Poverty And Health: Universal Abuse Of Human Rights

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Summary: The links between poverty and health have been well documented and proved. The first two articles of the Universal Declaration of Human Rights continue to be abused universally as the poor live a life bereft of human dignity and suffer from ill-health and early death in all countries. If the world is serious about going beyond the platitudes of declaration of human rights and see them as a reality, the author argues that there needs to be a universal acceptance of a definition of humans without discriminations of any kind, including on the basis of place of birth. Universalisation of Human Rights needs to be seen as priority and that it can be possible through a small amendment in the UDHR and a more democratic UN.

The Universal Declaration of Human Rights (UDHR) in 1948 can be said to be a landmark in the fight for human rights. Articles 1 and 2[1] set out the applicability and basis of the rights given in the subsequent articles. These state that all people are born equal in dignity and rights and that these rights are guaranteed to everyone[2].

The success of the efforts of the Human Rights agenda cannot be denied. Despite the continuing differences of opinion against the universalisation of standards, esp. from the Asian countries[3], the concept of universality has been ratified by the successes seen in the drafting of regional charters of Human Rights in different forms in Asia, Africa, Europe and America. While the Africans take the concept of cultural relativism, the Asians emphasise the State and the other two only deal with civil and political rights.[4] Since societal development has never been the same anywhere, and human rights contents are rooted in certain social facts of particular societies, human rights are both conceived and observed differently, and universality the world over is at least a myth for the present[5].

Poverty, Human Rights and Public Health

One fourth of the world's population lives in conditions of severe poverty[6] without basic necessities of food, clothing, shelter, and hygiene and sanitation. There needs little argument to prove that conditions of abject poverty in developing and underdeveloped countries often does not support conditions of human dignity. The frustration of living insecure lives, facing hunger and disease as a habit often drives people to a life of crime, prostitution, selling of children and suicide.

Infant Mortality Rates are considered to be the best indicator of a community's health status.[7] That deaths due to infantile diseases – and also diseases like tuberculosis -- were linked to poverty and living conditions was proved by the classical work of McKeown.[8] In recognition of its links with the deaths of many people, an international code of diagnosis Z59.5 was provided to Extreme Poverty in 1993 to be available to physicians as a cause of death.[9] It isn't surprising that most of the world's people who die of poverty linked diseases e.g., diseases due to lack of nutrition, hygiene or sanitation live in the developing and underdeveloped countries.[10]

Besides living conditions, respect for human dignity has also been considered to be an essential element of health and well-being for all people.[11] That poor and marginalised people have had to suffer more than their fair share of indignity of not only infectious diseases, but also of public health measures to prevent or treat them as has been seen in the case of smallpox, cholera, venereal diseases, AIDS[12], and TB[13] and this is not a new phenomenon in public health history. Even to date, the poor are considered to be increasing their misery by breeding too much and subjected to coercive reproductive porgrammes[14],[15] by their governments. Other links between public health and human rights have been comprehensively demonstrated by Jonathan Mann where he states that human rights and human dignity are engaged to such an extent that physicians are compelled to go beyond the usual limited boundaries of medical care.[16]

Imperialism, Neoliberalism and Human Rights

Ninety percent of the world's poor live in developing and underdeveloped countries,[17] most of which were under imperialist rules till a few decades ago in Asia and Africa. The industrialisation of Europe

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and America helped exploit the natural reserves of pre-industrial societies of the other continents, and delayed the movements for democracy and liberalisation that were sweeping their own continents.[18] The governments of these countries are still struggling to come to terms with providing their populations a life of basic human dignity and fundamental human rights. Although most have signed their regional charters for human rights, they are more serious about civil and political rights than about dealing with poverty.

Although 'neoliberalism' has substituted for imperialism and the 'oligarchy' in the discourse of the left, it cannot be said that liberalisation directly causes human rights violations. To the contrary, most international investors prefer to work in liberal democracies and promote them. 'Market forces, however, do not just favour the rule of the law, but also bring about the exclusion and marginalisation of all those who do not have the necessary skills to adapt to the market economy'. Economic Reform in many countries has been centred around the International Monetary Fund and not just social inequity, but the state provisions for sectors like education, health and social security for the traditional poor and the middle class have deteriorated under the structural adjustments. These effects are likely to cause abrogation of human rights.[19] The disintegration of public order, criminality and human rights violations because of a sudden return to poverty for a large part of population in South East Asia in last year's economic collapse can be seen in the same light.

Responsibility of Human Rights

Because of such effects of the recent history of imperialism, of marketisation of economies and other effects beyond their immediate control, many governments have been hesitating in accepting universal standards of human rights because the Preamble of the UDHR exhorts member states to provide the rights and liberties; consequently it is they who will be held responsible for any violation.

But is it fair that nation-states should be held accountable for all lapses in human rights? For crimes like those of ethnic cleansing with official complicity, as in the case of Rwanda and Yugoslavia[20], most seem to agree that the two tribunals that looked into the crimes cannot be faulted for their indictments of governments and their officials. Even then, there is a concern amongst smaller and poorer nations that their human rights are more likely to be highlighted and punished by the Americans and Europeans, who are seen as pushing the Human Rights agenda, in comparison to the violations of US -- and many of its world-wide authoritarian allies, like China -- which itself has had a rather vacillating and arbitrary concern for human rights[21].

External factors

For human rights violations that occur on account of nation states functioning in a global village scenario with a history and geography allocated to them without a democratic choice, can the distinction be clear as to who ought to be blamed?

Firstly, the tragedies of Rwanda cannot be wished away by a simple indictment and punishment of officials. Maurice King would argue that the Rwandan tragedy would be followed by many more and should be seen more as a public health crisis of decreasing mortality rates amongst demographic populations who are trapped in a fixed resource scenario and suffer from a phenomenon of 'demographic entrapment'.[22]

Secondly, although nations - states are expected to deliver human rights as a legacy of the Westphalian order of Europe developed since the 17th century,[23] the sovereignty of states over nations has not been so easy. The geography was allotted to states in a hurry after the Second World War by an arbitrary drawing of lines – often ruler-straight, as any map of Africa will display -- by cartographers cutting nations of people into several states, e.g., the Kurds in Turkey, Iraq, Iran, Syria, Armenia and Azerbaijan; the Tutsis and Hutus, both in Rwanda and Burundi; Tamils in India and Sri Lanka, etc. Also, nations held together by a brutal and undemocratic colonial power were handed over to the dominant nation-state at the time of departure by the Western powers. The new governments are expected to hold on to the pieces of cake by the processes of democracy, which is not easy if democracy can be equated to be the dictatorship of the majority. With the rights of indigenous people being recognised and supported by the international community, democratic governments coming to power by the will of the majority are unable to grant secession rights to the minorities. For instance,

India can be seen to face endless problems in balancing human rights concerns voiced from within and outside the country, and the majority's aspirations of not losing any more land in Nagaland and Kashmir.

Thirdly, armed conflicts are increasing instead of decreasing after the cold war period and numbered more than fifty around the world in 1997. They not only cause rampant human rights abuses, and prolonged exposures of poverty,[24] but also expose the role of many nations external to the conflict who are worsening the crisis by their help in terms of money, weapons and training, or sometimes, even humanitarian aid.

Suspicions about the West

In such situations, is it right for the UDHR to put the onus of preservation of human rights only on the governments of nation-states? The concern of smaller nation states that they will be held accountable for violating the UDHR for problems not entirely of their own making is genuine. Also proven repeatedly in the recent past is the fact that European nations and the US, sitting in a UN Security Council dominated by the victors of the second world war use their political and economic clout to initiate military action not by virtue of principle, but by matters of expediency. While China went scot-free despite its Tiananmen, Iraq trying to redraw its boundaries to precolonial times after being hit economically by Kuwaiti oil policy was severely punished. Many dictatorships were installed and supported by the West, e.g., Indonesia and South Korea despite their poor human rights records as long as they professed a market economy. So is the case of many other dictatorships in Africa which wouldn't survive a day without the support of Western countries who benefit from the large scale exploitation of their natural resources.

It is this arbitrariness that breeds cynicism about the intentions of the UN, the platform that gave birth to the UDHR. The human rights agenda can be universally adopted, as the spirit of human rights is something that all religions, cultures and nations are ready to concede and have believed in one form or the other[25].

Discrimination in the West

The West itself has one tenth of the World's poor and the number of people living in poverty has drastically increased in the last few decades, and this distribution of poverty is not random[26]. Although the West can boast of most of the world's richest 225 people whose wealth equals what 47% of the world's population can earn in a year,[27] it refuses to share more of its wealth, most of which was developed from the past or continued exploitation of the rest of the world. Yet, it denies human rights to anyone except its own citizens. Instead of leading the world to a place without any discrimination, as it would have us believe with its human rights concerns, its discrimination on the basis of place of birth has become worse if the curbs on immigration and treatment of immigrants is an indicator.[28]

The pace of globalisation in terms of 'economic, political and cultural interdependence on the other hand, has undermined the sovereignty as well as the autonomy of nation-states.[29] When resources get limited because nations are trapped within geographical confines of ecosystems unable to sustain the population without exploitation of natural resources, the continued departure from the pre-colonial right to free travel will have a worsening effect on human existence. The consequences of a failed reform of economic agenda (forced once again by a Western market system); the free trade agenda that has to be signed to survive in the global world in the form of GATT; newer public health problems that have their roots in faster travel[30] and communication; environmental degradation as a consequence of industrialised economic systems, e.g., AIDS – all point to a responsibility of Human Rights violations that cannot be placed only on the governments of nation states. The Universal Human Rights Agenda, though a legitimate one, becomes much more contentious to implement if carried out in the present paradigm of a world that shrugs off responsibility of the indignity that is heaped on human beings existing beyond its land boundaries.

The way forward

The goals of the UDHR are just and need universalisation. But before the distant 'universalisation,' let us try to achieve 'globalisation' first. Human beings globally need to have the basic needs for survival

without severe poverty to enjoy lives befitting human dignity of global citizens. Globalisation of the world is a reality and should appear as a boon rather than a curse for humanity. The need of the hour is to ensure that all humans enjoy the fruit of globalisation and of the scientific and technological advances made without discrimination. For this, the basic human right of equality of all human beings on the globe must be protected by global agencies under democratic controls to gain the confidence and co-operation of the majority of the world.

Global citizens

We have to recognise that 'the time of absolute sovereignty, has passed',[31] and there is a need for countries to recognise the need for co-operation and to press for the rights of human beings as are enshrined in the spirit and the first two articles of the UDHR.

Universal Human Rights will not be possible unless there is an 'agreement about the ontological foundations of those values (of human rights) and about the limits to the applicability of the principles'[32]. Liberalisation is here to stay and the freedom to travel across geographical boundaries that has been with us since the birth of civilisation has to be recognised. Article 13 of the UDHR needs to be amended consequently. Not just humans, all living beings have moved from a resource poor area to resource rich area until the previous ecosystem regenerated or was found conducive for living once again. *The right to travel without visas and passports* is in line with the logic of liberalism[33] and with Article 25 of the UDHR which grants the right to a person 'to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care ....'[34]

Modern civilisations and nation-state concepts have abrogated this right to move. The principles of Universal Human Rights must be in the spirit of liberalised thought and ought to recreate this ancient right rather than limit it under Article 13. The sooner this anomaly is corrected, the sooner will the just and humane goals of Universal human Rights be achieved. The contradictions between the sections of the UDHR keeping in mind the history, geography and economy of the modern world, need to be removed at the earliest.

Such a move to create 'global citizens' would not only go a long way in removing geo-social disparities of poverty and geographical entrapments, it would also prevent the cross border environmental damage and exploitation, because the effects would drive home the point much faster. It would, in one stroke, not just make the bases of human rights laid out in Articles 1 and 2 more real and meaningful, but would also help the cause of the environmentalists and have a tremendous effect on the determinants of health by redistributing resources and bringing equity.

Global equality

To safeguard this right however, there will be a need for a commitment at the level of the UN and that would not be possible unless *the UN gets democratised.* The constitution of the monitoring body of the UN that has different allocations of power to different nations and does not treat all its member states as equal, itself is violative of the UDHR. There is an urgent need to democratise and remove the permanent membership clause of the Security Council. Membership could be based on a rotating pattern, and in the spirit of equity as opposed to equality, there could be more seats allocated to the resource poor nations than to the resource rich. The principle of equality can be brought back once the universal basic needs of people of life with food, shelter and clothing that provide human dignity and determine health are achieved. Its job would be to monitor the human rights of people, including the right to a life with dignity and without poverty in all parts of the globe.

Since signatories of today have already pledged to the principles of equal human rights, it should follow that the UN's body needed to monitor human rights would be *funded by members based on their per capita GDP.* Although this has always been the principle agreed even for development aid, most of the richer nations have consistently defaulted on their aid commitments[35] both to the poorer countries and to the UN itself and often used it for political leverage.

Global military

Last, but not the least, *the control of Security Forces must pass on to the UN* in a globalised world that has a global, universal definition of human being. It would be necessary to ensure that people are not prevented from moving out from one ecosystem to another. A democratic framework of the UN which

sanctions the use of force in defence of human rights violations would be a necessary prerequisite of this.

Conclusion

Human beings are born equal and are equal in dignity and rights as per the UDHR signed by most countries of the world. However, the UN system that needs to monitor this, and the West which has been in the forefront of the human rights agenda, have themselves been violative of the spirit of the UDHR. The basic rights of peoples to move from resource depleted ecosystems to resource rich areas have been denied by the UDHR in its present form and the world order of today. This anomaly of the UDHR, whereby its Article 13 prevents Article 25 from being meaningful and allows discrimination on the basis of place of birth – that is protected under Article 1 and 2, must be removed at the earliest.

Universal Human Rights must see a right not as what someone gives you, but as what no one can take away from you[36]. In its present shape, UDHR tries to restrict this right rather than to promote it. A democratic UN to monitor an amended UDHR is the best way forward if we want the spirit of Universal Human Rights from becoming a reality in the near future.

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POVERTY IN INDIA: OPTIONS FOR ALLEVIATION

The Face of Poverty in India *

In half century since Independence in 1947, India has made notable social and economic achievements.

- Eradication of famine, reduction in population growth rate and creation of a large reservoir of scientific and technical manpower.
- Reduction of poverty since the 1970s.
- When policies have increased growth fate , particularly agricultural growth rate, and improved human development, poverty has fallen faster.

1950	1993-1994
45%	36%
164 million	320 million (76% live in rural areas)

- Being poor in India means lacking good health and skills to make the most of the economic opportunities growth can open.
- Better health status of the poor in Kerala is largely explained by its better education, water and sanitation and basic infrastructure services.
- Being a poor pregnant women means risking death. India's MMR at 437/100,000 means 1 in every 4 maternal deaths world wide.
- Differences in reaching the poor and reducing poverty reflect more than natural advantages or disadvantages. They partly reflect policy interventions to improve the health and education of the poor and, consequently, their opportunities to gain a share of economic progress.
- Having foregone such investments, Bihar has lowest literacy and sixth highest MMR.

Research for WDR 2000

* NOTES FROM MR-B.S. LAMBA

India – Health Poverty Facts Sheet 1992-1993

HNP Status	Lowest 20%	Highest 20%	Ratio
IMR	94.7	46.3	2.05
>5 MR	137.7	61.3	2.24
Percent Stunted	56.7	38.9	1 45
Percent underweight	59.3	40.3	1.47
TFR	4.5	3.4	1.32

HNP Services show corresponding variations.

Position is aggravated when Urban Rural data is desegregated

Achievements and Challenges in Reducing Poverty in India

Where does India stand?

Year	% below the poverty line		Total (millions) below the poverty line	
1951	50		164	
1993-94	35		312	
	36.7 Rural	30.5 Urban	240.5 Rural (77% of poor Indians)	71.5 Urban

Poverty in India is responsive to its economic growth:

1951-75	Annual per capita income grew by 1.7% Annual decline in poverty by 0.9%
Mid 70s – late 80s	Annual per capital income grew by 2.5% Annual decline in poverty by 2.4%

The above pattern holds for both rural and urban poverty.

Indicators that measure the depth (poverty gap) and severity (squared poverty gap) of poverty suggest the process of decline in poverty included those whose consumption levels were far below the poverty line.

Source: Research done for WDR 2000

Responsiveness of poverty to economic growth implies that through rapid growth India will be able to reduce poverty and generate the resources to invest in health and education of its people, who, in turn, will sustain this growth.

Nonetheless, because of rapid population growth rate, the **absolute number of poor** has increased by 190% between 1951 and 1993-94.

While the decline in poverty has been sizeable – from 56% in early 1970s to 35% in 1993-94, it has been modest compared to Indonesia, whose poverty dropped from 58% in 1970 to 8% in 1993 – an annual decline of nearly 10%.

As of 1993-94, India's poverty is predominantly rural, even though rural poverty declined faster than urban poverty: decline in national poverty has been mostly driven by the decline in rural poverty – not surprising given that 74% of the population lies in rural areas.

The above findings, based on 40 years of nationally representative household surveys, are reinforced by a host of multidisciplinary village studies.

How do the poor fare regarding other indicators of well-being?
Year - 1991

Literacy % (aged 7 and above) of total population

India	52
Sri Lanka	89
China	78
Thailand	94
Indonesia	84

Life expectancy (in years)

India	59	(30 in 1947)
Sri Lanka	72	
China	69	
Thailand	69	

Infant Mortality Rate (per 1000 live births)

India	79	(146 in the 1950)
China	31	
Thailand	26	
Sri Lanka	18	

Malnutrition

Notwithstanding significant improvements in food availability and its distribution, India's rates of malnutrition among children and women are among the highest in the world.

Analyses of cross-country patterns indicate that the most important factor accounting for differences in social indicators is India's per capita income.

Who are the Poor?

The following are closely associated with poverty:

- Gender
- Literacy (45% in households without anyone literate)
- Land ownership (52% for land less as a whole)
- Employment status (68% - land less wage earners)
- Caste (51% - including Tribes) (Population 206 million)

The figures in brackets against the above indicate the incidence of poverty revealed by a recent survey of rural households.

Disparities in Poverty in India

Different States in India have progressed at different paces and, even within States, different regions have achieved marked varied results.

Inequalities that persist across gender, caste and ethnic groups are even more noticeable. Social indicators for women–literacy, for example, are markedly lower than for men. The level of scheduled castes and tribes, in both social and economic achievements, are still below the national average.

The range of poverty reduction among the States is so wide that Kerala's progress in lowering the headcount index of poverty (2.4% per year, on an average between 1957-58 and 1993-94) is more than 120 times that of Bihar and more than 4 times that of Rajasthan.

These differences reflect more than natural advantages or disadvantages. They mirror, instead, conscious decisions on investing in the poor, especially in improving their health and education and, consequently, their opportunities to participate in economic progress.

As a result of these decisions, Bihar – the poorest amongst the 17 largest States which account for over 90% of the population, has the 5th lowest level of male life expectancy, the low level of male literacy,

the 2nd lowest level of female literacy and the 7th highest level of infant mortality. Kerala, by contrast, has the lowest infant mortality rate and the 2nd highest rates of male and female literacy.

Reducing Poverty : What matters most?

Since Independence in 1947, Governments have relied on two approaches to reducing poverty.

First, the effects of aggregate rural growth would spread to all groups in society such that poverty reduction is achieved side by side with increases in economic growth.

Second, specific anti-poverty programmes are required.

The slow reduction in poverty through the 1950s and 1960s reinforced skepticism regarding the strength of any trickle-down effect.

However, since the mid 1970s, the faster poverty decline alongside a higher rate of economic growth, both in India and the developing world, has led to a greater appreciation of the contribution of growth to lasting poverty reduction and, equally importantly, reinforced the need for investing more in human resources development, since these investments not only contribute to faster long term growth, they also increase the capacity of the poor to benefit from it.

Accordingly, government's strategy over the recent past increased its emphasis on providing the conditions for accelerated and sustained labour-intensive growth, while expanding investment in human capital development.

Puzzles

- Failure of India's primary health centers to deliver the care to reduce infant mortality.

- Low utilization of public health facilities, despite poverty.

- Increasing dependence on private (all types) health care: rising private expenditure on health care $\Rightarrow$ deepening poverty.

Public Policy ⇒Poverty Reduction

Impact of public expenditure on health outcomes, especially on the poor, appear to differ greatly from one intervention to another and place to place.

Four priority areas for increasing the impact of public spending on the health of the poor, and indeed the economy in general, are:

1. The gains from public health spending **combating communicable diseases**, particularly for the poor would be substantial.
2. **Improving access to safe water, sanitation and vaccinations** would help reduce IMR and child mortality, and thus lower fertility and improve maternal health.
3. **Health education** – basic hygiene, value of better nutrition, preventive health care, campaigns against tobacco use, HIV-AIDS/STDs prevention etc are important behavioural changes needed for cost effective health development.
4. The poor must often meet the financial burden of medical emergencies through debt, distress sale of real assets, and reduction in consumption of food etc. There is merit in **subsidizing hospital treatment**. (The benefit of subsidizing hospital treatment of the poor is in the range of 40 to 70% of the cost of providing the service to the lowest 40% of the population)

OPTIONS

How to meet the health need of the poor

Choices before the government

- Suppress private sector, particularly unqualified providers: How to replace their services?
  - Regulate
  - Self-regulate
- Continue as a provider of different levels of health services.
- To do so better – how to finance and manage quality?
  - What areas government should concentrate on
  - Empower consumers through education
  - Provide insurance against catastrophic illness.
  - Strengthen local planning, management and accountability of public health services.

Choices for NGO actions

- Continue business as usual-effective work in small populations/areas.
- How majority of people would be addressed?
  - New modalities in financing, organization and community participation
  - Go to scale
- Raise public awareness and increase demand

Choices for collaboration

- Support by government to private sector, e.g. training and supply of anticeptics, drugs and contraceptives, etc.
- Government grants for primary care to NGOs
- Develop provider networks serving the poor

Choices for external agencies

- Funding of better States/NGOs
- Policy advice
- Sharing expenses, information and advocacy

PEOPLE'S CAMPAIGN FOR DECENTRALISED PLANNING AND THE HEALTH SECTOR IN KERALA

Dr. B. Ekbal

In spite of the economic backwardness, Kerala has made remarkable achievements in health almost comparable to that of even developed countries. The widely accepted health indicators like crude death rate, infant mortality rate, and life expectancy evidence this. (Table 1)

Most analysts have seen Kerala's achievements in health as something of an enigma. Kerala achieved the health status as par with that of USA spending roughly 10 US $ per capita per year while US spends about 3500 $ per capita per year on health care. The GDP of Kerala is even less than that of the National average. Kerala's achievement in health in spite of its economic backwardness and very low health spending has prompted many analysts to talk about a unique "Kerala Model of Health," worth emulating by other developing parts of the world

KERALA MODEL OF HEALTH

There are many socio-economic conditions unique to Kerala, which have been postulated to make this health model possible. Kerala has a highly literate population compared to other Indian states. This especially the high female literacy, has to be given due credit when we look for explanatory factors. All over, the world indices such as infant mortality have shown an inverse relationship with female literacy.

It is also to be noted that Kerala has nurtured a political climate wherein the rights of the poor and the under privileged have been upheld and fought for. This was the result of a fairly long period of struggle for social reforms exphasising dignity of people who were considered socially 'inferior' which later found expression in secular-democratic movements culminating in nationalist and socialist movements. One common thrust of all such movements was on education and organisation of the downtrodden people. Hence, as has been pointed by many social scientists there is a remarkable reduction in the rate of exploitation of the underprivileged in Kerala compared to other Indian states.

The agrarian reforms that were implemented in the late 1950s ended the feudal relationship in agriculture and giving land to the tillers. This improved the social living conditions of the landless poor in the rural areas. This might have contributed to the alleviation of poverty among the agricultural laborers leading to the improvement of their health status.

The public distribution system of food through fair-priced rations shops distributed throughout Kerala assures minimum food materials at relatively cheap cost to the people. This has assured certain amount of nutritional status to the poor, warding of poverty related diseases.

Apart from the socio-economic factors outlined above the universally available public health. system in Kerala has also contributed to the high health status of the people. Kerala has a three-tier system of health care, the Primary Health Centres (PHC) and the Community Health Centres (CHC), Taluk and District Hospitals and the Medical Colleges evenly distributed both in the urban and the rural areas. Apart from Modern Medicine. Ayurveda, Homeopathy, and other alternative systems are also very popular in Kerala.

However. the widely acclaimed Kerala Model of Health has started showing a number of disturbing trends recently.

KERALA HEALTH FROM SUCCESS TO CRISIS

Although the mortality is low, the morbidity (those suffering from diseases) is high in Kerala compared to other Indian states. Though there is a data gap in this regard the NSS (1974) and KSSP (1987) studies confirmed these observations (Table 2). Hence the Kerala situation was described as 'Low Mortality High Morbidity Syndrome" (Panicker and Soman 1985). It can be argued that when the expectancy of life increases there can be a corresponding increase in morbidity in terms of the high incidence of diseases like Cancer, Heart diseases etc. that affect old age people more. However, here also the Kerala situation is peculiar in that the infectious diseases like diarrhoea, hepatitis, tuberculosis etc are still prevalent in Kerala. Moreover, many epidemics that were supposed to have been eliminated from Kerala like Malaria are definitely staging a come back. In addition, diseases like Japanese Encephalitis that was sporadic in Kerala has appeared in many parts of the state as epidemic apart from the appearance of the modern scourge like AIDS.

Another disturbing trend is that the Public Health System is getting alienated from the people and only 30% of the people even from the lower income group seek medical help from the Government hospitals (Table 3). This is because of the fall in the quality of services at the Government hospitals. Lack of political commitment, bureaucratic inefficiency, corruption at various levels, lack of proper planning etc has contributed to this sorry state of affairs.

This environment of the perceived inefficiency of the Government medical facilities is one of the factors that provided the impetus for the growth of the private medical care set up in the state. The social milieu of the state is changing and features of a consumer society are visible in all occupations. This has led to the commercialisation and the commodification of health care. Health is no more seen as a right but as a commodity to be purchased by money. The huge remittance of foreign exchange from gulf countries even to the low and middle-income group houses further reinforced this attitude. All these tendencies are leading to a virtual uncontrolled growth of the private medical care facilities in the state.

A comparison of the infrastructure and health manpower development in the private and public sectors confirms the supremacy of the private sector in the state. The number of beds in the government institutions grew from around 36000 to 38000 in the 10-year period from 1986 to 1996, whereas in the same period, beds in private institutions grew from 49000 to 675000. This amounts to nearly 40% growth in the private sector beds in a period of 10 years as against nearly 5.5% in the Government

sector. In the case of doctors about 5000 doctors work in the government sector whereas double the number work in the private sector (Table 4). More significantly, private sector has far outpaced the government facilities in the provision of sophisticated modalities of diagnosis and therapy, such as CT Scans, MRI Scans, Endoscopy Units etc. Simultaneously, public sector itself is being subjected to internal privatization. Because of the irregular supply of medicines and other materials patients seeking medical care from the government hospitals are forced to buy them from outside. Also the laboratory facilities are quite inadequate in the government hospitals and patients have to depend upon the private labs for getting investigations done in time.

The privatisation of medical care is leading to over medicalisation and escalation of the health care cost. The net result is the marginalisation of the poor and it is roughly estimated that at least 30% of the people in the state are denied health care or find it extremely difficult to meet the growing health expenditure.

The changing health scenario in Kerala has provoked analysts like the present author to comment that the Kerala Model of Health Care is slowly drifting towards an *American Model of Health Care.* The hallmarks of Kerala Model were low cost of health care and its universal accessibility and availability even to the poorer sections of society. This may be changing to the American Model where in spite of the technological supremacy 40 million people are denied health care because of privatisation and the escalation of the health care cost.

In short the important aspects of the present health scenario in Kerala are:

1. The simultaneous presence of the diseases of poverty and the diseases of affluence or life style diseases.
2. The decay of the public health system.
3. The uncontrolled growth of the private sector.
4. Escalation of health care cost.
5. Marginalisation of poor.

TOWARDS A PEOPLE'S HEALTH POLICY

Toning up of the health care system in the state and making it capable of taking on the burden of provision of equitable, efficient and good quality health care needs concerted actions from the political parties, social movements and the professional organisations. Taking into consideration the specific problems of the Kerala health scenario a **People's Health Policy for Kerala** should be formulated. Reinstating the primacy of the government health services, with its emphasis on primary health care should form the basis of the health policy for Kerala. There should be some amount of social control and auditing of the private sector.

DECENTRALISATION AND COMMUNITY INVOLVEMENT IN HEALTH

These objectives can be realised only through an administrative and financial decentralisation of the health services department, while ensuring community involvement in formulating and implementing health care programs and reforms. The

Panchath Raj now provides the possibility for the people to demand the resources to operate a health service in which the people themselves will play the dominant role and of which they will be the chief beneficiaries. All infrastructure, health manpower development, training, distribution, and production of drugs and equipment must conform to achieve this, and not in reverse as is at present. Only thus can a cost effective, human and accountable health service be provided that is funded and operated by the local bodies with the technical assistance of the health professionals. This system involves the entire community and especially the women in identifying their health problems. The people can be mobilised to improve not only the curative care but even more so in health education as well as in the prevention and control of the diseases that originate in their environment. The people have the greatest interest in improving the conditions that affect them and their children. This would also be an impetus to the overall improvement of the community of which they are a part.

The **World Health Organisation** was advocating Community Involvement in Health(CIH) as a pre-requisite for solving the health problems of the developing countries *(Community Involvement in Health Development: Challenging Health Services-Report of a WHO Study Group WHO Geneva – 1991).* WHO study group reports says that **"A critical step will be the decentralisation of health services and the corresponding strengthening of the local health services that will serve as the basis for CIH" and further "Structural changes in health systems will be necessary to support the CIH process. These changes include: decentralisation of planning, management, and budgeting ."**

The administration of the Primary Health Centres, Community Health Centres and the Taluk and District Hosptials are already handed over to the local bodies. Moreover, thanks to the on going Peoples' Campaign for Decentralised Planning, there is a tremendous scope for solving the health crisis through which Kerala is passing. And CIH as advocated by WHO has become an achievable objective in our state.

PANCHAYATH RAJ AND THE HEALTH SECTOR

The possibilities that are opened up with the financial and administrative decentralisation of the health sector and the People's Campaign for Decentralised Planning are the following:

1. The control of infectious diseases and even the prevention, early detection, and management of the life style diseases can be achieved only by strengthening the primary and secondary level health care facilities. With the local bodies in control, this can be achieved with better community involvement.
2. Once the primary and secondary health care facilities are improved through the local bodies , the tertiary care centers like the medical colleges can entirely concentrate on medical education, research, and tertiary health care.

3. The problem of resource constraint in health sector can be solved with a more need-based reallocation of resources and generating local resources through community participation.
4. A better relationship between the health workers, people's representatives, and the people at large can be accomplished.
5. Once the public health system is reinforced the poor people who cannot afford the private health services will be benefited social equity in health care will be re-established.
6. There are provisions in the Panchayath Raj Act which can be invoked for the social control of the private sector.

An analysis of the experiences of the campaign so far shows that the we are definitely moving in the correct direction in solving the rural health problems of the state.

DECENTRALISED PLANNING : ACHIEVEMENTS

The concrete achievements realised so far can be summarised as follows:
1. As evidenced by the participation in the Gramasabhas, Development Seminars, Task Forces, Voluntary Technical Corps, and voluntary contributions both in terms of money and labor power, community participation in local development has become a reality in Kerala. More than anything else the sense of optimism generated among the people by the campaign is the greatest achievement of the decentralisation process.

2. It was feared by many that, the health related projects would be confined to building more and more curative centres. It is true that there is a contradiction in health between the felt and real needs of the people. While only through a preventive and promotive approach the basic health problems can be solved, there is a growing demand for more sophisticated curative health facilities from the community. However, the preliminary examination of the health projects show that majority of them are for sanitation, health education and for improving the primary health care infrastructure in the villages. Of course, there are instances of unrealistic and inappropriate demands for hospitals. However, the thrust is on prevention and improvement of the existing health care facilities.

3. With the reallocation of plan funds within the health sector, the problem of financial constraints of the health sector appears to be solved. Of the 6000, Crores of rupees allotted to the local bodies for the Ninth Five Year 30% can be spent on social services sectors like health, education, water supply, sanitation etc. Of this at least 500 crores are available for heath sector. In the first year, the projects were mainly on water supply and sanitation. Nevertheless, the estimates from the first year projects shows that the local bodies are likely to spend at least 340 crores exclusively on health and health related projects. It may be interesting to note that the departmental allocation for Ninth Plan amounts to 310 crores. Thus, the primary and secondary health care institutions have been given adequate funding for improvement of the services rendered by these institutions. Once these facilities are better organised, the department can spend the fund allotted to them exclusively for improving the tertiary care facilities. Over all compared to the Eighth Plan, health funding has increased from 2.37 to 4.03 percentage of the total plan allocation.

4. A better working partnership is developing between the doctors, the health workers, the Panchayath functionaries, and the people in the rural areas. The health workers now feel that with out bureaucratic red-tapism and the involvement of the higher authorities improvements can be made at the Panchayath level itself. For the first time in the history of the medical profession, the doctors working at the rural areas have a role in the planning of the health care set up where they are working. This has given them a sense of participation and professional satisfaction.

5. The autonomy with in the decentralised set up has offered the local bodies to formulate and implement a number of imaginative community based health programmes. From organising blood donation camps to issuing health cards to the people of the Panchayats and conducting health surveys to study the health problems of the local community a number of innovative programmes are being accomplished by the local bodies.

THE PLANNING BOARD INITIATIVES

For the sustainability of the decentralised approach in health planning, horizontal and vertical integration of the health programmes at various levels is needed. Moreover, the decentralisation concept should be further popularised and institutionalised. With this in mind, with the help of the health department and the professional organisations the planning board organised health services doctors meeting in all the districts. It was quite gratifying to understand that a large number of doctors are actively involved in the decentralisation campaign by preparing health projects, participating in the Voluntary Technical Corps etc.

Planning Board also organised an orientation progamme for the faculty and postgraduate students of the community medicine departments of the medical colleges and the Achutha Menon Centre for Heath Sciences Studies. The conference came out with a number of recommendations that deserves serious consideration. The major recommendation is to link the community medicine departments with the functioning of the primary and secondary level health institutions in the state. Another recommendation was the formation of a state level health faculty to co-ordinate the local level health activities. It is also recommended that the health faculty should take the initiative to organise block level conventions of the doctors, health workers and the representatives of the local bodies.

It was pointed out that the widely acclaimed Kerala Model of Health that can be described as 'good health at low cost' and based on social justice is passing through a period of crisis and if unchecked this may lead to an American Model of Health based on privatisation and the marginalisation of the disadvantaged. The Panchayath Raj system rooted in community involvement is poised to change the health scenario in our state and is likely to conceive a new **Decentralised and Participatory Model of Health Care** in our state. In case this becomes a reality then Kerala will bestow another unique model of health care worth emulating not only by the other Indian states but also by other developing parts of the world.

TABLE ONE
KERALAM HEALTH STATUS
1996

Indicators	Keralam	India	USA
Crude Death Rate	6.3	10	7
Infant Mortality Rate	11	79	8
Crude Birth Rate	17.7	29	17
	Life Expectancy		
Male	66.8	57.7	73
Female	72.3	58.1	79

(Sources: 1. Health Services Data Government of Kerala 1996
2. World Health Report WHO Geneva 1996)

TABLE TWO
KERALAM MORBIDITY

	Keralam NSS 1974	India	Keralam KSSP 1987
Acute Diseases	71	22	206
Chronic Diseases	83	21	136

TABLE THREE
UTILISATION OF HEALTH SECTORS
1987

Group	Public %	Private
One	33	43
Two	25	50
Three	16	60
Four	8	66

(Group One - Poorest, Group Four – Richest)

(Source Table 2 to 3 Health and Development in Rural Kerala KP Kannan etal KSSP1991)

TABLE FOUR
GOVERNMENT AND PRIVATE SECTOR
1995

	Private	Government
No of Institutions	4288	1249
No of Beds	67517	42432
No of Doctors	10388	4907

(Source: Report on the Survey of Private Medical Institutions in Kerala 1995 Department of Economics and Statistics Government of Kerala 1996)

TABLE FIVE

PLAN ALLOCATION - HEALTH SECTOR

EIGHTH FIVE YEAR PLAN TOTAL ALLOCATION	HEALTH SECTOR	PERCENTAGE	NINTH FIVE YEAR PLAN ALLOCATION	HEALTH SECTOR	PERCENTAGE
5460	120	2.2	10100	309.4	3.06

TABLE SIX
PLAN ALLOCATION- HEALTH SECTOR
(LOCAL BODIES)

LOCAL BODIES ALLOCATION	HEALTH SECTOR (EXPECTED)	HEALTH SECTOR TOTAL	TOTAL NINTH PLAN ALLOCATION	HEALTH SECTOR PERCENTAGE
6000	500	500+309.4 = 809.6	16100	5.02

(Source: Planning Board Documents: 1999)

File → 22

The poverty of Amartya Sen

Even the "sensitive" Sen has failed to understand "ecological poverty"

ANIL AGARWAL

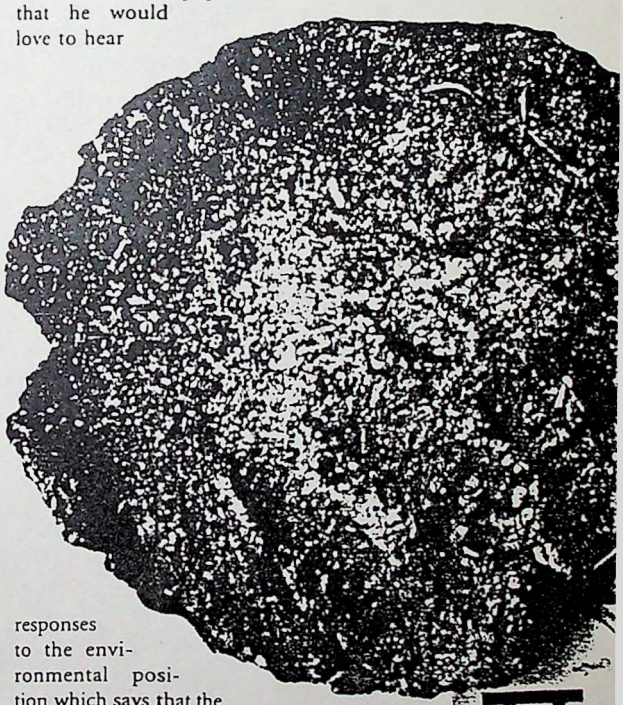
THIS is the time when paeans are being sung about the "poverty economist" Amartya Sen because of the Nobel Prize for economics. It is, therefore, probably churlish for an Indian to point out his grave shortcomings. But I have chosen to do so because there could not be a better moment to point out a weakness that most economists share, including the best of the best, namely, Amartya Sen.

Sen made his mark by pointing out that people often die of hunger not because there is a shortage of food but because there is a shortage of "entitlements". He has, therefore, talked about welfare systems that create those entitlements and that globalisation must be accompanied by "social security safety nets". So far so good! But this analysis restricts itself only to an exploration of a phenomenon that can be described as "economic poverty" and which Sen's professional colleagues — namely, economists — love to study. But another phenomenon which I would like to describe as "ecological poverty" is rarely understood by them, including the "sensitive" Sen, as many newspaper columnists describe him.

I first met Sen at a meeting in Stockholm in 1987 where we were part of a panel to discuss the relevance of the just-released Brundtland Commission report which called for sustainable development. I was appalled and livid to hear Sen make the remark that environment has precious little to do with poverty, the biggest problem facing the developing world. What he was saying was not just contrary to my own world view but also my face-to-face experiences with innumerable villages facing the dreadful droughts of the mid-1980s which the then Rajiv Gandhi government was trying to fight bravely. I told Sen that he seemed to be quite ignorant of the realities of poverty in his own country, but he could not understand what I was saying. In fact, another eminent Indian economist, Partha Dasgupta, who heard our debate, tried to bring us together that evening. But I came away feeling that Sen could not comprehend what I was saying.

Exactly 10 years later I was to get another rude shock. This time it was from Mahbub ul Haq, another economist with a human face and a friend of Sen's. Haq is known for his work on a new index to measure "human development" for which he has received considerable support from Sen. Arguing that the World Bank's (WB's) exclusive dependence on "per capita income" as the main indicator of development was incorrect, Sen and Haq worked with the support of the United Nations' Development Programme (UNDP) to produce a "human development index" which included other factors like infant mortality and literacy. In 1997, I was asked to address the UNDP's executive board on the subject of "poverty and environment".

I talked at length about how villages like Sukhomajri and Ralegan Siddhi had made an extraordinary economic transformation from destitute to prosperous villages through good environmental management. Haq, who was chairing the presentation, stunned me by saying, in his summing up, that he would love to hear responses to the environmental position which says that the environment should not be touched at all. Even before I could react to this, it was UNDP assistant administrator, Anders Wijkman, who immediately intervened to say that I had actually said exactly the opposite. Haq was obviously so lost in his outdated beliefs that he had not even cared to hear what I was saying. It is indeed appalling that it is Third Worlders like Sen and Haq who advise First Worlders on how to give aid to the poor.



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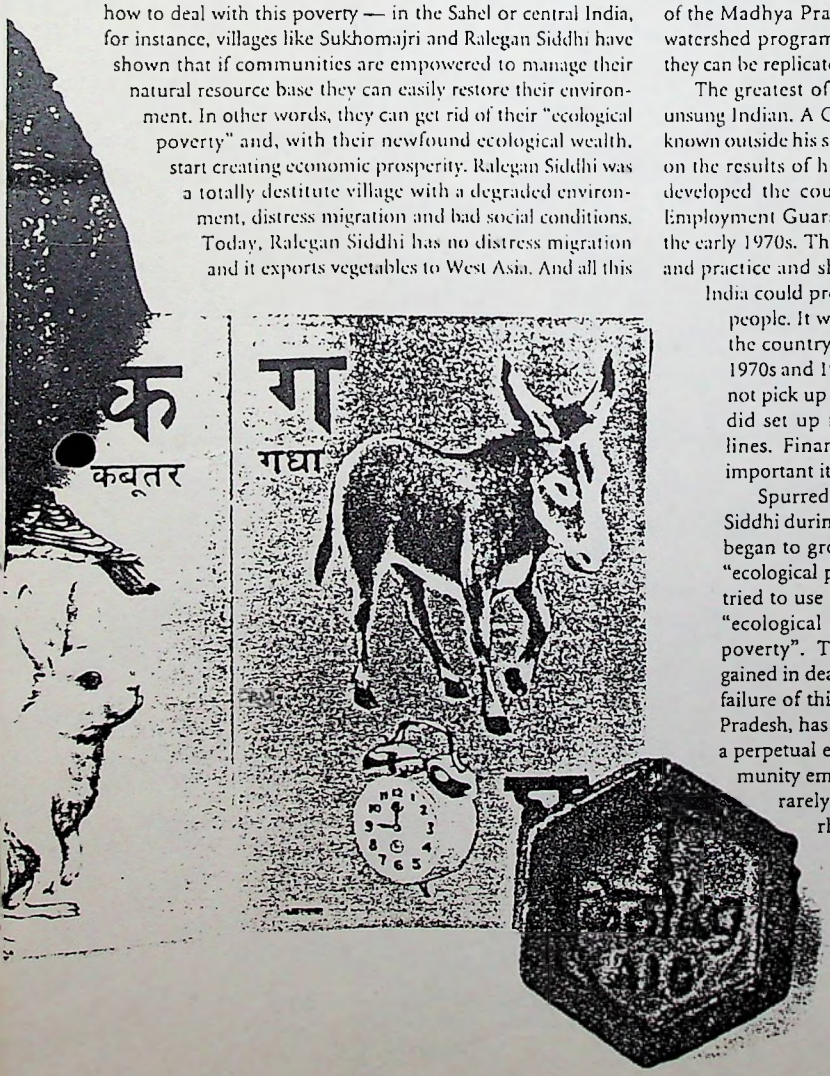
The unfortunate part is that Haq and Sen are not the only "insensitive" economists who go buzzing around about "poverty" but know precious little about how to tackle it. Fortunately, the situation is slowly changing

and the subject of "ecological poverty" is being understood a little more. The Nobel Prize committee will one day have to make amends by rewarding another and more sensitive economist who helps the world understand this far more critical problem.

The WB estimates that nearly a billion people live in absolute poverty. More than half these people still live within a biomass-based economy. For these people, their immediate environment yields — the Gross Nature Product — are far more than the Gross National Product which economists love to measure and swear by. But these people suffer from an acute "ecological poverty" because of the heavy degradation of their environmental resource base. The trees and grasses have gone, the land has eroded and the hydrological cycle has been disturbed. As a result, the basics of their economy have disappeared. Agricultural production has become precarious and animal care is equally threatened. Life has, therefore, become an unending trail of misery and hard labour resulting in distress migration, growing slums in increasingly unmanageable cities and atrocious labour conditions.

While all western economists are at their wit's end about how to deal with this poverty — in the Sahel or central India, for instance, villages like Sukhomajri and Ralegan Siddhi have shown that if communities are empowered to manage their natural resource base they can easily restore their environment. In other words, they can get rid of their "ecological poverty" and, with their newfound ecological wealth, start creating economic prosperity. Ralegan Siddhi was a totally destitute village with a degraded environment, distress migration and bad social conditions. Today, Ralegan Siddhi has no distress migration and it exports vegetables to West Asia. And all this has been achieved through ecological management. But this was not a Senish project of simple "social security safety nets" and dole. It was a scheme of "community empowerment" together with a "social security safety net". Studies have shown that in several other lesser-known projects, where efforts were made during the 1980s to reverse ecological degradation through "community empowerment", there was a reduction in distress migration. This shows that if India wants labour conditions to improve and cities to move towards manageable conditions, then the country must address itself to the problem of "ecological poverty". The successful effort of the Madhya Pradesh government in Jhabua to develop a watershed programme based on these principles shows that they can be replicated even on a large-scale.



The unfortunate part is that Haq and Sen are not the only 'insensitive' economists who go buzzing around about 'poverty' but know precious little about how to tackle it

The greatest of all "poverty experts" in India is a totally unsung Indian. A Gandhian social worker, V S Page is hardly known outside his state of Maharashtra. It was Page who, based on the results of his field projects carried out in the 1960s, developed the country's first entitlements scheme — the Employment Guarantee Scheme (EGS) of Maharashtra — in the early 1970s. The scheme was truly pioneering in concept and practice and showed that even a very poor country like India could provide a minimum social security net for its people. It was only after the launch of this scheme that the country could take the social sting out of the late 1970s and 1980s droughts. The central government did not pick up the courage to start a nationwide EGS but it did set up rural employment schemes on the same lines. Financial support to them has remained an important item on the political agenda.

Spurred on by success stories like that of Ralegan Siddhi during the mid and late 1980s, an understanding began to grow about the importance of dealing with "ecological poverty". The government has increasingly tried to use these rural employment schemes to build "ecological capital" and thus get rid of "ecological poverty". Thus, considerable experience has been gained in dealing with "ecological poverty". The overall failure of this effort, except for the success of Madhya Pradesh, has clearly shown that a safety net will remain a perpetual exercise unless it is accompanied by "community empowerment". And state governments have rarely shown the will to do so beyond political rhetoric. But things can't always be bad. I am convinced that they will change, howsoever slowly and painfully.

I am sorry, Dr Sen, but I had to say this because I think the challenge we face is quite different than the simple one you have put forward. ■

World Health Assembly Special

File → (14)

To Our Health

No. 4
21 May 1999

The Newsletter of the World Health Organization

Unified call to fight poverty

Good health is a question of priorities, not income – Dr Sen

"Financial conservatism should be the nightmare of the militarist, not the doctor, or the school teacher, or the hospital nurse," Nobel Laureate Amartya Sen told the World Health Assembly Tuesday.

Professor Sen, a scholar from India whose work produced a new understanding of the catastrophes that plague society's poorest people, won the Nobel Economics Prize last year for his contributions to welfare economics, which help explain the economic mechanisms underlying famines and poverty. Sen "restored an ethical dimension to the discussion of vital economic problems," the 1998 Nobel citation said.

Dr Sen speaking to delegates Tuesday

The 65 year-old economist, Master of Britain's Trinity College in Cambridge (UK) and former Lamont University Professor Emeritus at Harvard University, said that fast economic growth has helped improve health in some countries where the growth is wide-based and income is used to expand health care education and social security. However, other countries have used "support-led processes that work through a programme of skilful social support of health care, education and other relevant social arrangements" to enhance living conditions and reduce mortality rates, even without much economic growth", he noted.

Because of this support-led process, he said, "Despite their very low levels of income, the people of Kerala (India), or China, or Sri Lanka enjoy enormously higher levels of life expectancy than do the much richer populations of Brazil, South Africa and Namibia, not to mention Gabon."

"And yet, when it comes to health and survival, perhaps nothing is as immediately important in many poor countries in the world today as the lack of medical services and provisions of health care," Professor Sen said. Citing a recent study called "Infections and Inequalities: The modern plagues," by Paul Farmer, he said "a major difference can be brought about by a public determination to do something about" pervasive deprivation of biomedical services, both for easily treatable diseases like cholera and malaria and more challenging ailment like AIDS and drug-resistant Tuberculosis.

The issues of social allocation of economic resources "cannot be separated from the role of participatory politics and the reach of informed public discussion," he said.

"The public has to see itself not merely as a patient, but also as an agent of change. The penalty of inaction and apathy can be illness and death," Professor Sen concluded.

"Health is a fundamental human right," Dr Brundtland said. "We need public voices to speak out for all those who are denied their human rights to health. "You can count WHO as one (of these voices)."

Closer cooperation the way to better health – Dr Brundtland

The World Health Organization will work closely with Member States and other UN organizations to substantially improve the health conditions of the world's poorest.

"We are not aiming at modest gains," WHO Director-General Gro Harlem Brundtland told delegates at the 52nd World Health Assembly – the Organization's annual "shareholders' meeting". "In East Asia, life expectancy increased by over 18 years in the two decades that preceded the most dramatic economic take-off in history. Repeat these gains – and we could be launching a new leap forward for human progress and development."

In addition to the formal resolutions adopted at every Assembly, this one will also contain round-table discussions on key health questions, a lecture by Nobel Laureate Amartya Sen on health's role in development, and a large number of associated activities – ranging from a World Bank report on the economics of tobacco to briefings on WHO's role in relief work in the Balkans.

In her speech to the Assembly, Dr Brundtland spelt out the role WHO will play in the years to come to ensure that the one billion who have so far been excluded from the health "revolution" of the second half of the twentieth century will see drastic improvements in their health in the coming decade. Having restructured Headquarters and brought about a realignment to ensure that regional offices and Headquarters share priorities and work effectively, WHO is now ready to focus on the challenges ahead, Dr Brundtland said.

She said WHO is working more closely with Member States, both through increased day-to-day cooperation with the missions in Geneva, by establishing a closer and more strategic work with WHO's Executive Board, and through clearer political leadership of the World Health Assembly.

"It is my hope that discussions and decisions during the coming days will send a clear health message to the world," she said.

Dr Brundtland addressing the Assembly Tuesday

She added that the dialogue initiated with the World Bank and the International Monetary Fund over the past months had been fruitful and would be intensified.

A key factor in WHO's new priority-setting is to emphasize the economic benefits from improved health and the need for cost-effective, equitable health systems.

"A five year difference in life expectancy may yield an extra annual growth of 0.5 per cent. It is a powerful boost to economic growth," Dr Brundtland said, reaffirming conclusions of the World Health Report, which she presented to Assembly.

South African anti-smoking laws to stay

South Africa's health minister, Dr Nkozasana Zuma, has reiterated her country's determination not to bow to pressure from the powerful South African tobacco lobby smarting under the country's tough new anti-smoking laws.

The legislation, recently signed by President Nelson Mandela, bans the advertising of tobacco products. It also bans sports and arts sponsorship by tobacco interests, the use of tobacco trade marks on other products, and smoking in public places, including the workplace.

"They (the tobacco industry) are putting a lot of pressure on us through the media, sometimes attacking me personally and trying to mobilize the trade unions against us ...but our position is that everybody must comply (with the anti-smoking laws)," Dr Zuma told reporters.

Addressing charges by the tobacco lobby that the new laws violate the constitutional principle of freedom of expression, she replied: " Freedom of speech is not an unlimited right; there are limitations to every right and we strongly feel that this is an area where the limitation has to be applied."

The Minister said government would work with players in the tobacco industry to help them diversify into other equally profitable ventures. Tobacco is a multi-billion Rand industry in South Africa, employing some 200,000 people. "We did a study on the economic implications of doing something or doing nothing about tobacco use in our country, and came to the conclusion that the economic consequences of doing nothing are much more dire," she said.

With the introduction of tobacco advertising bans, South Africa joins more than 22 others with complete or near-complete advertising bans, in line with a May 1990 WHO resolution.

South African Health Minister Dr Nkozasana Zuma Monday was honoured by the World Health Organization for her efforts to rein in the tobacco industry and control the tobacco epidemic in South Africa.

INSIDE

Interview

Amartya Sen on development and health

By Adrea Mach

In her address to the World Health Assembly, Dr Brundtland lauded keynote speaker Professor Amartya Sen, 1998 Nobel Laureate in economics, as "having placed poverty and development at the core of economic theory and, linking the social and economic dimensions of human development". The interview below is a TO OUR HEALTH exclusive interview with Professor Sen.

Development economics focuses on "the world's most enduring problem", persistent, widespread poverty. Where does health fit into the poverty picture?

If one thinks of poverty only as low income, then the health link is indirect: it is easier to earn a living and alleviate poverty when one is in good health. On the other hand, if we think of poverty as basic deprivation of the quality of life and of elementary freedoms, then ill health is an aspect of poverty. Bad health is *constitutive* of poverty. Premature mortality, escapable morbidity, undernourishment are all manifestations of poverty. I believe that *health deprivation is really the most central aspect of poverty.*

You are keen to reduce poverty, especially through better education and improved health coverage, so that entire societies may benefit. But if we do a reality check, what about countries like India? Is universal health coverage really feasible over the short to medium term? Or is this an idealistic illusion?

Indeed, it would be quite difficult to provide sophisticated medicine for every person in India. But basic medical care can be guaranteed to every human being, even in a poor country like India.

Some areas of India are much better provided in terms of health care than others. For example, Kerala has very wide health care. Now Kerala is not any richer than the rest of India; it's in fact slightly poorer on average. If Kerala can do it, the rest of India also can. In fact, in terms of survival to mature ages, the African American population in the United States, though many times richer than the population of Kerala, actually has a lower chance of survival to mature ages. Low per capita income is not really such a barrier. That's the first thing.

Secondly, basic medical care is very labour-intensive. In a low wage economy, the state has less money to spend on health care, but it also *needs* less money to spend on the same amount of health care because the cost of medical services is lower. That is a very important economic consideration. So if you do a reality check, you should consider how much the state must spend but also what the expenses are and by how much good economic organization can reduce them, building on the low wages that make health care that much cheaper. Universal health coverage is no Utopian illusion at all, even for very poor economies.

What is the relative importance of public vs. private sector funding, especially for really impoverished countries?

The importance of the public sector in fields like health care is very well established. There is no way the private sector can do as much. Those who think privately financed medicine could do it all are mistaken. Private insurers don't have the incentive to cover the most vulnerable people because it's always against the interests of an insurance company to cover someone who is more likely to become ill.

However, I quite agree that we have to consider how to improve the quality of public sector health care delivery. The market gets its incentives from the profit motive, but it is rather neglectful in the field of health care. When it comes to the public sector, you have to provide the same incentive in other ways. That requires active public discussion on health care provision; it requires constant vigilance about the quality of hospital, medical, nursing services, etc. This incentive has to be provided through the medium of public discussion and criticism.

In the past, health has often been both isolated and isolationist. How can health now be mainstreamed into the broader development agenda?

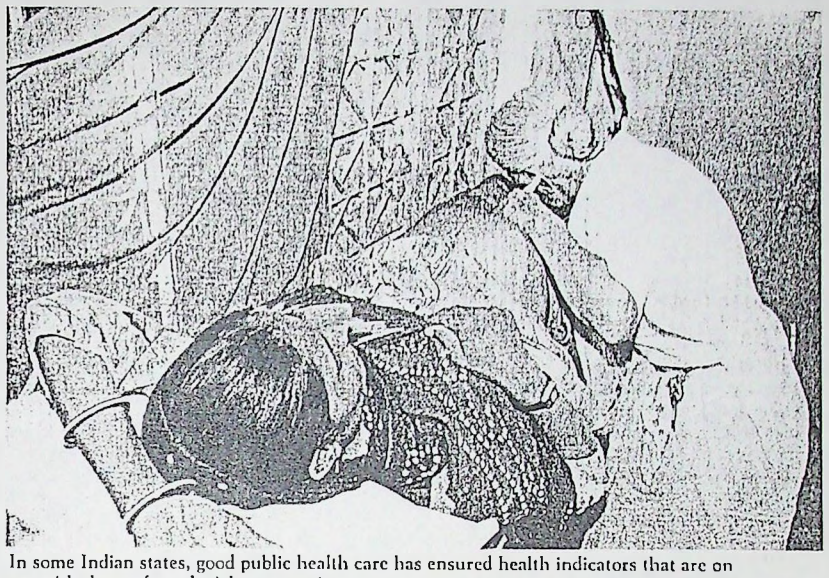
Health should be seen as an integral part of the development agenda. There is, first of all, the basic recognition that deprivation of health is an aspect of underdevelopment. Just as for the individual, not having medical treatment for curable ailments constitutes poverty, similarly, for a country, not having adequate health arrangements is a part of underdevelopment. So you have to place the issue of health care right at the centre of the development agenda.

Secondly, there are enormous interdependencies between different kinds of deprivations. For example, the deprivation of health is bad even for the economy because people's productivity depends on their level of nutrition and health. The functioning of the economy suffers from illness-related absenteeism.

One of the Director General's priorities is *Roll Back Malaria*. As someone who did suffer from malaria very early in my life, I can tell you that it's extremely debilitating. It is important to see the interconnection and the impact of health and health development, not just on the lives that human beings directly lead, but also what they can do as productive agents in the economy and as agents of social and political change. These are all part of the development agenda.

Today's world is characterized by increasing privatization of medical care. For example, consider the US model where costs are going up, quality is going down and more and more people are being left out. Today 16% of America's GDP is consumed by health related expenditures and even this doesn't do the job – there are still 44 million Americans without health insurance. If this type of model spreads, where will it lead in terms of the goal of Health for All?

That aspect of American medical arrangements is not one of glory. There are others which are quite glorious: the statistics of survival after the diagnosis of cancer, for example, show almost twice as many years in America as in, say, Britain. That is something that Americans do right. That is a characteristic of the efficiency of the system for those who can afford it.



In some Indian states, good public health care has ensured health indicators that are on par with those of much richer countries

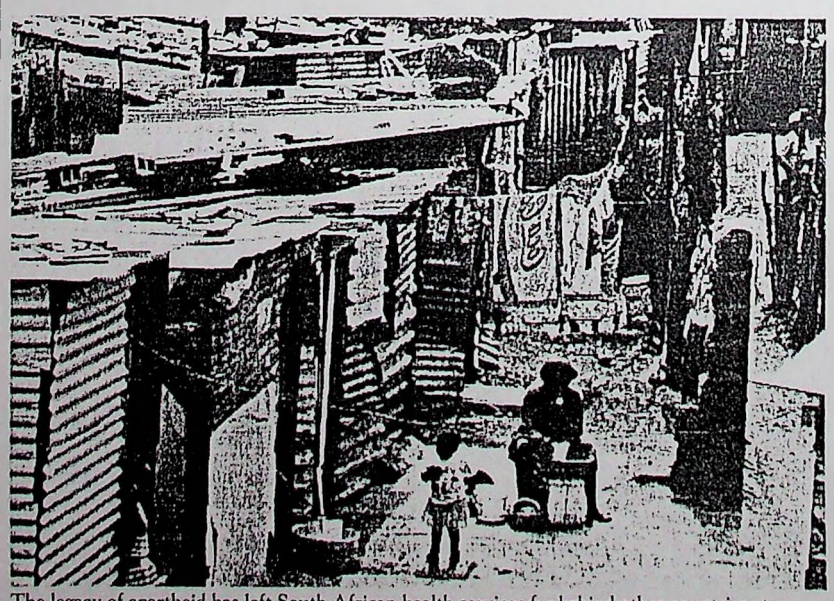
But the glaring defect of the American system is that it neglects lots of people who simply cannot afford it, like those who don't have medical insurance. You mentioned the number 44 million without medical insurance – that figure seems to be going up relentlessly. It is not just specialized medicine; people may be deprived of even the most elementary health care.

One has to recognize that the nature of the market economy makes it very efficient for certain types of production, like standard types of industries. But it's not very good for other kinds of economic activity, particularly medicine.

There are two reasons: one is that many of the results of medical care have the feature of being what economists call *public good* which affects not only the well-being of that person but also of others, for example with infectious diseases which are contagious to others. In dealing with public goods, markets are notoriously defective.

Second, the pattern of risk in medicine makes the market less efficient because, as I discussed before, it's always in the interest of private insurance to try to get out of covering those who are most likely to need medical care. But these are people for whom medical care is most important.

It's a question of trying to tain the efficiencies that American medical systems have – one should not deny those; they are radically important. If you have a serious illness, you have a very good reason to go to America for treatment – *if* you can afford it. And yet it's not very benign in terms of its coverage of the poorest. So we have lessons to learn. The way you put it, in terms of the limits of the market economy, is a very good way of understanding it. We must pay adequate attention to the role of public policy in dealing with medical care.



The legacy of apartheid has left South African health services far behind other countries at a similar economic level

You have emphasized "the abiding role of values as central to growth and development," saying that "development is a measure of human freedom" and that "health is crucial to freedom".

Yes, I have a book coming out in September which is called *Development as Freedom*. It's an attempt to see development as *enhancement* of human freedom. I argue that freedom is the primary end of development. Development isn't about raising GNP. No one wants money for its own sake. One wants money for something else, including good health. To be free to lead a good life, not to be cut off prematurely, not to have to suffer escapable ailments. Freedom of different kinds is constitutive of development.

Freedom is not only the primary end of development, it is also its principal means. Freedoms are of different kinds – social opportunities (which include health care), market and economic opportunities, and political freedom in the form of participation in society and decision-making. In different ways, freedoms affect our lives, from different ends. But as it happens, they are highly complementary.

For example, you do not have famines in a democratic country because the government could not face the polls or the criticism of opposition parties if it had a famine. There are other complementarities like social opportunities in the form of health care and education which make it easier for people to participate in a market economy, especially in a rapidly globalizing world. Freedoms of different kinds feed each other, support each other, consolidate each other.

I would like to argue that freedom is very central to development, both as ends and as means. It's the complementarity of different kinds of freedom which makes the analysis of "development as freedom" a particularly fruitful thing to pursue. Consolidating freedom of one kind helps consolidate freedom of other kinds. This is a very central issue in facing the challenges of the 21st century. The different aspects of freedom must influence the agenda of the coming century.

Professor Amartya Sen is Master of Trinity College, Cambridge and is former President of the International Economic Association, the American Economic Association, the Indian Economic Association, and the Econometric Society. The Royal Swedish Academy awarded him the Nobel Prize in economics in 1998 by citing his work in welfare economics and, in particular, on social choice theory, poverty and inequality.

SOUTH ASIAN DIALOGUE ON POVERTY AND HEALTH

15th To 18th November
Bangalore

This folder and bag should contain :

01. The Framework of the Dialogue (a note)
02. The Final Programme
03. The list of Participants
04. A Who is Who Document (Participant profile)
05. The Community Visit – Objectives
06. Some notes on the Community Visits
07. The Summary of the Opinion Survey
08. Suggested Questions for the Group Discussion
09. Learning from the Community – A Checklist of Parameters for the report
10. A Bibliography of the reading material received for the dialogue
11. A CHC pamphlet
12. An International Poverty and Health Network (IPHN) Note
13. A note on World Health Organisation – HSD
14. To Our Health - The newsletter of WHO – World Health Assembly Special (Pg. 1 & 3)
15. An Invitation Card for Cultural Programme and Special Dinner on 17th November, 1999
16. Symposium Paper 1 – Poverty, Disease and National & International Power structure – The Case of India by Prof. D. Banerji, India.
17. Symposium Paper 2 - Poverty and Development Paradigm – People's Perspective by Prof. Mathura Shrestha and Dr. Indira Shrestha, Nepal.
18. Symposium Paper 3 – Equity in Health Care – A Formidable Challenge for Sri Lanka (Synopsis) by Ms. Myrtle Perera, Sri Lanka.
19. Symposium Paper 4 – Crisis in Governance of Public Health System in Bangladesh : A Challenge of Humane Govenance (Synopsis) by Dr. Abul Barkat, Bangladesh.
20. Cartoon

Additional Background Papers

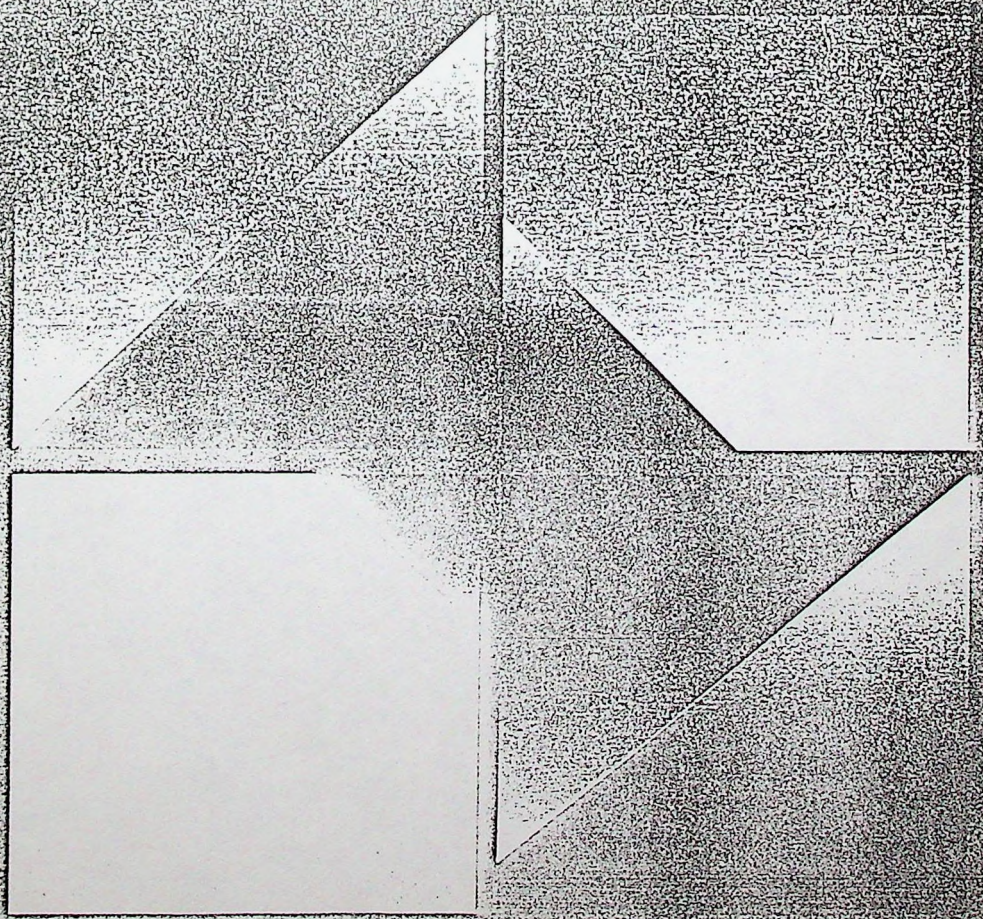
21 Health and Poverty in War by Dr. N. Sivarajah, Sri Lanka.
22. The Poverty of Amartya Sen by Mr. Anil Agarwal, India.
23. An Integrated approach to Community Health : The Sarvodaya experience in Sri Lanka by Dr. Vinya Ariyaratne, Sri Lanka.
24. A Report on The Rajiv Gandhi Missions – Government of Madhya Pradesh.
25. Strengthening Community Based Health Care in Madhya Pradesh through Decentralised Management of Health Services by Mr. R. Gopalakrishanan, India.
26. Peoples Campaign for Decentralised Planning and The Health Sector in Kerala by Dr. B. Ekbal, India.
27. A New Health Policy for Health Sector Reforms by Mr. Ravi Duggal, India.
28. Poverty and Health : Universal Abuse of Human Rights by Dr. Sunil Kaul, India.
29. A Note from Mr. B.S. Lamba, India.
30. Relevance of Ideas and Mass Mobilisation for the Removal of Poverty and Inequality by Dr. Devaki Jain, India.
31. Poverty and Health; Reaping a Richer Harvest – A book Notice
32. Special Issue – Health and Equity – Health for the Millions, New Delhi.
33. Special Issue – Community Health : Search for a New Paradigm - Health Action, Secunderabad.
34. A map / pamphlet on Bangalore

Others

35. Pad, Pen, Badge

HUMAN DEVELOPMENT IN SOUTH ASIA 1997

Mahbub ul Haq



5.1 BANGLADESH

Grameen Bank: credit to the poor

The Grameen Bank is one of the most successful experiments in extending credit to the landless poor. Since 1976, it has empowered over two million villagers in Bangladesh, mostly rural women, through the provision of small loans. The Grameen Bank idea has already been replicated in forty countries worldwide.

This world-renowned programme started rather modestly in the village of Jobra, Bangladesh, twenty years ago. It was the brainchild of Professor Mohammad Yunus who realized that lack of access to credit was the main hurdle in the progress of the rural poor.

From its inception, the programme had some very innovative features. First, no collateral was required from the poor. Individuals were asked to organize themselves into groups of five. The individuals in the group gave collective assurance for each other so that loan repayment became a collective responsibility. Second, credit was provided to the rural poor who owned less than half an acre of land; ninety-four per cent of these were women. Disregarding popular belief, women were considered more bankable and more trustworthy. This trust was amply rewarded through a recovery rate of ninety-eight per cent on all loans advanced to women. Third, the loans were small (an average of $100 each) and carried no interest subsidy. In fact, they were given at a much higher interest rate than bank loans in the market, reflecting the extra administrative cost of small loans. Fourth, the poor were required to put aside some saving—at least one taka (US 2.5 cents) a week. This encouraged the habit of self-reliance among the poor. Fifth, the bank went to the poor, rather than waiting for the poor to come to the bank.

By July 1996, the Grameen Bank had extended its services to 35,783 villages. Its membership had grown to over 2 million, of which 1.94 million were women. It had extended small credits amounting to $1810 million. The small savings of poor villagers added up to 4819 million takas ($128 million).

The Grameen Bank is now experimenting with other initiatives. Recently, the Grameen Trust initiated the process of creating a $100 million People's Fund to finance replication of this experiment in other developing countries. Starting from the small village of Jobra, the Grameen Bank has become a worldwide phenomenon.

5.2 BANGLADESH

BRAC: community development for the poorest of the poor

Since 1972, the Bangladesh Rural Advancement Committee (BRAC) has fought against malnutrition, illiteracy, disease, population growth, and unemployment in the villages of Bangladesh. At first, its activities were confined to the resettlement of refugees after the blood-soaked birth of the country. By 1976, BRAC had started to focus exclusively on the poorest of the poor: the landless, small farmers, artisans, and vulnerable women. By 1995, BRAC had emerged as one of the largest NGOs in the world, covering sixty out of the sixty-four districts of Bangladesh, with a total membership of 1.5 million, 85 per cent of them women.

Every village in which BRAC works has two Village Organizations (VOs), one each for men and women. Only the landless, or those owning less than half an acre of land, are eligible for membership. Members are encouraged to find solutions to their own problems and to join hands to pursue such solutions. Small credits are given without any collateral to the landless poor and to marginal farmers. The borrowers are asked to save at least two takas per week as well as to deposit five per cent of the loan they take from BRAC in their saving account. Currently, BRAC is operating several income-generating projects, such as poultry farming, fisheries, and the cultivation of vegetables.

One of the outstanding successes of BRAC is a non-formal education programme which was started in 1984. BRAC has two school models: one for 8-10-year-old children and the other for 11-14-year-olds. There is one teacher for every thirty-three students. The students are taught by the same teacher throughout the three years. Over 72 per cent of the students are girls, while 95 per cent of the teachers are women. The distinguishing features of this programme are: flexible school hours, a relevant curriculum, motivated teachers, reasonable class size, community support, involvement of parents, and a system of intensive supervision. BRAC has established over thirty thousand schools which accommodate nearly one million students.

BRAC has also started several programmes in the health field. Its Oral Rehydration Therapy programme is implementing a nation-wide battle against diarrhoea. 99 per cent of mothers in Bangladesh have been given training by BRAC workers, enabling them to treat diarrhoea at home. BRAC is an outstanding success story of a nation-wide programme of community development to benefit the poorest and most vulnerable sections of society.

5.3 BANGLADESH

Proshika: skills for the poor

Proshika, a nation-wide NGO, has been active in the field of rural development since 1976. By 1990, Proshika had a membership of over 20,000 people, half of them women. Its operations extended to more than 3,000 villages in twenty-two districts of Bangladesh.

Proshika has been engaged in imparting formal and non-formal education and practical skill-training to the rural poor. By 1990, the total number of participants in these training courses was 46,000 men and 76,000 women. Practical training was imparted to the participants, enabling them to obtain employment in the surrounding rural communities. During

the fiscal year 1990, the activities of Proshika had reached a level where 58 million takas (nearly $1.5 million) were disbursed for employment and income-generating activities. Besides skill-training, a health infrastructure programme was also developed, the chief feature of which was the organization of 446 courses in health care in which 14,000 group members participated; and 778 tubewells were installed, benefiting 20,000 households.

Since 1991, Proshika has also extended its activities to urban areas, training many workers in urban slums. An initiative that started rather modestly twenty years ago in a few villages of Bangladesh now has national coverage and a devoted following.

5.4 BANGLADESH

RDRS: social literacy centres

The Rangpur Dinajpur Rural Service (RDRS) is an international NGO working in the northern part of Bangladesh. RDRS has introduced new social literacy materials, developed out of its many years of experience with functional education. It has opened a network of schools in North Bengal and parents have been motivated to enrol their children because of the practical orientation of the literacy programme and its close link with daily life.

Since 1990, RDRS has been collaborating with another international NGO, Helen Keller International, to provide nutritional surveillance. It has motivated families to bring their children for immunization as a part of the Government/UNICEF Expanded Programme for Immunization. During the same period, it conducted a thorough review of the Community Health Unit programme. By 1990, 62 per cent of RDRS members enjoyed access to safe drinking water and 16 per cent of the households were using sanitary latrines.

RDRS has also started producing clay and concrete roof tiles and hollow sand-cement bricks for low-cost housing. It is now helping with the plantation of trees and the construction of small bridges and culverts as well.

The experience of RDRS illustrates how functional literacy at the local level can be a stepping-stone to many other beneficial community activities on a self-help basis.

5.5 BANGLADESH

Twenty-two landless women entrepreneurs

Civil society initiatives do not always have to be large, or nation-wide, or internationally famous. A great deal can be done at the local level through collective efforts.

In the small village of Faridpur in Bangladesh, a group of twenty-two women, between the ages of twenty and forty, came together in the early 1990s to manage an oil-pressing business. Their motivation was simple but powerful: traditional methods of oil-pressing were very labour-intensive and rewards from organized buyers were small when women approached them individually to sell their meagre produce. These twenty-two women got together and borrowed 5,000 takas ($1,250) from a local NGO to organize their own oil extraction enterprise.

Since they were all illiterate, some took literacy training in order to maintain their own books. And they slowly learnt the entrepreneurial skills needed to buy and store seeds when they were cheap and to sell them for the best price through collective bargaining. And when some social leaders objected, as profits of powerful elites were threatened, these illiterate women offered the most cogent and articulate response:

'When we were dying of hunger, our children were suffering from diseases, we had no homes of our own and we lived in thatched houses, the village leaders did not feed us, nor did they help save our children from hunger and disease, nor did they give us clothes to cover our bodies. These people have no right to tell us now what to do or not to do, nor do they have any right to judge us or condemn our activities.'

Now this spirited band of women has designed a pl[illegible]o buy their own oil-pressing machine. It will cost 50,000 takas ($1,250): they have been able to save only 20,000 takas ($500) so far. But with the collective determination they have already shown, the day may not be far off when twenty-two illiterate and desperately poor women celebrate the birth of a modern enterprise.

5.6 INDIA

Working Women's Forum: empowering women in urban slums

In the 1970s, the living conditions of poor women in the urban slums of Tamil Nadu, a south Indian state, were characterized by extreme poverty, unpaid debts, and illiteracy.

The government had started a credit scheme under which nationalized banks were directed to extend subsidized credit, at four per cent interest, to the urban poor, without the requirement of any collateral. But most poor people were unaware of this government offer. The Working Wom[illegible]s Forum (WWF) was organized in 1977 to enable indigent self-employed women to take advantage of this scheme.

During the 1980s, WWF expanded beyond this credit intermediary role. It organized its own credit and saving schemes, on a pattern similar to that of the Grameen Bank (see box 5.1), with collective group collateral, small savings by the poor, and income-generating micro-enterprises. The rule of collective borrowing generates peer pressure, which leads to high repayment rates. Groups are normally formed by a potential group leader who has become familiar with the WWF programme and is competent enough to guide the new members.

Currently, over 50,000 needy women benefit from these small credit programmes, and the loan repayment rate is 94 per cent. In many cases, the daily earnings of these women have gone up three to four times.

Using credit as an entry point, WWF has branched out into many other social programmes such as day-care centres,

night classes for children, skill-training, health and family planning, and the organization of advocacy and lobbying efforts. This civil society initiative has now reached a target population of 200,000 poor women working in the informal sector.

5.7 INDIA

SEWA: trade union of poor women

SEWA (meaning 'service' in Hindi) is a trade union with a difference. While trade unions normally organize permanent workers in various occupations to fight for their rights, SEWA (Self Employed Women's Association) has organized women working in the informal sector. These include vegetable vendors, rag and paper pickers, bamboo workers, head loaders, cart pullers, and garment workers. Before SEWA was formed in Ahmedabad in 1972, these poor hardworking women were totally at the mercy of their employers, often exploited for very low wages and insecure in their very low-paid jobs.

SEWA has successfully overcome the boundaries of the caste system in India, drawing its membership from all sections of society. One-third of its membership today is Muslim and another one-third belongs to the scheduled castes.

SEWA has empowered these women by combining the strategies of trade unions and co-operatives. SEWA has organized its own co-operative bank and a group life insurance scheme so that its members can become more self-reliant. It has also started several skill-training courses to enhance the income-earning potential of its members as well as providing legal services to enable indigent women to obtain the benefits of national labour legislation, which were earlier denied to them.

One of the novel features of SEWA is its close collaboration with the government. It has helped the government to organize several women's groups under the Development of Women and Children in the Rural Areas programme. The government has also used SEWA effectively in extending the outreach of several of its programmes to poor women.

5.8 INDIA

Lok Jumbish: a people's movement

The extreme educational backwardness in the Indian state of Rajasthan led to a unique collaboration between the people and the state. They established a movement aimed at providing education for all the people of Rajasthan by the year 2000. The objectives of LJ are: to provide access to and ensure the participation of all children in primary schools or non-formal education centres; to improve the quality of learning; to make education an instrument for women's empowerment; and to provide equal educational opportunities to lower castes. The strategies used to achieve the above objectives are: (a) mobilization of people and their involvement in the planning and implementation of programmes; (b) special emphasis on the education of girls; (c) improvement of the training and status of teachers; and (d) initiating a comprehensive programme for reform of the primary education system. Established in 1992, the project covered a population of 2.2 million during the first year of its operation.

Through school mapping, micro-planning, training of teachers, developing women's leadership, and expanding and improving schooling facilities, LJ has energized education in the rural areas of Rajasthan. The overall objective of this movement is not only to improve education, but also to bring about a positive change in the attitudes and capabilities of people, so that ultimately they themselves become responsible for their own education and empowerment.

5.9 INDIA

Jawahar Rozgar Yojana: employment for the poor

Two programmes—the National Rural Employment Programme and the Rural Landless Employment Guarantee Programme—were started by the Indian Government in 1980 and 1983 respectively, to provide employment opportunities to the poor through infrastructure projects which would create durable assets in the rural areas. In the first few years, these programmes taught the organizers two main lessons: assets which are created should be economically viable; local communities should be involved in deciding what assets to build. These lessons were learnt well and were reflected in a merger of both the projects in 1989 into a programme called Jawahar Rozgar Yojana (JRY).

The central government and the states have shared the cost of this programme in the ratio of 80:20. The funds from the Centre to the states are disbursed on the basis of the proportion of the rural poor in each state. At least 60 per cent of the funds are spent on wages and the rest on materials. The programme has large budgetary support: about 21 billion rupees have been allocated annually between 1990 and 1993.

Considerable success has been achieved under the JRY in the creation of employment opportunities for about 750 to 850 million man days per year. In addition, one million houses have been constructed, and 320,000 irrigation wells set up. These facilities have been developed mainly for scheduled castes and tribes living below the poverty line. The JRY programme is currently decentralizing decision-making authority even further, so that poor people can directly select the assets to be created.

5.10 INDIA

Employment Guarantee Scheme

In 1972, the state government of Maharashtra introduced an innovative Employment Guarantee Scheme based on the concept of the 'right to work'. Its basic objective was to provide productive employment opportunities to the rural areas and thereby to transform unemployed labour into national capital. The programme ensured that men and women were given equal

opportunities to benefit under the scheme.

The programme undertook several development works, such as soil and moisture conservation, afforestation, social forestry, and fisheries. The results of this programme have been very positive. During the first ten years, over 130 million man days of employment were created each year. The participation of women was more than 50 per cent.

An important feature of the programme is its flexibility in adapting to new possibilities. For instance, a special programme called 'Shram Shakti Dware Gram Vikas' (village development through labour) was introduced. This programme encouraged optimum utilization of land and water resources, sericulture, horticulture, and other schemes for small and marginal farmers below the poverty line.

EGS has greatly helped in alleviating poverty and in creating productive assets in the rural areas of the Maharashtra state. It is a good example of government collaboration with local communities.

5.11 INDIA

Asha Nagar Leper Resettlement Colony

Asha Nagar is the story of a good experiment gone wrong. The beginning was quite promising. The District Administration in Rajnandgaon in India developed a comprehensive project for the rehabilitation and welfare of lepers. They were provided group housing, medical facilities, and self-employment opportunities. Some social services were also provided: a school, a health centre, and safe drinking water. The project succeeded in its initial objective: not a single leper was seen begging anywhere in the town.

And then several problems surfaced. A barrage and a dam in the area collapsed, leading to the failure of several enterprises, such as the mulberry plantation and the fisheries. Looms were driven out of business due to shifts in market demand. Non-repayment of initial loans led to discontinuation of further assistance from the government. The school was not formally recognized and upgraded so that the single deputed teacher left. A well-designed and well-executed project failed for want of continuous government support and lack of self-help by target groups. The lepers were back on the streets.

The Asha Nagar Leper Resettlement Colony Project illustrates that community welfare efforts cannot prove sustainable unless they are owned and managed by the community itself.

5.12 PAKISTAN

AKRSP: a succesful experiment in community development

The Aga Khan Rural Support Project (AKRSP), a non-profit organization initiated by the Aga Khan Foundation, started operating in Gilgit in 1982 to improve the extremely poor socio-economic conditions of about one million inhabitants of the mountainous northern areas of Pakistan. The programme has a 'package approach': it provides basic education, health services, and credit; imparts technical skills; and it embarks on major infrastructure development projects.

The key feature of the programme is the formation of broad-based, multi-purpose Village Organizations (VOs) in village communities. The villagers themselves select the physical infrastructure project, such as a village road or an irrigation canal. They contribute their free labour and manage the project themselves. AKRSP trains the people nominated by the VOs in various skills required for the project. Each phase of project identification, preparation, and appraisal involves an interactive dialogue between the villagers and the AKRSP. The first project is offered as a grant to each VO. This leads to a partnership in which the VO members commit themselves to the discipline of the organization, collective savings, implementation, and maintenance of the project.

As a result of fourteen years of dedicated effort, AKRSP is now touching the lives of nearly one million people in the northern areas of Pakistan. About 1,964 Village Organizations have been formed, covering 77 per cent of rural households.

The total savings of these VOs have now reached Rs 220 million—no small feat in a backward area, where the concept of personal saving by poor people was unknown and untried only two decades ago. The small credit programme has benefited nearly half a million people, with loans worth Rs 518 million. Extensive physical infrastructure has been built with the active involvement of local communities.

5.13 PAKISTAN

Edhi Trust: the poor man's messiah

If you hear a siren in the dead of the night in Karachi, Pakistan's largest city, the odds are that it is neither a police van nor a government-run service. It is most probably the ambulance of the Edhi Foundation run by a remarkable man, Abdul Sattar Edhi, known as the Angel of Mercy in the death-haunted streets of Karachi.

Edhi's first mass-contact service was in 1957, when he rented tents on credit and put up camps all over Karachi to help the victims of a deadly influenza epidemic. A businessman impressed with Edhi's work donated Rs 20,000 ($ 4,000 at the time). Edhi bought his first van and started his journey of service to humanity. Soon, people began to inform Edhi of every accident, and even the police would seek his help.

Now the Edhi Foundation has 320 centres all over Pakistan, but its operations are still run from a modest office in Karachi. Edhi is sixty-six, but in times of need still drives the ambulance himself into some of the most dangerous and violence-prone areas of Karachi. Edhi's personal touch has never been missing from the work of his Foundation, despite the fact that it has now some 2,000 regular employees, besides thousands of volunteers.

Edhi, with the full support of his wife, runs a national network of orphanages, hospitals, care centres for the mentally ill, maternity homes, child adoption centres, and several other social services. The Edhi Foundation also arranges for the adoption of abandoned babies. Outside every Edhi Trust lies a cradle where women can leave their unwanted children without identifying themselves. Many innocent lives have been saved through this thoughtful initiative.

From modest beginnings, the Edhi Foundation has come a long way. Its present assets are valued at three billion rupees (around $750 million) and its yearly income is around one billion rupees. About one-third of this budget is contributed by Pakistanis living abroad.

The Edhi Foundation is a remarkable example of one man's life-long selfless struggle to alleviate the suffering of fellow human beings.

5.14 PAKISTAN

Orangi Pilot Project: cost effective social services

Orangi, a *katchi abadi* (slum) in Karachi, was established in 1965. It expanded rapidly after 1971, as nearly one million of the poorest people crowded into an area with no proper roads, no electricity, no pipelines for water, few schools, and hardly any other public services either. The worst environmental hazard was poor sanitation. Bucket latrines or soak pits were used for the disposal of human excreta and open sewers for waste materials. Diseases spread rapidly in such an unsanitary environment. People were aware of the problem but did not know how to solve it. They kept hoping that the government would solve it for them.

In 1980, Akhtar Hameed Khan, a charismatic leader with missionary zeal and considerable experience in organizing community self-help from his previous work in the Comilla Project in East Pakistan, walked into this environment of despair. Single-handedly, he convinced the local people that they could build the necessary sanitation facilities through self-help and at a low cost. This was the genesis of the Orangi Pilot Project (OPP).

OPP was set up as a modest research institute to analyse the problems of Orangi and to identify some viable solutions. One of its first breakthroughs was to discover that the cost of providing satisfactory sanitation facilities could be drastically reduced. By simplifying the designs, changing the methods of construction, eliminating kickbacks and profiteering, providing free technical guidance to lane managers and enabling them to work without contractors, the unit cost of sanitary latrines and manholes was reduced to *one-fourth* of the conventional cost.

OPP then persuaded the local people that they could tackle the problem themselves by joining hands. When people realized that with an investment of only Rs 1,000 (one month's average income), they could reap immediate benefits for their own health and the health of their families, they decided not to wait for the uncertain promises of the government to materialize and started the work themselves.

The results have been extremely impressive. By 1992, 430,000 feet of underground sewerage had been built as well as more than 28,000 latrines, benefiting 28,000 families. The local people financed this construction from Rs 30 million of their own savings, demonstrating how poor people can provide critical social services for themselves in a very cost-effective manner.

The success of the sanitation programme in turn led to programmes for low-cost housing, basic health and family planning, women's work centres, school upgrading, and provision of supervised credits for small family units which increased production, employment, and managerial skills. Many NGOs have adopted the basic approach of the Orangi Pilot Project and external donors (like UNICEF and the World Bank) have modelled some of their projects on a similar approach. From modest beginnings, OPP has begun to lead the way for other self-help community efforts.

5.15 PAKISTAN

Baanhn Beli: for forgotten people in remote villages

One million people inhabit the Thar desert that spreads across twenty thousand square kilometres in Sindh. These are the people who have never seen a metalled road, never used electricity, never heard of piped drinking water, and never had much contact with the outside world.

Baanhn Beli—a phrase in Sindhi, Seraiki, and Punjabi, meaning 'a friend forever'—is the sole voluntary organization to have entered the Tharparkar region of Pakistan, with the aim of improving people's lives. Established in 1987, its chief objective is to build an alliance between the disadvantaged people living in the area and professional specialists from cities in order to address the most pressing development concerns.

By 1991, with the financial help of the government-sponsored Trust for Voluntary Organizations and some international donors, activities started in female education, basic health care, supply of safe drinking water, computer literacy, agricultural production, veterinary services, and provision of small loans to the poor to encourage income-generating activities and self-employment. By now, over 200,000 people have benefited from the work of Baanhn Beli in about 200 settlements.

One of the cardinal principles of Baanhn Beli is the active consent and willing participation of the villagers in the programmes. For instance, the villagers themselves provide premises for schools. They identify a male or female teacher for interviews by the Baanhn Beli organization. They provide small savings out of their meagre earnings to finance a self-reliant and informal village banking system. This experience shows that much can be done even in a feudalistic structure, if local people can be mobilized to organize themselves.

5.16 PAKISTAN

AGHS Legal Aid Cell: fighting for unpopular causes

Asma Jahangir co-founded Pakistan's first all-female law firm, AGHS Legal Aid Cell. This Cell became the nucleus of her crusade to protest against human rights violations in Pakistan and to protect the legal rights of the weak and the poor in society, especially women.

The cases of human rights abuses she takes up make national and international headlines and provoke several threats to her life. But her courageous work as Chairperson of the Human Rights Commission of Pakistan and Chairperson of her own organization (AGHS Legal Aid Cell) is appreciated throughout the country and the world over. In 1992, AGHS Legal Aid Cell was the recipient of the Human Rights Award of the American Bar Association Section of Litigation.

Her office takes up an average of 350 cases every year. Many of these cases involve fundamental issues that other organizations are afraid to touch. For instance, Asma recently took up the case of a fourteen year old Christian boy, Salamat Masih, who was accused of having committed blasphemy by writing disrespectful words against the Holy Prophet on the wall of a mosque. The child was illiterate but the death sentence stared him in the face. When Asma took up the case and won it, saving the child's life, she received death threats. But this did not deter her in her efforts to prevent what she considered a serious miscarriage of justice.

The AGHS Legal Aid Cell not only gives legal aid to poor people, especially women, it also documents each case thoroughly and maintains proper records in order to point out the shortcomings in the judicial system. The Cell also runs a public campaign through newspapers and posters to raise national awareness about human rights abuses. It has awakened the sleeping conscience of many, who now support its activities.

5.17 PAKISTAN

Bunyad: accelerating female literacy

The Bunyad Literacy Community Council (BLCC) was established in 1993 to promote literacy, particularly among women. It started its work from Hafizabad, a backward area in the Punjab, with the dubious reputation of having a female literacy rate of only 6 per cent but the highest rate of rapes in the province.

BLCC established several non-formal centres in these remote areas. Initially, the focus was on the enrolment of both boys and girls, but it gradually shifted to girls alone. Community participation became a central feature of these efforts, with the villagers providing a location for the schools as well as participating in the selection of local teachers. These teachers were given proper training at the Bunyad teachers' training centres.

Bunyad has already established 500 centres in various areas of the Punjab province, in which 15,000 girls are receiving education as well as acquiring various life skills. The success of the programme can be judged by its low dropout rate at the primary school level: only 15 per cent compared to a 50 per cent national average.

Recently, BLCC has adopted a package approach. Besides education, it has begun to cover areas such as basic health care, family planning, environmental sanitation, and small credit to rural women for income-generating activities. It is not clear, however, whether Bunyad can successfully implement such comprehensive development packages in view of its limited financial resources.

The experience of Bunyad raises a fundamental issue. This civil society effort has come to rely a great deal on the financial support of one external donor which is about to phase out. The outstanding work done by this NGO is now threatened unless funds from some other sources materialize. It shows that unless an NGO's activities are supported by the self-help efforts of the community itself, the sustainability of these activities is always in danger.

5.18 SRI LANKA

SSM: integration of low-caste families

During the 1950s, a dedicated community leader in Sri Lanka, A. T. Ariyaratne, took up the challenge of integrating low-caste families into the mainstream of national life. Now, the Sarvodaya Sharamadana Movement (SSM) that was started as a result of this concern covers more than one-third of the total villages of Sri Lanka.

The Sarvodaya Sharamadana Movement deals with both income-generation and welfare activities. On the one hand, it organizes many income-generating programmes for the poor, such as workshops for mechanical repairs and carpentry, sewing shops, off-farm activities for small farmers and for the landless.

On the other, it arranges relief and rehabilitation programmes for the victims of ethnic conflicts and for the deaf and the disabled. It also organizes nutrition programmes for pre-school children.

The movement is based on the participation of the people. It instils a new sense of confidence among the poor that they can change their physical and economic environment through their own efforts.

The movement has created a new leadership which bypasses the traditional elitist culture of the state. And it has enabled the weakest and the most ignored groups in society to participate in the economic, social, and political life of the country.

5.19 SRI LANKA

SANASA: credit for the rural poor

The Sanasa movement was started in 1979 when a young social worker, P. K. Kiriwandeniya, attempted to convert a traditional

credit union movement into a non-traditional credit scheme, in order to reach those rural poor who were excluded from the formal financial sector.

At that time, 44 per cent of the households in Sri Lanka were under heavy debt, of which 70 per cent was owed to non-institutional sources, often from traditional money-lenders who charged exorbitant interest rates, well above those charged by formal sector financial institutions. These formal sector credit institutions had simply failed to reach the rural poor.

Sanasa operates on a voluntary basis. All members contribute some of their meagre savings to the central resource pool. This resource pool is then used to give credit in a systematic manner. The focus is on longer term credit for productive purposes, not on short-term emergency needs. The members are required to save and deposit at least one-third of their loans with the society. The availability of credit for the empowered sections of society has created many innovative entrepreneurial opportunities in rural areas.

Now, the Sanasa movement has started community development projects, target group initiatives, and several environment programmes aimed at the sustainable development of the rural areas. In addition, many community activities have been planned to reduce the ethnic strife that has unfortunately engulfed Sri Lanka.

Sanasa has become a national movement over the last two decades. The loan recovery rate is over 90 per cent compared to 60 per cent in the commercial banks. And, for once, credit is actually reaching the poorest people in rural areas.

5.20 SRI LANKA

SWM: a movement for the empowerment of women

The Sarvodaya Women's Movement (SWM) was started in 1987 to empower women as social workers, income generators, and spiritual leaders. The main programmes of SWM revolve around literacy, home gardening, nutrition, and income-generation.

The literacy programme provides education to women and girl children between the ages of 14 and 35. In order to make literacy more functional and meaningful, the courses include such elements as family health and sanitation, food and nutrition, home economics, and civic rights and responsibilities.

The home gardening programme teaches women to grow their own vegetables and to use herbs for medicinal purposes. Small income-generation projects include skill-training in dress-making and sewing.

The rehabilitation of street children and women in Colombo and Kandy is another major activity of the organization. Named Borella Centre, this programme provides various facilities, including a pre-school day-care centre, vocational training in sewing, carpentry, and welding. SWM also runs a rehabilitation centre for young women. It oversees several gender-sensitization programmes, aimed at the harmonious integration of women and men in grass-roots community development efforts.

Currently, SWM projects cover 64 villages in Sri Lanka, in which over 2,000 members participate in programmes aimed at empowering women and making them full partners in community life.

5.21 NEPAL

Small Farmer Development Programme

Agriculture contributes more than half of the national income of Nepal. Subsistence farming is a way of life, but availability of credit to subsistence farmers has remained limited. In 1975, the Agricultural Development Bank of Nepal set up a Small Farmer Development Programme (SFDP) to provide credit services to subsistence farmers.

The SFDP organized small farmers and landless labourers in small, homogenous groups of five to fifteen members in order to reduce their transaction costs and improve their bargaining power. The principle of joint liability was established so that credit was made available without collateral, and peer pressure ensured its proper use and repayment.

The SFDP has expanded rapidly in the last twenty years. By 1992, the programme covered 140,000 households in 575 villages. Besides provision of credit, over 9,000 hectares of land have been brought under irrigation. The cost of irrigating one hectare was only Rs 8,000 through this programme, whereas the cost was as high as Rs 100,000 in a similar government-run project. During the same period, literacy rates in the programme area increased from 59 to 76 per cent for males and from 15 to 18 per cent for females. The proportion of families using contraceptives increased from 24 to 30 per cent. A great deal of infrastructure was also created, ranging from water supply schemes to construction of much-needed bridges.

The impact of SFDP on the income of poor households has been highly encouraging. The human development indicators of families covered by the programme have shown a dramatic improvement. This experience demonstrates that when even a conventional bank (ADBN) sets aside a small proportion (only 7 per cent) of its total resources to help the poor and needy, it can achieve spectacular results by organizing the self-help efforts of the entire community.

5.22 BHUTAN

Mongar district health project

Mongar is one of the twenty districts in Bhutan. An integrated project to provide health services was launched in 1984 in the Mongar district with the involvement of the local community. Besides extending primary health care, it also ensured access to referral health services and other measures to improve the health of the local communities.

The contribution of the community included the provision of labour and locally available materials, construction of

latrines, outreach clinics, drinking water supply schemes, as well as transportation of the materials provided by the World Food Programme (WFP) and other agencies. Within four years of project implementation, the Mongar district achieved full coverage of primary health care, with 94 per cent of households having and using latrines and two-thirds of households having access to piped water. The infant mortality rate was halved between 1984 and 1991, as child immunization coverage increased to 90 per cent.

The key lesson from the Mongar district health project is the same as from many other grass-roots efforts: local communities must themselves participate in designing and implementing the projects which are intended to benefit them. Bhutan is now extending this lesson to other districts.

5.23 MALDIVES

Integrated Atolls Development Project (IADP)

In 1988, the government of the Maldives launched the Integrated Atolls Development Project (IDAP) to encourage community participation in social development. This programme aims at enabling the nineteen atoll communities to identify their own development needs, to formulate plans, and to implement programmes which would respond to those community needs which have been identified by poor people themselves.

Besides the provision of social services, the programme also encourages income-generating activities and provides credit for the development of the entrepreneurial talent in the local communities.

One of the refreshing features of IADP is the encouragement of the contribution of women in local development. Women are fully represented in all decision-making forums and every project that is designed is reviewed from the perspective of accelerating women's development.

This project is still in an evolutionary stage. During its brief existence, it has already demonstrated that the government and local communities can collaborate in an efficient and cost-effective manner.

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WORLD HEALTH ORGANIZATION

FINAL REPORT OF

MEETING ON POLICY-ORIENTED MONITORING OF EQUITY IN HEALTH AND HEALTH CARE

Geneva, 29 September - 3 October 1997

Organized together with the
Council for International Organizations of Medical Sciences
and the NGO Forum for Health

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EXECUTIVE SUMMARY

The challenge of promoting equity in health and health care is the major theme of the Equity Initiative launched by the World Health Organisation and Sida in 1995. One of the strategies adopted in focusing on equity has been the development of indicators to monitor equity, with an emphasis on using these data to influence the policy process.

To further advance this work, the Meeting on Policy-Oriented Monitoring of Equity in Health and Health Care was convened from 29 September to 3 October 1997 at WHO headquarters in Geneva. It was co-organized by WHO, the Council for International Organizations of Medical Sciences (CIOMS) and the Non-Governmental Forum for Health. Participants represented Ministries of Health, universities, research institutions, non-governmental organizations, donors and WHO regional and country offices.

This technical meeting was designed to assist WHO in developing the next steps forward in this major initiative focused on achieving greater equity in health and health care. Although the primary concern of the meeting was policy-oriented monitoring, it was intended that this be seen in the context of the broader range of activities proposed by the initiative including policy development, implementation and advocacy but also be seen in relation to WHO's new policy *Health for all in the 21st Century.*

The meeting acknowledged that a precise definition of equity is not available. However there was agreement that health inequities exist when there are inequalities in health status, risk factors, or health service utilisation between individuals or groups, that are unnecessary, avoidable and unfair. Equity in health requires equity in the distribution of the determinants of health including, but not limited to, health services. Even in relatively affluent nations that emphasize equity in access to services, there are significant inequalities in health status that reflect more fundamental social inequalities in socioeconomic status, education, working and living conditions.

Reducing inequalities in health status to the point where we can judge them unavoidable and fair, would therefore require: (1) special steps in the health sector to compensate for inequalities in risk factors that arise from other inequalities (socioeconomic, gender etc.) and (2) further efforts to reduce these other inequalities through intersectoral action.

Inequity is a problem in all regions and all countries. Socioeconomic inequalities are the most important determinants of avoidable inequalities in health status, with health care services playing a lesser role. Presentations showed that there is a need for disaggregated data at all levels to allow for the identification of inequities and that both the quality and practical use of existing data should be markedly increased. The use of routine data from the health sector needs to be supplemented with additional routine information from other sectors, e.g. the census or routine household surveys conducted by labour, commerce, agriculture, social welfare or other sectors, in order to identify neglected groups. The most disadvantaged are not a homogenous group of society; there are significant differences between, e.g. the "moderately poor" and the extremely poor or poorest. Measures of deprivation should be sensitive to these socioeconomic differences with health consequences. Policy makers need to be able to be effective advocates for greater equity, even when evidence of short-term overall economic gain is lacking.

Four key criteria for selecting indicators for monitoring equity in health and health care were recommended: Relevance to policy on equity in any relevant sector; accessibility of disaggregated data; simplicity; and meeting standard scientific and ethical criteria.

Different ways of formulating an equity target with a given indicator were discussed. Formulating an equity target is probably more important than which specific indicator is selected, as it is the target that is explicit about comparisons among the more and less advantaged. Using child mortality rates, the following examples illustrate what is meant by an equity target, as contrasted with a generic target that does not address issues of equity:

- A generic target: By the year ____, reduce child mortality to x%.

- Contrasted with possible equity targets, e.g.:
  By the year _____, reduce child mortality to x% overall, and reduce the disparities in child mortality between the highest and lowest income quintiles by z%; or

  By the year _____, reduce child stunting to x% overall, and reduce the disparity in stunting rates between girls and boys by y%.

The recommended indicators are summarized in the table below:

Table: Key indicators for monitoring equity in health and health care

Indicator categories	Indicators measuring differences between population groups
1: Health determinants indicators:	Prevalence and level of poverty Educational levels Adequate sanitation and safe water coverage
2: Health status indicators:	Under 5-year child mortality rate Prevalence of child stunting *Recommended additional indicators*: Maternal mortality ratio; life expectancy at birth; incidence/prevalence of relevant infectious diseases; infant mortality rate and 1-4 year old mortality rate expressed separately
3: Health care resource allocation indicators:	Per capita distribution of qualified personnel in selected categories. Per capita distribution of service facilities at primary, secondary, tertiary and quaternary levels. Per capita distribution of total health expenditures on personnel and supplies, as well as facilities.
4: Health care utilization indicators:	Immunisation coverage Antenatal coverage % of births attended by a qualified attendant Current use of contraception

In relation to WHO's new policy *Health for All in the 21st Century*, it was emphasized that health for all is equity. Equity is a core value of the new policy and the policy introduces equity-oriented indicators, in particular, child health and child growth. In order to achieve equity it should be made an explicit criterion for priority-setting. Health systems have to act and ensure universal access to adequate quality care and adopt life-span approaches which give priorities to prevention and health promotion.

The meeting identified a range of obstacles to equity, e.g. lack of clarity of the concept, lack of awareness among policy-makers, lack of data, lack of analysis of existing data, management of the health sector, general acceptance of inequities and global issues such as the role of private companies. Strategies for overcoming these obstacles and advance equity were recommended.

WHO needs to be bolder, and speak out on controversial issues such as privatization, unhealthy industries, unhealthy trades and unhealthy business practices. Progress on equity will not be achieved by a "business as usual" approach. WHO should disseminate evidence of where pursuing economic growth without a systematic and explicit focus on equity may increase inequity.

Among its highest priorities WHO should intensify its work to get equity higher up on the agendas of international organizations, governments, donors, and professional organizations. The capacity of governments to routinely monitor equity in health and health care need to be strengthened through suggesting options for simple yet valid approaches to ongoing policy-oriented monitoring of equity, using existing data sources from all relevant sectors and simple methods of analysis and presentation. Vital statistics capacity should be strengthened by incorporating socio-economic and geographic information as well as improving data quality, using census data in health equity assessments and population-based data from other key sectors.

WHO should reorientate itself to equity, and to the intersectoral cooperation required to achieve it. The Task Force on Equity in Health and Health Care should look into WHO programmes and the extent of their equity concerns. The Task Force should expand its membership to other international organizations, e.g. ILO, UNICEF, UNESCO. Similar mechanisms need to be established at regional and country levels.

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MEDICINE AND PUBLIC ISSUES

Poverty and Ill Health: Physicians Can, and Should, Make a Difference

Michael McCally, MD, PhD; Andrew Haines, MD; Oliver Fein, MD; Whitney Addington, MD; Robert S. Lawrence, MD; and Christine K. Cassel, MD

A growing body of research confirms the existence of a powerful connection between socioeconomic status and health. This research has implications for both clinical practice and public policy and deserves to be more widely understood by physicians. Absolute poverty, which implies a lack of resources deemed necessary for survival, is self-evidently associated with poor health, particularly in less developed countries. Over the past two decades, economic decline or stagnation has reduced the incomes of 1.6 billion people. Strong evidence now indicates that relative poverty, which is defined in relation to the average resources available in a society, is also a major determinant of health in industrialized countries. For example, persons in U.S. states with income distributions that are more equitable have longer life expectancies than persons in less egalitarian states.

There are numerous possible approaches to improving the health of poor populations. The most essential task is to ensure the satisfaction of basic human needs: shelter, clean air, safe drinking water, and adequate nutrition. Other approaches include reducing barriers to the adoption of healthier modes of living and improving access to appropriate and effective health and social services. Physicians as clinicians, educators, research scientists, and advocates for policy change can contribute to all of these approaches. Physicians and other health professionals should understand poverty and its effects on health and should endeavor to influence policymakers nationally and internationally to reduce the burden of ill health that is a consequence of poverty.

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Poverty and social inequalities may be the most important determinants of poor health worldwide. Socioeconomic differences in health status exist even in industrialized countries where access to modern health care is widespread (1). In this paper, we make a formal argument for physician concern and action about poverty based on the following assertions. Physicians have a professional and a moral responsibility to care for the sick and to prevent suffering. Poverty is a significant threat to the health of both individual persons and populations; thus, physicians have a social responsibility to take action against poverty and its consequences for health. Physicians can help improve population health by addressing poverty in their roles as clinicians, educators, research scientists, and participants in policymaking.

Concepts of Poverty and Health

Poverty is a multidimensional phenomenon that can be defined in both economic and social terms. An economic measure of poverty identifies an income sufficient to provide a minimum level of consumption of goods and services. A sociologic measure of poverty is concerned not with consumption but with social participation (2). Poverty leads to a person's exclusion from the mainstream way of life and activities in a society (3). There is a difference between absolute poverty, which implies a lack of resources deemed necessary for survival in a given society, and relative poverty, which is defined in relation to the average resources available in a society. Economic measures are easy to obtain, but social measures may provide a better understanding of the causes and consequences of poverty. Steps have been taken toward the development of indices of deprivation, which have promising uses in health services and public health research (4).

In 1978, the World Health Organization (WHO), in the Alma-Ata Declaration, spelled out the dependence of human health (defined broadly) on social and economic development and noted that adequate living conditions are necessary for health (5). Despite their knowledge of this, governments and major development organizations have largely con-

tinued to view health narrowly as a responsibility of the medical sector, outside the scope of economic development efforts. Consequently, governments have encouraged many large-scale but narrowly focused economic development efforts, ignoring the connection between poverty and health (6). In developed countries, governments promote various practices, such as heavy pesticide applications, that are designed to increase economic development and competitiveness but that are environmentally unsound and personally unhealthy.

Poverty Causes Death and Illness on a Massive Scale

During the second half of the 1980s, the number of persons in the world who were living in extreme poverty increased. Currently, extreme poverty afflicts more than 20% of the world's population. A recent report from WHO points out that up to 43% of children in the developing world—230 million children—have low height for their age and that about 50 million children have low weight for their height (7). Micronutrient malnutrition (deficiencies of vitamin A, iodine, and iron) affects about 2 billion persons worldwide.

It has been estimated that if developing countries enjoyed the same health and social conditions as the most developed nations, the current annual toll of more than 12 million deaths in children younger than 5 years of age could be reduced to less than 400 000. An average person in one of the least developed countries has a life expectancy of 43 years; the life expectancy of an average person in one of the most developed countries is 78 years (7). This is not to deny that real gains in health have occurred in recent decades. For example, since 1950, life expectancy at birth in several developing countries has increased from 40 to more than 60 years. Similarly, worldwide, mortality rates for children younger than 5 years of age decreased from 280 to 106 per 1000, on average. Some countries show much sharper declines (7), but indices of health in these countries still fall far short of those in wealthier nations.

Poverty and Sustainable Development

The relation between poverty and health is complex, and we believe that it is best understood in the framework of a new notion of "ecosystem health," which places poverty and health in the nexus of environment, development, and population growth (8). Ecosystems provide the fundamental underpinning for public health in both developed and less developed countries, not only through food production, for example, but also through their roles in economic development. For instance, they supply forest resources and biomass fuels and serve as habitats for the vectors of disease (9). Sustainability is produced by using resources in ways that meet the needs of current populations without compromising the ability of future generations to meet their own needs (10) and is predicated on the need to ensure a more equitable sharing of today's resources. Meeting the needs of the world's poor implies limitation of the current use of resources by industrialized nations.

Barriers to the benefits of development include rapid population growth, environmental degradation, and the unequal distribution of resources. At one extreme, traditional, preindustrial societies are characterized by relatively high birth rates coupled with high death rates attributable to acute infectious diseases and the hazards of childbearing; this leads to slow population growth. At the other extreme, in the most developed countries, population stability has occurred. In the intermediate situation, in less developed countries, population stability has not been reached, and the global population thus continues to increase. In some less developed countries, a "demographic trap" exists in which the development of resources cannot keep pace with the requirements of the growing population and poverty is worsened (11). The most developed countries escape the trap by buying additional essential resources in the global marketplace to make up the difference.

Environmental degradation exaggerates the imbalance between population and resources, increases the costs of development, and increases the extent and severity of poverty. For example, the need for fuel wood, timber for export, and farmland results in deforestation, which increases soil erosion, flooding, and mud slides and reduces agricultural productivity. As a result, biological diversity is lost, production becomes increasingly reliant on pesticides and fertilizers, and use of expensive fossil fuels increases. Water is a critical resource. In Punjab, the breadbasket of India, the major aquifer is decreasing at a rate of 20 cm per year, threatening health by reducing agricultural productivity and the supply of clean water (12). Economic development without regard to long-term environmental and social consequences also threatens sustainability by damaging the systems that sustain healthy communities.

Inequalities in Health Are Socially Determined

The strong and pervasive relation between an individual person's place in the structure of a soci-

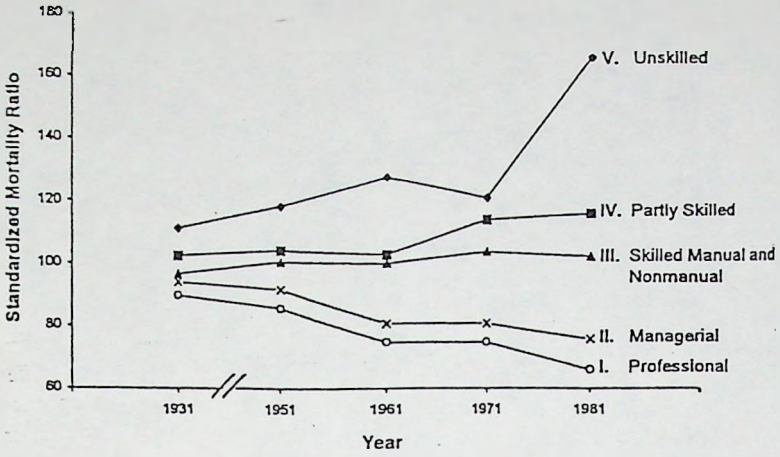

Figure 1. Comparison of standardized mortality ratios for men 15 to 64 years of age by social class over five decades in England and Wales. Figures have been adjusted to the classification of occupations used in 1951. Information on men 20 to 64 years of age in Great Britain was obtained from Black and colleagues (18).

ety and his or her health status has been clearly shown in research conducted over the past 30 years (13–16). In 1973, Kitagawa and Hauser (17) published convincing evidence of an increase in the differential mortality rates according to socioeconomic level in the United States between 1930 and 1960. They found that rates of death from most major causes was higher for persons in lower social classes. In Britain, research into health inequalities was summarized in 1980 in The Black Report (18), which was updated in 1992 (19) and is currently under review by an official working group. The report was prepared by a labor government–appointed research working group chaired by Sir Douglas Black, formerly Chief Scientist at the Department of Health and, at the time, President of the Royal College of Physicians. The Black Report concluded that "there a[illegible]marked inequalities in health between the social classes in Britain" (Figure 1). Marmot and colleagues, in the well-known Whitehall studies of British civil servants begun in 1967, showed that mortality rates are three times greater for the lowest employment grades (porters) than for the highest grades (administrators) and that no improvement occurred between 1968 and 1988 (20–22).

Such findings could, in theory, be due to differences in age, smoking, nutrition, types of employment, accident rates, or living conditions, but the Whitehall study participants were from a relatively homogeneous population of office-based civil servants in London. They had largely stable, sedentary jobs and access to comprehensive health care. A second observation of the Whitehall investigations, confirmed by the Multiple Risk Factor Intervention Trial (MRFIT) studies in the United States, is that conventional risk factors (smoking, obesity, low levels of physical activity, high blood pressure, and high plasma cholesterol levels) explain only about 25% to 35% of the differences in mortality rates among persons of different incomes (Figure 2) (23, 24).

An equally striking finding is Wilkinson's observations of the relation between income distribution and mortality (25, 26). Wilkinson assembled two sets of observations. First, he found no clear relation between income or wealth and health when comparisons were drawn between countries (for example, there is no relation between per capita gross domestic product and life expectancy at birth in comparisons between developed countries at similar levels of industrialization). But Wilkinson also showed a strong relation between income inequality and mortality within countries, a relation that has been confirmed more recently (27, 28). The countries with the longest life expectancy are not necessarily the wealthiest but rather are those with the smallest spread of incomes and the smallest proportion of the population living in relative poverty. These countries (such as Sweden) generally have a longer life expectancy at a given level of economic development than less equitable nations (such as the United States).

Recent analysis of U.S. data supports earlier observations that the distribution of wealth within societies is associated with all-cause mortality and suggests that the relative socioeconomic position of the individual in U.S. society may be associated with health. Populations in U.S. states with income distributions that are more equitable have longer life expectancies than do those in less egalitarian states, even when average per capita income is taken into account (27, 28). Authors of the studies that revealed these findings recently introduced the notion of "social capital," which is defined as civic engagement and levels of mutual trust among community

members, as an important variable intervening between income inequality and health status (29). Evans and associates (15) suggest that one's control of the work environment is an important connection between social and occupational class and mortality.

The Robin Hood index, also known as the Pietra ratio, is used to estimate the percentage of total income that would have to be transferred from groups above the mean to groups below the mean to equalize income distribution. A higher Robin Hood index value represents greater disparity in incomes. The strong correlation between income distribution and mortality rates shows that income disparity, in addition to absolute income level, is a powerful indicator of overall mortality (Figure 3) (27).

Inequalities in Income and Health Are Worsening

Many of the improvements in life expectancy and infant mortality rates that have occurred around the world are overshadowed by the countervailing influence of increasing disparities between rich and poor. Since 1980, economic decline or stagnation has affected 100 countries, reducing the incomes of 1.6 billion persons (19). Between 1990 and 1993, the average income decreased by 20% or more in 21 countries, particularly countries in eastern Europe and the countries of the former Soviet Union (30). The net worth of the world's 358 richest persons is equal to the combined income of the poorest 45% of the world's population: 2.3 billion persons. Between 1960 and 1991, the ratio of the global income of the richest 20% of the world's population relative to the poorest 20% increased from 30:1 to 61:1 (30, 31).

Many recent improvements in population health have been threatened and, in some cases, reversed at the same time that income differentials have widened. For example, the proportion of underweight children in Africa may decrease from 26% in 1990 to 25% in 2005, but the total number of underweight children is projected to increase from 31.6 million to 39.2 million because of population growth.

In the United States and the United Kingdom, income distribution has become more unequal. According to the United Nations Development Programme, income distributions within each of these countries are now among the most unequal distri-

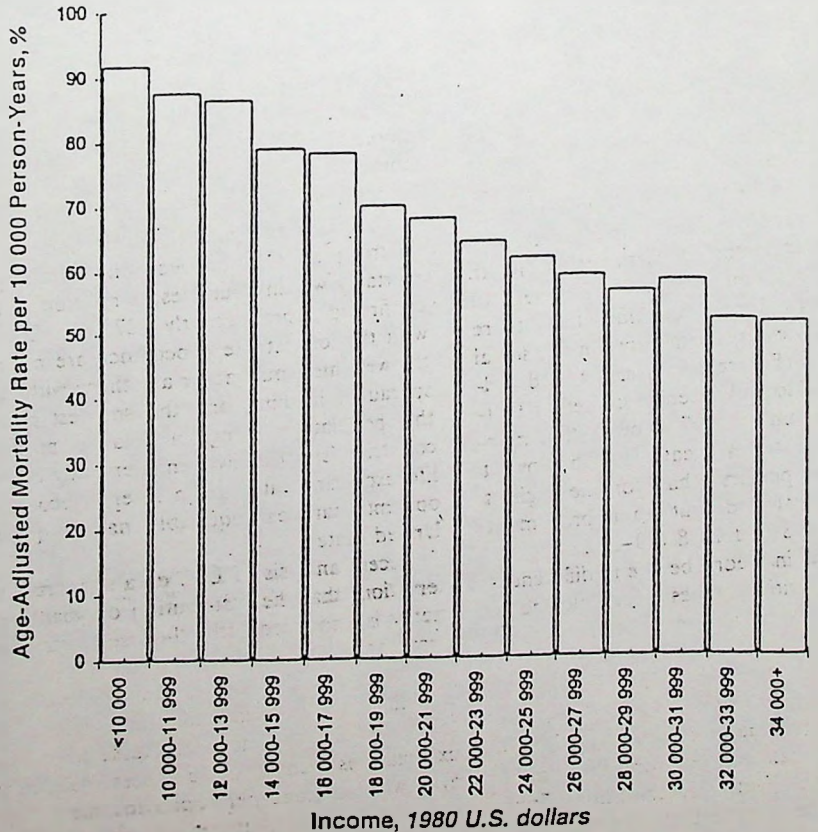

Figure 2. Income and age-adjusted mortality rates among 300 000 white men in the United States. Data obtained from Smith and colleagues (23).

butions in the world's industrialized countries (31, 32). For example, in the United Kingdom, the proportion of persons with an income less than half of the national average increased from less than 10% in 1982 to more than 20% in 1993, and unskilled men in Scotland now have a mortality rate three times that of professional men (33). This represents a widening from a twofold differential in the early 1970s. In the United Kingdom, the difference in mortality rates between rich and poor has increased because mortality rates have decreased faster among the rich than among the poor (34), and the proportion of children below the official poverty line has tripled in the past 10 years (35, 36). In the United States, inequality in income increased in all states except Alaska between 1980 and 1990 (37).

Effective Interventions Reduce Ill Health Due to Poverty

Some evidence suggests that improving the income of the poorest persons improves health in both developed and less developed countries. International data have been used to show that the doubling of per capita income (adjusted for purchasing power parity) from $1000, using 1990 figures, corresponds to an increase of 11 years in life expectancy. The relation flattens off above an average per capita income of approximately $5000 (Figure 4) (30). The distribution of income within households also influences health. It has been suggested, for example, that it takes 10 times more spending to achieve a given improvement in child nutrition in Guatemala when income is earned by the father than when it is earned by the mother because the mother is more likely to spend the money on essentials for the family (30).

An important, possibly unique, randomized trial in Gary, Indiana, suggests that increasing the income of poor expectant mothers receiving welfare increased the birthweight of their babies (38). Education, particularly for mothers, has dramatically affected health. In Peru, for instance, the children of mothers with 7 or more years of education have a reduction in child mortality of nearly 75% compared with the children of mothers with no schooling. Studies in several countries have shown that mothers who have completed secondary or higher education are much more likely to treat childhood diarrhea appropriately with oral rehydration therapy. Families are also likely to be smaller when women are more educated (30).

A recent systematic review of the effectiveness of health service interventions, predominantly in industrialized countries, to reduce poverty-related inequalities in health suggests several characteristics of interventions that may be successful although they do not directly affect income (39). These include programs that target high-risk groups; outreach programs that include home visits; and programs that overcome barriers to the use of services by providing transportation or convenient access and by using prompts and reminders. Large-scale multidisciplinary interventions involving a range of agencies and programs may be cost-effective. The Special Supplemental Food Program for Women, Infants and Chil-

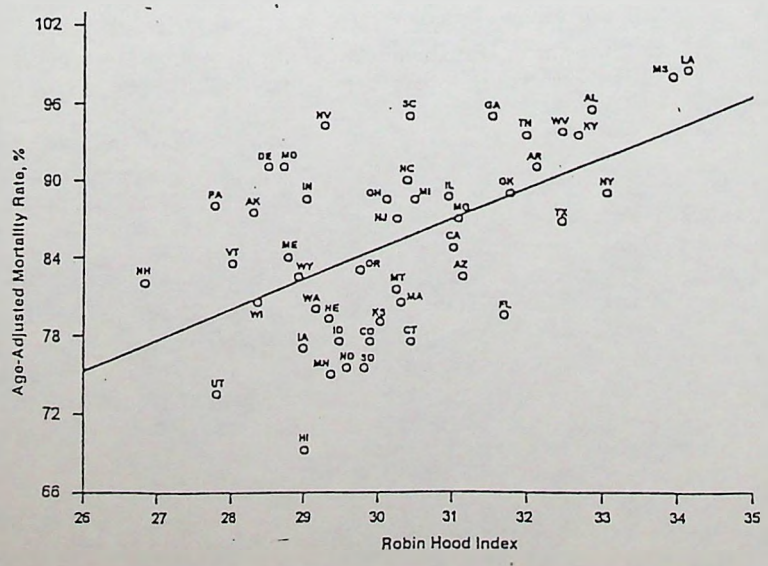

Figure 3. Age-adjusted mortality in the United States in 1990 and the Robin Hood index of income inequality. Circles represent the states of the United States. Data were not available for New Mexico, Rhode Island, and Virginia. Adapted from Kennedy and colleagues [27] with permission.

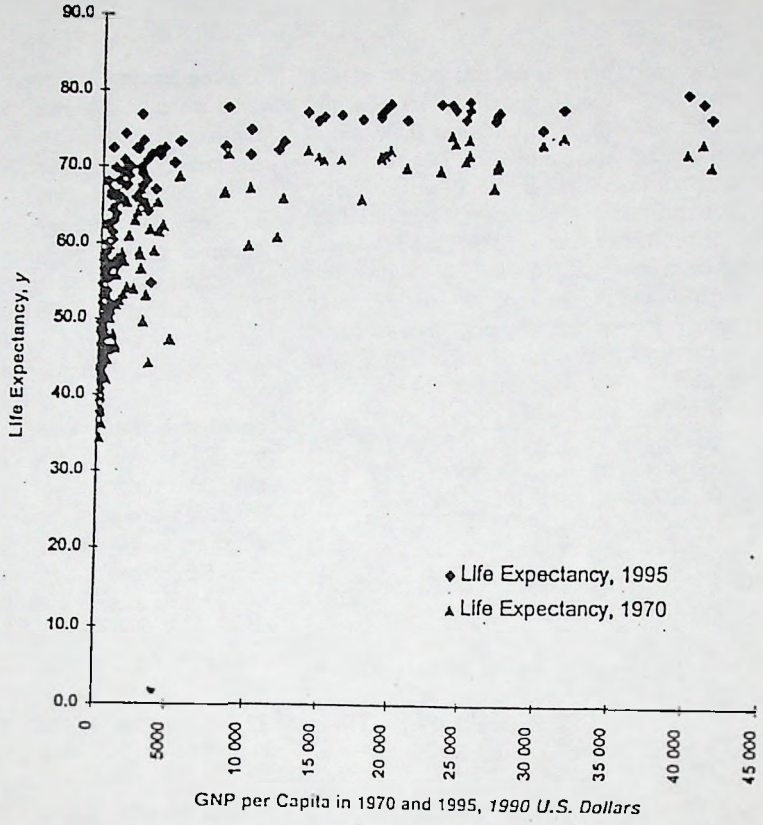

Figure 4. Life expectancy at birth and gross national product (*GNP*) in 1970 and 1995 in rich and poor countries in 1990 U.S. dollars. Triangles represent life expectancy in 1970, diamonds represent life expectancy in 1995. Data obtained from World Development Indicators, World Bank, 1995.

dren (WIC) was initiated in 1972 in the United States and provides healthy food, education about nutrition, and health services to low-income women and their children. Data analysis suggests substantial reductions in the number of babies with low and very low birth weights as a result (40). The project paid for itself through equivalent savings in medical care. Project Head Start provides preschool children and their families with education, health care, and social services. Short- and long-term benefits have been shown in health, developmental, and social outcomes (41).

Economic analysis confirms that primary care interventions, including measures designed to reduce childhood malnutrition, improve immunization against childhood diseases, provide chemotherapy against tuberculosis, provide condoms and education to combat the spread of HIV, and reduce smoking (including consumer taxes on tobacco) are cost-effective (42).

Physicians Have Special Responsibilities

It is widely accepted that physicians have a special and central professional responsibility to treat disease and reduce mortality rates, a responsibility that arises from their knowledge of medicine and medical practice (43). The physician–patient relationship is a fiduciary one, based on the inherent responsibility of physicians to deserve the trust of patients. Professionalism also extends this relationship to society, which confers on the profession respect and certain kinds of autonomy and authority. In the context of the physician–society relationship, the physician's fiduciary responsibility takes the form of concern for the public health. Most major traditions of medical ethics suggest that physicians have a special responsibility for the care of poor persons, defined as those who cannot afford to pay for treatment (44).

In addition, physician responsibilities in patient care extend to the social context of health and disease. Physicians regularly attempt to influence both patients' lifestyles and their environments to help prevent illness. They do so because illness is often precipitated by behavioral and social factors. Physicians in practice have an obligation to act on behalf of the general public welfare (for example, by reporting infectious diseases to the proper authorities). Recently, it has become widely accepted

that physicians should work to promote smoking cessation, encourage use of seatbelts, and prevent firearm injury. Health hazards should not be ruled out as medical concerns because their remedy requires social or political action. Although the proper form and extent of political involvement for physicians may at times be controversial, concern for the health of the public has been an important responsibility of the medical profession at least since the Industrial Revolution (45).

It may be argued that although physicians have a responsibility to care for persons who are ill even though they are poor and cannot pay, medicine has no particular responsibility with respect to the general condition of poverty. Physicians' efforts to mitigate poverty may be seen as going beyond the bounds of the patient–physician relationship. However, efforts against poverty may have parallels in widely accepted attempts by physicians to prevent child abuse or health hazards in the workplace. Although patients may not ask to be protected from toxins or abuse, physicians have agreed that they have a responsibility to assist patients who may be in danger and, when possible, to prevent harm. If poverty is connected to ill health in a direct and powerful way, it can be argued that physicians have some degree of responsibility for addressing poverty itself to the best of their ability.

Physicians Can Help Mitigate the Health Inequalities Caused by Poverty

A panel convened by the King's Fund of London recently proposed four types of interventions to correct health inequalities related to poverty: addressing social and economic factors; reducing barriers to the adoption of healthier ways of living; improving the physical environment; and improving access to appropriate, effective health and social services (46). Physicians have clear roles to play in each of these efforts.

Physicians can address social and economic factors both on the level of the individual patient and on the level of the community. By being aware of socioeconomic factors, such as insurance status, educational background, occupational history, housing conditions, and social isolation, physicians can make more comprehensive diagnoses and tailor therapies to patients' needs. Unfortunately, in residency training, the social history (if it is taken at all) is often labeled "noncontributory." Raik and colleagues (47) examined the content of resident case presentations on inpatient rounds and found remarkably low rates of mention of socioeconomic factors. Physicians as teachers can address these factors on rounds and in describing their own patients to trainees and colleagues.

On the community level, physicians can advocate for public policies to improve the health of the disadvantaged. Jarman (48) showed that physicians know that it is more complicated and takes more time to care for poor patients than for patients who are not poor. With this evidence, he was able to persuade the National Health Service in the United Kingdom to take patient economic status into account in rewarding general practitioners who work in deprived areas. Given the growth of managed care in the United States, physicians should be at the forefront of those calling for poverty-based risk adjustments to capitated payments.

As research scientists, physicians can advance the understanding of the mechanisms by which deprivation leads to ill health and the development of more effective interventions to reduce inequality in health (49). Similarly, physicians who are aware of the adverse effects of international debt on health can urge debt relief for the poorest countries (50).

Physicians may also be able to assist in removing barriers to healthy lifestyles—for example, campaigning against the promotion of tobacco, which is increasingly being targeted to adolescents in less developed countries and in minority communities in the United States (51).

Physicians can affect environmental factors associated with poverty by advocating for legislation to maintain and improve the quality of air, drinking water, and food. Physician-led public health efforts in the United States have been instrumental in reducing the incidence of lead poisoning, which is strongly associated with poverty. Internationally, physicians are participating in local initiatives surrounding Agenda 21, developed at the 1992 Earth Summit in Rio de Janeiro, Brazil. More than 1300 local communities in 31 countries have developed their own action plans, many of which feature health issues. Through the WHO Healthy Cities Project, cities have addressed such issues as smoking, sanitation, air pollution, and socioeconomic differences in health (52).

Approaches to improving access to effective health and social services in the United States and elsewhere have been extensively reviewed (39, 53). However, more than 800 million persons lack access to health services worldwide, and the increasing imposition of user fees (copayments and deductibles) in many countries has exacerbated inequities in care (54). Physicians and their associations should lead the movement for universal access to health care (55).

An international meeting on health and poverty hosted by WHO and Action in International Medicine (which has approximately 100 affiliated organizations in more than 30 countries) urged associa-

tions of health professionals to engage in activities to reduce health inequalities due to poverty (56). Dr. Gro Harlem Brundtland, the newly appointed Director General of WHO, has indicated that she intends to make the reduction of ill health due to poverty a priority for her term of office (57). The United Nations Declaration of Human Rights includes access to the basic necessities of life, such as food and water, as well as health care. However, 50 years after the Declaration was written, we are still far from providing this access to everyone. Physicians have an important role to play in helping to transform the rhetoric of the Declaration into reality.

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BMJ 1999;318:1020-1021 (17 April)

Communication III.
3/6

Editorials

Tackling health inequalities in primary care

Recording socioeconomic data in primary care is essential

The adverse health effects of social inequality are enormous. In the United Kingdom death rates at all ages are two to three times higher among people in social class V than among those in social class I. [1,2] Poor socioeconomic status also erodes social, psychological, and physical health.[3] Reducing health inequalities is central to the United Kingdom government's recently outlined health policy,[4] a commitment confirmed by the positive reception given to the recently published Acheson report on inequalities in health.[5] However, in spite of their importance both to the overall health care of individuals and in health policy, socioeconomic factors are not routinely assessed in clinical practice. The power of the socioeconomic determinants of ill health requires that we should adapt the traditional medical model. We now understand that diseases have both biological and societal causes, yet our interventions remain focused on the biological.[6] We need to begin to take histories which routinely include the eliciting and recording of societal risk factors, and we need to begin to use society's resources for both prevention and treatment of illness and disease.

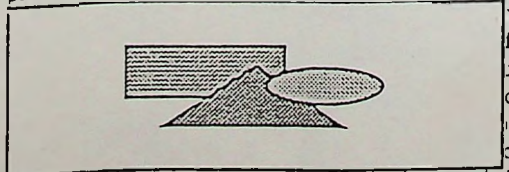
Deciding exactly what to ask and record will require further research. The registrar general's classification of social classes has been used in the United Kingdom for most of this century and is currently being modified. However, it is too cumbersome to use during a consultation, does not always provide a good measure of the socioeconomic factors important to health, and may be inappropriate in countries other than the United Kingdom.[6] General practitioners will want to concentrate their efforts where evidence for the influence on health is strongest by finding simple, user friendly, and non-stigmatising methods of eliciting and recording data on material poverty, unemployment, poor housing, and social isolation.

Factors reflecting the social environment and an individual's involvement within itwhich include levels of perceived hostility, trust in others, or membership of groups within the communitymay be important determinants of health inequalities. In addition, it is increasingly clear that people's cumulative socioeconomic experiences over their whole lifetimes play a greater part in determining health than does their socioeconomic level at a single point in time.[7]

Recording socioeconomic data would be useful for several reasons. Recent guidelines on preventing cardiovascular disease emphasise the need to base management on an individual assessment of absolute risk.[2] Socioeconomic status should be an important part of any such assessment. The approximate doubling of risk of coronary heart disease seen in people in the poorest socioeconomic groups in comparison to those in the richest groups is similar in size to the increased risk produced by cigarette smoking. No one would seriously suggest that an individual's risk of coronary heart disease could be accurately assessed without knowledge of their smoking habits. Knowledge of socioeconomic factors would also facilitate targeting of preventive healthcare measures such as cervical screening[10] and childhood immunisation,[11] which are known to reach those in poor socioeconomic circumstances less well. In addition, specific interventions designed to reduce health inequalities require knowledge of patients' socioeconomic status if they are to be offered to those people most likely to be helped.

The people registered with general practitioners in the United Kingdom represent one of the largest, most comprehensive, and most representative sources of epidemiological data in the world. Routinely collected socioeconomic data would be a valuable resource for research into health inequalities and for assessing progress in the efforts to reduce these. One of the central themes of the Acheson report was the need for high quality comprehensive data to improve the capacity to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them.[5]

With increasing computerisation of practices, the actual recording of socioeconomic data should be straightforward. Simple questions relevant to the particular patient could be asked when patients first register and opportunistically at subsequent consultations. New computer codes for the different questions and their responses could easily be produced.



not about asking intrusive questions, and it would take up very f doing what most clinicians in primary care already do, albeit rd way. Recent work from Norway has shown that while the cial factors varied widely, when such factors were known they eople are often asked if they live alone and about social ocial isolation, their housing situation, and other socioeconomic factors. Such information may not always be recorded and hence may not be put to the greatest usefor example, in generating a referral to a community organisation or to a health visitor.

The government seems to be sincere in its wish to tackle health inequalities. For general practice to play a full part in translating this commitment into improved health for those most in need we will need to record accurate and valid socioeconomic information about our patients.

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Communication III
2/6

MAKING HEALTH A PUBLIC AGENDA:

BEYOND ADVOCACY TO THE COMMON CONCERN OF ALL.

Indira Shrestha*
Mathura P Shrestha**

1. INTRODUCTION

Health is a state of equilibrium between a human's external and internal environment. Health is an expression of total facets of human being. These facets are determined by the physical, mental, psycho-social, cultural, economic, genetic, chemical and spiritual aspects. Health is an integral part of a human's living shared among and with other humans and biotic community. Health relates to everything that goes to constitute the human life-style and life system. Therefore, health must be holistic and health care must lead to health development and be actively participatory. The concept of health and health care has to transcend the present narrow techno-centric and unethical top-down prescriptive care system.

> **Health is an integral part of a human's living shared among and with other humans and biotic community.**

Health is a basic human right and is also everybody's responsibility. Like any right, health is to be asserted rather than given or taken. Responsibility for health policy development, management, and advocacy should not be limited to health professionals alone. All the stake-holders and all those contributing human development and services including the people, the politicians, inter- and intra-sector managers, and other related professionals should participate in the process of health development and management. Unfortunately, the people's right to participate in health and development is often ignored by everybody. Their needs are almost always compromised by the politicians and health administrators. People are often forgotten in the process of decision making at the political and management level. Nepal's constitution has invested sovereign right in the hands of people. This is now ignored by every policy maker.

It is our common social responsibility to make health a public agenda. Health is to be taken beyond the advocacy level and is to be the common concern of all. Quality of life cannot be developed without the people's participation and initiatives. However, the professionals should continue their role of advocacy to expand the awareness of the people about their health and its determinants, about themselves and their potentialities, and to motivate them to change and to create things around them for the development of their own and every one else's health. The professionals should develop such a system that the people are able to assess their real needs and to get organized to assert their health rights actively. This obligates the providers to empower themselves and the users. They should all work together with people of other professions and disciplines, including the politicians to make health care and health politics transparent, appropriate and accountable. This should at least do away with the present mismatch of inefficient, unitary, dictatorial, prescriptive, and top-down systems that are generating inequalities, injustices, disparity and deprivation in health and health care.

Health is also a precondition for development, and a powerful instrument in poverty reduction. Development and poverty alleviation should be inter-linked. As far as development is concerned, the fundamental debate is about whether the people should benefit, if at all, only from the spin-offs of the lop-sided accumulation or should be allowed to participate in the development on their own. Another dilemma for us is whether we should have an assisting, or even a colonial, attitude in making the people dependent on us as providers or whether we should have a facilitating attitude by empowering the people to assert their health rights.

The first option is the product of unethical, exploitative and domineering thinking which maintains a master-slave relationship in the society and subjugates the people to become mere parasites or passive receivers of the imposed choices or services. This would further widen the gaps between those assisting and those assisted, and between the rich and the poor – generating more and

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more poor and deprived ones. This again puts societies, communities, nations and the world in a permanent state of tension and conflicts.

The second option is ideal but difficult. It may at times be even impractical. However, if we are really in the business of health we should break the ***paradigm paralysis*** within and around us and take a bold step ahead. ***Paradigm paralysis*** refers to the severely restricted capacity of a person to see the prospects or future potentialities in a subject or an item beyond his/her narrow beliefs or understandings generated within the limits of norms binding him/her on that subject or item. Without the people's concern and participation, the health of the people and the nations becomes unpredictable. Quality of life, even if improved without the people's own initiative, becomes secondary or insignificant. Humans become passive tools of a giant system under external control. Here, the decision making process tends to be based on whims and fancies of politicians or providers rather than on objective reality. With so many deprived and marginalized poor around, a nation can not be called developed. Poverty alleviation in any country should have a definite agenda and the means by which the poor can have access to productive assets. By productive assets, we mean that people will have both sustained and recurrently productive employment and be able to utilize those assets to meet their needs as far as a decent and healthy livelihood is concerned. With a political commitment and good management we may make impossible possible. For a good management we need to have a good policy and plan. All these are possible with an informed decision of the concerned people. Essential national health research, if in-built in the health care system development, could provide those people options for the appropriate decision.

2. Pluralistic health care and freedom to have an informed choice

The so-called national health care system, although quoted and believed by many, never existed in any country as a single entity. Health seeking behavior of the people of any country has always been diverse. Hence, the health care system of any country has to be accepted as **pluralistic**. Pluralistic health care does not mean the multiple service units or institutions of a category of care only. It includes alternative care systems as well.

Health seeking behavior of the people of any country has always been diverse.

In promoting modern and scientific medicine we have inadvertently exposed ourselves and the people to aspect blindness and some types of paradigm paralysis. *Aspect blindness* is a common psychological condition in which the eyes do not see, or the conscious awareness is obliterated from, the aspects in which an observer is not interested or ignorant. We have conveniently managed to phase out many traditional systems of health care without a second thought and by removing all possibilities for them to prosper and survive. We brandished every thing associated with these traditional systems as superstition or inferior or out of date. Even within traditional systems, any thing foreign or related to it became superior to any thing national. Therefore, the most serious victims were our own Nepali traditional systems. This way, we restricted our own understanding and our capacity to develop our national health including national health research.

Ayurveda has at least a history which could amaze any modern scientist in health sciences for its empirical approach. A big stride made recently by Acupuncture, Chinese traditional medicine including Tibetan medicine and those of other regions of China, chiropractic and other systems of medicine in other parts of world should have broadened the horizon of scientific understanding of the health professionals. The authors recommend **NOT** to dismiss even ***Dhami, Jhankri and Gurau*** types of faith healing (*many believe them to be the most primitive healing practices*) as practices related to superstition. Scientific probing on their uses and potentialities should be encouraged. Benefits of these practices can at least be compared to modern "***suggestive hypnosis***" and "***stress-therapy***" undertaken by some "modern" psycho-therapists.

Whatever the system, the people should have freedom to make an informed decision after receiving comprehensive information in an open and transparent atmosphere. This should be within an accountable system, so that nobody is misguided or has a false sense of security. As far as **the freedom of informed choice** in health care of recipients is concerned, the later should be fully and properly informed or counseled so that they could take an independent decision (without pressure or false promises or false belief) with full understanding of the benefits as well as risks or side-effects after having used or received the item of health service. It is the professional responsibility of any health professional to provide all relevant information related to available options in the manner understandable to the patients or clients (or their legal wards, in case of patients or clients with restricted autonomy to make independent decision e.g., young children, mental handicaps, etc.).

Providers too should be given opportunity to develop, to compete, and to establish their credibility in their own right with responsible professionalism within a accountable and transparent system. Health professionals must not let themselves be imprisoned within the cocoons of ancient or present glory of their profession,

the secrecy of any kind, and any myth. They should learn that they are not healers by themselves but at the service of the people to help them in healing or in preventing health and related problems. Systems should compete each other to complement health and development without wasting their energies in phasing each other out.

3. PRIVATE–PUBLIC MIX

The private-public mix is a good idea if it is critically understood and correctly handled. At present the wave of privatization is deliberately fostered in order to ease the escapist mentality of unresponsive politicians and decision makers including so called experts and advisors. Together, they are evading their responsibilities towards the health for all. Time and again they try to redefine primary health care in order to subvert the philosophy and concept of Alma-Ata Declaration.

In some developed countries where privatization is in vogue, the question of equity and social justice in health is well taken care of with adequate access to and distribution of opportunities and resources, efficient insurance and social security systems, and an infrastructure developed to allow freedom of informed choice. There, the private sector thrives within the limits of professional discipline, working and transparent legal systems and multiple but independently viable regulatory mechanism, informed and protected consumerism, and accountable governance and bureaucracy.

Each country has developed its system according to its historical, social and national characteristics. In developing countries, the private sectors are heavily preoccupied in making profits and in importing technology and systems rather than developing and innovating according to the conditions of their countries. Open market system and privatization, instead of being developed to suit the historical, social and physical conditions of the country and the people to have the human development uplifted, are welded to make the rich richer and the poor poorer. Open market is advocated by the politicians with the promised benefit of competitive market that would bring the price down and raise the quality. They also harp that it is natural to make the market demand oriented. However, this make the market monopolized. As demand could be artificially boosted it is not always need or problem based. People are often coaxed to demand unnecessary and even harmful things. Cigarette smoking is one such example resulting from aggressive marketing for the profit. Just as "good money is driven out of market", equity and social justice are driven out of people's livelihood. Multinational companies are aggravating this process using their economic power and global networks.

> **Aggressive marketing often coaxed the people to demand unnecessary and even harmful things. Cigarette smoking is one such example.**

For a long time to come, the private sectors in the developing countries will only be able to provide viable alternatives in health care for those who could pay high price. However, the sector is not able, at present, to address the questions of equity and social justice in health. The public sector has to address those issues (equity and social justice) along with the issue of cost-benefit from an overall perspective. Therefore, the attempt to compare public and private sectors in developing countries can not be justified without critical notes or analysis.

The attempt to go private by any means is also related to the sub-conscious tendency of politicians, national executives and planners to disown their accountability towards the well-being of the people, to divert the resources from the needy sectors to so called development sectors without bothering to understand and implement the development process itself, or to cover up the widely prevalent incompetence, inefficiency, and corruption in and around them. This is a typical example of syndrome of backwardness. The syndrome is widely prevalent in Nepal and other developing countries. The syndrome is the result of deviant behavior in the power center and is related to opportunism (specially the tendency to gain affluence by subvert or covert means), and the psychological conditions of paradigm paralysis, aspect blindness, and imitation complexes. The term, *imitation complexes*, refers to series of weaknesses that make a person vulnerable to copy or imitate technology or methods without bothering to understand how these are originally developed and without testing their appropriateness in relation to the place or condition where these are transferred.

Another question is, should we classify all non-governmental organizations (NGOs) as the private sector? There are some NGOs in Nepal which are active, effective and popular and really are not after making a profit. They are campaigning to make health a public agenda by working hard to enable the people to assert their health rights, and by addressing the issues of equity and social justice in health. However, there are also many mushrooming NGOs controlled by the same elite groups in the power-center or who are under the tutelage of some donors or INGOs, and who are equally good as corrupt executives and bureaucrats in the government at hijacking

Therefore, we have to examine all aspects of this and work hard to find and the benefits intended for the people.test the appropriate private-public mix in our own historical, social, cultural, and political perspectives. We have got

to find our own solution to our problems. Private-public mix should have the country's own formula. We could learn from others and adapt well-tried systems to our own conditions. But we should never graft any thing to our own system dogmatically and uncritically.

Housing and financing companies provide opportunity to the people.

But at what cost?

Reality

If you take a loan from a *Shahu* - the money lender - you have to pay an interest of Rs. 1 per 1,000 per day which equals to 36.5 % per annum. This makes the people tolerate the existing racket.

The financing companies provide you a loan at a cheaper rate of 21%.

But the racket make you pay a minumum of Rs. 5 per 1,000 for the evaluation of your property or collateral against which the loan is released. This naturally gives an opportunity for more loan amount as the evaluation team would inflate the cost of collateral to twice the actual cost. An agent who negotiates the loan as a "security man" would charge you at least 7% of the total loan amount.

4. Foreign Aid, Foreign Assistance and Development.

Today, a common person is more convinced than ever before that the developing countries are no more independent. There is no lack of examples or evidences for such assumption. Developing countries are now more or less addicted to foreign aid. Like addicts these countries have lost their capacity as well as initiative to self-reliance and self sustenance. The improvement in services, distribution systems and living standard in developing countries, although not very much, is attributed to foreign assistance. It is widely publicized and believed to be so. The dependency syndrome of the countries has become so serious that they now have only piped dreams and empty or unfulfilled promises for human development. The aid intoxication has affected elite in power-centers from the capitals down to villages. They are now simply tools to "assistance" mentality. Instead of facilitating development by the process of empowering the people and concerned agencies or development units by sensitizing them to their real needs and enabling them to take initiatives and actions to solve these and develop, they are consciously or subconsciously promoting slavery with a message, "Be dependent and make others depend on you". Even at the community level, more and more people are made to believe that there is no way out for them and their countries without foreign assistance. Power elite in all developing countries are doing every thing to consolidate this "make belief" condition.

Nepal now receives foreign assistance to the tune of more than 200 million US Dollars per annum out of which 75 percent is in the form of loan (Based on calculation on the trend of foreign assistance between 1991 - 1996). Over and above this, an estimate of 65 to 125 million USD is flowing in Nepal to finance and assist hundreds of NGOs in Nepal. For the year 1996/97, the budget is set at 1.03 billion USD with a deficit of 301 million USD. According to Nepal National Bank's quarterly report on present economic performance, internal revenue collection is actually falling along with lower private sector investment and higher inflation rate of 10.1 percent. This may further increase economic burden of the people and dependence of the country on foreign loan. Government and NGO machinery are increasingly made dependent on foreign assistance. Their activity is increasingly fueled and tutelaged by foreign donors.

The promised socioeconomic development of the country and people with the foreign assistance was never realized. The proportion bellow the poverty line increased. The gap between the rich and the poor increased out of proportion. The expatriates could never really understand the plights and needs of the people. The donor agencies' follow up activity on what happened to their assistance ended with attractive and carefully worded evaluation reports prepared by smart men and women in the cozy cloister of executive rooms of Kathmandu and other urban centers.

The promised socioeconomic development with foreign assistance was never realized. Foreign aid has increased the economic burden of people by way of heated economy and inflation.

The foreign assistance not only pampered and corrupted urban and educated elite who place themselves in and around power center to ensure their interests and places for them on the back of ignorant and subjugated people, but increased economic burden of the people with inflation and taxes. When money is flushed in the market the economics get heated up even though the money barely trickle to the majority of people.

5. Commercialization of health

Trade and commerce is used more and more for unethical purposes by the people in power center. Marketing has become more and more aggressive serving the interest of profiteers. Almost every thing including biological attributes from taste to sex and maternity is commercialized. It may not be surprising if even an individual's thinking process is commercialized. Marketing of health can not be an exception. Health is now more a commodity for buying and selling.

Almost every thing including biological attributes from taste to sex and maternity is commercialized. It may not be surprising if even an individual's thinking process is commercialized.

Health care has remained prescriptive even today. Transparency and accountability in health care can not be imagined in developing countries where people are politically and socially so disimpowered. Health is being taken for granted as an obligation rather than that of right or responsibility. Governments have deregulated those rights which the people thought as their own. Instead, they are actively regulating exploitation, disparity and deprivation.

7. What we could do ?

If we are in the business called health it should be our social responsibility to promote health and defend health rights. First of all, we have to redefine politics. Politics is the process of development of lifestyle and living for the people and by the people. Politics is related to every thing determining the health of the people and the planet. Therefore, people specially the women should participate in all socio-political aspects of the locality and the country for their health and development. Politics can not be and should not be left at the hands of so called politicians. People should direct and control *politicians* but not other way round. People have to politicize health to protect their health rights and not in the terms of politicians nor for the purpose of power politics or partisan politics.

Secondly, we have to empower the people to have informed decision. Empowerment should include their ability to take leadership and initiatives in health right from research all the way through policy formulation, planning and programming, implementation, supervision, monitoring, evaluation and review.

Politics is the process of development of lifestyle and living for the people and by the people. Therefore, people specially the women should participate in all socio-political aspects of the locality and the country for their health and development. People should direct the politicians but not the other way round.

People should be made concerned of their health, their rights and potentiality. In short, we must make health a public agenda (Fig 1 and 2).

Figure 1

WHY HEALTH AND HEALTH CARE SHOULD BE ON THE PUBLIC AGENDA ?

- HEALTH IS BOTH THE RIGHT AND RESPONSIBILITY OF PEOPLE
- HEALTH PROVIDERS MERELY EXERCISE THEIR PROFESSIONAL ROLES DELEGATED BY THE PEOPLE / USERS WITH A TRUST IN THEIR PROFESSIONAL CAPACITY
- PEOPLE HAVE A RIGHT TO HAVE INFORMED CHOICES OF AVAILABLE HEALTH SERVICES WITH ADEQUATE KNOWLEDGE OF THE BENEFITS AND RISKS OF USING THEM
- HEALTH IS DETERMINED BY EVERY THING THAT RELATES TO HUMAN BEHAVIOR AND LIFE-STYLE, AND THUS THE PEOPLE NEED TO PARTICIPATE IN HEALTH AND DEVELOPMENT IN A RESPONSIBLE WAY
- PUBLIC CONCERN IS THE MOST IMPORTANT FACTOR TO GET POLITICAL COMMITMENT FOR HEALTH
- PUBLIC CONCERN WILL ADDRESS THE ISSUES OF EQUITY AND JUSTICE IN HEALTH CARE BETTER.

Figure 2

HOW CAN WE PUT HEALTH ON THE PUBLIC AGENDA ?

- BY EXPANDING THE KNOWLEDGE OF THE PEOPLE SO THAT THEY ARE CONCERNED TO COMMUNICATE, DEBATE AND PARTICIPATE IN MATTERS OF HEALTH
- BY MAKING THE HEALTH CARE SYSTEM TRANSPARENT AND COMPREHENSIVE
- BY DEVELOPING AN ACCOUNTABLE CARE SYSTEM
- BY INVOLVING ALL STAKE-HOLDERS INCLUDING POLITICIANS, THOSE IN THE MEDIA, NGOs, ASSOCIATIONS AND ORGANIZATIONS, AND THE PEOPLE IN HEALTH CARE DEVELOPMENT
- BY ORGANIZING PUBLIC FORA AND MASS CAMPAIGNS OR MOVEMENTS.

TO BE A GOOD DRESMER WE HAVE TO
REMOVE THE BARRIERS BETWEEN POLICY
MAKERS, PROVIDERS AND PEOPLE,
AND
OF THE PAST, PRESENT AND FUTURE.

WE HAVE TOO MANY PROBLEMS IN HEALTH.

BUT, BECAUSE

THESE ARE OUR PROBLEMS

WE HAVE GOT TO SOLVE THEM

AND

WE CAN SOLVE THEM.

Therefore, let all of us be concerned and participate in reforming health management.

Communication III - Background
1/6

EQUITY INITIATIVE
Paper No. 6

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Report of

Consultation on Equity and Health in South East Asia: Trends, Challenges and Future Strategies

Thimphu, Bhutan, 23-27 November 1998

World Health Organization

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Annexes

Executive Summary

A Consultation was held in Thimphu, Bhutan, on **Equity in Health in South-East Asia: Trends, Challenges and Strategies**, from 23 to 27 November 1998. The consultation was jointly organized by WHO/Headquarters and South-East Asia Regional Office. The consultation was attended by forty participants coming from countries of the South-East Asian Region and some from the Western Pacific Region. The purpose of the consultation was to share the experiences of countries in identifying and mapping inequities, and in designing policy changes to promote equity. The consultation was structured around six themes:

- Globalization and its impact on equity
- Mapping and monitoring inequities
- Inter-sectoral actions to reduce inequities
- Health sector reform
- Public/private mix in health care, and
- Resource allocation.

Each of the themes formed the forum for the presentation of papers by participants and discussions. As a result of these discussions four working groups were formed on:

- Mapping and monitoring inequities
- Influencing policy
- Resource allocation for equity, and
- Good governance for reducing inequities.

The consultation discussed the current economic crisis confronting many of the countries of the Asian region and concluded that while the crisis had its root in the banking sector, the banks themselves were seldom paying the price of their profligate lending while the poor who did not benefit from these lendings were now bearing the burden of the crisis. In addition the poor paid more of their income for health care than the rich. It is important to recognize issues related to equity in health as a human rights issue and health sector reform must be oriented towards an understanding of the causes that lead to systematic patterns of discrimination and devising ways to protect the vulnerable and the poor. The roots of inequities in health lay principally in socio-economic disparities and hence called for holistic approaches which involved other sectors. The recent rapid growth of the private sector has led to questioning the efficiency and effectiveness of the public sector and an insistent call for privatization by development agencies. However, the lack of regulation of the private sector and the absence of adequate social security measures for protecting the poor have led to increasing inequities. The role of governments, and that of the public sector, should be reassessed and strengthened.

The consultation felt that civil society, including appropriate NGOs and community groups, have a key role to play in highlighting growing inequities in health and in promoting policies to reduce them. Equity data banks could provide the necessary impetus towards action and academic institutions could provide the foci for collecting and synthesizing information that uncover disparities in health status and access to health care. WHO has a key role to play and the consultation recommended a set of actions for WHO to undertake. These recommendations are contained in the next section. Primary health care still remains the most useful approach to provide universal health care to all peoples through a sustainable and equitable framework.

Conclusions and Recommendations

WE, the participants in the Consultation on Equity in South and East Asia, having gathered in Thimphu, Bhutan, 23-27 November 1998,

WISH to express our gratitude to the Government of Bhutan and WHO for hosting the consultation and the extensive preparatory work performed,

CONCERNED at the growing poverty in the world and the consequent rise in inequities in health and socioeconomic conditions, and the negative influences of globalization on the plight of the poor,

EXHORT the countries represented in the consultation to pursue their goals of achieving equitable and sustainable health systems,

BELIEVE that WHO must assume a key role in promoting and coordinating social action against inequities in health,

CONCERNED that WHO's role in addressing inequities in health could have been more effective, we are convinced that its leadership and capacity in this area must be significantly strengthened, and it must exert renewed efforts to promote PHC as a key approach to achieve equity in health,

CONVINCED that its leadership in health matters among international agencies associated with socioeconomic development must be renewed and it must establish the necessary partnership with people and communities whose empowerment is essential to achieve equity and social justice,

WE strongly support the new Director-General's initiatives in reforming WHO into an efficient, transparent and influential leading international agency, and urge WHO to take the following actions toward reducing inequity in health:

1. To establish a cabinet project to address problems of inequity in health in all clusters of programmes,
2. To ensure that primary health care is fully supported through a holistic sustainable approach in keeping with local values and resources,
3. To pursue vigorously its collaboration with civil societies in countries as is being done by other international agencies and, to this effect, make significant allocation of its budget to support such organizations at international and country level,
4. To establish partnerships with other relevant international organizations involved with socio-economic development in order to intensify national efforts for health development.

WE further recommend that NGOs and other members of civil society in countries form networks to fulfil the function of health watch in countries. Such networks should also monitor the efforts of WHO in supporting civil societies in their efforts to reduce inequities in health.

Handout → (3)

First draft circulated for comments only. Do not quote without permission. Paper presented at the IPHN Conference at Bangalore, India, 15-18 November 1999.

Explaining Slow Progress in Human Poverty Reduction in South Asia

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13 November 1999

I. Introduction

Over the last two decades South Asia has made progress in both income and non-income dimensions of poverty. But the pace of reduction has been slow, and in some countries extremely slow. The South Asians have been described as the income-poorest, one of the most illiterate, the most malnourished, the least gender sensitive, rendering the region with highest human poverty of the world.[1]

[1] The concept of "human poverty" relates to "human development" much the same way income-poverty relates to economic growth and, as such, captures deprivations in all key dimensions of human development. The idea is elaborated in the background paper prepared by Sudhir Anand and Amartya Sen for the 1997 UNDP Human Development Report. It has been defined, in the broad terms, as the "denial of opportunities and choices most basic to human development--to lead a long, healthy and creative life and to enjoy a decent standard of living, freedom, dignity, self-esteem and the respect of others".

The centrality of human poverty reduction in South Asia as a major contributing factor to economic growth, income poverty reduction, and the general level of human development, is widely recognized.[2] Recent advances in theoretical and empirical literature on economic development indicate that regions and nations with lower initial human poverty are likely to have higher and sustainable economic growth, faster income poverty reduction and much higher levels of general human development. This is clearly borne out by the developmental experience of South Asia over the last four decades and, indeed, constitutes the most important policy message emerging from the review attempted in this paper.

Why the progress on human poverty reduction was extremely slow in South Asia? This is the question that looms large in the backdrop of the successes of the East and South East Asian countries. The present paper attempts to address this question by assembling supportive evidence on the countries of the region.3

The paper is motivated by the general approach of looking for lessons for South Asia from within and from the diversity of its own experiences. The findings supplement what can be learned from international comparisons of successes and failures in economic development and poverty reduction.

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[2] The centrality of this factor has been well recognized in recent intellectual traditions. It has been forcefully put forward in the human development literature, as in the case of successive Human Development Reports of UNDP. It has also been instrumental in the emergence of "new" growth-economics where "human capital" with implications for technological progress and positive externalities work as the driving force behind economic growth. The recent argument put forward in the World Development Report 1999 regarding increasing knowledge-gaps between and within countries as a factor of persistent divergence is derivative of the human capital-centric growth discourse. However, the distinction between "human development" and "human capital" needs to be kept in view as well. The concept of human development has a deeper, intrinsic value as an end (goal) of development. It is an objective that is to be valued for its own sake. But, something that is intrinsically important can also have the added advantage of being instrumentally conducive to achieving more conventional goals of economic success, without compromising its intrinsic value. Thus, human development can and does contribute to economic growth, to income-poverty reduction and to other usual measures of economic performance, but its value does not lie only in these instrumental contributions. A human development based criterion of judging economic success would, in turn, require these instrumental contributions to economic performance to actually translate into still higher and sustained levels of human development in a virtuous circle. In contrast, the notion of human capital is very much focused on the economic contributions of expansions of "human resources" as if people were just the means of production and not its ultimate end. As Amartya Sen (1998) pointed out that "the bettering of human life does not have to be justified by showing that a person with a better life is also a better producer" (p. 6). It is, of course, fair to acknowledge that new theories of economic growth putting emphasis on investing in peoples as a faster way of expediting economic progress and climbing out of income poverty are a big leap forward over the standard growth theories.

3 Data used in this paper are taken from Sen and Rahman (1998), 1997 Human Development Report, and 1999/00 World Development Report.

Mere recognition of the centrality of the factor of human poverty reduction is not enough. One needs to identify the links that render some policies and processes conducive to faster human poverty reduction. A review of diverse South Asian experience identifies four broad links. These pertain to pro-poor growth policies leading to income-poverty reduction, policies for reducing income (asset) inequality, broad-based and effective access to basic public provisionings, and gender empowerment. Each is reviewed in turn.

II. Slow Progress in Income-Poverty as Barrier to Faster Reduction in Human-Poverty

One of the key factors inhibiting the faster rate of human development has been the very slow progress in income-poverty. The rate of national income poverty reduction, as measured by the proportion of households below poverty line, has been minimal--less than 1 percentage point per year in all the countries of South Asia under review over the last two decades. Progress in human poverty would have been at a much higher rate had there been commensurate progress in income poverty, since a reduction in the latter creates private purchasing power, leading to further (private) investment in human capital and hence greater improvements in human poverty. The importance of this channel becomes even more transparent in the South Asian contexts with weak state capacities and endemic misgovernance over public goods access. Even for contexts where such capacities are pre-existent, the need for demand-driven mechanism (voices) "from below" is seen as a critical factor for effective functioning of the state. Such "voices from below" are, of course, a direct function of the level of empowerment in a society. But, they are also indirectly influenced by income-poverty reduction. In the South Asian context the income-poorest are also the most hard-hit category when it comes to accessing quality public services.[4] In short, policies that reduce income-poverty also help faster human poverty reduction via allowing the poor to meet the costs of publicly and privately provided services as well as through expressing greater voices influencing the access to, and quality of, public social services.

The very slow pace of income-poverty reduction is partly due to the fact that South Asian economies did not grow fast enough over the last two decades, or for that matter, during the entire period since the early sixties. The overall record in terms of per capita GDP growth has been modest judged by the standards of East and South East Asian economies. Between 1960 and 1997, per capita GDP trend growth rate in Sri Lanka was 2.84 per cent per annum, followed by India (2.13 per cent), Bangladesh (0.96 per cent), and Nepal (0.92 per cent). This may be contrasted to the matched figures of 6.43 per cent in South Korea, followed by 6.29 per cent in Singapore, 6.06 per cent in China, 5.01 per cent in Thailand, 4.55 per cent in Indonesia, and 4.10 per cent in Malaysia recorded during the same period.5 Even in contexts where one could observe relatively high GDP

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[4] Significant quality differentials exist in the access to basic social services such as between the poor and the rich districts (and households). For some evidence on India's basic education carried out by the PROBE team, see De et al (1999).

5 The estimates are based on data provided in World Development Indicators.

growth rate in the sixties quite at par with the historically observed rates for the high-performing Asian economies (HPAE), there has been a striking slow down in the recent decades, especially since the early eighties. Thus, in Pakistan which had the most impressive growth record in South Asia, the rate of growth in per capita GDP declined from the high-point of 3.48 per cent in 1960-73 to the low-point of 2.47 per cent in the 1983-97 period.6

The relatively slow rate of economic growth is attributable to two principal factors found particularly compelling in the South Asian context. First, growth potentials were undermined--at various degrees in all the countries of South Asia--by the persistence of inward-looking import-substitution oriented (ISO) development strategies in the entire period from the fifties through the eighties. This has eventually resulted in relatively high and rising incremental capital-output ratios and consequent slow down of growth for a given level of savings rate.7 Adoption of such a strategy was influenced by the doctrines of economic nationalism and the attendant ideas relating to infant-industry protection. Stark contrast to these is provided by the booming international trading environment during 1950-72 and inability of the countries of the region to exploit the powerful instrumental role of international trade in stepping up domestic rate of economic growth. Continued reliance on the ISO strategy even in the face of the changed circumstances of seventies (following the oil-shocks) and eighties (following the debt crisis) could only magnify adverse long-term growth implications of such a strategy. Two such implications may be highlighted here.

First, lack of openness (in general) and export-pessimism (in particular), that accompanied such inward-orientated strategy, also meant that the rate of technological progress has been slower in the South Asian economies compared to the East and South East Asia throughout this period, further undermining the potentials of long-term economic

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6 The per capita GDP growth rate in Pakistan during 1973-83 was lower than the sixties but still impressive at 3.28 per cent. Pakistan could sustain high-growth in the seventies despite having large fiscal deficits because the real interest rates on external debt were substantially negative during that period so debt-to-GDP ratios continued to decline till 1981. But the trend has been sharply reversed since then as the real interest rates turned positive in the eighties, with external debt rising from a low of around 37 per cent of GDP in 1981 to over 53 per cent in 1991. Pakistan quickly entered into a debt crisis which had adverse implications for growth and income poverty reduction during the nineties (see, Ahmed 1994).

7 The policy package associated with the import-substitution-oriented strategy had certain and, by now, well-known features. The package includes measures such as keeping the exchange rate overvalued (in the then prevailing system of fixed exchange rates), the imposition of various quantitative controls on foreign exchange and imports, and the graded tariffs (highest on consumer goods, lower on intermediates and the lowest on capital goods) to contain the excess demand for foreign exchange resulting from overvalued currency. It discriminated against exports and resulted in perpetual balance-of-payments deficits which, in turn, led to further tightening of import controls in an unending cycle. It has discriminated against agriculture, which was the major source of primary exports.

growth.8 Second, and perhaps more importantly, the policy-induced distortions created initially by the need for adopting inward-looking strategy aggravated, rather than reduced, the pre-existing dualisms between the traditional and modern segments in the output and factor markets (specially, in labor and capital markets). This has further eroded the basis for broad-based, shared, economic growth with potentials for faster income-poverty reduction.9 Note that these distortions are rather difficult to overcome even as the governments of South Asia attempt to carry out outward-oriented policy reforms because the distortions have by now taken deeper institutional roots, persisting as negative institutional structures and superstructures vested with strong political economy interests (North 1990; 1994). This is evidenced from the experience of the eighties and the nineties which saw successive moves towards policy reforms in all the South Asian economies to bring more openness, transparency and accountability to the system with emphasis on market regulators and private sector. The progress on these fronts was remarkably slow and the anti-poverty effects of these reforms, as measured by the corresponding poverty ratios, were clearly modest. This is largely because the institutions created by the past strategy of inward-orientation continue to remain as a drag on growth, giving rise to newer forms of distributional conflicts and breeding instabilities in the reform process itself.

While the product-market distortions emerging from restrictive trade and exchange rate policies under centrally initiated and public sector-oriented industrialization was a major causal factor behind the slow pace of economic growth in South Asia vis-a-vis the HPAEs, the situation was aggravated further by the relative--and conspicuous-- absence of the second, no less important, factor, namely, broad-based human development. The latter is epitomized by the fact that only less than 50 per cent of the South Asian population could get access to basic literacy even 50 years after the end of the colonial rule. The poverty-impact of economic growth was severely undercut by the very low level of public investments in human development in all the South Asian societies except Sri Lanka and

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8 The cost of neglecting the importance of greater integration with the world market (in general) and trade (in particular) as one of the factors of economic and social progress in South Asia has been considerable. As Amartya Sen (1998) has noted in the Indian context, "the scope of and rewards from greater integration with the world market have been and are large, and India too can reap much more fully the benefits of economies of scale and efficient division of labor that many other countries have already successfully used. While greater reliance on trade is sometimes seen as something that compromises a country's economic independence, that view is hard to sustain. Given the diversity of trading partners and the interest of the different partners to have access to the large economic market in India, the fear that India would be an economic prisoner in the international world of open exchange is quite unfounded. This does not deny the importance of getting the terms and conditions right, including having fair regulations from GATT (or its successor) and other international institutions. But in general there is little reason for fearfully abstaining from the benefits offered by the greater use of the facilities of international trade and exchange" (p.9).

9 There is a fairly large body of literature on "dualism" in the context of developing countries. On the nature and consequences of "dualism" in the backdrop of inward-looking development strategy, see Myint (1971; 1985).

Maldives.10 On one hand, this was a consequence of poor economic growth, as the governments in slow-growing economies have limited resources at their disposal to finance human development. But, this may provide only a part of the explanation, valid mostly for periods when a particular government was under severe fiscal constraints. But, South Asian governments never allocated the right amount of resources to the eradication of human poverty that it deserved even when they embarked on large-scale public investment programs. Thus, even when the economies in the region were growing at considerable pace, fiscal commitments to the removal of illiteracy, to the eradication of preventable diseases, and to the elimination of the very high level of malnutrition among women and children were minimal, to say the least. The case of Pakistan illustrates the point. While it was evidently the fastest growing economy in South Asia, its performance on account of a number of human development indicators lagged behind its neighbors with relatively low level of per capita GDP. For instance, Pakistan had the highest infant mortality rate in 1996 (101 against 74 in India, 77 in Bangladesh, and 79 in Nepal). It also had the region's second lowest literacy rate (after Nepal).11

Serious disparity in the level of human poverty exists among the Indian states. Some of the states such as Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh have been persistently poor performer in respect of basic education and health. These states have the highest illiteracy rates, highest mortality rates, and highest prevalence of child malnutrition.12In all these respects, these states paint a worse scenario than the average South Asian picture.13

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10 This is equally true for Myanmar (Burma) which was once considered part of the South Asia. In both the contexts a favorable confluence of a variety of institutional factors--including the strong egalitarian and populist traditions of Buddhism--led to, typically, historically higher initial levels of basic literacy compared to the other countries of South Asia. It is often maintained that Buddhist countries have typically had much higher levels of basic literacy than societies dominated by Hinduism or Islam. This, however, should not be seen as an "essentialist" explanation leading to some historical inevitability in the predictable direction, as there is considerable variation in the sociology and institution of the same religious tradition across the countries. For instance, in 1995, adult literacy rate among women was 93 per cent in Maldives, which is highest among South Asia. In this respect, it tops the list among all member countries of the Islamic Conference, much ahead of HPAEs such as Malaysia and Indonesia. In short, the case of Maldives provides yet another example of how the influence of "traditions" can be overcome through pro-active public policy and social action.

11 Indeed, Pakistan has made very slow progress in gross primary enrollment. In India and Sri Lanka the rates now exceed 100% and Bangladesh's rate is coming close. Pakistan has also shown some improvement, but is still only at 67%.

12 The illiteracy rate in these states was 56-62% as against the all-India average of 48% in 1991. The mortality rate, as captured by "probability of dying before 40", was in the range between 20-26% compared with the Indian average of 18% in 1989-93. Similarly, the proportion of underweight was 58-63% vs. 54% for all-India in 1992-93. The prevalence of malnutrition among under-five children is somewhat lower in Rajasthan, being assessed at 42%. The Indian-state level data are taken from Prabhu (1998).

13 The above-mentioned four states together with Andhra Pradesh are often aptly

There is no adequate explanation for the stunning lack of commensurate public action in the area of human development in South Asia. In India, for which the relevant data are available, the contrast between the government's attention to higher education and neglect of primary education had been intolerably large already in the sixties. That gap has, if anything, grown rather than shrunk over the subsequent period. Indeed, judged in 'real' terms, the percentage expansion of the number of teachers has actually fallen steadily from the fifties, to the sixties, to the seventies, and through the eighties, from 5.6 per cent per year during 1950-60 to 1.6 per cent during 1985-90 (Dreze and Sen 1995). The root cause for low investment in elementary education is possibly located in the "deep-seated class biases" that shaped distorted educational priorities.14

The above should not create the impression that it is the relative slowness of South Asian economies vis-a-vis the HPAEs only matters for still slower pace of progress in income-poverty. What is at stake is not just the issue of average growth rate, though that was surely an important aspect in the whole development narrative. Given the nature of the growth process, as summarily discussed above, it is hardly surprising that the outcome was quite modest not only in terms of growth rate, but also in respect of possible growth-impact on the poor. Distributionally, whatever growth that has taken place in South Asia, it did not favor the poor as much as one would have expected given the politics of "garibi hatao", and in some countries and periods, it was clearly anti-poor. Thus, both the issues of accelerating per capita GDP growth rate, on one hand, and the participatory nature of the growth process, on the other, need to be given due weights so that the pace of subsequent economic growth can be raised further for faster income-poverty reduction.

As a result of policy-distortions associated with the ISO strategy and as a consequence of low public investments in human development, the poor in South Asia had very limited

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summed up as BIMARU (literally, the "sick") states of India because of their relatively poor performance--in overall judgment--in areas of health, nutrition, and education indicators.

14 We owe this sociological explanation to Amartya Sen who pointed out in the 1970 Lal Bahadur Shastri Memorial Lecture entitled "The Crisis in Indian Education" that the above-mentioned "inequalities in education are, in fact, a reflection of inequalities of economic and social powers of different groups in India". His later commentaries on the issue is worth quoting in full given the contemporary relevance: "The educational inequalities both *reflect* and help to *sustain* social disparities, and for a real break, much more determined political action would be needed than has been provided so far by those in office, or by parties that have led the opposition. The traditionally elitist tendencies of the ruling cultural and religious traditions in India may have added to the political problem here" (Sen 1998, p.14). The persistence of endemic illiteracy and educational backwardness in South Asia had many side effects affecting other dimensions of human poverty reduction. For instance, it had a direct role in the relative deprivation of women, sustaining high mortality levels and fertility rates. It contributed to "low voices" and poor quality of democracy. These are over and above the point that the lack of elementary education also makes the realization of broader growth objectives (including integration with the world market) extremely difficult.

participation in the economic growth process outside agriculture and informal sectors where the return to labor was typically low. Poverty reduction thus became dependent on the growth potentials of these sectors which, by the very nature of policy biases discussed earlier, were placed in a much more disadvantageous position vis-a-vis the modern sector under a dualist economic setting. Because of such discriminations, there has been very limited productivity improvements in these sectors, undermining their long-term growth potentials. However, the experience of South Asia also shows that whenever these sectors had the chance to perform well, the pace of income poverty reduction was faster. The spells with fastest poverty reduction rates were also the periods when the agricultural growth rates were high, as observed in case of all three countries--Bangladesh, Pakistan and India--during the period between mid-seventies and mid-eighties.15 Note that agriculture was discriminated under the inward-looking development strategy pursued in the past, though the extent of discrimination varied according to the degree of inward-orientation, the latter being highest in India, followed by its neighbors. In case of Nepal the very slow overall reduction of poverty is mainly attributable to the poor performance of the agricultural sector. Of particular disturbing feature is the slow-down of agricultural growth since the late eighties in almost all the countries of South Asia.

Even this slow progress in income-poverty at the average national level masks significant regional and social differentiation. Although the inter-temporal comparisons are not always available, the cross-sectional variations in the poverty rates are large across social and regional characteristics. There are clear biases in poverty and social exclusion that favor majoritarian formations, as evidenced in the disparities between high-caste and low-caste (as in India and Nepal), between majority and minority groups classified according to ethnicity and religion (cutting across nearly all the countries of the region), and between advanced and backward areas. Social differentiation often reinforces and ossifies regional differentiation, and vice versa. This indicates the persistent negative influence of broader political and cultural factors that favour particular region, community, ethnicity, caste and religious groups. Without removal of (or, at the least, counteracting) these barriers, the participation of socially disadvantaged groups in the growth process would remain circumscribed and the faster progress in income-poverty at the national level would remain a daunting task.

Faster reduction of income-poverty is closely connected with the issue of fostering pro-poor (equitable) economic growth. If growth is accompanied by rising income inequality, opportunities are missed for poverty reduction.

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15 This implies that the "green revolution" eventually turned out to be pro-poor even on distributional terms, despite some initial disadvantage of the small farmers, which was gradually overcome as the process of diffusion of new technology in agriculture became operative over a larger area and variety. It is altogether a different story that a considerable part of the potentially irrigable land is still without such facility while the yield on the new variety remains much lower than the comparable international examples. There are also growing challenges on grounds of environmental sustainability. Without having adequate funding for research encouraging diversified agriculture and deep-cutting institutional reforms in the entire loop connecting agricultural research and extension, on one hand, and suitable land-tenurial and local government reforms, on the other, such pitfalls in the further modernization of agriculture would continue to persist.

III. Rising Inequality as Barrier to Faster Reduction in Human-Poverty

Many of the South Asian economies have entered into relatively high levels of income inequality at relatively low levels of income judged by the East and South Asian standard. Managing inequality has thus emerged as a separate area of policy concern along side the compulsion for reducing income-poverty. This has been a rather new trend in the nineties.

Inequality appears to be rising in all countries of South Asia except Sri Lanka for which income data are available.16 This has been happening even in countries where it had long remained relatively unchanged, leading many people to dismiss it as a peripheral concern. In Bangladesh between the early eighties and early nineties the Gini index for measuring relative inequality was 0.24 to 0.26, based on consumption data, and 0.35 to 0.36, based on income data. Recently released data for 1995/96, however, indicate a sharp rise--to 0.29 based on consumption, or 0.39 based on income. The increase has been even greater in urban areas: based on consumption it rose from around 0.32 in the 1980s to 0.37 in

16 Income data are not available for India to carry out inter-temporal comparison, which appears to be the most important knowledge-gap when it comes to monitoring welfare in the Indian context. In Sri Lanka most of the improvements in distribution of income (consumption) took place during the later half of the eighties. The Gini index for relative inequality in Sri Lanka was 0.34 in 1985/86 compared with 0.32 in 1990/91, based on consumption data. The corresponding figures based on income data were 0.49 and 0.44, respectively. Data for the recent period show marginal improvement: from 0.32 in 1990/91 to 0.321 in 1995/96, as per consumption data, and from 0.44 to 0.429, according to income data.

1995/96, and based on income the rise was from 0.37 to 0.44.17 There have been similar rises in both rural and urban inequality in Pakistan and Nepal.

17 Income-based Gini estimates for Bangladesh, as mentioned above, are carried out by the Bangladesh Bureau of Statistics (BBS). The definition of "current income" adopted by BBS includes capital receipts such as revenue from sale of assets; withdrawal from working capital, saving deposits and provident funds; repayment of loans made to others in the past, and borrowing. These clearly do not belong to income according to any acceptable definition. A revised estimate of Gini index excluding these items yield a considerably lower level of inequality: 0.310 as per the revised estimate vis-a-vis 0.384 as per BBS for 1995/96 (Khan and Sen 1999). However, the underlying trend of sharply rising inequality still comes through the data. The Bangladesh example is also instructive from the point of view generating estimates based on uniform definition for assessing comparative level of and monitoring change in income inequality in South Asia.

Growing income (asset) inequality has a dampening effect on the subsequent economic growth as well, though much more research is needed in this area in South Asia. The impact of inequality works through several channels. Increasing inequality may be accompanied by higher political instability, and hence disrupting the growth process. This is the standard political economy argument associated with higher inequality.18 The other influential argument is also linked with political economy, but this time the effect is operating through the fiscal channel. The higher the inequality, the greater (especially in democracies) the compulsion for making redistributive transfers. As these resources are likely to be diverted for supporting consumption, it may reduce the aggregate public investment rate, thereby leading to slower growth. If the resources thus diverted through the public channel contribute to increasing public debt, then the resulting process may even have some "crowding out" effects, depressing the level of private investment.19

Higher inequality in asset distribution also limits the poor's capacity for borrowing against collaterals and hence puts constraints on financing education as a way of climbing out of poverty. Even if the borrowing without collateral takes place, it is likely to be cheaper to acquire education out of one's own (or one's parents') savings instead of by borrowing from the capital market. One of the implications of this line of reasoning is that more equitable distribution of physical assets will help the process of accumulation of "human capital" and hence, long-term economic growth. All these arguments are in operation in South Asia in varying degree.

In short, high income inequality dampens the pace of human poverty reduction in two major ways: first, indirectly, through lowering the pace of income-poverty reduction by negatively impacting on growth; and second, directly, via limiting poor's own capacity to invest in human development in the backdrop a credit market that tends to exclude the assetless poor. High income-poverty causes low investment in mother and child health and nutrition, having adverse implications for the future schooling performance and productivity. Low household income also leads to high dropout and greater incidence of child labor. Policies that promote pro-poor equitable growth policies thus need to be pursued in order to break the links that bind high inequality, low-income growth, and slow income poverty reduction in a vicious circle.

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18 There is a growing body of literature on how inequality can affect subsequent economic growth and poverty reduction. See, Perotti (1992), Galor and Zeira (1993), Banerjee and Newman (1993), Persson and Tabellini (1994), Birdsall and Sabot (1994), Alesina and Rodrik (1994), Ravallion and Chen (1997).

19 Another fiscal version of this argument--proposed by Alesina and Rodrik (1994)--stipulates that the compulsion for making redistributive transfers leads to the imposition of higher distortionary taxes on the private investors, which, in turn, reduces private investment and hence, overall economic growth. In the South Asian context, however, the problem always has been one of inability to tax the rich in the first place rather than the distortions that such tax system entails. The share of direct taxes (income and corporate tax, wealth tax) in total tax revenue is typically very low in South Asia, being restricted to the order of 20%. The matched figure has changed very little over the last two decades. Thus, in Pakistan, the share of direct taxes in total tax revenue has actually registered minor decline from 17 to 14 per cent over the period between 1976 and 1986 (Ahmad and Stern 1991).

IV. Limited Access to Basic Public Goods as Barrier to Faster Reduction in Human-Poverty

With slow income growth, potentials for generating public revenue decline, thereby leading to the underprovisioning of public goods--a factor of paramount importance in human poverty reduction.

Basic public goods such as education, health, water, sanitation road, electricity, disaster management, and decent environment strongly influence human poverty reduction. The effect percolates through three main channels. First, it indirectly influences the pace of reduction of income-poverty by providing the poor non-market access to basic social services as well as by linking them with the upstream markets. Second, some of the basic public goods such as health and disaster management can prevent consumption shocks and/or help the coping capability of the income-poor. Mechanism for preventing income erosion via effective public provisioning is an important policy arena in its own right. But, the added benefit is that it also helps the human poverty reduction process since the consumption shocks have adverse implications for the nutritional status of the children as well as women, apart from the generally downward pressures in poverty associated with them. Third, it has a direct importance of its own, having bearing on the capability of the income-poor. The current state in South Asia in this respect leaves much to be desired despite some progress over time.

Public spending on education as proportion of GNP has increased in all the South Asian countries during 1980-96 for which data are available for international comparisons. India and Sri Lanka top the list in 1996 by allocating 3.4 per cent of its national income to public education, closely followed by Pakistan (3%), Bangladesh (2.9%) and Nepal (2.8%). Bangladesh's pace of progress was fastest during this period, as it could double the matched allocations from 1.5 to 3 per cent, thereby closing the gap with its neighbors. In contrast, there has been a very slow rise in public allocations for education in India (from 3 to 3.4 per cent) as well as Sri Lanka (from 2.7 to 3.4 per cent). Both Pakistan and Nepal experienced moderate increase.

The average figure for South Asia has increased from 2 per cent in 1980 to 3 per cent in 1996. This is lower than the 1996 average reported for the low-income countries (3.9 per cent) and much lower than the average for the middle-income (5.1 per cent). This shows that education is still not getting the attention it deserves in South Asia where the currently attained level of average affluence leaves considerable scope for increasing public allocations for the sector. There is also much room for improvement in allocating resources among the various sub-sectors, which needs to be attuned to the critical need of universal coverage of quality primary education. The comparative fiscal data for different levels of public education--the more relevant indicator for international comparison--is, however, currently not available.20

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20 But, as discussed earlier, the progress in primary enrollment (which is mostly driven by public expenditures) has been fairly uneven across the countries of the region, which may imply different allocation biases within public education. This aspect needs to be documented further.

A more disturbing picture emerges when one considers the international data on public spending on health, expressed as share of GNP, though here the lack of information is even more acute.21 Notwithstanding the gaps in data, two aspects are still noteworthy. Firstly, the insufficiency of public allocations for health in South Asia is particularly revealing in comparative perspective. Thus, public spending on health as proportion of GNP shows a secular increase, from just 1 per cent in low-income countries to 2.4 per cent in middle-income countries, rising to as high as 6 per cent for high-income countries. The corresponding figure for South Asia is only 0.8 per cent.

Secondly, considerable difference exists within the region. The highest allocation for public health was in Sri Lanka during the nineties (1.4 per cent), followed by Bangladesh and Nepal (1.2 per cent each), with Pakistan and India at the bottom of the table (0.8 and 0.7 per cent, respectively). Public allocations for health must be increased to at least 2-2.5 per cent in order to make any significant health-impact out of economic growth in South Asia.

Of course, mere increase in allocations will not necessarily lead to improvements in health care access and health status of the poor. The same applies to public education as well. For that one needs to improve upon the governance dimensions pertaining to public health and education. But, it is equally clear that policies for good governance in administering allocations for education and health have to weigh the current allocation priorities. Countries of South Asia need more doctors, nurses, primary health clinics, teachers, schools to better service the needs of the growing population, which also mean more allocations these sectors. The latter will also help to improve the quality of services. For instance, the student-teacher ratio has increased considerably in Bangladesh and Pakistan--the two countries for which inter-temporal data are available.22To counteract these tendencies requires more teachers, classrooms, and schools. There are also problems of intra-sectoral imbalances and policy distortions. In Bangladesh, for instance, there is an urgent need to increase the number of trained nurses, as it is the only country in South Asia where the number of doctors exceed the number of trained nurses by a large margin. Distorted priorities of this kind need to be removed, and social sector allocations must truly reflect the needs and choices of the people of South Asia.

In practice, "voices of the people" remained rather weak in influencing the priorities of public allocations for social sectors such as education, health and nutrition. On the contrary, often the pattern of social allocations has even exacerbated the pre-existing inequality in the system. Income inequality is only one face of the various inequities that exist in South Asian societies. The region is characterized by a very high degree of

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21 Both education and health data refer to the *World Development Report 1999/2000* published by the World Bank *and Human Development Report 1999* prepared by the UNDP. Public health data are insufficient on two counts. First, there is no reliable estimates regarding the directionality of the change in the indicator: we have only the average allocation ratio for the 1990-97 period. Second, as in the case of public education, allocations among various sub-sectors of public health are missing, which is a crucial gap in our knowledge.

22 In Bangladesh, the student-teacher ratio has increased from 50 in 1981/82 to 66 in 1995/96. The matched figure in Pakistan has risen from 38 to 46 during 1984-96.

inequality in the access to basic public goods. This is seen in the sharp and widening contrasts between agriculturally backward and advanced regions, high and low castes, majorities and minorities, rural and urban areas, in general between income-poor and non-poor, across cultures and nations. Thus, average pictures of progress in human development indicators conceal significant variation along the above lines of social, racial and regional divide.

Even in contexts where allocations for such provisionings increased as an overall budgetary ratio, the outcome was no better, because of leakage and deteriorating service quality. The effective functioning of the publicly provided basic social services represents one of the most important barriers to human-poverty reduction in South Asia. Such a functioning pre-requires a system of good governance through decentralisation and regulatory frameworks, on one side, and an equally effective pressure mechanism of people's organisations, citizens and consumers from below. There are a number of best practice examples in South Asia in this regard, but they seem to have by-passed the attention of the planners and the policymakers of the region at large. Learning from one's own civilisational past and from the experience of the South Asian neighbours has been a rarity in the post-colonial "national" quests for poverty eradication.

There are some innovative programs and policies initiated in South Asia which are not only relevant from the view-point of attaining "good governance", but also from their proven success in terms of imparting "greater voices" to the poor people. There are some larger-scale, "macro", success stories involving the entire territory of a state, though, admittedly, they were few in numbers. The success of elementary education and health in Kerala is much discussed, but still an instructive case in point. Of course, Kerala has had a rather special history of social initiatives. But, as Amartya Sen pointed out, "a region need not be imprisoned in the fixity of its history, and much depends on what is done here and now" (Sen 1998, p.17). 23 Kerala's success points to the importance of political leadership and initiative and of popular involvement. But, there are other kinds of "micro" success stories, ranging from BRAC's non-formal primary education in Bangladesh, social mobilization program pioneered by the AKRSP in Pakistan and now being implemented in all the countries of South Asia, to give some recent examples. 24

V. Women Disempowerment as Barrier to Faster Reduction in Human-Poverty

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23 This is clearly seen from the account of how the historical heterogeneity *within* Kerala was overcome through determined public action. When the state of Kerala was created in Independent India, it was made up, on linguistic grounds, of the erstwhile native states of Travancore and Cochin, and the region of Malabar from the old province of Madras in British India. The Malabar region was very much behind Travancore and Cochin in social development (including literacy, life expectancy, and mortality rates). The initiatives taken by the successive state governments of Kerala (which included regimes led by the Communist Party as well as by the Congress) succeeded in transforming Malabar. By the eighties, Malabar had so much "caught up" with the rest of Kerala that one could hardly see any inter-regional difference.

24 Compared with education, micro successes in primary health and nutritional care targeted to the poor communities were much less, and, as such, stand out as the key institutional challenge facing social development in South Asia.

Over the past two decades, women's status and opportunities have improved in South Asia. The improvement has been brought about by increased job opportunities, demographic change, better education, and better household technologies. These forces have partly liberalized women from childbearing, have enhanced their relative productivity outside the home, and have increased their voice in household spending decisions. Nonetheless, South Asian women face enormous challenges. The role of women in development varies considerably across the region.

The relative neglect of female agency in the process of development has been one of the most persistent cause of slow per capita GDP growth as well as sluggish rate of human poverty reduction in South Asia, especially when one compares with the experience of East and South-East Asia. This has effects at several levels. Recent theoretical and empirical works suggest that societies with higher "women empowerment" have been most successful in reducing population growth, infant and child mortality, and achieving better nutritional status of children and their performance at schools, with implications for productivity of the nation. This has been vindicated by the South Asian experience. Available macro and micro-level evidence provides ample statistical basis to support this.

Let us consider first the links between women empowerment and fertility rate, having bearing on population growth and, through the latter, on growth in per capita income.25 Thus, a study by Murthi et al (1995) considered a range of factors for explaining observed variation in fertility rate across the Indian districts.26 The list included factors such as the incidence of income-poverty, male literacy, female literacy, female work force participation, extent of urbanization, access to medical facilities, share of socially disadvantaged groups such as scheduled tribe and scheduled castes in the population, and specificity of geographical locations. It turned out that, among all the usual candidates for causal analysis, the only ones that have a statistically significant effect in reducing fertility rate are those related to higher women empowerment, i.e., higher female literacy and greater female work force participation.27 The independent impact of women empowerment was

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25 The endogeneity of population growth is well-recognized in new growth theory. Among various factors that can influence decisions to reduce fertility, women's agency appears to be one of the most important causal links. For further details, see Galor and Weil (1996), Schultz (1985).

26 The study is based on 1981 census data and relates to a sample of 296 districts located in 14 of India's 15 most populated states. These 14 states contained 326 districts in 1981 and accounted for 94 per cent of the total population of India. The missing state is Assam where the 1981 census was not conducted.

27 Two issues stand out as potentially important routes for further research. First, there is scope for probing further into the issue of "women empowerment" as the conventional variables such as literacy and labor force participation may not adequately capture the level and/or quality of empowerment. Second, the analysis presented in Murthi et al (1995) also suggested that fertility is significantly lower in the southern and western regions of India and in districts with a high proportion of scheduled tribes. The latter finding is sociologically curious and warrants further scrutiny.

also crucially important (along side the economic factors such as income-poverty, access to medical services, and urbanization) in explaining cross-district differentials in other aspects relating to human poverty such as under-five child mortality and female disadvantage in child survival.

The links between women empowerment and fertility also explain why some of the richest Indian states such as Punjab and Haryana have higher fertility rates compared to those in the South, which have lower incomes per capita but higher female literacy rates and female job opportunities. The argument is equally valid in case of cross-country comparisons within South Asia as well. Thus, Pakistan has about twice the level of per capita income than in Bangladesh, but it also has nearly twice as high fertility rate.28 The resultant divergence in fertility rate between the two countries has become particularly pronounced in the nineties with comparatively rapid progress in female literacy, female labor force participation, and contraceptive prevalence rate among currently married women in Bangladesh.29

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28 According to the 1997 Human Development Report, GNP per capita in 1994 in Pakistan and Bangladesh was 220 and 430 US$, respectively. The fertility rate in these countries was 5.5 and 2.9 in 1994, according to the same report. As per the 1996/97 Demographic and Health Survey, however, the fertility rate in Bangladesh is 3.3.

29 Admittedly, more works--including construction of reliable time series on basic indicators such as labor force participation, enrollment and mortality rates--need to be carried out to capture the comparative social progress in South Asia. Nevertheless, fairly striking cross-country contrasts in some of the key social indicators emerge from the available data. For instance, the adult (15+) female literacy rate in Pakistan was assessed at 27% in 1996/97, which may be compared with 38.4% recorded for Bangladesh in 1996. In general, one could see comparatively faster spread of primary education among girls in Bangladesh during the nineties. As a result, the gross enrollment rate at primary level for girls in Bangladesh was over 80% compared with 50% observed in Pakistan in 1993. The faster pace of progress in enrollment in Bangladesh is also vindicated by the 62-village panel survey carried out by BIDS in 1989/90 and 1994, showing a rapid increase in *net* female enrollment at primary level in rural areas--from 52 to 70 per cent. Similarly, the female (10+) labor force participation rate was found considerably higher in Bangladesh vis-a-vis Pakistan (18.1% in 1995/96 compared with 7.6% in 1994/95). Note that in line with the results relating to female literacy and work force participation ratio, the contraceptive prevalence rate among currently married women has been predictably higher in Bangladesh than in Pakistan (46% compared with 22% in 1996/97). The relatively high contraceptive prevalence rate in Bangladesh was caused by several factors. It may be seen as a consequence of falling demand for children as the opportunity cost of children went up in response to economic and social changes. It is also a result of a well-designed public policy, signaling the advent of a "new social norm" in which lower *desired* fertility was actually viewed socially as a "good thing". The signaling function of the population control program was seen to be a more important factor in the success story than the usual function of wider and easy access. The rapid fall in the fertility rate in Bangladesh has drawn considerable attention in the recent years (see, for instance, Phillips et al 1988, ADB 1997, Adnan 1998, Ray 1999, Mahmud 1999).

Another way of capturing the role of "women's agency" in fostering rapid reduction in human poverty is to consider the links that exist between maternal malnutrition and health care, on one hand, and the nutritional status of children and their subsequent academic performance at schools, on the other. Such links have strong implications for human capital formation, productivity, and future economic growth of the nations.

The state of maternal malnutrition and health care is extremely poor in South Asia. Maternal mortality rate estimated for this region is higher than the matched average for the developing countries. Considerable variation exists within the region itself, with Sri Lanka having the lowest maternal mortality rate (240 per 100,000 live births) compared with 539 for Nepal, 440 for Bangladesh, 437 for India, and 340 for Pakistan.30The higher the level of maternal malnutrition the greater is the likely incidence of "low birth-weight" infants.31 The latter ranges from the high point of 50% in Bangladesh to 33% in India, 25% in Sri Lanka and Pakistan. Higher incidence of low birth-weight infants also explains the relatively high prevalence of malnutrition among under-five children in India and Bangladesh. Thus, the share of underweight among children under 5 years varies from 37% in Sri Lanka (1993) and 39% in Pakistan (1995) to 56% in India (1992/93) and 66% in Bangladesh (1995).32Adverse impact of such a high degree of malnutrition would be considerable on the cognitive skills of children, affecting their educational performance and impairing their future productivity.

The most striking example of women's disadvantage is the issue of millions of "missing women" in South Asia (Dreze and Sen 1989). These countries have far fewer women relative to men than other parts of the world, indicating discrimination in the form of gender-selective child nutrition and health care. Intrahousehold discrimination in food, health and education reduces survival chances of women. In industrial countries, for instance, female life expectancy exceeds male life expectancy by about six years. Taking this six-year gap as the standard, the degree of female disadvantage in other societies can be assessed--the smaller the gap the greater is the likely degree of female disadvantage. According to this criterion, female disadvantage is worse in South Asia than elsewhere in

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30 Data on maternal mortality rate (MMR) remain suspect for a number of countries, however, as generation of such estimates requires a very large sample survey, not easily affordable within the periodic monitoring arrangement. The problem is magnified in the recent years in the face of rapidly declining fertility rate in some countries of the region. Inconsistency in data is particularly notable in case of Bangladesh (ranging from 440 to 850), Nepal (varying from 539 to 1500), and Sri Lanka (fluctuating from 30 to 240) across various sources. Rather sharp decline in MMR in Pakistan during the eighties also warrants further scrutiny.

31 Apart from maternal malnutrition, the precarious state of reproductive health care was an equally important contributing factor to high maternal and child mortality. Thus, in Nepal, births attended by trained health personnel constitute 7 per cent of cases. The corresponding figures for the other countries of the region are Bangladesh--14%, Pakistan--19%, India--34%, and Sri Lanka--94% (HDC 1999).

32 Estimates for 1996 puts the Bangladesh national average for the underweight children at 56%.

developing Asia. There is hardly any excess of female life expectancy over males in Bangladesh, India, and Nepal, and only a slight gap of two years in Pakistan (ADB 1997). In contrast, in the most advanced economies of Asia - Hong Kong, Korea, and Singapore - female life expectancy is comparable with that of the industrial world.

The key message emerging from the preceding discussion may be summarized as follows. Judged even by sheer economic terms, investment in women is surely one of the best-judged investments with possibly highest social returns, one that immensely enhances the future growth possibilities. Such "investment" must encompass a range of activities leading to better education, better health, improved nutrition, increased job opportunities, higher mobility, greater autonomy, greater authority, heightened civic activism, and higher security. Whatever the degree of social progress that has occurred in South Asia during the years of its Independence, it would not have been possible without the "agency" of women. They were the silent vehicles of some of the most impressive social changes in South Asia. But, they need to be "visibilised" more, and their "voices" need to be raised to a much higher level, so that they are able to unleash, and be part of, a much more dynamic, self-sustained and radical process of economic and social transformation. Removing the barriers to fuller participation of women in all walks of civic life thus represents one of the most important routes to human poverty eradication in South Asia.

VI. The Other Factors of Retrogression

Of course, there are other retrogressive factors in operation, dragging down the economy and pulling behind the social progress. They include race and communal riots, ethnic conflicts, militarisation, degradations of environment, criminalisation of politics, anti-democratic practices and gross violations of human rights. There are also problems of "closed" mind-sets with perverse grounding in deepening aid-mentality and state-centric mentality, breeding inefficiency and inequity corrupting the whole system of production and distribution under state patronage in South Asia.

For South Asia, the debate of the moment is not between "reform" and "no reform", nor even between "reform now" and "reform later". It is about the search for reforms, which will have maximum impact in terms of long-term poverty reduction. But, centrally, the debate is about the ways and means as to how to create institutional conditions to support such reforms on a sustained basis.33 The importance of creating effective institutions for sustaining even what one would readily categorize as equity-enhancing market reforms (such as providing credit access to the poor) is increasingly becoming apparent from South Asia's own experience as well as from the relevant international

33 The contrasting experience between Russia and China in managing the transition towards market economy and, between Malaysia and Indonesia, in responding to the Asian financial crisis, points to the critical importance of enabling institutions for managing and guiding the reform process. As argued earlier, the process of institutional capacity building has been adversely affected by the low level of human development, on one hand, and by the political economy constraints to the removal of market distortions created by the old policy regime of inward-orientation, on the other. The persistence of these factors also explains why the social results of the economic policy changes in the nineties with greater reliance on outward-oriented development strategy have been rather minimal in South Asia.

comparisons. Sustainable successes in development come only through policies that promote faster human poverty reduction supplemented by rapid technological progress in an institutional setting of humane governance and in an environment that promote competition in the market place, locally, regionally and globally. This calls for an approach balanced between the home and the world, the local and the global, the public and the private, the collective and the self-interests. Arguably, this goes beyond the agenda of conventional reforms of the re-distributive and market variety types, although there is something to consider in both. This is not going to be a one-time exercise in reform, a once-and-for all balancing act. Rather, in this approach, one needs to constantly learn the new skills (and un-learn the old habits) of managing the ups and downs, the zigzags, the darker and the brighter sides, the dialectics of the development process.

VII. Conclusion

The discussions of barriers to faster human poverty reduction, as outlined above based on South Asian experience, allow us to ground the possible policy choice on a firmer conceptual and empirical basis. It leads to the identification of the key policies that are needed to overcome the constraints that inhibit the future potentials for faster human poverty reduction. *First*, clearly, there is a need for pro-poor (equitable) growth policies with particular attention to the problems of the poor areas and communities. Such growth policies require the removal of distortions in the output and factor markets created by the old policy regime of inward-orientation. The importance of continued economic reforms geared towards outward-oriented development strategy needs to be seen in this light. *Second*, new growth policies should be backed up by public social allocations favorable to the poor, with right balance between physical (road, electricity, and communication) and social investments (education, health, nutrition, and disaster-mitigation). *Third*, effectiveness of such allocations would depend a great deal on how they are managed where the questions of good governance at central and local levels, on one hand, and community ownership (and authorship), on the other, become critical arenas of design. Good governance is not feasible without decentralization, but decentralized governance must be accountable to the people. Community ownership of the policies and programs via "social mobilization"--the strengthening of "social capital"--not only provides the institutional basis for accountable governance, but also ensures its cost-effective implementation and sustainability. *Fourth*, even "community" may have their own biases, especially in South Asia, where the interplay of entrenched class, caste, and patriarchal interests were instrumental to the exclusion of women from the public arena at large. Policies and processes that discriminate against women, disempower them, need to be tackled in their own rights. Such policies would be rewarding even from the view-point of conventional criteria of development, since "visibilising" women in all spheres of development and their empowerment will have strong growth and social multipliers.

SOUTH ASIAN DIALOGUE ON POVERTY AND HEALTH

15th to 18th November, 1999
Bangalore - India.

LIST OF PARTICIPANTS AS OF 15TH OCTOBER, 1999

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45 Mr. B.S.Lamba, Health For All Officer, WHO, SEARO, New Delhi

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CHC

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THE INTERNATIONAL POVERTY AND HEALTH NETWORK

Secretariat located in the Department of Health in Sustainable Development (HSD)
at the World Health Organization, Geneva

BACKGROUND

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THE INTERNATIONAL POVERTY AND HEALTH NETWORK

Secretariat located in the Department of Health in Sustainable Development (HSD)

at the World Health Organization, Geneva

BACKGROUND

Meetings on Poverty and Health

The Poverty and Health Network has formed as a result of a series of meetings which HSD (formerly ICO) has organized or co-sponsored on the theme of poverty and health:

The first meeting in London 1995 was held in association with Action in International Medicine (AIM). The "London Declaration" which summarized the concerns of the meeting, was addressed to all *institutions and associations of health professionals*, and called upon them, inter alia, to play an active role in reducing poverty and improving the health of populations in their charge.

This declaration has stimulated worldwide activity by professional groups. Three examples: the American College of Physicians hosted a symposium on international health at its annual meeting in 1997; in the United Kingdom, several organizations of health professionals came together to establish the Inter-Collegiate Poverty Forum, and in the Philippines, The Philippines Academy of Family Physicians set up a task force on health and poverty, and is discussing with the government how to expand the national coverage of primary health care.

The second meeting held in Maynooth, Ireland in 1996 co-sponsored by HSD and the government of Ireland, brought together *international and national NGOs* who shared valuable experiences of working with issues related to poverty and ill-health and in particular at community level. The meeting focused on the role of NGOs in stimulating community-based health initiatives, and on the need to think multi-sectorally. It recommended the promotion of active partnership between ministries of health, NGOs and the community in targeting poverty and its adverse effects on health status.

The third Congress in Baltimore in 1997 addressed itself particularly to the *business community and municipal authorities*. Its purpose was to explore ways in which these influential groups could use their special expertise and experience to tackle ill-health and poverty among urban communities in both developed and developing countries. A major innovation resulting from the Baltimore Congress was the concept of "Business for Health " championed by progressive business leaders from Australia, Europe and United States. Business leaders agreed to work with WHO to advocate and implement business policies aiming at social stability and the reduction in poverty and inequities.

In December 1997 in London, two meetings on poverty and health were organized as a follow-up of previous meetings. These meetings led to the formation of the *International Poverty and Health Network*, which saw as its role to advocate for health as a force of reducing poverty and improving health development. WHO was requested to act as Secretariat to the Network.

Four main areas of priority for follow up were identified by the meeting:

1. Mobilising stakeholders

The aim of mobilising all stakeholders is to ensure commitment by local, national and international sectors, business, health professionals, politicians and researchers etc to poverty reduction and improvement of health of the poorest populations; and to ensure co-operation between the different sectors to achieve results in priority areas. This would be done by:

- Developing a clear rationale for business involvement in poverty and health
- Involving new actors within business such as the Chicago commercial Club in the Network
- Identifying and involving stakeholders such as corporations, health associations, researchers, trade unions, politicians etc. at local levels
- Developing country specific plans and mobilising key stakeholders
- Disseminating information and experiences.
- Writing a joint letter on behalf of the Network, to all the world's health professional associations to join and share the mission, including also letters to medical journals.

2. Involvement in Copenhagen plus 5 summit meeting

The aim of focusing on the Copenhagen plus 5 meeting is to engage the network in national and international events and to bring health to the agenda of poverty reduction strategies. This will be done by:

- Sharing information on what is already been undertaken by network members such as BUSCO initiatives
- Disseminating the main outcomes of the 7 Summits to the Network members for their information
- Consultation of National Authorities by Network members on implementation of Copenhagen Summit agreements
- The Network, through the secretariat (WHO) will endeavour to be part of the Prep. Coms of the Summit and keep members informed about developments.
- An inventory will be established of Network members who have participated in previous Prep. Com Meetings or at the NGO meeting at the Copenhagen Summit. This information will be sought through a questionnaire by the WHO secretariat as well the network members such as Afri-CAN, BUSCO, DESCO, and CHC.
- The Network should become involved in different regions in influencing the agenda
- The network will be kept informed through-out the developments leading up to, and of the results following the Summit meeting.

During 1998, the Network gained momentum and a series of activities were undertaken by members: In several African countries, participatory analyses were undertaken on socio-economic determinants of ill-health and community strategies developed in response to the situation. In the U.K., the Intercollegiate Forum on Poverty and Health contributed to the Independent Inquiry commissioned to look at inequalities in health; conferences were planned in the Philippines on the role of health professionals in poverty reduction, and in the U.K. on health of adolescents living in poverty. An increasing number of people expressed interest in, and joined the network. Certain encouraging changes within WHO have given the Network further impetus.

The new leadership of WHO has firmly placed poverty eradication and health as a key to development at the top of WHO's agenda. In her "inaugural address" to the World Health Assembly in May, Dr. Gro Harlem Brundtland WHO's Director General declared:

> *"We must speak out for health in development, bringing health to the core of the development agenda. That is where it belongs, as the key to poverty reduction and development underpinned by the values of equity, human dignity and human rights".*

In order to consolidate the work of the Network, agree on key objectives and a plan of action, and strengthen participation in the network of people and organizations in the South, a meeting of a small advisory group was convened in Nairobi and Kisumu , Kenya during November 23-26, 1998.

Statement of Purpose of the Network:

One of the important elements of the meeting and for the continuing development of the network, was building consensus amongst the participants, of the Statement of Purpose of the Network. These were agreed on as follows:

- **What is the International Poverty and Health Network?**

  The IPHN is a world-wide network of people and organisations from health, business, NGOs, government and society in general who exchange experiences and share information on the most effective approaches and solutions for health in poverty eradication policies, strategies and actions

- **Who is it for?**

  People and organisations that wish to influence policy and action to protect and improve the health of the world's poor, with particular emphasis on the poorest in all countries.

- **What is its aim?**

  To integrate health into poverty eradication policies and strategies, promoting community partnership and intersectoral action, as a means to achieve effective and sustainable results.

3. Information and Research

The meeting recognised the need and importance of collating, exchanging and disseminating information regarding heath in poverty reduction in order to strengthen local and national and international capacities. This would be done through:

- Collection of research results, experience, interventions relating to poverty and health
- Exchange and dissemination of information – newsletters, Internet, existing networks, publications, national regional and international summits and conferences, journals, political arenas, media etc.
- Storage and retrieval of information experiences : creation of data base; publication of catalogue
- Shared methodology (share and disseminate the most successful as well as unsuccessful participatory methodology.
- Promote evidence based research
- Focus on community involvement in research

3.1 Capacity building

- For health professionals and people of other disciplines working with communities.
- Skills development for members in areas of management and governance, research skills and advocacy methodologies
- Producing workable CB models of addressing poverty and health currently developed by Network members such as:
  - Community based partnership model at TICH.
  - Community determined health and development at the Pan African Institute
  - Media training for community IPPHCN (S.Africa)
  - Management for poverty and health -Ceara BRAZIL

4. Strengthening the Network development

Efforts will be made to strengthen and expand the network through the following:

- Communication and exchange of information

- The language issue was raised and a concern expressed that the network also disseminate information in French and Spanish through its newsletter and reports from meetings etc. It was proposed that the newsletter be published three to four times a year.

- It was agreed that a central web site be created for the Network and that a list of members' names and addresses be included. This web-site could also link up with other useful web sites both of members and other organisations and associations, which could be of use to members. Once national and regional network are established, these could also link up with the web site. However, since not all members have access to the Internet, this information should also be available through other means.

- Identifying and Mobilising the Network Resources

- Creating a data base on existing resources within the Network which clearly informs on the capacity and resources of each member. This information should be disseminated through the Internet and on the web site and accessible in hard copy for those who are not on the Internet.

- Creating /linking up with networks at a national and international level

Your response is IMPORTANT

Establishing a network is not an objective in itself. Its value lies in what it is able to achieve in addition to what each member is doing individually. The network therefore depends on the creativity, ideas and active participation of its members in the development of joint activities and collaboration. As facilitator of the network, HSD will be in regular contact with the members, soliciting input to the newsletter, enquiring about activities and involvements of the area of poverty and health, and sharing ideas and thoughts. We will be counting on you!

We are very keen that you will be an active member of the network and we very much hope that you will accept the challenge and commitment which this involves. We would appreciate if you would manifest your interest in being a member of the network by returning the enclosed membership form. This will help us consolidate the network and enable us to start working actively on information sharing and news from network members.

Please return the attached form to:

Julia Jameson, HSD
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Avenue Appia 20
CH 1211 Genève 27
Suisse

Tel: (41 22) 791 2558
Fax: (41 22) 791 4153
Email: jamesonj@who.ch

INFORMATION ON MEMBERS/ MEMBER INSTITUTIONS

1. Type of membership (individual or institutional)

2. Name of individual member / institution:

3. Contact person (institution):

4. Address: (including telephone, fax and e-mail)

5. What are the goals, objectives, areas of activity/speciality and methods of working of your institution?

6. Publications

7. What tools could you/your institution share with the network?

8. How would you like to receive the letter in future?

- By hard copy
- By e-mail (as an attachmant or within the text - please specify)
- I will download from the internet

9. Comments and suggestions for making the network a success

THANK-YOU !

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SOUTH ASIAN DIALOGUE ON POVERTY AND HEALTH

Pre-Dialogue Opinion Survey – A Preliminary Compilation

- This compilation of the pre-dialogue Opinion Survey collates key perspectives, concerns and suggestions from 21 participants out of 50 who responded.

- The objective was to identify the range of concerns and perspectives; identify broad areas of consensus as well as differences, on issues and determinants in the complex links between poverty leading to ill health; ill health leading to poverty; the global, regional and national structural determinants of poverty and inequity in health; and the growing synergy between poverty alleviation, development programmes and health care initiatives and services.

- This compilation is a check list and background to the discussions. Responses have been classified into groups that are related. Notwithstanding differences in perspectives among respondents because of the differences in situation and experiences in different countries and regions of the world, we believe that the compilation would be a useful stimulus for participants to reflect upon. .

- *Perhaps you would like to tick some of them! Are these issues, responses relevant to your own country experience? Your own region experience? Are these consistent with your own perceptions about the global situation and global issues? Do you find the initiatives listed out to tackle poverty and ill health relevant to your own country / region? Do you agree with the responses for priority initiatives at global level?*

- *What you tick at the beginning of the dialogue will be what you already know! What you tick at the end of the dialogue will be ideas / perspectives that have been presented by others which have convinced or challenged you! There may be many others not in the list. You may wish to add as you go along.*

- This compilation has been an evolving process since participants have been sending responses well beyond the deadline. We welcome these and will do a more integrated compilation for the Proceedings of the Dialogue. For the present, we hope it will serve the purpose of being a 'collective' stimulus!!

- We thank the following particularly for their contributions which have been integrated into this compilation:

  - Prof. Abul Barkat and Dr. Sharifa Begum from **Bangladesh**;
  - Ms. Fathimath Moosa Didi from **Maldives**
  - Dr. Mathura Shrestha and Dr. Indira Shrestha from **Nepal**;
  - Dr. Barzgar from **Pakistan**;
  - Dr. N. Sivarajah and Ms. Myrtle Pereira from **Sri Lanka**;
  - Prof. D. Banerji, Dr. Prem John, Dr. Mani Kalliath, Mr. R. Gopalakrishnan, Ms. Nimitta Bhatt, Dr. Mohan Rao, Ms. Shilpa Pandya and Mr. Ravi Duggal from **India**;
  - Dr. Iona Heath, Prof. Andy Haines from **UK**;
  - Ms. Patricia Nickson from **Congo/Ivory Coast**; and
  - Mr. Kim Forley and Mr. B.S.Lamba from **WHO**.

Bangalore, 12th November 1999 CHC Organising Team

INTERNATIONAL POVERTY AND HEALTH NETWORK
SOUTH - ASIAN DIALOGUE.
PRE DIALOGUE QUESTIONNAIRE.

Collation of Responses

A. Key issues in order of priority linking poverty and ill health regionally.

S.No	Issue
1	*Lack of commitment of policy makers* for equitable development and distribution
	Lack of political will to implement social policies
	Lack of political will to tackle wider determinants of health
2	*Lack of access to health* and nutrition and lack of awareness
	Lack of access especially transport related
	Poor access to- and opportunities for- social welfare services leading to ill health
	Inaccessibility (cultural, economic, etc.)
	Lack of access to health care / lack of income leading to ill health
	Lack of state funded, people oriented health planning and programmes focusing on marginalised people
	Inadequate spread of public health services
	Linkage of ill health to social opportunities
3	*Inadequate understanding* of poverty
	Inadequate understanding of determinants of ill health
	Inadequate appreciation of the links both at policy and curriculum (medical education)
	Poor understanding of links between poverty and ill-health
	Redefinition of challenges and solutions
4	*Powerlessness of people*
	Power structure / social structure against the marginalised
	Non-participatory democracy / elitist policies
	Lack of choices for social and economic investment decrease capacity for empowering women
	Gender issue in health and poverty e.g., female literacy etc.
	Poverty and ill health related to breakdown of families
	Need for decentralised models - panchayati raj
5	*Lack of comprehensive government health infrastructure*
	Break down of public health systems
	Institutional development building for health education for new challenges
	Limits of current delivery model
	Deficient health services to marginalised communities
	Malgovernance of health systems
	Inequitable distribution of health resources
6	*Exploitation and marginalisation* of the poor
	Caste - system and lack of education as a cause of marginalisation of the poor
	Social exclusion
	Reversal of income inequalities
7	*Ill health causing decreased human capacity*
	Burden of ill health on poverty
	Capacity building in health to improve productivity and alleviate poverty
8	*Lack of educational opportunities* among girls and women
	Poor education among children linked with poverty
	Illiteracy causing ill health
	Role of education in links to poverty and ill health

S.No	Issue
9	*Onslaught of Structural Adjustment Programmes(SAPs)* and Global economic policies - decreased social sector spending
	Exclusion of marginalised in every sector due to SAPs
10	*Lack of integration of planning and programming* of health services within overall frame work to bring

about socio-economic development.
Too much concentration on health promotion rather than tackling socio-economic deprivation.

11 *Lack of simple and relevant research* focusing on determinants of ill health
Lack of health data by socio-economic categories
Lack of nutritional data by socio-economic categories

12 *Civil war*
Civic instability

13 *Links of behaviour, life style* and poverty.

14 *Low expectation* of poor people

15 *Poor pattern of rural development* – lack of access to skills and technology to alleviate poverty

16 *Poor nutrition*
Water for drinking and agriculture

17 *Environmental degradation*
Increasing degradation of the environment

18 *Decline in labour productivity*

19 *Employment* – both lack and under
Means of livelihood
Large scale under-employment

20 Repeated *disasters*

21 *Housing* and environment

22. *High teenage pregnancy*

23. *Large, unregulated private health sector*

B. **Three key issues in order of priority that are important globally for the links between poverty and ill health.**

S.No.	Issue
1	*Widening economic gaps between rich and poor* between and within countries.
	Skewed utilization of global resources
	Gaps due to discrimination,. Social inferiority , geographic and political and environmental factors
	Impact of globalisation on the non market goods important to poor ie health education and welfare.
	Response of globalisation on double and triple burden of diseases
	Impact of privatisation of health care
	Impact of globalisation and privatisation on human development
	Discriminatory aspects of World Trade Organisation and International Monetary Fund exploiting poorer countries
	Unequal trade
	Partisan and often hegemonistic role of IMF / WB etc
	Reduction of global health inequalities to be made part of IMF / WB agenda
	Prevailing monopoly of global knowledge / technology / resources
	Global opportunities unevenly distributed between countries and people
	Globalisation increasing inequalities within and between countries
	Rethinking SAPs
	Unequal distribution of global resources
	Structural readjustment
	Unequal distribution of wealth/resources
2	*Poverty eradication through pro poor land/ investment policies.*
	Supporting inter-sectoral action

S.No	Issue
	Economic development through human development
	Poor nutrition
	Hunger and malnutrition
3	*Malgovernance of public health*
	Catalysing decentralised management of health sector through targeted funds
	Focusing on issue of poor sanitation
	Governance of health programmes in accordance with Alma Ata declaration
	Universal access to healthcare as a right not pushed adequately
4	*Debt burden of the heavily indebted poor countries*

Cancellation of international debt
International debt

5 *Educational disadvantage*
Lack of education

6 *Strong evidence based data* linking poverty and ill-health

7 *Promotion of locally appropriate models of health care*

8 *Regional militarisation and arms race* engineered by first world diverting limited national resources.
Health impact assessment of international arms trading

9 *Ecological changes* and environmental degradation in third world caused by industrial pollution by Trans-national Corporations(TNCs)
Ecological degradation and environmental pollution
Environment

10 *Subservience of WHO to dictates of G-7*
Increasing TNC/Donor control over health programs
dismantle WHOs global initiatives and relate global actions to local actions
shift in perspective of personnel of WHO / international development agencies
Multinational Corporations

11 *Norms of basic preventive and curative services to be available to all people*

12 *Equity and sustatinability*

13 *Threat to human security* - economic / health / cultural / environmental
Manmade disasters wars , arms race etc.
National instability

14 *Efforts to minimise vulnerability of the poor* to health-related shocks

15 *Monitoring of provision of basic social services*
Lack of physical infrastructure

16 *Promoting value of social mobilization* and spirit of community particiaption in development activities.

17 *Powerlessness*

18 *Lack of political commitment*
Lack of commitment to PHC

19 *Employment*
Unemployment

20 *Low status of women*

22 *Population explosion* and its socio-economic and environmental consequences

23 *Globalisation only of capital, but not of labour*

C. **List of key initiatives in order of priority to tackle issue of poverty and ill-health regionally.**

S.No.	Issue
1	Vigorously pursuing *poverty eradication programmes*
	Reduction of child poverty
	Improved support in both cash and kind to support vulnerable young families

S.No.	Issue
	Poverty alleviation programs – Samrudhi Program
	Special measures for the extremely poor
	Provision of credit and asset and technical know-how to the poor
2	Providing *comprehensive health care* emphasis on women's health, at subsidized cost.
	Strengthen school programs, provide nutrition education promotion of home gardening
	Reorientation of PHC program to make it more intersectoral and relevant
	Ensuring good governance of public health
	District level health planning to be aggregated from panchayat levels
	Integrating health programs
	Institutional support through a "basic health services guarantee scheme
	Rejuvenate the health services by reviving the managerial physicians and rolling back the generalist administrators
	Integrated socio-economic development
	Social security programs
	take steps to prepare local bodies to take over health activities
	Creating mechanisms to assure universal access to health care irrespective of the capacity to pay

3	Giving teeth to *grassroots democracy* / empowering panchayati raj
	Strategy and programs for empowerment of the marginalised people
	Empowerment of people to assert their health and development rights
4	Encouraging *investments in health*
	Increased public health expenditure
	Increasing health expenditure
	Investment in public health services
	Higher allocation of resources to the health -sector
5	*Provision and analysis of health impact of various loans and investments in all sectors*
	Macro-economic policy that ensures equitable distribution of fruits of growth into investment in education / health /nutrition
	Campaign to ensure that all public service quality assurance programmes include measures of inequality
6	*Increasing educational attainments*
	converged human developmental action on female education
	investment into education and welfare
7	*Implementation of pro- poor health policy*
	political articulation of Health as a human right in order to redefine the national health agenda
	Bring health into the mainstream of development
8	*Increasing awareness of the linkages between poverty and ill health*
	Raise awareness about health impact of poverty
9	Operationalising of the growing realisation that the *ultimate goal of all the development is human health and well-being*
	All sectors committing to develop holistically ensuring all-round development
10	*Social action* oriented towards gender justice and equality
	Involve community based NGOs , Career guidance and vocation training
	Civil society initiatives through NGOs
	Creating broad alliance of peoples movements for countering exclusionist and authoritarian tendencies in the country
	Working with people and organising them
	NGOs to concentrate their work among the poor communities.
11	*Resolution of conflicts and cessation of war*
	Local, national and regional stability
	Reduction in militarism and spending on arms
12	*Identify the poor* and prepare special programmes for their upliftment

S.No.	Issue
13	*Research competence* ought to be developed to determine ways of most effective use of limited resources - concept of cost-recovery to be abandoned
	Locality specific and problem-based participatory research to enable all levels of society to make informed decisions
14	*Advocacy* to enforce social, political, legal, and ethical responsibility and obligation to implement various declarations etc
15	*Refugee doctors to be integrated* into the health services(specific to Britain)
16	*De-addiction of nations from foreign aids and grants*
17	Encouraging *small economic enterprises.*
	Micro credit schemes especially directed to women
18	Expand *health infrastructure and access*
19	Identifying root causes of *powerlessness*
20	Increasing *women's education*
21	*Stopping privatization*
22	*Employment guarantees* for the poor
23	*Environmental regeneration programmes*
24	*Saving lives, opportunity for all, work of social exclusion unit*
25.	*Tackling fuel-poverty*
26.	*Work of the Food Standard Agency*

27 *Regulation of private health sector*

D. **List of key initiatives- in order of priority- required globally to tackle the issue of poverty and ill-health.**

S.No.	Issue
1	Assign top priority to *poverty eradication policies*
	Priority to be given to all governments to assist the poor and backward comm.
	75% of international aid for next 2 yrs to be given to poor comm. In a country
	Implement ways and means of minimizing acute vulnerability of poor
	Sustain policy focus on poor regions and poor people
	Provide financial and technological support for development of services like health and education for the poor
	Pro-poor and pro-disadvantaged programs
	More funds to development infrastructure and social sectors.
2	Resolve *governance issues of public health*
	Promote community participation
	Do not fund vertical health plans
	Fund horizontal health programmes at grassroots level
	Conceptualise ways to integrate vertical health prog. Within overall perspective of dealing with poverty and ill-health
	Halt / reverse privatisation of health services
	Return to HFA through PHC
3	Inter-organisational dialogue - between *WHO / UN agencies/ NGOs / WB etc*
	Functional unity of concerned International Organisation
	Positive and enhanced role of UN organisation and Bretton Woods inst. In human development
	Democratisation of global decision making e.g., equal weightage in World Bank / UN Security Council etc.
	Soul-searching by international agencies to understand why they strayed
	Heart-searching by international agencies on reason for failing to develop competence in health systems research
	Global alliance esp. of civil societies
S.No.	Issue
	Global alliance for human capacity and resource building
	Health Impact Assessment methodology for the World Bank and IMF
	International commitment for universal access to health care
4	*Debt relief*
	writing off national debts of developing countries
	Moratorium on debt servicing
	Waiving unjust third world debt
	Cancellation of International Debt
	Greater commitment of resources by first world for health and poverty initiatives in third world
5	Just *trade practices*
	Developing mechanisms to correct unjust trade relationships
6	Removing *inequity in research* and development in the world
	Free and unhindered flow of information
	Essential national health research (ENHR)
7	*Pro-equity and sustainability development models*
	Integrated socio-economic development
	Prioritisation of human development over economic development
	Advocacy that human development is a prerequisite for sustainable development
	Mobilisation of resources and political will for implementation of UN summits
	Dialogue / coalition building / solidarity - towards sustainable development - including south-south and north and south
	75% of poorer community in a country should have access to potable water and good sanitation
	To replace dominance cult and subservient mentality with a liberation paradigm
	Alternative perspectives to address consequences of globalisation
8	*Dissemination of information on linkages between poverty and ill health* in lay and scientific media

Dissemination of success stories successful in alleviating poverty and ill health

9 *Encouraging and supporting initiatives for development of decision making abilities* e.g., in Panchayati Raj Institutions

10 *Gender sensitive social development*

11 *Micro- financing* as it has impacts on health equity

12 Problem of *powerlessness* needs to be researched

13 *Community based health care*

14 *Traditional remedies* and home care

15 *Strengthening equity initiatives* of WHO

16 *Bottom up rather than top down planning*

17 *International Control of the Arms Industry*

18. *Greater commitment of develop countries to reduce / rationalise their consumption patterns*

SOUTH ASIAN DIALOGUE
HSD comments on specific parts of the report

The comments are based on the draft report of 4.8.2000 and references that are made to page numbers are also based on the same draft.

On a general note, the main body of the report is long and could be shortened and tightened up in order to provide the reader with a summarized overview of the main issues presented at the meeting. Suggestions have therefore been made to restructure the report and to transfer some parts of the text to annexes. We think this will ensure the flow of the discussions. It also needs further work by a good editor, to make it reader friendly.

- Page 1: first bullet - HSD is the *department* (not cluster) of Health in Sustainable Development
- Page 2: Is the box a quote – would it not be possible to start with a quote that sets the report off in a more positive way, highlighting the opportunities that now exist to focus on the issues of health and poverty, commitments that have been made and the role of the civil society in putting pressure on governments to follow through their commitments...etc. and that this is one of the reasons the meeting was organized.
- Page 3: Statement – if HSD is mentioned, the WHO representation should also include representatives of the Regional and country offices.
- Page 5: Signatories of the statement could go out – it is not necessary since all the participants are listed in the participants list.
- Page 8: Preparation and process of dialogue – there is too much detail in this part and a one paragraph summary would be enough.
- Page 8: The data in the table is too old and could be replaced by more recent numbers.
- Page 9: the quote from Mark Twain is over simplistic and does not reflect that we are trying to create a dialogue environment. New language is needed !
- Page 10: Under the heading "Some of the key learning experiences from community visits" subheadings and regrouping the bullet points would be appropriate and would make reading easier. Obvious headings include: social participation, health services, governance...
- Page 12: Information on the communities visited could be transferred to an annex.
- Page 13: John Martin : text should be changed to : He assured the participants that WHO " is already actively involved in developing this approach".
- Page 13 table : again... somewhat old data
- Page 14 : Banerji – "he noted with concern that most people seem to assume a simplistic relationship between health and poverty" – *what does this mean?* It would be good to spell out.
- Page 16: Mathura Shresta's part - text too much like the tape recordings – it needs to be summarized into main points.

Could we take out the bullets in this and the following presentations in this section – bullet points become very tedious to read after the first three... it would be good if all the bullet points were summarized as in the case of Chowdhury's presentation.

- Page 17 : Abul Barkat has been given too much space if both diagrams are included. It throws off the balance between presenters.

- Page 19 : if statistics are used, as in the chart, it would be good to quote UNDP or other official sources.

- Page 20: Section 6 – if possible, again, it would be more interesting reading if the bullet points could be spelled out and summarized in a paragraph or two under each heading. Otherwise you risk losing the reader.

- Page 23: Who/what is the source of quotes in the boxes?

- Page 23: section 7 again- too many bullet points – the format of 7.4 and 7.6 is much better! Need for consistency in all the subheadings.

- Page 25.: box 1 – source?

- Page 26: the box is not very useful since nothing is mentioned about the process... in this case study it was the approach that was interesting!

- Page 29: box of Skolnik – surely it is not the poor *people* that should be considered a disaster but the extent to which poverty is rampant!

- Page 29 – WHO and Health which document is referred to? Is it the EB document on poverty and health – the information in the paragraph is not clear.

- Page 30: Under same heading WHO and health : Use present tense. Take out bullet 2 and 3 (starting "WHO was trying to make a difference...." And "WHO was under pressure.." Seattle) and replace with the following text:

  - WHO is actively participating in global processes, such as follow up of UN summits and joint activities on health in poverty reduction with other UN agencies, the World Bank and Development partners. WHO is also developing relationships with major trade bodies (WTO, UNCTAD). In discussions with them, WHO is promoting policies to ensure that trade agreements work to protect the health of people, especially the poor and vulnerable.

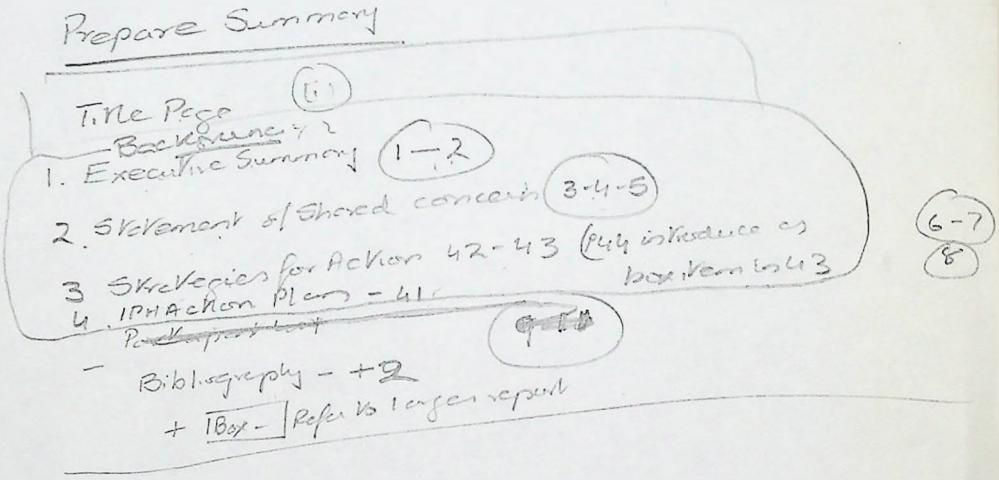
  - WHO is establishing dialogue with a broad range of actors, including civil society, the private sector and the pharmaceutical industry. This process of listening and reaching out to others offers a good opportunity also for countries in the South, to make sure their perspectives are reflected and their voices heard in the Organization.

- Page 30-31: section 9.3 **Some implications of international collaboration** – the text under this sub heading does not correspond to the heading... since it is about one agency, World Bank projects in one country, India... and not at all about international collaboration. It does not seem logical to keep it here under this heading. This section could be summarized into a few paragraphs.

- Page 34 –38: Section 10 – Action for change – some initiatives and emerging strategies in Asia. Since this section is descriptive (and at times too detailed) it could come into an annex – unless some actions for change could be summarized or drawn out from the case studies.

- Page 39 –40 section 11 is also very descriptive and could become an annex, unless we present the case studies as a learning experience as has been done for 11.6 Devaki Jain. The mere description of a case study is not so useful. 11.8 Towards an IPHN action plan could remain somewhere in the main text since it does reflect a discussion that took place

at the meeting. The PHA could also stay in the main text as this was discussed and action encouraged.



To Dr CMF

Enclosed the letter and comments from WHO-HSD

Please review these and suggest whether they are relevant / ok / acceptable. If so suggest changes

Thanks

Ravi

28/11

CM 3/12

Subject: Report of the South Asian Dialogue
Date: Thu, 23 Nov 2000 15:03:55 +0100
From: petersa@who.ch
To: sochara@blr.vsnl.net.in
CC: martinj@who.ch, skoldm@who.ch, villare@who.ch

Dear Ravi and Thelma,

After an extended period of silence due to new, demanding challenges in our work, I am writing to you with regard to the Report of the South Asian Dialogue. We discussed it recently in a management meeting, to agree on a way forward.

Many thanks for all the work that you and your team have put into developing the report. We feel that it reflects well the proceedings of the meeting, although we do have a few comments on specific parts of the report which we have annexed to this message. We recognize that getting such a report together has been both a time consuming and a rather complex task since you have been working from the recordings of the meeting. We started our discussions here by re-looking at the target audience and the potential use of the report. In its current format, the report is probably of most interest to those who participated in the meeting and we would therefore like to suggest that it be distributed to those who were involved in the dialogue. Since a year has now passed, we will not make it a formal HSD publication and we suggest that distribution could be done by e-mail. However, should CHC wish to make it into a document and send it out to participants, this would also be fine - we would see this as CHC's contribution to the process of dialogue and follow-up.

One of the main objectives of the meeting was to promote dialogue, exchange of ideas, experiences and strategic approaches to health in poverty reduction. I am sure that we all agree that these goals were very well reached. The news we hear about preparations for the PHA also seems to reflect that the dialogue and mobilization of many of those present, has continued after the meeting. We are delighted to hear this! In our view, a report from the meeting is therefore not so much a tool for change for people who were not present, but rather an aide memoire for those who were part of the dialogue. I am sure that the report will be a welcome reminder of what participants committed themselves to in terms of activities and joint efforts in the area of health and poverty.

Having said that, it would be important for us all, I imagine, to have a 4-5 page summary of the meeting, which reflects the main issues/messages that came out of it. We need to be able to share this information with our donors and others that are interested, and in the dialogue with colleagues, policy makers, and other decision-makers, and also to paste it on our web site. Since CHC have had the responsibility for writing the report of the meeting, I would request that you also develop this summary.

Many thanks once again to the team at CHC for all your hard work, both in making the meeting a success, and in the production of the report.

Greetings from us all in HSD.

Eva Wallstam
Director
Health in Sustainable Development
<<Comments report.doc>>

Dear Ms Eva Wallstam

Thanks for your letter/email dated 23rd Nov and for the comments on the report and the suggestions for follow up. We are all in the final hectic phase leading up to the Peoples Health Assembly (National Assembly - Calcutta 30th Nov/1st Dec) and the Global Assembly (Dhaka - 4-8th Dec 2000) We shall get back to you as soon as we return on 11th. The PHA will also be an opportunity to

Bookmarks from CHC
Yours sincerely
Ravi Narayan

TN/RN 24/11 RN 24/11

11/21/00 9:52 AM

Comments report.doc

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Type: Winword File (application/msword)
Encoding: base64

COMPLETE LIST OF MATERIAL DISTRIBUTED DURING THE
SOUTH ASIAN DIALOGUE
ON
POVERTY AND HEALTH
(Before and during dialogue)

P-Series

Communication I:

1. Pre Dialogue Opinion Survey.
2. Health and Development : Key Note Address by Prof. Amartya Sen. World Health Assembly, May 1999.
3. Poverty and Health - Regional Issues : South- East Asia. WHO-SEARO. (Booklet)

Communication II

1. Tentative Pre-final Program of Work.
2. List of Confirmed participants
3. Community Visits - a note.

Communication III (Background Papers).

1. Report of Consultation on Equity and Health in SEARO, Trends, Challenges and Future Strategies (Executive Summary).
2. Making Health a Public Agenda - Indira Shrestha and Mathura Shrestha.
3. Tackling Health inequalities in Primary Care - Editorial in BMJ by Liam Smeeth and Iona Health
4. Poverty and Ill-Health : Physicians can and should make a difference - From Annals of Internal Medicine by Michael McCally, Andrew Haines et al.
5. Final Report of meeting on Policy Oriented Monitoring of Equity in Health and Health Care, Geneva, September 1997. (Executive Summary)
6. Civil Society Initiatives - Human Development in South Asia, 1997 Mahbub ul Haq.

F Series

Contents of File Distributed at Dialogue

1. The Framework of the Dialogue
2. The Final Program
3. The List of Participants
4. Participants Profile I
5. The Community Visits - Objectives (?)
6. Some notes on Community Visits
7. The Summary of Opinion Survey
8. Suggested Questions for the Group Discussions
9. Learning from the Community - A Checklist of Parameters for the report
10. A Bibliography of the reading material received for the dialogue
11. A CHC Pamphlet
12. An International Poverty and Health Network (IPHN) Note
13. A note of WHO -HSD (not distributed)
14. To Our Health - The News letter of WHO - World Health Assembly Special 1999 (Pg1&3}
15. An Invitation card for Cultural Program and Special Dinner on 17th November, 1999

P = Pre dialogue communication
F = Background papers in the File
H = Handouts during dialogue
? = Other papers circulated by other groups/not presentations in dialogue.

D: completelist.doc

16. Symposium Paper I - Poverty , Disease and National and International Power Structure - The case of India by Prof. D. Banerji, India
17. Symposium Paper II - Poverty and Development Paradigm - Peoples Perspective by Prof. Mathrua Shrestha and Dr. Indira Shrestha, Nepal
18. Symposium Paper III - Equity in Health Care - A Formidable Challenge for Sri Lanka (synopsis) by Ms. Myrtle Perera
19. Symposium Paper IV - Crisis in Governance of Public Health System in Bangladesh : A Challenge of Humane Governance by Dr. Abul Barkat (Synopsis)
    19. (a) Full Paper
20. Cartoon
21. Health and Poverty in War by Dr. N. Sivarajah, Sri Lanka
22. The Poverty of Amartya Sen by Mr. Anil Agarwal, India
23. An Intergrated approach to Community Health : The Sarvodaya experience in Sri Lanka by Dr. Vinya Ariyaratne, Sri Lanka
24. A report on The Rajiv Gandhi Missions - Government of Madhya Pradesh
25. Strengthening Community based Health Care in Madhya Pradesh through Decentralised Management of Health Services by Mr. R. Goplakrishnan, India
26. Peoples Campaign for Decentralised planning the Health Sector in Kerala by Dr. B. Ekbal, India
27. A new Health Policy for Health Sector reforms by Mr. Ravi Duggal, India
28. Poverty and Health : a universal abuse of Human rights by Dr. Sunil Kaul, India
29. A note from Mr. B.S. Lamba
30. Relevance of Ideas and Mass Mobilisation for the Removal of Poverty and Inequality by Dr. Devaki Jain, India
31. Poverty and Health; Reaping a richer Harvest - a book notice
32. Special Issue - Health and Equity - Health for the Millions, New Delhi
33. Special Issue - Community Health: Search for a new Paradigm - Health Action, Secunderabad
34. A Map / pamphlet on Bangalore

H Series

Handouts

1. Inaugural Session and Symposium - program and speaker profile
2. Social Development initiatives in Pakistan By Dr. Yousuf Memon - Symposium Presentation (Synopsis)
   2. (a) Complete set of OHPs
3. Explaining Slow Progress in Poverty Reduction in South Asia by Binayak Sen, Bangladesh
4. Globalisation and the Health of the Poor; beyond the Rhetoric of Health for all by 2000 by Dr. Prem Chandran John, India
5. Comments on "Case Study of World bank activities in Health Sector in India". - Community Health Cell, India
   5. (a). Set of OHPs of Dr. Ravi Narayan's presentation
6. The World Bank Perspective - Set of OHPs presented by Dr. Richard Skolnik
7. Poverty and Health: Some Experiences from the Self Employed Women's Association (SEWA), India
8. Peoples participation in Maldives - pamphlet

8. (a). Booklet
9. Peoples campaign for decentralised planning - OHPs of presentation by Dr. B. Ekbal, India
10. Intersectoral Action - OHPs of presentation by Dr. Andrew Haines
11. Identification of Poverty and Health Risks - OHPs of presentation by Dr. Patricia Nickson, Congo and Ivory Coast
    11. (a) The Cultural context of PHC by Dr. Pat Nickson
    11. (b) Sustainability of Health Care in a Situation of Insecurity (case study of Congo) by Dr. Pat Nickson
12. Health and Human Power Development: Issues and Concerns - OHPs of presentation by Dr. D.K. Srinivasa , India
13. Role of Private Medical Practitioners - OHPs of presentation by Dr. Nimitta Bhatt, India
14. Basic Minimum Needs Program - OHPs of presentation by Mr. Barzgar, Pakistan
15. Group Discussion Notes:
    15. (a) Ill Health Leading to Poverty- Gr I / II
    15. (b) Pauperization of Women - Gr I / III
    15. (c) Disaster, Poverty and Health - Gr I / V
    15. (d) International Donor Agencies - Gr- II / I
16. Draft Statement of the South Asian Dialogue on Poverty and Health

Handouts (Others)

17. Major Areas of Concern on WHO "Health of all in the 21st Century" Draft Document, Voluntary Health Association of India, India
18. Draft Health Policy 1999 - Government of India
19. Peace and Poverty - Article
20. Poverty in Poverty Analysis – Article
21. The Twain the Most Americans Never Meet - email
22. Poverty - A Major Constraint in the Community Care of Orphans in Zimbabwe by Drew RS et al, Zimbabwe
23. A Violation of Citizens' Rights : The health sector and Tuberculosis by Dr. Thelma Narayan, India
24. A Solid Base for Health by M.A. Barzgar, Pakistan
25. Kofi Annan's Facts - Photocopy of News paper article
26. Articiles contributed by Dr. Naila Z Khan
    26. (a) Lead Poisoning and psychomotor delay in Bangladeshi children
    26. (b) Mortality of urban and rural children with cerebral palsy in Bangladesh
    26. (c) Effect of an equine movement therapy program on gait .... A pilot study
    26. (d) Destroying our childrens' brains with lead in air
    26. (e) Recognising child maltreatment in Bangladesh
    26. (f) Best resource use for disabled children
27. Amartya Sen on development and Health - Interview in To Our Health - May 1999
28. Link - Bulletin of ACHAN - June 1999
29. Orissa Cyclone Appeal - Action Aid
30. Publication lists - WHO - task force on Health Economics
    30. (a) Publication List - WHO - "Macro economics Health and Development"

PRE FINAL MAUSCRIPT

SOUTH ASIAN DIALOGUE ON POVERTY AND HEALTH

15th – 18th November, 1999
Bangalore, Karnataka, India

SUMMARY OF

PROCEEDINGS

Organised by

Community Health Cell, Bangalore;
International Poverty and Health Network, Advisory Group;
WHO-Health in Sustainable Development, Geneva.

JULY, 2000
World Health Organisation
2000

CONTENTS

APPENDICES

(This proceedings is an overview of a very comprehensive, analytical and intense dialogue where many participants contributed greatly through written papers and very active reflection, discussions and sharing of experiences. Due to constraints of the size of the planned proceedings an attempt has been made to summarise the key issues from every session focussing on 'what was said' and not always 'by whom'. An editorial prerogative to amalgamate presentations, to convert some into case studies and box items etc., has been proactively followed. A larger publication to do greater justice to all the contributions to the dialogue is planned)

(Proceedings as of 4.8.2000. Further editing in progress)

1. EXECUTIVE SUMMARY

- *A South Asian Dialogue on Poverty and Health* was organised by Community Health Cell of the Society for Community Health Awareness, Research and Action, Bangalore in collaboration with the Advisory Group of the International Poverty and Health Network and the Health in Sustainable Development Cluster of the World Health Organisation, Geneva from 15th – 18th November, 1999 at The National Institute of Advanced Studies, Bangalore (India).

- The dialogue was attended by 48 participants of whom 33 came from the South Asian Region including Bangladesh, India, Maldives, Nepal, Pakistan, Sri Lanka and National Regional Networks and 15 came from other countries like Kenya, Congo, France, United Kingdom, Peru, USA and International agencies including WHO-Geneva, WHO-SEARO and the World Bank.

- The pre-dialogue interactive planning process included three communications from the facilitating team in Bangalore; a series of background papers and reports; and a pre-dialogue opinion survey among the potential participants including a programme planning survey.

- The Dialogue began on the 15th with Community visits to Health, Development and Poverty alleviation programmes organised by voluntary agencies (NGO's); a medical college and a Corporate sector initiative. The aim of the Community Visits was to provide an opportunity to the participants to observe and listen to the experiences of people living in poor and marginalised communities and to learn how they cope with the situation, as well as what they think of the initiatives of government and non governmental agencies. The focus of these projects included bonded child labour; street children support; slum outreach; indigenous people; people with disabilities; rural women's development and a community development initiative of a corporate sector.

- At the end of the day there was a session at which the participants shared their group learning experiences from each visit.

- On 16th there was a special Public Symposium on ***Poverty and Health in South Asia : Crisis and Challenge*** at which experts from India, Bangladesh, Nepal, Sri Lanka, Pakistan and WHO-HSD presented their perspectives and concerns to a larger number of invitees.

- The 3 – day dialogue consisted of sessions on the following themes :

. ***Inaugural Session***

Orientation to Dialogue and Group Inventory on expectations and issues; Global, Regional and National Concerns impacting on Poverty and Health; Health and Poverty Eradication :- Perspectives of the World Bank and WHO; Health and Poverty Eradication : Action initiatives and strategies – local, national, government and NGO; Policy issues for Equity in

Health and Poverty Eradication; Experiences from the South and the North; Action Plan – 2000 AD and beyond.

- The 3 day dialogue was also interspersed with small group discussions on the following themes :

  Socio-Economic Deprivation and Ill health; Ill health leading to poverty; Feminization of Poverty; Globalisation and Health; Poverty, Ecology and Health; Disaster, Poverty and Health; Strategies at local / community level; Strategies at National Level; Strategies for SAARC Region; Strategies for WHO/IPHN; Strategies for International Donor agencies.

- Finally by the end of this intense dialogue – both through small group level and plenaries, a statement of shared concern and collective commitment emerged including an agenda for suggested action at various levels.

Globalisation and Health of People

The health care of the marginalized has always been a peripheral issue to the ruling structures, more particularly in Asia and other developing nations. What we term as 'malignant neglect' has led to a state where the poor have no access to even the most basic of health services and this is reflected in the shameful health statistics relating to them. The current processes of globalization and liberalization have compounded the problem. Especially affected are the already marginalised : the rural poor, the landless outcastes, the indigenous groups of people and among them, selectively women. Tangible proof already exists that the ill effects of continued neglect combined with the recent processes of globalization, have already selectively affected the marginalilsed. It is difficult to directly fight against global economic powers. All is not lost. There are specific roles that the voluntary sector can play capacitate the poor now to build up their inherent power and their solidarity through the formation of peoples' organizations which will, then, articulate their needs and place them in public eye. There are of course specific roles for organizations such as the World Health Organization, which are crucial as well. 2000 A.D. is a defining moment in the history of people's struggle for health since that is the year which will celebrate the empty rhetoric of 'Health For All'. Our concern is not health for all but rather, health for some, i.e., the poor of Asia. Our concern more specifically is to help the poor develop coping strategies that would help them deal with the looming threat of globalization.

- Prem John, ACHAN

Statement of Shared Concerns and Commitments of the South Asian Dialogue on Poverty and Health

We, the participants of the South Asian Dialogue on Poverty and Health, gathered at the National Institute of Advanced Studies, Bangalore between 15th and 18th November, 1999

Coming from the participant countries - Bangladesh, India, Maldives, Nepal, Pakistan and Sri Lanka;

With representatives of World Health Organisation – Health in Sustainable Development;

The International Poverty and Health Network (IPHN) Advisory Group; and

Facilitated by the Community Health Cell, Bangalore,

Are Concerned with :

- *The deepening social and economic inequalities between and within countries and peoples;*
- *The adverse consequences thereof on health across the globe;*
- *The nature and direction of change in health services and health policy;*
- *The major policy shifts in diverse sectors impacting on health such as agriculture and industry;*
- *The broad policies of globalization, economic liberalization and privatization under the aegis of international financial institutions which are weakening state commitment to the health and development of large sections of the people who are poor;*
- *The health sector reforms comprising a package of programmes involving cutbacks in public sector health expenditure and strengthening of vertical donor driven programmes which have considerably eroded the reach and effectiveness of already weak public health systems.*
- *The unregulated growth of the private sector which has undermined poor people's access to health care services and exacerbated regional, class and gender inequities;*
- *Widely prevalent hunger and a heavy burden of preventable communicable diseases,*
- *Trafficking of women and children and growing sex tourism,*
- *Increasing military expenditure for internal and external conflicts, and nuclearisation in the region which have all meant a neglect of the social security sector*
- *Increasing loss of traditional knowledge bases, skills, values and culture;*
- *Pauperisation of indigenous peoples and women, and environmental deterioration.*

We recognise :

- *The strength and potential of poor people themselves, especially women, who through community based efforts, peoples movements and local governance systems address these problems;*
- *The positive role played by the state including its public health interventions in improving health status of the people;*
- *The solidarity among different global, regional, national and local networks for health and development.*

We Declare our Commitment to :

- *Continuous improvement of the health of our people and to the reduction of socio-economic disparities and deprivation.*
- *Complete overhauling of the public health system and health services of our countries with democratisation, decentralisation and collective decision making, with affirmative action for the poor and the vulnerable.*
- *Equity as focus in all our programmes – social, economic, health and development so that disparities will be reduced.*
- *Greater transparency and accountability in all our programmes.*
- *Empowerment of people, especially women, children and disadvantaged groups.*
- *Working towards peoples movements for removing unnecessary ill-health and eradicating poverty .*
- *Working towards the formation of an informal network of all people interested in improving the health of the people and removing poverty, and thus support strongly the evolving International Poverty and Health Network.*
- *Promoting the generation of full employment of all people with living wages.*
- *Efforts to mobilise all sectors of human endeavour, such as education, agriculture, shelter and employment which are the determinants of health.*
- *Tackling malnutrition in our countries with efforts to improve nutrition and ensure nutrition security.*
- *Working towards greater resource allocation for health and meeting basic needs of people.*
- *Reducing rising costs of medical care which are already high, with indications of becoming increasingly out of reach of the poor.*
- *A continuing emphasis on primary health care and community health action.*
- *Organising communities to make community diagnosis and decide what is to be done.*
- *Consciously striving to reduce pollution of air, water and soil, which adversely affects the quality of living.*
- *Mobilising public opinion in the West, such that no harmful effects are brought to South Asian countries, including toxic waste and obsolete industries.*
- *Careful study of the effect of globalisation on health and socio-economic deprivation.*

- *Ensuring full access to information and work to have the right information. We request the governments and international agencies to help us in getting valid and reliable information.*
- *Ensuring clean and humane governance in the countries of regions protecting the health and well being of the poor and deprived.*

Finally we conclude that :

- *Health is a fundamental human right and an integral part of human development.*
- *The values of Equity, Social Justice; Empowerment; Humane Governance must be the corner stone of all our efforts towards Health For All.*
- *We shall work towards a movement for removing ill health and eradicating poverty which will address efforts at local, national, regional and global level tackling the broader determinants of ill health and the inequitous global systems so that they can be changed to support the Health For All Goal.*

Signatories of the Statement

1	Dr W. Addington	(United States)	25	Dr. Naila Z. Khan	(Bangladesh)
2	Prof. Debabar Banerji	(India)	26	Dr. Robert Kim-Farley	(WHO_SEARO)
3	Dr. Abul Barkat	(Bangladesh)	27	Dr. B.S. Lamba	(WHO_SEARO)
4	Dr. Mohammed Ali Barzgar	(Pakistan)	28	Dr John Martin	(WHO)
5	Dr. Sharifa Begum	(Bangladesh)	29	Mr Des McNulty	(United Kingdom)
6	Ms. Nimitta Bhatt	(India)	30	Ms. Aodiiti Mehtta	(India)
7	Prof. A. Gaffor Biloo	(Pakistan)	31	Dr. Yousuf Memon	(Pakistan)
8	Dr. Zafarullah Chowdhry	(Bangladesh)	32	Dr Ravi Narayan	(India)
9	Dr. Qasem Chowdhry	(Bangladesh)	33	Dr. Thelma Narayan	(India)
10	Ms Fatimath Moosa Didi	(Maldives)	34	Dr. Patricia Nickson	(Congo / Ivory Coast)
11	Dr. Richard Drew	(United Kingdom)	35	Mr. Charles Oyaya	(Kenya)
12	Mr. Ravi Duggal	(India)	36	Ms.Shilpa Pandya	(India)
13	Dr. B. Ekbal	(India)	37	Ms. Myrtle Perera	(Sri Lanka)
14	Dr. C.M. Francis	(India)	38	Dr. Mohan Rao	(India)
15	Mr Oliver Giscard d'Estaing	(France)	39	Dr. Rajendra Ravi	(India)
16	Mr. R. Gopalakrishna	(India)	40	Dr. Mira Shiva	(India)
17	Prof. Andy Haines	(United Kingdom)	41	Prof. Mathura Shrestha	(Nepal)
18	Dr Iona Heath	(United Kingdom)	42	Dr. N. Sivarajah	(Sri Lanka)
19	Dr. Mohan Isaac	(India)	43	Ms Margareta Sköld	(WHO)
20	Dr. Devaki Jain	(India)	44	Dr. D.K. Srinivasa	(India)
21	Dr. Prem Chandran John	(India)	45	Dr Oscar Ugarte	(Peru)
22	Mr. Geo Jose	(India)	46	Dr. Aruna Upreti	(Nepal)
23	Dr. Mani Kalliath	(India)	47	Fr. John Vattamattom	(India)
24	Dr. Geethani Kandaudahewa	(Sri Lanka)	48	Mr. Vimalanathan	(India)

2. BACKGROUND

- An International Poverty and Health Network, was created in December, 1997, following a series of conferences organised by the WHO on the theme of Health and Poverty in recent years. The Network brought together an increasing number of Health professionals, NGO's, Community groups, academics and researchers, government officials at various levels, and representatives from the business community - all of whom were either already engaged in activities designed to reduce poverty and improve the health of the poor and the marginalised or disadvantaged or who were beginning to recognise the need for such interventions. WHO was requested to act as the Secretariat for the Network.

- During 1998 the Network gained many new members and initiated some activities which included
  - Participatory analysis in six African Countries of the socio economic determinants of ill health and community strategies developed in response to the situation.
  - Contribution by the Intercollegiate Forum on Poverty and Health to the Independent Inquiry Commissioned to look at inequalities in health in the UK.
  - An opinion survey among participants on issues of concern on Poverty and Health in their countries and regionally and globally in the context of the evolving IPH Network. This was facilitated and collated by Community Health Cell, Bangalore, India.

- And finally an important meeting of a Small Network advisory group in Nairobi and Kisumu, Kenya from 23-26, November, 1998
  - consolidate the work of the Network;
  - agree on key objectives and priorities; and
  - strengthen participation in the network of people and organisations in the South.

- The Kisumu Meeting explored the links between Health and Poverty; reflected on the challenges in addressing the problems of poverty and ill health; identified the stakeholders of the Network; identified opportunities, strengths and weaknesses of the Network; and outlined four main areas of priority for follow up
  - Mobilising stakeholders
  - Involvement in Copenhagen plus 5 Summit meeting
  - Information and Research
  - Capacity building

  It also decided to make efforts to strengthen and expand the Network through
  - Communication and exchange of information
  - Identifying and mobilising Network resources
  - Creating and linking up with networks at a national and international level.

The most important element of the Kisumu Meeting was the reaching of a Consensus on the Statement of Purpose of the Network.

What is the IPHN Network?

The IPHN is a world-wide network of people and organisations from the fields of health, NGOs, business, government and society – in general who exchange experiences and share information on the most effective approaches and solutions for health in poverty eradication, policies, strategies and actions.

Who is it for?

People and organisations that wish to influence policy and action to protect and improve the health of the world's poor, with particular emphasis on the poorest in all countries.

What is its aim?

To integrate health into poverty eradication policies and strategies, promoting community partnership and intersectoral action, as a means to achieve effective and sustainable results.

Source : IPHN Advisory Group Meeting Report
Kenya, November, 1998.

- At the Kisumu Meeting apart from the representatives of the African Region there were five representatives from South Asia, who included a Health NGO from Gujarat, India; a representative of a National Health Network – India; the Coordinator of the Rajiv Gandhi Missions of the Government of Madhya Pradesh, India; a policy researcher from the Bangladesh Institute of Development Studies; and another from CHC, Bangalore, India. After the meeting, during the follow-up phase, the idea to host the next meeting of the advisory group in South Asia evolved and got linked to a larger South Asian dialogue.

- The Society for Community Health Awareness, Research and Action (also known as CHC), Bangalore agreed to facilitate a dialogue bringing together a diverse range of resource persons, members of networks; and many who shared the same concerns and objectives as the evolving IPHN Network from the South Asian Region.

3. PREPARATION AND PROCESS OF DIALOGUE

- The planning of the dialogue was facilitated by a very interesting interactive and participatory process which included three rounds of communications with all potential participants.

- The first round included a note on IPHN; the proceedings of the Kisumu meeting; the first two newsletters of the Network; a copy of the keynote address by Professor Amartya Sen entitled Health in Development (WHO Assembly, May 1999); a booklet entitled Poverty and Health – Regional issues : South East Asia from WHO-SEARO; and a Pre-dialogue opinion Survey which elicited opinions on the theme as well as programme planning.

- The second round included a tentative programme of work at the dialogue; a tentative list of participants to share an idea of the diversity and potentiality of the dialogue; and a short note on Community visits with six options.

- The third round included further background information on the dialogue; and six background papers which included a WHO-SEARO consultation on Equity; a WHO Geneva consultation on Policy oriented monitoring of Equity; three background papers from potential dialogue participants on the themes – Making Health a Public Agenda (Indira and Mathura Shrestha); Tackling Health inequalities in Primary Care (Licon Smeeth and Iona Heath); Poverty and Health : Physicians can and should make a difference (Michael Mc Cally and Andrew Haines et al); and the Civic Society Initiatives section of the Report on Human Development in South Asia, 1997.

- Finally a fourth round just a week before the dialogue included a first collation of the pre-dialogue opinion survey; a short perspective note of the whole programme; and a bibliography of all the materials (papers and reports) received for the meeting.

- Most of this interactive process was carried out by a sort of email networking and post wherever necessary and the general response of the participants was so enthusiastic that the foundation for an interesting and significant dialogue was laid.

Distribution of the world's poor 1985-90

Region	Number of poor in millions	
	1985	1990
All developing countries	1,051	1,133
South Asia	532	562
East Asia	182	169
Sub Saharan Africa	184	216
Middleeast & North Africa	60	73
East Europe	5	5
Latin America & Caribbean	87	108

Source : The World Development Report, 1992

The Agenda

Through the interactive pre dialogue process the following Agenda evolved for the South Asian Dialogue :

* Poverty is a global issue. There is both concern and increasing evidence that poverty and inequalities in health care are increasing the world over, in poor and rich countries; in developed and developing economies. These trends are directly linked to and are further exacerbated by the growing forces of liberalisation, globalisation and privatization (LPG phenomenon)

* There is increasing evidence particularly from South Asian experience that socio-economic-political and cultural determinants of poverty and ill health are not only local and national, but increasingly regional and global.

* Hence any action directed only at local or country level will have little impact on the health status and situation of inequity. There is increasing urgency to understand the global determinants of poverty, inequity and ill health and to tackle them at that level as well. There is need for analysis and action at all levels – global, regional, national and local.

The Participants

The Participants were carefully selected to ensure that the dialogue was between scholars, researchers; policy makers, administrators, NGOs, health and development activists, civic society, peoples movements and the business sector. There were experts from both government and non-government backgrounds. The dialogue was multidisciplinary and the group included doctors, nurses, public health professionals, economists, social scientists, epidemiologists, management, and other disciplines. Participants also represented multisectoral and multi level backgrounds to enhance the potential of the dialogue.

Mark Twain on Equity

"Who are the oppressors? The few : the king, the capitalist and a handful of other overseers and superintendents. Who are the oppressed? The many : the nations of the earth; the valuable personages; the workers; they that make the bread that the soft-handed and idle eat."

"Why is it right that there is not a fairer division of the spoil all around? Because laws and constitutions have ordered otherwise. Then it follows that laws and constitutions should change around and say there shall be a more nearly equal division."

4. LEARNING FROM THE COMMUNITY VISITS

On 15th November, 1999 the Dialogue began with the programme of Community Visits and all those participants who had arrived by then were taken in six groups to dialogue with the poor and marginalised in six community settings.

The aim was to

- ***visit** the community and observe;*
- ***listen** to the people living in the community especially the poor and the marginalised, regarding their experiences of poverty and ill health;*
- ***learn** how they cope with the situation and what they think of existing governmental and non-governmental initiatives in health care and poverty alleviation; and*
- ***identify** how the Network and other agencies could strengthen community initiatives at local level through support to governmental / non-governmental initiatives.*

The six projects selected also provided the participants to understand the diversity and complexity of poverty and ill health by focussing on marginalised groups which included ***poor rural women; bonded child labour and school dropouts; street children; children from slums and or urban poor; indigenous people (schedule tribes); and people with disabilities.***

The initiators of these projects included non-governmental organisations; a department of community health of a medical college; a corporate sector supported rural development initiative.

The field visits included dialogue with the community; visit to project initiatives; a shared meal with the community and a visit around the community wherever feasible. During the visits the links between ill health and poverty in each of these special situations was also probed.

The decision to start the South Asian dialogue with the Community Visit was to ensure that the participants keep the grassroots realities of the poor and marginalised in their minds as the dialogue proceeded so that practical suggestions rooted in their reality would emerge. It was also part of a decision of IPHN advisory group ***that listening to the people from the host region*** was to always be an important part of a dialogue.

At the end of the day all the Participants gathered at NIAS to share their learning experiences from the Community visits.

Some of the key learning experiences from the Community Visits were :

1. People perceived lack of food and employment as the most important problems of their rural community.
2. Urban poor cited land, housing, water and absence of sanitation facilities as the major problems they face. Food and health were not seen as equally important.
3. In the absence of good quality and accessible health care provided by government, the poor were forced to use private health sector even though this increased their economic burden and contributed to indebtedness.

4. Health interventions must include not only curative but also preventive and rehabilitative aspects especially when work is among people with disabilities in a community setting. Income generating activities and vocational training must be complementary to the whole effort.

5. Women's health needs to be addressed in ways that empower women. Income generating activity and micro-credit schemes can be an instrument of such empowerment. Health programmes can be implemented and monitored through the active involvement of women's groups. They can be empowered to address their human rights issues through appropriate local bodies.

6. Many bonded labour choose to remain within the exploitative system because of inadequate economic opportunity if they come out of it. Hence existing legislation against it continues to remain ineffective.

7. People often vote in elections not for particular programmes or needs but because of family and other loyalties to a particular party that can run through generations.

8. Bribery and corruption in the system were common but with greater community organisation and awareness, some resistance was beginning to be offered by the poor and marginalised.

9. For urban slum children and street children, a vocational orientation to educational initiatives makes the programme more effective and sustainable. For rural children summer camps and child to child and child to community awareness building initiatives using songs and other interactive approaches can be great fun.

10. Integrated development of indigenous people and other marginalised groups provide not only income generating activity but also maintain a sense of community and tradition and involve women.

11. Problems such as alcohol use / abuse in the community need a multipronged approach. There is need for legal control and bans. There needs to be peoples collective action to impose these bans socially and women are often willing to organise around the issue. Deaddiction programmes need to be complementary.

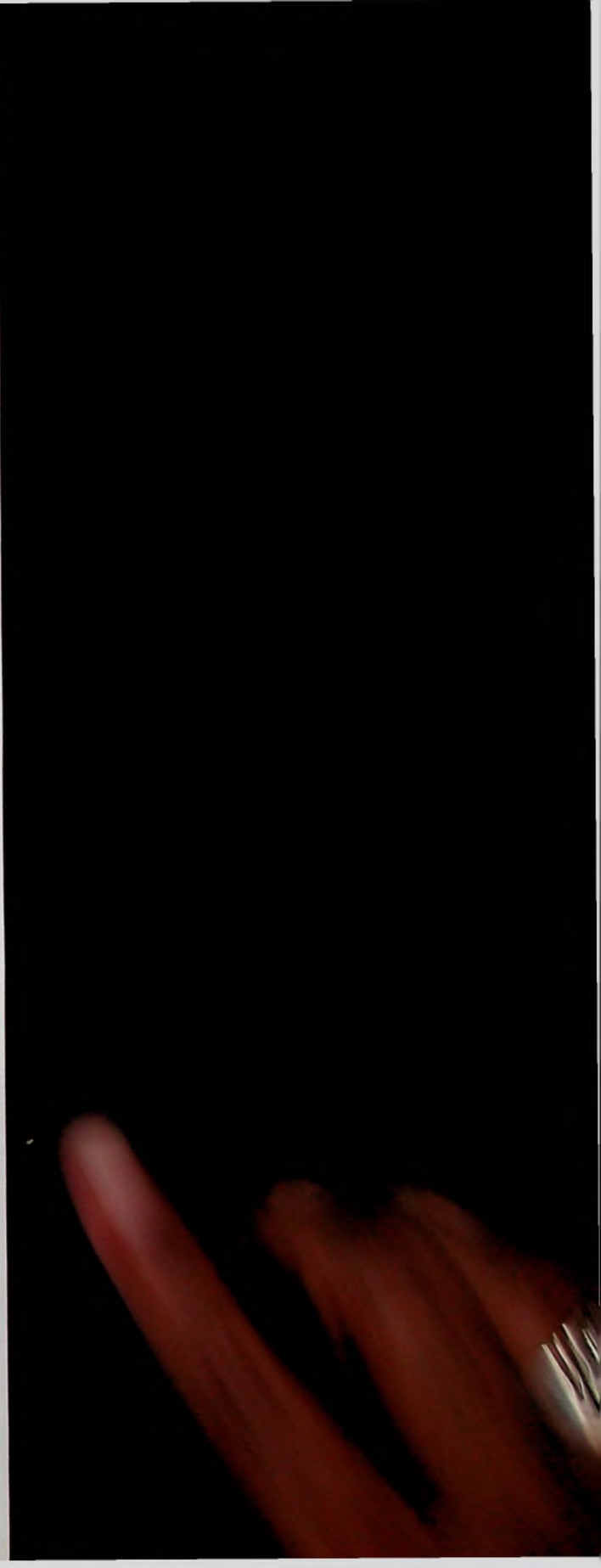
12. Community meetings should be held in open places and transparent so that everyone interested in the issue being discussed can observe the proceedings and are encouraged to contribute.

13. The community should be trained in participatory learning processes which contribute to effective discussion and decision making processes.

14. For models of intervention to be replicable and sustainable – two features are important i.e. leadership and the increasing involvement of volunteers from the community.

15. Joint collaborative action by NGOs, business groups and public authorities can support success stories and positive experiences of change in urban disadvantaged communications.

16. Corporate sector involvement in rural development can often be motivated by drawing upon cheap labour to do ancillary jobs at a cheaper rate. The challenge will be to change this to a fundamental motivation to improve economic lives of the local people rather than just reduce cost of production. However the economic spin offs and the contribution to tackling unemployment should not be underestimated.



annexure

THE COMMUNITIES VISITED

1. *JEEVIKA, Anekal*

An organisation working with bonded labourers (Children) and School dropouts who work in hotels, bars, restaurants and brick factories.

The children are identified through a network of village animators who intervene and dialogue to put these children through a bridge course at Jeevika, which is a rehabilitation method to put them back in Schools. They also organise unions of previously or former bonded labour in different villages around Anekal to demand their rights and benefits from government schemes.

2. *APSA, Bangalore*

The Association for Promoting Social Action is a voluntary organisation which works with children mainly from slums; street children; children sent into cities as migrant labour, bonded labour, or rag pickers and even those sexually abused or in prostitution.

The NGO runs residential centre providing accommodation and elementary education and vocational skills for children rescued from distress, a child line; sensitising police personnel to the needs of these children; slum outreach programmes; de addiction programme for street children addicted to drugs; and a college student sensitization project.

3. *GRAM RAKSHE, Kodahalli*

A Rural Development project of Sree Ramana Maharshi Academy which started in October 1994. The focus is on Lambanis, indigenous people in Kodihalli, who are now marginal farmers and agricultural labourers.

The four main activities of this project are agriculture and development; organising womens and farmers groups / clubs; health education and income generation activities.

4. *A.P.D., Bangalore*

The Association for People with Disabilities is an organisation working with People with Disabilities for many years. It is an institution with multi faceted activities including health and medical rehabilitation, education, vocational rehabilitation, community awareness and prevention programmes. In more recent years, it has begun community based rehabilitation initiatives in various slum outreach programmes to support parents of disabled children and teach them home based skills to cope with caring for people with disabilities.

5. *Mugalur Women's Development Project*

A project initiated by the faculty of the Community Health Department of St. John's Medical College, Bangalore where women are encouraged to form women's groups to empower themselves with inputs from the department. These include home based economic activities including micro finance and credit cooperatives and other income generating activities. This provided women greater economic security, status and control over their own lives.

6. *Meadows, IRDT and Snehalaya, Hosur*

Titan Watch Company which is a Tata's Corporate sector initiative is involved in rural development activities in the Hosur region through the support of small community based units for assembly of watches, metal bracelet manufacture and manufacture of clocks provided to self help groups of women facilitated by local ngos.

Meadows rural eneterprises is a self help group of women, 180 of whom work in the village unit of Midugarapalli. IRDT is another ngo runs another unit which provided support to 40 people from surrounding villages who include orphans, destitutes, widows and the disabled.

Snehalaya is a home for people with locomotor disabilities which also provides outreach physiotherapy and support to disabled in the village itself apart from undertaking awareness building programmes for polio, HIV/AIDS and other diseases.

All these three groups are supported by the corporate sector.

5. INAUGURAL SESSION AND SYMPOSIUM

5 A. INAUGURAL SESSION

The Inaugural session on 16th November, 1999 set the framework for the meeting.

- ***Dr. Thelma Narayan***, Coordinator of CHC (local host and facilitating organisation), in her welcome to the participants emphasised the need to understand the complex relationship between Poverty and health in the South Asian region and the urgent need to design appropriate policy measures to reduce poverty and ill health. ***'Above all'*** she pointed out ***'what we need is solidarity in supporting a movement for poverty reduction and improvement in the state of health of the poorest sections of our society".***

- ***Dr. Chandrashekara Shetty***, Vice Chancellor of the Rajiv Gandhi University of Health Sciences of Karnataka State began his inaugural address by first emphasising that the right to health should become a fundamental right. He argued that ***"poverty is not created and sustained by the poor. It is the system of policies and governance that creates and sustains poverty. Good governance can be achieved only with people's participation and accountability".*** He suggested that the process of change required good leadership; health partnership between government, ngos and the business community; setting priorities that focus on fulfilling unmet needs of the poor; stressing preventive health care significantly.

- ***Mr. Abhijit Sengupta***, the Principal Health Secretary of the Government of Karnataka, pointed that the State of Karnataka was the second state in the country to work on a state level human development index. He stressed ***the need for both poverty alleviation and health care strategies to address regional disparities and inequities and argued that we need at government levels a sort of corporate strategy which shifts from a structural focus to a socio-cultural framework.***

- ***Dr. Robert Kim Farley***, Regional Director of WHO SEARO, assured the participants , of WHO-SEAROs full involvement in the Poverty and Health initiative and he stressed the ***"need to place health on the top of country agendas and making access to health care a fundamental right. Dialogue was the first step always".***

- ***Dr. John Martin*** of WHO-Health in Sustainable Development Cluster in Geneva, stressed that ***"health cannot be left to the health sector alone and that there was urgent need to explore ways of protecting the health of the poor".*** He assured the participants that WHO ~~would be pleased to~~ participate in developing this new approach.
is already involved

Percent Share of the Poorest 20% of the World Population in Global Opportunity

	% of Global Economic Activity	
	1960-70	1990
Global GNP	2.3	1.3
Global Trade	1.3	0.9
Global domestic investment	3.5	1.1
Global domestic savings	3.5	0.9
Global commercial credit	0.3	0.2

any later data?

Source : The Human Development Report, 1993

5 B. *POVERTY AND HEALTH IN SOUTH ASIA : CRISIS AND CHALLENGES*

- The Public Symposium on 16th morning chaired by ***Dr. Devaki Jain*** an Economist, deeply involved in Women's policies and co-chaired by Prof. D.K. Srinivasa, Medical Education Consultant to the Rajiv Gandhi University of Health Sciences, provided an overview of the crisis and challenges of Poverty and Health in South Asia.

- ***Dr. Devaki Jain***, in her introductory remarks, observed that South Asia is a very special case with examples of both amazingly successful models of change and the most wretched figures in Poverty and underdevelopment. She emphasised that "wearing womens lens" i.e., reflecting on the whole Poverty and ill health keeping the women's perspective and women as central focus provides the best means for understanding the development dilemmas.

- ***Prof. D. Banerji***, began his keynote address on a very sombre note by highlighting that the world was in a deep crisis and that the gulf between the haves and the have-nots was increasing. His primary concern was that ***"the voiceless must fight and must be heard. The struggle of the poor is going to be very long and grinding."***

  He also noted with concern that most people seem to assume a simplistic relationship between health and poverty. Most people who hold such simplistic relationship do not recognise the "socio-economic factors underlying improvement in health".

  He argued that both national and international power structure did not allow realisation of the key messages of the Alma Ata declaration, namely that (a) Health is a fundamental right (b) people should be the prime movers of the health care system (c) there should be a social control over health policy and (d) co-operative efforts should be encouraged to achieve better health.

  He deplored the fact that even the most sensitive developmental economists have not given due attention to the adverse effects of globalisation and structural adjustment programmes on health. He further added that ***"health care system has deteriorated and has been decimated because of the bureaucratic and techno-centric approach adopted during the last decade.***

  He suggested the following to address effectively the current crisis in health:

  - ***allow access to health care for the poor;***
  - ***rebuild health care system, which includes "decentralisation of health care system" and "simultaneous rejuvenation of public health institution (for training of health professionals, not for bureaucrats)";***
  - ***merger of Family Welfare and Health Departments; and***
  - ***encourage multi-disciplinary policy research.***

Poverty, Disease and National and International Power Structure : The Case of India

- "Poverty in whatever way it is defined, has a number of deep human dimensions in the form of the way it affects individuals and groups. It also has deep cultural, social and human ecological implications. Over and above it has roots in the history, international politics and trade, geography, economy and power relations which determine the political setting.... At the very least these dimensions must be kept in mind while making judgements and conclusions about individual countries and populations. Very often this is not done".
- "Persistence of poverty and ill health and other social and economic maladies is due to the failure of those who command authority to translate the concept of 'purposive intervention' (Myrdal) into action (including intervention for improvement of health status). ***This is essentially a political question".***
- ".... properly designed health services to alleviate the suffering of the poor, due to health problems have a positive role in preventing people from going below the 'poverty line', in increasing their capacity to fight for their causes, increasing their capacity to earn more and in acting as entry points or a 'lever' to stimulate development in other poverty related areas of action".
- "There is a tendency for ambivalence among international agencies and economists who do not mention the devastating impact on the poor peoples of the world of the World Bank / IMF inspired programmes of globalisation, structural adjustment programmes and cost recovery for social services from the people and encouragement of the private sector in health; the World Trade Organisation had added to this predicament of the poor by importing many trade regimes which affect their lives".

  "The task of alleviating poverty disease syndrome is thus an uphill one. The deprived have to struggle hard to impel the ruling elite to make judicious social allocations for this purpose. In India the modest gains made during the first two decades after Independence were eroded by the over riding priority to resource allocation for implementation of the very defectively designed and extremely expensive and wasteful family planning programme. As if that was not enough, international agencies then come in with their own prefabricated technocentric global agenda against some specified diseases and managed to get the politician / bureaucrat to accord these unsuitable programmes priority over the basic health activities .. .. and finally this has been further compounded by severe cuts in budgetary allocation for health and social services; increased inefficiency in the use of whatever is allocated and gross inadequacies in finding more cost effective programmes for social interventions to break the vicious cycle of poverty and ill health ...."

  - D. Banerji, India.

➪ ***Dr Zafrullah Chowdhury*** the second keynote speaker, characterised the period from 1970's to 1990's as one from "Hope to Hopelessness". The 70's was full of hopes. In Bangladesh the War had ended. Independence was obtained, the struggle was over. This was also the decade of Alma Ata. By the 1990's the economic situation in the world had changed. Even developed countries were witnessing significant changes in the field of health care with cost of care spiraling and market forces becoming preponderant. In the 70's scholars talked about 'self sufficiency'; now in the 90's they talk about 'sustainability'.

He summarised the major components of the Health For All 2000 policy : education on common health problems, promoting food supply and nutrition, adequate safe drinking water and sanitation, MCH including family planning, immunisation against major infectious diseases, etc. But over a period of time, with increasing drive for privatisation, health care for the poor is being delivered at very high costs. Despite the World Bank's role in putting health top on the agenda, investment in health in most developing countries

is not adequate, if anything it has shrunk. He concluded his keynote speech by saying that ***"we need to work together", and have a sense of ownership, if we want to bring about any significant changes at all in the health of the people.***

This session was followed by brief presentations by Panel Members. They were: Mathura Shrestha (Nepal), Myrtle Perera (Sri Lanka), Yousuf Memon (Pakistan), Abul Barkat (Bangladesh) and John Martin (WHO, Geneva).

1. *Mathura Shrestha :* spoke on the Peoples Perspective of the Poverty and Development Paradigm

   - "We live in a world of un-equals. People are divided at various levels. Poverty and ill-health are the most painful remainders of unfinished tasks of this century. Poverty is an artificial state created by human beings. We must find ways to come out of this shameful existence."
   - He stated that all over the world, where there is more egalitarianism, better health has prevailed. South Asia has the highest concentration of poor people. In Nepal for example only 10% of the people have access to public heath care facilities and not more than 10% have access to sanitation facilities.
   - He argued for a change in the definition of the concept of development. The new concept should emphasise "equity and social justice, and life in harmony". We need good governance which includes: distributive justice, participatory governance, transparency, and accountability, among other things.

Poverty and Health of Indigenous People
Case Study : Nepal

Between 50 to 60 years ago, one could see quite a lot of 'Kusundas', in Tanahu - a district in Western Nepal (Dr. Shrestha's home district). They belonged to one of the most deprived ethnic groups. Many called them bush-people or forest-people. As a child, one of us had the impression then that they were 'short and stout' people of forest. They lived in closely social clusters and they were peace loving, shunning violence, and strictly vegetarian. Every body exploited because of their unusual tolerance and hard life. They, specially the children, were gifted singers and musicians producing enchanting tunes from leaves, ***murchungas*** (Nepalese ethno-musical instruments), bamboo reeds (kind of flutes), Mauris (miniature bagpipe like instrument with three bamboo reeds attached in a hardened wall of ***Bel*** fruit), wooden logs, ***sarangis*** (stringed violin like instruments), and ***madals*** (drums). They subsisted heavily in forest products. Occasionally, they practiced 'slash and burn' agriculture. None possessed land. They were known to produce beautiful wooden and stone utensils with which they occasionally bartered with the food grains of 'civilized' people in villages. Now, one can see not a single ***Kusunda*** in Tanahu or nearby districts. They became extinct from the area because of deprivation, exploitation, poverty, rapid deforestation, landlessness, and exchange entitlement that was a gross imbalance. Now some remnant clusters of Kusundas are living in a remote and deprived areas of Karnali zone in Mid - western Nepal. There too, their population dwindling and not growing.

Mathura Shrestha - Nepal

2. *Ms. Myrtle Perera* (from Sri Lanka) spoke about challenges in addressing equity issues in Sri Lanka:

   - The gross picture that is often portrayed in international literature on the state of health in Sri Lanka conceals much inequity that prevails within populations.
   - Her own research shows that there is inequity in outcome, utilisation and in capability of people. In Sri Lanka, even IMR varies vastly across districts, in fact some districts in the recent past have shown an increase in IMR. Also, she noted that in some districts, the proportion of children with low birth weight has been increasing.
   - What is even more worrying, she observed, is the increasing trend in youth violence, mental illness, occupational diseases, and pesticide poisoning.
   - In almost all districts, incidence of ischaemic disease is on the rise, but specialists are concentrated in northern districts.
   - She argued that the present health care system in Sri Lanka is highly ill-equipped and ill-prepared. Most policy makers seem to think that privatisation is the answer to the problems being faced. Sri Lanka had tradition of being concerned for equity, but this is no longer seen (at least explicitly) in the recent past. Serious inequities in the state of health are being covered up in aggregate data.

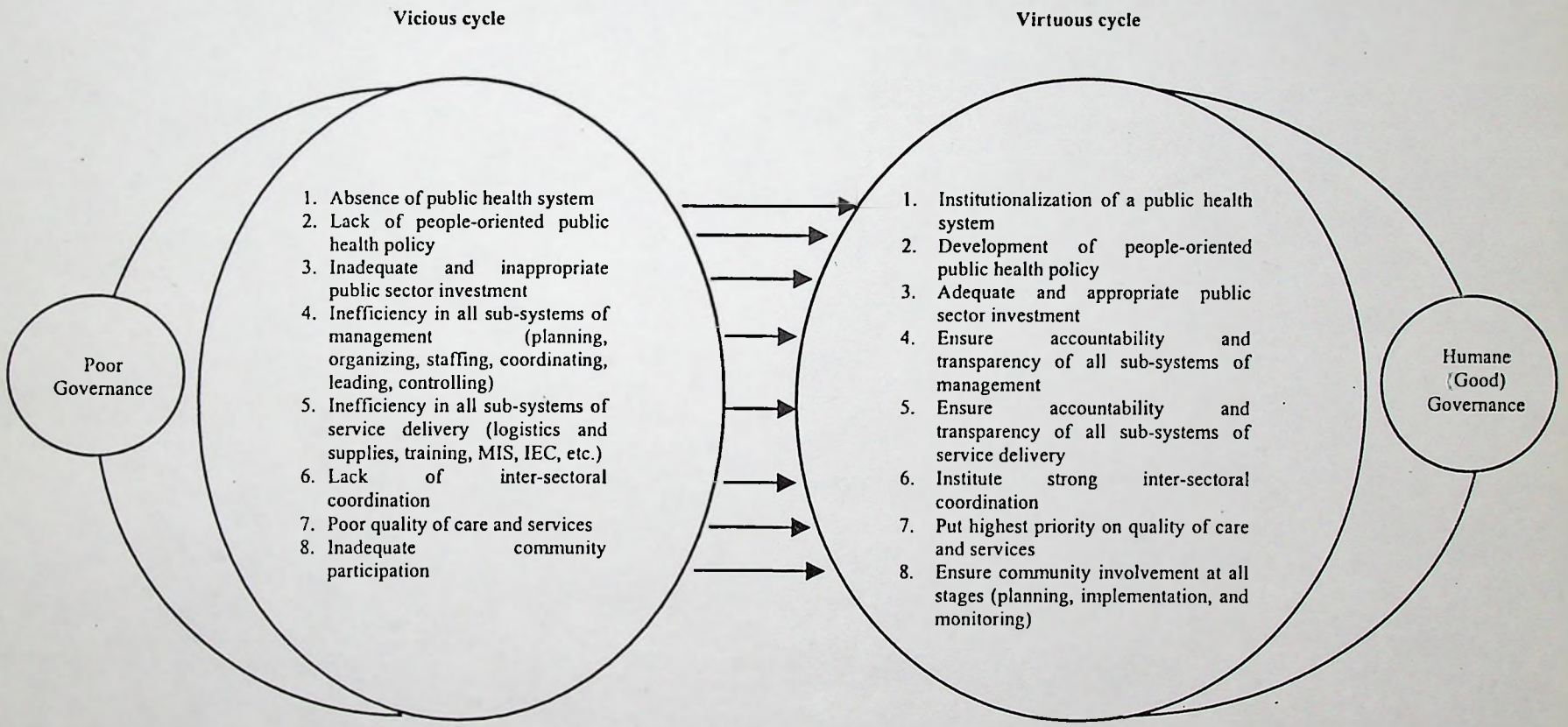
3. ***Prof. Abul Barkat*** spoke on "Crisis of governance in public health in Bangladesh".

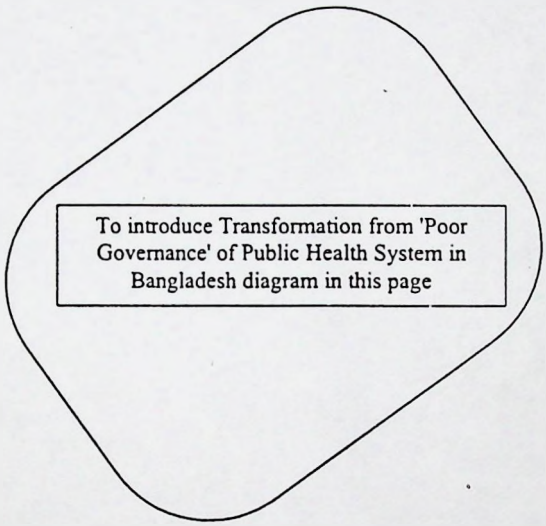
   His main thesis was that there is a crisis in governance of public health in Bangladesh. He considered HUMANE GOVERNANCE as having three specific dimensions: Economic, political and civic. Among the many crises that plague the system, he pointed out the following as the most worrisome:

   - Absence of well-organised structure of public health system – this refers to lack of co-ordination, lack of responsibility to safeguard public health
   - Allocative imbalance across various sectors in the economy – this refers to increase in military spending, upward trend in tertiary care, etc.
   - Gaps between targets and achievements – this includes over targeting, ineffective use and under utilisation of resource
   - Conflict between stake holders within health sector
   - Lack of public accountability – this includes, non-conducive environment for the poor, people not being aware of their rights, feudal and bureaucratic involvement of health professionals, huge wastage, lack of appropriate reward and punishment system, large scale corruption, etc.
   - Crisis in tertiary health care system, which is being highly mismanaged, misused, and misgoverned.
   - Misuse of public health sector by private health sector. .
   - Crisis in quality of services provided by both private and public health sector – there is frequent complaint of ill-treatment of patients by health professionals, and enormous increase in induced demand; and
   - There is increasing dependence on foreign aid – the crucial question is: who decides in setting priorities and how are allocations made?

   He appealed for a complete transformation from poor to humane governance. *(See diagram)*

Transformation from 'Poor Governance' to 'Humane Governance' of Public Health System in Bangladesh




To introduce Transformation from 'Poor Governance' of Public Health System in Bangladesh diagram in this page

4. *Dr. Yousuf Memon* spoke on "Poverty and Health" from his experience in Pakistan.

   Dr. Yousuf Memon of the Aga Khan University spoke about his experiences with Social Development Initiatives in Pakistan and highlighted some key learning experience from the involvement of his University in social development activities including Family Health Project, Urban Health Project and School Nutrition Project.

   - The process of empowerment in communities is a stepping stone towards sustainable primary health care and social development.
   - Community participation is of great value in improving the health of vulnerable groups and determine greatly the sustainability of the programmes.
   - Continuous improvement in health interventions of a development nature like Safe Water Supply, Sanitation and income generation were crucial.
   - Increasing female para medical staff and creating greater linkages with community health workers greatly increase access to services.
   - Access to services by the poor and marginalised is also increased by strengthening referral systems and improving drug supplies and diagnostic facilities.

5. *Dr. John Martin* (WHO, Geneva) spoke about WHO's perspectives on poverty and health:

   - He urged that we should be clear what we want and how we would like to achieve it. He emphasised that we must first achieve international consensus in protecting the poor. This requires putting the money where it matters.
   - There is urgent need for designing alternative financing schemes for increasing access to poor people. And there is need for a strong leadership and capacity to take the poor forward through the hardship that they are facing.

Following the brief presentations by the discussants, Dr Devaki Jain, the Chairperson of the symposium, made a few concluding remarks: "The major challenge seems to be" she said, "how to bring the various knowledge together and how to galvanise the various forces in giving voice to the voiceless". She urged for more meaningful and effective reforms in governance, which need a groundswell!!

The Marginalised in the Present Scenario

- Over a billion people are deprived of basic consumption needs.
- Three-fifths of the developing countries' people are deprived of basic sanitation.
- Almost a third of them have no access to clean water.
- A quarter exists with no adequate housing.
- A fifth live with no access to modern health services.
- A fifth of children do not attend school to grade 5.
- A fifth of them do not have enough dietary energy or protein.
- Two billion people are anaemic world wide, which includes around 55 million in the industrialised countries

- Prem John, ACHAN

6. HEALTH AND POVERTY : EXPLORING THE LINKAGES AND EVOLVING A FRAMEWORK FOR DIALOGUE

A pre-dialogue questionnaire and pre-dialogue brainstorming began a process of identifying a framework to discuss the Poverty and ill health linkages and identify specific concerns and context for action. After the symposium the first round of group discussions also explored the links between poverty and ill health in six different contexts and some issues and concerns for dialogue were identified.

FRAMEWORK FOR UNDERSTANDING

6.1 *Socio-economic Deprivation and ill health*

- Inadequate understanding of the dynamics of Poverty
- Exploitation and marginalisation of the poor by current economic policies including SAP
- Lack of educational / Social opportunities for women including girl child and gender disparities
- Lack of commitment of policy makers for equitable development and distribution.
- Powerlessness of people.
- Increased hunger and malnutrition.
- Increasing education disadvantage and disparity
- Class, caste and gender disparities increasing vulnerability to ill health.
- Lack of access to minimum needs and other basic determinants of health like housing, food, water, sanitation, income and land, can marginalise people and make them more vulnerable to disease.

6.2 *Ill health leading to Poverty*

- Ill health causes decreased human capacities.
- Lack of access to health, nutrition and awareness building proceses keeps up the cycle of ill health.
- Lack of relevant research focussing on determination of ill health.
- Malgovernance of public health increasing.
- Universal access to health care as a right not promoted adequately.
- Inappropriate and costly technology that is misused or overused can lead to further ill health by reduced access or increasing cost of care.
- Alcoholism and other addictions produces a drain on income and productivity and lead to a large number of diseases and social deprivation.
- Some occupational diseases lead to further marginalisation
- Unnecessary or excessive expenditure in funerals and other rituals / ceremonies following death can affect health of other members of the family.

6.3 *Feminisation of Poverty*

Women form a major percentage of the proportion of the poor and marginalised in the world and hence the term ***feminization of poverty***. Various elements of growth and development including newer economic policies are further worsening the condition of women - leading to ***pauperization of women***.

Some aspects of this feminization and pauperization in the region where particularly significant

- The discrimination against women in the region was virulent expressed as a deeply embedded son preference leading to female infanticide and foeticide.
- Sex ratios, IMR, MMR and discrimination in nutrition were all indicative of low status.
- Acute poverty of the region coupled with low status of women was responsible for some phenomena like sale of children into the flesh trade; general trafficking in women; increase in rape and incest; receding employment opportunities in a globalising, liberalising world.
- Lack of health services is also leading to excessive of ill health - anemia, depression; increased abortion, mental stress, suicides rates etc.
- Women's poverty indicates both the specially deprived and discriminated condition of women as well as the impact of economic policies that encroach into the spaces that have provided families with wherewithal for life namely livelihoods, water, fuel, child care are being encroached upon. This broad framework needs response at multiple levels.

6.4 ***Globalisation and health***

- Widening economic gaps between rich and poor; between and within communities.
- Impact of globalisation and privatization on human development and health.
- Discriminatory aspects of world trade organisation and other evolving International regulatory instruments.
- Unequal distribution and utilization of global resources.
- Increasing debt burden of heavily indebted poor countries.
- Subservience of WHO to dictates of G-7 through donor control over health programmes and an obvious shift in perspectives of WHO inhouse personnel and consultants.

6.5 ***Poverty, Ecology and Health***

- Concept of ecological poverty - i.e., heavy degradation of the environmental resource base of people whose local economy depends on these resources.
- Ecological changes and environmental degradation including industrial pollution, chemicals in agriculture, unsanitary surroundings in urban slums and rural areas.
- Need to empower communities to manage and increase their own resource bases to create greater ecological and economic wealth.

6.6 ***Disaster, Poverty and Health***

- The effects of War, Conflicts on health.
- The effects of natural disasters like earthquakes, droughts, floods on health.
- The worsening of poverty conditions in disaster situation.
- The effects on women, children and other marginal groups.
- How can the public health system be geared up for immediate response and to tackle the problems produced by disasters?
- What collaborative efforts can be made to prevent and counter the adverse effects of natural and man-made disasters?

FRAMEWORK FOR ACTION

Some overall perspectives on Action initiatives also evolved in the pre-dialogue process and the group.

6.7 Key initiatives to tackle issue of poverty and ill health regionally

- Increasing awareness of the linkages between poverty and ill health and greater evidence collation through participatory research;
- Vigorously pursuing poverty eradication programmes and policies;
- Providing comprehensive health care with emphasis on women and children's health at subsidised cost;
- Creating mechanisms to assure universal access to health care irrespective of capacity to pay;
- Ensuring good governance of public health;
- Increasing integrated socio-economic planning particularly through district level decentralilsation;
- Increasing investment in health and public health services;
- Analysis of health impact of various loans and investments in all sectors including health impact of developmental projects;
- Implementation of more pro-poor health policies;
- Giving greater emphasis on grassroots democracy and empowerment of the marginalised.
- Greater social action towards gender justice and equality;
- Resolution of conflicts and cessation of war.

6.8 *Key initiatives globally to tackle the issue of poverty and ill health*

- Assign top priority to poverty eradication policies and implement ways and means of minimising acute vulnerability of the poor;
- Sustain policy focus and funding on poor regions and poor people;
- Interorganisational dialogue between WHO/UN agencies /WB/NGOs to democratise global decision making and soul searching on reasons of policy failures and distortions;
- Moratorium on debt servicing;
- Promoting just trade practices;
- Promoting pro-equity and sustainable development models through greater south-south and south-north dialogue;
- Tackling inequity in research and development in world and increasing access to information;
- Tackling powerlessness by greater gender sensitive social development, micro financing and local decentralised decision making abilities;
- Strengthening equity initiatives of WHO and other Health and Social development organisations;
- International controls of arms industry and also greater commitment of developed countries to reduce / rationalise their consumption patterns.

7. GLOBAL, REGIONAL AND NATIONAL CONCERNS IMPACTING ON POVERTY AND HEALTH

In this session many participants identified and discussed concerns that were significant at global, regional and national levels.

7.1 Globalisation and health

- Deleterious effect on Health and Nutrition especially women and children.
- Erosion of local culture by an importation of alien values
- Increasing social violence and militarisation.
- Increasing of privatization has led to commodification of social services like health and education.
- Deregulation has led to uncontrolled prices of commodities including price of essential drugs.
- Liberalisation of trade has brought about inappropriate consumption patterns
- Shift of capital from productive purposes to the speculative markets.
- Increasing weakening of the state, reduction in the sanctity of borders, disempowerment of the south.
- Lack of control of the state on the increasingly privatising health industry.
- Poor have to pay much higher proportions of their meagre incomes for survival with increase in vulnerability and indebtedness.

> "All this is having serious consequences for the health of the poor and marginalised who seem to have become victims under the new dispensation. There is need for NGOs to promote legislative action and to bring people back into the central role in public health, so that indigenous capacity can be rebuilt and the people's movement against globalisation can strengthen the countries self reliance."

7.2 WTO and Health Agenda

The effects of the new WTO on health

- The commodification of agriculture and the drive to encourage commercial crops has driven the rich and powerful farmers to usurping common properly resources that were essential to maintain the lives of the marginalised and poor.
- The increasing control of seeds by multi nationals is increasing a culture of dependency in agriculture.
- Cost cutting drive and lack of protection from governments enforced by WTO are making rural artisans disappear.
- The new world trade order will not only increase the burden on women but may also increase the number of poor and street children.

> "When we talk about the poor, we shall have to decide whether food was meant for trade or for nutrition and freedom from hunger...."

7.3 Intellectual property rights and commodification of Health

- Developing countries have also got in a rush to 'go private by any means' and this rush and push of commercialisation has pushed the poorest people to the wall.
- The New Patent laws do not recognise traditional knowledge and traditional systems of ownership and the grossly unfair patenting of 'Neem' and 'Turmeric' was demonstrative of this fact - since both are age-old herbal medicine remedies used by indigenous people.
- Traditional knowledge that has allowed the control of diseases in the hands of common people is now being denied under the IPH rhetoric and is threatening the self reliance of people and their access to home remedies.

> "We have entered a phase of 'paradigm paralysis' and 'aspect blindness' that is preventing us from thinking about the poor and marginalised. The IPR regime has been the ultimate instrument that had been used to colonise the minds of the South"
>
> - Mathura Shrestha, Nepal

7.4 Privatization and Health

- Health care system development in India has seen the unbridled expansion of the private health sector thanks to state subsidies in the form of medical education, soft loans to set up medical practice etc. The private health sectors mainstay is curative care and is growing over the years at a rapid pace largely due to a lack of interest of the state sector in non-hospital medical care services especially in rural areas. Private sector accounts for over 70% of primary care treatment sought and over 40% of all hospital care. This is not a very healthy sign for a country where over three fourths of the population lives at or below subsistence levels. The trend is similar in most of South Asia.
- Private medical practitioners operate under conditions of complete absence of controls, monitoring or regulation by either the government or professional bodies whereas the public health sector is inadequately equipped to meet the health care demands of the poor, the private sector meets them without consideration of quality, rationality and social concern.
- Private sector in health care must be recognised and permitted but would need good regulation. State must control and regulate it. Eg., lack of regulation has led to a condition that 'supplier induced demand has caused a place like Mumbai to have about 55 CT Scan Centres but a place like London has about three'.
- This regulation would include licensing; setting up standards of practice and care; strong restrictions and disincentives in overserved areas and incentives to set up centres for underserved areas; norms for access and availability and disparities and health of the poor. A small established section of the medical profession would oppose any organised system of health care because it would threaten their position in the health care market. But regulating provider behaviour is necessary.

> "Health is one of the goods of life to which man has a right, wherever this concept prevails the logical sequence is to make all measures for protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State"
>
> - Henry Sigerist

7.5 Breakdown of Public Health System

- Public Health in many parts of South Asia has no money, poor quality and those in it had very poor motivation.
- The health sector is very poorly integrated with the other development sectors.
- Centralised control over the public health system also means that communities have no control over health service or its management.
- There is not enough priority for Primary Health Care in the overall plans.
- There is no effective mechanism to converge public / private and voluntary health sector.

All these factors, further worsened by the newer economic policies have led to a breakdown of the public health system at all levels. The poor are the most affected by this breakdown.

7.6 Neglect of Traditional Systems of Healing

- Traditional systems of healing and healers have been greatly neglected even though these have been used for centuries by all people and especially poor and marginalised who have regularly accessed locally available herbal medicines and folk health traditions.
- The neglect in the past has now been compounded by International trade laws including IPR and there is a great possibility of a loss of these traditions, knowledge and skills if suitable action is not taken by all those who are concerned about the health of the poor.
- The need to study, evaluate, promote and promote traditional knowledge systems in health must be done in such a way that the access of the poor to their own herbal medicines is protected and not jeopardised by commercialisation of these resources by multinationals and others.

> "We have come to the shameful point of time when the poor are not needed anymore, because machinery and technology can replace them. Earlier for better or for worse, at least there was a need for them"

7.7 Conflict, Poverty and Health

- One of the major effects of war and civil disturbances is to bring about a deterioration of the health status of the people. War leads to poverty and ill health and these in turn contribute to each other making living miserable.
- War affects the economy of the countries involved by affecting socio-economic conditions - like loss of employment; damage to industries; and migration of skilled persons and the wealthy. It also greatly affects the education and health services.

The Ethnic War in Sri Lanka

- War has disrupted all sections of the economy in the Northern provinces - agriculture, fisheries, manufacturing and trade.
- 59.3% of families in Jaffna now depend on rations
- 20% of agricultural land is inaccessible to civilians because of high security areas.
- The educational system has been affected due to damage of schools, migration of teachers and frequent displacement of people. Many Schools are used as refugee camps.
- IMR and MMR has increased tremendously and peaks during the times of escalation of war.
- Increase in anemic and low birth weight babies have increased.
- Under three malnutrition has increased by five times.
- An average of 10 persons are injured by landmines and unexploded devices every month. 25% of these are children.
- 55.8% of Malaria in Sri Lanka is in the North East Province which has 14% of the population.
- Psychological ill health is a major problem.

- Sivarajah - Sri Lanka

8. POLICY ISSUES FOR EQUITY IN HEALTH AND POVERTY REDUCTION

A wide range of policy issues emerged as significant to Poverty reduction and Equity in Health challenge.

8.1 Strengthening Civil Societies

The two principal features of civil society are humane governance and social capital. These have declined even in democratic countries like UK because of the gradual decimation of democratic accountability and forms of democracy by the focus on market forces. This has resulted in social exclusion reaching very high proportions; without democratic safeguards nothing worthwhile to improve well being of people especially the poor can be done. The current labour government is beginning to redemocratize and roll back initiatives of the past governments.

8.2 Promoting Intersectoral Action

There is need for synergistic action between health and environment and development initiatives. Action initiatives need to be at all levels - local, national, international and we need to identify expertise at various levels and tap their resources.

Intersectoral action must include developing an evidence base; conducting case studies of successes and failures; developing a common agenda; involving key players; identifying win win situations; overcoming barriers; creating public demand, developing south-north link; reinvigorating the public health system; and increasing the involvement of poor in all levels of action.

8.3 Tackling powerlessness through empowerment

Understanding cultural issues enables us to know what people think when they are sick and what action they would prefer to take during the sickness episode, and thus what role PHC has to play in the healing process. This listening and learning from people is an important skill of all those who wish to work with or reach the poor and marginalised with well developed listening / learning skills strategies that empower the people and move them beyond their state of powerlessness can be evolved.

The Cultural Context of PHC
Case Study : Marabo, Congo

A health and poverty survey was conducted by the communities with technical support from students in a village in Congo.

The village was described as marginalised, 'uncooperative', demotivated, apathetic, powerless, under 5 year malnutrition was 53%; and immunization coverage was +_20%.

15 months later the survey had stimulated a process which led to the following :

Fields and gardens had nutritious crops; School attendance increased; Protected water source (escaped cholera epidemic); Construction and use of health centre; Community discipline protected against rape; Malnutrition < 10%; Immunization > 80%; Antenatal clinic > 90%; Evidence of confidence and shared decision making.

A Survey to identify poverty and ill health can be useful if information is gathered and used by communities in their overall development plans. It may be useful to measure impact of action. Its not very useful if only for targeting individuals and families.

8.4 Politics of Health Policy implementation

TB is a curable disease, yet thousands of people die of it every year. We have policy statements but the focus on implementation is very inadequate. The political context of health policy implementation must be adequately understood if this implementation gaps have to be tackled effectively.

i. Who decides policy and who controls it? What are the stakes and conflicts of interest?

ii. Why are donors insisting on DOTS as the only method even though there is resistance from eminent scientists and policy makers? Why cannot flexible approaches be allowed?

iii. Is DOTS shifting responsibility in the system to the poor and health workers at the lowest level? Is it coercive?

iv. There is politics at delivery level as well with lots of negotiations taking place between doctors, health workers and patients which allow for distortions in the plans.

v. There is enormous apathy at all levels?

All these micro political elements have escaped the attention of policy researchers and hence TB programmes are not effective on the ground.

> ***Impact of implementation gaps on patients, families and society***
>
> It is a reflection of the structure and priorities of our society that we spend millions obtaining the latest medical technology, even in government institutions to diagnose relatively untreatable conditions, while resource constraint arguments are put forward to fund the treatment of killer diseases like TB which can be diagnosed relatively easily and cured. When one considers the amounts spent for sports extravaganzas and defect of borders, the disparities become more start and obscene. Somehow, the loss of half a million lives is not considered a national security problem calling for the best and urgent social defence. Some lives perhaps are more important than others.
>
> - Thelma Narayan, India

8.5 Identifying research priorities

Research priorities in the area of understanding poverty and health must arise out of the researchers local interaction with social realities and the local situation. Often health research has to look carefully beyond the health sector at the deeper determinants of health (non health sectors). Each country has to decide its own research agenda and not allow international funding partners or the market economy in research to evolve priorities.

8.6 Role of Private Practitioners

The private practitioners is often the first line of call before the poor reach government services or NGO services. They are often ignored by policy planners and decision makers.

The private practitioners need to be oriented and encouraged to focus on preventive measures at all levels. They need to have skills to handle epidemic situations. They need to be sensitized to key issues of women's health, occupational health, mental health and environmental health. They need CME's; back-up support for referral cases; and attempts at formal or informal standardization / accreditation.

The people must also be empowered to lessen their dependence on them and at the same time use their services judiciously.

8.7 Health Humanpower development

This is a very neglected issue but an important one. ***One of the most crucial challenges of equity and access of health care for poor and marginalised is the availability of pro-poor, equity sensitive, health humanpower - doctors, nurses and other health workers to run the increasing number of primary health care centres that are required to reach the poor, both in urban and rural areas.*** How is this possible in the present scenario marked by growing, uncontrolled, privatization of health humanpower education and training institutions; and declining professional standards at all levels? There is therefore urgent need to

- ***estimate*** humanpower needs;
- ***promote*** generalists rather than specialists;
- ***review*** and revise the curriculum for all cadres to make it more community oriented;
- ***strengthen*** all curricula on behavioural sciences, ethics and values, ecology, management and health economics;
- ***provide*** continuing education at all levels;
- ***promote*** alternative methods of training and pedagogy;
- ***enhance*** competence based learning strategies.

This is an urgent task which should not be further delayed.

8.8 Basic Minimum Needs approach

Any process of measuring inequalities in health invariably results in the discovery that absence of access to basic determinants of health are an important component of the inequalities. Hence all health interventions must ***focus on basic determinants like water, sanitation, housing, a living wage and so on.*** A basic minimum needs programme must therefore be considered. This BMN initiative would begin with people, involve all sections and ultimately emphasise better quality of life.

> "The concept of basic minimum needs should include adequate access or entitlement to :
>
> Food (calorie intake); clothing, housing, education, health, security including social security, productive employment with income, progressive development (physical, mental, intellectual and social), participation in social and political affairs outside ones home, active communication (for social relations); recreation and entertainment, and human rights"
>
> - Mathura Shrestha - Nepal

9. HEALTH AND POVERTY ERADICATION - THE ROLE OF INTERNATIONAL AGENCIES : PERSPECTIVES AND CONCERNS

During this session representatives from the World Bank and WHO (at various levels) presented their perspectives on Health and Poverty eradication.

9.1 World Bank and Health (Richard Skolnik)

- The bank was concerned about the increase in poor people; increasing population; an ageing population; an urbanising population; malnutrition.
- It had identified the high fertility and population growth, malnutrition, high infant and under five mortality rates, maternal mortality, women's health, communicable diseases; especially the new ones as critical issues.
- It was also concerned at some of the new and emerging diseases, environmental health issues, post-disaster situations.
- The bank had in its experience noted that health system initiatives of government often had corruption; weak management structures; inefficiency / lack of quality, misallocation of resources, higher costs, lack of resources or concern for the poor.
- The bank would definitely like to support community based primary health care but there were always ongoing debates on the approaches and addressing poverty, health, nutrition and equity was one of them. Other approaches included
  - structural adjustment;
  - sector wide approaches;
  - redefining public health priorities;
  - defining international public goods;
  - role of public sector and private-public partnership. There was also urgent need to monitor and evaluate the outcome of different strategies.
- The road to the future was to work on broader framework that should focus on outcomes and quality and would include some or all of the following :
  - health is an absolute right;
  - ensure governments are obliged to respect the rights dimension;
  - shift money to public health;
  - improve governance;
  - empower people and enhance transparency.

> "In South Asia, poor people should be seen as a National disaster"
>
> - Richard Skolnik, World Bank

9.2 WHO and Health (John Martin, Robert Kim Farley, B.S. Lamba)

- WHO's may not have had a credible policy on poverty eradication in the past but the 1998 document focuses on health for all; on poverty; on equity; and on protecting the health status of the poor for whom health is the most precious asset.

- WHO's new policy was focussing on
  - multisectoral action;
  - on socio-economic policies;
  - on health systems that were financially and procedurally fair;
  - on reducing risk factors and determinants of ill health;
  - and on reducing the burden of excess mortality and morbidity.
- WHO was trying to make a difference in an already globalising world, and the dialogue with the trade world starts at SEATTLE WTO review meeting.
- WHO was under pressure from Northern academics to dialogue with the pharmaceutical industry, and other industries as well. There was a virtual lack of southern perspective in WHO and there was urgent need for voices from the South to reach there as the environment at the moment for listening is rather good.
- WHO SEARO was trying to sensitise the Ministry of Health of various countries on implications of various current events, eg., globalisation; Intellectual Property Rights issue; collapse of South East Asian economies and the effect on the health of the country. In India it was looking at Health legislation and trying to find ways and means to strengthen it in the context of issues of pollution and waste management. The challenge was to see how social capital could be increased and how health could be integrated into social policies.

> "Health is the most precious asset of the poor and we need to protect it"
>
> - John Martin, WHO, Geneva

- The challenges before us are
  i. Health professionals and other committed to Equity and poverty issues must dialogue proactively with other action
  ii. Epidemiological evidence must drive WHO programmes.

In the discussion that followed participants raised some important issues about WHO and WB perspectives and programmes.

- There was concern that the cost per unit developmental programmes in different countries was very variable with poorer countries like Nepal being higher than neighbouring India.
- Why did WHO dilute its commitment to Primary Health Care in recent years and promote more selective strategies.
- How were World Bank and WHO collaborating when the former believed in the policies of health to only those who could afford to pay while the latter believed in Health for All.

9.3 Some implications of International Collaboration : A Caution

Earlier in a session preceding this CHC presented a critique of World Bank activities in the Health Sector in India based on the Banks own reports including a recent case study by its

Operations Evaluation Department of HNP programmes in India. The concerns about the projects included :

1. *Public Health devalued*

   Disturbingly lack of public health competence including lack of public health orientation and competence among the policy / project formulation

   - Confusion between socio epidemiology and techno managerialism
   - Ignoring of basic determinants of health
   - Absence of focus on poor indigent and marginalised
   - Regional diversities and disparities not adequately addressed

2. *Primary Health Care sidelined*

   - project partnerships totally uninformed about local formulations and expert committee recommendations
   - focus on selective strategies that make community needs, aspirations and capacities of communities subservant to needs of technology or the exigencies of topdown management systems
   - ignores Panchayatraj and focuses on creating Registered Societies
   - focus on secondary hospitals rather than primary health care; first referral units rather than primary health centres.

3. *Unconstitutional partnerships*

   - seeking to influence health policy even though contributing to small part of country's health budget.
   - conditionalities in project formulations that often overrule local expertise and formulations
   - funding muscle during periods of economic vulnerability
   - is World Bank willing to bear the costs of failures or distortions due to poor or inadequate programme planning that ultimately affects the poor the most?
   - accountability and transparency of projects that are often top down, externally inspired affecting local capacity development and distortions of existing health system.

4. *Ethical issues involved*

   - Promotion of private sector in the absence of evidence of its capacities for public health or primary health care.
   - Ethics of continuing with projects when the bank is aware of flaws, distortions of the contract guidelines.
   - Ethics of expanding 'quantity' over 'quality' or 'infrastructure' at the cost of services focussing on the poor.

5. *Management issues*

   Some problems encountered are

   - Inadequate focus on mechanisms for accountability and transparency
   - Absence of credible external evaluation
   - Focus on 'user fees' rather than diverse fund enhancing options
   - Inadequate attention to health humanpower development
   - Inadequate focus on long term ownership and sustainability

6. *Political economy ignored*

- Project planning focuses inadequate attention on the political, social and institutional dimensions of problem analysis including financial situation in the country and globally; reduction or stagnation of budgets; rise in prices of drugs and diagnostics; impact of liberalisation, privatization and globalisation on public health and access of poor to medical care; the potential impact of WTO and changing patent laws; increasing corruption etc.
- Finally there is need for building inhouse capacities in Ministries / Directorates of Health and Family Welfare in Public Health Policy and programme planning without too much reliance on adhoc freelancing consultancies and studies that sideline such capacity building.

9.4 Suggestions for further dialogue and action

A small group discussion held on the theme of International Donor Agencies later in the programme evolved the following perspectives and suggested some action initiatives :

1. International Donor Agencies including bilateral and multi lateral institutions, intergovernmental agencies; non governmental agencies including foundations, philanthropies, voluntary organisations and private sector initiatives. They have different perspectives and support different types of projects. Newer players are international banks, European Union and others.

2. They often have similar programmes and agendas because study promoted by one agency is shared through agency networks; or network of donors support specifically identified thrusts/priority programmes and projects.

3. Four concerns were identified as priority concerns in the context of the 'poverty and health' theme.

   a. ***'User fees'*** concept now promoted by many agencies may affect access to health care of the poor and marginalised.

   b. ***'Privatization'*** thrust without adequate evidence of capacity or orientation of private sector to primary health care or public health priorities may lead to distortions that affect long term goals and sustainability.

   c. ***'Consultancies'*** system that focus on freelancers and adhoc arrangements and external agencies mediating through a bidding process may prevent inhouse capacity building of health ministries and directorates.

   d. Promoting large development projects that promote import/export of labour and increased migration / displacement will enhance inequities.

4. A concerted effort must be made at all levels to dialogue with international donors and enhance the equity agenda in their work and mobilize their support towards this end.

   i. Bringing back Equity on the agenda of international donors

   ii. Focussing on debt burden / debt servicing related issues

   iii. In all programmes there should be an Equity focus i.e., benefits must go to the poorest of the poor.

   iv. Policies plans must be initiated or made by recipient countries with planning and formulation carried out by governmental representatives; NGO's; peoples organisation representatives and national level experts who are independent.

   v. Projects and plans should be transparent

vi. Issues in implementation should be considered or the policies formulated are operationalised.

vii. Local expertise must always be tapped and built up

viii. Need for good data and information that must be also available for public debate.

5. A similar orientation/dialogue must also be made with national policy makers, decision makers - both technocrats and bureaucrats and consultants.

6. Finally when we make any project / programme decisions, we must all 'think of the poor'. Would our programme make them poorer or help them to rise beyond their poverty?

The Unfinished Agenda

'There is a need to focus on a large unfinished agenda for the third world poor, especially women and children. They live in country caught up in debt, financial crisis imposed upon them by international capital markets, down sizing of public sector health care, not including endemic conditions of war, agricultural failure etc. Such a steady focus on nutrition prevention and low cost curative services with quality needs sustained public investment in health recognised to be the state responsibility for social development. As against this, the concept of sustainable health development, based on cost effective intervention in diseases, selected for value for money, would leave the overall health situations in these countries in total disarray".

- South Asian Group (VHAI)

10. ACTION FOR CHANGE - SOME INITIATIVES AND EMERGING STRATEGIES IN SOUTH ASIA

Many participants presented case studies of Action initiatives from their countries where approaches to tackle the challenges of poverty and ill health was being evolved. Six case studies which had been circulated are outlined here. (There were many others like the work of Gonoshasthya Kendra in Bangladesh, and smaller case studies which were shared by participants as part of their reflection on other issues. These are being included in the larger companion publication).

10.1 Poverty and Health : Experiences from SEWA (Self Employed Womens Association), Gujarat, India

Background : 94% of women workers in India are working in the unorganised sector that prevents them from accessing legal and social security and from getting the benefits of the organised sector like health and finance. An average woman spends Rs 800 ($18) per month on illnesses for herself or her family leading to a cycle of deteriorating health and increasing poverty. SEWA has tried to change these conditions since 1972 in Ahmedabad and elsewhere in Gujarat.

Strategy : SEWA is *a confluence of the trade union movement, women's movement and the cooperative movements*. It believes in organising women to achieve their goals of full employment and self- reliance and uses the strategy of struggle and development to strengthen the bargaining power of women and to offer them alternatives.

Methods

- *women's cooperatives* based on employment that bargain for better wages and social security.
- *women's banking* run by members of SEWA that provides for micro-credit for enhancing their employment opportunities of women's credit groups.
- *employment generation activities* involving women like dairy cooperatives, *bidi* rolling, tailoring, embroidery, designing, etc.
- *health activities* like health education, provision of primary health care by community health workers, mobile clinics, studies on occupational health, low-cost alternative therapies, TB treatment, and an integrated medical insurance scheme.

Results : SEWA's experience with over 210,000 workers in six states shows that poor women when organised and allowed to run, manage and own their organisations, have a better health status and quality of life by virtue of identifying and paying for services that improve their financial and health status.

10.2 Talking Poverty and Powerlessness for Community Health - Sarvodaya (Awakening of Everyone) Shramadana (Voluntary Labour) Movement, Srilanka

Background : Despite a good curative medical system well-run by the government, a large section of Sri Lankan society is devoid of comprehensive health services because of social, economic and geographical inequity. Sarvodaya Shramdana Movement (SSM) in the past thirty five years has been able to reach an exceptionally large proportion of Sri Lanka's underprivileged communities through an integrated approach to community health.

Strategy : SSM has helped to set up thousands of legally independent rural and urban communities that acquire a better understanding of the forces and circumstances that inhibit their development and thus gain confidence and the skills to act effectively on

their own behalf. While organising programmes to meet the immediate health and nutrition needs of the community, Sarvodaya lays the *foundation to address the deeper causes of ill-health, namely poverty and powerlessness.*

Methods and techniques : Keeping the *core principles of self reliance, community participation and planned action*, the communities are organised through five stages:

Stage One (Psychological Infrastructure building)

Request from village ⇒ visit of SSM worker ⇒ discussion with village elders ⇒ priority identification ⇒ Introductory Shramdana[i] camp in which villagers/families/government extension officers and villagers from other SSM villages participate to discuss local needs and organise self-help activities.

Stage Two (Social Infrastructure building)

One or more community groups of farmers /mothers/youth, etc. formed ⇒ training of such groups in leadership and skills for running community help programmes ⇒ establishment of children's services centres/ day care centres/ health clinics/ village libraries / community kitchen, etc.

Stage Three (building legal community based institutions)

Establishment of legally independent Sarvodaya Shramdana Society with hierarchy ⇒ survey of ten basic human needs programme ⇒ priority listing ⇒ village development plan ⇒ access to inputs for income and employment generation e.g., community shops/farms/industry/contracts/saving and credit/cost-benefit analysis.

Stage Four (building self sufficiency)

Ideological and skill training ⇒ structural changes ⇒ costing /pricing/marketing skills all leading to building self - sufficiency.

Stage Five (supporting other communities)

Providing support to other communities by sharing experience and guidance, providing capital, labour and raw material.

For building community capacity in tackling community needs, SSM takes the help of in-house specialised support units like Management Training Institute for leadership training, Rural Enterprises Development Services for technical support for agriculture, business and product development, Sarvodaya Rural Technical Services for technical and financial support in the fields of water supply, sanitation, energy and transport, and the Community Health and Environment Unit for technical support in community health.

Results : SSM is active in more than 8000 villages and has already facilitated the formation of more than 2500 dynamic village level societies that are responding to the growing challenges affecting the lives of community members in league with the government.

10.3 Peoples Participation in the Maldives - South Asia Poverty Alleviation Programme, Maldives

Objectives : Providing local communities with direct access to resources for financing development projects while guiding and directing community based organisations and NGOs in their formulation and execution.

Strategies

- Participatory rural appraisal of communities for identification and prioritising needs.
- involving local community development organisations, NGOs and government in training and capacity building for planning, implementation and evaluation of development activities.
- gradual transfer of responsibilities to local community development organisations of various islands and atolls.

Achievements

- *community mobilisation* in island development.
- *harbour improvement* to enhance economic development activities.
- *safe drinking water* by installing and improving tanks to reduce water-borne diseases and *better electrification*.
- *income generating activities* like fish-salting, agriculture and preschool construction and upgrading that are planned and managed by communities or community development organisations.
- *human resource development* for training women in tailoring and agriculture.
- *savings and credit* mobilisation in collaboration with banks.

10.4 People's Campaign for Decentralised Planning - Kerala Shasthra Sahitya Parishad, Kerala, India

Kerala Health Care Crisis : The health care crisis as it exists in Kerala is characterised by low mortality but high morbidity, resurgence of infectious diseases, rising diseases of affluence, overgrowth of the private health sector at the cost of the public health system, rising health expenditure and marginalisation of the poor.

Goals : The people's campaign aims to strengthen the local bodies for financial and planning decentralisation, solve the development crisis by increasing production and improving the quality of the services sector and initiating a new development culture while specifically targeting all the crisis points identified above. The overall aim is to provide good health at low cost and with social equity.

Strategy :

- Decentralisation of health services as a basis of community involvement in health.
- Structural changes in health systems like decentralisation of planning, management and budgeting.

Activities : After decentralised planning, the panchayats (elected local bodies) carry out the following health related activities:

* integrated disease control programmes * specific disease detection camps * geriatric care * school health programmes * rural cleaning campaign * nutrition programmes * sanitation * water supply * health survey * strengthening hospital infrastructure

Achievements : The Kerala health sector reform by involving the community in health has been able to bring about:

- a thrust on preventive and promotive health
- innovative health programmes

- a better working partnership between health workers and people
- reallocation and availability of health resources

The ninth five year plan has allocated 37.25 of the state budget to the local plans drafted by the local municipal bodies and panchayats of different levels, thus recognising the better utilisation of funds and implementation of programmes for better health.

10.5 Basic Minimum Needs Programme for Primary Health Care - The Nowshera Project, North West Frontier Province, Pakistan

Background : NWFP is a backward hilly province in the North West of Pakistan known for its socio-economic poverty and class inequities that influence its poor health indicators like infant and child mortality indicators. Basic Minimum Needs (BMN)identified by the people in the programme were:

* water, irrigation. * food, agriculture. * livestock for income generation.

* environmental health. * education. * health.

Concept : Basic Minimum Needs concept is an *integrated bottom-up* socio-economic development based on full *community involvement* and *self-reliance* through self-management and self-financing, supported through *intersectoral collaboration* and partnership by the government line departments. It is a *self-sustained people oriented strategy.*

Methodology : The BMN programme run by the government of Pakistan involves community preparation, selection of community representatives, community survey, community based analysis, priority setting and project formulation by the community.

The three interdependent pillars of self-reliance on which the BMN approach is based are:

- community organisation for planning and management.
- training in appropriate technology and provision of information to community.
- community financing through village revolving funds and village cooperatives.

Appropriate education, appropriate agriculture, appropriate health and appropriate community development cannot be seen as watertight compartments and their integration from conceptual to worker level has produced tangible results in the relevant communities.

Results : In Nowshera (NWFP), the Infant mortality rate dropped from 117 to 61 per thousand live births in two years. There was a 52%increase in boys enrollment and 65% increase in girls enrollment in Nizampur (NWFP) in the same period. Prevalence of third degree malnutrition dropped from 11% to 2 % as a result of the BMN programme in Nizampur while the immunisation rates reached an unbelievable 96 to 99% in the pilot areas from a dismal average of 25% in the same period. Loan recovery for income generation activities ranged from 77 to 98%.

10.6 Decentralised Management of Community Based Primary Health Care : Towards a Community Health Guarantee Scheme - Madhya Pradesh, India (An Action Proposal)

Background : Madhya Pradesh is India's largest state and its per capita income is the third lowest with 37% of population living below the poverty line. Its basic health indicators like Infant and Child Mortality Rates are far above national averages and diseases like TB, leprosy and water-borne diseases have a heavy toll on human lives. Although government spending has increased over the years, people living in far-flung areas and tribals have little or no access to the public health services.

Strategy :

- *Decentralised health action* through comprehensive institutional reform.
- *Involvement of elected Panchayati Raj Institutions (PRIs i.e.Elected village level legislative and executive bodies)* as partners in identifying health issues, health workers and managing the state sponsored schemes.
- *Intersectoral and inter-donor coordination* for harnessing and allocating resources for, health service programmes.

Core Components:

- People's health survey and health action ***(Lok Sampark Abhiyan)***.
- Panchayat[#] level health plans and guarantee by panchayats - with government support - to deliver a package of basic health services like safe water supply, sanitation, immunisation and child nutrition.
- Community health activists as paid service providers that are selected by panchayats and trained by the government to cater to the basic health needs. Also training of birth attendants for skill upgradation. Linking up of these workers with the public health system ***(Jana Swasthya Rakshak)***.
- Involvement of private health sector
- Strengthening of district level health units (including private sector) and district level health services management in cooperation with other departments.

10.7 Poverty and Child Disability - Case Study : Bangladesh

A ten-point questionnaire was used in a door-to-door survey of 1000 families. All children found to be potentially in need of disability services were invited to the Centre for assessment, treatment and rehabilitation based on both the Centre and their homes. The families were initially cautious and each one had to be persuaded by a social worker to attend.

In the five years since this project began, many of the initial notions about the community and the objectives have had to be modified. In particular the social development of families and the community, and the general health services for mothers and siblings, have been integrated into the project. Extra space has been allocated for the project in the outpatient department of the hospital. A regular health care and disability service is now operating, and parents attend on the recommendation of friends. The screening process is no longer required as the community itself identifies the children requiring care.

Parents with disabled children in Bangladesh are becoming increasingly concerned about their quality of life. A public health approach to the care of such children is necessary if they are all to be reached. It is important to deal with the social factors that lead to disability, such as poverty, social discrimination, and undernutrition. However, once a child is identified as disabled he or she becomes a responsibility of the health sector. Scarce resources should be used to adapt low-cost procedures based in the community and the home which have proved beneficial. Tertiary care is also required but its cost should be borne by local business people.

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11. SOME EXPERIENCES AND PERSPECTIVES FROM BEYOND THE SAARC REGION : South-South and South-North dialogue

While the South Asian Dialogue on Poverty and Health focussed much of its discussion on the situation and context in the South Asian region, the dialogue had participants from other parts of the globe, and a session to learn from experiences from other areas and countries in a spirit of South-South and South-North dialogue was held.

11.1 Health consequences of the uninsured in the U.S. (Whitney Addington, U.S.A.)

The American College of Physicians is a professional association of over 600,000 physicians who are concerned that a growing number of people in the U.S. are uninsured and this includes the poor, the blacks, the elderly and the marginalised. The Association is now campaigning for a Universal Insurance Policy. This is particularly significant because other medical associations have opposed medical reforms. As part of the efforts to influence policy makers, the association has organised a national talk show on television, interacted with local governors and are now planning to take the issue directly to the people.

11.2 Inter-collegiate forum on Poverty and Health, U.K. (Iona Heath, U.K.)

In the past, the medical professionals have shown little interest in understanding the links between poverty and ill health. The Inter-collegiate forum on Poverty and Health is therefore a significant initiative that has reflected on the issues of Poverty and Health in U.K., focussed on the growing inequalities and contributed to the policy dialogue in U.K. The forum responded to the Acheson Report and emphasized that better quality of life is more important than just saving lives. The forum is exploring the possibility of becoming a national health watch.

11.3 Partnership with Business for Global Health (Olivier Giscard D'Estiang, France)

Representing the Business Association for the World Social Summit (BUSCO), Mr. Estiang stressed the need to actively involve and tap the potential of ethical business partners in initiatives to respond to the Global Health crisis. While business increases productivity, helps to reduce the prices and eventually helps the consumer and creates jobs, it should also be ethical. This included higher workers salaries, enforcement of a minimum wage, strengthening unions, and involving the people in the benefits rather than exploiting them. Business must also maintain its responsibility towards the environment while trying to satisfy its employees and customers. For this it must be more transparent. Reforms must come from within industry through active dialogue, not just from regulation and rules.

11.4 Listening to the People (Charles Oyaya, Kenya)

There is need for academics to build their academic experience by building community participation and listening to the people and how they talk and feel about their experience of poverty. This will help us to develop new paradigms and to develop specific and alternate strategies for poverty reduction. There is need to move beyond 'income issue' in poverty assessment and look at other issues of integrity and dignified living. This will include factors such as a sense of belonging and spirituality.

11.5 Dialogues on Poverty and Health in Bangaldesh (Sharifa Begum)

The Bangladesh Institute of Development studies organised a dialogue on Poverty and ill Health in Bangladesh, bringing together academics, researchers, NGOs, government resource persons and others. The workshop suggested that rather than techno-managerial and purely bio medical solutions to public health problems, there is need to look to broader social mobilisation. The workshop suggested that there should be,

- A people's commission on Poverty and Health
- An effort to change medical education curriculum so that the medical profession will be more sensitive and responsive to the issue of poverty and ill health.
- An effort to dialogue with representatives of governments and other sectors to enhance intersectorality.

11.6 Some lessons from recent experiences of South-South dialogue (Devaki Jain, India)

Reflecting on some recent experiences of South-South dialogue including meetings of women's groups globally, Dr. Jain emphasised some key learning points, which included,

- Public policy action must be linked with personal morality issues and to identify with the poor we must restrain self-consumption.
- Dialogue must include an active sharing of information and strategies.
- We must identify existing agenda to them strategically.
- Regional efforts are an important way to deal effectively with globalisation
- We must stress the women's lens while initiating effective public action.
- While South-South dialogue is a must, every effort must be to get northern solidarity and make northerners join issues of common concern.

11.7 The People's Health Assembly, Dhaka 2000 A.D. (Dr. Zafarullah Chowdhury, Bangladesh)

The People's Health Assembly to be held in Dhaka in December 2000 is an effort by a growing coalition of grassroot organisations and networks dedicated to health and equitable development. The goal is to re-establish health and equitable development as top priorities in local, national and international policy making, with Primary Health Care as the strategy for achieving these priorities. The Assembly aims to draw on and support people's movements in their struggles to build up long term and sustainable solutions to health problems. The PHA process is a collective effort in opening up opportunities, drawing in communities and civil society organisations in their work towards just and equitable health and health related policies for all.

The PHA process is an effort to listen to the voiceless. The dialogue on poverty , ill health and so on must move beyond definitions and frameworks to sitting down with people to find way of spreading new ideas for action to achieve better health. WHO consultants, academic, research groups and policy makers must be ready for this task. The PHA may be an opportunity to get involved in such a process.

PEOPLE'S HEALTH ASSEMBLY : CONCERNS

- Retreat from the goal of national health and drug policies as part of an overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.
- The failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread – and often inequitable – privatization of health policies.
- A narrow, top-down, technology oriented view of health.

- PHA, Pamphlet, March 2000

11.8 Towards an IPHN Action Plan

A small group which represented the IPHN Advisory Group met a few times during the dialogue and tried to further clarify the emerging role of IPHN and the challenges ahead. Some ideas evolved,

- IPHN is a group that aims to facilitate interaction on poverty issues
- IPHN is a group that will act as an advisory group (a facilitating group rather than an action group)
- Actions should necessarily be taken up by the local people and local groups in a country or region. It will be most effective when action comes from people where they are. However, IPHN could link information through the internet and report it in the media, wherever possible, to strengthen the efforts in solidarity.
- IPHN plans to facilitate a letter to the BMJ or an Editorial on the 'Poverty and Health' theme to spread the concern and stimulate action.
- IPHN would also try to mobilise political and economic resources from the north for supporting the movements in the south.
- IPHN is glad to see that WHO and other agencies have supported the network process from the very beginning. We need to move towards a separate Secretariat outside of WHO to continue our facilitator role and take many emerging goals and issues forward.
- IPHN must struggle to keep the Poverty and Health agenda on the top of International concerns at all levels and increase the involvement of people from the North in these concerns.
- IPHN should build on the rich experience of its members, learning from it and proactively spreading it to others interested in similar concerns.
- IPHN should strive to facilitate the presence of the voiceless in the policy-making efforts of international agencies in solidarity with the poor and marginalsied of the world.

The South Asian Dialogue was an initiative of IPHN which addressed many of these ideas quite effectively. Much more needs to be done in many other parts of the world.

12. STRATEGIES FOR ACTION : An Agenda for 2000 AD and Beyond

The participants deliberated in five groups during the end of the dialogue to identify Strategies for Action. Each group, each participant, each country and each region has to evolve its own special agenda for 2000 AD and beyond. The following is a check list for all concerned :

12.1 Strategies for Change : Local / Community

- *Social mobilization and community diagnosis of and around risks and interventions required.*
- *Special attention and sensitization to the problems of the poorest sections.*
- *Sensitization of International bodies of the ground realities.*
- *Reassertment of importance of Primary Health Care through Community Health Workers, as several models in South Asia have proved.*
- *Ensuring Right To Information.*
- *Land Reform, recognising it as a crucial issue in poverty reduction and Health For All initiative.*
- *Ensurance of a Corruption free Society.*
- *Understanding peoples needs and perceptions.*

12.2 Strategies for Change : National Level

- *Ensuring people's participation at all levels of planning, implementation and evaluating.*
- *Integrating vertical programmes with the rest of the health care system.*
- *Effective implementation of legislation empowering women.*
- *Strengthening public health services.*
- *Monitoring and regulating private health sector.*

12.3 Strategies for Change : Regional / SAARC level

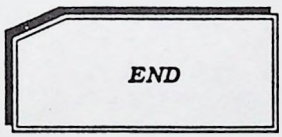
- *Enhancing regional cooperation especially tackling problems especially flood, malaria, water-disputes, that are commonly faced by SAARC countries.*
- *Sharing experiences within the region.*
- *Pressurizing SAARC heads to put health on their agenda through advocacy and information.*
- *Health sector should build upon existing lobbying groups to address women's issues*
- *Active consideration of the concept of the entire SAARC region as one economic block to maximise the regional economic potential.*

12.4 Strategies for Change : WHO level

- *Increasing the number of non-medical professionals in WHO to balance the bio-medical tilt.*
- *A policy to ensure that WHO consultants spend more time in the field to observe for themselves the reality.*
- *Making various WHO publications more accessible by printing locally etc.*
- *Community groups can be invited to the Assembly to influence the proceedings.*

12.5 Strategies for Change : International Donor Agency level:

- *Policies and plans must be made by the recipient countries. At present there is lack of transparency and lack of public debates on the role of donor agencies.*
- *Let the question of poverty reduction be central to all discussions.*
- *Reduce dependence on international consultants.*
- *Mobilize support from international communities.*
- *Reemphasize comprehensive Primary Health Care.*
- *Demand accountability and transparency of the donor agencies.*



THE NEW ECONOMICS AND HEALTH

- *"Never before did mankind have such formidable scientific and technological potential, such extraordinary capacity to produce ..... well being but never before were disparity and inequity so profound in the world .....*

- *The 'New Economics' is like a ship whose 85% passengers are crowded together suffering hunger, disease and helplessness .... And destined to clash with an iceberg .....*

- *Another 'Nuremberg' is required to put on trial the economic order imposed upon us. The current global system is killing by hunger and preventable and curable diseases, more men, women, children every three years than all those killed by world war II in six years ....*

- *Fidel Castro,*
  G-77 Meeting in Havana
  13th April, 2000

SOUTH ASIAN DIALOGUE ON POVERTY AND HEALTH

15th to 18th November 1999
Bangalore, India.

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South Asian Dialogue on Poverty & Health

WHO – Health in Sustainable Development,
International Poverty and Health Network Advisory Group,
Community Health Cell, Bangalore

15th to 18th November, 1999

Venue
National Institute of Advanced Studies (NIAS), Indian Institute of Science Campus, Bangalore - 560 012, India.

PROGRAMME OF WORK

Date / Time	Programme Details
Sunday, 14th November, 1999	
Whole Day	• Participants arrive in Bangalore Accommodation at 1. National Institute of Advanced Studies 2. Hotel Ashraya International
7.00 p.m.	• Welcome fellowship dinner with local organising team at National Institute of Advanced Studies.
Monday 15th November, 1999 - COMMUNITY VISITS	
8.30 a.m.	Briefing on Community visits by the CHC Team. All Participants gather at Hotel Ashraya International.
9.00 a.m. to 4.00 p.m.	*COMMUNITY VISITS*

Lunch at place of visit with the Organisation / Community

Group	Nature of Organisation
Group One	Bonded / Child Labour – Jeevika, Anekal.
Group Two	Urban Slum / Street Children – Association for Promoting Social Action Namma Mane, Indira Nagar
Group Three	Indigenous People - Ramana Maharishi Academy Project, Grama Rakshe, Kanakapura
Group Four	People with Disabilities - Association for People with Disability Lingarajapuram and Sriramapuram
Group Five	Women's Health and Development - St. John's Medical College, Mugalur Project, Mugalur
Group Six	Corporate Sector Initiative - Titan Industries, Hosur

See separate note with further details

- The visits will get over at different times, after which the participants will return to their hotel and NIAS

Date / Time	Programme Details
6.00 p.m. to 7.30 p.m.	Learning from the Community – Short reports by the 6 Groups on Key Learning Experiences followed by discussion.- At NIAS
8.00 p.m.	**Welcome Dinner (informal)** ***at NIAS***
Tuesday 16th November, 1999	
8.30 a.m. onwards	Registration of Participants
9.00 a.m. to 10.00 a.m.	*INAUGURATION* ***Chairperson*** : Dr. Chandhrashekara Shetty, Vice Chancellor, Rajiv Gandhi University of Health Sciences, Bangalore. ***Co Chairperson:*** Dr. C.M. Francis, Consultant, Community Health Cell, Bangalore
9.00 a.m. to 9.05 a.m.	o Welcome to Symposium and Dialogue : Community Health Cell – *Dr. Thelma Narayan*
9.05 a.m. to 9.10 a.m.	o Inauguration with lamp lighting
9.10 a.m. to 9.25 a.m.	o Inaugural Reflections *Dr. Chandrashekara Shetty , Vice-Chancellor* *Rajiv Gandhi University of Health Sciences*
9.25 a.m. to 9.55 a.m.	o Introductory Remarks • National Institute of Advanced Studies *Dr. Roddam Narasimha* • Government of Karnataka - *Mr. Abhijith Sengupta* • WR – India- *Dr. Robert Kim Farley* • WHO - HSD - *Dr. John Martin*
9.55 a.m. to 10.00 a.m.	o Vote of Thanks
10.00 a.m. to 10.30 a.m.	**Coffee / Tea**
10.30 a.m. to 1.00 p.m.	**Symposium** : **Poverty and Health in South Asia :** ***Crisis and Challenge.*** ***Chairperson :*** Dr. Devaki Jain ***Co Chairperson :*** Dr D.K. Srinivasa ***Speakers :*** o ***Keynote Addresses*** :
10.30 a.m. to 11.00 a.m.	*1. Poverty, Disease and National and International Power Structure – The Case of India* Prof. Debabar Banerji, Nucleus for Health Policies and Programmes, New Delhi, India.
11.00 a.m. to 11.20 a.m.	*2. Poverty and Health – Reflections from Bangladesh* Dr. Zafrullah Chowdhury, Gonoshasthya Kendra, Bangladesh.

<table>
<tr><th>Date / Time</th><th>Programme Details</th></tr>
<tr><td colspan="2">Tuesday 16th November, 1999 (Contd.)</td></tr>
<tr><td>11.20 a.m. to 12.10 p.m.</td><td>o Discussants :
1. Poverty and Development Paradigm – Peoples Perspective
Dr. Mathura Shrestha, Nepal
2. Equity in Health Care – A Formidable Challenge for Sri Lanka.
Ms. Myrtle Perera, Sri Lanka
3. Poverty and Health towards Equity and Poverty Eradication - Reflections.
Dr. Yousuf Memon, Pakistan
4. Crisis of Governance in Public Health - Bangladesh.
Dr. Abul Barkat, Bangladesh
5. A WHO Perspective
Dr John Martin, World Health Organization</td></tr>
<tr><td>12.10 p.m. to 12.30 p.m.</td><td>o Questions from the Floor</td></tr>
<tr><td>12.30 p.m. to 1.00 p.m.</td><td>o Chairperson's Remarks</td></tr>
<tr><td>1.00 p.m. to 2.00 p.m.</td><td>Lunch (Greenhouse – NIAS)</td></tr>
<tr><td>2.00 p.m. to 4.00 p.m.
Chair : Dr. Mathura Shrestha
Co Chair : Ms. Fathimath Moosa Didi</td><td>Session I:
• South Asian Dialogue : Orientation
Dr. Ravi Narayan, Community Health Cell, Bangalore
• Expectations and Issues : A Group Inventory
All Participants
• IPHN overview : Ms Margareta Skold</td></tr>
<tr><td>4.00 p.m. to 4.30 p.m.</td><td>Tea / Coffee</td></tr>
<tr><td>4.30 p.m. to 6.30 p.m.</td><td>Group Discussions I:
Exploring the Poverty and Health Framework
<table>
<tr><th>Group</th><th>Topic</th></tr>
<tr><td>I</td><td>Socio Economic Deprivation and Ill Health</td></tr>
<tr><td>II</td><td>Ill Health leading to Poverty</td></tr>
<tr><td>III</td><td>Feminization of Poverty</td></tr>
<tr><td>IV</td><td>Globalization and Health</td></tr>
<tr><td>V</td><td>Poverty, Ecology and Health</td></tr>
<tr><td>VI</td><td>Disaster, Poverty and Health</td></tr>
</table></td></tr>
</table>

Date / Time	Programme Details
Wednesday 17th November, 1999	
8.30 a.m. to 10.00 a.m. *Chair* : Dr. Patricia Nickson *Co Chair* : Dr. Naila Z. Khan	**Session II:** • *Listners Reflections on previous day's proceedings* • *Plenary :* Short report of Group Discussions *Discussion*
10.00 a.m. to 10.30 a.m.	Tea / Coffee
10.30 a.m. to 12.00 Noon *Chair* : Dr. B. Ekbal *Co Chair* : Dr. Oscar Ugarte	**Session III:** *Global, Regional, National Concerns impacting on Poverty and Health* o *Discussants :* • *Globalization* – Dr. Prem John • *WTO & Health Agenda of Third World Countries* - Dr. Mohan Rao • *IPR & Commodification of Health* – Dr. Mathura Shrestha • *Privatization and Health* - Dr. Ravi Duggal • *War, Poverty and Health* - Dr. Sivarajah • *Breakdown of Public Health Systems* – Dr. Mani Kalliath • *Neglect of Traditional Systems of Health Care* – Fr. John Vattamattom • *Implications of International Collaboration* - Dr. Ravi Narayan • *Any other*
12.00 Noon to 1.15 p.m. *Chair* : Mr. Gopala Krishnan *Co Chair* : Dr. Iona Heath	**Session IV:** *Health and Poverty Eradication Perspectives of World Bank and WHO* o *Presentations:* • Mr Richard Skolnik, *World Bank* • Dr. John Martin, *WHO* *Discussion*
1.15 p.m. to 2.15 p.m.	Lunch

<table>
<tr><th>Date / Time</th><th>Programme Details</th></tr>
<tr><td colspan="2">Wednesday, 17th November, 1999 (contd.)</td></tr>
<tr><td>2.15 p.m. to 4.00 p.m.

Chair : Mr. Oliver Giscard d'Estiang

Co Chair : Mr. Charles Oyaya</td><td>Session V :
Health and Poverty Eradication : Action Initiatives and Strategies – Local, National and Government, NGO
o Discussants (8 minutes each)
• The Sarvodaya Initiative (Sri Lanka) - Dr. Geethani Kandaudahewa
• Gonoshasthya Initiatives (Bangladesh) - Dr Qasem Chowdhury
• NGO initiatives in Pakistan (Pakistan) - Prof Gaffar Biloo
• National Alliance of Peoples Movements (India) – Mr. Geo Jose
• The SEWA Experience(Gujarat, India) - Ms Shilpa Pandya
• Peoples Participation (Maldives) - Ms Fathimath Moosa Didi
• Community Health Service Guarantee Scheme (Madhya Pradesh, India) – Mr. Gopalakrishnan
• Decentralised Health Planning (Kerala, India) - Dr. Ekbal
• Any other</td></tr>
<tr><td>4.15 p.m. to 4.30 p.m.</td><td>Tea / Coffee</td></tr>
<tr><td>4.30 p.m. to 6.30 p.m.</td><td>Group Discussions II :
Equity in Health and Poverty Eradication : What Strategies can be initiated?
<table><tr><th>Group</th><th>Level</th></tr><tr><td>I</td><td>Local / Community</td></tr><tr><td>II</td><td>National</td></tr><tr><td>III</td><td>Regional / SAARC</td></tr><tr><td>IV</td><td>WHO</td></tr><tr><td>V</td><td>International Donor Agencies</td></tr></table>IPHN Advisory Group may meet concurrently</td></tr>
<tr><td>7.30 p.m. to 8.30 p.m.</td><td>Cultural Evening – NIAS Auditorium</td></tr>
<tr><td>8.30 p.m.</td><td>Dinner at NIAS</td></tr>
</table>

Date / Time	Programme Details
Thursday 18th November, 1999	
8.30 a.m. to 10.00 a.m. *Chair* : Mr. Des McNulty *Co Chair* : Dr. Aruna Uprety	**Session VI :** *Strategies for Change* • *Listners Reflections on previous day's proceedings* • *Plenary :* Short report of Group Discussions II *Discussion*
10.00 a.m. to 10.30 a.m.	Tea / Coffee
10.30 a.m. to 12.00 Noon *Chair* : Dr. Debabar Banerji *Co Chair* : Dr. Roger Drew	**Session VII :** *Policy issues for Equity in Health and Poverty Eradication – Implication for WHO / IPHN* o *Discussants* • *Strengthening Civil Society* – Dr. Iona Heath • *Intersectoral Action* – Dr. Andrew Haines • *Powerlessness and Empowerment* – Dr. Patricia Nickson • *Politics of Health Policy Implementation* – Dr. Thelma Narayan • *Research Priorities* – Dr. Sharifa Begum • *Humanpower Development* – Dr. D.K. Srinivas • *Role of Private Practitioners* – Ms. Nimitta Bhatt • *Basic Minimum Needs Programme* - Dr. Barzgar • *Any other*
12.00 Noon to 1.15 p.m. *Chair* : Mr. B.S. Lamba *Co Chair* : Dr. Mohan Issac	**Session VIII :** o *South-South and North-South Dialogue and Experiences beyond the SAARC Region :* Participants o *Peoples Health Assembly 2000* - Dr. Zafrullah Chowdhury
1.15 p.m. to 2.00 p.m.	Lunch
2.00 p.m. to 3.00 p.m. *Chair* : Dr. Whitney Addington *Co Chair* : Dr. Prem John	**Session IX :** *Action Plan : 2000 AD and Beyond* (An IPHN Core group will collate ideas through the meeting and present an IPHN Development and action plan for consideration by the dialogue participants)
3.00 p.m. to 3.30 p.m.	Tea / Coffee
3.30 p.m. to 5.30 p.m. *Chair* : Dr. V. Benjamin	**Concluding Session :** o *South Asian Dialogue : Statement and Action Plan* – Steering Committee o *IPHN Action Plan* – Core Group o *WHO- HSD concluding remarks* o *Reflections by some participants* o *Wrap up and Thanks*

COMMUNITY VISITS - A NOTE

Community visits are being organised at six different project initiatives in and around Bangalore. These are Health / Development and Poverty alleviation programmes organised by Voluntary Agencies (NGO's); a Medical College and a Corporate Sector initiative.

- ***The six options are***

  Group One : ***Jeevika Vimukti Trust***, Anekal, A Programme to tackle ***Child Labour*** including bonded Child Labour.

  Group Two : ***Association for Promoting Social Action (APSA)*** - ***Slum Outreach Programme*** and ***Street Children Support and Rehabilitation***, Bangalore.

  Group Three : ***Gram Rakshe***, Extension programme among ***indigenous people*** (Lambanis), Kodihalli of the ***Sri Ramana Maharshi Academy of the Blind.***

  Group Four : ***Urban Slum Outreach Programmes*** of the ***Associaton of People with Disabilities, APD.***

  Group Five : ***Mahila Vikas Project***, Mugalur (***Rural Women's Development Project***) of Department of Community Health, St. John's Medical College.

  Group Six : ***A Corporate Sector Community Development*** initiative in villages around Bangalore.

- ***The aim of these community visits is to :***

  - ***Listen*** to the experiences of people living in the community, especially the poor and the marginalised, regarding their experiences of poverty and ill health.

- *Learn* how they cope with this situation and what they think of existing governmental and non-governmental initiatives in health care and poverty alleviation.

- *Identify* how the Network, WHO, and International Agencies could strengthen community initiatives at local level, through support to governmental / non governmental initiatives.

- A short briefing will be organised at the Dialogue venue on 15th November, from 9 to 10 a.m. Each group will consist of 6 – 8 members, accompanied by a CHC team member and a team member from the NGO / institution hosting the community visit, who will facilitate / translate. The community visits will be between 10.00 a.m. and 4.00 p.m. (the timing will vary depending on travel time and other logistics). Each group will share a meal with the local hosts / community.

- Each group will discuss their learning experiences and share it in a special session focussing on 'Learning from the Community'.

- All participants are requested to indicate which group they would like to join. In case a group gets too large the organisers may have to use their discretion to balance the groups.

- Each Community Visit option focusses on one deprived/marginal group in the community. A more detailed background note will be available for each visit and will be circulated during the briefing along with some questions.

- CHC Staff and associates accompanied each group as facilitators / translators.

CHC

Poverty and Health in Developing Countries (*especially SAARC region*)

Bibliography

This includes all the materials, papers and reports received by CHC during the interactive planning dialogue preceding the South Asian Dialogue on Poverty and Health in Bangalore 15-18th November, 1999.
(* indicates documents circulated with our correspondence or handed in the participant's pack).

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(NB: Documents at serial no. 9, 10, 17, 39, 52, 53 and 58 are available with WHO-HSD, Geneva, and are available on request.)