

# Health Dimension of Poverty in Rural Bangladesh: Some Evidence

Sharifa Begum

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# Health Dimension of Poverty in Rural Bangladesh: Some Evidence

Sharifa Begum<sup>1</sup>

## I Introduction

Health reflecting the soundness of physical condition essentially measures the quality of human life. In the language of Amartya Sen 'good health is an end in itself'. But this is no longer considered merely as a humanitarian value independent of the social environment. It is rather viewed more and more as an essential force for promoting socio-economic progress in a society. The development scientists believe good health can have quite significant implications for economic development and this is often viewed as a *means* for economic advancement also. Indeed, improvements in many preconditions for development are not likely to be attained without ensuring a better health for the people as productivity, earnings, supply of labor, dependency, individual capabilities, hopes and aspirations are all directly related to it. On the flip side, poor health imposes a direct burden on society/household not only by putting an extra pressure on health care cost but also because poor health and poverty create a vicious circle of poverty-deprivation-ill health-poverty in a mutually reinforcing manner dictating the process of poverty both at macro and micro level in a society.

The broad aim of the present study is to examine the situation of health of the country's people who live in rural area representing more than three-fourth of the total population. This is done using some key indicators, namely, the morbidity reflecting the health status<sup>2</sup>, utilization of curative health care services for morbidity, and consequences of ill health. Findings on them are presented disaggregating them along three dimensions i.e., age, sex, and household economic status. The first two variables are clear in meaning but the last is one is not. Being closely related to the theme of ill health and deprivation the economic status is defined in this study in terms of access to basic food viz., by the financial capacity to provide for minimum consumption basket for the family. Three economic status is identified based on this criteria viz., hardcore or extreme poor, moderate poor, and non-poor referring respectively to the potential calorie intake below 1800, between 1800-2112, and above 2112.

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<sup>1</sup> Senior Research Fellow, BIDS

<sup>2</sup> The conventional measures of health status are various measures of mortality such as, average death rate, infant mortality rate, life expectancy at birth etc. But illness, disability and other compromised state of well-being too represent critical dimensions of health (Murray and Chen, 1992).

## **II Data**

Data for this study have forms a part of a bigger study conducted by BIDS on poverty (Hossain Z. Rahman, Mahabub Hossain and Binayak Sen, 1996). The sample population of this study is selected using multi-stage random sampling method. In the first stage, one union (the lowest local level government unit) from each district of the country (except Chittagong Hill Tracts region) is selected randomly from the list of Unions under a district. This procedure gave 62 unions.

Then the information on the number of household, land area, total population, and literacy rates is obtained for all villages of each selected union from the district census report. Two villages were then selected purposively from each union such that (a) the selected villages are not too large or too small in size, and, (b) the land-person ratio and the literacy rate are similar to those for the union as a whole. At this stage, 124 villages were selected. But then one village out of these two is chosen from each union. This is done on the basis of which village is most representative of the union on these counts. Afterwards, an in-depth household survey is conducted in the finally selected village to collect information on ownership of land, and major source of income of the household. The household survey enumerated in all 9,874 households in 62 selected villages and they then served as the sample frame for final draw of the random sample of household. In order to do so the enumerated households are first classified into four landownership category: functionally landless (less than 0.5 acres), small owner (0.5-2.5), medium owner (2.5-5.0) and large owner (5.0 acre or more). Each of the landownership groups was classified further into two groups according to whether the household was engaged in tenancy cultivation or not. Then 20 households were selected from each village by the proportionate random sampling method so that each of the eight cells are represented according to their weights. This procedure yielded a final sample of 1316 households. The total number of population of 7,824 living in these households is the sample population for this study (for details of data collection and sampling procedure see Hossain Zillur Rahman et. al, 1996). The information is collected during the month of May 1995.

## **III Morbidity**

The household head supplied the information on sickness of the members in the household. The basis of morbidity statistics of the present study is individual perception and such statistics were collected for all members in the household. The information on morbidity was collected through three separate inquiries;

- (a) acute illnesses of the household members during one month preceding the date of enumeration;
- (b) the recurrent or repeat illness of the members not enumerated in the first inquiry i.e. members who were not ill during the preceding month but fall sick off and on from one or the other diseases;
- (c) major illnesses suffered by members during last one year prior to survey.

The morbidity information thus collected, allowed us to examine the rural morbidity situation from three perspectives, namely, the burden of acute illness that the society bears during a specified short period of time, the burden in terms of repeat sickness that persists largely on a continuous basis suggesting a bottom line of morbidity burden, and lastly, on major illnesses which bear special significance to rural people.

### **III.1 Level of Morbidity**

The rate of morbidity for all types of illness of rural people is presented in Table 1. The overall morbidity rate for rural population as defined by the proportion of sick household members during one month preceding the survey to total household members is 12.5 per cent. This indicates on an average more than 12 per cent of the rural people fall/remain sick during a month. Roughly one-third of them (4.6 per cent) fall sick frequently from the diseases they are found to be suffering acutely during the reference period. This group together with those who were not sick during the month preceding survey but otherwise fall sick often produces a rate of 9 per cent for the repeat illness. Hence, 9 per cent of the rural people remain morbid or sick largely on a continuous basis with intermittent escape from acute attack from the diseases while 4 per cent suffer from the major illnesses over the annual cycle. The estimate for major illness may be on the lower side however, as some of the current acute illnesses may be serious ones and major in nature.

### **III.2 Differentials in Morbidity**

#### **III.2.1 By Age**

The risk of falling sick from the diseases is not uniform across rural population of different ages. The period prevalence rate of morbidity (referring to one month period) and age of the people

have a U-shaped relationship indicating concentration of high risk at two ends of life. The morbidity rate of the elderly people aged 60+ is about 24 per cent and that for children aged under 5 is 22 per cent. The rate of those aged 15-29 years varies between 8 to 16 per cent with 15-29 age group recording the lowest rate of 8 per cent. According to the age-pattern of illness, morbidity risk of the rural people starts declining after age 5. This process continues up to age 29 and after this age the morbidity risk starts increasing again and do so monotonically in the remaining ages with an acceleration of speed in the elderly ages viz., in the ages 60+ (Table 1 ).

The prevalence of repeat illness over the ages highlights a critical aspect of rural illness. The repeat illness and age form an inverted J-shaped relationship. The risk is highest in the elderly ages followed by the risk in early ages. As the data reveal about 9 per cent of the rural children aged under 5 falls sick repeatedly from the diseases. The rate then falls to around 4 per cent and remains at this level until age 29. The risk for repeat illness too starts increasing again from age 30, and takes a sharp upward turn reaching a level of 31 per cent in the ages of 60+. A comparison of rates of repeat illness with those for acute ones reveal that the rural people aged above 45 suffer more from repeat illness than from acute illness viz., more of them suffer on a continuous basis from diseases than from acute attack of them. On the other hand, it is reverse for the younger people aged below 30.

Major illness and age too hold a J-shaped relationship but with a difference from that for repeat illness. After initial years of high risk such risk remains at lowest only in the ages of 5-14 and starts increasing again right from age 15 instead of 30 noted for acute and repeat illnesses. However, as with other types of sicknesses the risk for major illness too continues to rise with the passage of age reaching the height in elderly ages. The morbidity rate for major illness is 2 per cent for children aged under 5, around 1 per cent for children aged 5-14 and 10 per cent for elderly people aged 60 and above.

### **III.2.2 By Economic conditions**

The prevalence of period specific sickness and economic condition predictably hold an inverse relationship in rural area. The morbidity rate for acute illness among the extreme poor is about 15 per cent, that for moderate poor is little over 12 per cent and 11.6 per cent for the non-poor. For repeat illness these rates are respectively 9.4, 8.7 and 9.0 per cent and for major illness respectively 4.7, 3.7 and 3.9 per cents (Table 1). Thus, morbidity risk for moderate poor and non-poor seems to be about similar in rural area while extreme poor people, for whom the body fitness is their main economic asset,

fare worse than the other two categories. However, the lack of difference in morbidity risk between moderate poor and non-poor tends to indicate that the non-food physical environment still may be the dominant determinant of health status in rural Bangladesh viz., non-nutrition factors are more important than the nutrition.

### **III.2.3 By Gender**

The morbidity risk for rural male and female population particularly for acute and major illnesses does not seem to have much variation. The morbidity rate for female for acute illness is about 13 per cent and that for male is 12 per cent. For major illnesses these rates are respectively 4 and 4.1 per cent. However, sharp gender variation exists for repeat illness. The morbidity rate for male for such illness is 8 per cent and for female 11 per cent (Table 1). However one must exercise some caution in assessing the gender gap in morbidity risk in rural area from above statistics as morbid condition of women in traditional societies have great chance to get underreported. This may take place both voluntarily and involuntarily for socio-cultural reasons (Begum, 1990). Further, information on sickness of household members in this study being supplied by the household head who is often male, some underreporting of female sickness may take place as male household head may not always be aware of all sicknesses to all women.

However, although the overall morbidity rate by sex could reflect little gender variation the age-sex specific morbidity rates and these across economic conditions put into sharper focus the acuteness of health problem faced by rural women (Table 2). As the figures show, the rural males are somewhat disadvantaged health-wise firstly in the early ages of life up until 14 years of age and are so secondly in the elderly ages of 60+. In between ages of 15-59 the situation is reverse viz., women are much disadvantaged for health in these ages than the men and their relative disadvantage seems to be the highest in the age group of 30-44. All types of illness i.e. acute, repeat, and major, have indicated this age sex pattern of morbidity risk in rural Bangladesh.

The higher health risk of women in the 15-59 ages coinciding with the reproductive period may be linked to their reproductive role which has remained still a hazardous part of women's life for variety of conditions and reasons. For instance, incidence of early childbearing, pregnancy at older ages, and higher order births are still persisting in a significant manner in rural area. Also, at the same time the reproductive health care has remained wholly inadequate in rural area for only one-third of the pregnant women receive some antenatal care, less than 2 per cent of the deliveries take place in the institutions

and less than 7 per cent of the births are attended by doctors, trained nurses and midwives (Mitra et. al. 1995; Akhter, H.H, 1996). However, to note, the lower morbidity risk of women in other ages particularly in younger ages may be a matter for further investigation. Some socio-cultural biases having both positive and negative connotations could be active behind the evident better health status for younger women.

The sex-specific morbidity rates across different economic classes show that improvement in economic condition is not able to give as much protection to women's health as it does to men's health (Table 2). With the increase in economic status rural male show a definite improvement in morbidity risk but this is not so with the rural women. The morbidity risk for rural women across economic condition is about similar. The most likely reason for this may be the notoriously inadequate provisions for maternal health in rural area which affect women from all economic classes alike.

Another fact demonstrated by the morbidity rate for acute illness specific to sex and economic condition is that men may be more vulnerable to health risk than the women in extreme poor category. This sex-differential for this is negligible with the moderate poor while it is reverse with the non-poor people. Thus, as it seems, while poverty puts a strain on health of both rural men and women, it causes greater vulnerability to the former in comparison to the latter. A likely reason for this may be that although male from the extreme poor category may be equally malnourished or marginally better nourished than their womenfolk the need for excessive hard work by them and the tension to ensure the survival of the family which is a traditionally assigned role to them perhaps pushes them to a disadvantaged position than the women. However, an additional explanation to this may be that ill-health of extreme poor males become more apparent than that of the women as they compete for work in the labour market where it is identified easily.

### **III.3 Trends in Rural Morbidity**

While it is amply clear from above observations that the morbidity burden has remained in general still rather high in rural areas of the country, there are evidence suggesting that such burden has indeed come down over the recent years. The point prevalence rate of acute illness with reference to a day for rural people in the present study is estimated to be 4.3 per cent for 1995. But this was reported to be 16.2 per cent in 1984 and 11.5 per cent in 1987 (Begum 1988a, 1997) suggesting a substantial decline in morbidity risk during mid-80's to mid-90's. More remarkable about this decline however, has been that the improvement in morbidity risk has benefited all people in rural area cutting

across sex and economic conditions. Not only that poor and women seem to have benefited also relatively more from this development (Table 3).

#### **IV Disease Pattern**

Although there has been an improvement in the morbidity level the disease pattern of morbidity viz., diseases giving rise to sickness in rural area has remained largely unchanged over the past decade. A small number of diseases mostly infectious and parasitic in nature arising out of unhygienic environment, poor living condition, and poor personal hygiene still play the major role in determining this. This in other words, imply that despite improvement the environmental contamination is still persisting in the country and there is sufficient scope yet for further improvement in it for ensuring a perceptible epidemiological transition in rural area.

However, as noted from the data (Table 4) the dominant diseases in rural area are still the diarrhoeal diseases including cholera and dysentery and cold cough, viral fever and fever of unknown nature. The above two types illnesses account for nearly two-thirds of the acute illnesses suffered by rural people. The next important diseases are gastro-enteric problems such as, gastric/ulcer/acidity etc. They account for 8 per cent of the rural acute illnesses. Malaria, typhoid, measles, chicken pox, jaundice and scabies account for another 10 per cent, 7/8 per cent is accountable to non-communicable diseases like high blood pressure, rheumatism, diabetes etc. and around 4 per cent acute ailment is due to childbirth related causes.

With minor variation the above disease pattern holds good both for repeat and major illnesses too. However, for such illnesses gastro-enteric problems bear much higher responsibility than the acute illness. Nearly one-fifth of the repeat and major illnesses of rural people against 8 per cent of the acute illnesses are due to them. The non-communicable diseases too bear greater responsibility for repeat and major illnesses. An alarming observation with regard to major ailments is that the delivery related problems of women account for nearly one-tenth of the severe ailments of rural population (Table 4).

As it thus emerges from the above observations a high morbidity burden in rural area still falls on communicable but preventable diseases. The next important health problem of them arises out of gastric, acidity, ulcer etc. which may be related to their life style and food habits. Third, the childbirth related problems still continue to be a major threat to women's health. Fourth, the diseases specific to children such as diphtheria, measles, whooping cough, tetanus and polio have become negligible in

prevalence and credit for this perhaps goes to the vertical programmes mounted to control these diseases by the government through the Extended Programme of Immunization (EPI).

#### **IV.1 By Age**

The disease-pattern by age groups (Table 5 ) show that almost the entire health problems of rural infants and children aged under 15 arise out of infectious and parasitic diseases which are largely preventable through appropriate policy measures for health. Diarrhoeal diseases, cold, cough, and viral fevers are their biggest enemies accounting for more the 80 per cent of their acute illnesses. These diseases also play a major role but at lower level for the illnesses of rural adults aged 15-59. For them gastric/ulcer/acidity play a major role accounting for 13 per cent of their ailments. Various non-communicable diseases start making an incoming from this age group. But presence of both non-communicable diseases and gastric/acidity/ulcer is more pronounced in elderly ages of 60+. In adult ages of 15-59 a major cause of ailment is the childbirth related causes. Around 7 per cent of the acute illnesses to them are due to these causes while the proportion rises to 17 per cent if one confines to the age group of 15-44 only.

The repeat illnesses of the children arise from same diseases giving rise to acute illness to them viz., diarrhoeal diseases including cholera and dysentery, and cold, cough, fever. But they assume much less responsibility for the same of adults and elderly people. Instead, the repeat illness of them arise primarily from gastro-enteric problems, non-communicable diseases and childbirth related causes.

For major ailments of the children although the diarrhoeal diseases and cold, cough, fever still play the major role, do so at a much lower level. The role of other infectious and parasitic diseases such as, typhoid, malaria, measles, jaundice, chicken pox etc. instead is higher in this regard than that noted for acute and repeat illnesses. The major illnesses of the rural adults and elderly on the other hand arise primarily from non-communicable diseases although for adults childbirth related causes are also a prominent cause. About 14 per cent of the major ailments to them are due to childbirth related causes. This figure rises to 33 per cent for the ages of 15-44.

#### **IV.2 By Economic Condition**

Interestingly, the disease-pattern has shown no notable variation across economic classes except that the prevalence of diarrhoeal diseases is somewhat less among non-poor category

compared to the poor living in rural area. Other general features noted for acute, repeat, and major illnesses generally hold good for all the economic classes (Table 6). Thus, these observations too indicate that the physical non-food environment and other extraneous factors sustained at the community level affecting all are still the primary determinants of morbidity scenario in rural area.

However, the most illuminating observation across economic condition is that the delivery related morbidity has shown no definite trend over the economic classes. This is true for all types of illness i.e. acute, repeat and major. This highlight the pervasiveness of maternal risk faced by rural women cutting across sections and points out also the fact that the inadequate provision and practice of 'safe motherhood' in rural area also persists irrespective of economic condition.

### **IV.3 By Gender**

The disease-pattern for different types of ailment are again largely similar across sexes in rural area emphasizing the fact that the primary sources of health risk for rural men and women are basically the same, namely, the environmental hazards (Table 7). The only area of outstanding difference between them is the reproductive health problem of women. About 7 per cent of the acute illnesses, 8 per cent of the repeat illnesses and 20 per cent of the major illnesses of rural women are reportedly due to these problems. The gravity of the problem is brought into sharper focus if one considers only those women who are at risk. About 18 per cent of the acute, 24 per cent of the repeat, and as high as 35 per cent of the major illness of rural women aged 15-44 are indeed, attributable to puerperal causes.

That the childbearing function of rural women despite many improvements in health care provisions still continues to be a high risk phenomenon is evident further in the high and similarity in the proportion of sicknesses of women of different economic classes that are attributable to delivery related causes (Table 8). Yet, one should not lose sight of the fact that the extreme poor women of rural area are most vulnerable to these risks and this is particularly true in case of repeat and major illnesses. Among extreme poor category as high as 29 per cent of the repeat illness and 45 per cent of the major illnesses of the women of reproductive ages arise from them viz., originate from the faulty and improper maternal practices. These figures among non-poor women are respectively 20 and 37 per cents.

## **V Health Care**

Information on health care has been collected relating to the last treatment received for acute illnesses and main treatment received for major illness. Health care is defined very broadly in this

study. Every single attempt at removing the symptom of illness or recovery from it irrespective of its involvement of recognized therapy or medicine is identified as health care or treatment. Hence, it includes from modern allopathic medicine to crude totka and spiritual healing having little scientific basis.

## **V.1 Level and Differentials in Health Care Use**

The proportion of illnesses that have received some kind of treatment on or before the survey date is presented in Table 9. It is encouraging to note that the rural people by now have comprehensively overcome the fatalistic attitude towards the worldly management of sicknesses or prejudice against utilization of health care for recovery from the illness. Currently about 98 per cent of the acute illnesses in rural area receive some kind of treatment. This proportion rises to 100 per cent in case of major or severe illnesses. To note, the use rate of health care for acute illnesses was 77 per cent in 1984 and 85 per cent in 1987 (Begum 1988, 1997). Thus, there has been a visible improvement in health care utilization too over the recent years since mid-1980's.

In this regard viz., health care utilization further encouraging development has been that the rural people across all ages, sexes and economic conditions currently make similar use of health care services. The proportion acute illness receiving some kind of treatment is 98.4 percent for rural male and 97.5 per cent for rural female. The figure varies from 96 to 99 per cents across different age groups and economic conditions. The health care utilization rate for major illnesses, is universal at all levels of disaggregation.

## **V.2 Medicine Use Pattern**

For management or treating the sicknesses the overwhelming preference of rural people currently is for modern allopathic medicine. This, indeed, has been the trend for quite sometime, but present study recorded further concentration of this preference. In 1984, about 77 per cent of the treated sicknesses reported use of allopathic medicine. This proportion rose to 84 per cent in 1987 (Begum 1988, 1997) while the present study found this figure to be 90 per cent. The remaining 10 per cent is supplied by homeopathy (4 per cent), indigenous system of medicines like kabiraji and unani (4 per cent) own knowledge and other treatment (little over 1 per cent), and 'totka/spiritual' healing (0.5 per cent) (Table 10). Thus, another notable feature of the current health care practice of rural people

has been the virtual loss of ground of totka and spiritual healing for treating a sickness which used to enjoy much popularity earlier for the purpose. Even if the 'own knowledge and other treatment' is considered to be falling in the category of totka and spiritual healing the proportion contribution for them goes up somewhat in the limit of 1.8 per cent. Although the figure for this for the distant past is not available 'totka and spiritual healing' used to account for 9 per cent of the treatment for acute illness even in 1984 which dropped to 5 per cent in 1987 (Begum 1988a, 1997).

The above noted medicine use pattern is visible for major illnesses too. However, for them the indigenous (kibiraji) medicines find somewhat higher use than the acute illnesses. Perhaps for many of the chronic ailments periodically giving rise to severe attack such as asthma, gastric/acidity, arthritis etc. for which allopathic treatment is either less effective in giving a permanent cure or proves to be expensive over the long run, the rural people indulge in indigenous kibiraji or herbal medicine for relief or cure.

As noted for the health care utilization, the medicine use-pattern has little variation between sexes (Table 10). Variation for this across ages too is very small except that for treating the acute illness of the children under 5, homeopathy enjoys some special preference (Table 11). More than 11 per cent of their treatment comes from this branch of medicine.

Variation in the medicine use-pattern is negligible again over the economic conditions indicating that the economic status has little impact on this in rural area (Table-12). An interesting observation is that the kibiraji and unani system of medicine enjoys similar popularity with people of all economic classes and sexes. This tends to indicate that not the economic condition as such, rather, their popularity in treating certain chronic ailment/conditions may be responsible for their higher use for major ailments by rural people.

### **V.3 Source of Health Care**

The sources of health care utilized by the rural people can be divided broadly into two categories, private and public or government, the latter category including the Thana Health Complex, Union Sub-centre for health, government dispensaries, maternity centres, and other government facilities. An intermediate category is that of NGOs. The private sources can be subdivided again into two categories- individual practitioners and institutional facilities. Individual practitioners may be divided into two categories---qualified (referring to the holders of formal degree in medicine) and unqualified

(referring to those who have no formal training but have learnt the trade mostly by practicing medicine under a fellow practitioner). These varied classifications of sources however, applies only to the allopathic branch of medicine as other branches are essentially in the private sector. The facilities for formal training for them are also practically non-existent and they are not the recognized medicine by the government either. Hence, individual quack practitioners are virtually the sole providers of them.

In line with above categorization as observed (Table 10) the private sector play an overwhelmingly major role in supplying the curative health care services to the rural people. This sector accounts for as high as 88 per cent of the total treatment received for acute illnesses and 77 per cent for major ones in rural area. Further details about the source show that private clinics or institutional facilities provide little over 1 per cent of the private sector treatment, qualified individual practitioners provide about 21 per cent, quack allopathic practitioners provide 39 per cent, the pharmacies or medicine shops supply about 17 per cent, practitioners of other medicines supply about 8 per cent and 2 per cent is provided by the totka and spiritual healer including self-medication. Thus, the individual practitioners, more particularly the unqualified and untrained ones of them are the predominant suppliers of health care in rural area. Another notable supplier currently seems to be the medicine shops. In fact, they are the third largest providers of health care at least for acute illnesses (Table 10). This picture while no doubt is encouraging in view of fact that there is now a reasonable presence of medicine shops in rural area, but if they are run by the untrained person, chances for which are high in rural Bangladesh may diminish the return from them. However, one of the reasons for their popularity for treatment may be that it saves the cost payable to doctor's consultation and can be approached anytime the help is required. The NGOs play a relatively minor role in providing curative health-care services to the rural people.

Most striking fact however is that despite many planned efforts to develop a sound health care delivery network in rural area the public sector performance in taking care of people's health is appallingly poor. For acute illnesses their contribution stands only at 12 per cent and rises to 23 per cent for the major ones (Table 10). More distressing is the fact that the public sector role in taking care of the rural health has shrunk over the recent years. The contribution of this sector to total treatment received by the rural people in 1984 was about 20 per cent (Begum 1988a). This share declined to 13 per cent in 1987 (Begum 1997) and as noted above was further down at 12 per cent in 1995. As the available evidence suggests supply side constraints causing an erosion in the demand for public sector services are mainly responsible for this sorry state of affair. Even the government has admitted that the

government supply provision is deficient in numerous respects making services unattractive to the people (GOB, 1990). Inadequate management of the facilities and personnel, inadequate equipment and short supplies of pharmaceuticals and other supplies, and qualitative shortcomings in health personnel performance expressed in terms of apathy of the physicians towards the patients and ineffective treatment referring to their diagnostic skill and prescription practices are some of the major contributing factors that operate behind poor and declining utilization of the public sector facilities in rural area (Begum 1988, 1997, BRAC, 1990).

However, in comparison to the acute illnesses somewhat higher use of public facilities for the major illnesses in rural area may be because severe ailments often require sophisticated treatments and/or especial care to be provided under expert guidance.

### **V.3.1 Sources by Gender and Age**

There is no major variation in the utilization of various sources of health care across sexes in rural area. However, both for acute and major illnesses, rural women currently seem to make lesser use of the public sector facilities than the rural men do (Table 10). The situation was interestingly distinctly reverse ten years ago. In 1984, rural women used to receive about a quarter (24 per cent) of their treatment from the government health facilities against 15 per cent noted for the rural men (Begum, 1988). Currently, these figures are respectively 13 and 11 per cents. Thus, as it seems, in the process of losing popularity the government facilities have lost it faster with the rural women than with the rural men. This no doubt is a matter of grave concern in view of the fact that the rural maternal health face a dangerously gloomy situation and through appropriate policy measures only the government sector can heal it.

The use pattern of various sources of treatment both for acute and major illnesses across different age groups is again similar to that noted above for overall population of rural area (Table 11). Yet, children aged under 15 make somewhat lesser use of the government facilities for acute illnesses with children aged 5-14 making least use of them. One reason for this could be that women who generally accompany the children for treatment are currently more reluctant to use government facilities. For major illnesses, the children of all however, make the highest use of these facilities (Table 11).

### **V.3.2 Sources by Economic Condition**

Utilization of government and non-government sources including the private ones for treatment is largely similar again across economic classes. The rural people of all economic classes as usually, rely more on private sources although the dependence of the poorer ones is more on the quacks and better-off people rely more on the qualified private practitioners. A revealing observation is that the rural poor women in general but those from extreme poor households in particular are most displeased with the government health care facilities particularly for treatment of the acute illnesses. Use of these facilities by them for acute illnesses not only at present is distinctly lower than that of the women of other economic category but is so compared to the male members of their own category too (Table 13). Only around 7 percent of their treatment for acute illnesses originate from the public facilities. But to note, their use of these facilities for major illness is the highest of all. It is distinctly higher than that of the women in other economic categories and of the men of their own category (Table 14). For major illnesses they receive as high as 35 per cent of the treatment from the government health care facilities. This tends to suggest that despite reservations the poor women of rural area perhaps need to depend on the government facilities for health care at times of dire necessity

### **V.4 Quality of Health Care**

Quality of health care in essence is a multidimensional concept. Its understanding requires wide range of information determining the efficacy of health care such as adequacy, completeness appropriateness, timeliness, support facilities, etc. of the treatment. As these information are not available, a crude measure referring to the health care received from the recognized and competent source viz. from qualified and/or trained health personnel is applied to approximate it. Following this definition, health care received from the government facilities, qualified private practitioners, and private clinics are treated as 'quality care' while those from remaining sources as 'unqualified' ones.

Although there may be complacency with regard to the quantitative utilization of health care in rural area, the situation is very different if the quality of care is brought into the focus. Currently only about one-third of the total treatment (34.5 per cent) received by the rural people represents quality care and the remaining two-third is of dubious quality arising out of unqualified sources (Table 15). Interestingly, the share of quality treatment in the total treatment in rural area was 36.2 per cent in 1984 (Begum, 1988). Thus, instead of increase of late, there is a downward trend in the utilization of quality care in rural area. As the evidence suggests this downward trend has followed from the recent declining

trend in the use of government health care facilities by the rural people. Out of 36.2 per cent quality treatment in 1984 about 17 per cent had emerged from the private sector and government network provided little over 19 per cent. The corresponding figures in the present study are respectively 22.5 and 12 per cents. Thus, government sector contribution to quality health care while has declined by more than one-third in the recent years that of private sector increased and increased by the same margin. Thus, the government sector playing the larger role a decade ago in delivering the quality care in rural area has now been reduced to a minor partner for that supplying only about half of what the private sector contributes.

For treatment of the major illnesses the situation is somewhat different. Quality treatment constitutes about 62 per cent of all main treatments received for these illnesses. About 23 per cent of them is received from the government facilities and remaining more than 39 per cent from the private sector including a small contribution from the private clinics (Table 10).

#### **V.4.1 Quality of Care by Sex and Age**

Though the utilization of health care as such has not shown much variation over the sexes, the rural men and women differ by a degree for utilization of quality health care. However, such difference persists only for acute illnesses and is totally absent for major ones. The share of quality care in the total treatment is 37 per cent for rural male in case of acute illness while that for female is 31.5 per cent. For major illnesses the share for both the sexes however, is more than 60 per cent (Table 15). Thus, as it seems whatever negative discrimination is there for health care for the rural female takes place only when the illness is perceived to be not serious one. But when it is serious and life threatening one such discrimination largely disappears.

Age and quality care use varies positively in rural area. Again, such variation is sharper for the acute illnesses than for the major ones. Thus, alike that for sexes, the discrimination against children for quality care, which is expensive too arises primarily when the illness is not perceived to be serious one having grave consequences for the life.

For acute illness, the share of quality care for the children aged under 15 is around 25 per cent and the corresponding figure for the adults and elderly is more than 40 per cent. These figures are respectively 60 and less than 70 per cents for major illness. However, the importance of the individual member in the household while in part may determine the utilization of quality care part of the age variation may also lie in the fact that the adult and elderly people of rural area mostly suffer from non-

communicable and degenerative diseases (Table 5) which require sophisticated health care but transient type of illness suffered by the children may not require so often.

#### **V.4.2 Quality of Care by Economic Condition**

Again, although the healthcare utilization *per se* varies very little across economic classes (Table 9) the utilization of quality care, given the overwhelming dominance of private sector, expectedly do so. It varies positively and substantially with the economic condition. The quality care for acute illness represent around 25 per cent among extreme poor category but the figure is 40 per cent in the non-poor category. The corresponding figures for major illnesses are respectively 55 and 67 per cents (Table 15). Thus, unlike that for age and sex, the poor/non-poor gap in quality care use is about similar both for acute and major illnesses although for latter it is somewhat lower. These observations tend to suggest that for quality care use in rural area the economic condition of the people bears much relevance than the age and sex viz., it is a much more stronger determinant than the other two for quality care use.

To note, although the overall sex-differential in quality care use was found not to be very large in rural area such difference is quite prominent among extreme poor category particularly for acute illnesses although it persist by a degree for major illnesses too (Table 16). Women's relative deprivation for quality care is hardly visible in other economic classes and this is so both for acute and major illnesses. Indeed, as shown by the data women's deprivation for quality care in rural area is concentrated almost solely among poorest segment of population. It is hardly visible among moderate poor and non-poor categories both for acute and major illnesses. As it seems therefore, the discrimination against women in rural area at least for quality health care originates from the poverty condition only. It may not be an outcome of cultural biases against women. Among extreme poor category the male share of quality treatment for acute illness is 32 per cent and that for female is 18 per cent. The corresponding shares for major illnesses are respectively 61 and 53 per cents. However, the condition for quality health care for poor women could have been more intolerable had there been no government health care facilities in rural area. More than two-third of such care of them for major illness comes from these facilities (Table 14).

## **VI Consequence of Ill-Health**

Although it is by now recognized that the ill health has much negative impact on the wellbeing of individuals, household and community very little is known about these impacts in precise term. The exact identification of them particularly the impact of ill health on economy, productivity etc., at any level is very difficult. The primary reason for this has been the enormity in data requirement which the usual one shot survey can not fulfill. The present study too is a defaulter on this count.

In the present study we shall approach the understanding of the impact of ill health through duration of sickness for which the normal activities remain suspended either fully or partially and through expenditure incurred for the treatment of sickness.

### **VI.1 Duration of Suffering from Illness**

The average and median duration of suffering of rural people from acute and major illnesses by age, sex and economic condition are presented in Table 17. The rural people suffer on average 13 days per episode of an acute illness. This estimate however, may be on the lower side as many of the illnesses under observation have truncated episode. However, the detail distribution indicates less than 40 per cent of the rural people suffer up to a week from acute illness, another one-third suffer from these illnesses for 8 to 15 days, and duration for remaining 21 per cent is more than two weeks with 1.5 per cent suffering for more than a month (Table 18). The median duration for acute illness is estimated to be 8 days.

The average duration of major illness suffered by 4 per cent of the rural people is 72 days and median duration is 26 days. As observed around half of the major illnesses endure for less than one month period and remaining half inflicts suffering for more than a month with 20 per cent suffering for more than 3 months from major sicknesses (Table 18).

Over the ages, children under 15 suffer on average for 9-10 days per episode of acute illness. The duration rises to 14 days for adult population aged 15-59 years, and to 20 days for elderly ones aged 60+ (Table 17). Thus, age and duration of illness form a positive association. One of the reasons for this could be that the adult and elderly people suffer more from chronic degenerative illness.

Interestingly, a positive association was also noted between economic condition and the duration of acute illness though poverty is expected to lengthen the suffering from sicknesses at least,

by interfering into the process of recovery from illnesses (Table 17). This contrary observation presumably has arisen due to the fact that the poor people of rural area do not afford to remain sick for a long period for economic necessity. After a minimum or expiry of the peak period they just ignore the morbid condition for compulsion to work.

Duration of suffering from acute illness varies little across sexes. The average duration for male for acute illness is marginally higher than that for female. For major illnesses it is reverse with difference being somewhat more distinct. For acute illness the average duration for male is 13.7 days 12.4 days for female. For major illnesses they are respectively 68 and 76 days (Table 17). However, the shorter duration observed for female for acute illnesses needs some caution. The pressure of the household chores, need for child care, pressure of economic activity in case of poor women etc., may allow them little scope to remain sick beyond a basic minimum period. Thus, the duration of illness for female in reality may be higher than it is reported. In such a case implying a higher intensity of illness for the rural women despite the morbidity rate is similar for rural men and women.

### **VI.1.1 Extent of Inactivity**

Table 19 presents the proportion of sick persons who require to be bed-ridden due to acute and major illness. As shown by the data, more than 56 per cent of the acute and 81 per cent of the major illnesses require patients to be bed-ridden. For acute illness, the proportion rises steadily with the age. It is 36 per cent for children under 5 and 74 per cent for the elderly people aged 60+. Surprisingly, in comparison to the non-poor the extreme poor people of rural area who are most vulnerable to diseases and with whom intensity of sicknesses also should be higher, fell bed-ridden somewhat less than the better-off ones both from acute and major illnesses. They fell bed-ridden from 76 per cent of the major illnesses against 81 per cent noted for the non-poor. These figures for acute illnesses are respectively 57 and 59 per cents. However, this may not be the true reflection of reality. As noted above, the higher compulsion of the poor people to resume normal work-life may have something to do with it.

The proportion people falling bed-ridden from the sicknesses referring both the acute and major sicknesses does not vary much for rural men and women. Both from acute and major illnesses about similar proportion of male and female fell bed-ridden (Table 19)

### **VI.1.2 Duration of Inactivity**

Table 20 presents the average and median duration for which one requires to be bedridden. Those who fell bed-ridden from acute illness remain so on average for about a week. The figure is little more than a month (about 34 days) for major illness. This duration for acute illness is largely similar over the ages except for elderly people aged 60+. It is between 6-7 days for children and adults aged up to 59 and more than 11 days for elderly people. However, the duration of remaining in the bed in case of major illness varies positively with age and this tendency increases sharply after age 45. The children aged under 15 remain bed-ridden on average for 15-17 days from major illness. The duration increases to 28 days for those aged 15-44, 44 days for people aged 45-59, and to nearly two months (54 days) for elderly people. This variation presumably arise from the fact that the major ailments of adult and elderly people arise more from chronic degenerative illnesses.

The rural male both from acute and major illnesses tends to remain bed-ridden for somewhat longer period than the rural females do. As noted above perhaps their traditional responsibility for child-care, household-chores etc. allows them less opportunity to remain inactive after critical minimum period. From acute illness the rural males remain bed-ridden for about 8 and females do so for 7 days. For major illnesses these figures are respectively 37.5 and 29.6 days.

The variation in the duration of remaining bed-ridden across economic classes is about similar for acute illness but varies negatively for the major ones. For acute illness the duration is 7-8 days across economic condition but in case of major illness it is about 40 days for the extreme poor and 30 days for the non-poor (Table 20).

## **VI.2 Expenditure on Health Care**

As noted before, the health care cost in a poverty stricken society like rural Bangladesh puts an additional and often excessive financial burden on households leading to the curtailment of other well-being of life. This even sometimes initiates a downward movement through the poverty spiral causing many to slip below the poverty line or the line for extreme poverty.

Table 21 presents the average and median expenditure incurred by the rural people for treatment of an episode of acute and major illness. The rural people incur on average an expenditure of Tk.342 per episode of acute illness with 43 per cent spending for the purpose more than Tk.100. For major illness per episode treatment cost is estimated to be Tk.2,696 with 18 per cent incurring a cost of more than Tk.3,000 and 12 per cent spending more than Tk.5,000. The above cost estimates however,

may be on the lower side as many of the sicknesses for which the cost information is collected have incomplete episode. The reported monthly expenditure for repeat illness suffered by 9 per cent of the rural people is Tk.110 on average.

As evident from these estimates while ill-health restrict the work days causing wage loss to rural people particularly to those who are poor this imposes a reasonably heavy additional burden on them in terms of treatment cost as well. As gathered from the data nearly all rural households (97 per cent) make major expenses on health in a year and such health expenses account for 15 per cent of the annual major expenses made by a household. The data also reveal more than one-third of the rural household (36 per cent) during a year face economic crisis due to health expenses and more than 10 per cent of the rural households indeed, encounter economic deterioration for this additional health expenses.

The cost of treatment both for acute and major illness increases with age of the rural people. The estimated per episode cost for acute illness for the children under age is Tk.125. It increases to Tk.198 for children aged 5-14, jumps to Tk.411 for adult population aged 15-44, and above Tk.500 for those in the late adulthood and elderly ages of 45+. The corresponding figures for major illnesses are respectively Tk.1,836, Tk.1,252, Tk.2,711 and above Tk.3,000. This cost escalation with age however among other things may be due to the fact that with age the incidence of non-communicable and degenerative illnesses increases. Cost of treatment of them is more in comparison to the transient type of illness like, fever, common cold, diarrhoeal diseases, influenza, malaria, etc. suffered more by the young children/people (Rabbani et.al, 1997, Sohail, 1997).

The treatment cost varies positively with the economic condition. This is so for acute and major illness. Such variation for major illness however, seems to be of somewhat lower degree than the acute illness. This may be due to the reason that when the sickness is a serious one threatening life even poor make all out efforts for treatment whatever may be the consequences of that. The per episode treatment cost of the extreme poor people for acute illness is Tk.167 and that for non-poor is Tk.511. These figures for major illness are respectively Tk.1553 and Tk.3412. To note, the estimated income elasticity for the household medical expenditure of all categories is 0.31 and this was found to be statistically significant (Rabbani et, al., 1997).

The health care cost particularly for acute illness does not vary much for the sexes. It is Tk.343 for the rural male and Tk.341 for female. For major illness however, there is cost variation over the

sexes and rural male enjoys some privilege for it. The estimated cost per episode of major illness is Tk.2,964 for the rural male and Tk.2,421 for rural female (Table 21). Thus, although not for ordinary health care rural women seems to encounter discrimination for sophisticated health care requiring high cost. An explanation for this variation while may lie in the status variation between rural men and women the ground reality surrounding them also in part may be responsible for this. Given the men's role as earning member for the household in rural area the poor household may tolerate to an extent the inactivity of women from the sicknesses but may not do so in case of men in which case the welfare of the entire household may get affected.

### **VI.2.1 Financing of Health Care Cost**

The modus operandi of meeting the treatment cost highlights further the economic consequences of ill health in rural area. Table 22 presents the source of meeting the health care cost by rural people. As observed, in meeting such expenses for acute illness in about 57 per cent cases the rural households rely on their running income. In the remaining more than 40 per cent cases they either dissave or dispose-off assets including the productive ones, or incur loan.

The situation is worse in the case of major illness. Only in 45 per cent cases rural people can meet treatment cost for major illnesses from running income of the household. In remaining 55 per cent cases they rely on sources which may bear negative impact on the household welfare.

Across economic condition the situation is understandably worst for the extreme poor people. For acute illness, only in half of the cases extreme poor households meet the treatment costs out of current income and resort to dissaving or asset sale in remaining cases except for 5 per cent of the cases for which they secure kin assistance. The former figure drops down to 25 per cent in case of major illness. Thus, in the remaining 75 per cent cases the poor households of the rural area remain vulnerable to asset erosion and/or severe welfare loss. Again, the reported figure for running income or household savings for meeting health care cost in the case of extreme poor people needs to be viewed in the background that these household may have a negative savings rate (Khan, 1994).

However, more startling observation is that even a section of rural non-poor people are not always able to bear the burden of treatment cost without taking any economic risk. In 83 per cent cases they are able to meet their treatment cost for acute illness out of current income or past savings while in

remaining 17 per cent cases they either sell assets or secure high-interest loan to meet such cost. This burden is further heavier for them in case of major illness (Table 22).

## **VII Concluding Remarks**

Evidence from 62 villages reveals that although there is an improvement in the health status of rural people in recent years the morbidity burden in terms of both level and disease-pattern is yet to reach a satisfactory level in rural area. Taking all types illness i.e. period prevalence rate of acute illness, repeat illness giving rise to recurrent suffering, and major illness the morbidity burden is still very high in rural area. The morbidity disease pattern across all people is still dominated by the infectious and parasitic diseases. Thus, physical non-food environment and other extraneous factors sustained at the community level still are the major determinants of health status in rural area. Hence, for achieving further improvement in health in rural area although many of the health prerequisites would require still substantial improvement, the environmental sanitation directly controlling the incidence/prevalence of infectious and parasitic diseases would require priority attention. In other words, through strengthening and expanding the public health measures there is much scope still to improve the health status in rural area.

For improving health status of the rural people another area requiring priority attention is the reproductive health of women. As observed, much of the disadvantage in women's health can be removed through proper management of the reproductive role of women. Indeed, as the evidence suggest their relative disadvantage for health in comparison to rural men can be transformed into advantage if motherhood can be made safe for them. However, given the present state of affairs this may prove a challenging task. A satisfactory solution to it would require one the one hand, adequate supply/utilization of the reproductive health care which currently persist at a very low level and on the other, an improvement in maternal nutritional status which is believed to be the worst one in the world (Levinson,1998). A comprehensive improvement in maternal health would also require a priority attention to the female diseases and to the problems of adolescent girls having implications for women's reproductive wellbeing.

Although the utilization of health care services in rural area has achieved much quantitative successes with nearly all sicknesses currently receiving some kind of treatment the situation is hardly satisfactory for this. Only one-third of the health care received by rural people at present represent quality care and there has been little progress also on this count over the past decade. Since quality of

health care is a critical condition for improving the health status in low-income countries (Roy, 1995) this phenomenon requires urgent attention for further improvement in health in rural area.

In ensuring greater access of rural people to quality health care the role of public sector seems quite crucial. It influences directly utilization of such care by the rural people particularly by the underprivileged sections of them such as, poor, women, and children. Hence, public sector role has to be strengthened and expanded for a qualitative change in rural health and health care. It is above all necessary to safeguard the interest of the weaker sections of rural people who in the past more frequently used these facilities for treatment and even now turn to them in a large fashion at times of dire necessity.

Alarmingly, the role of public sector in delivering health care in rural area of late has declined significantly leaving greatest adverse effect on the poor, women and children. However, this declining role of public sector while may be a reflection of inability of the public sector to satisfy the growing demand for services there are also evidence that this sector suffer from lack of demand for poor quality of services. Thus, the problem has to be addressed both from supply and demand points of view.

However, an appropriate strategy for health care for the rural people requires serious consideration to another fact also viz., the private sector dominated by the untrained/unqualified practitioners supply nearly the 90 per cent of the treatment used by rural people. Hence, to make best use of the situation, particularly for achieving a comprehensive coverage of rural people for quality health care the private sector needs to be developed at the patronage of the government. The government has to adopt appropriate policies to train up this vast pool of untrained rural private practitioners in order to ensure minimum quality of primary care to rural people. To derive best out of the situation these practitioners including the 'pharmacy salesmen' who also have been emerging as a popular source of health care in rural area but in rural context are likely to be mostly untrained/unqualified, requires to be brought under a bigger framework of primary health care delivery network for rural area. Leaving this whole army outside the purview ensuring "health for all" within a minimum possible targeted period may remain an unrealistic goal.

Given the present reality that a sizeable proportion of rural people are unable to meet treatment expenses without inviting negative consequences on the household economic potentials, it is advisable that some alternative mechanisms in terms of health insurance, cooperative, community fund, etc., are put in place to facilitate financing such cost in rural area. A prudent policy in this regard

would go a long way to ensure people's health and wellbeing and would contribute much in neutralizing the ill-health-poverty nexus in the country.

At the same time, in view of the fact that nearly 90 per cent of the health care needs of the rural people are met by the private sector in exchange of money, the government can possibly think of sharing some health care cost with the people. But this has to be done keeping in mind the rural reality and a necessary precondition for this will be the satisfactory provision of services from the government network.

Finally, health gap in terms of morbidity although has narrowed down somewhat in recent years in rural area between rich and poor and between sexes the health vulnerability of rural poor compared to rural rich and that of rural women compared to that of rural men is still much higher. Thus, the equity concern for health would be served better if the health interventions in rural area maintain a pro-poor and pro-women bias.

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Table 1  
Morbidity Rate by Sex, Age, and Economic Condition: Rural Area

(Rate per 100)

Age/sex/economic condition	Type of illness		
	Acute	repeat	major
<b>All</b>	12.5	9.1	4.0
<b>Sex</b>			
Male	12.0	7.8	4.0
Female	13.1	10.6	4.1
<b>Age (in years)</b>			
0-4	22.1	9.2	2.1
5-14	10.1	4.1	1.3
15-29	8.1	3.6	3.7
30-44	12.9	11.6	5.6
45-59	15.7	22.1	7.6
60+	23.6	30.9	10.2
<b>Economic Condition</b>			
Hardcore poor	14.6	9.4	4.7
Moderate poor	12.4	8.7	3.7
Non-poor	11.6	9.0	3.9

Source: Analysis of Poverty Trend Project, 62 Village Survey, 1995

Table 2  
Sex-specific Morbidity Rate by Age Group and Economic Condition: Rural Area

Age/Occupation	Acute Illness		Repeat Illness		Major Illness	
	Male	Female	Male	Female	Male	Female
<b>Age</b>						
0-4	22.8	21.3	9.4	9.1	2.7	1.6
5-14	10.9	9.2	4.2	4.0	1.7	1.0
15-29	7.4	8.9	2.6	4.6	3.5	4.0
30-44	10.5	15.6	8.1	15.5	5.1	7.0
45-59	13.7	17.7	17.7	26.5	7.5	7.8
60+	24.4	22.5	31.8	29.9	10.8	9.3
<b>Economic Condition</b>						
Hardcore Poor	15.9	13.2	9.6	9.2	5.5	3.9
Moderate poor	12.5	12.3	8.8	8.9	3.6	3.7
Non-poor	10.0	13.6	6.6	12.0	3.6	4.3

Source: Analysis of Poverty Trends Project, 62 Village Survey, 1995.

Table 3  
Current Morbidity Rate (one day reference period) by Sex and Land Ownership Size over the Recent Years:  
Rural Area

Land holding size (acre)/sex	Rate per 100		
	1995	1987	1984
All	4.3	11.5	16.2
<b>Land holding size (in acres)</b>			
> 0.50	4.8	12.5	19.1
0.51-2.50	4.2	10.1	14.4
2.51 +	3.7	9.6	12.3
<b>Sex</b>			
Male	4.2	11.0	15.0
Female	4.4	12.1	17.4

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995

Table 4  
Disease Pattern of the Sickness : Rural Area

Disease Pattern	Acute Illness	Repeat Illness	Major Illness
Diarrhoeal diseases including	20.8	12.5	13.0
Cholera and dysentery fever, cold, cough etc.	40.7	22.4	6.0
Malaria	1.5	-.8	2.5
Typhoid	1.4	-	7.3
Measles	.7	.3	.9
Chicken Pox	3.0	-	.6
Jaundice	1.3	-	3.8
Skin diseases	2.1	2.2	1.6
Asthma/diabetes/T.B/Paralysis/Leprosy/Cancer	2.8	8.7	13.0
Rheumatism	1.8	8.2	1.9
Blood pressure	2.1	6.2	4.1
Other Gastro enteric problems	8.3	19.4	16.8
Delivery related	3.6	4.2	9.5
Others	9.9	13.8	19.0
All	100.0 (980)	100.0 (710)	100.0 (316)

Note: Figures in parentheses refer to the proportion of total sickness of women aged 15-44

Source : Analysis of Poverty Trends Project, 62 village Survey, 1995

Table 5  
Disease-pattern of Different Type of Illness by Age Group: Rural Area

Diseases	Acute illness				Repeat illness				Major Illness			
	0-4	5-14	15-59	60+	0-4	5-14	15-59	60+	0-4	5-14	15-59	60+
Diarrhoeal dis./ cholera/ dysentery	26.3	30.5	16.4	11.9	37.1	30.0	7.6	3.5	25.0	16.7	12.0	8.5
Fever,Cold, Cough	58.1	51.13	32.2	30.3	52.8	44.4	14.5	16.1	25.0	6.7	4.4	6.4
Malaria	.6	1.8	2.1	-	-	2.2	1.0	-	6.2	3.3	1.8	4.2
Typhoid	-	2.2	1.7	.9	-	1.1	-	-	12.5	13.3	6.7	4.2
Measles	1.2	1.3	-	-	-	-	-	-	6.2	6.7	-	-
Chickenpox	3.6	4.5	2.5	-	-	-	-	-	6.2	3.3	-	-
Jaundice	.6	.4	-	1.8	1.4	1.1	1.0	.7	6.2	3.3	4.0	-
Asthma/T.B/Diabetes/Paralysis/Cancer/Leprosy	-	.4	2.3	9.2	2.9	4.4	6.6	11.9	6.2	-	10.0	29.8
Rheumatism	-	.4	1.7	8.2	-	2.2	7.6	17.5	-	-	2.2	2.1
Blood Pressure	-	-	3.3	4.6	-	-	7.9	8.4	-	-	3.1	12.8
Gastric/Ulcer/Acidity	-	-	13.1	16.5	-	-	26.8	20.3	-	-	20.0	14.9
Delivery Related	-	.5	7.1 (16.8)	-	-	-	6.9 (18.7)	-	-	-	14.4	-
Other	9.6	6.9	17.6	16.6	5.8	14.6	20.1	21.6	6.5	46.7	21.2	17.1
All	100.0 (167)	100.0 (223)	100.0 (481)	100.0 (109)	100.0 (70)	100.0 (90)	100.0 (407)	100.0 (143)	100.0 (15)	100.0 (30)	100.0 (224)	100.0 (47)

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995.

Table 6  
Disease-pattern by Types of Illness and Economic Condition: Rural Area

Diseases	Acute illness			Repeat Illness			Major Illness		
	H	M	N	H	M	N	H	M	N
Diarrhoeal dis./ cholera/dysentery	23.	22.0	18.6	18.4	14.1	8.8	21.5	13.1	10.4
Fever,cold, cough	40.4	42.9	40.0	22.6	24.6	21.1	5.9	5.0	6.5
Malaria	3.5	-	1.3	1.8	.5	.6	2.4	3.8	2.0
Typoid	.4	1.9	1.8	.6	.5	-	10.7	8.9	4.6
Measles	1.1	-	.9	-	-	-	2.4	-	.6
Chicken pox	5.0	2.6	2.0	-	-	-	1.2	-	.6
Jaundice	1.5	1.5	1.1	1.8	.5	.8	2.4	2.5	5.2
Skin disease	1.5	4.1	1.3	1.2	5.8	1.1	-	2.5	2.0
Asthma/T.B/Diabetes /Paralysis/Cancer/Le prosy	3.1	1.5	3.1	11.9	5.2	8.8	11.9	12.6	12.4
Rheumatism	.4	.7	3.3	4.8	4.7	11.7	3.6	-	2.0
Blood Pressure	1.5	1.9	2.6	4.8	4.2	8.0	2.4	3.8	5.2
Gastric/Ulcer/Acidity	6.9	9.7	8.2	15.5	20.9	20.5	16.7	19.0	15.7
Delivery Related	3.5	2.6	4.2	4.8	3.1	4.6	10.7	6.3	10.5
Other	7.7	8.6	11.9	11.8	15.9	14.0	20.2	14.1	22.3
All (N)	100.0 (260)	100.0 (268)	100.0 (252)	100.0 (168)	100.0 (191)	100.0 (351)	100.0 (84)	100.0 (79)	100.0 (153)

Note : H----Hardcore Poor; M---- Moderate Poor; N---- Non poor

Source: Analysis of Poverty Trends; 62 Village Survey, 1995

Table.7  
Disease-pattern by Types of Illness and Sex: Rural Area

Disease Pattern	Acute illness		Repeat illness		Major illness	
Diarrhoeal dis./cholera/dysentery	21.2	20.4	14.5	10.9	13.2	12.5
Fever, Cold, Cough, etc.	43.0	38.4	23.5	21.5	6.0	5.9
Malaria	2.2	.8	1.5	-	3.0	2.0
Typhoid	2.2	.6	-	-	7.8	6.6
Measles	14.0	14.0	-	-	-	2.0
Chicken pox	3.4	2.5	-	-	-	-
Jaundice	1.2	1.4	-	.6	6.0	1.3
Skin disease	2.8	1.4	3.7	1.3	2.4	-
Asthma/T.B/Diabetes/Paralysis/Cancer/Le prosy	3.8	1.9	10.5	7.2	13.2	12.6
Rheumatism	1.0	2.7	7.1	9.1	-	-
Blood Pressure	1.0	3.3	4.3	7.8	4.2	3.9
Gastric/Ulcer/Acidity	7.9	8.7	20.1	19.0	19.9	13.2
Delivery Related	-	7.2 (17.8)	-	7.8 (23.8)	-	20.0 (35.0)
Others	9.9	9.3	14.2	19.4	24.3	20.9
All	100.0 (495)	100.0 (485)	100.0 (324)	100.0 (386)	100.0 (166)	100.0 (150)

Note : Figures in parentheses refer to proportions relating to age group 15-44 only.  
Source : Analysis of Poverty Trends Project; 62 Village Survey, 1995

Table 8  
Proportion Sickness of women Attributable to Delivery related causes by  
Economic Condition: Rural Area

Types of illness	Per cent illness of	
	All women	women aged 15-44
<b>Acute Illness</b>		
Hardcore poor	7.6	18.0
Moderate poor	5.5	12.5
Non-poor	5.0	21.1
<b>Repeat Illness</b>		
Hardcore poor	9.6	28.6
Moderate poor	6.5	14.3
Non-poor	7.6	20.0
<b>Major Illness</b>		
Hardcore poor	25.7	45.5
Moderate poor	12.8	21.7
Non-poor	21.0	37.2

Source : Analysis of poverty trends project, 62 village resurvey, 1995

Table 9  
Proportion of Acute and Major Sickness Received Treatment by Sex, Age, and  
Economic Condition: Rural Area

	Per cent received treatment	
	Acute illness	major illness
All	97.9	100.0
<b>Sex</b>		
Male	98.4	100.0
Female	97.5	99.3
<b>Age</b>		
0-4	96.4	100.0
5-14	97.7	100.0
15-29	98.9	100.0
30-44	98.9	100.0
45-59	97.4	98.2
60+	98.1	100.0
<b>Economic Condition</b>		
Hardcore poor	96.5	98.8
Moderate poor	98.9	100.0
Non-poor	98.2	100.0

Source : Analysis of Poverty Trends Project; 62 Village Survey, 1995

Table 10  
Source of Treatment by Types of Illnesses and Sex: Rural Area

Source/Types of Illness	Sex		All
	Male	Female	
<b>Acute Illness</b> (last treatment)			
<b>Govt. Health Facilities</b>	<b>12.9</b>	<b>10.6</b>	<b>12.0</b>
<b>Non-Govt. Health Facilities</b>	<b>87.1</b>	<b>89.4</b>	<b>88.0</b>
Private Clinic	1.0	1.7	1.3
Qualified pr. Doctor	23.2	19.2	21.2
Unqualified pr. Practitioner	36.1	41.0	38.5
Homeopathy	3.5	4.4	3.9
Kabiraji/Unani	4.1	4.2	4.1
Pharmacy	17.2	16.5	16.8
NGO	-	-	-
Totka	.4	.6	.5
Own Knowledge/other	1.4	1.2	1.3
All (N)	100.0 (487)	100.0 (473)	100.0 (960)
<b>Major Illness</b> (main treatment)			
<b>Govt. Health Facilities</b>	<b>24.1</b>	<b>21.5</b>	<b>23.1</b>
<b>Non-Govt. Health Facilities</b>	<b>75.9</b>	<b>78.5</b>	<b>76.9</b>
Private Clinic	3.0	2.0	2.5
Qualified practitioner	34.3	39.6	36.8
Unqualified practitioner	19.3	17.5	18.4
Homeopathy	.6	2.7	1.6
Kabiraji/Unani	9.6	6.0	7.9
Pharmacy	5.4	-	6.7
NGO	1.2	-	0.6
Totka	.6	-	.3
All (N)	100.0 (166)	100.0 (149)	100.0 (315)

Source : Analysis of Poverty Trends Project, 62 Village Surveyed, 1995

Table 11  
Source of Treatment by Types of Illness and Age Groups: Rural Area

Source	Age group				
	0-4	5-14	15-44	45-59	60+
<b>Acute illness (last treatment)</b>					
<b>Govt. Health Facilities</b>	<b>11.2</b>	<b>7.3</b>	<b>13.6</b>	<b>14.9</b>	<b>14.0</b>
<b>Non-Govt. Health Facilities</b>	<b>88.8</b>	<b>92.7</b>	<b>86.4</b>	<b>85.1</b>	<b>86.0</b>
Private Clinic	.6	.5	2.8	-	.9
Qualified doctor	11.8	17.4	22.8	32.5	26.2
Unqualified practitioner	41.6	42.7	35.3	35.1	40.2
Homeopathy	11.2	2.3	3.0	.9	2.8
Kabiraji/Unani	3.7	3.2	5.3	2.6	4.7
Pharmacy	19.2	26.1	14.4	11.4	8.4
NGO	-	-	-	-	-
Totka	.6	-	1.1	-	-
Own knowledge/other	-	.5	1.7	2.6	2.8
N	161	218	360	114	107
<b>Major illness (Main illness)</b>					
<b>Govt. Health Facilities</b>	<b>33.0</b>	<b>36.7</b>	<b>19.2</b>	<b>26.8</b>	<b>21.7</b>
<b>Non-Govt. Health Facilities</b>	<b>67.0</b>	<b>63.3</b>	<b>80.8</b>	<b>73.2</b>	<b>78.3</b>
Private Clinic	-	3.3	3.0	3.6	2.2
Qualified doctor	26.7	20.0	38.3	39.3	43.5
Unqualified practitioner	20.0	16.7	19.8	14.3	19.6
Homeopathy	6.7	3.3	1.2	1.8	-
Kabiraji/Unani	6.7	6.7	9.0	10.7	2.2
Pharmacy	6.7	10.0	6.0	3.6	10.9
NGO	-	-	1.8	-	-
Totka	-	3.3	-	-	-
Own knowledge/other	-	-	1.2	-	2.2
All (N)	100.0 (15)	100.0 (30)	100.0 (167)	100.0 (56)	100.0 (46)

Source : Analysis of Poverty Trends Project; 62 Village Survey, 1995

Table 12  
Source of Treatment by Types of Illness and Economic Categories: Rural Area

Source/Types of Illness	Hardcore Poor	Moderate poor	Non-poor
<b>Acute illness</b> (last treatment )			
<b>Govt. Health Facilities</b>	<b>11.9</b>	<b>12.5</b>	<b>11.7</b>
<b>Non-Govt. Health Facilities</b>	<b>88.1</b>	<b>87.5</b>	<b>88.3</b>
Private Clinic	.8	1.9	1.3
Qualified doctor	12.7	19.2	27.2
Unqualified practitioner	44.6	43.8	32.0
Homeopathy	5.2	3.4	3.6
Kabiraji/Unani	3.6	3.0	5.2
Pharmacy	17.5	15.5	17.3
NGO	-	-	-
Totka	2.0	-	-
Own knowledge/other	1.6	.7	1.6
All (N)	100.0 (251)	100.0 (265)	100.0 (444)
<b>Major Illness</b> (main treatment )			
<b>Govt. Health Facilities</b>	<b>25.3</b>	<b>21.5</b>	<b>22.9</b>
<b>Non-Govt. Health Facilities</b>	<b>74.7</b>	<b>78.5</b>	<b>77.1</b>
Private Clinic	.4	2.5	2.6
Qualified doctor	28.9	35.4	41.8
Unqualified practitioner	24.0	17.7	15.7
Homeopathy	2.4	-	2.0
Kabiraji/Unani	8.4	8.9	7.2
NGO	1.2	2.5	-
Totka	-	-	1.3
Own knowledge/other	2.4	-	1.3
All (N)	100.0 (83)	100.0 (79)	100.0 (153)

Source : Analysis of Poverty Trends Project; 62 Village Survey, 1995.

Table 13  
Source of Treatment for Acute Illness by Sex and Economic Condition: Rural Area

Source/Sex	Economic Condition		
	Hardcore poor	Moderate poor	Non-poor
<b>Male</b>			
<b>Govt. Health Facilities</b>	<b>15.9</b>	<b>12.9</b>	<b>10.9</b>
<b>Non-Govt. Health Facilities</b>	<b>84.1</b>	<b>87.1</b>	<b>89.1</b>
Private Clinic	-	1.4	1.4
Qualified doctor	15.9	19.4	30.5
Unqualified practitioner	40.6	37.4	32.4
Homeopathy	4.3	5.0	5.2
Kabiraji/Unani	1.4	5.0	5.2
Pharmacy	17.4	19.4	15.7
NGO	-	-	-
Totka	1.5	-	-
Own knowledge/other	2.9	-	-
All (N)	100.0 (138)	100.0 (139)	100.0 (210)
<b>Female</b>			
<b>Govt. Health Facilities</b>	<b>7.1</b>	<b>11.9</b>	<b>12.4</b>
<b>Non-Govt. Health Facilities</b>	<b>92.9</b>	<b>88.1</b>	<b>87.6</b>
Private Clinic	1.8	2.4	1.3
Qualified doctor	8.8	19.0	24.4
Unqualified practitioner	49.6	50.8	31.6
Homeopathy	6.2	2.4	4.7
Kabiraji/Unani	6.2	.8	5.1
Pharmacy	17.7	11.1	18.8
NGO	-	-	-
Totka	2.6	-	-
Own knowledge/other	-	1.6	1.7
All (N)	113	126	234

Source : Analysis of Poverty Trends Project; 62 Village Survey, 1995.

Table 14  
Source of Main Treatment for Major Illness by Sex and Economic Condition: Rural Area

Source/Type of Treatment	Economic Condition		
	Hardcore poor	Moderate poor	Non-poor
<b>Male</b>			
<b>Govt. Health Facilities</b>	<b>18.4</b>	<b>25.0</b>	<b>27.3</b>
<b>Non-Govt. Health Facilities</b>	<b>84.1</b>	<b>87.1</b>	<b>89.1</b>
Private Clinic	-	1.4	1.4
Qualified doctor	15.9	19.4	30.5
Unqualified practitioner	40.6	37.4	32.4
Homeopathy	4.3	5.0	5.2
Kabiraji/Unani	1.4	5.0	5.2
Pharmacy	17.4	19.4	15.7
NGO	-	-	-
Totka	1.5	-	-
Own knowledge/other	2.9	-	-
All (N)	100.0 (138)	100.0 (139)	100.0 (210)
<b>Female</b>			
<b>Govt. Health Facilities</b>	<b>7.1</b>	<b>11.9</b>	<b>12.4</b>
<b>Non-Govt. Health Facilities</b>	<b>92.9</b>	<b>88.1</b>	<b>87.6</b>
Private Clinic	1.8	2.4	1.3
Qualified doctor	8.8	19.0	24.4
Unqualified practitioner	49.6	50.8	31.6
Homeopathy	6.2	2.4	4.7
Kabiraji/Unani	6.2	.8	5.1
Pharmacy	17.7	11.1	18.8
NGO	-	-	-
Totka	2.6	-	-
Own knowledge/other	-	1.6	1.7
All (N)	100.0 (113)	100.0 (126)	100.0 (234)

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995.

Table 15  
The Percentage Share of Quality Care in the Total Treatment by Type of Illness,  
Age, Sex, and Economic Condition: Rural Area

Age/Sex/Eco. Condition	Type of Illness	
	Acute	Major
All	34.5	62.4
<b>Sex</b>		
Male	37.1	61.4
Female	31.5	63.1
<b>Age</b>		
0-4	23.6	59.7
5-14	25.2	60.0
15-44	39.2	60.5
45-59	47.4	69.7
60+	41.1	67.4
<b>Economic Condition</b>		
Extreme Poor	25.4	54.6
Moderate poor	33.6	59.4
Non-poor	40.2	67.3

Source: Analysis of Poverty Trends Project, 62 Village Survey, 1995

Table 16  
The Percentage Share of Quality Care by Type of Illness, Sex and Economic Condition: Rural Area

Economic Status	Acute illness		Major illness	
	Male	Female	Male	Female
Extreme Poor	31.8	17.7	61.2	52.9
Moderate poor	33.7	33.3	55.0	64.1
Non-poor	42.8	38.1	65.0	69.7

Source: Analysis of Poverty Trends Project, 62 Village Survey, 1995

Table 17  
Average and Median Duration (in days) of Suffering from Acute and Major Illnesses  
by Age, Sex, Economic Condition: Rural Area

Age/Sex/Econ. Condition	Acute Illness		Major Illness	
	Average	Median	Average	Median
All	13.0	7.9	72	26
<b>Age</b>				
0-4	9.3	6.5	45	19
5-14	9.8	6.7	53	26
15-44	14.4	8.5	94	29
45-59	14.0	8.5	94	29
60+	19.6	12.6	98	27
<b>Economic Condition</b>				
Hardcore poor	11.1	9.2	72	26
Moderate poor	12.3	7.4	69	24
Non-poor	14.6	7.2	73	27
<b>Sex</b>				
Male	13.7	8.3	68	25
Female	12.4	7.6	76	28

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995

Table 18  
Distribution of Sickness by Duration of Suffering (in days) by Type of Illness: Rural Area

Days	Type of Illness	
	Acute	Major
<3	11.4	
3-7	35.5	
8-15	32.5	30.8**
16-30	19.1	26.1
31-60	1.5*	17.0
61-90		5.0
91-180		11.9
181+		9.1
All (N)	100.0 (980)	100.0 (318)

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995

Table 19  
Proportion of Acute and Major Illnesses require patients to be Bedridden by Age, Sex and Economic Condition:  
Rural Area

Age/Sex/ Economic Condition	Per cent of Sickness	
	Acute	Major
All	56.0	81.3
<b>Age</b>		
0-4	3.9	53.3
5-14	46.2	80.0
15-44	63.2	79.6
45-57	67.5	91.2
60+	74.3	85.1
<b>Economic Condition</b>		
Hardcore poor	56.9	76.2
Moderate poor	51.1	87.3
Non-poor	59.3	81.0
<b>Sex</b>		
Male	56.8	79.5
Female	54.9	83.3

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995.

Table 20  
Average and Median Duration (in days) of remaining Bedridden from Acute and Major Illness by Age, Sex and  
Economic Condition: Rural Area

Age/Sex/ Economic Condition	Acute Illness		Major Illness	
	Average	Median	Average	Median
All	7.4	5.2	33.6	12.8
<b>Age</b>				
0-4	5.5	4.7	15.1	7.0
5-14	6.8	5.0	17.0	9.7
15-44	7.2	5.2	27.8	12.5
45-59	6.7	4.3	43.7	15.0
60+	11.1	7.0	53.7	13.7
<b>Economic Condition</b>				
Hardcore poor	7.7	6.0	39.7	13.3
Moderate poor	6.5	4.6	5.0	11.2
Non-poor	7.8	5.2	29.7	13.3
<b>Sex</b>				
Male	7.8	5.6	37.5	13.6
Female	7.0	4.8	29.6	11.9

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995

Table 21  
Average and Median Expenditure of Treatment (in Taka) per episode of Acute and Major Illness by Age, Sex and Economic Condition: Rural Area

Age/Sex/ Economic Condition	Acute Illness		Major Illness	
	Average	Median	Average	Median
All	342	83	2680	704
<b>Age</b>				
0-4	125	49	1836	475
5-14	198	64	1252	500
15-44	411	99	2711	648
45-59	648	>100	2737	845
60+	406	>100	3856	1608
<b>Economic Condition</b>				
Hardcore poor	167	56	1553	457
Moderate poor	220	69	2531	645
Non-poor	511	>100	3412	905
<b>Sex</b>				
Male	343	85	2964	731
Female	341	81	2421	648

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995

Table 22  
Source of Meeting Health Care Expenses for Acute and Major Illnesses: Rural Area

Source of Finance/Type of illness	Economic condition			
	All	Hardcore poor	Moderate poor	Non-poor
<b>Acute Illness</b>				
Income	56.8	48.8	55.1	62.2
Savings	23.6	27.9	24.1	21.0
Sale/Mortgage of land	0.6	0.8	1.5	-
Sale of Agri. Commodities	6.7	4.2	5.1	9.0
Sale of Cattle	0.5	1.1	0.4	0.2
Sale of poultry/Fruit/egg/milk/tree etc.	2.7	3.4	-	1.3
Sale/mortgage of gold/furniture	0.3	-	-	0.6
Loan	5.2	8.0	6.2	3.0
Relatives/Friends	2.9	-	-	0.2
NGO	0.1	-	-	0.2
Begging	0.4	1.1	-	0.2
Other	0.5	-	0.4	.2
All	100.0	100.0	100.0	100.0
<b>Major Illness</b>				
Income	45.2	25.0	42.1	59.7
Savings	17.5	25.0	13.7	14.8
Sale/Mortgage of land	3.1	0.9	5.2	2.3
Sale of Agri. Commodities	7.8	6.2	4.2	10.8
Sale of Cattle	3.1	1.8	3.2	2.8
Sale of poultry/Fruit/egg/milk/tree etc.	4.2	10.7	6.3	1.1
Sale/mortgage of gold/furniture	0.3	0.9	-	-
Loan	10.2	17.0	15.8	2.8
Relatives/Friends	7.6	10.7	7.4	6.2
NGO	-	-	-	-
Begging	0.8	1.8	1.0	-
Other	0.3	-	1.0	-
All	100.0	100.0	100.0	100.0

Source : Analysis of Poverty Trends Project, 62 Village Survey, 1995