Poverty persistence, entry and escape: Issues for consideration of the World Bank Tribunal

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The Poverty Context

Over the last six decades, systematic efforts have been made to alleviate poverty through:

- increasing economic growth,
- direct attacks on poverty using targeted programmes,
- land and tenancy reforms,
- participatory and empowerment based approaches
- provision of basic minimum services.

As a result of this and due to the efforts made by the poor themselves, the incidence of poverty has declined from

- 54.9 per cent in 1973-74 to
- 36% in 1993-94 and
- 27.5 per cent in 2004-05.
- However the decline in poverty is well below anticipated and these levels of poverty are based on an unrealistically low poverty line.

Despite plans and poverty alleviation strategies we have:

- 301.7 million people in poverty
- many of whom don’t get two square meals a day
- these are unacceptably high levels
- high growth has had little trickle down as the growth is not inclusive; agricultural growth is low and decelerating.

Percent of Population and Numbers of People Below the Poverty Line

1973-74 to 2004-05

Year	% population below the poverty line	Number of poor (millions)
1973-74	54.9	321.3
1977-78	51.3	328.9
1983	44.5	322.9
1987-88	38.9	307.1
1993-94	36	320.3
1999-00	26.1 ?? 30??	260.2 ??
2004-05	27.5	301.7

The Poverty Line

The poverty line on which these estimates are based is **Rs. 356.30** per capita per month for rural and **Rs. 538.60** per capita per month for urban areas.

28.3 per cent of Indians in rural areas (220.92 million persons) and

25.7 per cent of Indians in urban areas (80.79 million persons)

are unable to earn even these low levels of income.

Poverty Levels – far higher and more chronic than postulated

The official poverty line is rooted in calorific norms with a marginal allocation for non-food items on the assumption that basic needs for eg for health will be provided by the state. Structural Adjustment has led to roll back of the state such as for eg privatizing health care and levying user charges. The poverty line needs to be realistically corrected for basic needs not being met by the state. If this is done, most of India's population will fall below the poverty line.

World Bank –IMF pressures to reduce the Fiscal Deficit

The impact of structural adjustment and fiscal compression pressures to reduce govt expenditure has been on for eg:

i) Small and marginal farmers in agriculture – withdrawal of state support and public investment with adverse effects on agricultural productivity and poverty.

ii) The poor who depend on public provisioning for Health – with crumbling health infrastructure, poor diagnostics, user fees and lack of access to medicines.

Pace of Poverty Reduction

The pace of poverty reduction has slowed:
Poverty declined by **12.4%** over the **10 years** pre 1991 structural adjustment
from 51.3% BPL in 1977-78 to
38.9% BPL in 1987-88.

In comparison post 1991:
Reduction of **8.5%** over **11 years** from
36% in 1993-94 to
27.5% in 2004-05.

10th Plan Monitorable Target for Poverty

Target: Reduction of poverty ratio by 5 percentage points by 2007;
Status: Not achieved

36% in 1993-94 say 29% in 1999-00 and 27.5% 2004-05 using URP

Global MDG 1 for Poverty

Halve between 1990 and 2015 the proportion of people whose income is less than $ 1 a day;
Status: Will not be achieved for India
Annex Table page 65 of Global Monitoring Report 2007 shows that percent poor were
1990: 44.3%
2004: 35.8%
8.5% reduction over 14 years
Halving from 44.3% or reaching the Target of 22.15% by 2015 needs a 13.65% reduction in poverty in 11 years.
Cannot be attained with present approaches.

Chronic Poverty, Exit and Entry: 1970-71 and 1981-82

NCAER Panel Data for 3139 households from 260 villages of India shows that:

- More than half (52.61%) of the households remained in poverty
- 47.39% of poor households escaped from poverty.
- 25.74% of non poor households entered poverty.

"therefore the persistently poor are by no means a small subset of the poor."

Source: Bhide and Mehta CPRC-IIPA working papers 6 and 15

A recent wave of the NCAER Rural Panel Data Set (1981-1998) confirms:

- substantial persistence and
- substantial mobility
- into and out of poverty

Between 1981-98, of those who were poor in rural areas, 56.5% of the households were chronically poor while 33% entered poverty.

Source: Bhide and Mehta CPRC-IIPA working paper 28)

Who are the chronically poor

Casual agricultural labourers were the largest group

Most chronically poor

- were landless or near- landless
- had higher dependency burden and illiteracy.
- depended on wages.

The chronically poor are critically dependent on changes in wages.

Many of those in Chronic long duration poverty tend to be stuck in a low wage-high drudgery-tough job groove with little opportunity for escape.

Correct jobless growth, lack of employment opportunities, lack of transfer of skills and access to assets

Low wages and drudgery maintain casual agricultural labourers in chronic poverty

Ratnapandi is a labourer who climbs date palm trees every day to tap them for juice. (Sainath 1996)

- He works 16 hours a day
- climbs date palm trees he does not own,
- risks his neck,
- shins up using his hands and legs and
- earns as little as Rs.5 a day.

These are

- the toughest jobs
- with the lowest pay and
- the maximum danger

Factors that enable escape from poverty are:

- increased income earning opportunities –
- ownership of or access to income from physical assets –cropland, livestock, house
- proximity to urban areas,
- improved infrastructure relevant for the poor
- initial literacy status of the household head

Source: Bhide and Mehta CPRC-IIPA working papers 6 and 15

Perceived reasons for decline into poverty

Shocks such as

- crop failure
- high health care costs
- adverse market conditions
- loss of assets
- high interest from private money lenders
- social expenses on deaths and marriages.

Entry into poverty can be prevented by policies that reduce health care related shocks or costs and high interest debt.

Source: Anirudh Krishna JHD 2004; Bhide and Mehta JHD 2004

Address Persistence of Poverty

- Many of those in chronic poverty lack assets and are dependent on wages for survival.
- Wages in poverty stricken rural areas are well below the minimum wage. Women are are usually paid less than men for equivalent work.
- The ratio of female wages to male wages has declined and gender gaps have increased
- Therefore, at MINIMUM extend NREGA to work on demand for ALL adult individuals, both women and men, in all districts and enforce minimum wage.

Recognise the chronic nature of poverty for the bulk of the poor

- Multidimensional Deprivation and Poverty have persisted over decades and are chronic in nature in many districts of India.
- In addressing poverty reduction it is important to recognise factors causing entry into poverty, persistence of it and strengthen factors enabling exit from it.
- While several factors enable exit from poverty most important is ownership of/access to physical assets such as land and livestock.
- Even a small plot of land can enhance food security and enable exit from poverty.

Resist pressures to divert land to the rich

- In this context the pressure to displace the poor and divert their land to accommodate large projects (eg SEZs) is cause for current and future concern.
- Liberalisation and privatisation policies prioritise commercialisation over livelihoods
- The priority should be for food crops as they provide food and fodder security for the poor.
- Prime agricultural land must not be diverted from agriculture.

Entry into Poverty and Farmers Suicides

The suicides by cotton farmers occurred due to a combination of global and domestic factors and failures. These include unfair trade and roll back of the state due to pressures on the fisc.

High subsidies to cotton farmers in the US etc led to:

overproduction of cotton in those countries

artificially depressed world prices.

Pressures to reduce tariffs made cotton imports easier and cheaper.

As a result domestic prices declined.

Entry into Poverty and Farmers Suicides

Lack of technical support due to withdrawal of the state in Agricultural Extension Services.
Dependence on sales staff selling seeds, pesticides, fertiliser etc regarding when and how much to apply.
Decline in public investment in agriculture and irrigation due to pressure on the fisc.
Shift to commercial farming without support of state extension.

- Low rates of germination of seeds provided by large global firms, spurious seeds and pesticides.
- Debt at very high rates of interest from private moneylenders to sink borewells that failed.

Entry into Poverty and Farmers Suicides

The reports of globalisation related severe distress are not from the poorest states.

The suicides are not by the poorest as these are landed farmers who became poor or declined into poverty.

The distress and suicides are in Andhra Pradesh, Kerala, Maharashtra, Assam and Karnataka.

With large numbers of farmers entering poverty due to globalisation related shock, in states that have performed relatively well according to official estimates of poverty reduction, this has significant ramifications on national poverty trends.

Health related shocks

- In the context of health related shocks casual labourers cannot afford to take time off from work in case of ill health.
- The food that they and their families eat, depends on the money earned from working that day.
- The decline in share of public expenditure on health has meant that the poor are asked to pay user fees, pay for case papers, pay for X-rays, diagnostics and medicines.
- Morbidity rates are rising.

Public expenditure on health

Year	**As percent of Total Government Expenditure**	**As percent of GDP**
1992-93	3.12	1.01
1993-94	3.28	1.05
1994-95	3.26	1.01
1995-96	3.39	1.00
1996-97	3.21	0.93
1997-98	3.32	0.95
1998-99	3.33	0.99
1999-2000	3.34	1.04
2000-01	3.33	1.05
2001-02	3.25	1.03
2002-03	3.06	1.03
2003-04	2.99	0.99

Source: Mid Term Appraisal of the Tenth Plan, page 75

Policy Failure in Health: Low Access for the Poor

Funds are available for HIV/AIDS: Domestic public and private funds, Bilateral and multilateral funds, the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria.

And yet, despite several sources of funds, only 10% of those needing ARV received it in 2006. Many of those who are HIV affected, do not have access to these funds and incur severe debt and penury in dealing with medical etc expenditure.

Case of 25 year old HIV+ Maid

Z is a 25 year old woman with 2 daughters. She is HIV positive.
Her husband died of HIV/AIDS.
She works as a domestic servant and earns Rs 1800 per month.
She spends Rs 1500 on ARV medicine in the of getting access to ARV from the govt hospital.
Her major worry is providing for her daughters and what will happen to them after she dies.

Focus Group Discussion with HIV+ Commercial Sex Workers in Mumbai

A focus group discussion with about 30 commercial sex workers who are part of the CCDT Roshni Project in Mumbai made it clear that the worst affected are the CSWs. **Consequences include:-**

•Being thrown out of the brothel.

•Many of their 'sakhis' getting admitted to crisis centers and some to the hospice at the terminal stage. There is no hope and the future bleak.

•Frequent opportunistic illnesses.

• No place to live, no place to rest, or bathe or use the toilet or wash clothes. Having to pay to use the toilet.

•Police do not allow them to stay on the road and often take them into custody.

•Source: Aasha Kapur Mehta and Sreoshi Gupta 2005

Poverty and Gender Sensitive Priorities in the context of Allocations for Health

Strengthen **ALL Primary Health Centres and Public Hospitals** to ensure access to:

- Reliable and quality Medical Care
- 24 hour functional Diagnostic Testing facilities.
- Ambulances to link PHCs to Hospitals.
- effective drugs through revised schedules
- information wrt Medication Regimen.
- .
- Source: Aasha Kapur Mehta and Sreoshi Gupt, UNIFEM and IIPA, a 2005

- Provide community care homes and hospices to enable support in times of difficulty and reduce the burden on Home based care givers
- Ensure Universal access to preventive and curative treatment and care.
- Demand priority to access to safe drinking water in the home.

- Source: Aasha Kapur Mehta and Sreoshi Gupta, UNIFEM and IIPA, 2005

No User Fees for Toilets

In slums diarrhoea/other stomach related problems are frequent (as is TB) as water is
(i)not available
(ii)not safe
(iii)people don't know the importance of boiling water
Distant location of Toilets creates considerable distress for those who live in slums or on pavements. Hence the need for adequate public provision of clean toilets

To reduce the extreme hardship due to lack of access to toilet facilities and having to pay for use, plan for FREE access to public toilets at regular intervals in urban and rural areas. This is a major gender issue.

The health sector needs urgent attention and significant priority allocation of resources. No individual should fail to secure adequate medical care because of inability to pay for it. The importance of public provisioning of quality health care to enable access to affordable and reliable health services cannot be overestimated in the context of preventing the non-poor from entering into poverty or in terms of reducing the suffering of those who are already below the poverty line.

Monitorable Target for Health

Target: Reduction of Infant mortality rate (IMR) to 45 per 1000 live births by 2007

Status: Not achieved

- IMR was 80 in 1990.
- IMR was 58 in 2005.

Estimates are far higher at 75 for Orissa, 76 for MP, 73 for UP.

Target: Reduction of Maternal mortality ratio (MMR) to 2 per 1000 live births by 2007;

Status: Not achieved

- MMR was 4.37 in 1991
- MMR was 3.01 in 2001-2003
- MMR 5.17 for UP/Uttaranchal and 4.90 for Assam