 1.8
Human poverty index (HPI-2) for industrial countries

Countries	DEPRIVATION IN SURVIVAL: People not expected to survive to age 60 (%) 1995	DEPRIVATION IN KNOWLEDGE: People who are functionally illiterate[a] (% age 16–65) 1995	DEPRIVATION IN INCOME: Population below the income poverty line[b] (%) 1990	SOCIAL EXCLUSION: Long-term unemployment, 12 months or more (as % of total labour force) 1995[c]	HUMAN POVERTY INDEX: Human poverty index (HPI-2) for industrial countries — Value (%)	HPI-2 rank	Real GDP per capita (PPP$) rank
Sweden	8	7.5	6.7	1.5	6.8	1	13
Netherlands	9	10.5	6.7	3.2	8.2	2	10
Germany	11	14.4	5.9	4.0	10.5	3	8
Norway	9	—[d]	6.6	1.3	11.3	4	2
Italy	9	—[d]	6.5	7.6	11.6	5	9
Finland	11	—[d]	6.2	6.1	11.8	6	14
France	11	—[d]	7.5	4.9	11.8	7	7
Japan	8	—[d]	11.8	0.6	12.0	8	4
Denmark	12	—[d]	7.5	2.0	12.0	9	3
Canada	9	16.6	11.7	1.3	12.0	10	5
Belgium	10	18.4[e]	5.5	6.2	12.4	11	6
Australia	9	17.0	12.9	2.6	12.5	12	11
New Zealand	10	18.4	9.2[f]	1.3	12.6	13	16
Spain	10	—[d]	10.4	13.0	13.1	14	17
United Kingdom	9	21.8	13.5	3.8	15.0	15	12
Ireland	9	22.6	11.1	7.6	15.2	16	15
United States	13	20.7	19.1	0.5	16.5	17	1

a. Based on prose level 1, as reported in the International Adult Literacy Survey (IALS). Data are for 1995 or a year around 1995.
b. Poverty is measured at 50% of the median disposable personal income. Data are for 1990 or a year around 1990.
c. Standardized unemployment rates calculated by the International Labour Organisation.
d. No data available. For calculating the HPI-2 value, the average of 16.8% of all countries (except Poland) included in the International Adult Literacy Survey has been used.
e. Data refer to Flanders.
f. The unweighted average of the industrial countries (excluding Eastern Europe and CIS).
Source: column 1: UN 1994e; *column 2:* OECD, Human Resource Development Canada and Statistics Canada 1997; *column 3:* Smeeding 1997; *column 4:* OECD 1997d.

many goods considered essential for social participation in one community might not be seen as essential in another. Thus the minimum income needed to avoid social exclusion can be quite different across countries. For this reason 50% of the country's median personal disposable income was used as the poverty line, reflecting what is appropriate for each country. Moreover, this measure of income poverty is now the standard used in the European Union for making international comparisons.

Third, data availability and quality are an important concern. Income poverty data are available for only 48 developing countries and rely on many estimates. Data on malnourishment and access to public services have broader coverage. In industrial countries comparable data on income poverty are available.

What does the HPI-2 reveal?

Among 17 industrial countries Sweden has the lowest incidence of human poverty as measured by the HPI-2, with 6.8%, followed by the Netherlands and Germany (table 1.8). The countries with the most poverty are the United States, with 16.5%, followed by Ireland and the United Kingdom at 15.2% and 15%.

The extent of human poverty has little to do with the average level of income. The United States, with the highest per capita income measured in purchasing power parity (PPP) among the 17 countries, also has the highest human poverty. Sweden ranks first in the HPI-2, with the least poverty, but only 13th in average income. And the Netherlands and the United Kingdom have similar average incomes but very different human poverty levels, at 8.2% and 15%. One might expect that the higher a country's GDP, the fewer poor people there would be. But comparing GDP per capita with the HPI-2 suggests the opposite: poverty rates in higher-income countries are the same as—or higher than—rates in lower-income industrial countries (figure 1.6).

The level of the HPI-2 does not correlate with the overall human development achieved by a country. All 17 countries ranked on the HPI-2 have reached high levels of human development, with HDI values of more than 0.900. But the top HDI countries—Canada and France—have significant problems of poverty, and their progress in human development has been poorly distributed. Canada ranks tenth in the HPI-2 because 17% of its people lack adequate literacy skills, more than twice the proportion in Sweden (figure 1.7).

Human poverty is deprivation in multiple dimensions, not just income. Industrial countries need to monitor poverty in all its dimensions—not just income and unemployment, but also lack of basic capabilities such as health and literacy, important factors in whether a person is included in or excluded from the life of a community.

Human poverty is one side of the story of the backlog of human deprivation. The other side is persisting disparities—often the result of uneven progress in human development, but reinforced by the backlog of human poverty.

Persisting disparities

The inequalities that persist between poor people and rich, women and men, rural and urban, and among different ethnic groups are seldom isolated—instead, they are interrelated and overlapping.

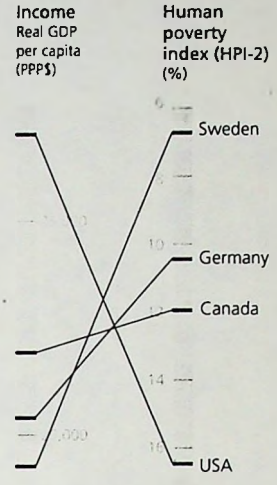
Income and wealth—stark inequality

In 1960 the 20% of the world's people who live in the richest countries had 30 times the income of the poorest 20%—by 1995 82 times as much income. Consider the extraordinary concentration of wealth among a small group of the ultra-rich (box 1.3).

Disparities are just as stark within countries. In Brazil the poorest 50% of the population received 18% of national income in 1960, falling to 11.6% in 1995. The richest 10% received 54% of national income in 1960, rising to 63% in 1995. In Costa Rica during the 1980s the richest 20% enjoyed a per capita income of PPP$14,400, while the poorest 20% had an average income of PPP$1,340.

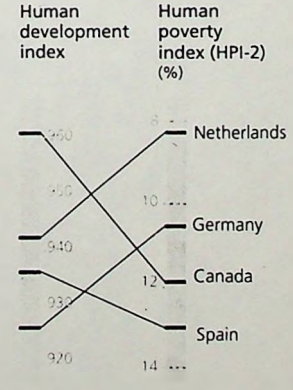
Income distribution in industrial countries also shows wide disparities between rich and poor. In the worst case, Russia, the

FIGURE 1.6
Incomes do not predict poverty levels



Source: Human Development Report Office.

FIGURE 1.7
No pattern between the HDI and human poverty



Source: Human Development Report Office.

households are malnourished. In Côte d'Ivoire research shows that doubling the income under women's control would lead to a 2% rise in the share of the budget for food—and a 26% decline in the share for alcohol, 14% for cigarettes. And a study in Guatemala shows improvements in children's nutritional status when the mother earns a higher share of the income.

Intrahousehold resource allocation shows bias not only by gender, but also by age and by sibling hierarchy. The point: intrahousehold power relations determine claims to consumption. The policy implication: assuming that equity reigns in the household is unrealistic, and policies that target household heads may well be ineffective. Food stamps and assistance to women, for example, are likely to be more effective in securing household food security than are income subsidies for the entire household.

Unequal claims on time restrict consumption choices. Consumption requires time, and each day's 24 hours need to accommodate a variety of consumption objectives. Everyone has those same 24 hours—but gender and differences in access to amenities and resources determine how much time is available—and how much is required—to meet a consumption objective. Just as food takes up the most resources for the poorest families in poor countries, walking—especially to collect firewood and water—takes up the most time resources for poor households, both urban and rural. As recent studies attest, time is the critical constraint people face in meeting all their needs—and in lifting themselves out of poverty.

A study in Ghana shows that a farmer spends 43 minutes a day collecting firewood, 25 minutes collecting water, 48 minutes walking to the farm, 28 minutes to reach the grinding mill and 2 hours and 8 minutes walking to the market—a total of almost five hours. So much time spent walking leaves little time for activities that might enhance health, knowledge and productivity, such as improving care of children and of the aged, improving cultivation of crops and preparing better food.

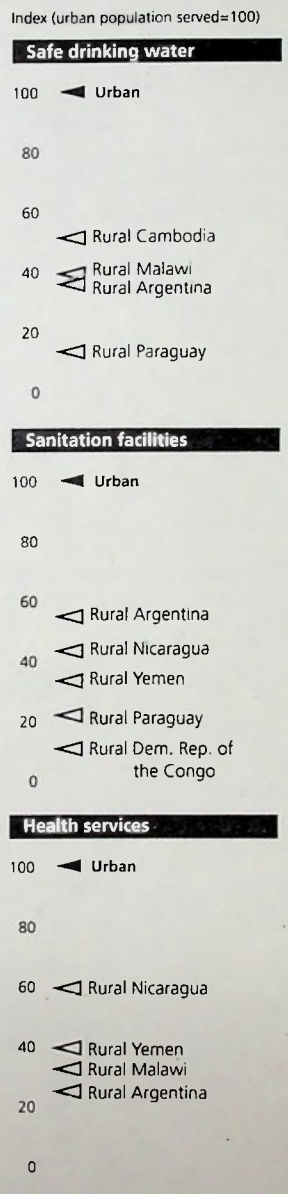
The time spent working is unequally distributed—with women spending much more time than men in work—paid and unpaid—in virtually every society for which time use studies exist. As *Human Development Report 1995* documented, women take on a larger share of the work—53% on average in developing countries, and 51% in industrial. But the disparities are particularly marked in rural areas of developing countries, where women's work burden is significantly larger than men's—35% more in Kenya, 21% in the Philippines, 17% in Guatemala (figure 3.5). In most industrial countries the disparity is less—but women still take on 28% more in Italy, 11% more in France and 6% more in the United States. A study of rural areas in the United Republic of Tanzania shows able-bodied women carrying 86 ton-kilometres a year, compared with only 11 ton-kilometres for able-bodied men. Women in these areas spend 1,842 hours a year walking—to markets, to fields, to fetch water—but men only 492 hours (figure 3.6).

Policies for securing basic consumption needs

Securing entitlements for all people to the basic essentials has long been an international commitment. The Universal Declaration of Human Rights set the objective 50 years ago: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services." In any country's poverty eradication strategy meeting basic consumption requirements should be an important goal.

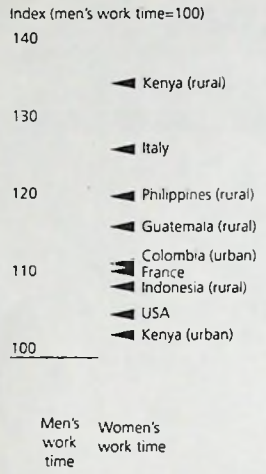
Such an objective would make a substantial difference in many sectoral policies. Transport and energy investments are considered primarily as "economic infrastructure" driven by the goal of economic growth rather than the needs of people for mobility and communications. Construction of walkways and bicycle lanes in cities receives little public attention—even though walking is how most people get about, and cycling is the first accessible improvement over walking. More equitable access to such

FIGURE 3.4
Rural populations are poorly served by public provisioning



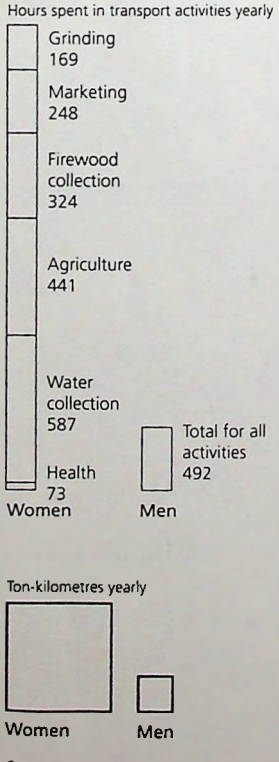
Source: UNICEF 1997.

FIGURE 3.5
Women work longer than men



Source: UNDP 1995a.

FIGURE 3.6
Rural transport activities in the United Republic of Tanzania—who carries the load?



Source: Howe 1998.

public infrastructure as clean water, energy, roads and public transport is a key criterion for assessing the performance of a state in democratic governance.

Housing also receives little public attention and is generally left to the private sector. But with the pace of urbanization outstripping the development of sites and services, families have little option but to resort to squatter settlements, where they face the constant threat of eviction. Singapore, in its vision of development and poverty elimination in the early 1960s, had explicit goals to meet needs for housing, transport and a clean environment in addition to schooling and health (box 3.1).

Achieving equitable access—through public investments, fair pricing of services and an enabling environment for private investment—should be a public policy goal in each sector in each country. The post-apartheid government in South Africa has articulated a comprehensive policy for assuring equitable access to basic services (box 3.2).

Rising consumption puts stress on the environment

Almost any human consumption activity produces environmental impacts throughout the life cycle of the product—from production to consumption to waste disposal. The impacts:

- Depletion of the stock of non-renewable resources (like metals and minerals).
- Mismanagement of renewable resources, leading to depletion and degradation—such as overfishing, overexploiting forests, overexploiting groundwater and exposing soils to erosion.
- Emissions of pollutants that create an unhealthy environment: cigarette smoke filling a room, traffic fumes hanging over a city, industrial effluents choking river life.
- Generation of pollution and waste beyond the sink capacity—the earth's capacity to absorb them—both locally and globally. Toxic waste builds up in landfills, and pollution from oil-burning industries releases carbon dioxide (CO_2), causing global warming.

The unprecedented growth in world consumption is leading to environmental stress through impacts that are both global and local. What are the principal environmental problems affecting human development? Contrary to the fears of the 1960s and 1970s, the problem is not the scarcity of non-renewables, such as metals and minerals. Quite the opposite. There is no immediate shortage, prices for these resources have been falling, and demand is depressed. Consumption of ores and minerals as a proportion of reserves has actually declined with the discovery of new reserves. Far more urgent: the scarcity of renewable resources and the generation of emissions and waste that exceed the sink capacity.

The crisis of renewable resources

The world is facing a growing scarcity of renewable resources essential for sustaining the ecosystem and for human survival—from deforestation, soil erosion, water depletion, declining fish stocks and lost biodiversity.

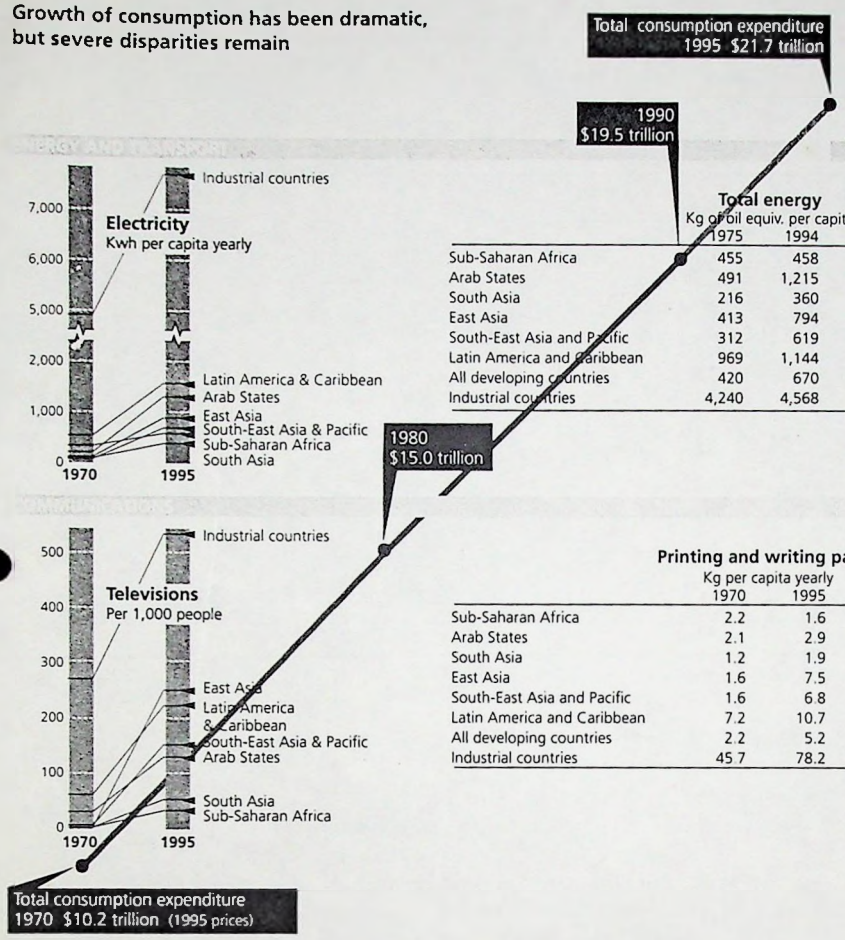
Deforestation. Since 1970 the world's wooded area has fallen from 11.4 square kilometres per 1,000 inhabitants to 7.3. Only 40 years ago most deforestation was in the industrial countries. Now it is concentrated in the developing world. Over the past decade at least 154 million hectares of tropical forest—three times the area of France—have been cut, and every year an area the size of Uruguay is lost. Latin America and the Caribbean fell 7 million hectares a year, and Asia and Sub-Saharan Africa 4 million each. These estimates tell only part of the story, for they count only land that has lost more than 90% of its forest cover—only a quarter of Africa's loss in the 1980s. Despite rapidly growing global demand for timber, the lost stocks are not being replenished. Worldwide, only 1 hectare of tropical forest is replanted for every 6 cut down—in Africa, 1 for every 32. India, a notable exception, now plants 4 hectares for every 1 felled.

Deforestation has many human and environmental consequences, from scarcity

COM H-70.

FIGURE 3.1

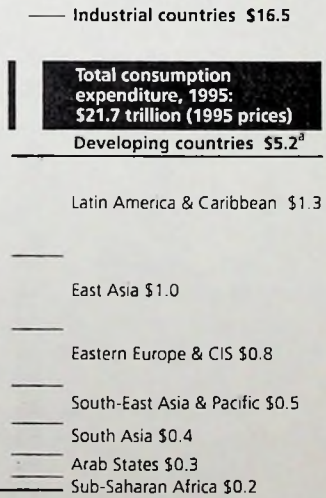
Growth of consumption has been dramatic, but severe disparities remain



	Total energy Kg of oil equiv. per capita 1975	1994	Cars Per 1,000 people 1975	1993	Petrol Kg per capita 1970	1995
Sub-Saharan Africa	455	458	..	11	22	27
Arab States	491	1,215	16	42	32	113
South Asia	216	360	2	5	5	10
East Asia	413	794	1	6	5	29
South-East Asia and Pacific	312	619	7	18	19	39
Latin America and Caribbean	969	1,144	40	61	99	152
All developing countries	420	670	8	16	21	43
Industrial countries	4,240	4,568	289	405	554	500

	Printing and writing paper Kg per capita yearly 1970	1995	Telephones Per 1,000 people 1975	1995
Sub-Saharan Africa	2.2	1.6	6	12
Arab States	2.1	2.9	8	49
South Asia	1.2	1.9	2	16
East Asia	1.6	7.5	4	49
South-East Asia and Pacific	1.6	6.8	3	29
Latin America and Caribbean	7.2	10.7	34	86
All developing countries	2.2	5.2	8	39
Industrial countries	45.7	78.2	178	414

	Calories per capita per day 1970	1995
Sub-Saharan Africa	2,225	2,237
Arab States	2,206	2,903
South Asia	2,094	2,385
East Asia	2,041	2,717
South-East Asia and Pacific	1,957	2,533
Latin America and Caribbean	2,491	2,781
All developing countries	2,131	2,572
Industrial countries	3,016	3,157



Total consumption expenditure (US$ trillions; 1995 prices)	1970	1980	1990	1995
Industrial countries	8.3	11.4	15.2	16.5
Developing countries	1.9	3.6	4.3	5.2

Note: Eastern Europe and the CIS countries are not included among industrial countries.

a. Developing country total includes countries not in regional aggregates.

Source: FAO 1997b and 1998; ITU 1997b; UN 1996c and 1997b, UNESCO 1997d; World Bank 1997d.

TABLE 3.1
Long-term trends in private consumption of selected items, by region

Item	Year	World	Industrial countries	Developing countries	Sub-Saharan Africa	Arab States	East Asia	South-East Asia and the Pacific	South Asia	Latin America and the Caribbean
Meat (millions of tons)	1970	87	57	29	3	2	8	3	3	10
	1995	199	95	103	6	5	53	8	8	23
Cereals (millions of tons)	1970	473	91	382	27	20	142	41	112	33
	1995	866	160	706	56	49	236	82	212	57
Total energy (millions of tons of oil equivalent)	1975	5,575	4,338	1,237	139	67	407	102	180	306
	1994	8,504	5,611	2,893	241	287	1,019	296	457	531
Electricity (billions of kilowatt-hours)	1980	6,286	5,026	1,260	147	98	390	73	161	364
	1995	12,875	9,300	3,575	255	327	1,284	278	576	772
Petrol (millions of tons)	1980	551	455	96	10	12	11	8	6	48
	1995	771	582	188	15	27	38	19	13	72
Cars (millions)	1975	249	228	21	3	2	0.5	2	2	12
	1993	456	390	65	5	10	7	7	6	27
Bicycles produced (millions)	1970	36	..	..	..	..	..	..	..	..
	1995	109	..	..	..	..	..	..	..	..
McDonald's restaurants	1991	12,418	11,970	448	0	0	123	113	0	212
	1996	21,022	19,198	1,824	17	69	489	409	3	837

Source: FAO 1998; McDonald's Corporation 1997; UN 1996a, 1996c and 1997b.

more than 20% refrigerators. Households owning a sewing machine increased from 39% to 64% in 1988–94, and those owning televisions from 31% to 57%. The upsurge in purchases of consumer durables and products reached even the 90 million lowest-income households in India. Although two-thirds of them had incomes below the official poverty line, more than 50% owned wrist watches, 41% bicycles, 31% transistor radios and 13% fans.

So, there have been many achievements in consumption that are propelling human development. But the current patterns and growth of consumption raise problems:

- The expansion of consumption is badly distributed, with about a fifth of the world's people left out.
- Consumption growth and patterns are environmentally damaging. Thus the consumption of some harms the well-being of others, in both present and future generations.
- Consumption growth and patterns have social impacts that deepen inequalities and social exclusion.
- Consumer rights to information and product safety are difficult to defend in the context of the global consumer market.

Consumption shortfalls and poverty

The poor distribution of the growth of global consumption has left an enormous backlog of shortfalls in areas of consumption essential to human development.

Although consumption is an essential means to human development, not all consumption has the same value. We focus here on those areas of consumption that are most essential to achieving basic capabilities to live long, healthy and creative lives and to enjoy a decent standard of living. These include such basics as food, shelter, clean water, schooling, health care, energy and transport as well as means of communication and freedom of creative and cultural expression (figures 3.1 and 3.2).

Uneven growth and increasing inequalities

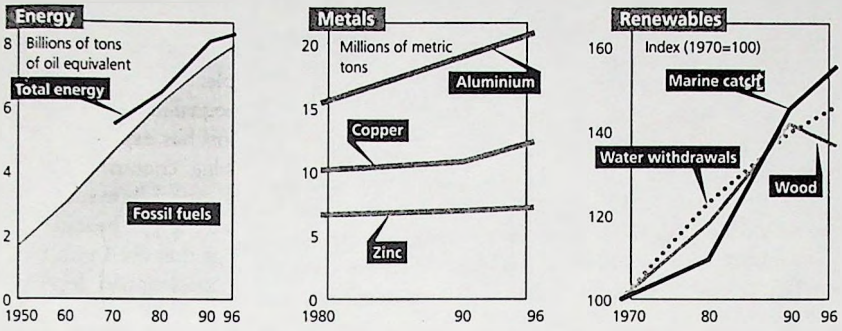
Global consumption expenditure, private and public, has grown an average 3% a year since 1970. But this overall figure masks enormous disparities in growth that have widened inequalities.

In low-income countries (except China and India) private consumption expenditure per capita has declined by about 1%

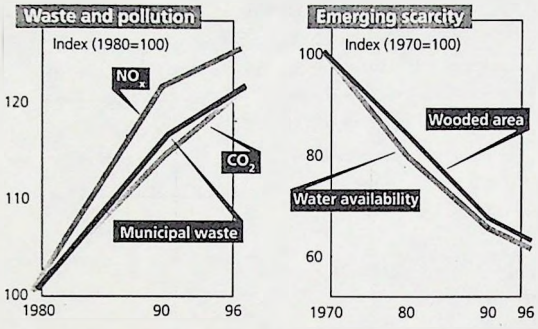
FIGURE 3.2

The environmental cost is also growing, and many basic deprivations remain

STEADY GROWTH IN CONSUMPTION



ENVIRONMENTAL COST



LOSS OF BIODIVERSITY

- About 12% of mammal species, 11% of bird species and almost 4% of fish and reptile species are classified as threatened.
- Between 5% and 10% of the world's coral reefs and half the world's mangroves have been destroyed.
- About 34% of the world's coasts are at high potential risk of degradation, and another 17% are at moderate risk.

DECLINING FISH STOCK

- About 25% of fish stocks for which data are available are either depleted or in danger of depletion, and another 44% are being fished at their biological limit.

SOIL DEPLETION

- Nine million hectares are extremely degraded, with their original biotic functions fully destroyed, and 10% of the earth's surface is at least moderately degraded.

BASIC CAPABILITIES, CONSUMPTION REQUIREMENTS AND DEPRIVATION

Long, healthy life
(freedom from premature mortality and avoidable morbidity)

Requirement	*Backlog of deprivation*
Clean water	1.3 billion deprived of access to safe water
Shelter	1 billion without adequate shelter
Food and nutrition	841 million malnourished
Health care	880 million without access to health services
Sanitation	2.6 billion without access to sanitation
Energy	2 billion deprived of electricity
Transport	3 cars per 1,000 people in least developed countries, 16 in developing countries, 405 in industrial countries

Knowledge
(freedom from illiteracy, innumeracy and lack of acquired basic skills)

Requirement	*Backlog of deprivation*
Schooling	109 million (22% of primary-school-age children) out of school
Information	885 million illiterate adults (age 15 and above)
	4 copies of daily newspapers circulated per 100 people in developing countries, 26 in industrial countries
Communication	3 telephone lines per 1,000 people in least developed countries, 40 in developing countries, 414 in industrial countries

Decent standard of living well distributed among members of society

Requirement	*Backlog of deprivation*
Secure access to material resources	1.3 billion people in developing countries living on less than $1 a day, 32% in transition economies on less than $4 a day and 11% in industrial countries on less than $14.40 a day

Creative life

Requirement	*Backlog of deprivation*
Culture—language, arts, traditions, philosophy	3,000 of the world's 6,000 languages endangered
Freedom from political and civil constraints	13.2 million refugees
Freedom from time constraints	6–8 hours a day spent by rural women in developing countries in fetching fuelwood and water

Source: CDIAC 1996; FAO 1995, 1996b and 1997c; ITU 1997b; OECD 1997e; Shiklomanov 1996; UN 1996b and 1996c; UNESCO 1997d; World Bureau of Metal Statistics 1996; Worldwatch Institute 1997b; WRI 1994 and 1996a.

TABLE 3.2A
Inequalities in consumption: the world's highest and lowest consumers

Telephone services, 1995

Top 5 countries	Lines per 1,000 people
Sweden	681
USA	626
Denmark	613
Switzerland	613
Canada	590

Bottom 5 countries	Lines per 1,000 people
Cambodia	1
Dem. Rep. of the Congo	1
Chad	1
Afghanistan	1
Niger	2

Meat consumption, 1995

Top 5 countries	Kilograms per capita a year
USA	119
New Zealand	119
Cyprus	108
Australia	107
Austria	105

Bottom 5 countries	Kilograms per capita a year
Bangladesh	3
Guinea	4
Malawi	4
Burundi	4
India	4

Source: FAO 1998; ITU 1997b.

annually over the past 15 years. Both public and private consumption per capita are about 20% lower in Africa today than in 1980.

For the world, average per capita food consumption rose dramatically in the past 25 years. The developing country average—only 2,131 calories per person in 1970, well below the minimum requirement of 2,300 calories—is now 2,572 per person, well above the minimum. But in Sub-Saharan Africa it rose only from 2,225 calories to 2,237. As a result Sub-Saharan Africa was the only region not to see a steady decline in malnutrition: the number of undernourished people more than doubled, from 103 million in 1970 to 215 million in 1990.

Inequalities in consumption patterns and levels are huge (see figure 3.1; tables 3.2a and 3.2b):

- Per capita private consumption expenditure is $15,910 (1995 prices) in industrial countries (excluding Eastern Europe and the CIS), but $275 in South Asia and $340 in Sub-Saharan Africa. And public consumption per capita is $3,985 in industrial countries, but $183 in developing countries.
- Industrial countries, with 15% of the world population, account for 76% of global consumption expenditure. Allowing for differences in purchasing power (using a $PPP measure) would moderate some of these consumption expenditure gaps—however the gaps are still very wide.
- The fifth of the world's people who live in the highest-income countries consume 58% of the world's energy, 65% of electricity, 87% of cars, 74% of telephones, 46% of meat and 84% of paper—86% of total expenditure. In each of these areas the share of the bottom fifth, in the lowest-income countries, is less than 10%.
- The average protein consumption per person is 115 grams a day in France, but only 32 grams in Mozambique. And while annual energy consumption per person is more than 4,500 kilograms of oil equivalent in industrial countries, it is less than a tenth of that in South Asia (300 kilograms).
- For the world the average number of cars per 1,000 people is 90—but it is 405 in industrial countries, only 11 in Sub-Saharan Africa, 6 in East Asia and 5 in South Asia.
- More than 600 telephone lines serve every 1,000 people in such countries as Sweden, the United States and Switzerland, but in Cambodia, Democratic Republic of the Congo, Chad and many other developing countries there is only one line per 1,000 people.

These huge inequalities remain even though consumption has expanded more rapidly in developing countries than in industrial countries, especially in such basic essentials as food and energy. The initial disparities were so large that even with spectacular increases, consumption levels in developing countries have not caught up with those in industrial countries.

- Per capita petrol consumption has increased sixfold in East Asia and ninefold in South Asia since 1950. But while it averages 500 kilograms per capita a year in industrial countries, it is still only 29 kilograms in East Asia and 10 in South Asia.
- Total meat consumption has risen more than fivefold in East Asia since 1970 but is still only 41 kilograms per capita a year, compared with 77 kilograms in industrial countries.

Pervasive consumption shortfalls

Of the 4.4 billion people in developing countries, nearly three-fifths lack access to sanitation, a third have no access to clean water, a quarter do not have adequate housing and a fifth have no access to modern health services of any kind (see figure 3.2). A fifth of primary-school-age children are out of school. About a fifth do not have enough dietary energy and protein, and micronutrient deficiencies are even more widespread—with 3.6 billion suffering iron deficiency, 2 billion of whom are anaemic. This, despite poor households spending at least half their incomes on food (table 3.3). And 2 billion people lack access to commercial energy such as electricity.

These consumption shortfalls hold back human development and lead to human poverty. About 17 million people in developing countries die each year from such curable infectious and parasitic diseases as diarrhoea, measles, malaria and tuberculosis. Micronutrient deficiencies reduce physical

strength, intellectual functioning and resistance to disease. Malnourished mothers pass these deficiencies on to their children, making them less alert at school and more prone to sickness. More than 850 million people in developing countries are illiterate, excluded from a wide range of information and knowledge. And in this day of ever-expanding global communications and networking, the poor in developing countries are isolated—economically, socially and culturally—from the burgeoning information and progress in the arts, sciences and technology.

Shortfalls in essential consumption are not just a problem of poor countries. In industrial countries too, many cannot meet their basic needs and the life choices of millions are limited. The United States may have among the highest levels of per capita food consumption in the world—fourth in calorie intake—yet 30 million of its people, including 13 million children under 12, are hungry because of difficulty getting the food they need. In Canada 2.5 million people (9% of the population) received food assistance in 1994—and in the United Kingdom more than 1.5 million families could not afford an adequate diet in 1994. Remarkably, iron deficiency anaemia affects 55 million people in industrial countries.

In Eastern Europe and the CIS the process of transition gave rise to many consumption shortfalls. Malnutrition rose to levels similar to those in many low-income countries. In Russia stunting affected 15% of children two years of age in 1994. In Romania the share of infants who were underweight at birth increased to 10% in 1993, and in Bulgaria in 1991, 17% of children aged three to six were undernourished.

Constraints to meeting basic needs

These inequalities and shortfalls in basic consumption reflect the unequal distribution of income and assets and the uneven rate of economic growth—globally and nationally. About 1.3 billion people still live on less than $1 a day (1985 PPP$), and almost 3 billion on less than $2 a day. In recent decades economic growth has been both qualitatively and quantitatively inadequate. In about 100 countries incomes today are lower in real terms than they were a decade or more ago. These issues are analysed in detail in *Human Development Report 1996* (on economic growth) and *Human Development Report 1997* (on poverty).

Apart from the basic constraints of income and economic growth, several other constraints limit poor people's options for meeting their basic needs: lack of access to public provisions, failure of the market to supply poor people's goods, intrahousehold power relations and the enormous amounts of time the poor must spend walking and carrying.

Public provisioning of basic social services is inadequate—and access is inequitable. Many essentials—schooling, transport, modern energy, health facilities—are provided publicly. For low-income groups public provisioning is often an important source for consumption. Yet the poor suffer consumption shortfalls because they lack access—to water supply, modern energy, sanitation, health, education, public transport and road infrastructure. Access is often highly inequitable, favouring high-income

TABLE 3.2B
Inequalities in consumption: the world's highest and lowest consumers

Private and public health expenditure, 1990

Top 5 countries	Expenditure per capita (US$)
USA	2,765
Switzerland	2,520
Sweden	2,343
Finland	2,046
Canada	1,945

Bottom 5 countries	Expenditure per capita (US$)
Viet Nam	3
Sierra Leone	4
Tanzania, U. Rep. of	4
Lao People's Dem. Rep.	5
Mozambique	5

Public expenditure on education (preprimary, first and second levels), 1992

Top 5 countries	Expenditure per pupil (US$)
Luxembourg	15,514
Finland	11,720
USA	11,329
Austria	9,065
Belgium	8,143

Bottom 5 countries	Expenditure per pupil (US$)
Sri Lanka	38
Nepal	44
Mozambique	46
China	57
Madagascar	60

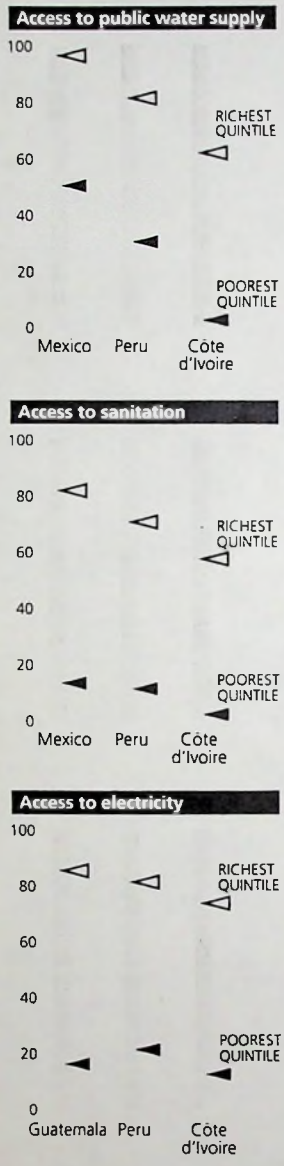
Source WHO 1995b, UNESCO 1995.

TABLE 3.3
The lower the household income, the larger the share spent on food and energy, the smaller the share spent on transport, health and education
(as a percentage of household expenditure)

	Lowest income quintile					Highest income quintile				
Country	Food	Energy	Transport	Health	Education	Food	Energy	Transport	Health	Education
Sierra Leone	67.9	6.6	1.9	2.7	1.8	53.9	3.3	8.9	4.7	3.2
Costa Rica	54.4	9.4	4.2	2.1	0.7	29.1	7.5	19.5	4.8	1.0
Thailand	52.8	5.0	3.8	2.6	1.2	25.2	2.9	20.3	3.9	2.1
Jordan	43.4	7.6	3.5	2.4	1.3	32.1	4.1	16.8	2.0	4.7

Note: Data are from household surveys conducted in 1987–94.
Source: Sierra Leone, Central Statistics Office 1993; Costa Rica, General Office of Statistics 1988; Thailand, National Statistical Office 1995; Jordan, Department of Statistics 1993.

FIGURE 3.3
Public provisioning is not equitable provisioning
Percentage of population quintile with access to public goods and services



Source: World Bank 1994.

groups and leaving the poor with little or without (figure 3.3). Access also heavily favours urban communities, leaving great deprivation in rural areas (figure 3.4). In Brazil disparities in access due to regional inequalities are marked: in the Central West region 98% of children aged 7–14 are enrolled in school, while in the lower-income North-East region 50% of children are not enrolled.

Even when the poor have access, pricing can undercut them. In Lima a poor family pays more than 20 times what a middle-class family pays for water. Unregulated water markets in the Indian state of Tamil Nadu lead to grotesque inequities: tubewell owners pump groundwater, often using subsidized electricity, and sell it to intermediaries, who then sell it to poor households. The mark-up can be 1,000%!

The increasing "marketization" of education and health services—with growing use of private facilities and private tutors, often accompanied by declining quality in public services—has added to disparities. In Egypt access to basic education has improved, but public spending on education per student has declined. In 1991 non-personnel expenditures were a fifth of what they had been 10 years before. To make up for the declining quality, middle-class parents send their children to fee-charging private schools, which are expanding rapidly.

Supplies of poor people's goods in the market are inadequate. Often, the goods most needed for human development—goods that are affordable for the poor, that meet basic needs, that are environmentally friendly, that create productive work for the needy—are not available in the market. Market incentives for innovation are much stronger for rich people's goods than for poor people's—because profits are larger. The incentives are also stronger for environmentally destructive goods than for environmentally friendly goods—because production costs are lower. And they are stronger for socially negative than for socially positive goods—again, because production costs are lower.

Provision of the goods essential for human development requires technological innovation and product development. Public investment has driven much of the progress in increasing the availability of such goods—oral rehydration salts, seeds of high-yielding varieties of rice, wheat and maize and many other products that have led to better health, improved food security and a cleaner environment.

New incentives are needed to accelerate the provision of poor people's goods—starting with pricing incentives, especially the removal of perverse subsidies, and support for technological development.

Intrahousehold power relations lead to inequitable access and consumption. Households are often assumed to be harmonious units of cooperation, and public policies often target the household as the beneficiary of assistance. But gender research consistently reveals flaws in this assumption. In reality power relations in households often favour boys over girls, and young adults over the aged—in nutrition, education and many other resources. Research shows evidence of boys receiving more food than girls in regions of India and Pakistan. Gender gaps in schooling may be narrowing in all regions of the world, but enrolment of girls still falls short of that of boys in developing countries as a whole—girls' enrolment is 88% of boys' at the primary level, and 78% at the secondary. And when user fees are introduced, it is the girls who are taken out of school, as studies in many countries show, including Côte d'Ivoire and Zambia.

When women retain control over household income, more resources tend to be channelled to the health, education and nutrition of children. Many empirical studies show that women spend their incomes for the entire household, while men spend more on items for themselves—such as entertainment, alcohol and cigarettes. A study in Jamaica shows that compared with male-headed households, female-headed households consume foods of a higher nutritional quality and spend less on alcohol. In Kenya and Malawi a smaller percentage of children in female-headed

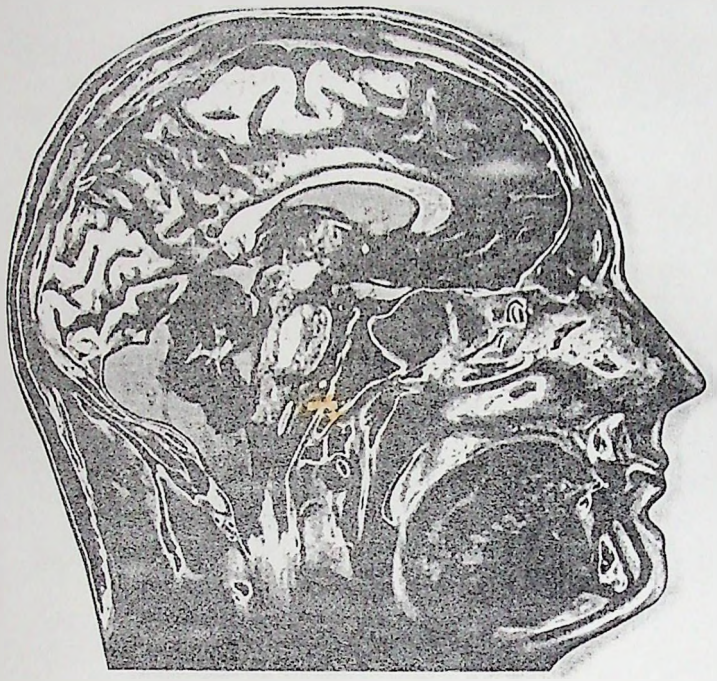
IN
INSIDE INSEAD

VOL 6 N°18 JULY 1999

Healthcare 2020

The Promise of Innovation

What will healthcare look like in 2020? Will genetic coding redefine how illnesses are treated? Will fitness and well-being centres replace hospitals? Will testing be conducted in patients' homes rather than laboratories?



On April 9th, more than 250 healthcare practitioners, educators and policy-makers converged at INSEAD to discuss these and other provocative questions. "We were delighted to welcome such an exciting mix of international participants from both the public and private sectors," said Professor John Kimberly, the Salmon and Rameau Fellow in Healthcare Management. "We wanted to stimulate their thinking during the conference, and send them off with some new ideas and perhaps even a different perspective."

Organised under the aegis of the Healthcare Management Initiative at INSEAD, "Healthcare 2020: The Promise of Innovation" was the second in the series Les Conférences Roger Godino. The series was started by this former Professor of Management and Strategy at INSEAD, who was the institute's Director and Dean of Faculty in 1964-70.

Though perhaps it might surprise some to see healthcare issues discussed at a business school, Dean Antonio Borges noted that the sector needs managers capable of dealing with broad and sophisticated issues. "We cannot provide all the answers, but we will certainly provide a lot of managers to the healthcare industry," he said. "Much of what we teach here can be transposed to this fast-growing and incredibly important sector."

The conference revolved around three themes, genetic profiling, innovations in medical technology, and new approaches to the organisation of health services.

Genetic Profiling: A View of the Future

The first keynote speaker was Dr. Kári Stefánsson, a neurologist and CEO of deCode Genetics. Dr Stefánsson's company was recently granted permission by the Icelandic government to create a database that will combine medical, genealogical and genetic data. He spoke about how this controversial approach will lead to increasing quality of life while decreasing healthcare costs. "Individual genetic profiles will become one of the most important tools in treating disease by helping tailor treatment to the disease," he said. Though he admitted that genetic profiling raises serious questions about who will have access to this information especially for insurance companies, employers and mothers-to-be, "it would be criminal not to develop this knowledge because it could save people's lives." He foresees that genetic counselling will become part of basic education: "treatment of disease will be not only based on the nature of the disease but also on the individual." For him, it will also lead to a paradigm shift in healthcare systems. In the future, healthcare systems will move from an intervention to a prevention mode, with more focus being placed on fitness and well-being centres instead of traditional provider structures.

Questions were raised about how genetic profiling would affect public policy, social dialogue and information access. "Any change needs careful management by governments," pointed out Strachan Heppel, Chairman of the Management Board, European Medicines Evaluation Agency (EMEA). "We have to identify general public concerns and there must be full, open and honest public discussions of issues." The audience questioned who would have access to this information, who would own it, and who would be allowed to use it. Professor Theodore Marmor of the Yale School of Management responded that the most obvious risk is that the information will be misused. "Insurance companies are paid to think about risk selection, not about policies in healthcare," he said.

Technological Innovation and the Hospital of the Future

The second plenary session discussed how digitalisation, computerisation, networking and the Internet are creating "e-healthcare." "We can predict a move towards home-based diagnostic screening, monitoring and ambulatory treatments which include remote check-ups and on-line follow-ups," noted Francis Bailly, Vice-President, GE Medical Systems Europe. "The role of hospitals might become that of 'centres of competence' which deal exclusively with the most complex diagnosis and treatments."

Continued on page 2

contents

2 Editorial: The Internet Revolution • IEP Fontainebleau Singapore
3 New Associate Dean Appointed • Asian Campus Update
4 Challenges of Large Corporations • World Bank President Speaks • New Campaign Gifts
5 Alumni Giving • Wendel/CGIP Chair Inauguration
6 Learning from Internet Leaders • Faculty Awards & Honours
7 Faculty Publications
8 IN Briefs • The INSEAD Calendar

The Novartis Chair in Healthcare Management

Daniel Vasella

Building on the HMI experience and developing further management knowledge and insight requires on-going and in-depth research. For this reason, Novartis, a global leader in the life sciences with 100,000 employees worldwide, has endowed the Novartis Chair in Healthcare Management. This chair will help develop understanding and insight into the future developments in the sector and the evolving role of the pharmaceutical industry. "Our industry is undergoing rapid change due to intense global competition, innovation and cost pressures around the world," said Daniel Vasella, Chairman and CEO of Novartis. "As a leader in our field, Novartis will best meet these challenges and fully maximise opportunities by sharing know-how and continuous learning throughout the company. Many members of our management team have benefited from INSEAD, further sharpening their skills. We are delighted to be deepening our relationship with the institute by funding a chair in healthcare management."

Formed through the 1996 merger of Ciba and Sandoz, Novartis is a long-time friend of INSEAD. Sandoz gave the Sandoz Chair in Management and the Environment in 1990, which is dedicated to the study of environmental problems and opportunities at management level. The chair was the first of its kind to be created at a European business school.

From 1985 to 1994, Ciba was a very important supporter of the Management of Technology and Innovation Programme at INSEAD. This project increased the institute's research and development efforts in the management of technology and innovation.

Novartis currently employs 29 MBA graduates, has sent more than 600 executives on programmes and is represented on several of INSEAD's advisory boards, including the INSEAD Board, the Swiss Council and the Advisory Committee for Management Education.

INSEAD's Focus on Healthcare

INSEAD's Healthcare Management Initiative (HMI) was conceived in 1996 in recognition of the enormous economic, social, and political significance of the healthcare sector and in the belief that the application of many of the tools and analytical approaches of management could add considerable value in this time of change. HMI is led by Professor John Kimberly, the Salmon and Rameau Fellow in Healthcare Management, and Dr Franz Schmidthaler, the programme director.

COMH770.

- Goal 1. Eradicate extreme poverty and hunger
  - Target 1. Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day
    - Poorest quintile's share in national income or consumption, per cent (WB)
    - Population below $1 (PPP) per day consumption, percentage
    - Population below national poverty line, rural, percentage
    - Population below national poverty line, total, percentage
    - Population below national poverty line, urban, percentage
    - Poverty gap ratio
    - Purchasing power parities (PPP) conversion factor, local currency unit to international dollar
  - Target 2. Halve, between 1990 and 2015, the proportion of people who suffer from Hunger
    - Children under 5 moderately or severely underweight, percentage
    - Children under 5 severely underweight, percentage
    - Population undernourished, number of people
    - Population undernourished, percentage
- Goal 2. Achieve universal primary education
  - Target 3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
    - Literacy rates of 15-24 years old, both sexes, percentage
    - Literacy rates of 15-24 years old, men, percentage
    - Literacy rates of 15-24 years old, women, percentage
    - Net enrolment ratio in primary education, both sexes
    - Net enrolment ratio in primary education, boys
    - Net enrolment ratio in primary education, girls
    - Percentage of pupils starting grade 1 reaching grade 5, both sexes
    - Percentage of pupils starting grade 1 reaching grade 5, boys
    - Percentage of pupils starting grade 1 reaching grade 5, girls
    - Primary completion rate, both sexes
    - Primary completion rate, boys
    - Primary completion rate, girls
- Goal 3. Promote gender equality and empower women
  - Target 4. Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015
    - Gender Parity Index in primary level enrolment
    - Gender Parity Index in secondary level enrolment
    - Gender Parity Index in tertiary level enrolment
    - Seats held by men in national parliament
    - Seats held by women in national parliament
    - Seats held by women in national parliament, percentage
    - Share of women in wage employment in the non-agricultural sector
    - Total number of seats in national parliament
    - Women to men parity index, as ratio of literacy rates, 15-24 years old
- Goal 4. Reduce child mortality
  - Target 5. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
    - Children 1 year old immunized against measles, percentage
    - Children under five mortality rate per 1,000 live births
    - Infant mortality rate (0-1 year) per 1,000 live births
- Goal 5. Improve maternal health
  - Target 6. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
    - Births attended by skilled health personnel, percentage
    - Maternal mortality ratio per 100,000 live births
- Goal 6. Combat HIV/AIDS, malaria and other diseases
  - Target 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS
    - Condom use at last high-risk sex, 15-24 years old, men, percentage
    - Condom use at last high-risk sex, 15-24 years old, women, percentage
    - Condom use to overall contraceptive use among currently married women 15-49 years old, percentage
    - Contraceptive use among currently married women 15-49 years old, any method, percentage
    - Contraceptive use among currently married women 15-49 years old, condom, percentage
    - Contraceptive use among currently married women 15-49 years old, modern methods, percentage
    - Men 15-24 years old with comprehensive correct knowledge of HIV/AIDS, percentage
    - Men 15-24 years old, who know that a person can protect himself from HIV infection by consistent condom use, percentage
    - People living with HIV, 15-49 years old, percentage

        - Women 15-24 years old with comprehensive correct knowledge of HIV/AIDS, percentage
        - Women 15-24 years old, who know that a person can protect himself from HIV infection by consistent condom use, percentage
    - Target 8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
        - Tuberculosis death rate per 100,000 population
        - Tuberculosis detection rate under DOTS, percentage
        - Tuberculosis prevalence rate per 100,000 population
        - Tuberculosis treatment success rate under DOTS, percentage
- Goal 7. Ensure environmental sustainability
    - Target 9. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources
        - Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC)
        - Carbon dioxide emissions (CO2), thousand metric tons of CO2 (CDIAC)
        - Consumption of all Ozone-Depleting Substances in ODP metric tons
        - Consumption of ozone-depleting CFCs in ODP metric tons
        - Energy use (Kg oil equivalent) per $1,000 (PPP) GDP
        - Land area covered by forest, percentage
        - Protected area to total surface area, percentage
        - Protected areas, sq. km.
    - Target 10. Halve by 2015 the proportion of people without sustainable access to safe drinking water
        - Proportion of the population using improved drinking water sources, rural
        - Proportion of the population using improved drinking water sources, total
        - Proportion of the population using improved drinking water sources, urban
        - Proportion of the population using improved sanitation facilities, rural
        - Proportion of the population using improved sanitation facilities, total
        - Proportion of the population using improved sanitation facilities, urban
    - Target 11. By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers
        - Slum population as percentage of urban, percentage
        - Slum population in urban areas
- Goal 8. Develop a global partnership for development
    - Target 15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term
        - Debt service as percentage of exports of goods and services and net income from abroad
    - Target 16. In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
        - Ratio of youth unemployment rate to adult unemployment rate, both sexes
        - Ratio of youth unemployment rate to adult unemployment rate, men
        - Ratio of youth unemployment rate to adult unemployment rate, women
        - Share of youth unemployed to total unemployed, both sexes
        - Share of youth unemployed to total unemployed, men
        - Share of youth unemployed to total unemployed, women
        - Share of youth unemployed to youth population, both sexes
        - Share of youth unemployed to youth population, men
        - Share of youth unemployed to youth population, women
        - Youth unemployment rate, aged 15-24, both sexes
        - Youth unemployment rate, aged 15-24, men
        - Youth unemployment rate, aged 15-24, women
    - Target 18. In cooperation with the private sector, make available the benefits of new technologies, especially information and communications
        - Internet users
        - Internet users per 100 population
        - Personal computers
        - Personal computers per 100 population
        - Telephone lines and cellular subscribers
        - Telephone lines and cellular subscribers per 100 population

50	Bangalore Urban Health Initiative	11th Dec	CHC	Consolidation of PHC Survey		JAAK	EP, KBO, RV, SR	Listing	Y	
51	Health as a Human Right Training	12th 13th Dec	Bagalkote	HHR Trg	Public Hearing	JAAK	EP & KBO	Listing	Y	
52	Public Hearing	23rd Dec	Davangere	Public Hearing		JAAK	EP, KBO, PL	Report	Y	
53	JAAK Planning Meeting	5th Jan 10	CHC	Planning about Pub Herg		JAAK	EP, KBO, PI and PL	Listing	Y	
54	Solidarity opposing the GM Foods & Bt Brinjal	18Jan10		Advocacy	JAAK					
55	MFC Meeting	8-10 Jan	Sewagram	Community Health Networking	CHLP					
56	" Public Health situation in India and Civil society responses with the students of IHP - 'Study Abroad' coordinated with Mani Kalliath	2nd Feb 10	CHC	Discusions	Public Health	CHC	EP, RV, PI	Report	Yes	
57	Workshop on SCP	8th Feb	ISI, Blr			CHC & JAAK	EP, KBO	Report	No	Obalesh
58	Public Hearing -Bagalkote	19th Feb10	Bagalkote	Public Hearing		JAAK	EP, KBO, PI	Report	No	Prahlad
59	Public Hearing -Belgaum	19th Mar10	Belgaum	Public Hearing		JAAK	EP, KBO, PI	Report	No	Prahlad
60	Public Hearing -Haveri	19th Mar10	Haveri	Public Hearing		JAAK	EP, KBO, PI	Report	No	Prahlad
61	BBMP Election manifesto	22th March	Bangalore		Public Health	CHC	EP, PI and Soumya	Report	Yes	
62	Workshop on Health	22nd March	Davangere		Public Health	JAAK	EP, KBO	List	No	EP
63	Public Hearing -Bellary	27th Mar10	Bellary	Public Hearing		JAAK	EP, KBO, PI	Report	No	Prahlad
64	CHLP announcement/interviews/ final sharing /Final feedback/advisory comm. meeting/orientation	5 Feb – Mar								

NATIONAL MEETING UPDATE FORM

BE PART OF THE GLOBAL CALL
TO ACTION AGAINST POVERTY

Please return via email to info@whiteband.org or by fax to +44 (0)870 010 8707 by January 14th 2005 after your national meeting.
This form will give the International Facilitation Group an initial record of your national plans and discussions, and the main contacts who will lead the communication with us on the Global Call to Action against Poverty.

1. Major national organisations networks, and groups planning to be involved in the Global Call to Action Against Poverty

1 _____ 11 _____
2 _____ 12 _____
3 _____ 13 _____
4 _____ 14 _____
5 _____ 15 _____
6 _____ 16 _____
7 _____ 17 _____
8 _____ 18 _____
9 _____ 19 _____
10 _____ 20 _____

2. Communications co-ordinators for the Global Call to Action Against Poverty

Name	Organisation	Position	Telephone	Email address

3. **Main outcomes of your meeting - what actions do you have planned in 2005?**

When?	Where?	Action	Aims

4. **Will you be supporting the White Band Action on July 1st?** YES / NO

   In early September? YES / NO

5. **Have you decided on any particular slogans / statements to write on the white band?**

6. **Will you use the White Band action nationally on any dates other than July and September? Please note when and explain significance.**

India – National Contacts List

This is a list of all the people in **India** who have received this mailing, please pass it on to anyone else you think might be interested. There are many activities already being organised and planned for next year. The aim of the White Band action is to support these efforts and provide an opportunity to join up in solidarity with others all over the world at the same time.

In **India** there is no national platform already active. You can make this happen and start your national platform in support of the Global Call to Action against Poverty by talking to the other organisations on this list, and then letting us know your plans.

University of Delhi
C-516 Defence Colony,
New Delhi 110024
India

Prof. S. Dasgupta,
Priyaranjani Dass
A-12Paryavaran Complex,
Maidangarhi Road,
New Delhi
110030
India

Minar Pimple,
Young Men's Christian Association (YMCA) - Beirut
53/2 Nare Municiple School,
opp. Nare Park Parel,
Mumbai ? 400012,
India

Mr. Arbind Singh,
NIDAN
Sudama Bhawan,
Boring Road,
Patna 800001
India

Alika Khosla,,
Director-Operations,
Breakthrough Trust
C 3/15, Safdarjung Development Area,
New Delhi 110016
India

Arvind Ojha,,
Secretary,
Urmul Rural Health Research and Development Trust
P.O. Box 55, Urmul Bhawan,
Sri Ganganagar Road,
Bikaner 334001, Rajasthan,
Near Central Roadways Bus Stand
India

Muralidhar Koteshwar,
SriSri Ravishankar Vidya Mandir Trust
No. 1987-A, 26th Main,
South Road C Cross,
Bangalore 560069,
9th Block, Jayanagar
India

Ashok Nanda,,
Secretary,
VIKASH
D-2/7, Industrial Estate,
Rasulgarh,
Orissa,
Bhubaneswar 751010
India

K.M. Sheshagiri,
Learning Advisor,
Plan India
C-210 Sarvodaya Enclave,
New Delhi,
Pin-110 017,
India

Mr. Rajesh Tandon,
PRIA (Society for Participatory Research in Asia
42 Tughlakabad Institutional Area,
New Delhi
110062
India

Manmohan Singh,
India

Ashok Singh,
Ramon Aboitiz Foundation, Inc.
Sahbhagi Road,
Behind Police Fire Stattion,
Sitapur Rd.,
Lucknow, 227 208
India

Dr. Claude Alvares,
Director,
Goa Foundation
G-8 St Britto's Apartments,
Feira Alta,Mapusa,
Goa
403 507 Goa
India

Ms Claire Noronha,
PROBE / CORD
R. 20 W, Indian Social Institute,
10 Lodhe Inst. Area,
New Delhi
110 003
India

Dr. Ravesh Tandon,
PRIA
42 Tughlakabad Institutional Area,
New Delhi
110 062
India

Director,
Potters House Trust Inc.
18 Infantry Rd. 517 Maple
Monroe, MI 48162 (US),
Karnataka
01 Bangalore
India

Mr. Rohit Jain,
Executive-Director,
SRUTI - Society for Rural, Urban & Tribal Initiative
Q-1, Hauz Khas Enclave,
NEW DELHI - 110016
India

Mr. Pradeep Priyadarshi,
Secretary,
Pragati Grameen Vikas Samity
East of Anurag Hospital,
Patna 801503, Bihar,
West Bailey Road
India

Subash Chandra-Mohapatra,
Forum for Fact-finding Documentation and Advocacy
A-3, Shahni Vihar,
Telibandha Ring Rd. no. 1,
CHHATTISGARH - 492006,
P.O. Ravigram, Raipur Dist.
India

N.B. Sarojini,
Management-Trustee,
Sama Resource Group for Women & Health
G-19, 2nd Floor,
Marg no. 24, Saket,
New Delhi 17
India

Dr. Yogesh Jain,
Jan Swasthya Sahyog
I-4, Parijat Colony,
Nehru Nagar,
Bilaspur - 495001,
Chhattisgarh
India

Savita Varde-Naqvi,
Senior Officer Media and External Relations,
United Nations Children's Fund
India Country Office,
Unicef House,
73 Lodi Estate,
New Delhi
110 003

Shobha Sakharwade,
Secretary,
PRAKRITI
Water Tank Road,
Lonara,
Gumthi-441111,
Nagpur (Maharashtra)
India

Colleague,
Centre for Youth & Social Development (CYSD)
E/I Institutional Area,
Bhubaneswar 751013
India

Ms. Shobha Gasti,
Mahila Abhivrudhi Mathu Samrakshana Samste (MASS)
House no. 574, Patil Building,
Mruthyunjayanagar,
Belgaum District, KARNAT,
Ghataprabha 591306, Gokak Taluk,

Arun Jindal,
Society for Sustainable Development
Jagdamba Colony,
Karauli, Rajasthan 322241
India

Mr. J. Vimalanathan,
Executive-Dire,
NESA - New Entity for Social Action
93/2 Charles Campbell Road,
Cox Town,
BANGALORE - 560005,
Karnataka
India

Mr. Girish Sant,
Trustee,
Prayas
Amrita Clinic, Athawale Corner,
Karve Road,
Pune 411004, Maharashtra,
Deccan Gymkhana Corner
India

Mr. Ravi Duggal,
CEHAT - Research Centre of Anusandhan Trust
Aram Society Road, Sai Ashray,
Village Kole Kalyan,
Mumbai 400055,
Vakola, Santa Cruz (E)
India

Dr. Narendra Gupta,
Secretary,
PRAYAS HEALTH
B-8, Bapu Nagar,
Senthi,
Chittorgarh 312025,
Rajasthan
India

Mr. Yogendra Executive-Director,
Bodh Shiksha Samiti
AA-1, Anita Colony,
Bajaj Nagar,
Jaipur 302015, Rajasthan
India

Shakil Ahmed Kakvi,
Chairman,
KAINAT FOUNDATION
KAINAT INTERNATIONAL SCHOOL.KAINAT NAGAR,KAKO(JEHANABAD),
BIHAR 800418
India

Mr. Amit Singh,
Development Manager,
Network of Entrepreneurship & Economic Development (NEED)
39- Neel Vihar
Near 14- Sec. Power House,
Indira Nagar
,
Lucknow 226016

Dr Vijay Rukmini Rao,
GRAMYA - Gramya Resource Centre for Women
1-16-79/3, Sainagar Colony,
Alwal,
Secunderbad 500015,
Andhra Pradesh
India

PRIA, Participatory Research in Asia
42, Tughlakabad Institutional Area,
NEW DELHI
110 062
India

Mr. Badal Kumar-Tah,,
Secretary,
SANHATI
Plot no. 163/361,
Gajpati Nagar,
Orissa,
Sainik School, Bhubaneswar
751005
India

Dr. Mani Jacob,
General Secretary,
All India Association for Christian Higher Educati
Ecumenical House,
39 Institutional Area, D-Block,
Janakpuri,
New Delhi
110 058

Dr B Ekbal,
People's Health Movement
India

Professor Ali Baquer,
CAN - Concerned Action Now
3067, B-4 Vasant Kunj
Aruna Asaf Ali Road,
New Delhi
110 070
India

Burnad Fatima,
Coordinator,
Tamil Nadu Women's Collective
E-53,15th street,2nd cross
Periyar Nagar
Chennai
,
Tamilnadu
Tamilnadu 600 082

Nav Bharat Jagriti Kendra
Amritnagar, P.O. Korrah,
Post Box 37,
Hazaribag,
BIHAR
825 301
India

Cherian Mathews,
Oxfam (India) Trust
C-5 Qutab Institutional Area,
New Delhi
110 016
India

Babu Mathew,
ActionAid Int India
India

George Mathew,
Institute of Social Sciences
8, Nelson Mandela Road
Vasant Kunj
,
New Delhi
110070 New Delhi
India

Director,
Strategic Alliance of Organisations
C 75, South Extension Part II,,
New Delhi
New Delhi 110049
India

Kailash Satyarthi,
SACCS Central Office
(Global March Against Child Labour)
L-6 Kalkaji,
NEW DELHI
India

Dr. Stephen Maveley,
President,
All India Association for Christian Higher Educati
Ecumenical House,
39 Institutional Area, D-Block,
Janakpuri,
New Delhi
110 058

Director,
IndianNGOs.com Pvt Ltd
Prasad, Ghantali,
Naupada
,
Thane
Thane 400 602
India

Director,
Centre for Youth and Social Development
E-1, Institutional Area,
Chandrashekharpur
,
ORISSA
Bhubaneswar 751013
India

Ms Neelima Khetan,
Chief Executive,
Seva Mandir
Old Fatehpura,
Udaipur,
Rajasthan
313 004
India

Director,
Potters House Trust Inc.
18 Infantry Rd. 517 Maple
Monroe, MI 48162 (US),
Karnataka
01 Bangalore
India

T.J.P.S. Vardhan,
SIDUR
144/2RT, Vijayanagar Colony,
HYDERABAD 500 057, A.P.
India

Malini Ghosh,
Nirantar
B-64 2nd Floor,
Sarvodaya Enclave,
New Delhi
100 017
India

Mr Kedar Nath Bishoyi,
District Project Director,
National Child Labour Project (NCLP)
Qr. No. 3RI Irrigation Colony,
At/Post: Balimela,
Dist. Malkangiri,
Orissa
India

Shri Ranjit Mukherji,
Programme Coordinator,
Ramakrishna Mission Lokshiksha Parishad
PO Narendrapur,
Kolkata, Dist South,
25 Paraganas,
West Bengal
701 103, 743 508
India

Gagan Sethi,
President,
YUVA - Youth for Unity and Voluntary Action
2nd Floor, Kamgar Bhavan,,
Baidhyanath Square
Rambagh,
Nagpur
440 044
India

Prof. Jaroslav Vanek,
Director,
Renaissance Universal
527, VIP Nagar
Tiljala
,
CALCUTTA
Calcutta 70039
West Bengal

Prema Gopalan,
Director,
Swayam Shikshan Prayog
58 CVOD Jainn High School,
5th Floor,
84 Samuel Street,
Pali Galli, Chaar Null Dongri,
Mumbai
400 009
India

Ms. Deepika D'Souza,
Executive Director,
India Centre for Human Rights and Law (ICHRL)
5th Floor, CVOD Jain School,
84, Samuel Street,
Dongri
,
Mumbai

Mr Jacob Thundiyl,
President,
People's Rural Education Movement
Mandiapalli, Rangailunda,
Bhanjavihar,
ORISSA
BERHAMPUR 760007
India

Abha Bhaiya,
Coordinator,
JWRC - Jagori Women's Resource Centre
C-54 (Top Floor), South Extension II,
New Delhi
110 049
India

Manu Alphonse,
Social Watch Tamilnadu
India

Jagdanand ,
Social Watch/CYSD
India

Mr. ,
Chairman,
MITHRAM
Mithram Rehabilitation Complex,
Kanjirikkappilly,
Arakunnam P.O
Mulanthuruthy 682313
,
Kerala

Dr Thakur V. Hari Prasad,
president,
Thakur Hari Prasad Institute of Research and Rehabilitation for the Mentally Handicapped
Vivekananda Nagar,
Dilsukh Nagar,
,
HYDERABAD

Director,
MC - Mobile Creches
DIZ Area, Raja Bazaar
Sector IV,
New Delhi
110 001
India

Dr. D. Suryakumari,
Director,
Centre for People's Forestry
12-13-445, Street no. 1,
Tarnaka,
Secunderabad 500017, A.P.
India

Director,
The Samabhavana Society
602 Debonair,
153B V.S. Marg,
Mahim,
Mumbai
400016
India

Chevian L Mathew,
Oxfam GB
India

Campaign against Child Labour
c/o PECUC, House no. VII-H-26,
Sailashree Vihar,
bhubaneswar 751021,
Orissa
India

Director,
India Social
11/158 (LGF)Malviya Nagar,
NEW DELHI
New Delhi17 1100
India

Sugandhi Baliga,
Executive Director,
Youth for Unity and Voluntary Action
52/53 Nare Park Municipal High School,
Parel,
Mumbai
400012
India

Dr. Jitendra Uniyal,
Doctor,
International society for alternative medicine
14 A Circular road,
Dehra dun
248001 Dehra dun
India

Mr. R. N. Dey,
President-Executive Committee,
CUTS - Consumer Unity and Trust Society
D-217, Bhaskar Marg
Bani Park,
Jaipur
302 016
India

Nancy Gaikwad,
Executive Director,
DISHA - Disha Social Organisation
5 Ratnaraj Apartments
Karjat Road
RAIGAD DIST,
Maharashtra
410 201
India

Hari Dev Goyal,
Nkong Hill Top Common Initiative Group
P.O. Box 10518, JNU Post Office, E-6-b, MIG Flats,,
New Delhi, 110067
India

Mr.Subhransu-Bhusan Swain ,
Paribartan
At - Pendarabasa,
Dimiria,
Po.-Pallahara,
Angul - 759119, ORISSA
India

Mr Ashish Sen,
Director,
Voices
165 9th Cross 1st Stage,
Indiranagar,
Bangalore
560 034
India

Dadi Janki,
Director,
BRAHMA KUMARIS WORLD SPIRITUAL UNIVERSITY
Pandav Bhawan P.O.Box No. 2 Mount Abu 307501,
Rajasthan
307501 Rajasthan
India

Dr Vasudha Prakash,
Director,
V-Excel Educational Trust
77 "Anugtaha",
Greenways Lane,
R.A. Puram,
Chennai
600 028
India

Director,
Regional Centre for Development Cooperation
424, Sahidnagar,
ORISSA
Bhubaneswar 751007
India

Roli Prasad,
President,
India Development Service
1920 S. Highland Avenue,
Suite 300,
Lombard, IL
60148
India

Soni Srivastava,
Policy and Research Coordinator,
National Alliance for Right to Education and Equity
T-101-C,
Bharat Nagar,
New Friends Colony,
New Delhi
110 065
India

Shri Arvind. N. Lalbhai,
President,
Blind People's Association
Dr. Vikram Sarabhai Road
Near IIM, Ahmedabad
Vastrapur
,
Gujarat
Ahmedabad 380015
India

Director,
Muktangan International Foundation
503, Ivory Towers-1,
Juhu Tara Road,
,
Mumbai
Mumbai 400049
India

Mr Vivekanandan,
Chief Executive,
South Indian Federation Of Fishermen Societies
T.C. 20/816-1 Karamana,
PO Trivandrum,
Kerala
695 002
India

Swami Asaktananda,
Director,
Ramakrishna Mission Lokshiksha Parishad
PO Narendrapur,
Kolkata, Dist South,
24 Paraganas,
West Bengal
700 103, 743 508
India

G Placid,
Sahayi Centre for Collective Learning
T.C. 5/789 Peroorkada P.O.,
Thiruvananthapuram,
Kerala
695 005
India

Fr. Louis Mascrenhas,
Director,
DDWS - Diocesan Development and Welfare Society
Diocesan Deve. & Welfare Society, Bishop's House,,
32, Thornhill Road,
Allahabad
211-002

Director,
The Global Communication Center for Development Organisations
63C Bharahtiar complex,
100ft Rd,
Vadapalani,
Chennai
600026
India

Inu Annue Stephen,
Childline India Foundation
2nd Floor Nanachowk Munucipal School,
Frere Bridge,
Low Level, Near Grant Road Station,
Mumbai
400 007
India

Dr Ramanath Nayak,
National Conference of Dalit Organisations (NACDOR)
India

Mohammad Rafiuddin,
Hyderabad Council of Human Welfare
#12-2-790/56,
Ayodhya Nagar Colony,
HYDERABAD 500028,
Andhra,
Mehdipatnam
India

Dr. Yogesh Kumar,
Director,
Samarthan - Centre For Development Support
E-7/81 Arera Colony,
Bhopal
426 016
India

Sulabha A Donde,
Leader,
Happy Home Society
Resi 205 Aradhana,
J Sawant Marg Dahisar (W),
Mumbai
400 068
India

Nishat Farooq,
SFC
Jamia Millia Islamia,
Jamia Nagar,
New Delhi
110 025
India

Anuta Anand,
Director,
Women's Feature Service
G-69 Nizamuddin West,
New Delhi
100 013
India

Swati Narayan,
Asian South Pacific Bureau of Adult Education
India

Director,
Barefoot College
Tilonia
Madanganj
District Ajmer
Tilonia 305816
,
Rajasthan
Tilonia 305816
India

Mukul Sharma,
Action Aid Int Asia
India

Ms Elizabeth Sivakumar,
Executive Director,
Positive People
A/7 Skylark Apts., Near Govinda Building,
GOA
Pajim 403 001
India

Mr. Srinivas Mudrakartha,
Director,
Vikram Sarabhai Centre for
Development Interaction
Nehru Foundation for
Development
Thaltej Tekra,
Ahmedabad
380 054
India

Director,
CRE-The Centre for
Resource Education
CRE - Center for Resource
Education
201, Maheshwari Complex
Masab tank,
Hyderabad
500 028
India

Ms. Aparna Bhat,
Director,
Human Rights Law Network
65, Masjid Road Jungpura,
NEW DELHI
New Delhi-110014
India

Shireen Miller,
Save the Children
2nd floor,
A-20 Kailash Colony,
New Dehli
110048
India

Javed Anand,
Sabrang Communications
Post Box No. 28253, Juhu
P.O., Juhu,
Bombay
400 049
India

Sh. Binoy Acharya,
Director,
UNNATI - Organisation for
Development Education
G-1, 200 Azad Society
Ahmedabad,
Gujarat
380 015
India

Mr Hemraj Bhati,
General Secretary,
Seva Mandir
Old Fatehpura,
Udaipur,
Rajasthan
313 004
India

Ashok K Bharti,
National Conference of Dalit
Organisations (NACDOR)
India

Mr. K.Somnath Nayak,
President,
Nagarika Seva Trust
P.O. Guruvayanakere 574,
217 Belthangady Taluk,
DAKSHINA KANNADA, DT.
India

Director,
Peaceful Action
157/J, P. G. H. Shah Road
Kolkata 700032
West Bengal/India

,
Kolkata
700032 Kolkata
India

Mr N. Paul Divakar,
National Convenor,
National Campaign on Dalit
Human Rights
Premier Residency PLot No.
165, 1-8-142B, 3rd Cross,
Prenderghast Road,
Secunderabad
Secunderabad 500 003
India

Director,
Gene Campaign
J-235/A, Lane W 15 C,
Sainik Farms,
New Delhi
110062
India

P Chennaiah,
APVVU/NAPM
India

Mr. Achyut Das,
Director,
AGRAGAMEE
AT/P.O.-KASHIPUR-765015
DIST.-RAYAGADA

,
ORISSA
India

Mr . Vijay Tendulkar,
President,
National Centre for
Advocacy Studies
Serenity Complex
Ram Nagar Colony
Pashan

,
Pune
India

Director,
People's Institute for
Development and Training
People's House,
A12 Paryavaran complex
Saidullajab

,
New Delhi
New Delhi 110070
India

Jayashri Balachander,
President,
CCD - The Covenant Centre
for Development
18-C/1, Kennett Cross Road,
Ellis Nagar,
Madurai
625 010
India

Dr. Shiraz A.Wajih,
Secretary,
Gorakhpur Environmental
Action Group
224, Purdilpur,
M.G. College Road,
Postbox # 60,
GORAKHPUR 273 001 U.P.
India

Mr. Rajesh Kumar,
Chief-Functionar,
LOKMITRA
B-57 & 62,
Anand Nagar,
Raebareli, 229001,
Uttar Pradesh
India

Mrs. Mumtaz Ben,
Chairperson,
MMBA - Mahila Mandal
Barmer Agor – Gender
Equity and Justice
Indira Colony ,Barmer
Rajasthan,
India

Mr. K. Satyarthi,
AVA - Association for
Voluntary Action
L-6, Kalkaji,
NEW DELHI 110019
India

Fr. Varghese Pallipuram,
Executive Director,
BOSCO
91 'B' Street,
6th Cross
Gandhinagar
,
Bangalore
Bangalore 560009
India

Mr. K.P. Sinha,
Secretary,
(JSS) Jagriti Sewa Sanstha
Vill. UrlaP.O. Abhanpur,
RAIPUR 493 661, MADHYA
PRADESH
India

Mr. Satyendra Kumar-Singh,
Secretar,
AAA - Agrarian Assistance
Association
Near Forest Range Office,
Bandorjori Ch.,
DUMKA 814 101, Jharkhand
India

Mr. Umasankar Sahu,
Coordinator,
Association for Development
& Health Action in Rural
Areas
At/P.O. Loisingha, Dist.
Bolangir (Orissa)
Pin Code. 767 020
,
ORISSA

Mrs. Lalita Missal,
Vice-President,
Council of Professional
Social Workers
D-49,MAITREE
VIHAR,CHANDRASEKHAR
PUR,
ORISSA
BHUBANESWAR-751023
India

Damodaram Kuppuswami,
ActionAid Int India
India

Director,
INDIAN COMMITTEE OF
NON-GOVERNMENTAL
ORGANIZATIONS FOR
THE UNITED NATIONS
C-4/70. Safdarjung
Development Area,
New Delhi
India

Mr. M.V.N. Rao,
Executive-Directo,
Grama Vikas
Honnsetthalli,
Yelagondahalli P.O.,
KOLAR DISTRICT 563 127,
Karnataka S
India

Pradeep S. Mehta,
Canadian Crossroads
International
D-218 Bhaskar Marg,
Bani Park,
Jaipur 302016, Rajasthan
India

Nalini Abraham,
Plan India
C-210 Sarvodaya Enclave,
New Delhi,
Pin-110 017,
India

Mr. Raju Samson,
Project-Manager,
Lokshakti Samajsevi
Sanstha (LSS)
16/391, Hanuman Nagar,
Titurdih,
Durg 491001, Chhattisgarh
India

Himanshu Rath,
Director,
AGEWELL FOUNDATION
M-8A, Lajpat Nagar-IINew
Delhi,
New Delhi
Delhi-11 00 24
India

Mr. K.Rama Rao,
(CWS) Centre for World
Solidarity
12-13-448,
St.No.1, Tarnaka,
SECUNDERABAD 500 017
India

Mr. Biswajit Sen,
Grameen Development
Services
B 1/84, Sector-B,
Aliganj,
LUCKNOW 226 024
India

B.C. Rokadiya,
166 Mandakini Enclave,
New Delhi
110 019
India

Sushil Kumar,
87 Panchwat,
Udaipur,
Rajasthan
313 001
India

Mr Ashok Kumar Singh,
SAHBAGHI SHIKSHAN KENDRA
Sahbhagi Rd,
Lucknow,
India

Dr. Rama Ch.Dash,
Member-Secretar,
NIPDIT - National Institute for People's Development, Investig. & Training
College Road,
Phulbani, Dist. Kandhamal,
ORISSA 762 001
India

Dr.Mrs. Daisy Dharmaraj,
PREPARE
4, Sathalvar Street
Mogappair West,,
Chennai, MADRAS 600 050
T.N.
India

Ms Charmaine Rodrigues,
Commonwealth Human Rights Initiative
N-8 Second Floor,
India

Dr. Imrana Qadeer,
Founder,
PSI - Peoples Science Institute
252 Vasant Vihar-1,,
Dehra Doon
248006
India

Director,
INDIAN COMMITTEE OF NON-GOVERNMENTAL ORGANIZATIONS FOR THE UNITED NATIONS
C-4/70. Safdarjung Development Area,
New Delhi
India

Sandeep Chachra,
ActionAid Int India
India

Mr. N. Samson,
GRAM - Gram Abhuydaya Mandali
Dharmaram, 503 230,
DHARMARAM 503 230,NIZAMABAD DT.
India

Amitabh Behar,
National Center for Advocacy Studies (NCAS)
India

India Alliance for Child Rights
A64,
Gulrnohar Park,
New Delhi 110049,
India

Dr. Vasudha Dhagamwar,
Executive Director,
Multiple Action Research Group (MARG)
125 Shahpur Jat, Second Floor,
Near Asiad Village,
New Delhi
110 049
India

Mr. C. Ramachandraiah,
Centre for Economic & Social Studies
Nizamiah Observatory Campus,
India

Ms Sheela Bharat Patel,
SPARC
3691 Ellengale Drive,
India

Mr Jagadananda,
CYSD Social Watch
E -1 Institutional Area,
India

John Chaloner,
National Director,
Plan India
C-6/6, SDA,
New Delhi
100 016
India

J Vincent Manoharan,
NCDHR
India

Mr Ranjan Rao Yerdoor,
Credibility Alliance
C/o Voluntary Action Network India,
D25-D,South Extension Part II,
New Delhi 110049
India

Dr. Madhav Chavan,
Prog.Director,
Pratham Mumbai Education Initiative
Adarsha Mithai Mandir,
2nd Floor,
Mumbai 400007,
309 Tardeo Road, Nana Chowk
India

Mr. N.S. Bedi,
President,
YIP - Young India Project
Bangalore High Way,
PENUKONDA 515110
ANANTAPUR DT.
India

Anil K Singh,
SANSAD
India

President,
Teachers' Association of the Republic of Indonesia
Jalan Tanah Abang Tiga 24,
Jakarta
10160
India

Mr Madhusudan,
Executive Secretary,
Yakshi
B-135, Sainikpuri,
Secunderabad,
Andhra Pradesh
500 094
India

Director,
People's Institute for Development and Training
People's House,
A12 Paryavaran complex
Saidullajab
,
New Delhi
New Delhi 110070
India

Mr. A.P. Rao,
Centre for Education and Agriculture Development
Sastry Nagar Colony,
NIRMAL 504 106,
ADILABAD District
India

Mr. George Kadankavil,
President,
Cyriac Elias Voluntary Association
CEVA Bhavan
Monastery Road
Karikkamuri
,
Kerala
Ernakulam 683 011

K.C Choudhary,
Indian Adult Education Association
17B Indraprastha Estate,
New Delhi
110 002
India

Binoy Acharya,
UNNATI Organisation for Development Education
G1-200,
Azad Society,
Ahmedabad
380 015
India

Mr. Henri Tiphagne,
People's Watch Tamil Nadu
6A Vallabhai Road,
Chokkikulam,
Tamil Nadu,
Madurai
625 002
India

Mr M.G Karrunanithi,
Award Trust
99/1 N.H. Road,
Nungambakkam,
India

Mr. Aloysius P.Fern,
MYRADA
2, Service Road,
Domlur Layout,
BANGALORE 560 071,
KARNATAKA
India

Mr. M.P. Vasimalai,
Development of Humane Action Foundation
No.18, Pillaiyar Koil Street,
S.S. Colony,
MADURAI 625 010, TAMIL NADU
India

Savita Sinha,
F1,
University Officers' Quarters,
Vikram University,
Ujjain Madhya Pradesh
India

Meena Raghunathan,
Program Officer,
Centre for Environment Education (CEE)
Nehru Foundation for Development,
Thaltej Takra,
Ahmedabad
380 054
India

Mr. Santi Karar,
Executive Director,
FRIENDS' SOCIETY IN SOCIAL SERVICE
GPO BOX # 2943,
CALCUTTA- 1
CK-165, SECTOR -II,
SALT LAKE CITY
,
CALCUTTA

Dr. S.Y Shah,
Director,
Adult, Continuing Education & Extension
Unit 204,
School Of Social Sciences,
Jawaharlal Nehru University,
New Delhi
110 067
India

A Kalamani,
Center for World Solidarity (CWS)
India

Fr. Robert Simon,
Ilaiya Deepam
P.O.Box 146,
Karumandapam,
Trichy
620001
India

Mr. Jambu Kumar Jain,
Pan African Dev't Education and Advocacy Programme (PADEAP)
1-K-22, Dadabari,
Kota-324009 (Rajasthan),
India

Mr Chaurasia,
Association for Voluntary Action
L-6 Klakaji,
New Delhi
110 019
India

Prof. Ila Patel,
Institute of Rural Management
C-42 Near NDDB Campus,
P.O. Box 60,
Anand,
Gujarat
388 001
India

Maria Lourdes Almazan Khan,
Secretary General,
Asian South Pacific Bureau of Adult Education (APS
Ist Floor Shroff Chambers,
259/261 Perin Nariman Street Fort,
Mumbai
400 001

Mr Mohd Khasim,
General Secretary,
All Indian Federation of Teachers Organisations, A
C-6/30 Lawrence,
Delhi
110 035
India

Director,
Peaceful Action
157/J, P. G. H. Shah Road
Kolkata 700032
West Bengal/India

Kolkata
700032 Kolkata
India

Indrani Sinha,
Director,
SANLAAP
38 B Mahanirban Road,
Kolkata 700 029, West Bengal
India

Dr MG Shilpa Society,
president,
Shilpa Society
Shruti Shilpam, 21/1252 A
Palluruthy,
682006 Cochin
India

Director,
India Social
11/158 (LGF)Malviya Nagar,
NEW DELHI
New Delhi17 1100
India

Tasqeen Macchiwala,
Action Aid India, Olicay Advocacy Unit
D-3 Blessington Apartments,
34 Serpentine Street,
Richmond Town,
Bangalore
560 025
India

Ms. Maja Daruwala,
Director,
Commonwealth Human Rights Initiative
B-117 Sarvodaya Enclave,
New Delhi
New Delhi 110017
India

Mr. P.K. Sahoo,,
Chairman,CYSD,
CYSD - Center for Youth and Social Development
E-1, Institutional Area,
P.O.: R.R.L.,
BHUBANESWAR 751 013,
ORISSA
India

Anil Dharker,
Senior editor,
InfoChange
Flat No. 3, Silver Spurs
NIBM Road
Kondhva

Pune
PUNE 411048
India

Manjeet Ahluwalia,
698 Sector 11-B,
Chandigarh,
UT
160 011
India

Education Co-ordinator,
VSO India
VSO Programme Office,
B-8/25 Vasant Vihar,
New Delhi
110 057
India

Ravi Pratap Singh,
Senior Manager,
Action Aid
Country Office 71,
Uday Park,
New Delhi
110 049
India

Action Aid
INDIA NORTH,
E.7-727 – Arera Colony,
Bhopal
462 016
India

Action Aid
INDIA SOUTH,
225, Peters'Road,
Chennai
600 086
India

Jagdish Manubhai,
Chairman,
Indian Society for
Community Education
(ISCE)
Community Education
House, Dr. Navjivan Press
Road,
Gujrat Vidyapith,
Ashram Road,
[illegible]

Director,
Regional Centre for
Development Cooperation
424, Sahidnagar,
ORISSA
Bhubaneswar 751007
India

Mahendra Singh Kunwar,
Himalayan Research Centre
(HARC)
744 Indira Nagar, Phase II,
PO New Forest,
Dehradun,
Uttar Pradesh
248 006
India

Director,
IndianNGOs.com Pvt Ltd
Prasad, Ghantali,
Naupada

Thane
Thane 400 602
India

Shri Bhawani Shankar
Garg,
President,
Indian Adult Education
Association
17B Indraprastha Estate,
New Delhi
111 002
India

Mr Dhani Ram Singh Negi,
General Secretary,
All India Secondary
Teachers' Federation, AISTF
Central Office N.P.-129-B,
Maurya Enclave,
Pitampura,
Delhi
110 034
India

RN Mahlawat,
Treasurer,
Indian Adult Education
Association
17B Indraprastha Estate,
New Delhi
110 002
India

Dr. Alexander V. Daniel,
President,
Institute for Integrated Rural
Development (IIRD)
Kanchan Nagar,
Nakshatrawadi,
P.O. Box 562,
Aurangabad,
Maharashtra State
431002
[illegible]

Mrs Lalita Ramdas,
Lara' Ramu Farm
61 Bhaimala,
Alibag Dist. Raigad,
Maharashtra
402 201
India

Seema Gaikwad,
Coordinator,
Commonwealth Education
Fund- India
C-88, South Extension Part
II,
New Delhi
110049
India

Mr Yashwant Singh Rana,
General Secretary,
All India Secondary
Teachers' Federation, AISTF
C-8/302, Yamuna Vihar,
Delhi 53
110 053
India

FODRA
302, Jai Apartments,
Sector 9, Rohini,
DELHI
110 085
India

Dr. Manorama Bawa,
Secretary General,
All India Women's
Conference
6 Bhagwan Dass Road,
Sarojini House,
New Delhi
110001
India

Mr Subramaniam Eswaran,
General Secretary,
All India Primary Teachers
Federation, AIPTF
41 Institutional Area,
Pankha Road, D-Block,
Janakpuri,
New Delhi
110 058
India

Mr Rohit Trivedi,
Director,
Arushi
E-7/793 Arera Colony,
Bhopal
462 016
India

Mr. E. Deenadayalan,
The Other Media
B-14 Second Floor,
Gulmohar Park,
New Delhi
110 049
India

Joe Madiath,
Gram Vikas
Mahuda Village, Via
Berhampur,
Dist. Ganjam,
Orissa
760002
India

RORES
Srinivasapura PO,
Kolar Dt.,
KARNATAKA
563 135
India

C Upendranadh,
PU Learning Advisor,
Plan India
C-210 Sarvodaya Enclave,
New Delhi,
Pin-110 017,
India

Vandana Shiva,
India

Ajaib Singh,
Director,
Department of Adult,
Continuing Education and
Exte
Punjab University Sector-14,
Chandigarh
160 014
India

Director,
Strategic Alliance of
Organisations
C 75, South Extension Part
II,,
New Delhi
New Delhi 110049
India

Ms Vasanth Kannabiran,
ASMITA Resource Centre
For Women
10-3-96 Plot 283, 4th Floor,
Street 6, Teachers Colony,
East Marredapalli,
Secundrabad,
Andhra Pradesh
500 026
India

Bina Agarwal,
President,
International Association of
Feminist Economics
Institute of Economic
Growth,,
University of Delhi,
Delhi
110007
India

Bosco Reach-out
Don Bosco,
Guwahati 781 001,
ASSAM
India

Alison Aldred,
Regional Director,
Oxfam (RMC)
C-28-29 Qutab Institutional
Area,
New Delhi 110 016,
New Delhi
India

Chris Marsden,
Country Representative,
Oxfam
C-28-29 Qutab Institutional
Area,
New Delhi 110 016,
New Delhi
India

Mr Lakshman Khanna,
President,
All India Secondary
Teachers' Federation, AISTF
C-8/302, Yamuna Vihar,
Delhi 53
110 053
India

Mr. Paul Divakar,
NCDHR
136/42 Street No. 10,
Venkat Rao Nagar Colony,
P.G. Road - A.P.,
Secunderabad
500 003
India

Friends of WWB, India
G-7, Sakar I Building,
Opp.Gandhigram,
Station, Ashram Road,
AHMEDABAD
380 009
India

CENDERET, Centre for
Devt. Research and Training
C/o: Xavier Institute of
Management,
Bhubaneswar 751 013,
ORISSA
India

Mr Nitin Paranjape,
Executive Director,
Abhivyakti Media for
Development
31-A Kalyani Nagar,
Anandwali Shiwar,
Ganagpur Road,
Nashik
422 005
India

Rajiv Tikoo,
One World South Asia
India

Director,
Muktangan International
Foundation
503, Ivory Towers-1,
Juhu Tara Road,
,
Mumbai
Mumbai 400049
India

Mr Bibekananda Dash,
General Secretary,
All India Federation of
Educational Associations,
Mahantypara,
Cuttack,
Orissa
753 002
India

Virginia Shrivastava,
ASTHA Sansthan
39 Kharol Colony,
Udaipur 313 001,
Rajasthan
India

Raffaele K Salinar,
president,
Terre des hommes
781, Regie House
Nana Peth
Padamjee Park
,
Pune
PUNE 411002
India

Dr. M Elias,
Professor,
Dept. of Social Dynamics,
St. Joseph's College
Tiruchirappalli,
Tamil Nadu
620 002
India

Jeevana Datha Rural
Development Project
St. Joseph's House,
Ramanthapur,
Amberpet P.O.,
HYDERABAD
500 013 - A.P.
India

Care India
PO Box 4657,
New Delhi,
110-016,
India

K. G. Kannabiran,
President,
People's Union for Civil
Liberties
81 Sahayoga Apartments
Mayur Vihar -I
,
Delhi
110091 Delhi
India

CORE, Collective Order for
Rural Rec.
D No. 14-145-14,
Om Sakthi Lay out,
Palace Road,
KUPPAM
517425
India

Mr Dharamvijay Pandit,
General Secretary,
All Indian Federation of
Teachers Organisations, A
E-15/13 Krishna Nagar,
Delhi
110 051
India

Dr. P Illango,
Honorary Director,
Ageing Research
Foundation of India (ARFI)
No.2 Second Street,
Gandhi Nagar,
Crawford Tiruchirapalli
620012
India

CHC, Community Health
Cell
No. 367, Srinivasa Nilaya,
Jakkasandra, 1st Main, 1st
Block,
Koramangala,
BANGALORE
560 034
India

COVA, Confederation of
Voluntary Associations
20-4-10, Near Bus Stand,
Charminar,
Hyderabad,
ANDHRA PRADESH
500 002
India

Fr. Aloysius Irudayam s.j.,
IDEAS
26/A Vallaithoppu
Chinthamani Road,
Tamil Nadu,
Madurai
625 001
India

Mr Ram Pal Singh,
President,
All India Primary Teachers
Federation, AIPTF
41 Institutional Area,
Pankha Road, D-Block,
Janakpuri,
New Delhi
110 058
India

Mr Rohit Dhankar,
Digantar, India
Todi Ramzanipura,
Jagatpura,
Jaipur
302 017
India

Y. Padmavathi,
Zonal Director,
Save the Children, India
Plot No. 8, 1st Floor,,
D.No:6-3-852/2/B/6-1,
Aparajita Housing,
Colony, Ameerpet
Hyderabad 500 016
India

Mr. Sifaji,
Sanghamitra Service Society
74-14-52 Krishna Nagar,
Vijayawada - 7,
Krishna District, AP,
India

Ms Eunice Pamie,
National Campaign
Coordinator,
Micah Challenge
Prabhaav-Association of
Christian services,
D7/7417,
Vasant Kunj,
New Delhi
110070

Suneeta Dhar,
C1 Paposh Enclave,
New Delhi
India

Arvind Kumar,
Lok Jagruti Kendra
Madhupur 815353,
Deogarh,
Bihar
India

Utpal Moitra,
Head, Programmes,
Save the Children, India
2nd floor,
A-20 Kailash Colony,
New Delhi 110048,
India

Asha Iyer,
Zonal Director,
Save the Children, Calcutta
Flat No. 1 C (1st Floor),
37 A, Carcha Road,
Calcutta,
India

Deen Khan,
Zonal Director,
Save the Children, India
Post Box No. 23,
Leh, Ladakh - 194 101,
Jammu & Kashmir,
India

National Centre for Advocay
Studies (NCAS)
Serenity Complex,,
Ramnagar Colony, Pashan,
Pune
411 021
INDIA

Jagadananda ,
CYSD Centre for Youth and
Social Development
E-1 Institutional Area,,
Bhubaneswar 751 013,,
Orissa
INDIA

Fr John L. Noronha,
Executive Director,
Caritas India
C.B.C.I. Centre, Ashok Place
(Gole Dakhana),
110001,
New Delhi
India

Ambika Prasad Nanda,
CIEE
Sector Specialist Education,
12 Patliputra Colony,
Patna
800 013
India

Steve Hollingworth,
Care India
PO Box 4657,
New Delhi,
110-016,
India

N.C Pant,
215 Sanghi Street,
Mhow,
Madhya Pradesh
453 441
India

Ms. Nafisa Barot,
Utthan
36 Chitrakut Twins,
Nehru Park Vastrapur,
Gujarat,
Ahmedabad
380 015
India

International Commission on
Irrigation & Drainage
48 Nyaya Marg.,
Chanakyapuri,
New Dheli
110 021
India

Balkan-Ji-Bari International
C-129 Ganesh Nagar,
New Delhi
110018
India

Meenakshi Batra,
Zonal Director,
Save the Children, India
20 Kiran Path,
Suraj Nagar (west),
Civil Lines,
Jaipur 302 006
Rajasthan
India

Jai Chandiram,
President,
International Association of
Women in Radio and
Television
D-2D, DDA Flats,
Munirka,
New Delhi
110067
India

Working Group on the CRC
c/o Butterflies U-4,
1st Floor Green Park
Extension,
New Delhi 110 016,
India

The Asian Women's Institute
Women's Christian College,
Madras
600006
India

Indian Council of World Affairs
Saru House barakhamba Road,
New Dheli
110001
India

All India Boy Scouts Association
7 Mathura Road Janpura "B",
New Delhi
110014
India

ICSD
Valakom,
P.O. Box 691532,
Kollam Dist.,
Kerala State
India

Jiya Lal Jain,
Secretary General,
United Schools International
USO House,
USO Road,
6 Special Institution Area,
New Dheli
110067
India

Foundation for Amity and National Solidarity
10168 East Park Road (KCP),
PO Karol Bagh,
New Dheli
110 005
India

Mr Ram Prakash Gupta,
President,
All Indian Federation of Teachers Organisations, A E-15/13 Krishna Nagar,
Delhi
110 051
India

Kailash Satyarthi,
Chairperson,
Global March Against Child Labour
Main Address L-6, Kalkaji,
New Delhi
New Delhi
110019

India

Brian Heidel,
Programme Director,
Save the Children, India
2nd floor,
A-20 Kailash Colony,
New Delhi 110048,
India

Mrs. Swarn Kohli,
President,
Consumer Education and Research Centre (CERC)
Suraksha Sankool Sarkhej-Gandhinagar HWY,
Thaltej,
Ahmedabad,
Gujarat State
380 054

Jayakumar Christian,
National Director,
World Vision India
Post Bag No. 5305,
Kodambakkam,
Chennai 600 024
India

WEAR THE WHITE BAND BECAUSE...

...EVERY DAY 24,000 PEOPLE DIE FROM HUNGER.

...EVERY DAY MORE THAN 100 MILLION CHILDREN ARE DENIED THE CHANCE TO GO TO SCHOOL

...EVERY DAY 1.1 BILLION PEOPLE HAVE TO DRINK POLLUTED WATER

...EVERY DAY 8,200 PEOPLE DIE DUE TO HIV/AIDS

IT IS TIME FOR ALL OF US TO SPEAK OUT TOGETHER

IT IS TIME TO DEMAND THAT WORLD LEADERS DO MORE TO FIGHT POVERTY

GLOBAL CALL TO ACTION AGAINST POVERTY

BE PART OF THE GLOBAL CALL TO ACTION AGAINST POVERTY!

www.whiteband.org

"If one of us has a problem, it is everyone's. Also we have become well-known. People hear about us and encourage us, because we're a group. Three are stronger than two, and sixty are much stronger than one. Being together makes us determined."

Fatuma Mint Suleymane, a member of the Rosso Naja women's association in Mauritania, on the advantages of forming a group.

Ami Vitale/Oxfam

GLOBAL CALL TO ACTION AGAINST POVERTY

ACTION GUIDE

WHAT IS THE GLOBAL CALL TO ACTION AGAINST POVERTY?

The Global Call to Action against Poverty is a growing alliance of organisations, networks and national campaigns committed to eradicating extreme poverty, which will be working together in 2005 to take action across the world to force world leaders to tackle the causes of poverty, and meet and exceed their own promises on the MDGs.

Why are we writing to you?

We are writing to your organisation to invite you and your members to join and become part of this global effort to ensure that world leaders keep their promises to eradicate poverty and achieve the Millennium Development Goals. As an alliance, we have a shared goal to ensure that world leaders put their promises into action. In 2005, and particularly on a few key dates, we will be working in solidarity with thousands of other organisations across the world to put the interests of the poorest people in the world at the top of the political agenda.

This pack explains the 'white band action', which will visibly link the efforts and activities of organisations and individuals all over the world around key dates in 2005. While groups in different countries will be planning their own campaign strategies and activities, by wearing the white band they can associate themselves with the wider call to make change a reality in 2005.

This is your chance to ask politicians and leaders what they are going to do to eradicate poverty, and to demand that they do it now.

What are we asking world leaders to do?

In the 21st century 58,000 people die every day from hunger and easily preventable diseases. 2005 is the time for world leaders to make eradicating global poverty the priority it deserves to be.

Together, we will pressure governments to eliminate poverty and achieve the Millennium Development Goals. We want Trade Justice, Debt Cancellation, and a major increase in the quantity and quality of aid. Also we want national efforts to eradicate poverty that are developed and implemented in a way that is democratic, transparent and accountable to citizens.

Visit the website www.whiteband.org to see more detail on what we are calling for together.

Why 2005?

We know that 2005 will be an important year to make progress in the fight against poverty. There are several key moments in the year when campaigners will be active on a national and international level. Around at least two of the key dates we will be organising two events where

people all over the world will wear white bands as a sign of solidarity with other campaigners and those living in poverty.

In **July 2005, the G8 Summit** will take place in Scotland, UK and promises have been made to put poverty at the top of the agenda. This is our opportunity to make sure that action is agreed by the world leaders who have the power to cancel debt, deliver more and better aid, and change unfair trade rules and practices. On **1st July** we will attempt to get everyone in the world who is against poverty to act in solidarity, and wear a white band to call for world leaders to do more to eradicate poverty.

Then in **September 2005 the UN Millennium Summit** will discuss the progress made on the Millennium Development Goals. This is a vital time to ensure that countries and world leaders are on track to meet their commitments to eradicate poverty and that government policy and decisions aiming to eliminate poverty and reach the Millennium Development Goals are developed and implemented in a way that is democratic, transparent and accountable to citizens. We will organise a second white band day in early September.

What if the organisations acting together in this coalition have different views on how world leaders should eradicate poverty?

We will be stronger and achieve more for the poorest people in the world if we concentrate on what unites us rather than on what divides us. For instance, Jubilee 2000 saw groups and networks from all over the world coming together to campaign on debt. There was a loose international co-ordination, but the campaigns were planned and implemented at the national level with focus on relevant specific issues. These groups and networks may have had different detailed policies, but everyone came together and rallied around the call to 'drop the debt'. Similarly this alliance is backed by a wide range of global organisations which may have different priorities and policies, but we are all united in our belief that progress on debt, aid and trade is necessary to lift millions out of poverty.

"2005 is a year of great opportunity we can really do something to change the world and make it a better place. The time has come to stop talking and start taking some action.
If everyone who wants to see an end to poverty, hunger and suffering speaks out then the noise will be deafening. Politicians will have to listen"
Archbishop Desmond Tutu, 2004

JOIN THE GLOBAL CALL TO ACTION AGAINST POVERTY

It is important that you and your members are part of this effort. It is not possible for one person, one group, one organisation or one country to bring about this change on their own. Together though, we can unite all organisations and individuals who want to eradicate poverty, and show our solidarity in this important year.

How does this mobilisation relate to other campaigns that some of us are already involved in?

The white band mobilisations are designed to be as "light and loose" as possible, with very broad policy messages and a minimum of coordination, so that they complement, and don't compete with or displace, ongoing campaigns and lobby efforts by our separate networks and organisations.

In fact, if all of us link our ongoing lobby and campaign efforts to the white band actions, together we can build cumulative pressure on decision-makers as the year goes on. Particular opportunities to do this exist in April, just ahead of the World Bank-IMF Spring Meetings, when many groups around the world mobilise around the Trade Week of Action (April 10-16) and the Education Week of Action (April 25-30). There may be other opportunities to target forums such as the G5, G20, NEPAD, etc.

Groups involved in the Global Call to Action can decide whether, and to what extent, they want to link or coordinate their advocacy efforts beyond the white band days. You may decide that there is "added value" in organising additional joint events or actions (beyond the white band days) to target national or regional forums. Or you may feel that it is most effective for existing campaigns and networks to work mainly separately, but to link their efforts in the simplest possible way by adding the Call to Action logo and policy messages to their separate materials and media work. Whether we do it separately or do it together, the key thing is to get the Call to Action message resounding louder and louder in the corridors of power everywhere.

What happens now?

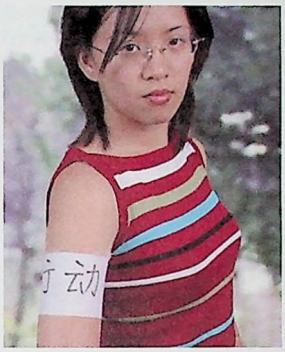
Over the next month, we are encouraging organisations active on poverty-related issues in each country to come together to have their first national meetings on making the call to action a reality at national level. Their role is information-sharing, coordination and facilitation rather than leadership or gate-keeping. In many countries there are already groups that have indicated their readiness and availability to help facilitate the Global Call to Action against Poverty at national level. We encourage you to work with them – working together our call will be louder and more powerful. If you have problems finding partners at national level, we invite you to contact one of the supporters of the call to action, listed in Section 5.

What happens at the national meetings?

The aim of the Global Call to Action against Poverty is to support and build on pre-existing activities and campaigns in your country. We encourage you in your national group to plan your strategy and activities for 2005, discuss how to support the white band action and who could be involved in your country. You might want to develop a national platform to support the call to action, or work in an existing coalition or network. You could also work in a consortium or committee that has come together solely for the purpose of backing the call.
At these meetings, you would, most probably, want to decide the following:

- Which organisations are working together on their national plan for 2005?
- Who are the main points of contact for liaison with the international coordinators of the call to action?
- What events will you organise in your country.
- In addition to the two key dates for action (1st July, early September), are there any other significant dates in your country that you would like to target, with or without the white band (for more info on the white band see the questions later on).
- Will your country have a title / banner under which you will work together? What will this be?
- How will you show that you are linking to the Global Call to Action against Poverty?

You might also wish to explore strategies to motivate citizens in your country who cares about eradicating poverty to wear a white band during these key moments. By doing it at the same time worldwide you will be part of what we hope will be the biggest mobilisation ever against poverty in history.



What happens after the national meeting?

Together, the organisations in your country that decide they want to be part of it, will make the decisions about what steps your country will take between now and the start of activities in 2005. You each know best what will work in your own country/area. The best results will be achieved by working at a national level and keeping in touch with all the other organisations and groups involved. All together we will form a global network that will use the symbol of the white band to unite our demand to eradicate poverty.

We are asking you to fill in the **Update Form** attached at the back of this pack and return it to the International Facilitation Group. The form should be used to update us when the plans at your country level have been formed, so that the global network of participating organisations are aware of your plans, and can be inspired by your plans and activities. Alternatively, you can e-mail us at (info@whiteband.org or via one of the contacts listed in Section 5) with the information.

BEING A NATIONAL PLATFORM
QUESTIONS AND ANSWERS

If our national meeting is already planned by other organisations, how do we get involved?

It is not too late to get involved, and the more organisations working together in 2005, the stronger your national voice will be. You can either talk to organisations already active in your country, or to one of the organisations listed in Section 5 to find out more and to discuss getting involved.

If our national meeting is already planned by other organisations and we do not attend, how can we get involved in the Global Call to Action against Poverty?

You do not have to attend this national meeting to be part of this action. You can still be involved in planning your national strategy for 2005 by getting in touch with the main organisations working to organise your national meeting.

If there is no national planning underway at present in our country, how can we get started?

If there is no national planning going on in your country at this stage, you can help to make this happen by getting in touch with other organisations in your country. Please let us know what happens!

What if some of the different organisations in our coalition don't have the same policy on all issues?

This action aims to bring together organisations who share the same overall belief that more must be done to eradicate poverty, even if they have some different policies. It is likely and expected that the networks and organizations working together in 2005 will have some differences in exact policies and priorities on how to eradicate poverty. What we will all share is a commitment to eradicating poverty, and by demanding it together we will be stronger and achieve more for the world's poorest people.

What do we want world leaders to do?

Together, we will pressure governments to eliminate poverty and achieve the Millennium Development Goals. We want Trade Justice, Debt Cancellation, and a major increase in the quantity and quality of aid. Also we want national efforts to eradicate poverty that are developed and implemented in a way that is democratic, transparent and accountable to citizens.

What if different national groups want to organise different activities?

Again, it is likely that some organisations will want to organise their own activities. One way to manage this is to synchronise the actions, and also to make the white band part of all of them. The great thing about the white band idea is that it is easy to combine with other activities that are already planned. The important thing is to have as many people as possible wearing the band at the same time on the key dates.

Can I use the White Band outside of the key dates?

Yes. It is up to each national platform to choose how the white band idea will be used, and if there are any other national or regional events that you would like to wear it for.

Why 1st July?

We want to put pressure on the G8 meeting to make some real decisions to benefit the world's poorest people in 2005. We have chosen a date a few days before the summit so that leaders can be pressured in their own countries before they leave.

Should we target the G8?

The G8 countries still control most of the world's resources and are choosing to spend it in ways that allow millions to die from poverty every year.

Actions linked to the Global Call to Action against Poverty are expected to happen all over the world, but for one day, groups around the world want to unite in holding the richest countries to account. As the richest countries have overseen the world economy during the debt crisis, introduced conditions for aid that force countries to liberalise, and have developed unfair rules on trade, we feel it is appropriate to have a date when the leaders of these rich countries are held to account. Whilst millions die every month, these leaders oversee both the financial and political resources to save them. The G8 provides the perfect moment to ensure we do not let world leaders off the hook in the fight against world poverty.

Hillbrow Tower, Johannesburg

Why early September

The UN summit in September will see leaders from all over the word come together to discuss how they are addressing poverty. Just five years into the establishment of the Millennium Development Goals, the world is way off track, with some targets in Africa not likely to be met for 150 years, let alone 15 years after the goals were set. We have picked this date so that world leaders can be targeted before they leave home to go to the UN Millennium Summit. By wearing a white band on this day you will be able to deliver a clear message to world leaders, and your country's head of state, that this time they need to put the world's poorest people first.

BEING A NATIONAL PLATFORM
QUESTIONS AND ANSWERS

How do we launch our national campaigning?

It is entirely up to your national platform. There are a number of warm-up actions being chosen in December/January to get the campaign off to a strong start. These are different in different countries, and national platforms are invited to pick one that is most relevant for them. A launch can be a moment where you just announce the campaign to the media or a moment for significant mobilisation. The following ideas are already being supported by campaigners in certain countries:

- Skip a Million meals event on 10th December (India)
- Media Launch on 1st January (UK). Mainly a media event with white bands appearing on some famous landmarks across the world.
- New Years Greetings cards throughout January (France). For those countries where New Years Greetings cards are sent, campaigners present cards to their leaders on behalf of the worlds poor.
- Launch at the World Social Forum (Brazil). A number of groups in Brazil are keen to use the World Social Forum to launch national platforms, and the global action.

Will we get any updates on what is happening internationally?

If you let us know that you want to be kept up to date (see www.whiteband.org), we will then add you to the "Global Action Forum", a list of all organisations, national and international, which are involved in one way or another with the campaign. Via this list, you will receive e-mail updates. From the website you will be able to see what other countries have planned if they have provided the information. On the website you will also be able to sign up for weekly updates, keeping the organisers around the world in touch with the latest developments.

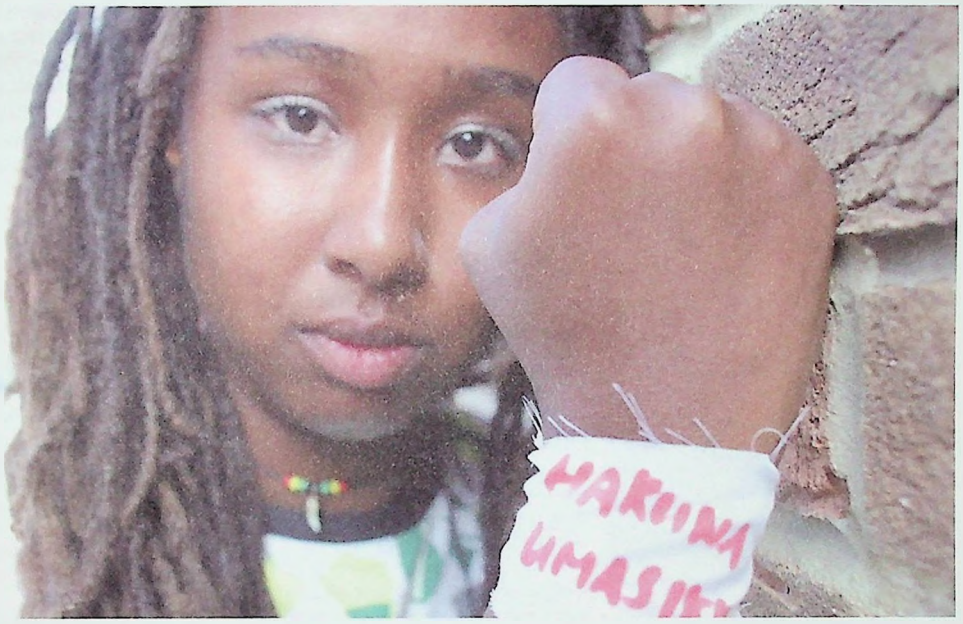
Who do I ask if I have any questions/want more information?

If you have any questions about the your national plans and activities, you should use the national contacts list to get in touch with the organisation which is hosting the initial meeting in your country, or one of the organisation contacts listed in Section 5, who can help put you in touch with others in your country. If there is no planning going on in your country at this stage you should talk to other organisations about holding a national planning meeting.

Once the national groups have communicated their plans to the international alliance, you will be able to see what plans are in place in your country and across the world.

If you have any other questions about this mailing please contact the International Facilitation Group at info@whiteband.org. Please also visit the website at www.whiteband.org which will be launched on December 1st. This will have information and materials from national platforms around the world.

USING THE WHITE BAND



Why a white band?

The white band was agreed to as the one symbol to unite all of our activities and demonstrate the truly worldwide nature of the Global Call to Action against Poverty. The white band has lots of potential to get everyone involved – it is deliberately easy for anyone in the world, no matter how poor, to take part. It is also easy to adapt to fit your existing plans and actions, to visibly display your key messages, and to draw media attention.

So what should the white band look like?

This is entirely up to you. Some suggestions are wrist bands, arm bands, head bands etc. The most important thing is that you work with the ideas that will be most successful and appealing in your country. The white band you wear does not have to be professionally produced, and we would encourage you to show other organisations and individuals taking part in your country that they can make their own bands from pieces of fabric or paper.

Do our white bands have to bear a slogan or a message?

Many groups will be organising under a national slogan. India, for example, will be organising the action under the banner of 'Deliver the Promises'. The UK is organising the action under the banner 'Make Poverty History' and that will be written on many of the bands. And of course individuals can write their own messages, for instance if your national campaign decides that the white bands will sent to an embassy or a national politician.

How will the white bands be made?

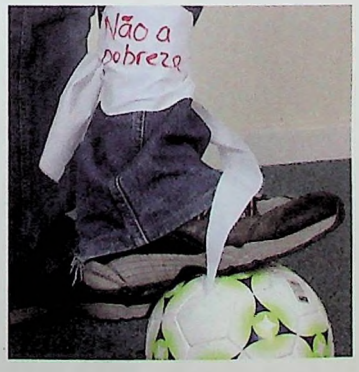
This action has been chosen because anyone, anywhere can take part. All they need is to make a white band from a piece of white cloth, plastic, paper or similar material. It is a cheap and simple action, so that everyone is able to be a part of this demand for change.

How else can we use the white band?

The white band can also be used as a media opportunity. For example:

1. Famous people and celebrities can wear the band in support of this global movement.
2. You may choose to stage stunts where the white band is put around a famous building or monument, or around the venue of a key meeting of leaders to make your point visible.
3. Small white bands can be tied together to form chains.
4. Bands could be worn at demonstrations and marches, union meetings, conferences etc

All of these concepts add to the opportunity to catch media attention and gain more support for the action, and each national group will have other eye-catching and high-impact ideas. The most important thing though, is that everyone can wear the band around the key dates in 2005, regardless of what they are doing on those days. People can wear the bands at work, at school, whilst travelling, shopping, cooking, or socialising, or just at home with their families.



USING THE WHITE BAND




How many people are we expecting to wear the white band?

We firmly believe that there are hundreds of millions of people world-wide who agree that world leaders should do more to eradicate poverty now. By organising the white band action we hope to prove the extent of this solidarity by aiming to have 100 million people wearing a white band on the two key dates in 2005.

Who should wear the white band?

ANYONE who believes in eradicating poverty should wear the white band, and we want as many people as possible to feel part of this movement. This could be school children, campaigners, activists, trade unionists, community groups, celebrities, families; whoever you are, this action is for you.

How will we know how many people are wearing the white band?

Each country will be asked to count the number of people in their country who wear the band - there will be numerous ideas on how you can do this on the campaign website.

For example after the actions have taken place, you could ask people to write their name on their white band and send it to be collected and counted nationally. Some groups could tie their white bands together locally and make larger bands for display around famous buildings and monuments.

What will happen to the white bands after the actions in 2005?

It is up to each country to decide, national groups will have their own final ideas of what they will do with the national collections of white bands at the end of the 2005 actions. Some ideas are to post them en mass to a political leader or to tie them around a national monument.

Will this get in the way of other actions we are already planning?

The white band has been chosen because it is complementary to any other actions. Whatever issue your country and your organisation wants to raise next year, and whatever specific activities you plan, the white band can be worn alongside those plans. The key message is that we all believe in eradicating poverty.

Will any white bands be produced centrally?

We will be producing some white bands centrally on "fair trade" cotton. When you have returned your update form we will let you know which types of band we have available and how you can order them.

Also some national groups may produce their own white bands to distribute in their country. It is not necessary to wear a professionally produced white band, the vast majority of people wearing one will make their own. The quality of the band is not important, and everyone should feel able to take part by making their own band.


WHO IS ORGANISING THE GLOBAL CALL TO ACTION AGAINST POVERTY?

National Groups will be organising the activity in each country. A wide range of organisations have already agreed to work together to this, but the aim is to go further and to get every organisation committed to eradicating poverty involved in what will hopefully be the biggest mobilisation ever against poverty.

List of supporting organisations:
Alliance bringing together the International Confederation of Free Trade Unions, the 10 Global Union Federations and TUAC-OECD (contact@global-unions.org(contact@global-unions.org www.global-unions.org)

Public Services International
Action Aid International
African CSO Network on Water (ANEW)
AFRODAD
Agency Coordinating Body for Afghan Relief
Afghanistan
Agir ici
Alianza Social Continental
All Africa Council of Churches
ALOP
ANCEFA
ANND
APVVU / NAPM, India
Asia Forum for Human Rights & Development
Asia Pacific Network on Food Sovereignty (APNFS), Philippines
AWEPON
AWN
BRAC
Broederlijk Delen
CAFOD
Cambodian Human Rights and Development Association (ADHOC)
Campaign for Popular Education, Bangladesh
Caritas Internationalis
CCFD
Centre for Social Development, Cambodia
Centre for World Solidarity (CWS)
Christian Aid
CIDSE
CIVICUS: World Alliance for Citizen Participation
COMGAD
Comic Relief
CONGO
Coordination SUD
Cordaid
CRID
CSACEFA
DATA
Development and Peace
Entraide et Fraternite
Fastenopfer
Feminist Dalit Organization (FEDO)
Global Campaign for Education
Global Movement for Children
IBASE
ICAE
ICW
INESC
Integrated Rural Development Foundation (IRDF)
Interaction
International Council for Adult Education
Japan International Volunteer Centre (JVC)
Koordinierungsstelle
LEGAMBIENTE
LUMANTI
Manos Unidas
MICAH Challenge
MWENGO
NANGOF
National Campaign on Dalit Human Rights
National Conference of Dalit Organizations (NACDOR)
NCDHR
NGO Federation of Nepal
NOVIB
One World Africa
One World South Asia
Oxfam International
People's Health Movement
PIDHDD
Plan International
Poverty Action Network Ethiopia Steering Committee."
PSI Brazil
SAAPE, Nepal
SAMARTHAN
Samay Weekly
Sanayee Development Foundation, Afghanistan
SANGOCO
SANSAD
Santi Sena, Cambodia
SAPPK, Pakistan
Secours catholique - Caritas France
Social Watch
South Asia Watch on Trade, Economics & Environment
South Asia Partnership Pakistan (SAP-PK Lahore)
STAR KAMPUCHIA, Cambodia
TANGO
Transparency International
Trocaire
UN Millennium Campaign
Urban Sector Group, Cambodia
VnM / Focsiv
Volontari nel mondo – FOCSIV
World Vision International
Yayasan Bina Usaha Lingkungan/GEF – SGP
Yes Country Network Nepal, Youth Initiative
Zambia Trade Network
Zimbabwe Coalition on Debt and Development (ZIMCODD)

All of the above are asking their national members, partner organisations and other civil society groups to become part of this global movement. Those involved so far are individuals, existing coalitions, charities, NGOs, INGOs, trade unions, religious and faith groups, community groups, activists and campaigners from all over the world. After the initial meetings happen, each country could have its own autonomous national platform to co-ordinate activities in that country and to communicate with the International Facilitation Group.

A national platform is just a group of civil society organisations (this could be a formal coalition or network, or it could be a consortium or committee that has come together solely for the purpose of the Call to Action against Poverty.

CHC, Community Health Cell
No. 367, Srinivasa Nilaya
Jakkasandra, 1st Main, 1st Block
Koramangala
BANGALORE
560 034
India

BE PART OF THE GLOBAL CALL TO ACTION AGAINST POVERTY

Dear Friend

A growing group of civil society organizations is working together to pressure world leaders to act against poverty in 2005. We are writing to invite you to be part of this global effort to demand that the world stops allowing millions to die every year because of extreme poverty. This movement will call for world leaders to start keeping their promises,and to do all they can to achieve the Millennium Development Goals and move towards eradicating poverty.

WEAR THE WHITE BAND

During 2005,millions of people around the world will be taking part in activities that coincide with significant international,national,and local events. Community organisations,national and regional networks, international NGOs, trade unions,school children,faith groups,and celebrities,are calling for action to eradicate poverty. In countries all over the world, people will be asked to wear a simple white band to show their desire for world leaders to act now. There will be key dates in 2005 where we will aim to mobilize together, but we also foresee a series of dynamic campaign processes to put pressure on decision-makers in the South, the North and at the global level throughout the year.

The more people we can encourage to take part,the louder the call for action will be. Together, we will pressure governments to eliminate poverty and achieve the Millennium Development Goals. We want Trade Justice, Debt Cancellation,and a major increase in the quantity and quality of aid. Also we want national efforts to eradicate poverty that are developed and implemented in a way that is democratic, transparent and accountable to citizens.

Poverty denies hundreds of millions of people their rights to water, health care,and education,and fuels the HIV/AIDs epidemic. This is not an unchangeable fact of life – for instance the WHO estimates that vaccinations could prevent – of all infant mortalities. But change will not happen unless all of us, together, demand it loud and clear. If we can get all of those who want to eradicate poverty to speak at the same time then leaders will be forced to act.

We know from past experience that success,and a better world,is possible.Global campaigns to ban landmines, to end apartheid,and to realise women's rights have all made a huge difference. These campaigns have helped to change - and save - lives. That's why we really hope that you become part of this global effort.

There are many national platforms and groups already working on these issues,and this action is designed to compliment, support and build on activity at the national level. The attached list of contacts in your country shows some of those this mailing has gone to, and in some cases highlights the organisation that has been involved in the coordination of the Global Call to Action against Poverty so far.

Please read the enclosed action pack and national contacts list. The action pack contains ideas on mobilizing people at national level,and details on the various international and regional organizations which have already backed the Global Call to Action against Poverty. Feel free to distribute the pack to others who you think may be interested.Please don't miss the opportunity to add your influence.

Global Call to Action Against Poverty

WEAR THE WHITE BAND BECAUSE...

...EVERY DAY 24,000 PEOPLE DIE FROM HUNGER.

...EVERY DAY MORE THAN 100 MILLION CHILDREN ARE DENIED THE CHANCE TO GO TO SCHOOL

...EVERY DAY 1.1 BILLION PEOPLE HAVE TO DRINK POLLUTED WATER

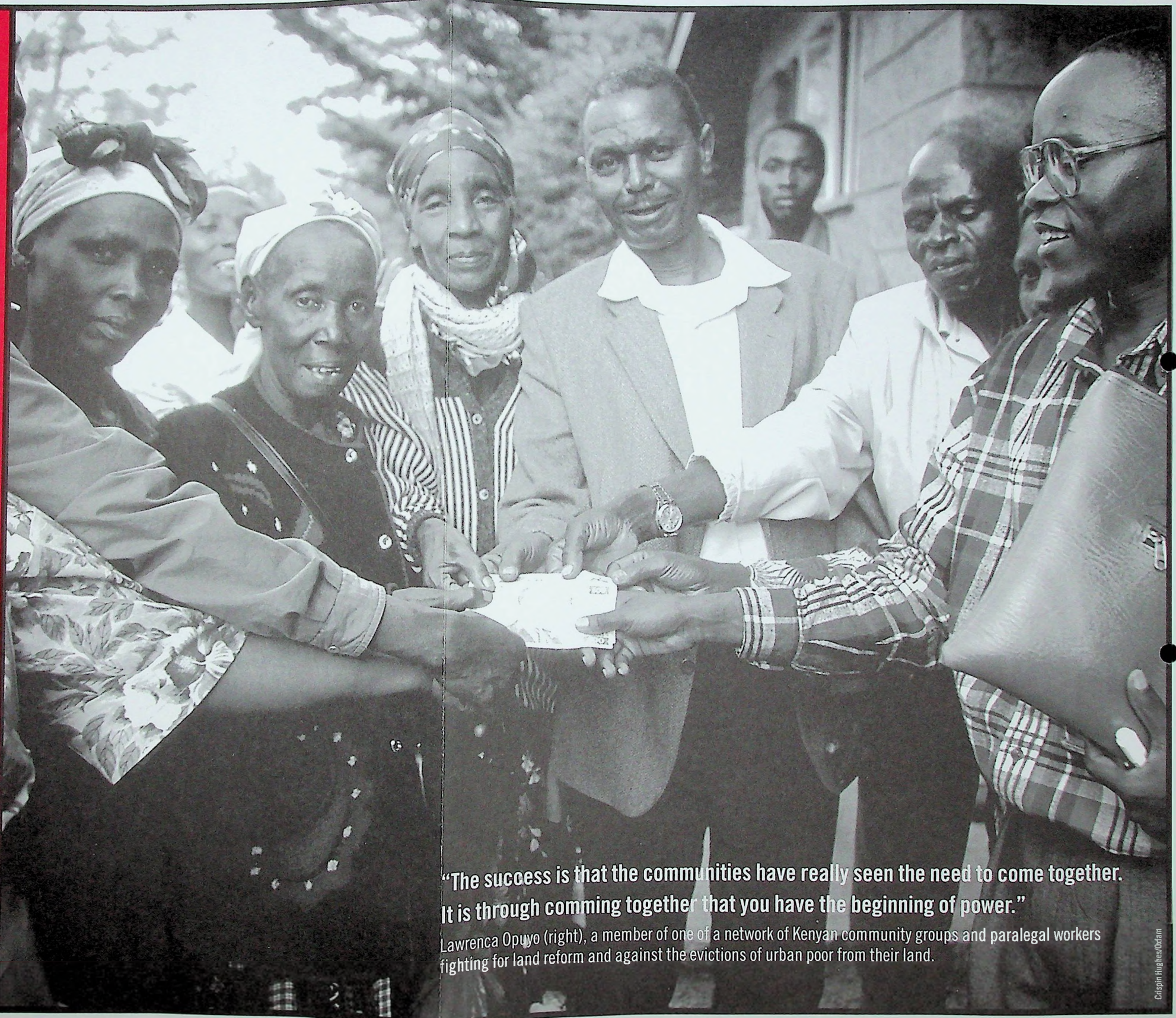
...EVERY DAY 8,200 PEOPLE DIE DUE TO HIV/AIDS

IT IS TIME FOR ALL OF US TO SPEAK OUT TOGETHER

IT IS TIME TO DEMAND THAT WORLD LEADERS DO MORE TO FIGHT POVERTY

GLOBAL CALL TO ACTION AGAINST POVERTY

BE PART OF THE GLOBAL CALL TO ACTION AGAINST POVERTY!
www.whiteband.org



"The success is that the communities have really seen the need to come together. It is through comming together that you have the beginning of power."

Lawrenca Opuyo (right), a member of one of a network of Kenyan community groups and paralegal workers fighting for land reform and against the evictions of urban poor from their land.

Crispin Hughes/Oxfam

CIDSE-E

CIDSE
Coopération Internationale pour le Développement et la Solidarité

International Cooperation for Development and Solidarity

Internationale Arbeitsgemeinschaft für Entwicklung und Solidarität

Cooperación Internacional Para el Desarollo y la Solidaridad

Secrétariat général :
Rue Stévin, 16
1000 Bruxelles
Belgique

Tél: (32) 02 230 77 22
Fax: (32) 02 230 70 82
E-mail: postmaster@cidse.org
Site-web: http://www.cidse.org

Brussels, 2 November 2004

Re: Global Call to Action Against Poverty

Dear friend,

We invite you to read the attached mailing of the Global Call to Action against Poverty and to consider your participation in this unique civil society effort in the year 2005. The Global Call is a loose alliance, of which CIDSE and many of its members are part, working on facilitation and co-ordination of campaigns that organisations and networks all over the world will organise in 2005.

Riding on the optimism of the new millennium, the world's political leaders agreed on the Millennium Development Goals (MDGs), set to be reached by 2015. Though only a first step towards the total eradication of global inequality, the MDGs represent a unique set of internationally agreed poverty reduction commitments. In 2005, we begin the 10-year countdown to ensuring that governments live up to their commitment.

Informed by our values emphasising human dignity, social justice and care for God's creation, CIDSE and its Member Organisations recognise that achieving the MDGs is a challenge that, on current trends, risks being lost in many countries principally in Africa. We believe that only through mobilisation and campaigning all over the world is there any hope to change the life for millions of people across our shared planet. For this reason CIDSE and many of its Members are part of the Global Call to Action Against Poverty. You too are invited to be part of this Global Call and the attached mailing explains how you can get involved.

CIDSE and its Member Organisations will contribute to the Global Call through different activities. One initiative is a post-card campaign to put pressure on the leaders of the richest nations to double aid and improve aid quality; to cancel debt that prevents the achievement of the MDGs; and to end dumping now and allow developing countries to protect their farmers. Beyond these demands we are advocating for fundamental changes towards a more equal division of power in the system of global governance.

Please visit our website www.cidse.org to learn more about our activities. For background information please order our brochure on the MDGs "International Campaign on the Millennium Development Goals". If you have any questions do not hesitate to contact Jean Letitia Saldanha at CIDSE (saldanha@CIDSE.org).

Remaining in Solidarity

Christiane Overkamp
Secretary General

Com H-7d6

COMMUNITY BASED PREVENTIVE HEALTH INITIATIVES IN THE POVERTY ALLEVIATION PROGRAMME (UNDP RAS/96/600) IN ANDHRA PRADESH – AN OVERVIEW (1996-99)

Q Almis Ali

PREAMBLE

Though the health initiatives in the project RAS/96/600 India component started from September 1996 but it was of a pilot/experimental nature and was mostly confined to the Orvakal mandal of Kurnool district. In the progress report for the year 1996-97 and in the document "Community Based Health Initiatives" published in September 1997, a detailed account of the activities taken up during the period under reference was furnished, similarly in both the strategy papers (Health Initiatives) for the year 1998 and 1999 – detail activities to be taken up during the respective years has also been submitted along with the progress reports for the year 1998 and 1999. Keeping in this mind, therefore, we feel there is no need to go over the ground once again and shall report hereunder an overview of all the activities in a nut shell since inception till date and justify the need to install an effective functional monitoring system and to document in detail the operationalisation of field level modalities in developing a full proof monitoring mechanism to be taken up on an experimental/pilot basis in the Hindupur sector (Hindupur, Guribanda and Madakasira mandals) in next three months (January – March 2000).

OVERVIEW OF THE ACTIVITIES UNDER HEALTH INITIATIVES (1996-99)

Introduction:

It is now becoming increasingly clear that there is a strong relationship between sustained poverty, ill-health and cost of medical care. Poverty is a fertile ground on which overwhelming majority of diseases grow and affect the poor. In addition, poverty is directly related to poor social status, which drastically reduces the access of the poor to the available health care resources, making them even further vulnerable to diseases. This chain continues, as the outcome of ill-health is more poverty. Thus, in brief, for the poor, health status is an outcome of an indicator of the degree of, and a condition for emancipation from poverty.

The Human Development Reports (HDRs) published by the United Nations Development Programme (UNDP) looks at Poverty much beyond income or material poverty and defines Human Poverty as denial of choices and opportunities to live a tolerable life. The new concept of Human Poverty Index (HPI) as advocated in these reports concentrates on deprivations in 3 essential elements of human life i.e., a) longevity (vulnerability to death at a relatively early age i.e., 40 years), b) knowledge (illiteracy) and c) decent standard of living {access to: safe drinking water, basic health facilities, food (in terms of malnourished children)}. Interestingly enough, most of the variables used in the HPI directly or indirectly are related to health.

The cost of medical care borne by poor when accessing services, purchasing medicines and other necessities (including the travel cost etc.) – is likely to be one of the important cause in perpetuating an increasing poverty. Several studies have also shown that the poorest segments of the population spend higher amounts in proportion to their incomes for seeking medical care, even the NCAER study has shown that the poor spend on an average about 15% to 20% on treatment of diseases as against 6% among the better off. From our own experience under the SAPAP, we have also observed that a substantial part of medical/health expenditure of poor families is taken on loans.

Background about the SAPAP

The UNDP supported SAPAP being implemented since 1996 in 671 habitations spreadover 20 mandals in 3 districts of Kurnool, Mahabubnagar and Ananthapur of Andhra Pradesh, seeks to demonstrate a pro-poor perspective nurturing the potentialities within the poor with thrust on social mobilisation as a critical element for poverty alleviation. The project strategy relied on the triad of 1) social organisation of poor - facilitated through social guidance, 2) skill development - to nurture inherent capacities and potentialities and 3) capital formation - for improved quality of life. The programme initiatives have enabled the poor build their own organisations (SHGs, VOs and Mandal Samakhyas/Ikya Sanghams) at grassroots through social mobilisation. The programme invigorates the process of empowerment of poor to secure greater access to resource for poverty alleviation.

During these 2 years, the poor in the project area have demonstrated their inherent potential to help themselves. The SHGs, VOs and Mandala Samakhyas promoted and developed with programme initiatives are attaining self-reliance. The organisations of the poor are effectively addressing social dimension of poverty also.

HEALTH INITIATIVES

In the background indicated above, recognising the importance of health in a Poverty Alleviation Programme such as ours, a health component has been incorporated. The approach and strategy of health initiatives followed is in consonance and congruence with broader conceptual framework of the main poverty alleviation programme, which is based on the premise and conviction that "*willingness within the people to help themselves*". The focus and emphasis is on developing community based preventive health initiatives in which the community fully participates and is involved at every stage. The other main areas of strategic emphasis are training, communication, social mobilisation and advocacy.

Community Health Activist (CHA) is the nucleus of the initiative. A woman form among the members of SHGs chosen by the Village Organisation (VO) is designated as CHA. She is trained intensively for 15 days (in tow spells of 8 & 7 days) so that she is adequately equiped with knowledge and skills needed to perform her tasks effectively. CHA is well trained to provide preventive and promotive health care and is expected to be a dynamic link between the community and formal health system, a critical factor hitherto missiing.

To begin with, before initiating health activities in Orvakal mandal of Kurnool District, Sakunala village of the same mandal was taken up for an in-depth study during the month of November'96 to test whether the approach of community based health initiatives was feasible for replication. And the Sakunala study brought out very clearly that the approach of involving people at every stage and at every level was possible, feasible and practical.

It was found that in a small colony of less than 100 households (98), the people had spent a staggering Rs.97,560-00 (nearly 1.00 lakh) in preceding 6 months apparently for health (but in real sense, it was for their ill-health and treatment of diseases only). The amount spent was not just only for treatment (medical consultancy and purchase of medicines) but also included such other expenses like travel cost, accommodation, food etc., not only for the patient but for attendants as well. Loss of daily wages (both for the patient and for the attendants) has also been included. In simple terms it meant that Rs.2.00 lakhs drained off form this small colony of about 100 households in one year i.e., on an average a family/household was spending Rs.2000/- annually as compared to Rs.365/- (@ Re.1 per day) which it was saving through thrift by the help of the SHG, which can very well be compared to a "*Leaking Bucket*". People themselves understood the implication of such a huge amount

drained off, and here exactly, the people (women of the SHGs) were very much keen and interested to reduce the burden substantially by receiving inputs in terms of information and knowledge aimed at prevention of disease, nutrition, water, sanitation and personal hygiene from any source that is available. It is for this very reason that there is an increasing concern to empower the poor (particularly the women) with information and knowledge that would enable them to lead healthier lives by bringing about changes in their behaviour and attitudes towards their own health.

The minimum programme goals of this initiative are the following:

- To improve the health knowledge of the poor (with a focus on the poorest of the poor SHG members and their families)
- To bring about a perceptible positive behavioural change in relation specifically to sanitation and personal hygiene among the poor
- To help access the existing health facilities by the poor by establishing linkages with the providers
- To benefit such vulnerable/focal groups namely pregnant women, infants, children, adolescent girls, old/disabled persons and persons suffering from chronic diseases in terms of availing relevant services/referrals etc.

In order to achieve the above goals, the specific activities, which are being initiated, are the following.

1. Establish linkages with Village Organisations (VOs), Self Help Group (SHG) members and other organised groups like Balika Sanghams, wherever male snaghams exist etc., for health education in a regular basis by-
   - Conducting specific sessions on important topics directed towards bringing about change in health related behaviour particularly in relation to sanitation and personal hygiene.
   - Interacting with groups informally during routine self help group meetings, meeting of the Village Ikya Sangham etc.
2. Establish linkages with focal groups viz., pregnant women, mothers of infants/children under 5, adolescent girls by organising special sessions with adolescent girls and by providing necessary inputs in terms of ANC and PNC in case of pregnant women and lactating mothers.
3. Conduct sessions with adolescent girls especially on issues of personal and menstrual hygiene.
4. Establish linkages with the Government Health/ICDS Functionaries at mandal level (PHC Doctor, ANM, ICDS Supervisor, AWW and otehrs)
5. Conduct training for the CHAs in tow phases of 8 & 7 days each and refresher training as well.
6. Provide CHAs with a kit containing pictorial charts (posters) and corresponding manuals to impart health education/sensitisation among the SHG members.

The CHA is the main actor in this initiative and for all practical purpose, she is a health educator. The three main objectives of health education are:

- Informing people
- Motivating people and
- Guiding into action

The Tasks which are being performed by the CHAs are the following:

- Providing health education
- Motivating mothers to bring children for immunisation
- Motivating pregnant women for Ante-Natal Care (ANC) Registration and follow-up of ANC and Post-Natal Care (PNC)
- Motivating Eligible Couples to adopt Family Planning
- Register Births and Deaths
- To support and co-operate the Auxiliary Nurse Midwife (ANM) and Health Workers of Government Machinery, Anganwadi Workers (AWW) & other functionaries of ICDS etc (to establish meaningful linkages)
- To provide first aid and treat minor ailments and refer cases in right time
- Promoting simple home remedies (which has usually no harmful side effects) and if possible use of herbs.

Keeping in mind that most of the CHAs are semi-literate/illiterate, to makethe task of providing health education simple and understandable, 8 modules have been prepared in Telugu containing 85 pictorial charts.

Thus, an attempt has been made to give all necessary information in pictorial form and brief messages in these multi-coloured posters. The posters are accompanied by corresponding manuals instructing the users how to use the charts. (The manuals are also in Telugu). They cover the following topics.

- Pre-natal and Post-natal care
- Child care
- Food and Nutrition
- Family planning
- Reproductive health care of women
- Communicable diseases
- Environmental sanitation & personal hygiene and
- First Aid.

What follows in the next page is the information on the modules and the posters in detail.

COMMUNITY HEALTH

MODULE-1

PRE-NATAL & POST- NATAL CARE

1) Conception at right age
2) Early Registration 1st Examination–weight & Height Urine test BP testing
3) " " Tetanus injection
4) " " Blood test for HB
Foetal Heart Sounds

5) Health check-ups for pregnant women
6) Diet for Pregnant woman
7) Enough rest
8) Minor problems – (Morning sickness Nausea, Vomiting, Backpain, Heartburn, Constipation,
9) High risk problems 1) Early age, late age, short height, prime, BOH
10) " " 1) Oedema, severe bleeding
11) Preparing for delivery

12) Safe delivery... 1) 5 cleans and delivery with the help of Dai.
13) Emergencies during child birth –Malposition, Malpresentations prolonged labour etc.
14) Post-Natal care of mother
15) Care of the new born child

MODULE-2

CHILD CARE

1) Breast-feed
2) The care of new born
3) Food for child – 0 to 12 months
4) Growth mile-stones – 0 to 12 months
5 stages wt and progress
5) Six killer diseases – symptoms
6) Immunization schedule Fundal Palpation
7) Growth of the child 1st to 5th year-Growth in wt.
8) AR - Common cold –Symptoms/ remedies, Sore throat, Pneumonia (Referrals Doctor's advice)
9) Diarrhoea/Dysentry – Continue light feed extra feed
- after recovery, ORS
10) Malnutrition (Vicious cycle)

11) Deficiencies
- Kwashiorkor * Marasmus * Vit A Deficiency
- Vit B Deficiency * Anaemia * Iodine Deficiency

MODULE-3

FOOD & NUTRITION

Types of Food:
1) Types of food
2) Carbohydrates/Proteins

3) Fats/Vitamins Minerals
4) Balanced diet
5) Malnutrition (Kwashiorkor Marasmus)

6) Vit.A deficiency (night blindness), Vit. B deficiency (cracking of lips)
7) Anaemia -Iodine deficiency

FOOD FOR CHILD
8) Breast-feeding
9) Immediately after birth (0-3 months)
10) Food for Child (4-6 months)
11) Food for Child (7-9 months)
12) Food for Child (10-12 months)
FOOD FOR
13) Pregnant woman, Lactating mother, Sick/ill aged

MODULE-4

FAMILY PLANNING

1) Small happy family
A happy family with 2 children
2) Too big family (5 children) children working with parents
3) When to have the first child
4) When to have the second child
5) Temporary methods of contraception for Women (copper-T, oral pills)
6) Temporary methods of contraception for Men (Nirodh)
7) Permanent methods of contraception Women–Tubectomy&Men Vasectomy

8) Medical termination of pregnancy

MODULE-5

REPRODUCTIVE HEALTH CARE OF WOMEN

1) Life cycle of woman
2) Puberty
3) Menstrual cycle and care
4) Pregnancy & Child Birth
5) Anaemia
6) Reproductive health problems-1
7) Reproductive health problems-2
8) Care at Menopause Age 45 to 55

MODULE-6

COMMUNICABLE DISEASES

1) Malaria
2) Filariasis and brain fever
3) Tuberculosis (TB)
4) Leprosy
5) AIDS (HIV)
6) Jaundice
7) Diarrhea – Dysentry-1
8) Diarrhea – Dysentry-2 (Dehydration)
9) Typhoid

MODULE-7

ENVIRONMENTAL SANITATION & PERSONAL HYGIENE

Environmental Sanitation

1) What is Sanitation?
2) Sanitation at home
3) Sanitation outside house
4) Management of drainage
5) Usage of –latrines & construction
6) Management of Garbage & Animal waste
7) Safe Drinking Water
8) Personal Hygiene (1) Keep the body clean
9) Personal Hygiene (2) Some good habits

MODULE-8

FIRST - AID

1) Unconsciousness
2) Wounds & Bleeding
3) Falls, Injuries
4) Broken Bones
5) Some Bandages & Slings
6) Burns & Scalds
7) Electric shock & Effects of heat
8) Fevers, Loose motions, vomiting
9) Poisoning
10) Foreign Bodies in throat, ear, nose, Eye
11) Bites & Stings.

Need to document and develop effective functional monitoring system:- An experimental exercise in Hindupur Sector, Ananthapur District – January – March 2000.

As things stand today, about 250 CHAs (to be precise 248 in all – 104 from Ananthapur district, 72 each from Kurnool and Mahaboobnagar districts) have been trained and positioned in their respective villages, where the Village Organisations (VOs) are owning and sustaining them

Now that CHAs are already positioned in their respective villages and are implementing their tasks, in order to have a continuous follow up and close monitoring every month refresher course /review of 2 days duration is no doubt conducted at the mandal/PHC level, but still much is desired and there is an urgent need to install an effective functional monitoring system which can be used for mandal level planning as well as constant feed back for health programme improvement. Some preliminary efforts in this direction have already been made in Hindupur sector (Hindupur, Gunibanda and Madakasira mandals) in Ananthapur district where maximum number of CHAs (over 60) have been trained and positioned. Keeping the above in mind there is a need to document in detail the operationalisation of field level modalities in developing a full proof monitoring mechanism. This exercise is needed to be taken up on an experimental/pilot basis in the three mandals of Hindupur sector (viz. Hindupur, Gunibanda and Madakasira mandal) and the PO(H) can be stationed at Hindupur for next three months i.e form January to March end, 2000 to implement to this pilot project.

Health and Poverty in the Context of Country Development Strategy

By
Binayak Sen, Ph.D.

For
World Health Organization
Dhaka, Bangladesh
September 1996

I. Health in the Overall Strategy for Poverty Alleviation

The poverty alleviation strategy adopted by the Government is based essentially on three mutually supporting approaches. The first and foremost is to influence poverty indirectly via the growth channel. Development of physical infrastructures such as road, electrification, and modern irrigation are examples of growth oriented programmes. The second approach is to raise the direct capability of the poor via increased social sector allocations (education and health). The spread of primary education and expanded programmes for immunization in the recent years are relevant examples in this regard. The last but not the least, governments also attempts to help directly in mitigating the severity of poverty via public safety net schemes. Food for Works and Vulnerable Group Development for the extreme poor households are examples of the third kind. Many of these programmes are implemented through the collaboration of government and NGO agencies.

Despite some modest progress in poverty reduction in recent years, there are several areas of policy concern which are important to take into account in the context of the Fifth Population and Health project. Of all the measures that are currently under implementation, curative health care for the poor in both rural and urban areas remains in the most dismal state. It is not only an issue of quality (which is also important in case of other programmes such as primary and secondary education), but also one of quantitative access. The sheer absence of any urban health infrastructure is a case in point. The access of the rural population to public health care is extremely limited, being restricted to 12 per cent of rural households. This proportion has remained remarkably stable over the years, at least during the period since mid eighties.

The above realization has brought to the fore the issue of health care as an integral part of the national poverty alleviation strategy. What is the level of access by various groups of the poor to different health care providers? How successful is the existing network of public health facility in reaching the poor and mitigating the stress of the health-hazards? What is the consequence of having ill health for a faster and sustained poverty alleviation? And, finally, how to situate and strengthen the poverty focus in the design of health interventions? While comprehensive answer to these issues requires a much detailed review, we shall discuss some of the first-order concerns relating to the nexus of health and poverty.

Summary Points

* ***Although three prong approaches to poverty via growth, direct interventions in education and health, and safety net transfer programmes are widely recognised, the actual progress made on the health front is highly unsatisfactory.***

* ***It is postulated that the lack of adequate attention to health concerns has adverse poverty implications both in the short and the long-term.***

II. Profile of the Poor and the Poorest

Before we proceed to discuss the health implications of poverty, it is useful to know the profile of the poor. Who constitute the poor? What are their socio-economic characteristics? Is there differentiation within the poor community? These are some of the questions which lie at the heart of the following discussion. The empirical evidence is mainly drawn from rural surveys supplemented by broad observations culled from the urban scenario. This has been conditioned by two principal considerations. *First*, urban poverty situation is a relatively under-researched area and comparable urban data do not exist on many counts not the least of which is the absence of a standard poverty profile according to per capita income (consumption) classification.[1] *Second*, about 90 per cent of the poor still live in rural areas which requires that special emphasis be given to analyzing the rural conditions.

(A) Differentiation within the Poor

Using a number of criteria (i.e., income/calorie measure, self-categorization of households according to surplus/ deficit status, living standard indicators, etc), one can examine whether a sharp differentiation exists within the poor community. All of these measures are, however, scarcely available for a given survey year and survey agency. The 62-village panel survey periodically carried out by Bangladesh Institute of Development Studies (BIDS), for instance, provides income-based poverty estimates but do not present consumption (calorie) based estimates. The Household Expenditure Surveys (HES) of the Bangladesh Bureau of Statistics (BBS) present both income and calorie based estimates but do not use the self-categorization indicator. Similarly, until recently, the housing indicator (which is more directly expressive of the poverty scale compared to the income or self-evaluation indicators) is also missing in HES as a means for identifying the poor. Despite these differences in terms of emphasis between various agencies, sharp differentiation within the poor community can be seen through the prism of every single indicator.

The BIDS survey provides a recent estimate of rural poverty measured in the income space. It reveals that about 52 per cent of the rural population lived in absolute poverty in 1994. This poor

---

[1] The recently concluded ADB-sponsored study on urban poverty is, perhaps, the only exception in this regard. But, the poverty estimates presented in this study seem to be biased rather to the high side (about 60 per cent, which is substantially higher than even the current level of rural absolute poverty of 48-52 per cent). At least, this is the preliminary impression that one gets when the findings of this study are analyzed in the backdrop of Household Expenditure Surveys (HES) of the Bangladesh Bureau of Statistics (BBS).

population is divided into two distinct groups-- moderate poor (29 per cent) and hard core poor (23 per cent). In other words, in 1994 about 44 per cent of the poor population fell into the category of 'hard core' poor.

The most recent HES that is currently available relates to 1991/92 which allows to construct poverty estimates by the direct calorie intake method. Following this approach, one may identify several layers among the poor. BBS, for instance, considers two extreme poverty lines: one corresponds to 1805 calories per day per person (i.e., about 85 per cent of the absolute poverty line of 2122 calories per day per person); the other line corresponds to 1600 calories per day per person (i.e., about 75 per cent of the absolute poverty line). Despite the arbitrariness involved in ascertaining the second extreme poverty line, it relays an alarming message. Even if one takes 1600 calories per day person as the cut-off mark for severest poverty, the proportion of rural population living below that line would be 18.3 per cent in 1991/92. As a proportion of the total rural poor in 1991/92, this translates into an alarming figure of 38 percent.

The above picture of sharp differentiation among the poor is also confirmed by the perception survey. According to the self-categorization of the respondents of the BIDS survey, in 1994 the number of rural households who lived in chronic deficit throughout the year was 19 per cent, while households facing occasional deficit stood at 32 per cent.

The housing indicator identifies an even more extreme level of distress. This is done by using the BIDS survey data. The housing status is defined by considering the roof/ wall characteristics of the structure as well as the number of rooms in a house. This yields 4 categories: (i) jhupri, (ii) single structure house, (iii) thatch and more than one room, and (iv) other more durable types. In 1989/90, the "single structure" category represented 23 per cent and the "Jhupri" category represented 9 per cent of rural households. If one focuses on the hard core poor (defined in income space) residing in these two categories at the bottom end of the housing scale, one may capture the most vulnerable segment (the poorest of the poor) within the rural poor. This segment constituted about 13 per cent of rural households and represented 23 per cent of the rural poor.

Access to minimum clothing is another identifying indicator for capturing the extreme expression of poverty. Proportion of rural population without two sets of minimum clothing was assessed at 15 per cent in 1989/90; those without any winter clothing was as high as 22 per cent.

While various identifying indicators point to the existence of significant differentiation within the poor community, it is difficult to conclude which of these best captures the extent of disparity among the poor. The choice of particular method of estimating poverty may have significant implication for assessing the *size* of the hard core poor population (an obvious item of

concern for the policy makers). The 1991/92 HES carried out by BBS may be used to illustrate the nature of the problem. Thus, according to the direct calorie intake method, the proportion living in moderate poverty (1805-2111 Kcal per person per day) in that year was 18 per cent. This is much lower than the estimated share of the hard core poor (defined up to 1805 K. cal per person per day) which was assessed at 28 per cent. However, if one goes by the yardstick of income measure, the rural poor population becomes almost evenly divided into moderate and hard core poor groups (24 and 26 per cent, respectively).

The upshot of the above is to point out the large gap that exists between the poor and the poorest in rural Bangladesh. The poorest are not small in number or to be viewed as a localized phenomenon limited to particular regions. They are spread across the country. The next section explores their demarcating characteristics vis-a-vis the moderate poor and the non-poor.

Summary Points

* ***A significant differentiation exists within the poor irrespective of the criteria one chooses for demarcating the poor (income, consumption, housing, clothing, etc).***

* ***In designing health interventions, particular emphasis needs to be placed on reaching the extreme poor who represent about 44 per cent of the total poor as per the income criteria.***

(B) The Face of the Hard Core Poverty

The poor are defined in this section in the income space. The absolute poverty line of taka 4790 per person per year in 1989/90 prices has been used to differentiate the poor from the non-poor; the extreme poverty line corresponds to about 60 per cent of the absolute poverty line. The main variables that have been used in this section for identifying the population who comprise the hard core poor are: land ownership, land tenure, principal occupation, level of education, and gender status (see, annex tables 1 through 6).

Nearly 53 per cent of the hard core poor are concentrated in households having no cultivated land and 90 per cent in households owning less than 1.5 acres. This suggests that hard core poverty inflicts mostly landless and marginal landowning households. This is not surprising since land still remains the most important income earning asset within the rural economy. One implication of this finding is that the current (NGO) practice of targeting households owning up to 0.5 acres may still

miss a considerable section of the hard core poor. About 37 per cent of the latter reside in the land-size group of 0.5-1.5 acres. There is a need to bring these households under poverty alleviation programmes.

Access of land through the tenancy market does not improve the extreme poverty situation of the landless households. The incidence of hard core poverty is almost the same for the landless non-cultivator households as for the pure tenant farmers (47 vis-a-vis 44 per cent) who rent their entire holding. These two categories considered together constitute 41 per cent of rural households but contain 60 per cent of the hard core poor. In contrast, the mixed tenants and the owner cultivators are mostly represented by the moderate and the non-poor. Thus, only 15 to 17 per cent of the population belonging to these households are "hard core" poor. It is possible that, lacking capital as well as networking capacity, most of the extreme poor households are competed out in the tenancy market by the more entrepreneurial sections belonging to the moderate and the non-poor groups.

Among various occupational groups the cultivator households have the lowest incidence of poverty. Only 16 per cent of the population in the cultivator households are hard core poor and another 25 per cent-- moderate poor. At the other end, households who depend entirely on manual labour, such as agricultural and non-agricultural wage workers, transport and construction workers have the highest incidence of poverty, particularly hard core poverty. Non-farm households with capital (trader) and better quality human resources (service holder) occupy an intermediate position in terms of poverty ranking and are substantially better off than the wage labourers (47-53 per cent compared with 84-86 per cent).

An overwhelming proportion of the hard core poor (75 per cent) are located in marginal cultivator and wage labour households. Within the category of wage labour, non-agricultural households have lower incidence of hard core poverty than agricultural labour households. A further differentiation can be observed within the agricultural wage labour households as well: workers who have better health and are better endowed with mental and physical skills generally hire out for piece rated work which have much higher return to labour compared to work which are valued at daily wage rate. The share of contract labour for piece rated work is increasing over time and now constitutes about 30 per cent of those who supply their labour to the agricultural labour market. A recent comparison between various category of agricultural workers shows that the average wage income for piece rated workers is about 30 per cent higher than that earned by those working for a daily wage.

The level of education is also found to be an important correlate of hard core poverty. Households whose heads had no formal schooling contain 60 per cent of the hard core poor while those with "above secondary" education, only 5 per cent. Nearly 88 per cent of the hard core poor

remain in households who are either illiterate or have attended only primary schools. The importance of education is amply demonstrated by these findings.

A significant gender dimension is associated with the phenomenon of hard core poverty. While 28 per cent of male headed households fall within the hard core poor, the corresponding figure for female headed households is 33 per cent. On average, it is seen that females have a nutritional intake only 88 per cent that of males and 46 per cent of the wage rate earned by males. Only 29 per cent of females are literate compared to 45 per cent males. Female headed and female managed households constitute about one-tenth of rural households and represent perhaps the most vulnerable social group within rural society.

This provides us the context within which the issues related to the health-poverty interface need to be articulated and contested. This is attempted in the subsequent section.

Summary Points

* *There are important correlates of hard core poverty. They provide a useful guide for identifying the poorest as potential beneficiaries of public health related interventions.*

* *The hard core poor own little land but not necessarily is restricted to the lowest land-size group. While 53 per cent of the hard core poor belong to the above group, another 37 per cent belong to the marginal category owning less than 1.5 acres. Thus, the current (NGO) practice of targeting households owning up to 0.5 acres may still miss a considerable section of the hard core poor. There is a need to bring these households under poverty alleviation programmes.*

* *The hard core poor has very little link with the tenancy market and almost entirely comprise of illiterates who earn their livelihood mainly as low productive agricultural wage labour. They reside in single structure and extremely fragile (jhupri) houses.*

* *A large section of these households are female headed or female managed who experience additional vulnerability as women over and above the problem of severe income poverty.*

III. Interface between Health and Poverty

(A) Morbidity Rate by Poverty Status

Here we consider the rate of morbidity for all types of illness. The 62-village survey of BIDS carried out in 1994 has been used for the purpose. The overall morbidity rate is defined as the proportion of sick household members during one month preceding the survey. It is estimated at 12.5 per cent in the rural area. Several aspects are noteworthy in this regard (Annex table 7).

First, morbidity varies considerably by age. The period prevalence rate of morbidity (referring to one month period) and age have an U-shaped relationship indicating concentration of high morbidity risk at the two ends of life. The morbidity rate for the elderly people aged 60+ is about 24 per cent and that for children aged under 5 is 22 per cent. The morbidity risk of the rural people starts declining after age 5 and the process continues up to age 29 and then take an upward trend. From age 30 the morbidity risk increases monotonically with an acceleration after age 59.

Second, there is some variation in morbidity rate by poverty status. The morbidity rate for acute illness is about 15 per cent in case of the hard core poor which is considerably higher than the matched figure for the moderate and non-poor (about 12 per cent). The greater vulnerability of the hard core poor is also revealed in the incidence of repeat and major illness.[2] This has strong implication for the income earning capacity of the hard core poor. The latter's only income generating asset is the labour power which is mostly employed in hard manual work and hence, the added importance of maintaining better health for this group.

The higher proneness of the hard core poor households to diseases and sickness is also reflected in the BBS data. Prevalence of morbidity per 1000 rural population in 1994 was 147 in case of households owning more than 5 acres of land which may be contrasted to 175 observed for households with less than 50 decimals of land. Such sharp differentiation in morbidity will predictably entail higher mortality rates in the poorer groups. Thus, as per the BBS data, infant mortality rate recorded in case of landless and functionally landless households (owning up to 0.5

---

[2] The information on sickness was collected through three separate inquiries: (a) acute illness of the household members during one month preceding the date of enumeration; (b) the repeat illnesses of the members not enumerated in the first inquiry i.e. members who are not ill during the preceding month but fall sick off and on from one or the other diseases; and (c) major illnesses suffered by the members during last one year.

acre of land and largely corresponding to hardcore poverty) is more than two times higher than the matched level observed in the large landowning groups (90-95 vis-a-vis 40). The same applies to the indicator of crude death rate as well (Annex tables 8 and 9).

Third, both the moderate and the non-poor categories face almost similar risk from diseases. This may be one indication that, after a certain income interval, the non-food physical environment still may be the major determinant of health status in rural area.

Summary Points

* ***Poverty is associated with higher incidence of sickness and diseases. Both BIDS and BBS data point to the much higher morbidity and mortality rates among the hard core poor vis-a-vis the moderate and the non-poor.***

* ***Both the moderate and the non-poor categories face almost similar risk from diseases indicating that, after a certain income interval, the non-food physical environment still may be the major determinant of health status.***

(B) Health Care Access by Poverty Status

What is the current status of health care access by different groups of the poor in rural areas? Health care is defined broadly in this section and includes modern allopathy to crude *totka* and spiritual healing having little scientific basis.

The most striking aspect that emerges from the available evidence relates to the very limited access to public health care facility (Annex table 10). In general, the level of access varies little across poverty status, averaging at about 12 per cent for acute illness. For major illness, the access level is higher (about 23 per cent). More disturbing is the fact that the public sector role is shrinking over time. In 1984, about 20 per cent of the total rural treatment for acute illness was done in the public sector. This declined to 13 per cent in 1987 while the recent estimate for 1994 is just 12 per cent (Begum 1995).

What are the factors underlying the poor performance of public health care facility in rural areas? It appears that the supply side constraints play the dominant role here. According to one estimate, about 30 per cent of the Thana Health Complex (THC) lack adequate equipment and

supplies of pharmaceutical. The absenteeism of the doctors is rampant: 3 out of 9 doctors are physically present in THCs and that too for only a limited period of time. The problem of inadequate personnel management is also linked to the poor incentives for the urban-centric doctors with higher medical degrees to work in the rural areas. This is related to the overall problem of incentive compatibility of the institutional design and can be traced back to the abolishment of the very important intermediate tier of health service personnel, i.e., the paramedics.

The above trends are confirmed through a perception survey carried out in the late eighties (Annex table 11). "Inadequate attention given by the physician" is cited as the major reason for non-visit to public health facility (representing 28 per cent of responses), followed by lack of medicine (26 per cent of responses). Another 24 per cent cited poor quality of services involving long waiting time, absenteeism, ineffective treatment, charge of "extra" fees. While more needs to be documented on the quality of medicare as applied to rural and urban areas, there are strong impressions that the quality of public health care accessed by the urban poor is no better. Indeed, in one respect, urban public health care even lags behind its rural counterpart. In rural areas, there is a public health infrastructure at thana and union levels (THCs, sub-centres, dispensaries, maternity centres), and a referral system can be developed linking these levels with the district hospitals. Such infrastructure is virtually non-existent in urban areas. This results in tremendous load on the existing outpatient facility in the public hospitals which could have been reduced by lower tier medicare facility (say, at the Word level). Such a practice adversely affects both the access and the quality aspects.

If one focuses on the health care providers in the private sector, several trends are discernible. In general, the most notable development in this sector pertains to the emergence of medicine shops as a major actor in the area of rural private health. About 17 per cent of private treatment is provided by this source which is only next to the weight of quack allopathy practitioners. Another notable feature of current health care practice of rural people is that the totka and spiritual healing which used to enjoy much popularity earlier have virtually lost ground for the management of illness: these sources accounted for 9 per cent of the total treatment for acute illness in 1984; it has come down sharply to only 2 per cent in 1994. At the other end, only 21 per cent of private treatment is provided by qualified individual practitioner. The stunning absence of NGOs or private clinics is also notable.[3] This suggests that the predominant supplier of the rural health care is still the unqualified and untrained ones. Outside the sphere of public health care, rural population has only limited option for accessing quality services. This is particularly true for the hard core poor who can hardly afford to pay for the visits to quality private medicare.

---

[3] The case of qualified individual practitioners is not without some irony, however. The widely held view is that many of these practitioners are actually in the pay-roll of rural public health centres, but work most of the time as private doctors, often in their own medical shops.

Some variation in access can be noted among the poverty groups. As expected, the share of private treatment provided by qualified private practitioner is much lower in case of the hard core poor compared with the moderate and non-poor (13 vis-a-vis 19-27 per cent for the category of acute illness). This is matched by higher prevalence of totka and unqualified allopathy practitioner as sources of private medicare for the hard core poor. Hence, it is safe to conclude that not only the hard core poor are more prone to sickness and disease, the average quality of health care accessed by them is worse compared to their more privileged counterparts. This is suggestive of vicious circle of "morbidity-ill care-morbidity" that characterizes the existential destiny of the hard core poor.

Summary Points

* *The access to public health care in rural areas is extremely limited, about 12 per cent for acute illness and 23 per cent for major illness. Even at that low level, the access to public health is declining over time.*

* *The level of access varies little by rural poverty status reflecting in general the primacy of the supply side constraints.*

* *In general, the public health has suffered in a major way from the abolishment of the very important intermediate tier of health service personnel, i.e., the paramedics.*

* *The quality of public health access is very poor. This is true not only for rural areas, but also applies to urban areas. The quality issue, however, needs to be studied in greater details.*

* *From the policy point of view, the situation with regard to the urban poor seems to be in an even more precarious state. In rural areas, after all, there is a health infrastructure, and a referral system can be potentially developed linking the lower (thana/ union) levels with the district levels. Such infrastructure is virtually non-existent in urban areas. This results in tremendous load on the existing outpatient facility in the public hospitals which could have been reduced by lower tier medicare facility (say, at the Word level).*

(C) Poverty Implications Ill-health

So far the discussion has centered around only one aspect of the health economics of being poor, namely, how poverty affects the likelihood of getting sick and receiving quality health care service at affordable price for the treatment of such sickness. In this section, we shall consider the reverse causation, i.e., how lack of adequate health care places the rural households at even greater risks of slippage into the downward spiral of poverty.

We start by exploring the cost of the burden that private treatment expenditures impose on the rural poor. Households are ranked by per capita income and grouped into ten deciles. Average private expenditure per household on medical treatment is computed for each decile and expressed as percentage of total household income. We also did the similar "incidence" exercise for estimating the "gross" benefits from public health allocations that are currently received by different rural income groups.[4]

Several aspects of the health-poverty interface are notable from this exercise (Annex table 12). *First*, the hard core poor households (corresponding to the lowest two income deciles) currently spend 7-10 per cent of their income to cover private health expenses which is a sizable burden by any reckoning. If this burden can be relieved through greater targeting and provision of public health care, this would have substantial poverty alleviating effect.

Second, this is just one aspect of the income erosion. The other, more critical, aspect of it lies

---

[4] The latter estimate is relatively tentative in nature, though the emerging trends seem plausible. To estimate the distribution of "benefits" from public health expenditure in rural areas, the relevant indicator to consider is the number of annual visits of household members to government facility. The survey-based figure of average annual visits per rural person has been used to approximate the total visits to government health facility by rural population, as recorded in 1994. Combining this information with macro budgetary data, one can estimate the "gross" subsidy per (rural) visit to government health facility. This is estimated to be taka 211 in 1994. Once the estimate of subsidy per health visit is known, one can calculate the total amount of benefits accruing to various income deciles using the survey information on the utilization of health facility. This is, of course, based on the assumption that unit costs are the same for the various income levels which is hardly satisfactory. However, such disaggregated data are not currently available.

in the acute vulnerability of the poor households to sudden and unanticipated health related shocks, leading to the loss of income and employment, and increased indebtedness. Health related shock represents important determinant of the downward mobility along the poverty spiral. Thus, additional analysis of panel data reveals that health hazard related risk-events explain, on average, 16 per cent of causes of deterioration experienced by households during the 1990-94 period. For non-poor households who slipped into hard core poverty, the share of health related causes is as high as 21 per cent. The importance of the health factor is also considerable (explaining 18 per cent of causes) for those among the moderate poor who descended into hard core poverty in the subsequent period (Sen 1996).

Third, underlying the adverse dynamic effects of ill-health on poverty is the way the households cope with the sudden and unanticipated crisis events. Data are available at the average rural household level. Only in 15 per cent of cases, the option of soft credit mobilization can be obtained. Negative methods of coping such as asset sale is recorded in 15 per cent of cases, while other forms of dissaving explain 60 per cent of coping mechanisms. High interest borrowing is recorded in only a few cases (4 per cent), implying the limited role that rural informal credit plays in providing risk-insurance. Thus, the almost exclusive reliance on disinvestment and dissaving has long-term adverse consequence for recovery, upward mobility and poverty alleviation.

Fourth, a comparison of the relative proportion of public and private health expenditures indicates that benefits through public health still cover a small part of the health care demand. The amount of "gross" benefits derived from public health spending represents only 0.5 per cent of average rural household income. The pattern of distribution of public health spending, however, shows certain degree of progressivity. Benefit from the latter source, as proportion of income, is found highest for the poorest (2.9 per cent) which declines almost secularly to 0.2 per cent in case of the top two deciles. This shows the potential re-distributive benefits associated with effective expansion of public health programmes in rural areas.

Summary Points

* ***Poor health imposes a significant burden on the poor. Such burden represents 7-10 per cent of the hard core poor's income. If this burden can be relieved through greater targeting and provision of public health care, this would have substantial poverty alleviating effect.***

* ***Acute vulnerability of the poor households to sudden and unanticipated health related shocks leads not only to the loss of income and employment, but also to increased***

indebtedness associated with the raising of coping costs. Poor health thus reduces the long-term accumulation and hence, growth capacity of the poor.

* *Health hazard related risk-events explain, on average, 16 per cent of causes of deterioration along the poverty spiral experienced by households during the 1990-94 period. For non-poor households who slipped subsequently into hard core poverty, the share of health related causes is as high as 21 per cent. While such slippage may origin in the stochastic nature of events, for many of these households it may well turn out to be a route to permanent poverty.*

* *Benefit from the public health spending is quite low, representing only 0.5 per cent of rural household income. The incidence of such spending, as proportion of income, however displays certain progressivity. It is found highest for the poorest decile (2.9 per cent), declining almost secularly to 0.2 per cent in case of the top two deciles. This shows the potential re-distributive benefits associated with effective expansion of public health programmes.*

IV. Some Broad Policy Implications

The preceding review points to several aspects of the health-poverty interface. *First*, the focus on income is just not enough for sustainable poverty alleviation. The routine approach to poverty alleviation through various growth-promoting (including micro credit) policies misses out a very important dimension of the income erosion problem facing the poor households. The threat of income erosion constantly exerts downward pressures along the poverty spiral. *Second*, Lack of adequate health care represents a particular source of income erosion for the poor, particularly the hard core segment of it. The burden of income loss represents about a tenth of hard core poor's income. The dynamic implications of ill health are even greater: health hazard related risks explain 16 per cent of all cases of downward movement along the poverty spiral. *Third*, to a large extent, such risks also explain the vulnerability of the *tomorrow's poor*. Thus, even for households who are otherwise classified as non-poor as per the income criteria, ill health has emerged as a prime concern and an important explanator of downward mobility.

It is in the above context that one needs to re-think the current strategy of poverty alleviation with its near total reliance on giving access to non-farm micro credit, training and the like through NGOs. Many of these programmes lack any explicit focus on health, particularly in its curative dimension. While access to credit/ training helps the poor to generate additional incomes, the net

impact of such policies is often nearly wiped out (or, at least greatly reduced) by the lack of adequate insurance mechanism against health-related risks. This may provide an important explanation as to why despite the proliferation of micro credit programmes, their net impact on poverty reduction at the aggregate level has been marginal.[5] We argue that all routes matter: what is needed is a mix of income generation and risks-insurance policies aiming at a faster reduction of poverty. In concrete terms, it would translate into an effective combination of health and micro credit (along with education) interventions targeted specifically to the poor.

Another major lacuna in the current thinking on poverty alleviation lies in the stunning lack of knowledge about possible health implications of the various sectoral policies that currently pass under "development". Many of these policies are implemented without considering the possible negative externalities associated with ill health. Expansion of primary education without a minimum provision for school-based health care, sanctioning of industrial units regardless of their pollution contents, the highly inadequate system for the safety of industrial workers, deteriorating quality of the so-called "safe" tubewell water, etc are some of the cases in point. Even for the readymade garments sector which employs over 600,000 women workers and earn over 65 per cent of the country's exports, there are no direct health care policies. But, the issue goes beyond just identifying the potential areas of health-distress in the profile of on-going sectoral policies and interventions.

A greater health awareness in the design of the sectoral policies will also help to promote positive health actions in many unexplored ways and areas. To what extent is health awareness built in the current primary and secondary education curricula? How can one strengthen public health awareness through mass media? What roles local governments (including the City Corporations) can play in ensuring a clean environment? At the moment we can only pose these questions. There is hardly any study in Bangladesh which looked into the impact of sectoral policies on health.

As noted in the review, public health care is in a very dismal state in both rural and urban areas. The incentive compatibility of the institutional arrangement for public health is yet to be worked out, as revealed in the endemic problem of absenteeism of the doctors at rural THC. The abolishment of the paramedics as a very important tier of health personnel management had a far reaching adverse consequence for the rural poor's health care.

---

[5] This can be judged by various data. According to the household expenditure survey of BBS, rural poverty declined by only 1 per cent during the entire eight year period between 1983/94 and 1991/92. i.e., at a time when most of the NGOs have gone into credit operations (Ravallion and Sen 1996). The 62-village surveys carried out by BIDS also show the rate of poverty reduction to be rather modest: rural headcount declined by only 6 per cent in the seven year period between 1987 and 1994.

What are the options that exist beyond routine drives to improve upon the existing quality of public health? The involvement of NGOs in the field of curative health care is still in the stage of infancy and the strategic thinking on this score lacks a sense of direction and dynamism. The same applies to the potential case of promoting local social development activities with focus on community health care. The role of local government in this vital area of public life has been restricted to the minimum, if not virtually non-existent. How to re-orient the public agencies, NGOs and local communities to address the health concerns of the poor is something for which we do not yet possess a definitive institutional answer, but it surely represents a question marked with urgency that needs to be articulated and contested further.

References

Hossain, Mahabub, "Socioeconomic Characteristics of the Poor" in:
Rahman, Hossain Zillur, and Mahabub Hossain (ed.), Rethinking Rural Poverty. Bangladesh as a Case Study, Sage Publications, New Delhi, 1995.

Begum, Sharifa, "Health Dimensions of Poverty" in: Rahman, Hossain Zillur, Mahabub Hossain, and Binayak Sen (ed.), 1987-94: Dynamics of Rural Poverty in Bangladesh, Bangladesh Institute of Development Studies (BIDS), Dhaka, April 1996.

BBS (1996) Bangladesh Bureau of Statistics (BBS), Divisionwise Health and Social Statistics of Rural Bangladesh by Land Ownership 1994, Dhaka, April 1996.

Ravallion, Martin and Binayak Sen, "When Method Matters: Monitoring Poverty in Bangladesh" in Economic Development and Cultural Change, Vol. 44, No. 4, July 1996.

Sen, Binayak, "Movement In and Out of Poverty: A Tentative Explanation" in: Rahman, Hossain Zillur, Mahabub Hossain, and Binayak Sen (ed.), 1987-94: Dynamics of Rural Poverty in Bangladesh, Bangladesh Institute of Development Studies (BIDS), Dhaka, April 1996.

Sen (1996b), "Poverty and Policy" in Independent Review of Bangladesh's Development 1995/96, Centre for Policy Dialogue (forthcoming).

Annex

Table 1

Incidence of Poverty by Size of Land Ownership, 1989-90

Land ownership group (acres)	Extreme poverty		Extreme and moderate poverty	
	Incidence of poverty (per cent)	Share of the poor (per cent)	Incidence of poverty (per cent)	Share of the poor (per cent)
No cultivated land	47.0	53.0	78.3	43.9
Up to 0.49	42.3	19.1	71.4	16.0
0.5 - 1.49	24.8	17.4	60.9	21.2
1.5 - 2.49	11.8	4.5	44.5	9.1
2.5 - 4.99	8.4	4.1	31.2	7.7
5.0 and more	3.4	1.5	9.1	2.1
Total	27.5	100.0	55.4	100.0

Source: Hossain (1995). Analysis of Poverty Trends Project, BIDS: 62 Village Survey.

Table 2

Incidence of Poverty by Land Tenure, 1989-90

Land tenure group	Extreme poverty		Extreme and moderate poverty	
	Incidence of poverty (per cent)	Share of the poor (per cent)	Incidence of poverty (per cent)	Share of the poor (per cent)
Landless Non-cultivator	46.7	47.9	78.8	39.2
Pure-tenant	44.0	13.1	78.7	11.7
Tenant-owner	24.7	9.7	60.8	11.9
Owner-tenant	16.5	6.6	38.4	7.6
Owner culti-vator	14.9	22.6	39.3	29.6
Total	27.5	100.0	55.4	100.0

Source: Hossain (1995). Analysis of Poverty Trends Project, BIDS: 62 Village Survey.

Table 3

Incidence of Poverty by Education Status, 1989-90

Education level of the head	Extreme poverty		Extreme and moderate poverty	
	Incidence of poverty (per cent)	Share of the poor (per cent)	Incidence of poverty (per cent)	Share of the poor (per cent)
No formal schooling	37.5	60.1	68.5	54.5
Primary	22.2	28.2	56.0	32.3
Secondary	16.9	7.9	35.9	7.6
Above secondary	10.4	4.5	26.7	5.6
Total	27.5	100.0	55.4	100.0

Source: Hossain (1995). Analysis of Poverty Trends Project, BIDS: 62 Village Survey.

Table 5

Incidence of Extreme Poverty by Occupation Controlling Landholding Size, 1989-90

(Per cent of population)

Occupation	Landholding size (acres)			
	Less than 0.50	0.5 - 2.49	2.5 - 4.99	5.00 and above
Cultivator	54.1	18.9	7.5	3.0
Wage Labour	57.9	39.9	*	*
Traders	25.6	13.6	12.2	14.6
Service	35.8	20.5	17.1	16.4
Others	49.5	25.5	21.8	4.3

Source: Hossain (1995). Analysis of Poverty Trends Project, BIDS: 62 Village Survey.

Table 6

Characteristics of Hard Core Poor, Moderate Poor and Non-Poor Households, 1987/88

Variables	Extremely Poor	Moderately Poor	Non-Poor
Land and New Technology			
Land owned (acre)	1.02	1.14	2.15
Land Cultivated (acre)	1.59	1.85	2.72
Proportion of Area under Tenancy (%)	23.1	25.0	21.5
Proportion of Area under Modern Variety Rice (%)	30.9	37.1	45.1
Proportion of Area Irrigated (%)	24.2	26.1	35.1
Demographic Characteristics			
Family Size	6.53	5.96	5.85
Per Cent of Family			
Children below age 10	34.6	31.6	24.2
Males above age 10	33.3	35.0	42.7
Adult males (16 years and over)	24.1	26.8	33.4
Child-Woman Ratio	78.7	69.2	56.9

Education

Proportion of Students in Age Group 6-15 (%)			
Male	52.8	63.0	70.0
Female	43.0	56.5	61.8
Proportion of Illiterate Adult Members (%)	85.5	63.6	47.0
Proportion of Literate Adult Members with Higher Education (%)	9.7	14.4	24.7

Source: Hossain and Sen (1992)

Table 7

Morbidity rate by Sex, Age and Economic Condition: Rural Area

	Rate per 100		
	Acute illness	Repeat illness	Major illness
All	12.5	9.1	4.0
Sex			
Male	12.0	7.8	4.0
Female	13.1	10.6	4.1
Age (years)			
0-4	22.1	9.2	2.1
5-14	10.1	4.1	1.3
15-29	8.1	3.6	3.7
30-44	12.9	11.6	5.6
45-59	15.7	22.1	7.6
60+	23.6	30.9	10.2
Economic Condition			
Hardcore Poor	14.6	9.4	4.7
Moderate Poor	12.4	8.7	3.7
Non-Poor	11.6	9.0	3.9

Source: Begum (1996). Analysis of Poverty Trends Project, 62 Village Resurvey, 1995.

Table 8

Infant mortality rate (IMR) per 1000 live births by size of land owned (acres) and division in rural Bangladesh, 1994

Size of Land owned (Acres)	Total	Division				
		Barisal	Chittagong	Dhaka	Khulna	Rajshahi
Total	84.5	102.1	79.3	82.0	79.4	85.9
0.00 - 0.04	95.2	104.2	86.8	91.2	102.3	102.1
0.05 - 0.49	90.3	105.1	82.8	81.6	93.6	98.6
0.50 - 2.49	89.7	112.0	81.2	89.5	65.6	89.9
2.50 - 4.99	41.1	71.4	50.9	48.5	60.6	28.6
5.00 +	39.9	85.1	44.1	25.0	37.0	21.3

Source: BBS (1996).

Table 9

Crude death rate (CDR) per 1000 population by size of land owned (acres) and division in rural Bangladesh, 1994

Size of Land owned (Acres)	Total	Division				
		Barisal	Chittagong	Dhaka	Khulna	Rajshahi
Total	8.9	9.7	9.0	9.1	8.7	8.5
0.00 - 0.04	11.8	12.8	10.9	12.4	14.6	1.4
0.05 - 0.49	10.3	11.7	8.6	9.1	13.7	11.8
0.50 - 2.49	9.0	9.3	9.6	9.1	8.1	8.5
2.50 - 4.99	6.0	6.0	6.2	7.3	3.1	6.1
5.00 +	5.7	5.6	5.4	8.5	7.4	5.1

Source: BBS (1996).

Table 10

Source of Treatment by Economic Categories: Rural Area

(% household)

	Hardcore Poor	Moderate Poor	Non-Poor
Acute Illness (last treatment)			
A. Government Health Facilities	11.9	12.5	11.7
B. Non-Government Health Facilities	88.1	87.5	88.3
(i) Private Clinic	.8	1.9	1.3
(ii) Qualified Practitioner	12.7	19.2	27.2
(iii) Unqualified Practitioner	44.6	43.8	32.0
(iv) Homeopathy	5.2	3.4	3.6
(v) Kabiraji/Unani	3.6	3.0	5.2
(vi) Pharmacy	17.5	15.5	17.3
(vii) NGO	-	-	-
(viii) Totka	2.0	-	-
(ix) Own Knowledge/Other	1.6	.7	1.6
Major Illness (main treatment)			
A. Government Health Facilities	25.3	21.5	22.9
B. Non-Government Health Facilities	74.7	78.5	77.1
(i) Private Clinic	.4	2.5	2.6
(ii) Qualified Practitioner	28.9	35.4	41.8
(iii) Unqualified Practitioner	24.0	17.7	15.7
(iv) Homeopathy	2.4	-	2.0
(v) Kabiraji/Unani	8.4	8.9	7.2
(vi) NGO	1.2	2.5	-
(vii) Totka	-	1.3	-
(viii) Own Knowledge/Other	2.4	-	1.3

Source: Begum (1996). Analysis of Poverty Trends Project, 62 Village Resurvey, 1995.

Table 11

Reasons for Non-visiting the Government Health Centres by Allopathy users from Non-Government Sources

Reason	Percentage
Government health centre is far away and communication with the health centre is bad	9.2 (62)
Long waiting time	4.9 (33)
Doctors are not available often	1.9 (13)
Inadequate attention given by the physician*	28.1 (186)
Medicines ar not available	25.7 (172)
Government health centres ask for money	12.7 (85)
Treatment is no good	3.7 (25)
Other	13.6 (91)
All	100.0 (669)

* Includes answers like "doctors do not examine the patients carefully" or "doctors do not listen to the patients".

Note: Figures in parentheses indicate number of cases.

Table 12
Public and Private Health Expenditure Incidence by Per Capita Income Decile in Rural Bangladesh: 1994

(Annual figure in taka)

Decile	Per Capita income	Per Capita private health expenditure	Per Capita public health expenditure	(2) as % of (1)	(3) as % of (1)	(3) as % of (2)
	(1)	(2)	(3)	(4)	(5)	(6)
1	1693.58	173.50	48.71	10.2	2.9	28.0
2	2911.38	202.19	33.51	6.9	1.2	16.6
3	3678.96	208.29	46.20	5.7	1.3	22.2
4	4457.10	170.80	13.87	3.8	0.3	8.1
5	5361.35	187.40	67.46	3.5	1.3	36.0
6	6352.07	205.56	30.75	3.2	0.5	15.0
7	7930.18	194.14	32.59	2.4	0.4	16.8
8	9986.57	251.23	25.97	2.5	0.3	10.3
9	14291.59	297.74	27.50	2.1	0.2	9.2
10	26915.58	626.57	51.66	2.3	0.2	8.2