

5 What should be done about chronic poverty?

There are many policies that are potentially beneficial for the poor AND for the chronically poor. But people living in chronic poverty are not 'just like the poor but a little bit further down the poverty spectrum'. Overcoming chronic poverty requires policy makers to reorder their priorities and set their sights higher than the current consensus on poverty reduction policy.

Development strategy needs to move beyond the bounds of its present emphasis on economic growth – hundreds of millions of people are born poor and die poor in the midst of increasing wealth. Chronically poor people need more than 'opportunities' to improve their situation. They need targeted support and protection, and political action that confronts exclusion. If policy is to open the door to genuine development for chronically poor people, it must address the inequality, discrimination and exploitation that drive and maintain chronic poverty.

Action on chronic poverty needs a framework to:

Prioritise livelihood security: *A much greater emphasis is needed on preventing and mitigating the shocks and insecurities that create and maintain chronic poverty. This is not only about providing recovery assistance but also about giving chronically poor people a secure position from which to seize opportunities and demand their rights. Thus, social protection policies are of great importance.*

Ensure chronically poor people can take up opportunities: *It is crucial both to promote broad-based growth and to redistribute material and human assets, so that chronically poor people are in a position to take up opportunities and can better cope with shocks.*

Take empowerment seriously: *Policy must move beyond the cosy rhetoric of participatory approaches, decentralisation and theoretical approaches on rights. It needs to address the difficult political process of challenging the layers of discrimination that keep people trapped in poverty*

Recognise obligations to provide resources: *Chronic poverty cannot be seriously reduced without real transfers of resources and sustained, predictable finance. The political indifference to meeting national and international obligations on poverty eradication needs to be challenged, and ways found to foster social solidarity across households, communities and nations.*

The need for policy change must not mask the fact that it is the chronically poor themselves who are the leading actors in overcoming their own chronic poverty. As Maymana and Mofizul reveal (Box 4.7), poor people are not passively waiting for assistance: they are actively working to maintain and improve their circumstances. Most of the action to tackle chronic poverty is at individual, household and community levels. The benchmark of effective policy is whether it enables people to get a better return on the efforts that they are already making.

There is now an unprecedented window of opportunity for pushing forward with the eradication of poverty:

- the MDGs provide an agreed framework for action;
- the 'Monterrey consensus' and the proposal for an International Finance Facility (IFF) indicate a new seriousness in the provision of resources;
- we are a decade on from the World Summit on Social Development in Copenhagen when heads of state signed up to the global commitment to eradicate poverty; and
- globally, people are recognising the interconnectedness of the world and the responsibilities that this creates.

Analysis of chronic poverty points to the need to reduce vulnerabilities by investing in human capacity, supporting the acquisition of assets and strengthening people's capacity to assert their rights. In the short-term this is challenging and costly, but it is essential to achieve and sustain MDG gains.

Security first

Prioritising livelihood security for chronically poor people

The current development consensus, expressed in the World Development Report 2000–01,¹ argues that because of their interconnectedness there is 'no hierarchy' between opportunity, empowerment and (livelihood) security. And then, apparently by chance, opportunity always comes first and security always comes last. A related invisible hand seems to guide the drafting of PRSPs: economic policies and growth rates take priority. This covert prioritisation of economic opportunity may or may not be appropriate for the poor. For the chronically poor, however, one thing is clear – such an emphasis is incorrect. Livelihood security must come first. Insecurity dominates their lives, constraining their ability to take advantage of opportunities or risk pushing for empowerment. Chronic insecurity means that the long-term poor engage in economic activities that destroy their human capital,² and social relationships that block off opportunities for asset accumulation.³

Different poverty reduction strategies are appropriate for different mixes of chronic and transitory poverty.

- In a country where poverty is more transitory than chronic, where ‘the poor’ at any particular time have a high probability of improving their position, policies should focus predominantly on social safety nets that help people to avoid descending into chronic poverty, rapidly return to a non-poor status and reduce vulnerability. This includes limited term unemployment allowances, social grants, workfare, micro-credit and new skills acquisition programmes.
- In a country where a significant proportion of the poor are chronically poor, then policies to redistribute assets, direct investment toward basic physical infrastructure, reduce social exclusion (from employment, markets and public institutions) and provide long-term social security will be necessary if poverty is to be significantly reduced.

Quite different national development strategies, roles for the state and forms and levels of international support are needed in the two cases.

The benchmark of effective policy is whether it enables people to get a better return on the efforts that they are already making.

Prioritising livelihood security entails developing cost-effective social protection systems for the poor and chronically poor, rather than the residual concept of ‘modular social safety nets’⁴ that has shaped contemporary policy. As the chronically poor are predominantly both dependent on their physical labour to make a living, and exposed to high incidences of health problems, providing them with the means to maintain their health is of over-riding importance as both a goal in itself and a means to improving their lives. For those chronically poor who are not economically active – sometimes, but not always,⁵ the old and infirm, the severely disabled, the chronically ill, the stigmatised, those with full-time caring duties – then short-term assistance is inadequate and mechanisms for longer term support must be established.

Recognising the need to prioritise the security of the chronically poor is not a recipe for creating welfare dependency. The interconnectedness of security,

Box 5.1 Poverty reduction policies that assist the poor and the chronically poor

- Pro-poor, broad-based economic growth
- Peace-building and conflict prevention
- HIV/AIDS prevention (especially in India, China and the CIS) and greater access to retroviral treatment (in Africa)
- Slowing down global warming
- Strengthening national and international governance
- Making trade fair (especially removing the obscene agricultural protectionism of rich countries)
- Effectively managing national indebtedness (through debt relief and fiscal prudence)
- Improving the effectiveness of basic service delivery in the public and non-profit sectors
- Making markets work for all

opportunity and empowerment, allied to the agency of chronically poor people, means that social protection policies and expenditures are often directly productive. They permit people to spend more days labouring (because they are not ill). They are often used for income generation and children’s education – the various uses and impacts of old age pensions in South Africa are good examples⁶ – and they create the space for chronically poor people to choose between economic and social relationships (rather than having to take on ‘last resort’ options that mortgage their future opportunities).

Examples of the positive effects of social protection on growth and asset creation include the Maharashtra Employment Guarantee Scheme and India’s Midday Meal Programme.⁷ Indeed, the most innovative schemes for helping the chronically poor escape poverty, such as BRAC’s Income Generation for Vulnerable Group Development and Ultra-poor

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programmes,⁸ and Bonded Labourer Schemes in Nepal,⁹ conceptualise social protection and income generation as integral, not as a choice between consumption/welfare or investment/growth expenditures. Transfers enhance efficiency and growth when they reduce risk and excessive inequality that prevent people participating in and contributing to growth.¹⁰ The South African pension has been shown to be an effective tool of

redistribution, reaching poor households and the poorest children. The gross impact of pension incomes is estimated to reduce poverty by 12.5%.¹¹

Given the large number of people who are chronically poor, a major re-orientation of international thinking about social protection policy is called for, focusing on protecting breadwinners’ and carers’ incomes, and working to in-

Social protection policies and expenditures are often directly productive.

crease their (and their children’s) assets, whether financial, physical or human. This is not to deny the continued importance of preventing descent into poverty, but to add to the social protection agenda a significant new and urgent dimension – helping the chronically poor avoid catastrophic situations leading to destitution, family breakdown and early death, and providing social assistance to people who cannot work enough but who are nevertheless contributors to household welfare through caring and other roles.

There is now significant evidence that social protection – in combination with other policies and interventions – can enable persistently poor people to escape poverty. It can shore up consumption so potentially irreversible welfare effects (reducing nutrition, avoiding essential medical expenditures or withdrawing children from school) do not occur. It can prevent the erosion of savings and other assets, and help poor people avoid becoming trapped in debt.¹² It also

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provides the security that permits very poor households to invest in economic activities and human capital. By permitting a greater level of household risk-taking, it facilitates economic diversification, making local economies more robust and reducing the degree to which communities are exposed to covariant risk. There is emerging evidence that social protection measures can also achieve a more gender neutral distribution of benefits than other development initiatives.¹³

There is an urgent need to synthesise experience in this field and see whether it can form a base for innovative larger-scale programmes – by governments and/or the profit and non-profit sectors. Knowledge about how to design strategies that permit chronically poor people to move from partial dependence on welfare through to independent livelihoods should soon be sufficient to develop effective programmes during the coming decade.¹⁴

Tackling childhood poverty

Any attack on chronic poverty must incorporate an attack on present childhood poverty, and on the ways poverty is

transmitted over lives and generations. Even a relatively short period of deprivation in childhood can harm child nutrition, health, education and aspirations, with dramatic and irreversible consequences for the long-term well-being of both the child and her/his own children.¹⁵

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Access to basic services and household assets are crucial to children's survival, protection and development. Needs are well understood: adults without sufficient time and assets cannot adequately nurture their children; children in remote areas often cannot attend school; states without adequate resources cannot finance education. Investments that allow chronically poor people to take up opportunities for development are key to the interruption of child and intergenerational poverty. At a minimum, this requires the development of adequate adult labour markets; financing of state provision of public services and social protection; and programmes that support asset generation and retention. It can also require campaigns and legal action to prevent discrimination against particular children, households and groups.

Policies to interrupt the relationship between ill-health and poverty are essential to prevent the chronically poor from becoming destitute and to permit exit from poverty.

Sectoral policies should focus on the most crucial aspects of child well-being:

- First, action to foster child health and nutrition includes the promotion of greater food security; food supplementation; the promotion of later marriage and childbearing, helping to prevent the intergenerational transmission of poor nutritional and health status; and combating gender and other biases in child-feeding practices.
- Second, enhancing and equalising opportunities for both child and adult education requires substantial financial investment; a wider environment that prioritises and enables this investment; an enabling social context, involving public action (to promote girls' education for example); and sustained efforts to create skilled employment opportunities for youth.
- Third, the negative effects of work in childhood can be countered through enhancing school quality and accessibility, particularly for girls; developing adult education; more effective regulation of working conditions; and a wide range of poverty reducing measures that dthe need for children to work. Blanket policies regarding child work must be treated with caution.
- Finally, policies that acknowledge the crucial role of good adult-provided care and nurture in child development.

Preventing and interrupting chronic poverty through health services

Chronically poor people rely on their personal labour power and hence their health for survival: they have few other assets to utilise. In study after study, ill-health comes out as a major driver and maintainer of long-term poverty.¹⁶ Maintaining the health of breadwinners and carers in chronically poor households is absolutely critical, combined with social protection against the effects on the ability to labour of ill-health and other crises. Mounting evidence suggests that the ill-health, morbidity, disability or premature mortality of adults,



This boy, like many others, is working to help his family survive, but missing out on the education that might give him better prospects.

particularly household breadwinners, matter more to the economic viability of households than was previously recognised.¹⁷ Sick people are more likely to become poor, while poor people are more vulnerable to accidents, disease and disability.¹⁸ Ill-health shocks can trap already resource-poor households and individuals in poverty.

There is a need to focus policy on the role that redistribution can play in extending the opportunity of the poorest.

Policies to interrupt the relationship between ill-health and poverty are essential to prevent the chronically poor from becoming destitute and to permit exit from poverty. There are two main aspects to this: preventing ill-health through better environmental and occupational health, greater health awareness, and better infant, child and maternal nutrition and care; and, preventing the impoverishing effects of ill-health through better and more accessible and affordable curative care, drug availability and insurance. This is especially important for breadwinners and carers as their ill-health can set off cycles of asset depletion that have irreversible consequences for household well-being. While most countries and the international community already focus significant attention on the former (but arguably insufficient attention on occupational health, nutrition or reproductive health), there is little focus on combating the impoverishing effects of ill-health. This demands a focus on curative services. In particular:

- Making public curative health services more accessible and affordable to the chronically poor through reducing the direct costs (fees, medication) and transaction costs (travel, time, food expenses) of treatment. This would also foster a reduction in the number of chronically poor people delaying seeking treatment, or withdrawing early from treatment programmes.
- Strengthening curative health services (public and private), so that they can cope with the major killer and impoverishing diseases (such as malaria and TB). This would permit breadwinners to get back to work more quickly

through avoiding protracted illness and death, and allow poor carers to maintain their own health while looking after others.

- Linking health services to social protection, so that where there are impoverishing effects these can be mitigated through accessing an appropriate protective scheme. This can be done universally, through health insurance, or in a targeted way if there is a range of protective public policy instruments to hand (the issue is to structure these to include the chronically poor).

Special efforts are needed to tackle the ways in which HIV/AIDS is driving households into long-lasting, deep poverty. This involves:

- Making low-cost anti-retroviral treatments available so that breadwinners, parents and caregivers can continue in their roles for as long as possible. Persuading pharmaceutical companies to lower prices, facilitating the import or

local manufacture of generic medicines, and increasing aid that permits anti-retroviral drugs to be provided free or at low cost, are means of moving this agenda forward.

- Raising awareness of the consequences of the HIV/AIDS epidemic, and how it might be minimised, in 'late starter' countries such as China, India and the former Soviet Union. If countries such as these do not pursue effective and high-profile campaigns to lower transmission rates of HIV/AIDS then one of the greatest drivers of chronic poverty will reshape poverty dynamics in these countries (see Box 5.2).
- Focusing greater resources on the development of a vaccine against HIV/AIDS as a global public good. As most AIDS deaths have been in Africa, the resources put into finding a vaccine or cure have been much lower than would have been the case had these deaths been in high-income countries.

Box 5.2 Lesson learned? HIV/AIDS in India and China

The significance of HIV/AIDS for households and states in much of sub-Saharan Africa, in terms of its importance in driving and maintaining chronic, severe and multidimensional poverty and deprivation, is overwhelming. While the pandemic is nowhere near under control, there are some positive trends. In Uganda, for example, sustained and large-scale prevention efforts focused on young people fostering significant changes in sexual behaviour, and political commitment to reducing stigma and providing treatment, have combined to lead to a marked decline in infection rates over the past decade. Outside Africa, in Brazil, HIV/AIDS death rates have been cut by half and hospitalisation by 80% by making generic anti-retroviral drugs free to all who need them.

In other parts of the world – notably the populous countries of India, China and the Russian Federation, already battling huge poverty problems – HIV/AIDS rates are increasing rapidly, and not only among high risk groups. Low overall prevalence rates mask huge regional differences. It is crucial that Asian and European states learn from the successes and failures experienced in Africa, and that the international community – including drugs companies – facilitate this process.

China presently has about one million people with HIV/AIDS. UNAIDS expect the incidence of HIV to soar in the context of ever-widening socio-economic disparities and massive amounts of migration. Thus prevalence rates are estimated to rise tenfold by the end of the decade. In 2001, China launched a five-year AIDS action plan, signalling a growing recognition of the huge task at hand.

After South Africa, India has the most people living with HIV/AIDS of any country – an estimated 3.97 million as of the end of 2001, and rising. If HIV/AIDS is not brought under control, it is likely to undermine progress made in reducing poverty, particularly in the southern states. In July 2003, a National Parliamentary Convention on HIV/AIDS was convened, in which over 1000 political leaders from mayors to ministers took part. The Executive Director of UNAIDS described the event as 'historic':

'Never before, in any nation of the world, has there been such a large and committed gathering of the leaders from every level of decision-making, dedicated to the common cause of fighting AIDS.'

Sources: UNAIDS 2002; Joint UNAIDS/Parliamentary Forum on AIDS 2003.

Opportunity is not enough: growth, inequality and redistribution

Enabling chronically poor people to engage in economic activity, and to reduce their unemployment, underemployment and low-productivity work, is a vital step on the road out of chronic poverty.

Economic growth can directly increase incomes and assets, and expand the revenues available to government to provide services and promote progressive social change.¹⁹ However, the quality of economic growth is as important for the chronically poor as is the rate of growth: growth must be broad-based so that increased demand for their labour, goods and services occurs and so that they are able to improve their productivity. And, given the evidence that the poorest 20% of the population benefit less from economic growth than do others,²⁰ it must be supported by other actions, especially those that increase livelihood security. Middle-income countries such as Brazil and South Africa have managed to grow their economies over the years, but millions remain trapped in poverty.

Patterns of growth need to be fostered that make use of the labour of the poorest, expand demand for the services and goods they produce, and enable them to increase their labour productivity. In many economies, this means focusing on and investing in agricultural and casual labourers and the labour markets

they depend on, and prioritising the type of trade that increases employment, improves working conditions and wage levels. This may require evolving a different balance between public regulation and the private sector's (especially the informal sector's) freedom to determine working conditions. This presents significant policy dilemmas in cases where such measures might undermine fragile growth prospects, but should be easier where growth is more robust. Avoiding undermining the labour productivity of the chronically poor is a major challenge in today's globalised economy.

Confronting deeply engrained attitudes, social structures and economic interests that deny chronically poor people their rights presents difficult challenges but should not deter action.

There is substantial evidence that poverty reduction is achieved most rapidly, and is most likely to reach the poorest, when income and asset inequality are at modest levels. It is therefore crucial to encourage growth that does not rapidly increase inequality.²¹ There is a need to focus policy on the role that redistribution can play in extending the opportunity of the poorest. The massive declines in chronic poverty in South Korea²² and Taiwan were based on economic growth following effective land reforms that dramatically reduced inequality. Malaysia's

rapid poverty and chronic poverty reduction achievements have derived in part from policies involving the redistribution of land, and public expenditures on health and education that have been skewed towards the poorest and thus are redistributive.²³ The challenge is to generate the political commitment to implement land and other asset reforms, since such policies can dramatically improve the economic opportunities for chronically poor people.

In a significant number of countries, growth is likely to remain low in the short to medium-term (at least) because of structural factors and severe governance problems. In addition to the humanitarian arguments, there are two reasons why the international community should not abandon such countries. First, they require forms of support that protect poor populations (many of whom are chronically poor) from preventable deaths and capability-depleting experiences (malnutrition, ill-health, impairment), and to maintain their capacities to seize opportunities when (and if) growth returns.²⁴ Second, effective international transfers require relationships of trust, and when regime change occurs these are most likely to be rapidly established if there are pre-existing relationships to build on.

The distinct geographies of chronic poverty in most countries point to the need for growth policies to have a strong regional dimension. Much depends on the nature of the factors that discourage growth and underpin high levels of chronic poverty in a region. Where these are based on a lack of connectivity then major investments in infrastructure – through foreign aid or public funds leveraging in private investment – can provide the lead. Malaysia's land settlement schemes and industrial plans led to opportunity being relatively broadly distributed across peninsular Malaysia and a rapid assault on chronic poverty across rural areas.²⁵ In Bangladesh, the aid-financed Jamuna Bridge has transformed the patterns of opportunity available to the poor and chronically poor on the west side of the river.²⁶ In other contexts, migration may be the mechanism by which people seize opportunities, but this can have both beneficial and adverse impacts on the chronically poor.²⁷ Accessible services that facilitate the transfer and use of remittance monies can help.²⁸



Growth and prosperity exist side by side with chronic poverty

Empowerment: making rights real

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care . . . Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realised.

– Articles 25 and 28 of the Universal Declaration of Human Rights.²⁹

Issues of livelihood security and economic growth fit relatively easily into debates about policy. Empowerment is an issue that has quite different dimensions. Existing patterns of power relations are the outcome of deeply embedded historical processes and social structures. Intervening in such social and political relationships is about engagement with long-term social change, not simply about ‘policy decisions’. Unfortunately, where empowerment is most needed – for example where repressive regimes operate or agrarian relations are quasi-feudal – it is also most difficult to foster.

Many of the debates around empowerment in recent years have focused on rights-based approaches to development and poverty reduction. Empowerment is particularly important for the chronically poor as they are the most likely to be denied their rights and the most prone to discrimination. The big question around the promotion of empowerment and rights is not so much about ‘what?’ as ‘how?’. Confronting deeply-engrained attitudes, social structures and economic interests that deny chronically poor people their rights, especially when they are embedded in state institutions, private businesses and local communities, can appear both hopeless and very dangerous for the chronically poor.³⁰ They may be ‘punished’ or ‘taught a lesson’ by those whom they challenge when they seek their rights. Occasionally, though, there are advances, as illustrated by Rojamma and her associates who successfully confronted domestic violence (Box 5.3). The more such events happen and succeed, and the more they are publicised and lauded, the more likely it is that they will take place again in the future.

Empowerment and the achievement of rights are direct goals for development, but they also contribute to the

Box 5.3 Rojamma and the campaign against domestic violence and drunkenness

When Rojamma, from Andhra Pradesh, attended a literacy class, she read a story which described a life very like her own. A poor woman was struggling to make ends meet. Whatever her husband earned, he spent on liquor, and then, drunk and violent, he attacked her because she had no food to give him. Unable to stand the continuing violence, the woman went from house to house in her village, to find other women who had the same story to tell. They got together and decided to picket liquor shops and stop liquor being sold. Their husbands then would have no liquor to drink, and the money they earned would be saved.

Rojamma was inspired by the story, collected her friends together, and began to picket liquor shops. The campaign spread. In village after village, women refused to allow their husbands to squander money on liquor. And, they succeeded. The sale of liquor was banned by the government in Andhra Pradesh, savings went up, violence went down, and lives began to improve.

Source: Butalia 1998.

attainment of other goals. A rights-based approach means that poverty is not just regarded as morally unacceptable, but that clear duties are identified that different institutions must fulfil in order to combat poverty.³¹ This is not purely an argument for social justice (an important goal in its own right) but for the economic logic of securing rights. A rights-based approach is not anti-growth; on the contrary, many, if not most, rights are pro-growth – when people are properly fed, healthy and educated they can contribute more to their local and national economies and raise global levels of demand.

But this still leaves the problem of how to promote empowerment. Much faith has been put in the capacity of participatory approaches – to gather information, plan implementing programmes

and evaluation, to engender changes in social relations. The work of CPRC researchers³² indicates that, at best, such approaches achieve mixed results in terms of empowering the poorest. While they create a political space for previously ‘unheard’ voices to engage with decision-making, they can often reinforce pre-existing forms of social stratification.³³

At present the CPRC partnership is exploring the degree to which concepts such as ‘political space’,³⁴ ‘social solidarity’³⁵ and ‘social energy’³⁶ might aid the understanding of how to promote rights and mobilise poor and non-poor people to support such efforts. The rhetoric of support for the poor and chronically poor is easy to generate – but the important issue is moving beyond that into action. MDG Goal 8 provides a classic



Holding powerful institutions to account: Bangladeshi disabled people challenge the processes that keep them poor.

example of this dilemma (Box 5.4). The citizens of rich countries are content to let their leaders make big promises about poverty reduction, but they lack the social solidarity with the poor in the poorest countries, and are not prepared to take on vested interests in their own countries to demand that their leaders honour such promises.

A rights-based approach is not anti-growth; on the contrary, many, if not most, rights are pro-growth.

Discussions about empowerment and rights are often naively critical of elites. Analytical frameworks and practical action must look at the real world settings in which pro-poor elites can play key roles in promoting the rights of disadvantaged groups. How can energetic leaderships and mass action be mobilised both at the ‘top’ of the social spectrum and at the ‘grassroots’, in order to force the rights of chronically poor people onto national and international agendas? How can the perceptions of elites and middle classes be shaped, through the media, education and civil society, so that those trapped in poverty are not invisible, ignored or believed to be non-deserving? These difficult questions need to be prioritised by poverty analysts.

The national agenda: reaching chronically poor people

Delivering basic services

Improving the security and enabling chronically poor people to take up opportunities requires access to basic services (education, health, water and sanitation, social assistance). To achieve this three interlinked issues must be addressed. First, access barriers need to be reduced. Second, the quality of service outputs needs to be improved so they are capable of assisting people out of long-term poverty. Finally, attitudes and perceptions of the value of services, and therefore the demand for services, need to be fostered among the chronically poor.

Some access barriers are relatively simple to bring down – formal charges on basic services can be abolished, although this is not the case for informal charges. Others may be more difficult, due to remote location, unclear land or residential rights, disability, or discrimination. The lack of information can constitute a formidable barrier, especially for people who do not have access to many media, and who are isolated, illiterate or don’t speak a national language. Information provision – through media accessible to the chronically poor (e.g. local radio) is a critical means of both expanding access and raising demand.

Demand is stimulated both by the knowledge that the service exists and on how to use it, and by knowing that using it is a right. However, changing demand for services may involve complex economic and cultural calculations and power relations: examples would be the demand for family spacing/planning services, and for education, both contingent on logical ‘cost-benefit analyses’ and subject to the influence of powerful individuals in households and communities who determine that boys should be prioritised over girls, or that women should ideally bear a certain number of children, or that contraception is immoral.

Neither access nor demand will improve outcomes if quality is not addressed. The degree of quality enhancement required to make access worthwhile and contribute to stimulating demand is substantial in many situations. Encouragingly, there is much work in this area, through sectoral programmes. The quality of private provision, on which the chronically poor often depend, is a particular concern. Quality relates also to the level of service provided. If this is too basic, demand for the service may be limited: for example, if there are no referrals from primary to secondary health services, the incentive to attend a clinic is greatly reduced.

Delivering social assistance

If it is accepted that the poor have a right to social protection, as agreed in the Universal Declaration of Human Rights, how would this best be accomplished? The key issues in delivering social assistance are whether and what form of targeting will benefit the chronically poor; whether the value of transfers can be sufficient to have development as well as relief outcomes (so that the chronically poor may accumulate assets); and how technology and institutional innovation can make targeting and delivery easier.

Where administration is weak, targeting is difficult. In such situations, common in the poorest countries, the politics of transferring resources to the poor is much easier if the non-poor benefit too. Universal provision is thus preferable, wherever resources permit. Where targeting is imperative, self-targeting or targeting by readily-observable indicators is preferable to

Box 5.4 Are rich countries and their citizens really committed to reducing poverty? Targetting MDG 8

The bold Millennium Declaration from 189 countries that “We are committed to making the Right to Development a reality for everyone and to freeing the entire human race from want” is not yet matched by bold actions on the part of the developed world.

Goal 8 of the Millennium Development Goals declares the establishment of a global partnership for development. It promises the Least Developed Countries (where the greatest concentrations of chronically poor people live) tariff and quota-free access for their exports; an enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more aid for countries committed to poverty reduction.

What has followed this declaration? Trade talks at Cancun have failed as OECD countries refused to open up their highly-protected agricultural markets; debt reduction has proceeded at a snail’s pace; and rich countries have made promises of more ODA at Monterrey but have not committed anything like the necessary resources.

MDG Goals 1 to 7 – all of which are the primary responsibility of developing countries – have agreed targets that are regularly monitored. There is less emphasis on quantifiable targets, however, for MDG Goal 8, which is about what rich countries do.

more complex administrative approaches involving means-testing. Self-targeting schemes, where resources being transferred (such as wages or food in a public works scheme) are kept at low levels, are only attractive to people with no other options. Such programmes are more suited to preventing destitution than reducing chronic poverty, although well administered public works programmes, like the Maharashtra Employment Guarantee Scheme, can contribute to both.³⁷

Evidence is mounting that even very small transfers can have positive impacts on welfare and investment.

Studies of 'free' school lunches, subsidised basic foods and pensions in India also point to the protective and promotional roles of such interventions.³⁸

Spatial or social targeting (for instance targeting poor areas, minority ethnic groups, older people or children) may have developmental benefits for the area or group and, depending on the target group, may result in targeting on chronic poverty.³⁹ Demographic targeting can be effective in contexts where the number of children in a household is strongly linked to chronic poverty, but there is a risk of creating perverse incentives. Community-based identification of the poor and poorest has become popular, but may fall victim to elite capture, especially in unequal communities.⁴⁰

To make policy prescription even more complex, context has been found to be a key determinant of the success of targeting in reaching the poor or very poor.⁴¹ This makes generalisation difficult but suggests that it may be best to build on local experience rather than to adopt 'best practice' solutions that may be inappropriate in new contexts.

In many countries, the coverage of social assistance schemes is constrained by public expenditure ceilings. If these are reduced or removed, as schemes mature and demonstrate their effectiveness, then the chance of reaching the chronically poor can be greatly improved. For example, in the social protection trend-setting state of Tamil Nadu in southern India, budget ceilings for pensions and other allowances were dropped in the early 1990s. As a result, by March 2003 there



Alvera, like many millions of older people, is using her pension to support and educate her grandchildren

were almost 1.2 million 'destitute' pensioners (defined as those with no other sources of support) receiving Rs 200 (US\$5) per month. Without such assistance the state's growing population of chronically poor older people would have been larger and even more deprived.⁴²

New forms of delivery can help reduce the often considerable costs of transferring resources. For example, direct transfers through post offices, banks, mobile vans, and taking advantage of computerised information systems and electronic identity cards, may offer significant advantages over other possibilities for getting resources to poor people, and can inject substantial resources into weakly integrated areas⁴³ and marginal groups, provided they are adequately registered. Linking service delivery with social protection transfers through 'conditional transfers' can make a difference to demand: the Food for Education programme in Bangladesh and the Progresca scheme in Mexico have both resulted in parents keeping more children out of the labour force for longer, thus reducing the likelihood of their being poor in the future.

The value of a transfer is a critical aspect of scheme design as it shapes cost and potential impact – but evidence is mounting that even very small transfers can have positive impacts on welfare and investment. The 80% national coverage achieved by Nepal's old age pension

scheme within six years of start-up, despite the physical and communication obstacles in this mountainous state, provides evidence of the feasibility of effective social assistance programmes for the chronically poor. The value of the pension, at 2.5 days' agricultural wages per month, is low, but this could be incrementally increased over time to permit it not merely to provide security but to facilitate opportunities for the younger members of the household.⁴⁴

Social assistance is not about 'doles'. Pensioners support grandchildren's schooling; public works schemes provide the savings for small scale business start-ups.

Both the coverage and value of social assistance programmes are affected by how social protection is perceived by the non-poor. There is a need to point out to national and international policy-makers, the middle classes and the general public, how transfers are often used not only for current consumption but also for saving, investment and further redistribution within the household. Social assistance is not about 'doles'. Pensioners support grandchildren's schooling; public works schemes provide the savings for small scale business start-ups.⁴⁵

Using PRSs to prioritise the chronically poor

A major advantage of national Poverty Reduction Strategies is that they put the issue of poverty at the heart of dialogue between donors and developing countries. They also offer the potential for improved analysis and coordination of efforts to target poorer groups.

But from the perspective of chronic poverty, evidence to date suggests that PRSPs could play a more effective role.

Few PRSPs disaggregate poverty adequately; few specifically recognise the needs of the chronically poor, though many discuss vulnerability; most exaggerate the extent to which economic growth will deliver poverty reduction; and few emphasise strongly protecting the assets and rights of the poor. International structural factors that contribute to chronic poverty, (such as casualisation and insecurity for workers in the global fruit market), are not currently part of

most PRSP processes. (See Chapter 4).

In principle, the ‘joined up thinking’ that is supposed to inform PRSPs, could enable government and donor agencies to take better account of the multidimensional nature of chronic poverty.

‘Joined up thinking’ in PRSPs, could enable government and donor agencies to take better account of the multidimensional nature of chronic poverty.

What PRSPs have achieved to date is the establishment of *processes* that may ultimately create disaggregated strategies to be developed that take account of the particular problems facing chronically poor people. But sustained commitment and attention from governments and donors will be required if PRSPs are to result in effective measures to tackle multidimensional and persistent poverty.

Putting chronic poverty on the international action agenda

Inevitably, the whole framing of development policy is in the hands of people who have never experienced malnutrition, disabling exclusion, and the humiliating lack of capabilities like illiteracy. For the global elite (north and south), perhaps the biggest challenge is to understand the real obstacles facing people who have never had these advantages.

There is a kind of intellectual recidivism in policy making, which means that however well intentioned, policy keeps returning to the idea of broad based growth as a complete solution. But the reality is that many people are never going to be able to grasp the opportunities that the global market is supposed to offer. Facing up to this reality, and properly taking into account the rights of 300–400 million people in chronic poverty, requires more than the grudging provision of patchy safety nets and policies governed by the illusion that opportunity will be enough. A much more creative and dynamic policy approach to chronic poverty is not only essential on rights grounds, but it also recognises emerging evidence that measures to increase security for the poorest can contribute to aggregate growth and long term poverty reduction.

Using the Millennium Development Goals to address chronic poverty

The implications of the eight MDGs, and their many targets and indicators, for the chronically poor are varied (see Table 5.1). Only Goal 2 sets a universal target – primary education for all children. This goal cannot be reached unless children in chronic poverty are included.

The other targets for 2015 are not measured by universal achievement. This means that policymakers can decide to exclude those who are hardest to reach, from efforts to achieve the MDGs. Most significantly, the Goal 1 target of halving US\$1/day poverty by 2015, *may* be achieved, by concentrating on those nearest the poverty line.⁴⁶

But as Table 5.1 illustrates, the case for insisting that people in chronic poverty must be fully incorporated in efforts to achieve the MDGs rests not only on rights. The sustained reduction and eventual eradication of absolute poverty will be achieved more effectively if current policy and action is informed by chronic poverty analysis.

The coherence of MDGs and international policy

The MDGs cannot be viewed in isolation from other international policies and negotiations, some of which result in conditions in which chronic poverty is sustained and may even increase. There are still too many stark cases when ‘northern’ interests are crudely asserted. For example, shortly after agreeing to the complete eradication of hunger by 2015 at the World Food Summit in 1996, the US government published an ‘interpretive statement’ that ‘the attainment of any ‘right to adequate food’ or ‘fundamental right to be free from hunger’ is a goal or aspiration to be realised progressively that does not give rise to any international obligations’.⁴⁷ As a consequence, the MDGs seek only to halve global hunger by 2015 – only 900 million people will need to suffer hunger longer than agreed in 1996!

The Millennium Declaration on eliminating poverty should inform all government actions – not only those on aid and development co-operation. At present there is a major inconsistency between developed countries’ commitment to the

MDGs and their stance on trade. It is difficult to see how developed countries can justify entering into trade meetings knowing ‘that the better they succeed, the more people will die of poverty’.⁴⁸

The Millennium Declaration on eliminating poverty should inform all government actions – not only those on aid and development co-operation.

Financing chronic poverty reduction

Resources from governments and Official Development Assistance

The resources to finance poverty reduction mainly come from developing country governments, aid donors and, importantly but often overlooked, from poor people themselves. Government resources in many developing countries are under immense pressure. During the 1990s, many countries in Africa experienced a worsening of both economic and poverty indicators, as communities and whole nations suffered a range of shocks, including conflict, deteriorating terms of trade and HIV/AIDS.⁴⁹

The only international resource that is meant to be focused on poverty reduction is international aid – Official Development Assistance (ODA). But over the 1990s, global aid experienced a sharp reversal, falling 20% in real terms by 2001. Between 1990 and 2001, ODA aid fell from 0.33% to 0.22% as a share of donor GNI – compared to the UN target of 0.7%. In 2002, ODA rose by 7% in real terms from its 2001 total, up modestly to 0.23% of donor country GNI.⁵⁰ But just one donor out of 22 DAC donors was giving more in real terms in 2002 than they had a decade earlier. Just to restore aid to its per capita levels in 1990 would require US\$23 billion in additional funding – a 45% increase.

In 2002, the year of the Financing for Development (FfD) Summit in Monterrey, Mexico, global aid stood at almost US\$58.3 billion. Estimates prepared for the FfD Summit by the Zedillo Panel suggested that to achieve the MDGs, an additional US\$50 billion/year in ODA was needed.⁵¹ This was almost certainly an underestimate, as it did not include costs for clean water and sanitation

Table 5.1 The MDGs and the chronically poor – helping each other?

Millennium Development Goals	Significance of this goal for the chronically poor	Significance of including the chronically poor for the achievement of the MDG
Goal 1 Eradicate extreme poverty and hunger	<ul style="list-style-type: none"> Target 1 (halve the proportion of those living on less than US\$1/day) could lead to a focus on the less poor at the expense of the chronically poor. Although the introduction of indicators 2 (poverty gap) and 3 (share of poorest quintile) improved the ability of this goal to focus attention on the chronically poor, the lack of a specified target means that these indicators exercise relatively little influence on policy-makers. Target 2 (halve the proportion of people who suffer from hunger, in terms of prevalence of underweight children under five and proportion of population below minimum level of dietary energy consumption) is useful in guiding policy towards the needs of the chronically poor, and those likely to become chronically poor. 	<ul style="list-style-type: none"> Progress on reducing child malnutrition is very slow. Addressing chronic poverty could speed this up considerably, since chronically poor households are significantly more likely to contain under and malnourished children. Progress on increasing the share of the poorest in national income would be enhanced by specific attempts to transfer income to the chronically poor.
Goal 2 Achieve Universal Primary Education	<ul style="list-style-type: none"> Universal Primary Education must, by definition, include chronically poor children. In the shorter term, some countries may target more resources to those more likely to enrol, in order to improve rates as much as possible, acknowledging the impossibility of achieving 100% enrolment by 2015. 	<ul style="list-style-type: none"> This goal cannot be achieved without the chronically poor. In low literacy countries (where many chronically poor people live) the 'increase literacy among youth' indicator may encourage a focus on the 'easy to reach' poor.
Goal 3 Promote gender equality and empower women	<ul style="list-style-type: none"> Potentially mixed impacts. Essential in the long term, but could work against the interests of the chronically poor in the short and medium term, if non-poor women (and their households) gain privileged access to education, employment and parliament at the expense of poorer men (and their households). 	<ul style="list-style-type: none"> Interrupting chronic poverty requires girls to go to school and stay in school for longer, among other things, which fosters the achievement of this goal.
Goal 4 Reduce child mortality	<ul style="list-style-type: none"> Reducing the number of preventable deaths is crucial to the interruption of chronic poverty. However, as the target is articulated in terms of improvements in national averages, there is a real danger that the focus will initially be on the non-poor and less poor. Redirection of resources away from the chronically poor may even worsen their situation. 	<ul style="list-style-type: none"> Very slow progress, especially in sub-Saharan Africa, where there is the biggest incidence of chronic poverty. Addressing the multidimensional and intergenerational nature of chronic poverty would significantly improve the chances of meeting the targets.
Goal 5 Improve maternal health	<ul style="list-style-type: none"> Improved maternal health is crucial to the interruption of the intergenerational transmission of poverty. However, as the target is articulated in terms of improvements in national averages, there is a real danger that the focus will initially be on the non-poor and less poor. Redirection of resources away from the chronically poor may even worsen their situation. 	<ul style="list-style-type: none"> Current rates of progress on the maternal mortality indicator is one-third that required. Addressing chronic poverty requires a comprehensive and multi-sectoral approach to maternal health, and would contribute significantly to the decline in maternal mortality.
Goal 6 Combat HIV/AIDS, malaria and other diseases	<ul style="list-style-type: none"> Indicators 18 and 20 (reduced HIV prevalence in young, pregnant women and reduced numbers of AIDS orphans) are central to reducing chronic poverty, particularly in Africa. In the coming decade this indicator will have increasing significance in many other parts of the world (e.g. India and China). Indicators 21–24 (combating malaria and TB) are important: in many countries the chronically poor have their physical strength, health and livelihoods undermined, and die preventable deaths However, as the target is articulated in terms of improvements in national averages, there is a real danger that the focus will initially be on the non-poor and less poor. Redirection of resources away from the chronically poor may even worsen their situation. 	<ul style="list-style-type: none"> Reducing chronic poverty is likely to improve the capacity of poor people to access, afford and complete treatment, helping to interrupt transmission paths of contagious diseases.
Goal 7 Ensure environmental sustainability	<ul style="list-style-type: none"> Could have beneficial effects for the chronically poor (e.g. indicators 29 and 30 on improved access to safe water and sanitation) and directly negative effects (e.g. indicators 25 and 26 would limit the opportunity for the chronically poor to modify land use in ways they believe will improve their livelihoods). The lack of progress by industrialised nations on reducing energy use (indicator 27) and CO₂ emissions (indicator 28) undermines this goal. 	<ul style="list-style-type: none"> On target to achieve indicator 25.
Goal 8 Develop a global partnership for development	<ul style="list-style-type: none"> A wide range of indicators for official development assistance, market access, debt reduction, employment and access to medicines and ICT. Indicators include: proportion of aid to basic social services, and to Least Developed Countries, both of which should benefit the chronically poor. 	<ul style="list-style-type: none"> A focus on chronic poverty can help to achieve this goal. Public support for aid in donor countries is strong based on humanitarian principles and a wish to see resources spent on the poorest people. Serious efforts to create public support and solidarity around combating chronic poverty could help to mobilise public commitment to the MDGs.

(estimated by the World Bank at between US\$5 and US\$20 billion/year), or for reducing child and maternal mortality (estimated at US\$20–25 billion/year); and education may have been underestimated by more than US\$6 billion/year. These revisions suggest that between US\$70 and US\$100 billion/year is needed, on top of current levels of ODA. This increase could be achieved if donors were to fulfil commitments on reaching the 0.7% target.⁵² However, two years on from FfD, a major financing gap puts the 2015 goals for poverty reduction in jeopardy. The modest US\$16 billion/year in increases promised by donors for 2003 falls far short of what is required.

One pragmatic response to this shortfall, is the proposed International Finance Facility. This proposal, backed by the UK and France, would substantially increase aid spending in the years to 2015 by using additional aid pledged at FfD to back the issue of bonds. Resources generated by the sale of bonds would be immediately available for spending on poverty reduction. Children whose growth may be stunted by malnutrition and who run the risk of growing up illiterate, and grandparents struggling to care for AIDS orphans, are among the people in chronic poverty whose need for assistance cannot be put off – and who would stand to benefit most from the IFF.

Aid allocation, as well as volume, is important

It is not only volumes of aid that matter. The sectors and countries in which aid is spent have a major effect on the potential

impact of aid on chronic poverty.

Aid to basic social services, like health and education, receives a small fraction of total bilateral commitments. 2002 was a record year for spending on basic health and basic education. But total commitments from all donors amounted to only US\$1 billion for basic education and US\$1.3 billion for basic health – less than 5% of bilateral commitments. Overall spending on health also reached its highest level in 2002 (US\$2.4 billion) but education has yet to match its 1995 figure of US\$6 billion. Spending in 2002 was US\$4.4 billion (Figure 5.1).⁵³

In 1990, donors held their first Least Developed Countries conference. This set a target for donors of 0.15% GNI in aid to this group of particularly deprived countries, home to 700 million people, a disproportionate number of whom are in chronic poverty. In 1992, DAC donors were allocating 0.05% of their total GNI to Least Developed Countries (LDCs). Ten years later, aid to LDCs was just 0.04% of GNI, despite being at its highest level of the decade in real terms.⁵⁴

Despite the rhetoric, poverty is not the only consideration governing aid allocations. Regional preferences, political priorities, commerce and history all have their effect on the allocation of ODA. Aid generally has a positive effect on economic growth.⁵⁵ But the special significance of aid is that, unlike other flows which can contribute to growth, aid can be targeted to those who most need assistance – people and countries whose poverty is persistent and severe. Therefore, aligning aid with the

US\$70–100 billion a year is needed to finance the MDGs. This could be achieved if donors fulfil commitments to reach the 0.7% target.

incidence of poverty is important. This would mean giving far more aid to South Asia and to larger high-poverty countries, particularly in sub-Saharan Africa where chronic poverty seems the most intractable. See Box 11.01, 'Aid Concentration Curves', for an analysis of aid flows to countries with the largest numbers and highest concentration of people living on less than US\$1/day.

Persistent poverty requires sustained assistance

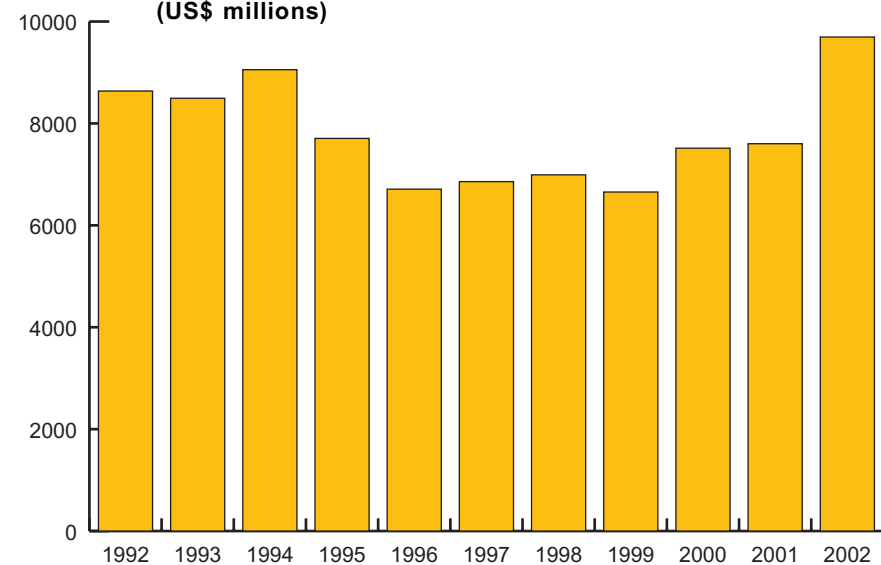
The intractable nature of chronic poverty clearly requires flexible, predictable and long-term financial support. The record on this is not good. Aid has been dominated by a project based approach with relatively short time horizons and which frequently bypass national aid coordination mechanisms. In Ethiopia, for instance, recurrent cost budget finance is needed to deliver the public expenditure set out in the Poverty Reduction Strategy. This would need to be sustained for 20 years, and the reliability of donor commitments will be critical. Recently initiatives such as the DAC Task Force on Donor Practices have signalled a growing awareness of the need for progress on aid harmonisation, genuine developing country leadership and medium to long-term financial frameworks.

Without reliable aid commitments, governments may be reluctant to make long-term commitments to recurrent costs which cannot yet be financed from revenues. The proposed International Finance Facility would require donors to make legally binding commitments over the long term. This predictable finance could enable developing country governments to plan interventions in areas such as social services, on the basis of assured availability of recurrent funding needs.

Financing targeted transfers

Generally, it is the poor who finance poverty reduction, both through their own efforts, and through gifts, loans and remittances from family and neighbours.

Figure 5.1 ODA to least developed countries in real (2001) prices (US\$ millions)



Putting more resources directly in the hands of the poor can therefore be critical for sustained poverty reduction.

Social assistance is one means of reaching very disadvantaged people directly. But are social assistance transfers, such as pensions, affordable? Evidence is clear that they can be, even for an LDC like Nepal. Nepal's universal pension for men and women over 75, which reaches between 83% and 86% of those eligible, costs only 0.4–0.6% of public expenditure. Namibia's old age cash transfer programme costs just under 2% of GDP, and South Africa's pensions cost around 1.4% of GNP.⁵⁶

This experience of existing social transfer programmes means that blanket assumptions on the unaffordability of transfers should be replaced by detailed thinking on issues, such as the balance between universal and targeted schemes. Attention also needs to be focused on how existing social assistance can be extended and most effectively managed.

Many aid donors have been very reluctant to promote, or help foot the bill for, social assistance. Donors prefer projects which produce visible short-term results. They are wary of becoming involved in government-managed schemes. Many donors also fear ongoing commitment to what some have perceived as welfarist schemes. But there are sound reasons for donors revisiting this issue:

- There is increasing evidence that improved social protection can be both redistributive, a productive investment, and therefore a very sound use of aid money.

- Donors may be well placed, especially in the context of PRS processes, to ensure that the interests of chronically poor groups are taken properly into account by governments who face pressure from domestic interest groups with more political weight.

Generally, it is the poor who finance poverty reduction, both through their own efforts, and help from family and neighbours. Putting more resources in the hands of the poor could be critical to sustained poverty reduction.

- Helping developing country governments to finance social assistance programmes could fit well with increasing efforts by donors to coordinate their aid within a framework of developing country ownership, using budget support where appropriate.
- There is no doubt that public support for aid in OECD donor countries is at its strongest around humanitarian and basic needs expenditure.

Obligations on aid must be met

Changes in aid modalities will not be enough to address chronic poverty – a step change in the levels of financing for basic services and predictable funding flows is indispensable. If chronic poverty is to be eradicated, it is necessary to look beyond 2015 and to recognise that, while some chronic poverty can be reduced through policy changes, increased

international transfers are essential.

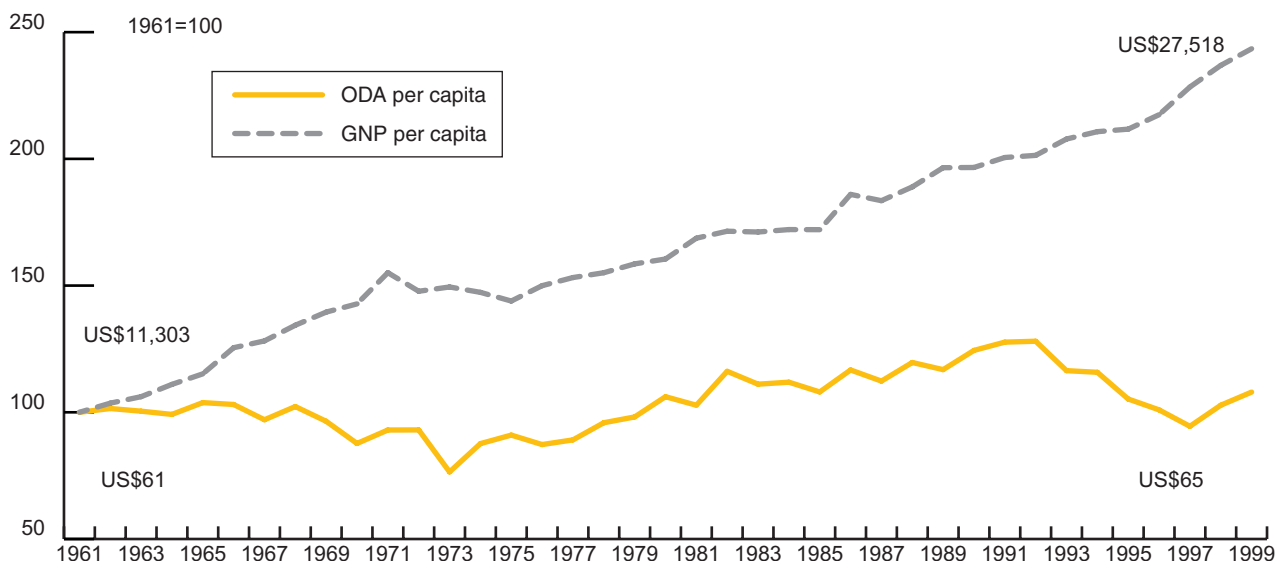
Political commitment is the essential factor in achieving these changes. There are some grounds for optimism: the public and politicians in donor countries regularly re-state their support for economic justice and aid, particularly for the poorest. Proposals such as the ILO's Global Trust to finance global social assistance are based on concept of international solidarity in the effort to achieve basic social protection. The international community is currently discussing different proposals to secure reliable finance for poverty reduction and global public goods including the International Finance Facility and forms of global taxation.⁵⁷

But optimism needs to be tempered by the knowledge that in 13 countries, aid is less than half way to the target of 0.7% of GNI established in 1970. GNP growth in donor countries has risen from US\$11,000 per person in 1960 to US\$28,000 in 2002 (in real terms). Aid has increased by just US\$6 per person over the past 40 years.⁵⁸

Chronic poverty – an agenda for action

Between 300 and 420 million people are trapped in poverty. They experience multiple forms of deprivation over many years, often over their entire lives, often passing poverty on to their children, and often dying premature, preventable deaths. The causes of their poverty are complex and involve sets of overlaying factors. These causes commonly include social exclusion, adverse incorporation

Figure 5.2 DAC donors – gap between income and aid per capita (at 1988 prices and exchange rates)



in the economy and living in parts of the world that are poorly governed and/or weakly connected to national and international economies.

This first Chronic Poverty Report has set out to raise awareness of the extent and experience of long term poverty. It has also drawn some initial conclusions about policy and action. Most importantly, although many of the components of the contemporary 'orthodoxy' on poverty reduction can also benefit chronically poor people (Table 5.1) it is clear that to tackle chronic poverty it is necessary to go beyond this orthodoxy.

Increasing opportunity, reducing vulnerability, and empowerment are all necessary for chronic poverty reduction, but livelihood security must be prioritised. The chronic insecurity of those trapped in poverty constrains their ability to pursue opportunities and seek empowerment so much that social protection policies must play a major role in strategy. There are many elements to such social protection policies; CPRC research highlights the need to:

- put security first and use existing evidence to develop larger scale, cost effective social protection programmes that enable chronically poor people to make choices that do not undermine their current or future well-being;

- tackle child poverty by ensuring adult livelihood security and investing in nutrition, health and education programmes;
- improve health care systems, including curative services, so that households are not caught in health shock-induced spirals of asset depletion; and,
- reduce the disastrous effects of HIV/AIDS through preventive programmes and by rapidly increasing the availability of affordable anti-retroviral treatments.

Increasing economic opportunity is also important and, for the chronically poor, the quality of growth – broad-based and reaching rural areas – is probably as important as the rate of growth. Growth that is associated with rapidly increasing inequality is unlikely to bring much benefit to those trapped in poverty. Asset transfers, such as land reform, and indirect redistribution, such as progressive public revenue and expenditure systems that skew educational resources towards the poorest, are important elements of chronic poverty reduction strategies.

While this report concurs with many on the importance of empowerment, it finds that the big question is not so much 'what?' but 'how?'. How can we foster the social solidarity – at household, community, national and global levels – that

will mean the chronically poor are not invisible, ignored, pushed aside or exploited? This issue should be a major concern for policy-makers and will be a key task for the second Chronic Poverty Report.

At the national level, this report highlights the need for developing more effective service delivery for chronically poor people and reveals that this is possible through, for example, non-contributory pensions in Brazil, Nepal and South Africa, food-for-work and employment guarantee schemes in many African and Asian countries, and initiatives linking access to assets and education.

At the international level, the MDGs provide a partial – but only a partial – framework for tackling chronic poverty. The big issues remain – rich country commitment to economic justice through aid, trade and debt reform – as do detailed questions about whether some MDGs encourage policymakers to avoid the poorest. At the global level, greater transfers of resources from North to South, and the political commitment to co-operate on tackling conflict and discrimination are urgently needed.

Chronic poverty is a global challenge. It demands a response that requires action at all levels. People in chronic poverty cannot wait for change.

Notes

1. WDR2000/1:41.
2. Begum and Sen 2004.
3. Wood 2003.
4. WDR 2000/1.
5. See Chapter Two.
6. Lund 2002.
7. Dreze 2003 in EPW.
8. Matin and Hulme 2003.
9. Daru and Churchill 2003.
10. Ravallion 2003.
11. Case and Deaton 2003.
12. This is particularly true of cash transfers, which can be used for whatever purpose the recipient decides.
13. Although micro-finance programmes provide examples in which women are most usually the development recipient.
14. See later for a discussion of how the chronically poor can best be targeted for social assistance.
15. Harper, Marcus and Moore 2003.
16. The likelihood that an episode of ill-health will lead to a household or individual falling into chronic poverty as opposed to a period of transitory poverty depends largely on the nature, severity and duration of the episode, and its resultant effect on income, employment, household assets, level of indebtedness, redistribution of household income and assets, and whether the episode leads to lasting morbidity, disability, incapacitation or death.
17. Corbett 1989.
18. WHO (n.d.): 4 and Goudge and Govender 2000.
19. Conversely, policies that lead to economic collapse, such as the over rapid liberalisation of the former Soviet Union's economy, must be avoided as they reduce opportunity and create transitory and chronic poverty (Stiglitz 2001).
20. Timmer 1997.
21. McKay 2004.
22. Park and Kim 1998.
23. Bruton et al. 1992.
24. For example, aid agencies supported NGOs throughout the civil war/Taliban era in Afghanistan. When 'peace' arrived in 2002, the staff of these NGOs provided the basis for the re-establishment of a civil service – few other Afghans had relevant training and experience in civil management, record keeping, civilian logistics, accounting, electronic communications etc.
25. Bruton et al 1992.
26. Sen and Ali 2003.
27. Kothari 2002.
28. China is developing plans to relocate long-term poor people from spatial poverty traps in rural areas to more dynamic regions, but few other countries have considered such 'closures' of regions. The implications for the regions expected to absorb such populations are uncertain.
29. UNHCHR 1948/2004.
30. While the assassination of Chico Mendes, the leader of the rubber tappers' union in Brazil, was widely reported the deaths and beatings of thousands of other frontline activists for the poor goes unmentioned in the media.
31. Piron 2003.
32. Most obviously Uma Kothari in Cooke and Kothari 2001.
33. Mosse 2001.
34. Hickey 2003; Esping Anderson.
35. Esping-Anderson 1999.
36. Uphoff 1992 Gal Oya book.
37. Gaiha and Imai 2003.
38. Guhan 1993.
39. Ravallion 2003: 17–18.
40. Ravallion 2003:22 Bangladesh example.
41. Coady, Grosh and Hoddinott 2003.
42. Government of Tamil Nadu 2003.
43. Devereux 2002; Farrington et al. 2003.
44. Rajan 2003.
45. Devereux 2002.
46. Paradoxically, this target might be more rapidly achieved if chronically poor people die, thus reducing the proportion of people below a dollar a day.
47. Pogge (forthcoming: 10).
48. Pogge (forthcoming: 20).
49. Table 12, Human Development Report 2003, UNDP.
50. OECD DAC Statistics, Table 1.
51. Zedillo Commission 2001.
52. If ODA had reached 0.7% of GNI in 2002 it would have been US\$174 billion.
53. OECD DAC Statistics Table 5.
54. OECD DAC Statistics Table 2a.
55. Tarp 2000; Morrissey 2001.
56. South Africa Department of Social Development 2002: 20.
57. As the costs of borrowing are much less than the rates of return from aid investments (and because people in developing countries prefer to have funds now rather than later (the Social Time Preference Rate) this should result in increased poverty reduction.
58. The Reality of Aid 2004, forthcoming.