BODHI TIMES

Benevolent Organisation for Development, Health & Insight (BODHI)

June, 2001 No. 20

The 3Rs

Adult literacy in Northeast India

BODHI is working with Dr Hallelohim Ghonglah (whom we have known since 1995) of the Human Development Foundation, to start an adult literacy project in the village of Sohbar, population 3000, seventy kilometres from Shillong, the state capital of Meghalaya.

Dr Ghonglah has trained more than one hundred community health workers and teaches in the Health Institute of Meghalaya. He is a well-known commentator on social, health and economic issues on Indian TV. He has received several awards, including Best Citizen of India in 1999 and the Jawaharlal Nehru Award for Scholastic Achievement in 1990. He is also Chairman of NEIDAC, a group working to reduce HIV/AIDS in Northeast India, which has the highest infection rates on the Subcontinent.

"The school will be at night after the people come back from work," Dr Ghonglah writes. "Women will definitely be there and there is no doubt about motivation. The school will teach other subjects besides literacy. We expect to have not less than 50 students initially and it will provide 10 hours of instruction a week."

A house in the village of Sohbar

Sohbar nestles into the southern slope of the Khasijaintia hills, which border Bangladesh. The people of the area long ago adopted a matrilineal system of inheritance through the youngest daughter. Dr Ghonglah reports that there is no caste system. Men control all non-domestic work. This area, unlike the rest of Meghalaya, sometimes divides financial inheritance equally between men and women.

Welsh missionaries started the first school in this otherwise illiterate region in 1854, with a Middle English school by 1928. This school system disintegrated slowly after the missionaries left. Today's literacy rate is thirty-two percent.

The Government started the primary health centre in the late 1990s but the centre is woefully inadequate. People suffer from acute shortage of water and whatever is available is unsafe for drinking. There is no system of pumping water from underground sources. Poverty and negative attitudes hinder development.

Urgent requirements include: a **good school** to increase the literacy rate and see that those educated find a way to use their skills and earn a living; **better health facilities** through good health education, kitchen gardens, teaching how to test for the quality of water supply and demand for better quality of the same; and a **small laboratory** facility, including for testing water.

The approximate budget for this project is: room rent for 12 month Rs 2,000, honorarium for two teachers: 12,000; books & materials for fifty participants: 6,000; two almirahs: 2,000; two chairs & two tables: 12,000; blackboards & others: 1,000; travel & supervision from Shillong: 12,000; contingencies: 6,000.00; BODHI administration 10%: 3500; Total Rs 58,300.

A day in the life of a volunteer

Kevin Gobeske writes of Mundgod, South India.

5.30. A typical day begins. Nuns recite their morning scriptures in the fields. I usually fall back to sleep until 6:30, in time to meet Mr. Toutup, the hospital cook, who brings a thermos of tea. "Tashi delek," I say, and bow "toog ji chay" (thank you). Mr. Toutup always smiles and chuckles.

8:00. I walk to the hospital, picking my way through the monsoon mud puddles, to meet the nurses for morning rounds in the TB ward. There I help take temperatures and heart rates, record medications, give streptomycin injections and inquire "chaopsang dweembay" to the patients about their bowels. Nurses and patients chat for a while and I return to the hospital for morning in-patient rounds with Dr. Phuntsok and Dr. Niliwani. In-patients are divided into male and female wards. The former invariably has twice as many patients.

Skin conditions, respiratory infections and hypertension are the most common illnesses, followed by malaria, cholera, snake bites, leprosy, schizophrenia, an array of enteric parasites, cardiac problems, hepatitis, minor trauma, and a suspected AIDS patient. The most complex cases often escape our ability to make a definitive laboratory or clinical diagnosis. I learn the importance of carefully observing patients and treating symptoms rather than simply the presumed disease.

9.00. By the time we finish rounds, a line of patients is waiting for Dr. Phuntsok to begin morning office hours. I receive the patients, review their personal health booklets, take vital signs and note a brief physical impression. Dr. Phuntsok asks questions and

cont. p. 3

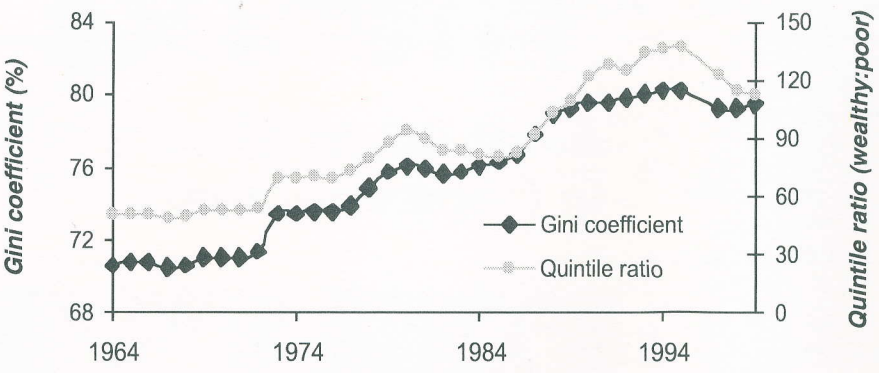
From the Medical Director's Desk

Global Income Inequality

As part of my PhD thesis, I calculated a time series of exchange-adjusted (FX) global income distribution for the period 1964-1999 (see figure). This shows that the trend of global income inequality, measured in US dollars, has increased enormously, using both the quintile ratio (the ratio of annual income receive by the world's wealthiest 20% compared to the income received by the world's poorest 20%) and the Gini coefficient, a measure of inequality that uses slightly more information.

The recent fall in global income inequality is encouraging and intriguing. It appears to be caused mainly by unusually large increases in the per capita incomes of several populous poor nations, including China, India and Bangladesh.

Global exchange adjusted income distribution: 1964-1999



Purchasing power parity

Contrary to the pattern shown in the figure, some economists and statisticians contend that the trend of global income inequality measured by income adjusted for "purchasing power parity" (PPP) is far less clear. Some claim that global income distribution has become less unequal in recent decades. While there is insufficient space here to fully rebut these claims, I'd like to make a few points.

The issue is not just academic. Most commentators on global inequality who use FX measures simply ignore the PPP issue. There is thus very little criticism of PPP measures by critics of the status quo. At the same time, most supporters of PPP incomes simply assert that their measure is superior.

PPP incomes attempt to measure the "real" value of goods and services consumed in any economy. "Real" in this case means purchasing power adjusted not for inflation but for the lower cost of many goods and services in many relatively poor economies, especially goods and service that are not internationally traded.

An inverse relationship exists between the rank of a country's average per capita FX income and the size of the multiplier used to estimate the PPP-adjusted income from the FX income. For example, in 1990 the average annual FX income for the poorest 10% of Guinea-Bissau, one of the world's poorest countries, was only US$9. This equals 40 PPP-adjusted dollars. The multiplier was about 4. In comparison, the multiplier for the reference economy, the USA, is always one.

> The distribution of income, globally, is far more unequal than in any single country, including Brazil, which has a Gini coefficient of less than 65%.

PPP-adjusted incomes, like FX incomes, make no attempt to account for economic "externalities" such as the availability and quality of centrally provided goods and services, including safe water and the function of civil society. These contribute substantially to domestic living standards. However, their quality is more likely to correlate with FX than with PPP incomes.

Haircuts, bricks and racism

National incomes are composed of both traded and non-traded goods and services. The relative cost of the latter largely determines PPP incomes. A country with comparatively cheap non-traded services (a haircut is the classic example) will have a comparatively large multiplier. The price of non-tradeables is principally determined by the price of labor and externalities, such as work safety standards. Lower absolute wages in poor countries causes less impoverishment than in wealthy countries because of the lower price structure which permeates poor economies.

In some poor countries, this low wage structure is underpinned not only by poor standards of safety and centrally provided services but also by child and forced labor, debt bondage and slavery. For example, a brick house of identical quality will be substantially cheaper if built in India than Australia. But most of the bricks in India are handmade by families held in inherited debt bondage. The price of bricks is so low that machine-made bricks cannot compete.

Higher PPP-adjusted incomes are also enabled by inadequate social safety nets, including for insurance, health care and retirement. The misfortune of those at the lowest income levels subsidises the purchasing power of higher earners. Although the same analysis–that the labor of the poor subsidises the well-being of the wealthy–also applies in richer countries, the minimum standards of wages and working conditions in such countries are, generally, far superior.

Resources available for collecting PPP data are also very poor. As much as 95% of the total country-year observations are based on extrapolation, rather than repeated measurement. This greatly reduces confidence in the precision and validity of any detected trends in global PPP-adjusted inequality.

But the most important difference between FX and PPP measures of income may relate to international influence. International negotiations such as for the WTO are rarely held in poor countries. US or Swiss hotels do not give discounts to delegates from countries with low FX incomes. Travel by residents of countries with low FX incomes is almost entirely restricted to similarly poor countries. Arguments that the incomes of such populations are far higher than apparent reek of economic racism, particularly if the world is viewed as a single economic unit.

Rural apartheid

In Australia, proposals occasionally surface for the payment of lower wages to populations living in rural areas where, for example, the price of housing is cheaper. Adoption of such policies would lead to economic apartheid, effectively imprisoning people with lower incomes to permanent residence in economically depressed areas. Importantly, the reverse is not true. People with higher incomes would retain the freedom to go wherever they care, either living in affluent enclaves, or enjoying bargain-basement priced travel in areas populated by the comparatively (and increasingly subservient) poor.

PPP measures of income have a role, but they must not be used to justify or disguise economic apartheid on a global scale.

◆

Year 2

Revolving Sheep Bank

BODHI provided US$3100/A$6200 to enable five more nomad households to purchase 200 ewes and nannies.

Funds went to Tibet in February and will be taken to the nomad area later this northern summer.

Sheep counts are done in late May and June. Yonden hopes to make the transfer at the nomad fair in August, as the sellers can bring their sheep and all the nomads are scattered. Read about it in the next newsletter.

We are currently fundraising for Year 3 of the project, for which we need US$5000/A$10,000. Individual support worldwide continues to be wonderful. The corporate vein remains untapped; we are working to change this.

Fundraising help

Mr. Julian Green has been helping BODHI to fundraise for the Revolving Sheep Bank. In addition to providing advice and expertise, he has been making corporate approaches on BODHI's behalf.

BODHI adviser Sister Mila de Gimeno writes from the Philippines.

'At last we have ousted our president and the new one has been sworn in. Our struggle is just beginning. The present leadership still belongs to the elite class and most of them are in business. We have learned our lessons and shall have to continue being analytical, critical and vigilant.'

In a reflection during the Advent Celebration in December, 2000, Sr. Mila urges people to be courageous in working for justice and peace and asks in *Bangkaw [December, 2000]*, the official publication of the Assumption College of Davao, 'What feeling evoked in your heart if I mention to you the word oppression? What about the words freedom and justice? Just listen to your heart. Today, our country is peopled by traditional politicians united in the old ways of patronage, subservient to elitist private groups and the dictates of the International Monetary Fund-World Bank and foreign monopolistic interests. Our legislation is marked with much bribery; our taxation and justice systems are dispensed with high financial considerations.

'Corruption, cronyism, gambling and womanising are rampant among our government leaders. Private ownership, colonial mentality and profitability within the present system of Philippine social life dictate the type of education we are getting.

'With all this as the backdrop, what sort of education shall we fashion for the 21st century?'

Volunteer's Day, *continued from page 1*

takes histories, performs various tests, explains to me what he sees and makes his prescriptions. I learn to be very observant of physical presentations, since I know just a few phrases in Tibetan and can only understand the gist of what is said. We see roughly 15 patients each morning and 20 each afternoon, often without electricity and running water. My small MagLite flashlight acts as our constant otoscope/retinoscope/laryngoscope, and my stethoscope doubles as a source of entertainment for countless Tibetan children.

12 noon. I eat lunch in the hospital and give English lessons to the staff. I try to learn a little Tibetan in return, but think my students make much better progress than I.

1.00. I accompany Dr. Niliwani (recently returned from his morning visit to the branch clinic in Camp 6) on his rounds to the TB ward, and help him listen to lung sounds and analyse the latest X-rays.

3.00. I help with afternoon consultations.

5.00. Depending on the number of patients, I help Tenpa TK develop a patient database or plan the next community health talk with my friend Sonam Tsephel, a monastery health worker and translator.

7.00. I play soccer with the villagers, work on the computer database, help the nurses with especially intensive cases or read books on dharma and medicine on loan from my friends.

Although I spend the day trying to help others, I always feel that I gain so much more than I give. Each day is an entirely new and wonderful experience. My time in Mundgod will stay with me always—I hope I can share with others all that it has given me.

Tax Update

The long-awaited independent evaluation of five of BODHI's projects in the largest Tibetan refugee camp in India, at Mundgod, has arrived. Many thanks to its authors, volunteers Dr. Dan Rikleen and Dr. Kristin Lobo. We hope this further convinces the Australian authorities to grant BODHI Australia tax-deductible status, something BODHI has had in the US for almost a decade.

We need your help

Thanks to your generosity, BODHI has supported numerous exciting and innovative projects. Current examples include continuing education for remote health workers, adult literacy–a key to better health–and a micro-credit scheme working with Tibetan nomads called the Revolving Sheep Bank.

In order to continue, we need your support. Please send your donation, payable in US or Australian dollars, to an address below.

US donations tax-deductible

Benevolent Organisation for Development, Health & Insight (BODHI) aims to find sustainable ways to improve health, education and the environment in low-income countries, which we feel is achievable by providing a hook, not a fish.

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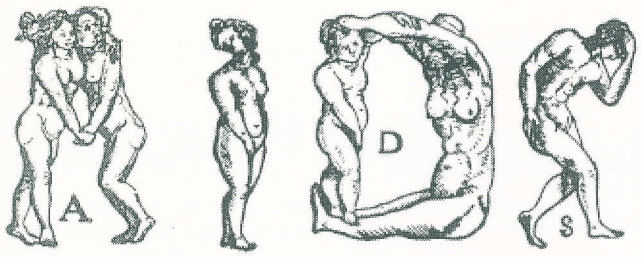

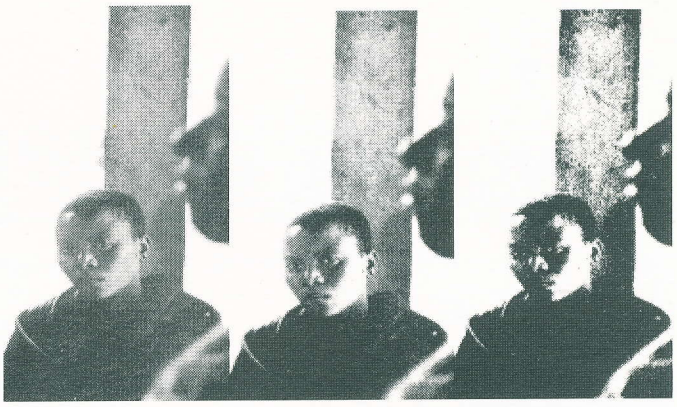

In Africa

HIV & Politics

Australian paediatrician Dr Stephen Graham has worked in Malawi since 1995.

Joe Davies, eighty-five
Winters old and still alive
After the slow poison
And treachery of the seasons

Miserable? Kick my arse!
It needs more than the rain's hearse
Wind-drawn, to pull me off
The great perch of my laugh

RS Thomas ("Lore")

As large parts of Asia and Latin America stabilise, the media portrays Africa as a festering sore on the planet's face. What television and newspapers rarely report is the dignity, compassion, resourcefulness and humour of Africans who stubbornly resist being "pulled off the great perch." The skewed view we see is patronising and damaging. There are things Africans can teach Westerners, who might just occasionally be a little self-satisfied and self-righteous. For instance, South Africa's oft-vilified president, Thabo Mbeki, envisions an "African Renaissance." This must be embraced, although from afar it may seem like political hyperbole in the face of despair.

Last year's International AIDS conference in Durban focussed the spotlight on Africa, especially Southern Africa, which now endures the world's heaviest burden of HIV infection. Political leadership is a powerful weapon in the fight against AIDS. Mbeki's strategy (see *BTimes 19*) of denying the importance of HIV infection in the causal pathway to AIDS could, at the worst, falsely send a message that people have nothing to fear from HIV infection. This could undermine the sort of progress made elsewhere in Africa such as in Uganda or Senegal. It is reassuring that Nelson Mandela was prepared to stand up and steady the ship. However, the broader issues in this complex problem demand global responsibility. It was wrong for conference publicity to make Mbeki a scapegoat—they doth protest too much.

Mbeki becomes justifiably agitated when Western scientists and leaders tell him what to think and say. Aside from South Africa's own apartheid history, Africans have not forgotten the assault on their people and cultural integrity because of slavery, colonialism and the cold war. It is important to move on. Victims of injustices perpetuated elsewhere on this planet know the importance of healing and demand reparation and apology. *A gross disservice is done when the debate is reported as an issue of whether AIDS is due to HIV or to poverty.* HIV infection has long been recognised as a poverty-related disease in Africa by many experienced workers in the field, who also believe that HIV causes AIDS. HIV is like many other infectious diseases, such as dysentery, tuberculosis, cholera or other sexually transmitted diseases. After the initial arrival and early phase of the epidemic, the disease settles and creates most havoc amongst the poor. Further, it is more difficult to promote prevention among the poor, illiterate and dispossessed.

The same amount of global attention was not evident when poorer African countries reached then-unprecedented levels of HIV-prevalence before then. South Africans should have seen the epidemic descending over a decade ago. Earlier leaders, including Mandela, bear responsibility for not mobilising sooner. The pressing problems they faced were relevant to the debate.

Recent trials have shown that the use of anti-viral drugs for a brief period around the time of delivery can greatly reduce the risk of mother-to-child HIV transmission. This offers a relatively simple solution to one part of the problem. South Africa is one of the few sub-Saharan African countries that might be able to afford routine use of antiviral drugs in certain circumstances.

This complex issue puts its leaders between a rock and a hard place, which Mbeki's feet-dragging stance may reflect. Opportunity exists to prevent infection in babies, but there is real uncertainty of benefit versus risk. Extra demands on the health budget may jeopardise other aspects of health care. Data presented at the Durban conference cast doubt on the size of the protective effect to babies born to briefly treated mothers. Then there is the ethical dilemma. The mother is identified as being HIV-positive but the health service is not capable of providing the level of care available in richer countries that could mean a much longer and better quality of life as well as the opportunity to rear this baby rather than leave it as an orphan. After briefly being treated for her infection, how many mothers would then willingly stop? Infected women risk blame, rejection and beatings from their partners. It will also be difficult to make powerful drugs available for limited purposes and then control their supply and usage; a lucrative black market could arise, with inappropriate, unsafe use of the drugs.

The pharmaceutical industry could make a difference. The free supply of Ivermectin has been very effective for control of the debilitating disease *onchocerciasis*, or "river blindness," prevalent in many parts of Africa. Drug companies may gain kudos, and business, from posturing to supply free drugs to poor populations; but will they also help provide the best system for drug delivery? Will they rationalise the pricing of other drugs needed by poor populations? Will they encourage the development of local pharmaceutical industries? If not, it might look simply like self-promotion. That's business; but excessive profits from human tragedies is unethical.

Finally, the scientific community in Durban have their own agenda, including a great need to be seen to be doing something. Limiting their focus risks losing sight of the broader issues. Much of the medical research that takes place in Africa is controlled from abroad. Increasingly, for example in a heated debate in the *New England Journal of Medicine,* the ethics of such research are being scrutinised, but research that is more accountable to overseas funding bodies than to communities in which the research is conducted remains problematic. Similar to the economic "reforms" often imposed on Africans from abroad, timeframes demanded for research results are often unreasonably short.

Living and working in such an environment can make one long for a simple, rapid solution to the vast AIDS problem in Africa. Strong political leadership can make a real difference. However, we should not forget that Africans are ultimately responsible. We should not forget to look, think, ask and listen. We should not forget that there is more to Africa than misery. Responses from outside Africa that alienate one of its most important political leaders, that are ignorant or guilty, arrogant or mercenary, over-sentimental or patronising may combine to be as damaging as the denial of AIDS within. Africa deserves the respect and support that will allow it to endure with dignity, and the optimism and imagination that treatment is possible.