Poverty, Health and Integration of Homoeopathy as a Dimension to End Extreme Poverty

Dr. Tridibesh Tripathy

BHMS (Utkal University, Bhubaneswar), MD (BFUHS, Faridkot), MHA (TISS, Mumbai), Ph.D. in Health Systems Studies (TISS, Mumbai), Homoeopathic & Public Health Expert, Visiting Professor, Master of Public Health (Community Medicine) program, Department of Social Work, Lucknow University, Lucknow, UP, India.

Co-author- Professor Shankar Das

Dean, School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai & Former Director, IIHMR, Delhi.

Co-author- Prof. D.P. Singh

Dean, School of Research Methodology, Tata Institute of Social Sciences, Mumbai.

Co-author- Prof. Byomakesh Tripathy

Department of History, Indira Gandhi National Tribal University, Amarkantak, M.P. and Former Vice Chancellor, Utkal University of Culture, Bhubaneswar.

Co-author- Anjali Tripathy

Senior Program Manager, LLF office, Lucknow, Former employee of International Development Agencies like 'WaterAid' and 'Catholic Relief Services'.

Co-author- Dr. Ashutosh Singh

Assistant Professor, Department of Biochemistry, Lucknow university, Lucknow.

Co-Author- Prof, D.R.Sahu, HOD

Department of Sociology, Lucknow University, Lucknow

Co-author- Prof. Rakesh Dwivedi

Co-ordinator, Master of Public Health (Community Medicine) program, Department of Social Work, Lucknow University, Lucknow.

Co-author- Dr. Mohini Gautam

Assistant Professor, Faculty, Master of Public Health (Community Medicine) program, Department of Social Work, Lucknow University, sLucknow.

Co-author- Dr. Umakant Prusty

Research officer (Homoeopathy), Regional Research Institute (Homoeopathy), Puri, Odisha under Central Council for Research in Homoeopathy, Ministry of AYUSH, Government of India.

Co-author- Dr. Madan Mohan Mishra

Homoeopathic Practitioner with 30 years of Experience, Anugul, Odisha.

Co-author- Dr. Pramod Bihari Pradhan

Nodal Officer (Homoeopathy), Directorate of AYUSH, Government of Odisha, Bhubaneswar.

Co-author- Mr. Sovesh Chandra Tripathy

Tripathy, Proponent of Homoeopathy and Employee of IB valley project of Coal India Limited, Jharsuguda, Odisha.

I. Outline of the article[1,2,3,4,7]

'Poverty' resounds with slogans like 'Garibi Hatao' of late Prime Minister Indira Gandhi and 'The Poor Has no Caste' quote of Mr. Biju Pattnaik, late Chief Minister of Odisha in the 1990s. The country has been grappling with the issue of poverty from the pre-independence era. The issue of poverty has come to the fore again because of the pandemic.

Poverty is defined as a condition in which an individual or household lacks the financial resources to afford a basic minimum standard of living. The World Bank (WB) defines poverty as deprivation in well being comprising many dimensions. The World Bank defines three poverty lines. The first is the international poverty line set at $1.90 a day which remains the headline poverty threshold and continues to define the bank's goal of ending global extreme poverty by 2030. The second is the Lower Middle Income (LMI) international poverty line set at $3.20 a day and Upper Middle Income (UMI) international poverty line set at $ 5.50 a day.

The World Bank (WB) has defined the extreme poverty line to the consumption of $ 1.9 per day. WB defines Extreme poverty or Purchasing Power Parity (PPP) of $1.9 & PPP of $3.2 and consumption inequality in India for each of the years 2004-05 through the pandemic year 2020-21. The effect of in-kind food subsidies was measured on poverty and inequality in the recent International Monetary Fund working series paper. The paper found that extreme poverty was as low as 0.8% in pre-pandemic year 2019. Food transfers were instrumental to ensure that poverty remained low during 2020. Post food subsidy inequality at 0.294 is now very close to its level 0.284 observed in 1993/94.

The reader will get an idea of the problem of poverty at global & national level through the eyes of the public system in the beginning sections before delving in to the history of the poverty issue. Currently, the poverty line debate has regained its value in the era of the current pandemic. The pandemic has escalated the poverty issues further. In the absence of effective and long time therapy in the current system, the article peeps through what the cost effective and popular therapeutic system of homoeopathy can offer to deal with these social issues that fulfil the triad criteria of essential medicines as per the National List of Essential Medicines (NLEM). The criteria is that these medicines need to be effective clinically, safe clinically and should be without side effects. If these people living below poverty line are introduced to this homoeopathic system through the public, private, corporate and other network, the country will get one such therapeutic ammunition to deal with this social evil of poverty.

II. Background[5,7,9]

The current article looks into the aspects of poverty during the life period out of which food consumption is one of the main challenges along with the non food consumptions.

The article looks into the brief history of programs on poverty issues in India & the emergence of food consumption as an issue. It moves on to the current situation on poverty in India & how homoeopathy can be integrated to deal with this poverty related issues as a component of Ministry of AYUSH. The article suggests the integration of medical pluralism in dealing with poverty through inclusion of Homoeopathy in the gamete of social issues such as poverty.

As each & every drug in Homoeopathy is only proved on human beings, all the drugs have mental component, physical component and emotional components as it is only human beings who can express their physical & mental symptoms during proving of the drugs as per the guidelines set by the Homoeopathic Research Councils (HRC) of each nation. In India, Central Council for Research in Homoeopathy, an autonomous body under the ministry of AYUSH lays out such guidelines.

The article gains more relevance during the current COVID 19 pandemic which has precipitated the stress levels and reduced the consumption level of population at house hold since March 2020 and most of them are more prone to nutritional disorders during their life stage.

Keywords- Poverty, PPP, GDP, Homoeopathic Materia Medica, Constitutional medicine, Bach Flower Remedy, Bowel Nosode, Miasms. OOPE, Financial Inclusion.

III. Introduction[24-41]

Here, in this section, the poverty estimation in the pre and post independence era is detailed out using the contents of the working paper of the Ministry of Rural Development (MORD) of Government of India (GOI) published in September 2020.

The very first step in estimating poverty is to define and quantify a poverty line. These two aspects have been mentioned above. The Box below gives a snapshot of the steps taken at the national level from the pre independence era to the post independence era.

Box 1- Poverty Estimations in India

Pre Independence Era

1. Dadabhai Naoroji' in his book 'Poverty and Un-British Rule in India,' made the earliest estimate of poverty line at 1867-68 prices (□ 16 to □ 35 per capita per year) based on the cost of a subsistence diet for the emigrant coolies during their voyage living in a state of quietude.
2. In 1938, the National Planning Committee set up under the chairmanship of Jawaharlal Nehru suggested a poverty line ranging from □ 15 to □ 20 per capita per month based on a minimum standard of living.
3. The Bombay Plan proponents suggested a poverty line of □ 75 per capita per year, which was much more modest than that of the NPC. The Bombay Plan was a set of a proposal of a small group of influential business leaders in for the development of the post independent economy in India.

Post Independence Era

- The poverty line in India was quantified for the first time in 1962 by the appointed Working Group in terms of a minimum requirement (food and non-food) of individuals for healthy living. The Group formulated the separate poverty lines for rural and urban areas (□ 20 and □ 25 per capita per month respectively in terms of 1960-61 prices) without any regional variation.
- The origins of India's poverty line lie in the seminal work of two economists, V N Dandekar and N Rath, who first established the consumption levels required to meet a minimum calorie norm of an average calorie norm of 2,250 calories per capita per day. They found poverty lines to be Rs. 15 per capita per month for rural households and Rs. 22.5 per capita per month for urban households at 1960-61 prices.
- Task Force on "Projections of Minimum Needs and Effective Consumption Demand" headed by Dr. Y. K. Alagh in 1979. This Task Force was constituted in 1977 and it submitted its report in 1979. Based on 1973-74 prices, the Task Force set the rural and urban poverty lines at Rs. 49.09 and Rs. 56.64 per capita per month at 1973-74 prices.
- In 1989, The Planning Commission constituted the Lakdawala Expert Group to "look into the methodology for estimation of poverty and to re-define the poverty line, if necessary". The Expert Group submitted its report in 1993. It did not redefine the poverty line and retained the separate rural

and urban poverty lines recommended by the Alagh Committee at the national level based on minimum nutritional requirements.

- In 2005, another expert group chaired by SureshTendulkar was constituted to review the methodology for poverty estimation. The Expert Group submitted its report in 2009. It did not construct a poverty line and adopted the officially measured urban poverty line of 2004-05 (25.7%) based on Expert Group (Lakdawala) methodology.
- Rangarajan Committee was set up in 2012. This Committee submitted its report in June 2014. This committee raised the daily per capita expenditure to Rs 47 for urban and Rs 32 for rural at 2011-12 prices.
- The Ministry of Rural Development (MoRD) appointed an expert committee chaired by Dr. N. C. Saxena to propose a new methodology for identifying BPL households. Based on Saxena Committee's recommendations, in 2011, the MoRD launched the Socio-Economic and Caste Census (SECC) - a door-to-door enumeration across both rural and urban India collecting household-level socio-economic data.
- In 2020, Multidimensional Poverty Index developed by NITI Ayog based on the Multidimensional Poverty Index Co-ordination Committee (MPICC) recommendations. MPI parameter dashboard developed to rank states, UTs and a State Reform Action Plan (SRAP) at an advanced stage of development.

IV. About Poverty Measurement[25,26]

There are two types of measurement where one is at national level and the other at global level. Currently, India is in the process of adopting the global approach as NITI Ayog's process is in the pipeline.

V. Global Multidimensional Poverty Index (MPI)[27,41]

The Global MPI is released at the High Level Political Forum (HLPF) on Sustainable Development of the United Nations in July every year. This method goes beyond the income as the sole indicator for poverty and tracks deprivation across three dimensions and 10 indicators. These are given below in order along with the weightage for each of the indicators.

The first dimension is Education followed by Health and the final dimension is Standard of Living. Each dimension has 1/3rd weightage.

Education- 'Years of Schooling' and 'Child Enrollment' are the two indicators where each indicator has 1/6 weightage thus totalling to 2/6 or 1/3.

Health- 'Child Mortality' and 'Nutrition' are the two indicators where each indicator has 1/6 weightage thus totalling 2/6 or 1/3.

Standard of Living- 'Electricity', 'Flooring', 'Drinking Water', 'Sanitation', 'Cooking Fuel' and 'Assets'. Each indicator has 1/18 weightage thus totalling 2/6 or 1/3.

A person is multi-dimensionally poor if he/she is deprived in 1/3rd or more (means 33% or more) of the weighted ten indicators. Those who are deprived in ½ or more of the weighted indicators are considered living in extreme multidimensional poverty.

The MPI ranges from 0 to 1 where higher values imply higher poverty. It is the product of the incidence of poverty (proportion of poor people) and the intensity of poverty (average deprivation score of people). Currently, it is the most comprehensive measure of multidimensional poverty compared to the conventional methodology that measures poverty only in income or monetary terms.

VI. National Level Efforts[24,25,26]

At the national level, it is prudent to write about the measurement of poverty through the eyes of the former Governor of Reserve Bank of India, C. Rangarajan.

'The planning commission appointed an expert group under the chairmanship of C. Rangarajan in June 2012 to go into the methodology for the measurement of poverty and drawing up an appropriate poverty line. The planning commission had constituted expert groups on poverty measurement usually after a gap of about 12 to 15 years. However, this new group was appointed within less than 3 years after the submission of the recommendations of the Tendulkar expert group. The apparent urgency with which the new group was appointed reflected perhaps the changed aspirations regarding minimally acceptable standards of living in the country.

The group continued with the practice of defining poverty in terms of income or in the absence of such data, in terms of expenditure. Multidimensional indicators for defining poverty face several problems, which are indicated in the report. In defining the new consumption basket separating the poor from the rest, the group was of the view that it should contain a food component that addresses the capability to be adequately nourished as well as some normative level of consumption expenditure for essential non-food item groups such as education, clothing, conveyance and house rent besides a residual set of behaviourally determined no-food expenditure.

The introduction of essential non-food consumption expenditure in the basket was an innovation. The group also went in favour of separate consumption baskets for the rural and urban areas. As a result of these changes introduced by the new group, the new poverty line was 19 percent and 41% higher in the rural and urban areas than Tendulkar group estimates. The Rangarajan group translated the poverty line into monthly per household expenditure of 4880 in rural India and of 7035 for urban India assuming a family of five members in each case in 2011-2012. In 2011-2012, the Tendulkar group methodology gave a poverty ratio of 21.9% while the Rangarajan group gave a ratio of 29.5%.

The proposed poverty line level seen in terms of Purchasing Power Parity (PPP) dollar per day gives a simplified translation of poverty line. As per the World Bank (WB) PPP value in 2014, the poverty line translates to $2.14 per capita per day for rural India and $3.10 per capita per day for urban India and $2.44 per capita per day for the country as a whole. Here, the PPP conversion value is US1$= 15.11.

On analysing the poverty ratio, we see that there was a sharp decline in the poverty ratio between 2009-10 and 2011-12 from 38.2% to 29.5% showing a drop of 8.7% points. The Tendulkar methodology also shows same pattern. This shows that during periods of high growth or high GDP, poverty ratios fall significantly. In absolute numbers, the number of people below the poverty line came down from 454.6 million in 2009-10 to 263 million in 2011-12 showing a reduction of 91.6 million.

The Oxford study that estimates poverty through a multidimensional poverty index wrote 'India has momentous progress in reducing multi dimensional poverty. The incidence of multidimensional poverty was almost halved between 2005-06 and 2015-16 climbing down to 27.5%. This shows that in a decade the number of poor people in India fell by more than 271 million.

VII. Poverty Ratio[25,26]

The major objectives of a monetary policy are to have growth and reduce the number of people living below poverty line. Problems are associated with the definition of poverty and the kind of data required to measure poverty. The procedure adopted by the erstwhile planning commission using the Tendulkar expert group methodology showed that the overall poverty ratio came down from 45.3% in 1993-94 to 37.2% in 2004-05 and it fell again to 21.9% in 2011-12.

The per year reduction in % points in poverty ratio between 1993-94 and 2004-05 was 0.7 and between 2004-05 and 2011-12 it was 2.18. The annual per capita income growth in the first period was 4.3% and in the second

period it was 6.7%. The post reform period up to 2011-12 saw a significant reduction in the poverty ratio because of faster growth supplemented by appropriate poverty reduction programmes as the Mahatma Gandhi National Rural Employment Guarantee Scheme and Extended Food Security Scheme. The decline in poverty is also corroborated by multiple indicator index computed by the Oxford study.

With the decline in growth rate since 2011-12 and with a negative growth in 2020-21, the decline in poverty reduction may have slowed down. The basic premise is that to reduce poverty, high growth is needed. The people also need safety net measures like the Ayushman Bharat. There are two tables given below. The table 1 below gives the % and number of poor estimated from expert group Tendulkar methodology. Table 2 gives the decline in poverty ratio estimated from expert group Tendulkar methodology.

Table 1- Percentage and number of poor estimated from expert group Tendulkar methodology[24]

Poverty Ratio in Percentage				Number of Poor in Millions		
Years	Rural	Urban	Total	Rural	Urban	Total
1993-94	50.1	31.8	45.3	328.6	74.5	403.7
2004-05	41.8	25.7	37.2	326.3	80.8	407.1
2009-10	33.8	20.9	29.8	278.2	76.5	354.7
2011-12	25.7	13.7	21.9	216.7	53.1	269.8

Table 2- Decline in poverty ratio estimated from expert group Tendulkar methodology[24]

	Percentage points per year		
Period	Rural	Urban	Total
1993-94 to 2004-05	0.75	0.55	0.74
2004-05 to 2011-12	2.32	1.69	2.18
1993-94 to 2011-12	1.36	1.01	1.3

About the diagnosis of Social Issues[41]

As mentioned above in the box, the Socio Economic Caste Census (SECC) was done to identify the Below Poverty Line (BPL) households in the country.

SECC 2011 captured data on socio economic status of 17.97 crore rural households which has resulted in automatic exclusion of 7.07 crore (39.36 %) of households as not poor, automatic inclusion of 0.16 crore (0.91 %) households as poorest of the poor, and grading of deprivation of 8.72 crore (48.54%) of rural households. Unlike BPL Censuses, SECC-2011 allows for the first time to track the deprivation of households and address gaps effectively with focus on multi-dimensionality of poverty. Seven criteria are used to measure deprivations. These are given below.

- Households with only one room with no solid walls and roof.
- Households with no adult male aged 15 to 59 years old.
- Households that are female headed.
- Households with differently-abled members.
- Households with no able bodied members.
- Households that are SC/ST with no literate member above the age of 25 years old.
- Households that are landless and deriving major portion of their income from manual labor.

Being outside the Census Act, it provides a rare opportunity to know the specific deprivation of each

household. The Sumit Bose Committee (2017) recommended using SECC 2011 data to identify beneficiaries for all centrally sponsored, central and state government schemes as far as possible.

VIII. Way Forward[4,42,43,44]

A World Bank (WB) policy research working paper in 2022 states that poverty declined from 22.5% (270 million people) in 2011 to 10.2% (140 million people) in 2019. This is a substantial reduction. Further, the website of WB informs that using an updated poverty line of $2.15 at 2017 prices showed that the poverty ratio fell from 47.6% (441 million people) in 1993 to 10% (138 million people) in 2019.

Five year surveys on consumption used to be the periodic survey to estimate poverty in India till 2011. Since the last 12 years, these surveys are not done. Hence, the WB policy research paper assumes that consumption for all classes has gone up in line with Gross Domestic Product (GDP) growth since 2011. A mixed recall period (weekly for perishables) is now India's standard methodology for poverty related surveys. The method of 'recall' of consumption of all items over a uniform period of 30 days is applied in surveys. So, perishable items are recalled only for four times in that uniform period of 30 days.

The WB policy research paper used the mixed recall and estimated that the poverty ratio in India fell from 32.7% in 2004 to 7.4% in 2014. It fell to 2.5% from 2014 to 2020. When researchers adjusted for highly subsidized food, the poverty ratio fell from 31.9% in 2004 to 5.1% in 2014. It fell to 0.86% in 2020. Analysis of the subsidized food adjustments shows that after 2013, the poverty ratio was 2.5% without adjustments and 0.86% with adjustments. So, the poverty ratio fall attributed to subsidized food is just 1.64%. Therefore, it is clearly inferred that high GDP growth leads to plummeting of poverty. The food subsidy was only 1% of GDP in 2022. In the post COVID era, this will fall to 0.63% of GDP. These subsidies or welfare benefits were fiscally affordable because of the high GDP.

Another author opines that among the consumption baskets of items asked during poverty surveys, there should be a distinction between the items we earn and items we get as a dole. The first if rising indicates poverty removal but if the latter goes up, it signifies poverty relief. The poverty relief is different from poverty removal as relief is short term approach and removal is long term approach. Hence, the food subsidy has provided poverty relief only.

IX. Burden of Poverty[8,20,45]

The current article has chosen two indicators related to poverty in National Health Family Survey 5, 2019-2021 and the current status of these two indicators are given in the table given below. These are the Out Of Pocket Expenditures (OOPE) and health insurance as a measure of financial inclusion of households.

Table 3- Average OOPE and financial inclusion among households India (Source- NFHS 5, 2019-21)

Indicator	NFHS 4	Urban (NFHS 5)	Rural (NFHS5)	Total (NFHS5)
Percentage of households with any usual member covered under a health insurance/financing scheme	28.7 (Total)	38.1	42.4	41.0
Average Out of Pocket Expenditure (OOPE) per delivery	□ 3197 (Total)	□ 3385	□ 2770	□ 2916

in a public health facility				

The above table shows that there is improvement of 22.3% in India in both the rural and urban areas from 2015-16 to 2019-21 regarding financial inclusion indicating that at least one member of the household has a health insurance or financing scheme. NFHS 5 shows that the gain is more in rural India in comparison to urban India. This will reduce catastrophic poverty which any household goes through when the cost of medical expenses goes up arbitrarily. The financial inclusion approach reduces the risk.

Similarly, the average OOPE per delivery in a public health facility has reduced by 281 from 2015-16 to 2019-21. This is because of the Janani Surakshya Yojana (Maternal Protection Scheme) and the Pradhan Mantri Jan Arogya Yojana (PMJAY) or popularly called Ayushman Bharat (AB) Scheme. Further, the Pradhan Mantri Bharatiya Jan Ausadhi Pariyojana(PMBJP) has helped reduced the cost of medicines. This will encourage people to reduce their hospitalization expenses during delivery and Out Patient Door (OPD) expenses for multiple types of treatment.

X. Homoeopathic Integration[6,10-23,46,47]

As discussed above, poverty is multi dimensional and among that under 'health' 'child mortality' and 'nutrition' contributes to 1/3rd of the entire burden of poverty. Along with other multiple inputs, the low cost & clinically effective system of homoeopathic medicine is integrated actively for the selected BPL households; achieving the 1/3rd weightage will gain more teeth. Besides, it will also reduce catastrophic poverty. Through the network of the public health system of homoeopathy if all these families are integrated into the system, it can cover those areas which the modern system cannot cover.

Sometimes, not only the child but also adults cannot utilize the food or nutrients in-spite of having no infections or infestations. The metabolic assimilation and metabolic breakdown capacity of the body fails to optimize these supplements or foods. It is here that the constitutional and potentized medicines can help as they have action on each tissue and organ of the body at a deeper level. Hence, it can help complete the cycle of food security as the integration will help in fulfilling the 'Utilization' component besides the 'Availability' and 'Accessibility' components that are being addressed by the public system.

In India, Homoeopathy is the third preferred system of treatment after Allopathy and Ayurveda. About 10% of the population depend on Homoeopathy for their health issues. Homoeopathy is used by 10% of the population in India. So, out of the 1300 million populations, 130 million use Homoeopathy or 130 million use Homoeopathy for their health issues. These 130 million consist of all age groups i.e. infant to old age. Among all these groups, as mentioned above, 140 million people are poor in India. Hypothetically, out of these 140 million, 14 million are using homoeopathy currently. If the rest 126 million are roped in through the public health system to use homoeopathy, the above mentioned schemes such as PMBJP and PMJAY will have a complementary system. These complementarities approach will complete the cycle of food security while strengthening the 'health' related indicators of 'child mortality' and 'nutrition'.

Effective roll out of New Born Care both at home and facility will reduce chances of mortality among newborns while addressing the nutrition related indicators like Early Initiation of Breast Feeding and Exclusive Breast Feeding that are practiced at this stage. Following that the concept of EBF and Infant & Young Child Feeding till one year of age will strengthen the nutrition related indicators. After that, the concept of Complementary Feeding along with Breast Feeding under the IYCF approach will help us to optimize the nutritional benefits to the 0-2 year child. As already established, reduction in neonatal mortality will eventually reduce Under 5 Mortality Rate (U5MR). Currently across the globe, the rate of reduction of U5 Mortality Rate (U5MR) is slow

because the rate of reduction of Neonatal Mortality Rate (NMR) is slow. Homoeopathic system can play a preventive and curative role along the entire path of 0-5 years while being effective cost wise and therapeutic/clinical wise. The protective part lies with the indicators like EIBF, EBF and IYCF as mentioned above. The homoeopathic system can take care of both physical and mental health especially through the range of Dilutions, Biochemics, Bowel Nosodes and Bach Flower remedies (used for mental health).

XI. Conclusion[5,6,10,23,46]

In fact, the detailed case taking of a case & empathetic hearing are the elements of supportive therapy as cases from BPL households will be acute and chronic as well. The Homoeopathic approach of case-taking/anamnesis exactly fits into the criteria of supportive therapy. Hence, as a part of support to the BPL population, the supportive therapy is inherent in Homoeopathic treatment. In fact, the coarse grain that the system gives to the BPL households are nutrition dense and homoeopathy will act as a catalyst to help the body use the benefits from these grains. In fact, these foods are 'Sattvic' in nature as per Ayurveda and keep the body free from inertia.

The Homoeopathic fraternity should be ready to cover the masses as there is no other therapeutic system that can cover the masses effectively while being economical, cost effective and no side effects. Simultaneously, it has a wide range of medicines that are broad spectrum and are available at a low cost that no other therapeutic system can offer. The entire approach can be seen through the mirror of NLEM as described above.

Declaration of the lead author

Prof. Shankar Das was the Ph.D. guide of the lead author at Tata Institute of Social Sciences, Mumbai. The lead author also certifies that he has expressed his personal opinion based upon his public health and clinical experiences. The integration approach or the processes described are only suggestive in nature.

Acknowledgement

The lead author thanks Dr. Umakant, Dr. Pramod and Dr. Madan and Mr. Sovesh for their inputs in the Homoeopathic section and all the other co-authors for their inputs in the Non-Homoeopathic section.

Financial support and sponsorship

Nil

Conflict of interest

Nil

References

[1.] Bhalla S, Bhasin K, Virmani A, Pandemic, Poverty & Inequality; Evidence from India, IMF Working Paper Number 2022/069, ISBN/ISSN:9798400205170/1018-5941.
[2.] Garibi Hatao slogan, 5th Five Year Plan, GOI, Indira Gandhi's 1971 Election Campaign.
[3.] Pattnaik Biju, Quotes- 'Poor has no caste', Odisha Legislative Assembly Archives. 1990s.
[4.] Aiyar SSA, Why Researchers Differ on India's Poverty Rate, TOI, All That Matters, Page Number 17, Lucknow Edition, April 16, 2023.
[5.] NLEM, GOI, PIB, 13th September 2022, https://pib.gov.in
[6.] Davidson, Principles & Practice of Medicine, ELBS 16th Edition, Longman Group (FE) Limited, ISBN-0-443-04482-1.
[7.] GOI, AYUSH Update, 2019. 2020, 2021, 2022. https://www.ccrh.india.nic.in
[8.] GoI, MOHFW, NRHM document, April 2005, www.nrhm.com.
[9.] Coalition of NGOs report on Food Consumption in rural India during pandemic, 2020.

[10.] Murphy R, Homoeopathic Materia Medica, 3rd edition, B. Jain publishers (P) Ltd, 2017, ISBN-978-81-319-0859-4.
[11.] Murphy R, Homoeopathic Medical Repertory, 3rd edition, B. Jain publishers (p) Ltd, 2017, ISBN-978-81-319-0858-7.
[12.] Phatak SR, A Concise Repertory of Homoeopathic Medicines, B. Jain publishers (P) Ltd, 2002, Reprint edition, ISBN-81-7021-757-1.
[13.] Allen, H C, Key notes and characteristics with comparisons of some of the leading remedies of the Homoeopathic Materia Medica with Bowel Nosodes, Reprint edition, B. Jain publishers Pvt. Ltd, 1993, ISBN-81-7021-187-5, book code, B-2001.
[14.] Boericke William, New Manual of Homoeopathic Materia Medica with Repertory, reprint edition, 2008, B. Jain publishers private limited, New Delhi, pages- 362-366, ISBN- 978-81-319-0184-7.
[15.] Hobhouse Rosa Waugh, Life of Christian Samuel Hahnemann, B. Jain Publishers Private Ltd, Delhi, Reprint Edition 2001, ISBN- 81-7021-685-0.
[16.] Paterson J, Introduction to bowel Nosodes, Paper presented at International Homoeopathic League council, Lyons, France,1949: as an addendum in H.C. Allen Key Notes, Reprint Edition, 1993.
[17.] Sarkar B K, Organon of Medicine by Hahnemann, M. Bhattacharya & Co. 1st edition 1955, 8th edition, 1984.
[18.] Phatak D S&Phatak S R, Repertory of the Bio-chemic medicines, B. Jain Publishers (p) Ltd, 2006 edition, 1st edition 1986. ISBN- 81-7021-723-7.
[19.] Boedler CR, applying Bach flower therapy to the healing profession of Homoeopathy, B. Jain publishers(p) Ltd, reprint edition 1998, 1st edition 1996. ISBN-81-7021-786-5.
[20.] IIPS and ICF.2021. NFHS 5, 2019-2021:India:volume 1, Mumbai:IIPS.
[21.] Chaturvedi S et.al, India & its pluralistic health system- a new philosophy for universal health coverage, The Lancet Regional Health, South East Asia 2023:10:100136, December 2022.
[22.] Popularity of Homoeopathy in India, bjainpharma.com/blog/popularity-of-homoeopathy-in-india, 2023.
[23.] Three types of food, healthline, www.healthline.com
[24.] Ranagrajan C et.al, Counting the poor in India: Where Do We Stand, 2017, Academic Foundation.
[25.] Rangarajan C, Forks In The Road, My days at RBI and beyond, Business, An imprint of Penguin Random House, 2022, ISBN- 9780670096992.
[26.] Planning Commission, Expert Group on Measurement of Poverty, Members- S. Mahindra Dev: K.Sundaram; Mahesh Vyas: K L Datta as Convener & C. Rangarajan as Chairman, June 2012.
[27.] Alkire Sabina and Maria Emma Santos (2010). Multidimensional poverty index, Oxford Poverty and Human Development Initiative, July.
[28.] Dandekar V.M. and N. Rath (1971), 'Poverty in India', Economic and Political Weekly, Vol. 6,Nos. 1 & 2, January 9.
[29.] Datta, K. (2010). Index of Poverty and Deprivation in Context of Inclusive Growth. Indian Journal of Human Development, 4 (1), 45-73.
[30.] Dev Mahendra S (2005). "Calorie Norms and Poverty", Economic & Political Weekly, 40(8):789-92.
[31.] Government of India (2016a). 'Report of the Expert Group on Socio-Economic Caste Survey", Ministry of Rural Development, New Delhi.
[32.] Government of India (2016b). Eliminating Poverty: Creating Jobs and Strengthening Social Programs, Occasional Paper No. 2, 21. March, NITI Aayog, New Delhi.
[33.] Government of India (2014). Report of the Expert Group to Review The Methodology ForMeasurement Of Poverty, Planning Commission, New Delhi.
[34.] Government of India (2009a). 'Report of the Expert Group to Review the Methodology for Estimation of Poverty', Chaired by S.D. Tendulkar, Planning Commission, New Delhi.
[35.] Government of India (2009b). 'Report of the Expert Group to Advise the Ministry of Rural Development on the Methodology for Conducting the Below Poverty Line (BPL) Census for11th

Five Year Plan', Ministry of Rural Development, New Delhi.
[36.] Government of India (1993). Report of the Expert Group on Estimation of Proportion and Number of Poor, Planning Commission.
[37.] Government of India (1979). Report of the Task Force on Projection of Minimum Needs and Effective Consumption Demands, Planning Commission, New Delhi.
[38.] NITI Aayog (2020a). Press Note on Global Multidimensional Poverty Index and India, 7 SEP. Report of the Expert Group on SECC
[39.] Niti Ayog and United Nations (2020b). SDG India Index and Dashboard 2019-20. New Delhi.
[40.] Sharma Savita (2004). "Poverty Estimates in India: Some Key Issues", ERD Working Paper No51, Asian Development Bank, Manila.
[41.] Gaur S et.al, Poverty Measurement in India: A status update, Working Paper Number 1/2020, September 2020, GOI, MORD.
[42.] Roy S et.al, poverty in India has declined over the last decade but not as much as previously thought. Policy research working paper, 9994, 2022, World Bank, Washington DC.
[43.] India's profile on poverty, website of WB, 2022.
[44.] Gupta D, Wrong Number: Life isn't Math, Page 12, TOI, Lucknow edition, 29th April, 2023.
[45.] GOI, PMJAY document & PMBJP document, 2014.
[46.] GOI, Food Security document, National Food Security Act, 2013.
[47.] GOI, MOHFW, India Newborn Action Plan, 2014.