

HEALTH AND URBAN POVERTY LINKAGES

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ABSTRACT :

This study was conducted in Kabwe town of Central Province in Zambia. The study used multi-stage random sampling technique. In the first stage Kabwe town, in the second stage Makululu slum area and in third stage 160 households were selected. A questionnaire was used to collect required information. This study aimed to know the socio-economic conditions, determinants of health, availability and utilization of health facility by the slum dwellers. The study investigated the effects of ill-health on employment, income, assets and food security. The study also enquired the sources of credit to the slum dwellers. This study used Excel and SPSS to analyze the data. Regression Model was used to know the impact of ill-health on employment, income, assets and food security. This study found that the socio-economic conditions and determinants of health were poor. There was negative impact of ill-health on employment, income, assets and food security. The main source of credit was relatives and friends. The study suggested to concentrate on the implementation of poverty reduction programs in the slums and to improve the determinants of health.

Key Words: Slums; Preventive health expenditure; Curative health expenditure; Effect of ill-health; Sources of credit; Food security.

INTRODUCTION:

Nearly one billion people – one third of the urban population – are living in urban slums and shanty towns (UNPF 2007). For the urban poor, the advantages of city life are lacking or non-existent. For example, availability of and access to health care does not ensure affordability and utilization of health services. Unfortunately, some city dwellers experience inequalities, various forms of exclusion and marginalization (Chan 2008). By far the greatest share of health problems in rapidly urbanizing contexts is attributable to living and working conditions. These conditions include social determinants such poor and overcrowded housing, un-healthy and un-safe working conditions, lack of access to clean water and decent sanitation and social exclusion (Klevby 2010). Slum dwellers often experience difficult social and economic conditions that manifest different forms of deprivation- material, physical, social and political (Merkel and Otai 2007). Health equity is an ethical principle and is related closely to human rights principles.

According to U.N Habitat Report (2003) the Sub- Saharan Africa hosts the highest proportion of urban population in slums (71.9%). Around 43% of urban population of all developing world combined lives in slums. South Central Asia has the slum population of 262 million , accounting for 58% of the total urban slum population of the world. This report revealed that 924 million (31.6%) of global urban population in the world lives in slums. The report has also declared that the slum dwellers are victims of crime rather than they spreading crime which is

the common myth. This report has revealed the positive side of the slums, i.e., the slum dwellers are providing very important services, without which the urban life would not be successful.

The health workers are not equally distributed between and within countries. There are more than 59 million health workers in the world. More health workers are found in rich countries, where the health needs are less severe, where as in poor countries, where the health needs are severe, there is shortage of health workers. It is estimated that there is shortage of 4.3 million health workers in poor countries. The WHO region of the America, with 10% of the global burden of disease, has 37% of the world's health workers spending more than 50% of the world's health financing, whereas the African region has 24% of the burden but only 3% of health workers commanding less than 1% of world health expenditure (World Health Report 2006).

Although on average health indicators in cities score better than in rural areas, the enormous social and economic stratification within urban areas results in significant health inequities (Hewett 2004). In the high-income area of Nairobi, the under-five mortality rate is below 15 per thousand, but in the **Emabakasi slum** of the same city the rate is 254 per thousand (APHR 2002). These and other similar examples lead to the more general observation that within developing countries, the best local governance can help produce 75 years or more of life expectancy, with poor urban governance, life expectancy can be as low as 35 years (WHO 2008). One third of the urban population today – over one billion people – lives in slums, in places that lack durable housing, sufficient living area, access to clean water, sanitation, and secure tenure (UNPF 2007). Slums are prone to fire, floods and landslides, their inhabitants are disproportionately exposed to pollution, accidents, work-place hazards and urban violence. Loss of social cohesion and globalization of unhealthy lifestyles contribute to an environment that is decidedly unfavorable for health. There are 200 million international migrants in the cities of the world where the health conditions are not favorable. They constitute at least 20% of the population in 41 countries, 31% of which have less than a million inhabitants (UN 2006).

According to the World Health Report (2008) the global health economy is growing faster than gross domestic product (GDP), having increased its share from 8 percent to 8.6 percent of the world's GDP between 2000 and 2005. In absolute terms, adjusted for inflation, this represents a 35 percent growth in the world's expenditure on health over a five year period. Knowledge and understanding of health are growing rapidly. The accelerated technological revolution is multiplying the potential for improving health and transforming health literacy in a better-educated and modernizing global society. A global stewardship is emerging from intensified exchanges between countries, often in recognition of shared threats, challenges or opportunities, from growing solidarity and from the global commitment to eliminate poverty exemplified in the Millennium Development Goals (MDGs).

Access to information about health hazards in our globalizing world is increasing. Knowledge is spreading beyond the community of health professionals and scientific experts. Concerns about health hazards are no longer limited to the traditional public health agenda of improving the quality of drinking water and sanitation to prevent and control infectious diseases. In the wake of the 1986 Ottawa Charter for Health –Promotion (WHO 1986), a much wider array of issues constitute the health promotion agenda, including food safety and environmental hazards as well as collective lifestyles, and the social environment that affects health and quality of life (Kickbusch 2003).

The public spending on health services most often benefits the rich more than the poor (WDR 2004).

Health has a key role in determining the livelihoods and development of communities. Despite acknowledgment in the United Nations Millennium poll that health is the most important thing that people value in life, it remains a topic largely shunned by political leaders. The condition of

healthcare and the health of citizens is an issue which must not be ignored: as both a cause and consequence of poverty, an unhealthy community leads to an unhealthy nation. The prominence of AIDS, HIV and the deaths of children are big reasons why we need to make a big difference (Global Poverty Project)..

Generally, it is believed that the city dwellers on average enjoy better health than the rural people. But the present study reveals health differences that exist within city. While Kabwe Town of Central Province in Zambia offers many opportunities for residents to benefit from education, health and social services and to optimize their health and quality of life, at the same time health hazards such as poor housing conditions and lack of access to safe water and sanitation etc. are causing health problems. The health in-equalities are socially produced, which are the result of the circumstances in which people live and health systems they can access. The present study aimed to know the health inequity in the urban city of Kabwe in Central Province of Zambia. The study also aims to find out the determinants of health and the impact of ill-health on employment, income and poverty.

OBJECTIVES:

The specific objectives of this study were to:

1. Know the socio-economic conditions of slum dwellers.
2. Find out the determinants of their health, i.e., housing conditions, access to clean water, toilet, drainage and kitchen facilities etc.
3. Ascertain access to health facilities and health expenditure.
4. Investigate the impact of ill-health on employment, income, assets and food security
5. Research the credit facilities available to slum dwellers

REVIEW OF LITERATURE:

Jabeen (2013) studied the impact of illness of slum dwellers of Hyderabad in India and revealed that 22.25 working days per household per year were reduced due to illness. The income reduced was Rs. 3168 per household. The below poverty line households were increased by 3 per cent due to illness of the slum dwellers.

Purnendu Jha (1992) revealed that many of the slum dwellers cannot afford missing work and going to a hospital when they are sick and this makes slums the places of serious health hazards. He suggested that health care has to be taken to the door steps of slum dwellers and simultaneously mal-nutrition has to be tackled. The maladies of slum life stems from poverty and to relieve them from this, skill development and provision of gainful employment are needed.

According to **Corbett (1989)** sickness impoverishes already poor households which are plunged into a progressive spiral of declining health and economic status.

Asfaw (2003) revealed that the mean duration of illness for the poorest quartile of a sample population in Ethiopia was 1.6 times longer than that of the richest quartile.

Pryer et.al,(2003) revealed that the urban poor in Dhaka paying for treatment was the most important reason for their indebtedness.

Kyegombe (2003) reported that wages may be lost if ill-health reduces capacity to work productively or if ill-health requires another household member to reduce income earning in order

to provide care. In Bangladesh illness or incapacitation of an income earner is the most commonly reported reason for deterioration in the financial situation of a household.

According to **Goudge and Govender (2000)** as the main asset of most poor people is their body, they are much more dependent on their physical ability as a source of income.

The Study by **Ruthven and Kumar (2003)** revealed that prolonged illness rapidly uncovered household or individual vulnerabilities and their edge over poverty was eroded. Physical assets provided a buffer during good times but they were sold off or mortgaged. Due to prolonged illness their ability to remain buoyant was weakened. He suggested that movement out of poverty must be supported long enough to become established or it remains very fragile.

Kabir (1998) revealed that children were required to enter the workforce to help meet household consumption needs and treatment costs. Being removed from school following contributes to poverty being transmitted across generations, affecting the long-term productivity and earning potential of the children.

Grant (2005) suggested that inadequate public provision is not only the realm of the health sector. Related developmental sectors, such as education, social security and the productive sectors, are often not adequate to support households during severe health shocks. Ill-health is evidently more than its medical components alone and so successful policies and interventions will reflect the living and working conditions of the poor. Interventions are required to reduce the barriers to adequate food and asset building, alongside quality and timely health care. The poorest people experience extreme difficulties in accessing appropriate care, with devastating impacts on individuals, households and whole communities. Prioritising health of poor and poorest in society is justifiable economically as well as ethically – a healthy population is more productive and stable.

Adam and Jane (1995) in Pakistan and **Campa and Webb (1999)** in Peru found that increased levels of education reduced the probability of chronic poverty.

Studies by **Mc Culloch and Baulch (2000)** and **Jalan and Ravallion (1998)** revealed that education of the household head reduces transient poverty. Jalan and Ravallion (1998) found that in rural China the health of household members was the important determinant for chronic poverty. **Sen (2003)** found that in Bangladesh sickness was the important factor for transient (movements into) poverty. **Dercon (2003)** found in Ethiopia that the poor suffered disproportionately from health shocks.

Deininger (2001) revealed that the households affected by health problems experienced lower income growth than those free of health problems.

The Study by **David Lawson (2004)** found that ill health was associated with households moving into poverty. Asset decreases for all households headed by the sick were distinctly larger than the decreases for the non-sick households.

Adam Wagstaff (2002) suggested that the policies aimed at combating health sector inequalities should aim to reduce both inequalities in, for example, the quality and availability of health services (i.e. the supply side), and inequalities in income, knowledge, especially health-specific knowledge, accessibility of health services, the availability of safe drinking-water, and sanitation and so on (i.e. the demand side).

METHODOLOGY:

Kabwe is the second largest city in Zambia. It is located about 150 kilometers north of Zambia's capital city of Lusaka. Kabwe Municipal Council has a total of Twenty One (21) un-planned Settlements. Of which, only 10 were earmarked for upgrading. Makululu (Slum) area was one of them. Makululu is the second largest informal settlement in Africa, the first being "Soweto" in South Africa.

This Study was based on multi-stage random sampling technique. In the first stage Kabwe town, in the second stage Makululu slum area was selected because it was the largest un-planned settlement in Kabwe town and in the third stage 160 households were selected randomly. A

questionnaire was used to collect the primary data on demographic and housing characteristics, sources of drinking water, electricity, toilet and drainage facility, income health expenditure - preventive and curative- utilization of health facilities, effects of ill-health on employment, income, assets and food security for the last 12 months prior to data collection. The preventive health expenditure includes expenditure on mosquito nets, etc., and the curative health expenditure includes fees of doctor, price of medicine, etc. The impact of ill-health on employment was measured by the number of working days reduced. The impact of ill-health on income was measured by the income reduced due to reduction in working days. Food security was measured by the number of times a day the family members eat food. This study used Excel and SPSS to analyze the data. Regression model was used to know the impact of ill-health on employment, income, assets and food security.

DATA ANALYSIS AND DISCUSSION:

1. DETERMINANTS OF ILL-HEALTH:

The following regression results showed that ill-health was depended on a variety of factors like availability of house, toilet, sources of cooking, electricity, drinking water kitchen and drainage facilities.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
	.194 ^a	.037	-.007	1.000

a. Predictors: (Constant) availability of house, toilet, source of cooking, electricity, drinking water, kitchen and drainage facilities.

b. Dependent Variable: Illness

Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	1.13	2.76	1.51	.193	160
Residual	1.659	2.504	.000	.978	160
Std. Predicted Value	1.951	6.472	.000	1.000	160
Std. Residual	1.659	2.503	.000	.978	160

a. Dependent Variable: Illness

Majority of the slum dwellers were residing in kacha houses (41.87%), 40.63 percent in pacca houses and 17.50 percent in huts. Almost half of the sample slum dwellers (45.63%) were residing in rented houses, 34 percent were having two or less than two rooms. More than half (56.25%) were not having separate kitchen and the main source of cooking was wood (51.25%) and coal (26.25%). The households using gas and kerosene were negligible.

The source of drinking water to 97.5 percent households was public bore-well/tap and only 2.5 percent households were having their own. 75 percent households did not have electricity

facility and the source of toilet for 93 percent was pit latrine. 43.75 percent did not have drainage facility and 38.75 percent had open drainage system, which caused for malaria due to mosquitoes.

2. ACCESS TO HEALTH FACILITIES AND HEALTH EXPENDITURE:

5 percent of the sample households did not have hospital/clinic or pharmacy facility and 90 percent were visiting government hospitals/clinics for their treatment.

The average health expenditure per household during the last 12 months was K 112.23, out of which, preventive and curative expenditure was 30.38 percent and 69.62 percent respectively.

During the last 12 months 62.50 percent sample households were suffering from malaria, 3.12 percent from T.B and 25 percent from other types of illness. The households which did not suffer from any illness were only 9.38 percent.

3. IMPACT OF ILL-HEALTH ON EMPLOYMENT, INCOME AND ASSETS:

a) Impact of Illness on Employment (Working days):

The following regression results show that illness had negative impact on employment (working days) because the adjusted R square value was less than the regression R square value. The computed F value is 1.947. At 99 per cent confidence level the critical value is 0.165.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
	.110 ^a	.012	.006	42.191

a. Predictors: (Constant), Illness

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	16.996	6.057		2.806	.006
Illness	4.683	3.357	.110	1.395	.165

a. Dependent Variable: working days

Model Summary and Parameter Estimates

Dependent Variable :working days

Equation	Model Summary					Parameter Estimates	
	R Square	F	df1	df2	Sig.	Constant	b1
Linear	.012	1.947	1	158	.165	16.996	4.683

The independent variable is Illness.

b) Impact of illness on Income:

The following regression results showed that as one stayed away from work due to ill-health, the income reduced. It was predicted that income reduced by 2.502 per cent due to illness.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
	.086 ^a	.007	.001	976.765

a. Predictors: (Constant), Illness

b. Dependent Variable: Income

Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	504.34	840.57	713.96	83.790	160
Residual	-790.567	4443.490	.000	973.689	160
Std. Predicted Value	2.502	1.511	.000	1.000	160
Std. Residual	.809	4.549	.000	.997	160

a. Dependent Variable: Income

(c) Impact of Illness on Assets:

The following regression results showed that the impact of illness on assets was negative. As one fell ill the possibility of selling assets is more likely. The model predicted that the assets were reduced by -1.511 per cent due to illness.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
	.060 ^a	.004	-.003	134.152

a. Predictors: (Constant), Illness

b. Dependent Variable: assets

Residuals Statistics

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	46.39	78.71	58.56	8.053	160
Residual	-70.631	945.528	.000	133.730	160
Std. Predicted Value	-1.511	2.502	.000	1.000	160
Std. Residual	-.526	7.048	.000	.997	160

a Dependent Variable: Value of assets sold

24 working days (employment) and K 147.53 income per year were reduced due to illness. They had to sell their assets worth of K 58.56, for treatment of illness.

78 percent revealed that their income and consumption were reduced due to illness. 73.75 percent said that their employment position would not improve and 65.63 percent revealed that their income would not increase and they would have to sell their assets in the next 12 months.

4. IMPACT OF ILL-HEALTH ON FOOD SECURITY:

The following regression results show that there was negative impact of ill-health on food security of slum dwellers. As one became ill, food security was reduced by 1.511 per cent.

Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
	.093 ^a	.009	.002	63.264

a. Predictors: (Constant), Illness

b. Dependent Variable: Food shortage

Residuals Statistics^a

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	58.57	82.31	67.51	5.915	160
Residual	-76.376	300.491	.000	63.065	160
Std. Predicted Value	1.511	2.502	.000	1.000	160
Std. Residual	1.207	4.750	.000	.997	160

a. Dependent Variable: Food Shortage

72.5 per cent slum dwellers could not eat three times a day during the last 12 months. The quality of food was not good. The slum households were having shortage of food for 64 days during the last 12 months. During food shortage period more than half of the households eaten only one time a day. Their quality of food during food shortage period was decreased. In the next 12 months 71.25 per cent slum households would have food shortage.

5. SOURCES OF CREDIT :

83.12 per cent of slum dwellers were in need of credit during last 12 months. The highest need of credit was to meet their basic needs. The main source of credit was relatives and friends (50%). The source of credit from banks and co-operative credit societies was negligible. Nearly half of the sample slum dwellers did not have any source of credit. The average amount borrowed was K 1050.45 only. In the next 12 months also the sample slum dwellers need credit.

CONCLUSION AND SUGGESTION:

1. The determinants of health of slum dwellers were poor. More than half of the sample slum dwellers were living in huts and kacha houses and nearly half of them were living in rented houses. More than half, i.e., 56.25 per cent households were not having separate kitchen and their main source of cooking was wood and coal. Due to smoke they were suffering with respiratory problems. 75 per cent households did not have electricity facility and 93.12 per cent households were using pit latrines. More than 75 per cent households did not have drainage facility. Due to this reason mosquitoes were growing and the slum dwellers were facing problem of malaria.

The main source of treatment was government hospitals and the average health expenditure was K. 112.23 only. 62.5 per cent slum dwellers were suffering from malaria

It is suggested that the determinants of health of slum dwellers should be improved. The slum dwellers should be educated regarding the importance of having separate kitchen and covered underground drainage system. The Department of Health should not only provide mosquito nets to newly born babies and their mothers but also to every member of the family.

2. There were negative effects of ill-health on employment, income and assets. Due to ill-health 24 working days during the last 12 months and K 147.53 income per month per sample slum dweller were reduced. The value of assets sold for treatment was K. 58.56 per household. Moreover, in the next 12 months their employment, income position would not increase.

Hence, it was suggested that every effort should be made to improve the health conditions of slum dwellers.

3. There was food insecurity for slum dwellers. 72.5 per cent slum households could not eat for 3 times a day during the last 12 months and the quality of food was low. The average number of days of food shortage was 64.28 during the last 12 months and the problem of food scarcity would continue in next 12 months also.

It is suggested that slum dwellers should be provided employable training and skills so that their income could be increased and their food needs could be fulfilled. The slum households involved in agriculture should shift from traditional agriculture to Conservation Agriculture method which would give higher production and income.

4. The slum dwellers were having credit needs for various purposes. But for 45 per cent sample slum dwellers there was no any source of credit. The main source of credit was their relatives and friends. The credit source from banks and co-operative credit societies was negligible. The average credit received was only K.1050. In the next 12 months also they need credit.

Hence, it is suggested that the slum dwellers should be encouraged to form co-operative credit societies. The bank branches should be established in slums and credit should be provided at lower rate of interest.

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