SOUTH ASIAN DIALOGUE

ON

POVERTY AND HEALTH

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

PROCEEDINGS

Organised by

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

JULY, 2000
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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 marginalised. 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, NGOs, 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

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
Middle East & 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, people's 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

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 multi-pronged approach. There is need for legal control and bans. There needs to be people's collective action to impose these bans socially and women are often willing to organise around the issue. De-addiction 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.

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 enterprises is a self help group of women, 180 of whom work in the village unit of Midugarapalli. IRDT is another NGO run 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 sustain 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 inequitie,s and argued that we need at government levels a sort of corporate strateg,y 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-SEARO's 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.

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

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.

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 on top in 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.

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 heart 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 a 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.

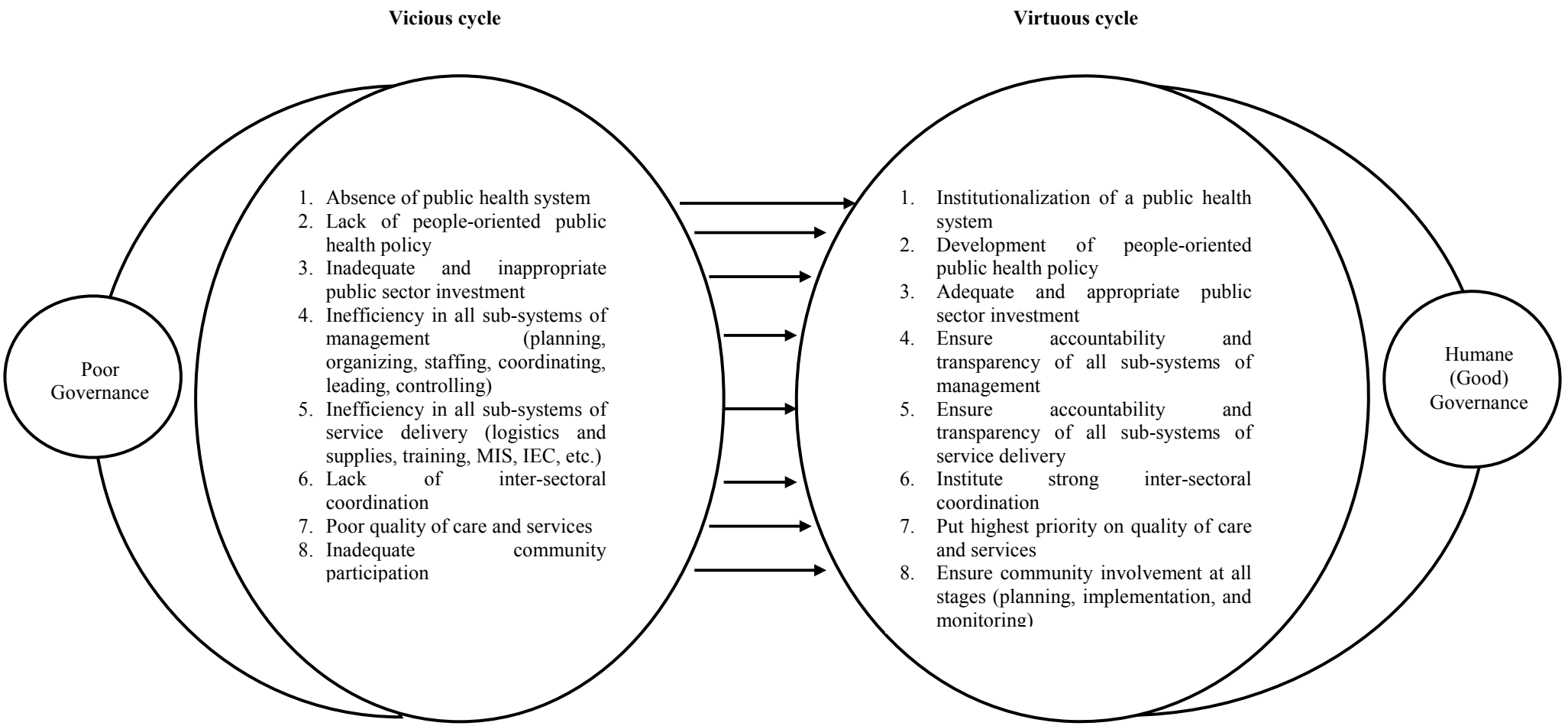
3. ***Prof. Abul Barkat*** spoke on "Crisis of governance in public health in Bangladesh".

   His main theme 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



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 experiences 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 processes 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 produce 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 decentralisation;
- 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"

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 anaemic and low birth weight babies .
- 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 re-democratize 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 $\pm$ 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 defence of borders, the disparities become more startling 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.

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 behavioral 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.

9.

"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

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 aging 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 a 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 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 subservient 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; NGOs; people's 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 a 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 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 Bangladesh (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.*
- / *Reassertion 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.*
- / *Ensuring 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

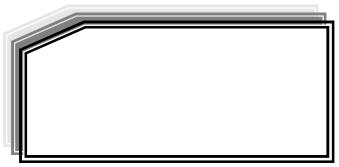
- / *Enhancing regional cooperation especially tackling problems especially flood, malaria, water-disputes, that are commonly faced by SAARC countries.*
- / *Sharing experiences within the region.*
- / *Pressurizing SAARC heads to put health on their agenda through advocacy and information.*
- / *Health 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.*



- ***"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

Appendix - A

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

<table>
<tr><th>Date / Time</th><th colspan="2">Programme Details</th></tr>
<tr><td colspan="3">Sunday, 14th November, 1999</td></tr>
<tr><td>Whole Day</td><td colspan="2">• Participants arrive in Bangalore
Accommodation at
1. National Institute of Advanced Studies
2. Hotel Ashraya International</td></tr>
<tr><td>7.00 p.m.</td><td colspan="2">• Welcome fellowship dinner with local organising team at National Institute of Advanced Studies.</td></tr>
<tr><td colspan="3">Monday 15th November, 1999 - COMMUNITY VISITS</td></tr>
<tr><td>8.30 a.m.

9.00 a.m. to 4.00 p.m.</td><td colspan="2">Briefing on Community visits by the CHC Team. All Participants gather at Hotel Ashraya International.
COMMUNITY VISITS</td></tr>
<tr><td rowspan="7">Lunch at place of visit with the Organisation / Community</td><td>Group</td><td>Nature of Organisation</td></tr>
<tr><td>Group One</td><td>Bonded / Child Labour –Jeevika, Anekal.</td></tr>
<tr><td>Group Two</td><td>Urban Slum / Street Children –Association for Promoting Social Action Namma Mane, Indira Nagar</td></tr>
<tr><td>Group Three</td><td>Indigenous People - Ramana Maharishi Academy Project, Grama Rakshe, Kanakapura</td></tr>
<tr><td>Group Four</td><td>People with Disabilities - Association for People with Disability Lingarajapuram and Sriramapuram</td></tr>
<tr><td>Group Five</td><td>Women’s Health and Development -St. John’s Medical College, Mugalur Project, Mugalur</td></tr>
<tr><td>Group Six</td><td>Corporate Sector Initiative -Titan Industries, Hosur</td></tr>
<tr><td colspan="3">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</td></tr>
</table>

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.	ϑ Welcome to Symposium and Dialogue : Community Health Cell – *Dr. Thelma Narayan*
9.05 a.m. to 9.10 a.m.	ϑ Inauguration with lamp lighting
9.10 a.m. to 9.25 a.m.	ϑ Inaugural Reflections Dr. Chandrashekara Shetty , Vice-Chancellor *Rajiv Gandhi University of Health Sciences*
9.25 a.m. to 9.55 a.m.	ϑ Introductory Remarks • National Institute of Advanced Studies *Dr. Roddam Narasimha* • Government of Karnataka - *Mr. Abhijit Sengupta* • WR – India- *Dr. Robert Kim Farley* • WHO - HSD - *Dr. John Martin*
9.55 a.m. to 10.00 a.m.	ϑ 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 :*** ϑ ***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>

Discussants :

Poverty and Development Paradigm – Peoples Perspective
Dr. Mathura Shrestha, Nepal
Equity in Health Care – A Formidable Challenge for Sri Lanka.
Ms. Myrtle Perera, Sri Lanka
Poverty and Health towards Equity and Poverty Eradication - Reflections.
Dr. Yousuf Memon, Pakistan
Crisis of Governance in Public Health - Bangladesh.
Dr. Abul Barkat, Bangladesh
A WHO Perspective
Dr John Martin, World Health Organization

</td></tr>
<tr><td>12.10 p.m. to 12.30 p.m.</td><td>Questions from the Floor</td></tr>
<tr><td>12.30 p.m. to 1.00 p.m.</td><td>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 :*** • ***Listeners 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*** ***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** *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

❧ 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** ϑ ***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 :** ϑ ***South-South and North-South Dialogue and Experiences beyond the SAARC Region :*** Participants ϑ ***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 :*** ϑ ***South Asian Dialogue : Statement and Action Plan –*** Steering Committee ϑ ***IPHN Action Plan –*** Core Group ϑ ***WHO- HSD concluding remarks*** ϑ ***Reflections by some participants*** ϑ ***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 (NGOs); 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 ***Association 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.

Appendix - D

Poverty and Health in Developing Countries (*especially SAARC region*)

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