Searchlight SOUTH ASIA

TRACKING URBAN POVERTY TRENDS IN INDIA, BANGLADESH, NEPAL AND PAKISTAN

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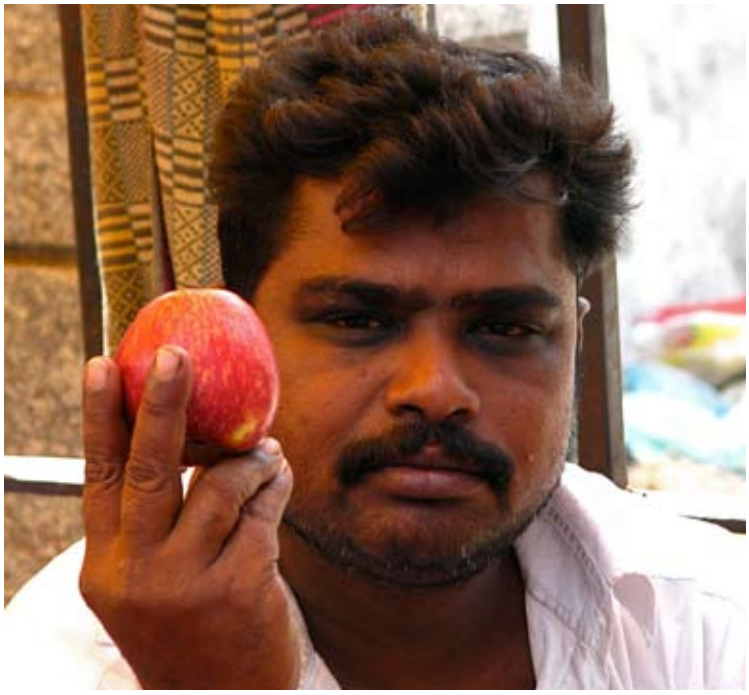

FLICKR USER MCKAY SAVAGE

FEATURE

No magic bullet: NCDs and the Urban Poor

BY SHREE RAVINDRANATH

A study released in July 2013, "Socioeconomic Inequalities in Non-Communicable Diseases Prevalence in India: Disparities between Self-Reported Diagnoses and Standardized Measures", based on the

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World Health Survey, begins by observing that most analyses of non-communicable diseases (NCDs) are based on self-reported figures, and show a higher prevalence among the affluent. It goes on to analyze that the data may be biased because of better health facilities for the rich. Standardized assessment criteria for NCD prevalence reveals that the poor face the same risks as the affluent when it comes to lifestyle diseases; the incidence and occurrence of NCDs in low-income communities are merely likely to be under-reported.

For the poor in urban slums, the majority of the programs targeting community health are often to combat communicable diseases or do not prioritize NCD related outcomes. Communicable diseases such as diarrheal diseases and vector-borne-diseases (VBDs) such as malaria and dengue can take on epidemic proportions rapidly. As a consequence, community health programs target these immediate and visible diseases, where the problem and the cure are apparent within a short period of time. On the other hand, NCDs are silent killers, and treatment and monitoring is over a prolonged period of time- with gradual cure, or none at all. Because of this, NCDs are often not the focus of such efforts. Diagnosing and managing NCDs is even more complex for the migrant urban poor, who have little time and few facilities to turn to.

For the poor in urban slums, the majority of the programs targeting community health are often to combat communicable diseases or do not prioritize NCD related outcomes.

ECONOMIC EFFECTS AND MORBIDITY RISK FACTORS

According to statistics provided by the World Health Organization (WHO), NCDs accounted for over 60% (36 million) of the deaths occurring globally, and for nearly 80% (25 million) of the deaths in Low- and Middle-Income Countries (LMIC). The NCD burden is forecast to increase 17% globally over 2011-2020, and the highest absolute number of deaths are projected to be in the South-East Asia and Pacific regions. LMICs can ill-afford to take on largely preventable deaths due to NCDs, while still grappling with the significant burden of communicable diseases.

Dr. Sukumar Vellakkal, part of the team that conducted the study released in July 2013, says, "In general, a delay in accessing healthcare by [the] poor would further worsen their disease conditions leading to premature death, disability and loss of national income, thus identification and early treatment of several NCDs is important from the perspective of any effective development policy. On a microeconomic perspective, the NCDs would cause impoverishment of households through treatment cost and loss of wage. This would have both short term and long term consequences such as loss of employment, reduction in consumption and savings, and then falling into [a] debt trap."

The three risk factors for NCDs are socioeconomic factors, modifiable behaviors and genetic factors. The urban poor in South Asia are in a high risk category because all three factors significantly affect them.

The main factors for NCDs amongst the urban poor include, amongst others, inadequate childhood nutrition and unhealthy living and working environments. There is a global consensus that adequate and appropriate nutrition during early childhood may make it possible to reduce the risk of NCDs during adult life. Estimates say that the impact of good nutrition could increase a country's GDP by up to 2% through reduced NCD burden amongst other factors. Workplaces of the urban poor, which may be their own home or informal enterprises, offer little safety infrastructure and consistently expose workers to environmental pollutants and carcinogens. These

FEATURE continued

factors, combined with high work-related stress and uncertainty due to informality, mean a high risk of NCDs.

Further, the four main behavioral risk factors that contribute to NCDs are tobacco use, physical inactivity, harmful use of alcohol and an unhealthy diet. It is a well-known fact that tobacco chewing and alcohol abuse are long-standing problems among the poor. Many slum dwellers work in cramped environments where physical activity is difficult. In addition, their diets are likely to have lower than ideal proportions of healthy grains or vegetables and fruits due to the high cost of food. Cheap processed foods that are high in sodium and fats are also convenient snacks for the harried working urban poor and often their children.

> Initiatives that target the urban poor with NCD related outcomes are gaining prominence in public health discourses and in the plans of city municipalities.

The genetic angle forms the final risk factor. People of South-Asian descent are 1.5 times more prone to Ischaemic Heart Disease (IHD) as compared to other groups of people. Across South Asia, IHD, Chronic Obstructive Pulmonary Disease (COPD), stroke, diarrheal diseases and lower respiratory tract infections are amongst the top ten causes of death. According to the Global Burden of Disease Study (GBD), the greatest risks to health in Nepal and Pakistan are household air pollution due to use of solid fuels, in Bangladesh it is tobacco smoking, while in India it is dietary concerns. Many of the non-NCDs show a downward trend in these countries, while NCDs are on the increase. In Bangladesh alone, reports of IHD have increased over 200% from 2000 to 2010.

REFOCUSING EXISTING INTERVENTIONS ON NCDS

The paradigm for NCD prevention, control and health promotion advocates a multi-pronged approach that addresses all stages of NCD management, from prevention to rehabilitation. Interventions mainly address socioeconomic and behavioral risk factors. Investments are being made in educating the public, including courses for children in schools and through awareness programs for adults. Better childhood nutrition through mid-day meal programs, and the use of clean energy sources for cooking and household use are being promoted. In order to address the modifiable behaviors, alcohol and tobacco use is being actively discouraged. To promote physical activity, cities are being improved to encourage physical activity such as walking and cycling.

However, due to the limited data on NCD prevalence, many of these initiatives have not been designed to target NCDs among the urban poor. Education and substance abuse programs are largely aimed at promoting literacy and a reduction in abuse, but may not firmly send across the message for a healthier lifestyle to prevent or manage NCDs. Given the low levels of education amongst the urban poor, they are therefore unable to draw the link between NCDs and their behavior.

Increasing physical activity for the sedentary urban poor may not be achieved through parks, cycling tracks and pavements. In fact, some urban development initiatives may even be completely counterproductive, and deprive the urban poor of what little they have in terms of housing, public spaces and livelihoods. For example, city beautification and redesigning may call for diverting the use of land from slums and public open spaces, demolition of irregular tenements, eviction of street vendors, clearing of pavements and cordoning off spaces below flyovers. Better laid out parks and public spaces may mean entry fees and charges for upkeep, and result in reduced access for the urban poor.

FEATURE continued

INTERVENTIONS TO MANAGE NCDS

Nonetheless, some things are changing for the better. Initiatives that target the urban poor with NCD related outcomes are gaining prominence in public health discourses and in the plans of city municipalities. The Municipal Corporation of Greater Mumbai (MCGM), in a first of its kind effort for the municipal body, created a separate outlay for NCDs. In 2011, the MCGM allocated INR 20 million (approximately USD 182,000) for NCDs, up from no separate budget in the previous year. According to MCGM authorities, a gap analysis revealed the need for such interventions, and they have further made special provisions for NCDs such as hypertension, diabetes and cancer. In 2013-14, the MCGM is planning to augment its outreach program for low income communities and slums, to include mental health, diabetes, TB, dialysis and diagnostic facilities such as MRI and CT scans. Community based programs for NCD control have been implemented for over a decade by the WHO globally, and have shown signs of success.

The government of India's National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS)- a pilot program for promoting healthy lifestyle through massive health education and mass media efforts at country level, opportunistic screening of persons above the age of 30 years, and establishment of NCD clinics, is being rolled out across the country.

With support from the WHO, Pakistan has announced a National Action Plan on non-communicable diseases prevention, control and health promotion. In Pakistan, the NGO Heartfile not only creates awareness and supports NCD outcomes, but has also run a pilot project to provide health financing for the poor through an IT-supported, automated demand side health financing platform that that can be used to provide urgent support for those running the risk of catastrophically spending on heart-related NCDs.

In Bangladesh, community based programs for combating NCD are being run by NGOs such as Eminence.

In spite of these efforts, the combined outcome of existing interventions may merely serve as a starting point, by helping to realistically estimate the magnitude of the problem. Dr. Sukumar says, "It is very difficult make any predictions about future trends in the socioeconomic patterning of NCDs because we do not have any time series data sets to make such predictions. However, as India is moving towards rapid economic growth with enhancement in access to healthcare and increasing levels of education among various population groups including the poor, I would expect that relatively more NCD cases will be reported from the poor in the future than the present."

DIAGNOSIS AND MONITORING FOR THE FUTURE

While the prevailing strategy is largely to create intensive treatment facilities in tertiary care centres, models for better NCD diagnosis and care advocate that the facilities and capabilities be available closer to the patient's home. Emerging technologies such as smart phone based assessments, molecular analysis, and genetic risk profiling are making rapid progress towards doorstep diagnosis and monitoring. They also have potential to contribute to data-based management of these diseases by creating a usable dataset.

However, moving from the laboratory to affordable technology that can be used at the doorstep will take time. On the bright side, given that technology penetration often happens from urban to rural areas, the urban poor may be able to benefit from these advances sooner than their rural counterparts.

CONCLUSION

Apart from helping them with better livelihood opportunities, the most appropriate manner of helping the urban poor may be to redesign the messaging from existing programs, undertake planning of cities by viewing them with a pro-poor NCD lens, and ensure implementation of laws that require better working conditions for informal labor.

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Experience tells us that changes that need significant and sustained effort, irrespective of how beneficial they may be, are adopted slowly. In order to make a significant impact, the poor will have to change deep rooted behavior and beliefs. They will have to tackle the lurking NCD demons on a daily basis by making the right choices at every step- even if they are more expensive, which they can ill afford. No matter what steps are taken, controlling NCDs amongst the urban poor will be a challenge.

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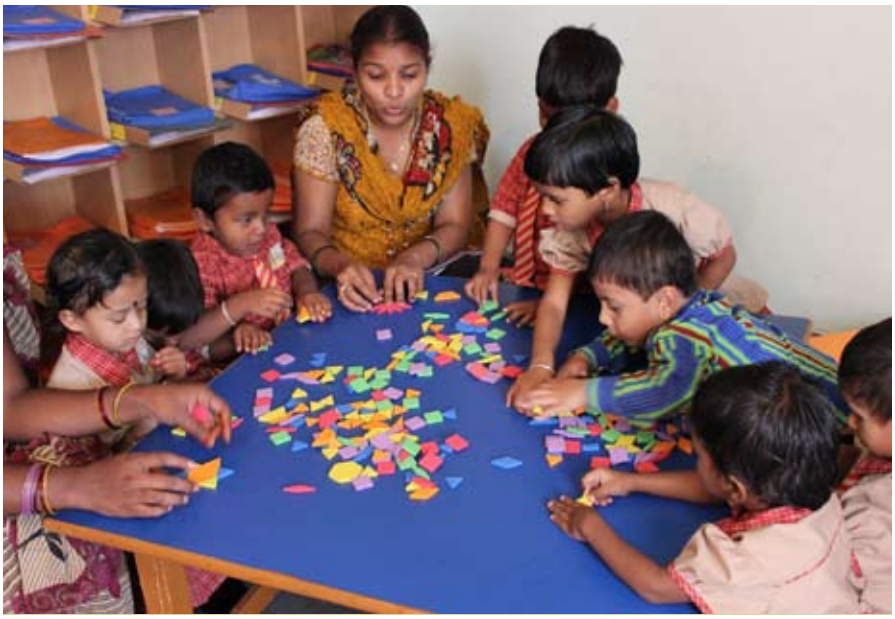

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DEVELOPMENT INITIATIVE

Investing in Early Childhood Education

BY USHA GANESH

Children from poor families are the unfortunate inheritors of poverty – in India, every eighth urban child in the 0-6 years age group stays in slums, as per a report published by the Indian government in 2011. Early Childhood Care and Education (ECCE) is critical to help these children begin their climb out of poverty, and yet it receives scant attention in national policies such as the Right to Education Act.

India has the world's largest integrated program – the Integrated Child Development Services (ICDS) – that focuses on nutrition, health and education for children. The program covers 48% or 75.7 million children of the total 158.7 million children in the 0-6 age group in India. It is largely implemented through centres called *Balwadis* and *Anganwadis* that operate in rural areas as well as urban slums. These centres provide a range of ECCE services such as immunization, health check-ups and monitoring as well as referral services in addition to pre-school education. Given the implementation focus on health and nutrition due to high incidence of malnutrition and its impact on child development, the education component of the program has been found wanting.

The proposed National Early Childhood Care and Education (ECCE) Policy is expected to set some standards for a comprehensive approach towards pre-school interventions. Reports indicate that a thematic ECCE Committee will be initially constituted under the ICDS Mission Steering Group. It will eventually form a National council for ECCE with corresponding State and district level councils to ensure better co-ordination and implementation. In the meanwhile, private sector stakeholders are working to improve the pre-school education experience for children at the BoP. While most initiatives aim to strengthen the *Anganwadis* though capacity building and curriculum development, a few aim to provide affordable pre-schools for the poor.

FRAMEWORK IN PLACE, BUT IN NEED OF CAPACITY BUILDING

In a three-country study across India, Peru and Ethiopia that examines the discrepancies in quality of services available to children, a child from Andhra Pradesh reported that their *Anganwadi* had one "old lady" who worked there, and she fed the children and sent them off. This is not unusual, because typically, the *Anganwadi* worker is not selected for her skills in education delivery, and she is only aided by a single helper. This severely hampers her ability to deliver pre-school education, in addition to the other services pertaining to healthcare and nutrition. The *Anganwadi* workers are also paid a very low honorarium of INR 1500 (US$ 24.24), which was recently increased to INR 2250 (US$ 36.36) in July 2013.

> The ICDS program covers 75.7 million children of the total 158.7 million children in the 0-6 age group in India. It is largely implemented through centres called Balwadis and Anganwadis that operate in rural areas as well as urban slums.

Given these severe capacity constraints, *Anganwadis* form an excellent framework, but are essentially ineffective. Says Venita Kaul, Director of Centre for Early Childhood Education and Development (CECED) at Ambedkar University, Delhi, "*Anganwadis* are now in almost every habitation but it is a situation, in most cases, of access without quality. Kaul is currently leading path-breaking research and early indications show that current provisions are mainly in two sectors – *Anganwadis* and private pre-schools. Kaul adds that while *Anganwadis* either function as food centers only or follow a minimalist ECE program, the private preschools are bad models of primary schooling with a focus on learning by rote in crowded classrooms.

PRIVATE SECTOR PARTICIPATION

Sudiksha Knowledge Solutions' Naveen Kumar opted to build a business model that runs parallel to the Government's *Anganwadis* for this very reason. He started out with setting up affordable primary schools, and soon realized that most children at the BoP were not prepared for schooling, and it was tough to get them to learn concepts. Says Kumar, "We realized that we had to start even earlier, and that interventions in the early years help the child, particularly when they have nothing else to build these skills in their slum communities." He studied the slum communities, interacted with the parents and realized that a significant percentage of the drop-outs in later school years and the low learning levels were due to the children's inability to cope with the curriculum in primary schools, they found it very tough and saw dropping out as the easier option. He explains, "We felt that early education needs a high degree of teacher involvement in order to develop the child's social, emotional growth. There has to be trust, some value education provided to the child, well beyond just reciting numbers or the alphabet. The child needs to discover the joy of learning and we need confident children going into primary school."

Sudiksha now has 22 pre-schools in the slums of Hyderabad (12% of the city is covered by over 1000 slum settlements that house 26% of the population). From the outset, the Sudiksha team was sure they wanted to build a model that could scale as impact could not be achieved with setting up 50-100 schools. In order to build for scale, they developed the Sudiksha model of partnering with women entrepreneurs

DEVELOPMENT INITIATIVE
continued

that are selected from within the community. The women entrepreneurs are educated housewives who undergo a process of selection that assesses them for ability to manage the pre-schools and their entrepreneurial drive. Once selected, they undergo training and are paid a fixed salary plus 10% of the centre's profits – Sudiksha thus has a champion for its cause within the community it seeks to serve.

Others like Sesame Workshop, Akshara Foundation and the Centre for Learning Resources work in the area of capacity building and training the *Anganwadi* workers so that they are better empowered to deliver education. Akshara Foundation initially set up their own Balwadis in slums where children could not access the government-run *Anganwadis*. Over time, they felt it made little sense to work parallel to the system, and they invited the Director of Women and Child Health Department in Bangalore to visit their centres. Says B S Latha Devi, Head – Pre School Programme, "The IAS officer saw the difference in the enthusiasm and interest at our Akshara centres and invited us to work with the State." Today Akshara Foundation supports *Anganwadi* workers in over 1700 centres across Bangalore by providing teaching learning material, training and community engagement. It has also developed assessment tools to measure learning outcomes.

> The private sector is mushrooming all over at a phenomenal pace, and needs to be encouraged but with greater social responsibility and regulation.

Content is critical to the delivery of quality education, and Sesame Workshop leverages decades of global experience to produce well-researched teaching learning content that meets with the national curriculum framework requirements. Says Sashwati Banerjee, Managing Director, Sesame Workshop India, "The largest provider of ECCE in India is the government, and that kind of scale is difficult to achieve. The ICDS also focuses on food insecurity, which affects cognitive learning. Our aim is to strengthen the system from within, provide supplemental material and training for the *Anganwadi* workers." The content development organization ensures its teaching learning material is innovative, attractive, appealing and extremely localized – its popular show *Gali Gali Sim Sim* has reached over 10 million young viewers through television.

Sesame Workshop works with ICDS teams in several states like Uttarakhand, Bihar and Gujarat, and Banerjee says they have been extremely forthcoming and supportive in taking on board Sesame Workshop's suggestions. The content created is tested with *Anganwadi* workers and children to ensure they are appealing, engaging and provide learning through observation, reinforcement, recall and application. Sesame too works with the trainers and supervisors, who in turn train the *Anganwadi* workers. Says Banerjee, "We leverage technology extensively. The *Anganwadi* workers are provided with an SD (memory) card that has pre-loaded content that they can play on their mobile phones. We have all their mobile numbers and broadcast messages every week that they can apply and revert to us with questions." Sesame's footprint across the country would have reached around 500,000 children only through the *Anganwadis*.

WAY FORWARD

Challenges to ensuring reach and efficacy of early childhood education remain – there is very little focus on ECCE and the budgets provided for this age group is very low. The issue remains neglected and still finds only a fleeting mention in policy even though experts agree that this is a critical age for education interventions. Latha Devi, Banerjee and Kumar agree the state of *Anganwadis* in the urban slums is in

DEVELOPMENT INITIATIVE
continued

a far worse condition than their rural counterparts – space is a huge constraint as is capacity and motivation to enroll children. Kumar adds that finding the entrepreneur is a challenge too, especially at scale. In response, Sudiksha is planning to launch an education entrepreneurship training program that will help create a cadre of trained manpower to lead their scale efforts.

Kaul adds that some of the biggest challenges include a lack of parental awareness regarding what is good quality ECE and a very weak *Anganwadi* system despite significant government investment which is perceived as good only for food and is being utilized only by the poorest category who cannot afford private pre-schools. Additionally the lack of any regulatory system and inadequate priority in Anganwadis to ECE further impede the efficacy of the framework set by ICDS. Latha Devi shares that Akshara s team ensures that they speak to the community about education at every opportunity, as the *Anganwadi* workers tend to only speak to them about nutrition and health. Says Kaul, The most important need is for political will, and for MHRD (Ministry of Human Resource Development) and MWCD (Ministry of Women and Child Development) to take stronger ownership of ECE and set up quality standards and effective mechanisms for regulation. The private sector is mushrooming all over at a phenomenal pace, and needs to be encouraged but with greater social responsibility and regulation.

Meanwhile, all the player are gearing for scale – be it working with *Anganwadi* workers to build quality into a framework that can and has achieved scale or with a completely private sector approach through women entrepreneurs. Sudiksha aims to roll out 200 new schools by 2017, while Akshara and Sesame plans to increase its reach to more *Anganwadis*. Even as they build their plans for the future, they are all hoping that the draft National ECCE Policy will soon be implemented – and the spotlight is firmly on the pre-schoolers, and how to leverage the early formative years to develop young minds to their best potential.

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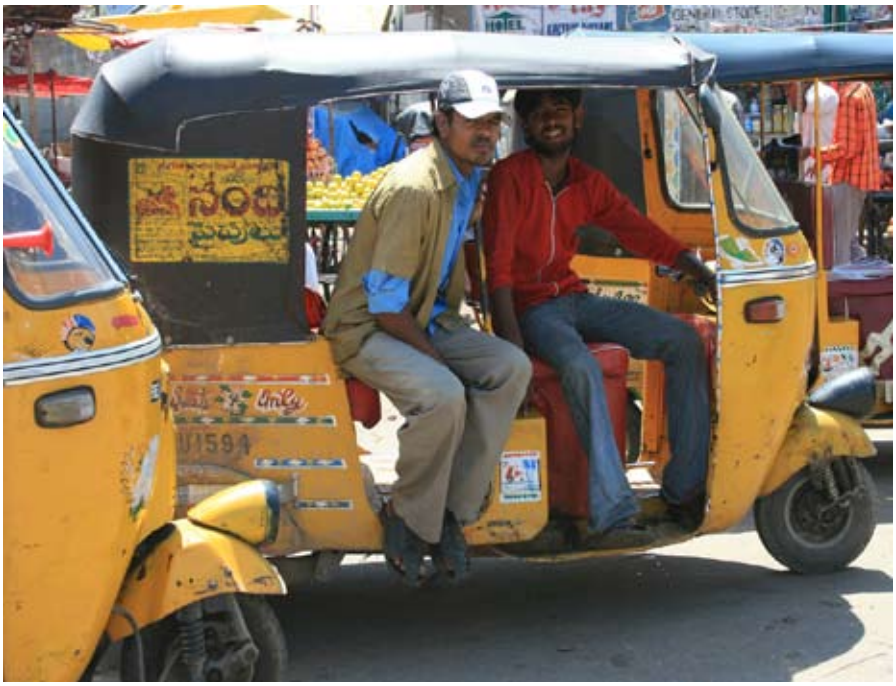

FLICKR USER CAROL MITCHELL

CASE STUDY

The Auto Rickshaw Diaries

BY NOOPUR DESAI

The three-wheeled motorized vehicles popularly known as auto rickshaws are a backbone to urban mobility. Commuters in urban India are served by about 5 million auto rickshaw drivers who move through traffic-tangled streets all day for a living. The drivers work for over 10-12 hours per day, and form part of the urban informal sector in India. They are generally self-employed and lack employment benefits such as health insurance and social security. Income insecurity is a significant concern for the drivers - they earn on a daily basis leading to no fixed income. While over 20 million lives are dependent on the drivers' income; their earnings could be as low as US$ 3 per day. Health expenses are a big challenge for most auto rickshaw drivers. They suffer from serious respiratory health threats as they are constantly exposed to vehicular pollution. The drivers are also prone to road accidents given poor road infrastructure and badly maintained vehicles. On the road for most of their day, they suffer due to the poor quality and availability of hygienic water and sanitation facilities in the country, leading to further health issues.

Auto rickshaw drivers incur high costs to ply their trade. A study in Delhi suggests that about 80% of auto rickshaw drivers rent their vehicles and roughly half of their daily revenue covers the rental fees. Their other large expense is that of gas for the auto rickshaw. Their daily wage depends on the number of customers and the distances travelled. However, they face a daily battle of optimizing their trips and avoiding empty returns, when they have drive long distances without passengers. The drivers, sometimes also face trouble with the police authorities which leads to a cycle of bribery.

CASE STUDY continued

Faced with increasing costs, auto rickshaw drivers find the preset fare meters a pain point. The fares of auto rickshaws are fixed by a meter system decided by the State Transport Authority. Negotiating fares is a common practice in most cities, despite the fixed fare charts. The passengers face a constant hassle of bargaining prices with the drivers. For the drivers, the fixed fare does not suffice or meet their needs. This has led to several auto strikes for higher base rates backed by strong auto unions. Therefore, regardless of the demand and customer base for auto rickshaws in the country, the auto rickshaw driver lives a rather strenuous life of urban poverty and marginalization.

BETTER THE AUTO RICKSHAW EXPERIENCE: DIAL A RICKSHAW

In light of the issues faced by passengers and auto rickshaw drivers, interventions that addresses the concerns and demand of the various stakeholders is imperative. One such intervention that has gained momentum, is the Dial-a-Rickshaw service started by young entrepreneurs in some cities across India. The Dial-a-Rickshaw business essentially allows for people to book an auto rickshaw via phone or internet and in the process addresses the strong dissatisfaction amongst both the stakeholders involved.

> While over 20 million lives are dependent on the drivers' income, their earnings could be as low as US$ 3 per day.

These enterprises have not only provided the "hassle free auto rickshaw experience" to commuters but have simultaneously empowered the auto rickshaw drivers for a better income and living.

MAKING A DIFFERENCE

Nirmal Kumar started G-Auto initiative with three objectives – to provide "*Suraksha*, *Samridhi* and *Samman*" (Security, Prosperity and Dignity) to auto drivers. G-Auto runs an Any Time Rickshaw service with a mission of empowering auto rickshaw drivers as well as proving customer satisfaction. The initiative runs across most cities in Gujarat and is set to launch in Delhi as well. Any Time Rickshaw service allows for passengers to book an auto rickshaw on the basic metered fare with a service charge of INR 15 (US$ 0.25) per booking. The ATR model reduces the nuisance of negotiating fare prices between commuters and auto rickshaw drivers. In its first year of operation, G-Auto earned a revenue of INR 17.5 million (US$ 285481.24) with a net profit of INR 2 million (US$ 32626.43). The organization also earns sizeable revenue through advertising in G-Auto vehicles. With this model, the initiative organizes Auto Rickshaw drivers under one umbrella and improves their living conditions. "G-Auto provides prosperity and security to auto rickshaw drivers with regular income generating rides through the ATR service and also protecting them from the cycle of bribery by taking up any issues with the police to the highest level of authority. By organizing the drivers, also known as G-Pilots under the initiatives, we are also enabling them to live a life of dignity and respect, while providing them with income and job satisfaction," suggests Kumar. Currently G-Auto has 10,000 auto rickshaw drivers from different cities in Gujarat.

SOCIAL VENTURES TO THE RESCUE: AUTO WALE

Entrepreneurs cum Engineers, Mukesh Jha and Janardan Prasad were at the receiving end of long and taxing negotiations with auto rickshaw drivers along with hiring an auto rickshaw in certain areas of Pune, in Maharashtra. As citizens who relied extensively on auto rickshaws for commute, they set up Auto Wale, an enterprise that improved the experience for customers. The idea was to improve the already existing

CASE STUDY continued

options of commuting as compared to building new infrastructure. In-depth surveys in Pune suggested that "most customers had complaints about the auto fares and the constant hassle with auto rickshaw drivers, whereas on the other hand auto-rickshaw drivers were unhappy about unstable earnings and not finding enough customers in a day," says Prasad. Some persistent problems of auto rickshaw drivers included "unpredictable revenue, empty returns and competition from cab/taxi companies." Additionally, many drivers seemed to have some form of debt to repay, worsening their financial condition. Auto Wale's Dial-a-Rickshaw strategy was ideated to use technology, IT systems and communications in the best way to reduce the plight of both parties.

Auto Wale uses two approaches for its dial-a-rickshaw model. The first one incorporates buying miles in bulk from auto rickshaw drivers on a monthly basis. As and when customer requests come in, auto rickshaws depending on their location are assigned to the customers. In this approach, the drivers are paid on a monthly basis, customers get to use the auto rickshaws on metered fare prices with a conveyance charge of INR 20 (US$ 0.33) and time is optimized as the network of auto rickshaws is already established. The registration process is simple as long as all the compliance documents are met by the drivers. Auto Wale also helps in opening bank accounts, where the monthly payments are deposited. In the other approach, generally used during surplus demand, auto rickshaws drivers who want daily earning and more freedom in terms of commute, use a prepaid balance method where an advance is paid for a particular number of trips (for example, INR 1000 (US$ 16.31) for 50 trips). Auto Wale helps these drivers by giving them leads to customers.

> Dial-a-Rickshaw models have not only provided the "hassle free auto rickshaw experience" to commuters but have simultaneously empowered the auto rickshaw drivers for a better income and living.

Auto Wale is focused on increasing the earning potential of the auto rickshaw drivers. "The gross income of the drives has increased by twice and the earning potential by almost 100%," says Prasad. The strategy is simple, to reduce as many empty returns as possible. To that end, Auto Wale has put technology to its best use. They use algorithms to predict future locations of customers and connect the drivers' accordingly. The driver is generally informed of 2-3 simultaneous trips reducing, drastically, the wait for customers. "This method has reduced empty running by almost 25%," suggests Prasad. Auto Wale works in Pune and has validated the model in Bangalore, where it should launch soon. There are about 400 auto rickshaws registered with a customer base of more 10000 commuters. "We are running a business to make it profitable, where all three aspects – the customers, the drivers and the company is satisfied," says Prasad.

SCALING DIAL-A-RICKSHAW MODELS: CHALLENGES AND THE FUTURE

Ay Auto is another enterprise based out of Pune that tried its stint with the Dial-a-Rickshaw model. The approach used was to be an on call service for auto rickshaws. They put together a network of drivers and marketed to customers about the service. The challenge that Ay Auto faced was more to do with bringing about changes in the behavior and mindset of auto rickshaw drivers. "We were unable to change the mindset on one big aspect, we couldn't get them to move from what was a daily struggle

CASE STUDY continued

to a monthly living; we couldn't get them to pay in advance for a benefit that Ay Auto would give. That made it very unsustainable as post-paid collections are nearly impossible," suggests Gopi Aravind, co-founder, Ay Auto. The firm eventually exited and sold its operations to Auto Wale.

"Awareness levels of the customers and the drivers are continuing challenges with Dial-a -Rickshaw models," suggest Kumar and Prasad. The initial implementation itself is tedious, as the enterprises have to ensure that the communication of the concept is put across well to the auto rickshaw unions and authorities to put together a network of auto rickshaws. "One of the larger challenges faced by these models is the unequal demand and supply of auto rickshaw versus the customer requests," says Prasad. Demand in unpredictable with good and bad days. However, as the business scales and awareness increases, "there could be a more uniform distribution solving the demand supply conundrum." For Dial-a-Rickshaw to scale across India, accessing funds for daily operations is critical. "With more players in the market, the scope for validation and expansion increases," says Prasad. In the future, apart from scaling the business, empowering this section of the urban poor through overall community development, increased incomes and health security via insurance are on the cards for Auto Wale.

CONCLUSION

Along with increasing the earning potential, these models have the potential to improve their overall living conditions and have a work-life balance. While the auto rickshaws drivers are self-employed, the idea behind Dial-a-Rickshaw model is "not to kill the entrepreneur in them," but to help them nurture the spirit and improve their lives. "A Dial-a-Rickshaw model where all stakeholders (drivers, customers, unions, government and the company) benefit, is a sustainable one; hopefully we'll get there soon," says Aravind. Dial-a-Rickshaw model presents a sustainable solution to the growing insecurities of auto rickshaw drivers while addressing the customer's plight and in long term, solve the commute issues in urban areas.

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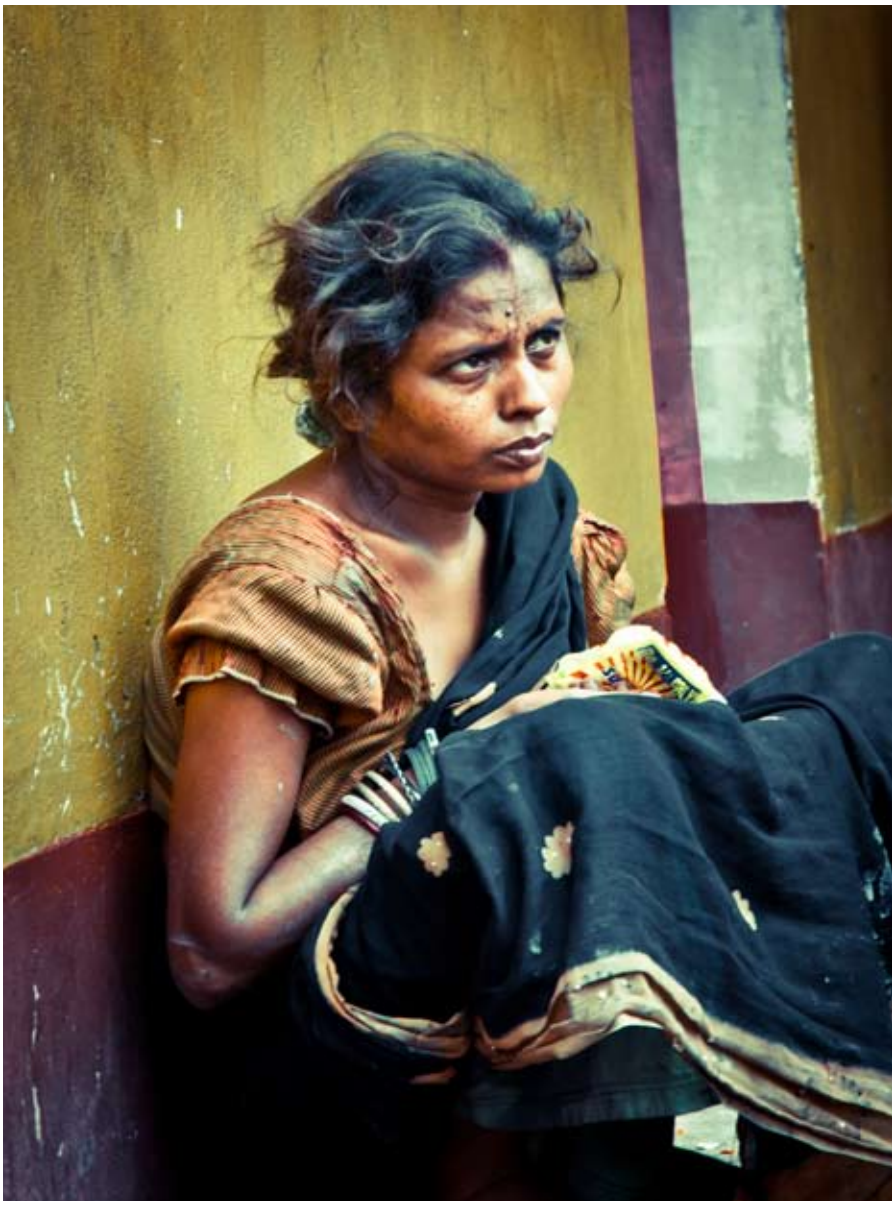

FLICKR USER HUW THOMAS

NEWS DEEP DIVE

Mental Health in India

BY NOOPUR DESAI

A distressed, half naked woman was found running in the streets of Hyderabad, India. Her clothes were torn; she was coated with and dirt, and had no idea of what her name was or where she came from. She was speaking to herself and was clearly delusional. Passersby ignored her. She also went through abuse and harassment. Eventually, she committed suicide.

The above narrates a story of many mentally ill, homeless people across India.

Globally, mental illness has affected over 450 million people, and 80% of them live in middle and low income countries. According to a community based study under

the WHO Mental Health GAP Action Program, in India, the life time prevalence of mental disorders range from 12.2% to 48.6%. The Ministry of Health and Family Welfare suggests that 6-7% of India's population suffers from mental disorders with about 1% suffering from severe mental disorders. Mental Illnesses like Schizophrenia and Bi-polar disorder are prevalent in about 200 cases per 10000 people. The burden of these disorders is likely to increase to 15% by 2020.

Urbanization has an effect on mental health owing to the influence of factors such as overcrowded, polluted and a fast paced environment. Research shows that conditions of poverty have a direct relationship with risk of mental illness. The fight for survival with poor living conditions puts immense strain on the mental health of the poor. The urban poor are faced with problems of violence and abuse coupled with increased costs and reduced social support. Urban slums play host to rural migrants who are highly vulnerable to mental illness due to the strenuous city life and difficult living conditions. A study in Sangam Vihar area of Delhi where a large number of migrants from Uttar Pradesh, Bihar, Haryana and Rajasthan live, 23.4% of the migrants were at moderate risk of mental illness and 3.4% were at high risk. Mental

With over 70 million people mentally ill in India, there are approximately only 3000 psychiatrists, 30000 psychiatric beds and only 43 mental health hospitals, bringing to light the vast treatment gap.

illness is attached with age old stigmas in India as well as across South Asia, and is therefore neglected, suppressed and untreated. Overall, the cycle of mental illness can push people further into poverty, making conditions even worse.

Mental illness is definitely a burden to India, there remains to be a massive treatment gap. A consultant with the National Institute of Mental Health and Neuro-Sciences, in an interview suggested that "while it is desirable to have at least one psychiatrist per 100 000 people in the general population, India has less than one psychiatrist for every 300 000 people, most of whom practice in urban areas where treatment costs are prohibitively high." With over 70 million people mentally ill in India, there are approximately only 3000 psychiatrists, 30000 psychiatric beds and only 43 mental health hospitals. The vast treatment gap is not about the numbers only; the conditions of existing infrastructure are extremely poor.

The dire states of mental asylums (those licensed and non-licensed) have been in the headlines since early 2000s when 26 mentally ill people died in a fire in Moideen Badusha mental home in Tamil Nadu. The reason they were unable to escape is because they were chained to their beds. While the Supreme Court ordered for license, which is a tedious task in itself, the issue still continues to exist. In 2012, the issue of poor mental asylums resurfaced when the police raided a small, unlicensed home for the mentally ill because the neighbors complained of a foul smell. Inside the home 70 mentally ill men were found chained to windows and other was sitting in filth that was probably accumulated for years. A report from the National Commission for Human Rights suggest that the "state of mental healthcare in India, most of the mental health institutes or the hospitals are over-crowded with unhygienic surroundings as they are facing serious financial problems to provide adequate requirements." Given the conditions of mental illness and care in India, the current government has put across a rather comprehensive bill that advocates an approach that ensures rights of the mentally ill patients.

THE INVISIBLE ON THE STREETS

Lack of social support combined with the absolute lack of care, streets have become home to the mentally ill in India. Statistics suggest that 25% of the mentally ill in India are homeless. Nimesh Desai, the director of department of psychiatry at the Institute of Human Behavior and Allied Sciences (IHBAS) in an interview suggested that "Homelessness among mentally ill is growing significantly—it has really become my major concern."

While it is assumed that the mentally ill on the streets are suffering from common mental disorders like depression and anxiety, it is not always the case. "It is difficult to survive the highly bustling streets if the person is going through extreme mental retardation or common mental disorders. 90% of the mentally ill homeless people are suffering from Schizophrenia or an alternate mood disorder. These mentally ill people are capable of harming themselves or those around them," suggests Mukul Goswami of Ashadeep, a mental health society that operates in Guhawati, Assam. "Out of approximately 450 mentally ill admitted in Ashadeep has managed to treat around 400 patients, with 62% rate of follow up. Most of the treated are taken back to their homes that are sometimes all the way in states like Gujarat and Tamil Nadu, which are more than 1000 kilometers from Assam," suggests Goswami. Out of the 450 patients, most of the women are sexually abused and almost all have health issues like skin diseases and respiratory problems. Locating and admitting these homeless patients is a persistent challenge. The ones that do get admitted are either found by the police authorities or volunteers from NGOs.

> In order to break the cycle of poverty and treat mental illness, there is a need to go beyond making mental health a concern of public health and human rights. It needs to become a development priority.

THE MENTAL HEALTH BILL 2012

In June 2013, India's cabinet approved the Mental Health Care Bill 2012. While the Parliament is yet to pass the law, the new bill has been in the headlines for a while. Along with addressing the massive treatment gap, the bill uses a rights-based approach in which the citizens have a right to proper mental health care. The action plan of the bill focuses on "four key objectives: to strengthen effective leadership and governance for mental health; provide comprehensive, integrated and responsive mental health care and social services in community-based settings; implement strategies for promotion and prevention in mental health; strengthen information systems, evidence and research for mental health."

One of the flaws in the previous mental health bill was the legal and administrative process, where if a person was rescued from the streets or was found in mental distress, the court of law needed to deem the person as mentally ill. This essentially meant prolonged suffering for the patient until the legal procedures were completed. With the new bill, "the court is no longer involved, the person is to admitted to the NGO or the hospital, it is then their job to inform the Mental Health Review Commission, making things more practical without delaying the process," suggests Goswami.

The new bill also suggests the right to make an "advance directive", which is a pre-empted written statement that allows for the person (with or without a mental disorder) to state how they want to be treated. The person is also allowed to nominate a representative who can take decisions for the person. While the advance directive is a major shift in India's mental health care system, it is a cause for criticism of the bill. From the lens of the poor and vulnerable, this method might never come into play.

The other important features of the bill include decriminalization of suicide and ban on electroconvulsive therapy without anesthesia. The bill also provides for the patient to challenge the doctor's decision to admit them. While it is important to maintain the rights of the patient, in case of the homeless and poor, they may not necessarily be accompanied and therefore this is slightly risky in the light of the harm patients can cause to themselves. However, many experts have deemed the bill to be practical and groundbreaking given negligence and lack of mental health care in India. Michelle Funk, coordinator of Mental Health Policy and Service Development at WHO's Department of Mental Health and Substance Abuse, in an interview suggested that, "Too few people with mental disorders and psychosocial disabilities in India have access to good quality mental health care, and too many within the system have experienced extensive human rights violations, including inhumane and degrading treatment, restraint, seclusion, physical, sexual, or emotional abuse, and neglect." Most importantly the bill is looking to address the lack of proper infrastructure for mental health care in India and have provision s for a various treatment options, including outpatient and community services and half-way homes.

While the outcomes of this bill are yet to be seen, it is definitely a positive step in dealing with the mental health crises that India is facing. However, some interventions in the recent past have shown a new ray of hope for treating the problem. The civil society and NGO's play an important role improving the situation of mental illness and health.

WAY FORWARD

A number of NGOs are coming to the rescue of the mentally ill poor. The Banyan, a Chennai based home for destitute and mentally ill women has gained international attention for the model rehabilitation program. The program extends its support beyond the treatment as it found that families refuse to accept the mentally ill once treated owing to the stigma attached to mental ill-health,. Recognizing that the support for the mentally ill is minimal and rehabilitation is huge challenge, the Banyan has created Adaikalam, which is a transit center for women rescued from the streets. It has rehabilitated over 1000 people who are now leading meaningful lives with economic activities. Women who have been treated at mental health homes like Ashadeep and The Banyan have taken up various jobs with handicrafts, beauticians, house help, etc with support from the NGO's.

The biggest challenge that Mental Health Care in India faces is the lack of awareness and social stigmas attached to the illness. In light of this challenge, community mental health programs in slums seem to an option for combating the issue. The Banyan runs community mental health projects and community living projects across rural and urban areas. "Community mental health care is the only way that will help the person to recover holistically and spread awareness about mental health at the same time in the neighborhood; solving the issues of stigma and ill treatment," suggests Goswami.

CONCLUSION

It is imperative to increase manpower and reduce the treatment gap that exists with mental health care in India. The forced invisibility of this issue is portrayed not only by the lack of proper facilities but also by the lack of comprehensive data on mental health in India and the budget allotted to combat the problem. Mental illness is definitely one of the causes that pushes the already marginalized further into poverty. The urban poor fight a hard and strenuous battle for survival and strong mental health is extremely important for them to develop. In order to break the cycle of poverty and treat mental illness, there is a need to go beyond making mental health a concern of public health and human rights. It needs to become a development priority.

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Regional News Summaries

Development & the Economy

A recent survey in India suggests that the rich-poor gap widens. Bangladesh makes an uneven progress in attaining social equity

RICH-POOR GAP WIDENS IN URBAN & RURAL INDIA

July 6, 2013

[India] A recent report by the National Sample Survey Organization suggests that the median monthly per capita expenditure has increased by 33% in rural areas and 34% in urban areas. Rural households are spending more on health care whereas urban households seems to be spending more on transportation. Food spending is still low with spending on non-food products has increased from 59% to 61% in urban areas from 2010 to 2011-2012. 5.7% of urban India's miscellaneous expenditure budget is on education.

http://www.indiaspend.com/sectors/rich-poor-gap-widens-in-urban-rural-india-45473

NEPAL'S ECONOMIC SURVEY PAINTS A BLEAK PICTURE

July 14, 2013

[Nepal] Nepal's economic survey at end of the fiscal year 2012-2013 suggests that economy has been marked with low economic growth, minimum progress in poverty reduction coupled with high rates of currency depreciation. Nepal targeted to bring poverty to 21% from 25.3%, but settled at 23. 8%. The currency depreciated by 8.2%.

http://www.gulf-times.com/nepal/250/details/359430/nepal%E2%80%99s-economic-survey-paints-bleak-picture

PROGRESS IN ATTAINING EQUITY IN SOCIAL INDICATORS UNEVEN: STUDY

July 25, 2013

[Bangladesh] UNICEF, Bangladesh Bureau of Statistics (BBS) and the Bangladesh Institute of Development Studies (BIDS) launched the Child Equity Atlas: Pockets of Social Deprivation report. The report understand the patterns of social inequalities, identifies areas of progress and pockets of deprivation based on the 2011 census data. Key social deprivations are face by women and children. The prevalence of child labor is higher in urban areas at 9%. The Child Equity Atlas was released in order to contribute to the policy dialogue for better reform and relevant policies.

http://www.thefinancialexpress-bd.com/index.php?ref=MjBfMDdfMjVfMTNfMV8zXzE3Nzc1NQ

Education & Health

Bangladesh makes progress in health sector. More Children in Pakistan remain uneducated and are victims of child labor.

BANGLADESH'S HEALTH SECTOR GROWTH 'STRIKING'

July 20, 2013

[Bangladesh] A British medical journal, The Lancet in a recent issue suggests that Bangladesh has made enormous health advances and the pace of growth of the sector is the most striking amongst South Asian countries, despite spending less on the sector. The country has achieved the longest life expectancy, the lowest total fertility rate; and the lowest infant and under-5 mortality rates within the region.

http://bdnews24.com/health/2013/07/20/bangladeshs-health-sector-growth-striking

NEWS SUMMARIES continued

18 MILLION HEPATITIS PATIENTS IN PAKISTAN

July 27, 2013

[Pakistan] Every 10th Pakistani is believed to be suffering from viral hepatitis. An estimated 18 million people are infected with the hepatitis B and C virus. On an average, Pakistan witnesses 150000 deaths per year. Awareness is extremely low on the disease and more often than so, those who are infected are unaware. Hygienic habits like washing hands, drinking boiled water and eating hygienic food can prevent the incidence of hepatitis A & E.

http://www.thenews.com.pk/Todays-News-6-192589-18m-hepatitis-patients-in-Pakistan

MILLIONS OF KIDS STILL OUT OF SCHOOL IN MALALA'S PAKISTAN

July 29, 2013

[Pakistan] The most recent annual State of Pakistan's Children report by an Islamabad based NGO found that out of 120 countries in the world, Pakistan has the second largest number of children out of school (after Nigeria). 5.1 million children between ages 5-9 are not attending educational institutions. While education is vital for development, a significant number end up in workplaces, with as many as 12 million being victims of child labor.

http://southasia.oneworld.net/news/millions-of-kids-still-out-of-school-in-malala2019s-pakistan#.Ug1yNdI3Cn8

Energy & Environment

Pakistan faces impending climate change and food insecurity challenge. India is bearing the burden of high environmental costs.

PAKISTAN FACING A DAUNTING CHALLENGE OF FOOD INSECURITY

July 7, 2013

[Pakistan] Globally, while countries are increasing budgets to counter climate change, Pakistan is reducing the development budget for the environment sector. The country needs to produce 29 million tons of wheat during the next two years to feed the growing population, face the challenges of poverty and food insecurity in the backdrop of adverse climate change effects.

http://www.thenews.com.pk/Todays-News-6-188282-Pakistan-facing-daunting-challenge-of-food-insecurity

POLLUTION COSTING INDIAN ECONOMY 5.7% OF ITS GDP EVERY YEAR

July 24, 2013

[India] A World Bank study suggests that the cost of environment degradation in India is equivalent to 5.7% of its GDP. Outdoor pollution in urban areas itself claims about 0.1 million lives along with 7513 children below 5 years of age. Unfettered urban growth, outdoor and indoor pollution accounts for 52% of the environmental cost borne by the country.

http://southasia.oneworld.net/news/pollution-costing-indian-economy-rs-3.75l-cr-a-year-study#.Ug3JPtI3Cn8

People & Poverty

Steps are being taken to promote workplace safety in Bangladesh. Poverty percentage declines in two states of India.

HOW AID CAN HELP PROMOTE WORKPLACE SAFETY IN BANGLADESH

July 19, 2013

[Bangladesh] Following the Rana Plaza industrial disaster that claimed many garment workers lives, over 70 apparel brands and retailers, international and local trade unions along with nonprofit groups have agreed on a legally binding document that puts labor rights and occupational safety within reach. The plan allows for independent building and fire safety inspections, the publication of inspection reports, worker-led health and safety committees in every factory and renovations of existing structures; with all expenses to be shouldered by the brands profiting from the garments industry. While these reforms are the first of its kind in Bangladesh, many influencers including the International Labor Organization are lobbying for larger reforms of the new labor that conforms to international labor standards.

http://southasia.oneworld.net/news/how-aid-can-help-promote-workplace-safety-in-bangladesh#.Ug1jytI3Cn9

ODISHA, BIHAR SHOW BIGGEST DROP IN PERCENTAGE OF POOR

July 24, 2013

[India] The two states of Odisha and Bihar in India have shown the sharpest decline in poverty levels between 2004-2005 and 2011-2012. While the percentage of poor has declined, the proportion of poor in these states remains to be well above the national average. At the all-India level, the share of the below poverty line population was estimated at 21.9%, which is almost 270 million.

http://articles.timesofindia.indiatimes.com/2013-07-24/india/40771094_1_bpl-population-poverty-line-bpl-group

DELHI BECOMES FIRST STATE TO ROLL OUT FOOD SECURITY SCHEME

July 27, 2013

[India] Delhi announced the implementation of the ambitious food security scheme from September 1, 2013. The scheme will benefit 3.2 million people in the first phase. The first phase will include all below poverty line families along with above poverty line card holders. The city government has decided to include homeless people, daily wage earners, rag pickers, and people living in resettlement colonies and slum clusters in the first phase of implementation.

http://southasia.oneworld.net/news/delhi-becomes-first-state-to-roll-out-food-security-programme#.Ug1yUNI3Cn8

Water & Sanitation

Pakistan is increasingly becoming a water scarce country as groundwater sources deplete.

GOVERNMENT SPENDING INR 36.5 BILLION TO PROVIDE WATER FOR SELECT FEW

July 10, 2013

[Nepal] The Government of Nepal is spending as much as INR 36.5 billion (US$ 468 million) in the Kathmandu Valley to reform the water supply system alone. Each resident of the valley is obliged to pay INR 22500 (US$ 359.57) to buy a pipeline post project completion. This huge expenditure on water supply in the valley is synonymous to unequal distribution of resources. While drinking water is a major problem across Nepal, the government seems to be spending about 10% of GDP on one million residents who can afford the pipelines.

http://thehimalayantimes.com/fullNews.php?headline=THT+10+years+ago%3A+Govt+spending+Rs+36.5+billion+to+provide+water+for+select+few&NewsID=383247

GROUNDWATER DEPLETION: ANOTHER CRISIS LOOMING IN PAKISTAN

July 13, 2013

[Pakistan] In Pakistan, the underground water is running out with the per capita availability of water drops at 990 cubic meters in 2013 as compared to 5650 cubic meters in 1947. The Asian Development Bank and The World Bank have place Pakistan in the red zone category as a water stressed country, which is likely to face acute water shortage over the next five years and the ground water table going down to 800 cubic meters by 2020. The over extraction of ground water has led to fast depletion of aquifer, raising alarming levels of bacterial consumption. Currently over 45% of Pakistan's population does not have access to safe drinking water.

http://www.international.to/index.php?option=com_content&view=article&id=8950:groundwater-depletion-another-crisis-looming-in-pakistan&catid=97:breaking-news&Itemid=74

Events

INDIAN ECONOMY IN 21ST CENTURY: ISSUES AND CHALLENGES

September 14, 2013
Mumbai, India

http://www.sjrscollege.org/pdf/National%20Conference%20on%20Indian%20Economy%20in%2021th%20Century%20issues%20and%20Challenges%20(14-09-2013).pdf

GOVERNING YOUTH IN SOUTH ASIA

September 24-25, 2013
Kathmandu, Nepal

http://www.sasnet.lu.se/sites/default/files/kathconf13.pdf

INDIA WATER FORUM

October 28-30, 2013
New Delhi, India

http://www.teriin.org/events/iwf/

SDPI'S SIXTEENTH SUSTAINABLE DEVELOPMENT CONFERENCE

December 10-12, 2013
Islamabad, Pakistan

http://www.sdpi.org/sdc/index.php?event_id=325

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Intellecap is a pioneer in providing innovative business solutions that help build and scale profitable and sustainable enterprises dedicated to social and environmental change.

We seek to build institutional capacity and channel investments in the development sector through Knowledge Services, Consulting, and Investment Banking Services. Intellecap hosts Sankalp Social Enterprise and Investment Forum, Asia's largest social enterprise forum that brings together over 700 investors, innovative social enterprises, policy makers, funders and other key stakeholders from across the world.

Intellecap also promotes I^3N, India's first angel investment network that makes early stage investments in double bottom line for-profit enterprises.